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# Lee Geropalliative Caring Model

## A Situation-Specific Theory for Older Adults

CE 1.0 Contact Hour

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This article describes the Lee Geropalliative Caring Model (GCM), a situation-specific theory that guides geropalliative care, defined as the care of older adults in the last 2 years of life. Underpinned by the theory of human caring, the GCM offers a framework for achieving the person/family outcome of well-being by suggesting caring interventions within 4 priority domains: aligning care, keeping safe, comforting body/mind/spirit, and facilitating transitions to persons with late-stage illness, including frailty and dementia. The GCM can be used to inform practice, policy, education, and research. **Key words:** *geriatric caring model*, *geropalliative care*, *human caring*

THE Lee Geropalliative Caring Model (GCM) is a situation-specific theory that guides nursing practice in the care of older adults in the last 1 to 2 years of life. Situation-specific theory addresses the unique needs of a group of people in a specific context.[1,2] The GCM focuses on older adults with late-stage chronic disease, life-threatening disease, cancer, dementia, and frailty who would benefit from an approach to health care that focuses on well-being in the setting of limited life expectancy. The nurse's unique relationship with older persons and families is central to the GCM. Nurses advocate for and facilitate older persons' goals of care, which involves helping persons envision the future, identify and clarify values and preferences, and weigh the benefits and burdens of specific medical interventions that may lead to physical/functional decline, unplanned nursing home admissions, intensive care, and death. The purpose of the article is to describe the GCM, which will enhance nurses' effectiveness in delivering caring-healing interventions that result in well-being among older persons and their families.

## ORIGINS OF THE GEROPALLIATIVE CARING MODEL

The GCM was derived from a synthesis of practice, ethics, and research. The findings of focus groups, conducted as part of the development of a postlicensure educational program in 2006 at a Boston teaching hospital, revealed nurses' desire to be more effective advocates when caring for hospitalized older persons who may be experiencing overuse of medical care near end of life. Nurses questioned aggressive medical care that was not proportional to life expectancy, believing that patients and families were not fully informed of the likely outcomes. Thereafter, a concept synthesis of geropalliative care was developed, identifying specific attributes at the intersection of geriatrics and palliative care to be considered when caring

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**Statements of Significance**

**What is known or assumed to be true about this topic:**

Older persons with frailty or comorbidities are vulnerable to overuse of medical and surgical interventions that may not lead to improved quality of life. The aim of geropalliative care is to provide person-centered care that aligns with older persons' values and preferences, particularly in situations where the burdens of care may outweigh the benefits. When frail older adults are expected to live another year or two, the focus should be on well-being and assisting them to live at home, when at all possible. Geropalliative care suggests a more thoughtful approach that involves older persons and their families in shared health care decision making, an approach that demands better informed consumers.

**What this article adds:**

The Lee Geropalliative Caring Model is a helpful framework for the provision of person-centered geropalliative care that aims to achieve well-being among the frail elderly in the last 2 or so years of life. This article is the first to link nursing theory—the theory of human caring—to the emerging specialty of geropalliative care in a philosophical-moral-existential situation-specific theory for practice, education, and research. It provides nurses with information about the current paradigm of goal-concordant care as well as specific caring interventions that lead to well-being. Finally, it offers nurses voice and language as well as theoretical, ethical, and disciplinary legitimacy to hold conversations with persons about their illness, options, preferences, and values.

for older persons.[3] The knowledge derived from the focus groups and concept synthesis was used to develop the educational curriculum for the purpose of increasing nurses' effectiveness when caring for older persons during the last years of life.[4]

The educational program was subsequently refined and disseminated as AgeWISE, an evidence-based, theory-guided, reflective practice, to 14 hospitals.[5] The goal of AgeWISE is to upskill nurses in primary palliative care as a basic competency of practice in order to address the unmet palliative care needs of older persons, the clear majority of whom do not have access to the expertise of palliative care consult teams. Four priority areas of geropalliative care were identified and incorporated into the curriculum. These priority areas were refined over the next 5 years and evolved into the GCM, a situation-specific theory that aims to guide care. To the author's knowledge, this is the first time that a nursing grand theory, the theory of human caring,[6] has been proposed to underpin the practice of palliative care nursing.

## POPULATION

While Americans are living longer, as many a 67% have multimorbidity, which is defined as 2 or more chronic conditions.[7] In addition to chronic illness, older persons carry a disproportionate burden of cancers—by 2030, 70% of all cancers will be diagnosed in older persons[8]—and dementia, as 1 in 3 older persons will die with Alzheimer disease or another form of dementia.[9] Older persons could benefit from palliative care to alleviate distressing symptoms of chronic illness, including cancer and dementia and frailty; yet, they are less likely to receive it.[10]

*Dying in America*, a landmark report of the Institute of Medicine, concludes that "a palliative approach provides patients and families the highest quality of life for the most time possible."[11(p2)] Palliative care "means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient

autonomy, access to information, and choice."[11(p9)] Palliative care is characterized as *primary* when frontline clinicians are applying basic palliative care knowledge in practice and, *secondary*, when interprofessional teams deliver specialized care, such as palliative care consult services.[12] *Dying in America* concluded that the current health care workforce lacks training and experience required to meet persons' palliative care needs.[11] Because access to secondary palliative care is limited, expanding primary palliative care competencies to all frontline clinicians is viewed as a solution to the gap in access.[12]

## SPECIFIC SITUATION

As the US population grows older, acute-on-chronic diseases lead to increased hospitalizations for acute decompensation. Although medical decision-making has traditionally taken a disease-focused approach, there is a lack of data to guide the treatment of persons with multimorbidity.[13] Nurses need to be aware that the science of treating multiple conditions is underdeveloped. For example, frequently seen diagnoses in the hospital, such as cardiorenal or hepatorenal, signal a fragile relationship between organ systems, whereby treating one condition, such as heart failure, worsens another condition, such as renal function. This is the reason that new models of clinical decision-making, such as shared decision-making and goal-concordant care, described later, are prevalent.

Nurses are very familiar with multimorbidity; yet, they are less familiar with frailty, which has become the new organizing framework of geriatrics. Frailty is defined as "a state of vulnerability to poor resolution of homoeostasis after a stressor event and is a consequence of cumulative decline in many physiological systems during a lifetime."[14(p752)] Estimated to affect 25% to 50% of those 80 years or older, frailty is associated with a cascade of decline that leads to falls, admission to hospitals and nursing homes, worsening disability, and death.[14] Frailty is characterized by weakness, fatigue, and difficulty walking, which results in significant functional disability. It also negatively affects older persons' tolerance to medical and surgical treatments. For example, among older persons with cancer, Hanforth and colleagues[15] found that frailty or prefrailty places older persons at increased risk of chemotherapy intolerance, postoperative complications, and mortality.

Validated measures that classify older persons as robust, prefrail, or frail are now being used in the context of medical decision-making to identify those at risk for poor outcomes.[16] Much of the evidence comes from studies of surgical outcomes. Bellal and colleagues,[16] for example, revealed that the Frailty Index measure was the strongest predictor of surgical outcomes, more so than age or the American Society of Anesthesiologists score.

Goal-concordant care is the gold standard in the care of frail older persons but has not been adopted in all settings. Defined as "clinical care that helps reach a patient-identified goal, and respects any treatment limitations the patient has placed on clinical care,"[17(p1)] goal-concordant care addresses the uncertainty of a disease-focused approach by suggesting goal setting over the trajectory of illness.[18] Goal-concordant care proposes that persons decide health outcomes they care about most across several dimensions, for example, symptoms, function, mobility, social, and role, which are distinctly different from therapeutic goals, such as cure or life prolongation.[17,18]

Nursing research findings suggest that older persons prefer discussing their priorities and goals rather than speculating about treatment choices.[19] Goal-concordant care is aligned with the professional values of nursing as reflected in the American Nurses Association's (ANA) Scope and Standards of Practice,[20] which recognizes not only the patient "as the authority on her or his own health by honoring their care preferences" (standard 1, competency)[20(p33)]

but also the nurse's role in assisting "health care consumers in self-determination and informed decision-making" (standard 7, competency).[20(p47)]

A variety of clinical scales, such as the Functional Assessment Staging Tool for Alzheimer disease,[21] the Clinical Frailty Scale,[22] activities of daily living and instrumental activities of daily living for overall function,[23] along with the "surprise question" that asks providers, "Would you be surprised if this person died in the next year?" to name only a few, can be used to predict the natural phase of decline in the last year of life, making it easier for clinicians to help patients/families make decisions that are most meaningful to them. Still, conversations about goals and preferences continue to occur late, if at all.[24]

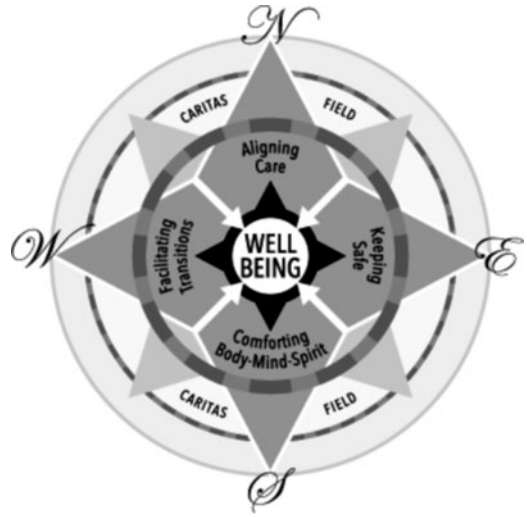


**Figure**. Lee Geriatric Caring Model. Copyright 2015 Susan M. Lee.

## LEE GEROPALLIATIVE CARING MODEL

The purpose of the GCM is to increase nurses' effectiveness in achieving well-being among older persons experiencing serious illness/frailty who are likely in the last year of life. The model aims to inform and support caring-healing practices delivered within the Caritas field in 4 areas: (1) aligning care, (2) keeping safe, (3) comforting body/mind/spirit, and (4) facilitating transitions (Figure).

### Assumptions

The underlying assumptions associated with the GCM are as follows:

*Well-being is attainable in end-stage disease and dying*. Persons with serious illness who are nearing death can experience well-being when they are assured of continued caring-healing presence, their preferences for care are honored, they are kept safe and free from distressing symptoms, through to a peaceful and dignified death. Ira Byock, MD,[25] who emphasizes the human potential for love, gratitude, joy, and growth until death, holds that well-being can exist at end of life.

*It is within nurses' scope of practice to hold goals of care discussions with patients/families*. Nurses are supported by the *ANA Scope and Standards of Practice*[20] and by the nursing intervention anticipatory guidance,[26] both of which uphold the independent action of nurses in helping patients and families weigh health care options and their meaning.

*Patients/families find discussions about the future helpful*. Evidence shows that advance care planning positively impacts quality of end of life and that these conversations are well received by most patients.[27]

### Well-being as outcome

The overarching goal of the GCM is the attainment of well-being among older persons. Well-being is defined as one's subjective assessment across multiple, personally relevant domains that ultimately leads one to judge life positively and with hope for the future.[28,29] In the specific situation of end-stage frailty, dementia, heart/liver/kidney disease, cancer, neurologic diseases, etc, caring-healing interventions become the primary ways that persons experience well-being and have hope

for the future—hope that their preferences for care will be met, that no harm will come to them, that their symptoms will be well managed, and that necessary support is provided as their condition declines, as depicted in the GCM. When older Americans were asked about the most important ways to keep a positive outlook on life, the top 5 answers were as follows: a loving family, faith or spirituality, a positive attitude, a happy marriage or relationship, and taking care of one's health.[30]

Supportive relationships are one of the strongest predictors of well-being. Therefore, it is not surprising that cognitively intact nursing home residents credited their well-being to ongoing relationships with nurses.[31] Other research identified specific ways that nurses impacted patients' well-being: (1) being there with a willingness to relate; (2) being with each other enables the feeling of comfort; and (3) being in tune while creating the future.[32] These themes directly relate to Caritas processes 1, 2, 4, 5, 6, and 8 (Box),[33] which are one of the core aspects of the theory of human caring.[6]

**Box. Dr Jean Watson's Theory of Human Caring: Ten Caritas Processes[33]**

1. Sustaining Humanistic-altruistic Values by Practice of loving-kindness, compassion, & equanimity with self/other.
2. Being Authentically present, enabling faith/hope/belief system; honoring subjective inner, life-world of self/other.
3. Being sensitive to self and others by cultivating own spiritual practices; beyond "ego-self" to transpersonal presence.
4. Developing and sustaining loving, trusting-caring relationships.
5. Allowing for expression of positive and negative feelings—authentically listening to another person's story.
6. Creatively problem-solving-"solution-seeking" through caring process; full use of self and artistry of caring-healing practices via use of all ways of Knowing/Being/Doing/Becoming.
7. Engaging in Transpersonal teaching and learning within context of caring relationship; staying within each other's frame of reference—shift toward coaching model for expanded health/wellness.
8. Creating a healing environment at all levels; subtle environment for energetic authentic caring presence.
9. Reverentially assisting with basic needs as sacred acts, touching mind/body/spirit of spirit of other; sustaining human dignity.
10. Opening to spiritual, mystery, unknowns—Allowing for miracles.



Along with health, well-being is widely recognized to be the goal of nursing. The definition of nursing by the ANA states, "Nursing encompasses the protection, promotion, and restoration of health and *well-being* (*italics added)*; the prevention of illness and injury; and the alleviation of suffering, in the care of individuals, families, groups, communities, and populations."[20(p1)] Nursing theorists such as Watson,[34] Rogers,[35] and Swanson,[36] to name just a few, have identified well-being as the purpose or outcome of nursing.

Swanson states, "To experience well-being is to live the subjective, meaning-filled, experience of wholeness.... Healing, the process of re-establishing well-being, includes releasing inner pain, establishing new meanings, restoring integration and emerging into a sense of renewed wholeness."[36(p353)] Given the population addressed by the GCM for which the restoration of health is

unattainable, the primary goal of well-being is an ethical-moral-philosophical one, consistent with disciplinary values.

When the restoration of health is not possible as in end-stage illness, the model claims that well-being should be the focus of caring-healing interventions. This reflects current thinking among geriatric and palliative care experts who discourage aggressive medical care at end of life, which does not prolong life in meaningful ways, nor promote well-being.[25,27,37] The GCM proposes that older persons nearing end of life derive well-being when they are attended to by professional and family caregivers, assuring them that they will not be alone, that they will not be allowed to suffer, and that their needs will be met. Therefore, a proposition of the GCM is that well-being is the goal of nursing care and that the interventions in the 4 domains delivered in the Caritas field will result in well-being.

## Four domains

### *Aligning care*

The first caring domain is *aligning care*, which is defined as the intentional acts of ensuring that health care is aligned with the person's values, goals, and preferences. The ethical principle that guides this domain is autonomy, an "agreement to respect another's right to self-determine a course of action; support of independent decision making."[38]

Aligning care can be fostered by asking questions of older persons/families. "What is your understanding of your illness?" This question provides an opening for the nurse to confirm the patient's understanding or to clarify misunderstandings. Before providing information, the nurse might ask, "Would you like me to review some options with you?" The nurse helps the patient envision the future by explaining available options and the meaning that each holds for the patient/family, a nursing intervention known as anticipatory guidance.[26] If the patient declines this information, a response such as "I respect your wishes. I'll check back with you in the future in case you have any questions," allowing the patient to control the type, amount, and timing of the information he or she wishes to receive.

Asking, "What is most important to you at this time?" helps establish the patient's priorities for care. This caring domain requires the nurse to advocate for the person/family using his or her knowledge of the clinical options, professional communication skills, underlying ethical principles, and moral courage to persist when others (professional or family) choose to proceed with treatment other than that which the person has chosen or when others attempt to withhold treatment the person has elected.

Turnbull and Hartog[17] suggest 2 questions as a litmus test for goal-concordant care. First, "Was the patient's goal potentially achievable at the time of treatment?" and "Will the treatment help achieve the patient's goal and respect the patient's treatment limitations?"[17(p2)] The authors point out that goal-concordant care may differ from providing appropriate medical treatment as defined by clinicians. Patients may opt for being able to return home, attend a family wedding, be comfortable, or see a grandchild born.

Standard 3 of the ANA Scope and Standards of Practice states, "The registered nurse identifies expected outcomes for a plan individualized to the health care consumer or the situation."[20(p3)] The competencies associated with this standard directly relate to the GCM, a few that are especially important at end of life.

The registered nurse:

- Involves the health care consumer, family, health care providers, and others in formulating expected outcomes when possible and appropriate.
- Considers associated risks, benefits, costs, current scientific evidence, expected trajectory of the condition, and clinical expertise when formulating expected outcomes.
- Modifies expected outcomes according to changes in the status of the health care consumer or evaluation of the situation.[20(p35)]

This standard and its associated competencies provide professional evidence that these activities are clearly within the nurses' scope of practice.

Possible caring-healing interventions in this domain are:

- Deep listening, being with;
- Ensuring goals of care are understood by all;
- Helping patients envision the future;
- Preparing patients/families for the future;
- Providing patient/family information about palliative care; and
- Requesting palliative care consult.

Finally, stopping treatment is to be offered as an important option for all patients in late-stage illness, particularly when treatments are no longer effective.

*Links to Caritas processes*: This caring domain relates to Caritas processes 2, 4, 5, and 7 (see the Box).

*Outcomes*: The expected outcomes of these caring-healing interventions are that the older person/family experiences well-being because they can tell their story, expressed in an authentic way, without judgment or fear of reprisal, and receive assurance that their preferences will be honored.

### *Keeping safe*

The second caring domain is *keeping safe*, which is defined as those population-specific strategies that prevent harm and promote healing tailored to the individual person. The ethical principle that guides this domain is nonmaleficence, which is defined as the "avoidance of harm or hurt; core of medical oath and nursing ethics."[38] Watson states that "safety considerations . . . are critical needs largely confined to the professional nurse's domain.[6(p132)] Keeping safe requires the nurse to consider, "What are the likely harms that can occur for this particular person, given his/her functional, cognitive, and medical status?" and "What interventions should be included in the plan of care to avoid those harms?"

This caring domain requires the nurse to know and apply state-of-the-science geriatric evidence in order to identify and mitigate risk. Despite the success of geriatric models of care, for example, acute care of the elderly units and the geriatric resource nurse model put forth by Nurses Improving Care to Healthsystem Elders (NICHE),[39] widespread dissemination has been lacking.[40] *Retooling for an Aging America* points to the urgent need for a geriatric-trained workforce and the need for widespread dissemination and adoption of evidence-based, geriatric guidelines.[40]

Possible caring-healing interventions in this domain are:

- Reviewing medications for inappropriate use in the elderly;
- Assessing risk for falls and developing a tailored plan to prevent;
- Protecting skin with lotion and sleeves to prevent skin tears;
- Encouraging early mobility to prevent deconditioning; and
- Implementing a delirium prevention plan.

*Links to Caritas processes*: This caring domain relates to Caritas processes 6, 8, and 9 (see the Box).

*Outcomes*: The expected outcomes of these caring-healing interventions are that the older person experiences well-being because of the nurse's commitment and actions to protect him or her from harm.

### *Comforting body-mind-spirit*

The third caring domain is called *comforting body-mind-spirit*, which is defined as caring-healing acts that minimize human suffering. The ethical principle that guides this domain is beneficence, which is defined as "compassion; taking positive action to help others; desire to do good."[38] Comforting body-mind-spirit requires assessment by asking such questions, "What is distressing to you?" and "Tell me about your suffering." This caring domain requires the nurse's knowledge of palliative care, which is an

expanded view of human suffering and the assessment and interventions to alleviate suffering from physical, emotional, spiritual, and existential sources to promote well-being. This domain correlates with ANA definition of nursing, which includes, "... the alleviation of suffering,"[20(p1)]

Possible caring-healing interventions in this domain are:

- Offering hope to another through presence and healing energy;
- Using standardized approaches to symptom assessment and management;
- Remaining present until distressing symptoms subside;
- Reflecting on one's own understanding of illness, end of life, faith, and cultural beliefs that may impact one's response to others; and
- Listening to both positive and negative feelings to allow for healing.

*Links to Caritas processes*: This caring domain relates to Caritas processes 5, 6, 9, and 10 (see the Box).

*Outcomes*: The expected outcomes of these caring-healing interventions are that the older person experiences well-being because his or her distressing symptoms were addressed in a timely, effective manner, helping him or her avoid suffering while maintaining a close, supportive human connection.

### *Facilitating transitions*

The fourth caring domain is called *facilitating transitions*, which is defined as the acts of helping persons/families transition to the next place of care, the next mind-set, a lower functional status, or a peaceful death. The ethical principle that guides this domain is fidelity, which is based upon "loyalty, fairness, truthfulness, advocacy, and dedication to our patients. It involves an agreement to keep our promises. Fidelity refers to the concept of keeping a commitment and is based upon the virtue of caring."[38] Facilitating transitions requires assessment by asking questions, such as "What are your goals of care at this point in your illness?" and "What is *most* important to you?" This caring domain represents the physical movement of a person from one care setting to another, as well as the emotional/spiritual/existential movement of a person from one mind-set to another, that is, curative treatment either to a palliative approach or to a peaceful death. Jormfeldt summarizes,

> The concept of "transition" is closely related to health and well-being because the meaning of the term involves psychological processes in which the patients adapt to a changing reality. Transition is accordingly a main concern in nursing irrespective of specialization as it involves processes of movement from one state, condition, or situation to another.[41(p23026)]

Possible caring-healing interventions in this domain are:

- Deep authentic listening and being with through this stage of loss;
- Gently asking simple questions, such as "What most concerns you?" "What are your fears?" "What are your worries?"[37]
- Setting the stage for private and meaningful discussions with family that entail loving memories, appreciation, gratitude, forgiveness, and reconciliation;
- Exploring sources of strength, hope, faith, growth, and love through simple questions, such as "What gives you hope?"
- Assisting the person to transfer to his or her preferred setting of care, if possible; and
- Envisioning the future and providing anticipatory guidance.

*Links to Caritas processes*: This caring domain relates to Caritas processes 3, 5, 8, and 10 (see the Box).

*Outcomes*: The expected outcomes of these caring-healing interventions are that the older person experiences well-being because he or she is supported as he or she enters the next phase of illness, which may entail the end of curative treatments, transfer to another setting, losses, potential for growth, or a dignified death; that the older person can

articulate his or her source of hope-strength and be in right relation with Source and others.[6]

### Theoretical framework

The GCM is based in caring science, which is a distinct disciplinary view of the profession of nursing, a moral-philosophical-theoretical-foundation that honors what it means to be human and the oneness of mind/body/spirit/universe.[6] Palliative care is defined as a philosophy of care as well as a structured delivery model of care to persons with serious illness that addresses physical, psychosocial, emotional, spiritual, and existential needs.[42] Palliative care, in general, requires of its practitioners an overall approach to others that honors autonomy, choice, and meaning through deep human connection. Similarly, caring science requires a deeper way of being with other and is synergistic with the goals of palliative care.

### Caritas field

*Caring science makes more explicit that unity and connectedness exist among all things in the great circle of life: change, illness, suffering, death, and rebirth.*[6(p17)]

The Caritas field is "the inner world of practice at the heart level."[6(p197)] It is created by the nurse through intentionality, authentic presence, and deep listening, the matrix of the person-nurse interaction, the place of human-to-human connection, and understanding. Watson describes it as a field of compassion, an evolving Caritas consciousness, a calming, soothing "loving presence amid life, threats, and despair."[6(p197)] Notably, nurses who intentionally create this sacred space *become* the field,[6] allowing for healing and well-being.

Caring literacy is described as the capacity to access ontological ways of being that allow the nurse to enter the other's life world and build loving, trusting relationships.[43] Examples of caring literacy are manifest as, "the nurse's ability to center, read the field when entering the other's life space, be present, maintain eye contact, authentically listen/hear behind the words, be in silence waiting for other to reflect, hold other with an attitude of unconditional loving kindness, to name a few."[6(p25)] These competencies, or caring literacy, are precisely those required when working in palliative care. Persons with serious or life-limiting illness, or extreme old age or frailty, can be helped to find meaning, wholeness, integrity, and purpose through the nurse who becomes the energetic-vibrational field of consciousness.

The Caritas field is the moral-philosophical-ontological starting point that promotes well-being in and of itself and without which the interventions in the 4 domains would be relegated to tasks. Caring literacy, required in the specialty of palliative care, must be cultivated by "a lifelong process of journey of self-growth and self-awareness."[6(p27)]

## DISCUSSION

The GCM is urgently needed because of unprecedented growth in the world's aging population that could benefit from palliative care in the setting of decline. As Rogers pointed out, "Health and welfare services relevant to the past are no longer germane. Nursing carries a significant responsibility in the great task of designing and implementing health and welfare services commensurate with changing times and human needs."[35(pviii)] The emphasis on technocure,[6] which originated with the advent of the intensive care unit, is fortunately beginning to shift to person-centered care, although there is great geographic variability in the United States. Nurses are signaling their support of a paradigm change to that which serves older persons who are nearing end of life—to be home (if desired), with loved ones, and support that ensures well-being. Achieving person-centered goals requires moral courage of nurses who, having committed to this philosophy and practice of geropalliative care, are speaking up and serving as catalysts for systems change in the United States and abroad.

### Implications for practice

End of life for older persons is complicated by prognostic uncertainty; yet, nurses are often the first to recognize irreversible decline. The GCM, which is underpinned by the ANA Scope and Standards of Practice,[20] provides moral, theoretical, and disciplinary legitimacy for nurses to engage in all aspects of caring for persons nearing end of life.

Holding discussions about persons' priorities and goals of care in humane and sensitive ways requires caring literacy, which Watson defines as ontological or people skills, an "evolved and continually evolving emotional heart intelligence, consciousness, intentionality and level of sensitivity and efficacy, followed by a continuing lifelong process and journey of self-growth and self-awareness."[6(p23)] Training in End-of-Life Nursing Education Consortium (ELNEC),[44] AgeWISE,[5] family meetings, interprofessional communication are essential competencies of nurses.

### Implications for policy

Older persons are less likely to access palliative care despite their disproportionate burden of illness.[24] Primary palliative care is a disruptive innovation because the basic work of secondary palliative care (consult teams) is being accomplished by clinicians on the front line. Nurses are having goals of care conversations, which have historically been the purview of medicine. Although evidence shows that physicians are not having timely conversations,[24] nurses are engaging with patients to meet their needs in meaningful ways.

Recognizing the national shortage of geriatric resources[40] and the underlying societal values that are reflected therein, the interpersonal caring-healing focus of the GCM can increase access to palliative care and maintain human dignity and choice. In the instance where providers deny access to palliative care consults, nurses can assemble teams of professionals, such as social workers, chaplains, ethicists, and nutritionists, to provide enhanced well-being and comfort to patients and families.

Well-being is threatened where resources do not exist to support care for older persons in the setting of their choice. Seventy-five percent of older Americans state that they intend to live in their current homes for the rest of their lives, and 79% expressed confidence that they would be able to find help and support in their communities as they age.[30] Medicare, however, does not provide support for functional assistance in the home, nor in long-term care. It is typically left to nurses, as clinicians, care coordinators, and discharge planners, to bear the bad news to older persons and their families when resources fall short of expectations. Fortunately, the current generation of older persons typically expresses gratitude for the efforts of nurses and is accepting of the shortcomings of the health care system.

### Implications for education

One of the greatest barriers to access is the inadequate medical and nursing workforce with expertise in palliative care.[11,40] Primary palliative education for all frontline clinicians is a national priority.[11] The Institute of Medicine recommends geriatric and end-of-life content in undergraduate and graduate nursing education to improve the lives of our aging population.[11,40] Improving nurses' effectiveness and influence on teams, through ELNEC[44] or AgeWISE,[5] for example, can help nurses communicate with evidence: "I suggest we consider this decision as a team. Mr. X has Stage 7 Alzheimer's Disease and is severely frail. The likelihood of him surviving the surgery and achieving his family's goal of taking him home are very low. Can we explore what going home would entail?" Education programming in geropalliative care and ethics should focus on increasing nurses' effectiveness when advocating for patients in ways that are collegial, evidence-based, person-centered, and, ultimately, influence the decision of the team.

### Implications for research

The GCM has evolved from a synthesis of research in geropalliative care and in practice. Evaluation of the model has occurred in situ

(practice) for 7 years by more than 500 nurses. Formal evaluation of the model is required and will entail a mixed-methods approach, using surveys as well as a phenomenological inquiry that honors the subjective experiences of older persons, consistent with its underlying theory of human caring.[6] Future research should include an exploration into the experiences of patients/families/nurses who are exposed to this model of care.

Evaluation feedback from more than 500 registered nurses who completed AgeWISE using an early iteration of the GCM shared the common experience of moral distress when caring for older adults whom they perceived were not benefitting from aggressive medical treatments. In a similar residency program, called the Clinical Ethics Residency for Nurses, the authors demonstrated a reduction in moral distress through increased self-efficacy and moral effectiveness.[45] Further research is warranted on the GCM to determine whether the use of the GCM impacts moral distress as well.

## Implications for the evolution of nursing knowledge

This article, through a synthesis of current thinking in geropalliative care, nursing disciplinary values, and nursing theory, describes the GCM, a situation-specific theory that evolved from practice. The goal of the GCM is to increase nurses' effectiveness in achieving well-being among older persons who are likely in the last year of life through caring interventions in 4 priority domains. The GCM is consistent with the properties of situation-specific theories as outlined by Im and Meleis[2]; it is at a low level of abstraction, reflects the specific nursing phenomena of caring, uncertainty, anticipatory guidance, in the context of limited life expectancy, is connected to practice, and is limited in generalizability. As demonstrated here, the GCM was not only clinically derived but also emerged from synthesizing and integrating research.[2]

The GCM has been used in practice by nurses who have been educated in the model since 2010, with reports of their feeling better informed and empowered to deliver person-centered care in the setting of limited life expectancy. The intent of this article is to demonstrate the usefulness of the GCM as a framework for primary geropalliative nursing practice, education, and clinical decision-making within the current paradigm of goal-concordant care, which is consistent with nursing's professional scope and standards and values. This article attempts to empower nurses with language, voice, and legitimacy in their sacred work of caring for persons at end-of-life.

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