Managing symptoms, providing information, and supporting families as well as patients are key aspects of palliative care. However, palliative care definitions and perspectives vary widely in clinical practice and often do not align with palliative care organizations’ perspectives. Definitional discrepancies may result in delayed referrals and role confusion, which often limit the effectiveness of palliative care programs and contribute to gaps in care and services for patients and their families. The aim of this research study was to explore oncology nurses’ perspectives of palliative care through narrative analysis of participants’ descriptions of life experiences. Studying nurses’ perceptions of their roles in palliative care offers an opportunity to examine and improve clinical practice. Nine focus groups were conducted with 33 oncology nurses in three medical centers in the midwestern region of the United States. Researchers inductively coded research text within each focus group session, sorted across sessions using Atlas.ti 5.2 software, and then applied categorical-content narrative analysis. Findings revealed five primary nursing roles: teaching, caring, coordinating, advocating, and mobilizing. In all five roles, seven professional attributes were described: clinical expertise, honesty, family orientation, perceptive attentiveness, presence, collaboration, and deliberateness. Integrating palliative care standards into role and attribute development and working with palliative care specialty teams are suggested.
Nursing Roles in Palliative Care

Very few research studies have explored perspectives of nursing roles in palliative care (Johnston, 2005) and most that have were conducted before the conceptual shift in palliative care’s scope of practice (Philip & Komesaroff, 2006). Research on palliative care nursing primarily focuses on gaining insights about nursing care at the end of life. For example, in a study by Degner, Gow, and Thompson (1991) of palliative care nurses and nurse educators, seven critical nursing responsibilities were described: providing comfort, responding during the death scene, responding to anger, enhancing personal growth, responding to colleagues, enhancing quality of life during dying, and responding to the family.

Using a grounded theory approach to examine nurses’ clinical roles in palliative care, Davies and Oberle (1990) found that providing support was the primary role that nurses enacted. The authors described nursing support in palliative care as having six interwoven dimensions: valuing, connecting, empowering, doing for, finding meaning, and preserving integrity. Valuing their own support role allowed nurses to connect to palliative care patients in an effort to help patients discover meaning in their struggles. Preserving patients’ integrity was the central concept which required nurses to perform tasks for patients within a framework of empowerment. The authors developed a supportive care model which has been widely accepted in clinical practice (Davies & Oberle, 1992).

Perry (1998) studied nursing narratives to explore exemplary nursing practice in palliative care and oncology nursing. The author found connectedness at the heart of exemplary nursing practice whereby care providers and care receivers are co-participants in caring. Sharing the human experience of caring allowed nurses and patients to transcend self and engage with each other toward healing and harmony.

Johnston and Smith (2006) explored the experience of being expert palliative care nurses from the perspective of the nurses and the dying patients. The central theme of ‘connecting’ allowed all other aspects of care to occur. Patients emphasized their preference for maintaining independence while accepting nurses’ support, comfort, and care. Nurses emphasized interpersonal skills and knowledge in working to provide care and comfort for their patients.

Philip and Komesaroff (2006) conducted focus groups with palliative care specialists including nurses, physicians, social workers, and pastors to examine the concept of ideal palliative care. Participants were asked to consider an expanded palliative care view which extends beyond end-of-life care to include patients in all stages of living with life-limiting diseases. According to those palliative care specialists, establishing a relationship, setting goals, providing symptom relief, advocating, communicating, accepting, being flexible, and recognizing the uniqueness of each person were the primary palliative care ideals. However, participants also described real-world obstacles such as time constraints which often prevented ideal practices from being fully implemented. Role stress can be experienced as palliative care professionals negotiate between palliative care ideals and real-world obstacles.

Methods

Two institutional review boards approved this study. Exploring oncology nurses’ life experiences with palliative care, the authors conducted nine, one-hour focus group sessions with 33 oncology nurses in three urban medical centers in the midwestern region of the United States. Participants’ nursing experience ranged from 1.5 to 40 years and averaged 15.9 years; oncology nursing experience ranged from 1.5 to 29 years and averaged 11.8 years. A palliative care consult team and educational conferences based on the End-of-Life Nursing Education Consortium (2005) were available at each center. Using a semi-structured interview guide, the authors asked nurses to describe their involvement in specific palliative care situations. The audio-recorded sessions were then transcribed into written research text. Implementing the categorical-content method of narrative analysis (Lieblich, Tuval-Mashiach, & Zilber, 1998), the authors inductively coded each focus group session sentence by sentence and then sorted codes across sessions by using Atlas.ti 5.2 data management software. Five data categories emerged from initial coding—one of which was nursing roles in palliative care. Focusing on the role data category, the authors recoded and identified words, phrases, and groups of sentences that suggested specific role clusters. A circular procedure which included careful reading, cluster identification and comparison, re-reading, and refining coding clusters resulted in five primary nursing roles with specific attribute descriptors within each role.

Findings

Palliative care definitions varied to some degree among participants. For example, although a few participants believed that palliative care pertains to the spectrum of cancer, most participants believed that palliative care is restricted to patients toward or at the conclusion of life. However, all participants described palliative care nursing as encompassing a process of working with patients and their families to alleviate suffering, achieve holistic comfort and well-being, and attain patients’ quality-of-life goals and preferences.

In enacting palliative care, oncology nurses described five nursing roles: teaching, caring, coordinating, advocating, and mobilizing (see Table 1). However, participants rarely illustrated the roles with functional activities. Instead, nurses described their clinical practice with palliative care patients in terms of professional attributes. As character descriptions, the attributes seemed to reflect a philosophical mindset through which roles were enacted and nurses practiced palliative care. Seven professional attributes occurred in all five roles (see Table 2).

Clinical Expertise

Whether helping patients to consider treatment options, responding to patients’ queries about symptom management, or...
offering information to allay anxiety, nurses emphasized that being knowledgeable is an important responsibility. For example, several nurses commented on using their knowledge to inform patients and families about risks and benefits of treatment options so that patients “feel like they are making fully informed decisions.” Linking their clinical expertise about disease trajectory, treatment options, and symptom management to being a “better nurse and forming a stronger team to benefit patient care,” nurses suggested that being knowledgeable improves patient outcomes. Knowing various pain-management strategies offered “more chances to achieve patient comfort.”

In addition, nurses often applied their clinical expertise within an awareness of patient preferences. For example, several participants indicated that the most important aspect of palliative care is to “know what treatments patients want, what they want their plan of care to look like, and also what the family wants to be happening.” Nurses discussed using their clinical knowledge to help patients consider their own preferences when examining treatment options. For example, one nurse described using her clinical expertise when helping patients decide on venous access options. Other nurses described applying their knowledge to alleviate patients’ fears of dying. One stated,

A lot of people are afraid of dying, so they ask, “What will it be like?” and I tell them all the things that we can do to make them comfortable so they feel less anxious about feeling short of breath or experiencing pain.

Nurses emphasized that, in palliative care, “There’s always something that can be done,” and being knowledgeable provides many ideas for alleviating symptoms and improving quality of life and, therefore, patient outcomes in the living-while-dying process.

Clinical expertise often was described in the context of knowing the patient. For example, one nurse explained,

We have to advocate for [the patients] so we can say, “Okay, don’t do [metoclopramide] with her nausea. Start with [ondansetron]. If that doesn’t work, then try [lorazepam]. And she loves back rubs, but don’t touch her feet. Or if her pain exacerbates, give two of morphine. Don’t go further than that or you’ll put her out.” I think it means a lot to [patients] to know that we are advocating for them.

Knowing the patient became part of the clinical expertise that nurses use to advocate more effectively and ensure that “the right things are happening” and “the right things are being done for [patients].” Commenting on the most important aspect of palliative care, one nurse stated, “I think patients want to know they’re been heard, that their top priority is being addressed.” Similarly, another nurse suggested, “It’s very important for each patient to individually define what quality of life means to them. That’s where we need to focus our care.” Clinical expertise offered nurses multiple options in helping patients achieve quality of life.

Honesty

Many nurses suggested that being honest demonstrates respect and is essential to a trusting and therapeutic relationship with patients and their families. For example, one participant stated,

Since I care about them, I try to be honest. When questions arise, I don’t dodge the bullet. But I also do it in a kind way and ask them, “Where do you think you are? What are your beliefs on dying? What about afterlife?” and help them define what it is and address their fears too.

Several nurses commented that being honest is a prerequisite to advocating for patient preferences. For example, one nurse said,
Many nurses commented on the importance of honesty so that patients, families, and the healthcare team are all on the same page with similar and realistic goals in mind.

Family Orientation

Although participants clearly aligned their advocacy role with patients, participants also described many incidents of working with families. The stories included helping family members develop confidence in their abilities to care for patients at home, preparing families for the grieving process, assisting families in accepting patients’ expressed preferences, and teaching families ways to relate to their dying loved ones. For example, when describing her interactions with families of dying patients, one nurse stated,

Family members ask “What do I do?” and I say, “You know what I think is nice? Go in and talk about a time that you spent together and that you will always remember. Be honest about what they mean to you.” I remember this one older gentleman told his dying son about the time he had taught him how to fish. It was such a touching story, and we were all crying. [Family care] is an important part of our palliative care.

Some nurses described bridging relationships between patients and their families. When family disagreements occur, nurses described attempting to open communication by “finding common ground” among family members. Commenting on family discord, one nurse stated, “We need to open dialogue and make sure everyone’s on the same page so when the time comes, everyone can show respect for the patient who is dying.” Another nurse described her advocacy role with patients.

Dealing with different family factions increases the patient’s anxiety. I could see this woman who was very alert pained by the arguing. When the family left the room, I said, “Ultimately this is your decision.” She needed to hear that and be supported in that, and within a couple of days, she chose hospice.

Being able to see their patients within the context of multiple relationships and assisting patients to reconnect with family members were cited as important aspects of palliative care.

Perceptive Attentiveness

Attending to patients’ unique situations and often-subtle needs was consistently emphasized in all focus group sessions. Details pertaining to the patient, such as “recognizing the need in someone’s eyes” or “feeling the need in the room” required perceptive attentiveness. Commenting on her perceptual awareness of patients’ unstated needs, one nurse said,

I become an extension of the patients. When I help them with their cares, I feel their needs and become an extension of their body or their mind so I can better help them when things feel out of control.

Several nurses noted that palliative care required them to “tune into” their patients and families. For example, describing her work with brain tumor patients who have a very short timeframe, a nurse commented, “I tune into their hopes. I will

I will always be truthful, but sometimes it’s bits of information, so it’s a process over a period of time. Then I say, “With that in mind, what do you really want to do? What’s important to you, what’s okay and what’s not okay?”

Interestingly, participants also emphasized “supporting patients even when they deny something because they just aren’t ready to say, ‘this is what’s happening.’” Without abandoning the ideal of honesty, nurses described the importance of remaining within a caring relationship and accepting patients “where they are with the disease.” For example, one participant described being honest with a patient who at first refused to enter hospice.

Later, she sent me a long e-mail after [entering the hospice]. She had been so angry with me every time I suggested hospice, even in a really gentle way, and she wrote, “Now I see what a gift you were trying to give me.” This is why I come to work.

Many nurses stressed the importance of being honest during end-of-life situations. One nurse stated,

Some patients get confused, and they ask me, “Do you think I am going to get better?” You don’t want to take hope away, but I think in a kind and gentle way you have to say, “You know from what I have seen, it seems to me that [this treatment] isn’t working, and this is probably what’s going to be happening next.” You have to be truthful without knocking the pins out from underneath them.

Similarly, commenting on advocating for patients’ preferences at the end of life, another nurse stated,

When I have an 82-year-old dying woman who no longer wants a feeding tube and she’s alert, I do not want to argue with the physician. I want to be able to do what the patient wants me to do.

Clinical Journal of Oncology Nursing • Volume 13, Number 4 • Nursing Roles and Professional Attributes in Palliative Care

| Table 2. Nursing Attributes in Palliative Care |
| PROFESSIONAL ATTRIBUTE | PERTINENCE IN PALLIATIVE CARE |
| Clinical expertise | Symptom management and comfort strategies |
| | Patients and their preferences and unique responses to treatment |
| | Dying process |
| Honesty | Foundation to a trusting and therapeutic relationship with patients and families |
| | Prerequisite to patient advocacy |
| | Foundation to a cohesive treatment plan |
| Family orientation | Patients within context of multiple and dynamic relationships |
| Perceptive attentiveness | Unspoken needs |
| | Situation-specific details |
| | Life needs in the context of illness |
| Presence | Calmness or peacefulness |
| | Spiritual and existential connection |
| Collaboration | Cohesive treatment plan (being on the same page) |
| | Patients as experts |
| Deliberateness | Goal-directed, purposeful Preparation |

I become an extension of the patients. When I help them with their cares, I feel their needs and become an extension of their body or their mind so I can better help them when things feel out of control.

Several nurses noted that palliative care required them to “tune into” their patients and families. For example, describing her work with brain tumor patients who have a very short timeframe, a nurse commented, “I tune into their hopes. I will
Being perceptive about subtle details often was linked to nurses’ attempt to tailor their care and alleviate distress.

Many nurses indicated that the most significant aspect of palliative care is “listening and investigating who your patient is and making them feel like a real person and not just a patient with an IV or [nasogastric tube].” Seeing patients as “multi-faceted and multi-layered,” nurses often attended to “patients’ life needs in the context of chronic illness.” One nurse asserted, “We need to get away from the medical stuff sometimes and just sit and listen, find out about their interests, what they enjoy in life, personal things they may want to share.” Another nurse suggested, “Time is needed to develop relationships with patients. Knowing [patients] makes a huge difference, so patients and families aren’t all by themselves but have providers they know and can trust.”

Additionally, being consistently attentive in the lives of hospitalized patients, nurses felt they had the unique responsibility to detect subtle changes. For example, describing attentiveness to fluctuations, one nurse said,

Physical needs might not change often, but emotional needs change all the time. Today, maybe the daughter is coming from California and she needs someone to listen to her, and so we need to be there. And maybe she knows something that needs attention that no one else has brought up, and maybe the social worker needs to be brought into the picture, but no one has known about that. Maybe no one has thought to bring it up. But if you stand and attend to her, you’ll hear that. But you have to have time to be in the room to catch all that.

Another participant narrated a situation about a young patient who had difficulty deciding whether to die at home or in the hospital. Once the patient decided to go home, the nurse described how several nurses worked hard to prepare the patient, who had a complex care regime, to return home for her “final journey.” Being attentive to multiple family and patient-specific needs eased anxieties and facilitated the transition. The nurse poignantly summarized by saying, “Even though she died in the car on her way home, she died knowing that we cared enough to attend to all of those details, and that’s very reassuring to patients and their families.”

Presence

Participants often described the importance of “being available” and “being with” palliative care patients and their families. For example, one nurse commented, “I think an overall presence where [patients and families] can feel comfortable is needed. They have to be able to trust you.” Another nurse stated, “It’s a kind of calmness and peacefulness that you bring into the room so they really feel you are there for them.” Other nurses represented presence in the midst of “complicated technology” as “listening carefully,” “speaking last,” or “making people feel cared about.”

Participants also depicted presence in an abstract, spiritual manner. Some nurses discussed the importance of recognizing common human bonds “within the circle of life” or being “on the wheel of life together.” One nurse summarized,

You feel like you’ve gone full circle with the patient and their families. That you were there in the beginning when they were trying really hard and now you can be there for them to make things more comfortable at the end. You feel honored to be part of the whole process.

Another nurse elaborated on presence simply as caring. “Palliative always comes with care behind it, which means we’re able to take the care path rather than focusing just on all the nursing tasks that have to get done.”

Collaboration

That all team members “should be on the same page” was iterated repeatedly as an important aspect of palliative care. Regretting busy schedules and brief encounters with other healthcare members, nurses expressed frustration with conflicted goals, fractured communication, and fragmented care. Describing nurses as liaisons to all other healthcare services, one nurse stated,

Nursing gets put in the middle of everything. Dietary, pharmacy, supplies, therapists, doctors, families, social workers, home health coordinators … we’re in the middle of it. The logistics of coordination are very difficult.

Believing in the importance of open communication and clear goals, many nurses reported expending considerable effort toward “being diplomatic” and “coordinating services” to improve patient care. Another nurse said, “The goal is to bring the patient, family, and the whole care team to the same page, because someone who’s been given a terminal diagnosis is pretty lonely unless everybody is on the same page.”

Other nurses described collaboration as the spirit within which nurses entered the nurse-patient relationship. Working with chronically ill patients who manage their own care outside of the hospital required recognizing patients as the experts of their own experiences. “Following [patients’] home regimen” and “asking for their priority goals” were important aspects of collaboration. In addition, “seeking family perspectives,” “avoiding our own agendas,” and “bending a bit more to do things the way they want” illustrated participants’ emphasis on collaboration in all roles.

Deliberateness

Participants frequently suggested that being deliberate and goal-directed benefited palliative care. For example, some nurses discussed the need to think deliberately about a cohesive team approach, and other nurses described the importance of carefully determining long- and short-term goals. Depicting a very successful care conference, one nurse narrated,

We cared for an elderly, spry woman who was diagnosed with new disease in a different spot. She had surgery options and chemotherapy options, and neither she nor her family knew what that would be like. Physicians were asked ahead of time to focus on expected outcomes of treatment options and her quality of life. I think the reason it worked well was because the [healthcare team] were all prepped ahead of time that this was going to be different. The family was also prepped ahead of time to really sit back and listen and let the patient decide for herself what she was willing to put up with or not put up with. It was very successful.
Another aspect of deliberateness was illustrated by a nurse who described the “fast-paced” healthcare system with patients who move in and out very quickly. She stated that, “Our challenge is to take that moment, that one window of opportunity, and transmit that we care about them because we do.” Being deliberate and transparent about care was essential to “developing trust whereby everything goes better.” Suggesting that society devalues the dying process, another nurse stated, “We deliberately set up a birth plan that everyone agrees to. We look forward to it. Why can’t we have a death plan where people say, ‘Well, here’s what I want it to look like?’”

**Discussion**

The results of this study revealed that participants’ definitions of palliative care are, for the most part, consistent with palliative care principles. For example, palliative care specialists in professional organizations such as the Hospice and Palliative Nurses Association, American Academy of Hospice and Palliative Medicine, and Center to Advance Palliative Care collaborated to develop palliative care standards and published the *Clinical Practice Guidelines for Quality Palliative Care* (National Consensus Project, 2009). To promote the highest quality of palliative care in all settings and with a variety of healthcare providers, the specialists asserted that excellence in palliative care services requires expertise in eight domains (see Table 3). Similar to the palliative care definitions offered by participants in this study, the domains emphasize holistic comfort as well as person-centered and family-oriented care. Respect for patient preferences also is evident. However, three differences are noted. First, although a few participants mentioned culture, most did not stress the cultural aspects of providing palliative care. Second, although aspects of ethical practices were evident in the participants’ narratives, nurses did not specifically name or describe ethical principles that guide their practice (American Nurses Association, 2001). In addition, mention of legal aspects as such as advanced directives or healthcare proxy was absent. The Hospice and Palliative Nursing Association (2007) emphasized culture and ethics in its care standards. Therefore, these differences provide direction for advancing oncology nurses’ practice in palliative care.

The World Health Organization’s (2002) definition of palliative care pertains to all patients and families who are experiencing life-threatening illness. In addition, NCCN (2008) identified standards for integrating palliative care into all health care for persons across the continuum of living with debilitating and life-threatening cancers. Most oncology nurses in the current study indicated that they applied palliative care practices only toward the end of life rather than across the continuum of oncology care. This difference indicates that more education is required to recognize the need for palliative care across the spectrum of care rather than just end-of-life care.

The five primary roles that oncology nurses perform in caring for palliative care patients and families seem very consistent with the palliative care standards suggested by professional organizations. For example, coordinating care is an essential component of quality palliative care services (American Academy of Hospice and Palliative Medicine, 2006; Hospice and Palliative Nurses Association, 2007). Interestingly, some nurses in the current study expressed frustration with their role of coordinating care among services. Several nurses suggested that the information they gather while being attentive to patients’ preferences is important to communicate to the health team. Regular care conferences were viewed as important opportunities to share patient-specific needs and details so that “patient and family priorities or problems can be addressed as a team effort.” However, many nurses followed these comments with regrets about limited time available in the acute-care setting for healthcare team collaboration and cited systemic barriers such as busy physician clinic schedules, inconsistent staff assignments, and workload demands.

In their narratives, research participants consistently emphasized professional attributes instead of specific role activities. Some possible explanations exist. First, research limitations such as the small number of participants and the semi-structured nature of a focus group might have resulted in inadequate data on role activities. Second, oncology nurses’ palliative care roles are perhaps in this context not specifically stated and become folded within their larger oncology practice. Therefore, participants could not distinguish specific palliative activities from oncology role activities. Third, participants might be operating from various, unstated palliative care perspectives which often lead to lack of role clarity and cohesion (Yachon, 2001). With palliative care specialty teams available at each of the three medical centers within which this research occurred, role boundaries were perhaps unclear.

Although the authors did not necessarily learn more about role activities in this research, a deeper understanding about professional attributes that prevail in all five palliative care roles was realized. The authors note several consistencies between the current findings and other research on palliative nursing care. For example, participants substantiated Johnston and Smith’s (2006) finding that “connecting” is a vital component of palliative care. In the current research, nurses also included the idea of connecting to patients. Whether being present to patients’ experiences, being knowledgeable about patient preferences, or being attentive to patients’ needs, being able to connect to palliative care patients and their families was essential. Exemplifying another similarity, Georges, Grypdonck, and De Casterle (2002) discovered that nurses strive to apply a “well-organized and purposeful approach” to palliative care situations (p. 787). Participants in the current study described clinical expertise and deliberateness as important professional attributes for palliative care. Research participants also added evidence to the idea that palliative care has expanded beyond simply enacting professional role functions and into developing trusting and caring relationships (Mok & Chiu, 2004). In addition, professional attribute descriptions found in the current study are consistent with the nursing literature on caring processes that include values, intent, knowledge, and advocacy (Gadow, 1985; Watson, 1988).

As part of professional attribute descriptions, the participants emphasized the importance of “knowing the patient.” Other research studies have linked “knowing the patient” to quality palliative care (Luker, Austin, Caress, & Hallett, 2000), ideal palliative care (Philip & Komesaroff, 2006), and trust development (Mok & Chiu, 2004). However, although being knowledgeable about patients’ preferences and priorities was highly valued in the current study, several nurses expressed frustration with acute care’s emphasis on technological care, which sometimes limited...
A comprehensive interdisciplinary assessment identifies the social needs of patients and families and a care plan is developed. The interdiscipli

dary team provides services to patients and family consistent with the care plan. In addition to nursing, medicine, and social work, other therapeutic disciplines with important assessment of patients and families include physical therapists, occupational therapists, speech and language pathologists, nutritionists, psychologists, chaplains, and nursing assistants. For pediatrics, this should include child-life specialists. Complementary and alternative therapies may be included. The use of appropriately trained and supervised volunteers within the interdisciplinary team is strongly encouraged. Support for education and training is available to the interdisciplinary team.

In its commitment to quality assessment and performance improvement, the palliative care program develops, implements, and maintains an ongoing data-driven process that reflects the complexity of the organization and focuses on palliative care outcomes. The palliative care program recognizes the emotional impact on the palliative care team of providing care to patients with life-threatening illnesses and their families. The palliative care programs should have a relationship with one or more hospices and other community resources to ensure continuity of the highest-quality palliative care across the illness trajectory. The physical environment in which care is provided should meet the preferences, needs, and circumstances of the patient and family to the best extent possible.

The palliative care program is knowledgeable about legal and regulatory aspects of palliative care. The palliative care program is aware of and addresses the complex ethical issues arising in the care of patients with life-threatening illnesses and their families. The patient’s goals, preferences, and choices are respected within the limits of applicable state and federal law, within current accepted standards of medical care, and form the basis for the plan of care. The palliative care program is aware of and addresses the complex ethical issues arising in the care of patients with life-threatening illness. The palliative care program is knowledgeable about legal and regulatory aspects of palliative care.

Table 3. Domains of Quality Palliative Care

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>CLINICAL PRACTICE GUIDELINES FOR QUALITY PALLIATIVE CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure and processes of care</td>
<td>The plan of care is based on a comprehensive interdisciplinary assessment of patient and family. The care plan is based on identified and expressed preferences, values, goals, and needs of patients and family, and is developed with professional guidance and support for decision making. The interdisciplinary team provides services to patients and family consistent with the care plan. In addition to nursing, medicine, and social work, other therapeutic disciplines with important assessment of patients and families include physical therapists, occupational therapists, speech and language pathologists, nutritionists, psychologists, chaplains, and nursing assistants. For pediatrics, this should include child-life specialists. Complementary and alternative therapies may be included. The use of appropriately trained and supervised volunteers within the interdisciplinary team is strongly encouraged. Support for education and training is available to the interdisciplinary team. In its commitment to quality assessment and performance improvement, the palliative care program develops, implements, and maintains an ongoing data-driven process that reflects the complexity of the organization and focuses on palliative care outcomes. The palliative care program recognizes the emotional impact on the palliative care team of providing care to patients with life-threatening illnesses and their families. The palliative care programs should have a relationship with one or more hospices and other community resources to ensure continuity of the highest-quality palliative care across the illness trajectory. The physical environment in which care is provided should meet the preferences, needs, and circumstances of the patient and family to the best extent possible.</td>
</tr>
<tr>
<td>Physical aspects of care</td>
<td>Pain, other symptoms, and side effects are managed based on the best available evidence, with attention to disease-specific pain and symptoms, which is skillfully and systematically applied.</td>
</tr>
<tr>
<td>Psychological and psychiatric aspects of care</td>
<td>Psychological and psychiatric issues are assessed and managed based on the best available evidence, which is skillfully and systematically applied. When necessary, psychiatric issues are addressed and treated. A grief and bereavement program is available to patients and families based on the assessed need for services.</td>
</tr>
<tr>
<td>Social aspects of care</td>
<td>A comprehensive interdisciplinary assessment identifies the social needs of patients and families and a care plan is developed to respond to these needs as effectively as possible.</td>
</tr>
<tr>
<td>Spiritual, religious, and existential aspects of care</td>
<td>Spiritual and existential dimensions are assessed and responded to based on the best available evidence, which is skillfully and systematically applied.</td>
</tr>
<tr>
<td>Cultural aspects of care</td>
<td>The palliative care program assesses and attempts to meet the needs of the patient, family, and community in a culturally sensitive manner.</td>
</tr>
<tr>
<td>Care of the imminently dying patient</td>
<td>The signs and symptoms of impending death are recognized and communicated in developmentally appropriate language for children and patients with cognitive disabilities with respect to family preferences. Care appropriate for this phase of illness is provided to patient and family. Postdeath care is delivered in a respectful manner. Cultural and religious practices particular to the postdeath period are assessed and documented. Care of the body postdeath is delivered with respect to these practices, as well as in accordance to both organizational practice and local law. A postdeath bereavement plan is activated. An interdisciplinary team member is assigned to the family in the postdeath period to help with religious practices, funeral arrangement, and burial planning.</td>
</tr>
<tr>
<td>Ethical and legal aspects of care</td>
<td>The patient’s goals, preferences, and choices are respected within the limits of applicable state and federal law, within current accepted standards of medical care, and form the basis for the plan of care. The palliative care program is aware of and addresses the complex ethical issues arising in the care of patients with life-threatening illness. The palliative care program is knowledgeable about legal and regulatory aspects of palliative care.</td>
</tr>
</tbody>
</table>


the amount of time for developing meaningful relationships with patients. Similarly, Philip and Komesaroff found that palliative care specialists’ pursuit of ideal palliative care, which included meaningful relationships with patients, often met real-world obstacles, such as competing demands and obligations.

Implications for Practice

Based on the research, the authors offer suggestions for oncology nursing practice. First, opportunities for oncology nurses to further develop their professional roles and attributes in palliative care nursing should be made available. Typically, role development relies on educational opportunities such as professional development offerings and formal mentoring systems (Froggatt & Hoult, 2002; Ingvarson, 1998). However, professional role development should become broader. The authors suggest using a standards-based professional development system whereby palliative care standards provide a systematic and transparent infrastructure for role and attribute development. For example, the Hospice and Palliative Nurses Association (2007) published standards for all levels of palliative care nursing practice. Issuing a position statement on
end-of-life care, the Oncology Nursing Society (2007) identified a list of skilled palliative care practices. In addition, NCCN (2008) updated its palliative care standards (see Figure 1) and the National Quality Forum (2006) published a set of preferred practices for palliative and hospice care quality (see Figure 2). These standards can specifically guide attribute and role development opportunities, which, in turn, can improve oncology nurses’ role performance and palliative care practices. Quality palliative care standards should be integrated into oncology documentation and reporting systems.

Second, because oncology nurses clearly offer important professional attributes in palliative care situations, nurses must carefully document the manner in which these attributes make a difference to patients and families. Research studies that investigate the impact of specific nurse attributes on patient outcomes and family well-being should be implemented.

Third, early and prompt referrals to palliative care specialty teams should become routine in oncology nursing practice. This

### Figure 1. Standards of Palliative Care

Please go to www.nccn.org for the most up to date figure.


### Figure 2. Examples of Preferred Practices for Palliative and Hospice Care


- Enable patients to make informed decisions about their care by educating them on the process of their disease, prognosis, and the benefits and burdens of potential interventions.
- Assess and manage symptoms and side effects in a timely, safe, and effective manner to a level that is acceptable to the patient and family.
- Assess and manage the psychological reactions of patients and families (including stress, anticipatory grief, and coping) in a regular, ongoing fashion to address emotional and functional impairment and loss.
- Conduct regular patient and family care conferences with physicians and other appropriate members of the interdisciplinary team to provide information, to discuss goals of care, disease prognosis, and advance care planning, and to offer support.
- Incorporate cultural assessment as a component of comprehensive and hospice care assessment including, but not limited to, locus of decision making, preferences regarding disclosure of information, truth telling and decision making, dietary preferences, language, family communication, desire for support measures such as palliative therapies and complementary and alternative medicine, perspectives on death, suffering and grieving, and funeral or burial rituals.
- Ensure that, during transfer between healthcare settings, a timely and thorough communication of the patient’s goals, preferences, values, and clinical information is conducted so that continuity of care and seamless follow-up are ensured.
- Convert patient treatment goals into medical orders and ensure that the information is transferable and applicable across care settings, including long-term care, emergency medical services, and hospital care, through a program such as the Physician Orders for Life-Sustaining Treatment program.
- Develop healthcare and community collaborations to promote advance care planning and the completion of advance directives for all individuals, for example, the Respecting Choices and Community Conversations on Compassionate Care programs.

A timely approach will open communication channels, offer interdisciplinary expertise, and provide cost-effective approaches to treatment plans (Morrison et al., 2008). However, where palliative care specialty teams are not available, an oncology nurse who becomes certified in palliative care and serves as a palliative care coordinator could facilitate team communication and coordinate care plans across settings.

### Conclusion

With advancing technology and increasing longevity, care situations are becoming more complex and demands for palliative care are becoming even more numerous. Blending technological work with complicated interpersonal interactions and the spiritual elements of finding meaning, oncology nurses play a key role in applying palliative care principles to their oncology practice. By implementing specific palliative care roles, advancing competence in professional attributes, and collaborating
with palliative care specialty teams, oncology nurses can make more significant contributions toward the best possible quality of life for patients and their families.

**The authors take full responsibility for the content of the paper. This research was funded, in part, by a faculty research grant from the College of St. Catherine in St. Paul, MN. The authors did not receive honoraria for this work. The content of this article has been reviewed by independent peer reviewers to ensure that it is balanced, objective, and free from commercial bias. No financial relationships relevant to the content of this article have been disclosed by the authors, planners, independent peer reviewers, or editorial staff.**

**Author Contact:** Carol Pavlish, PhD, MSN, RN, can be reached at cpavlish@sonnet.ucla.edu, with copy to editor at CJOINEditor@ons.org.

**References**


**Receive free continuing nursing education credit for reading this article and taking a brief quiz online. To access the test for this and other articles, visit http://evaluationcenter.ons.org. After entering your Oncology Nursing Society profile username and password, select CNE Listing from the left-hand tabs. Scroll down to Clinical Journal of Oncology Nursing and choose the test(s) you would like to take.**

412

August 2009 • Volume 13, Number 4 • Clinical Journal of Oncology Nursing