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# Nurses' Perceptions and Experiences With End-of-Life Communication and Care

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**S**eriously ill patients at the end of life (EOL) and their families report that honest communication is vitally important (Heyland et al., 2006). Challenges and opportunities for communication exist for healthcare providers who come into contact with these patients and their families. When carried out, discussions of prognosis can be important catalysts for later discussions of preferences for treatment and care. Unfortunately, communication about prognosis occurs with only a minority of patients with advanced cancer (Bradley, Hallemeier, et al., 2001; Wright et al., 2008). Communication about prognosis is necessary to facilitate decisions about treatment options, such as hospice and palliative care, and has been associated with significantly fewer aggressive medical interventions near death, more hospice care, and enhanced quality of life in patients and bereaved family members (Wright et al., 2008). Hospice care has been available to terminally ill patients and their families in the United States since 1982. However, only 39% of deaths occur in hospice facilities (National Hospice and Palliative Care Organization [NHPCO], 2009, 2010). Lack of communication and lack of hospice care usage result in many patients at EOL and their families being unable to experience a "good death."

Conceptual clarity is necessary when considering EOL communications and care. EOL care encompasses care delivered in an unspecified period close to a patient's death (Coyle, 2005). Hospice care specifically aims to ameliorate suffering that may focus on physical, spiritual, psychological, and practical concerns of dying patients and their family members; symptom management is a domain within hospice care. Hospice care is a specific benefit provided by many insurers, both public and private, and it requires a formal referral by a licensed healthcare provider (NHPCO, 2010). Palliative care more broadly is offered to patients facing serious life-threatening illnesses, and to their families

**Purpose/Objectives:** To characterize oncology nurses' attitudes toward care at the end of life (EOL) and their experiences in caring for terminally ill patients, hospice discussions with patients and families, and the use of palliative care practices.

**Design:** Descriptive correlational survey study.

**Setting:** A Magnet<sup>®</sup>-designated hospital in southern California with more than 500 beds.

**Sample:** 31 oncology nurses.

**Methods:** Nurses completed the adapted version of the Caring for Terminally Ill Patients Nurse Survey.

**Main Research Variables:** Attitudes toward care at EOL and care experiences with terminally ill patients.

**Findings:** Despite having fairly positive attitudes toward hospice and having discussions about prognosis with terminally ill patients, nurses reported missed opportunities for discussions and patient referrals to hospice. On average, nurses cared for more than seven terminally ill patients during a three-month period while only discussing hospice care with a third of these patients and their family members. Most nurses acknowledged that patients would benefit from earlier initiation of hospice care. Specific palliative care practices used by nurses in the past three months varied, with active and passive listening and requesting increased pain medications used most frequently and aromatherapy and guided imagery used least.

**Conclusions:** Missed opportunities may reflect nurses' attitudes. However, lack of patient and family member acceptance was the most important barrier to discussion of hospice.

**Implications for Nursing:** Strategies to enable nurses to have a stronger voice during this critical time for their patients are needed and, when developed, supported in practice to ensure that they are used.

(Coyle, 2005); these patients may not be imminently dying. According to the National Consensus Project for Quality Palliative Care, care planning should be based on values and needs of patients and their families and