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ORIGINAL RESEARCH

Staff Nurses' Perceptions Regarding Palliative Care for Hospitalized Older Adults

Study findings reveal a need for a shift in perspective.

For many hospitalized older adults with serious illnesses, early implementation of palliative care can be of critical importance. Many older patients have multiple chronic comorbidities, and may experience exacerbations that result in increased debility and alter their life circumstances. It's not surprising that their care often involves "medically and ethically complex treatment decisions."[1] And while technological advances have often made it possible to prolong life, they haven't necessarily led to an improved quality of life.[2]

For one, older people typically have diminished physiologic reserve, lessening their ability to recover and "bounce back" from bodily insult, and with each insult this reserve is further depleted.[3] Indeed, as the number of older adults living with multiple chronic illnesses has risen, their rates of hospitalization and of in-hospital mortality have also increased.[3-5] Moreover, views on aging have changed. Rather than being accepted as part of a natural process, aging has become associated with frailty and infirmity, an "age as disease" model that may encourage prolonged and aggressive efforts to cure even when the patient is unlikely to respond.[6, 7] Staff nurses—who generally spend more time with these patients than physicians and other health care providers[8, 9]—often bear witness to patients' and families' distress and frustration surrounding care options.[10, 11]

Of course, not all hospitalized older adults need palliative care. But those who might benefit from it are less likely to receive it if their providers are unclear about the concept. As Ferrell and Coyle have explained, palliative care "aims not only to relieve symptoms of disease, but also to promote favorable outcomes by helping patients and families to reach personal goals, reconcile conflicts, and derive meaning from their experiences."[8] This approach has the potential to benefit countless older adults in acute care settings. And staff nurses are well positioned to facilitate a palliative approach and ease the transition in goals of care as illness progresses and health declines.[12, 13] To learn more about how staff nurses understand and manage palliative care, I decided to conduct an exploratory study addressing the research question "What are the perceptions of staff nurses regarding palliative care for hospitalized older adults?"

BACKGROUND AND LITERATURE REVIEW

The evolving nature of palliative care is apparent in the varying interpretations of just what is meant by the term. Many nurses and other health care professionals, as well as the general public, have difficulty distinguishing between palliative care and hospice care, which are not synonymous.[14-18] Briefly, *palliative care* refers to care that focuses on preventing and relieving symptoms without necessarily trying to effect a cure; it can be appropriate not only for patients who are actively dying, but also for many who are living with incurable illness.[8] *Hospice care* refers to care that supports patients and families through the dying process; it includes and goes beyond palliation.[8] Yet even among the organizations and specialties that support and promote palliative care, there is a wide range of definitions and perspectives.[16, 19]

This lack of clarity about what palliative care is acts as a barrier to its use, despite research indicating that participation in hospital-based interdisciplinary

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ABSTRACT

Purpose: This exploratory study addressed the research question "What are the perceptions of staff nurses regarding palliative care for hospitalized older adults?"

Design: A qualitative descriptive study design using focus groups was selected.

Methods: Eighteen staff nurses participated in semistructured focus group interviews. The audio-recorded data were transcribed, sorted, and coded using NVivo 9 software and analyzed using Ritchie and Spencer's framework approach to qualitative data analysis.

Findings: Five main thematic categories emerged that captured the essence of the nurses' perceptions: ambiguity regarding the concept of palliative care, communication challenges, a sense of informed advocacy, cognitive and emotional dissonance, and health care system constraints.

Conclusions: For many seriously ill hospitalized older patients, staff nurses can be pivotal as informed advocates for palliative care early in the course of an illness trajectory. But nurses (and other providers) often confuse palliative and hospice care; thus there is a need for increased understanding and knowledge in this area. Collaborative interdisciplinary education regarding the evolving concept of palliative care may be useful. Further research into the perceptions and experiences of staff nurses who care for hospitalized older adults is warranted.

Keywords: hospitalized older adults, palliative care, perceptions, staff nurses

palliative care programs is associated with improved outcomes: identified benefits include more effective symptom management; increased patient, family, and provider satisfaction with care; and reduced hospital costs.[20, 21] Furthermore, there are inherent challenges in determining patient prognoses and care preferences among older patients with multiple comorbidities,[1, 14, 21] and this may contribute to what Davidson and colleagues called "a perceived dissonance between acute and palliative care."[14] And chronic debilitating illnesses such as heart failure and dementia tend to have less predictable trajectories than diseases such as terminal cancer.[6] Yet many people with chronic illnesses also spend significant time in the hospital for disease management.

Nursing perspective. There is scant literature regarding staff nurses' perspectives on palliative care for hospitalized older adults in acute care settings. Several studies have focused on nurses caring for patients who are nearing the end of their lives.[22-25] While these studies provide important information, they were limited to patients with terminal diagnoses. Several studies have investigated the palliative care experiences of nurses working in specialty areas, such as hospice and palliative care,[26] oncology,[15, 27, 28] cardiorespiratory,[14, 22] and intensive care settings.[17] But in general, few researchers have investigated the use of palliative care for older people with chronic diseases other than cancer.[29, 30] And relatively little is known about how staff nurses perceive palliative care for older adults. This is a significant omission, as nurses have the potential to facilitate a palliative approach sooner in the course of an illness trajectory—thereby giving patients and families time to adjust to the patient's status and possible death, avoiding futile curative efforts, and improving the quality of life.[17]

METHODS

Design. A qualitative descriptive study design utilizing focus groups was selected, as this would allow the gathering of in-depth information about staff nurses' perceptions.

Sample. A purposive convenience sample was recruited by distributing flyers and inviting participation at professional meetings, via e-mail contacts, and during conversations with colleagues to reach the intended sample of 12 to 24 staff nurses employed at acute care hospitals. The recruitment period lasted from April 29 through June 15, 2011. Staff nurses who expressed interest and met the inclusion criteria were invited to participate. Inclusion criteria were being a licensed nurse, being able to speak fluent English, and being presently employed in an acute care inpatient hospital setting providing direct care to hospitalized older adults. The exclusion criterion was being currently employed in hospice or palliative care. Institutional review board approval was obtained.

For this exploratory study, five one-hour focus groups were conducted between May 6 and June 15, 2011. Each group had between three and five participants, for a total of 18 participants. I conducted the focus groups; a colleague with qualitative research experience assisted as an observer and note taker. Before the start of each group, I explained the procedures, risks, benefits, and voluntary nature of the study. Each participant signed a voluntary consent form.

Interview Guide

Introductory Question (10 minutes)

As you know, the purpose of this focus group is to discuss your thoughts and experiences regarding palliative care for hospitalized older adults.

Please discuss what the term *palliative care* means to you.

Encourage participation through use of probes:

- Can you say more about that?
- Tell us more . . .

Transition Question (10–15 minutes)

Please discuss your experience with palliative care for hospitalized older adults.

- Can you say more about that?
- Could you give an example of what you mean?

(Silence and pauses may allow expressions to surface.)

Key Question (20–25 minutes)

What do you think matters most regarding palliative care for hospitalized older adults?

- Would you explain further?
- Please describe more . . .

Ending Question (10 minutes)

Is there anything else related to your experiences with palliative care for hospitalized older adults that you would like to discuss?

- Is there anything you'd like to emphasize or point out?
- Something that you thought of but may not have said yet?

Instrument. A semistructured interview guide designed to elicit discussion was developed based on the literature review and my prior clinical experience with palliative care. The interview guide was pilot tested with three nurses, and minor modifications were made. (Interviews with these three nurses were not included in this analysis.) The guide included introductory, transitional, main, and summary questions, as follows:

1. Please discuss what the term *palliative care* means to you.
2. Please discuss your experience with palliative care for hospitalized older adults.
3. What do you think matters most regarding palliative care for hospitalized older adults?
4. Is there anything else related to your experiences with palliative care for hospitalized older adults that you would like to discuss?

Pauses and silence were used by the interviewer to allow further expression by participants. Possible additional probing questions were also included. (See *Interview Guide*.)

Data analysis was guided by Ritchie and Spencer's framework, a systematic, step-by-step approach to qualitative data analysis consisting of five stages: familiarizing through immersion in transcript data; developing an initial thematic framework; indexing the data as key issues emerge; devising thematic charts to depict the full pattern; and interpreting the data.[31] Data analysis began with the first interview. Each transcript was summarized, compressed, and indexed into broad categorical clusters for content analysis. Transcripts and field notes were read comprehensively at least four times by both me and a research assistant, compared with the recorded interviews and corrected (as necessary), and then uploaded into NVivo 9 software, which facilitated the display and analysis of relationships in the data.

After initial categories were identified, the data were synthesized into thematic charts, allowing further refinement of categories and generation of descriptive accounts. Categories were reviewed and affirmed by the research assistant and by another researcher with qualitative research expertise.

FINDINGS

Sample. All 18 participants were women; current practice settings included three community and two urban hospitals in the northeastern United States. Each group met at a mutually agreeable location. Participants had experience ranging from two to 39 years in various acute care areas. Within each focus group, most participants were work colleagues or acquaintances. One participant did not complete the demographic form, but her interview responses are included as part of the data.

Participants were currently employed in six different acute care areas: ICUs, postanesthesia units, general medical–surgical floors, an orthopedic–urology floor, a hematology–oncology floor, and the ED. Two had previous experience working in hospice care elsewhere. Educational levels of participants also varied. One participant had completed a diploma program; two had associate's degrees in nursing; eight held bachelor of science in nursing (BSN) degrees, and three of these had also completed some coursework toward a master of science in nursing (MSN) degree; three held MSNs; one held a master of science in rehabilitation; one held a master of arts in public administration; and one held a doctor of nursing practice degree.

Asked about their personal experience with palliative care, participants gave varying responses. Several had gained such experience caring for patients who

Table 1. Participants' Current Employment Settings (N = 18)

Current Setting	No. of Years in Current Setting
ICU or postanesthesia unit	8
Medical–surgical floor	5
Specialty areas	
Orthopedic–urology floor	1
Hematology–oncology floor	1
ED	2
Did not answer	1

were being followed by palliative care services or were receiving hospice services while in the acute care setting. Three participants had gained such experience through caring for family members in home settings. One participant had a friend who had received palliative and hospice care at home. One participant had a family member who received palliative care in a nursing home; another had a family member who received palliative care in an acute care setting. One participant did not disclose her personal experience with palliative care. (See Tables 1–4 for additional demographic data.)

Perceptions. Participants spoke readily and passionately about their perceptions of and experiences with palliative care for hospitalized older adults. Many spoke of the inherent complexities of caring for hospitalized older adults with multiple chronic illnesses. Five main thematic categories ultimately emerged from the data: ambiguity regarding the concept of palliative care, communication challenges, a sense of informed advocacy, cognitive and emotional dissonance, and health care system constraints. These themes are discussed below, with examples of supporting quotations. Table 5 shows the five themes along with associated subcategories. (For more examples of supporting quotations by theme, see Tables 6–10 at http://links.lww.com/AJN/A62.)

*Ambiguity regarding the concept of palliative care.*Participants expressed varying perceptions about the meaning of palliative care and how it differs from hospice care. Some participants believed that palliative care was intended only for cases in which death was imminent. Most participants equated palliative care with end-of-life care when palliative care services became involved in the acute care setting. Both palliative and hospice care services were perceived as valuable resources when a patient could no longer benefit from curative treatment. Three subcategories became evident: confusion regarding the differences between palliative and hospice care, the timing of referral to palliative care as a key issue, and the need for further education in palliative care.

As one participant stated, "In the clinical setting, it really is the end of life when it seems the palliative care team is called in." Others said:

> The confusion is the hospice and the palliative care, where they meet and where they separate, and again, from experience it seems like once palliative care becomes involved, the next thing you know they're really on hospice and then they're [on] comfort measures only and then, poof, they're gone.

> [Palliative care is] a confusing concept to people, a little level of resistance because we're not sure what it is . . . what's the difference between palliative care and hospice . . . it's a spectrum and kind of intermingles a bit.

The timing of referral to palliative care services was a recurrent theme. Participants indicated that nurses often recognized when a patient was receiving little benefit from a treatment plan and might be better served with a more realistic, comprehensive palliative care approach. As one participant stated,

> I think [palliative care is] also for that portion of the population that falls in the crack, in terms of, they're not quite ready for the hospice thing but they're not really ready for new aggressive chemo or anything else. They're kind of in this no man's land where they're sort of [getting] palliative care, but not really. They're not saying comfort measures, but no aggressive treatments . . . they're in that vague no man's land of where they fit in terms of services.

Participants also noted that at times palliative care wasn't considered until late in the course of an illness trajectory:

> I kind of see the team being less aggressive with palliative care involvement in the older folks because they see their illnesses as a natural

Table 2. Participants' Years of Experience (N = 18)

No. of Years	n
2–20	4
21–30	8
> 30	5
Did not answer	1

Table 3. Participants' Educational Levels (N = 18)

Nursing Degrees	n
Diploma or ADN	3
BSN or BSN with coursework toward master's	8
MSN or MS in rehabilitation	4
DNP	1
Nonnursing Degrees	
BA in education	1
MA in public administration	1
Did not answer	1

ADN = associate's degree in nursing; BA = bachelor of arts; BSN = bachelor of science in nursing; DNP = doctor of nursing practice; MA = master of arts; MS = master of science; MSN = master of science in nursing.

Note: Numbers don't sum to 18 because one participant held both a BA in education and an MSN.

> part of aging, and yet they don't really see it, and they manage it in terms of disease processes and what their specialty is rather than what the overall needs or wants of the patients are, and I think that's part of the issue too.

Participants identified a need for further information and education in the concept of palliative care as an approach to managing serious illness. As one said, "I think nurses, just the regular staff nurses, could still be better educated at what the whole deal, the whole concept, is."

Communication challenges. Participants emphasized the importance of communication among health care team members, patients, and families. They discussed how "being on the same page" allowed a more cohesive approach to care. Participants recognized the value of listening to patients' and families' perspectives as they were coping with difficult circumstances. Some acknowledged that the discussion could be complex. One participant said, "I think most patients want to know . . . sometimes the patient only hears what they want to hear"; another stated, "You're trying to hit the nail on the head for them." Three subcategories emerged: communication as an ongoing process among stakeholders, differing perspectives on the roles of nurses and physicians, and preparedness for open and honest dialogue.

Participants noted how important it was for health care team members to share information with each other and listen to patients and their family members. One participant stated,

> All the information is just faxed over, through the computer system . . . you don't actually talk to anybody . . . they don't tell you the whole story, what's really going on.

Differing perspectives on the roles of nurses and physicians became evident during dialogue about how and when to address the health status of a very ill person:

> I never fully understood why the docs don't like to go in and have a palliative discussion. Why aren't we going in and discussing this, there's nothing else we can do for her, and she's dying, and it's, well, I'm only here for this weekend, and then the other doctor comes on who's covering for the month, but then he's only there for the last two days of the month, and then it's a new doctor. . . . So, whose job does it become to sit down and say to the patient . . . no one initiates, takes on the job of saying, okay, well now we need to have the palliative care discussion.

Several participants spoke about the importance of open and honest communication with hospitalized older patients regarding their status or prognosis. Several also expressed hesitancy about doing so. At times they were reluctant to broach a difficult topic; they also recognized that physicians sometimes didn't seem prepared to give adequate time for such conversations. One participant stated,

> It's interesting, the perception that giving that information might be cold, and I know how hard that is to say, and have that kind

Table 4. Additional Certifications (N = 18)

Certification	n
BLS, ACLS, PALS	8
Oncology	4
Clinical nurse leader	1
BLS/ACLS instructor	2
IV certification	1
Reiki certification	1
Certified emergency nurse	2
Critical care RN	1
Family NP	1
Did not answer	1

ACLS = advanced cardiac life support; BLS = basic life support; PALS = pediatric advanced life support.

Note: Numbers don't sum to 18 because some participants held multiple certifications.

Table 5. Five Main Thematic Categories with Associated Subcategories

Main Categories	Associated Subcategories
Category 1 Ambiguity regarding the concept of palliative care	• Confusion regarding the differences between palliative and hospice care • Timing of referral to palliative care as a key issue • Need for further education in palliative care
Category 2 Communication challenges	• Communication as an ongoing process among stakeholders • Differing perspectives on the roles of nurses and physicians • Preparedness for open and honest dialogue
Category 3 Sense of informed advocacy	• Understanding of patients' contextual circumstances • Sustaining patients' dignity while facilitating care
Category 4 Cognitive and emotional dissonance	• The burden of maintaining composure while bearing witness to suffering on a regular basis • Prolonging the inevitable by going along with the process
Category 5 Health care system constraints	• Rapid patient turnover with fragmentation of care • Compromised resources

> of discussion with people too, but I always think of it as a gift because they need to know their options.

Sense of informed advocacy. Participants discussed the importance of advocating care that alleviated suffering while treating the patient as a whole person rather than as a disease entity. Participants often raised questions about the use of an aggressive curative approach for debilitated patients who seemed unlikely to recuperate. They advocated a more pragmatic approach to care, one that took into consideration an individual patient's overall situation. One participant stated, "You've got to be the champion [for these patients]." These staff nurses also emphasized the importance of voicing concern when they felt a patient's needs weren't being adequately addressed. Two subcategories emerged from this category: an understanding of patients' contextual circumstances and sustaining patients' dignity while facilitating care.

Participants described feeling that they had to consider the impact of multiple factors on patient care, including working with younger physicians who might still be learning how to manage care:

> You're still working with a learner, doctors are learners, residents who are learners, attendings who are a little bit braver depending on how long they've been attendings, and fellows who are new to a specialty. So it really is the nurse that is in a position to do the advocacy, and I think that's an important role we have.

Participants noted that nurses often recognized when a patient wasn't benefiting from a treatment plan and might be better served with a more realistic and comprehensive palliative care approach. Nurses would address the need for a shift in the focus of care during interactions with colleagues; as one participant reported,

> If the nurse is on rounds, it will be the nurse, and you'll sometimes get the answer: "They're not ready for that yet."

Cognitive and emotional dissonance. Participants described the burden of bearing witness to the suffering of hospitalized older adults on a regular basis. These patients often had multiple comorbidities or poor baseline functional status, and did not fare well. Participants reported feeling conflicted and suppressing their own emotional responses, which included frustration, anger, and sadness. They expressed discomfort with being involved in seemingly futile care that often prolonged the patient's ordeal. They described striving to maintain composure in such situations; one participant said, "It was all I could do, to just keep my composure to carry on, and then I left work, and I cried all the way home." Two subcategories emerged: the burden of maintaining composure while bearing witness to suffering on a regular basis and prolonging the inevitable by going along with the process.

> I just kind of wonder what people's thinking is when it's an older patient, if they are

> diagnosed with an illness and from the onset you know that they're not going to do well.
>
> Sometimes the treatment is terrible and causes more pain and suffering than the lack of treatment.

Participants also recognized that patients and families were grieving the lives they had known before hospitalization, while often clinging to an uncertain future. One participant said, "It just keeps going on and on . . . the options just seem never-ending."

Health care system constraints. Participants described the challenges of providing nursing care in a setting with rapid patient turnover and frequent transitions. They spoke of having limited time for patient interactions because of various factors, including patient acuity, nursing workload and schedules, and working in a teaching institution. Care was perceived as fragmented because of the involvement of multiple services and providers, the complexity of patient care, and limited resources. This category contained two subcategories: rapid patient turnover with fragmentation of care and compromised resources.

Participants recognized the importance of the nurse–patient relationship and how the nature of that relationship was affected by time constraints. They described their work as consisting of condensed interactions within a tight time frame:

> Our interactions with the patients are so limited. You come in, you do your stuff, and then you go do your other five people, and then you come back and hang that next antibiotic and so on, turn and reposition.
>
> The palliative care thing is very time consuming . . . we don't get to know the patients like we used to. . . . It's woefully inadequate at addressing end-of-life needs.

These staff nurses also described how fragmentation of care affected older adults:

> For elders it becomes even more complicated . . . so many people involved . . . not necessarily linked . . . the information just never gets transmitted or discussed.
>
> They get lost in the transition for a couple of days . . . when you have the older person . . . oftentimes, you don't have the family support, so they're really left to the system.

And they spoke of the challenges posed by the overall complexity of care:

> The time that goes into taking care of all this, and you want to do it for them, and you stand on your head to make it happen, while all the other acute care issues are going on and you're trying to take care of them too.

DISCUSSION

Participants in this study commonly equated palliative care with hospice care, using the terms interchangeably. This confusion is consistent with what the literature review showed. And while some participants were aware that palliative care services often became involved late in the course of an illness trajectory, there was little recognition of the benefits of involving such services earlier. If practicing nurses currently employed in acute care settings are uncertain about the concept and use of palliative care, then it's understandable that the general public lacks an adequate awareness and understanding as well.

The finding that participants experienced cognitive and emotional dissonance when caring for hospitalized older adults warrants further exploration. Perhaps such dissonance can be lessened with a deeper understanding of both the contextual circumstances and patients' preferences. And while participants spoke of their sense of the need for informed advocacy, they also described communication challenges and health care system constraints. Taken together, these findings indicate an overall need for a more pragmatic approach to health care for hospitalized older adults—one that, as Gardner and colleagues have noted, acknowledges the contextual factors of chronic illness and cultural views about aging.[29]

With regard to staff nurses, this study's findings support the need for a fundamental shift in perspective. The concept of palliative care must be included as an integral part of foundational nursing knowledge in both undergraduate and graduate nursing school programs, in continuing education for practicing nurses, and in interdisciplinary core curricula. The American Association of Colleges of Nursing is among the organizations supporting improved education in such care for all nurses.[32] Indeed, much of the extant literature endorses further education in palliative care for all health care providers, including those who have an interest in the field and those already employed in palliative or hospice care settings.[33, 34] An increased awareness and knowledge about palliative care, together with recognition of the limitations of a curative approach, are particularly essential for staff nurses caring for hospitalized older adults. Further research into the scope and effectiveness of educational initiatives, as well as the perspectives and experiences of nurses regarding palliative care for older adults, may provide further insight into the complexities of nursing's role in palliative care for hospitalized older adults.

Table 11. Recommendations

Category	Recommendations
Confusion regarding the differences between palliative and hospice care	Provide education and promote use of best-practice guidelines to integrate palliative care content with core competencies for all health care providers, in order to achieve • optimal communication. • pain and symptom management. • psychosocial and spiritual support. • minimal suffering.
Communication challenges	Support interdisciplinary collaboration that fosters • open dialogue. • shared understanding of individual contextual circumstances. • dignity and respect for patient and family preferences. • enhanced provider perspectives.
Sense of informed advocacy	Identify palliative and hospice experts as resource liaisons. Provide access to palliative and hospice care resources via informational seminars and relevant Web sites for interdisciplinary health care team members, patients, and families.
Cognitive and emotional dissonance	Provide compassionate support rounds for health care team members.
Health care system constraints	Develop strategic screening methods to identify patients with serious or advanced illness who might benefit from integrating palliative care into acute care admissions. Use bridge programs to integrate and promote palliative care services among primary care providers and outpatient, home, and extended care resources. Monitor the effectiveness of strategies through admissions tracking, referrals, symptom documentation, and feedback surveys.

For some of these patients, nurses can potentially improve their quality of life by acting as informed advocates and promoting palliative care services sooner in the course of an illness trajectory. As Duggleby and Berry have reported, when referral to palliative care occurred late, patients had insufficient time to adjust; a timely, skilled introduction to palliative care facilitated the transition and eased fears.[15]

And nurses themselves can benefit by developing a greater understanding of various aspects of palliative care. For example, the recognition that bearing witness to patients' suffering may contribute to cognitive and emotional dissonance might prompt staff nurses to seek support in such circumstances.[35] Recognizing how health care system constraints such as fragmentation of care and compromised resources can affect nursing practice might foster new insights and strategies to address these issues. (See Table 11 for a complete list of recommendations.)

Strengths and limitations. Rigor, including trustworthiness, was ensured by the generally accepted criteria for evaluating qualitative research.[36] Credibility of the accuracy of the descriptive findings was affirmed by the research assistant and by another researcher with qualitative research expertise. Transferability was facilitated through a rich presentation of the findings. Dependability and confirmability were sought through recording the decision-making process such that another researcher could "audit" this decision trail and likely arrive at similar results.[37]

This study was conducted with participants who had particular experience with a specific population in an acute care hospital setting. The findings are context-specific and might not be generalizable to other populations and settings. All participants in this study were women, so their views may not reflect those of men in the nursing profession. The purposive sample recruitment approach may have contributed to a homogeneous sample of participants with similar interests and perspectives. Nurses who chose to take part in the study may have had a particular interest based on prior experiences with palliative care, either personally or professionally. And the use of focus groups involves an inherent possibility that participants may be influenced by others' thoughts and beliefs.

CONCLUSIONS

For many seriously ill hospitalized older patients, staff nurses can be pivotal as informed advocates for palliative care early in the course of an illness trajectory. But nurses (and other providers) are often confused about just what palliative care entails and how it differs from hospice care; thus, there is a need for increased understanding and knowledge in this area. Collaborative interdisciplinary education regarding the concept of palliative care, which continues to evolve, may be useful. Further research into the perceptions and experiences of staff nurses who care for hospitalized older adults is warranted, in order to provide additional insights and ensure optimal care for this population. ▼

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