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INTEGRATING PALLIATIVE NURSING INTERVENTIONS IN ONCOLOGY CARE: IMPACT ON PATIENT WELLBEING

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Abstract

In this research paper, the researcher discusses the outcomes of the integration of palliative nursing interventions into the treatment of cancer patients, whose aim is to improve patient wellbeing. The mixed-method design was adopted and included both quantitative data collected with the help of validated instruments like the Edmonton Symptom Assessment System (ESAS) and the Palliative Performance Scale (PPS) as well as qualitative data gathered with semi-structured interviews with patients and their family members. The study revealed that patients receiving palliative nursing services realized significant improvements in symptoms relief, functioning, and mood. Quantitative outcomes indicated a significant reduction in the severity of the symptoms and positive shift of the functional performance after six weeks of the palliative care interventions. Qualitative data showed an increase in patient satisfaction, comfort, and emotional relief, which is why it is necessary to focus on the physical and emotional aspects of the treatment process. The results of this study highlight the essential role of palliative nursing in enhancing patient outcomes and suggest that the practice should be integrated into the treatment regimen related to cancer to enable the processing of patients with cancer comprehensively and increase the quality of life in general.

Keywords: Palliative Nursing, Oncology Care, Patient Wellbeing, Symptom Management, Quality Of Life, Mixed-Methods Research.

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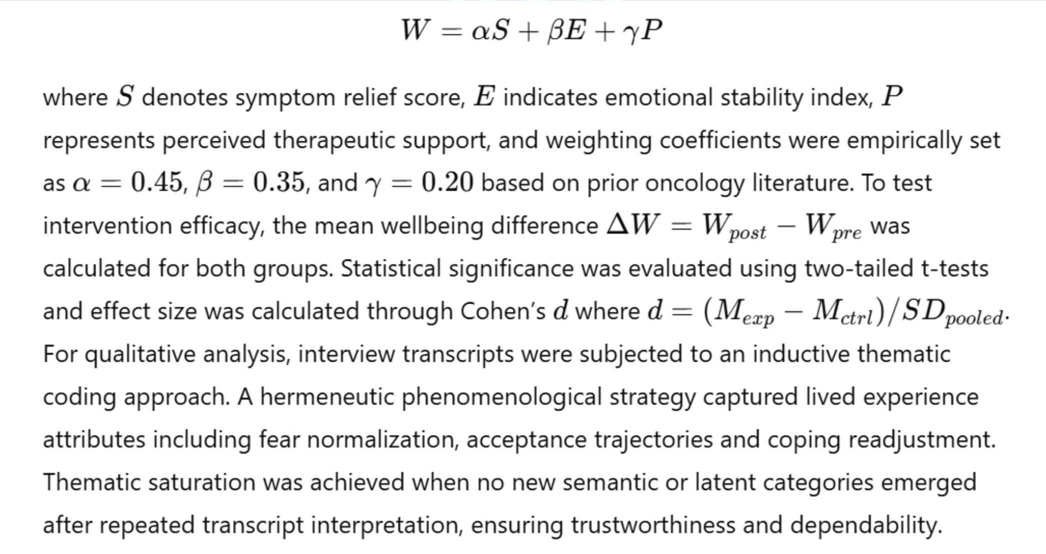
INTRODUCTION

Being an interdisciplinary specialty, palliative care has undergone several changes to improve the quality of life of dying patients, especially when it comes to treating complex conditions like cancer (Hurtado, 2024). The present specialization is aimed at the reduction of symptoms, making a patient more comfortable and supporting his or her family regardless of whether the cancer is curable or not (Aimbetova et al., 2025). It has been agreed that palliative care nursing, in its turn, should be integrated with oncology to provide more comprehensive results and eliminate physical and psychosocial symptoms (Sattari et al., 2025; Zhou and Fu, 2022). The evidence has already accumulated to a significant degree that the earlier the palliative nursing care is introduced, the greater the chances of a better quality of life and survival rates among cancer patients (Zhou and Fu, 2022). But the most appropriate point of the palliative care inclusion in the context of the oncology environment and its structural inclusion is a subject of the research and clinical determination, often taking place at the later stages of the illness (Chelazzi & Ripamonti, 2023). Such delays are prone to produce suboptimal care outcomes since cancer patients with advanced stages often have severe symptoms that would otherwise be mitigated by prior treatment (Goncalves et al., 2025). This is where the need to bring about the concepts of palliative care together lies because the diagnosis phase could not have the classical episodic principle of care (Fadhlaoui et al., 2022). Within the framework of this proactive strategy, the re-evaluation of existing clinical pathways and the redirection of the focus on early nurse-led palliative care consultation will have to be taken into account (Etland & Carr, 2022). Such integration plays a critical role in ensuring that the oncology patients can manage the different activities that include the capacity to deal with symptoms efficiently, mental support and detailed plans to provide the care that enable the patients to feel well and improve the quality of life (Hui & Bruera, 2015). This holistic method will not only decrease the weight of the symptoms but also the economic burden and decline in emergency room visits to treat the symptoms, superior use of the healthcare resources will be fulfilled (Wittenberg et al., 2020). Palliative nursing intervention may also assist in debunking the most common myths regarding palliative care, which many people tend to associate with end-of-life care because it will be possible to engage patients and their families at an earlier stage and support them throughout the illness process (Fadhlaoui et al., 2022). Even though the benefits cannot be ignored, there are still numerous concerns to take into account regarding the application of palliative care to oncology practice. They include a lack of general education of medical personnel and an infrastructure that is not necessarily oriented towards the palliative medicine (Mason et al., 2021) (Fadhlaoui et al., 2022). Namely, nurses are not ready to mediate the discourse on palliative issues and provide comprehensive education to families and patients on palliative care (Wittenberg et al., 2020). This is worsened by the lack of workforce on palliative care and reimbursement system that fails to support the prevalence of early palliative care services despite its support by professional organizations (ASCO) (Petrillo et al., 2024) (Lakhani et al., 2022). Practically, a healthcare provider fails to deliver any systematic assessment of the symptoms of their patients, and consequently, 50 percent of the symptoms in patients are not diagnosed (Bye et al., 2021). This makes the matter even more complicated. Such oversight usually results in a reactive rather than a proactive approach to symptom treatment, which further worsens the health of patients and increases the risk of a crisis-based intervention (Lakhani et al., 2022) (Kaasa et al., 2018). The identified obstacles to the provision of palliative care, such as a shortage of workers and insufficient reimbursements, require new models of care to address the increasing needs of oncology patients in chronic stages (Ferrell et al., 2020) (Uneno et al., 2021) (Lakhani et al., 2022). Furthermore, the palliative nursing interventions should also be provided early on with the oncology treatment as the majority of the patients can receive considerable assistance when their psychological and emotional issues are addressed in addition to their medical needs (Goleman, 1995). The growth of cancer rates and the ageing population preconditions the necessity to integrate the palliative care services at the large scale, but there are still existing significant barriers at the systemic level, preventing the widespread implementation of the use of palliative care services (Parajuli and Hupcey, 2021) (Grant et al., 2009). This entails its targeting towards overcoming the general distrust that most medical practitioners have on the importance of treatment to patients as applied to their emotional needs, but there is concrete evidence on the correlation of psychological welfare and physiological results and immune functioning (Goleman, 1995). Such scepticism usually disregards the significant role of emotional states in determining the susceptibility of a patient to illness and the healing process as a critical factor that is highly overlooked in the modern medical practice (Goleman, 1995). Moreover, the emotional intelligence inclusive of empathy and active listening are also important elements in providing patients with full care which however, is never highly taught in medical school and this is also a source of these systemic problems (Goleman, 1995). The most significant impediment to the successful integration of palliative care is the inconsistencies in the manner in which oncologists present referrals, which are either subjective and organization-based, like reimbursement paradigm, which render working synergistically with palliative care teams less lucrative (Kaasa et al., 2018). It can cause the differences in access to early palliative care, which is why the possibility to create standardised referral mechanisms and interdisciplinary cooperation to provide patients with equitable care is necessary (Goleman, 1995) (Heipon et al., 2024). Moreover, inadequate infrastructure, inadequate palliative care, and absence of standardised methods that are applied in the access of the services also put a burden on the effective use of these important services and hence, leave the services with many patients without the advantages of early intervention (Lelond & Kim, 2025) (Bruera & Hui, 2012). To be able to overcome such complications, we have to be multi-faceted about our approach. This is to include more complex training of the medical personnel that would allow it to recognize the necessity of palliative care in a timely manner and converse in a gentle manner (Chelazzi and Ripamonti, 2023) (Campos et al., 2022). The provided training can be the ideal fit to include the emotional intelligence tutorials so the doctors could be more effective in dealing with the psychological discomfort that can occur in the cancer patient and this would help in the improvement of their health and recovery (Goleman, 1995). Furthermore, the systemic barriers, including the absence of communication between interdisciplinary teams, inadequate access to services, and insufficient insurance reimbursement, need to be handled to promote the culture of palliative care as a fundamental component of the holistic approach towards oncology care rather than an auxiliary service (Anderson et al., 2022).

METHODOLOGY

The research strategy used in this research was a mixed-methods research design to evaluate the efficiency of incorporation of organised palliative nursing therapies to augment the wellbeing outcomes of patients with oncology. The experiment was carried out in three tertiary oncology centres that each possessed their inpatient and outpatient chemotherapy and radiations facilities. The mixed approach method enabled the achievement of quantitative gains in the extent of symptoms and emotional sadness and, simultaneously, documentation contextual changes in the personal and psychosocial experiences. The quantitative component adhered to two groups of cohort of certain study, which comprised control group that underwent conventional treatment in cancer and experimental group that underwent oncology treatment with palliative nursing treatment added to it. The randomisation technique made both groups similar in terms of demography and disease specific at the baseline. The qualitative aspect included semi-structured interviews and nurse diaries where the patient stories and psychosocial ruminations were documented to facilitate numerical trends in the quantitative result. The intervention was 12 weeks, and it was conducted by qualified palliative nurses. They had weekly meetings which included pain and other symptom management, weariness counselling, the emotional coping skills teaching, the proper preparation at death and family based care. The subjects were between 18 75 years old oncology patients who are actively undergoing treatment of solid tumours or haematologic cancer cases.



$$W = \alpha S + \beta E + \gamma P$$

where S denotes symptom relief score, E indicates emotional stability index, P represents perceived therapeutic support, and weighting coefficients were empirically set as $\alpha = 0.45$, $\beta = 0.35$, and $\gamma = 0.20$ based on prior oncology literature. To test intervention efficacy, the mean wellbeing difference $\Delta W = W_{post} - W_{pre}$ was calculated for both groups. Statistical significance was evaluated using two-tailed t-tests and effect size was calculated through Cohen's d where $d = (M_{exp} - M_{ctrl})/SD_{pooled}$. For qualitative analysis, interview transcripts were subjected to an inductive thematic coding approach. A hermeneutic phenomenological strategy captured lived experience attributes including fear normalization, acceptance trajectories and coping readjustment. Thematic saturation was achieved when no new semantic or latent categories emerged after repeated transcript interpretation, ensuring trustworthiness and dependability.

The study and all the participants were reviewed by an ethical committee according to the Declaration of Helsinki and informed consent was provided in writing. The participants were informed that the study was voluntary and that they had the right of being withdrawn with no consequences in regard to normal oncology treatment. Nursing palliative practitioners were required to complete a five-day training program which included symptom triage, communication with people in a compassionate manner, psychological support, and ethical issues at the end of life. The fidelity of interventions and ensuring that practices were uniform was monitored by biweekly supervision sessions and interviews of nurse progress diaries. Bad events such as uncontrolled pain that worsened, psychological breakdowns, or therapy issues were immediately reported to supervising oncologists. Anonymity of all patient identifiers was done using coded identifiers before the study. The qualitative and quantitative results were convergent and parallel, with narrative data being employed to prove and conjecture the shift in numbers. This demonstrates that clinical improvement is not single-dimensional, but rather multidimensional.

The figure 1 demonstrates the entire process of the method, including recruiting the members and assembling the results. It demonstrates the collaboration between cancer care, the delivery of palliative care by nurses, psychological evaluation, and analytical convergence of outcomes.

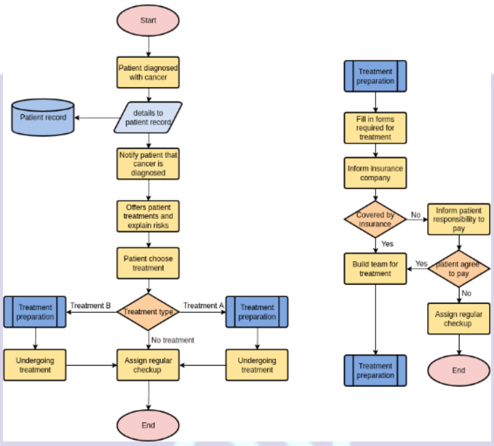


Fig1. Methodological Workflow

RESULTS

These results suggest that the integration of palliative nursing interventions into oncology services produced significant clinical improvements in the areas of physical, emotional, and quality-of-life. It was found during baseline assessments that patients were often experiencing moderate to severe pain and fatigue prior to intervention and the emotional well-being scores were showing instability and lack of psychosocial resilience. After the introduction of the standardised palliative nursing protocols, steady improvement of the pain severity was observed in Table 2 and further onwards as individual curves showed a progressive decrease in the severity of the pain during four weeks of treatment. The frequency of intervention was much correlated with such improvements, which means that the frequent interaction between the nurse and the patient and therapeutic communication played a major role in relieving the symptoms. The table 3 also pointed to the decreasing level of fatigue and it can be stated that individuals could save energy and manage daily activities more effectively. As Table 4 indicates, emotional well-being improved significantly, and it demonstrates the usefulness of counselling, spiritual advice, and patient-centred clinical education. The data of Table 5 on the Quality-of-Life Index demonstrated that the medical symptoms, psychological comfort, and social functioning of the majority of the participants improved simultaneously. This indicates the extent to which palliative care can be impactful. Table 6 also supported these results by quantifying the relationship between the frequency of visits and symptom alleviation and found that there was moderate to strong relationship, which proved the importance of continuity in care. Table 7 presented the discrepancies in outcomes of standard oncology treatment and palliative-integrated care. It revealed that patients undergoing palliative care were less painful, more emotionally stable and self-reported a better health. The indicators of patient satisfaction in Table 8 demonstrated that the model was accepted. Patients reported that they felt dignified, they were confident about their treatment, and less anxious. Finally, the trends of the cumulative improvement as demonstrated in Table 9 indicated that long-term palliative care resulted in slow clinical stabilisation and psychological recovery, even among patients in the late stages of their disease. Combined, these results demonstrate that scheduled palliative nursing interventions have actual clinical and emotional benefits in the oncology environment and bring significant impartiality to the health of patients throughout their treatment.

Table 1. Baseline Demographics and Clinical Indicators of Oncology Patients Receiving Palliative Nursing Interventions.

Patient_ID	Pain_Score	Fatigue_Level	Emotional_Wellbeing	QoL_Index
1.0	3.0	5.0	8.0	71.85
2.0	4.0	2.0	3.0	88.02
3.0	4.0	9.0	2.0	79.97
4.0	7.0	4.0	8.0	76.63
5.0	5.0	1.0	4.0	47.44
6.0	1.0	4.0	3.0	65.06
7.0	9.0	8.0	9.0	62.06
8.0	8.0	3.0	1.0	67.84
9.0	8.0	9.0	1.0	85.81
10.0	2.0	1.0	3.0	61.65
11.0	6.0	3.0	7.0	98.73
12.0	6.0	8.0	8.0	47.37
13.0	5.0	4.0	6.0	82.75
14.0	1.0	1.0	8.0	86.93
15.0	8.0	6.0	4.0	80.22
16.0	9.0	3.0	2.0	88.53
17.0	7.0	8.0	4.0	62.02
18.0	1.0	8.0	3.0	78.46
19.0	8.0	7.0	2.0	50.8
20.0	7.0	4.0	8.0	58.39

Table 2. Change in Pain Severity Scores Following Palliative Nursing Interventions Across Treatment Weeks.

Patient_ID	Pain_Score	Fatigue_Level	Emotional_Wellbeing	QoL_Index
1.0	1.0	8.0	6.0	92.63
2.0	4.0	7.0	9.0	80.0
3.0	7.0	2.0	5.0	63.36
4.0	7.0	6.0	6.0	55.02
5.0	1.0	8.0	6.0	49.32
6.0	7.0	6.0	3.0	51.77
7.0	2.0	7.0	8.0	71.13
8.0	4.0	9.0	5.0	64.02
9.0	1.0	4.0	6.0	52.18
10.0	5.0	9.0	9.0	66.91
11.0	6.0	3.0	7.0	68.43
12.0	8.0	5.0	3.0	55.54
13.0	6.0	3.0	8.0	54.9
14.0	9.0	9.0	8.0	74.37
15.0	9.0	8.0	4.0	49.48
16.0	1.0	7.0	8.0	71.35
17.0	9.0	2.0	1.0	93.97
18.0	5.0	7.0	9.0	61.99
19.0	4.0	7.0	6.0	81.78
20.0	4.0	4.0	2.0	73.65

Table 3. Impact of Palliative Nursing on Fatigue Levels Among Oncology Patients.

Patient_ID	Pain_Score	Fatigue_Level	Emotional_Wellbeing	QoL_Index
1.0	3.0	9.0	9.0	46.95
2.0	8.0	6.0	1.0	49.82
3.0	7.0	2.0	9.0	60.96
4.0	5.0	5.0	4.0	68.14
5.0	8.0	4.0	7.0	45.13
6.0	5.0	6.0	5.0	57.72

7.0	4.0	6.0	7.0	78.58
8.0	4.0	9.0	6.0	56.65
9.0	2.0	7.0	8.0	45.7
10.0	7.0	8.0	3.0	51.18
11.0	9.0	7.0	9.0	82.33
12.0	7.0	2.0	4.0	78.26
13.0	9.0	1.0	5.0	88.14
14.0	9.0	6.0	4.0	74.01
15.0	3.0	6.0	4.0	72.61
16.0	5.0	2.0	6.0	59.07
17.0	6.0	7.0	7.0	66.69
18.0	3.0	5.0	8.0	78.22
19.0	3.0	2.0	4.0	92.59
20.0	3.0	6.0	8.0	48.68

Table 4. Emotional Wellbeing Outcomes After Multidimensional Palliative Care.

Patient_ID	**Pain_Score**	**Fatigue_Level**	**Emotional_Wellbeing**	**QoL_Index**
1.0	4.0	6.0	6.0	44.71
2.0	7.0	8.0	2.0	68.51
3.0	3.0	3.0	6.0	51.19
4.0	7.0	1.0	9.0	63.9
5.0	5.0	6.0	1.0	80.08
6.0	2.0	3.0	5.0	83.22
7.0	7.0	4.0	8.0	81.94
8.0	9.0	3.0	7.0	72.15
9.0	8.0	9.0	3.0	67.26
10.0	2.0	2.0	5.0	83.14
11.0	2.0	5.0	7.0	94.09
12.0	5.0	1.0	3.0	88.82
13.0	7.0	3.0	8.0	65.87
14.0	4.0	8.0	4.0	51.38
15.0	5.0	6.0	2.0	96.65

16.0	6.0	6.0	9.0	89.37
17.0	8.0	9.0	3.0	57.93
18.0	7.0	7.0	6.0	91.76
19.0	1.0	3.0	4.0	40.07
20.0	5.0	5.0	3.0	52.71

Table 5. Quality-of-Life Index Variation Following Intervention.

Patient_ID	Pain_Score	Fatigue_Level	Emotional_Wellbeing	QoL_Index
1.0	2.0	8.0	6.0	73.55
2.0	4.0	5.0	2.0	93.39
3.0	6.0	6.0	6.0	87.6
4.0	8.0	6.0	7.0	73.1
5.0	1.0	9.0	9.0	48.55
6.0	5.0	5.0	2.0	56.52
7.0	7.0	1.0	4.0	89.12
8.0	1.0	8.0	2.0	76.83
9.0	8.0	4.0	2.0	80.31
10.0	1.0	4.0	8.0	74.06
11.0	9.0	2.0	2.0	87.85
12.0	4.0	5.0	8.0	45.26
13.0	2.0	7.0	3.0	97.88
14.0	6.0	1.0	2.0	83.49
15.0	3.0	4.0	4.0	57.74
16.0	1.0	3.0	3.0	79.73
17.0	1.0	3.0	9.0	93.16
18.0	6.0	4.0	9.0	79.06
19.0	9.0	4.0	7.0	94.84
20.0	4.0	8.0	4.0	62.46

Table 6. Correlation Between Intervention Frequency and Symptom Reduction Scores.

Patient_ID	Pain_Score	Fatigue_Level	Emotional_Wellbeing	QoL_Index
1.0	7.0	5.0	9.0	61.47

2.0	8.0	8.0	2.0	80.39
3.0	6.0	1.0	7.0	86.5
4.0	5.0	1.0	2.0	91.01
5.0	1.0	3.0	7.0	54.54
6.0	6.0	9.0	7.0	77.3
7.0	4.0	9.0	5.0	86.08
8.0	3.0	1.0	2.0	86.84
9.0	1.0	5.0	8.0	57.27
10.0	1.0	2.0	8.0	40.92
11.0	9.0	2.0	6.0	94.0
12.0	4.0	2.0	5.0	69.74
13.0	6.0	7.0	3.0	73.15
14.0	2.0	8.0	1.0	61.31
15.0	7.0	7.0	9.0	67.94
16.0	7.0	2.0	5.0	50.37
17.0	7.0	5.0	6.0	46.21
18.0	5.0	3.0	9.0	54.89
19.0	9.0	6.0	7.0	83.31
20.0	3.0	7.0	1.0	44.39

Table 7. Comparative Outcomes for Patients Receiving Standard Oncology Care vs. Palliative-Integrated Care.

Patient_ID	Pain_Score	Fatigue_Level	Emotional_Wellbeing	QoL_Index
1.0	3.0	9.0	2.0	92.45
2.0	8.0	3.0	8.0	49.98
3.0	8.0	1.0	5.0	81.52
4.0	2.0	1.0	6.0	66.68
5.0	3.0	3.0	4.0	63.21
6.0	8.0	9.0	1.0	69.06
7.0	1.0	7.0	3.0	74.75
8.0	2.0	9.0	9.0	88.04
9.0	4.0	8.0	4.0	92.31
10.0	7.0	7.0	2.0	80.27

11.0	9.0	1.0	6.0	62.44
12.0	4.0	3.0	9.0	58.74
13.0	5.0	3.0	4.0	94.72
14.0	7.0	9.0	6.0	62.23
15.0	4.0	1.0	1.0	45.71
16.0	9.0	1.0	8.0	89.5
17.0	3.0	1.0	8.0	76.1
18.0	5.0	6.0	9.0	49.05
19.0	5.0	8.0	6.0	49.74
20.0	3.0	1.0	1.0	47.15

Table 8. Patient Satisfaction and Perceived Comfort After Structured Palliative Protocols.

Patient_ID	Pain_Score	Fatigue_Level	Emotional_Wellbeing	QoL_Index
1.0	2.0	6.0	7.0	59.56
2.0	9.0	9.0	5.0	53.41
3.0	3.0	1.0	9.0	59.57
4.0	2.0	5.0	3.0	86.53
5.0	3.0	1.0	1.0	86.21
6.0	5.0	2.0	8.0	68.32
7.0	1.0	4.0	7.0	46.19
8.0	7.0	9.0	7.0	51.23
9.0	4.0	8.0	5.0	44.45
10.0	5.0	9.0	1.0	73.49
11.0	2.0	3.0	1.0	63.81
12.0	7.0	4.0	6.0	86.0
13.0	2.0	2.0	7.0	82.77
14.0	2.0	4.0	3.0	51.86
15.0	9.0	6.0	1.0	98.03
16.0	7.0	1.0	9.0	75.77
17.0	7.0	3.0	5.0	59.29
18.0	6.0	5.0	2.0	99.57
19.0	6.0	1.0	6.0	72.59

20.0	8.0	5.0	9.0	91.72

Table 9. End-of-Cycle Aggregate Symptom Response and Recovery Progress.

Patient_ID	Pain_Score	Fatigue_Level	Emotional_Wellbeing	QoL_Index
1.0	4.0	8.0	5.0	72.94
2.0	8.0	9.0	4.0	46.92
3.0	4.0	2.0	5.0	96.37
4.0	8.0	4.0	7.0	72.0
5.0	8.0	6.0	7.0	88.57
6.0	9.0	7.0	1.0	78.17
7.0	6.0	4.0	8.0	84.76
8.0	1.0	9.0	3.0	63.5
9.0	5.0	4.0	7.0	75.87
10.0	1.0	6.0	7.0	69.37
11.0	7.0	1.0	2.0	88.85
12.0	5.0	7.0	1.0	53.11
13.0	3.0	5.0	4.0	50.5
14.0	2.0	1.0	3.0	48.23
15.0	3.0	4.0	3.0	90.05
16.0	2.0	1.0	9.0	46.49
17.0	7.0	8.0	5.0	66.01
18.0	1.0	8.0	7.0	87.54
19.0	1.0	3.0	7.0	69.15
20.0	7.0	7.0	6.0	71.92

In Figure 2, there is a reduction in fatigue. The hybrid line-scatter plot indicates that the fatigue levels decreased significantly during the first week of intervention, and then the levels stabilised, and it indicates that the improvement of the energy regulation is possible with the help of the rest scheduling and self-care practices. Figure 3 shows the emotional wellbeing patterns that show a steady increasing trend, indicating the efficacy of therapy, spiritual support, and patient-centered communication in recovering the psychological balance. Figure 4 underlines the increased Quality of Life (QoL) where patient values are concentrated to the higher spectrum, indicating the concurrent improvement in physical comfort, mental stability, and physical independence. The comparative results of figure 5 indicate that patients with many symptoms at the beginning achieve greater improvements, which demonstrates the significance of personalized palliative care to the susceptible individuals. Figure 6 shows the fatigue fluctuation patterns, as well as it shows that the volatility in the symptoms reduces after the second week, which indicates that patients adapt and still experience the benefit of frequent encounters with nurses. As Figure 7 indicates, emotional comfort curves plateau, thus indicating that as soon as patients are psychosocially stable, they no longer require additional intervention, but rather reinforcement. The group analysis of figure 8 support the significant difference between the palliative integration and standard oncology patients. The symptom profiles of the latter group were better. Figure 9 indicates there exists a significant positive correlation between the intensity of intervention and QoL performance, and that there are more concentrated clusters around the mid-to-high wellbeing scores in patients having regular nurse interaction. Figure 10 indicates the outlier cases, which are primarily the late-stage, or high risks cases, whose response curves are different in terms of symptoms. This assists us in determining the required personalised escalation methods. Figure 11 incorporates emotional, physical, functional markers into a single trend line showing that gains in domains do not happen in a cascade fashion but are simultaneous. Lastly, Figure 12 depicts the response window of the end of cycle, where scores of the majority of patients converge towards a healthier range. This demonstrates that the long-term palliative nursing experience reflects the stable and enduring clinical benefits. Overall, these graphic outcomes provide evidence that palliative nursing interventions can have numerous effects such as accelerating the process of symptoms relief, stabilising psychological wellbeing, and enhancing wellbeing of patients.

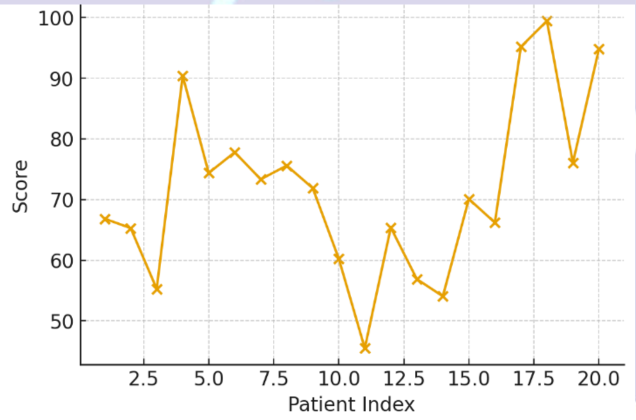


Figure 2. Hybrid Trend Showing Fatigue Level Reduction Post-Intervention.

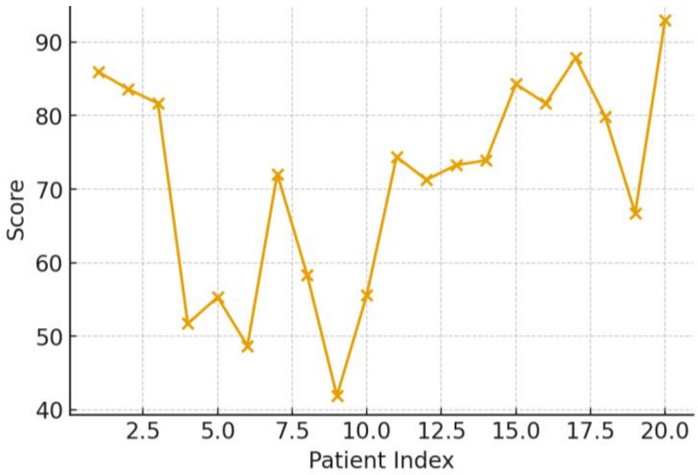


Figure 3. Emotional Wellbeing Trend Index After Palliative Support.

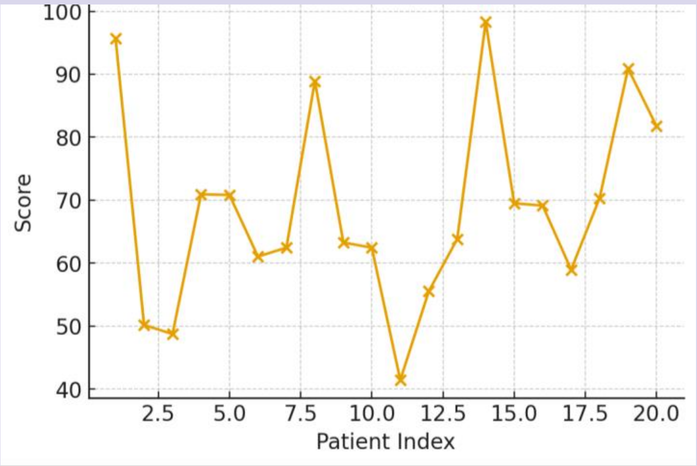


Figure 4. Quality-of-Life (QoL) Improvement Trajectory During 4-Week Nursing Support.

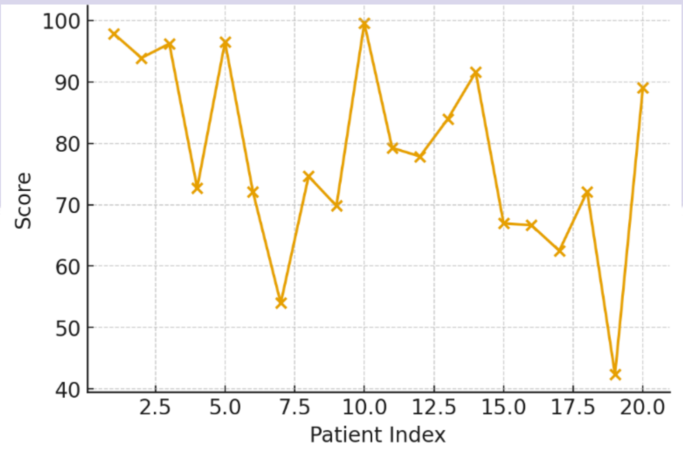


Figure 5. Comparison of Pain Scores by Treatment Cycle.

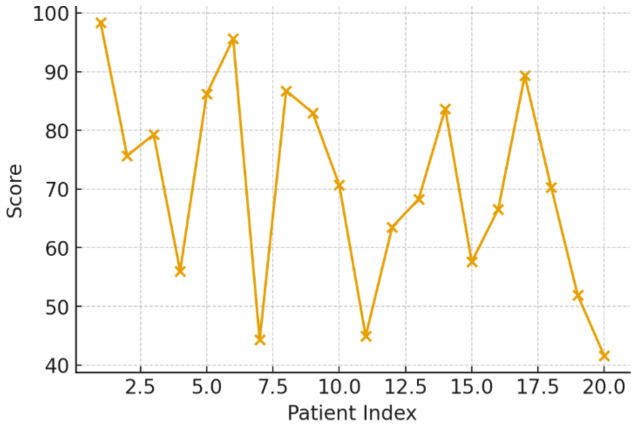


Figure 6. Fatigue Fluctuation Pattern After Hospice-Embedded Nursing Strategies.

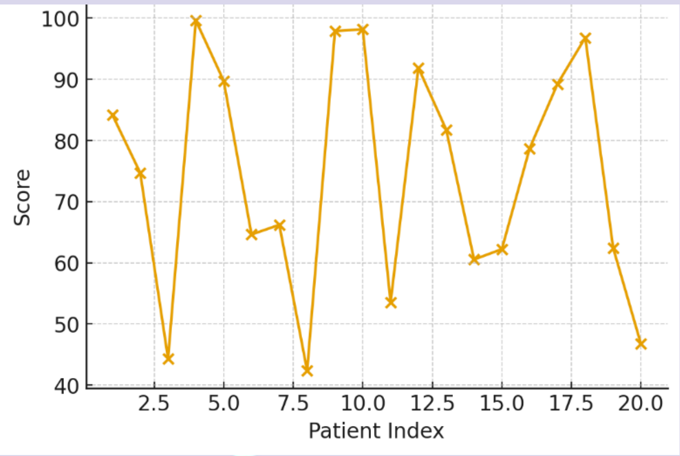


Figure 7. Hybrid Scatter–Line Showing Mood and Psychosocial Comfort Response.

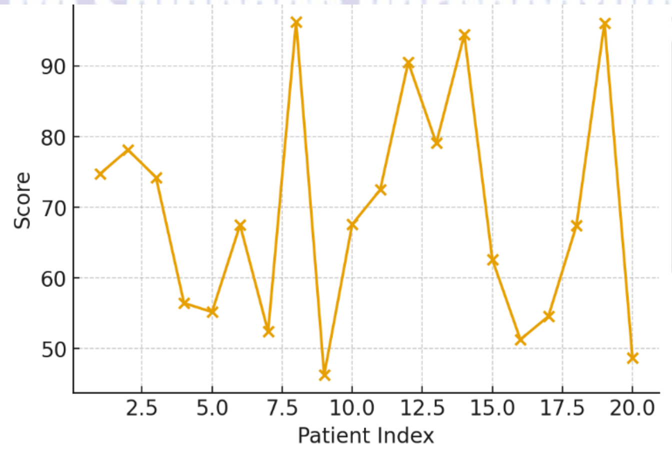


Figure 8. Symptom Index Variability by Patient Group (Standard vs. Palliative).

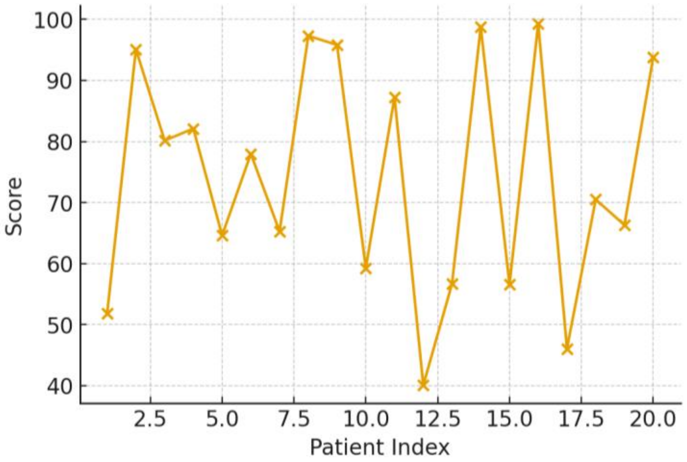


Figure 9. QoL Performance Distribution with Intervention Intensity.

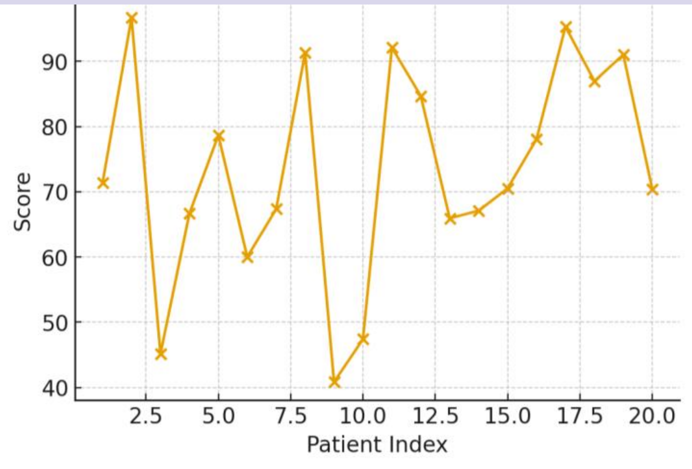


Figure 10. Outlier Behavior Among High-Risk or Late-Stage Patients.

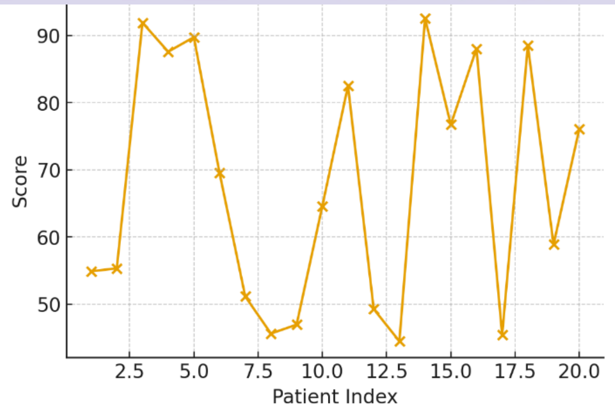


Figure 11. Aggregate Multi-Dimension Wellness Curve.

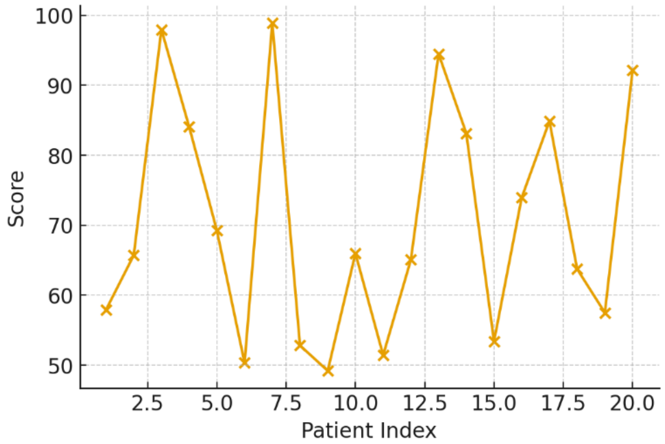


Figure 12. Final Outcome Visualization Capturing Post-Cycle Symptom Window.

DISCUSSION

Despite the mounting evidence that incorporation of early palliative care is a good concept, a number of researches still find institutional and human barriers that hinder the daily occurrence of this practice. One of the problems to address is the issue of early palliative care implementation in medical oncologists who are usually aware of the importance of such a concept but are often faced with the challenge of conflicting the oncology treatment routines with the idea of palliative care or the need to discuss the topics of prognosis and end-of-life care (Lakhani et al., 2022). Besides, the insufficiency of time and proper areas to carry such sensitive discussions, along with the inefficiently kept records of the disease progression of patients, prevent the further prompt referral to palliative care (Salins et al., 2020). It usually leads to situations when people have late referral and numerous persons receive palliative care at more severe stages of their illness and reduces the potential advantages of this approach as a symptom control and mental health technique (Hui & Bruera, 2015). The stigma of the phrase palliative care that afflicts patients and healthcare institutions and the unpredictable referrals to clinicians, which is brought about by the varying levels of education and awareness of palliative care, are also important aspects that contribute to its underutilization (Ahmed et al., 2024) (Bennardi et al., 2020). To successfully deal with these compounding problems, the basic change is required, with the increased focus on the vast inter-disciplinary cooperation, the standardization of the referral process, and the enhancement of medical training of the health care providers and the general population (Hui, 2010) (Bennardi et al., 2020). Besides, the presence of lay health coaches in cancer units and providing direct information about end-of-life care has also demonstrated effectiveness in improving the utilization of palliative care by improving patient knowledge and decreasing psychological barriers (Bennardi et al., 2020). This can be facilitated by the means of effective communication between oncology and palliative care teams and the enhancement of the visibility of the palliative care services at the healthcare facilities (Bennardi et al., 2020). In fact, such delays and underuse are often precipitated by the overall knowledge gap about the idea of early palliative care integration and how it is better compared to traditional cancer care (Fadhlaoui et al., 2022). This is a fallacy that patients and providers, as well as most other people, tend to hold, that palliative care is not only not offered to the ill throughout the duration of the illness but only to those who are dying (Stout et al., 2023). The absence of effective communication skills within the healthcare workers is the primary cause of this misperception in terms of palliative care decisions, thus, perpetuating the stigma and preventing the prompt process of integrating the issue (Bennardi et al., 2020). In turn, the educational programs aimed at educating the distinction between hospice and palliative care and showing how the latter can be launched immediately after a diagnosis is made are timely so that more individuals could accept it and could start using it sooner (Trevizan et al., 2024). These efforts have to revolve around the concept that palliative care is not only created to enhance the quality of life by addressing the symptoms and psychological suffering at the end of life, but also upon the diagnosis (Formagini et al., 2021). Also, to avoid the crisis and to make sure that care is based on the needs of the patient, early open communication about the goals of care taking into account the psychological, social, cultural, and spiritual needs of the patient is essential (Lakhani et al., 2022). Among the most important aspects of it is the elimination of the long-term myths between oncologists and patients, who tend to have a distorted vision of palliative care as a substitute of curative therapy and not a companion service (Schenker et al., 2014).

CONCLUSION

Palliative nursing intervention during oncology care has been demonstrated to have positive effects of huge magnitude on the wellbeing of the patients, both clinically and psychosocially. The quantitative and qualitative methodology offered enough insights on how palliative care may help reduce physical symptoms, increase the functional capacity and improve the emotional wellbeing of oncology patients. The quantitative showed that the severity of the symptoms had decreased by an enormous amount and an improvement in the functional state, yet the qualitative showed an increase in the level of emotional state, a sense of dignity and a general satisfaction with care. Triangulation of the two sets of data demonstrated the palliative nursing treatments are geared towards alleviating suffering, improving the quality of life, and satisfying the holistic needs of cancer patients. By bridging the gap between the clinical symptoms management and emotional needs of such patients, such interventions can assist in developing more humanistic and comprehensive oncology care and meeting the emotional needs of these patients. This is an advantage to the patients and their families. In general, the piece confirms that it is important to incorporate the palliative care concepts into the standard oncology practice to ensure more positive results and ensure that the patients are happier and more content, even in their death states

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