

Nursing activities for health promotion in palliative home care: an integrative review

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Abstract: Palliative care in community contexts is undergoing significant change as a result of public policy and new models of care, which link health promotion principles with palliative care practices. These models support the creation of partnerships between formal care structures and the communities in which care is provided. Given the central role of nurses in the institutional delivery of palliative care, particularly in the home, it is important to provide a systematic description of the activities of nurses that fall within the principles of health promotion. The objective was to describe the diverse range of nursing activities for health promotion that are provided in the palliative home care setting. This is an integrative review. Fifty-five studies listed in the MEDLINE, CINAHL and EMBASE databases, and published between 1999 and December 2022, were identified. Data analysis and presentation of the results were guided by Kellehear's Health-Promoting Palliative Care (HPPC) model. Six themes were identified to describe nursing activities for health promotion in the context of palliative home care: creating a meaningful relationship, supplying medical information, promoting self-care throughout the trajectory, providing emotional support, involving professional or community services and supporting change. The findings point to nurses focusing more on the individual context and on direct care. The relationship with communities in which they work remains unidirectional. However, some HPPC principles are relevant to nursing activities through the contextualization of nurses' actions and their moral responsibility to work towards the respect of patient's values. Being poorly described, how nurses can truly engage their practice towards health-promoting principles, such as the enhancement of support and control over their lives for people living with serious illness, still requires further empirical research.

Keywords: community nursing, health promotion, home-based care, nurses, palliative care

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Introduction

The health promotion principles outlined by the Ottawa Charter were adopted globally in the mid-1990s as a new public health ideology, separate from individual or behavioural perspectives on health.^{1–3} Within this movement, health is considered as a resource for daily life⁴ that influences all areas of an individual's life. The movement stresses the need for structural actions on public policies, as well as the need for the participation of individuals, groups and communities for their own health.^{5,6}

A concept of health, incorporating social and environmental determinants, has been proposed. Health promotion thus becomes an action area in which the aim is to understand and act, in concert with individuals, groups and communities, on all the social and environmental conditions that influence their health.^{1,2,5,7} These determinants include education, employment and working conditions, gender expression, housing, health services and social inclusion.⁸ Because of its social nature and the values it implies, health promotion, as an action area, evokes certain socio-political principles such

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as empowerment, equity and the creation of partnerships with local and community resources.^{6,9}

To support the idea of health as a collective responsibility and a part of everyone's life, health promotion has been deployed in several fields of practice and care,⁴ including palliative care. Until the 2000s, there was an apparent disconnection between the principles of health promotion and those of palliative care: health promotion supported community policies for maintaining good health, while palliative care intervened when these policies failed.¹⁰⁻¹² In 1999, Kellehear proposed the Health-Promoting Palliative Care (HPPC) as a new model for palliative care.^{10,11} By recognizing death as a social fact shared by everyone at some point in their life, HPPC aims to foster a sense of control over the final stages of life and to increase community support for people living with a life-threatening illness.^{10,11} HPPC principles 'underline the deeper view that health care should be participatory, not something we *do to others* but a style of health care that we *do with others*' (p. 25).¹³ It recognizes the social character of health and illness.^{11,13} This approach recognizes that the patient and their formal and informal networks are part of a system of complex social and environmental relationships that include policies, norms, knowledges and experiences related to death.¹⁴⁻¹⁶ Within the HPPC model, individuals, groups and communities participate at a local level to make palliative care a part of everyday life.¹⁴⁻¹⁶ To integrate HPPC into various community and social settings, Kellehear suggests five strategies, inspired by the Ottawa Charter for Health Promotion³: (1) the provision of education and information for health, dying and death; (2) the provision of social supports, both personal and community, which includes support groups or the coordination of support services; (3) the encouragement of interpersonal reorientation which includes problem-solving abilities to be prepared for personal changes that arise with a terminal or life-limiting condition; (4) the reorientation of palliative care services towards an health-promoting perspective; and (5) the combating of death-denying health policies and attitudes.¹¹ The HPPC model puts forward a social concept of palliative and end-of-life care that situates the care of professionals – including nurses – in support of individuals, groups and communities.^{10,17,18} It is illustrated through initiatives such as compassionate communities, which aim at strengthening and building partnerships and community support for issues regarding death, dying and bereavement.¹⁹

Given the central place of nurses in the delivery and coordination of palliative care,²⁰ some authors question the integration of HPPC principles into their practice.²¹⁻²⁵ With regard to the social nature of HPPC, these authors suggest that nurses instead work primarily within biomedical and individual parameters,^{24,25} such as managing physical illness or medication, relieving symptoms or providing information about care. Without denying the potential contribution of these activities to health promotion, it would seem that in this context, their purpose is linked more to a biomedical concept of care than to a desire for participation in, or recognition of, the social and community space of care.

Although health promotion principles (such as social participation or empowerment) are frequently cited as areas of activity and intervention within the nursing practice,²⁶⁻³⁰ when it comes to palliative care, the literature specifically addressing nursing activities related to HPPC principles (such as creating supportive environments, social participation or building partnerships with local and community resources) is restricted to position papers or anecdotal evidence.^{25,31}

At this stage in the development of knowledge regarding nursing practices for health promotion in palliative care, it is worth questioning how HPPC principles can be used to explore nursing practices, as they are described empirically. We contend that there is a need to clarify, *via* the theoretical referent of the HPPC, the nature of nursing activities currently deployed in care settings where nursing is embedded in communities – that is, in home care. We hypothesize that health-promoting nursing activities exist within palliative home care, but are not described or named as such. To this end, we have conducted an integrative review of the literature, which provides a comprehensive understanding of the diverse range of nursing activities for health promotion that are performed in palliative home care.

Objective

This integrative review aims to describe the diverse range of health-promoting nursing activities performed in the palliative home care setting.

Methods

An integrative review aims to provide a comprehensive understanding of a topic, through the

synthesis of all relevant forms of knowledge, including experimental and non-experimental research.^{32,33}

Problem identification

The study population was nurses working in palliative home care. The main concept, that of activities for health promotion, is described according to the five strategies proposed by Kellehear,¹¹ from the perspective of nurses themselves. In addition, nursing activities are understood to be developed with individuals, groups and communities.

Literature search

The inclusion criteria were: (1) All documents reporting nursing home care activities, from the perspective of nurses themselves; (2) written in English or French; (3) published between 1999 and August 2020. The year 1999 was chosen because this was when the first papers on HPPC were published. An update of the search strategy was conducted in the three databases in January 2023 to target the period between August 2020 and December 2022; and (4) published in a peer-reviewed journal. The following exclusion criteria were used: (1) palliative care among people living with cognitive impairment, as the nursing practice in this context may take different forms; (2) articles describing the perspective of the patient, their caregivers or other caregivers on the role of nurses; (3) paediatric palliative care, which, in the home care setting, may be very different from adult care³⁴; (4) context that was not limited to home care; and (5) articles describing nursing home care activities during the COVID-19 pandemic.

The search strategy was built for three databases. The research was conducted in CINAHL, MEDLINE and EMBASE. The complete search strategy is available in Supplemental Table 1. In addition, the references from all included articles were also examined for relevant documents. Moreover, all archives from five journals on palliative care nursing or home care were consulted for additional documents.

In terms of the selection of studies, Figure 1 shows the flow chart, along with the number of items included at each step and the reasons for exclusion, if any.³⁵ First, all the titles and abstracts of the 9554 articles identified were read, retaining those that

met the inclusion criteria as well as those whose status was uncertain. In total, 132 articles were retained, of which full texts were available. Second, after reading the articles in their entirety to establish their eligibility, 77 were rejected. The reasons for exclusion are described in Figure 1. These two steps were performed by JLL. The bibliographic reference management software DistillerSR© was used for article selection and extraction.

Data evaluation

The quality of studies included in this review was evaluated using the Mixed Methods Appraisal Tool (MMAT), version 2018.³⁶ Since all the included studies were published in peer-reviewed journals, no study was excluded based on MMAT score. The assessments were performed by JLL. The studies were rated as high, moderate or low in quality.

Data analysis

Data extraction was also performed by JLL. The following were extracted: authors, title, year of publication, country, purpose, population and sample, theoretical background, design and methods, and main results (the description of nursing activities for health promotion). The extracted data were presented in a summary table and by a thematic classification according to the five strategies proposed in Kellehear's¹¹ HPPC model.

A thematic analysis was then conducted,³⁷ oriented by the scope and specific actions of each strategy. For each, a list of nursing activities was compiled. Using an inductive approach,³⁷ similarities and particularities were sought, and classified into sub-themes. Sub-themes were then synthesized, and themes were proposed to encompass for the diverse range of health-promoting nursing activities performed by nurses. The QDA Miner© software (Provalis research) was used to support the thematic analysis. The results were validated by going back and forth between the literature identified and Kellehear's¹¹ description of strategies. Moreover, discussions with the second and third authors were held to support coherence between themes and to avoid redundancies. Further, the principle of activity recurrence, that is, the presence of the same theme in several articles, was used both to present these activities and to highlight how these activities are expressed.

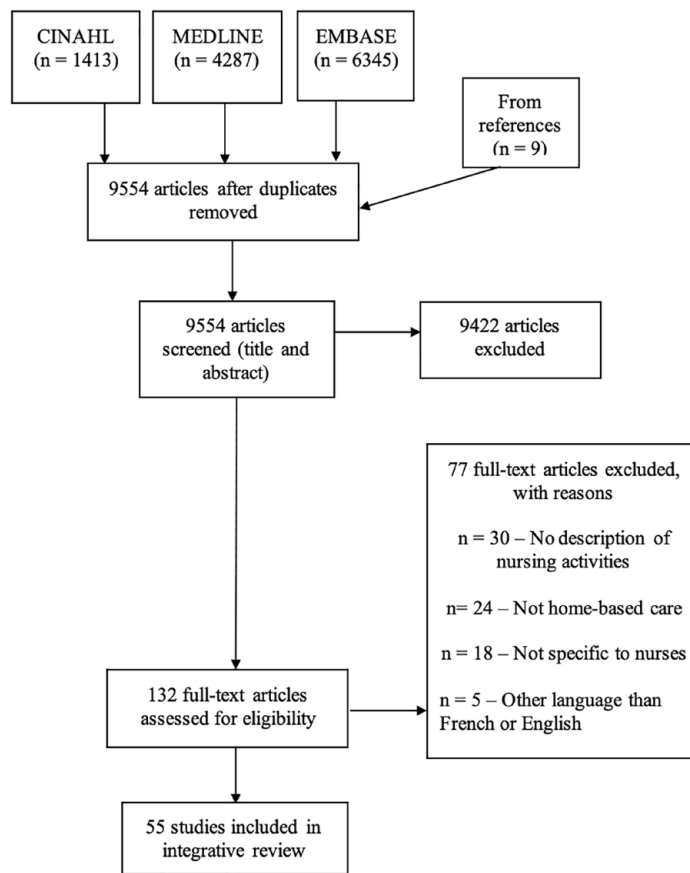


Figure 1. Flow chart of included studies.

Results

Characteristics of the studies

Table 1 provides an overview of the included studies and their main characteristics. A more comprehensive description of the included studies is available in Supplemental Table 2. Of the 55 studies included, 47 address nursing activities within palliative home care using qualitative methods. These included 23 descriptive or explorative studies, 11 phenomenological studies, 5 studies using a case study approach, 3 using a grounded theory approach, 3 studies using an ethnographic approach, 1 secondary analyses of qualitative data and 1 narrative research. Five studies used quantitative methods, including three surveys using polls and two observational studies using observation grids. Finally, three studies used mixed methods combining a survey and a qualitative descriptive approach. The theoretical foundations underpinning the studies were poorly articulated, with only six studies making explicit mention of them. Three studies were situated in Gadamer's Hermeneutics,

two used Ricœur's concepts and one used those of Bourdieu. For all these studies, the theoretical foundations were used for data analysis and data interpretation. The studies were conducted in the United Kingdom (14), Sweden (9), Canada (8), the United States (6), Australia (5), Finland (3), Japan (2) and the Netherlands (2). One study was conducted in each of the following countries: South Africa, Germany, Indonesia, Singapore, Taiwan and Switzerland. Results of the quality assessment are shown in Table 1. Six studies were rated low quality, 18 moderate quality and 31 high quality.

Themes identified

Six themes are consistent with the proposed strategies. It should be noted that the first theme, *creating a meaningful relationship*, is not a strategy explicitly proposed by Kellehear. However, the creation of a meaningful relationship between the nurse, the patient and their caregivers is a prerequisite for the realization of nursing activities. Table 2 illustrates the relation between Kellehear's strategies and the six themes identified.

Table 1. Characteristics of included studies.

No.	References	Aim	Design	Participants	MMAT
1	Alvariza and Mjörnberg ³⁸ Sweden	Explore palliative care nurses' work experiences caring for patients at the end of life in private homes.	Qualitative interpretative descriptive inquiry: Photo-elicitation	Ten palliative care nurses working in private homes	High
2	Aoun <i>et al.</i> ³⁹ Australia	Explore the perspectives of health service providers regarding challenges and service provision needs of palliative care clients living alone.	Qualitative descriptive inquiry: In-depth semi-structured interviews	Nine health service providers (all nurses)	High
3	Arnaert and Wainwright ⁴⁰ Canada	Explore the experiences, perspectives and reflections of nurse specialists in palliative home care, whose dual role includes caring for patients in their daily practice as well as sharing their knowledge, skills, expertise and experiences with other home care nurses in the community.	Qualitative descriptive inquiry: Semi-structured interviews	Five nurse specialists	Moderate
4	Arnaert <i>et al.</i> ⁴¹ Canada	Explore homecare nurses' attitudes to palliative care in a rural community.	Qualitative descriptive inquiry: Semi-structured interviews	Five nurse specialists	Moderate
5	Becqué <i>et al.</i> ⁴² The Netherlands	Explore: (1) how nurses currently approach and support family caregivers in end-of-life home care; and (2) which factors influence their support of family caregivers.	Qualitative descriptive inquiry: Semi-structured interviews	14 nurses from 9 home care organizations	High
6	Bergdahl <i>et al.</i> ⁴³ Sweden	Explore how nurses, patients and relatives act in planned palliative home care nursing encounters.	Multiple case study: Observations	Five nurses during planned home care nursing encounters in the patients' homes	High
7	Bergdahl <i>et al.</i> ⁴⁴ Sweden	Test the theoretical conceptualization of the co-creative process in home care nursing encounters over time.	Multiple case study: Interviews and observation	Three nurses in advanced palliative home care	High
8	Bliss and White ⁴⁵ United Kingdom	Explore the different ways that district nurses and social workers work in delivering palliative and continuing care.	Multiple case study: Semi-structured interviews	Eight cases: The package of care provisioned from a district nurse and a social worker	Low
9	Brännström <i>et al.</i> ⁴⁶ Sweden	Illuminate the meaning of being a palliative nurse for persons with chronic health-failure in advanced homecare as disclosed through nurses' narratives.	Hermeneutic phenomenology, inspired by Ricœur: Interviews	11 advanced homecare nurses	High
10	Brant <i>et al.</i> ⁴⁷ United States	Examine home health care nurses' duties, [. . .] related to (1) palliative care development and capacity according to criteria identified [. . .].	Quantitative: Needs assessment survey	532 home health care nurses in 29 countries	Moderate
11	Brown <i>et al.</i> ⁴⁸ United Kingdom	Suggest care actions that conserve dignity at the end-of-life based on evidence from local experience and community nursing practice.	Qualitative descriptive inquiry: Focus groups	14 clinical nurses, 3 general practitioners, 8 patients and 5 carers	Moderate

(Continued)

Table 1. (Continued)

No.	References	Aim	Design	Participants	MMAT
12	Burt and Shipman ⁴⁹ United Kingdom	Explore community nurses' perceptions of their palliative care role, and their provision of such care within the context of their wider generalist workload.	Qualitative descriptive inquiry: Focus groups	51 participants, all were members of community nurse teams	High
13	Campbell ⁵⁰ South Africa	Explore the experiences of nurses practicing HBPC in rural KwaZulu-Natal, South Africa.	Qualitative explorative research: Photo-elicitation and interviews.	Four nurses working in HBPC	Moderate
14	Chong and Poon ⁵¹ Singapore	Understand homecare nurses in the context of the work that they perform.	Hermeneutic phenomenology: Focus groups.	Ten nurses from five agencies that provide palliative homecare	Low
15	Clayton <i>et al.</i> ⁵² United States	Present an investigation of hospice nurse-caregiver communication occurring on the day of patient death.	Quantitative descriptive secondary analysis: Audiotaped home-nursing visits.	44 audiotaped home hospice nursing visits representing 42 caregiver-patient dyads	Low
16	Cumming <i>et al.</i> ⁵³ Australia	Explore the experiences of palliative home care nurses in rural and remote New South Wales who are required to provide palliative care as part of their generalist role [. . .].	Mixed-method design: Quantitative inquiry: Survey Qualitative inquiry: Face-to-face interviews.	Survey: 30 registered nurses and 4 enrolled nurses Interviews: 10 registered nurses	Moderate
17	Deitrick <i>et al.</i> ⁵⁴ United States	Explore the role of nurse practitioner providers in a specialized palliative medicine house call service.	Grounded theory: Pre-existing documents and interviews.	Three nurse practitioner and three program staff	High
18	Disler and Jones ⁵⁵ United Kingdom	Explore the role of district nurses in providing end-stage care for patients living with chronic obstructive pulmonary disease in metropolitan London.	Mixed-method design: Qualitative inquiry: Face-to-face interviews Quantitative inquiry: Mailed survey.	Interviews: 14 district nurses Survey: 29 district nurses	Moderate
19	Dunne <i>et al.</i> ⁵⁶ United Kingdom	Gain insight into the district nurse's experience of providing palliative care for patients with cancer and their families.	Husserlian phenomenology: Unstructured interviews	25 district nurses	High
20	Ellington <i>et al.</i> ⁵⁷ United States	Describe and compare the perspectives of national hospice thought leaders, hospice nurses and former family caregivers on factors that promote or threaten family caregiver perceptions of support.	Qualitative inquiry: Face-to-face interviews and focus groups.	11 hospice thought leaders, 13 hospice nurses and 14 former family caregivers.	Moderate
21	Ellington <i>et al.</i> ⁵⁸ United States	Describe communication content and processes of hospice nurse home visits at a detailed level using RIAS	Quantitative prospective observational longitudinal study: Audio-recorded home hospice visits	537 visits from 101 patient-caregiver dyads. It included 58 nurses	Moderate

(Continued)

Table 1. (Continued)

No.	References	Aim	Design	Participants	MMAT
22	Funk <i>et al.</i> ⁵⁹ Canada	Examine, through an analysis of how home care nurses talk about their practice with clients and families, the ways in which empowerment discourse operates in accounts of practice.	Secondary analysis of qualitative data. ^a	27 home care nurses	High
23	Glasdam <i>et al.</i> ⁶⁰ Sweden	Explore, from nurses' perspective, the practice of nurses in specialized palliative homecare, and how this practice is influenced by organizational and cultural structures.	Qualitative inquiry using Bourdieu's concepts of field, habitus and capital: Semi-structured interviews.	Nine nurses in specialized palliative homecare	High
24	Griffiths <i>et al.</i> ⁶¹ United Kingdom	Explore how United-Kingdom district nurses (a) describe and (b) conduct ESVs with palliative care patients at home.	Qualitative inquiry: Focus groups, interviews and observations.	58 district nurses: 47 in focus groups, 5 in observation visits and 6 in both focus groups and observation visits	High
25	Griffiths <i>et al.</i> ⁶² United Kingdom	Present district nurses' descriptions of the value and content of ESVs, researcher's observations of what actually took place and patient's and carer's perceptions of outcomes.	Qualitative inquiry: Focus groups, interviews and observations.	58 district nurses: 47 in focus groups, 5 in observation visits and 6 in both focus groups and observation visits	High
26	Griffiths <i>et al.</i> ⁶³ United Kingdom	Examine United-Kingdom district nurses' perceptions of their role in supporting palliative care cancer patients.	Qualitative descriptive inquiry: Semi-structured interviews.	34 district nurses	High
27	Hemberg and Bergdahl ⁶⁴ Finland	Explore how co-creation can be experienced as a phenomenon by nurses working in palliative home care.	Gadamer's Hermeneutical phenomenology: In-depth interviews.	12 home care nurses	High
28	Hemberg and Bergdahl ⁶⁵ Finland	Explore nurses' experiences of caring encounters and co-creation in palliative home care from an ethical perspective.	Gadamer's Hermeneutical phenomenology: In-depth interviews.	12 home care nurses	High
29	Hemberg and Bergdahl ⁶⁶ Finland	Explore nurses' experiences of dealing with ethical and existential issues through co-creation at the end-of-life in palliative home care.	Gadamer's Hermeneutical phenomenology: In-depth interviews.	12 home care nurses	High
30	Hirano <i>et al.</i> ⁶⁷ Japan	Describe the changes in the type of support offered over time, while comparing cancer and non-cancer cases.	Qualitative inquiry: Semi-structured interviews.	31 nurses from home care nursing stations	High
31	Howell <i>et al.</i> ⁶⁸ United Kingdom	Describe community palliative care clinical nurse specialist activities during interactions with patients.	Qualitative inquiry: Observations and audio-records of interactions with patients.	Four community palliative care clinical nurses specialists during 38 interactions	High

(Continued)

Table 1. (Continued)

No.	References	Aim	Design	Participants	MMAT
32	Huisman <i>et al.</i> ⁶⁹ The Netherlands	Describe the perspectives on the role of nurses in medication management at the end of life.	Multiple case study: Semi-structured interviews.	18 cases (15 nurses, 17 patients, 12 informal caregivers, 20 trainees and 12 physicians)	Moderate
33	Imhof <i>et al.</i> ⁷⁰ Switzerland	Describe the characteristics of a specialist palliative service from the perspective of the providers [. . .] in order to understand the benefits and the nursing contribution to care.	Grounded theory: Semi-structured interviews.	15 home care nurses, 5 nurse specialists of the nurse-led service and 21 other participants	High
34	Karlsson and Berggren ⁷¹ Sweden	Illuminate nurses' experiences of significant factors that contribute to a good end-of-life care in the patient's own home.	Phenomenology: Face-to-face interviews.	Ten nurses with experience in end-of-life homecare	High
35	Kennedy ⁷² United Kingdom	Examine district nurses' ongoing care for patients with cancer requiring palliative care, and to illuminate issues which impact on care planning by district nurses.	Case study: Observations and in-depth interviews.	Three district nurses through 11 participant observation and 12 in-depth interviews	Moderate
36	Lau <i>et al.</i> ⁷³ United States	Explore the key approaches that hospice providers use to facilitate medication management for caregivers.	Qualitative descriptive inquiry: Open-ended interviews.	22 providers: 14 nurses, 4 physicians and 4 social workers from 4 hospice organizations	High
37	Law ⁷⁴ United Kingdom	Develop a grounded theory to explain how district nurses meet the emotional needs of dying patients in the community.	Grounded theory: Non-participant observation (shadowing) and semi-structured interviews.	Nine district nurses, 9 patients and 4 family carers in 6 primary care trusts. A further sample of five books and three district nurses were selected.	Moderate
38	Leclerc-Loiselle and Legault ⁷⁵ Canada	Describe the perceptions of home-based health professionals concerning the introduction of a palliative care approach in the care trajectory of people living with advanced multiple sclerosis.	Qualitative descriptive inquiry: Focus groups and face-to-face interviews.	Six nurses, five occupational therapists and two social workers working in two general home care programs	Moderate
39	Luker <i>et al.</i> ⁷⁶ United Kingdom	Report the way community nurses, working within the district nursing service, perceive their work with terminally ill patients and their families.	Qualitative descriptive inquiry: Interviews.	62 nurses (grade B-H) in one Community Health Trust	High
40	Marchessault <i>et al.</i> ⁷⁷ Canada	Understand the experiences of homecare nurses providing palliative care within a generalist caseload.	Heideggerian's phenomenology: Unstructured interviews	Eight nurses working in the general homecare programme	Moderate
41	Midlöv and Lindberg ⁷⁸ Sweden	Illuminate district nurses' experiences of providing palliative care in the home.	Qualitative descriptive inquiry: Semi-structured interviews.	12 district nurses	High

(Continued)

Table 1. (Continued)

No.	References	Aim	Design	Participants	MMAT
42	Newbury <i>et al.</i> ⁷⁹ United Kingdom	Quantify time spent in different activities of the nurse specialist role.	Quantitative descriptive inquiry: Grid with 15-min time intervals and activity codes.	15 community palliative care nurse specialists	Low
43	Pegg and Tan ²³ Australia	Draw the links between health promotion and palliative care in the meaning expressed by nurses who in their daily experiences are striving for the quality of life of people in suffering.	van Manen's phenomenology: Interviews.	12 registered nurses	Moderate
44	Reed <i>et al.</i> ⁸⁰ Australia	Develop a holistic district nursing practice model to inform person-centred end-of-life advocacy.	Narrative inquiry: Interviews.	Seven nurses from five rural regions	High
45	Reed <i>et al.</i> ⁸¹ Australia	Develop a practice model from a study exploring how district nurses advocate successfully for the end-of life goals of rural Australians and a comparison with existing theory.	Sequential mixed-method design: Qualitative inquiry: Interviews Quantitative inquiry: Surveys.	Qualitative: Seven nurses from five rural regions Quantitative: 91 nurses	Moderate
46	Sijabat <i>et al.</i> ⁸² Indonesia	Research question: 'What and how is the experience of palliative care nurses in providing HBPC to patients with advanced cancer?'	Phenomenology: Face-to-face interviews.	Eight nurses who had experience in providing HBPC	Moderate
47	Stajduhar <i>et al.</i> ⁸³ Canada	Examine how relationships between nurses and family caregivers intersected with access to palliative home care nursing services.	Ethnographic study: Narrative think aloud and interviews.	Think aloud: 25 nurses Interviews: 27 nurses	High
48	Stajduhar <i>et al.</i> ⁸⁴ Canada	Explore home care nurses' decision-making about the need for and amount of service by clients and families at the end of life, through an analysis of their accounts of these decisions.	Qualitative multi-sample inquiry: Narrative think aloud and full interviews.	Think aloud: 25 nurses Full interviews: 27 nurses	High
49	Stoltz <i>et al.</i> ⁸⁵ Sweden	Illuminate the meaning of being supportive to family caregivers of relatives at home as narrated by registered nurses working in palliative home care.	Hermeneutic phenomenology, inspired by Ricœur: Unstructured interviews.	20 registered nurses	High
50	Teruya <i>et al.</i> ⁸⁶ Japan	Examine visiting nurses' critical practices to ensure that they can advocate for patients who prefer to die at home.	Qualitative descriptive inquiry: Interviews.	16 visiting nurses working at 2 home-visit nursing agencies	Low
51	Wallerstedt <i>et al.</i> ⁸⁷ Sweden	Describe enrolled nurses' experiences of working in a sitting service for dying patients at home.	Qualitative descriptive inquiry: Focus groups.	17 nurses in a special home-sitting service organization	High
52	Walshe ⁸⁸ United Kingdom	Questions: (1) How, why and when do district nurses provide palliative care to patients? And (2) What is the nature and content of district nurse palliative care provision?	Ethnographic study: Non-participant observation.	17 district nursing/patient encounters in 12 teams of district nurses	Moderate

(Continued)

Table 1. (Continued)

No.	References	Aim	Design	Participants	MMAT
53	Ward-Griffin <i>et al.</i> ⁸⁹ Canada	Explore relationships within the socio-cultural context of HBPC.	Focused ethnographic study: In-depth interviews and participant observation.	Three palliative care nurses in four households	High
54	Weber and Grohmann ⁹⁰ Germany	Examine time expenditure in direct patient-related care provided by specialist palliative care nurses.	Quantitative: Time sheets.	Time registration sheets concerning 351 patients	Low
55	Wu <i>et al.</i> ⁹¹ Taiwan	Understand (1) how community nurses implement community-based palliative care, (2) what preparations are needed and (3) what challenges they may face.	Qualitative descriptive inquiry: Semi-structured interviews.	Eight community nurses providing home care	High

^aSee Stajduhar *et al.*⁸⁴

ESV, early support visit; MMAT, Mixed Methods Appraisal Tool; HBPC, home-based palliative care; RIAS, Roter interactional analysis system.

Table 2. Relation between Kellehear’s strategies and identified themes.

Kellehear’s strategies	Themes
The provision of education and information for health, dying and death;	Supplying medical information; Promoting self-care throughout the trajectory;
The provision of social supports, both personal and community;	Providing emotional support; Involving professional or community services;
The encouragement of interpersonal reorientation;	Creating a meaningful relationship Supporting change.
The reorientation of palliative care services towards a health-promoting perspective;	
The combating of death-denying health policies and attitudes;	

Creating a meaningful relationship. Health-promotion activities rely on the participation of others.¹³ This partnership, cooperation, co-creation, connection or collaboration aims to establish a bond of trust between the nurse, the patient and their caregivers.^{38,41–46,51,66,71–73,77,81,83,85,89,91} This relationship requires a mutual commitment.^{83,85,89} In order to develop this relationship, the nurse must take the time to get to know the patient, their caregivers, the experiences of illness and their life context.^{50,54,65,67,72,80,81,83,85,88} To build this relationship, the nurse can collect information by asking questions^{64,67,68,76,84,86} or by

observing the environment.⁶³ Attentive, respectful, curious or interested listening is also described as a posture for getting to know the patient and their caregivers.^{48,54,67,68,77,80,85,91} Moreover, the home is seen as a place that is conducive to an overall ‘holistic’ or multidimensional understanding of the patient, including the social and cultural context in which they live.^{69,80,81,84,85,89}

Initially, the nurse needs to create this relationship in order to understand the patient’s values, goals of care, vital goals, wishes, abilities, current and anticipated needs, and desires for the life

ahead.^{43,44,52,64,65,67,75,76,80,81,83,84,89} This knowledge allows the nurse to make decisions adapted or contextualized to individual realities, to offer resources that meet the needs expressed and to draw on the capacities of the patient or their caregivers.^{38,39,46,54,67,70,81,83,85} This knowledge can also help the patient and their caregivers to develop a feeling of safety, which is necessary for their engagement in care.^{46–48,64,65,70,71,78,85,86}

Once created, this relationship must be maintained, by working in line with the needs, objectives and resources of the patient and their caregivers.^{38,48,59,70,71,80} The nurses adapt or negotiate their care according to the goals defined and redefined by the patient and their caregivers.^{67,80} The nurse has a moral responsibility to respect individual values and to accept the decisions, even if they conflict with the nurse's own values, or the caregivers'.^{59,66,67,77,80,85} It was seen as a 'balancing act'.⁴⁴ Should conflicts arise with a caregiver, the nurse can even take on the role of mediator.^{46,66,67,70,87}

Once a relationship of mutual trust has been created, in which the nurse develops a thorough understanding of the patient and their social environment, nursing activities contextualized to individual realities become possible.^{38,39,46,54,67,70,81,83,85} Five themes related to three strategies of the HPPC model can be used to describe the identified nursing activities, namely: supplying medical information, promoting self-care throughout the trajectory, providing emotional support, involving professional or community services and supporting change. It should be specified that the activities identified are part of a relational vision of home care involving the nurse, the patient, their caregivers, the interdisciplinary team and the community.

Supplying medical information. Supplying medical information to patients and their caregivers is a communication-based activity frequently described in the literature. Based on the identified needs,⁴² this communication aims to make medical information accessible⁷³ in order to explain the illness and its trajectory,^{48,52,57,59,68,74} as well as medication use, side effects and symptom management.^{23,42–44,48,54,57,62,69,77,86} According to some of the literature, the nurse's role also includes gradually preparing patients and their caregivers for death.^{67,68,80,85,89} As such, nurses provide information on the dying process and on monitoring the various clinical signs that may

occur.^{42,47,67,77} Supplying medical information supports informed decision-making by advising the patient of their options in terms of actions to take.^{23,42,43,64,71,72,75}

Promoting self-care throughout the trajectory. Promoting self-care is described in the literature as a strategy to help develop the autonomy of patients.^{23,38,46,65,70,75,81} This activity takes the form of developing individual skills around managing illness, medication or care.^{23,38,46,65,69,70,75,81} The nurse has a role in developing the patient's confidence in their own skills and abilities.^{38,73,81,85} Nurses emphasize the need to reinforce what has been learned, to focus on strengths and to validate actions taken, especially those related to illness management.^{38,69,73,81,85} Self-care education is sometimes seen as a form of advocacy, by which the nurse helps the patient achieve their goals in line with their wishes or desires.^{54,71,81} Within this context, the nurse is often described as a guide^{54,64,67} supporting and validating the patient's learning.

Promoting patient care to caregivers is an activity frequently described in the literature. This activity aims to provide information to caregivers, shed light on incorrect information about care or delegate some degree of care.^{23,41,47,57,59,62,67,69,73,79,85,90} The nurse may teach basic care practices, key monitoring activities or techniques for administering medication. Teaching to caregivers is frequently described as an activity that empowers the individuals to act towards their goals or intended future.^{23,64,71,75,89}

Providing emotional support. Emotional support is directed towards both the patient and their caregivers. For the patient, the activities identified are mainly generic without going into detail about their nature.^{42,47,52,55,60,68,72,74,79,82,89,90} However, some nursing activities for emotional support are specifically identified, including focused conversations and active listening.^{48,52,54,64,65,67,69,72,75,76,78,80,81,83,84,88,89} This emotional support activity makes it possible to clarify the patient's thoughts and goals, particularly with regard to the advance care planning, preferred place of death, preparation of the inheritance and bequests, the desired involvement of caregivers and the resources available.^{47,48,57,67,68,77,85,88} This allows the nurse to play a supportive role and to facilitate shared or joint decision-making.^{59,68,69,84,85,88} Humour is also described as a positive strategy for providing emotional support.^{64,66,86}

Emotional support from the nurse can also take the form of spiritual support and be a source of hope for the patient.^{52,54,66,68} This support can include the search for meaning, justifying concerns, acceptance of the condition or the creation of a space for dialogue.^{65–68,74} Finally, emotional support sometimes takes the form of an egalitarian or friendly human approach between the nurse and the patient.^{43,48,63,65,78,87,89} The boundaries of the professional relationship may become porous, encouraging mutual openness and honesty through which emotions and values can be shared.^{43,65,78,89} However, this proximity is sometimes qualified as a risk, particularly concerning the possible attachment of the nurse.^{78,87,89}

For caregivers, nurses' emotional support can mean supporting their involvement, as well as acknowledging their concerns. First, the nurse ensures that space is created for caregivers to be included in decision-making and care planning.^{23,64,71,72} This helps to clarify the caregivers' desired involvement and to identify their own goals.^{23,38,67,72,80} Second, nurses' emotional support can take the form of reassurance, listening, availability or being present.^{39,41,46,52,54,57,59,63,67,68,71,77,87,90} This support may be linked with normalizing the caregivers' experience,^{48,61,73,85} or promoting the expression of difficulties that may be experienced, such as exhaustion or grief.^{62,86}

Involving professional or community services. Nurses also coordinate the involvement of professional services within its own institution.^{40,41,53,56,60,62,68,72,78,82,86,90,91} The involvement of other professionals is sometimes related to the need for advice, sometimes to the need for care.^{60,67} It includes the tasks of circulating information to all members of the multidisciplinary team.^{49,55,58,60,68,69,77,81} The nurse also has a pivotal role in the coordination of various professionals working for professional organizations such as hospitals and hospices.^{72,86}

Outside their organization, nurses see the community in which they work as a source of social support for the patient and their caregivers. The literature reports that nurses solicit and consult with community workers in order to integrate support services that are not provided by their own organization.^{56,59,62,67,68,80,85,90} Nurses are also called upon to assess and encourage the involvement of the existing support network for the patient and their caregivers.^{39,70} Finally,

nurses can provide information about available resources, such as respite care, and how to access them.^{39,42,48,54,62,67,80,85} In all the articles, the relationship remains unidirectional, from nurses to the community, and it takes the form of referrals or information.

Supporting change. Finally, nurses must also deal with change through the redefinition of social roles or through changes in functional status. The literature reports that nurses have a role in creating opportunities and supporting freedom of choice to enable the life desired by the patient.^{43,64,67,85,86} To support change and transitions, the nurse, in collaboration with other professionals, plays a role in adapting the physical environment of the home or in gradually integrating technical equipment.^{38,45,46,48,53,55,61,62,67,78,81,86} This includes equipment to support the patient's independence in performing domestic and daily tasks (such as a wheelchair, walking aid or electric bed),^{38,46,62,67} care equipment or equipment required to limit the risk of physical complications (such as mattresses, syringe pumps or monitoring equipment)^{38,46,62,67} and equipment to facilitate the provision of care by caregivers.³⁸

Discussion

The results of this integrative review highlight that the identified nursing activities are mostly strategies aimed at: (1) the provision of education and information for health, dying and death; (2) the provision of social support; and (3) the encouragement of interpersonal reorientation. In addition, the second and third strategies are generally considered from an individual perspective, in which nurses focus on the physiological or psychological needs of the patient and their caregivers. To a lesser extent, the nurse plays a part in creating opportunities or carrying out interventions that allow the patient to continue living despite the redefinition of social roles and functional status. None of the identified nursing activities are linked to the reorientation of palliative care services towards a health-promoting perspective or the combating of death-denying health policies and attitudes. All nursing activities were described as part of a caregiving relationship with a patient and their caregivers.

The goals of HPPC, as described by Kellehear,¹¹ support a social and community-based reorientation of palliative care, affirming the need for professionals to act in support of community practice

or social and political interventions.^{10,11} However, the activities described in our review suggest that nurses are not very involved in the social space they work in, and that their practice is mainly restricted to the care context. In terms of relationships between the nurse, their community and professional partners, activities are related to providing referrals to other professionals or soliciting community resources, such as respite, funding or support services. The nature of this relationship appears to be more transactional.

Consequently, a common criticism of the way health promotion principles are integrated into nurses' clinical practice is that this practice is often individualistic in nature.⁹²⁻⁹⁴ Some authors suggest that nurses frequently focus on managing individual needs or developing individual skills for health, rather than engaging in issues that affect the community in which they work⁹³ or in the empowerment in terms of social or political participation.^{27,95} Nurses have only minimally integrated socio-political and community-focused models of health promotion practice, instead retaining approaches that focus on the health of individuals and families.^{30,95} Schaffer *et al.*⁹⁶ argue that nursing interventions aimed at public policy advocacy and community relationship building are sometimes carried out, but they are the activities least described or discussed by nurses.

This finding also echoes some of the criticism of the ways in which collaborative approaches to health promotion are integrated into nurses' clinical practice.^{26-28,30,95} Indeed, the need to build partnerships with local and community resources, as well as supporting local initiatives or political action are frequently mentioned in the literature as areas of activities and interventions within the nursing practice.^{26-30,97} However, some of the literature points out that nurses do not consider these roles to be part of their job or that they see them as extra tasks, beyond what is normally expected.^{12,26} According to Whitehead,⁹⁵ these roles imply political motivation and the ability of nurses to navigate outside the healthcare context, including within local agencies or spaces where other professionals operate.

As a result, nursing practices for health promotion can become 'invisible' from the clinical and empirical perspective, given that nurses have difficulty articulating or describing the scope of this practice.^{96,98} This is even more the case since the governance of caregiving practices situates nurses

within a person-family system, rather than a person-family-community system.⁹⁹ The difficulties in articulating this practice may explain the results of this integrative review. However, the near absence of any description of activities at the social and community level does not necessarily mean they are absent at the clinical level.

Although opportunities for partnership development may be present in nurses' practice,^{26,94} how they can engage in them remains a topic for further study. It would be useful to carry out further studies on the existing collaborative relationships between formal care structures and communities involved in palliative care.^{22,100} This is also true for political engagement, a tool that is not widely used by nurses for health promotion.^{94,101}

Some health-promoting nursing activities are nonetheless described in our integrative review. Indeed, we highlight the importance that nurses place on building a relationship with the patient and their caregivers, as well as on understanding the context in which they live. According to the literature identified, this may include adapting nursing interventions to support decision-making or providing resources based on the particular needs expressed. Nurses confirm the importance of contextualizing their activities to ensure that they are consistent with the values, desires and goals of the patient and their caregivers. This contextualization brings the nursing activities closer to the principles of health promotion^{21,30} and of HPPC,¹¹ such as participation and involvement. Through contextualization, nurses strive for coherence between the patient and them, which is even described as a moral responsibility.

In relation to current discussions and ideas regarding palliative care, our integrative review puts forward how nurses, despite criticisms,¹⁰²⁻¹⁰⁴ are seeking a 'good death' for everyone. Based on certain understandings of what a 'well-managed death' (p. 147)¹⁰⁵ is, the concept of 'good death' refers to socially defined normative standards that orient healthcare practices, as well as actions that patients or their caregivers should take to ensure that death is socially recognized as good.¹⁰² It encompasses changing socio-political and cultural values on oneself, physicality, suffering or engagement in palliative care.^{102,105,106} Without being intentional, palliative seeking a 'good death' could, in part, be detrimental of the recognition of the patients' true goals and choices.¹⁰² Consequently, our integrative review exemplifies

how some ideas of a ‘good death’ are embedded in nursing activities in terms of actions regarding care planning, decision-making or the nature of the relationship. Nurses seem to sometimes orient their activities towards what they, themselves, consider good for the patient in palliative care. That focus towards a ‘good death’ could explain why health care institutions are at the centre of palliative home care delivery,¹⁰⁷ and thus the lack of social or community engagement from nurses.

However, our integrative review does not only exemplify how a ‘good death’ is pursued by nurses. It also suggests that alternative nursing activities, that aim for the respect of patient’s unique values and goals through the identification of individualized needs and contextualized support, or through wellbeing-oriented practices such as self-care or death education, exist. Those activities attempt to support people with serious illness or their caregivers to regain control over the life they value, while in palliative or end-of-life care. The description of those nursing activities is nonetheless currently limited and should be of interest for further research.

In closing, it is important to highlight some limitations of this integrative review. Considering the current emergence of HPPC principles, there are very few studies specifically discussing the place of health promotion principles in palliative care. The themes were developed through an analysis of descriptions of nurses’ clinical activities. As such, community or collective activities may have been carried out but not described because researchers or nurses themselves have not questioned their place within the social context they work in. Furthermore, the near absence of theoretical references in the studies included may have limited our capacity to make sense of the social space in which nursing practice takes place. Finally, the studies identified were mostly carried out in Europe or North America, societies where the culture is sometimes described as death-denying, that is, tending to exclude death and those who are dying from the sphere of social life.^{102,108} Literature incorporating greater cultural, ethnic or religious diversity might have shed a different light on collaborative or supportive nursing activities with communities.

Conclusion

This integrative review is, to our knowledge, the first to report a comprehensive understanding of

nursing activities for health promotion in the context of palliative home care. It suggests that the literature on nursing in this context is more individual and focused on direct care. However, through the contextualization of their actions, and the moral responsibility of some nurses to work towards the respect of patient’s values and unique objectives, some HPPC principles seem still relevant to nursing activities. Yet, those nursing activities are poorly described and undertheorized. We defend the need to better understand how nurses can truly engage their practice towards health-promoting principles, such as the enhancement of support and control over their lives for people living with serious illness. Seeking this reflection, through further empirical research, may help identify how nurses, within the context of palliative home care, can support people to live the life they value before their death.

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Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Author contributions

Jérôme Leclerc-Loiselle: Conceptualization; Data curation; Formal analysis; Methodology; Writing – original draft; Writing – review & editing.

Sylvie Gendron: Conceptualization; Supervision; Validation; Writing – review & editing.

Serge Daneault: Conceptualization; Supervision; Validation; Writing – review & editing.

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Competing interests

The authors declare that there is no conflict of interest.

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Supplemental material

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