



Clinical Experience of Nurses in a Consultative Hospice Palliative Care Service

Sinyoung Kwon, A.P.N., Ph.D. and Jinyee Byun, Ph.D.*

Department of Nursing, Gangdong University, Eumseong,
*Department of Nursing, Kyungil University, Gyeongsan, Korea

Purpose: The purpose of this qualitative study was to employ Colaizzi's phenomenological research method to elucidate and understand the essence of practical experiences among consultative hospice palliative care nurses working in hospice institutions. **Methods:** The participants in the study were 15 consultative hospice palliative care nurses with over 1 year of work experience in institutions located in S City, I City, and K Province in South Korea. Data were collected from 23 in-depth interviews and analyzed using Colaizzi's phenomenological qualitative method. **Results:** The practical experiences of consultative hospice palliative nurses were categorized into five categories, 10 theme clusters, and 25 themes. The five categories included "being aware of patients' situations at the time of transition to hospice palliative care," "empathizing with patients and their families by putting oneself in the other's shoes," "providing patient and family-centered end-of-life care," "experiencing difficulties in practical tasks," and "striving to improve hospice service quality." **Conclusion:** This study is significant in that it provides practical data for understanding the experiences of consultative hospice palliative care nurses caring for terminally ill patients. This could enhance our understanding of care solutions that effectively tackle the challenges consultative hospice palliative care nurses encounter while fulfilling their roles.

Key Words: Hospice care, Hospice and palliative care nursing, Qualitative research

Received September 11, 2023

Revised February 3, 2024

Accepted February 5, 2024

Correspondence to

Jinyee Byun

ORCID:

<https://orcid.org/0000-0002-6321-5055>

E-mail: jinyee@kiu.kr

Funding/Support

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

INTRODUCTION

Hospice and palliative care is a healthcare service that offers comprehensive support across physical, psychosocial, and spiritual domains for patients with terminal illnesses and their families [1]. This form of care is crucial as it not only eases the symptoms experienced by terminally ill patients but also assists them in coming to terms with their impending death. Additionally, it extends emotional support and care to both the patients and their families [2,3]. Medical institutions that wish to provide hospice services to terminally ill patients must meet specific criteria regarding facilities, staff, and equipment as

established by the Minister of Health and Welfare. Once these criteria are met, institutions can be officially designated as hospice providers. The services offered by hospices are categorized into three types: inpatient, consultative, and home care [2].

Consultative hospice services involve consultations for terminally ill or dying patients and their families who are being cared for in general wards, outpatient departments, or emergency rooms [1,2]. The introduction of consultative hospice services aimed to enable terminally ill patients to access hospice services while hospitalized in general wards. This approach was designed to prevent late referrals to hospice and pallia-

This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/4.0/>) which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

Copyright © 2024 by Korean Society for Hospice and Palliative Care

tive care and to avoid situations where patients die awaiting admission to a hospice ward [1,3]. This type of hospice care involves a multidisciplinary team of physicians, nurses, and social workers who have undergone standard education in hospice and palliative care and have received additional training specific to consultative hospice [2]. The team offers direct care and counseling upon request from attending physicians, including guidance on managing physical symptoms, care planning, and referrals to other resources [1]. In Korea, the number of institutions offering consultative hospice services began with 20 at the start of a pilot project in 2017. As of 2023, after the project's transition to a main initiative in 2022, there are 39 hospice institutions (including tertiary and general hospitals) providing consultative hospice services [4]. Despite this growth, several practical challenges have arisen, such as patients' reluctance to utilize consultative hospice services, inadequate communication between attending and hospice physicians [3], and a general lack of awareness among healthcare professionals regarding consultative hospice services [5].

In Europe, where consultative hospice services are relatively well-established, these services have been shown to alleviate symptoms such as pain and anorexia in terminally ill patients [6]. Consultative hospice services also improve quality of life by reducing anxiety and shortening hospital stays for patients who engage with hospice services from the time of diagnosis [7], and have been associated with reduced healthcare costs due to fewer excessive hospitalizations [6] and medical interventions, including transfers to intensive care units [8]. Patients benefit from the convenience of receiving services in their own hospital rooms [8]. Families of patients regard consultative hospice as a valuable healthcare service. It supports patients and their families in making timely decisions about advanced directives for treatment and care, which enhances the quality of life for both patients and their families [9].

Nurses on consultative hospice teams carry out a range of tasks that encompass supportive counseling for patients and their families, offering information on advance directives, planning hospice and palliative care, and facilitating communication between patients and healthcare professionals. They also educate on managing physical symptoms and end-of-life care [1,10]. Furthermore, these nurses handle administrative duties, including responding to referral inquiries for hospice

institutions, and collaborate with other departments and institutions [1,10].

International studies have examined nurses' and patients' perceptions [11] and attitudes [5,12] towards consultative hospice care and its effects [13]. However, in Korea, research on attitudes towards end-of-life care among consultative hospice palliative care nurses [14] and the development of nursing practice protocols [10] has been limited. Therefore, this study aimed to explore and understand the meaning and essence of the practical experiences of consultative hospice palliative care nurses. The ultimate goal is to improve the quality of consultative hospice care and increase its recognition. This understanding will be instrumental in identifying ways to support consultative hospice palliative care nurses.

METHODS

1. Study design

This qualitative study utilized Colaizzi's [15] phenomenological research method to explore in depth the meaning and consultative hospice palliative care nurses.

2. Participants

The participants of this study were 15 consultative hospice palliative care nurses at hospice institutions in S City, I City, and K Province who understood the purpose of this study and voluntarily agreed to participate in the study.

To select participants, we identified 10 university hospitals and general hospitals through convenience sampling from the list of institutions that provide consultative hospice services on the National Hospice Center's website at the National Cancer Center. The study researchers directly contacted the heads of nursing departments to provide an advance explanation of the study and to obtain permission for data collection. After discussing the study's purpose with the heads of hospice wards, they introduced consultative hospice palliative care nurses who had at least 1 year of experience in caring for terminally ill patients. consultative hospice palliative care nurses are either advanced hospice palliative care nurses, advanced oncology nurses, or nurses with a minimum of 2 years of experience in hospice institutions, who have also completed 16 hours of ad-

ditional training in consultative hospice services [2]. The average age of the participants was 44.2 years, ranging from 33 to 54 years, and all were female. On average, they had 21 years and 5 months of total clinical experience, with a range from 10 years to 35 years and 1 month, and an average of 4 years and 5 months of experience in consultative hospice, ranging from 1 year and 3 months to 6 years and 4 months. One nurse (6.7%) held a bachelor's degree, while 14 nurses (93.3%) had earned a master's degree. Nine nurses (60%) had experienced illness or hospitalization of family members, and seven nurses (46.7%) had experienced the death of parents or relatives due to terminal cancer.

3. Data collection

From March 25, 2023, to October 15, 2023, the lead author of this study, who is experienced in conducting qualitative research, gathered data through unstructured in-depth interviews. The central research question posed was, "What are the practical experiences of consultative hospice palliative care nurses working with terminally ill patients in hospice institutions?" The interviews commenced with a broad, open-ended question: "What do you think the situation is for patients referred to consultative hospice?" The interviewer tailored subsequent questions to delve into the participants' challenges and care needs in providing consultative hospice services, adapting the line of inquiry based on their responses. Interviews typically ranged from 40 to 60 minutes, with two to three sessions per participant to further explore their responses or to elaborate on the information provided. In total, 23 interviews were conducted: 15 initial interviews, five second-round interviews, and three third-round interviews. Following the interviews, two researchers transcribed the participants' verbatim accounts and reviewed them multiple times to analyze their statements. The interview process concluded after the 23rd session, when it became apparent that the participants' statements were repetitive and no new information was forthcoming. Throughout the interviews, the researcher observed and recorded the participants' facial expressions, tones, and behaviors, as well as the researcher's own reflections, in field notes.

4. Ethical considerations

The content and method of this study received approval from

the Institutional Review Board of K University (1041459-202303-HR-002-01). The researcher clearly outlined the study's purpose and methods to the participants, ensuring they understood that all interviews would be voice-recorded and their anonymity preserved. Participants were also made aware that the collected data would be exclusively used for research purposes. Voice recordings and transcriptions would be securely stored on a password-protected external hard drive and would be disposed of upon the research's completion. It was emphasized that participants had the right to withdraw from the study at any point without consequences and that their personally identifiable information would remain confidential. As a token of gratitude, participants received a small gift.

5. Data analysis

According to Colaizzi's analysis method [15], the researchers meticulously read through the transcriptions multiple times from start to finish to gain a comprehensive understanding and impression. They highlighted the significant aspects of the consultative hospice nurses' experiences and identified meaningful or recurrent statements that were directly relevant to the research phenomenon. The team delved into the underlying meanings within these statements, organized them into abstract concepts, and then compared and analyzed similar meanings to formulate themes, theme clusters, and categories. This process of review and discussion was repeated until a unanimous agreement was reached. Ultimately, the researchers crafted detailed descriptions that focused on the practical experiences of consultative hospice palliative care nurses who provide care to terminally ill patients. These descriptions were used to confirm the core structure of the research topic.

6. Rigor

The qualitative assessment of this study was conducted through the application of credibility, applicability, consistency, and neutrality, as suggested by Guba and Lincoln [16].

To ensure credibility, we selected participants who had extensive experience with the research phenomenon using a purposive sampling method. Consequently, the interviews were conducted with consultative hospice palliative care nurses who had a minimum of one year's experience in caring for terminally ill patients. During the interviews, participants were

prompted with open-ended questions to encourage a comprehensive articulation of their practical experiences in consultative hospice care, using their own words. Furthermore, with the participants' consent, all interviews were audio-recorded. The researchers meticulously listened to these recordings multiple times and transcribed the participants' accounts verbatim. To verify the accuracy of the findings, the final analysis was presented to four participants, ensuring it faithfully represented the experiences they intended to convey.

Applicability was ensured by conducting interviews with consultative hospice palliative care nurses employed at nine hospice facilities in S City, I City, and K Province. Addition-

ally, three nurses with experience in consultative hospice palliative care, who were not participants in this study, validated the findings based on their professional expertise.

To ensure consistency, two researchers carried out all data collection and analysis processes in accordance with Colaizzi's method of analysis [15]. They categorized the content of the interviews through mutual discussion. Furthermore, two nursing professors with extensive experience in qualitative research reviewed and provided feedback on the study's findings.

To ensure neutrality, the first author, who served as an advanced hospice palliative care nurse, endeavored to prevent her experience from introducing bias and prejudice. Before com-

Table 1. Clinical Experience of Nurses in a Consultative Hospice Palliative Care Service.

Categories	Theme clusters	Theme
Being aware of patients' situations at the time of transition to hospice palliative care	Encountering patients in terminal situations where treatment is being discontinued	<ul style="list-style-type: none"> - Initial consultations held after diagnosis with a terminal illness - Confirming that chemotherapy is no longer effective
	Noticing when a hospice care intervention is needed	<ul style="list-style-type: none"> - Recognizing the care needs of unstable patients with physical symptoms and feelings of despair - Anticipating the need for terminal care - Needing assistance for transitioning to hospice institutions
Empathizing with patients and their families by putting oneself in the other's shoes	Understanding patients and their families through personal experiences	<ul style="list-style-type: none"> - Becoming more empathetic towards patients and their families through the experience of a loved one's illness - Realizing the importance of terminal care through the death of a family member
	Advocating and providing emotional support to patients and their families	<ul style="list-style-type: none"> - Becoming a mediator for patients and their families - Comforting patients and their families facing impending terminal situations - Providing support while sharing the suffering of patients and their families
Providing patient and family-centered end of life care	Providing professional alternatives for the comprehensive needs of patients and their families	<ul style="list-style-type: none"> - Counseling patients and their families to establish an advanced care plan - Providing education on how to care for anticipated situations
	Collaborating and coordinating for the provision of hospice services	<ul style="list-style-type: none"> - Mediating between patients and their families and healthcare professionals - Consulting on the management of terminal symptoms - Coordinating collaborative systems between healthcare professionals and other professionals - Linking hospitalized patients to hospice institutions
Experiencing difficulties in practical tasks	Feeling the burden of work due to limited resources	<ul style="list-style-type: none"> - Restricted use of a single room for end-of-life care - Prolonged wait for hospitalization at a hospice institution - Difficulty in performing tasks due to the absence of substitute workers
	Feeling frustrated by blocked communication	<ul style="list-style-type: none"> - Futile advice on managing end-stage patients' symptoms - Failure to conduct a handover with the ward nurse
Striving to improve hospice service quality	Searching for efficient communication methods	<ul style="list-style-type: none"> - Providing detailed reports and documentation - Discussing interventions for patients with medical staff
	Focusing on improving awareness of hospice care	<ul style="list-style-type: none"> - Providing protocols and educational materials - Promoting activities related to hospice

mencing the research, the team held meetings to address potential assumptions, biases, and prejudices related to the study. They aimed to minimize researcher subjectivity by regularly reviewing research logs documented throughout the data collection and analysis phases.

RESULTS

A total of 279 meaningful statements were extracted from the raw data collected from participants. These statements were integrated based on similarity, resulting in 225 constructed meanings. These meanings were then categorized, leading to the identification of 25 themes, 10 theme clusters, and 5 categories. The specific contents are as follows (Table 1).

Category 1. Being aware of patients' situations at the time of transition to hospice palliative care

The participants encountered patients and their families primarily when the patients had been diagnosed with terminal illnesses and were transitioning from life-prolonging treatments to hospice and palliative care. In this context, comprehensive hospice and palliative care was required, encompassing physical, psychosocial, and spiritual support, as well as pain and symptom management for patients receiving treatment in general wards and outpatient departments.

1) Encountering patients in terminal situations where treatment is being discontinued

The participants provided care for individuals with terminal cancer and those with incurable chronic diseases, such as chronic obstructive pulmonary disease or chronic liver cirrhosis. These patients often experienced cycles of improvement and deterioration. Typically, patients were referred to consultative hospice care after receiving a terminal diagnosis from their attending physicians, at which point their treatment objectives shifted to palliative care. The attending physicians verified the terminal diagnosis, filled out a consultative hospice referral form, and directed the patients to the hospice care team. Cancer patients were typically referred to consultative hospice either when the possibility of further chemotherapy was being considered or when it was discontinued after multiple hospital admissions. Alternatively, some patients encoun-

tered consultative hospice palliative care nurses during their chemotherapy sessions without prior notification of their terminal status, which sometimes resulted in their refusal to meet with the hospice palliative care team.

(1) Initial consultations held after diagnosis with a terminal illness

We receive consultation inquiries from attending physicians regarding patients with cancer, chronic liver cirrhosis, chronic obstructive pulmonary disease, and AIDS. The majority of referrals concern terminal cancer patients who are referred when chemotherapy is no longer a viable option. We encounter patients with non-cancerous diseases when they require control of terminal symptoms. Patients are referred for consultative care when active treatment is no longer considered beneficial, or when the treatment goal has shifted to palliative care. (Participant 11)

(2) Confirming that chemotherapy is no longer effective

We typically encounter terminal cancer patients when they learn that chemotherapy may be discontinued, or when it has already been stopped. These patients are usually aware of their cancer diagnosis. However, given that they are at a stage where chemotherapy is nearing its conclusion or is being considered for discontinuation, they have been informed that they could resume chemotherapy if their condition improves, although this may not be possible. (Participant 15)

2) Noticing when a hospice care intervention is needed

Patients referred to consultative hospice care often presented with a range of physical symptoms, such as pain, delirium, dyspnea, fatigue, and anorexia. They also experienced psychological distress as their health conditions worsened. These individuals were unable to manage their daily activities independently and required both pain and symptom management, as well as psychological support. Occasionally, referrals for end-of-life care were made too late, with patients expected to pass away within hours of admission. Moreover, the majority of patients referred to consultative hospice required care in a hospice ward, necessitating their transfer to inpatient hospice facilities or medical institutions closer to their homes.

(1) Recognizing the care needs of unstable patients with physical symptoms and feelings of despair

The patients I met in the ward spent nearly half of their waking hours bedridden or unable to ambulate without the assistance of a wheelchair. They also experienced significant psychological distress. Among them, some suffered from intense death anxiety, which left them in a state of constant restlessness. (Participant 4)

(2) Anticipating the need for terminal care

When I was called for a consultation, I occasionally encountered patients on the verge of death with Cheyne–Stokes respiration. Upon reviewing the electronic medical records and proceeding to the room, I discovered the patient experiencing severe pain, with vitals so unstable that they were about to die. (Participant 14)

(3) Needing assistance for transitioning to hospice institutions

In fact, many patients would benefit from earlier admission to hospice care, yet it appears that referrals from physicians often come quite late. Many individuals who are referred for hospice consultations are in a precarious state of health, nearing the end of life. Additionally, when treatment options become limited, family members often struggle with the psychological demands of caring for a terminally ill loved one. The responsibility of caregiving becomes burdensome, particularly when it conflicts with their work obligations. (Participant 10)

Category 2. Empathizing with patients and their families by putting oneself in the other's shoes

As they experienced illness and the death of family members or loved ones, the participants highlighted the need to prioritize the perspectives of patients and their families in the care of those with terminal illnesses. They aimed to support the decision-making process for hospice and palliative care among patients and their families, particularly when facing a terminal diagnosis and the challenges of chemotherapy. Additionally, they sought to provide comfort and support to the families anticipating the loss of a patient nearing the end of life.

1) Understanding patients and their families through personal experiences

When participants cared for patients of a similar age to their own parents, they were often reminded of their family members' illnesses, which allowed them to empathize with the patients' children. Drawing from their personal experiences with illness and the loss of family members or loved ones, they could understand and consider the perspectives of both patients and their families.

(1) Becoming more empathetic towards patients and their families through the experience of a loved one's illness

I can't get it out of my head that the patient expressed the desire to stop chemotherapy. Was there anything I could have done to help? Did the patient really have to die so suddenly? When I see patients of a similar age, I sometimes have flashbacks of my uncle. Caregivers have asked me whether I've ever gone through a similar experience. (Participant 4)

(2) Realizing the importance of terminal care through the death of a family member

My father passed away from stomach cancer, and experiencing it firsthand certainly made a difference. He was admitted to the hospital towards the end, primarily because he was initially reluctant to go. This experience really changed my perspective on end-of-life care for patients. Since then, I've had numerous discussions with ward nurses about the importance of providing detailed explanations to families and ensuring they spend quality time with their loved ones. Often, family members are so overwhelmed with panic that they struggle to adequately prepare for the end of life. (Participant 9)

2) Advocating and providing emotional support to patients and their families

The participants provided counseling to patients and their families, offering support as they navigated the expression of negative emotions associated with treatment. In cases of terminal illness, they facilitated communication between healthcare professionals, patients, and their families, serving as intermediaries. They also exchanged information about the patients and their families with the hospice team and collaborated on the development of care plans. When families of patients who had

ceased chemotherapy were confronted with the prospect of death and directed blame toward previous healthcare providers, the participants were attentive to their distress and offered consolation. They addressed the care needs of patients and their families with a focus on end-of-life concerns, striving to alleviate their suffering.

(1) Becoming a mediator for patients and their families

Upon receiving consultative hospice services, many patients exhibit denial or anger toward their attending physicians. When I took the time to listen to them attentively, I sensed that they began to calm down. This experience gave me the impression that I was acting as a bridge, mediating between healthcare professionals and patients. (Participant 2)

(2) Comforting patients and their families who are facing impending terminal situations

From the patients' perspective, they have diligently followed their physicians' instructions, only to be informed that no further treatment options are available. They interpret this as a death sentence, believing that they can no longer receive treatment and that their death is imminent. This revelation leaves patients feeling extremely anxious; they have been advised to prepare for what comes next, yet they are uncertain about every aspect of what that means. In these moments, I strive to support both the patients and their families. Whether they are overcome with sadness or in need of reassurance, I offer them tissues, hold their hands, or provide words of comfort. (Participant 5)

(3) Providing support while sharing the suffering of patients and their families

Most patients and their families are extremely exhausted. Many had no one to turn to and were overwhelmed. When I visited their rooms, checked their conditions, and inquired about how they were feeling that day, their comprehension of the attending physician's rounds, and their preparedness for end-of-life issues, they were initially hesitant to respond. Over time, however, they expressed a significant reliance on me. (Participant 3)

Category 3. Providing patient and family-centered end-of-life care

The participants provided counseling to patients and their families, facilitating advance care planning to ensure that terminally ill patients understood their condition, prognosis, and the medical care they would receive at the end of life. This process empowered patients to make their own decisions. Recognizing the significant physical needs of terminally ill patients, the participants, serving as coordinators of a consultative hospice team, endeavored to enhance quality of life. They achieved this by developing collaborative systems with healthcare professionals and offering guidance on managing terminal symptoms.

1) Providing professional alternatives for the comprehensive needs of patients and their families

In order to provide dignified and comfortable end-of-life care, consultative hospice palliative care nurses assessed patients' understanding of their illness, identified their preferred care settings, and facilitated advance care planning. They provided education to patients and their families on managing symptoms such as pain, dry mouth, mouth sores, and pressure sores, which may arise as the patient's condition progressively worsens. Furthermore, they informed families about the preparations needed and coping strategies for when the patient's end of life is imminent.

(1) Counseling patients and their families to establish an advance care plan

Since we've been doing this for a long time, we counsel patients and their families about what will happen in the future. I think that my role is to advise them that taking action now is preferable and will likely lead to fewer regrets later on. (Participant 10)

(2) Providing education on how to care for anticipated situations

In general wards, analgesics are typically administered to patients when they report experiencing pain. Terminally ill patients often describe episodes of breakthrough pain, which can occur during activities such as eating or when they suddenly

rise from a lying position, and the symptoms can vary widely. Therefore, I provide families with a leaflet about pain management and educate them by detailing the information through both illustrations and text. (Participant 12)

2) Collaborating and coordinating for the provision of hospice services

The participants worked in partnership with consultative hospice teams and community organizations to develop care plans that were tailored to the needs and preferences of both patients and their families, as well as to deliver hospice services accordingly. As care goals evolved following a terminal diagnosis, they facilitated discussions among patients, their families, and healthcare professionals to agree on symptom management strategies and appropriate care settings, and they offered guidance on managing end-of-life symptoms. Furthermore, the participants supplied essential information to support transitions in the patient's care setting and collaborated with home hospice centers and community hospice facilities.

(1) Mediating between patients and their families and healthcare professionals

We serve as intermediaries between patients and attending physicians regarding the patients' place of stay and their future treatment plans. When a patient prefers to be treated at a certain hospital and undergo a specific treatment, but healthcare professionals have different recommendations, it is our responsibility to facilitate coordination between them. (Participant 6)

(2) Consulting on the management of terminal symptoms

Attending physicians in hospice palliative care are adept at managing symptoms, and they also provide guidance to healthcare professionals on further symptom management strategies. Their advice encompasses not only physical care but also psychological and spiritual support. Additionally, they monitor the implementation of the care plans they recommend. (Participant 3)

(3) Coordinating collaborative systems between healthcare professionals and other professionals

The patient was from abroad and had terminal cancer. He

struggled with pain management due to communication barriers. To address his pain, he would have needed to return to his home country. The issue remained unresolved within the department, prompting a consultative referral. I requested an interpreter from the international cooperation team and visited the patient's room during rounds. Accompanied by the interpreter and the attending physician, we assessed the patient's pain patterns and discussed pain management strategies. Ultimately, his pain was alleviated, and he was able to return to his home country. (Participant 11)

(4) Linking hospitalized patients to hospice institutions

When a patient is referred to a hospice institution, we initiate direct contact, provide a detailed explanation of the patient's condition, and coordinate accordingly. We inquire about the current status of the institution to determine if it aligns with the family's needs. If it does, we facilitate the connection between the patient and the institution and proceed with a formal referral through the referral center. (Participant 12)

Category 4. Experiencing difficulties in practical tasks

The participants reported feeling stressed when access to a single room for end-of-life care was limited in a general ward, and when they faced extended waits for hospice institution admission. They also experienced psychological strain and burnout stemming from a lack of substitute staff and the challenges of attending to patients with quickly evolving medical needs during weekends, holidays, and weekday evenings. Furthermore, their frustration was compounded when advice on managing symptoms for terminally ill patients was not adequately implemented in the general ward, or when there was a failure in the handover of responsibilities by general ward nurses.

1) Feeling the burden of work due to limited resources

The participants experienced difficulties when single rooms designated for end-of-life care in the general ward were occupied by other patients, and when access to a single room was limited for hospice patients nearing death. Unlike in hospice wards, nurses in general wards were often uncomfortable with the presence of dying patients, leading participants to occasionally disregard single room assignments to avoid conflicts

with ward nurses. Additionally, the participants faced stress due to extended waits for outpatient referrals when transferring patients to hospice wards at other facilities. Despite being part of a consultative hospice team, they typically managed most responsibilities on their own, which resulted in a significant burden. Furthermore, they were expected to provide counseling to families of dying patients and fulfill their duties outside of regular working hours, often feeling overwhelmed by the number of patients in need of care after hours or on holidays.

(1) Restricted use of a single room for end-of-life care

A single room is intended for use over a three-day period for end-of-life care. However, if a patient from the ward is already occupying it, we cannot utilize the space. There are instances when a room is available, yet it is not assigned, which is frustrating. I feel as though I have to battle with the ward staff to secure a single room for my patient. The attending physician advised against making enemies of everyone and suggested that I should just let it go if they say there is no single room available. It presents quite a dilemma. (Participant 3)

(2) Prolonged wait for hospitalization at a hospice institution

When attempting to transfer a patient to a hospice ward, we must wait until a bed becomes available at an inpatient hospice facility. Even though we intended to move patients from a general ward to a hospice ward, the number of beds in inpatient hospice facilities is limited. Beds only become available when a patient passes away or is discharged to their home. Consequently, the wait for hospitalization can be lengthy. (Participant 5)

(3) Difficulty in performing tasks due to the absence of substitute workers

We consult with patients not only in the outpatient department or on the ward but also enter their information into the system following counseling. My responsibilities include making rounds to see patients in the general ward and providing education on pain and symptom management. However, due to the absence of a substitute worker, I am unable to take a vacation or a break. This situation is extremely challenging. (Participant 12)

2) Feeling frustrated by blocked communication

The participants reported feeling increasingly exhausted by recurring scenarios, such as instances where the patient's pain and symptoms remained poorly managed because the consultative hospice team's recommendations for symptom management were not incorporated into the physician's prescriptions. Exhaustion also stemmed from situations where they were unable to obtain consent for hospice care from a guardian due to a shift nurse in the general ward failing to properly hand over information, or when a patient was transferred to an inpatient hospice facility unprepared because the transfer instructions had not been clearly communicated.

(1) Futile advice on managing end-stage patients' symptoms

We can only recommend these medications for the patient's uncontrolled pain. The decision to use them now rests with the healthcare professionals in the referring department. We have provided ample advice, but if the referring department chooses not to administer the medications and the patient's symptoms remain uncontrolled, it is evident that the patient has suffered significantly. (Participant 13)

(2) Failure to conduct a handover with the ward nurse

As the ward operates on a three-shift system, the nurses in charge rotate with each of my visits. There have been times when I told a dayshift nurse about an issue, but the information was not relayed to the subsequent duty nurse. Despite documenting these matters in a notepad or on a record sheet, the problem persists, so sometimes I think I should become a ward nurse. (Participant 2)

Category 5. Striving to improve hospice service quality

The participants strived to communicate efficiently with physicians and nurses responsible for managing terminal illnesses, aiming to ensure effective symptom management, counseling, and education for patients and their families, as well as terminal care and referrals to hospice institutions. Furthermore, they concentrated on education, the development of protocols, and promotional activities for healthcare professionals to raise awareness of hospice care. They also endeavored to improve the quality of hospice services.

1) Searching for efficient communication methods

The participants provided advisory services to both general wards and outpatient departments. When a prescription was needed for symptom management, a consultative hospice physician would annotate the electronic record with comments and communicate requests via phone or text message. The consultative hospice team convened weekly meetings to develop or discuss care plans. If in-person meetings were impractical, social network services facilitated discussions on the holistic assessment of patients and their families, as well as care planning. Participants exchanged views with the consultative hospice teams and sought advice on patient care strategies that had not previously occurred to them. This effective communication was aimed at improving the efficiency of symptom management for terminally ill patients.

(1) Providing detailed reports and documentation

When the consultative hospice team advises ward or outpatient physicians, we often don't have the opportunity to meet in person. Instead, we document our recommendations and comments on prescriptions within the electronic record. This approach encourages physicians to review the information more thoroughly. We also inform the ward nurses that we have added comments to the prescriptions in the electronic record. (Participant 1)

(2) Discussing interventions for patients with healthcare professionals

We frequently met with healthcare professionals. The consulting hospice physician, a nurse, and a social worker convened at least once a week to discuss patient care and exchange information. In urgent situations, we communicated through Kakao Talk to coordinate patient interventions in our respective areas. (Participant 8)

2) Focusing on improving awareness of hospice care

The participants developed pain management protocols for healthcare professionals and supplied educational resources to interns to ensure effective pain control for patients. Furthermore, to raise awareness of hospice care, they conducted promotional efforts, which included placing banners throughout the hospital and affixing hospice-related posters in elevators

and waiting areas frequented by patients and their families.

(1) Providing protocols and educational materials

We provided education on hospice and palliative care to care teams and departments responsible for consultative hospice patients. A consultative hospice leaflet was developed for healthcare professionals, which included detailed information on eligibility criteria, the referral process and methods, as well as the benefits of referral. To proactively educate and promote these services, we distributed the leaflets in departments that care for terminally ill patients and visited each care team to discuss the content. (Participant 11)

(2) Promoting activities related to hospice

Banners and posters were installed throughout the hospital to enhance visibility for caregivers, particularly in elevators and waiting areas. Additionally, during hospice days or pain awareness campaigns, concerted efforts are made to disseminate information about hospice care to healthcare professionals and visitors. (Participant 2)

DISCUSSION

This qualitative study employed a phenomenological methodology to examine the experiences of consultative hospice palliative care nurses. The first identified category was "being aware of patients' situations at the time of transition to hospice palliative care." Most participants reported encountering consultative hospice patients following a terminal diagnosis by their attending physicians. The nurses met with terminally ill patients and their families during collaborative care, at the point when the focus of care shifted from life-prolonging treatments to hospice and palliative care. At this juncture, they recognized the need for emotional support alongside physical symptom management. This finding aligns with previous research [10], which indicated that consultative hospice palliative care nurses often meet patients and their families during the acute phase of decision-making about care plans post-terminal diagnosis, assisting them in transitioning from active treatment to palliative care. In contrast, inpatient hospice nurses typically encounter patients in a ward setting after terminal diagnoses have been made and care decisions finalized,

allowing them to establish care goals, manage terminal symptoms, and support a meaningful end-of-life experience [17,18]. Conversely, consultative hospice provides care to patients with terminal diagnoses and their families in general wards or outpatient departments, with the hospice team and attending physicians collaboratively delivering care [2]. Notably, consultative hospice nurses facilitate an early transition to hospice and palliative care [3] by engaging with patients early in their hospice palliative trajectory, offering counseling, education, and care to terminally ill patients and their families when decisions regarding the treatment process are required [10]. Despite recognizing the importance of early engagement in hospice and palliative care, the participants noted that referrals to consultative hospice were often delayed. Consequently, future research is needed to explore the reasons behind these late referrals to consultative hospice, and the timing of such referrals should be discussed.

The second category was “empathizing with patients and their families by putting oneself in the other’s shoes.” Participants who had experienced illness and death among their own family members or loved ones could relate to the distress of patients and their families. They were able to empathize with those facing the end of life by imagining themselves in the patient’s situation. This finding aligns with a previous study where inpatient hospice nurses with personal cancer diagnoses drew upon their experiences when caring for patients confronting death [17]. Similarly, another study found that the loss experiences of inpatient hospice nurses enhanced their ability to understand the suffering of terminally ill patients and their families, as well as to adeptly identify the patients’ needs [19]. Conversely, inpatient hospice nurses without personal bereavement experiences struggled to grasp the concepts of end-of-life and bereavement loss, finding it challenging to empathize with the pain and grief of patients and their families [18]. Empathy is a critical factor that enables inpatient hospice nurses to deliver person-centered care [20]. By deepening their empathy, they can better comprehend the grief of families preparing for death and play a pivotal role in helping patients maintain their dignity until life’s end [18]. Thus, consultative hospice nurses who care for terminally ill patients have the opportunity to reflect on their personal experiences with illness and death, fostering the essential competency of em-

pathy for patients and their families. Looking ahead, ongoing education aimed at nurturing a respectful attitude, including empathy, will be essential for consultative hospice nurses to provide high-quality care for terminally ill patients and their families. Additionally, the participants served as advocates for patients and families, drawing on their experiences to support them in understanding and expressing the negative emotions encountered during treatment. This parallels a study [21] in which nurses attending to terminal cancer patients considered the patients’ feelings by reflecting on their own medical tests and hospitalizations, and they provided care for patients and their families informed by the experience of a family member’s death. Therefore, the prior caregiving experiences of consultative hospice nurses, as well as their personal experiences with illness and death, may shape their approach to comprehending and supporting the suffering of patients and their families. Even in the absence of such experiences, it remains crucial for them to attentively listen to, comfort, and support patients and their families by acknowledging their pain.

The third category was “providing patient and family-centered end-of-life care.” Participants worked to develop care plans that addressed the needs of consultative hospice patients and their families by preparing counseling, education, and professional options for anticipated situations. Most terminally ill patients exhibited significant physical needs due to pain and terminal symptoms [22,23], as well as substantial emotional needs for psychological comfort and peace, and spiritual needs to find meaning in life in the face of death [24]. Consultative hospice offers comprehensive palliative care to terminally ill patients in general wards and outpatient departments, providing advice on symptom management, counseling and education for patients and families, direct care, and facilitating referrals and collaboration with hospice institutions [25]. Within a consultative hospice team, which comprises a multidisciplinary group, nurses delivered the majority of services, averaging 6.4 encounters per patient, followed by physicians at 4.1 times, and social workers at 3.3 times [10]. Studies have shown that consultative hospice nurses’ understanding of the importance of treatment decisions and advance directives for patients with metastatic cancer, as well as their discussions about the benefits of hospice care, were linked to improved emotional quality of life for patients [9]. Furthermore, profes-

sional practice competency, along with the ability to coordinate and collaborate, was crucial for consultative hospice nurses in setting patient care goals in conjunction with other healthcare professionals treating terminal illnesses [10]. In the current study, consultative hospice nurses played a pivotal role in mediating and collaborating with patients, their families, and healthcare professionals to deliver hospice services. Therefore, it is vital to support consultative hospice nurses in their role as primary counselors, enabling them to identify the needs of patients and their families and to collaborate effectively with healthcare professionals.

The fourth category was “experiencing difficulties in practical tasks.” The participants, who were dedicated personnel of the consultative hospice team, often faced end-of-life situations during weekends, holidays, and after-hours without the availability of substitute workers. This lack of support led to experiences of burnout. Consultative hospice nurses, who are considered essential personnel, typically work full-time for five days a week and over 40 hours during that period. They should not be assigned additional duties in other hospice services or roles, and nurses with other responsibilities cannot serve as their substitutes [3]. Home care hospice nurses, despite working in a different setting, also reported feeling anxious when their work cell phones rang. They felt pressured due to the demands of providing phone counseling and being on call for emergencies, both day and night [26]. This sentiment echoes findings from a study [27] where inpatient hospice nurses, employed in high-acuity settings, faced burnout and job turnover due to continuous work without adequate breaks and insufficient staffing. Participants in the current study also reported feeling a psychological burden when access to a single room for end-of-life care was limited or when the wait for hospitalization at an inpatient hospice facility was extended. This finding aligns with reports from intensive care unit nurses who identified challenges in end-of-life care, such as inadequate spaces and a lack of resources [28]. Furthermore, consultative hospice nurses in this study expressed frustration when their recommendations were not implemented or when communication was hindered by incomplete handovers. They considered leaving their consultative roles for ward nursing positions when their advice on analgesic use or medication prescriptions was disregarded due to disagreements with at-

tending physicians or when patients were referred without adequate prior explanation [3]. Therefore, to reduce the physical and psychological burdens on consultative hospice nurses caring for terminally ill patients, there is a need for administrative and emotional support. This support could include securing substitute personnel and implementing efficient work distribution strategies.

The fifth category was “striving to improve hospice service quality.” Participants meticulously documented advice from consultative hospice teams to ensure its effective delivery to general wards or outpatient departments. They also sought efficient communication methods with attending physicians through weekly meetings. However, McDarby and Carpenter [29] noted that opportunities for in-depth collaboration were limited due to a reluctance to accept the recommendations of consultative hospice teams or due to superficial interactions. Despite formal interactions such as interdisciplinary meetings, hospital lectures, and grand rounds, these were not conducive to direct conversations. To address this, the authors suggested strategies such as “chart(ing) in the area where she was more visible” and engaging in conversations while passing in the hallway [29].

The participants in the current study endeavored to enhance the quality of hospice care by developing educational programs and protocols, and by focusing on promotional activities to raise awareness of hospice services among patients, their families, and healthcare professionals. Unlike in countries such as Japan, where consultative hospice is actively practiced, awareness of consultative hospice remains low among these groups in Korea [1]. In fact, due to this lack of awareness, initial counseling may not occur, or the intervention of the consultative hospice team may be delayed [29]. These issues present barriers [29] to the crucial role of consultative hospice in counseling and facilitating the transition from active treatment to hospice and palliative care [10]. Therefore, it is necessary to boost awareness of consultative hospice by expanding palliative care education among healthcare professionals and non-healthcare staff, and by establishing a collaborative system to broaden the scope of consultative hospice eligibility.

The consultative hospice nurses have endeavored to meet the needs of patients referred for consultative hospice care, aiming to identify their physical and emotional conditions and provide

comprehensive care to both the patients and their families. Despite facing challenges such as poor communication among healthcare professionals, limited access to end-of-life care rooms, and a shortage of backup staff, they have committed themselves to ensuring a dignified death for the patients and have worked diligently to raise awareness of consultative hospice services. By thoroughly investigating the experiences of consultative hospice nurses, this study may help to increase awareness of consultative hospice care and enhance understanding of the roles and responsibilities of these nurses. However, the study has limitations, as the data were gathered solely through interviews, and the practical experiences discussed were confined to the accounts of the participants. Additionally, since the study focused exclusively on the perspectives of consultative hospice nurses, it did not capture the experiences of the patients receiving hospice care. Therefore, based on the findings of this study, we recommend further research to explore the experiences of consultative hospice patients or to examine the experiences of both patients and nurses concurrently. Moreover, given the low awareness of consultative hospice despite its potential benefits, there is a need to identify strategies to enhance awareness and promote the utilization of consultative hospice services.

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

ORCID

Sinyoung Kwon, <https://orcid.org/0000-0001-8707-9281>

Jinyee Byun, <https://orcid.org/0000-0002-6321-5055>

AUTHOR'S CONTRIBUTIONS

Conception or design of the work: all authors. Data collection: SK. Data analysis and interpretation: all authors. Drafting the article: all authors. Critical revision of the article: SK. Final approval of the version to be published: all authors.

SUPPLEMENTARY MATERIALS

Supplementary materials can be found via <https://doi.org/10.14475/jhpc.2024.27.1.31>.

REFERENCES

1. Lee SW, Lee YS, Ko JA. Team-focused advisory hospice development of palliative care delivery model. *Wonju:Health Insurance Review and Assessment Service*:2018.
2. Ministry of Health and Welfare. Guide to the provision of hospice services. *Sejong:Ministry of Health and Welfare*:2023. p 13, 14, 20, 25. [cited 2020 Sep 2]. Available from: https://www.mohw.go.kr/board.es?mid=a10413000000&bid=0021&act=view&list_no=375533.
3. Park YT, Oh JY, Sin h JY, Sin YJ, Lee DH. A study on the evaluation of the national hospice pilot project providing consultative hospice services in general wards and the application plan for the national health insurance program. *Wonju:Health Insurance Review and Assessment Service*:2020.
4. hospice.go.kr [Internet]. Seoul, Goyang: National Cancer Center, National Hospice Center: 2023 [cited 2020 Sep 2]. Available from: <https://hospice.go.kr:8444/?menu=48>.
5. Pan HH, Shih HL, Wu LF, Hung YC, Chu CM, Wang KY. Path modeling of knowledge, attitude and practice toward palliative care consultation service among Taiwanese nursing staff: a cross-sectional study. *BMC Palliat Care* 2017;16:42.
6. Engel PT, Thavayogarahaj T, G rlich D, Lenz P. Establishment of a palliative care consultation service (PCCS) in an acute hospital setting. *Int J Environ Res Public Health* 2020;17:4977.
7. Miller SC, Lima JC, Intrator O, Martin E, Bull J, Hanson LC. Palliative care consults in nursing homes and reductions in acute care use and potentially burdensome end-of-life transitions. *J Am Geriatr Soc* 2016;64:2280-7.
8. May P, Garrido MM, Cassel JB, Kelley AS, Meier D, Normand C, et al. Prospective Cohort Study of hospital palliative care teams for inpatients with advanced cancer: earlier consultation is associated with larger cost-saving effect. *J Clin Oncol* 2015;33:2745-52.
9. Dyar S, Lesperance M, Shannon R, Sloan J, Colon-Otero G. A nurse practitioner directed intervention improves the quality of life of patients with metastatic cancer: results of a randomized pilot study. *J Palliat Med* 2012;15:890-5.
10. Hu YJ. Development of a protocol for advanced nursing practice in consultation-based hospice and palliative care [master's thesis]. Seoul:

- Yonsei Univ.:2014. Korean.
11. Chou WC, Hung YS, Kao CY, Su PJ, Hsieh CH, Chen JS, et al. Impact of palliative care consultative service on disease awareness for patients with terminal cancer. *Support Care Cancer* 2013;21:1973–81.
 12. Huang LC, Tung HJ, Lin PC. Associations among knowledge, attitudes, and practices toward palliative care consultation service in healthcare staffs: A cross-sectional study. *PLoS One* 2019;14:e0223754.
 13. O'Connor NR, Moyer ME, Behta M, Casarett DJ. The impact of inpatient palliative care consultations on 30-day hospital readmissions. *J Palliat Med* 2015;18:956–61.
 14. Choi JH. End-of-Life care stress and end-of-life care attitudes of nurses: focusing on nurse's experience of caring for patients receiving consultation-based hospice [master's thesis]. Seoul: Catholic Univ.: 2023. Korean.
 15. Colaizzi PE. Psychological research as the phenomenologist views it. In: Valle RS, King M, eds. *Existential-phenomenological alternatives for psychology*. New York:Oxford University Press:1978. p.48–71.
 16. Guba EG, Lincoln YS. *Effective evaluation: improving the usefulness of evaluation results through responsive and naturalistic approaches*. San Francisco:Jossey-Bass:c1981.
 17. Clipsham L, Islam Z, Faull C. Experiences of hospice inpatient nurses in supporting children before the death of a parent. *Int J Palliat Nurs* 2015;21:453–9.
 18. Kwak SY, Lee BS. The process of adapting to the role of a hospice nurse. *J Korean Acad Nurs Adm* 2018;24:149–60.
 19. Huang CC, Chen JY, Chiang HH. The transformation process in nurses caring for dying patients. *J Nurs Res* 2016;24:109–17.
 20. Kwon S, Kim KH. Factors associated with person-centered care among hospice nurses. *J Hosp Palliat Care* 2022;25:66–75.
 21. Kwon S, Kim M, Choi S. Nurses' experiences of providing "sensitive nursing care" for terminally-ill individuals with cancer: a qualitative study. *Eur J Oncol Nurs* 2020;46:101773.
 22. Kim HJ, Goh SJ. Understanding the needs of patients in palliative care. *KJCC* 2014;25:93–112.
 23. Kim JA, Kim KH, Kang HS, Kim JS. Nursing need and satisfaction of patients in hospice ward. *J Hosp Palliat Care* 2014;17:248–58.
 24. Pearce MJ, Coan AD, Herndon JE 2nd, Koenig HG, Abernethy AP. Unmet spiritual care needs impact emotional and spiritual well-being in advanced cancer patients. *Support Care Cancer* 2012;20:2269–76.
 25. Ministry of Health and Welfare. Guide to the provision of consultative hospice services [Internet]. Sejong:Ministry of Health and Welfare:2018 p. 3–35. [cited 2020 Sep 2]. Available from: <https://hospice.go.kr:8444/index.html?menu=22>.
 26. Kwon HS. Caring experience at home among hospice nurses: Phenomenological study [dissertation]. Jeonju: Jeonbuk National Univ.: 2023. Korean.
 27. Ye HN. The experience of hospice nurse on caring for terminal cancer patients in the era of convergence. *Journal of Digital Convergence* 2020;18:307–15.
 28. Kim HS, Choi EK, Kim TH, Yun HY, Kim EJ, Hong JJ, et al. Difficulties in end-of-life care and educational needs of intensive care unit nurses: a mixed methods study. *J Hosp Palliat Care* 2019;22:87–99.
 29. McDarby M, Carpenter BD. Barriers and facilitators to effective inpatient palliative care consultations: a qualitative analysis of interviews with palliative care and nonpalliative care providers. *Am J Hosp Palliat Care* 2019;36:191–9.