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Enhancing End-Of-Life Care For Older Adults: The Critical Role Of Nursing

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Abstract

Background: The aging global population has increased the demand for high-quality end-of-life (EOL) care. Nurses play a foundational role in ensuring comfort, dignity, and autonomy for older adults experiencing complex, life-limiting conditions.

Methods: A narrative synthesis of current literature was reviewed, focusing on nursing roles, competencies, challenges, and best practices in geriatric EOL care. Key themes included symptom management, interdisciplinary collaboration, communication, advance care planning, and cultural competence.

Results: Findings highlight nurses' central involvement in holistic assessment, pain and symptom management, decision-making support, and family education. Nurse-led coordination improves continuity of care, reduces unnecessary hospitalizations, and enhances satisfaction among patients and caregivers. Barriers such as staffing shortages, communication gaps, legal uncertainties, and emotional burden negatively impact care quality. Facilitators including targeted education, institutional support, and telehealth innovations strengthen nursing capacity and patient outcomes.

Conclusions: Nurses are essential to deliver comprehensive EOL care for geriatric populations. Enhancing training, resources, and supportive policies can mitigate existing challenges and elevate the standard of care, ensuring older adults receive compassionate, person-centered support at the end of life.

Keywords End-of-life care; geriatric nursing; palliative care; symptom management; patient autonomy; interdisciplinary care; advanced care planning; family support; cultural competence; nursing competencies.

Introduction

The global population is experiencing a marked demographic shift characterized by an unprecedented increase in the number and proportion of older adults. This phenomenon, often referred to as population aging, presents significant challenges and opportunities for healthcare systems worldwide, particularly concerning end-of-life (EOL) care. End-of-life care encompasses the range of physical, psychological, social, and spiritual support provided to individuals who are nearing the end of their lives, with a focus on quality of life, dignity, and symptom management rather than curative treatments. Nursing professionals occupy a central role in this context, acting as primary caregivers, advocates, and coordinators of care for elderly patients. Their involvement spans from managing complex symptoms and facilitating communication among patients, families, and healthcare teams to providing emotional support and upholding patient autonomy in decision-making processes. The complexities of geriatric end-of-life care demand specialized knowledge and skills, emphasizing the need for enhanced educational and policy frameworks to support nurses in fulfilling this indispensable role in aging societies (Nacak & Erden, 2022).

Population aging is a pervasive global trend impacting both developed and developing countries. The proportion of individuals aged 60 and above is projected to nearly double from 12% in 2015 to 22% by 2050, reflecting increased longevity driven by advances in medical technology, public health, and social determinants of health. This demographic shift is accompanied by a rising prevalence of chronic conditions that increase with age, including cardiovascular diseases, neurodegenerative disorders such as Alzheimer's disease, cancer, and respiratory diseases. Mortality rates from these conditions exhibit an exponential increase with advancing age, thereby elevating the demand for healthcare services tailored to the unique needs of older adults. These epidemiological patterns indicate that as populations live longer, they also face extended periods of morbidity, necessitating comprehensive, multidisciplinary approaches to managing health, particularly at the end of life (Khan et al., 2024).

The growing aging population has precipitated a surge in demand for end-of-life care services, placing pressure on healthcare infrastructures and resources. Older adults often endure complex health trajectories characterized by multimorbidity, frailty, and functional decline, which complicates care delivery. The emphasis of care shifts progressively from curative interventions to palliative approaches that prioritize symptom relief, psychosocial support, and quality of life. There is a growing recognition that EOL care must be proactive, patient-centered, and culturally sensitive to meet the diverse needs of geriatric patients. Furthermore, healthcare systems worldwide face the challenge of reorganizing care to accommodate these demands, including the integration of home-based, hospice, and community care models that allow older adults to die with dignity in their preferred settings. Such shifts necessitate a robust workforce skilled in geriatric palliative care and capable of navigating the ethical and communication complexities inherent in EOL decision-making (Lewis et al., 2019).

Nurses are integral to the delivery of high-quality end-of-life care for geriatric populations, given their continuous presence at the bedside and comprehensive caregiving roles. They act as managers of comfort-oriented care, facilitating transitions from curative to palliative phases while advocating for patient rights and preferences. Nurses engage in complex decision-making processes alongside patients and families, ensuring informed choices about treatments and care goals that respect patient autonomy. Their roles extend to addressing physical symptoms such as pain and dyspnea, providing psychosocial and spiritual support, and coordinating interdisciplinary care efforts. Moreover, nurses are vital in educating patients and families about the dying process and available care options, which mitigates fear and enhances coping mechanisms. The effectiveness of nursing care in this domain directly influences the quality of dying and the bereavement experiences of families, highlighting the necessity of specialized training and institutional support to empower nurses in fulfilling this role optimally (Nacak & Erden, 2022).

Background and Definitions

End-of-life care (EOLC) fundamentally involves providing palliative and humanistic care focused on holistic and team-based approaches that address the multifaceted needs biological, psychological, social, and economics of individuals nearing the final stages of life, typically defined for geriatrics as those aged 60 or older with deteriorating health and irreversible dependence. This care aims to improve quality of life in the last phase or at the time of death and extends support to families coping with grief, ultimately reducing psychological stress and healthcare costs. EOLC encompasses symptom management, emotional support, and ethical considerations tailored to the patient's condition and preferences, defining it as care for those expected to live within months or a year, characterized by serious progressive illness or frailty with a high likelihood of death in that time frame (Abbaspour & Heydari, 2021).

Palliative care is an approach that encompasses the active holistic management of individuals facing serious illnesses, aiming to prevent and relieve suffering early and throughout the disease trajectory. According to the World Health Organization, it is designed to improve the quality of life of patients and their families confronting life-threatening illnesses by addressing pain, physical symptoms, psychological distress, and spiritual needs. Unlike hospice or end-of-life care, palliative care is not restricted by prognosis or timeline and can be provided alongside curative treatments, supporting patients from diagnosis through advanced illness and even post-bereavement for families. Specialist palliative care involves multidisciplinary teams skilled at managing complex problems beyond standard medical treatment (Abbaspour & Heydari, 2021).

Hospice care specifically refers to a model of palliative care delivered at the end of life, primarily when a person has a terminal illness with an estimated life expectancy of six months or less. This care emphasizes comprehensive comfort measures, including pain management, emotional support, and addressing spiritual needs. Hospice services typically exclude curative treatments, shifting the focus entirely to quality of life and dignity in dying as the disease runs its course. It also provides extensive support to family members during the patient’s decline and the bereavement period, thus ensuring a coordinated and compassionate approach in the final months or weeks of life (Sheikh et al., 2022).

Distinct differences exist between end-of-life care and palliative care. While the terms are sometimes used interchangeably, palliative care is broader, applicable to patients at any stage of serious illness and designed to improve quality of life regardless of prognosis. It can be integrated early in disease management, alongside curative or life-prolonging treatments. End-of-life care, by contrast, refers specifically to care provided during the final phase of life when death is imminent, and curative treatments are no longer effective or desired. Hospice care is a subset of palliative care focused on this terminal phase. Thus, end-of-life care is more narrowly focused on comfort during dying, whereas palliative care takes a comprehensive, ongoing approach to symptom relief and support at any illness stage (Sheikh et al., 2022).

Ethical and legal considerations in end-of-life care are critical and often complex, revolving around respecting patient autonomy while balancing beneficence, nonmaleficence, and justice. Patients have the right to make informed decisions about their care, including refusing or discontinuing treatments, but cannot demand treatments that are medically inappropriate or harmful. Healthcare providers must navigate decisions about withholding or withdrawing interventions when treatments no longer provide benefit or only prolong suffering. Legal frameworks typically support preserving life when in doubt but emphasize the need to honor advance directives, capacity assessments, and ethical guidelines that encompass patient values, clinical evidence, and resource considerations. Transparency, detailed communication, and empowering patients and families in decision-making processes are ethical imperatives to ensure dignified and respectful end-of-life care (Akdeniz et al., 2021).

Epidemiology and Demographics

The epidemiology of end-of-life care in geriatric populations reveals significant shifts in the diagnoses, complexity, and patterns of care in the last phase of life. There is an increasing diversity in primary

diagnoses among elderly decedents, marked by a rise in multimorbidity and illness complexity. This epidemiological evolution places new demands on healthcare systems, especially on hospice and palliative care services, which must adapt to provide high-quality end-of-life care across diverse settings. Older adults now frequently face multiple chronic conditions simultaneously, altering traditional single-disease trajectories and necessitating more comprehensive, multidisciplinary approaches in their care planning. These trends underscore a growing need for tailored health services to address the complex end-of-life needs of aging populations (Md & Eh, 2017).

Aging demographics profoundly impact healthcare systems worldwide by increasing demand for medical resources, changing service delivery models, and requiring systemic adaptation. The global increase in the proportion of elderly individuals has resulted in a higher healthcare burden, as older adults tend to experience declining physical and mental health, accompanied by multiple chronic illnesses requiring complex care. For example, in the United States, the elderly population aged 65 and over accounted for a disproportionate share of healthcare spending, with projections indicating continued growth. This demographic shift compels healthcare institutions to reassess strategies, including long-term care planning, workforce training in geriatrics, and integration of health and social services to support aging in place. Moreover, due to multiple comorbidities, there is a shift from disease-centered care to goal-oriented, patient-centered care frameworks that prioritize quality of life and functional maintenance (Hajizadeh et al., 2025).

Common illnesses at the end of life for geriatric populations predominantly include hypertension, diabetes mellitus, cancer, heart disease, dementia, and chronic obstructive pulmonary disease. These illnesses manifest through distinct trajectories characterized by gradual functional decline, periods of exacerbation, and complex symptom burdens such as pain, anorexia, fatigue, depression, dyspnea, and cognitive impairments. Older adults commonly experience progressive limitations in activities of daily living and instrumental activities, especially in the months preceding death. Different settings of death such as home versus long-term care facilities influence the symptom profiles and care needs, with residents in long-term care often facing more intense symptom burdens requiring specialized palliative care interventions. Beyond disease-specific trajectory models, frailty and multimorbidity further complicate end-of-life care needs and outcomes in this population segment (Kim, 2022).

Principles of End-of-Life Care in the Elderly

End-of-life care in geriatric populations requires embracing a series of fundamental principles that prioritize comfort, dignity, and quality of life during the final stages of life. At the core, this care approach affirms life while neither hastening nor postponing death, focusing intensely on relief from pain and other distressing symptoms commonly experienced by elderly patients. Effective end-of-life care also integrates a holistic understanding of suffering, recognizing that it is not limited to physical symptoms but extends to psychological, social, and spiritual dimensions. A comprehensive assessment to identify evolving needs, timely interventions, and coordination among interdisciplinary teams are essential for upholding high standards of care. Importantly, these principles emphasize respect for patient autonomy, beneficence, nonmaleficence, and justice, tailoring care to the unique needs and wishes of each individual elder, while also supporting their families through the bereavement process. Chronic conditions, frailty, cognitive decline, and multimorbidity common in elderly populations amplify the need for careful symptom management and decision-making that preserve dignity until death (Alsararatee et al., 2025).

A hallmark of exemplary end-of-life care in older adults is the implementation of holistic and person-centered approaches, which recognize the individual as a whole person rather than a biochemical entity defined by disease alone. This approach extends beyond the biomedical focus on symptom control to encompass the emotional, social, cultural, and spiritual realms of experience, all of which profoundly influence the quality of the dying process. Person-centered care honors the values, preferences, and experiences of elderly patients, actively involving them and their families in care planning and decision-making to promote autonomy and personalized support. It requires interdisciplinary collaboration among

nurses, physicians, social workers, chaplains, and other health professionals who collectively address the broad spectrum of needs. Through such an integrative approach, care plans are tailored dynamically to reflect changing goals and wishes, ensuring that interventions promote comfort, dignity, and meaning. This philosophy is especially critical in geriatrics, where complex psychosocial contexts and ethical considerations demand sensitivity and flexibility in care delivery (Arimany-Manso et al., 2025).

End-of-life care for the elderly must attentively balance multidimensional aspects of well-being, recognizing that emotional, physical, social, and spiritual needs are intricately intertwined. Physically, the priority lies in effective pain and symptom management to alleviate distress and maintain comfort. Emotionally, patients may experience anxiety, depression, fear, and grief, requiring empathetic communication, psychological support, and sometimes pharmacologic treatment. Socially, the role of family, caregivers, and community connections profoundly influences the patient's sense of belonging and support, necessitating psychosocial interventions and caregiver assistance to address isolation and relational stress. Spiritually, older adults often face existential questions about meaning, forgiveness, and legacy, making spiritual care an indispensable component of holistic end-of-life care. Nurses play a vital role in assessing spiritual distress, facilitating conversations about values and beliefs, and connecting patients with pastoral care or counseling resources. The integration of these domains into a cohesive care plan helps ensure that patients' total suffering is addressed and that dignity and peace are preserved as death approaches (De Luca et al., 2025).

Patient assessment and symptom management

In geriatric end-of-life care, nurses are central to continuous, holistic assessment that integrates physical, cognitive, functional, psychological, social, and spiritual dimensions rather than focusing narrowly on single disease trajectories. Older adults commonly experience multimorbidity, frailty, polypharmacy, cognitive impairment, and geriatric syndromes, which complicate symptom presentation and require structured approaches such as comprehensive geriatric assessment (CGA) aligned with palliative principles. Within this framework, nurses use validated tools to screen for pain, dyspnea, delirium, fatigue, constipation, anorexia, and insomnia, while also appraising functional decline, falls risk, caregiver burden, and environmental safety in home, long-term care, or acute settings. Regular reassessment allows early identification of changes in symptom patterns, triggers anticipatory adjustments in care plans, and supports timely transition from disease-modifying regimens to comfort-focused interventions when curative goals are no longer achievable (Castagna et al., 2024).

Nurse-led palliative care models in older adults, particularly in geriatric oncology, demonstrate that systematic assessment combined with individualized symptom management significantly improves pain, fatigue, sleep quality, functional capacity, and overall quality of life compared with routine care. These interventions typically include structured pain assessment, titration of opioids and adjuvants, monitoring of side effects (e.g., constipation, nausea, sedation), proactive management of non-pain symptoms, and integration of non-pharmacologic strategies such as positioning, relaxation, cognitive behavioral techniques, and environmental modifications. Evidence from home-based and community palliative nursing shows that embedding regular symptom review into the care plan allows nurses to detect medication-related problems, escalate concerns to prescribers, and advocate for deprescribing or regimen simplification, which is crucial in frail older people. Reviews of pain and symptom management at the end of life underscore that nurses, through close proximity and frequent contact, are uniquely placed to evaluate treatment effectiveness in real time and to balance analgesia against risks such as falls, delirium, or respiratory depression in geriatric populations (Li et al., 2024).

Nurses also play a critical role in integrating psychological and existential assessment into routine symptom review, recognizing that anxiety, depression, demoralization, loneliness, and fear of burdening others are highly prevalent in older adults nearing the end of life and often manifest somatically. By employing standardized screening tools for mood and distress and by facilitating referrals to psychosocial, spiritual, or mental health services, nurses help ensure that symptom management is not limited to physical comfort but

extends to emotional and spiritual well-being. In home health and long-term care, palliative nurses frequently educate patients and families about self-monitoring of symptoms, safe medication use, and recognition of "red flags," thereby enhancing self-efficacy and enabling shared responsibility for symptom control. Such collaborative, nurse-driven symptom management has been linked with reduced emergency department visits and hospitalizations at the end of life, more deaths in preferred settings, and higher satisfaction with care among older patients and their caregivers (Murali et al., 2024).

Advocacy and safeguarding patient autonomy

Safeguarding the autonomy of older adults at the end of life is an ethical and professional imperative for nurses, who often act as the primary advocates within complex family and organizational systems. Respect for autonomy entails supporting older patients' rights to receive honest information, to consent to or refuse life-sustaining treatments, and to participate in decisions about goals of care, even when cognitive impairment, frailty, or family pressure threaten self-determination. Empirical studies on nurses caring for older persons highlight how advocacy involves identifying situations in which self-determination is undermined, such as withholding diagnoses at relatives' request, excluding the patient from discussions, or continuing burdensome treatments contrary to expressed wishes. By raising ethical concerns in interprofessional forums, clarifying patient values, and challenging paternalistic practices, nurses help ensure that the end-of-life trajectory reflects the elder's preferences rather than solely biomedical imperatives or family demands (Luca et al., 2021).

Nurses defending the autonomy of elderly patients describe drawing on professional codes of ethics, ethical principles, and leadership skills to negotiate with physicians and families when there is tension between beneficence, non-maleficence, and respect for patient choice. This may involve ensuring that older people are adequately informed about prognosis, risks and benefits of interventions such as feeding tubes, non-invasive ventilation, dialysis, or resuscitation, and that they have opportunities to reconsider earlier decisions as health status evolves. End-of-life care literature emphasizes that when clinicians fail to communicate clearly about life-sustaining treatments, patients are more likely to undergo unwanted aggressive care, experience avoidable suffering, and die in settings misaligned with their values, outcomes that nurses are well placed to prevent through persistent advocacy. Furthermore, advocacy in geriatric end-of-life care includes defending vulnerable elders from neglect, discrimination, or ageism within health systems, and ensuring equitable access to palliative resources, pain relief, psychosocial support, and hospice services irrespective of age, cognitive status, or social position (Gaspar et al., 2019).

Coordination of interdisciplinary care

End-of-life care for geriatric populations is inherently interdisciplinary, intersecting geriatric medicine, palliative care, primary care, nursing, social work, rehabilitation, chaplaincy, and community services, with nurses frequently serving as the central coordinators of this network. Interdisciplinary geriatric–palliative care teams aim to meet the complex medical, functional, and psychosocial needs of older adults and their families, and nurses contribute by synthesizing information from multiple disciplines, monitoring implementation of agreed plans, and closing communication loops between settings such as hospital, home, and long-term care. In community-based palliative care, effective coordination requires clear role delineation, regular feedback mechanisms, and structured communication channels between primary care providers and specialist palliative services; nurses are often the "named coordinators" who maintain continuity and ensure that recommendations are translated into day-to-day practice. Interdisciplinary approaches that explicitly integrate geriatric and palliative principles have been associated with improved symptom control, fewer hospitalizations, and higher satisfaction, outcomes that are contingent on strong nursing leadership and coordination (Visser et al., 2021).

Care coordination for older adults near the end of life also involves aligning clinical interventions with the evolving goals of patients and caregivers, addressing social determinants such as living conditions and caregiver capacity, and organizing community resources like home care, respite, and volunteer support.

Reviews of palliative care coordination interventions highlight that having a designated coordinator, frequently a nurse, is linked to better individualized care planning, more effective navigation of services, and reduced fragmentation, particularly for elders with multimorbidity and complex trajectories. Nurses in geriatric palliative settings routinely orchestrate case conferences, facilitate interdisciplinary rounds, and document and share updates on symptoms, function, and goals of care, thereby helping teams respond promptly to changes and preventing crises that lead to avoidable emergency utilization. Furthermore, advanced practice and clinical nurse specialist roles in geropalliative care illustrate how nurses can lead program development, staff education, and quality improvement initiatives that embed palliative principles across geriatric care pathways, strengthening system-level coordination for this growing population (Dudley et al., 2019).

Communication and decision-making support

Communication is a cornerstone of high-quality geriatric end-of-life care, and nurses are often the professionals who spend the most time with patients and families, enabling them to build trust and facilitate complex conversations. Effective communication includes exploring older adults' understanding of their illness, eliciting their values and priorities, clarifying misconceptions, and helping them weigh the burdens and benefits of treatments within the context of limited life expectancy and functional decline. End-of-life decision-making literature underscores that respect for autonomy requires ongoing dialogue rather than a single consent event, with nurses supporting iterative conversations as conditions evolve and as families process prognostic information. For older adults with communication barriers arising from cognitive impairment, sensory deficits, or delirium, nurses adapt communication strategies, involve surrogates appropriately, and advocate for approaches that maximize remaining decision-making capacity rather than defaulting prematurely to substituted judgment (Alanazi et al., 2024).

Nurses also provide structured decision-making support by translating technical information into accessible language, preparing patients and relatives for meetings with physicians, and helping them formulate questions and articulate concerns. When values conflicts or decisional regret arise, nurses are often the first to recognize distress and can initiate ethics consultations, family meetings, or referral to specialist palliative care to address unresolved conflicts about life-sustaining treatments, place of care, or hospice enrollment. Studies focusing on nursing perspectives in end-of-life decisions highlight that nurses frequently experience moral distress when they perceive that care is inconsistent with an elder's wishes, and that enhanced communication skills, ethical support, and clear organizational policies can strengthen their capacity to advocate effectively in these situations. Furthermore, educational initiatives in palliative communication for nurses, including training in goals-of-care discussions, bad-news delivery frameworks, and shared decision-making models, have been associated with improved confidence, better alignment of care with patient preferences, and reduced aggressive interventions at the end of life in older cohorts (Rhee et al., 2019).

Advance care planning and documentation

Advance care planning (ACP) is a critical process in geriatric end-of-life care, and nurses are pivotal in initiating, revisiting, and documenting these conversations across settings and along disease trajectories. ACP enables older adults to articulate their values, treatment preferences, and surrogate decision-makers before they lose capacity, thereby guiding future clinical decisions about resuscitation, hospitalization, artificial nutrition and hydration, and other life-sustaining therapies. Given their longitudinal contact with patients in primary care, home health, long-term care, and oncology, nurses are well placed to normalize ACP as part of routine care, introduce topics gradually, and identify "teachable moments" such as after hospitalizations or functional decline. Literature on end-of-life care indicates that when ACP discussions are delayed until acute crises, older patients are more likely to experience non-beneficial intensive treatments, while earlier, nurse-supported ACP is associated with care that more closely reflects documented preferences and fewer invasive interventions (Murali et al., 2024).

Documentation is integral to making ACP operational, and nurses contribute by recording detailed notes about conversations, completing or verifying advance directives, do-not-resuscitate (DNR) or do-not-hospitalize orders, and ensuring that these documents are accessible across care transitions. In many jurisdictions and organizations, nursing protocols specify responsibilities for confirming the presence and validity of ACP documents on admission, during transfers, and before major procedures, roles that are particularly salient for older adults with fluctuating capacity or living in residential facilities. Historical and contemporary analyses of advance directives emphasize the importance of advocacy by health professionals, including nurses, in explaining legal instruments, clarifying limitations, and preventing misinterpretation that might either unduly restrict beneficial care or, conversely, lead to the disregard of an elder's expressed wishes. By integrating ACP into routine nursing assessment and ensuring consistent documentation and communication, nurses help create a reliable framework within which clinicians and families can make ethically and legally sound decisions as the end of life approaches (Alodhialah et al., 2024).

Emotional and psychosocial support for patients and families

Geriatric end-of-life care entails profound emotional and psychosocial challenges for patients and families, and nurses occupy a central role in providing ongoing support, often serving as the most accessible and trusted professionals. Older adults facing the end of life frequently grapple with grief over losses of independence and role, fear of pain or abandonment, concerns about burdening loved ones, and existential distress, all of which can exacerbate physical symptoms if left unaddressed. Nurse-led palliative interventions that incorporate systematic psychological assessment, emotional counseling, relaxation techniques, and coping-skills training have been shown to reduce anxiety and depression, enhance resilience, and improve quality of life in elderly patients with advanced cancer. In home health and community palliative nursing, practitioners often support elders in maintaining routines, engaging in meaningful activities, and adapting the home environment to preserve dignity and autonomy despite functional decline (Abdel-Aziz et al., 2025).

Families and informal caregivers of older persons nearing the end of life experience high levels of burden, anticipatory grief, and decisional conflict, and nurses play a key role in caregiver education, support, and advocacy. Care coordination interventions that include structured caregiver support, often nurse-led, are associated with improved caregiver outcomes, better preparedness for the dying process, and more confident home care, which in turn align with elders' preferences to remain at home when possible. Nurses provide practical training in symptom management, safe handling of medications and equipment, and recognition of emergencies, while also creating spaces for caregivers to express fears and grief and to access bereavement resources. By maintaining a therapeutic presence at the bedside, bearing witness to suffering, and modeling compassionate, person-centered care, nurses help families reinterpret the dying process as one that can be dignified and meaningful rather than solely traumatic, thereby influencing long-term psychological outcomes (Nacak & Erden, 2022).

Cultural competence and sensitivity

Cultural, religious, and generational factors profoundly shape older adults' perceptions of illness, death, and acceptable care, making cultural competence a core nursing responsibility in geriatric end-of-life practice. Nurses must recognize that elders may hold diverse beliefs about disclosure of diagnosis, decision-making roles, suffering, and afterlife, and that family structures and migration histories can influence expectations regarding filial duty, place of death, and the use of life-sustaining treatments. Ethical analyses of end-of-life care highlight potential tensions between respect for individual autonomy and family-centered or community-based decision-making traditions, particularly in older cohorts, requiring nurses to navigate these differences without imposing their own cultural norms. Through culturally sensitive assessment, use of interpreters, awareness of health literacy, and openness to rituals and practices important to elders and their families, nurses can foster trust, reduce misunderstandings, and tailor care plans that honor both clinical realities and cultural values (Castagna et al., 2024).

Cultural competence also involves recognizing structural inequities and ageism that disproportionately affect older adults from minority, rural, or socioeconomically disadvantaged backgrounds, limiting their access to timely palliative and hospice services. Nurses are well positioned to identify these disparities, advocate for equitable resource allocation, and adapt care models to better reach marginalized elders, for example through community-based palliative programs and home health initiatives. Interdisciplinary geriatric–palliative frameworks increasingly emphasize the need for education and training in cultural humility for all team members, with nurses often leading practice changes and quality improvement projects that integrate cultural assessment tools, staff reflection, and community engagement. By embedding cultural sensitivity into every aspect of assessment, communication, decision-making, and symptom management, nurses help ensure that geriatric end-of-life care is not only clinically competent but also morally responsive to the diverse identities and histories of older people and their families (Castagna et al., 2024).

Core Nursing Competencies and Skills

End-of-life care in geriatric populations demands a specialized set of nursing competencies and skills that cover physical, psychological, and spiritual dimensions of care. Core nursing competencies include comprehensive assessment and management of symptoms, effective communication with patients and families, ethical decision-making, and holistic care planning tailored to the complex needs of older adults facing life-limiting illnesses. Nurses provide crucial advocacy for patient autonomy by ensuring that care preferences are respected and advance care planning is promoted. Their role extends to supporting family members emotionally and practically throughout the dying process. These competencies equip nurses to deliver dignified, personalized, and compassionate end-of-life care, which is pivotal for improving quality of life in geriatric patients (Pautex et al., 2021).

Pain and symptom management are foundational skills in geriatric end-of-life nursing, encompassing both pharmacologic and non-pharmacologic approaches. Effective pain control relies on recognizing that each elder's pain experience is unique, influenced by psychological, social, and cultural factors. Nurses must master multidimensional assessment techniques to evaluate pain intensity, quality, and related symptoms such as dyspnea, fatigue, and nausea, which tend to intensify near death. Sophisticated symptom management also includes the integration of complementary therapies like massage, acupuncture, cognitive-behavioral therapy, and mindfulness practices, which address psychosocial elements contributing to pain perception and improve coping mechanisms. This holistic approach extends beyond pain to alleviate distressing symptoms and optimize comfort while honoring the patient's values and goals (Wilkie & Ezenwa, 2012).

Provision of psychological and spiritual comfort is a critical dimension of nursing care at the end of life, especially for geriatric patients who often face existential challenges such as loss of meaning and fear of dying. Nurses act as spiritual care generalists who create a supportive environment through authentic human connection, active listening, and presence. This includes facilitating discussions around faith, hope, forgiveness, and life review that help patients find peace and resilience despite illness. Spiritual care also supports emotional well-being by addressing spiritual pain manifested as feelings of abandonment or inner turmoil. Nurses' awareness of diverse cultural and religious backgrounds ensures that spiritual interventions respect individual preferences and foster dignity. This dimension of care helps maintain patients' sense of identity and purpose as they navigate the end-of-life journey (Wilkie & Ezenwa, 2012).

The impact of nursing education and clinical experience on quality of end-of-life care in geriatric populations is substantial. Evidence shows that targeted end-of-life nursing education significantly enhances nurses' knowledge, attitudes, and clinical competence, leading to improved patient outcomes and family satisfaction. Experience in caring for dying patients fosters greater confidence in managing complex symptoms, communicating effectively about prognosis and goals of care, and collaborating within multiprofessional teams. Continuous professional development in palliative care principles empowers nurses to uphold ethical standards and deliver holistic care tailored to older adults' unique needs. Institutions

supporting ongoing education and reflective practice create environments that promote excellence in end-of-life nursing care and reduce nurses' emotional burden (Lee et al., 2025).

Challenges and Barriers

End-of-life care in geriatric populations presents multifaceted challenges and barriers that significantly impact the quality and delivery of nursing care. One of the most prominent issues is resource limitations and staffing shortages. These constraints severely hamper the capacity of nursing staff to provide comprehensive, compassionate care to dying elderly patients. Staffing shortages lead to increased workload, burnout, and reduce the time nurses can dedicate to the complex psychosocial and physical needs of patients at the end of life. Studies highlight that insufficient nursing staff in hospitals and community settings, especially amid rising numbers of elderly patients preferring to die at home, create a profound strain on care delivery and diminish care quality. This shortage is linked to increased stress among nurses and diminished patient satisfaction, underscoring the urgent need for better staffing levels and resource allocation to meet demand (Lee et al., 2025).

Communication breakdowns within care teams constitute another critical barrier in end-of-life care for geriatric patients. Effective communication is central to coordinating care, making informed decisions, and providing continuity of care that respects the patient's preferences and dignity. However, communication can falter due to time constraints, varying levels of training among team members, and difficulties in discussing sensitive topics such as prognosis and dying. Nurses often face challenges in initiating and sustaining open, empathetic conversations with patients, families, and interdisciplinary teams, which can lead to misunderstandings, misaligned care goals, and increased family distress. Strategies such as specialized communication training, regular family meetings, and use of communication aids have been identified as crucial in overcoming these barriers. The literature emphasizes the importance of clear, consistent, and compassionate communication to foster trust, alleviate anxiety, and support shared decision-making in end-of-life scenarios (Lee et al., 2025).

Societal and institutional barriers further complicate end-of-life care in the elderly. Societal attitudes toward death and dying often include denial, stigma, and unrealistic expectations about medical interventions, which can influence patient and family acceptance of palliative care. Institutional cultures may not adequately prioritize or support palliative approaches, with organizational policies and norms sometimes impeding personalized and holistic care. Healthcare institutions may lack dedicated spaces for end-of-life care, insufficient mental health and spiritual support services, and inadequate integration of geriatrics and palliative expertise. Emotional reactions such as grief and denial by family members, compounded by limited frailty knowledge, are also barriers recognized by care providers. This interplay of social and systemic obstacles requires a cultural shift in how death is perceived and managed institutionally and in the broader community (Hodge et al., 2025).

Legal and policy constraints present a further set of challenges in geriatric end-of-life care. There is often ambiguity or absence of clear legal frameworks guiding nurses and other clinicians in providing end-of-life care, particularly regarding decisions to withhold or withdraw treatment, advance care planning, and medical assistance in dying where applicable. These conditions create ethical dilemmas and fears of litigation, which can hinder timely and appropriate care decisions. Nurses must navigate complex legal provisions, which may vary regionally, and balance respect for patient autonomy with professional and legal responsibilities. In some jurisdictions, restrictive policies or lack of coherent legislation undermine care quality by limiting nurses' roles or complicating communications about death and dying. Ethical principles such as patient self-determination, beneficence, and justice often intersect with legal challenges, making policy clarity and education essential for supporting nurses in end-of-life care (Harasym et al., 2020).

Facilitators and Best Practices

Training and education programs are consistently identified as key facilitators of high-quality end-of-life (EOL) care for older adults, because they strengthen nurses' knowledge, confidence, and communication skills in addressing complex symptom management, ethical dilemmas, and family support at the end of life. Structured geriatric- and palliative-care-focused curricula such as the End-of-Life Nursing Education Consortium (ELNEC) and similar national programs have been shown to improve nurses' understanding of pain and symptom control, cultural and spiritual aspects of care, and interdisciplinary collaboration, which in turn enhances the quality of EOL care in long-term care facilities, home care, and acute settings. Interventions ranging from brief two-day courses to extended modular or blended-learning programs have demonstrated sustained improvements in nurses' attitudes toward caring for dying older people, increased self-competence in "death work," and reduced fear of death and burnout, suggesting that continuing education is also a protective factor for nurses' professional quality of life in high-mortality geriatric environments. Nevertheless, competency assessments in geriatric nursing indicate persistent gaps around communication about prognosis, advance care planning, and sexual and existential concerns in late life, highlighting the need for targeted training in relational and ethical dimensions of EOL care, and for integrating EOL content longitudinally across undergraduate, postgraduate, and in-service education rather than offering one-off standalone courses. In this context, best practice is to combine didactic content with case-based discussions, role-play, simulation, and supervised practice, with explicit learning outcomes mapped to internationally recommended geriatric palliative competencies so nurses can reliably initiate goals-of-care conversations, support shared decision-making, and advocate for comfort-focused care when curative treatment is no longer appropriate (Okumura-Hiroshige et al., 2020).

Policy initiatives and institutional support are critical system-level facilitators that enable nurses to translate palliative and EOL principles into routine geriatric practice by standardizing access, clarifying responsibilities, and securing resources across care settings. National palliative-care policies and strategies for older people increasingly emphasize universal access to palliative services, integration across primary care, hospitals, and long-term care, and reduction of financial and geographic inequities, thereby creating a regulatory environment in which nurse-led palliative assessments, advance care planning, and family counseling are recognized as core components of quality elder care rather than optional add-ons. International consensus recommendations further stress that palliative care should be framed as a human right and explicitly embedded in broader aging and chronic-disease policies, with nurses represented at policy-making tables and supported through funded roles, protected time, and career pathways in generalist and specialist palliative nursing. At the organizational level, institutional best practices include adopting evidence-based EOL care guidelines, implementing standardized symptom-assessment tools and comfort-care order sets, establishing ethics and palliative-care consultation services, and creating policies that normalize early palliative referral for frail older adults with multimorbidity rather than restricting it to the final days of life. Supportive workplace cultures characterized by leadership commitment, interprofessional collaboration, staffing levels that allow time for communication, and structured debriefing or bereavement support for staff are also essential, because they empower nurses to advocate for patient preferences, challenge non-beneficial interventions, and provide relational as well as technical care at the end of life (N et al., 2022).

Innovation in care delivery, particularly through telehealth and structured advance care planning processes, offers additional facilitators and emerging best practices that can expand access to geriatric EOL care, enhance person-centredness, and support nurses in coordinating complex care across settings. Telehealth-enabled palliative care in nursing homes and community settings has been associated with more frequent documentation of goals-of-care discussions, improved symptom management, reduced avoidable emergency transfers, and better continuity between facility staff, primary providers, and specialist palliative teams, with nurses often acting as the on-site coordinators of virtual consultations and family meetings. In home-based palliative care, nurse-delivered telehealth interventions have been reported to improve quality of life, anxiety, and depression among patients with advanced illnesses, while facilitating timely titration of analgesics and other supportive therapies and allowing family caregivers to receive education and emotional

support without travel burdens an especially important benefit for frail older adults and their careers. Concurrently, systematic implementation of advance directives and broader advance care planning, supported by clear organizational protocols and digital documentation systems, enables nurses to elicit and record older patients' values and preferences earlier in the disease trajectory, strengthen surrogate decision-makers' confidence, and reduce the likelihood of burdensome, non-concordant interventions near death. Best practice is to integrate these innovations into routine geriatric workflows for example, combining telehealth family conferences with structured goals-of-care tools and standardized documentation of code status and preferred place of death while also addressing barriers such as technology infrastructure, reimbursement models, staff training, and the digital divide that may disproportionately affect very old or cognitively impaired populations (Walton et al., 2023).

Emotional Impact and Wellbeing of Nurses

Nurses providing end-of-life care in geriatric populations often experience profound emotional impacts due to the nature of their work. The frequent exposure to death, dying, and the complex suffering of elderly patients can lead to feelings of compassion fatigue, grief, moral distress, sadness, anger, and a pervasive sense of helplessness. These emotions are consistent regardless of the nurse's years of experience or care setting, though the intensity may vary. The emotional toll extends beyond the professional realm, often affecting nurses' personal lives and self-confidence. Such emotional burden influences nurses' ability to maintain compassionate care and may lead them to emotionally disengage from patients or their families to protect their psychological wellbeing. This emotional labor is a critical dimension of end-of-life nursing that requires acknowledgment and adequate support structures to ensure nurses can sustain quality care over time (Alruwaili et al., 2024).

Due to the intense emotional demands, nurses working in geriatric end-of-life care are at increased risk for burnout, characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment. Stressors include high patient mortality rates, ethical dilemmas, inadequate staffing, and insufficient time for meaningful interactions, which compound nurses' distress. Coping mechanisms identified in the literature range from personal resilience to reliance on peer support and professional mental health resources. Emotional resilience, the ability to manage feelings of grief and sadness while continuing compassionate care is central to mitigating burnout. Resilience training, counseling availability, and organizational support significantly enhance nurses' capacity to navigate emotional challenges. Unaddressed stress may lead to compassion fatigue, reduced job satisfaction, and even attrition from the nursing workforce, negatively impacting patient care continuity (Pehlivan Sarıbudak, 2023).

Effective support mechanisms are essential to sustain nurses' emotional wellbeing in the demanding context of geriatric end-of-life care. These mechanisms include formal institutional support such as regular debriefing sessions, counseling services, resilience training programs, and creating a supportive team culture that fosters camaraderie and open communication. Informal peer support among nursing colleagues also plays an important role by providing empathy, shared understanding, and emotional validation. Additionally, healthcare organizations can implement policies to reduce workload stress and ensure adequate staffing, thereby allowing nurses sufficient time to process their experiences and deliver holistic care. Long-term, integrated approaches combining mental health resources, professional development opportunities, and recognition for nurses' emotional labor are critical to improving nurse retention and wellbeing (Patynowska et al., 2025).

Future Directions and Recommendations

Despite advances in understanding emotional impacts and coping strategies, significant research gaps remain in geriatric end-of-life care nursing. There is a limited focus on longitudinal studies exploring the long-term psychological effects on nurses. The diversity of cultural backgrounds and its impact on nurses' coping strategies is underexplored, as is the effect of institutional variables such as policy and resources on nurse wellbeing. Furthermore, formal evaluation of the effectiveness of various support interventions in

diverse healthcare settings is lacking. Bridging these gaps requires dedicated research efforts with strong interdisciplinary collaboration and enhanced institutional support for nursing-led research initiatives focused on emotional resilience and caregiving outcomes (Antonacci et al., 2020).

Innovative approaches are emerging that promise to improve care delivery and nurse wellbeing in geriatric end-of-life nursing. Telehealth technologies and remote monitoring facilitate continuous patient engagement and multidisciplinary communication, reducing nurse workload and enhancing care coordination. Gerontechnology integration enables improved assessment and management of patient needs, while care platforms like dementia homecare systems foster personalized care and support caregiver coordination. Multidisciplinary team collaboration and age-friendly care environments synthesize psychosocial and medical care to optimize patient outcomes. These innovations not only enhance patient quality of life but also promote sustainable nursing practices by mitigating burnout and stress (Hayes*, 2023).

Conclusion

End-of-life care for geriatric populations demands highly skilled, compassionate, and ethically grounded nursing practice. Nurses play a pivotal role in assessing complex symptoms, supporting patient autonomy, coordinating interdisciplinary care, and guiding families through emotionally challenging decisions. Their responsibilities extend beyond clinical tasks to include advocacy, communication, cultural sensitivity, and spiritual support. Despite significant barriers—such as staffing limitations, communication challenges, legal ambiguities, and emotional burden—nurses remain central to ensuring dignified, person-centered care. Strengthening education, institutional support, policy frameworks, and innovative care models such as telehealth can enhance the quality of geriatric end-of-life care. Prioritizing these improvements will empower nurses, promote equitable access, and ensure that older adults receive compassionate, high-quality care aligned with their values and preferences.

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