Chapter

Holistic/Palliative Management of Patient's Health Care and Home Situation in a Depressed Economy

Akon Emmanuel Ndiok, Emilia Oyira and Busisiwe Ncama

Abstract

In most middle and low economic nations, problem in the active management of health complaints is patients defaulting on follow-up appointments, attributable to financial constraints and cost of health services due to economic recession. This increases the danger of aggravation and deterioration of the condition and leads to re-hospitalisation. Most terminally ill patients and elderly prefer to be cared for at home by family caregivers or paid health professionals towards the end of their life. Holistic/palliative care is a key component of home health care. Current structure of health and social care services shows that the home is gradually becoming a significant location of long-term care. Holistic care as advocated by Florence Nightingale and others takes cognizance of the care of total human being looking at the spiritual, physical, social and psychosocial care of individual. Quality care for patients and their families can be achieved by establishing principles of holistic/palliative care as an integral part of daily practice both in the hospital and home care, as advocated by the WHO. Challenges in seeking to do this can be overcome if adequate funding is allocated for palliative care activities and setting up machineries for training of families on home care.

Keywords: depressed economy, holistic/palliative care, home care, management

1. Introduction

The economic recession in developing countries especially in sub-Saharan region has affected various sectors of the economy. This includes the health sector, leading to low productivity, poor service delivery and poor health outcome [1]. In some of these countries, home services are not available. The health sector is still trying to deliver basic health care services with the collective efforts of government but efforts to accomplish this seem not achievable due to the present state of the economy. Holistic health care is good, both ethically and practically but it is hard to find as any obvious expression of what holistic health care is or any plain explanation of its realistic usefulness especially in terminally ill patients in need of palliative care, which may require home care.

In most developing countries, patients generally report late to health facility due to a sequence response to event: improper health-seeking behaviour, economy and ignorance of the disease, treatment by unqualified and unorthodox medication, non-availability of personnel, equipment, culture/belief and family decisions [2].

Terminal diseases have often been linked with having one of the worst effects on the quality of life among affected patients and their families.

This chapter, therefore, considers what holism is and then what a holistic approach to illness might be, and how this might improve health care at home in a depressed economy.

1.1 Learning outcomes

By the end of this chapter you should be able to:

- review holistic care and identify its principles
- understand palliative care and its principles
- recognise the relevance of spirituality in health care
- assess the impact of economic depression on health
- assess the home care situation in a depressed economy
- discuss the integration of palliative/holistic care in clinical and home-based care in terminally ill patients and the elderly.

2. What is holistic care?

Holistic care means reflection of the whole person, physically, psychologically, socially and spiritually, in the care and prevention of disease. These different conditions can be similarly important. They should be managed together so that a person is cared for as a whole. A holistic approach means that the health care providers are well versed with a patient's whole life situation. Maintaining one's health requires continuous effort to attain a balance of all aspects of life. To accomplish this balance, an amount of consistent factors must be considered when providing health care to patients/clients. Such factors include age, sex, family relationship, cultural influences and economic status. This broad approach to health care is recognised as holistic health care [3]. In order to have a good understanding of holistic nursing, Katie Eriksson, who is a nurse, came up with the theory of Caritative care that helps distinguish the relationship between a nurse and a patient and the concept of caring principles, which guide the nurses in decision-making. The theory of Caritative care comprises love, which is known as caritas. It shows the significance of regarding the self-esteem of a human being and holiness [4].

Almost all health care professionals would assert to put into practice holistic health care. It is obvious that; no one would declare or have the same opinion that their individual, professional or organisational practice was not holistic. Consequently, few if any of these professions, people or organisations make it apparent what they mean by 'being holistic'. They do not provide any explanation, or examples of how they manifest their holism. It is difficult to discover any criteria against which their success at being holistic could be measured. I doubt that many of the people, professions or organisations have any comprehensible conceptual understanding of what they mean by 'being holistic'.

The word holism has its foundation in two Greek words, both of which denote 'whole'. This first 'holos' is the base for holism and the second 'hale' is the base for

healing and health [5]. Health in general is believed to be concerned with the state of a person's mind and body, commonly meaning free from illness, injury or pain. Healing is the process of re-establishing health to a diseased, injured or damaged individual. Mariano defines healing as the consolidation of total human being in body, mind, feeling and spirit [6]. Therefore, it is an associate to holism.

'Holism' in health care is a philosophy that emanates from Florence Nightingale who advocated care that centred on unity, wellness and the interrelationship among human beings, events and the environment [6]. She discerned the importance of such components as the environment, sense of touch, light, smells, music and silent expression in the treatment process [7], hence, reaching patients in fashions that went beyond rendering just physical care. The philosophy behind holistic care is founded on the thought of holism, which stresses that for human beings the whole is greater than the sum of its parts and that mind and spirit affect the body [8]. Holistic nursing has a higher cognizance of self, others, nature and spirit. This is the same approach Florence Nightingale integrated as the first holistic nurse, which centred on harmony, wellness and interrelatedness of human beings, likewise their surroundings. Holistic nurses also have the same self-care and self-awareness of body, mind and spirit as part of their belief structure (**Figure 1**). Through caring for themselves, it is believed it gives a holistic nurse the capability to have that same consciousness for the care of others [7]. Florence Nightingale once expressed the role of nurses as 'to put the patient in the best condition for nature to act upon him' [9]. She thought that touch, kindness and other measures of comfort, provided within the setting of treatment environment, are essential for nursing care. These assumptions are applied nowadays. Even these days, nurses are educated to deal with the environment and use touch, knead, eye contact, voice and other measures to make patients more relaxed. These nursing actions, known as 'the art of nursing', constitute the basis of professional nursing [10]. Currently, different fields, such as physics, mathematics, science, philosophy, sociology, medicine, nursing, etc. endorse the opinion that the honesty of an individual is much more complicated and greater than the sum of their individual parts [10].

Figure 1.
Diagrammatic presentation of the components of holistic care.

2.1 Principles of a holistic approach

- All people have natural healing powers;
- The patient is a person, not just a disease;
- Suitable healing therapy needs a team approach;
- Patient and health care professionals are collaborators in the healing process;
- Treatment comprises fixing the cause of the illness, not just reliving the symptoms [5].

3. Palliative care and its principles

The World Health Assembly approved the resolution to integrate hospice and palliative care services into national health services [11]. The body recognises these important health services as an important component of health systems worldwide and therefore calls on national authorities to make sure they be given the awareness they deserve. This is the first time that the World Health Assembly has considered a declaration on palliative care. It endorses that all countries need to take palliative care seriously [11]. The main recommendations to all member states of WHO as seen in the resolution are to integrate palliative care into health care systems, to make sure that palliative care is incorporated into the introductory and continuing education and training for all health care personnel and to make sure that appropriate medications, as well as strong pain medications, are accessible to patients [11].

Many individuals, organisations and bodies including the WHO have suggested different definitions of palliative care. WHO revised the meaning of palliative care to be 'an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual' [12]. WHO further listed the following features of palliative care: 'provides relief from pain and other distressing symptoms; affirms life and regards dying as a normal process; intends neither to hasten nor postpone death; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patients illness and in their own bereavement; uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated; will enhance quality of life, and may also absolutely influence the progression of illness; is applicable early in the course of illness, in conjunction with other treatments that are aimed to prolong life, such as chemotherapy or radiation therapy, and includes those examinations needed to better understand and manage distressing clinical complications' [12].

Boltz defined palliative care 'as expert curative care of patients with severe disorders, and it emphases providing patients with relief from symptoms, discomfort and worry of serious illness, irrespective of the diagnosis' [13]. She further explained that the word 'palliative' has its origin in the Latin word meaning to 'cloak or cover'. And upheld that, Viewpoint of how cancer, which is one of the terminal diseases is observed and not properly diagnosed, is suitable description because most cancers progress without warning signs for an extensive period before the individual tries to seek help. The National Consensus Project (NCP) and National

Quality Forum (NQF) jointly formulated the concept of palliative care so as to separate it from other types of care [14]. And so they came up with eight domains of palliative care: 'structure and processes of care; physical aspects of care; psychosocial and psychiatric aspects of care; social aspect of care; spiritual, religious, and existential aspects of care; cultural aspects of care; care of the imminently dying patient and ethical and legal aspect of care' [14].

Palliative care is often misidentified as being the same as care given to the patient approaching death where no cure is expected to be achieved [15]. It is focused on the relief of distress during the advancement of patient's illness. Even though hospice and palliative care is extensively used in the western world, many patients are seen to register in hospice very close to death, which limits the advantage these services would have obtained.

Rosser and Walsh cited WHO's principles of palliative care as follows:

- "provides relief from pain and other distressing symptoms;
- intends neither to hasten nor postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in
- their own bereavement;
- uses a team approach to address the needs of patients and their families, including
- bereavement counselling, if indicated;
- is applicable early in the course of illness, in conjunction with other therapies that
- are intended to prolong life, such as chemotherapy or radiation therapy, and includes complications" [5].

These principles according to Rosser and Walsh focus on a whole, humanistic method of caring for the total being during the course of their illness, instead of concentrating on the ailment or situation [5]. Palliative care answers to the altering wishes of the patient and family, identifying that the illness development and the related involvements are distinctive to each individual. Rosser and Walsh opined that palliative care is seen as supportive care [5]. They see it as care delivered to patients, friends and family during the course of their illness; this includes the period before diagnosis has been made, as soon as patients start undergoing series of examinations, treatment and home care. The purpose of supportive care is to assist the patients and their families to be able to handle their illness and management at home.

Becker also penned principles that are relevant to providing palliative care. These include the following:

- Follow-up of all patients diagnosed with terminal illness at any stage of the disease

- Competence at putting patients at ease
- Listening and attention skills
- Questioning techniques [16].

These principles will put humanity back into the care offered by nurses. After physicians, nurses are the most important members of the palliative care team in the sense that they spend 24 hours with the patients and should be able to display the principles [16]. Skill is an important characteristic for ensuring quality, safety and cost-effective health care. The term competence according to the Royal College of Nursing "(RCN) comprises the skills, knowledge, practices, qualities and manners essential for an individual" so as to execute the work successfully [16]. A nurse is said to be competent when she has the skills and talents vital for lawful, safe and effective professional practice without direct guidance [17]. Competence can be said to be basic features of persons that result in effective performance. They can be described as a mixture of knowledge, skills, purposes and personal character traits. It can also be seen as the way someone behaves or acts.

Areas of competency include verbal message, written communication, enquiring skills and team skills [17]. Nurses are expected to communicate efficiently, generating talking and listening skills. Nurses should be able to use their knowledge and skills to promote open and honest communication skills to support open and honest interaction that recognises the needs of patients, and also creates a satisfying association in which they are able to apply counselling skills and initiate follow-up programmes to help them to adjust to their illness and care. Their knowledge and skill will also ascertain that patients obtain full evidence-based nursing care. They understand and identify the impact of terminal disease when dealing with clinical or home situation, so that they can be able to assess the outcome of care and give appropriate intervention. Competence also includes the ability of the nurses to use the e11 function health patterns to assess the patient. Gordon Morgan, according to Doenges and Moorhouse, devised 11 functional health patterns to be used by nurses in nursing process to provide more comprehensive nursing assessment of the patient. This will help the nurses to give holistic care to patients [18].

The model of palliative care put together by the Canadian Hospice and Palliative Care Association (CHPCA) [19] is the model that is used to guide this chapter. This model is effective because it was developed to plan, evaluate and develop educational programmes [19]. In adopting this model, the paper considered the prominent position of the hospital management, without which it would be impossible to develop a programme for home care. The key role played by nurses as members of the palliative care team begins as soon as diagnosis is confirmed by the physician. Based on gaps identified after confirmation of diagnosis, the model provides guidance in tracking and tracing each patient, and planning home care. Communicating the true position of diagnoses at this stage is very important as it will help to reduce anxiety—after which, follow-up and home care measures will then be put in place.

Two fundamental elements in the framework as utilised are the 'square of care' and the 'square of organization'. As set out in the model [19], the 'square of care' has six components and the 'square of organization' has six stages that are relevant to palliative care integration. The composition of the conceptual framework is shown in **Figure 2** covers all phases of a palliative care programme, service or group. The patient and family are at the middle of the joint square, and their needs decide the concerns to be covered, the care necessary and the purposes and means to deliver care [20].

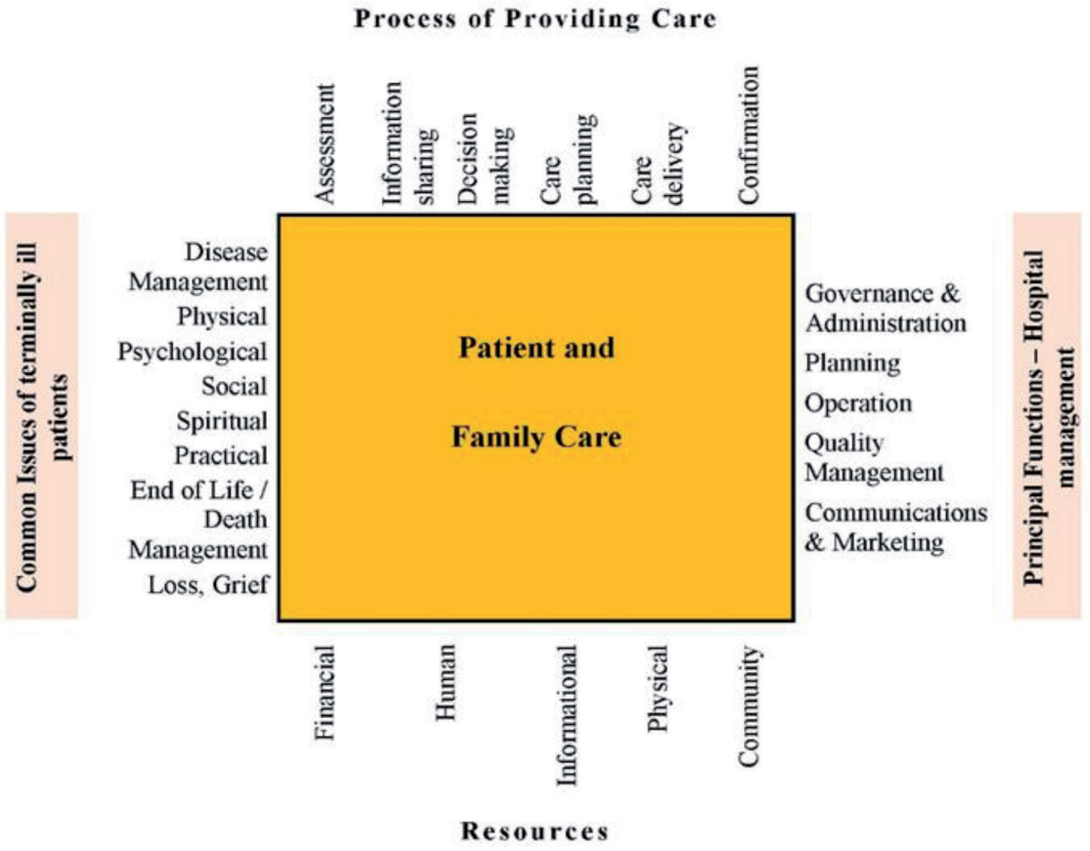

Figure 2.
Square of care and organisation (Source: adopted from CHPCA).

The Square of Care refers to the six important phases during the process of rendering care to patients and family. The phases of square of care include:

- assessment
- information sharing
- decision-making
- care planning
- care delivery and
- confirmation, and demonstration that they relate to the concerns (or areas) that patients and families usually encounter.

Square of organisation also has six stages, which comprise:

- governance and administration
- planning
- operation
- quality improvement communication/marketing
- collection and use of data.

The main concepts of the model are the standards and regulatory beliefs that were established and decided upon through a national consensus-based practice [20].

There should be plans for both the health care professional and patients/families to manage physical and psychosocial suffering and to get ready for the likelihood of advanced disease. This aspect of palliative care involves ways to provide physical and emotional care that will help patients to get through treatments. It enhances patients' compliance with disease management, helps them accept changes in care and prepares patients and their families for the tasks ahead if the disease eventually does not lead to a cure.

3.1 Application of the model

Based on the model of palliative care as developed by CHPCA, the model takes into consideration the prominent position of the hospital management without which it will be impossible to develop any programme of such magnitude [19, 20]. This is because, a lot of things will be considered, especially, developing human resources example training of palliative care nurses, setting up palliative care team, providing other means of integrating palliative care into daily care of patients. Again, patients and families should also be seen at the centre of developing this programme as compliance is the key to success of any programme.

A nurse as an important member of palliative care team has an important role to play as soon as a patient is indicated for home care. Based on the gaps identified, after confirmation of diagnosis, tools that are going to be adapted will be used to track each patient; communication of the true position of diagnoses at this level is very important as this will help to reduce anxiety and follow-up measures will then be put in place. Studies conducted by Temel et al. indicate that patients who had palliative care integrated into normal treatment had a better outcome even when they were diagnosed at the advanced stage of the disease than patients who managed with only normal treatments [21].

4. The relevance of spirituality in health care

Spirituality is a part of holistic care for clients and families. Patients getting palliative care benefit much from the special care that is devoted to physical, personal and social needs [22]. Spiritual care is seen as very significant for a lot of terminally ill patients, but professionals have trouble determining what such care they could embrace. From the viewpoints of the patients/clients at the end of life, their family caregivers and health care workers, the main aims are: to search the notion of spirituality and the meaning of this term; to discover beliefs, understandings and prospects with respect to spirituality, spiritual needs, pain or distress and spiritual care and, eventually, to see how spiritual care can best be provided for patients at home in a depressed economy.

Spirituality and health is an increasing new area of health care; the first textbook on spirituality and health was published by Oxford University Press [23]. Puchalski et al. established that patients would like their spirituality to be addressed in their health care. As the trends and research developed, ethical queries began to come up as to the definition of spirituality within medical care, its role in patient care and the implementation of spiritual care in the clinical setting.

Rosser and Walsh are of the opinion that spirituality takes account of an individual's beliefs, values, identity, a sense of meaning and purpose [5]. Some people see religion as being a component of spirituality. Wright and Neuberger designate spirituality to be pertained to how we see ourselves in the pattern of

things, how we relate to other human beings and the wider world and how we ascertain meaning, purpose and association in life [24]. By its very nature, spirituality is often subjective, absolute and personal. In addition to the suggested principles for health care professionals to take care of the whole person, together with the patient's spirituality, studies have established that patients appreciate a more whole-person emphasis on care and value health care professional's probe into their spiritual beliefs [25].

Spirituality according to some schools of thought covers the confidence in self and others and this may include a belief in a divine being or higher authority [26]. The RCN also describes the following as factors of spirituality:

- hope
- strength
- trust
- forgiveness
- love
- relationships
- creativity
- self-expression [26].

If patients' needs could be recognised early and their care adequately planned to include (but not limiting to) follow-up of all patients diagnosed with terminal illness through telephone calls, home visiting, advanced care planning, assessment and treatment of physical, psychosocial and spiritual aspect of patient's needs, etc., there will be better outcome when the condition reaches advanced stage. Some may reason that because spirituality is so personal, it has no relationship in health care but when the perception of total pain is looked into, it is obvious that spiritual care is a vital element of care [5].

5. The impact of economic depression on health

Economic depression is a period of time of economic slowdown presenting low output, not having enough funds and unemployment. It is considered by its length, abnormal upsurges in unemployment, falls in the obtainability of adequate health services, shrinking output and investment, etc.

5.1 General causes of economic depression

The major causes of economic depression in any given economy (lessons from great depressions, 1981, 1991, 2008 economic recession) may include:

- High inflation, a general rise in price of goods and services—leading to low purchasing power.
- Accumulation of debt servicing especially foreign debt.

- High-interest rate—discouraging investors.
- Fall in aggregate demand; fall in wages, income etc.
- Mass unemployment and general loss of confidence in the government [27]

Health is an essential part of man's existence even in the midst of economic depression. Before the current economic crisis, most present-day societies especially in the developing countries were still suffering disease epidemics while other nations incessantly experienced the endemic diseases affecting millions of lives. The global economic crisis persists to worsen the structure and purpose of the health sector. The economic depression has affected several segments of the economy including the health sector, contributing to low output, poor service delivery and poor health outcome. This has led so many people to resort to home care where so much will not be required from them.

The health sector is still struggling to provide rudimentary health care services with the collaborative efforts of government and individuals but determinations to realise this seem unfeasible due to the current state of the economy especially in the developing countries. The current economic position has affected health care funding and the level of support of the public and private health care services particularly among the rural poor is reduced due to increased proportion of poverty [28]. The economic predicament has contributed essentially to poor health outcome; it offers the occasion for careful government health modifications to improve the health system operation [28]. Health is directly or indirectly connected to other sectors such as food security and nutrition, family income generation, housing, education, employment status and other social security services.

Following initial treatment for terminal diseases or elderly patients, they are usually given dates for followed-up appointment in hospital outpatient departments at steady intervals for routine checking in order to assess the patient and timely discovery of recurring of the ailment [29]. This method of follow-up places anxiety on the patient and their family members and most of them defaulted due to religious and cultural beliefs. Secondly, they may complain of inability to travel to the hospital, especially patients living in the rural communities. Most of these patients present late in the hospital either because of poor knowledge, cultural/spiritual beliefs and non-availability of resources for prevention, diagnosis and treatment [28]. Patients and families are not well prepared after diagnosis about the diseases or palliation; this has led to most of the patients not responding to check-up appointments because they are not well informed and no form of follow-up programmes are put in place to track these patients [29].

Based on the above premise, several countries have been able to put in place measures for providing home care services to a lot of their citizenry so as to alleviate the suffering of the poor masses. Most of the developing countries are still struggling as a result of poor economic position of these nations. Home care cannot be instituted without adequate resources.

6. The home care situation in a depressed economy

From a nursing viewpoint, it is imperative to have information about the type of care needed, the explanations of care needed and quality of life among the elderly people and those diagnosed with terminal illnesses living in their own homes, in order to sustain their independence and make best use of their quality of life.

At several stages during our lives, we are each dependent on the care of others [30]. For many, that need comes with old age, chronic illness or ill health. In some occasions, the care is provided by a family member or a friend; in other cases, it comes from a paid care worker such as a registered nurse, a registered practical nurse or a personal support worker. Sometimes, the care is given by a combination of both [30].

This chapter describes the involvements of these three care beneficiaries, their family caregivers and their paid care workers in our survey of the direction of the substantial practices of care associations in home care. Current reorganisation of health and social care services means the home is gradually the site of long-term care and is a place where implications of both home and care must be discussed [31]. The focus on the familiar care points up the diverse forces at work of care through which caregivers, care recipients and home space are established.

Most nurses have their own individual principles and morals, and there are certain professional standards on which all nurses are anticipated to establish their care. Nurses have a duty to make the care of patients their major concern and to practise care giving without harm and efficiently. They must be ethical and truthful [1]. Patients trust their nurses because they believe that, in addition to being experienced, their nurses will not take advantage of them and will demonstrate character traits such as honesty, straightforwardness, reliability and empathy. Good professional decision and behaviour in clinical practice should be patient-centred. It involves nurses understanding that each patient at the end stage of his or her disorder is exceptional, and working in partnership with their patients to discourse the needs and realistic prospects of each patient. The moral pronouncement as proposed by Plato and Aristotle highlighted the part of purpose both in observing what is fair and in permitting us to act reasonably rather than give in to conflicting desires and feelings [32].

Hellström and Hallberg examined people aged 75 years and older dependent on care from professionals and/or a next of kin, their functional health, diseases and complaints in relation to quality of life as perceived by themselves [32]. The study revealed that the number of elderly persons in need of support ranged from 18.5 to 79.1% in the different age groups, and that aid came mostly from informal caregivers [32]. The authors also discovered that assistance from formal caregivers was given in combination with that from a next of kin in 38.8% of the cases. Furthermore, next of kin function more than formal carers; they assisted in all Contributory Activities of Daily Living (CADL) and Personal Activities of Daily Living (PADL) chores, with the exclusion of house cleaning and rendering a bath/shower. Although the respondents had supported themselves, they were also of assistance to another person in 6.5% of circumstances [1].

From the above study, it is seen that care giving at home is mostly carried out by informal caregivers, than the professionals. Patients, therefore, would see care at home more acceptable during this critical period of their lives. Most patients resolved to care at home because their financial status cannot cope with hospital bills, transportation, waiting time in the health care facilities among other reasons that promote home care.

7. The integration of palliative/holistic care in clinical and home-based care in terminally ill patients and the elderly

Nurses are the most valuable member of the palliative care team who are in the best position to look into the physical, purposeful, social and spiritual needs of the patients, but in most situations, they (nurses) are not well-prepared to give the

adequate care, especially to elderly and terminally ill patients. The main focus of nursing care as observed is curative approach without taking into consideration effective communication between them and patients/families the truth about diagnosis/prognosis of the disease, lack of patient and family readiness as a result of inadequate training/discharge planning and lack of follow-up [33].

Specifically, since there are no functional palliative care programmes in most health care facilities, the phases being addressed are:

A. Outpatient clinics

B. Hospital service

C. Home care service

D. Approach to care

A. Outpatient clinics:

1. Staff: Palliative care physician and nurse to be identified
2. Terminally ill patients identified after diagnosis is confirmed
3. Visit: To plan routine visit as necessary
4. Symptom assessment in clinic: Routine assessment during every visit by the nurse and physician
5. Psychosocial assessment in clinic: Routine assessment and discussion of goal with patient and family, support system, psychosocial distress and discussion on advance care planning according to their willingness
6. Telephone follow-up: Routine by the nurse after each visit
7. On-call service: 24 hours on-call service to be clarify during first visit after diagnosis has been established.

B. Hospital service:

1. In-patient care: access to palliative care for symptom management
2. In-patient staff training for nurses: identification of nurses, physician and family caregivers for continued education and training in palliative and home care
3. Palliative care in-patient follow-up: follow-up by palliative care team when the patient is admitted to other unit of the hospital.

C. Home care:

1. Community care contact health centre service: health centre closer to the patient will be identified for care continuation and this would be reassessed at each visit.
2. Communication with the family and community health centre: this should be done routinely.

D. Approach to care:

All care providers: Multidisciplinary, this is hope to address physical, psychological, social and spiritual needs of both the patient and the family identifying other specialist. The approach to care takes cognizance of the fact that the economic depression affects the type of care the less privileged members of the population attained. This may affect proper access to good health care services and as such provision of home care will be beneficial to them where they will be taken care of in their familiar environment.

8. Summary/conclusion

Nurses should strive to always make the most of the short time they have with each patient. As nurses, we need to promote a patient's psychological and emotional well-being in order to facilitate physical healing, especially in a poor economic situation. When we do this, our relationship with the patient alters and develops into something more encouraging than it was before. This contributes to better patient outcomes and can heighten the happiness and perseverance in our work as nurses. By doing this, informal caregivers would emulate and continue home care.

There are many easy ways to develop relationships with patients and encourage a sound psychological, emotional and spiritual environment.

- Learn the patient's name and use it
- Make good, strong eye contact
- Ask how a patient is feeling and honestly care
- Smile and laugh when suitable
- Use relaxing touch
- Assist the patient to see themselves as someone who merits self-esteem
- Maintain their self-worth
- Educate patients on the significance of self-care
- Ask the patient how you can decrease their anxiety or pain

Holistic nursing is the concept of caring for a person as a whole. The purpose is to return the patient as a whole to as close to normal as possible even when receiving care at home. Holistic nursing highlights on the nurses considering the link between minds, body, emotion, spirit, social, cultural, environmental and past relationships in order to return the patient to a whole. This however has not always been likely to attain. The idea of caring for the whole person, not just their physical body, is one that dates back to Florence Nightingale. Florence Nightingale devotedness was to care for those who could not care for themselves. Florence Nightingale herself advocated holistic care by recognising the importance of environment touch, light, scents, music and silent reflection in treatment process.

There is a direct relationship between economy and health and by implication of nursing profession. The present economic depression places an enormous threat

as its end is not sure. This chapter therefore tried to bridge the gap between holistic care, palliative care, which embodied all the components of spirituality, and the terminally ill patients needing home care. This has a lot to do with economic situation of the populace, especially in the low- and middle-class countries of the world. Since the elderly and the terminally ill patients preferred home care, it is pertinent that all the components of care be provided to take care of the total man.

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Conflicts of interest

The authors declare no conflict of interest.

Author contributions

AN, EO and BN designed the study, compiled and wrote the manuscript. All the authors reviewed the manuscript and provided critical comments, read and approved the final version of the manuscript.

Author details

Akon Emmanuel Ndiok[1,2]*, Emilia Oyira[1] and Busisiwe Ncama[2]

1 Department of Nursing Science, University of Calabar, Calabar, Nigeria

2 School of Nursing and Public Health, University of KwaZulu-Natal, Durban, South Africa

*Address all correspondence to: ndioka@unical.edu.ng

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