

## Quality of Death: A Dimensional Analysis of Palliative Care in the Nursing Home

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### ABSTRACT

Palliative care in nursing homes is increasingly discussed, investigated, and implemented, yet the term lacks conceptual clarity and definition. Furthermore, the components, process, and outcomes of palliative care as it is delivered in the nursing home have not been clearly articulated. This paper provides a dimensional analysis of palliative care in the nursing home to elucidate the concept and its context and consequences, as portrayed through available literature. As a method, dimensional analysis is rooted in symbolic interaction and grounded theory. As such, it provides a useful tool with which to analyze existing literature on palliative care in the nursing home. In this dimensional analysis, communication is the dominant perspective of palliative care in the nursing home. This analysis demonstrates that the consequences of palliative care in the nursing home are personhood and identity, and quality of death rather than quality of life. These consequences suggest that the focus of palliative care should be on the nursing home resident and the dying experience, rather than quality of life and issues around living that exclude the dying experience and do not acknowledge the personhood and identity of the resident. These elements represent a shift in focus away from one that does not include death, toward the dying experience, and that such a change in focus is necessary to achieve palliative care in the nursing home. Finally, the analysis elucidates potential outcome measures for the study of palliative care in nursing homes and outlines possibilities for further research.

### INTRODUCTION

UNDERSTANDING CARE of the dying in nursing homes is mandated both by demographics and morality in an aging society. Palliative care is a widely used term used to describe all that encompasses humane care of the dying. Yet because of its socially constructed nature, the meaning and dimensions of palliative care are not well articulated in the literature, particularly the literature concerned with the nursing home setting. Recognition and facilitation of the dying process is physically and psychologically complex, and there is considerable ambiguity surrounding what constitutes appropriate care of the dying.

Currently, approximately 1.6 million Americans live in nursing homes,<sup>1</sup> and an estimated 20% of Amer-

icans die there.<sup>2</sup> As the population continues to live longer with multiple chronic illnesses such as Alzheimer's disease, chronic obstructive pulmonary disease, cancer, and cardiovascular disease, attention to palliation in the nursing home setting is of utmost importance. Although this phenomenon is not unique to the nursing home setting, this setting is the focus for this discussion.

### BACKGROUND AND SIGNIFICANCE

Several themes dominate existing literature on palliative care. These themes include, but are not limited to, preferences, decision making, prognosis, and policy issues. They have been explored in various set-

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tings, and among various populations of frail elderly, most notably those with cancer, congestive heart failure (CHF), or dementia.<sup>3-6</sup> Additionally, the literature regarding palliative care is often blurred with hospice. This can lead to confusion about their distinctive components and hinder the understanding of each.

Steinhauser and colleagues<sup>5</sup> found that patients, families, physicians, and other care providers overwhelmingly preferred to focus on pain and symptom management, and patients stressed the importance of constant communication and being mentally aware. Ziad and colleagues<sup>6</sup> found that the care plans for those with dementia were more likely to focus on symptom relief and anticipation of dying than those with CHF. These studies demonstrate that interventions for palliative care tend to focus on symptom management and relief, but that patients primarily value communication at the end of life.

Decision making naturally follows elicitation of preferences. Boockvar and Meier<sup>4</sup> used a case study approach with the hypothesis that decision making around goals of care should begin when the patient is designated as frail. They conclude that as frailty progresses, palliative care focused on symptom relief and quality of life should be instituted. The case study highlights the complexity clinicians must face in determining frailty and the relative proximity to end of life, and the subsequent events that will take place. This complexity is a common theme in the end of life decision-making literature, especially as it relates to palliative care.<sup>7-12</sup>

Lorenz and colleagues<sup>3</sup> outline important policy issues at the end of life, many of which touch on the themes stated above. They discuss the limitations of prognostication, which include both provider ability and willingness. Lorenz and colleagues<sup>3</sup> also review the policy implications of measuring quality of end-of-life care, focusing on structure, process, and outcomes. Similarly, Ferrell<sup>13</sup> states that the lack of clearly defined outcome variables with respect to research on care of the dying has hindered advancement of the science thus far. She stresses the importance of defining relevant outcome variables and clarification of concepts, especially in light of the rapid growth of palliative care and hospice programs.

Hospice, with its specific criteria based on terminal status and Medicare eligibility, is generally well defined, at least in a regulatory sense. Conversely, palliative care is more nebulous, because it lacks regulatory criteria and other policy markers of acceptance.<sup>14-17</sup> Furthermore, the increasing presence of hospice in nursing homes contributes to confusion about the scope of palliative care, especially nomenclature and documentation of

care. Although many similarities exist between hospice and palliative care, hospice is not necessary for palliative care to occur, while the converse relationship is required. As a result, the presence of both hospice and palliative care in nursing homes renders palliative care unclear and makes articulation of its components difficult.

The existing literature on palliative care as described above covers broad themes and crosses many settings and diseases. Although the knowledge base concerning palliative care is growing, a theoretical synthesis of the literature specifically focusing on palliative care delivery in the nursing home setting is absent. This paper provides a dimensional analysis of palliative care in the nursing home, which incorporates the existing topics important in palliative care, as well as elicits new themes to guide future inquiry.

## METHODS

### *Dimensional analysis*

Dimensional analysis is a qualitative method and approach to theory generation. It is rooted in grounded theory, a qualitative methodology useful in articulating theoretical explanations of social and behavioral phenomena. Dimensional analysis was developed by Schatzman<sup>18</sup> to structure the analytic process of grounded theory. In contrast to grounded theory, which carries no theoretical assumptions, dimensional analysis assumes concepts are socially constructed, contextually situated, and defined from an implicit perspective.<sup>19</sup> Dimensionality includes parts, attributes, interconnections, context, process, and implications, thus providing an understanding of the whole phenomenon.<sup>20</sup> Dimensional analysis has been used to investigate varied human phenomena, such as the experience of neutropenia<sup>21</sup> and perspectives of female nurse administrators in Japan.<sup>22</sup>

Constant comparison and dimensionalizing are two techniques used in dimensional analysis to maintain theoretical sensitivity and ensure that all aspects of dimensionality are realized. Constant comparative technique involves taking a particular open code and recording what is known about it from literature and the investigator's experience. Once this is completed, the open code is subjected to questioning that reveals possible interpretive bias. Constant comparison bypasses conventional thinking to explore less conventional interpretation.<sup>23</sup>

Dimensionalization similarly reduces the density of a particular open code. The technique involves ex-

tracting characteristics or attributes of a code and determining their possible variation or extent. With this method, closely related ideas are analyzed to capture precise meaning and attributes of each code. Dimensionalization also reduces language bias in description.<sup>18</sup>

### Literature sampling

Dimensional analysis can use a wide variety of data, depending upon the nature of the phenomenon under study. Data may include field notes, interviews, focus groups, and published literature. This dimensional analysis relied on published literature to examine the various aspects of palliative care in the nursing home.

Theoretical sampling was used to obtain literature containing relevant data.<sup>23</sup> Articles addressing palliative care in the nursing home were selected for inclusion in the sample under a set of theoretical criteria. An initial literature search was conducted using the MEDLINE, CINHAI, PSYCHinfo, and ISI databases. Search terms used were “palliative care and nursing home,” “palliative care and long-term care,” “end-of-life care and nursing home,” and “end-of-life care and long-term care.” No date limit was imposed on the literature search so that the date limits inherent in each search engine could be used. Hospice was not used as a search term. Furthermore, articles without a specific focus on the nursing home setting were also eliminated. As appropriate articles were identified, they were also manually reviewed for additional relevant citations. The search continued until saturation was achieved and no articles containing new information were discovered.

Forty-six multidisciplinary, international, English-language journal articles ultimately comprised the database. Articles represented work from the disciplines of nursing, medicine, psychology, social work, public health, and law. International representation included three articles authored by investigators from The Netherlands, four from England, one from Sweden, and two from Canada.

### Data analysis

Dimensional analysis relies on a three-part coding scheme. Data analysis began with open coding, a process in which key words and phrases were extracted from each article in the literature sample.<sup>23</sup> This was done manually by the researcher during careful reading of each article. The process was done twice for each article on different days to ensure a comprehensive list of extractions. Key words and phrases were recorded in a list by author’s name, each list on a sep-

arate piece of paper. In total, 1222 open codes were extracted from the literature sample. Axial coding followed, which rearranged or condensed open codes into conceptually related groups.<sup>23</sup> Once open codes were condensed, the resulting lists were reviewed for redundancy and refined into small groups of related open codes representing a single concept or axial code. Finally, theoretical coding was performed. Theoretical coding links axial codes via theoretical relationships into a unified conceptualization of the phenomenon under study.<sup>23</sup> Axial codes were grouped by conceptual scope and content. Groups of theoretically related axial codes were labeled in a manner such that the label was most theoretically representative of the codes in the group. These theoretical codes were then further arranged by scope and content into the explanatory matrix, representing interrelationships with one another. Based on conceptual content, the dimensional analysis matrix was named Quality of Death (Fig. 1). Through application of dimensional analysis and development of an explanatory matrix, Schatzman’s fundamental question, “What ‘all’ is involved here?,”<sup>20</sup> is answered.

Schatzman<sup>20</sup> proposed the explanatory matrix as a mechanism to structure the analytic and interpretative process of grounded theory. The explanatory matrix details dimensions of a phenomenon, in this case palliative care in the nursing home, and acts as a vehicle to move analysis from the level of description to one of explanation. The analytic matrix incorporates five categories: perspective, context, conditions, processes, and consequences. Perspective serves as the vantage point from which analysis occurs.<sup>20</sup> Context bounds the inquiry and describes the environment in which the phenomenon exists.<sup>18</sup> Conditions are those dimensions that facilitate or block processes of the phenomenon of interest. Conditions are affected by context and act as precursors to process.<sup>18</sup> Finally, consequences are the manifestations of the interactions that exist as a result of the perspective, context, conditions, and processes.



FIG. 1. Dimensional analysis matrix.

Table 1 provides a summary of the five dimensional matrix categories, as well as the associated theoretical and axial codes that were generated from this analysis. Whereas Figure 1 is a conceptual schematic of the matrix categories and associated theoretical codes, Table 1 provides similar information in direct chart form, with the addition of the axial codes, which are referred to throughout the text and do not appear in the matrix. The purpose of the figure is to portray the relationship between the theoretical codes identified in this analysis as they are situated within the five categories of Schatzman's dimensional analysis. Both Table 1 and Figure 1 will be referred to throughout the paper to clarify and expand upon references to theoretical and axial codes.

#### *Data management and rigor*

An audit trail consisting of data, code lists, and memos, or records of analytic decisions and actions, was used to maintain analytic rigor. Memos were categorized by content: observations, methodological insights, and theoretical assertions.<sup>23</sup> Original articles comprising the sample were printed for ease in coding and bound for reference. Most materials were stored electronically in Microsoft WORD® (Microsoft, Seattle, WA) with back-up hard copies. These and copies of hand-written notes were all chronologically integrated into a bound notebook.

## FINDINGS

#### *Explanatory matrix*

Quality of Death is the explanatory matrix for palliative care in the nursing home generated by this dimensional analysis (Fig. 1). Quality of Death depicts a complex social phenomenon situated within an overarching perspective of communication. Several contextual elements are both barriers and facilitators to palliative care, and have a direct impact on conditions, processes, and consequences, as shown in Figure 1. As shown in the matrix, the ultimate consequence of palliative care in the nursing home is quality of death. The perspective, context, conditions, processes, and consequences are described sequentially and in detail, and demonstrate often subtle yet critical dimensions of palliative care in the nursing home.

#### *Perspective*

Communication pervaded the literature reviewed, both implicitly and explicitly. Although all dimensions

were given theoretical consideration for the crucial position of perspective, only communication fulfilled the necessary criteria of openness, inclusiveness, and presence in every other dimension. The axial codes listed in Table 1 that comprised communication demonstrate familiar actions to all stakeholders who deliver palliative care in the nursing home.

#### *Context*

Four dominant dimensions created context for palliative care. These dimensions are policy and government regulations, nursing home factors, role and staffing issues, and knowledge and education. Policy and government regulations encompass the broad overarching issues of laws, data collection, policy, reimbursement, and regulations. Nursing home factors, on the other hand, represent local issues and encompass unique set of axial codes (Table 1). Knowledge and education was derived from axial codes such as expertise, training, education, knowledge, and palliative care curriculum. Role and staffing issues further compound issues around knowledge and education, and are represented by axial codes such as staff shortage, staff turnover, interdisciplinary team, role complexity, and staff support.

Standards for data collection and reporting are regulated by governmental agencies and include such instruments as the Minimum Data Set (MDS) and Resident Assessment Instrument (RAI).<sup>24</sup> Reimbursement for services rendered in the nursing home is directly related to the data reported on these instruments, thus creating a local environment that favors rehabilitation and restoration rather than palliative care.<sup>15,25</sup>

The dimensions knowledge and education and role and staffing issues delimited delivery of palliative care in the nursing home. Knowledge, competence, and expertise must be present to deliver such care in nursing homes. Lack of education among staff, as well as residents and families, were frequently cited barriers to palliative care.<sup>26-33</sup> Deficiencies in palliative care curricula were discussed as further limiting practice and skill development.<sup>15,29,33-35</sup> However, even when staff have necessary education for palliative care, staff shortages, staff turnover, and lack of staff support were cited as barriers to implementation.<sup>15,34,36-38</sup>

#### *Conditions*

Within the perspective of communication, and the context of policy and government regulations, nursing home factors, knowledge and education, and role and staffing issues, the conditions of Quality of Death can be articulated. These conditions are humanism, ad-

TABLE 1. COMPONENTS OF THE EXPLANATORY MATRIX IN DIMENSIONAL ANALYSIS<sup>18,20</sup>

<i>Matrix component</i>	<i>Coding levels</i>	
	<i>Theoretical codes</i>	<i>Axial codes</i>
<b>Perspective:</b> A single dimension that emerges as the vantage point from which to examine the concept.	Communication	Communication Collaboration Discussions Relationships Documentation Coordination Information sharing Cooperation
<b>Context:</b> Dimensions that set the theoretical boundaries for inquiry and represent the environment in which the phenomenon under study takes place.	Policy and government regulations	Data collection Policy Reimbursement Laws Regulations
	Nursing home factors	Care delivery Quality Environment Culture Resources Policy Standards of care Finances Culture Ethics
	Knowledge and education	Legal issues Knowledge Education Training Practice development P.C. curriculum Competence Expertise Skills
	Role and staffing issues	Information Staff shortage Staff turnover Role complexity Interdisciplinary team People Staff support Time
<b>Conditions:</b> Dimensions that are necessary for the processes to take place and either facilitate or block the processes.	Humanism	Approach to care of the dying Values and beliefs Attitude Philosophy
	Advance care planning	Hospitalization Preferences Wishes Family involvement Advance directives Planning Choice Decisions
	Trajectory and prognosis	Coordination Family involvement Trajectory Expectations Transition Prognosis Terminal Disease process Dying process Futility

TABLE 1. COMPONENTS OF THE EXPLANATORY MATRIX IN DIMENSIONAL ANALYSIS<sup>18,20</sup> (CONT'D)

<i>Matrix component</i>	<i>Coding levels</i>	
	<i>Theoretical codes</i>	<i>Axial codes</i>
<b>Processes:</b> The actions of the phenomenon under study.	Pain and symptom management	Individualized care Pain Dyspnea Comfort Symptom management Hygiene Interventions
	Psychosocial and emotional issues	Grief and bereavement Fear and anxiety Guilt and burden Emotions Psychosocial issues Support Religion and spirituality Stress
	Care	Opportunity for palliation Philosophy of palliation Holism Palliative care Hospice End-of-life care Terminal care Comfort care
<b>Consequences:</b> Dimensions that evolve as a result of the conditions and processes and represent the outcomes of the phenomenon.	Personhood and identity	Loss of personhood Identity Autonomy Being valued Dignity and respect Isolated Privacy Dependency
	Quality of death	Quality of life Quality of death Experience of dying Acknowledgement Care for the dying End-of-life experience Preparing for death

vance care planning, and trajectory and prognosis. Advance care planning and trajectory and prognosis stem from the condition of humanism, a necessary precursor to advance care planning and trajectory and prognosis, which are communicated with the intention of creating a quality death (Fig. 1).

Humanism was embodied by a set of abstract but intensely palpable open codes. These codes were not the main topics of the literature reviewed, but rather existed on the periphery of other issues. However, they collectively emerged as a necessary foundation for the overall existence of palliative care in the nursing home. Open codes such as “compassionate,”<sup>39(p539)</sup> “care provider attitudes,”<sup>32(p24)</sup> “concordance of values,”<sup>40(p40)</sup> and “humane care”<sup>41(p21)</sup>

were grouped into the axial codes listed in Table 1. Humanism, therefore, represented inherent personal attributes necessary for advance care planning and determination of trajectory and prognosis.

Although planning future care is a central activity in the nursing home, advance directives were minimally represented as a small subset of advance care planning. Difficulty creating, maintaining, and executing advance directives were frequently mentioned but incompletely described.<sup>28,42-44</sup> Advance directives may be uncomplicated in concrete terms, but the actual process of advance care planning demands consideration of more nebulous notions such as choice, wishes, preferences, and family involvement.

Determination of life trajectory and prognosis was a clinically and ethically complex issue in much of the literature. Multiple chronic illnesses typical of nursing home residents generally led to uncertain or unpredictable trajectories. The axial codes that comprised trajectory and prognosis collectively communicated the dynamic fluidity of this dimension (Table 1). Transition was commonly mentioned but not clearly articulated in the literature, as seen in “shift in emphasis,”<sup>45(p856)</sup> “dying recognized as an undeniable part of living,”<sup>46(pS41)</sup> and “peaceful acceptance.”<sup>47(p119)</sup> Transition was also negatively portrayed, as in “nursing home as a warehouse for those who are declining into death.”<sup>46(pS41)</sup>

Transition critically represents recognition that a resident is actively dying. Whereas trajectory and prognosis are futuristic connotations, transition epitomizes the resident’s present state. Furthermore, transitions are closely tied to expectations. At the time of a transition, expectations regarding trajectory and prognosis must be confronted.

### *Processes*

Pain and symptom management, psychosocial and emotional issues, and care were processes of palliative care in the nursing home (Fig. 1). Pain and symptom management were palliative care actions composed of a conglomerate of elements listed in Table 1. Pain and dyspnea were the most frequent symptoms mentioned in the literature. Their frequent mention corresponded to descriptions of distress for residents, families, and care providers. When pain and dyspnea are well managed, it appears that palliative care is considered largely successful.

Subsequently, comfort represented the intended outcome of pain and symptom management. Achieving comfort may be conceptually linked to individualized care, yet this relationship was not fully developed in the literature. Theoretically, an individualized approach to care would increase the likelihood of achieving comfort.<sup>24,43,47</sup>

Psychosocial and emotional issues encompassed a myriad of axial codes (Table 1). Although some extracted open codes described specific psychosocial and emotional issues, these issues were most frequently described in very general ways. Open codes such as “bereavement care,”<sup>48(p234)</sup> “emotional needs,”<sup>17p(221)</sup> and “psychosocial care”<sup>14(p276)</sup> demonstrate the non-specific manner in which psychosocial and emotional issues are described. The lack of specificity in discussing psychosocial care obviates the targeted interventions required for individualized care.<sup>14,49,50</sup>

Care was the manifestation of all that is enacted under the umbrella of palliative care in the nursing home. Care was confounded by two significant themes: ambiguity of terms and opportunity for palliation. Whereas ambiguity of terms represents a grouping of axial codes, opportunity for palliation is an individual axial code. Actual and potential care delivery were represented by precarious terms. The terms palliative care, end-of-life care, terminal care, and comfort care were often used interchangeably by the same author to describe a consonant method and philosophy of care delivery. For example, Raudonis and colleagues<sup>27(p297)</sup> state their study “explored the level of palliative care knowledge among licensed nurses delivering end-of-life care.” Similarly, Cassarett and colleagues state “there are many opportunities to improve end-of-life care,”<sup>51(p1493)</sup> but also that their study “describes the needs for palliative care.”<sup>51(p1496)</sup> Consequently, the ambiguity of terms with respect to palliative care in the nursing home fosters potential opportunity for palliation rather than actual palliation.

The opportunity for palliation represented the culmination of care. It appeared in retrospect and connoted a missed opportunity rather than a potential opportunity. For example, the continuum of palliative care<sup>24</sup> was counterbalanced by delayed palliation<sup>34</sup> and referrals frequently made too late or not at all.<sup>34,38</sup> Such implicit recognition about missed opportunities for palliative care are not surprising given barriers associated with communication, staffing, advance care planning, and pain management.<sup>15,38,50</sup> Whether or not a nursing home resident fully realizes the opportunity for palliation likely dictates whether or not he or she experiences quality of death.

### *Consequences*

Personhood and identity and quality of death were consequences of palliative care in the nursing home. Together, they emerged directly from opportunity for palliation. The axial codes comprising personhood and identity (Table 1) represented fundamental human issues critical to palliative care, especially as death approaches. Furthermore, a strong polarity was represented by the particular codes loss of personhood and identity. Loss of personhood was the negative outcome often cited by authors, and maintenance of identity was the positive outcome of palliative care in the nursing home (Fig. 1).

The dying nursing home resident was described in one of three ways: person, resident, and patient. The label selected seemed dependent on prognosis, thereby subtly implying loss of personhood as the resident approaches death.<sup>26,39,42,52</sup> As a nursing home resident

nears death his or her status as a person or resident with associated identity, autonomy, privacy, respect, and dignity, appears to shift to that of a patient, with associated features of being isolated, devalued, and dependent. Theoretically, the analysis suggests that when life remains the focus of care, the resident is not acknowledged as a dying person, thereby losing personhood. Identity is maintained, however, when the resident is recognized as dying, and in tandem, the desired outcome is quality of death.

Throughout the literature, language of quality of life was very visible. Language such as “quality of remaining life”<sup>31(p120)</sup> and “quality of life at the end of life,”<sup>53(p334)</sup> however, suggest awkwardness in overlaying quality of life on the consequences of dying. Perhaps there is disutility in trying to situate palliative care in the nursing home within the familiar frame of quality of life. Discussion of dying trajectory, referred to as the “dying process,”<sup>28(p148)</sup> underscores this awkwardness and suggests further exploration of the previously unacknowledged quality of death.

When quality of life is used to measure outcomes of palliative care, this scenario could be described as a life-to-dying trajectory followed by a short dying-to-death trajectory. A theoretical fracture represents the point at which a nursing home resident is considered to be dying. This determination, however, is impossible. A single smooth life-to-death trajectory in which the transition to dying in advance of death is imperceptible may be more appropriate than the current representations. Furthermore, applying quality of death to describe the goal of palliative care in the nursing home is congruent with a single trajectory, where death is expected and not disconnected from life. Quality of death assumes explicit acknowledgement of death and hence ample opportunity for palliation with maintenance of the resident’s identity throughout the process.

## DISCUSSION

Quality of death focuses on the transitional experience of dying and the maintenance of identity through death. This research elucidates two fundamental concepts that can serve as theoretical bases for future palliative care outcomes research in the nursing home setting and beyond. The first is the understanding that dying cannot be identified as a singular point in time. When this type of identification is attempted, the opportunity for palliation is often missed. The second is that as death approaches, the resident’s identity must be maintained. The maintenance of identity ensures quality of death, while the alternative does not. The

following discussion elaborates on these, as well as other important findings, and their potential roles in future outcomes research.

In her dialogue of the prospective measurement of outcomes at end of life, Steinhauer<sup>54</sup> states that the fundamental question is, “What time period constitutes the end of life?” She recommends a broader conceptualization of the life to death trajectory, which parallels the current analysis. Relaxation of the time period that constitutes dying would allow for a more thorough evaluation of patients’ and families’ perceptions of the dying experience.<sup>54</sup> This would provide the opportunity to evaluate the quality of proxy reporting, which becomes critical as death approaches, and is an important aspect of measurement in outcomes research. It would also provide insight into how best to measure quality of death, the primary outcome of interest.

Johnson<sup>46</sup> asserts that if clinicians try to identify an exact time at which a resident is dying, then residents and their families are not receiving optimal palliative care. This position is congruent with the opportunity for palliation, an opportunity that is often missed. It highlights the fracture in the trajectory toward death created by forcing the dying to death trajectory into a focus on quality of life. Curtis and colleagues<sup>55</sup> work on missed opportunities to discuss palliative care options for patients in intensive care further support this important finding. Future research could focus on methods for proactive determination of prognosis and study subsequent illness trajectories for nursing home residents with end-stage chronic illness from varied perspectives. An exploration of the barriers inherent in the determination of trajectory and prognosis would also be useful in isolating outcome measures that identify trajectories congruent with resident and family expectations and avoid forced acceptance of dying and death.

This analysis suggests that quality of death in the nursing home is difficult to achieve without the maintenance of personhood and identity for the dying nursing home resident. Existing literature on the maintenance of dignity supports this finding for both nursing home residents<sup>52</sup> and those receiving care in a wide range of settings.<sup>56</sup> Chochinov<sup>56</sup> states that helping dying patients in any setting do so with dignity is the basic tenet of palliative care. He asserts that recognizing the subtle qualities that embody each person, through the time of death, is fundamental to the preservation of dignity, and thus the delivery of palliative care. Chochinov<sup>56</sup> concludes that the conservation of dignity should be a standard of care for all dying patients. In the present analysis, dignity was certainly a com-

ponent of the maintenance of personhood and identity. Therefore, it is possible that dignity could serve as a potential proxy for the maintenance of identity in measuring quality of death as an outcome of palliative care.

Several researchers highlight the importance of the timing of palliative care, which converges with the opportunity for palliation in this analysis.<sup>5,13</sup> Research aimed at identifying indicators for the opportunity for palliation, including retrospective studies examining missed opportunities, would help to proactively elucidate appropriate timing of palliative care for nursing home residents. Elucidating indicators for the opportunity for palliation for nursing home residents would subsequently enhance the potential for maintenance of identity and quality of death.

Communication was an important domain in Ferrell's<sup>13</sup> work, which is congruent with the overarching perspective of this analysis. This analysis corroborates the shift called for by Ferrell<sup>13</sup> and others<sup>30</sup> to redirect current dialogue from a focus on life with inherent barriers that arise in mismatched plans and expectations, toward communication and care that achieves quality of death. Research that describes, explains, and improves communication around palliative care in the context of the nursing home is requisite for improvement in palliative care in the nursing home and beyond.

There are several limitations inherent in this project, and in the research itself. Although the literature was searched until data saturation occurred, it is possible that key articles could have been missed. Also, because this work is based on theoretical analysis, it is subject to researcher interpretation at each level of coding. Similar work performed by another researcher could yield different conclusions.

## CONCLUSION

The present dimensional analysis of palliative care in the nursing home reveals a complex, contextual, and relatively unexplored phenomenon. The dimensional matrix that emerged from the analysis demonstrates, to paraphrase Schatzman,<sup>20</sup> "all that is involved" in palliative care in the nursing home setting. The perspective of communication overarches the matrix and shapes the subsequent components within it. Personhood and identity and quality of death are the consequences of palliative care in the nursing home. Maintenance of personhood and identity with the goal of quality of death, the critical assertion of this analysis, was not explicitly argued in the literature. Rather, these aims were drawn through analysis from statements in

the literature that likely reflect societal values about death in the nursing home but not actual care provided.

The present analysis surfaces important imbedded assumptions about palliative care in the nursing home and makes overt and structured what are largely covert beliefs about this care. It identifies key themes critical to palliative care delivery in the nursing home, as well as their complex interrelationships. Most importantly, it articulates themes that are not well explored in the current literature, and demonstrates their importance in advancing the study of palliative care in the nursing home and other settings. Finally, the dimensional analysis matrix provides a framework from which to explore these emergent themes.

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