document and chose not to complete it (Storey, 2007).

The literature review also identified a lack of nurse training in communication skills and palliative care.

Caring for patients at the end of life can be extremely stressful for nurses (Wilkinson et al., 2008), yet end-of-life care is not a mandatory part of pre-registration nurse training or post-registration district nurse training programmes. This can leave some nurses ill-equipped to initiate and manage complex conversations about end-of-life care with patients and their families (Henry and Fenner, 2007; Lowson, 2007; Chapple et al., 2005).

Taylor (2007) argued a lack of training in communication affected how nurses worked: “Communication appears to have low priority within training, so why would it have high priority within care?”

Some nurses’ lack of experience and knowledge made them reluctant to use the PPC tool (Henry and Fenner, 2007; McKenzie et al., 2007; Storey, 2007; Newton, 2006).

**Method**

This study took a descriptive, phenomenological approach.

After ethical approval was secured, district nurses at West Essex Primary Care Trust were invited to participate. They had to have completed two PPC documents in the community and agree to be interviewed to take part. Eleven district nurses were included in the study (Table 1).

In-depth interviews were carried out with all the nurses to determine their experiences of using the PPC document. The interviews were transcribed, and the data broken down into categories and themes.

Although the sample size was small, limiting the study participants to district nurses who had experience of using the PPC document produced in-depth data.

**Results**

Five major themes emerged from the interviews (Fig 1). These were: communication skills; hopelessness; empowerment; admission avoidance; and multiprofessional working.

**Communication skills**

Study participants said the PPC document enabled in-depth conversations. The more they used the document, the more confident district nurses felt in starting difficult conversations:

“"The document is quite straightforward and is a good tool for opening up discussions with families" (P9).

**STUDY PARTICIPANT PROFILES**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Years of experience</th>
<th>Number of PPCs completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>P2</td>
<td>31</td>
<td>22</td>
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<td>P3</td>
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<td>6</td>
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<td>P11</td>
<td>26</td>
<td>12</td>
</tr>
</tbody>
</table>

“I have 30 years’ experience but these subjects can be quite difficult to raise for junior staff. The PPC is helpful as it gives them something to work with” (P9).

The nurses acknowledged that using the PPC document was initially challenging, but said that experience gave them confidence. Personal experiences and reflection through peer support also helped them to achieve the confidence required to start and maintain conversations around end-of-life care:

“"It's difficult for nurses with not as much experience. I think that, as you form your own personal experiences, you know how to deal with situations" (P3).

“Get a good relationship going with your patient, then gently introduce the document. Showing empathy will help” (P4).

“"You need practice, and time to share with the patient and your colleagues. This is what we do in our team and it helps our confidence” (P9).

Active listening was a key skill required to use the PPC effectively. The nurses felt they needed time to get to know patients so they could listen to them and build a rapport.

Some participants felt they would like to take part in advanced communication skills training. Others expressed dissatisfaction at nurse training, saying it did not prepare them for the types of conversations they were experiencing. With no formal guidelines to consult for clarification, they relied on peer support.

**Hopelessness**

Participants recognised that lack of confidence in using the PPC prevented some members of the team from using it.

Some staff felt the PPC document was seen as a “death” document for patients, and that talking to families about their preferred priorities for end-of-life care could take away any hope and goals they had left. To prevent feelings of hopelessness, participants used empathy to build a rapport with patients and their relatives so they felt able to discuss priorities for care with the nurse:

“"It is taking away hope for some people. Different people accept things in different ways, and when you start discussing the PPC you can still feel you’re taking away hope” (P3).

“I find it quite difficult to introduce [the PPC] because sometimes it feels like you are taking away people’s hopes when they are striving to survive. We shy away from using it as feel it may upset people” (P4).

**CHALLENGES ASSOCIATED WITH END-OF-LIFE CARE**

- Health and social care staff often find it difficult to initiate discussions about end-of-life care. This makes it difficult to determine people’s needs and preferences for care and to plan accordingly
- People frequently need care from several services, yet care is often poorly coordinated
- People approaching the end of life need around-the-clock access to care and support. Even when services are available, they do not always meet people’s needs. This may be because health and social care professionals have not received adequate training
- When people enter the dying phase, health and social care professionals may not know what to do or have the resources to ensure maximum comfort for the patient and support for carers

Source: Department of Health (2008)