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Attitude toward care of the dying and practice of peaceful end-of-life care in community hospitals in China

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Abstract

Aim: To evaluate nurses' attitude toward caring for dying patients, their practice of peaceful end-of-life care in community hospitals, and the association between these two variables.

Background: Community hospitals play an important role in the peaceful end-of-life care. For nurses, one of the key points of offering high-level care is to improve attitude. However, there are very few studies exploring how the attitude of nurses toward caring for dying patients relates to the practice of peaceful end-of-life care in community hospitals across China.

Methods: A total of 363 questionnaires were included in this study. Simple random sampling was used to recruit participants from six community hospitals in China. A new instrument, Nurses' Practice of Peaceful End-of-Life Care Instrument (NP-PECI), was developed according to the Theory of Peaceful End of Life to assess the practice of nurses. Besides, Frommelt Attitudes toward Care of the Dying (FATCOD) was adopted to assess nurses for their attitude toward caring for dying patients.

Results: The nurses' attitude toward caring for dying patients showed a significant positive correlation with their practice of peaceful end-of-life care statistically ($r = 0.175$, $p < 0.01$).

Conclusion: For community nurses, it is necessary to improve the attitude of nurses toward the practice of caring for dying patients, thus enhancing the outcome of peaceful end-of-life care.

Implications for nursing practice: The Theory of Peaceful End of Life provides a theoretical framework and guideline on the practice of clinical nursing for quality control of peaceful end-of-life care, which is significant for improving the palliative care system. In the future, it is worth developing programs based on the Theory of Peaceful End of Life.

Implications for nursing policy: For healthcare policy makers, this study can be helpful to refine the existing palliative care support policies and strategies targeted at community hospitals and their nurses.

KEYWORDS
Attitude toward caring for dying, community hospital, nurses, peaceful end-of-life care

INTRODUCTION

With the aging of the global population and increase in various intractable diseases such as malignant tumors, palliative care has played an indispensable part in the practice of nursing care (Nwosu et al., 2022). According to the World Health Organization (WHO), palliative care is purposed to prevent and alleviate sufferings through early identification and thorough assessment, thus improving the life quality for patients with life-threatening illnesses and their family members, and managing various physical, psychological, and spiritual problems (WHO, 2022). In respect of palliative care, it is worth noting that what concerns most dying people is not death itself, but the process of dying and its impact on those left behind. Therefore, they share the wish to end life peacefully (Fleming et al., 2016).

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In view of this, peaceful end-of-life care based on the Theory of Peaceful End of Life as proposed by Ruland and Moore (1998) serves as a significant reference because of similar concepts and scope to palliative care (Zaccara et al., 2020). Besides, it is widely assumed that people have the wish to die peacefully.

BACKGROUND

Available evidence suggests that 40 million people need palliative care each year, and 78% of these belong to developing countries (WHO, 2022). China is also encountering the same problem as other countries. Cardiovascular disease (CVD), cancer and respiratory diseases are now known as the top three causes of death (80%) among the rural and urban population in China (China Health Committee, 2020). There are 6 million people in need of palliative care in China (Xie et al., 2020).

In fact, as many as millions of vulnerable people in many countries around the world are deprived of the highest standard of palliative care available to them (WHO, 2022). On the contrary, community hospitals are optimizing the utilization of various medical resources for people suffering from chronic disease, severe symptom burden, and poor functionality (Tang, 2021). According to a policy enforced in China to promote hospice care in community settings (Lu et al., 2018), some community hospitals have trialed the construction of hospice care units in mainland China (Zheng et al., 2021).

Nurses play a vitaly role in palliative care provision, and one of the key points to offer high level of palliative care is to improve their attitude (Chen et al., 2022; Hao et al., 2021). As revealed by a survey conducted among 553 nurses in Malaysia, one of the significant influencing factors in the level of palliative care was their attitude toward caring for dying persons, and more excellent practice was provided by those nurses with higher-level attitude toward caring for the dying (Hussin et al., 2018). Another study from Taiwan revealed that good attitude was closely correlated with competence ($r = 0.48$, $p < 0.001$) (Lin et al., 2021). Therefore, it is considered worthwhile to study attitude toward care for dying and its relationship to peaceful end-of-life care among nurses.

The Theory of Peaceful End of Life is considered a theoretical framework for nurses during the process of caring patients near the end of life (Ruland & Moore, 1998). However, no study is conducted using this theory to explore the practice of peaceful end-of-life care provided by nurses, as well as the relationship between nurses' attitude toward caring for dying patients and their practice of peaceful end-of-life care in community hospitals.

METHODS

Study design

This is a cross-sectional online survey study.

Setting

The study involved six community hospitals in Southwest China.

Sample size

Participants were recruited using the following inclusion criteria: (1) nurses who are registered; (2) having work experience of more than 1 year; and (3) nurses who have cared for at least one patient near the end of life. Simple random sampling was used in this study.

The sample size of the study was estimated according to $\alpha = 0.05$, power $= 0.8$, and effect size $r = 0.15$. The required total sample size (G power) was calculated to be 273. Given the 35% response rate of the online survey (Cook et al., 2016), this study had a sample size of 376 participants. The details are presented in Appendix Table A1 in the Supporting Information.

Instruments

There were three sections in the questionnaire and these included: Demographic Data Questionnaire (DDQ), Nurses' Practice of Peaceful End-of-Life Care Instrument (NP-PECI), and Chinese version of Frommelt Attitude Toward Care of Dying Scale (FATCOD-B). The content validity of the NP-PECI was tested by three nursing experts, with the item-level content validity index reaching 0.94. The reliability of two instruments was evaluated by conducting a pilot study of 60 community nurses, with the NP-PECI and FATCOD-B showing 0.973 and 0.837, respectively.

Developed by the researchers, the DDQ covers age, gender, religion, marital status, educational level, work experience, experience in caring for dying patients, the death experience of family members/friends, and training about palliative care.

The NP-PECI was developed by the researchers in line with the Theory of Peaceful End of Life to assess nurses' peaceful end-of-life care (Li et al., 2021). There are 30 items categorized into five domains of the Theory of Peaceful End-of-Life. The mean score range of each item is from 0–4 (0 = never practice, 1 = rarely practice, 2 = occasionally practice, 3 = usually practice, and 4 = always practice). A higher mean score of each item represents a higher-level practice. The level of each item is interpreted as follows: low (0.00–1.33), moderate (1.34–2.67), and high (2.68–4.00). Cronbach's alpha reliability coefficient of 363 participants is 0.987.

The Chinese version scale of FATCOD-B (29 items) (Wang et al., 2016a, 2018b) was adopted to measure the attitude of nurses toward caring for the dying person. In order to meet the requirements of the current research, the researchers obtained permission from the author Dr. Prof. Liping Wang, to revise this tool by using the six domains. Ultimately, it is presented as a 5-point Likert scale (ranging from 1 = strongly disagree to 5 = strongly agree). For those negative items, the scoring was reversed. That is, the higher mean score for each item,

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the higher the attitude level. The level of each item is interpreted as follows: high (3.67–5.00), moderate (2.34–3.66), low (1.00–2.33). Cronbach's alpha reliability coefficient of 363 participants is 0.837.

Data collection

This study was conducted from 1st March to 1st April 2021. The Questionnaire QR Code of Wen Juan Xing was distributed by the researcher through email to the participants from each community hospital. Wen Juan Xing Questionnaire Star is recognized as a professional online questionnaire survey. The director of the whole nursing department was not allowed to interfere while the participants filled in the questionnaire.

The total number of items is 59, and the response rate is 100%. The researchers checked all questionnaires after data collection, with all data inputted into a data file using the double-entry data method. Among them, all questions of 13 questionnaires were marked as "0" or "5," which is considered invalid due to an obvious logical contradiction (participant codes 32, 52, 78, 93, 104, 115, 162, 186, 201, 215, 298, 318, and 375). Finally, a total of 363 questionnaires were included in this study.

Ethical considerations

This study was approved by the Institutional Review Board (IRB), Faculty of Nursing, Prince of Songkla University (No. 2021-St-Nur-001), with permission granted from the research settings of Guizhou Province in China. The participants in this study were able to reject or withdraw from the study at any time. The researchers kept the information about all participants confidential by using an access code. All data will be deleted five years after the completion of the study.

Data analysis

The demographic characteristics of nurses were described by using frequency and percentage, age, and work experience in the form of mean (M), standard deviation (SD), maximum, and minimum. The scores of attitudes and practice in each domain and their total score were indicated by using the ($M \pm SD$). Pearson's correlation was used to detect the correlation between nurses' attitude toward caring for dying persons and the practice of peaceful end-of-life care. In addition, it was also applied to establish the relationship between the nurses' practice of peaceful end-of-life care and the subscales of attitude toward care of dying. The statistical test was one-tail, and it was treated as statistically significant if $p < 0.05$.

The normality of data distribution was examined through the Shapiro–Wilk test ($p < 0.05$), except that His-gram, linearity, QQ plot, and skewness/kurtosis also indicated that the hypothesis test was met. For statistical data processing, statistical software (SPSS Statistics, version 23.0; SPSS, Inc., Chicago, IL, USA) was applied.

RESULTS

The participants' characteristics are shown in Appendix Table A2 in the Supporting Information. The participants ranged in age from 20 to 58 years, with a mean age of 30.89 ± 6.53 years. A vast majority of participants were female (n = 322, 88.7%), and the proportion of male participants was 11.3% (n = 41). More than 65.6% (n = 238) were married. As for educational level, about 98.9% (n = 359) of the nurses held a bachelor's degree. Among all the participants, most nurses admitted to having no religious beliefs, with those believing in Buddhism accounting for merely 2.2% (n = 8). Their length of work experience as a registered nurse ranged significantly from 2 to 38 years, the mean is 8.37 ± 6.89 years. However, the number of dying people who were cared for by each nurse varied every month, with 1–2 people/month, 3–4 people/month and >4 people/month being 71.3% (n = 259), 5.8% (n = 21), and 22.9% (n = 83), respectively. By comparison, 85.1% (n = 309) had experienced the death of relatives or close friends. Regarding palliative care training, only 31.7% (n = 115) of them revealed that they had attended the relevant courses for palliative care.

Level of nurses' attitude toward caring for dying persons

The attitude of nurses toward caring for the dying person in the investigated community hospitals was reportedly at a moderate level (3.42 ± 0.39). The subscale with the highest mean score was "attitude toward the necessity of family support" (3.61 ± 0.48), and that with the second highest mean score was "attitude toward communication with the dying person" (3.54 ± 0.61). The subscale with the lowest mean score was "attitude toward fear of caring for the dying person" (2.84 ± 0.80), and that with the second lowest score was "willingness toward caring for the dying person" (3.17 ± 0.53). Table 1 lists the mean score of nurses' attitudes toward caring for the dying and its subscales.

Level of nurses' practice of peaceful end-of-life care

It was discovered that the practice of nurses to provide peaceful end-of-life care was at a high level (2.74 ± 0.82) in the community hospitals under investigation. Among the subscales, only "not being in pain" was at a moderate level, having the lowest mean score (2.66 ± 0.89). Subscale with the highest mean score was "experience of comfort" (2.81 ± 0.87), and that with the second highest mean score was "being at peace" (2.76 ± 0.90). Table 2 lists the mean

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TABLE 1 Level of mean, SD of nurses' attitude toward caring for the dying person ($N = 363$)

Variables	Score *M*	*SD*	*Level*
I. Attitude toward the interests of the dying person	**3.459**	**0.562**	**Moderate**
1. The dying person should not be allowed to make decisions about his/her physical care	2.427	1.152	
2. It is beneficial for the dying person to verbalize his/her feelings	4.027	0.943	
3. Nurses should permit dying persons to have flexible visiting schedules	3.978	0.957	
4. The dying person and his/her family should be the in-charge decision-makers	3.791	0.946	
5. Addiction to pain-relieving medication should not be a concern when dealing with a dying person	3.331	1.217	
6. Nurses should give honest answers about their condition to dying persons	3.201	0.964	
II. Willingness toward caring for the dying person	**3.175**	**0.526**	**Moderate**
7. Giving nursing care to the dying person is a worthwhile learning experience	4.212	0.861	
8. Death is not the worst thing that can happen to a person	3.325	1.122	
9. I would not want to be assigned to care for a dying person	2.355	1.021	
10. The nurse should not be the one to talk about death with the dying person	3.306	1.050	
11. The length of time required to give nursing care to a dying person would frustrate me	2.900	1.025	
12. I hope the person I take care of will die when I am away	2.950	1.071	
III. Attitude toward the necessity of family support	**3.612**	**0.482**	**Moderate**
13. The family should be involved in the physical care of the dying person	4.102	0.782	
14. As a patient nears death, the nurse should withdraw from his/her involvement with the patient	2.466	1.028	
15. Families should be concerned about helping their dying member make the best of his/her remaining life	4.218	0.860	
16. Families should maintain an environment that is as normal as possible for their dying member	4.113	0.838	
17. Family members who stay close to a dying person often interfere with the professionals' job with the patient	3.165	0.992	
IV. Attitude toward communication with the dying person	**3.543**	**0.607**	**Moderate**
18. I would be uncomfortable talking about impending death with the dying person	3.132	1.032	
19. I would be upset when the dying person I was caring for gave up hope of getting better	3.741	0.873	
20. When a patient asks "Nurse am I dying?" I think it is best to change the subject to something cheerful	3.782	0.904	
21. I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying	3.455	0.980	
22. It is possible for nurses to help patients prepare for death	3.603	0.896	
V. Attitude toward fear of caring for the dying person	**2.838**	**0.798**	**Moderate**
23. It is difficult to form a close relationship with the family of the dying person	2.984	0.960	
24. I am afraid to become friends with a dying person	2.736	1.028	
25. I would feel like running away when the person actually died	2.796	1.025	
VI. Attitude toward caring for the dying person's families	**3.429**	**0.591**	**Moderate**
26. Nursing care for the patient's family should continue throughout the period of grief and bereavement	3.587	0.983	
27. Families need emotional support to accept the behavior changes of the dying person	3.851	0.828	
28. Nursing care should extend to the family of the dying person	3.628	0.927	
29. Educating families about death and dying is not a nursing responsibility	2.653	1.041	
Mean score of each item	**3.426**	**0.395**	**Moderate**

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TABLE 2 Level of mean, SD of nurses' practice of peaceful end-of-Life care (*N* = 363)

Variables	Score		Level
	M	*SD*	
I. Not being in pain	**2.669**	**0.892**	**Moderate**
1. You use suitable tools such as numeric rating scale and faces pain scale or others to assess pain of persons in the end stage of life	2.539	1.059	
2. When persons experience pain in the end stage of life, you maintain close communication and work with doctor to develop a pain treatment plan	2.678	1.039	
3. You use pain strategies or methods to relieve pain for persons; for example, you apply nonpharmacy pain relief methods such as music, art relaxation, and touch together with pain analgesics to reduce pain for persons in the end stage of life	2.703	1.008	
4. You assess pain score of persons in the end stage of life accurately before and after pain treatment	2.650	1.033	
5. You administer pain analgesics following standard guideline and the nurse's role in reducing dying persons' pain	2.647	1.012	
6. You educate the persons in the end stage of life and their families to understand about causes of pain, pain management, and its effects	2.686	0.995	
7. You practice pain relief to persons in the end stage of life compassionately	2.785	0.977	
II. Experience of comfort	**2.807**	**0.871**	**High**
8. Although you may not be able to fully meet all of the dying persons' needs for comfort, you continue to prevent, follow up, and be proactive on the needs of persons in the end stage of life for their physical comfort	2.796	0.979	
9. You provide psychological support care for persons in the end stage of life to achieve comfortable inner heart	2.821	0.939	
10. While managing the dying persons' symptoms, you set the suitable environment to be comfortable for the persons in the end stage of life	2.782	0.971	
11. You help persons in the end stage of life to distract their uncomfortable symptoms by encouraging to do relaxation such as hug and touch	2.804	0.939	
12. You prevent complications such as pressure sores and wound infections that would occur to persons in the end stage of life	2.832	0.970	
III. Experience of dignity/respect	**2.728**	**0.846**	**High**
13. You take into account the cultural background and religious customs of persons near the end stage of life in your nursing care	2.642	0.985	
14. You care for persons in the end stage of life through your empathy and respect on patients' human dignity	2.937	0.954	
15. You involve persons in the end stage of life and their family members in decision-making process at the end of life	2.736	0.976	
16. You care fairly for all persons in the end stage of life	2.906	0.973	
17. You understand the persons' attitude toward dying and death	2.562	0.988	
18. You pay attention to dying persons' wishes such as preferable place for dying in the end stage of life	2.589	1.027	
IV. Being at peace	**2.758**	**0.901**	
19. You provide emotional support to persons in the end stage of life to make them be peaceful	2.744	0.971	
20. You provide a peaceful environment including the presence of another caring person, and contribute to the dying persons' experience of being at peace	2.752	1.005	
21. You care about the anxiety of persons in the end stage of life and provide care to reduce their anxiety as needed	2.793	0.963	
22. You assist persons in the end stage of life to deal with conscience and mental worries (such as feelings of spiritual emptiness, being abandoned by or angry at own belief) to maintain peaceful mind	2.689	0.977	
23. You build trust with persons in the end stage of life and their family members	2.807	0.978	
24. You manage symptoms well and provide practical guidance for persons in the end stage of life to achieve their greater physical peace	2.763	0.951	
V. Closeness to significant others/who care	**2.743**	**0.907**	
25. You encourage persons' family members and significant others or the loved ones to participate in your caring in the end stage of life	2.774	0.991	
26. You help the persons' family members balance their roles during the process of caring for the persons in the end stage of life	2.730	0.966	

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TABLE 2 (Continued)

Variables	Score		Level
	M	*SD*	
27. You provide clear guidance and help in care activities to persons in the end stage of life and their family members or significant persons (relatives or friends) who visit the persons in the end stage of life	2.752	0.951	
28. You show concern and provide care for dying persons' family members and relatives when they are grieving and worrying	2.744	0.950	
29. You assess the need of family members, relatives, friends to be with the persons in the end stage of life	2.708	0.988	
30. You promote a positive relationship between persons in the end stage of life and their family members or other significant persons/loved ones	2.749	0.964	
Mean score of each item	**2.736**	**0.821**	**High**

TABLE 3 Pearson's correlation coefficient between nurses' attitude toward caring for dying patients and practice of peaceful end-of-life care ($N = 363$)

Variables	1	2	3	4	5	6	7	8
1. Attitude toward the interests of the dying person	1							
2. Willingness toward caring for the dying person	0.331**	1						
3. Attitude toward the necessity of family support	0.567**	0.447**	1					
4. Attitude toward communication with the dying person	0.503**	0.276**	0.519**	1				
5. Attitude toward fear of caring for the dying person	0.379**	0.479**	0.418**	0.269**	1			
6. Attitude toward caring for the dying person's families	0.387**	0.181**	0.370**	0.295**	0.307**	1		
7. Overall attitude in caring for the dying person	0.780**	0.674**	0.791**	0.698**	0.643**	0.579**	1	
8. Practice of peaceful end-of-life care	0.247**	−.082	0.237**	0.233**	−.069	0.139**	0.175**	1

Note. $^{**}p < 0.01$.

score of total NP-PECI and mean score of each subscale of NP-PECI.

Relationship between nurses' attitude toward caring for dying persons and practice of peaceful end-of-life care

There was a significant positive correlation between the attitude of nurses toward caring for the dying and the practice of peaceful end-of-life care ($r = 0.175$, $p < 0.01$). The results demonstrated a significantly positive correlation that the practice of nurses providing peaceful end-of-life care had with their attitude toward the interests of the dying person ($r = 0.247$, $p < 0.01$), attitude toward the necessity of family support ($r = 0.237$, $p < 0.01$), attitude toward the communication with the dying ($r = 0.233$, $p < 0.01$), and attitude toward caring for the families of the dying ($r = 0.139$, $p < 0.01$). However, the items "attitude toward fear of caring for the dying" and "nurses' willingness toward caring for the dying" did not show a statistically significant relationship with the nurses' practice of peaceful end-of-life care. Table 3 lists the results of Pearson's correlation analyses.

Other findings

The support most needed by community nurses was also investigated in this study. According to the results, the top four forms of support were social support (70.8%), parents (65.1%), salary (64.6%), and policy (62.2%) (Appendix Table A3 in the Supporting Information).

DISCUSSION

This is the first study conducted to assess nurses for their practice of peaceful end-of-life care, as well as the relationship between their attitude toward caring for the dying and the practice of peaceful end-of-life care in community hospitals.

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Level of nurses' attitude of caring for dying persons

The attitude of community nurses toward caring for the dying was reportedly at a moderate level when the FATCOD-B yielding 29 items was used in this study. Compared with the findings about the attitude of nurses in other studies conducted by using the FATCOD-B scale, this finding was similar to that of a study of 770 clinical nurses in 15 large public hospitals in China ($M = 3.41$) (Wang et al., 2018b). However, the findings of this study indicated lower scores than a survey study of 395 multinational nurses who came from 19 countries and worked in the nursing homes in Saudi Arabia ($M = 3.90$) (Abudari et al., 2014).

It is suspected that the moderate level of attitude is contributed to by two factors in this study. One of the factors is age. In this study, most nurses were young, with the lowest score item being "I would not want to be assigned to care for a dying person" ($M = 2.36$). Some previous nursing studies have reported that younger nurses are likely to have more fears or psychological burdens about death or the end-of-life process, thus showing lower level of attitude toward end-of-life care (Chang et al., 2020; Okamura et al., 2018).

The other factor is relevant training. Due to the lack of educational resources and professional training in China, most nurses are incompetent to care for terminally ill patients in an appropriate way (Chen et al., 2022). Recently, the delivery of relevant training is determined mainly on a range of continued education programs including seminars, conferences, or workshops in China (Zheng et al., 2021). In this study, 31.7% of the participants received training in nursing-related knowledge, which is lower than the study conducted in Spain (58.1%) (Martínez-Sabater et al., 2021) but higher than the study conducted in Nepal, where only 29.5% of nurses have palliative care training and education (Nepal et al., 2021).

There are some studies suggesting that the training received by nurses on palliative care could exert influence on their nursing attitudes (Abate et al., 2019; Etafa et al., 2020; Kim et al., 2020). Therefore, future policies should be focused on strengthening death education and the training provided to young nurses in community hospitals. Besides, an intervention program should be initiated to mobilize the enthusiasm of young nurses to accumulate nursing experience.

Level of nurses' practice of peaceful end-of-life care

This study was the first one to monitor the practice of community hospital nurses to provide peaceful end-of-life care by using a new tool developed in line with the Theory of Peaceful End of Life (Ruland & Moore, 1998). According to the research results, the practice of nurses providing peaceful end-of-life care was at a high level.

The reason of the high-level practice may be because of the death experience of family members or friends. A significant percentage (85.1%) of the participants in this study revealed their experiences as to the death of family members or friends. In two previous studies, it was indicated that experiencing the death of relatives and friends had a statistically significant relationship with the practice of nurses to provide palliative care (Farmani et al., 2018; Kim et al., 2020).

However, it is worth noting that the subscale "not being in pain" was at a moderate level. Meanwhile, the lowest score was the item "you use suitable tools such as numeric rating scale and faces pain scale or others to assess pain of persons in the end stage of life" ($M = 2.53$). A community hospice study conducted in China on 132 community healthcare providers also revealed the inadequate ability of pain management in palliative care (Shi et al., 2019). This is probably attributed to the work experience of nurses. As indicated by a survey carried out by Samarkandi (2018), nurses with a longer work experience have a better understanding of pain. In this study, 73.3% ($n = 266$) of nurses had less than 10 years of work experience. As reported in another study, nurses with more than 10 years of work experience have better skills in pain assessment management than nurses with less than 10 years of experience (Farmani et al., 2018).

According to The American Society for Pain Management Nursing (ASPMN) and the Hospice and Palliative Care Nurses Association (HPNA), nurses and other health care providers must advocate for the effective, efficient, and safe management of pain and symptoms, so as to alleviate the pain suffered by every patient receiving palliative care (Coyne et al., 2018, p. 3). Knowledge and relevant training are the potential facilitators (Turrillas et al., 2019). Therefore, young nurses need to quickly accumulate more experience through on-site scenario simulation. For this reason, the government should introduce corresponding support policies such as providing funds to improve the training environment and equipment for nurses in community hospitals.

The relationship between nurses' attitude toward caring for dying persons and practice of peaceful end-of-life care

The results of this study suggested a positive relationship between the attitude of nurses toward caring for dying patients and nurses' practice of peaceful end-of-life care. Despite no previous research being conducted on the basis of the Theory of Peaceful End-of-Life to explore the relationship between these two variables, many studies have proposed a significant correlation between nurses' attitude toward caring for the dying and their palliative care (Hao et al., 2021; Huang et al., 2019; Hussin et al., 2018; Park et al., 2020).

Regarding the relationship between the subscales of nurses' attitude toward caring for the dying and the practice of peaceful end-of-life care, these four subscales showed a significantly positive correlation with the practice of nurses providing peaceful end-of-life care. These items were (1) "attitude toward the interests of the dying person," (2) "attitude toward the communication with the dying person," (3) "attitude toward the necessity of family support," and

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(4) "attitude toward caring for the families of the dying person."

The dying is keen to have a peaceful end of life. Being at peace is defined as a "feeling of calmness, harmony, and contentment, free of anxiety, restlessness, worries, and fear" (Ruland & Moore, 1998, p. 172). In essence, it is a peaceful state involving physical, psychological, and spiritual dimensions (Ruland & Moore, 1998). In a study, peace is also described as having an association with a positive end-of-life experience including the freedom to die peacefully in a setting of their own choice (Austin et al., 2016). Therefore, it is necessary to provide the dying with the appropriate care at the right time, and to guide people on how to confront death properly. In this way, they can make well-informed decisions about the care to be provided. In addition, it is necessary to address the challenge of respecting and integrating cultural beliefs when high-quality care is provided. Hence, nurses are required to enhance their communication skills and the use of technology to provide compassionate and effective care, as their contributions in collaborative teams will be essential in the future.

Meanwhile, the support and caring of nurses are also needed by family members of the dying. In addition to imposing physical burdens on family caregivers, long-term care also causes psychological anxiety, which is another increasing burden (Moss et al., 2019). Many family members were pushed to the brink of collapse and felt helpless. At this time, the intervention of nurses is needed to fill the family with a sense of relief and security (Becqué et al., 2021). A reasonable guidance should be provided by nurses for family members, which is essential for boosting the confidence of family members and improving their care skills (Choi & Seo, 2019). Such a mutual understanding in a supportive environment is beneficial to involve nursing practice more actively in the care of dying people, and the family members would also be fully cooperative for a win-win result.

In contrast, no statistically significant relationship was shown by the two subclasses, (1) "attitude toward fear of caring for the dying person" and (2) "nurses' willingness toward caring for the dying person," with the practice of nurses providing peaceful end-of-life care. This result contradicts the results of another hospice study where it was demonstrated that the attitude and willingness to practice played a significant role in improving care, although limited data available on the willingness of clinical nurses to practice (Chen et al., 2022). This may be attributable to the fact that nurses are reluctant to reveal their wishes intuitively under certain policies. The International Council of Nurses (ICN, 2022) describes that nurses should be given an opportunity to voice during the process of developing and implementing health policies, which are critical to confirm that these policies are useful and match the real needs of patients, families, and communities. Therefore, future research can be conducted by incorporating the policies of encouragement and aesthetic expression, so as to explore and stimulate the inner thoughts of nurses for support and targeted training.

Meanwhile, the other findings of this study demonstrated that the top four forms of support that nurses most needed during the process of palliative care were social support (70.8%), parents (65.1%), salary (64.6%), and policy (62.2%). However, all of these four aspects may be neglected. Therefore, what should be a concern for the government is to formulate the policies intended to improve nurses' social support, salary, and family support. In many cases, the patients and their families receive considerable support, but the needs of nurses are often overlooked, which can lead to an increase in stress, anxiety, and workload of the nursing staff. Future policies should be made to provide support when nurses are too busy at work to have time allowed to manage their own family. If not distracted by their familial duties during the working hours, nurses will fully devote themselves to work.

Limitation

This was a cross-sectional descriptive study conducted by using a large sample in community hospitals located in Western China. Due to the disparities in the level of economic, cultural, and medical development in North and South China, it is crucial to consider the generalizability of these findings when they are applied to other contexts.

CONCLUSION

According to the results of this study, the nurses working in community hospitals had not only a moderate level of attitude toward caring for the dying but also a high level of practice of peaceful end-of-life care. Furthermore, a positive relationship between them was revealed. These findings provide the basic and replaceable data required for the development of peaceful end-of-life care in community hospitals.

IMPLICATIONS FOR NURSING PRACTICE AND HEALTH POLICY

Based on the aforementioned findings and discussion, the Theory of Peaceful End of Life provided a theoretical framework and clinical nursing practice guidelines for the control on quality of peaceful end-of-life care, thus improving the whole palliative care system. It is essential to strengthen the relevant training received by young nurses. The findings are applicable to recommend healthcare policy makers to develop relevant support policies with strategies that prioritize the roles of nurses in community hospitals. In the future, studies will be required to determine what kind of intervention programs or educational programs can better elevate the level of nurses' attitudes toward caring for the dying and practice of pain management in peaceful end-of-life care. Moreover, this study provides a new reliable tool based on the Theory of Peaceful End of Life to assess nurses for their level of practice of peaceful end-of-life care. This tool is applicable for future

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studies to be conducted in other regions of China and other countries.

AUTHOR CONTRIBUTIONS

Study conception and design: XL, WK; data collection: XL; data analysis and interpretation: XL, WK, KY; drafting: XL, WK, KY; critical revision: XL, WK, KY.

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CONFLICT OF INTEREST

The authors have no conflict of interest to report.

ETHICAL CONDUCT OF RESEARCH

The authors received approval for human research from the IRB (No. 2021- St- Nur- 001), Faculty of Nursing, Prince of Songkla University and permission for data collection from research settings in Guiyang city of Guizhou Province in China.

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