

## SAMMENDRAG

Introduksjon: I Finnmark har de fleste kommunene spredt bebyggelse, isolerte, ubebodde strekninger, og fjelloverganger som ofte er kolonnekjørt, eller stengt vinterstid. Dette kan medføre isolasjon og daglige utfordringer med avstand til fagmiljø og sykehus. Disse spesielle forholdene gjør at sykepleierne må være selvstendige i større grad enn andre steder.

Formål: Hensikten var å utforske distriktsykepleiernes utfordringer i palliativ kreftomsorg, og undersøke forutsetningene for å opprettholde faglig forsvarlighet.

Metode: Studiet er kvalitativt med et eksplorativt design, og rapporterer resultatene fra innholdsanalysen av intervjuer med fem sykepleiere, bosatt i små, multi-etniske samfunn.

Funn: Hovedfunnet i studiet er at sykepleiere i distriktene, som utøver palliasjon til pasienter med kreft, rapporterte at de var alene; geografisk og profesjonelt. Den etablerte infrastrukturen for å utføre avansert sykepleie på pasientens hjemsted er ikke tilpasset de geografiske og faglige forutsetningene i distrikt som Finnmark, og suboptimal informasjon om ferdigbehandlet pasient fra sykehusene gjør at kvaliteten på omsorgen kan bli kompromittert. Det utøves avansert sykepleie der spesialistene er langt unna, og sykepleierne mangler lokale palliative team å støtte seg til. Pasientene er ofte familie, venner og bekjente, noe som medfører rolleklarhet og fare for overinvolvering.

Konklusjon: Studien viser at anbefalinger for å styrke palliativ kreftomsorg er etablering av palliative team, epikrise som følger pasienten, nødvendige medikamenter og medisinsk utstyr til flere dagers forbruk, samt opplæring av personell.

Nøkkelord: Kommunehelsetjeneste, palliative team, distriktskommuner, distriktsykepleie, Samhandlingsreformen

## ABSTRACT

**Introduction:** In Finnmark, the northernmost county of Norway, many villages are remote and scattered between vast stretches of uninhabited land, with mountain crossings that are often closed in winter or where one can only drive in single file behind a snowplough. This may mean periodic total isolation and daily challenges with long distances to other professionals and hospitals. These special circumstances mean that nurses must act more independently than elsewhere.

**Objectives:** The aim was to explore the challenges of rural nurses in palliative cancer care, and the prerequisites to maintain a suitable professional standard in their nursing.

**Methods:** This study is qualitative with an explorative design, and reports the results of the content analysis of interviews with five nurses, living in small, multi-ethnic villages.

**Findings:** The main finding of the study is that the nurses experienced themselves as being alone geographically and professionally in their practice of palliative care. The established infrastructure for performing advanced nursing in patients' homes is poorly adapted to the geographical and professional situation in rural areas such as Finnmark, and suboptimal information about patients arriving from hospitals can compromise the quality of care.

Advanced nursing is performed when specialists are far away and there is no palliative team, and they caring for patients who are often their family members, friends and acquaintances, which involves role ambiguity and a risk of over-involvement.

**Conclusion:** The study shows that requirements to enhance palliative cancer care are to establish palliative teams, discharge summaries present in transition, the necessary drugs and medical equipment for several days, and relevant training of personnel.

Keywords: community health, palliative team, rural and remote communities, rural nursing, healthcare reform

## INTRODUCTION

The demand for palliative care is increasing worldwide due to the ageing population and greater longevity with chronic or deadly diseases (1-7). The Care Coordination Reform in Norway stipulates that hospitals will continue to provide specialist care, but patients will be discharged earlier to return to primary care for the final phases of their treatment and follow-up care (8). Consequently, the local patient population has increased, primary treatment is more advanced, and patients are more treatment-intensive than before (9).

Kaasa describes how palliative teams primarily provide specialist care in Norway, as in the other Nordic countries and elsewhere (10). These teams are interdisciplinary and have broad expertise in palliative care; they are based in a hospital, but also visit patients at home and in nursing homes as well as providing consulting in the hospital. They consist of a physician, nurse, physiotherapist, social worker, priest and others in order to meet the complex needs of the patient and family in the final phase of life. The support from the palliative team can enhance the ability of GPs and nurses to provide effective palliative care (6,10-12). Palliative cancer care is particularly challenging. In cancer patients, causes and effects in treatment may be unclear and overlap. The treatment may alter the symptoms and lead to new conditions. Complex mental, social and existential issues can also aggravate the symptoms, and require a high level of organization and coordination of care. Such complexity of patient treatment is even more challenging in a rural context where nurses are based far from patients' homes (6,13,14).

This study was conducted in a rural and remote county. Wakerman defines a remote community as one with a distance of 80-400 km or 1-4 hours' journey in good weather to the nearest large hospital and a population density below 15 per km<sup>2</sup> (15). Finnmark has an area of 48 637 km<sup>2</sup>, but also has the smallest population of Norwegian counties at 76 228, giving a

population density of 2 per km<sup>2</sup> (16). The county is divided into 19 local authority areas, ranging in size from 555 km<sup>2</sup> to 9700 km<sup>2</sup>. There are six towns; the smallest has 2110 inhabitants and the largest has 20 635 (16,17). By comparison, the area of the capital Oslo is 454 km<sup>2</sup>, with a population density of 1462 per km<sup>2</sup> (17). All parts of Finnmark have scattered settlements, vast stretches of uninhabited land, difficult mountain roads that are often closed in winter and island communities only accessible by boat. Snow cover can last from October to June, and in December and January, it is dark almost 24 hours a day. The weather is unstable; calm, fine weather can quickly change to strong wind with drifting snow and very poor visibility. The population is multi-ethnic, including Sami, Norwegians, Finns, Russians and other nationalities. Seventy percent of the population live in thinly populated areas. The population in the study area has a four-hour journey on average to the nearest hospital, in good weather, with several mountain roads in some areas. Several villages have a health centre and nursing homes where home care nurses are based. In one location, nurses have to drive 100 km to reach their patients. Public transport may be limited to return journeys once or twice a week, and many places are without an airport. All local authorities have GPs and nurses on shift duty, but some do not have 24-hour services in all areas.

The aim of this study is to explore the challenges faced by nurses in providing palliative cancer care in the northernmost part of Norway. There have been few studies in Norway of this particular nursing context (18,19), but more studies have been conducted in Canada, the USA and Australia on nurses' working conditions in rural palliative care (20-24).

The research questions are:

- What challenges do rural nurses face in their efforts to care for palliative cancer patients?

- What is required for palliative cancer care to be of an adequate professional standard in a remote context?

The study aim is to provide new knowledge of the challenges of nurses in palliative cancer care in Finnmark, and the prerequisites to maintain a suitable professional standard in their nursing.

## METHOD

This was a qualitative study with an explorative design (25). We wished to examine the challenges nurses meet in palliative cancer home care and how the circumstances affect their possibility to provide professional care. The first author is a cancer nurse with ten years of experience from a local hospital and a cancer outpatient clinic, where cooperation with nurses in such areas formed part of her daily work. This study reports the results of interviews with five nurses with broad experience of cancer nursing in rural and remote areas, but the observations of the first author also serve as crucial background information for this study. The fieldwork was conducted in connection with a master's thesis (26).

The sample was strategic (27) in the sense that we recruited participants that had relevant experience for the research questions. Leaders of care services in ten of nineteen local authorities were asked by email for assistance in recruiting participants. After reminders were sent, five female nurses responded and were included after receiving an information letter.

The participants worked in palliative care in western and eastern Finnmark, and had at least two years' experience of providing palliative cancer care in these areas. The age range was

36-54 years, and the average length of nursing experience was 15.2 years. Two had further education in cancer care (Table 1).

(Table 1) in here:

The 60- to 80-minute semi-structured in-depth interviews took place at the participants' workplaces during two weeks in October 2015. An interview guide with open questions and follow-up topics was used. The interview started with "Please tell me about your experiences with palliative cancer care in your municipality" and "Are there any things that you find particularly challenging?". Participants were engaged in the topic and spoke freely. Follow-up questions were added as needed, such as "How do you feel about being alone in such difficult situations?". The interviews were recorded and transcribed by the first author.

## Research ethics considerations

The study followed the Helsinki Declaration and was approved by the Norwegian Centre for Research Data, number 43860, based on voluntary, informed and signed consent. Data collection was anonymized and data were stored in accordance with the Personal Data Act (28). Participants signed voluntary, informed consent forms with the possibility to withdraw from the study at any time. They were offered to read the transcriptions to clarify misunderstandings, but none of them did so. Quotes are marked with letters and numbers to ensure anonymization.

## ANALYSIS

Graneheim and Lundman's content analysis model was used (29). All authors analysed and discussed the transcriptions in several rounds. Raw text as meaning units was condensed and

interpreted, formed into sub- and main themes separately and then together until consensus was reached.

(Table 2) in here:

## RESULTS

The results are presented based on some sub-themes that emerged from the analysis (Table 2).

The main finding of the study is that the nurses experienced themselves as being alone, and they described two different modes of being alone: 1) geographical distance from a hospital, palliative teams and colleagues when visiting patients in remote areas, and 2) professional distance from colleagues, and poor access to information during transition of patients to home care. A further finding was 3) that they reported closeness to the patients and knowledge about the local community, which led to contradictory challenges in the distinction between their professional and private lives.

### Geographical distance

Remote locations and adverse weather conditions represented great challenges for nurses in palliative home care. Several participants pointed out challenges in winter, such as mountain roads, harsh weather and long distances, in their efforts to maintain continuity of care when visiting patients in their homes. Three of them described this as follows:

In the winter, it's a challenge to drive across the mountains. It's not always that easy to get there and back. We had a woman out there who was having IV treatment. She was having chemotherapy here (in the clinic) once a fortnight, and IV treatment at night at home. Then what actually happened was that we drove out to her, connected her IV, but we couldn't be sure of getting back there when it was to be disconnected or if her alarm went off at night. We couldn't be sure we'd be able to get there the next morning either. This was mid-winter and the weather was very unstable at that time (N3).



It's 40 kilometres to Nedrebygd. There are 30 inhabitants, and it may be challenging in winter if someone wants to die at home. Then an oncology nurse or assistant nurse would have to spend the night with the patient until the next day and go back with the snowplough. The road's often closed and there are avalanches (N5).

I dread the day when they (the patients) get so ill that they need help from home nursing. Then it looks like we'll have to use the snowmobile to get across the mountains (N4).

In some areas, there were small island communities that were only accessible by boat; this was public transport but did not run every day. The authorities could not offer daily home care:

They cannot get that service. It's impossible with this boat. We don't really have any regular nursing service out there on the islands. (...) People who cannot continue to live in rural areas like this are offered a place in a retirement home or care home, if they don't stay in the local health centre (N1).

This quote shows that patients could receive care, but not at home. They had to move to the local administrative centre when they needed assistance. Lack of daily public transport and bad weather can prevent home care nurses from reaching patients at the agreed times, and for islanders, care services must be adapted to the possibility of transport to the islands. Patients who lived near the health centre could receive care at any time of the day or night, unlike those living in outlying areas.

Not only was the infrastructure a problem in everyday, planned care provision, but also in emergencies, as one participant describes here:

This winter we had a situation when the roads were closed. We often use the rescue boat as a sea ambulance. That didn't work because in the bad weather they expected it to take 7 to 8 hours to get to the local hospital. The helicopter couldn't land here. Then we're stuck. It's really a desperate situation. We eventually tried to arrange transport if the helicopter managed to land. They have an anaesthetist who can come and treat the patient on the spot. But that was impossible. When the helicopter could finally land here, the airports in Hammerfest and Tromsø were closed, so they had nowhere to take the helicopter. So then, you're helpless (N1).

Such situations mean that nurses and GPs must administer life-saving, stabilizing treatment and keep patients for some time until transition to hospital.

The care and treatment offered depended on where patients lived. The peripheral parts of the areas covered by the participants did not have a night service. Some local authorities did not even have regular daily home care. Consequently, GPs and nurses had to create local, sometimes suboptimal, adaptations for patients.

One participant recalled an episode where she had to fetch a patient from his home one night. She was the only nurse on duty and was responsible for patients both in the nursing home and in their homes. She judged that this patient could not be at home alone without supervision. She said:

...I put the patient in the council van and drove him straight up here to the nursing home and fixed up a bed in the corridor (N4).

This nurse faced a typical ethical dilemma often found in small local authorities without permanent night duty for home care. She felt unable to stay with the patient in his home despite his needs, yet she was responsible for all the nursing home patients. This patient needed regular supervision, which could only be provided at the nursing home.

## Professional distance

Nurses in remote communities must be solution-oriented and see the possibilities in the local situation because of the distances. They are often far from a hospital and the only GP may not be available.

...and then as for the GPs, if the GP leaves with the ambulance, he may be away for several hours and then you're the only clinician on duty in the village (N2).

With cancer patients, things may be unpredictable at the end. Acute conditions may develop with new symptoms. We see seizures, breathlessness, haemorrhages and many things that come suddenly. Then we have to be a bit prepared, so we always plan so we've got things pre-prescribed in advance so they're available if we need them (N2).

These quotes demonstrate rural nurses' complex professional, ethical and moral challenges. They solved the problem of the GP who had to leave in the ambulance by obtaining pre-prescribed palliative medications for possible acute situations. The participants' recounted episodes where they had sole responsibility in emergencies, and therefore needed action competence and the ability to initiate action with what they had. In home care, they may be alone without a GP for several hours when the GP is out on an emergency call.

The nurses mentioned cases where they had to provide training to the patient's family and friends. One patient needed IV treatment at home following chemotherapy, and since the weather made the nurses unsure about reaching the patient's home, they taught the patient's daughter-in-law the necessary procedures:

“... she wanted to lend a hand to her mother-in-law” (N3).

In another case, neighbours who were healthcare professionals helped in their spare time.

Participants expressed frustration that patients did not have discharge summaries from the hospital or that these were incomplete. They then had to deal with patients without knowing the treatment they had received, the follow-up care needed, and any further plans for the patient. This represented poor cooperation between professionals in what should be a seamless transition from hospital to home.

People who are ill shouldn't be responsible for giving us this information ... for many years this has actually been our biggest frustration ... communication, especially with hospitals. It's not that they're unwilling but you can't get hold of the right people to answer your questions (N1).

There's also a challenge concerning discharge summaries when they (patients) come from hospitals. The summaries don't arrive soon enough. They're not written until some time has passed. I spend a lot of time calling hospitals and clinics. Many people get palliative treatment and chemotherapy treatment. Something must be done about getting these discharge summaries. We don't get them from the clinics, and patients aren't always sure about what treatments they've had and why and how many they have left. They can't remember everything (N5).

Participants also reported the lack of an equipment store and a local pharmacy. They expressed concern that patients were at risk of not receiving necessary treatment when the planning of their return home did not take into account the remoteness of their home. If there is no local pharmacy, it may take days or weeks to receive vital medicine and equipment.

Participants reported cooperating with three hospitals that all had different procedures. Patients might arrive from hospital with unfamiliar medical equipment (e.g. an epidural pump) or treatment might be planned without knowledge of the locally available equipment. However, sometimes the nurse from the hospital accompanied the patient and trained the local nurses in the relevant procedures. In other situations, they had to improvise:

Once I called the regional hospital, in the middle of the night, for instructions on CPAP without success, so then I had to go to YouTube (N2).

All participants reported that the cancer nurse or a specially trained nurse was in charge of the training when patients with new equipment arrived or in cases where special observations were necessary. It can have serious consequences for patients if nurses cannot provide the necessary care and treatment. In summary, these three quotes are examples of how patient safety can be jeopardized.

When asked whether they cooperated with the local hospital, several participants answered that they found it easier to contact the regional hospital than the local one. One reason mentioned was that the regional hospital had a cancer ward, oncologists and a palliative team

who could answer their questions. They used the telephone and had established regular telemedicine meetings to cooperate with oncologists at the regional hospital.

We have had audio-visual communication with the hospital in Tromsø for many years. In this way, a patient with prostate cancer received an assessment leading to termination of chemotherapy. Both he and his wife were happy with this and the fact that they did not have to make the long journey to the hospital (N3).

The participants said that local hospitals in Finnmark had no palliative teams, and no oncological wards or palliative units. The patients came from general wards of local hospitals. It was therefore somewhat arbitrary which clinicians had treated these patients. However, several participants reported good cooperation with GPs in the same local authority, and some GPs were even on call day and night for palliative care.

### Closeness to the local community

The participants often found that their patients were relatives, friends, neighbours and acquaintances. It could therefore be difficult to separate private and professional life in many situations, for both nurses and villagers. Patients' knowledge of the nurses in a private setting in the community affected their perceptions of the nurses as professional:

...as you know, everybody knows everybody. I have actually experienced in home care that a patient denied a nurse access to her home, for private reasons, despite the fact that she had cancer and needed home care (N1).

Another participant told about a situation where a good friend wanted her to have sole responsibility for her treatment, but she found this difficult. She felt that she was expected to help since she was the patient's friend, but she had to follow her plan for the day, regardless of whether the friend was included in the plan or not. This is an example of the type of dilemma nurses face in small villages.

One participant recalled an episode at work when a patient was being transferred from hospital; she had been told on the phone that his treatment was no longer curative and that he would soon die of the disease. The patient was her father-in-law. She said:

Then I knew it before the rest of the family. Not particularly pleasant but not that unexpected either. Things like that are a bit extraordinary (N2).

When we know the patients in private and meet them in a treatment situation, it's difficult when they start talking privately about other patients. How much can I say without seeming dismissive... (N3).

These are small closely-knit villages, so people can't always see that you're a cancer nurse at work and a private person and the mother of two children when you meet them in the shop (N5).

The distinction between private and professional is a familiar phenomenon for the nurses, although it can be difficult to maintain a clear professional role in small communities. (Table 2). Four of the five participants (N1, 2, 3 and 5) mentioned mixing of professional and private roles as a challenge. One participant was not local and found it straightforward to set limits for patients, because she had no connection to them (N4), (Table 2).

## DISCUSSION

The study findings show that rural nurses providing palliative cancer care in patients' homes found themselves isolated both professionally and geographically. The distinction between the professional and private role in relation to the patients was challenging but also offered some advantages. Despite these challenges, the nurses worked hard to provide home cancer nursing, which is a prerequisite of the Care Coordination Reform. However, the experience from Finnmark was that the infrastructures established to ensure safe and equally distributed health services were insufficient to compensate for the distances involved and the requirements for safe palliative care.

## Distance and Closeness

Nursing practice in rural and remote areas requires good knowledge of the infrastructure, environment, terrain, shifting seasons, family structures, patients' networks and the voluntary organizations or private individuals that can provide additional support.

In such areas, both nationally and internationally, patients and palliative care providers must travel great distances to receive or provide treatment and care (19-21) (Table 2). Nurses in general are familiar with everyday time pressure, but the difference for nurses in our study, is that when visiting one patient, weather conditions may prevent them from reaching the next patient, which is also seen in studies from Canada and Australia (21,30). When they are stuck in a snowstorm and have to ride with the snowplough in avalanche-prone areas, and spend the night in the patient's house, this far exceeds normal working hours, and they place themselves at risk. This, in turn, could be stressful for a nurse who will not reach the next patient and may be concerned about her loyalty to her colleagues and family. In such situations a multidimensional cross-pressure may occur (31). However, the participants did not make an issue of this, perhaps because that was the normal situation. Nurses often go beyond the resources available in primary care to ensure quality in home care (11). They do what is expected of them as nurses in order to fulfil their societal duties, which are stipulated by law (32,33). For altruistic or ethical reasons, nurses sometimes stay with a patient or, as one participant described, take a patient to the nursing home without consulting the doctor. The nurses have to trust their own decisions because they are sometimes the only nurse available. Johansen and Ervik (18) refer to similar situations in northern Norway where oncological nurses were unable to contact GPs for necessary clinical discussions. The nurses felt left alone with seriously ill patients, waiting for solutions. This implies considerable responsibility for nurses, who have to make assessments normally made by a GP. Characteristic of the phenomenon of rural nursing is that nurses work alone and independently. They have no

colleague present to consult with and must be able to start emergency treatment while waiting for the GP, who may be far away (34,35).

The participants gave examples of situations where they had given training to relatives, friends and neighbours of the patient. Research from other countries shows that voluntary, informal helpers are commonly used in rural and remote areas (22,36-37). To maintain ethical standards regarding patient anonymity involves treading a fine line, and the use of volunteers and informal helpers complicates this matter further. In some cultures, patients do not mind if neighbours are involved, while this can be of great importance in other cultures (38-39).

These are ethical dilemmas in terms of confidentiality, policy statements on access to professional palliative care and the protection of patient autonomy.

When the requirements for good palliative home care involve a professional standard (11) with qualified staff (10), one may wonder whether it is advisable to use private individuals to provide care and especially to perform specialized tasks such as IV treatment and symptom relief. Due to the complexity of these care situations, carers need specialized training. This presupposes that both patient and relatives are clearly informed of possible risks and sudden clinical changes, when the patient chooses to stay at home. The nurses and GP who provide the training will therefore have a particularly great responsibility in terms of the quality of the information and training, and the subsequent monitoring. The part of the care the helper will be responsible for is an important factor. If the alternative is hospital admission, the patient may prefer the help available at home, although not provided by professionals.

Nurses in small closely-knit communities know most of their patients personally (3,34). One participant told of a situation in which she is admitted to a patient with a serious diagnosis, and this is her father-in-law. Urban nurses can refuse to participate in care of people they know, because there are other nurses on duty to take over. Our participants may be the only



nurse on duty and must also cope with such difficult situations. In these areas where everyone knows everyone else, this can increase pressure on nurses; whether a patient improves or dies, everyone will know who the nurse was (2,30,34,40). In this way, nurses can encounter both stigmatization and glorification, which can increase pressure on their own and others' expectations. The high visibility and attentiveness of palliative care nurses, coupled with little anonymity and privacy, could lead to burnout and greater nurse turnover.

### Requirements for a professional standard of palliative cancer care

The findings reveal several examples of challenges connected to transitions. Given the long distances to the main village and the nearest hospital, it can have serious consequences for patients if nurses are unaware of planned interventions (Table 2). Good interaction and cooperation between healthcare levels is necessary to provide patients with professional treatment. Nurses in general are dependent on a good flow of information between the levels (12,41). The Norwegian National Action Plan for Palliative Cancer Care states that all staff should have professional qualifications, knowledge, skills and attitudes as a prerequisite for optimal palliative care (11). In addition, the Care Coordination Reform (8) has a sound objective of patients receiving treatment at the lowest possible level of healthcare, but the participants reported that this intention did not work as expected, because of the complicated infrastructure, conditions and few specialists. Clinicians cannot expect and take for granted that relatives or neighbours are ready to take care of palliative patients, even though the new health reform implies this. A safe transition from hospital to home is essential, and home care staff have to be informed and prepared for this.

In a study from Canada, Pesut et al. (40), show that rural nurses often lack palliative teams to support them, which increases their feeling of sole responsibility. Higginson and Evans (6)

found that specialized palliative care should be part of cancer care because patients treated by palliative teams showed improved pain and symptom control, which in turn led to fewer hospital admissions. In addition, this will save the patients from unnecessary exhausting journeys, when they want to spend their last days at home, and reduce admissions.

In many towns where specialists are available, interdisciplinary teams are established, but this is often a challenge in rural areas, which tend to have few or no specialists (20). The participants reported a lack of palliative teams in hospitals. This can compromise the measures needed to transfer patients to their homes, because of poor coordination and preparations such as ordering equipment and medications for the patients' home. If established, such teams in local hospitals can contribute to the seamless transition of patients, which is one of the objectives of the Care Coordination Reform (8). Two studies have confirmed that cooperation works in cancer care in other parts of Norway, where a well-qualified team prepares patients' return to primary care (12,41).

Ray et al. state that education via video conferencing provides clinicians with the confidence to deliver palliative care in remote areas (42). The use of information and communication technology (ICT) requires up-to-date equipment and expertise. However, Huemer and Eriksen concluded in their study that lack of competence, user interface, time and economic factors were challenges associated with the implementation in Finnmark of ICT as introduced in the Care Coordination Reform (8,43). According to recommendations by Bakitas et al. (44), it is possible to provide specialized care in such areas by using telemedicine, professional support, and supervision. However, telemedicine can never replace face-to-face meetings, and the feeling of being alone when one shuts off the screen, and are alone with patients and family who have received bad news.

More research is needed on patients' and their relatives' experiences of palliative care in rural and remote areas.

## LIMITATIONS

A strength of the study is that the participants were recruited from different parts of Finnmark and only from communities with a population below 4000 and without a hospital nearby. The data were therefore rich in the sense that a broad range of experiences was documented. The study had few participants, but all participants had long experience (Table 1). The results provide insight and descriptions of the practice of palliative care in Finnmark (Table 2). We cannot say whether these experiences are common to this group of nurses, but we can conclude that they are typical in the sense they are recognizable for nurses in similar settings. Nurses working under similar conditions will recognize the participants' descriptions of their everyday work, and nurses in specialist healthcare can benefit from learning the necessary measures for the efficient transfer of patients from specialist to primary care. The first author has the benefit of knowing the field both geographically and professionally, with experience from hospitals and cooperation with primary care for several years. Such an advantage could also be considered as bias because of the author's pre-understanding.

## CONCLUSION

This study shows that the established infrastructure for performing advanced nursing in patients' homes is poorly adapted to the geographical and professional situation in rural and remote areas such as Finnmark. Requirements to enhance palliative cancer care are palliative teams, improved conditions such as the provision of discharge summaries, the necessary drugs and medical equipment for several days, and relevant training of personnel.

Establishment of palliative teams in local hospitals to cooperate closely with primary healthcare would enhance the care provided by nurses, and reduce admissions that are unnecessary for patients and hospitals.

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