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Where would acute care nurses prefer to receive end-of-life care? A cross-sectional survey

Authors:

Jan Shepherd¹

Amy Waller¹

Rob Sanson-Fisher^{1,2}

Katherine Clark^{3,4}

Jean Ball²

Author affiliations:

- 1 University of Newcastle, University Drive, Callaghan, NSW, 2308, Australia
- 2 Hunter Medical Research Institute, Lot 1 Kookaburra Circuit, New Lambton Heights, NSW, 2305, Australia
- 3 Northern Sydney Local Health District, Royal North Shore Hospital Campus, Reserve Road, St Leonards, NSW, 2065, Australia
- 4 Northern Clinical School, The University of Sydney, Royal North Shore Hospital Campus, Reserve Road, St Leonards, NSW, 2065, Australia

Corresponding author:

Jan Shepherd

Health Behaviour Research Group

University of Newcastle

Hunter Medical Research Institute

Callaghan NSW 2308

Jan.Shepherd@uon.edu.au

ABSTRACT

Background: Hospital-based nurses can offer a unique perspective about factors that can contribute to a good end-of-life experience, including the location in which end-of-life care is delivered.

Objectives: To examine in a sample of hospital-based nurses, the location in which they personally would most and least prefer to be cared for at the end of life, and the reasons for these preferences.

Design: Questionnaire-based, cross-sectional study.

Setting and participants: 170 registered and enrolled nurses employed in acute care wards of three metropolitan hospitals in Australia between April 2016 and February 2017.

Results: Nurses would most prefer to be cared for at home (53%) or in a hospice/palliative care unit (41%) at the end-of-life. Being in a familiar environment and feeling like dying is a more normal process were the main reasons reported for choosing these settings. The main reasons given by nurses for choosing a hospice/palliative care unit were that being cared for at home may place a burden on family/friends and hinder appropriate symptom management. Nurses would least prefer being cared for in an emergency department (49%) due to a perceived lack of privacy and adverse impact on the family; and residential aged care facilities (25%) due to perceived suboptimal symptom management and reduced likelihood of wishes being respected.

Conclusion: Nurses in this study value familiarity of environment and normalising the dying process. The majority do not wish to burden their family and friends at the end of their lives. Important next steps in providing services that meet the needs of people facing the end of their lives include understanding how nurses' personal views may influence decision-making conversations with patients and families about location of care at the end-of-life, as well as determining the capacity of available services to meet patient and family needs.

Keywords: Nurses; terminal care; acute care; communication; Australia

What is already known about the topic?

- Despite it being the preferred location for end-of-life care for many, few people will die at home.
- Nurses are an important source of information and support for patients and families facing decisions about location of end-of-life care.
- Few studies have examined nurses' attitudes about where they would prefer to be cared for at the end-of-life.

What this paper adds

- At the end-of-life, most nurses would want to be cared for either at home or in a hospice/palliative care unit.
- Perceived burden that providing end-of-life care may have on their loved ones was an important consideration for nurses.
- Very few nurses would want to be cared for in a hospital at the end-of-life.

INTRODUCTION

End of life care refers to care that helps people who have been diagnosed with an advanced, incurable illness to live as well as possible until they die (Palliative Care Australia, 2010). Being cared for at home at the end-of-life is highly valued by many people; however, few people achieve this aim (Broad et al., 2013). The majority of people will spend time in hospital in their final year of life, and more than half of people will die in hospital (Nilsson et al., 2017). Community nurses caring for patients approaching the end of their lives report an increased burden on carers as a common reason for hospital admission at the end-of-life (Jack & O'Brien, 2010). Similarly, excessive workloads can impact the ability of acute-care nurses to provide adequate end-of-life care to patients and their families (Raymond, Lee, & Bloomer, 2017).

Emergency departments are a common point of contact for patients in the last year of life (Broad et al., 2013). People typically present to EDs following unexpected illness any time of the night or day; and the duration of visits is often short, requiring rapid as well as appropriate clinical decisions (Gloss, 2017). It is often the first contact point for patients with poorly managed symptoms, including those in need of palliative care and end-of-life care (Alqahtani, 2019 #113). Up to 75% of residents of aged care facilities experiencing an unplanned transfer to an emergency department annually (Dwyer, Stoelwinder, Gabbe, & Lowthian, 2015). Emergency department nurses who care for patients nearing the end of their lives report that the lack of privacy, lack of areas for family to grieve, and excessive workloads often contribute to unsatisfactory experiences when people nearing the end of their lives are brought to the emergency department (Beckstrand, Wood, Callister, Luthy, & Heaston, 2012).

The proportion of people admitted to hospice/palliative care facilities is comparatively low, with figures reported to be below 5% for patients with cancer, and less than 1% for patients with other life-limiting conditions (Reeve et al., 2018). The appropriateness of different end-of-life care locations may depend on the individual's personal and functional circumstances (Burge et al., 2015; Costa et al., 2016). Other factors that reportedly influence place of care include: environment-related factors, such as health care access and social support; macrosocial factors (i.e. historical trends) and patient-related factors, such as socio-demographics and type of disease (Costa et al., 2016).

There is increasing interest in incorporating individual preference in decisions about where people receive care at the end-of-life (Higginson, Sarmento, Calanzani, Benalia, & Gomes, 2013; Nilsson et al., 2017). Being cared for in the location of choice can have a number of benefits, including better outcomes for bereaved family members and friends (Gallagher & Krawczyk, 2013; Higginson et al., 2013). Where there is a perception that the dying person's wishes and care needs have been met, family and friends experience less distress (Gallagher & Krawczyk, 2013). Previous studies undertaken with seriously ill patients and families indicate that each group has similar concerns about being cared for at home, including a fear of burdening the family and not wanting the family to experience their suffering, as well as more practical issues such as managing pain and inadequate space at home (Gomes, Calanzani, Gysels, Hall, & Higginson, 2013). Greater clarity regarding both positive (i.e. most preferred) and negative (i.e. least preferred) perceptions in relation to location of care, as well as people's reasons for these preferences, has been emphasised in the literature (Higginson et al., 2017). This information can help guide conversations regarding the feasibility of achieving preferences, and rectify any misconceptions individuals hold about the potential benefits and risks associated with different care locations (Higginson et al., 2017). Previous studies highlight that 'least preferred' location is not the reverse of 'most preferred' (Higginson et al., 2017).

Little is known about people's preferences for where they want to be cared for at the end of life, compared to where they are actually cared for (Higginson et al., 2017). It is suggested that cognitive biases, such as unrealistic perceptions about quality of care available in different locations and the nature of the problems that patients and families might experience may influence their expressed choices (Higginson et al., 2017). Health care providers are therefore a valuable source of credible information for patients and families about what to expect in relation to illness progression and treatment options, as well as the resources available to assist them at the end-of-life in different care locations (Halcomb, Daly, Jackson, & Davidson, 2004). However, providers own attitudes and experiences of caring for patients at the end-of-life have the potential to influence conversations they have with patients and families regarding their end-of-life options, and the feasibility of achieving their preferences (Adams, Bailey, Anderson, & Docherty, 2011). This may subsequently impact the end-of-life choices that patients and families make. Eliciting nurses preferences in relation to important end of life issues, such as location of end of life care, can offer a unique insight

into the quality end-of-life care currently being provided, and factors that contribute to a suboptimal dying process (Cartwright, Montgomery, Rhee, Zwar, & Banbury, 2014; Halcomb et al., 2004). Understanding their reasons for these choices can help clarify perceived gaps in care and help to inform future quality improvements initiatives (Woodman, Baillie, & Sivell, 2016). Despite this, nurses' views regarding where they would prefer to be cared for at the end-of-life, and the reasons they give for these choices remain relatively unexplored in the literature (Calanzani et al., 2014; Higginson et al., 2017).

AIMS

To examine in a cross-sectional sample of hospital-based nurses, the location in which they would most and least prefer to be cared for at the end-of-life, and the reasons for these preferences. Choices were home; hospice/palliative care unit; residential aged care facility; and several acute-care settings.

METHODS

Sample

A convenience sample of registered and enrolled nurses aged 18 years or over and working in acute care wards of three metropolitan hospitals in Australia completed the survey. The nurses worked in a range of wards including general medicine, general surgery, cardiology, intensive care, neurology, respiratory, emergency, medical oncology and haematological oncology.

Procedure

Eligible nurses were approached while on the ward between April 2016 and January 2017. The research team visited all units and spoke with the unit manager and/or clinical nurse educator in each instance. Where possible, the team also spoke directly with nurses performing direct patient care. Consenting nurses completed a pen-and-paper survey assessing socio-demographic characteristics, clinical expertise, preferences for location of care at end-of-life, and rationale for their choices (see *outcome measures*). The front page of the survey advised nurses that completion of the survey indicated implied consent. Nurses either completed the survey during pre-scheduled in-service education sessions held on the ward during shift or in their own time. Completed surveys were sealed in unmarked envelopes and returned to a box in a common area for collection by the research team.

Survey development

The survey was adapted from a cross-sectional patient survey used in previous studies of oncology outpatients (Waller et al., 2018) and older, hospitalised patients (Waller, Sanson-Fisher, Nair, & Evans, 2019). Steps in the development and establishment of face and content validity of the patient version have been described previously (Waller et al., 2019; Waller, 2018 #33). Briefly, it included: (1) health care providers and consumers participating in 20-minute individual interviews to elicit their views and experiences in relation to end of life care; (2) review of potential items by an expert panel selected based on their role in caring for patients that represent common trajectories of decline that are eventually fatal and have the greatest probability of dying in hospital (Swerissen, 2014 #29); and (3) modifications and pilot testing of items with a convenience sample of 20 patients for acceptability, relevance and clarity, with refinements based on their feedback. A similar approach was used to adapt the patient version to the nurses's version of the survey administered in this study. It include: (1) qualitative interviews (n=15) and a focus group (n=9) with nurses; (2) review of items by an expert panel comprised of behavioural scientists experienced in survey development, as well as clinicians with more than 20 years of experience, including a palliative care physician, a surgeon, an oncologist, a geriatrician, a nephrologist and nurses working in acute-care settings; and (3) and pilot testing procedures with a small number of nurses (n=xx). The final survey included items assessing: advance care planning knowledge and attitudes (Shepherd, Waller, Sanson-Fisher, Clark, & Ball, 2018), preferences for location of care and perceived barriers to delivering end of life care in hospitals; however only the location of care items are presented here.

Outcome measures

Most preferred place of care (1 item): Nurses were asked “If you could choose, where would you *MOST* want to be cared for at the end-of-life?” Nurses selected one location from the following response options: 1) home; 2) hospital emergency department; 3) hospital intensive care unit; 4) hospital general ward; 5) hospice/palliative care unit; 6) residential aged care facility; or 7) other.

Reasons for choice (1 items): Nurses were then presented with a list of potential reasons for their choice of most preferred place of care with items derived from the literature. Nurses were asked to rank the top three most important reasons from the list, with ‘1’ being the most

important reason. Response options were provided: 1) Family and/or friends willing/able to care for me at home; 2) Have expert medical care/equipment; 3) More likely to have my wishes respected; 4) Symptoms will be managed well; 5) Less of a burden on family/friends; 6) Religious/spiritual beliefs (or lack thereof) will be respected; 7) Positive past experience; 8) Family/friends last memory of me being in that environment; 9) Less distance for visitors to travel/more visiting hours; 10) Other.

Least preferred place of care (1 item): Nurses were asked “If you could choose, where would you *LEAST* want to be cared for at the end-of-life?” Nurses selected one location from the following response options: 1) home; 2) hospital emergency department 3) hospital intensive care unit; 4) hospital general ward; 5) hospice/palliative care unit; 6) residential aged care facility; or 7) other.

Reason for choice (1 item): Nurses were then presented with a list of potential reasons for their choice of least preferred place of care. Items were derived from the literature. Nurses were asked to rank the top three most important reasons from the list, with ‘1’ being the most important reason. Response options were provided: 1) Do not have family and/or friends to care for me at home; 2) No/limited access to expert medical care/equipment; 3) Less likely to have my wishes respected; 4) Will be a burden on family/friends; 5) Religious/spiritual beliefs (or lack thereof) will be respected; 6) Negative past experience; 7) Family/friends last memory of me being in that environment; 8) Distance for visitors to travel/visiting hours; 9) Other.

Socio-demographics and clinical experience

Nurses self-reported sex and age group and the following clinical items: years of experience as a nurse, years worked in current hospital and current ward, number of shifts worked per week, number of dying patients cared for in the past six months, and field of expertise.

Statistical analysis

Stata/IC 14 (StataCorp, 2015) was used for all analyses. Consent bias for age and sex was assessed using Chi-square analyses. One-sample proportion testing was conducted on comparable national data (sex, age group, and full-time/part-time status) collected by the Australian Institute of Health and Welfare (Australian Institute of Health and Welfare, 2015). Frequency and percentage data were used to describe (1) nurses’ most preferred place of care

and (2) nurses' least preferred place of care. The percentage and frequency of nurses ranking each reason as either '1', '2' or '3' was calculated. To assess the relative importance that nurses attributed to each reason, the rank of each item was reverse scored and then the sum of each item was calculated (e.g. each time an item was ranked 1, it received a score of 3; each time an item was ranked 2, it received a score of 2; and each time an item was ranked 3, it received a score of 1). The item that received the highest overall score is presented as the most important reason in each table, followed by the item that received the second highest overall score, and so on. Sample size calculations were performed on the preferred location for end-of-life care. Fifty-six percent of nurses would prefer to be cared for at home, and 44 percent would prefer to be cared for in a hospice/palliative care unit, with a margin of error of 0.077 (7.7%) and a 95% confidence interval. Due to concerns about survey length and potential burden on time-poor nursing participants, nurses were asked to give reasons for choosing their most preferred and least preferred location of care only.

Ethics approvals

The University of Newcastle Human Research Ethics Committee (16/02/17/5.03) and the ethics committee of the participating health services approved the study (LNRSSA/17/HNE/65; LNRSSA/17HNE/66 – 23/3/2016; and 0916-086C – 10/10/2016).

RESULTS

Sample

Of the 306 nurses who were invited to participate, 170 returned surveys (56% of eligible respondents). The characteristics of those who returned the survey are presented in Table 1. The sample was predominantly female (n=151; 89%), and half were employed full-time (n=88; 50%). More than 80 percent had cared for at least one dying patient in the past six months (n=145; 82%), with one-fifth of those caring for 11 or more dying patients (n=36; 20%). There were significantly fewer nurses in the 51+ age group in the sample when compared to the national data (Australian Institute of Health and Welfare, 2015) ($p=0.01$), though the national data does not separate acute-care nurses by age.

Table 1: Nurse socio-demographic characteristics and clinical expertise (n=170)

Characteristic		Number	%	2015 national data (%)
Sex	Male	19	11.2	10
	Female	151	88.8	90
Age group	Under 30	33	19.4	16
	31 – 40	34	20.0	20
	41 – 50	49	28.8	25
	51 and over	51	30.0	39
	Missing	3	1.8	
Number of years nursing experience				
	1 or less	9	5.3	-
	2 – 10	54	31.8	-
	11 – 20	41	24.1	-
	21+	59	34.7	-
	Missing	7	4.1	
Number of years at this hospital				
	1 or less	17	10.0	-
	2 – 10	78	45.9	-
	11 – 20	40	23.5	-
	21+	33	19.4	-
	Missing	2	1.2	
Number of years in this ward				
	1 or less	29	17.1	-
	2 – 10	84	49.4	-
	11 – 20	31	18.2	-
	21+	19	11.2	-
	Missing	7	4.1	
Full-time or part-time workload				
	Part-time	75	44.1	49
	Full-time	88	51.8	51
	Missing	7	4.1	
Number of dying patients cared for in the past 6 months				
	None	12	7.1	-
	1 – 10	109	64.1	-
	11 – 30	24	14.1	-
	31+	12	7.1	-
	Missing	18	10.6	
Group of patients usually cared for				
	Cancer	64	37.6	-
	Geriatric	23	13.5	-
	Renal	23	13.5	-
	Respiratory	18	10.6	-
	Cardiac	9	5.3	-
	Neurology	4	2.4	-
	Missing	3	1.8	

Note: As all questions were voluntary, there was a small amount of missing data in each variable (between 1% and 10%). Non-respondents were distributed across items and socio-demographic categories.

Where would nurses MOST prefer to be cared for?

Nurses would most prefer to be cared for at home (53%, n=89) or in a hospice/palliative care unit (41%, n=70) at the end-of-life. Fewer nurses chose a hospital general ward (3%; n=5), emergency department (1%; n=1) or residential aged care facility (2%; n=4) as their most preferred location of care.

Nurses' self-reported reasons for choosing most preferred locations

Table 2 presents the reasons nurses gave for selecting home as their most-preferred location for end-of-life care. The top five reasons were, in descending order, being in a familiar environment, feeling like dying is a more normal process, not being alone, more likely to have my wishes respected, and family/friends willing/able to care for me at home.

Table 2: Reasons nurses selected 'home' as their most-preferred location.
(Ratings: the first three most important reasons, with 1 being the most important)

Reasons (n=89)	Rated '1' n (%)	Rated '2' n (%)	Rated '3' n (%)	Total score
Familiar environment	12 (13%)	22(25%)	14(16%)	94
Feel like dying is a more normal process	14(16%)	10(11%)	5(6%)	67
Not being alone	13(15%)	10(11%)	5(6%)	64
More likely to have my wishes respected	5(6%)	12(13%)	15(17%)	54
Family and/or friends willing/able to care for me at home	4(4%)	7(8%)	21(24%)	47
Physical closeness	9(10%)	2(2%)	3(3%)	34
Family/friends last memory of me being in that environment	4(4%)	1(1%)	3(3%)	17
Symptoms will be well managed	3(3%)	1(1%)	2(2%)	13
Positive past experience	-	2(2%)	-	4
Less of a burden on family/friends	1(1%)	-	-	3
Religious/spiritual beliefs (or lack thereof) will be respected	1(1%)	-	-	3
Less distance for visitors to travel/more visiting hours	-	1(1%)	-	2

Table 3 presents the reasons nurses gave for selecting hospice/palliative care unit as their most-preferred location for end-of-life care. The top five reasons were, in descending order, being less of a burden on family/friends, having symptoms well managed, having expert

medical care/equipment, being more likely to have my wishes respected, and family/friends last memory of me being in that environment.

Table 3: Reasons nurses selected ‘hospice/palliative care unit’ as their most-preferred location

(Ratings: the first three most important reasons, with 1 being the most important)

Benefits (n=70)	Rated ‘1’ n (%)	Rated ‘2’ n (%)	Rated ‘3’ n (%)	Total score
Less of a burden on family/friends	12(17%)	16(23%)	19(27%)	87
Symptoms will be well managed	4(6%)	23(33%)	22(31%)	80
Have expert medical care/equipment	13(19%)	5(7%)	2(3%)	51
More likely to have my wishes respected	9(13%)	5 (7%)	8(11%)	45
Family/friends last memory of me being in that environment	6(9%)	1(1%)	-	20
Feel like dying is a more normal process	4(6%)	2(3%)	4(6%)	20
Positive past experience	1(1%)	2(3%)	-	7
Family and/or friends willing/able to care for me at home	2(3%)	-	-	6
Familiar environment	1(1%)	-	-	3
Not being alone	1(1%)	-	-	3
Religious/spiritual beliefs (or lack thereof) will be respected	1(1%)	-	-	3
Less distance for visitors to travel/more visiting hours	1(1%)	-	-	3
Other	-	-	1(1%)	1

Where would nurses LEAST prefer to be cared for?

Nurses would least prefer to be cared for in the emergency department (49%, n=85) or in a residential aged care facility (25%, n=45). Fewer nurses chose a hospital general ward (16%; n=29), home (8%; n=14) and hospice/palliative care unit (1%; n=2) as their least preferred location of care.

Nurses' self-reported reasons for choosing Emergency Department as the least-preferred location

Table 4 presents the reasons nurses gave for selecting the emergency department as their least-preferred location for end-of-life care. The top five reasons were, in descending order, lack of privacy, family/friends last memory of me being in that environment, emotional scarring on family/friends, being less likely to have my wishes respected, and being less likely to have symptoms managed well.

Table 4: Reasons nurses selected 'the emergency department' as their least-preferred location

(Ratings: the first three most important reasons, with 1 being the most important)

Reasons (n=85)	Rated '1' n (%)	Rated '2' n (%)	Rated '3' n (%)	Total score
Lack of privacy	12(14%)	19(22%)	18(21%)	92
Family/friends last memory of me being in that environment	13(15%)	11(13%)	7(8%)	68
Emotional scarring on family/friends	13(15%)	7(8%)	11(13%)	64
Less likely to have my wishes respected	8(9%)	6(7%)	12(14%)	48
Less likely to have symptoms managed well	5(6%)	10(12%)	7(8%)	42
Fear of dying alone	5(6%)	3(4%)	4(5%)	25
Negative past experience	1(1%)	2(2%)	-	7
Will be a burden on family/friends	1(1%)	1(1%)	1(1%)	6
Do not have family and/or friends willing/able to care for me at home	-	1(1%)	1(1%)	3
Religious/spiritual beliefs (or lack thereof) will not be respected	1(1%)	-	-	3

Nurses' self-reported reasons for choosing Residential Aged-Care Facility as the least-preferred location

Table 5 presents the reasons nurses gave for selecting a residential aged care facility as their least-preferred location for end-of-life care. The top five reasons were, in descending order, being less likely to have symptoms managed well, having no/limited access to expert medical care/equipment, lack of privacy, being less likely to have wishes respected, and a fear of dying alone.

Table 5: Reasons nurses selected ‘a residential aged care facility’ as their least-preferred location
(Ratings: the first three most important reasons, with 1 being the most important)

Worries (n=45)	Rated ‘1’ score (n)	Rated ‘2’ score (n)	Rated ‘3’ score (n)	Total score score (n)
Less likely to have symptoms managed well	7(16%)	6(13%)	7(16%)	40
No/limited access to expert medical care/equipment	5(11%)	3(7%)	3(7%)	24
Lack of privacy	3(7%)	4(9%)	5(11%)	22
Less likely to have my wishes respected	3(7%)	3(7%)	5(11%)	20
Fear of dying alone	2(4%)	5(11%)	4(9%)	20
Family/friends last memory of me being in that environment	3(7%)	3(7%)	2(4%)	17
Negative past experience	2(4%)	3(7%)	2(4%)	14
Emotional scarring on family/friends	-	3(7%)	1(2%)	7
Will be a burden on family/friends	2(4%)	-	-	6
Distance for visitors to travel/visiting hours	-	2(4%)	1(2%)	5
Do not have family and/or friends willing/able to care for me at home	-	-	1(2%)	1

DISCUSSION

In this multi-centre study of nurses employed in three Australian hospitals, the most-preferred location to receive end-of-life care was home (53%). Interpersonal factors such as familiarity of environment, feeling like dying is a normal process, and likelihood of having wishes respected were the most common reasons given for this choice. Home is also the location of choice identified in previous studies conducted with patients, with perceived quality of life, the availability and capacity of informal caregivers, and poor care continuity or coordination typically identified as factors influencing preferences (Higginson et al., 2017; Waller et al., 2019; Waller et al., 2018). However, not all nurses favoured home. A key issue for nurses choosing other locations than home as their most preferred was the potential impact of home care on family and friends. They did not wish to be a burden and nor did they want to potentially inflict emotional scarring on family and friends. This is also a pervasive perceptions among patients (Nilsson et al., 2017; Waller et al., 2019; Wilson, Shen, Errasti-Ibarrondo, & Birch, 2018). In addition to the potential burden placed on informal caregivers, it is possible that nurses who did not choose home care were more aware of the shortfall of

community services available to support patients with complex care needs and their families at home (Higginson et al., 2013). For instance, only 14,300 of the estimated 130,000 Australians that should have received palliative care in 2016 received a Medicare Benefits Schedule subsidized palliative care medicine specialist service (Borbasi, 2017).

The majority of remaining nurses (41%) instead chose the hospice/palliative care unit as their most-preferred location for end-of-life care. There is a large and well-respected palliative care facility within the region from which the nurses in this study were drawn, and this may account for the difference. Nurses may also have a greater understanding of the potential benefits of care in a hospice/palliative care environment, and, this may, in turn, create a more positive view of care in such a location (Tait et al., 2015). Stigma surrounding the use of hospice/palliative care services has been reported in studies of patients (Shen & Wellman, 2019). Nurses may be an important resource for providing patients and families with credible information on the role of hospice/palliative care services in end of life care. Despite the increasing availability of palliative care services in many countries (Wright, Wood, Lynch, & Clark, 2008), not all patients are able to access them (Firn, Preston, & Walshe, 2016; Le & Watt, 2010; Meier, McCormick, & Lagman, 2014). Furthermore, receipt of these services is still typically associated with having a diagnosis of cancer (Meier et al., 2014; Russ et al., 2015).

Half of all nurses (49%) reported that they did not want to be cared for in the emergency department. Nurses were most concerned about the lack of privacy afforded by such an environment, together with the emotional scarring such a death would have on their loved ones. Though not surprising, this is an important finding as many people with life-limiting conditions, particularly older people and residents of aged care facilities, present to emergency departments in the last weeks and days of life (Hullick et al., 2016). Emergency departments are often noisy and staff workloads high, and there is often little opportunity to identify end-of-life preferences before treatment is implemented (Beckstrand, Smith, Heaston, & Bond, 2008). While studies suggest that some emergency department staff are confident in their ability to provide adequate symptom management, they have been found to underestimate the potential role of palliative care in non-cancer diagnoses and express a desire for education in end-of-life communication and issues (Russ et al., 2015). Reducing avoidable transfers of elderly, frail patients from residential aged care facilities to emergency

departments is a key healthcare goal in many countries (Testa, Seah, Ludlow, Braithwaite, & Mitchell, 2019). These patients often have multiple co-morbidities, complex medication regimes, and sometimes cognitive impairment, all of which can lead to problems such as medication errors, and poor treatment co-ordination and follow-up care (Kessler, Williams, Moustoukas, & Pappas, 2013).

Two-thirds of nurses in this study reported that they did not wish to be cared for in any hospital environment at the end-of-life. The top reasons given were lack of privacy, negative impact on family and friends (emotional scarring/last memory of their loved one being in that environment), and being less likely to have their wishes respected. Nurses' concerns are supported by studies that suggest patients' physical symptoms may not always be well-managed in a hospital environment (Carey, 2017; Clark et al., 2014). Residential aged care facilities were also identified by a significant minority of nurses least-preferred location for end-of-life care. Perceptions about the adequacy of symptom management was again a contributing factor in this choice. It may be that these hospital-based nurses have less experience caring for people in a residential aged care facility, though they may have some experience with caring for patients who have been transferred from a residential aged care facility. They may also have prior personal experience that leads to negative perceptions regarding the quality of care delivered in residential aged care facilities.

Strengths and limitations

The sample of nurses included in this study represent a wide range of disciplines and several hospitals. This may increase the generalisability of our results. However, as a convenience sample was used and a sample size calculation was not carried out, this may limit the generalisability of the results. The 56% response rate compares favourably to other studies using similar methodologies and involving nurses. Psychometric testing of the survey was limited to establishing face and content validity and acceptability. The survey was conducted with nurses working in metropolitan centres, and as most hospice/palliative care services are located in metropolitan areas, the findings from this study may not be representative of nurses working in rural and remote health services. Nurses were allowed to complete the survey in their own time and there is a small chance that there may have been some conferring, although nurses were instructed not to do this. There is a possibility that

nurses equated *end-of-life* care with *dying*. A qualitative component may have provided a more in-depth understanding of nurses' reasons for their choices, but was beyond the scope of this study.

Conclusion

Nurses place a significant value on familiarity of environment and normalising the dying process, and they do not wish to burden their family and friends at the end of their lives.

That most nurses did not want to be cared for in a hospital at the end-of-life suggests that this informed population group perceive the quality of care in this setting to be suboptimal.

Understanding how nurses' personal views may influence decision-making conversations with patients and families about location of care at the end-of-life, as well as determining the capacity of available services to meet patient and family needs, are important next steps in ensuring that the right services are delivered to people facing the end of their life.

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