SCHOOL OF NURSING AND MIDWIFERY

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF GHANA LEGON

EXPERIENCES OF NURSES CARING FOR PATIENTS WITH BREAST CANCER IN THE KORLE BU TEACHING HOSPITAL, ACCRA

BY

AUGUSTINA NAA SHORME NOI

(10064400)

A THESIS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MASTER OF PHILOSOPHY NURSING DEGREE

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DECLARATION

I Augustina Naa Shorme Noi attest that this thesis is a sole result of my personal effort to attain Master of Philosophy Degree in Nursing at the School of Nursing and Midwifery, University of Ghana. This work has never been presented in parts or in whole to any institution for the ward of any degree. However, the works of authors and publishers that has been presented in this work has been duly acknowledged in the text and reference section.

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..... 24-10-2020

DR LILLIAN AKORFA OHENE — DATE

(CO-SUPERVISOR)

DEDICATION

I dedicate this work to my father, Benjamin Nortey Noi, my dear children and nieces: Bernard, Benjamin Jrn, Ernestina, Margaret and Belinda for their encouragement and support

ACKNOWLEDGEMENTS

To God be the glory great things he has done. Indeed the Lord has been my strength and my rock. I am grateful to all the participants of the study. My deepest appreciation goes to my lead supervisor Professor Lydia Aziato and my Co-supervisor Dr. Lilian Akofa Ohene for their support, motivation and guidance throughout the study. I am also thankful to all other lectures at the School of Nursing for the knowledge, skills and attitude gained through their academic guidance and tutoring. I am grateful to all the supporting staffs of the School of Nursing who also contributed to the successful completion of this study.

My special thanks go to my father who instilled discipline, honesty, and the value of hard work in me. Also, he supported me emotionally, spiritually and financially as I embarked on this academic journey. I wish to express my appreciation to all my colleagues and every person who contributed towards the writing of this research study in diverse ways. I am grateful to the Korle Bu Teaching Hospital for permitting me to use their facility for the conduct of the study and all the staffs of radiotherapy department and adult surgical ward II were I recruited the study participants. To all the authors and publishers, I am thankful and I cherish your immersed knowledge and wisdom. God Bless you all.

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LIST OF ABBREVIATION

ANS	American Nursing Society
APN	Advanced practice nurse
ASW	Adult Surgical Ward
ASW2	Adult Surgical Ward II
BC	Breast Cancer
BCN	Breast Care Nurse
BSE	Breast Self-exams
CBE	Clinical Breast Examination
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CPD	Continuous Professional Development
Dept.	Department
IRB	Institutional Review Board
KASRP	Knowledge Attitude Survey Regarding Pain
KBTH	Korle Bu Teaching Hospital
MOH	Ministry of Health
NMC	Nursing and Midwifery Council
PCQN	Palliative Care Quiz for Nurses
RN	Registered Nurse
SRN	State Registered Nurse
TPB	Theory of Planned Behaviour

ABSTRACT

The nurse plays a key role in the Breast Cancer (BC) care continuum to provide quality care to patients and family. This study aims to explore the experiences of nurses caring for patients with BC at the Korle Bu Teaching Hospital, Accra. The study employed a qualitative descriptive design which was guided by the Theory of Planned Behaviour by Ajzen, (1991). Thirteen (13) participants from the radiotherapy department and the adult surgical ward were purposively recruited. A semi structured interview guide was used to elicit information from the participants. The audio recorded data was transcribed verbatim and analysed manually using thematic content analysis procedure. Four main themes were generated using thematic content analysis approach. These were nurses' knowledge on BC care, attitude of nurses' towards BC care, subjective norms of nurses' towards BC care and perceived behavioural control of nurses' towards BC care. The study revealed inadequate knowledge on non-pharmarcological pain management of patients with BC. Positive attitude exhibited by the nurses included comforting patient and paying patient's bills. However, nurses expressed negative attitude like giving placebo for pain management and avoiding wound dressing assignment. Also, nurses practiced favouritsm during job assignment. The study also identified factors such as inadequate infrastructure, lack of logistics and staffs, lack of time, and increased workload was associated with BC care. The study concluded that nurses should be knowledgeable in cancer pain management, wound dressing, and promote organizational work climate that can meet the needs of patients with BC.

CHAPTER ONE

1.0 INTRODUCTION

This chapter focuses on the background to the study, purpose of the study, statement of the problem, research objectives and research questions as well as the significance of the study and operational definitions of keywords used in the study.

1.1 Background of the Study

Breast cancer is of global concern as it is a cause of morbidity and mortality. Globally, breast cancer is the second highest cause of cancer deaths among women (Bray et al., 2018). Breast cancer accounts for 28% of all cancers and 20% of cancer deaths in women in Africa (Clegg-Lamptey, 2017). Incidence of breast cancer in South Africa is 38.9/100 000 women; 30.4 in East Africa, 26.8 in Central Africa, and 38.6 in West Africa. It is expected that breast cancer incidence will double in all parts of Africa in 2050. The burden of breast cancer may even become greater due to improvement in technology. A systematic review and meta-analysis conducted by Maajani et al., (2019) showed that survival rates from 2010 - 2017 were higher than in the 1960s even though it is lower in the low and middle-income countries.

Ghana is not left out of the cancer burden since the current statistic revealed that breast cancer diagnosis among women has doubled over the years (Thomas et al., 2017). However, one cannot emphasize the estimated values on cancer mortality in Ghana since some deaths may not have been reported (Yarney et al., 2020). Nonetheless, breast cancer is curable when diagnosed early (Ghasemi, Rasekhi, & Haghighat, 2019; Ramires et al., 2018). A study was done by Mensah, Yarney, Nokoe, Opoku, & Clegg-Lamptey, (2016) in Ghana, in which the cases were followed up to 2011, showed a cumulative five years survival rate of 47.91%. Despite the upsurge of breast cancer cases in Ghana, there are not

many treatment options when diagnosed early (Ghasemi et al., 2019; Ramires et al., 2018). Currently, breast cancer treatment centres are located within the Government-owned tertiary hospitals within the southern part of Ghana and few privately owned institutions in the capital city of Ghana ("Cancer Radiotherapy in Ghana Cancer Control," 2016).

Nurses who care for patients with breast cancer also called oncology nurses (Pennbrant, Tomaszewska, & Penttilä, 2015; Watts, Botti, & Hunter, 2010) and are the main allied team members in cancer care (Adler, 2010; Prades, Remue, Van Hoof, & Borras, 2015). The oncology nurses are specialized clinicians trained to deal with psychosocial issues as well as the physical and physiological care process (Dahlin, 2015; Komatsu & Yagasaki, 2014). The oncology nurse gives care to the patient with cancer from the early stages to late stages when palliative care becomes the ultimate (Abrahm, 2017). Nurses caring for patients with breast cancer need to be supportive to provide for the needs of their clients who present with severe life-threatening symptoms (Van den Heever, Poggenpoel, & Myburgh, 2015; Zhao, Gao, Wang, Liu, & Hao, 2016). The oncology nurse helps patients with breast cancer to cope with their situation (Gjesdal, Dysvik, & Furnes, 2019; Taylor et al., 2019). Thus, the nurse is expected to periodically review current knowledge available in oncology nursing to help implement the appropriate comfort measures for the patients.

In Europe, it is recommended that all patients suffering from cancer should be cared for by specialist nurses (Leary, White, & Yarnell, 2014). Therefore, nurses who take care of patients with breast cancer are known as Breast Care Nurses (BCN). The BCN is a Registered Nurse (RN) who is trained to care for patients with breast cancer (Eicher et al., 2012). Also, in America, the nurse who cares for patients with breast cancer is an Advanced Practice Nurse (APN) in oncology and a licensed RN with a master's degree (American Cancer Society, 2012).

In South Africa, nurses who care for breast cancer patients are required to complete a diploma in oncology nursing (Maree & Mulonda, 2017). However, in Ghana, the nurses who care for patients with breast cancer are generally RNs who hold a Diploma in either general nursing or midwifery. Currently, the Ghana College of Nurses and Midwives offers a three-year certificate in oncology nursing for nurses holding a degree in nursing and a two -year certificate program for nurses with a Master's Degree. It is therefore perceived that fewer oncology nurses exist in Ghana. Globally, there is a shortage of oncology nurses (Shang, Friese, Wu, & Aiken, 2013; Toh, Ang, & Devi, 2012; Vichare et al., 2013). Thus, general nurses take up the role since they have been trained in the management of both acute and chronic medical/surgical cases (Joyce & Johnson, 2018). This shortage places much pressure on nurses working in cancer care settings as the workload is complex (Gilroy, 2018; Toh, Ang, & Devi, 2012). Also, the shortage can affect the quality of care being offered by the nurse.

The oncology nurse needs both human and material resources to give effective care from admission until discharge (Lanzarone, Matta, & Sahin, 2012; Saad et al., 2011). A material resource such as Opioids is used by the oncology nurse to manage pains for the patient with breast cancer (Gorlén, Gorlén, Vass, & Neergaard, 2012; Mantyh, 2014; Villapiano, Winkelman, Kozhimannil, Davis, & Patrick, 2017). Some other professionals that the oncology nurse collaborates with to help improve the quality of life of the patient with breast cancer are pharmacists, chaplains or spiritualists, palliative trained social worker and the occupational therapist (Bakitas, Bishop, Caron, & Stephens, 2010; Koczywas et al., 2013).

Patients suffering from breast cancer pass through difficult times as they seek for treatment and possible cure. Therefore, the nurse who coordinates the activities of the health team in caring for the patient may benefit from the interaction as well as encounter

challenges which can be termed as experiences. Some of the signs and symptoms that patients with BC may suffer , for example, the fungating breast may lead to the grieving of both the patient and the nurse. (Agra, Helena, Oliveira, Miriam, & Costa, 2015). As such, a nurse who has more experience in cancer care settings can allay fears and anxiety of the patient with breast cancer (Hermann, Long, & Trotta, 2019; Kaltenhäuser et al., 2017; Nicoloro-SantaBarbara et al., 2017). Thus, one of the main areas that the nurse pays attention to in cancer care is supportive care (Fiszer, Dolbeault, Sultan, & Brédart, 2014; Peteet & Balboni, 2013). This may include exercise and spiritual care of the patient with breast cancer. Also, the nurse must care for the patient in a safe environment which promotes cordial relationship (Maree & Mulonda, 2017).

In highlighting some of the experiences oncology nurses go through in Jordan Khalaf and colleagues asserted that nurses are confronted with fear when caring for the patient with breast cancer (Khalaf et al., 2018). Nurses experience emotions such as powerlessness, fear and denial (Khalaf et al., 2018; Pennbrant et al., 2015). Also, as nurses care for patients suffering from breast cancer, their conditions cause the nurse to grief (Bonsu, Aziato, & Clegg-Lamptey, 2014; Khalaf et al., 2018). Many other factors such as job strain have been reported to influence the nurse's effectiveness in the nurse-patient interrelationship (Wazqar, Kerr, Regan, & Orchard, 2017). Understanding the Ghanaian nurse encounters during an engagement with patients with breast cancer will help plan for support and de-stress or repose the caring processAlso, even though some research has been conducted in this area, little is known about the experiences of the Ghanaian nurse caring for patients with breast cancer. The theory of planned behaviour (TPB) will be used as the framework of the study as no known studies on the experiences of nurses caring for breast cancer has been conducted in Ghana using this model.

1.2 Problem Statement

In Ghana, most of the patients suffering from breast cancer report with advanced breast cancer (Ghartey Jrn, Anyanful, Eliason, Adamu, & Debrah, 2016). Thus, the patients present with complex physical, psychological, social and financial problems. Engaging with nurses with a speciality in oncology nursing will provide a more quality therapy to the experiences of these patients as these nurses effectively perform assessment and manage patients with breast cancer . Statistics obtained from Korle Bu Teaching Hospital over five years shows an increase in the reported breast cancer cases.

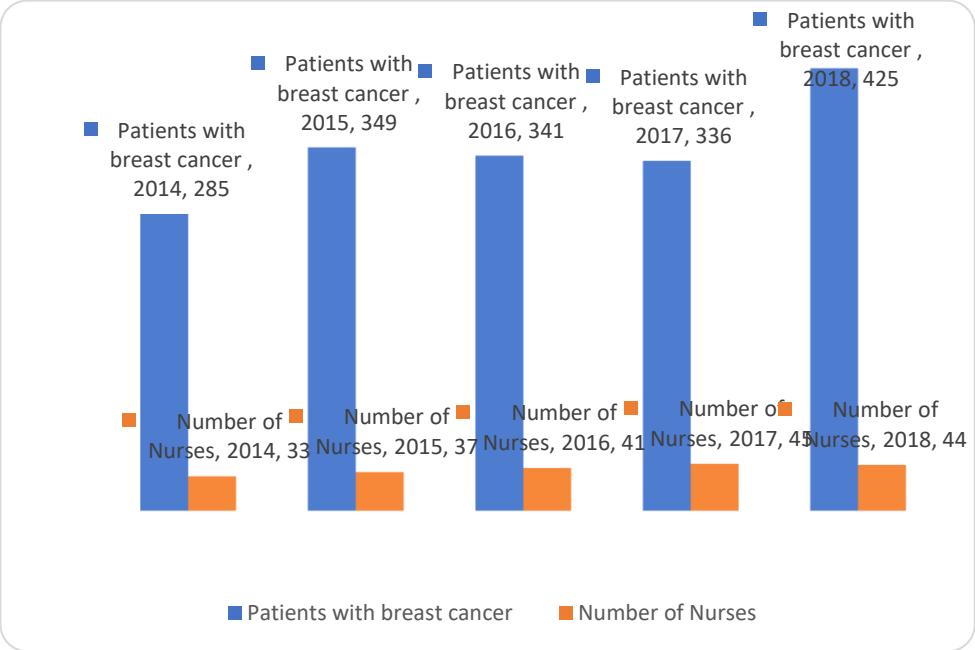

Figure 1.1: A graph Showing Reported Cases of Breast Cancer from 2014-2018 and Caring Nurses at the Korle Bu Teaching Hospital

Currently, the total number of registered professional nurses in the designated units for caring for patients with breast cancer in adult surgical Ward II and radiotherapy department is 53. Meanwhile, the first batch of oncological Ghanaian nurses were graduated in 2018. It is pertinent to note that the same 53 nurses also care for other patients with other

types of cancers. As a result of this, when the number of patients outnumbers the designated units, the patients are sent to another adult surgical wards and such hindrances could affect the cancer care trajectory. This obviously have direct impact on the experiences of the nurse in the care giving process. However, these experiences are not investigated and this remains a gap in the literature. Considering the increasing incidence in breast cancer diagnoses, a newly certified nurses of Ghana and the heavy workload, the question arises: what are the experiences (knowledge and attitude) of Ghanaian nurses working with breast cancer patients? Understanding the experiences of the nurses will help provide basis for improvement of cancer care in Ghana.

1.3 Purpose of the study

The purpose of the study is to explore the experiences of nurses caring for patients with breast cancer at the radiotherapy department and adult surgical wards at the Korle Bu Teaching Hospital in Accra.

1.4 Research Objectives

1. To elicit the knowledge of nurses regarding the care of breast cancer.
2. To describe the attitude of nurses caring for patients with breast cancer.
3. To describe the normative beliefs of nurses caring for patients with breast cancer.
4. To describe the perceived behavioural control of nurses towards breast cancer care.

1.5 Research Questions

1. What is the specialized knowledge of nurses caring for breast cancer patients?
2. What is the attitude of nurses towards caring for breast cancer patients?
3. What are the influences of significant others on the nurse towards breast cancer care?

4. How do resources, time and opportunities affect nurses' behaviour towards breast cancer care?

1.6 Significance of the study

It is believed that the findings of this study will be used to improve education, research, health care, administration and health policy. The result of the study will help to understand the knowledge, attitude, influence of significant others, availability of resources, time and opportunities of nurses caring for patients with breast cancer. Also, it will help identify nurses' intentions in deciding to work in cancer care settings and how the knowledge of breast cancer affects their lives. The understanding will also help improve the knowledge base of the health worker especially the oncology nurse. The study will serve as a reference for further research to provide quality care and help improve the quality of life of breast cancer patients and other patients suffering from cancer as well as the nurse. Also, further studies can be conducted to fill in the gaps identified to improve breast cancer care and ensure nurse/patient satisfaction.

The hospital employment policy for cancer care reflects the experiences of nurses caring for patients with breast cancer which helps improve the image of the hospital. In this regard, based on the study, the hospital management will be able to formulate protocols for breast cancer care to make breast cancer care more attractive. The study findings will help identify the needs of nurses caring for patients with breast cancer. This will help health care providers when planning for cancer care services. The study will again help to reveal the factors that influence the behaviour of nurses caring for patients with breast cancer as it may serve as a potential conflict reducer in the health care system. The findings of the study will also help to inform health policymakers to understand the needs and behaviour of nurses caring for patients with breast cancer to help improve policies based on oncology care. As

improved policy on oncology care will help attract more patients with cancer to the health care facilities, as such, the survival rate of cancer patients will increase.

1.7 Definition of Terms

Breast Cancer: Abnormal cell growth of the breast tissue.

Caring: It is the act of showing concern and helping the sick person to live with a disease condition.

Experiences: knowledge, skills and attitudes gained through personal engagements.

Nurse: A professional who helps to take care of the sick and the dying patient and their relatives.

Patient: An individual who is sick and undergoing medical treatment in a hospital

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

A literature review deals with critically analysing the existing information on a topic in a given research area . This chapter includes a literature review on experiences of nurses caring for patients with breast cancer which is discussed in five sections. There is also a review of the theoretical framework. The theory of planned behaviour which guides the study is highlighted in the first section. The second section addresses the literature reviewed on eliciting the knowledge level of nurses regarding the care of breast cancer. The third section reviewed the literature on the attitude of nurses caring for breast cancer patients while the fourth reviewed the normative beliefs of nurses caring for breast cancer patients and the last section reviewed the perceived behavioural control (resources, time, opportunities and challenges) of nurses caring for patients with breast cancer. The sources of the reviewed data are CINAHL, Science Direct, SAGE, PubMed and Wiley. Key Terms included breast cancer, caring, nurse, experiences and patient. Below is a review of planned behaviour theory which was used serve as the conceptual framework for the study.

Theoretical Framework

During the engagement with the literature in search of a theory that will guide the phenomenon under study, the researcher searched for and came across the theory of reason action which was developed by Ajzen and Fishbein in1980 (Ajzen & Madden, 1986). Through social psychological research, the theory was propounded and it is based on the assumption that some behaviours that are important to the society like health behaviours are under the control of the will, and the intention to perform those behaviours are rooted in the attitude and subjective norms of the individual (Hausenblas, Carron &Mack, 1997). Attitude deals with the evaluation and the weight individual places on a belief while

subjective norms involve the reflection of the expectations of significant others (Hausenblas, Carron, Mack, 1997). However, this theory is limited to the effect that attitude and subjective norm have on behaviour since not all behaviours are under the control of the will (Ajzen, 2002). Therefore, the theory of reason action was not chosen as the theory underpinning this research because the constructs of the theory will not be able to address all the objectives of the study. Thus, the theory of planned behaviour was chosen for it to serve as the framework that will enable the researcher to understand the phenomenon being studied.

2.1 Theory of Planned Behaviour (TPB) of Care Experience

Planned behaviour can be defined as individuals' beliefs that may have either a direct influence or an indirect influence on an attitude expressed towards a behaviour (Ajzen & Madden, 1986). Though it is difficult to explain behaviour, the theory of planned behaviour has tended to synthesize how knowledge available can influence biological and environmental factors associated with behaviour (Ajzen, 1991). A behaviour expressed may not be as a result of the influence of a particular choice but there may be other relevant factors that influence the behaviour being observed. Such relevant factors may include the strength of the individual and the occasion at hand. Also, an individual's attitude and personality traits can influence a person's collective behaviour (Ajzen, 1985).

Additionally, an intention to perform behaviour relies not only on the ability to decide but also, on the availability of resources, skills and opportunities created for the expected outcome. Thus, another construct which is perceived behavioural control was generated to include behaviours that may not be under the conscious control, for example, giving up alcoholism (Norman & Conner, 2006).

Key to the heart of the theory of planned behaviour is an intention to perform the behaviour. Intention pertains to how an individual is being motivated to perform the behaviour. Also, it depicts the efforts of an individual invests in deciding to perform a given behaviour. However, some behaviours can be expressed when non-motivational factors which may be intrinsic or extrinsic are taken into consideration (Ajzen, 1985, 1991). An example of non-intrinsic motivational control is knowledge and that of extrinsic non-motivational factors is the availability of adequate time, which can determine the individuals' control over the behaviour. Through past learning experience in association with current social situations, an intention is formed (Tryon, 2012).

The figure below shows the graphical representation of Ajzen, (1991) model showing the five constructs; Attitude, subjective norm, perceived behavioural control, behavioural intention and behaviour.

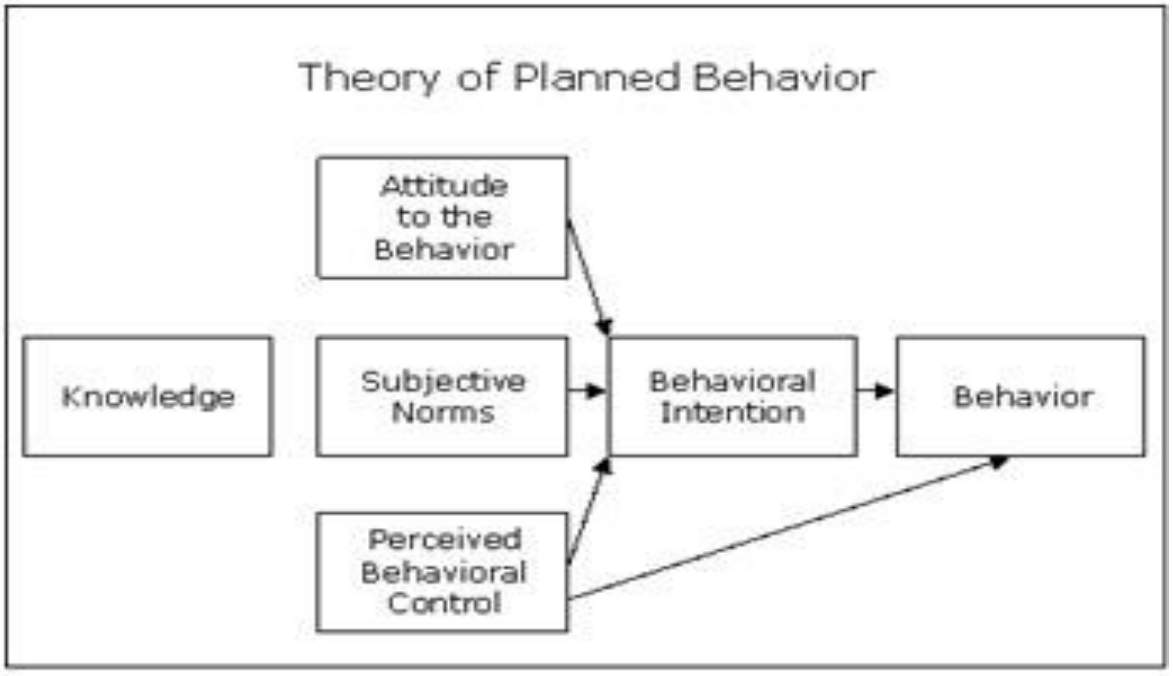

Figure 2.1: Adopted from the Theory of Planned Behaviour by Ajzen, (1991)

Behavioural intention is a product of an attitude towards behaviour, the subjective norms and the perceived behavioural control. The outcome of behaviour which results in an

attitude is through the reflection of the individuals' salient beliefs (Sutton, 2001). Also, attitude towards behaviour is based on merits and demerits as the individual assesses behaviour at hand. One of such beliefs is behavioural beliefs which are linked to attitude towards behaviour (Ajzen, 1991). Attitude can be drawn from the beliefs people have concerning an object. Through the association of attributes to an object, beliefs about the object are formed. The attribute may be evaluated as either positive or negative thus, the individual acquires an attitude towards the behaviour automatically. The individual may therefore form a favourable attitude towards a behaviour that rewards positively and unfavourable attitude towards behaviours that rewards negatively (Monroe & Read, 2008).

The construct subjective norm pertains to the perception that people have about whether that individual should perform a behaviour or not (Conner & Norman, 2017). The subjective norms are determined by the individuals' normative beliefs (Ajzen, 1991). The belief that significant referent wants an individual to perform behaviour can be perceived as social pressure that results in the performance of that behaviour (Sutton, 2001). Thus, a nurse caring for the breast cancer patient may put up behaviour to please the patient and the family as that is the expectation of the society.

The construct perceived behavioural control deals with the perceived barriers that an individual reflects on to determine how readily or the difficulty with which an individual performs behaviour (Ajzen, 1991). The perceived behavioural control can be likened to the construct self-efficacy by (Bandura, 2009) which is concerned with an individuals' appraisal of how one can achieve goals during favourable conditions. The individuals' choice of activities and efforts put in to achieve such goals is influenced by self-efficacy beliefs. However, perceived behavioural control deals with the expression of the behaviour in both favourable and unfavourable conditions (Ajzen, 1991). Therefore, with the availability of resources and adequate time, the nurse may express a positive behaviour towards caring for

the breast cancer patient. In predicting the outcome of behaviour, one needs to use both behavioural intention and perceived behaviour control because, how a person executes a behaviour depends on the perceived behavioural control when the intention is being held constant (Ajzen, 1991).

Applying the model to this study, the planned behaviour theory depicts how nurses' attitude (behavioural beliefs), the normative beliefs affects the intentions of nurses caring for breast cancer (BC) disease leading to a particular behaviour towards the patient with BC or the self. Also, the knowledge and attitude are based on opportunities available to put up that behaviour. Thus, according to the (TPB), nurses are bound to follow a particular health care behaviour if they believe that performance of the care activity towards patients with breast cancer will lead to an outcome which may be positive or negative. Also, even though the model does not show a link between knowledge and attitude, normative beliefs, perceived behavioural control and the behaviour, the researcher deemed it fit to explore whether the knowledge of the nurses about breast cancer influences the caring behaviour.

The theory has been used in many health behaviour studies (Conner & Norman, 2017; Swann et al., 2010). Also, its application has been widespread among the field of sociology, psychology, communication, microeconomic and medical. Specifically, it has been used in predicting the behaviour of nurses during blood pressure monitoring, predict the intention of the nursing midwife towards the provision of home birth services, knowledge sharing behaviour, education, individual interventions, fat burn studies, withdrawal from alcohol, works and management of rheumatic disease (Charani, Drumright, Holmes, & Shah, 2015; Muhammed, Khuan, Shariff-ghazali, & Said, 2019; Nelson, Cook, & Ingram, 2013).

Nonetheless, the constructs in the theory have been suggested not to be sufficient enough to explain an individual's intention and actions (Armitage & Conner, 2001). Also,

the perceived behavioural control cannot be deemed as good in place of actual control as the predictive validity of intention is being reduced due to lack of actual control; intentions are poor predictors of actions, even when it is being observed over short periods (Kor & Mullan, 2011). It is being argued that it is time to stop using the theory to predict health behaviour as cognition affects behaviour (Sniehotta, Presseau, & Araújo-soares, 2014).

However, according to Ajzen, (2015), that assertion is based on the false judgement of the theory. The most frequent criticism of the theory is that it is too rational as it does not take into consideration the cognitive and affect the aspect of the being that can influence judgement and behaviour of the individual (Ajzen, 2011). Nonetheless, the theory has been able to successfully predict intention, attitude and behaviour (Geraerts et al., 2008). Although the theory deals with human information control, the outcomes of the behaviour stem from "conscious self- regulatory processes" (Ajzen, 2011 p.1116) where the information available is being reviewed in an unbiased state to make a behavioural decision. This study will adopt the TPB to explore the experiences of nurses caring for patients with breast cancer at the Korle Bu Teaching Hospital, Accra.

The literature will be reviewed based on the assumptions and construct of the planned behaviour theory which defines the objectives of the study.

2.2 The Knowledge of Nurses Regarding the Care of Breast Cancer

Nurses caring for patients with breast cancer need specialized knowledge to help in early diagnosis of breast cancer, administration of pain medication and chemotherapy and give the appropriate end of life care (Ahern, Gardner, & Courtney, 2015; Gill & Duffy, 2010; Nwozichi, Ojewole, & Oluwatosin, 2017). Nurses need to protect the lives of patients with breast cancer as well as themselves in the cancer care trajectory (Fukuda, Shimizu, & Seto, 2015; Haddad & Geiger, 2019). Also, they need to guard against being dismissed from their job through incompetence. Studies have shown that nurses have lost their jobs through

medication errors (Mostafaei et al., 2014). Therefore, it is important to explore the knowledge of nurses caring for patients with breast cancer as one of the roles of nurses is to encourage patients to get to know their breast very well.

Also, since nurses are core to the fight against breast cancer and they seem to influence the behaviour of patients suffering from breast cancer, they must have adequate knowledge on the care of breast cancer before they will be able to educate the women effectively (Khalil & Mashaqbeh, 2019). Studies done in Africa concerning the knowledge level of nurses on breast cancer ranged from a relatively low to a high (Bello et al., 2011; Fotedar et al., 2013; Lemlem, Sinishaw, Hailu, Abebe, & Aregay, 2013; Prolla, Da Silva, Oliveira Netto, Goldim, & Ashton-Prolla, 2015). There are also studies that indicated that nurses have an unsatisfactory level of knowledge about breast cancer (Andegiorgish, Kidane, & Gebrezgi, 2018; Lemlem et al., 2013). However, those with appreciable knowledge were influenced by frequent in-service training in nursing, family history and working experience in cancer settings as well as marital status (Lemlem et al., 2013).

A study that was done by Prolla, Da Silva, Oliveira Netto, Goldim, & Ashton-Prolla, (2015) in Brazil on nurses knowledge on breast cancer and hereditary showed that nurses have good knowledge about the epidemiology of breast cancer

Furthermore, available literature has shown that nurses have a low knowledge level associated with the risk factors of breast cancer (Andegiorgish, Kidane, & Gebrezgi, 2018; Dnsc & Shoma, 2010). However, nurses have average knowledge level on breast cancer risk factors (Prolla et al., 2015). As a result, the nurse may help educate patients on a healthy lifestyle since, unhealthy lifestyle has been associated with an increased rate of breast cancer (Cifu & Arem, 2018; Jerônimo & Weller, 2017). The lifestyle factors include sedentary lifestyle, high body index, smoking and alcohol usage. Studies had shown that tamoxifen intake reduces the incidence of breast cancer (Cuzick et al., 1992; Vogel et al., 2010).

Therefore, the nurse needs adequate knowledge on breast cancer presentations to counsel patients for treatment. Studies have also shown that nurses have adequate knowledge of the signs and symptoms of breast cancer (Andegiorgish et al., 2018). The patient may present with advanced breast cancer features like breast pain, static breast lump and infiltration of the cancer cells to other organs (Bloom et al., 2011; Eyigor, Uslu, Apayd, Caramat, & Yesil, 2018; Gale et al., 2013). Thus, the nurse may be able to identify identify early symptoms of breast cancer in order to help reduce the incidence of advanced breast cancer

Premature detection of the breast cancer can be done through breast self-exam (BSE), Clinical Breast Exam (CBE) and by mammography in other to reduce the morbidity and the mortality associated with it (Bello et al., 2011; Shah & Guraya, 2017). It is recommended that mammography and CBE should be done for women who are 40 years and above (American Cancer Society, 2019). BSE is made optional every month and emphasis should be made on the importance of breast self-awareness. A systematic review done by Skrobanski, Ream, Poole, & Whitaker, (2019) showed that nurses do not have adequate knowledge of breast cancer screening.

However, other studies done about the knowledge level of nurses as to the method of breast cancer screening shows that nurses have good knowledge in the methods (Andsoy & Gul, 2014; Fotedar et al., 2013). Also, the good knowledge level of the nurses was inversely associated with maturity and number of years worked on that field (Prolla et al., 2015). It was found that nurses with a

Bachelor'sdegree in nursing have the highest level of knowledge (Andegiorgish et al., 2018).

Nonetheless, a study done in Pakistan showed that nurses have weak skills in the preparation before, during and after the administration of chemotherapy (Khan, Khowaja, & Ali, 2012). However, most often, safe handling of chemotherapy drugs policies are

available but outdated (Polovich & Clark, 2012). Nurse managers who monitor the use of those drug precautions tend to be few (Polovich & Clark, 2012). Additionally, nurses lack current knowledge about the safety guidelines (Neuss et al., 2016; Polovich & Martin, 2011). A survey of nurses has revealed a knowledge deficit in the administration of chemotherapy principles (Taghizadeh Kermani, Hosseini, Salek, & Pourali, 2015; Khan et al., 2012).

However, the nurses' level of knowledge improved after the institution of educational course in the administration of chemotherapy. The participants were taught several protocols of chemotherapy, complications associated with its administration and management of adverse effects of chemotherapy with emphasis on nursing consideration within two weeks (Taghizadeh Kermani et al., 2015). In contrast, other studies show that nurses have a high knowledge level in chemotherapy administration (Verstrate, 2015). This may be due to the small sample size (68) with a response rate of 58.8% used for the survey.

Additionally, nurses need to have sufficient knowledge about the care of patients undergoing radiation treatment. However, studies have shown that nurses do not have adequate knowledge about principles regarding radiotherapy and its safety measures (Miettunen & Mikkonen, 2019; Sree, 2016; Thambura, Vinette, & Klopper, 2019). Nevertheless, the nurse is supposed to educate the patient on adequate nutrition and skincare during radiotherapy. Literature available shows that, when the patient is well informed about nutrition it leads to improved appetite (Hopkinson, 2018; Schiavon et al., 2015). Also, radiation therapy can affect some aspects of the patient's life (Andersen, Eilertsen, Myklebust, & Eriksen, 2018). Therefore, the nurse must have sufficient knowledge of skin care creams to give good guidance to the patient during the purchase of skin cream (Mcquestion, 2011).

Furthermore, nurses are supposed to have adequate knowledge and skills to effectively manage patient's pain. Also, since patients with breast cancer receive analgesics which are mostly narcotic drugs, nurses need to understand the pathophysiology of pain to identify patient's pain and manage effectively that pain (Craig, 2014). When managing the patient's breakthrough pain, the nurse must employ both pharmacological and non-pharmacological treatments (Mahfudh, 2011). The nurse is required to administer the analgesia as prescribed regularly and prophylactically. The nurse may teach the patient how to stretch the muscles and move the joint to aid in easing pains.

However, a closer study done in Ghana on postoperative management of pain reported that nurses have inadequate knowledge in pain management (Aziato & Adejumo, 2014). Also, unsatisfactory care was associated with poor cancer pain management (Bonsu, Aziato, & Clegg-Lamptey, 2014). However, other studies have depicted that, deficiency in nurses' knowledge about the administration of pain medication was not associated with the nurses' level of education or working experience (Craig, 2014). Additionally, a systematic review by Sameen & Al-Attar, (2015) on oncology nurses' knowledge about cancer pain management indicates that most nurses had poor knowledge of cancer pain management. On the contrary, a related study shows that nurses had adequate knowledge of pharmacological breakthrough pain management (Rustøen et al., 2013). The study indicated that 85.5% of Dutch and 83.1% of German nurses had satisfactory knowledge of pharmacological breakthrough cancer pain management. Morphine was the drug of choice for the nurses in managing moderate to severe cancer pains (Samarkandi, 2018).

Caring for patients with breast cancer involves giving the right information about the ailment and any available treatment alternatives to the patient (Molina, 2012). However, a study was done in Iran by Iranmanesh, Razban, Tirgari, & Zahra, (2014) indicated that nurses lack satisfactory knowledge in palliative care. This may be due to the cultural and

educational background of the respondents. The knowledge level of the nurses improved over the study period of seven years. The improvement in the knowledge level was related to expect support to nurses within the designated cancer hospitals.

Also, numerous studies have confirmed that nurses have poor knowledge level in palliative care (Ayed, Sayej, Harazneh, & Fashafsheh, 2015; Farmani et al., 2019; Kassa, Murugan, Zewdu, Hailu, & Woldeyohannes, 2014). It was evident that nurses' knowledge level in palliative care was associated with the level of professional qualification, training in palliative care and the age group (Kassa et al., 2014; Sorifa & Mosphea, 2015). However, when cure is no more significant for the patient, maintenance of the quality of life becomes paramount (Singh, Kaur, Banipal, Singh, & Bala, 2014; Thaniyath, 2019).

Some of the studies reviewed used a self-designed questionnaire which does not have the Cronbach's alpha. However, the studies that used internationally validated tools like the Palliative Care Quiz for Nursing (PCQN) might have affected the results due to the measurement of multi-construct in the tool (Kassa et al., 2014). To this end, the literature suggests that a high level of knowledge in the care of breast patients in terms of administering the right dosage of drugs and excellent pain management skills as well as their enlightenment on other alternative treatment plans go a long way to improve the delivery of care to patients with breast cancer. It is evident that if these nurses have a low level of knowledge in breast cancer management, it will affect the quality of care given to them. It is in light of this that the current research seeks to explore the knowledge base of nurses working with women with breast cancer

2.3 Attitude of Nurses Caring for Patients with Breast Cancer

The attitude of the nurse towards breast cancer screening is very important in the early diagnosis and prevention of breast cancer. In a study conducted in Ethiopia by

Wurjine, Bogale, & Menji, (2019) on early detection methods, the results indicated that 287 (73.8%) of the participants depicted positive attitude towards early detection methods for breast cancer. However, in another study, 203 (53.4%) female health professionals believed abnormalities of the breast cannot be detected through breast self-examination (Heena et al., 2019). Also, the nurses indicated that when early detection methods are employed it is not effective for the treatment. However, the study population was chosen from one centre.

The nurse has a responsibility in providing information, advising and acting as an advocate to the patient who is undergoing chemotherapy. The nurse assesses the agreed treatment plan and adjusts the treatment as and when necessary (Lennan & Roe, 2014). Chemotherapy has a lot of side effects associated with it and most often the side effects occur while the patient is at home. Also, administration of intravenous infusion is of great risk (Westbrook, Rob, Woods, & Parry, 2011). Therefore, the nurse assesses the patient to establish a patient's fitness for chemotherapy administration through observation. Again, the side effects of chemotherapy can be minimised through premedication and patient education (Lennan & Roe, 2014).

Also, the nurse needs to obtain information from patients on how they are feeling. Therefore, it is imperative for the nurse to monitor and advice the patient 24hours through telecommunication services. However, a study has done by Khan et al., (2012) on nurses' knowledge, skills and attitude in chemotherapy indicated that nurses have a negative attitude towards chemotherapy administration. Most of the nurses lack knowledge in the management of the side effects of cytotoxic drugs. However, the organized educational session did not yield an improvement in the nurses' attitude.

Moreover, other studies have shown that nurses' attitude towards pain administration is negative (Al-Atiyyat et al., 2018; Kassa & Kassa, 2014). A study done by

Yava et al., (2013) revealed that nurses scored less than 50% correct response on the block for giving water for injection when the patient complained of pains. Also, studies have shown that nurses believed that through the administration of pain medications, patients become addicted (Khalaileh & Qadire, 2012). Again, Aziato & Adejumo, (2014) demonstrated that nurses who have a negative attitude towards caring for patients hold on to old ideas rather than reflecting on their current knowledge.

On the contrary, a study done by Asadi-noghabi, Tavassoli-farahi, Yousefi, & Sadeghi, (2014) on knowledge of nurses in neonatal pain management indicated nurses had a positive attitude towards pain management. Also, the attitude of nurses towards breast cancer significantly influences nurses' practice. However, nurses who had a positive attitude towards administration of pain medication were able to assess the patient's pain correctly but administered higher doses of the pain medication to the patient even if the patient's pain score was low.

It was however found out that the nurses' level of education, as well as current knowledge on pain management, affected the way pain is assessed and the dosage of the pain medication given (Al-Atiyyat et al., 2018; Aziato & Adejumo, 2014). Nurses may also include alternative treatment in patients care to manage patients' pain (Zoe et al., 2014). Also, the attitude of the nurse towards alternative treatment may determine whether the nurse will incorporate it into patients' care (Brewer, Turrise, Kim-Godwin, & Pond Jr., 2019; Smith & Wu, 2012). A scoping review done by Chang & Chang, (2015), indicated that (66.4%) nurses had a positive attitude towards alternative medicine. It was revealed that 74% of the nurses did not have an idea about the risks and benefits of alternative medicine. However, alternative medicine possesses some benefit for patients' quality of life (Brewer et al., 2019; Chang & Chang, 2015).

Knowledge about palliative care and attitude towards the care of the patient has a significant influence on the quality of care given to patients. Studies conducted by Farmani et al., (2019) showed that nurses have a moderate attitude towards palliative care, however, most of the nurses (58.8%) 63 believed that the family interfere with the care process even though there is the need to involve the family in the care process. In addition, the study results suggested nurses help patients accept death and settle issues about their personal lives amicably before passing away (Tornøe, Danbolt, Kvigne, & Sørlie, 2015).

However, nurses saw the interaction with the patient as a beneficial experience although talking to the patient about death was a challenge (Al-Atiyyat et al., 2018; Chang & Iskandar, 2018; Farmani et al., 2019). A study by Razban, Iranmanesh, & Rafiei, (2013) showed that almost half (46%) 56 of the nurses involved in the study believed patients should not be told the truth about prognosis which may be due to the belief of the nurse to maintain patients' hope (McLennon, Uhrich, Lasiter, Chamness & Helft, 2013). Nurses who had a higher degree level showed a more positive attitude towards patients. More knowledgeable nurses showed a positive attitude towards the patient (Chang & Iskandar, 2018; Shoqirat, Mahasneh, Al-Khawaldeh, & Al Hadid, 2019). It was found that nurses who had specialised in oncology nursing showed a more positive attitude towards the patient as compared to nurses who do not have that speciality (Al-Atiyyat et al., 2018; Farmani et al., 2019).

Furthermore, other studies have revealed that the attitude of nurses towards palliative care ranges from moderately negative to neutral (Razban et al., 2013). Also, age had a significant influence on the attitude of the nurse towards the care. Older nurses showed a more positive attitude towards caring for the patients as compared to the younger ones (Chang & Iskandar, 2018). Older nurses can communicate effectively with the family. Also,

they may be able to prepare both the family and the dying patient towards death and assist them throughout the grieving process before and after death.

Moreover, it was found that nurses with working experience in similar care settings have a positive attitude towards caring for the patients (Chang & Iskandar, 2018; Farmani et al., 2019). Also, those nurses were able to communicate with patients and extended the care to the family members. It is interesting to note that some of those nurses found it uncomfortable discussing death with the patient who was about dying (Farmani et al., 2019). However, patients may feel when their death is predetermined, then, they can put their house in order and die a good death (Kastbom, Milberg, & Karlsson, 2016).

The positive attitude of nurses towards supportive care improves the quality of life through counselling and treatment adherence (Sakai, Umeda, Okuyama, & Nakamura, 2020). A study by pin Korea indicated that most of the nurses believed psychological care and patient education should be included in patients' treatment. Also, nurses believed smooth communication is necessary for patients' treatment and rehabilitation. According to Traveller, the four phases in nurse-patient communication includes empathy and sympathy (Song, Lv, Liu, & Huang, 2016). Therefore, mutual understanding between the nurse and the patient may be reached through these phases. Therefore, it may be possible for the nurse who empathises and sympathises with the patient to stay close to the patient (Lelorain, Brédart, Dolbeault & Sultan, 2012).

Nurses can help facilitate patients' expectations of professional support. Also, in a related study, nurses caring for cardiovascular disease patients believed the presence of family members is necessary for the care process (Goossens, Jaarsma, & Moons, 2016). Therefore, the family may act as a liaison between the nurse and the other relations (Laidsaar-Powell, Butow, Bu, Fisher, & Juraskova, 2017). Financial support is also an

aspect of the cancer care that the nurse needs to focus on for a successful treatment. In another related study, nurses believed financial support can enhance patients' health (Negarandeh, Oskouie, Ahmadi, & Nikravesh, 2008). Furthermore, the Religion of nurses and attitude towards care may be related and significantly influence the quality of care. In the review of the literature, the religion of the nurse did not predict positive attitude. However, spirituality cannot be ignored since spirituality is an aspect of human life that one cannot ignore since the human being is made up of integral parts which are regarded as a whole (Kadar et al., 2015; Puchalski, Ferrell, & Virani, 2009).

Also, Spirituality can be attributed to the relationship people have with a higher God or His power, as well as how one sees life experiences and its linkages to nature, to others and the self (Borras et al., 2010; Torskenæs et al., 2015). This means that spirituality may be a solid foundation in the breast cancer disease trajectory. A study by Phelps et al., (2012) indicated that nurses have a positive attitude towards spiritual care. Nonetheless, nurses are not always attentive to the spiritual, nutritional and educational needs of patients with cancer (Bailey, Moran, & Graham, 2009; Suhonen et al., 2018).

Furthermore, nurses generally give routine care like wound dressing and administration of medication (Ledesma-Delgado & Mendes, 2009; Lindh, Kihlgren, & Perseius, 2013). A related study conducted by Kumarasinghe & Hettiarachchi, (2018) in Sri Lanka on the attitude of nurses towards patients affected with diabetic foot ulcer showed that nurses had a positive attitude towards wound care. However, the positive attitude was not related to the knowledge level of the nurses. Therefore, although nurses may have adequate knowledge of wound care, there is the need for regular practice of the skills for wound dressing to develop positive attitude towards wound dressing.

A validated and reliable instrument employed in the studies were too lengthy; an example is the Knowledge Attitude Survey Regarding Pain (KASRP), (Al-Atiyyat et al., 2018). The attitude scale which was adopted from Frommelt Attitude Toward Care of the Dying was done in the United States of America which is not cultural specific to the research settings of where the researchers conducted the research (Farmani et al., 2019). Comparability of the studies is also a problem since some of the studies the researchers were looking at the attitude of the nurses towards post-operative pain management as compared to the attitude in pain management in palliative care/cancer care (Aziato & Adejumo, 2014; Shoqirat et al., 2019).

Attitude is related to the quality of care. There are many definitions of quality care in healthcare (Cullen, 2018). To appreciate the quality of care, it is important to relate it to the one who is accessing health care. Quality may be viewed from the user's perspective as to whether he/she receives the needed care and as to whether the care offered is effective. Clinical effectiveness and effective nurse-patient relationship are two aspects of quality that may be linked with needs. Quality health care is ensuring patient safety and prevention of malpractice (Albrecht, 2015) thus, negative attitude towards pain management can endanger a patient's life. The positive attitude that the nurse expresses whiles communicating with the patient may let the patient find meaning to life (Hemsley, Balandin, & Worrall, 2012) thus, it may build trust between the nurse and the patient.

In summary, it boils down to the question of whether moderate attitude indicates the good standard of care and if this is true, then what is the experiences of nurses towards patients with breast cancer in a bid to enhance the quality of care they receive in hospitals? Again, the existing literature to some extent shows a relationship between the level of knowledge of nurses in the management of breast cancer and their attitudes towards patients with cancer. Nurses who have a moderate attitude towards cancer care can also have some

negative attitude which can affect the delivery of quality care. Given this, the study will explore the attitude of nurses towards breast cancer care.

2.4 Normative Beliefs of Nurses Caring for Patients with Breast Cancer

The beliefs of the nurse about others like the patient, relatives and team members may affect breast cancer care. Nurses' believe there is the need for patients and their relatives to participate in the care to accept recommendations being made by the nurse (Pongthavornkamol, Khamkon, Phligbua, Cohen, & Botti, 2018). It is seen that a patient's relatives participate in cancer care decision-making when the patient is dependent (Laidsaar-powell et al., 2017). Although the family may also be supportive in the decision making process, the family may exert influence over the decision by undermining patients' preferences (Aziato & Clegg-Lamptey, 2015; Laidsaar-powell et al., 2017). Family beliefs may determine whether the patient will undergo treatment or not (Wang, Geng, Ji, Lu, & Lu, 2020). Culture may also influence the decision making process in breast cancer treatment in Ghana (Boateng, East, & Evans, 2018). However, a study done in the UK has shown that although the family get involved in the decision-making process, the final decision is taken by the patient (Gilbar, 2011). Also, studies have shown that the family supports the patient financially and emotionally in breast cancer care (Adam & Koranteng, 2020; Bonsu, Aziato, & Clegg-lamptey, 2014). Benevolent groups also assist the patient emotionally and financially through the cancer care continuum (Azenha et al., 2011).

Furthermore, since the nurse is the first health team member to come into contact with the patient, the patient may get attached to the nurse (Brooks, Manias, & Bloomer, 2019; Popescu, 2012; Wittenberg, Reb, & Kanter, 2018). The nurse is most often with the patient whether in good times or bad times. Therefore, the patient feels more comfortable to communicate with the nurse (Cook, McIntyre, Recoche, & Lee, 2019). Nurses caring for patients with breast cancer share in their problems and listen attentively to them (Komatsu

& Yagasaki, 2014; Maree & Mulonda, 2017). However, patients' participation involves allowing the patient to be part of any decision that pertains to their wellbeings like food, medication, exercise and personal hygiene and also to make their own decisions. Therefore, the nurse may administer drugs based on the wish of the patient.

Also, the health and the emotional states in which the patient is in may affect the level of involvement of the patient by the nurse and this may bring conflict between the nurse and the patient (Simpson et al., 2017). However, when the nurse gets cues from the patient that indicates an unwillingness to participate in the care, the nurse may make decisions for the patient (Williams, Hauck, & Bosco, 2017). Therefore, the difficult patient may reject medication and find fault with everything the nurse does (Khalil, 2009). Also, patient and family rudeness towards health professionals may compromise the care given (Riskin et al., 2015). Regardless of how occupied the nurse is, patients try to get what they want (Khalil, 2009) and this may create confusion as the nurse have other patients to attend to.

Again, nurses believe they fill in the gaps for physicians although they are supposed to collaborate with them in the dissemination of information (McLennon, Uhrich, et al., 2013). Studies have revealed that discussion of prognosis with patients and relatives is being avoided by health workers (Millar, Reid, & Porter, 2013; Sarafis, Tsounis, Malliarou, & Lahana, 2014). Therefore, the oncologist may not tell the patient she is dying and this may make the nurse feel uncomfortable to be the one giving bad news (Detering, Hancock, Reade, & Silvester, 2010). However, when the nurse is knowledgeable about the information to be given to the patient, she feels more comfortable and confident (Williams et al., 2017). Nurses are empowered to advocate for the patient when they believe what they say matters (Tariman et al., 2016).

Additionally, the nurse acts as the patients' advocate to ensure safety and quality of life (McLennon, Lasiter, et al., 2013). It is believed that Doctors or physicians make errors in medication prescriptions which may affect the patient's safety and quality of life (Alsulami, Conroy, & Choonara, 2013). In ensuring the safety and quality of life of the patient, the nurse must report medication errors. Yet, nurses can correct medication errors to reduce patients' negative health outcomes (Gaffney, Hatcher, & Milligan, 2016). However, it is believed that some doctors display dominance over nurses and do not accept corrections (Tang, Zhou, Chan, & Liaw, 2018).

Available literature has shown that nursing leadership style has a role in the quality of care given to patients (Lin, Maclennan, Hunt, & Cox, 2015). Therefore, Charge Nurses may prefer to work with those they like, although studies have shown that inappropriate job assignment can impact patients care negatively (Saleh, Connor, Al-subhi, Alkattan, & Al-harbi, 2018; Wolf, Perhats, Clark, Moon, & Evanovich, 2017; Wolf et al., 2017). Also, favouritism may lead to organizational mistrust which may frustrate the nurses (Keles, Ozkan, & Bezirci, 2011).

Furthermore, institutional policies can influence the quality of care given. The increasing number of patients at the outpatient department for chemotherapy has increased in recent times leading to delays at the centre (Hahn-Goldberg et al., 2014). Nonetheless, quality care can be assessed by patients receiving chemotherapy in the outpatient department (Farrell, Molassiotis, Beaver, & Heaven, 2011). Therefore, this calls for the rescheduling of patients for effective care (Gocgun & Puterman, 2014; Santibáñez et al., 2012). However, the booking of an appointment for chemotherapy is to ensure effective results although it may be problematic (Gocgun & Puterman, 2014; Rest & Puterman, 2011). Thus, it may lead to delays in treatment. Studies have shown that the delay between chemotherapy treatment is associated with the centre for the care (Bouche et al., 2010). The geographical location

was not linked to the delay. Also, the delay in treatment may be associated with poverty (Sharma, Costas, Shulman, & Meara, 2012). However, has been realised that booking for a treatment appointment has been helpful (Suss, Bhuiyan, Demirli, & Batist, 2019).

It is believed that longer waiting time has been associated with death risk in patients who could have been well if they had been admitted on time (Guttmann, Schull, Vermeulen, & Stukel, 2011). It is also believed that patients with longer waiting time exhibit violence towards the nurse who is assisting the patient during delays (Morphet, Ed, Grif, & Campus, 2014; Pich, Kable, & Hazelton, 2017). The violence could be verbal or physical. Nurses may yell at each other when patients had to wait longer (Embree & White, 2010; Vagharseyyedin, 2015).

Furthermore, ambulance services have bearing on the care given by nurses since ambulance transports patients who need care in-between treatment centres. However, in Ghana, the transportation of patients by the ambulance has been left unattended to (Frimpong & Dinye, 2014). Also, available literature shows that patients were transported by taxis to treatment centres (Roy et al., 2010). Therefore, the nurse may leave more important work roles to accompany patients (Liu et al., 2018) in taxis to other treatment centres.

Although patients look forward to having a doctor leading the cancer care continuum, doctors taking charge across the domains are absent (Weldon, Friedewald, & Kulkarni, 2016). Absence of a particular doctor taking leading role throughout patients' care may lead to distortion in patients' health information. Distortion in a patient's health information may also cause a delay in patients' treatment. Thus, leading to the progression of the disease and subsequent death.

2.5 Perceived Behavioural Control (resources, time and opportunity) of Nurses Caring for Patients with Breast Cancer

In the delivery of quality healthcare to patients, some challenges nurses caring for patients with breast cancer encounter which can affect their work are limited resources, inadequate time and lack of training opportunities. Working resources and good opportunities available for nurses may lead to a healthy nurse working environment. Good working environment includes adequate resources, workload within the ability of the nurse, adequate time to meet patients' needs and availability of training opportunities for the nurse (Copanitsanou, Fotos, & Brokalaki, 2017). A systematic review which was done by Wei, Sewell, Woody, & Rose, (2018) in the United States on nurse work environment revealed that, there is an association with nurse interpersonal relationship and job performance with the healthy work environment.

However, a study done in Ghana on oncology paediatrics nurses showed that a well-structured oncology unit is absent for patients care and again, they lack personal protective equipment, gloves and face masks (Nukpezah, Fomani, Hasanpour, & Nasrabadi, 2020). In a similar study done in Zambia, nurses reported a lack of adequate logistics in caring for patients with breast cancer (Maree & Mulonda, 2017). However, the nurse manager may lobby for the logistics needed and also, manage the logistics effectively (Spano-Szekely, Griffin, Clavelle, & Fitzpatrick, 2016). Inadequate logistics may increase the time taken to perform a particular task thus, increasing the workload and pressure on nurses (Khademi, Mohammadi, & Vanaki, 2015). The nurse perceived workload may lead to injuries such as needle prick, drug splashes on the skin and back pains (Hosseinabadi et al., 2019).

Additionally, the high workload is suggestive of nurse attrition causing staff shortage (Rawal & A. Pardeshi, 2014). Shortage of professional nurses could be very crucial to breast cancer care (Haryanto, 2019; Maresova, Prochazka, Barakovic, Baraković Husić,

& Kuca, 2020; Rawal & A. Pardeshi, 2014). A systematic review by Toh, Ang, & Kamala Devi, (2012) on the shortage of nurses and job satisfaction revealed that nurse shortage cause stress and burnout in the nurse. High nurse staffing strength may be associated with shorter length of stay and patients' safety (Griffiths et al., 2016). However, lower staffing strength may lead to increased patient mortality and job dissatisfaction. Also, it was found out that nurses working in units with lower standards tend to show more stress, burnout and job dissatisfaction. Nurses may not be able to attend to patients as they would have preferred to, due to low staff strength (Maree & Mulonda, 2017). A qualitative descriptive study done in Turkey on psychosocial care in oncology showed that high patient ratios serve as a challenge for psychosocial care (Güner, Hiçdurmaz, Kocaman Yıldırım, & İnci, 2018; Pongthavornkamol et al., 2018).

Furthermore, nurses experience time constraints caring for patients with cancer (Liang & Turkcan, 2016; Nukpezah et al., 2020). Lack of adequate time may be associated with tasks left undone by the nurse (Liu et al., 2018). Nevertheless, nurses prioritize care according to what is an emergency (Edwards, Pang, Shiu, & Chan, 2010; Kieft, de Brouwer, Francke, & Delnoij, 2014; Suhonen et al., 2018). The missed care due to priority setting of care may cause moral distress in the nurse (Suhonen et al., 2018). Also, the lack of time has been associated with ineffective communication in cancer care (Güner et al., 2018; Pongthavornkamol et al., 2018; Wittenberg-Lyles, Goldsmith, & Platt, 2014).

Again, as indicated earlier, nurses in cancer care work with other team members to plan and implement the nursing intervention. However, nurses do not have authority over time for allocation for psychosocial care (Karanikola et al., 2014). Since physicians and managers have hierarchical power in hospitals (Karlou, Papathanassoglou, & Patiraki, 2015). The structures within the health system create challenging communication environment for the nurse, for example, lack of team/ institutional support (Güner,

Hiçdurmaz, Yıldırım, & İnci, 2018; Wittenberg et al., 2018). It was realised that, when nurses are given communication training in oncology, they tend to respond empathetically to patients (Pehrson et al., 2016).

It has been documented that there is a lack of specialized oncology nursing education in Nigeria (Nwozichi et al., 2017). However, training in oncology nursing exists in Ghana. Also, oncology nurses training exists elsewhere (Komatsu, 2010). Specialized training in breast cancer care or oncology nursing is a necessity for both patient and nurse satisfaction in the cancer care continuum (Case, 2010; Fillion et al., 2012; Pedersen, Hack, McClement, & Taylor-Brown, 2014). Also, nurses lack the opportunity for carreer progression (Holmberg, 2017). Chance is available for nurses to attend workshops for example, on pain management in Ghana (Aziato & Adejumo, (2014). A study was done by Güner et al., (2018) on psychosocial care, showed that nurses who were aware they had limited knowledge in psychosocial care felt the need to be trained. Therefore, nurses who are more experienced may participate in the discussion of patients' care (McLennon, Lasiter, et al., 2013).

Through the journey of cancer care, nurses become emotionally attached to the patient and family (Zheng, Guo, Dong, & Owens, 2015; Perry, Toffner, Merrick, & Dalton, 2011). When caring for the dying patient, emotionally attached nurses could reflect on the meaning of life and death which could help them give better care to others (Zheng et al., 2015). The emotional status of the nurse could also be associated with the treatment choices that the patient makes (Coulter, 2012). The emotions that nurses attach to caring for a patient with breast cancer experienced may cause the nurse to examine her breast regularly. Also, psychological fatigue experienced by the nurse may affect the nurse's relationships (Perry, Toffner, Merrick, & Dalton, 2011)

Furthermore, although nurses try to give their best based on the professional training they have acquired, nurses need to be motivated to give quality care. Previous studies have shown that intrinsic motivators such as finding meaning to the work, collaboration with other health professionals and good interpersonal relationship empowers the nurse to improve quality of care (Lambrou, Kontodimopoulos, & Niakas, 2010; Yang, Liu, Chen, & Pan, 2014). When nurses make a difference in the lives of patients and their relations, they find meaning to life (Stokes, Vanderspank-Wright, Fothergill Bourbonnais, & Wright, 2019). This suggests that the retention of nurses in an institution may be due to intrinsic motivation. Also, extrinsic motivation, for example, monetary compensation has been associated with nurse retention.

2.6 Summary of the literature review

The experiences of nurses caring for cancer patients have been evaluated by both qualitative and quantitative researchers with varying experiences identified. Most of the studies reviewed literature in palliative care, even though breast cancer is curable and does not always lead to palliation. Some of the nurses' experience in association with pain management was highlighted in post-operative pain management.

In all the studies reviewed, most of the studies are from Europe and Asia, few from Africa. Also, there is limited study available in Ghana on experiences of nurses caring for patients with breast cancer although there is a need for oncology nurses to improve quality care to patients with breast cancer. This indicates a gap and therefore the need to conduct the study to fill it. . The available literature has shown that nurses have moderate knowledge in the epidemiology of breast cancer, adequate knowledge in breast cancer screening, low knowledge in chemotherapy and radiotherapy, pain management and palliative care. However, a higher knowledge level was associated with the level of education and experience in the cancer setting. The literature also revealed that nurses who have a positive

attitude towards breast cancer care may also possess some negative attitude to the care. The literature indicated that the organizational climate, team members, booking system, ambulance services, support groups, patients, colleagues, availability of resources, time, opportunities, workload, emotions and motivation affect the care being given by the nurse.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This section presents the type of research design employed by the researcher and the methodology for the study. This chapter is organized as follows: research design, research setting, target population, sample size and technique, the procedure for data collection, data gathering tool, data analysis and data management. The methodological rigour and ethical considerations are also discussed in this chapter.

3.1 Research Design

Research designs or strategies of enquiry are the approaches that guide either the quantitative or qualitative or mixed-method type of enquiry within a research design (Creswell, 2014). In this study qualitative approach was used.

Qualitative research is an enquiry that has its tenets rooted in the viewpoints of participants to have a vivid idea of what the realities are (Creswell, 2014; Polit & Beck, 2012). The experiences of human beings need to be explored to have adequate knowledge about human behaviour which depends on what has already been learned (Creswell, 2014; Polit & Beck, 2012). Exploratory descriptive design to qualitative research was employed in this study. The design is appropriate for the study because, in the day to day interaction between the nurse, patients with breast cancer and their relatives, it is possible for the nurse to gain some experiences during the care process. Thus, the use of an exploratory descriptive design to qualitative research was employed to enable the researcher understand and describe the experiences of nurses caring for patients with breast cancer.

3.2 Research Setting

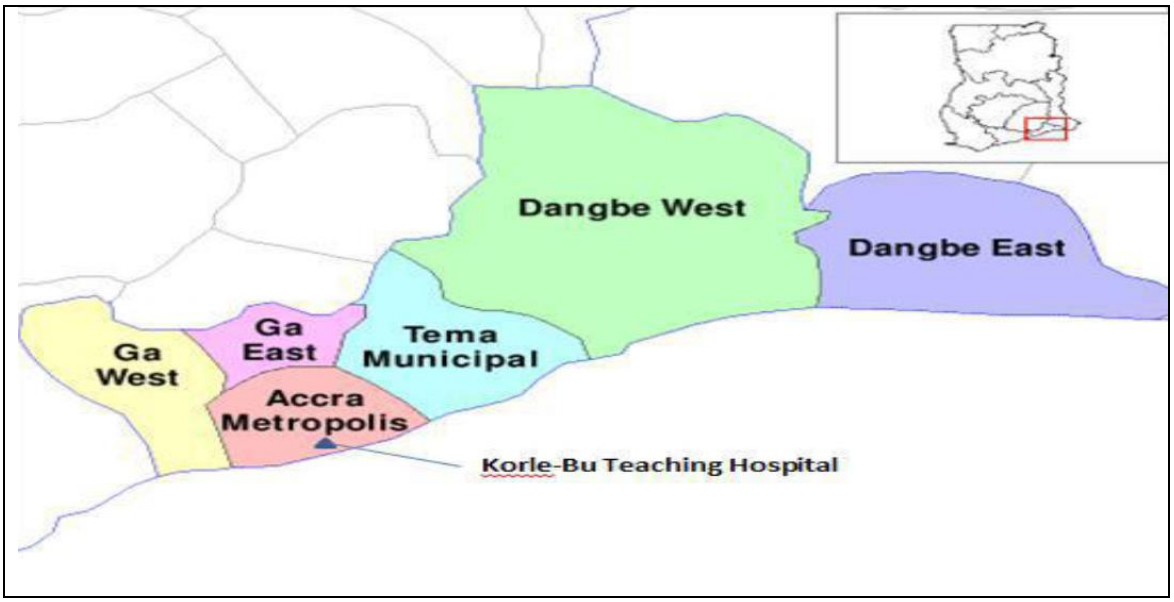

Figure 3. 1 Map of Greater Accra Region indicating the Location og Korle Bu Teaching Hospital and its Surrounding Areas

Korle-Bu Teaching Hospital (KBTH) is situated in Accra, Ghana. It is the largest Teaching Hospital in the Country. It was established on October 9, 1923, and it is the main national referral centre in Ghana and the third largest hospital in Africa. Currently, the KBTH has a bed capacity of about 2000 and 17 clinical and diagnostic Departments. The attendance is about 1500 patients and about 250 patient admissions daily. The departments of KBTH include Medicine, Child Health, Obstetrics and Gynaecology, Pathology, Laboratories, Radiology, Anaesthesia, Surgery, Polyclinic, Accident Centre and the Surgical/Medical Emergency as well as Pharmacy. Other Departments include Pharmacy, Finance, Engineering and General Administration.

The Hospital also provides sophisticated and scientific investigative procedures and specialization in various fields such as Neurosurgery, Cardiothoracic surgery, Paediatric Surgery Dentistry, Ophthalmology, Ear, Nose and Throat (ENT), Renal, Orthopaedics, Oncology, Dermatology, Radiotherapy, Radiodiagnosis, and Reconstructive Plastic Surgery and Burns. The National Reconstructive Plastic Surgery and Burn Centre, the National Cardiothoracic Centre and the National Centre for Radiotherapy and Nuclear Medicine in

particular also draw a sizeable number of their clientele from neighbouring countries such as Burkina Faso, Nigeria, and Togo ("About us – Brief History – Korle-Bu Teaching Hospital," n.d.).

Korle-Bu Teaching Hospital in Accra was chosen as study settings because it is a major point of referral in the country and it has most of the new technologies. Korle-Bu Teaching Hospital is a catchment area for southern Ghana Cancer Registry (Calys-Tagoe et al., 2014). Thus, it is bound to have most patients with breast cancer across the country patronizing the facility. Also, most health professionals such as nurses, x-ray technicians, laboratory technicians, doctors and others are being trained in the facility.

The specific research setting is the oncology and radiotherapy department and adult surgical wards, mainly surgical Ward II. The oncology and radiotherapy Centre is located on the southern part of KBTH opposite the blood bank**.** It was commissioned on 26th May 1998. It contains a simulation room, moulding room, treatment room, planning room, pharmacy, disease and surveillance unit, records/ statistics unit/ cancer registry, out-patient unit and chemotherapy room. Some of the machines used in the units are; cobalt 60, simulator, for brachytherapy and orthovoltage. Some of the services offered there are Breast cancer screening, Counselling, Radiotherapy and Chemotherapy.

Also, the surgical department is located opposite the maternity block with a car park in front of it. The department performs general surgery and neurosurgery. Adult surgical ward II is on the second floor of the building. The ward is designated for oncology cases. It has a 32-bed capacity. It has a chemotherapy suite for constituting chemotherapy drugs. Some of the services offered there are surgical treatment, chemotherapy, palliative care and counselling.

3.3 Target population

The target population consisted of nurses caring for patients with breast cancer in the surgical adult ward II and the radiotherapy department of KBTH.

3. 4 Inclusion criteria

The research included nurses caring for patients with breast cancer in the adult surgical ward II and the radiotherapy department who have worked for at least 2 years. This is to ensure that only nurses who have had many encounters with patients with breast cancer and could comprehend the contents of the interview without much apprehension were recruited. All participants were able to communicate in the English language.

3. 5 Exclusion criteria

The research excluded nurses caring for patients with breast cancer in the surgical adult wards and radiotherapy department who were on sick leave, on rotation and auxiliary nurses.

3.6 Sampling Technique and Sample Size

Sampling technique can be referred to as the selection of participants from a target group to collect rich information from the selected group that is representative of the entire group (Lopez & Whitehead, 2013). In this study, purposive sampling technique was employed to select the participants for the study, since the aim of qualitative research is not about the numerical representation of the sample. Also, since the selected participants were deemed to possess rich information that will be gathered and analysed to address the research problem. The researcher took the sample from a population of nurses caring for patients with breast cancer within the surgical adult ward II and the radiotherapy department who have the characteristics of the study objectives. The researcher introduced herself to

the study participants after permission was sought from the nurse managers of the surgical adult ward II and the radiotherapy department during one of their ward/unit meetings.

The researcher contacted the nurses who were willing to participate in the study to build trust and for the participants to have confidence in the researcher. The researcher briefly introduced the nurses to the background and purpose of the study. The inclusion and exclusion criteria were also explained by the researcher. Participants who agreed to be part of the study and were able to meet the inclusion criterion were provided with a consent form to either sign or confirm their consent for the study. The first participant was introduced to the researcher and upon a brief interaction with her, she was willing to participate so was listed and scheduled to begin interviews at time and day convenient to her. This approach continued until saturation point was reached by the 13th participant when no new themes emerged.

3.7 Data collection tool and procedure

A semi-structured interview guide was used to conduct face to face interview to explore the experiences of nurses caring for patients with breast cancer. The semi-structured interview guide was more appropriate for the study as the participants had freedom in expressing their views about the phenomenon under study. Additionally, it enabled the researcher to divert from the interview guide to probe to facilitate more rich responses from the participants. The semi-structured interview guide was generated from the study objectives.

Section A comprises of demographical data about the participants while Section B is the main interview guide that comprises of open-ended questions and probes. The researcher allowed the participants to decide on the time and also choose the venue for the interview. The interview was conducted in the Nurse Manager's office as agreed by the interviewees. However, interference by colleaques on the study environment was minimal.

Throughout the interview, the researcher ensured maximum comfort of the participants and observed adequate privacy so that the participants were in a relaxed state to provide the information needed.

A consent form was administered to the participants to read and any misconception was clarified before allowing them to sign it for the interview session to begin. Permission was also sought from the participants to audiotape the interview with a digital recorder. There were no right or wrong answers but the interviewer probed till there was a clarification of what was being said. The researcher took field notes during the data collection process. Field notes were taken based on the context and behaviour of both the researcher and the participants which included the condition of the environment, gestures, the researcher's feelings, thoughts, biases, confusion and interpretation. The study participants were not given monetary compensation for participating. However, all the participants were given a hand sanitizer and snacks to show gratitude for their time and contribution towards the study. The participants were informed that the researcher will be back for further clarification when necessary. The interview lasted between 47- 63 minutes and the questions focused on the knowledge of nurses regarding breast cancer, the attitude of nurses towards breast cancer care, normative beliefs of the nurses caring for patients with breast cancer and the perceived behavioural control (resources, time and opportunities) of nurses towards breast cancer care. Verbatim transcription of the recorded interview was done in English.

3.8 Pre-testing of Data Collection Instrument

When the research instrument is piloted, it ensures that all misconceptions about the instrument are removed for it to be authentic before being administered to elicit the expected responses from the study participants (Young Lives, 2011). The semi-structured interview guide was pre-tested at the Greater Accra Regional Hospital. This hospital was chosen

because it also has an adult surgical ward with similar characteristics as that of KBTH. The pre-testing enabled the researcher to develop her interviewing skills.

3.9 Data Management

Data collected during the study were protected under lock and key as stated earlier to maintain the confidentiality of participants. Each participant was given a code depending on the ward or department where the participant was recruited. The codes were replaced with pseudonyms during the presentation of data in the study findings. Also, a folder was created to contain each participant's transcribed responses and field notes. In addition, an external hard drive was used to store raw data to prevent data loss. The data would be kept in a stored place for about 5 years before being discarded. Also, should anybody need it for further studies then, permission will be sought from the Institutional Review Board of the Korle Bu Teaching Hospital.

3.10 Data Analysis

The qualitative analysis deals with the classification and interpretation of verbal and or visual material to discover their meanings and make statements about their relationships (Flick, 2013). The meanings may be subjective or have a social meaning. Also, data analysis involves the combination of analysis of the overviews and detailed elaboration of categories interpretations that compares different texts leading to the formation of themes or codes (Flick, 2013; Hesse-biber, 2010). Manual data analysis was done concurrently with data collection using thematic content analysis approach (Snowden & Atkinson, 2012). The approach includes familiarizing with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report.

The researcher familiarized herself with the data by reading over the transcriptions and field notes several times to identify sentences and phrases that are worth taking note of. Statements or phrases which are similar were searched for, grouped into different files and

given names. Files that resemble each other were brought together and organized into meaningful units to generate the initial codes that will lead to the formation of themes and subthemes that will describe the experiences of nurses caring for patients with breast cancer.

3.11 Methodological Rigour

Methodological rigour is a robust enquiry into all crucial issues related to the study that will make readers evaluate the study as credible. For evaluating qualitative studies, trustworthiness is regarded as more appropriate (Maher, Hadfield, Hutchings, & de Eyto, 2018) and it can be ensured through (Lincoln & Guba's, 1985) framework; credibility, transferability, dependability, and confirmability of the study (Forero et al., 2018).

Credibility was ensured as the researcher selected purposefully to share with the researcher their experience in caring for patients with breast cancer. The researcher also ensured that the study participants who met the inclusive criteria come from different backgrounds to strengthen triangulation. The researcher persistently observed non-verbal conmmunication of the participants during data collection and kept notes of it. To ensure that the participants give the needed response to questions, the questions were asked in diverse ways. The interpreted data was cross-checked with the participants to correct any anomalies. The researcher provided her supervisors with about two codes generated from the data for guidance and corrections.

On transferability, the researcher kept a journal to record personal values and interest about breast cancer, the methodological decisions that were taken and the reasons why such decisions were taken for the researcher to relate and cross-reference the data that were collected for clear audit. Also, the researcher ensured that the the various themes emerged from the data as guided by the theoretical framework. An audit trail was kept to trace all activities of the research. All phases of the study was well described and documented.

Dependability refers to the constancy of the data over similar conditions (Polit & Beck, 2012; Tobin & Begley, 2004). This was achieved when my supervisors (researchers) agrees with the decision trails at each stage of the research process. Through the researcher's process and descriptions, this study is made dependable and if the study findings were replicated with similar participants in similar conditions (Koch, 2006) similar findings will result.

Furthermore, all the processes through which the data was collected were made available to the researcher's supervisor to ensure that the mode of enquiry falls within the acceptable practice.

With confirmability, the researcher ensured that the result of the study is a true reflection of the participants' views.This was achieved by discussing transcripts with participants to confirm their stories.Thus, the researcher did not let her perceptions or biases overshadow the views of the participants. The researcher demonstrated confirmability by describing how conclusions and interpretations were established by providing rich quotes from the participants that depict each emerging theme.

3.12 Ethical Considerations

Ethical clearance was sought and obtained from the Kole-Bu Teaching Hospital's Review Board before data was collected. An introductory letter was also taken from the School of Nursing and Midwifery to the Korle Bu Teaching Hospital (KBTH) to seek permission for the conduct of the study. In addition, permission was asked from the Departmental Heads of the surgical wards and the radiotherapy department of the KBTH where the study participants were recruited. The departmental heads introduced the researcher to the nurse managers of the surgical ward II and the radiotherapy department.

The purpose of the study, its risks and benefits were explained to the participants. Also, their consent was solicited before recruitment.

The participants were also informed of the right to opt-out of the study anytime without any adverse consequences such as transfer to another ward. The participants who voluntarily accepted to be part of the study and met the inclusion criterion were given a consent form to read. Any misunderstanding was addressed before the participants were allowed to sign it. The participants were also assured that all information given will be confidential. The researcher paused for the participants who were under tension during the data collection session to relax before continuing with the interview. The recorded tapes were kept under lock and key and it is only the researcher's two supervisors who had access to it. Pseudonyms were used in place of names during data presentation in study results to allow for anonymity.

CHAPTER FOUR

FINDINGS

4.0 Introduction

This Chapter presents the findings of the data gathered from the study participants. The study aimed at exploring the Experiences of Nurses Caring for Patients with Breast Cancer. Four (4) major themes with their corresponding fifteen (15) sub-themes emerged from the data. The major themes and the sub-themes have been depicted and supported with anonymized verbatim quotations from the study participants. The four major themes were generated based on the objectives of the study. The major themes that emerged were: Knowledge of Nurses Caring for Patients with Breast Cancer, Attitude of Nurses Caring for Patients with Breast Cancer, Normative Belief of Nurses Caring for Patients with Breast Cancer and Perceived Behavioural control of Nurses towards Breast Cancer Care. In this chapter, the demographic characteristics of the study participants are being presented followed by the identified themes.

4.1 Demographic Characteristics of Participants

Thirteen participants (nurses) working at the radiotherapy department and adult Surgical Ward II of the Korle Bu Teaching Hospital were sampled. Six (6) nurses were interviewed from the radiotherapy department and seven (7) from the adult surgical ward II for the study. Twelve (12) females and one (1) male participated in the study before data saturation was reached. The ages of the participants ranged from 28 to 59 years: Six (6) of the participants were between the ages of 25-34 years; two (two) were between the ages of 35-39; two (2) aged between 40-49 years and three (3) participants were between ages 50-59. Concerning educational level, three (3) were State Registered Nurse (SRN) Certificate holders; three (3) Diploma Holders; five (5) Degree Holders and two (2) Masters of Science

Holders. Concerning tribe; seven (7) were Akans, two (3) were Ewes and three (3) were GaAdangbes. All the study participants were Ghanaians. With the religious background, twelve (12) out of the thirteen (13) participants were Christians and one (1) was a Muslim. Regarding the work experience of the participants, the number of years served ranged between 3 to 34 years. With the work experience of the study participants, two (2) had worked between 0-4 years; three (3) had worked between 5-9 years; three (3) had worked between 10-14; one (1) had worked between 15-19; one (1) between 20-24; one (1) had worked between 25-29 and two (2) had worked between 30-34 years. Also, concerning the number of years, the participants had worked in the cancer setting, two (2) had worked for 0-4 years; seven (7) had worked for 5-9; one (1) had worked between10-14 and two (3) had worked for 20-24 years. However, only one (1) participant had a speciality in oncology. All the participants were married except two who were single. Apart from one participant, there was no history of cancer in the family history of the participants. Data saturation was reached at the thirteenth participant. The profile of the study participants is in appendix D.

4.2 Organization of Themes

Using thematic content analysis, four (4) major themes, fifteen (15) subthemes emerged from the study. All the four major themes were derived from the constructs of the planned behavioural control model which guided the study. The detailed representation of the major themes and subthemes are as follows;

Table 4.1: Themes and Subthemes

Theme	Subtheme
1. Knowledge	• Epidemiology • Diagnosis • Signs and symptoms • Chemotherapy and Radiotherapy • Pain management and Palliation
2. Attitude	• Positive attitude • Negative attitude
3. Normative belief	• Teamwork • Institutional policies • Social support • Patient's mindset and attitude
4. Perceived Behavioural Control	• Availability of resources • Availability of time • Availability of Training opportunity • Motivation

4.3 Nurses Knowledge in Caring for Patients with Breast Cancer

This theme focuses on the knowledge nurses have in caring for patients with breast cancer. To answer the first research question: What is the knowledge of nurses caring for patients with breast cancer? As many as five subthemes emerged from the data collected. These were: epidemiology, diagnosis, signs and symptoms, chemotherapy and radiotherapy, and pain management and palliation. Although most of the nurses have not been trained in oncology nursing or breast care, they seem to have adequate knowledge of breast cancer care.

4.3.1 Epidemiology

Most of the study participants were aware of the incidence of breast cancer. Some of them verbalized that Breast Cancer (BC) is on the increase with advance BC more common thus, people are dying from the disease.

> *"Breast cancer is increasing day by day, people are still presenting very late and so a lot of people are dying out of breast cancer…"*-Nurse 3)

> *"… You could say that it's increasing in numbers, instead of you expecting it to go down … unfortunately, most people come in and they are metastatic ... patient won't live for long …"* -Nurse 13

Also, some of the study participants revealed that breast cancer is now affecting younger women.

> *"… initially we had the ages from 35 years and above, now we have 18 years, 19 years coming in with breast cancer …"*-Nurse 4

> *"… of late you will realize that even younger ones are being affected. Formerly, we use to say it is common among the older ones but now we have seen that 14 years, 16 years are also being affected …"*-Nurse 1

In addition, some of the participants stated that patients' misconception, fear of mastectomy and stigmatization contributed to the late case reporting.

> *"… They turn to hide the disease because of misconception, because of stigmatization yes, yeah! some of them are stigmatized and then hearing news about the fact that if you go to the hospital, your breast will be removed and you will die … so it is better to go to the herbalist …"*-Nurse 2

> *"Some tell you they had a dream that someone was injecting their breast … was sucking their breast … if you have breast cancer and you go to the hospital and they cut your breast, you will die ... they delay in coming … they made the disease spread to other organs."* -Nurse 12

Again, some of the study participants had some idea about the cause, the preventable and unpreventable risk factors as well as methods of breast cancer prevention.

According to two of the participants, the cause of breast cancer is unknown and people tend to have different ideas about it.

> *"… The causes are still not well defined; everybody has different explanations … so the particular causes for some is unknown …"*-Nurse 3
> *"…the cause as science is saying is unknown …"*-Nurse 11

Also, two of the participants stated that there are risk factors associated with the cause of breast cancer. The risk factors may be preventable or unpreventable.

> *"... Our choice of diet that is, we take too much fatty food ... too much red meat... drinking inadequate water... lack of exercise ..."*-Nurse 2

> *"... Then also, those (women) who are highly at risk, maybe the mother had it, the aunty had it, the grandmother too had it"*-Nurse 11

One participant stipulated that preventive measures include regular education, eating of fruits and vegetables; white meat or fish, regular body exercise and weight reduction can help minimize the occurrence of breast cancer.

> *"... we should increase the education, education is the key, with intense education, regular education ...we should take fish, I think white meat like chicken is good and then fruits and vegetables to help them prevent some of the breast cancer ... there is the need for them to exercise regularly so that they can reduce weight because the excess weight comes with a lot of fat and this fat can convert into oestrogen that can fuel cancer growth or breast cancer growth ...mostly in post-menopausal women when they are overweight."*Nurse 2

The only male among the participants indicated that taking of prophylaxis by women who are genetically prone to breast cancer will help prevent breast cancer.

> "*Those (women) who are highly at risk, maybe the mother had it, the aunty had it and the grandmother too had it. That one too, there's a test called breast cancer antigen where the gene for breast cancer is tested to see if one is positive or not. So if you are positive you can be put on prophylaxes.... tablet tamoxifen."*-Nurse 11

4.3.2 Diagnosis

All the thirteen participants had some knowledge of breast cancer screening and breast tissue analysis to establish the disease. The participants revealed how to screen for breast cancer through breast self-exams, clinical breast examination, mammography and tissue analysis.

For the breast-self examination, the participants stated that the individual will have to expose the upper part of the body in front of a mirror. Palpate the breasts and the armpit taking note of discharges from the nipple, skin changes, lumps and the size of the breast.

> *"… The colour, the shape and then how the nipple is, some nipples are inverted others are out all these things must be observed by the person in front of a mirror … palpate, light palpation, medium palpation and deep palpation to the chest wall that wherever tumour or any swollen is they can observe, so they will do that and then examine the armpit as well"* -Nurse 2

> *"… Press nipple for any discharge* **…** *examine the armpit … in a circular form going around the breast towards the nipple in a circular motion, when they get to the nipple press they nipple to see if there is any discharge coming from it then move down a bit then in circles looking for a lump, thickness of the skin. They should also stand in front of a mirror stand and raise their hand and observe the size of the breast"* -Nurse 3

Concerning the clinical breast examination, mammography and the tissue analysis, some of the participants stipulated that the patients are referred to the clinical specialist for further investigations such as mammography at age 40 and above and biopsy is taken when necessary.

> *"… When that abnormality is detected they go to the consulting room (to see the specialist), and then various investigations especially the biopsy is requested …"*-Nurse 11

> *"… below age 40 we normally request for breast scan to confirm, if you are above 40 we normally request for a mammogram … if it is confirmed that it is a lump then they will do incision biopsy …"*-Nurse 9

4.3.3 Signs and Symptoms

All thirteen participants had adequate knowledge of the signs and symptoms of breast cancer. The participants indicated the presence of abnormal colour of the breast, bloody discharge from the nipple, bigger than normal breast and the lump in the breast.

> *"… Change in the colour of the breast …. the discharge may be from one breast and it may be yellowish, greenish or blood-stained … we have one breast becoming bigger than the other … you will see that even the one which is smaller is becoming bigger and that …and then when you have lump in the breast that feels like a kernel; it comes in sizes …"* -Nurse 2

> *"… the colour … you realize that it is different from the other breast … the nipple discharge it may be bloody … sometimes one breast becomes very bigger than the other breast though some maybe normal … there is breast lump …"* -Nurse 7

The participants also had adequate knowledge about advance breast cancer. They stated that advance breast cancer leads to pains which are associated with the spread of cancer cells to other organs. The lump is static and very hard.

> *"… late cases of the breast cancer they come with pains, they come with pains because it has advanced to the lungs, to the kidneys, to the brain, the and pains all over the body …. the lump feels very hard like a stone and it doesn't move, is static it feels very, very hard…. at times too you will notice that there is a sore … then is smells too."*- Nurse 5

> *"… most of them who come in with the end stage disease some is fixed -with their breast is fixed like a stone sort of or a moulded clay of the chest, some come with ulcers some very offensive ulcers, some come with lung metastasis, lever metastasis some come very jaundice some come with severe anaemia; a whole lot of complications … the same time, they also come in with severe pain."*-Nurse 6

4.3.4 Chemotherapy and Radiotherapy

Most of the participants had adequate knowledge on chemotherapy, the participants stated that they wear personal protective equipment, administer rehydration, check the patient's vital signs before and after administration of the chemotherapy, gives premedication and educate patients on the side effects of the drugs.

> *"Before we administer the drug we wear protective clothing, we wear gloves gowns with long sleeves and protect our hair, we wear nose mask and then we wear goggles …… we take their vital signs … if the BP is high we wouldn't give because one of the agents which is Adriamycin … might increase the BP… we monitor their vital signs after the chemotherapy … their pre-medication we give Phenergan … some after the administration of the drug will say I am feeling some palpitation so we monitor them."*-Nurse 8

> *"… we have the face mask that we use, we have goggles because some of the drugs with a splash, we have gloves they are thick enough to prevent penetration of the drugs … you have to take the vital signs so that you know the base line reading so that in case patient reacts then you take the vital signs again …we start with the pre-hydration … you have to do your regularly observation of the patient when the patient is taking the chemotherapy … then we monitor the flow of the drug … taking the vital signs, giving pre-medication so that we reduce some of the side effects of the drugs."* -Nurse 2

Also, most of the nurses seem not have adequate information on radiotherapy. The participants stated that they were not directly involved in the care of the patient undergoing radiotherapy.

> *"…. I ensure that they undergo the therapy as specified by the Doctor, and then most at times they come for review on their clinic days…. so what we do is we make sure they come for review, and then we call them to see the Doctor."*-Nurse 4

> *"when you go to the radiotherapy section you will not see any Nurse available there, when they need us to give pre-medication then we go there, when they need us to dress somebody's wounds then we go there but we don't usually stay there."*-Nurse 3

Again, one of the participants stated that, when there is adverse reaction due to the radiation therapy, the nurse educates the patient on nutrition and how to protect the skin against further damage.

> *"… we … help them understand that it will take a while for the muscle to be able to get back to its normal state … they should wear lighter clothing's when they are indoors or in the house, they don't have to apply synthetic fabrics to that portion of the skin,"*-Nurse 6

4.3.5 Pain Management and Palliation

In addition, all the participants had some knowledge of pain management. Some of the participants indicated that patient with breast cancer goes through severe pains thus; the nurse administers morphine and gives breakthrough dose analgesia.

> *"… they (patients) also have bone pain, yes so the pain is so severe so you have the rate the pain, rate the pain on the scale of 0-10 on the numerical scale, and then depending on the severity it gives an idea so with the advance pain we give … opioids … initially we start with 5 milligrams … we are aiming at a zero pain … if the pain is not all that severe then the patient can go on analgesic like tramadol is also good … we also have paracetamol to give in between as a breakthrough dose."*-Nurse 2

> *"… so because the pain is unbearable even when we are giving it every 4 hours and then breakthrough dose in between."*-Nurse 7

Moreover, most of the participants had adequate knowledge on palliation. Some of the participants indicated that palliation should start immediately patient is diagnosed and the patient should be nursed to a peaceful death.

> *"Ideally, palliative should start on the very first day of diagnosis. Yes …. We take them through what they have to understand. We counsel them to take it a day at a time …. The goal of treatment is more of palliative, more of trying to make you feel more comfortable to your end of life*" -Nurse 13

> *"… I heard that they are saying immediately the person is diagnosed. It should be referred to palliative care … need to manage them until … they die a peaceful death".* **–Nurse 11**

> *"… palliation should start when the patient starts treatment, so the patient is taken through treatment as well as palliative care, advising the patient on how to care for herself, because you know that cancer is difficult to treat …"*-Nurse 2

4.4 Nurses' Attitude towards Breast Cancer Care.

One of the main themes identified is the attitude that the nurse shows while caring for the patient with breast cancer. To answer the second research question– the attitude of nurses towards caring for breast cancer patients, two main subthemes emerged from the data. These were the positive attitude of the nurse towards breast cancer care and the negative attitude of the nurse towards breast cancer care.

4.4.1 Positive Attitude

The study participants showed that some nurses have a positive attitude towards caring for the patient with breast cancer. Most of the participants had a positive attitude towards breast cancer screening, chemotherapy, breast cancer pain management and palliation and supportive care.

Participants were of the view that the disease needs to be identified for early treatment and private institutions; schools, churches and younger ones should be included.

> *"We are trying to screen younger girls … we go to schools and then organize a screening for these school girls so that we can identify those who have the disease so that we can catch them early for treatment … we even go to churches to screen and we include the younger ones."*-Nurse 1

> *"… What we think is best that we can do is outreaches, so there have been a lot of outreaches from us, we are doing a lot even private institutions have been liaising with us a lot of us but we still need to do more, because in the awareness even in my church the first time I took my colleagues we went there we spoke about this … we examine any woman that is available from the age of 15 years."*-Nurse3

However, one participant was of the view that information on breast cancer has gone far; people know but it is left with the individual to choose between orthodox treatment and herbal treatment.

> *"I think the awareness of breast cancer is going far in Ghana at the moment … the information has gone but is up to the people to decide as to whether to seek orthodox care or herbal care, but on a whole I think the information has gone out and mostly people have knowledge about breast cancer."*-Nurse 7

Some participants thought that chemotherapy should start in the morning, be given slowly than the stipulated time, the first time of administration for the patient to relax throughout the treatment and to prevent side effects.

> *"We start out new treatments in the morning, the reason is that because of all the anxiety that they may go through you have to give them enough time to relax, to be able to go through the cycles … so we try to use the correct time that they are supposed to have for that particular treatment and for the first time that they do it, we do it slower than the actual time … patients who rush through their treatment end up coming with neutropenia."*-Nurse 6

> *"… You have to receive the patient warmly, sit her comfortably … you are going to give the chemo for a number of hours,depending on the type of drug that you are using, it could be 1 hour, 2 hours or even 3 hours so you are going to regulate the drug threat (side effects) according to the hours you are giving it."*-Nurse 1

However, one of the female participants thought that each drug has its flow rate so, to prevent adverse effects, the nurse will have to observe patients regularly, educate the patients on the effects of chemotherapy, monitor the vital signs and give premedication that will prevent the side effects.

> *"every drug has its own flow so that it doesn't cause any adverse reaction in the patient,so regular monitoring, regular observation, education of the patient about the immediate effect that the chemotherapy will give … taking the vital signs, giving pre-medication so that we reduce some of the side effects of the drugs immediate and extended."*-Nurse 2

Also, some of the participants were of the view that patients are followed up by calls to help solve severe side effects of the chemotherapy.

> *"We give our numbers to them. They call us, if there's any problem at home, they call us we try to help them solve it especially, the severe side effects of the chemo…we follow up by call to see how they are doing."*-Nurse 11

Most of the nurses had a positive attitude towards the management of breast cancer pain. The participants stipulated that morphine is the drug of choice since the hope is to achieve zero pain in the patient.

> *"…there are people (patients with breast cancer) that their pain only works with morphine and we give it to them, we don't want to see any of our patients in pain and, that is one of rule of cancer; zero pain, the hope of the zero pain."* -Nurse 3

> *"… We are aiming at a zero pain so if a patient's pain is not going down then we will be increasing it (morphine)."*-Nurse 2

However, one of the participants expressed that drug addiction is not considered when dealing with breast cancer pain management but rather, the aim is to ensure the quality of life of the patient.

> *"… since is pain we don't have drug addiction at the back of our mind … for patient, we are looking for quality of life … we don't think about the addiction."*-Nurse 4

Some of the participants had positive attitude towards palliation, the participants verbalized that the patient needs to be managed till a peaceful death.

> *"… Because the person is one leg out of this life, so you want to nurse the person to a comfortable death …"*-Nurse 6

> *"We (nurses) need to manage (pain) … until they (patients) die …. a peaceful death."*- --Nurse 11

However, some of the participants had a divergent attitude towards palliation. The participants were of the view that palliation should start before the patient is at the point of dying and prepare the patient and family towards death.

> *"… My opinion, I think it (palliation) should start way before that (patient at the point of dying), so that the patient is prepared, the family too is prepared to know that."*-Nurse 8

Some of the patients depicted some positive attitude towards psychological, family support, spiritual care and financial support.

The participants believed that nurses should play their role as professionals, empathise with the patient; encourage; draw closer to the patient, communicate effectively with the patient and introduce survivors to the patient.

> *"So when they come, we calm them down, they are not alone, we are all in the fight together, we also try to introduce other survivors, those who have completed treatment to them … to encourage them to have hope … as a nurse what we do as I said is to get closer to the patient, try to comfort the patient … anytime you are available to talk to them to give them psychological support."*-Nurse 11

> *"… as a Nurse you know this is a bad case … but the fact that is a bad case does not mean you should just leave it like that, you play your role as a Nurse … just to comfort the patient … then they need help so they talk a lot most of them talk a lot, not just that the person is talking but you as a Nurse you see the thing as unnecessary but you don't just brush the person aside, just give the person a listening ear."*-Nurse 8

Concerning the attitude of the nurse towards family involvement, some of the participants asserted that the family needs to be involved in the patient's care.

> *"You always have to involve the family, because they (patient) need support"*-Nurse 13
> *"I think the family should support when it comes to breast cancer. You know, the family members, they are the nearest people closer to the patient".* -Nurse 12

With the attitude of the nurse towards financial support, nurses plead for the patient to have the free cost of care and pay for the cost of care. Also, the nurse borrows money to buy drugs for the patient.

> *"So we (nurse) had to go and talk to the pathologist begging, for them to take the sample and do it free for us. But for how long can we continue begging … They pay for the reagent so how long can we continue to beg? So at times, we have to even contribute to pay for bills."*-Nurse 12

> *"… You (nurse) go out of your way to help the patient financially, for example, the last somebody needed blood she didn't have money I have to use my own money …I had to borrow money to buy drugs for her because the sister had gone home and wasn't coming, the patient needed treatment, and we needed to give treatment so from your own pocket you have to borrow money to buy drugs."*-Nurse 1

Two of the participants had a positive attitude toward spiritual care. One of them was of the view that the nurse draws strength through the Grace of God to deliver quality care to patients. Also, the nurse should be the patient's source of hope.

> *"It is God that has been our strength we have to ask for grace each day to be able to handle them (patients) … I tell myself is that the Lord should use me as a blessing for somebody … I want to be the one that stands in a ray of hope for that patient."*-Nurse 6

4.4.2 Negative Attitude

The data collected from the study participants indicated that nurses have a negative attitude towards cancer pain management, palliation, financial support, physical care and alternative treatment of patients with breast cancer.

Two of the participants were of the view that when the patient complains of pain frequently, they tend to give a placebo to verify whether the patient was really in pain.

> *"Cancer, he comes in and he will complain of pain, pain, so one day he came and I was for afternoon shift and I decided to draw normal saline and just (laughs) I injected him with it, like 1ml and I did that and he said he was okay, he was fine, that was the day I realized that truly some of the patients are addicted to the morphine,"*-Nurse 4

> *"… Patient is screaming too much maybe she is trying to exaggerate, from experience you can tell that so, sometimes they said we shouldn't give placebo but we tend to give togive placebo …"* -Nurse 1

One of the study participants stipulated that traditional treatment (medicine) should be abrogated. Since it is not helping patients with breast cancer but rather killing them.

> *"… We (the health system) should do away with this traditional treatment, it is not helping it is rather killing the patients."*-Nurse 5

Some of the participants thought that, the patients are not told the truth about prognosis since bad news (prognosis) tend to cause emotional distress, increase the blood pressure and can speed up the death of the patient with breast cancer.

> *"I personally feel that sometimes that bad news (prognosis) kills faster, so we like to give them hope … you don't want to break their heart because you know emotional stress can kill, people think and will rather get BP and die faster than when the cancer will even kill them … but us Nurses want to cushion patients and pamper them so we don't really tell them the truth from the beginning … you see them (patients), they are palliative alright and they are strong we turn to forget that this people are palliative patient,"*-Nurse 3

> *"… Some of them you know the truth but you cannot tell them in the face because you know how devastating it will be for them, you know how the family setting is, how they will take that news as negative news and not able…"*-Nurse 6

Most of the participants were of the view that nurses cannot stand the smell of ulcerated breast cancer so they do not like being close to such a wound and when assigned to dress it, nurses reject to do so or dress it haphazardly.

> *"… Breast cancer dressing here my sister, you can't stand it, the whole room you can't even enter … so we go outside and then do the dressing for them because of the smell, is very offensive … at the back of the building."*-Nurse 5

> *"… they come in with offensive wound some (nurses) will not like to go near to the patient because their wounds are very offensive …, someone will categorically tell you that me I am not working here because of the smell … some people (nurses) will not like to touch the wound at all, they won't touch it (dress), others too will touch it but the way they will do it is as if let me just do something and go that is it."* -Nurse 8

Again, one of the participants was of the view that nurses are afraid to dress huge bleeding breast cancer wounds.

> *"… They (nurses) are scared of managing breast cancer because when they see the thing so huge (malignant tumour) and it's bleeding, they are scared. They are scared of touching (dressing) the wound."*-Nurse 12

4.5 Nurses' Nomative Beliefs Associated with Breast Cancer Care.

Another main theme identified is the Normative Beliefs of the nurse that affects the care of patients with breast cancer. To answer the third research question what are the influences of significant others on the nurse towards breast cancer care, four main subthemes emerged from the data. These were; team work, institutional policies, social support and patient's mindset and attitude.

4.5.1 Team Members

With regards to the sub-theme above, some of the study participants stipulated doctors make errors with treatment; sometimes accept corrections easily; delay in the authorization of palliative care and most often there is a conflict between nurses and doctors. Also, colleagues of the nurses practice favouritism in the dispensation of their duty.

Concerning errors with treatment, some of the participants stated that at times, doctors do make mistakes with patients' prescription and sometimes they accept the corrections easily.

> *"…Sometimes they will like to complete the course (treatment) before maybe reviewing the patient … sometimes the prescriptions that they give you see that oh! this one the weight and the dosage is not in line, … sometimes they will accept corrections easily, sometimes they will tell you the reason why they have put the patient on this particular drug or why they cannot stop …"*-Nurse 1
>
> *"… In case of executing the plan and you realize there is something the doctor has written that is not in standing with the treatment or there is a little deviation you call the doctor's attention and the remedy is done or the change is done…"* -Nurse 2

With the delayed authorization of palliative care, some of the participants acknowledged that doctors refer patients for palliation when the patient is not in the position to take decisions before dying.

> *"… As soon as they see that the disease has advanced. I think that they should declare the prognosis so that the patient and the relation will prepare their mind, but what is been done here is they wait until the situation has deteriorated then they declare the prognosis than that one, after a day or two then the patient will die …"*-Nurse 10

> *"… The patient is becoming weak and is obvious … sometimes when the patient is unconscious and is unresponsive that is when the palliative comes in"*-Nurse 8

Concerning the conflict between nurses and doctors, some of the study participants stated that, there is always some kind of tension between doctors and nurses. Doctors want nurses to follow their orders and they feel nurses want to take their position.

> *"… There is always this kind of friction between Nurses and Doctors, Nurses feel like we do so well to be appreciated, but the Doctors always want to get that kind of recognition because they feel they do better …"* - Nurse 3

> *"Most of the Doctors, you know Doctors and Nurses, they only want you to follow their order, the orders they give … they feel like we want to take their job …"*-Nurse 5

> *"Most of the time when it is so obvious that … you know this thing, this patient can't survive it but they keep on requesting for labs upon labs, … you might talk and then a senior colleague that is a resident or Professor or someone might think you are rubbing shoulders with him on that"*-Nurse 8

However, one of the study participants depicted that, doctors are good and they interact with nurses cordially.

> *"Our doctors are good, whatever issues we have we approach the Doctors because they will help you solve it, so I think in interacting with them our cordiality is okay, it's fine…"*- Nurse 4

With the association of other colleagues on the nurses in breast cancer care, one of the study participants indicated that most nurses practice favouritism regularly when it comes to job assignment on the ward. Nurses want to choose who they want to work with and where they want to work; and if the favourite one is not available, then, they will prefer to work alone.

> *"… Most of the time, the challenges that we face here is like, I don't want to work with this person, I want to work with this person, this person I don't want to work with, like they have their favourite … like she wants to work with this particular person, she doesn't want to go to OPD she wants to be at the chemo … is something which is rampant here, everybody has his or her favourite that she always want to work with, but if that person is not around she doesn't want to work with anybody…"*-Nurse 5

4.5.2 Institutional Policies

Addressing the institutional policies on breast cancer care, the participants had some concerns on the booking system in the care of patients with breast cancer. Also, participants raised concerns on the difficulties associated with the transportation of patients and most importantly, the different doctors who are in charge of taking care of these patients. They argued that the differences in the doctors in charge of handling patients create inconsistencies in treatment plans, therefore, creating complications in quality healthcare delivery. These were the three main factors regarding the effect of institutional policies on breast cancer care.

With the booking system practised in the centre, some of the participants were of the view that it is problematic because, when patients are late in coming to the clinic, it is difficult for them to be reviewed by the doctor even if it is an emergency. Patients had to rebook for another date irrespective of their geographical location and this results in quarrels between nurses and also, between nurses and patients.

> *"…she was coming and got caught up in traffic she comes and they say you are late, your time has passed, you have to re-book meanwhile, the patient has travelled from elsewhere to this place, it is not easy, it is not easy sometimes it becomes a quarrel between the Nurses, a quarrel between nurse and patient and then sometimes they say your name is not on the list, patiently ask if it is an emergency … it becomes a problem you see, sometimes some of the policies affect our work"* -Nurse 1

> *"… Radiotherapy if you don't book it becomes difficult for a doctor to review your labs"*-Nurse 4

However, one of the study participants stipulated that the booking system is helpful.

> *"… We began booking our cases from the last four to five years … It's quite helpful now because we don't have people coming and staying from morning through to the end of the day"* -Nurse 6

Also, there were various concerns about the institutional policies on breast cancer care. One of the participants indicated that the hospital ambulance is not mandated to travel outside

the institution with a patient. Therefore, nurses use a taxi when the need arises in the absence of a private vehicle.

> *"... Per the hospital policy, the ambulance doesn't go out of the hospital so sometimes we resort to use taxis around, that is, if the patients don't have their own personal..."*-Nurse 8

In addition, one of the participants indicated that the patient is attended to by different doctors with divergent views on treatment, thus, the treatment is back and forth.

> *"... Some of them (patients) will come "okay go and do this, go and do that" and is not one Doctor that sees them, ... then the patient will go and come back then meet the senior the senior one will say no, that is not what you are supposed to do this and do that so, it is like this back and forth"*-Nurse 9

4.5.3 Social Support

With social support on the care of the patient, the participants showed that both relations and social groups influence the care delivery.

The study participants stipulated that, sometimes, the relatives dictate to the patient and the patient is neglected if advice is not taken.

> *"... sometimes the relatives are not willing for the patient to undergo the treatment ... because the brothers and aunties said she shouldn't come for the mastectomy ... now the aunties and the brothers are not on talking terms with her, ...somebody will come and then tell you that I don't have anybody around to take care of me after I have taken the drug and I am becoming weak so this week I am not coming, I am waiting till I get someone"*-Nurse 8

> *"... Their family members neglect them. You don't see anybody coming near the patient. They come and dump the patient ... the family support is not there ... The patient doesn't get good food, balanced diet to eat ... a woman came and she said the husband said, we should throw the tissue away. He doesn't have money for these things ... she should invite the husband that we want to see him ... she told me that he was not coming anywhere. As for the family, they don't care"*-Nurse 12

On the other hand, some of the study participants admitted that some patients' relations are supportive of the treatment of the patient.

> *"... Other relatives too ... they are very supportive they help with the treatment ... Nurse 3*

> *"... The family members, most of the family members are supportive"-Nurse 5*

In relation to support groups, some of the participants indicated that, the patients were being helped financially and emotionally.

> *"… second line treatment, third line treatment … are very expensive … we have few NGOs that come around to support such patients but they don't come around all the time … we do have the breast cancer society that regularly meets to deliberate on breast cancer issues, we also have Road for Recovery that is an advocacy and survival group to help those who have been … to be able to cope with the situation …"*-Nurse 6

> *"… Recovery Ghana is a support group; they give support to patients who are in need who cannot afford their drugs"*-Nurse 1

4.5.4 Patients' Mindset and Attitude

In assessing how the patient is associated with breast cancer care, some of the participants indicated that patients have an immense association with care delivery. They argue that the mindset of the patient, the attitude of the patient and the financial status of the patient have an association with breast cancer care.

Concerning the mindset of the patient on breast cancer care, some of the study participants were of the view that patients are difficult and uncooperative and are sometimes very rude to the nurses.

> *"Some of the patients are difficult … some of them, what they have heard outside, they want to bring it in, they think, excuse me to say, they know better … "I know, I know. Why are you not doing this? "Why are you not doing that?" Whiles, we have explained everything … still they won't understand, anything you tell them they won't understand. It makes it difficult …"*-Nurse 9

> *"… Such a patient is not cooperative, they wouldn't cooperate in any way, you say this, the patient will say that… such patients are very difficult to handle …It's time for medication we are about to serve you, she will tell you I will take it at my own time I am not ready for the medication, food I am not ready to eat, even whiles on oxygen she can take it off, she will take it off"*-Nurse 8

> *"… when she came she was rude to … she was very, very rude to us under her case, … maybe she just came to test us to see whether Nurses are doing their work, so over here … sometimes when you are talking to him he gives you cheeky answers"*-Nurse 7

Also, a participant was of the view that patients demand a lot of attention regardless of what the nurse is already doing.

> *"... the patients ... come and they demand a lot, irrespective of what you are doing, because I remember some time ago we had one patient when you go to the patient to render care, this patient will be telling you so many things even things that doesn't even concern her ... so they want attention"*-Nurse 10

On the subject of how the financial status of a patient affects breast cancer care,expressed worry over how some patients quit treatment due to lack of funds.

> *"... They come and finances are not good, they take one chemo and they will go for as long as three months or four months before they come "*-Nurse 4

> *"... Because of lack of funds ... patients are not able to afford their drugs so sometimes, the patient is due for treatment but she doesn't come"*-Nurse 1

4.6 Nurses' Perceived Behavioural Control Towards Breast Cancer Care

Also, one of the major themes identified is the perceived behavioural control of the nurse that can affect breast cancer care. To address the fourth research question on how resources, time, opportunities and challenges affect nurses' behaviour towards breast cancer care, five main subthemes emerged from the data collected. These were availability of resources, availability of time, availability of training opportunities and motivation experienced by these nurses in general.

4.6.1 Availability of Resources

The study participants stated that the availability of both material and human resources for the nurse to work with affects breast cancer care. Material resources included infrastructure and logistics.

They indicated that the units for caring for the patients do not have an X-ray department, laboratory and a pharmacy for easy accessibility.

> *"... Pharmacy is not inside the department. They go outside the department which is a bit far from the unit to pick their drugs so the patients who are a bit weak cannot walk up and down. We would have to look for people to do that"* -Nurse 6

> *"... We are at surgical department and you have to go and do let's say a scan, you have to move out. We don't have a scan place here ... you have to move out of the building to go and do scan and when you go you will be in queue ..."*-Nurse 10

Moreover, some of the participants indicated that they lacked the necessary logistics and consumables to aid them deliver quality healthcare to patients suffering from breast cancer. They also bemoaned the inadequate logistics and equipment they have to work with in their line of duty.

> *"... We did not even have gloves, at the moment we are even lacking 5mls syringes, and 10ml syringes, so if we have to give them antibiotic such as Clydamycin you know it burns and it is Aminoglycoside so, sometimes you have to use 60mls or 40mls to dilute it and you can imagine having 2mls syringes, how many of those will you be able to use to give them their antibiotics ..."*-Nurse 7

> *"... Those who come with ulceration if you are dressing they take a lot of plaster because of the breast and you know the breasts we have different sizes, so assuming you are dressing a patient with breast cancer and the breast is ulcerated ... you have to use a lot of plaster ... always we are under resource ... we don't have monitors, we have only one ... one patient could be on it at a particular time, so if you need or the patient's condition demands that you put the patient on a monitor it will be only one patient, and the other patient cannot get it"* -Nurse 10

However, some of the participants stated that they have most of the logistics they need to care for the patient with breast cancer.

> ***"...** most at times, we have the things that we need to work with, not like I want gloves and there is none. It is not that, as such, we have most of our things (logistics)"*-Nurse 1

> *"... I will say, is one of the best we have here, ... because we have infusion pumps that helps in the monitoring of the flow of drugs when you set it up ... We have things (logistics) at our disposal that we work with"*-Nurse 4

It was also gathered from the data that inadequate professional nurses influence breast cancer care. Some of the participants stated that professional nurses were few.

> *"... In a day, you might have 3 patients go to radiotherapy and the patients cannot go with their relatives only. They need to go with the staff. Aside from the patient going to radiotherapy, the patient would have to go and do an x-ray. The patient would have to go with the staff. The patient cannot go with relation alone. Sometimes, we have a few of them (professional nurses) about 2 or 3 of them"* -Nurse 12

> *"... One patient can take maybe let's say, you are four, one patient can occupy the four of you, just one breast cancer patient, at the same time, maybe the oxygen is dropping, the saturation is dropping, the line blocked including the Doctor*

everybody is running so imagine you have two or three patients … they need a lot of hands, but here is the case you are not many"-Nurse 10

4.6.2 Availability of Time.

Regarding the time available for nurses to care for the breast cancer patient, some of the study participants showed that caring for breast cancer patients is time consuming such that, at times the nurses do not get time to even eat as the patients demand a lot of attention.

"… Most of the time they come with this fungating thing and breast discharges is offensive, if you are not fortunate and it's bleeding … you can stand there for like 45 minutes doing one job".-Nurse 13

"… They (patients) are in distress psychologically, and they are not one, they are not two a lot of them so if this one is demanding your attention, this one also needs your attention … at the end of the day you taking care of the patient is like you become very tired and at times too you come to work you don't even have time to eat, you don't have time to eat …"-Nurse 10

Some also indicated that time is a challenge and nurses had to sacrifice to ensure that the needs of patients are met.

"… As for time there is a bit of challenge and some of them (patients) know they are coming for chemotherapy but some will come in as late as 12 pm… 12 pm you (patient) are taking tazotere which will last for 6 hours; then what time will you (nurse) go home". Nurse 4

" …For the time, we sacrifice whatever that we are going to do to ensure that, at that moment, you (nurse) needs to be sure the patient is fine". Nurse 11

However, one participant revealed that sometimes the nurse leaves work undone due to limited time.

… We have limited time, and at times you come and you want to do a lot of work and something just takes you (nurse) out and you don't have the time to work". Nurse 2

4.6.3 Availability of Training Opportunity

Some of the study participants indicated that no special training is organized for nurses who care for patients with breast cancer. As such, the nurses research on their own to build their knowledge capacity.

> *"…When you are sent to that room, no special training is given to you, you are just sent there "go and administer the therapy" so you have to be doing the reading and research on your own, that one is nobody's business …"*-Nurse 8

> *"… Most people they have to look for opportunities elsewhere. Or maybe they go online, they notice there's a workshop on this. I would benefit from this. Then out of pocket pay so that you enhance their knowledge to help a patient"* -Nurse 13

However, some of the participants stated that nurses do have a lot of training related to the care of the patient with breast cancer which is scheduled.

> *"… We do have a lot of training opportunities here, and I think there is a quota for each year, and so depending on the HR's quota for the year … but as and when it is necessary"*-Nurse 6

> *"… We have a speciality program that most people are doing, some are in now, and when they come out everybody will go through so that everybody is involved"*-Nurse 3

Also, one of the participants revealed that the nurses trained in breast care work at the outpatient department but not in the ward.

> *"… Here the breast care nurses are there, but here, the breast care nurses are at the OPD, they don't come to the ward"*-Nurse 10

Also, one of the study participants indicated that nurses who gained experience from the ward are moved out of the ward during the reshuffle. Thus, new nurses do not get experienced nurses to train them.

> *"… The experience, like on the job experience with the patient, nurses at a point in time are moved out of the ward … sometimes we change, we do reshuffle, do you get it, so the people who have had the experience like on the job experience with the patient at a point in time are moved out of the ward, so, people come and the experienced people are not there to train them …"*-Nurse 10

4.6.4 Motivation

Most of the participants stipulated that the love for the profession, to help the patient, saving a life and successful treatment were their motivational factors in breast cancer care. In addition, emotional characteristics associated with the patients being comfortable and

happy were the nurses' motivational factors in breast cancer care. Two of the participants said that

> *" ... The love of the profession, love of caring for patients. The aim of looking after someone who has gone for the treatment and successfulness pushes me, because, at the end of the day, I want to make someone comfortable; put a smile on someone's face at the end of the day".*-Nurse 13

> *"... I have the interest to come and care for patients, and seeing them happy, and at the end of the day I know I have done something great, so that motivates me, every ... I have done something great ... something good to save someone's life ...when we can achieve something, we are okay, we are happy that at least we have done something"*-Nurse 2

On the other hand, one of the female participants admitted that a conducive working environment with a good Nurse Manager and supportive staff is her motivation in breast cancer care.

> *"... My Matron is a nice person so though you are stressed, you still talk to her and you become comfortable, you are just happy, ha! And we have beautiful staff among us, ..."*-Nurse 7

On the contrary, some of the perceived factors that obstructed care for patients with breast cancer according to the participants were; managing emotions and heavy workloads.

Concerning the management of their emotions, some of the participants indicated that as nurses, they are the prime caregivers and as such, they become emotionally attached to patients which affect them when some of the patients die. Again, they expressed the feeling of fear of getting the disease is overpowering and they periodically examine their breast to see if they have the disease.

> *"... Most at times, when I wake up in the morning sometimes it becomes emotional caring for them (patients), because ... at the end of the year you end up losing a whole lot of them, and then the issue is when you become attached to a patient and then you end up losing that patient, it affects you. Sometimes, psychologically we are afraid, I sometimes psychologically I am afraid because I might have some pain in my breast ... I will be massaging my breast wanting to know what is going on in there, so is not easy caring for the patients ..."*-Nurse 4

> *"…If you the nurse, you are not strong-willed or emotionally strong, you end up not able to give the right options or you are not able to help them go through their treatment. For some patients too, you feel you've been emotionally attached to them and one of the reason is they have families, they are young, so you tend to be emotionally attached so you are not able to detach. So it makes it difficult to care for them".*-Nurse 13

With the workload, the study participants stipulated that, in caring for the patient with breast cancer, most of the times, the task is very hectic making the ward always busy, culminating in a huge workload which is overburdening.

> *"… Cancer, most at times, our ward is full especially the female, most at times, it is full the only time you can see that maybe the ward is free is when the patient has passed on or our mastectomy cases have been discharged home, other than that, almost every time the ward is very, very hectic because most of them are that bad, they are on oxygen we are only managing them, and most at times we pass chest tube for them so the ward is always busy for us, …"*-Nurse 7

> *"… You have to do this daily alternate dressing for them… it's a huge load of work and the rate at which they come in that state, sometimes, overburdening on as the nurses"*- Nurse 13

4.7 Summary of Findings

The study explored four objectives based on the Planned Behaviour Theory to find out the experiences of nurses caring for patients with breast cancer in the Korle Bu Teaching Hospital. Thirteen nurses gave their consent and participated in the study after the study's objectives and purpose had been explained to them. The interview was done with the help of an interview guide. The researcher recorded the interview sessions and transcribed them using the principles of thematic content analysis to analyse the data. The findings proved that nurses have adequate knowledge on breast cancer care although it was only one of the participants who is an oncology nurse. However, the nurses have inadequate knowledge of nonpharmacological pain management. Moreover, the participants expressed both positive and negative attitude towards breast cancer care. The participants indicated that nurses have a positive attitude towards breast cancer care such as chemotherapy, breast cancer pain management and palliation, supportive care. Nonetheless, some of the nurses had a negative

attitude towards pain management, palliation, wound care and alternative treatment of patients with breast cancer. Most of the negative attitude that emanated from the data was linked to attitude towards wound care. The reason being that most nurses cannot stand the smell associated to ulcerated breast cancer, and they do not want to be close to such wounds and when assigned to dress the wound, nurses reject the task. Also, it was identified that nurses' normative beliefs such as team members, organizational policies, social support and the mindset and attitudes of patients were associated with the care of patients with breast cancer. Also, with nurses' perceived behavioural control towards breast cancer care, the participants explained that the availability of resources like inadequate infrastructure and logistics, human resource, time; training opportunity, management of emotions, workload and motivation affect nurses in breast cancer care. The results of the study will be discussed in detail in the next chapter.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.0 Introduction

The chapter discusses the key findings of the study using the existing literature as a framework and concludes by evaluating the usefulness of the theory of Planned Behaviour in this the research. The study explored the experiences of nurses caring for patients with breast cancer at the Korle Bu Teaching Hospital. The research was specifically intended to:

- To elicit the knowledge of nurses regarding the care of breast cancer.
- To describe the attitude of nurses caring for patients with breast cancer.
- To describe the normative beliefs of nurses towards breast cancer care.
- To describe the perceived behavioural control resources, time and opportunities of nurses towards breast cancer care.

5.1 Nurses Knowledge in Caring for Patients with Breast Cancer

The first major theme showed the knowledge nurses had in caring for patients with breast cancer. This includes epidemiology of breast cancer; diagnosis; signs and symptoms; chemotherapy and radiotherapy and pain management and palliation. The result of this theme is consistent with the findings of other researches which show that nurses have adequate knowledge on breast cancer (Fotedar et al., 2013; Maria et al., 2015). Although the studies conducted were done in various geographical locations with different methodological approaches, the participants had varying knowledge level in breast cancer care due to their demographical characteristics (Bello et al., 2011; Fotedar et al., 2013; Lemlem et al., 2013).

In this present study, most of the participants indicated that breast cancer is on the rise in Ghana with advanced breast cancer being more common. This result is similar to a

study conducted by Prolla et al., 2015 which indicated adequate nurse knowledge level on the epidemiology of breast cancer. Nurses who have adequate knowledge of epidemiology may be able to counsel clients for early breast cancer detection (Oluwatosin, 2012). Also, with adequate knowledge of the epidemiology of breast cancer, the nurse may practice self-breast exams (Woynarowska-Sołdan et al., 2019). Breast cancer also affects younger age group between 24-39 in Ghana (Seshie et al., 2015) as shown by studies conducted elsewhere (Chauhan et al., 2011; Lebel, Beattie et al., 2013). In this instance, the study indicated that the incidence of breast cancer is increasing in the younger population (14 - .35) years. The participants stated how young women including teenagers are being affected with the disease. This is a disturbing trend as it can have an adverse effect on the economic growth of a nation (Bloom, Canning, & Fink, 2010). They argue that with increasing young individuals affected by breast cancer, the economic growth of the country may slow down as a result of absenteeism. Since the young in the population are the future economy working forces.

Nonetheless, the study results indicate that six (6) of the participants had some idea about the causes, preventable and unpreventable risk factors of breast cancer. The result is consistent with other related studies which show that nurses have average knowledge in the risk factors of breast cancer (Prolla et al., 2015). On the contrary, a previous study shows nurses have low knowledge on the risk factors of breast cancer (Andegiorgish et al., 2018; Dnsc & Shoma, 2010). Although previous studies indicated that low knowledge level on breast cancer care may be associated with the educational level of the nurse (Fotedar et al., 2013), this study results reveal that low knowledge level may be associated with lack of specialization in oncology nursing. Since the percentage of nurses with oncology nursing as compared to those without is 7.7% (1). Therefore, the general nurse may not be well prepared to take care of patients with breast cancer (Jones et al., 2010).

In addition, few of the participants indicated that nutrition, exercise and tamoxifen prophylaxis can prevent breast cancer. Some literature had also shown that a healthy lifestyle reduces the incidence of breast cancer and its morbidity (Cifu & Arem, 2018; Jerônimo & Weller, 2017). This suggests that when nurses educate community members on healthy diet, obesity and exercise, it will help reduce the burden of breast cancer (Forster et al., 2011; Steele et al., 2017). Also, the association of nutritional education with improved patients' appetite reported in this study is consistent with the existing literature (Hopkinson, 2018; Schiavon et al., 2015).

Also, the early integration of nutritional counselling improves the quality of life of patients (Paccagnella et al., 2010). This suggests that nurses with high knowledge levels on nutrition may influence the early introduction of nutritional counselling of patients undergoing radiation therapy. A national policy on healthy lifestyle and breast cancer prevention may help reduce the burden of breast cancer. Available research results have shown that tamoxifen can prevent breast cancer in a healthy individual (Vogel et al., 2010) which corroborates with the current results of this study. This suggests that awareness of the nurse on the effects of tamoxifen can help educate healthy individuals, who are at risk of developing breast cancer especially, post-menopausal women who are at risk of breast cancer.

Furthermore, all the study participants had some knowledge of breast cancer screening and breast tissue analysis for diagnosis. The results corroborate with various studies which depict that nurses have sufficient knowledge level on breast cancer screening methods and diagnosis (Andsoy & Gul, 2014; Fotedar et al., 2013; Prolla et al., 2015). However, other findings have shown that nurses are not well knowledgeable in the method of breast cancer screening (Skrobanski et al., 2019). This present result is likely to suggest that nurses may educate and encourage patients to go in for tissue analysis when necessary.

However, the knowledge level of the nurses may not be related to age and years of work experience of the participants as other studies have established (Prolla et al., 2015).

A study conducted in Eritrea suggests that more than half of the nurses' knew the signs and symptoms of breast cancer (Andegiorgish et al., 2018). The current study found out that the nurses who were studious had adequate knowledge concerning the signs and symptoms of breast cancer. The nurses relate that the signs and symptoms identified in advanced breast cancer include breast pain, static breast lump and spread of the cancer cells to other organs, breast ulcer and bloody discharge. This result is consistent with the existing literature (Bloom et al., 2011; Eyigor et al., 2018; Gale et al., 2013). This suggests that nurses may be able to identify patients with breast cancer for counselling and subsequent treatment.

Furthermore, other studies have revealed a high knowledge level in chemotherapy administration among nurses (Verstrate, 2015) and this is seen in the current study. In contrast, some research results have shown that nurses have insufficient knowledge level in chemotherapy administration (Taghizadeh Kermani et al., 2015; Khan et al., 2012). The result may be due to the self-motivated study in chemotherapy by the nurses. Taghizadeh Kermani et al., (2015) demonstrated that the knowledge level of nurses on chemotherapy improved after they were taught for two weeks on chemotherapy. Also, the nurses' knowledge of chemotherapy may ensure that the nurse maintains safety standards and provide quality care to the patient undergoing chemotherapy (Esmail et al., 2015).

Again, it was observed from the study that most of the participants seem not to have adequate information on radiotherapy. This suggests that the nurses may not be able to give the necessary information on radiotherapy of the breast to the patients. This study result agrees with other studies which show that nurses have insufficient knowledge concerning

the care of the patient who is undergoing radiotherapy and radiation safety principles (Miettunen & Mikkonen, 2019; Sree, 2016; Thambura et al., 2019). This suggests that the nurse may recommend skincare creams to the patient to help protect the skin (McQuestion, 2011). Evidence shows that reaction to radiation therapy by the skin can affect the patient's social life and other aspects of the being (Andersen et al., 2018). Therefore, the nurse must know about evidenced-based skincare creams to avoid marketing skincare products that are not beneficial to the patient (Mcquestion, 2011).

Also, all the thirteen (13) participants had some level of knowledge on the management of breast cancer pain as they indicated that severe pains needed to be managed with morphine and breakthrough dose when necessary. This result is similar to the study conducted by Rustøen et al., (2013) Swhich indicated that 85.5% of Dutch and 83.1% of German nurses knew pharmacological treatment of cancer pain. Also, these current results confirm with the study results that show that nurses 67.2% of nurses chose morphine as the drug of choice for severe and moderate cancer pain (Samarkandi, 2018).

On the contrary, a systematic review done on pain management by nurses revealed that most nurses had poor knowledge on the management of cancer pain (Sameen & Al-Attar, 2015). Adequate knowledge of pharmacological management by the nurse may help reduce medication errors and improve the quality of life of the patient (Shahrokhi et al., 2013; Simone et al., 2018). It is important to note that none of the nurses made mention of the use of non-pharmacological treatment for breast cancer breakthrough pain in the current study. This may suggest that breast cancer pain may not be entirely managed well by the nurses. This finding corroborates with the study done by Bonsu et al., (2014) in Ghana which showed unsatisfactory care which was associated with poor pain management of breast cancer pain. The poor management of patients' pain may not be associated with the nurses' educational background or working experience.

Also, the present study found out that, most of the study participants had some knowledge of palliation. However, this current study had limitation per the methodology that was employed. Contrary to the study results, several studies have shown that nurses have poor knowledge in palliative care (Ayed et al., 2015; Farmani et al., 2019; Kassa et al., 2014). Also, the study participants indicated that, if the patient must die, it must be a peaceful death. This may suggest that the nurses may ensure the quality of end of life care for the patients. Available literature shows that, when cancer cannot be cured and the patient may not live longer, then, the next option is to promote quality of life (Singh et al., 2014; Thaniyath, 2019).

5.2 Nurses' Attitude towards Breast Cancer Care.

The above theme discusses the attitude that nurses had towards breast cancer care. It was revealed that nurses had a positive attitude and a negative attitude toward breast cancer care. However, some of the nurses who had a positive attitude also showed a negative attitude towards breast cancer care as has been indicated earlier.

It was identified that most of the participants had a positive attitude towards screening of breast cancer, chemotherapy, pain management, palliative care and supportive care. The participants believed that breast cancer screening outreaches should be organised for early identification in private institutions, schools, churches and the young must be included for early treatment. The results suggest that nurses are likely to do breast self-examinations and counsel those who are predisposed to breast cancer for further clinical examination during breast cancer screening outreaches. Wurjine et al., (2019) showed that most nurses have a positive attitude towards breast cancer screening methods and this is congruent to the results of the current study.

On the contrary, in a related study, Heena et al., (2019) indicated that female health professionals believed breast self-examination cannot identify abnormalities of the breast. Also, effective treatment is not achieved through early detection methods. However, one participant thought that the knowledge of breast cancer screening is inherent in the general population. Therefore, the decision to choose the mode of treatment lies with the individual. Some studies have shown limited knowledge in breast cancer screening methods by women (Dnsc & Shoma, 2010; Elobaid, Aw, Grivna, & Nagelkerke, 2014; Khanjani, Noori, & Rostami, 2012)

Furthermore, some of the nurses in the current study believed that chemotherapy should start in the day and the side effects of the chemotherapy should be minimised by giving it slowly. The results suggest that nurses believed in reducing risks associated with intravenous infusion therapy. Although a similar study could not be found, a closer study indicates that patients are at great risk during the administration of intravenous infusion (Westbrook et al., 2011). Also, when necessary, nurses should assess and adjust the agreed treatment plan (Lennan & Roe, 2014) as depicted by this study. However, a participant thought that patient education, regular observation, monitoring of vital signs and administration of premedication minimises side effects. This corroborates with related literature which shows that the nurse must be able to gather key information from the patient, provide available information on the side effect and give appropriate premedication to the patient (Lennan & Roe, 2014). Also, some of the participants believed that patients needed to be monitored at home through telecommunications which is in consonance with existing literature (Khan et al., 2012). On the other hand, the literature shows that nurses have negative attitude towards the administration of chemotherapy. Therefore, the results of the study may be due to personal research done by the nurses on chemotherapy.

Also, studies have shown that zero pain may be achieved by giving the right pain medication for the type of pain identified (Mahfudh, 2011). Some of the participants in the study believed that the hope to achieve zero pain through the administration of morphine when a patient's pain is only relieved through morphine administration. This current result corroborates with a related study which indicated nurses had a positive attitude towards pain management in the neonate (Asadi-noghabi et al., 2014). Also, a participant in this current study believed that addiction is not a point to consider in pain management. On the other hand, some nurses believed that addiction is dangerous to the patient (Khalaileh & Qadire, 2012). This suggests that the Ghanaian nurse may ensure that patients' pain is relieved through the regular administration of analgesia as depicted by other studies (Mahfudh, 2011).

Again, some of the participants showed some positive attitude towards palliative care which corroborates with the findings of Farmani et al., (2019). The participants believed palliation should commence early for the patient to prepare towards death and he/she should be managed to have a peaceful death. Patients feel good death is when their death is predetermined and they can maintain their social relations intact (Kastbom et. al., 2016). Therefore, the results suggest that nurses are likely to help the dying patient accept death and settle issues with their relatives before dying (Tornøe et al., 2015). Also, the experience of the nurses in the cancer setting may influence the study result as indicated in the literature (Chang & Iskandar, 2018; Farmani et al., 2019).

Furthermore, participants of the study showed some positive attitude towards supportive care. This suggests that nurses may help prevent patients from discontinuing treatment through counselling and improve patients' quality of life (Sakai et al., 2020). This result corroborates with a related study which revealed that nurses believed in the importance of psychological support of patients (Park et al., 2012). This suggests that nurses

may help ease the psychological stress of patients and their relations since empathy is one of the values of a professional nurse. The participants believed that the nurse should empathise, draw closer to the patient, and have effective communication with the patient which corroborates with a systematic review by Lelorain et al., (2012) on clinicians association of empathy and patients' outcome. Therefore, mutual understanding may be reached between the nurse and the patient for effective treatment and rehabilitation (Song et al., 2016).

Some of the study participants had a positive attitude towards family involvement in patients care which corroborates with literature (Goossens et al.,2016). This shows that the nurse may allow the family to act as a liaison between the nurse and other family members to assist the patient (Laidsaar-Powell et al., 2017). Some of the participants believed in assisting the patient financially. This suggests that the nurses believed financial assistance can facilitate treatment and enhance patients' wellbeing (Negarandeh et al., 2008). Again, two of the study participants believed that the patient's source of hope should be the nurse. This also suggests that nurses attribute the relationship they have with the patient to a higher God as well as their views on life experiences and relates it to the patient (Borras et al., 2010; Puchalski et al., 2009; Torskenæs et al., 2015). Again, literature has shown that spiritual needs of the patient are not primarily being paid attention to by nurses (Bailey et al., 2009; Suhonen et al., 2018). This suggests that the importance of religion and spirituality in patients' health care should be an important feature in the curriculum for training professional nurses.

It was observed that some of the study participants who had a positive attitude towards breast cancer care also had some negative attitude towards pain management, palliation, wound care and alternative treatment.

Studies have shown that nurses have a negative attitude towards pain management (Al-Atiyyat et al., 2018; Kassa & Kassa, 2014). In this study, it was observed that two of the nurses tend to give a placebo when the patient complained of pain frequently. The results corroborate with a study which indicated that nurses scored less than 50% correct response on the block for giving water for injection when the patient complained of pains (Yava et al., 2013). This suggests that the nurses may not reflect on current knowledge on pain management but rather hold on to past beliefs (Aziato & Adejumo, 2014).

Nonetheless, the attitude of the nurse towards alternative treatment influences its usage (Brewer et al., 2019; Smith & Wu, 2012). Studies have shown that when nurses believe that the use of alternative treatment will interact with other prescribed medicine, they may discourage its usage(Brewer et al., 2019). (Brewer et al., 2019; Smith & Wu, 2012)However, alternative medicine/traditional medicine has benefits (Brewer et al., 2019; Chang & Chang, 2015). One of the participants in the study believed traditional treatment (medicine) kills patients, thus, it should be abrogated. This result suggests that nurses may not have knowledge on the benefits of alternative treatment in breast cancer care (Chang & Chang, 2015).

Furthermore, studies have shown that health workers avoid discussing prognosis with patients (Millar et al., 2014). Telling the patient the truth may lead to better care of the patient although it may be a dilemma for the nurse. Some of the participants in this current study believed patients should not be told the truth about prognosis as depicted in other studies (Razban et al., 2013). This suggests that nurses may not want to take away the hope the patient has since they believed bad news kills faster (McLennon et al., 2013). It may be better not to tell the patient about the prognosis if the nurse does not have adequate information. However, this study results suggest that nurses who have adequate information on patients' prognosis may withhold the truth from the patient.

Also, it was observed that most of the participants believed nurses cannot withstand the scent that emanates from breast cancer wounds to the extent that some reject wound dressing assignment on the ward. This suggests that nurses may contribute to the low self-esteem of patients as the undressed wound may cause distress in the patient. The results may also be due to a lack of training in wound care for the nurses. Also, a related study done in diabetic food ulcer revealed that nurses had a positive attitude towards wound care (Kumarasinghe & Hettiarachchi, 2018). However, one of the participants believed the negative attitude of the nurse towards breast cancer wound is related to fear. This result suggests that dressing of breast cancer wounds can cause anxiety in nurses.

5.3 Nurses' Normative Beliefs Associated with Breast Cancer Care.

The findings in this thematic section revealed the association of teamwork; institutional policies; social support, colleagues and patients' mindset and attitudes on breast cancer care.

The present study found out that, when doctors make mistakes with treatment, they sometimes accept corrections easily. This is similar to a related study which indicated that some doctors heeded to medication error alert (Coleman et al., 2012). Secondly, the results showed that doctors delayed in declaring patients' prognosis and palliative care. This suggests doctors avoid communicating life expectancy issues with patients and patients may not receive advance care planning (Detering et al., 2010). Also, the nurse may not have confidence in caring for the patient (Williams et al., 2017). The participants indicated that friction existed between nurses and doctors because doctors want nurses to follow orders given and felt nurses want to take their position when they challenged them. This result is similar to a study which indicated that nurses encountered physicians who were not willing to accept inputs from nurses concerning patients' care but rather, displayed dominance over nurses (Tang et al., 2018). Again, the current study results showed that nurses practice

favouritism during job assignment on the ward which corroborates with literature (Saleh et al., 2018; Wolf et al., 2017). This suggests that inappropriate job assignment to the patient due to favouritism can impede patients care (Wolf et al., 2017).

The present results show that participants identified that booking for treatment at the centre is problematic as indicated by other studies (Gocgun & Puterman, 2014; Rest & Puterman, 2011). The number of patients reporting for treatment at the centre had increased (Hahn-Goldberg et al., 2014). Therefore, for effective care, patients would have to be scheduled for another date (Gocgun & Puterman, 2014; Santibáñez et al., 2012) as revealed by this current study. The results suggest that delay in treatment may be related to the centre but not the geographical location (Bouche et al., 2010). However, participants indicated that delay leads to a quarrel between nurse-nurse and nurse-patient which corroborates with other studies (Embree & White, 2010; Morphet, Ed, Grif, & Campus, 2014; Pich, Kable, & Hazelton, 2017; Vagharseyyedin, 2015). This suggests that the nurse may either be verbally or physically abused by patients (Morphet et al., 2014; Pich et al., 2017). However, a participant stipulated that booking for an appointment is helpful as shown in other studies (Suss et al.; 2019). Therefore, the nurse may be able to give the care with ease.

Moreover, one of the participants indicated that the hospital's ambulance is not permitted to travel outside the premises with a patient. This suggests that ambulance services are not being taken seriously by the hospital (Frimpong & Dinye, 2014). Also, taxis were used as a means of transportation to treatment centres. Therefore, nurses may board taxis with patients to centres outside the facility when the need arises as depicted by this study. This suggests that nurses may abandon important work roles (Liu et al., 2018) to accompany patients in taxis and this may endanger their lives. There is therefore the need for an institutional policy on ambulance services to be included in the transportation of patients outside the hospital premises for further investigations and treatment.

Furthermore, the study results showed that patients do not have a lead doctor in the cancer care continuum (Weldon et al., 2016). Therefore, treatment ordered for the patient may not be consistent as the participants indicated that the nurse had to go back and forth with treatment ordered by different doctors. This suggests that there may be distortions in patients' treatment which can lead to delayed treatment and eventually deaths among patients. It is therefore essential that the hospital put in place a measure for patients to be treated by one senior doctor at a time to allow for consistency and effective care delivery.

Also, the participants indicated that relatives influence patients' treatment decisions by dictating to the patient which corroborates with other studies (Laidsaar-powell et al., 2017). This suggests that culture and values may influence breast cancer care (Boateng et al., 2018; Wang et al., 2020). Also, patients who did not heed to the family's advice were being neglected. This suggests that patients who are dependent on the family may not receive the needed care. On the contrary, a study done in the UK indicated that the patient is the one who takes the final decision in the cancer treatment decisions (Gilbar, 2011). However, some of the participants indicated that family members are supportive of treatment decisions as shown by other studies (Aziato & Clegg-Lamptey, 2015; Laidsaar-powell et al., 2017). This suggests that the family may support the patients emotionally and financially (Adam & Koranteng, 2020; Bonsu et al., 2014) as depicted by the participants. Also, Non-Governmental Organizations may add up to the financial and emotional support system of the patient (Azenha et al., 2011) as indicated in this study.

The cultural beliefs and myths by patients in Ghana affect the late reporting of patients with breast cancer (Martei et al, 2018; Opoku et al., 2012). In this study, patients reported to the hospital with advanced breast cancer as a result of misconception and fear of mastectomy which is similar to existing findings (Ibrahim & Oludara, 2012 and Rauscher

et al., 2010) . However, the fear of stigmatization was also seen as a predisposing factor in late reporting. Fear of stigmatization can influence patients' engagement with breast cancer care and may result in advanced breast cancer morbidity (Meacham et al., 2016; Solikhah et al., 2020). Also, lack of funds made patients with breast cancer quit treatment (Sharma et al., 2012) as shown by this study. This suggests that lack of funds may decrease the surviaval rate of breast cancer.

Furthermore, the participants indicated that difficult patients are uncooperative which is in consonance with other studies (Khalil, 2009; Williams et al., 2017). The results suggest that patients may sometimes not receive their medication since the nurse believes the patient must be part of the decision-making process (Komatsu & Yagasaki, 2014; Maree & Mulonda, 2017; Pongthavornkamol et al., 2018). The patients labelled as rude as revealed by the study participants may receive substandard care (Riskin et al., 2015). A participant indicated that patients demand a lot of attention which corroborates with existing literature (Khalil, 2009). Therefore, the nurse may not be able to execute the care plan outlined for the patient effectively.

5.4.Nurses' Perceived Behavioral Control: Resources, Time, and Opportunities in Breast Cancer Care

This theme discusses the influence of resources, time, opportunities and motivation in breast cancer care by nurses. Studies have shown that healthy working environment of the nurses and availability of material and human resources, a manageable workload, adequate time, career opportunities and good interpersonal relationships go a long way to ensure improved breast cancer care (Copanitsanou et al., 2017; Wei et al., 2018).

The study depicted inadequate provision of logistics which included gloves, personal protective equipment and face mask agrees with available studies done in Ghana (Nukpezah

et al., 2020). This result also corroborates with literature in other parts of Africa (Maree & Mulonda, 2017). Also, the result is similar to a study done in Ghana which showed that inadequate infrastructure affects nurses workload (Nukpezah et al., 2020). This suggests that the nurse will have to employ a lot of time in caring for patients with breast cancer leading to increased workload (Khademi et al., 2015). However, some of the participants indicated that they have adequate logistics. This suggests that the nurse manager may lobby for the logistics needed (Spano-Szekely et al., 2016) and also, manage the logistics allocated by management.

In this study, the participants showed that high workload overburdens the nurse which is in consonance with the literature (Khademi et al., 2015). The perceived workload is suggestive of occupational hazards like chemical splashes and needle pricks (Hosseinabadi et al., 2019). Also, the high workload may lead to nurse attrition causing a shortage in nursing staff (Rawal & A. Pardeshi, 2014). The participants revealed that there is a shortage of professional which substantiates available literature (Haryanto, 2019; Maresova et al., 2020; Rawal & Pardeshi, 2014). Available literature shows that the shortage of nurses leads to stress and burnout of nurses (Toh et al., 2012) which may cause job dissatisfaction.

However, caring for patients with breast cancer is time-consuming (Liang & Turkcan, 2016; Nukpezah et al., 2020) due to demand for attention as depicted by this study. The result suggests that nurses may leave tasks which may be an emergency undone due to time constraint (Liu et al., 2018). However, priority setting is a key factor in the care trajectory (Edwards et al., 2010; Kieft et al., 2014; Suhonen et al., 2018). The nurse may experience distress as a result of missed care (Suhonen et al., 2018). Also, ineffective communication can be associated with a lack of time in cancer care (Güner et al., 2018;

Pongthavornkamol et al., 2018; Wittenberg-Lyles et al., 2014). Due to time constraints, nurses may not be able to understand patients' concerns fully.

Furthermore, the participants revealed that there is no special training given to the nurse who is assigned to care for patients with breast cancer. This result is consistent with a study done by Holmberg, (2017) in mental nursing which revealed that there is a lack of career progression for the nurse. However, training in oncology nursing does exist (Komatsu, 2010). This suggests that, when nurses specialise in oncology nursing, they would be able to satisfy the patients through the care delivery as well as themselves (Case, 2010; Fillion et al., 2012; Pedersen et al., 2014). Although the chance for training is available for the nurse (Aziato & Adejumo, 2014), it was indicated in this study that nurses who are specialized in breast care were moved out of the ward to the outpatient department.

In addition, the current study revealed that experienced nurses move to other wards as a result of the reshuffle of nurses by the nursing administration. This suggests that newly posted nurses may not be able to meet the care needs of the patient such as the administration of complex therapies and psychosocial care. Again, participants who acknowledged limitation in oncology nursing were willing to have some form of training in oncology nursing. This result corroborates with a study that indicated that nurses with limited knowledge were willing to be trained in psychosocial care (Güner et al., 2018). This suggests that though registered nurses lack the requisite training in oncology nursing, they try to fill in the gaps to give the needed care.

Nurses get emotionally attached as they are in constant contact with the patient throughout treatment till a successful cure or through palliative care till death (Perry et al., 2011; Zheng et al.,2015) as indicated in this study. This suggests that the nurses may reflect on the meaning of life and death which would help them improve on care given to the dying

patient and family (Zheng et al., 2015). Also, the participants revealed that nurses who are not strong emotionally may not be able to guide the patients to make the right treatment choices. The treatment choices that the patient makes contribute to the survival rate and the general wellbeing of the patient (Coulter, 2012). Therefore, the wrong choices made by the patient may be associated with an emotionally weak nurse. The emotions experienced by the nurse as shown by the participants may cause the nurse to examine her breast regularly. Also, the nurse may experience fatigue of the mind which may affect the nurse's relationships (Perry et al., 2011).

The nurse is motivated intrinsically by interpersonal relationships, work meaningfulness and good organizational climate (Lambrou et al., 2010; Yang et al., 2014). The findings reveal that nurses are intrinsically motivated by the love for the profession. Also, some of them were intrinsically motivated by patients' characteristics like happiness, joy being comfortable and successful treatment. This could lead to nurses finding meaning to life as supported by previous studies (Stokes et al., 2019). In addition, a participant indicated that the nurse is intrinsically motivated by factors Concerning the work environment like nice Nurse Manager and good interpersonal relationships. This could lead to the retention of the nurse in the field of oncology nursing (Kossivi et al., 2016; Tillott, Walsh et al, 2013). However, other studies had also shown that nurses could be motivated extrinsically for them to be retained in an institution (Dave et al., 2011).

5.5 Evaluation of the Planned Behaviour Theory

The theory of planned behaviour developed by Ajzen in 1991 was useful in this study because it helped the researcher to explore the experiences of nurses caring for patients with breast cancer. The researcher used the construct for the attitude, subjective norm, perceived behavioural control and added knowledge to the constructions based on the views of the theorist. The researcher employed those constructs and assumptions of the theory to

formulate the study objectives and the generation of the interview guide. Although the researcher carved out knowledge for a construct, it is evident that knowledge influence the attitude and behaviour of the individual.

The planned behaviour theory indicates that behaviour is influenced by the beliefs of individuals, beliefs of others, past experiences, knowledge and opportunities. The theory assumes that the behaviour depicted by a person may be based on the perceived outcome. The expressed behaviour may also depend on whether the condition surrounding the individual is favourable or unfavourable. The theory assisted the researcher to explore the experiences of the nurses in breast cancer care which revealed that most nurses have both positive and negative attitude towards breast cancer care. It also helped in eliciting responses from the participants which indicated the knowledge nurses have in respect to breast cancer care. Nurses considered the effects that the team members, organizational policies, support groups, patients and colleagues had on breast cancer care. The nurses also identified barriers to breast cancer care such as heavy workloads and emotions. Again, it was realised that nurses showed behaviour which was influenced by intrinsic motivation like love for the profession and the happiness of patients. All the constructs employed were useful for the study. The construct perceived behavioural control is very broad thus; it was able to encompass any other behaviour that the study participants expressed.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATION

This chapter presents a summary of the study, the implication of the findings on nursing education, research, practice, and policy. It also identifies limitations of the study, recommendations and conclusions.

6.1 Summary of the Study

The increasing number of patients with breast cancer has been of a challenge globally. Coupled with reports on the shortage of professional nurses who play key roles in the cancer care continuum globally, it was expedient to explore the experiences of nurses in breast cancer care in the biggest hospital in Ghana The construct of the Model of Planned Behaviour by Ajzen, (1991), served as a guide for this study. A qualitative descriptive research design was used to explore the experiences of nurses caring for patients with breast cancer at the Korle Bu Teaching Hospital in Accra, Ghana. Thirteen nurses who have been working at the radiotherapy department and adult surgical ward II for two years and above were recruited through purposive sampling technique. A semi-structured interview guide designed was used to elicit the responses from the participants. The interview guide was piloted at the adult surgical ward of the Greater Accra Reginal Hospital.

Ethical clearance was sought from the Korle Bu Teaching Hospital Institutional Review Board for Ethics and also, the Greater Accra Regional Hospital granted authorization for the pilot study to be conducted. The Heads of Department for Radiotherapy and Adult Surgical granted authorization to access the study setting after clearance has been granted by the ethical review committee of the institution. Self-introduction was done to the participants in a ward/unit meeting session one week before the commencement of the study. Only participants who gave their consent were recruited into the study. Consent was sought

from the participants to record the interview which was transcribed verbatim. The data were analysed manually using thematic content analysis and methodological rigour was ensured using Lincoln and Guba's (1985) criteria.

Four major themes and fifteen subthemes emerged from the data analysed. The major themes were nurses' knowledge on breast cancer care, the attitude of nurses towards breast cancer care, normative beliefs of nurses in breast cancer care and perceived behavioural control of nurses in breast cancer care. The findings mostly showed that the experiences of nurses in breast cancer and general cancer care continuum are consistent with previous studies. The nurses indicated that they have some knowledge in the epidemiology, diagnosis, signs and symptoms, chemotherapy and radiotherapy and, pharmacological pain management and palliation of breast cancer. However, none of the participants indicated the use of nonpharmacological pain management. Some of the responses given on the knowledge of breast cancer care were that it is increasing; affects young population within ages 14-39; the cause is unknown; risk factors include lack of exercise, fatty diet and genetic make-up and they advise breast self-examination for lumps. It is interesting to note that the nurses performed breast self-exams due to fear associated with patients' death. Some of the positive attitudes towards breast care exhibited by the nurses were to get closer to patient, comfort patient, pay patient's bills and borrow money to buy drugs for the patient. However, the nurses exhibited a negative attitude like giving placebo for pain management, doing wound dressing at the back of the building and refusal in dressing the patient's wound. Also, the doctors declare prognosis then after a day or two, the patient dies which the nurse see as inappropriate but when they complain about this, the doctors feel like the nurses want to take their job. It was also seen that the nurses practise favouritism in their line of work as they prefer working with some colleagues better than others and they will rather work alone than to work with a nurse they are not comfortable with. Also, the hospital policy does not

allow the ambulance to go outside so, nurses sometimes use a taxi when the need arises. It was also identified that patients quit treatment due to financial constraint. The nurses also identified other factors that are associated with the care of the patient with breast cancer like the lack of syringes, gloves and monitors; inadequate nursing professionals; standing for 45minustes doing wound dressing; no special training is given to the nurse before being sent to chemotherapy suite and the reshuffle of experienced nurses. The nurses encounter challenges such as overwhelming workloads and emotional stress. A participant indicated that most of the times when she wakes up from bed, she becomes so emotional caring for the patient because at the end of the year many patients with breast cancer die. However, the nurses were motivated by the emotional wellbeing of their patient's attributes which they exhibited through smiling and being comfortable; their love for the profession and the successful treatment of patients.

6.2 Implication of the Findings

The findings of the study have implications for nursing education, research and practice.

6.2.1 Implication for Nursing Education

The findings of the study showed some knowledge gap in non-pharmacological management of pain by the nurses' as none of the nurses stated its use in the treatment of the patients' pain. In the short to medium term, service training should be organized to train nurses who care for patients with breast cancer on non-pharmacological pain management to equip them with the skills, knowledge and attitude for non-pharmacological pain management in breast cancer. The study also found out that, most of the nurses caring for patients with breast cancer at the radiotherapy department and the adult surgical ward II were professional nurses who had no specialised training in oncology or breast care.

6.2.2 Implication for Nursing Research

The study findings could be the basis for further nursing research in the following areas:

1. Examine the knowledge level of non-pharmacological pain management among patients with breast cancer.
2. Evaluate the influence of breast cancer care on the nurses' self-breast examination.
3. Explore wound care of patients with breast cancer
4. Explore the coping strategies of nurses at the radiotherapy department and the adult surgical ward II amidst limited resources.
5. Evaluate the influence of institutional factors on breast cancer care

6.2.3 Implication for Nursing Practice

In this study, the findings have identified some issues that need to be addressed to improve breast cancer care. Nurses should employ pharmacological and non-pharmacological pain management in patients with breast cancer. Although pharmacological management is very crucial to breast cancer pain management, the non-pharmacological management of pain must also be incorporated into patients' pain management plan for satisfactory care. In view of this, nurses at the radiotherapy department and adult surgical ward II should learn about non-pharmacological pain management to use it to ensure patients' maximum comfort. To ensure good attitude towards dressing of breast cancer wounds, nurses must learn how to care for fungated and bleeding breast cancer wounds. The nurses should also learn about good working climate to prevent the practice of favouritism. Some institutional factors such as policies, team members, inadequate infrastructure; lack of logistics and professional staff, lack of time, workload were identified to have negative association on breast cancer care. It is, therefore, necessary to improve on the identified limitations to enhance effective breast cancer care.The nurisng administration should organize, on regular basis, workshops and seminars to facility this need.

6.3 Limitations of the Study

The study recruited only professional nurses from the facility that offers breast cancer care services.

6.4 Researcher's Reflections on the study

During the process of data collection, the researcher saw that most of the nurses were passionate about the area which was being studied. However, some of them were not confident in responding during the interview session. Therefore, the researcher had to continue nodding the head as there was no such thing as a wrong response to enhance their confidence.

6.5 The influence of the study on the researcher

The researcher has been educated by this research as the findings have offered her a better understanding of the experiences of nurses' caring for patients with breast cancer patients. The researcher has also gained insight into the experiences of patients with breast cancer undergoing treatment. The researcher has also learnt more about qualitative research approach. Furthermore, the researcher had her breast clinically examined and took mammography and ultrasound of the breast to check for breast cancer. Also, during the study to date, the researcher continues to perform breast self-examination.

6.6 Recommendations

The following recommendations are made to equip nurses at the radiotherapy and adult surgical ward II based on the findings of the study.

6.6.1 Recommendation for Ministry of Health

1. The Ministry of Health (MOH) should put policies in place that would train nurses caring for patients with breast cancer with the required knowledge and skills. This could take the form of designing sponsorship packages for such nurses and also,

tasking some institutions to train the nurses. This would provide specialised oncology nurse/breast care nurses to manage the various units and departments that care for patients with breast cancer.

6.6.2 Recommendation for Nursing and Midwifery Council of Ghana

1. The Nursing and Midwifery Council of Ghana (NMC) as the regulatory body of nurses should collaborate with stakeholders to develop curriculum to train specialised oncology nurses/breast care nurses.
2. The council should emphasise on cancer pain management especially non-pharmacological pain management in the curriculum at all levels of nursing education.

6.6.3 Recommendation for Nursing Administration

1. Nursing Administrators should consider the workload and turnover rate of nurses caring for patients with breast cancer to allocate enough nurses to such units.
2. Efforts should be made to ensure effective organizational work climate of the nurses at breast cancer care units.
3. Adequate infrastructure and supply of logistics to enhance effective breast cancer care should be given a priority.
4. There is the need to develop suitable non-pharmacological pain management protocols to aid nurses in the management of cancer pain amidst the limited professional nurses at the breast cancer care units.

6.6.4 Recommendation for Korle Bu Teaching Hospital

1. Periodically, the hospital should organise in-service training on pain management for nurses working at the radiotherapy department and Adult Surgical Ward II

(ASW2) to equip the staff with current trends in cancer pain management. It should be designed so as not to aggravate the strength of the existing limited staff.

2. Also, periodically the hospital should organise in-service training on organization work climate for nurses working at the radiotherapy department and ASW2.
3. The staff strength should be increased to meet the increasing demand for patients reporting at the radiotherapy department and the ASW2 regularly.
4. Management should improve on the existing policy on ambulance services to facilitate the work of nurses.
5. Management should review existing protocols on infrastructures, supply and access to logistics at the radiotherapy department and ASW2 to improve on breast cancer care.

6.7 Conclusion

The study explored the experiences of nurses who provide care for patients with breast cancer at the Korle Bu Teaching Hospital in Accra, Ghana. A qualitative descriptive research design was used with a face-to-face interview with 13 participants. The findings indicated that nurse had adequate knowledge on breast cancer care. However, it was revealed that none of the participants identified non-pharmacological treatment for breast cancer pain. Although it was found that nurses had some positive attitude towards breast cancer care, they also exhibited some negative attitude like giving of placebo for pain management and neglecting patients' wound care. The study also found inadequate infrastructure and logistics, inadequate professional staffs, lack of time, overwhelming workloads were some of the factors identified to have negative association breast cancer care.

REFERENCES

Abrahm, J. (2017). Involve the Palliative Care Team Early to Minimize Symptom Impact. *ONS Voice*, *32*(12), 23. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=126921469&site=ehost-live

Adam, A., & Koranteng, F. (2020). *Availability , accessibility , and impact of social support on breast cancer treatment among breast cancer patients in Kumasi , Ghana : A qualitative study*. 1–15. https://doi.org/10.1371/journal.pone.0231691

Adler, F. (2010). Overview of Ethical Principles. *The Doctor of Nursing Practice Essentials*, 317. Burlington: Jones & Bartlett Learning.

Agra, G., Helena, S., Oliveira, S., Miriam, M., & Costa, L. (2015). *Clinical Case Report Article Nursing Care To Patient With Breast Fungating Malignant Wound : Case Study*. *9*(6), 8295–8303. https://doi.org/10.5205/reuol.7585-66362-1-ED.0906201519

Ahern, T., Gardner, A., & Courtney, M. (2015). A survey of the breast care nurse role in the provision of information and supportive care to Australian women diagnosed with breast cancer. *Nursing Open*, *2*(2), 62–71. https://doi.org/10.1002/nop2.18

Ajzen, I. (2002). Ajzen I. Perceived Behavioral Control, Self-Efficacy, Locus of Control, and the Theory of Planned Behavior1. Journal of applied social psychology. 2002;32(4):665-83.No Title. *Journal of Applied Social Psychology.*, *32*(4), 665–683. http://dx.doi.org/10.1111/j.1559-1816.2002.tb00236.x

Ajzen, Icek. (1985). From intentions to actions: A theory of planned behavior. In *Action control* (pp. 11–39). Springer. https://doi.org/10.1007/978-3-642-69746-3_2

Ajzen, Icek. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, *50*(2), 179–211. https://doi.org/10.1016/0749-5978(91)90020-T

Ajzen, Icek. (2011). The theory of planned behaviour: Reactions and reflections. *Psychology & Health*, 26:9, 1113-1127. https://doi.org/10.1080/08870446.2011.613995

Ajzen, Icek. (2015). The theory of planned behaviour is alive and well , and not ready to retire : a commentary on. *Health Psychology Review*, *9*(2), 131–137. https://doi.org/10.1080/17437199.2014.883474

Ajzen, Icek, & Madden, T. J. (1986). Prediction of goal-directed behavior: Attitudes, intentions, and perceived behavioral control. *Journal of Experimental Social Psychology*, *22*(5), 453–474. https://doi.org/10.1016/0022-1031(86)90045-4

Al-Atiyyat, N., Salim, N. A., Tuffaha, M. G., Abu Nigim, H. A., Saleh, M. M. d., Alkhodary, M. E., & Brant, J. M. (2018). A Survey of the Knowledge and Attitudes of Oncology Nurses toward Pain in United Arab Emirates Oncology Settings. *Pain Management Nursing*, 1–12. https://doi.org/10.1016/j.pmn.2018.08.005

Albrecht, R. M. (2015). Patient safety : the what , how , and when. *The American Journal of Surgery*, *210*(6), 978–982. https://doi.org/10.1016/j.amjsurg.2015.09.003

Al Khalaileh, M., & Al Qadire, M. (2012). Barriers to cancer pain management: Jordanian nurses' perspectives. *International journal of palliative nursing*, *18*(11), 535–540. https://doi.org/10.12968/ijpn.2012.18.11.535

Alsulami, Z., Conroy, S., & Choonara, I. (2013). *Medication errors in the Middle East countries : A systematic review of the literature*. 995–1008. https://doi.org/10.1007/s00228012-1435-y

American Cancer Society, (2019). Cancer Screening Guidelines | Detecting Cancer Early. Retrieved August 31, 2019, from https://www.cancer.org/healthy/find-cancer-early/cancer-screening-guidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html

American Cancer Society, (2012).). Health Professionals Associated with Cancer Care. Retrieved from https://www. cancer.org/treatment/finding-and- paying-for-treatment/choosing-your- treatment-team/health-professionals-associated-with-cancer- care. html

Andegiorgish, A. K., Kidane, E. A., & Gebrezgi, M. T. (2018). Knowledge, attitude, and practice of breast Cancer among nurses in hospitals in Asmara, Eritrea. *BMC Nursing*, *17*(1), 1–7. https://doi.org/10.1186/s12912-018-0300-4

Andersen, E. R., Eilertsen, G., Myklebust, A. M., & Eriksen, S. (2018). *Women ' s experience of acute skin toxicity following radiation therapy in breast cancer*. 139–148. http://dx.doi.org/10.2147/ JMDH.S155

Andsoy, I. I., & Gul, A. (2014). Breast, cervix and colorectal cancer knowledge among nurses in Turkey. *Asian Pac J Cancer Prev*, *15*(5), 2267–2272. *http://dx.doi.org/10.7314/APJCP.2014.15.5.2267*

Armitage, C. J., & Conner, M. (2001). *E Y cacy of the Theory of Planned Behaviour : A meta-analytic review*. 40, 471–499. *http://dx*.doi *org* /10. 1348/014466601164939

Asadi-noghabi, F., Tavassoli-farahi, M., Yousefi, H., & Sadeghi, T. (2014). *Neonate Pain Management : What do Nurses Really Know ? 6*(5), 284–293. https://doi.org/10.5539/gjhs.v6n5p284

Ayed, A., Sayej, S., Harazneh, L., & Fashafsheh, I. (2015). *The Nurses ' Knowledge and Attitudes towards the Palliative Care The Nurses ' Knowledge and Attitudes towards the Palliative Care*. *6*(4), 91–99. ISSN 2222-1735

Azenha, G., Pace, L., Calef, M., Smith, R., Pretorius, L., Durstine, A., & Parsons, C. (2011). *The role of breast cancer civil society in different resource settings*. *20*. https://doi.org/10.1016/j.breast.2011.02.005

Aziato, L., & Adejumo, O. (2014). Determinants of nurses' knowledge gap on pain management in Ghana. *Nurse Education in Practice*, *14*(2), 195–199. https://doi.org/10.1016/j.nepr.2013.08.004

Aziato, L., & Clegg-Lamptey, J. N. A. (2015). Breast Cancer Diagnosis and Factors Influencing Treatment Decisions in Ghana. *Health Care for Women International*, *36*(5), 543–557. https://doi.org/10.1080/07399332.2014.911299

Bailey, M. E., Moran, S., & Graham, M. M. (2009). Creating a spiritual tapestry: nurses' experiences of delivering spiritual care to patients in an Irish hospice. *Journal of palliative nursing. 15*(1), 42–48. https://doi.org/10.129668/ ijpn.2009. 15.1.37952

Bakitas, M., Bishop, M. F., Caron, P., & Stephens, L. (2010). Developing Successful Models of Cancer Palliative Care Services. *Seminars in Oncology Nursing*. https://doi.org/10.1016/j.soncn.2010.08.006

Bandura, A. (2009). Social cognitive theory of mass communication. In *Media effects* (pp. 110–140).New York: Routledge.

Bello, T. O., Olugbenga-Bello, A. I., Oguntola, A. S., Adeoti, M. L., & Ojemakinde, O. M. (2011). Knowledge and practice of breast cancer screening among female nurses and lay women in Osogbo, Nigeria. *West African Journal of Medicine*, *30*(4), 296–300. PMID:**22669837**

Bloom, A. P., Jimenez-andrade, J. M., Taylor, R. N., Kaczmarska, M. J., Freeman, K. T., Coughlin, K. A., … Mantyh, P. W. (2011). *Breast Cancer-Induced Bone Remodeling, Skeletal Pain, and Sprouting of Sensory Nerve Fibers*. *12*(6), 698–711. https://doi.org/10.1016/j.jpain.2010.12.016

Bloom, D. E., Canning, D., & Fink, G. (2010). Implications of population ageing for economic growth. *Oxford Review of Economic Policy*, *26*(4), 583–612. https://doi.org/10.1093/oxrep/grq038

Boateng, E. A., East, L., & Evans, C. (2018). *Decision-making experiences of patients with end-stage kidney disease (ESKD) regarding treatment in Ghana : a qualitative study*. 1–12.

Bonsu, A. B., Aziato, L., & Clegg-Lamptey, J. N. A. (2014). Living with Advanced Breast Cancer among Ghanaian Women: Emotional and Psychosocial Experiences. *International Journal of Palliative Care*, *2014*, 1–9. https://doi.org/10.1155/2014/403473

Borras, L., Mohr, S., Gillieron, C., Brandt, P.-Y., Rieben, I., Leclerc, C., & Huguelet, P. %J C. M. H. J. (2010). *Religion and spirituality: How clinicians in Quebec and Geneva cope with the issue when faced with patients suffering from chronic psychosis*. *46*(1), 77–86. https://doi.org/10.1007/s10597-009-9247-y

Bouche, G., Ingrand, I., Mathoulin-Pelissier, S., Ingrand, P., Breton-Callu, C., & Migeot, V. (2010). Determinants of variability in waiting times for radiotherapy in the treatment of breast cancer. *Radiotherapy and Oncology*, *97*(3), 541–547. https://doi.org/10.1016/j.radonc.2010.09.011

Bray, F., Ferlay, J., Soerjomataram, I., Siegel, R. L., Torre, L. A., & Jemal, A. (2018). Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *Cancer Journal for Clinicians*.*68*(6), 394–424. https://doi.org/10.33222/caac. 21492

Brewer, N. J., Turrise, S. L., Kim-Godwin, Y. S., & Pond Jr., R. S. (2019). Nurses' Knowledge and Treatment Beliefs: Use of Complementary and Alternative Medicine for Pain Management. *Journal of holistic nursing : official journal of the American Holistic Nurses' Association*, *37*(3), 248–259. https://doi.org/10.1016/

j.pmn.2011.06.001

Brooks, L. A., Manias, E., & Bloomer, M. J. (2019). Culturally sensitive communication in healthcare: A concept analysis. *Collegian*, *26*(3), 383–391. https://doi.org/10.1016/j.colegn.2018.09.007

Calys-Tagoe, B. N., Yarney, J., Kenu, E., Owusu Amanhyia, N. A. K., Enchill, E., & Obeng, I. (2014). Profile of cancer patients' seen at Korle Bu teaching hospital in Ghana (A cancer registry review). *BMC Research Notes*, *7*(1). https://doi.org/10.1186/1756-0500-7-577

Cancer Radiotherapy in Ghana | Cancer Control. (2016). Retrieved October 9, 2019, from http://www.cancercontrol.info/cc2016/cancer-radiotherapy-in-ghana/

Case M. A. (2011). Oncology nurse navigator. *Clinical journal of oncology nursing*, *15*(1), 33–40. https://doi.org/10.1188/11.CJON.33-40

Chang, H., & Chang, H. (2015). *A review of nurses ' knowledge , attitudes , and ability to communicate the risks and benefits of complementary and alternative medicine*. 1466–1478. https://doi.org/10.1111/jocn.12790

Chang, W. C., & Iskandar, M. (2018). Attitudes towards death among nurses caring for patients on haemodialysis. *Singapore Nursing Journal*, *45*(2), 17–22. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=133277969&site=ehost-live

Charani, E., Drumright, L. N., Holmes, A. H., & Shah, N. (2015). *Towards changing healthcare workers ' behaviour : a qualitative study exploring non-compliance through appraisals of infection prevention and control practices*. *90*, 126–134. https://doi.org/10.1016/j.jhin.2015.01.023

Chauhan, A., Subba, S. H., Menezes, R. G., Shetty, B. S., Thakur, V., Chabra, S., & Warrier, R. (2011). Younger women are affected by breast cancer in South India - a hospital-based descriptive study. *Asian Pacific journal of cancer prevention : APJCP*, *12*(3), 709–711. https://doi.org/10.7314/apjcp.2014.15.24.10735.

Cifu, G., & Arem, H. (2018). Adherence to lifestyle-related cancer prevention guidelines and breast cancer incidence and mortality. *Annals of Epidemiology*, *28*(11), 767-773.e1. https://doi.org/10.1016/j.annepidem.2018.09.002

Clegg-Lamptey, J.-N. (2017). Epidemiology of breast cancer in Africa. *Accra-Ghana.* (Master Thesis) School of Medicine and Dentistry, University of Ghana.

Coleman, J. J., Hemming, K., Nightingale, P. G., Clark, I. R., Dixon-Woods, M., Ferner, R. E., & Lilford, R. J. (2012). Can an electronic prescribing system detect doctors who are more likely to make a serious prescribing error? *Journal of the Royal Society of Medicine*, *105*(7), 208–218. https://doi.org/10.1258/jrsm.2011.110061

Conner, M., & Norman, P. (2017). *Health behaviour: Current issues and challenges*. New York: Taylor & Francis.

Cook, O., McIntyre, M., Recoche, K., & Lee, S. (2019). "Our nurse is the glue for our team" - Multidisciplinary team members' experiences and perceptions of the

gynaecological oncology specialist nurse role. *European Journal of Oncology Nursing*, *41*(October 2018), 7–15. https://doi.org/10.1016/j.ejon.2019.05.004

Copanitsanou, P., Fotos, N., & Brokalaki, H. (2017). Effects of work environment on patient and nurse outcomes. *British Journal of Nursing*, *26*(3), 172–176. https://doi.org/10.12968/bjon.2017.26.3.172

Coulter, A. (2012). *Patient Engagement — What Works ? 35*(2), 80–89. https://doi.org/10.1097/JAC.0b013e318249e0fd

Craig, J. a. (2014). Nursing Knowledge and Attitudes toward Pain Management. *ProQuest Dissertations and Theses*, 71. Retrieved from http://search.proquest.com/docview/1630099799?accountid=14525%5Cnhttp://ucelinks.cdlib.org:8888/sfx_local?url_ver=Z39.88-2004&rft_val_fmt=info:ofi/fmt:kev:mtx:dissertation&genre=dissertations+&+theses&sid=ProQ:ProQuest+Dissertations+&+Theses+A&I&atitle

Creswell, J. W. (2014). *Research Design, Qualitative, Quantitative and Mixed Methods Approaches* (4th ed.). Thousand Oaks, *California*: *SAGE Publications*.

Cullen, W. K. L. (2018). Evaluating quality in clinical care. *Surgery*, *36*(9), 497–502. https://doi.org/10.1016/j.mpsur.2018.07.002

Cuzick, J., Sestak, I., Cawthorn, S., Hamed, H., Holli, K., Howell, A., Forbes, J. F., & IBIS-I Investigators (2015). Tamoxifen for prevention of breast cancer: extended long-term follow-up of the IBIS-I breast cancer prevention trial. *The Lancet. Oncology*, *16*(1), 67–75. https://doi.org/10.1016

Dahlin C. (2015). Palliative Care: Delivering Comprehensive Oncology Nursing Care. *Seminars in oncology nursing*, *31*(4), 327–337. https://doi.org/10.1016/j.soncn.2015.08.008

Dānishgāh-i ‘Ulūm-i Pizishkī-i Tihrān. Hospital Management Research Center, S. S., Kalhor, R., Nejatzadegan, Z., Kohpeima Jahromi, V., & Sharifi, T. (2014). Barriers to Medication Error Reporting from Nurses’ Perspective: A Private Hospital Surve. *International Journal of Hospital Research*, *3*(2), 97–102. Retrieved from http://ijhr.iums.ac.ir/index.php/article_6126_1009.html

Dave, D. S., Dotson, M. J., Cazier, J. A., Chawla, S. K., & Badgett, T. F. (2011). The impact of intrinsic motivation on satisfaction with extrinsic rewards in a nursing environment. *Journal of Management & Marketing in Healthcare*, *4*(2), 101–107. https://doi.org/10.1179/175330311x12943314049493

Detering, K. M., Hancock, A. D., Reade, M. C., & Silvester, W. (2010). The impact of advance care planning on end of life care in elderly patients: Randomised controlled trial. *BMJ (Online)*, *340*(7751), 847. https://doi.org/10.1136/bmj.c1345

Edwards, A., Pang, N., Shiu, V., & Chan, C. (2010). The understanding of spirituality and the potential role of spiritual care in end-of-life and palliative care: a meta-study of qualitative research. *Palliative medicine*, *24*(8), 753–770. https://doi.org/10.1177/0269216310375860

Eicher, M., Kadmon, I., Claassen, S., Marquard, S., Pennery, E., Wengstrom, Y., & Fenlon, D. (2012). Training breast care nurses throughout Europe: The EONS postbasic curriculum for breast cancer nursing. *European Journal of Cancer*, *48*(9), 1257–1262. https://doi.org/10.1016/j.ejca.2011.07.011

Elobaid, Y. E., Aw, T. C., Grivna, M., & Nagelkerke, N. (2014). Breast cancer screening awareness, knowledge, and practice among arab women in the United Arab Emirates: a cross-sectional survey. *PloS one*, *9*(9), e105783. https://doi.org/10.1371/journal.pone.0105783

Embree, J. L., & White, A. H. (2010). Concept analysis: nurse-to-nurse lateral violence. *Nursing Forum*, *45*(3), 166–173. https://doi.org/10.1111/j.1744-6198.2010.00185.x

Esmail, D. H., Qadir, C. S., Mahmood, E. K., Osman, G. A., & Omar, Y. B. (2016). Safe Handling Knowledge and Practices of Chemotherapy among Oncology Nurses in Erbil City. *kufa Journal for Nursing sciences*, *6*(1), 84-90.

Eyigor, S., Uslu, R., Apaydın, S., Caramat, I., & Yesil, H. (2018). Can yoga have any effect on shoulder and arm pain and quality of life in patients with breast cancer? A randomized, controlled, single-blind trial. *Complementary therapies in clinical practice*, *32*, 40–45. https://doi.org/10.1016/j.ctcp.2018.04.010

Farmani, A. H., Mirhafez, S. R., Kavosi, A., Moghadam Pasha, A., Jamali nasab, A., Mohammadi, G., … Movahedi, A. (2019). Dataset on the nurses' knowledge, attitude and practice towards palliative care. *Data in Brief*, *22*, 319–325. https://doi.org/10.1016/j.dib.2018.11.133

Farrell, C., Molassiotis, A., Beaver, K., & Heaven, C. (2011). Exploring the scope of oncology specialist nurses' practice in the UK. *European Journal of Oncology Nursing*, *15*(2), 160–166. https://doi.org/10.1016/j.ejon.2010.07.009

Fillion, L., Cook, S., Veillette, A. M., de Serres, M., Aubin, M., Rainville, F., … Doll, R. (2012). Professional navigation: a comparative study of two Canadian models. *Canadian Oncology Nursing Journal/Revue Canadienne de Nursing Oncologique*, *22*(4), 257–277. https://doi.org/10.5737/1181912x224257266

Fiszer, C., Dolbeault, S., Sultan, S., & Brédart, A. (2014). Prevalence, intensity, and predictors of the supportive care needs of women diagnosed with breast cancer: a systematic review. *Psycho-oncology*, *23*(4), 361–374. https://doi.org/10.1002/pon.3432

Flick, U. (2013). *The Sage Hand Book of Qualitative Data Analysis: Mapping the Feild*. SAGE Publications Sage CA: Los Angeles, CA.

Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., … Aboagye-Sarfo, P. (2018). Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. *BMC Health Services Research*, *18*(1), 1–11. https://doi.org/10.1186/s12913-018-2915-2

Forster, M., Veerman, J. L., Barendregt, J. J., & Vos, T. (2011). Cost-effectiveness of diet and exercise interventions to reduce overweight and obesity. *International Journal of Obesity*, *35*(8), 1071–1078. https://doi.org/10.1038/ijo.2010.246

Fotedar, V., Seam, R. K., Gupta, M. K., Gupta, M., Vats, S., & Verma, S. (2013). Knowledge of risk factors and early detection methods and practices towards breast cancer among nurses in Indira Gandhi Medical College, Shimla, Himachal Pradesh, India. *Asian Pacific journal of cancer prevention : APJCP*, *14*(1), 117–120. https://doi.org/10.7314/apjcp.2013.14.1.117

Frimpong, J., & Dinye, R. D. (2014). Ambulance Emergency Services and Healthcare Provision in Ghana : A District Level Performance Appraisal. *International Journal of Health and Medical Information*, *3*(1), 13–23. ISSN: 2350-2150

Fukuda, R., Shimizu, Y., & Seto, N. (2015). Issues experienced while administering care to patients with dementia in acute care hospitals: A study based on focus group interviews. *International Journal of Qualitative Studies on Health and Well-Being*, *10*, 1–13. https://doi.org/10.3402/qhw.v10.25828

Gaffney, T. A., Hatcher, B. J., & Milligan, R. (2016). Nurses ' role in medical error recovery : an integrative review. Journal of Clinical *Nursing*,*25*, 906–917. https://doi.org/10.1111/jocn.13126

Gale, D., Sc, B., Forshew, T., Ph, D., Mahler-araujo, B., Rajan, S., … Sci, F. M. (2013). Analysis of Circulating Tumor DNA to Monitor Metastatic Breast Cancer. *The New England journal of medicine*, *368*(13), 1199–1209. https://doi.org/10.1056/NEJMoa1213261

Geraerts, E., Bernstein, D. M., Merckelbach, H., Linders, C., Raymaekers, L., & Loftus, E. F. (2008). Lasting false beliefs and their behavioral consequences. *Psychological science*, *19*(8), 749–753. https://doi.org/10.1111/j.1467-9280.2008.02151.x

Ghartey Jrn Naku, F., Anyanful, Eliason Akwasi, S., Saanid, A. M., & Debrah, S. (2016). Pattern of Breast Cancer Distribution in Ghana: A Survey to Enhance Early Detection, Diagnosis, and Treatment. *International Journal of Breast Cancer*, *2016*, 1–9. https://doi.org/10.1155/2016/3645308

Ghasemi, F., Rasekhi, A., & Haghighat, S. (2019). Analysis of the Survival of Breast Cancer Patients Using Weibull and Poisson Beta-Weibull Non-Mixture Cure Models. *Research in Medicine: Journal of Research in Medical Sciences*, *42*(4), 236–242. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=134439189&site=ehost-live

Gilbar, R. (2011). Family involvement, independence, and patient autonomy in practice. *Medical Law Review*, *19*(2), 192–234. https://doi.org/10.1093/medlaw/fwr008

Gill, F., & Duffy, A. (2010). Caring for cancer patients on non-specialist wards. *British journal of nursing (Mark Allen Publishing)*, *19*(12), 761–767. https://doi.org/10.12968/bjon.2010.19.12.48654

Gilroy Rebecca. (2018). Findings reveal a shortage of cancer nurses. Retrieved July 11, 2019, from http://www.independentnurse.co.uk/news/findings-reveal-a-shortage-of-cancer-nurses/173341/

Gjesdal, K., Dysvik, E., & Furnes, B. (2019). Nurses' experiences with health care in pain clinics: A qualitative study. *International Journal of Nursing Sciences*, *6*(2), 169–

175. https://doi.org/10.1016/j.ijnss.2019.03.005

Gocgun, Y., & Puterman, M. L. (2014). Dynamic scheduling with due dates and time windows: An application to chemotherapy patient appointment booking. *Health Care Management Science*, *17*(1), 60–76. https://doi.org/10.1007/s10729-013-9253-z

Goossens, E., Luttik, M., Ågren, S., Jaarsma, T., Mårtensson, J., Thompson, D. R., Moons, P., Strömberg, A., & Undertaking Nursing Interventions Throughout Europe (UNITE) research group (2017). Attitudes of nurses towards family involvement in the care for patients with cardiovascular diseases. *European journal of cardiovascular nursing :Journal of the Working Group on Cardiovascular Nursing of the European Society of Cardiology*, *16*(4), 299–308. https://doi.org/10.1177/1474515116663143

Gorlén, T., Gorlén, T. F., Vass, M., & Neergaard, M. A. (2012). Low confidence among general practitioners in end-of-life care and subcutaneous administration of medicine. *Danish medical journal*, *59*(4),1–6. PMID: 22459718

Griffiths, P., Ball, J., Drennan, J., Dall'Ora, C., Jones, J., Maruotti, A., … Simon, M. (2016). Nurse staffing and patient outcomes: Strengths and limitations of the evidence to inform policy and practice. A review and discussion paper based on evidence reviewed for the National Institute for Health and Care Excellence Safe Staffing guideline develo. *International Journal of Nursing Studies*, *63*, 213–225. https://doi.org/10.1016/j.ijnurstu.2016.03.012

Güner, P., Hiçdurmaz, D., Kocaman Yıldırım, N., & İnci, F. (2018). Psychosocial care from the perspective of nurses working in oncology: A qualitative study. *European Journal of Oncology Nursing*, *34*(4), 68–75. https://doi.org/10.1016/j.ejon.2018.03.005

Guttmann, A., Schull, M. J., Vermeulen, M. J., & Stukel, T. A. (2011). Association between waiting times and short term mortality and hospital admission after departure from emergency department: Population based cohort study from Ontario, Canada. *Bmj*, *342*(7809), 1–8. https://doi.org/10.1136/bmj.d2983

Haddad, L. M., & Geiger, R. A. (2020). Nursing Ethical Considerations. In *StatPearls*. StatPearls Publishing. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/30252310

Hahn-Goldberg, S., Carter, M. W., Beck, J. C., Trudeau, M., Sousa, P., & Beattie, K. (2014). Dynamic optimization of chemotherapy outpatient scheduling with uncertainty. *Health Care Management Science*, *17*(4), 379–392. https://doi.org/10.1007/s10729-014-9268-0

Haryanto, M. (2019). Nursing shortage: Myth or fact? *Orthopaedic Nursing*, *38*(1), 1–2. https://doi.org/10.1097/NOR.0000000000000535

Hausenblas, H.A., Carron, A.V., Mack, D. E. (1997). The Theory of Planned Behaviour and Intentions to Attend a Sport Event. *Journal of Sport & Exercise Psychology*, 19, pp. 35–51. https://doi.org/10.1016/S1441-3523(03)70056-4

Heena, H., Durrani, S., Riaz, M., Alfayyad, I., Tabasim, R., Parvez, G., & Abu-shaheen, A. (2019). *Knowledge , attitudes , and practices related to breast cancer screening*

among female health care professionals : a cross sectional study.. *Texila International Journal of Public Health*, 19(122), 1–11. https://doi.org/10.21522/TIJPH.2013.08.03.Art026

Hemsley, B., Balandin, S., & Worral, L. (2012). Nursing the patient with complex communication neds:time as a barrier and a facilitator to successful communication in hospital. *Journal of advanced nursing*, *68*(1), 116–126. https://doi.org/10.1111/j.13652648.2011.05722.x

Hermann, R. M., Long, E., & Trotta, R. L. (2019). Improving Patients' Experiences Communicating With Nurses and Providers in the Emergency Department. *Journal of Emergency Nursing*, 45(5), 523–530. https://doi.org/10.1016/j.jen.2018.12.001

Hesse-biber, S. (2010). *Analyzing Qualitative Data : With or without software*. Massachusetts, USA : Boston College.

Holmberg, C., Caro, J., & Sobis, I. (2018). Job satisfaction among Swedish mental health nursing personnel: Revisiting the two-factor theory. *International journal of mental health nursing*, *27*(2), 581–592. https://doi.org/10.1111/inm.12339

Hopkinson J. (2018). Psychosocial Support in Cancer Cachexia Syndrome: The Evidence for Supported Self-Management of Eating Problems during Radiotherapy or Chemotherapy Treatment. *Asia-Pacific journal of oncology nursing*, *5*(4), 358–368. https://doi.org/10.4103/apjon.apjon_12_18

Hosseinabadi, B. M., Khanjani, N., Etemadinezhad, S., Samaei, S. E., Raadabadi, M., & Mostafaee, M. (2019). The associations of workload, individual and organisational factors on nurses' occupational injuries. *Journal of Clinical Nursing*, *28*(5–6), 902–911. https://doi.org/10.1111/jocn.14699

Ibrahim, N. A., & Oludara, M. A. (2012). Socio-demographic factors and reasons associated with delay in breast cancer presentation : A study in Nigerian women. *The Breast*, *21*(3), 416–418. https://doi.org/10.1016/j.breast.2012.02.006

Iranmanesh, S., Razban, F., Tirgari, B., & Zahra, G. (2014). Nurses' knowledge about palliative care in Southeast Iran. *Palliative and Supportive Care*, *12*(3), 203–210. https://doi.org/10.1017/S1478951512001058

Jacobs, L. A., Scarpa, R., Lester, J., & Smith, J. (2004). Oncology Nursing as a Specialty: The Education, Scope, and Standards for Advanced Practice Nursing in Oncology. *Oncology Nursing Forum*, *31*(3), 507–509. https://doi.org/10.1188/04.onf.507-509

Jerônimo, A. F. de A., & Weller, M. (2017). Differential association of the lifestyle-related risk factors smoking and obesity with triple negative breast cancer in a Brazilian Population. *Asian Pacific Journal of Cancer Prevention*, *18*(6), 1585–1593. https://doi.org/10.22034/APJCP.2017.18.6.1585

Jones, L., Leach, L., Chambers, S., & Occhipinti, S. (2010). Scope of practice of the breast care nurse: A comparison of health professional perspectives. *European Journal of Oncology Nursing*, *14*(4), 322–327. https://doi.org/10.1016/j.ejon.2010.03.006

Joyce, E., & Johnson, L. (2018). Redesigning Care in the PACU With an Adult-Gerontology Acute Care Nurse Practitioner (A-GACNP). *Journal of PeriAnesthesia*

Nursing, *33*(4), 407–411. https://doi.org/10.1016/j.jopan.2017.03.002

Kaltenhäuser, J., Kneuer, C., Marx-Stoelting, P., Niemann, L., Schubert, J., Stein, B., … Pharmacology. (2017). Relevance and reliability of experimental data in human health risk assessment of pesticides. *Regulatory Toxicology and Pharmacology*. *88*, 227–237. https://doi.org/10.1016/j. yrtph.2017.06.010

Kadar, J. L., Scott, A. B., Hipp, K., Belavich, T. G., Butfer, E. M., Rye, M. S., … Zinnbauer, B. J. (2015). Religion and spirituality. London: Routledge.

Karanikola, M. N., Albarran, J. W., Drigo, E., Giannakopoulou, M., Kalafati, M., Mpouzika, M., Tsiaousis, G. Z., & Papathanassoglou, E. D. (2014). Moral distress, autonomy and nurse-physician collaboration among intensive care unit nurses in Italy. *Journal of nursing management*, *22*(4), 472–484. https://doi.org/10.1111/jonm.12046

Karlou, C., Papathanassoglou, E., & Patiraki, E. (2015). Caring behaviours in cancer care in Greece. Comparison of patients', their caregivers' and nurses' perceptions. *European Journal of Oncology Nursing*, *19*(3), 244–250. https://doi.org/10.1016/j.ejon.2014.11.005

Kassa, H., Murugan, R., Zewdu, F., Hailu, M., & Woldeyohannes, D. (2014). Assessment of knowledge, attitude and practice and associated factors towards palliative care among nurses working in selected hospitals, Addis Ababa, Ethiopia. *BMC Palliative Care*, *13*(1), 1–11. https://doi.org/10.1186/1472-684X-13-6

Kassa, R., & Kassa, G. (2014). Nurses ' Attitude , Practice and Barriers toward Cancer Pain Management ,. *Cancer Science & Therapy*, *Volume 6(1*(January 2014), 483–487. https://doi.org/10.4172/1948-5956.1000312

Kastbom, L., Milberg, A., & Karlsson, M. (2016). A good death from the perspective of palliative cancer patients. *Supportive Care in Cancer*. https://doi.org/10.1007/s005200163483-9

Keles, H. N., Ozkan, T. K., & Bezirci, M. (2011). A Study On The Effects Of Nepotism, Favoritism And Cronyism On Organizational Trust In The Auditing Process In Family Businesses In Turkey. *International Business & Economics Research Journal (IBER)*, *10*(9), 9–16. https://doi.org/10.19030/iber.v10i9.5622

Korle-Bu Teaching Hospital (2020). About us – Brief History – Korle-Bu Teaching Hospital. Retrieved June 14, 2019, from http://kbth.gov.gh/brief-history/

Khademi, M., Mohammadi, E., & Vanaki, Z. (2015). Resources-tasks imbalance: Experiences of nurses from factors influencing workload to increase. *Iranian Journal of Nursing and Midwifery Research*, *20*(4), 476–483. https://doi.org/10.4103/1735-9066.160994

Khalaf, I. A., Al-Dweik, G., Abu-Snieneh, H., Al-Daken, L., Musallam, R. M., BaniYounis, M., … Masadeh, A. (2018). Nurses' Experiences of Grief Following Patient Death: A Qualitative Approach. *Journal of Holistic Nursing*, *36*(3), 228–240. https://doi.org/10.1177/0898010117720341

Khalil, D. D. (2009). Nurses' attitude towards 'difficult' and 'good' patients in eight public hospitals. *International Journal of Nursing Practice*, *15*, 437–443. https://doi.org/10.1111/j.1440-172X.2009.01771.x

Khalil, H., & Mashaqbeh, M. (2019). Areas of Knowledge Deficit and Misconceptions Regarding Pain among Jordanian Nurses. *Pain Management Nursing*, 20(6), 649-655 https://doi.org/10.1016/j.pmn.2019.02.010

Khan, N., Khowaja, K. Z. A., & Ali, T. S. (2012). Assessment of knowledge, skill and attitude of oncology nurses in chemotherapy administration in tertiary hospital Pakistan. *Open Journal* of *Nursing*, *2*, *97*-103. doi: 10.4236/ojn.2012.22015.

Khanjani, N., Noori, A., & Rostami, F. (2012). *The Knowledge and Practice of Breast Cancer Screening Among Women in Kerman , Iran*. *5*, 177–182. I S S N: 09 7 4 - 1143

Koch, T. (2006). Establishing rigour in qualitative research: The decision trail. Journal of Advanced Nursing, 53, 91–100.

Koczywas, M., Cristea, M., Thomas, J., McCarty, C., Borneman, T., Del Ferraro, C., Sun, V., Uman, G., & Ferrell, B. (2013). Interdisciplinary palliative care intervention in metastatic non-small-cell lung cancer. *Clinical lung cancer*, *14*(6), 736–744. https://doi.org/10.1016/j.cllc.2013.06.008

Komatsu, H. (2010). Oncology certified nurse specialist in Japan. *Japanese Journal of Clinical Oncology*, *40*(9), 876–880. https://doi.org/10.1093/jjco/hyq139

Komatsu, H., & Yagasaki, K. (2014). The power of nursing: Guiding patients through a journey of uncertainty. *European Journal of Oncology Nursing*, *18*(4), 419–424. https://doi.org/10.1016/j.ejon.2014.03.006

Kor, K., & Mullan, B. A. (2011). Sleep hygiene behaviours: an application of the theory of planned behaviour and the investigation of perceived autonomy support, past behaviour and response inhibition. *Psychology & health*, *26*(9), 1208–1224. https://doi.org/10.1080/08870446.2010.551210

Kossivi, B., Xu, M., & Kalgora, B. (2016). Study on Determining Factors of Employee Retention. *Open Journal of Social Sciences*, *04*(05), 261–268. https://doi.org/10.4236/jss.2016.45029

Kumarasinghe, S. A., & Hettiarachchi, L. P. (2018). Nurses ' knowledge on diabetic foot ulcer disease and their attitudes towards patients affected : A cross-sectional institution-based study. *Journal of clinical nursing*, 27: e203– e212. https://doi.org/10.1111/jocn.13917

Laidsaar-Powell, R., Butow, P., Bu, S., Fisher, A., & Juraskova, I. (2017). Oncologists' and oncology nurses' attitudes and practices towards family involvement in cancer consultations. *European Journal of Cancer Care*, *26*(1), 1–14. https://doi.org/10.1111/ecc.12470

Laidsaar-powell, R., Butow, P., Charles, C., Gafni, A., Entwistle, V., Epstein, R., & Juraskova, I. (2017). Patient Education and Counseling The TRIO Framework : Conceptual insights into family caregiver involvement and in fl uence throughout

cancer treatment. *Patient Education and Counseling*, *100(2017)*, *2035*–2046.. https://doi.org/10.1016/j.pec.2017.05.014

Lambrou, P., Kontodimopoulos, N., & Niakas, D. (2010). Motivation and job satisfaction among medical and nursing staff in a Cyprus public general hospital. *Human resources for health*, *8*, 1–9. https://doi.org/10.1186/1478-4491-8-26

Lanzarone, E., Matta, A., & Sahin, E. (2012). Operations management applied to home care services: the problem of assigning human resources to patients. *IEEE Transactions on Systems, Man, and Cybernetics-Part A: Systems and Humans*, *42*(6), 1346–1363. https://doi.org/10. 1109/TSMCA. 2012.2210207

Leary, A., White, J., & Yarnell, L. (2014). The work left undone: Understanding the challenge of providing holistic lung cancer nursing care in the UK. *European Journal of Oncolog ,Nursing*, *18(2014)*, *23*–28. https://doi.org/10.1016/j.ejon.2013.10.002

Lebel, S., Beattie, S., Arés, I., & Bielajew, C. (2013). Young and worried: Age and fear of recurrence in breast cancer survivors. *Health Psychology*, *32*(6), 695–705. https://doi.org/10.1037/a0030186

Ledesma-Delgado, M. E., & Mendes, M. M. R. (2009). The nursing process presented as routine care actions: building its meaning in clinical nurses' perspective TT - El proceso de enfermería como acciones de cuidado rutinarias: construyendo su significado en la perspectiva de las enfermeras asistencia. *Rev Lat Am Enfermagem*, *17*(3), 328–334. https://doi.org/10. 1590/50104-11692009000300008

Lelorain, S., Brédart, A., Dolbeault, S., & Sultan, S. (2012). A systematic review of the associations between empathy measures and patient outcomes in cancer care. *Psycho-oncology*, *21*(12), 1255–1264. https://doi.org/10.1002/pon.2115

Lemlem, S. B., Sinishaw, W., Hailu, M., Abebe, M., & Aregay, A. (2013a). Assessment of Knowledge of Breast Cancer and Screening Methods among Nurses in University Hospitals in Addis Ababa, Ethiopia, 2011. *ISRN Oncology*, *2013*, 1–8. https://doi.org/10.1155/2013/470981

Lennan, E., & Roe, H. (2014). Role of nurses in the assessment and management of chemotherapy-related side effects in cancer patients. *Nursing: Research and Reviews*, 4(2014)103–114. https://doi.org/10.2147/nrr.s41845

Liang, B., & Turkcan, A. (2016). Acuity-based nurse assignment and patient scheduling in oncology clinics. *Health Care Management Science*, *19*(3), 207–226. https://doi.org/10.1007/s10729-014-9313-z

Lin, P., Maclennan, S., Hunt, N., & Cox, T. (2015). *The influences of nursing transformational leadership style on the quality of nurses ' working lives in Taiwan : a cross-sectional quantitative study*. 1–9. https://doi.org/10.1186/s12912-015-0082-x

Lindh, M., Kihlgren, A., & Perseius, K. I. (2013). Factors influencing compliance to hygiene routines in community care - the viewpoint of medically responsible nurses in Sweden. *Scandinavian Journal of Caring Sciences*, *27*(2), 224–230. https://doi.org/10.1111/j.1471-6712.2012.01022.x

Liu, X., Zheng, J., Liu, K., Baggs, J. G., Liu, J., Wu, Y., & You, L. (2018). Hospital

nursing organizational factors, nursing care left undone, and nurse burnout as predictors of patient safety: A structural equation modeling analysis. *International Journal of Nursing Studies*, *86*, 82–89. https://doi.org/10.1016/j.ijnurstu.2018.05.005

Lopez, V., & Whitehead, D. (2013). Sampling and data collection in qualitative research. *Nursing and Midwifery Research: Methods and Appraisal for Evidence-Based Practice*. Mosby: Elsevier.

Maajani, K., Jalali, A., Alipour, S., Khodadost, M., Tohidinik, H. R., & Yazdani, K. (2019). The Global and Regional Survival Rate of Women With Breast Cancer: A Systematic Review and Meta-analysis. *Clinical Breast Cancer*. https://doi.org/10.1016/j.clbc.2019.01.006

Maher, C., Hadfield, M., Hutchings, M., & de Eyto, A. (2018). Ensuring rigor in qualitative data analysis: A design research approach to coding combining NVivo with traditional material methods. *International Journal of Qualitative Methods*, *17*(1), 1–13. https://doi.org/10.1177/609406918786362.

Mahfudh, S. S. (2011). Nurse's role in controlling cancer pain. *Journal of Pediatric Hematology/Oncology*, *33*(SUPPL. 2), 146–148. https://doi.org/10.1097/MPH.0b013e318230dfd8

Mahon, M. M., & McAuley, W. J. (2010). Oncology nurses' personal understandings about palliative care. *Oncology nursing forum*, *37*(3), E141–E150. https://doi.org/10.1188/10.ONF.E141-E150

Mantyh P. W. (2014). Bone cancer pain: from mechanism to therapy. *Current opinion in supportive and palliative care*, *8*(2), 83–90. https://doi.org/10.1097/SPC.0000000000000048

Maree, J., & Mulonda, J. (2017). Caring for patients with advanced breast cancer: The experiences of Zambian nurses. *Asia-Pacific Journal of Oncology Nursing*, *4*(1), 23–28. https://doi.org/10.4103/2347-5625.199077

Maresova, P., Prochazka, M., Barakovic, S., Baraković Husić, J., & Kuca, K. (2020). A Shortage in the Number of Nurses—A Case Study from a Selected Region in the Czech Republic and International Context. *Healthcare*, *8*(1), 1–16. https://doi.org/10.3390/healthcare8020152

Martei YM, Vanderpuye V, Jones BA. Fear of Mastectomy Associated with Delayed Breast Cancer Presentation Among Ghanaian Women. The Oncologist. 2018 Dec;23(12):1446-1452. https://doi.org/10.1634/theoncologist.2017-0409.

McLennon, S. M., Lasiter, S., Miller, W. R., Amlin, K., Chamness, A. R., & Helft, P. R. (2013). Oncology nurses' experiences with prognosis-related communication with patients who have advanced cancer. *Nursing Outlook*, *61*(6), 427–436. https://doi.org/10.1016/j.outlook.2012.12.001

McLennon, S. M., Uhrich, M., Lasiter, S., Chamness, A. R., & Helft, P. R. (2013). Oncology nurses' narratives about ethical dilemmas and prognosis-related communication in advanced cancer patients. *Cancer nursing*, *36*(2), 114–121. https://doi.org/10.1097

McQuestion M. (2011). Evidence-based skin care management in radiation therapy: clinical update. *Seminars in oncology nursing*, *27*(2), e1–e17. https://doi.org/10.1016/j.soncn.2011.02.009

Meacham, E., Orem, J., Nakigudde, G., Zujewski, J. A., & Rao, D. (2016). Exploring stigma as a barrier to cancer service engagement with breast cancer survivors in Kampala, Uganda. *Psycho-Oncology*, (July), 1206–1211. https://doi.org/10.1002/pon.4215

Mensah, A. C., Yarney, J., Nokoe, S. K., Opoku, S., & Clegg-Lamptey, J. N. (2016). Survival Outcomes of Breast Cancer in Ghana: An Analysis of Clinicopathological Features. *OALib*, *03*(01), 1–11. https://doi.org/10.4236/oalib.1102145

Miettunen, J., & Mikkonen, K. (2019). *Radiography Nurses ' knowledge of radiation protection : A cross-sectional study*. *25*, 108–112. https://doi.org/10.1016/j.radi.2019.04.011

Millar, C., Reid, J., & Porter, S. (2013). Refractory cachexia and truth-telling about terminal prognosis: A qualitative study. *European Journal of Cancer Care*, *22*(3), 326–333. https://doi.org/10.1111/ecc.12032

Molina, J. G. (2012). End-of-Life Care: A Paradigm of Nursing Knowledge. *Journal of Nursing & Care*, *01*(05), 10–11. https://doi.org/10.4172/2167-1168.1000e113

Monroe, B. M., & Read, S. J. (2008). A general connectionist model of attitude structure and change: The ACS (Attitudes as Constraint Satisfaction) model. *Psychological Review*, *115*(3), 733. doi: 10.1037/0033-295X.115.3.*733*.

Morphet, J., Griffiths, D., Plummer, V., Innes, K., Fairhall, R., & Beattie, J. (2014). At the crossroads of violence and aggression in the emergency department: perspectives of Australian emergency nurses. *Australian health review : a publication of the Australian Hospital Association*, *38*(2), 194–201. https://doi.org/10.1071/AH13189

Mostafaei, D., Marnani, A. B., Esfahani, H. M., Estebsari, F., Shahzaidi, S., Jamshidi, E., & Aghamiri, S. S. (2014). Medication errors of nurses and factors in refusal to report medication errors among nurses in a teaching medical center of Iran in 2012. *Iranian Red Crescent Medical Journal*, *16*(10), 1–6. https://doi.org/10.5812/ircmj.16600

Muhammed, A., Khuan, L., Shariff-ghazali, S., & Said, S. (2019). Predictors of midwives ' intention to provide planned home birth services to low-risk women : A theory of planned behaviour approach. *Midwifery*, *73*, 62–68. https://doi.org/10.1016/j.midw.2019.03.004

Negarandeh, R., Oskouie, F., Ahmadi, F., & Nikravesh, M. (2008). The meaning of patient advocacy for Iranian nurses. *Nursing ethics*, *15*(4), 457–467. https://doi.org/10.1177/0969733008090517

Nelson, J. M., Cook, P. F., & Ingram, J. C. (2013). *Utility of the theory of planned behavior to predict nursing staff blood pressure monitoring behaviours*. 461–470. https://doi.org/10.1111/jocn.12183

Neuss, M. N., Gilmore, T. R., Belderson, K. M., Billett, A. L., Conti-Kalchik, T., Harvet, B. E., Hendricks, C., LeFebvre, K. B., Mangu, P. B., McNiff, K., Olsen, M.,

Schulmeister, L., Von Gehr, A., & Polovich, M. (2017). 2016 Updated American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards, Including Standards for Pediatric Oncology. *Oncology nursing forum*, *44*(1), 31–43. https://doi.org/10.1188/17.ONF.31-43

Nicoloro-SantaBarbara, J., Rosenthal, L., Auerbach, M. V., Kocis, C., Busso, C., & Lobel, M. (2017). Patient-provider communication, maternal anxiety, and self-care in pregnancy. *Social Science and Medicine, 190(2017), 133*–140 . https://doi.org/10.1016/j.socscimed.2017.08.011

Norman, P., & Conner, M. (2006). The theory of planned behaviour and binge drinking: Assessing the moderating role of past behaviour within the theory of planned behaviour. *British journal of health psychology*, *11*(Pt 1), 55–70. https://doi.org/10.1348/135910705X43741

Nukpezah, R. N., Fomani, F. K., Hasanpour, M., & Nasrabadi, A. N. (2020). *Low Caring Morale: A Qualitative Study of Ghanaian Pediatric Oncology Nurses' Care Practice Challenges.* 1–20. https://doi.org/10.21203/rs.3.rs-33095/v1

Nwozichi, C., Ojewole, F., & Oluwatosin, A. (2017). Understanding the challenges of providing holistic oncology nursing care in Nigeria. *Asia-Pacific Journal of Oncology Nursing*, *4*(1), 18. https://doi.org/10.4103/2347-5625.199074

Oluwatosin, Oa. (2012). Primary health care nurses' knowledge practice and client teaching of early detection measures of breast cancer in Ibadan. *BMC Nursing*, *11*(1), 1–8. https://doi.org/10.1186/1472-6955-11-22

Opoku, S. Y., Benwell, M., & Yarney, J. (2012). Knowledge, attitudes, beliefs, behaviour and breast cancer screening practices in Ghana, West Africa. *The Pan African medical journal*, *11*(1), 1–10. PMID: PMC3325066

Paccagnella, A., Morello, M., Mosto, M. C. Da, Baruffi, C., Babare, R., Rosti, G., … Boscolo-rizzo, P. (2010). *Early nutritional intervention improves treatment tolerance and outcomes in head and neck cancer patients undergoing concurrent chemoradiotherapy*, 18(1), 837–845. https://doi.org/10.1007/s00520-009-0717-0

Park, S.-A., Chung, S. H., & Shin, E. H. (2012). Attitudes of Nurses toward Supportive Care for Advanced Cancer Patients. *Asian Pacific Journal of Cancer Prevention*, *13*(10), 4953–4958. https://doi.org/http://dx.doi.org/10.7314/APJCP.2012.13.10.4953

Pedersen, A. E., Hack, T. F., McClement, S. E., & Taylor-Brown, J. (2014). An exploration of the patient navigator role: Perspectives of younger women with breast cancer. *Oncology Nursing Forum*, *41*(1), 77–88. https://doi.org/10.1188/14.ONF.77-88

Pehrson, C., Banerjee, S. C., Manna, R., Johnson, M., Hammonds, S., Coyle, N., … Bylund, C. L. (2016). Patient Education and Counseling Responding empathically to patients : Development , implementation , and evaluation of a communication skills training module for oncology nurses. *Patient Education and Counseling*, *99*(4), 610–616. https://doi.org/10.1016/j.pec.2015.11.021

Pennbrant, S., Tomaszewska, M., & Penttilä, G. L. (2015). Nurses' experience of caring for palliative-stage patients in a hospital setting in Sweden. *Clinical Nursing Studies*,

3(2, 97–108. https://doi.org/10.5430/cns.v3n2p97

Perry, B., Toffner, G., Merrick, T., & Dalton, J. (2011). An exploration of the experience of compassion fatigue in clinical oncology nurses. *Canadian Oncology Nursing Journal = Revue Canadienne de Nursing Oncologique*, *21*(2), 91–105. https://doi.org/10.5737/1181912x2129197

Peteet, J. R., & Balboni, M. J. (2013). Spirituality and religion in oncology. *CA: a cancer journal for clinicians*, *63*(4), 280–289. https://doi.org/10.3322/caac.21187

Phelps, A. C., Lauderdale, K. E., Alcorn, S., Dillinger, J., Balboni, M. T., Van Wert, M., Vanderweele, T. J., & Balboni, T. A. (2012). Addressing spirituality within the care of patients at the end of life: perspectives of patients with advanced cancer, oncologists, and oncology nurses. *Journal of clinical oncology : official journal of the American Society of Clinical Oncology*, *30*(20), 2538–2544. https://doi.org/10.1200/JCO.2011.40.3766

Pich, J. V, Kable, A., & Hazelton, M. (2017). Violence in Emergency Nursing and Triage. *Australasian Emergency Nursing Journal*, *20(2017)*, *107*–113. https://doi.org/10.1016/j.aenj.2017.05.005

Polit, D.F., & Beck, C.T. (2012). *Nursing Research, Generating and Assessing Evidence for Nursing Practice* (9th ed.). New York: Lippincott Williams & Wilkins.

Polovich, M., & Clark, P. C. (2012). Factors influencing oncology nurses' use of hazardous drug safe-handling precautions. *Oncology nursing forum*, *39*(3), E299–E309. https://doi.org/10.1188/12.ONF.E299-E309

Polovich, M., & Martin, S. (2011). Nurses' use of hazardous drug-handling precautions and awareness of national safety guidelines. *Oncology nursing forum*, *38*(6), 718–726. https://doi.org/10.1188/11.ONF.718-726

Pongthavornkamol, K., Khamkon, A., Phligbua, W., Cohen, E., & Botti, M. (2018). Thai Oncology Nurses' Perceptions of Patient Participation in Acute Cancer Care. *Asian Nursing Research*, *12*(3), 209–215. https://doi.org/10.1016/j.anr.2018.08.004

Popescu, M. (2012). Psychology of Communication – Between Myth and Reality. *International Journal of Academic Research in Accounting, Finance and Management Sciences*, *2*(1), 321–325.

Prades, J., Remue, E., van Hoof, E., & Borras, J. M. (2015). Is it worth reorganising cancer services on the basis of multidisciplinary teams (MDTs)? A systematic review of the objectives and organisation of MDTs and their impact on patient outcomes. *Health policy (Amsterdam, Netherlands)*, *119*(4), 464–474. https://doi.org/10.1016/j.healthpol.2014.09.006

Prolla, C. M. D., Da Silva, P. S., Oliveira Netto, C. B., Goldim, J. R., & Ashton-Prolla, P. (2015). Knowledge about breast cancer and hereditary breast cancer among nurses in a public hospital. *Revista Latino-Americana de Enfermagem*, *23*(1), 90–97. https://doi.org/10.1590/0104-1169.0185.2529

Puchalski, C., Ferrell, B., Virani, R., Otis-Green, S., Baird, P., Bull, J., Chochinov, H., Handzo, G., Nelson-Becker, H., Prince-Paul, M., Pugliese, K., & Sulmasy, D. (2009).

Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. *Journal of palliative medicine*, *12*(10), 885–904. https://doi.org/10.1089/jpm.2009.0142

Ramathuba, D. U., Ratshirumbi, C. T., & Mashamba, T. M. (2015). Knowledge, attitudes and practices toward breast cancer screening in a rural South African community. *Curationis*, *38*(1), 1172. https://doi.org/10.4102/curationis.v38i1.1172

Ramires, T. G., Cordeiro, G. M., Kattan, M. W., Hens, N., Ortega, E. M. M., & Ortega, E. M. (2018). Predicting the cure rate of breast cancer using a new regression model with four regression structures. *Statistical Methods in Medical Research*, *27*(11), 3207–3223. https://doi.org/10.1177/0962280217695344

Rauscher, G. H., Ferrans, C. E., Kaiser, K., Campbell, R. T., Calhoun, E. E., & Warnecke, R. B. (2010). Misconceptions about breast lumps and delayed medical presentation in urban breast cancer patients. *Cancer epidemiology, biomarkers & prevention : a publication of the American Association for Cancer Research, cosponsored by the American Society of Preventive Oncology*, *19*(3), 640–647. https://doi.org/10.1158/1055-9965.EPI-09-0997

Rawal, D. C. N., & A. Pardeshi, M. S. (2014). Job Stress Causes Attrition among Nurses in Public and Private Hospitals. *IOSR Journal of Nursing and Health Science*, *3*(2), 42–47. https://doi.org/10.9790/1959-03224247

Razban, F., Iranmanesh, S., & Rafiei, H. (2013). Nurses' attitudes toward palliative care in south-east Iran. *International journal of palliative nursing*, *19*(8), 403–410. https://doi.org/10.12968/ijpn.2013.19.8.403

Rest, F. V. (2011). *Advance appointment booking in chemotherapy.* (Master Thesis), University of British Columbia, Columbia. Retrieved from https://www.math.leidenuniv.nl/scripties/MasterVanRest.pdf

Riskin, A., Erez, A., Foulk, T. A., Kugelman, A., Gover, A., & Shoris, I. (2015). *The Impact of Rudeness on Medical Team Performance : A Randomized Trial*. *136*(3), 487–495. https://doi.org/10.1542/peds.2015-1385

Roy, N., Murlidhar, V., Chowdhury, R., Patil, S. B., Supe, P. A., Vaishnav, P. D., & Vatkar, A. (2010). Where there are no emergency medical services-prehospital care for the injured in Mumbai, India. *Prehospital and disaster medicine*, *25*(2), 145–151. https://doi.org/10.1017/s1049023x00007883

Rustøen, T., Geerling, J. I., Pappa, T., Rundström, C., Weisse, I., Williams, S. C., … Wengström, Y. (2013). *European Journal of Oncology Nursing A European survey of oncology nurse breakthrough cancer pain practices*, *17(13)*, *95*–100. https://doi.org/10.1016/j.ejon.2012.05.005

Saad, R., Huijer, H. A., Noureddine, S., Muwakkit, S., Saab, R., & Abboud, M. R. (2011). Bereaved parental evaluation of the quality of a palliative care program in Lebanon. *Pediatric blood & cancer*, *57*(2), 310–316. https://doi.org/10.1002/pbc.23082

Sakai, H., Umeda, M., Okuyama, H., & Nakamura, S. (2020). *Differences in perception of*

breast cancer treatment between patients , physicians , and nurses and unmet information needs in Japan. 2331–2338. https://doi.org/10.1007/s00520-019-05029-z

Saleh, U., O'Connor, T., Al-Subhi, H., Alkattan, R., Al-Harbi, S., & Patton, D. (2018). The impact of nurse managers' leadership styles on ward staff. *British journal of nursing (Mark Allen Publishing)*, *27*(4), 197–203. https://doi.org/10.12968/bjon.2018.27.4.197

Samarkandi Osama Abdulhaleem. (2018). Knowledge and attitudes of nurses toward pain management. *Saudi J Anaesth*, 12(2), *220*–226. https://doi.org/10.4103/sja.SJA

Sameen, F. Y., & Al-Attar, W. M. A. (2015). Nurse's Knowledge and Attitudes toward Cancer Pain Management at Baghdad Hospitals. *Kufa Journal for Nursing Sciences*, *5*(3), 134–143

Santibáñez, P., Aristizabal, R., Puterman, M. L., Chow, V. S., Huang, W., Kollmannsberger, C., … Tyldesley, S. (2012). Operations research methods improve chemotherapy patient appointment scheduling. *Joint Commission Journal on Quality and Patient Safety*, *38*(12), 541–553. https://doi.org/10.1016/s1553-7250(12)38071-9

Sarafis, P., Tsounis, A., Malliarou, M., & Lahana, E. (2014). Disclosing the truth: a dilemma between instilling hope and respecting patient autonomy in everyday clinical practice. *Global Journal of Health Science*, *6*(2), 128–137. https://doi.org/10.5539/gjhs.v6n2p128

Schiavon, C. C., Vieira, F. G. K., Ceccatto, V., Liz, S. De, Cardoso, A. L., Sabel, C., … P, P. De. (2015). *Nutrition Education Intervention for Women With Breast Cancer : Effect on Nutritional Factors and Oxidative Stress*. *47*(1), 2–9. https://doi.org/10.1016/j.jneb.2014.09.005

Seshie, B., Adu-Aryee, N. A., Dedey, F., Calys-Tagoe, B., & Clegg-Lamptey, J. N. (2015). A retrospective analysis of breast cancer subtype based on ER/PR and HER2 status in Ghanaian patients at the Korle Bu Teaching Hospital, Ghana. *BMC Clinical Pathology*, *15*(1), 1–8. https://doi.org/10.1186/s12907-015-0014-4

Shah, T. A., & Guraya, S. S. (2017). Breast cancer screening programs: Review of merits, demerits, and recent recommendations practiced across the world. *Journal of Microscopy and Ultrastructure*, *5*(2), 59–69. https://doi.org/10.1016/j.jmau.2016.10.002

Shahrokhi, A., Ebrahimpour, F., & Ghodousi, A. (2013). *Journal of Research in Pharmacy Practice Factors effective on medication errors : A nursing view 2*(1), 18–23. https://doi.org/10.4103/2279-042X.114084

Shang, J., Friese, C. R., Wu, E., & Aiken, L. H. (2013). Nursing practice environment and outcomes for oncology nursing. *Cancer nursing*, *36*(3), 206–212. https://doi.org/10.1097/NCC.0b013e31825e4293

Sharma, K., Costas, A., Shulman, L. N., & Meara, J. G. (2012). A systematic review of barriers to breast cancer care in developing countries resulting in delayed patient presentation. *Journal of Oncology*, *2012*, *1*–8. https://doi.org/10.1155/2012/121873

Shoqirat, N., Mahasneh, D., Al-Khawaldeh, O., & Al Hadid, L. (2019). Nurses'

Knowledge, Attitudes, and Barriers Toward Pain Management Among Postoperative Patients in Jordan. *Journal of Perianesthesia Nursing*, *34*(2), 359–367. https://doi.org/10.1016/j.jopan.2018.05.012

Shoqirat, N., Mahasneh, D., Al-Khawaldeh, O., & Singh, C. (2019). Using Opioids With Surgical Patients: Nurses' Attitudes and Experiences. *Journal of Trauma Nursing*, *26*(1), 26–32. https://doi.org/10.1097/JTN.0000000000000412

Simone, E. Di, Giannetta, N., Auddino, F., Cicotto, A., Grilli, D., & Muzio, M. Di. (2018). *Medication Errors in the Emergency Department : Knowledge , Attitude , Behavior , and Training Needs of Nurses*. 22(5), 346–342. https://doi.org/10.4103/ijccm.IJCCM

Simpson, P., Thomas, R., Bendall, J., Lord, B., Lord, S., & Close, J. (2017). 'Popping nana back into bed' - a qualitative exploration of paramedic decision making when caring for older people who have fallen. *BMC Health Services Research*, *17*(1), 1–14. https://doi.org/10.1186/s12913-017-2243-y

Singh, H., Kaur, K., Banipal, R. P., Singh, S., & Bala, R. (2014). Quality of life in cancer patients undergoing chemotherapy in a tertiary care center in Malwa region of Punjab. *Indian journal of palliative care*, *20*(2), 116–122. https://doi.org/10.4103/0973-1075.132627

Skrobanski, H., Ream, E., Poole, K., & Whitaker, K. L. (2019). Understanding primary care nurses' contribution to cancer early diagnosis: A systematic review. *European journal of oncology nursing : the official journal of European Oncology Nursing Society*, *41*, 149–164. https://doi.org/10.1016/j.ejon.2019.06.007

Smith, G. D., & Wu, S. (2012). *Nurses ' beliefs , experiences and practice regarding complementary and alternative medicine in Taiwan*. 1–9. https://doi.org/10.1111/j.1365-2702.2011.04008.x

Sniehotta, F. F., Presseau, J., & Araújo-soares, V. (2014). Time to retire the theory of planned behaviour. *Health Psychology Review*, *8*(1), 1–7. https://doi.org/10.1080/17437199.2013.869710

Snowden, A., & Atkinson, J. (2012). Concurrent analysis: A pragmatic justification. *Nursing Philosophy*, *13*(2), 126–141. https://doi.org/10.1111/j.1466-769X.2011.00523.x

Solikhah, S., Matahari, R., Utami, F. P., Handayani, L., & Marwati, T. A. (2020). Breast cancer stigma among Indonesian women: A case study of breast cancer patients. *BMC Women's Health*, *20*(1), 1–5. https://doi.org/10.1186/s12905-020-00983-x

Song, Y., Lv, X., Liu, J., & Huang, D. (2016). *Experience of nursing support from the perspective of patients with cancer in mainland China*. 510–518. https://doi.org/10.1111/nhs.12303

Sorifa, B., & Mosphea, K. (2015). *Knowledge and Practice of Staff Nurses on Palliative Care*. 41–45.Retreived from http://www.ijhrmlp.org/pdfs/61.pdf

Spano-Szekely, L., Griffin, M. T. Q., Clavelle, J., & Fitzpatrick, J. J. (2016). Emotional intelligence and transformational leadership in nurse managers. *Journal of Nursing Administration*, *46*(2), 101–108. https://doi.org/10.1097/NNA.0000000000000303

Sree, C. Y. M. (2016). Knowledge Regarding Care of Patients Undergoing Radiation Therapy among Staff Nurses And Nursing Students. *Journal of Medical Science And Clinical Research*, *04*(06), 11116–11122. https://doi.org/10.18535/jmscr/v4i6.71

Steele, C. B., Thomas, C. C., Henley, ; S Jane, Massetti, G. M., Galuska, D. A., Agurs-Collins, T., … Richardson, L. C. (2017). Morbidity and Mortality Weekly Report Vital Signs: Trends in Incidence of Cancers Associated with Overweight and Obesity — United States, 2005–2014. *Centers for Disease Control and Prevention*, *66*(39), 1052–1058. https://doi.org/10. 15585/mmwr.mm6639e1

Stokes, H., Vanderspank-Wright, B., Fothergill Bourbonnais, F., & Wright, D. K. (2019). Meaningful experiences and end-of-life care in the intensive care unit: A qualitative study. *Intensive and Critical Care Nursing*, *53*, 1–7. https://doi.org/10.1016/j.iccn.2019.03.010

Suhonen, R., Stolt, M., Habermann, M., Hjaltadottir, I., Vryonides, S., Tonnessen, S., … Action, C. (2018). *Ethical elements in priority setting in nursing care : A scoping review*. *88*(August), 25–42. https://doi.org/10.1016/j.ijnurstu.2018.08.006

Suss, S., Bhuiyan, N., Demirli, K., & Batist, G. (2017). Toward implementing patient flow in a cancer treatment center to reduce patient waiting time and improve efficiency. *Journal of oncology practice*, *13*(6), e530-e537. https://doi.org/10.1200/JOP.2016.020008

Sutton, S. R. (2001). Health Behavior: Psychosocial Theories. In *International Encyclopedia of the Social & Behavioral Sciences*, 6499–6506. https://doi.org/10.1016/B0080430767/03872-9

Swann, C., Carmona, C., Ryan, M., Raynor, M., Baris, E., Dunsdon, S., & Kelly, M. P. (2010). Health systems and health-related behaviour change: a review of primary and secondary evidence. *National Institute for Health and Clinical Excellence*.77.

Taghizadeh Kermani, A., Hosseini, S., Salek, R., Pourali, L. (2015). Improving knowledge and attitude of nurses working in chemotherapy wards through a short educational course: a successful experience in Mashhad. *Future of Medical Education Journal*, 5(4), 10-13. https://doi.org/10.22038/fmej.2015.6298

Tang, C. J., Zhou, W. T., Chan, S. W. C., & Liaw, S. Y. (2018). Interprofessional collaboration between junior doctors and nurses in the general ward setting: A qualitative exploratory study. *Journal of Nursing Management*, *26*(1), 11–18. https://doi.org/10.1111/jonm.12503

Tariman, J. D., Mehmeti, E., Spawn, N., McCarter, S. P., Bishop-Royse, J., Garcia, I., Hartle, L., & Szubski, K. (2016). Oncology Nursing and Shared Decision Making for Cancer Treatment. *Clinical journal of oncology nursing*, *20*(5), 560–563. https://doi.org/10.1188/16.CJON.560-563

Taylor, K., Chivers, P., Bulsara, C., Joske, D., Bulsara, M., & Monterosso, L. (2019). Care After Lymphoma (CALy) trial: A phase II pilot pragmatic randomised controlled trial of a nurse-led model of survivorship care. *European Journal of Oncology Nursing*, *40(2019)*, *53*–62. https://doi.org/10.1016/j.ejon.2019.03.005

Thambura, M. J., Vinette, C. I., & Klopper, S. (2019). *Nurses ' Knowledge of Ionizing*

Radiation in Northern Gauteng State Hospitals in South Africa. *38*, 56–60. https://doi.org/10.1016/j.jradnu.2018.11.002

Thaniyath, T. A. (2019). The Quality of Life of the Patients Under Palliative Care: The Features of Appropriate Assessment Tools and the Impact of Early Integration of Palliative Care. In *Palliative Care*. IntechOpen. doi: 10.5772/intechopen.85161

Thomas, A. S., Kidwell, K. M., Oppong, J. K., Adjei, E. K., Osei-Bonsu, E., Boahene, A., … Merajver, S. D. (2017). Breast Cancer in Ghana: Demonstrating the Need for Population-Based Cancer Registries in Low- and Middle-Income Countries. *Journal of Global Oncology*, *3*(6), 765–772. https://doi.org/10.1200/JGO.2016.006098

Tillott, S., Walsh, K., & Moxham, L. (2013). Encouraging engagement at work to improve retention. *Nursing Management*, *19*(10), 27–31. https://doi.org/10.7748/nm2013.03.19.10.27.e697

Tobin, G.A., & Begley, C.M. (2004). Methodological rigour within a qualitative framework. Journal of Advanced Nursing, 48, 388–396.

Toh, S. G., Ang, E., & Devi, M. K. (2012). Systematic review on the relationship between the nursing shortage and job satisfaction, stress and burnout levels among nurses in oncology/haematology settings. *International journal of evidence-based healthcare*, *10*(2), 126–141. https://doi.org/10.1111/j.1744-1609.2012.00271.x

Toh, S. G., Ang, E., & Kamala Devi, M. (2012). Systematic review on the relationship between the nursing shortage and job satisfaction, stress and burnout levels among nurses in oncology/haematology settings. *International Journal of Evidence-Based Healthcare*, *10*(2), 126–141. https://doi.org/10.1111/j.1744-1609.2012.00271.x

Tornøe, K. A., Danbolt, L. J., Kvigne, K., & Sørlie, V. (2015). *The challenge of consolation : nurses ' experiences with spiritual and existential care for the dying-a phenomenological hermeneutical study*. 1–12. https://doi.org/10.1186/s12912-015-0114-6

Torskenæs, K. B., Baldacchino, D. R., Kalfoss, M., Baldacchino, T., Borg, J., Falzon, M., & Grima, K. (2015). Nurses' and caregivers' definition of spirituality from the Christian perspective: a comparative study between Malta and Norway. *Journal of nursing management*, *23*(1), 39–53. https://doi.org/10.1111/jonm.12080

Tryon, W. W. (2012). A connectionist network approach to psychological science: Core and corollary principles. *Review of General Psychology*, *16*(3), 305–317. https://doi.org/10.1037/a0027135

Vagharseyyedin, S. A. (2015). Workplace incivility: A concept analysis. *Contemporary Nurse*, *50*(1), 115–125. https://doi.org/10.1080/10376178.2015.1010262

Van den Heever, A. E., Poggenpoel, M., & Myburgh, C. P. H. (2015). Nurses' perceptions of facilitating genuineness in a nurse-patient relationship. *Health SA Gesondheid*, *20*(1), 109–117. https://doi.org/10.1016/j.hsag.2015.02.003

VerStrate, C. A. (2015). Exploration of Chemotherapy Safe-Handling Practices and Identification of Knowledge Deficits among Oncology Nurses in the Ambulatory Care Setting. (Doctorial Thesis), Grand Valley State University, Michigan.

ttps://scholarworks.gvsu.edu/cgi/viewcontent.cgi?article=1027&context=dissertations

Vichare, A., Washington, R., Patton, C., Arnone, A., Olsen, C., Fung, C. Y., … Pohar, S. (2013). An assessment of the current US radiation oncology workforce: methodology and global results of the American Society for Radiation Oncology 2012 Workforce Study. *International Journal of Radiation Oncology Biology Physics*, *87*(5), 1129–1134. https://doi.org/10.1016/j. ijrobp.2013. 08.050

Villapiano, N. L. G., Winkelman, T. N. A., Kozhimannil, K. B., Davis, M. M., & Patrick, S. W. (2017). Rural and urban differences in neonatal abstinence syndrome and maternal opioid use, 2004 to 2013. *JAMA Pediatrics*, *171*(2), 194–196. https://doi:10.1001/jamapediatrics.2016.3750

Vogel, V. G., Costantino, J. P., Wickerham, D. L., Cronin, W. M., Cecchini, R. S., Atkins, J. N., … Runowicz, C. D. (2010). *Update of the National Surgical Adjuvant Breast and Bowel Project Study of Tamoxifen and Raloxifene (STAR) P-2 Trial : Preventing Breast Cancer*. *3*(June), 696–707. https://doi.org/10.1158/1940-6207.CAPR-10-0076

Wang, L., Geng, X., Ji, L., Lu, G., & Lu, Q. (2020). Treatment decision-making, family influences, and cultural influences of Chinese breast cancer survivors: a qualitative study using an expressive writing method. *Supportive Care in Cancer*, *28*(7), 3259–3266. https://doi.org/10.1007/s00520-019-05161-w

Watts, R., Botti, M., & Hunter, M. (2010). Nurses' perspectives on the care provided to cancer patients. *Cancer Nursing*, *33*(2), 1–8. https://doi.org/10.1097/NCC.0b013e3181b5575a

Wazqar, D. Y., Kerr, M., Regan, S., & Orchard, C. (2017). An integrative review of the influence of job strain and coping on nurses' work performance: Understanding the gaps in oncology nursing research. *International Journal of Nursing Sciences*, *4*(4), 418–429. https://doi.org/10.1016/j.ijnss.2017.09.003

Wei, H., Sewell, K. A., Woody, G., & Rose, M. A. (2018). The state of the science of nurse work environments in the United States: A systematic review. *International Journal of Nursing Sciences*, *5*(3), 287–300. https://doi.org/10.1016/j.ijnss.2018.04.010

Weldon, C. B., Friedewald, S. M., & Kulkarni, S. A. (2016). Radiology as the Point of Cancer Patient and Care Team Engagement : Applying the 4R Model at a Patient ' s Breast Cancer Care Initiation. *Journal of the American College of Radiology*, *13*(12), 1579–1589. https://doi.org/10.1016/j.jacr.2016.09.008

Westbrook, J. I., Rob, M. I., Woods, A., & Parry, D. (2011). Errors in the administration of intravenous medications in hospital and the role of correct procedures and nurse experience. *BMJ Quality and Safety*, *20*(12), 1027–1034. https://doi.org/10.1136/bmjqs-2011-000089

Williams, N. F., Hauck, Y. L., & Bosco, A. M. (2017). Nurses' perceptions of providing psychosexual care for women experiencing gynaecological cancer. *European Journal of Oncology Nursing*, *30*, 35–42. https://doi.org/10.1016/j.ejon.2017.07.006

Wittenberg-Lyles, E., Goldsmith, J., & Platt, C. S. (2014). Palliative Care Communication.

Seminars in Oncology Nursing, *30*(4), 280–286. https://doi.org/10.1016/j.soncn.2014.08.010

Wittenberg, E., Reb, A., & Kanter, E. (2018). Communicating with Patients and Families Around Difficult Topics in Cancer Care Using the COMFORT Communication Curriculum. *Seminars in Oncology Nursing*, *34*(3), 264–273. https://doi.org/10.1016/j.soncn.2018.06.007

Wolf, L. A., Perhats, C., Clark, P. R., Moon, M. D., & Evanovich, K. (2017). *Workplace bullying in emergency nursing : Development of a grounded theory using situational analysis*. International Emergency Nursing, 39 (2018), 33–39. https://doi.org/10.1016/j.ienj.2017.09.002

Woynarowska-Sołdan, M., Panczyk, M., Iwanow, L., Bączek, G., Gałązkowski, R., & Gotlib, J. (2019). Breast self-examination among nurses in Poland and their reparation in this regard. *Annals of Agricultural and Environmental Medicine*, *26*(3), 450–455. https://doi.org/10.26444/aaem/102762

Wurjine, T. H., Bogale, N., & Menji, Z. A. (2019). *Assessment of knowledge , attitude and practice towards breast cancer early detection methods among female health professionals at public health centers of Addis Ababa , Ethiopia , 2017*. *8*(3), 201–209. https://doi.org/10.15406/mojwh.2019.08.00237

Yang, J., Liu, Y., Chen, Y., & Pan, X. (2014). The effect of structural empowerment and organizational commitment on Chinese nurses ' job satisfaction. *Applied Nursing Research*, 27(2014), 186–191. https://doi.org/10.1016/j.apnr.2013.12.001

Yarney, J., Ohene Oti, N. O., Calys-Tagoe, B. N. L., Calys-Tagoe, B. N. L., Calys-Tagoe, B. N. L., Akoto- Aidoo, C., … Hsing, A. W. (2020). Establishing a Cancer Registry in a Resource- Constrained Region: Process Experience From Ghana. *JCO Global Oncology*, 6, 610–616. https:// doi.org/10.1200/jgo.19.00387

Yava, A., Çicek, H., Tosun, N., Özcan, C., Yildiz, D., & Dizer, B. (2013). Knowledge and Attitudes of Nurses about Pain Management in Turkey. *International Journal of Caring Sciences*, *6*(3), 494–505. ISSN: 1791-5201

Young Lives. (2011). Piloting: Testing Instruments and Training Field Teams. Retrieved from Young Lives, website: http://www.younglives.org.uk/files/methods-guide/methods-guide-piloting-and-training

Yu, H. Y., Yu, S., Chen, I. J., & Wang, K. W. K. (2013). Evaluating Nurses' Knowledge of Chemotherapy. *The Journal of Continuing Education in Nursing*, *44*(12), 553–563. https://doi.org/10. 1016/j.e jon.2012.05.005

Zamanzadeh, V., Rassouli, M., Abbaszadeh, A., Nikanfar, A., Alavi-Majd, H., & Ghahramanian, A. (2014). Factors influencing communication between the patients with cancer and their nurses in oncology wards. *Indian Journal of Palliative Care*, *20*(1), 12. https://doi.org/10.4103/0973-1075. 125549

Zhao, J., Gao, S., Wang, J., Liu, X., & Hao, Y. (2016). Differentiation between two healthcare concepts: Person-centered and patient-centered care. *International Journal of Nursing Sciences*, *3*(4), 398–402. https://doi.org/10.1016/j.ijnss.2016.08.009

Zheng, R. S., Guo, Q. H., Dong, F. Q., & Owens, R. G. (2015). Chinese oncology nurses' experience on caring for dying patients who are on their final days: A qualitative study. *International Journal of Nursing Studies*, *52*(1), 288–296. https://doi.org/10.1016/j.ijnurstu.2014.09.009

Zoe, R., Charalambous, C., Popi, S., Maria, R., Aris, V., Agoritsa, K., & Evangelia, K. (2014). Complementary Therapies in Clinical Practice Cypriot nurses ' knowledge and attitudes towards alternative medicine. *Complementary Therapies in Clinical Practice*, *20*(1), 89–92. https://doi.org/10.1016/j.ctcp.2013.08.003

APPENDICES

Appendix A: Letter of Introduction

UNIVERSITY OF GHANA
DEPARTMENT OF ADULT HEALTH
SCHOOL OF NURSING

Ref. No.: 10064400 October 14, 2019

The Chairperson
Institutional Review Board
Korle-Bu Teaching Hospital
Korle-Bu

Dear Sir/Madam,

LETTER OF INTRODUCTION

I write to introduce to you **Augustina Naa Shorme Noi**, an MPhil second year student of the School of Nursing and Midwifery.

The Scientific Review Committee of the School has approved the thesis topic: **"Experiences of Nurses Caring for Patients with Breast Cancer in the Accra Metropolis".**

I hope that the board will consider the proposal and grant her Ethical Clearance to enable her collect data.

Counting on your usual co-operation.

Thank you.

Yours faithfully,

Dr. Gladys Dzansi
Ag. Head of Department

COLLEGE OF HEALTH SCIENCES
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• **Email:** adulthealth.son@chs.ug.edu.gh • **Website:** www.nursing.chs.ug.edu.gh

Appendix B: Ethical Clearance – Korle Bu Teaching Hospital

In case of reply the number
And the date of this
Letter should be quoted
My Ref. No. KBTH/MS/983/19
Your Ref. No.....

KORLE BU TEACHING HOSPITAL
P. O. BOX KB 77,
KORLE BU, ACCRA.

Tel: +233 302 667759/673034-6
Fax: +233 302 667759
Email: Info@kbth.gov.gh
pr@kbth.gov.gh
Website: www.kbth.gov.gh

31st December, 2019

AUGUSTINA NAA SHORME NOI
DEPT OF ADULT HEALTH, SCHOOL OF NURSING
UNIVERSITY OF GHANA, LEGON

EXPERIENCES OF NURSES CARING FOR PATIENTS WITH BREAST CANCER IN KORLE BU TEACHING HOSPITAL

KBTH-IRB /000128/2019

Investigator: Augustina Naa Shorme Noi

The Korle Bu Teaching Hospital Institutional Review Board (KBTH IRB) reviewed and granted approval to the study entitled: "Experiences of Nurses Caring for Patients with Breast Cancer in Korle Bu Teaching Hospital"

Please note that the Board requires you to submit a final review report on completion of this study to the KBTH-IRB.

Kindly, note that, any modification/amendment to the approved study protocol without approval from KBTH-IRB renders this certificate invalid.

Please report all serious adverse events related to this study to KBTH-IRB within seven days verbally and fourteen days in writing.

This IRB approval is valid till 30th November, 2020. You are to submit annual report for continuing review.

Sincere regards,

DR. DANIEL ANKRAH
VICE CHAIR (KBTH-IRB)
FOR: CHAIR (KBTH-IRB

Cc: The Chief Executive Officer
Korle Bu Teaching Hospital

Appendix C: Consent Form

APPENDICES

CONSENT FORM

Title: Experiences of Nurses Caring for Patients with Breast Cancer in Korle Bu Teaching Hospital.

Principal Investigator: Augustina Naa Shorme Noi

Address: School of Nursing, College of Health Sciences, University of Ghana

General Information about Research

I will like to seek information from you pertaining to your experiences when caring for women suffering from breast cancer. The information that will be collected will contribute to the understanding of the level of knowledge the nurse has in caring for breast cancer patient, attitude of nurses towards breast cancer care, the subjective beliefs and the perceived behavioural control of nurses caring for breast cancer patients

I will have a face to face interview with you, and this will last for about forty five to sixty minutes in English, Ga or Twi Languages. There will be no right or wrong answer and therefore you should be free to share your views on the questions posed to you. The interview will be related to your experiences during the care given to women suffering from breast cancer. You will be asked to sign a consent form before the interview. With your permission, the interview will be recorded.

Possible Risks and Discomforts

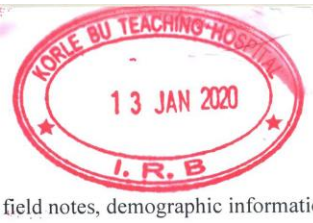
It is not expected you will be exposed to any danger by participating in this study. However should you become emotional during the interview section, the researcher will allow you to relax before continuing with the interview.

Possible Benefits

Participating in this study will enable the senior management team to understand the experiences of nurses caring for women suffering from breast cancer. Nurses may use the findings of this research to inform their practice and also, in evaluating the care given to patients with breast cancer.

Confidentiality

All information given would be held in confidence. Your name will not appear in any of the reports even though you will be audio recorded. The information given will be attached to a pseudonym or a code number. The researcher and her two supervisors are the only people who will have access to the information given by you either written or audio



recorded. Also the audiotapes, transcripts, field notes, demographic information and consent forms will be kept under lock and key. Permission will be sought from the Korle Bu Teaching Hospital Ethics Review Board.

Compensation

You will be provided with a hand sanitizer and snacks at the end of the interview as an appreciation for your time.

Voluntary Participation and Right to Leave the Research

Your participation in this study is voluntary, thus, you have the right to withdraw from the study at any point in time without any explanation. Also, your participation in the study or your withdrawal at any particular time will not affect your work in the hospital.

Contacts for Additional Information

You have the rights to contact any of the following persons should you have any questions or challenges pertaining to the study:

Augustina Naa Shorme Noi
School of Nursing, University of Ghana, Legon, Accra, Ghana
Tel: 0502304269/0242389635
Email: tinanoi73@gmail.com
Prof. Lydia Aziato
School of Nursing, University of Ghana
Tel: 0244719686
Email: aziatol@yahoo.com
Dr. Lillian AkorfaOhene
School of Nursing, University of Ghana
Tel:0246395696
Email: lohene@ug.edu.gh

Your rights as a Participant

This research has been reviewed and conditionally approved by the Institutional Review Board of Korle Bu Teaching Hospital for Medical Research (KBTH-IRB).If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline*0302666766 or email addresses: rdo@kbth.gov.gh*

Volunteer Agreement

The above document describing the benefits, risks and procedures for the research title (Experiences of Nurses Caring for Patients with Breast Cancer) has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

_____ _____

Name and signature or mark of volunteer Date

If volunteers cannot read the forms themselves, a witness must sign here.
I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

_____ _____

Name and signature of witness Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

_____ _____

Name Signature of Person Who Obtained Consent Date

Appendix D: Information Sheet and Interview Guide

SEMISTTRUCTURE INTERVIEW GUIDE

Code Number: .....

SECTION A: Demographic Information

Code number .....

Age: .....

Gender: .....

Ward/Unit: .....

Religion: .....

Ethnicity: .....

Educational level: .....

Years of Work Experience: .....

Years of Work in Cancer Settings: .....

Oncology Care Training (speciality)

Yes: .....

No: .....

Marital Status: .....

Family History of Breast Cancer: .....

SECTION B: Main Questions

1. Pleases share with me your views about breast cancer in Ghana.
2. Please tell me about the investigations used to diagnosis breast cancer.
    - Breast self examination
    - Other breast screening Methods
3. Please tell me how you manage patients with breast cancer.
    - Pain management
    - Chemotherapy
    - Radiotherapy
    - Surgery
    - Roles of the nurse
    - Supportive care
    - Palliative care
4. Tell me about the challenges faced in respect to others whiles caring for the patient with breast cancer.
    - Institutional procedures
    - Team members
    - Resources
    - Patient and relatives
    - Cost
5. What do you think would enhance your care of patients with cancer?
    - Training Opportunity
    - Equipments
    - Self efficacy
    - Support systems
6. What else do you want to share with me in terms of caring for patients with breast cancer?

Thank You.

Appendix H: Participants Biographical Data

Code Number	Age (Years)	Gender	Ward/Unit	Religion	Ethnicity	Educational Level	Years of Work Experience	Years of Work in Cancer Settings	Oncology care Training/Specialty: Yes/No	Marital Status	Family history of Breast Cancer
N1	59	Female	Radiotherapy Dept.	Christian	Ewe	SRN Certificate	34	20	No	Married	Present
N2	59	Female	Radiotherapy Dept.	Moslem	Ga Adangbe	Degree	33	20	Yes	Married	None
N3	32	Female	Radiotherapy Dept.	Christian	Akan	Masters	10	8	No	Married	None
N4	34	Female	Radiotherapy Dept.	Christian	Akan	Diploma	8	8	No	Married	None
N5	32	Female	Radiotherapy Dept.	Christian	Akan	Degree	7	7	No	Married	None
N6	46	Female	Radiotherapy Dept.	Christian	Akan	SRN Certificate	21	12	No	Married	None
N7	28	Female	ASW2	Christian	Ga Adangbe	Degree	3	3	No	Married	None
N8	36	Female	ASW2	Christian	Akan	Diploma	8	5	No	Married	None
N9	28	Female	ASW2	Christian	Ewe	Diploma	3	2	No	Not Married	None
N10	40	Female	ASW2	Christian	Akan	Masters	18	8	No	Married	None
N11	37	Male	ASW2	Christian	Akan	Degree	10	7	No	Married	None
N12	51	Female	ASW2	Christian	Ewe	SRN Certificate	23	20	No	Married	None
N13	34	Female	ASW2	Christian	Ga Adangbe	Degree	10	7	No	Married	None