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HOSPICE CARE IN THE CONTEXT OF NURSING: A CONCEPT ANALYSIS

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ABSTRACT

Hospice care is widely used in nursing practice; however, its meaning remains unclear and is often used interchangeably with palliative and end-of-life care, resulting in conceptual ambiguity. Therefore, this study aimed to clarify the concept of hospice care in the context of nursing. Walker and Avant's eight-step concept analysis approach was applied. A literature review was conducted using the keywords Hospice care AND Nursing across PubMed, CINAHL, Scopus, and ProQuest databases. Inclusion criteria were English-language, peer-reviewed articles published between 2000 and 2025 that explicitly discussed hospice care in relation to Nursing. Exclusion criteria included non-English publications, conference abstracts, editorials, opinion pieces, and articles that did not focus on hospice care within the nursing discipline. Following the screening and selection process, a total of 11 articles were included in the final analysis. The defining attributes of hospice care were identified as (1) comfort-focused, not curative care, (2) holistic care, and (3) support during the dying process. Antecedents included a diagnosis of terminal illness, prognosis of limited life expectancy, and the patient's informed decision to forego curative treatment. Consequences were enhanced comfort and symptom control, improved quality of life for patients and families, and a peaceful and dignified death experience. This concept analysis offers conceptual clarity regarding hospice care in nursing; however, the findings are based on a literature-driven theoretical approach and should be interpreted as a conceptual foundation to inform, rather than definitively determine, nursing practice, education, and future research in end-of-life care.

Keywords: Concept Analysis; End-of-life Care; Hospice Care; Nursing

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INTRODUCTION

Hospice care is a specialized approach to healthcare that focuses on patients with advanced, life-limiting illnesses, typically when life expectancy is limited to approximately six months or less, and shifts the emphasis from curative treatment to comfort-oriented care. The primary aim of hospice care is to relieve suffering through effective pain and symptom management while addressing patients' physical, psychological, social, and spiritual needs, thereby supporting a dignified and peaceful end of life (DiSantostefano, 2011; Mulville et al., 2019).To understand the origins of this ambiguity, it is important to consider the historical development of hospice care. Historically, the care of dying patients, especially those with advanced diseases, was largely neglected within mainstream medical and nursing practice, as the primary focus remained on curative treatment rather than hospice care (Clemens & Klaschik, 2004). During the mid-twentieth century, patients approaching the end of life often experienced unrelieved pain, psychological distress, social isolation, and spiritual suffering, with limited professional attention directed toward these needs (Saunders & Clark, 2006).

The hospice movement began to take shape in the late 1960s, largely influenced by the pioneering work of Cicely Saunders, who emphasized the need for compassionate, holistic care for individuals at the terminal stage of illness. In 1967, Saunders founded St. Christopher's Hospice in London. Saunders introduced the concept of "total pain," highlighting that suffering at the end of life is multidimensional, encompassing physical, psychological, social, and spiritual components (Saunders & Clark, 2006). This perspective marked a significant shift in nursing and healthcare philosophy, reframing end-of-life care from a failure of treatment to a legitimate and essential domain of professional practice.

Over subsequent decades, hospice care evolved from marginal services into integral elements of cancer and chronic illness care across diverse healthcare settings, including hospitals, hospices, and community-based services (Levy et al., 2006; Saga et al., 2018). This evolution was closely linked to nursing practice, as nurses assumed central roles in symptom management, psychosocial support, care coordination, and patient and family advocacy. Hospice care became synonymous with an interdisciplinary approach that prioritizes comfort, dignity, and quality of life rather than cure, while supporting both patients and their families throughout the illness trajectory.

Despite its widespread use, the lack of a clear and consistent conceptual definition of hospice care has important implications for nursing outcomes. Conceptual ambiguity may lead to inconsistent clinical decision-making, delayed hospice referrals, unclear nursing roles, and variability in symptom management and family support. For nurses, uncertainty about the boundaries between hospice, palliative, and end-of-life care can affect care planning, interdisciplinary collaboration, and the delivery of timely, comfort-focused interventions, ultimately influencing patient comfort, quality of life, and family experiences at the end of life.

These inconsistencies create challenges for education, practice, policy development, and research, underscoring the need for conceptual clarity. A concept analysis of hospice care within the context of nursing is therefore essential to identify its defining attributes, antecedents, and consequences, and to provide a clear, discipline-specific understanding that can guide nursing practice, education, and future research.

CONCEPT ANALYSIS OF HOSPICE CARE IN THE CONTEXT OF NURSING

Although hospice care is widely referenced in healthcare literature, its meaning varies across contexts. In clinical settings, hospice care is often defined based on prognosis and service eligibility, commonly referring to care provided to patients with a life expectancy of six months or less and a focus on comfort rather than cure (Spiess, 2017). In cultural contexts, hospice care may be understood more broadly as compassionate care for the dying, shaped by cultural beliefs, family roles, and spiritual practices (Frey et al., 2013). In policy and healthcare system contexts, hospice care is frequently defined through regulatory and reimbursement frameworks that emphasize service models and eligibility criteria rather than nursing roles or holistic care principles (Choi, 2012a). These varied uses contribute to conceptual ambiguity and highlight the need for a clear nursing-focused definition of hospice care.

Walker and Avant's eight-step concept analysis framework was applied in this study (Walker & Avant, 2019). The process comprises eight steps 1) selection of a concept, 2) determination of the aim of analysis, 3) identification of all concept uses, 4) determination of defining attributes, 5) identification of a model case, 6) identification of borderline and contrary cases, 7) identification of antecedents and consequences, and 8) identification of an empirical referent.
Accordingly, this framework was selected because it provides a systematic approach to clarifying complex and inconsistently defined concepts in nursing.

SELECTION OF THE CONCEPT

The concept of hospice care was selected for analysis because of its central role in nursing care at the end of life. Hospice care is a multifaceted concept that encompasses physical, psychological, social, and spiritual dimensions of care and is primarily delivered by nurses in close collaboration with patients and families. Although hospice care is widely used in clinical practice, its meaning varies across healthcare settings and among healthcare professionals, including nurses.

The term hospice care is often used interchangeably with related concepts such as palliative care, terminal care, and end-of-life care, despite important differences between these terms. Palliative care may be provided at any stage of a serious illness and alongside curative treatment, whereas hospice care typically focuses on comfort-oriented care when curative treatment is no longer pursued. End-of-life and terminal care are sometimes used to describe similar phases of care, but may lack the comprehensive, interdisciplinary, and family-centered approach that characterizes hospice care. This interchangeable use of terms contributes to conceptual ambiguity and inconsistent application in nursing practice.

Hospice care was therefore selected for concept analysis to support nurses in developing a clearer understanding of its meaning, boundaries, and defining characteristics. Clarifying the concept of hospice care is essential for strengthening nursing practice, education, and research in end-of-life care.

DETERMINATION OF THE AIM OF THE ANALYSIS

Determining the aim of the analysis is the second step in the concept analysis process and serves to clarify how the findings can be applied in nursing practice (Walker & Avant, 2019). This concept analysis aimed to clarify the concept of hospice care in the context of nursing care by identifying its defining attributes, antecedents, and consequences. Clarifying this concept is intended to strengthen nurses' understanding of hospice care, support consistent application in clinical practice, and guide nursing education and research related to end-of-life care.

IDENTIFICATION OF ALL CONCEPT USES

The concept of hospice care consists of two terms: hospice and care. The term hospice originates from the Latin word hospitium, meaning hospitality or shelter, and historically refers to a place that offers care and comfort to individuals who are ill or dying. In contemporary healthcare, hospice refers to a philosophy and system of care designed to support individuals with life-limiting illnesses (dos Anjos & Feijó, 2019; Kim, 2008). Care in the nursing context refers to professional actions aimed at maintaining comfort, dignity, and well-being (Cara & O'Reilly, 2008).

A literature review was conducted to examine the uses of hospice care across multiple databases, including PubMed, CINAHL, Scopus, and ProQuest. The search was limited to English-language publications published between 2000 and 2025 with full-text availability. The keywords used during the literature search were Hospice care AND Nursing. Literature from various disciplines, including nursing, medicine, and other health sciences fields, was considered to capture the multidisciplinary use of the concept. Many of the reviewed studies used the term hospice care without providing a clear conceptual definition. Consequently, only a limited number of publications were identified that explicitly defined hospice care, highlighting ongoing conceptual ambiguity in the literature. A total of 460 articles were initially identified through the database search. Titles and abstracts were screened to assess relevance to hospice care in the context of nursing. Articles were excluded if they did not provide a conceptual, theoretical, or descriptive discussion of hospice care, focused exclusively on palliative care without reference to hospice care, or lacked relevance to nursing practice. Following this initial screening, eleven articles were purposively selected because they explicitly addressed the concept of hospice care, provided definitional clarity, and contributed substantively. This purposive

selection approach was consistent with concept analysis methodology, which prioritizes conceptual depth and definitional clarity over exhaustive inclusion. Table 1 summarizes the characteristics and key conceptual focus of the selected articles.

Table 1. Characteristics of Selected Articles (n = 11)

Author (Year)	Field	Definition
(Roth & Canedo, 2019)	Medicine	Hospice care is a philosophy and model of care for patients with a life expectancy of less than six months, in which curative treatment is discontinued, and care focuses on comfort, quality of life, and preparation for death, using a multidisciplinary and family-centered approach with bereavement support.
(Camden, 2022a)	Nursing	Hospice care is a multidisciplinary, comfort-centered model for individuals with terminal illness that emphasizes symptom management, psychosocial and spiritual support, and preparation for death, while viewing the patient and family as a unified focus of care.
(Pilewski, 2020a)	Medicine	While not all palliative care constitutes hospice care, all hospice care falls within the scope of palliative care. Hospice represents the final phase of palliative care, in which the focus of treatment transitions from curative intent to comfort, supporting the natural process of dying.
(Huang et al., 2022)	Nursing	Hospice care is designed for terminally ill and elderly patients to reduce suffering, improve quality of life, and facilitate a comfortable, peaceful, and dignified end of life.
(Tatum & Mills, 2020)	Medicine	Hospice care is end-of-life palliative care that provides comprehensive comfort-focused services for patients and supportive care for families, including symptom management and emotional and spiritual support, for individuals with a physician-certified prognosis of six months or less.
(Buss et al., 2017a)	Medicine	Hospice care services are typically provided at home to support a patient's comfortable end of life, allowing them to be surrounded by their loved ones.
(Onyechi et al., 2016)	Health Sciences	The expression “hospice care” denotes end-of-life care and represents an aspect of palliative care.

(Mulville et al., 2019b)	Medicine	Hospice care is provided to individuals with terminal illness and a life expectancy of six months or less and encompasses symptom control, pain management, palliative interventions, and supportive services such as the provision of home medical equipment and oxygen therapy.
(Choi, 2012b)	Health Sciences	Hospice is a palliative care program that delivers comprehensive supportive services addressing the physical, psychosocial, spiritual, legal, and financial needs of individuals with terminal illness and their families, to enhance quality of life by promoting comfort and dignity in the final stages of life.
(Lee et al., 2024)	Nursing	Pediatric hospice and palliative care provide holistic, family-centered support to children with acute or chronic illnesses and uncertain prognoses near the end of life.
(Clark, 2007)	Medicine	Hospice care is a holistic, comfort-focused approach to caring for patients with advanced illness, emphasizing symptom relief, dignity, and multidisciplinary support during the final stages of life

DETERMINATIONS OF DEFINING ATTRIBUTES

At this stage, the authors identified the terms that appeared most frequently across existing meanings of hospice care and classified words with comparable meanings into keyword clusters. Keywords with similar meanings were manually grouped using Table 2. The authors subsequently determined the defining attributes corresponding to each identified keyword cluster of hospice care (Walker & Avant, 2019). In particular, three defining attributes of hospice care were identified.

COMFORT-FOCUSED, NOT CURATIVE CARE

Comfort-focused care prioritizes comfort, symptom relief, and dignity over cure or life-prolonging treatments (Camden, 2022a). In hospice care, the goal is to enhance quality of life by minimizing physical and emotional suffering during the final stages of life (Pilewski, 2020a). From a nursing perspective, comfort-focused care involves assessing and managing pain, breathlessness, fatigue, nausea, anxiety, and other distressing symptoms. Nurses emphasize supportive, non-aggressive interventions and provide continuous comfort measures to promote a peaceful and dignified dying experience (Buss et al., 2017b; Camden, 2022b) .

HOLISTIC CARE (PHYSICAL, PSYCHOLOGICAL, SOCIAL, AND SPIRITUAL)

Holistic care in hospice involves addressing the whole person rather than focusing solely on the disease (Pilewski, 2020b; Tatum & Mills, 2020). From a nursing perspective, holistic care includes assessing and responding to physical symptoms such as pain and dyspnea, psychological distress

including fear and depression, social needs related to family support and financial concerns, and spiritual issues such as meaning, faith, and hope (Buss et al., 2017b; Camden, 2022b). By attending to these interconnected dimensions, hospice nurses support comprehensive care that promotes comfort, dignity, and quality of life during the end-of-life period (Clark, 2007).

SUPPORT DURING THE DYING PROCESS

Support during the dying process in hospice care involves actively assisting patients during the final phase of life while recognizing dying as a natural process (Camden, 2022b; Clark, 2007). From a nursing perspective, this support includes managing terminal symptoms, recognizing signs of imminent death, providing emotional and practical support to families at the bedside, and ensuring a peaceful and dignified dying experience (Buss et al., 2017b; Camden, 2022b). Through continuous presence and compassionate care, hospice nurses help minimize suffering and promote comfort at the end of life (Camden, 2022b; Pilewski, 2020b).

Table 2. Attributes of Hospice Care

Keywords Cluster	Sources	Attributes
• Prioritizing comfort, symptom relief, and dignity rather than cure • Enhancing quality of life by minimizing physical and emotional suffering • Managing pain, breathlessness, fatigue, nausea, and anxiety • Providing supportive, non-aggressive interventions • Offering continuous comfort measures to support a peaceful dying process	(Buss et al., 2017b; Camden, 2022b; Pilewski, 2020b)	Comfort-Focused, Not Curative Care
• Addressing the whole person rather than focusing only on the disease • Assessing and managing physical symptoms such as pain and dyspnea • Responding to psychological distress, including fear and depression • Addressing social needs related to family support and financial concerns • Supporting spiritual concerns such as meaning, faith, and hope	(Buss et al., 2017b; Camden, 2022b; Clark, 2007; Pilewski, 2020b; Tatum & Mills, 2020)	Holistic care (Physical, Psychological, Social, and Spiritual)
• Actively assisting patients during the final phase of life • Recognizing dying as a natural process • Managing terminal symptoms • Recognizing signs of imminent death • Providing emotional and practical support to families at the bedside • Ensuring a peaceful and dignified dying experience	(Buss et al., 2017b; Camden, 2022b; Clark, 2007; Pilewski, 2020b)	Support during the dying Process

IDENTIFICATION OF THE MODEL CASE

M, a 70-year-old woman with advanced metastatic breast cancer, was enrolled in a hospice care program after her physician confirmed that curative treatment was no longer effective and her prognosis was less than six months. Upon admission to hospice care, the nursing team shifted the focus of care from disease-directed treatment to comfort-oriented management. Hospice nurses conducted a comprehensive assessment and developed an individualized plan of care in collaboration with the patient and her family.

Hospice nurses prioritized comfort-focused, not curative care by regularly assessing and managing M's pain, dyspnea, fatigue, and anxiety through appropriate pharmacological and non-pharmacological interventions (Attribute 1: Comfort-focused, not curative care). Aggressive life-prolonging treatments were discontinued, and nursing interventions emphasized symptom relief, comfort, and dignity to enhance quality of life during the end-of-life period.

Holistic care was provided by addressing M's physical, psychological, social, and spiritual needs (Attribute 2: Holistic care). In addition to managing physical symptoms, nurses offered emotional support to reduce fear and emotional distress. Family members were actively involved in care planning and received guidance regarding caregiving and decision-making. Spiritual support was facilitated according to the patient's beliefs, allowing her to find meaning, peace, and acceptance during the final stage of life.

As M's condition declined, hospice nurses provided continuous support during the dying process (Attribute 3: Support during the dying process). Nurses recognized signs of imminent death, maintained a calm and comforting environment, and remained present at the bedside to ensure comfort and dignity. Emotional and practical support was provided to family members throughout the final hours. M died peacefully at home, surrounded by her family, with comfort maintained until death."

A model case is a clear and comprehensive example of the concept that includes all defining attributes (Walker & Avant, 2019). The case above illustrates comfort-focused, not curative care, holistic care addressing physical, psychological, social, and spiritual needs, and support during the dying process.

IDENTIFICATION OF BORDERLINE AND CONTRARY CASES

BORDERLINE CASE

P, a 65-year-old man with advanced chronic obstructive pulmonary disease, was referred to hospice care due to disease progression and frequent hospitalizations. Hospice nurses initiated comfort-oriented interventions, including pain and symptom management, to reduce breathlessness and fatigue. Non-beneficial curative treatments were limited, and nursing care focused on improving comfort (Attribute 1: Comfort-focused, not curative care).

Nurses addressed some aspects of holistic care by managing physical symptoms and providing limited emotional support (Attribute 2: Holistic care). However, P declined discussions related to spiritual concerns, and family involvement in care planning was minimal. As his condition worsened, hospice nurses provided intermittent support, but P was frequently transferred to the hospital during periods of symptom exacerbation. Consequently, consistent support during the dying process was not fully established, and end-of-life care remained fragmented (Lack of Attribute 3: Support during the dying process)."

A borderline case contains some but not all defining attributes of the concept (Walker & Avant, 2019). The case above demonstrates 1. Comfort-focused, not curative care, and 2. partial holistic care, but lacks consistent support during the dying process, as continuous presence and comprehensive family support were not fully achieved.

CONTRARY CASE

R, a 72-year-old woman with terminal colorectal cancer, continued to receive aggressive curative treatments despite a poor prognosis. Medical and nursing care remained focused on repeated hospital admissions, invasive procedures, and life-prolonging interventions. Pain and symptom management were not adequately addressed, resulting in persistent discomfort and distress (No Attribute 1: Comfort-focused, not curative care).

Care was primarily disease-centered, with little attention given to psychological, social, or spiritual needs. Family members were excluded from care discussions, and emotional support was minimal (No Attribute 2: Holistic care). During the final stage of illness, R died in an acute care hospital setting without adequate preparation, emotional support, or nursing presence to support either the patient or her family (No Attribute 3: Support during the dying process)."

A contrary case represents an example that does not include any defining attributes of the concept (Walker & Avant, 2019). The case above illustrates the absence of comfort-focused care, holistic care, and support during the dying process, thereby demonstrating a situation that is opposite to hospice care in the context of nursing.

IDENTIFICATION OF ANTECEDENTS AND CONSEQUENCES

ANTECEDENTS

Antecedents are events, conditions, or situations that must occur before the occurrence of the concept (Walker & Avant, 2019). Antecedents of Hospice care in the context of Nursing care extracted from the literature review were categorized into three groups. The diagnosis of a terminal illness, the prognosis of limited life expectancy, and the patient's informed decision to forego curative treatment. The diagnosis of a terminal illness occurs when a patient receives a confirmed medical diagnosis of an incurable and progressive condition, such as advanced cancer, end-stage heart failure, chronic obstructive pulmonary disease, and dementia (Campos-Calderón et al., 2017; Sánchez et al., 2015). This diagnosis is typically established and documented by a physician and indicates that disease-directed or aggressive treatments are unlikely to alter the illness trajectory (Blažeković-Milaković et al., 2006). Recognition of terminal illness provides the clinical foundation for shifting the focus of care from cure to comfort-oriented nursing care.

The prognosis of limited life expectancy occurs when a physician certifies that the patient is expected to have a life expectancy of approximately six months or less if the disease follows its usual course (Crusse & Messler, 2014). This prognostic determination is often based on indicators such as functional decline, escalating symptom burden, and disease progression (Gramling et al., 2019).

The patient's informed decision to forego curative treatment is an essential antecedent of hospice care. Hospice care requires a voluntary decision by the patient, or a legally authorized surrogate if the patient lacks decision-making capacity (Wang et al., 2022), to discontinue treatments aimed at prolonging life, such as chemotherapy, dialysis, or mechanical ventilation (Deodhar et al., 2021). This decision is commonly reached through advance care planning and shared decision-making processes. As a result of these antecedents, hospice care leads to several important consequences.

CONSEQUENCES

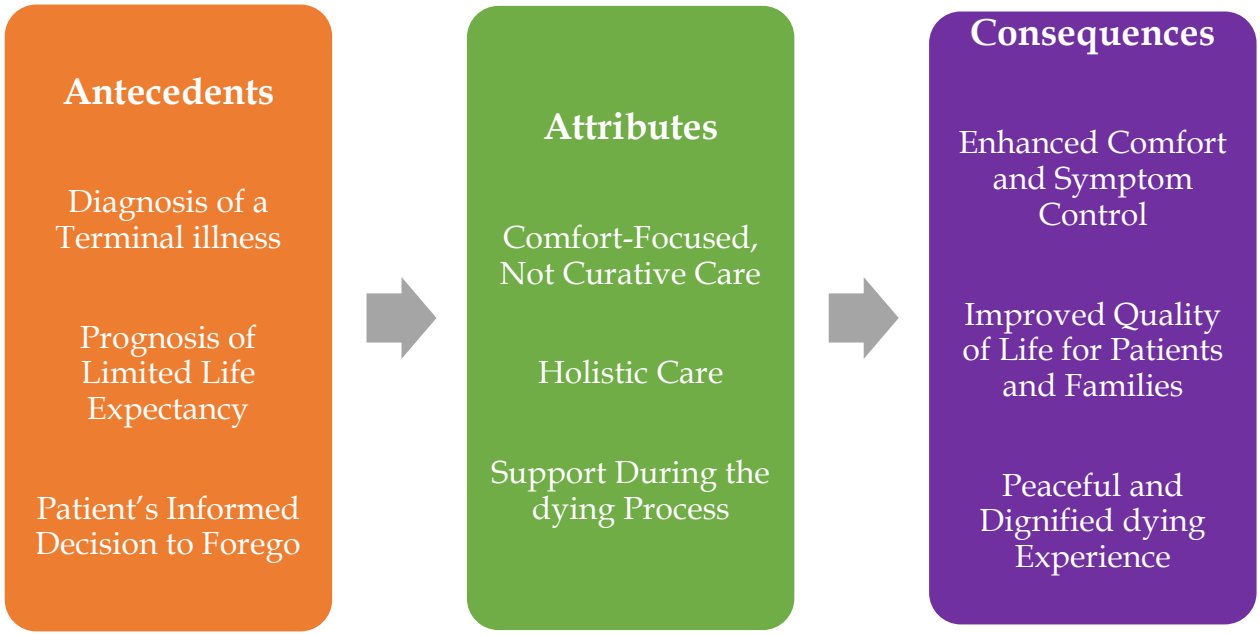
Consequences are events or outcomes that occur as a result of the concept (Walker & Avant, 2019).The consequences of hospice care in the context of nursing were identified from the literature and include enhanced comfort and symptom control, improved quality of life for patients and families, and a peaceful and dignified dying experience.

The primary consequence of hospice care is enhanced comfort and effective symptom control. Through continuous nursing assessment and intervention, patients experience reduced physical suffering related to pain, dyspnea, fatigue, nausea, and anxiety (Tatum, 2020). Comfort-focused nursing care minimizes distress and promotes physical and emotional ease during the end-of-life period (Hou et al., 2021).

Another important consequence of hospice care is improved quality of life for both patients and their families (Currow et al., 2020). Hospice care addresses not only physical symptoms but also psychological, social, and spiritual needs (Turriziani, 2016a). Emotional support, family involvement, and guidance throughout the illness trajectory contribute to reduced fear, improved coping, and a sense of support for both patients and caregivers (Ogden, 2015).

A further consequence of hospice care is the promotion of a peaceful and dignified dying experience. Nurses support patients during the dying process by recognizing signs of imminent death, maintaining a calm and supportive environment, and ensuring the presence of compassionate care (Elshamy, 2020). Families receive emotional and practical support, which may also facilitate healthier bereavement and adjustment after the patient's death (Morris et al., 2023).

Figure 1. Conceptual Model of Hospice Care in the Context of Nursing



CLARIFICATION OF DEFINING ATTRIBUTES

Although holistic care and support during the dying process share related elements, they represent conceptually distinct attributes of hospice care. Holistic care refers to the comprehensive approach

addressing physical, psychological, social, and spiritual needs throughout the hospice trajectory, whereas support during the dying process specifically pertains to nursing actions focused on the final phase of life, including recognition of imminent death, continuous presence, and support for patients and families at the bedside. These attributes are not hierarchical or sequential; rather, they are complementary and may occur concurrently, with support during the dying process representing a focused intensification of holistic care at the end of life.

IDENTIFICATION OF EMPIRICAL REFERENTS

Empirical referents are not measurement instruments for the concept itself, but serve to quantify and demonstrate the defining attributes of the concept (Walker & Avant, 2019). Empirical referents of hospice care in nursing include observable and measurable indicators that reflect comfort-focused care, holistic care, and support during the dying process. Comfort-focused care can be identified through validated pain and symptom assessment tools such as the Numeric Rating Scale (NRS), Visual Analog Scale (VAS) (Göransson et al., 2015; Hjermstad et al., 2011) and the Edmonton Symptom Assessment System (ESAS) (Chan et al., 2016). Holistic care can be empirically assessed using multidimensional quality-of-life and psychosocial instruments, including the McGill Quality of Life Questionnaire (MQOL) (Cohen et al., 2017), The European Organization for Research and Treatment of Cancer Quality of Life Questionnaire Core 15 for Palliative Care (EORTC QLQ-C15-PAL) (Golčić et al., 2018), the Functional Assessment of Chronic Illness Therapy Spiritual (FACIT-SP) (Brown et al., 2017), the Hospital Anxiety and Depression Scale (HADS) (Kandasamy et al., 2011), and spiritual well-being measures. Support during the dying process can be evaluated through end-of-life care quality and family-related measures, such as the Quality of Dying and Death Questionnaire (QODD) (Hales et al., 2014), Family Evaluation of Hospice Care (FEHC) (Connor et al., 2005), bereavement assessment tools such as the Carer Support Needs Assessment Tool (CSNAT) (Aoun et al., 2018), and nursing documentation of end-of-life support and family presence. Together, these empirical referents provide measurable evidence of hospice care in nursing practice.

DISCUSSION

Overall, the findings of this concept analysis clarify that hospice care is not a new concept in healthcare; however, its meaning and application within nursing practice remain variably interpreted across disciplines and settings. This concept analysis was conducted to clarify hospice care in the context of nursing by identifying its defining attributes, antecedents, and consequences. The findings contribute to a clearer and more discipline-specific understanding of hospice care, which is essential for consistent nursing practice, education, and research.

Based on the analysis, hospice care in nursing can be understood as comfort-focused, not curative care, delivered through a holistic approach addressing physical, psychological, social, and spiritual needs, and characterized by continuous support during the dying process. These attributes emphasize that hospice care is not merely the withdrawal of curative treatment, but an active and intentional nursing practice aimed at promoting comfort, dignity, and quality of life at the end of life. This finding is consistent with earlier literature describing hospice care as a philosophy of care rather than a specific location or service model (Pederson & Emmers-Sommer, 2012; Turriziani, 2016b) .

The identification of comfort-focused, not curative care, as a defining attribute highlights the central role of nurses in symptom management and comfort promotion. Nurses are often the primary providers responsible for assessing pain, dyspnea, fatigue, anxiety, and other distressing symptoms, and for implementing supportive, non-aggressive interventions (Godfrey, 2005).

Holistic care emerged as another core attribute of hospice care, underscoring the multidimensional nature of suffering at the end of life. The findings demonstrate that hospice nursing extends beyond physical symptom management to include emotional support, family involvement, social considerations, and spiritual care. This aligns with the concept of "total pain" and supports the view that hospice nurses play a critical role in addressing the interconnected needs of patients and families. Failure to address these dimensions may result in fragmented care and unmet end-of-life needs.

Support during the dying process further distinguishes hospice care from other forms of palliative or end-of-life care. Continuous nursing presence, recognition of signs of imminent death, and provision of emotional and practical support to families were identified as essential elements. This attribute emphasizes that hospice care does not end with symptom control but includes guiding patients and families through the final phase of life, thereby promoting a peaceful and dignified dying experience. The antecedents identified in this analysis, diagnosis of a terminal illness, prognosis of limited life expectancy, and the patient's informed decision to forego curative treatment, clarify the conditions necessary for hospice care initiation. These findings highlight the importance of timely communication, shared decision-making, and advanced care planning in nursing practice. Nurses are uniquely positioned to support patients and families during this transition by providing education, facilitating discussions, and advocating for patient-centered goals of care.

The consequences of hospice care, including enhanced comfort, improved quality of life, and a peaceful and dignified death, further demonstrate the value of hospice nursing interventions. These

outcomes reflect not only patient benefits but also positive effects on families, such as reduced distress and improved bereavement experiences. Clarifying these consequences strengthens the evidence base for hospice care and supports translation into nursing education and policy.

From a broader nursing perspective, these findings have important implications for education and policy. From a nursing education perspective, clarifying the concept of hospice care provides a clear framework for curriculum development, competency-based training, and clinical education in end-of-life care. Clearly articulated conceptual boundaries support nurses' understanding of their roles, responsibilities, and scope of practice within hospice settings. From a nursing policy perspective, a well-defined concept of hospice care informs policy development, service guidelines, and referral criteria, thereby supporting timely access to hospice services and consistent standards of care. Collectively, these implications underscore the importance of conceptual clarity in strengthening nursing education, guiding policy formulation, and improving the delivery of hospice care.

CONCEPTUAL DEFINITION OF HOSPICE CARE IN THE CONTEXT OF NURSING

Based on this concept analysis, hospice care in the context of nursing is defined as a comfort-focused, not curative approach to care for individuals with life-limiting illness, in which nurses provide holistic care addressing physical, psychological, social, and spiritual needs, while offering continuous support to patients and their families during the dying process.

LIMITATIONS

This concept analysis was conducted using Walker and Avant's 2019 classical concept analysis framework, which is well-suited for clarifying concepts but is inherently theoretical in nature. As such, the analysis emphasizes conceptual structure and internal coherence rather than empirical verification or contextual variability. The findings are based on a focused review of published literature and therefore reflect existing scholarly interpretations of hospice care rather than direct observations from clinical practice. In addition, the conceptual boundaries of hospice care were examined primarily from a nursing perspective, which may not fully capture interdisciplinary, policy-level, or culturally specific variations in the delivery of hospice care. Despite these methodological and conceptual constraints, the classical concept analysis approach provided a systematic and rigorous method for clarifying hospice care in nursing and establishing a clear theoretical foundation for future empirical research, cross-cultural examination, and practice-based refinement. Despite these limitations, this concept analysis makes an important contribution to nursing knowledge.

CONCLUSION

This concept analysis focused on the importance, application, and use of hospice care in nursing practice. The findings clearly identified the antecedents, defining attributes, and consequences of hospice care, providing conceptual clarity for a term that has been used inconsistently across disciplines. Hospice care in the context of nursing is characterized by comfort-focused, not curative care, holistic care addressing physical, psychological, social, and spiritual needs, and continuous support during the dying process. This clarified definition provides nurses with a shared conceptual foundation to support consistent hospice care delivery across settings.

DECLARATION OF CONFLICTING INTEREST

The authors declared no conflict of interest

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AUTHORS' CONTRIBUTIONS

KK conceptualized the study, designed the methodology, conducted the analysis, and drafted the manuscript under the supervision of YR, who provided scholarly guidance and critical intellectual input throughout the concept analysis and writing process. KK and MA reviewed and approved the final version of the manuscript and take full responsibility for the integrity and accuracy of the work. The author meets all four authorship criteria in accordance with the ICMJE Recommendations.

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