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Nursing Care Plan: a Panacea for Quality Assurance in Palliative Oncology Care in Nigeria.

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Abstract: Professionals in the healthcare sector take responsibility for practice in view of the pace of change experienced within the field of practice aiming at personal and professional advancement (Jasper, Rosser and Mooney, 2013).This is more challenging particularly in this era of amplified emphasis on providing evidence-based care in health and social care. Owing to this fact, clinical judgement and decision making are pertinent to delivery of high quality, client-centred nursing and inter-professional care (Holland, 2013). Thus, it can be said that professional development is strongly related to advancement in professional practice. Therefore, the aim of this opinion paper is to critically appraise the concept of change, leadership styles, decision making, decision making theories and models relevant to the proposed innovation in palliative oncology care with the aim of enhancing quality care for cancer patients and nursing practice in general.

INTRODUCTION

In recent times, numerous sub-specialities in medicine have emerged, including palliative oncology care which in Nigeria, has clear-cut evidence of receiving relatively minimal attention from stakeholders at all levels of care (Onyeka, 2011). This emphasizes the need to increase awareness in this area of care. Palliative care is an indispensable aspect of the healthcare system that focuses on people living with terminal illnesses and basically entails providing patients with pain and other symptoms relief care regardless of their diagnosis, with the aim of improving quality of life for the patients and their families (Zagonel*et al.*, 2009). Medical, nursing and other paramedical support specialists provide palliative care which has been proven suitable at any stage of the disease process and could be rendered concurrently with other curative therapies (NICE, 2011). Likewise, palliative care emphasizes improvement of quality living for cancer patients through early identification, impeccable assessment and all-inclusive care (WHO, 2014). Therefore, it can be contended that implementation of care plan in palliative oncology practice is no longer targeted at patient survival but on quality living.

According to the recommendation made by NICE (2012), documentation of care planning is essential in providing a quality standard palliative care for adult patients. Among other statements in support of quality palliative care in the UK, the need to improve the low standard of care given to palliative care was emphasised. In addition to this, the NICE guideline suggested the incorporation of comprehensive quality assurance framework into planning care in order to sensitize healthcare stakeholders to deliver standardized care. Hence, organised model of care is essential to delivering quality healthcare service (Holland, 2013). The implementation of end of life care framework and models are relatively high in developed countries compared to developing countries (Onyeka, 2011). According to Clark (2007), palliative care was introduced by Cicely Saunders in 1967 and since then, policies and pathways of care have been evolving while palliative care was formally introduced to policy makers and the general populace in Nigeria in 2003.This indicates that Nigeria has been lagging behind in palliative care for more than three decades and this is attributable to political and socio-economic disparity.

Palliative care is targeted at symptom relief among other key principles and being a new field of healthcare, many developing countries are yet to incorporate it into their existing health systems (Onyeka, 2011). However, among several end-of-life care pathways is the Liverpool Care Pathway (LCP), an end-of-life care tool implemented within a hospital setting in the UK to ensure quality care for oncology palliative patients (Ellershaw and Wilkinson, 2010). This has been accepted worldwide and endorsed as a model of good practice to support care in the last few hours of life (GMC, 2010; DoH, 2009 and NICE Quality Standard, 2011). According to the findings of study conducted on cancer patients in the UK and Africa, it suggested that the main concern for oncology care in Africa was for physiological pain relief and analgesia while among UK patients, the major concern was emotional pain (Soyannwo, 2009). In our opinion, the reasons for this variation in pain perception could be related to culture, socio-economic inequality and national drug policy.

LIVERPOOL CARE PATHWAY (LCP)

The LCP was developed in 1997 by Marie Curie Palliative Care institute in Liverpool for palliative care with the aim of introducing the hospice model of cancer care into hospitals and other care settings (Trueland, 2013).This pathway provides framework for care planning in four vital aspects of care which includes pain and symptoms relief, anticipatory

medical prescription, discontinuation of inappropriate intervention, psychological and spiritual care for the last few hours of life (Christian, 2013). For emphasis, LCP was ranked first for overall care in terms of quality, availability, pain management and nurse-patient transparency (EIU and Britain, 2010) meaning that the domains of LCP are comprehensive enough to meet the challenges of terminal cancer care and the coverage of LCP framework is all-encompassing and effective (Devlin, 2009). In accordance to a publication of Nursing Standard (2013), out of the total 75 NHS Trusts in the UK, 48 are currently using the LCP indicating that its use is largely accepted as more than half of the NHS trustshave it implemented (NICE, 2011). Despite this, there are various contrasting reports relating to euthanasia and withdrawal of treatment associated with LCP implementation which has prevented its general acceptability. This was corroborated by Neuberger *et al* (2013) who noted that insufficient systematic reviews on LCP, misuse of the pathway and the complexity of LCP form were identified contributory factors to the moratorium of the pathway by the UK government. In contrast however, the study of Gamblesand colleagues (2010) on medication at the end-of-life care found that there was no evidence to prove these allegations especially on medications. Although, healthcare professionals have persistently tried to convince the populace of the benefits of the pathway which evidence has shown to outweigh the supposed harm (Christian, 2013). In regards to the effectiveness, flexibility and principles of LCP in relation to cancer pain and symptom relief, it has been recommended as a guide for care plan in palliative oncology care (GMC, 2010; DH, 2009 and NICE, 2011).

RATIONALE FOR THE PROPOSED CHANGE

The proposal to champion change in palliative cancer care plan was borne out of our clinical experiences in Nigeria, considering the prevalence of cancer among the adult population. Nigeria Health Watch (2015) reported that cancer is an aspect of public health that has received little or no attention in the country, in contrast to what obtains in the developed countries. Palliative cancer patients are poorly nursed in the general ward and their nursing care plans are not usually dutifully followed until death. Thereafter, the nurse in charge patches up the care plan to defend herself in case of ethical and legal issues pertaining to the care rendered (NMC, 2015). However, high quality palliative cancer care is necessitated at all levels of care and studies have shown that if quality palliative care is not ensured, the nurse will provide inconsistent care associated with errors which are preventable with quality care (Ferris*et al*., 2007).

Cancer is a global public health problem that cuts across both economically developing and developed countries (GLOBOCAN, 2012). The disease is characterised by varying symptoms throughout the disease process. WHO (2013) reported that in Africa, Nigeria has the highest cancer death rate evidenced by about 10,000 cancer deaths and 250,000 new cancer cases being recorded annually. Findings have also gathered that 17% of African countries are insufficiently funded on cancer control plans while less than 50% of these countries have functional plans to provide treatment and care to cancer patients (WHO, 2013). According to Cancer research statistics in the UK, about 331,000 cancer cases were recorded in 2011 out of which about half of these cases will experience pain at varying stages of the disease process (British Pain Society, 2010) In Nigeria, an estimate of 60-70% of cancer patients presents at the terminal stage of the disease with pain and other clinical symptoms (Size *et* al., 2007; Vanguard, 2015). This implies that symptom relief is pertinent to palliative care and consequent to the high incidence of cancer disease, there is need to sensitize nursing leaders towards incorporating the LCP as a framework for effective palliative care planning with the aim of ensuring quality assurance in nursing care. Apparently, this requires a lot of commitment and responsibility from healthcare organizations including nurses at all levels of care to ensure quality living for palliative cancer patients. To be realistic and for the purpose of this paper, we would be focusing on the strategies to ensure drawing and implementing a detailed but succinct mode of care plan in managing palliative cancer patients. Currently, the palliative care rendered to cancer patients in the organization is ineffective and this is traceable to many factors such as poor pain relief and nursing documentation of care plan which has been observed as an impediment to quality care (Lee, 2005).

OVERVIEW OF THE HEALTH SYSTEM AND PALLIATIVE CARE IN NIGERIA

Nigeria is located in the western part of Africa. The levels of healthcare system operating in the country are generally structured along the primary, secondary and tertiary care. This system is synchronously run by the local, state and federal governments whereby the human and material allocations are directly or indirectly influenced at the federal level with respect to each level of care (Asuzu, 2005). This structure allows for even allocation of resources regardless of the geographical location. Considering the present economic status of Nigeria, in 2014 budget, 5.7% of the total budget was allocated to the health sector which opposed WHO recommendation of 15% for health (Oyedele, 2014). Out of this health financial allocation; 70% was earmarked for urban expenditure where the majority of the population are abundant (Egbulem, 2011) while the remaining 30% goes to the rural area. Despite this allocation, individuals living with cancer are responsible for the healthcare services they receive from the time of diagnosis throughout treatment phases (Nigeria Health Watch, 2015). Globally, palliative care was inaugurated in 1967 in the UK with several models and pathways of palliative care whereas in Nigeria, it was formally introduced in 2003 through palliative care of Nigeria and ever since, only few teaching hospitals have established the department (Onyeka, 2011). Even with the National Health Insurance Scheme in Nigeria, accessibility to cancer care is limited (Vanguard, 2015; Nigeria Health Watch, 2015) while HIV and Tuberculosis patients benefits from the scheme whereas in the UK, the National Health Service offers unrestricted healthcare services to all her citizens including palliative patients. Thus, it can be contended that, prioritization is lacking and palliative oncology care is not receiving the appropriate healthcare attention in Nigeria. Similarly, the National Health Bill (2008) was implemented for standard provision of healthcare services in Nigeria. Although, the first part of the bill emphasizes that the health system will support and enhance the rights of Nigerians by prompt accessibility to best possible healthcare, this is

untrue with palliative care since cancer patients are not receiving the best end-of-life care when compared to the other nations. In the UK palliative care bill has been approved and it imposes free specialized health care for all categories of patients with end of life care needs.

Furthermore, considering the estimated minimum wage of an average worker of about £68 monthly compared to UK estimated monthly wage of £850 (BBC, 2014),patients in Nigeria are still expected to foot their hospital bills. While in the UK, the NHS bears the financial responsibility of healthcare regardless of the patient's financial status. This could deter palliative patients from accessing and enjoying quality care in Nigeria and invariably, this poses a huge challenge to quality of palliative oncology care rendered in the country. Despite these challenges, there is still no pathway of care for these patients. According to Mohanti (2009), nursing care plan is mandatory in managing patients with advanced stages of incurable malignancies. Therefore, it both poses healthcare and ethical demand as it involves the latter part of life characterized by multiple distressing symptoms. Legally, the Nigerian government has the major responsibility to enact laws regarding palliative oncology care pathway but at present, there is no specific health policy and pathway of care for cancer patients at the end-of-life; despite that the association for hospice and palliative care has required every country of the world to develop a palliative care plan, above all integrating hospice and palliative care to suit individual health needs (NICE, 2011).

ORGANISATIONAL CHALLENGE

The challenges associated with the Nigerian healthcare delivery system are a combination of environmental and organizational factors.This justifies the need for strong leadership at all levels of care (Mitchelle, 2013).The emphasis is to define and ensure quality of care and life for health stakeholders (Trochim and Kane, 2005). Firstly, allocation of resources is a significant challenge that most organization experiences and considering the national health budget, it is evident that inadequate resources are being allocated to healthcare sector while the little available fund is unevenly distributed. According to Azuzu (2005), financing being a major health system conflict in the developing countries of the world is associated with socio-political values. Hence, prioritized budget aimed at reducing health disparities should be targeted. Likewise, the low staffing level is another challenge encountered by Nigerian hospitals, this consequently leads to poor quality of health services rendered to consumers, complaint of dissatisfaction and high rate of stress among healthcare providers especially nurses (Oyetunde, 2012).Not only that, the influence of organisational and professional culture on decisions to advance an area of practice cannot be overemphasized.

APPROACHING THE CHALLENGE

As professional nurses aiming at implementing change in palliative oncology care planning, the APIE approach of continuous improvement cycle which has been validated as a conceptual framework for problem solving and decision making could be applied (Emerson, 2007). This includes Assessment, Planning, Implementation and Evaluation stages.

Stage 1: Assessment:

Having identified the problem, an in-depth analysis would be done using different viewpoints of the information obtained from staff, patients and relatives with the aim of understanding the current provision of palliative care in the organization. Similarly, considering the appraisal of this pathway whether the organisation wants to improve on the present level of nursing care plan for palliative oncology patients by incorporating the LCP or they want the procedure to remain as it is. Although, initiating change demands effective leadership in hospital settings especially when decisions are made on clinical matter (Del Mar, Doust and Glasziou, 2007); nonetheless, the disparity in care and gaps identified should be discussed with colleagues and considered in terms of cost and timing which are important to the proposed change in palliative oncology care.

Subsequently, application of change theory and assessing leadership styles will be pertinent to successful implementation of change in palliative care (Walshe and Smith, 2011). Lewin (1951) cited the three step model of change even though other theorists have reviewed and modified Lewin's theory of change. U*nfreezing* involves identifying the need for a change, using information to understand discrepancies and selecting a suitable solution. *The moving stage* involves seeking collusion between those who will be affected considering their participation and consent with the aim of convincing them that the current status is no longer beneficial while *refreezing* emphasizes integrating the change and maintaining it using policies and laws. Rogers (2003) identified five steps which include awareness, interest, evaluation, trial and adoption.These are similar but more elaborate than Lewin's theory. However, in this context, Lewin's theory is being considered for initiating the change in palliative care due to its simplicity and relevance to the proposed pathway of care (Mitchelle, 2013). In the light of this, it has been validated that leadership, effective communication and inter-professional teamwork are vital aspects of planned change (Tomey, 2009).

The transformational, transactional and situational leadership styles have been appraised in relation to achieving healthcare goals (Giltinane, 2013). Transformational leaders are usually democratic in approach believing that workers are motivated to combine effort towards achieving an improved patient's outcome considering its characteristics (Wong and Cumming, 2007) whereas, transactional approach is task-oriented, compels people to work and could lead to poor outcome of care as nurses tend to focus more on completing care procedure and not holistic care (Bach and Ellis, 2011). On the other hand, the situational leadership emphasizes flexibility and ability of a leader to identify competence and commitment of others. In view of these leadership styles, researches have shown that there is no definitive evidence on the superiority of any leadership style to others (Rolfe, 2011). However, situational leadership approach could be more appropriate to cope with change processes in the healthcare system (Giltinane, 2013). Although, the nursing manager to be approached for this proposed change operates a transactional leadership style while we are transformational leaders, bearing in mind the attributes of both styles discussed

previously; we could motivate and influence support of other colleagues to fine-tune the proposed solution prior presenting it for acceptance whereas the autocracy of our manager's leadership style will influence successful adoption and adaptation of the solution. According to Bass and Stogdill (2009), an autocratic leader enforces obedience and adherence to rules. Therefore, nurses managing palliative cancer patients could adapt to the new care pathway in view of the nursing leader's attributes which will invariably improve care.

Stage 2: Planning:

This is the solution stage and involves selecting the best impression that is not decisive initially, through proper assessment and collection of appropriate data before making a final decision (Gopee and Galloway, 2013). Thus, identification of end-of-life care needs, pain relief and symptom management will be effective with good nursing care. The proposed solution of incorporating LCP into a succinct care plan aimed at assisting Nigerian nurses to render individualized care to palliative cancer patients has evolved from creative and critical thinking skills. Owing to this fact, the relevant information collected and the realistic alternatives to approaching the problem will be discoursed and contemplated in relation to time and financial constraints which may limit the numbers of alternative at hand. This will be done for the purpose of comparative analysis, an important aspect of decision making(Astolfi, Lorenzoni and Odedrik, 2012). The possible solutions are to develop a succinct care plan record with the LCP checklist focusing on pain and symptom relief initially, training of nurses during monthly continuing education, employment of oncology nurses and building of specialized ward for cancer patients. Out of the possible solutions highlighted, the options that seem most feasible will be considered in terms of the anticipated organizational challenge of human and material costs. Besides, this section will include communicating alternative decisions to our superior in the hospital.

Among the obtainable solutions, we would overlook the aspect of training nurses and building an oncology ward at the initial stage. This is because of the extra cost it will incur on the hospital and if the implementation will be effective, putting an additional cost on the management could make the goal not feasible especially on a long term and continuous basis. Nurses are being rotated through the wards yearly as part of the organisational policy. Hence, a trained oncology nurse may be transferred to another unit and a new nurse posted to replace her on the former ward. Likewise, training nurses will have a financial burden on the hospital and the process of selecting nurses for training may be biased which could result in organizational conflict among nurses. Furthermore, building an oncology ward will involve huge capital for the structure and equipment. This may seem unrealistic as this is a capital project and is subject to government approval. Having nullified two out of the four options available, employing trained personnel with specialist knowledge in oncology will be a good idea in training other staff and rendering care. Although, the organization will need to employ and pay them, it is cost effective compared to training specialist nurses who can resign their present appointment for greener pasture at any time. Despite the selection of these two seemingly suitable solutions, the resources involved should be deliberated. Resources have been argued to be the means from which benefit is produced from a source in an organisation (Miller and Spool man, 2011). These are money, materials, staff, services or other consumable services. Therefore, the likely needed materials are stationeries and forms. Similarly, employment of specialist nurses will cost the management more money to pay their salary and since the hospital is funded by the government and the internally generated revenue, another considerable option is to liaise with some non-governmental organisations that have oncology specialist nurses as a member staff. They could be willing to offer voluntary assistance that will not bother the organisation financially.

Moreover, the nursing department of the organization comprises of both junior and senior managers where the chain of communication is vertical for possible feedback; from the nurse in the lower cadre to the top managers who implements decision. In view of the long channel that information will pass through before reaching the senior manager, it is possible that they do not receive the right information which may prevent adequate understanding of the proposed solution and impede decision making process. Thus, appropriate decision model and theories should be considered.

Decision-Making Models:

Daft and Lane (2010) identified the classical, administrative and political models of decision-making which clarifies that the choice of a model is dependent on whether decision is the programmed or non-programmed, the manager's preference and the degree of uncertainty associated with the decision. Furthermore, Daft (2010) argued that classical model is normative, as it defines how a manager should make a decision while Roussel and Swansburg (2009) identified the strategic model, descriptive model and the normative model. The seven steps of normative model are entrenched upon the assumption that the consequences of choices made during decisions are predetermined. Although, they further posited that the application of this decision-making model is unrealistic as it presumes that there is definite choice between options.While the administrative model involves the actual procedure of decision-making undertaken by the manager, this has been assumed to be an unclear and a non-programmed decision (Daft, 2010). Finally, the political model is said to describe a democratically inclined organization whose staff are being empowered equally to participate in decision-making process. This model is said to be useful and suitable for difficult circumstances that requires decision (Daft, 2010). Considering these models, it can be said that the organisational task and setting at a time influences the choice of model and theory. However, in the context of the proposed change and the leadership styles discussed earlier, the political model will be more appropriate to introducing LCP into palliative care.

Decision-Making Theories:

Decision making theories are structures that can be used to underpin how an advanced practitioner acts when involved in decision-making (Roussel and Swansburg, 2009). Theory of decision making is strongly related to the development of social and cognitive psychology, processing of information,

perception researches, clinical judgement and social behaviour (Standing, 2010). On the other hand, Dowie and Elstein (1997,pp 81-82) cited in Standing (2010) identified a competing theory for decision-making which are intuitive and analytical. Calder*et al* (2012) argued that decision-making using the intuitive theory is an experiential preconscious act which is related to habits formed upon the basis of knowledge. It is holistic, emotional and resistant to change whereas the analytical theory is rational and deliberate. However, in order to match decision tactics to changing practice priorities, the two competing theories were merged to form the cognitive continuum theory by Hammond 1998 cited in Standing (2010). According to Calder, Campbell and Watson (2005), cognitive continuum theory has three key assumptions and has been validated to be more appropriate than a two-way approach in medical problem solving and decision-making. In view of these, the relationship of cognitive continuum theory to our profession as nurses cannot be over-emphasised as it influences the choice of a problematic area of care.

Ethical Consideration in Decision-Making:

The ethical issues related to decision-making will be reviewed. It has been debated that ethical issues in the clinical settings are considered when identifying a problem and making the 'right' decision (kinlaw, 2005). This is usually difficult especially when changing the pattern of care. Hence, healthcare decision makers must reflect ethical principles that embrace autonomy, justice, beneficence and non-maleficence (Fricker, 2007). Not only that, professional and ethical codes and standards should be considered and upheld (ACHE, 2011). In light of the above, healthcare organizations should develop strategies for palliative care which includes, research and ethics committee, written policies, procedures, guidelines and checklist to familiarise staff with both legal and ethical concepts of decision making (kinlaw, 2005). In this context, the solution was chosen from the LCP for ethico-legal reasons since its components are evidence-based (GMC, 2010). Furthermore, autonomy involves patients' right to make choices about their clinical state and it has been asserted that healthcare givers are obliged to respect this as long as the patient is capable (Fricker, 2007). In support of this, Beauchamp (2009) added that patients should make decisions based on adequate information and understanding of situation without being coerced. Thus it can be debated that informed consent and respect of patient's choice is an ethical concern when the organization is proposing a change. Secondly, justice entails being fair to service users by prioritizing their need (Fricker, 2007).

On the other hand, beneficence as an ethical issue is concerned with the maximal advantage of the decision with a view to minimizing harm to the service users and caregivers (Polit and Beck, 2013) while non-maleficence is the duty to avoid harm to those involved as much as possible. However, the professional standard expected of nursing is embedded in the code of ethics guiding nursing practice which demands that nurses should provide a high standard of care at all times (NMC, 2015).Thus, it can be inferred that nurses should render quality care to patients regardless of their clinical status. The organization's awareness on these ethical consideration and principles has obliged them to have a legal practitioner among the top executive board member of the hospital. In view of the stated principles, since the services to be implemented are dignifying and life changing for service users and relatives involved in palliative care, it has been suggested that organizations should assess the associated risks and likely consequences of decision made before implementation (Bain and Carson, 2008).

Stage 3: Implementation:

This is the action phase of the proposed change and scholars have argued that the implementation phase is the most time-consuming of the decision-making process (Hunter and Marks, 2002). Therefore, decision made in the organization is not considered operative without effective implementation. According to Daft (2010), implementation is the most difficult part of change process and without it; the previous steps are of no benefit (Hunter and Marks, 2002). Conversely, for this stage to be more effective, the organization needs human and material resources. While approaching this stage at least about four hospital staff would be met about the decision.This could be top ranked executives and the ward manager due to her leadership style and her involvement in managerial decisions. Similarly, the needed resources would be utilized by printing a draft of the proposed care plan record, organising a continuing education program for nurses to orientate and familiarize them with steps involved in the LCP implementation. In the light of this, timing of the proposed change should be noted as the efficacy of change is dependent on an agreed time frame (Northouse, 2012). The pathway of care to improve palliative oncology care would also be included in the content of continuing education program for nurses to create awareness.

All the outlined strategies will be gradually scheduled with specific time frame to ensure successful implementation this is in line with the study of Tomey, (2009) that change is a gradual process and should be introduced steadily.Notably, if the organization is able to implement this recommendation against all odds, it would enhance the hospital's reputation in palliative care and being a relatively new sub-speciality, this would boost the nation's healthcare image globally. As a result, more cancer patients would patronize and be referred there for quality palliative care. Overall, whether the solution is temporary or permanent it would definitely pose change to the organization and the staff involved in the change process. Although, if collaboration with NGO for the provision of palliative care services or training for nurses is accepted as a resolution, the effect will be positive for the patient as it would ensure quality end-of-life care. This would also heighten our understanding as nurses in respect to the principles of pain and symptom relief through nursing care plan. Furthermore, there would be allowance forrelatives' participation in care. More importantly, it wouldundeniably have positive effect on patients, relatives and job satisfaction on the part of the healthcare givers. This specifies that the reflection on patient's death is not restricted to relations only but also nurses.

In light of these, there is need to provide privacy since there is no separate ward for cancer patients and privacy should be ensured in conformity to the ethical principles of decision making. Similarly, nurses will coordinate all other members of the palliative care team and ensure appropriate delivery of

consultation request through the health assistants with the aim of ensuring prompt patient's review by the team, the solution will then be realistic.

Other considerations to be reflected upon are risk assessment, professional and organizational culture. It is imperative to anticipate the effect of the proposed change on the values of the organisation. This would be approached using the Roger's theory of change highlighted earlier. Likewise, considering the high rate of competitive professionalism in the organization, involving oncology experts from outside the organization could predispose doctors and nurses to assuming that their individual knowledge and experience on cancer care is underestimated. However, the involvement of other healthcare team members and oncology specialist does not indicate that general nurses and doctors should be restricted from rendering cancer care.

Our Decision-Making:

Healthcare professionals' contribution to the growing body of knowledge is essential to providing clarifications to problems through researches and criticisms. These are imperative for growth and all is aiming at improving the healthcare services rendered. Considering this fact, this can be well achieved through the professionals' commitment to the increasingly developing health measures. Thus, this decision is focused on contributing to the existing body of knowledge in palliative care. The decision is immensely established on the knowledge and limited experience gathered in the organization for several years as nurses. Therefore, this has helped in identifying an area of patients' needs. In a wider perspective, being resident in Nigeria for several decades has also facilitated the understanding and prediction of peoples' reaction to varying situations. Owing to these, we would attribute this decision-making to the accumulated knowledge from life and work experiences.

Moreover, this decision is basically from intuitive knowledge although complemented rationally due to the flexibility employed. It is also an acknowledged fact that personal factors such as emotions and preference for the topic is involved. The combinations of these theories have positively influenced the decision-making. Another identified factor could be the limited years of experience as nurses which could be argued that with additional years of experience will be more analytical than being intuitive in respect to decision-making issues. In addition, the focus of this clinical decision-making process has increased our knowledge which can be said to have facilitated the decision considering the fact that learning process is still ongoing. On the other hand, the involvements of reflective reasoning on our individual lives and the acquired professional acumen have been contemplated both negatively and positively with the aim of improving nursing practice in future. Therefore, the anticipated organisational problems will be reflected and resolved to achieve effective LCP implementation and quality assurance in palliative care; which is aimed at pain and other symptom relief as this is the major clinical symptom experienced every stage of cancer (Daher, 2010).

Stage 4: Evaluation:

This is the last stage of decision making which would involve a proof to show that if the proposed plan were to be rightly implemented, nurses will draw and implement succinct care plan for palliative oncology patients and both patients and families will demonstrate satisfaction of care. The management should also make room for continuous review and adjustment by following up the staff's view with the aim of making necessary amendments through the identified problems. On the other hand, follow up could be done by probing patients and relatives about their experiences on the current provision of care.This could be conducted through oral interviews or surveys on a regular basis with the aim of improving the services provided. During the course of the review, it is pertinent to ensure that the rights of both service users and healthcare givers are protected.

Influences on decision making:

Professional judgement and decision-making are complementary as decisions made are exposed to review by people, service users, their families, colleagues, other professional staff and the public (Jasper, Rosser and Mooney, 2013). In clinical practice, decision-making is unavoidable; hence it is essential to identify the factors influencing it. These influences could be positive which aims at enhancing the outcome of healthcare while the negative influence on decision-making contributes to mistakes which may consequently have adverse effects on the health service consumers (Roussel and Swansburg, 2009). Moreover, the identified practitioner and organisational factors affecting clinical decisions are linked to social, physical, professional and organizational sources. The practitioner factors are sense of identity, personal frames of reference, practice model and multidimensional knowledge while organizational factors are evaluated in relation to the organizational structure and culture. On the other hand, social factors regards reflecting on societal values, attitudes, norms and customs of the stakeholders that are involved in the change process and how this affects them. Similarly, professional factors are related to implementation of a solution based on policy and guidelines. Owing to this fact, it is expected of a professional to act according to regulations. Therefore, considering palliative oncology care; money, staffing and organisational cultures are influencing factors.

RECOMMENDATIONS

During the course of this decision process, an enhanced level of knowledge about palliative cancer care has been attained. Based on the gaps identified, the measures recommended includes the need for a comprehensive national programme on palliative cancer care, inclusion of palliative medications such as opioids in the essential drug list to ensure cancer pain relief (WHO, 2013) and inclusion of pain interventions into nursing curriculum. Furthermore, the cancer registries should endeavour to follow up patients up till death in order to monitor the survival rate. In the same vein, there is need to create awareness on oncology nursing certification in order to enhance palliative care and finally, the federal government of Nigeria needs to include cancer care into the national health insurance scheme, thus making palliative oncology care free at all levels of care in the country.

CONCLUSION

This opinion paper has identified an area of care and has critically demonstrated palliative oncology care concepts in Nigeria with a view to influencing decision making. The introduction of the Liverpool care pathway to improve symptom relief for cancer patients have been appraised and analysed through the application of the APIE implementation cycle. It has also proposed ways of solving the identified challenges through the application of change theories and leadership styles and not without critiquing the appropriate decision-making models and theories that are pertinent to successful decision-making. Therefore, the influences of this decision-making process were contemplated and both negative and positive phases encountered alongside knowledge gained would be useful to advancing our decision-making skills as professional nurses in the future.

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