Palliative and Supportive Care

cambridge.org/pax

Validating a theoretical framework for end-of-life communication by nursing staff as part of advance care planning with older people: An international Delphi study

Fran B.A.L. Peerboom, RN, PHD[1,2], Jolanda H.H.M. Friesen-Storms, RN, PHD[1,2,3], Jenny T. van der Steen, MSC, PHD, FGSA[4,5,6], Daisy J.A. Janssen, PHD, FERS[2,7,8] and Judith M.M. Meijers, PHD[2,9,10]

[1]Department of nursing science, Zuyderland Medical Center, Sittard-Geleen, Netherlands; [2]Department of Health Services Research, Care and Public Health Research Institute, Maastricht University, Maastricht, Netherlands; [3]Research Center for Autonomy and Participation in Health Care and Social Welfare and Academy of Nursing, Zuyd University of Applied Sciences, Heerlen, Netherlands; [4]Department of Public Health and Primary Care (PHEG), Leiden University Medical Center, Leiden, Netherlands; [5]Radboudumc Alzheimer Center and Department of Primary and Community Care, Radboud University Medical Center, Nijmegen, Netherlands; [6]Cicely Saunders Institute of Palliative Care and Rehabilitation, King's College London, UK; [7]Department of Family Medicine, Care and Public Health Research Institute, Faculty of Health Medicine and Life Sciences, Maastricht University, Maastricht, Netherlands; [8]Department of Expertise and Treatment, Proteion, Horn, Netherlands; [9]Zuyderland Care, Sittard-Geleen, Netherlands and [10]Research Center for Nursing Leadership in a Changing Context and Research Center for Community Care, Academy of Nursing, Zuyd University of Applied Sciences, Heerlen, Netherlands

Original Article

Cite this article: Peerboom FBAL, Friesen-Storms JHHM, van der Steen JT, Janssen DJA, Meijers JMM (2026) Validating a theoretical framework for end-of-life communication by nursing staff as part of advance care planning with older people: An international Delphi study. *Palliative and Supportive Care* **24**, e290, 1–11. https://doi.org/10.1017/S1478951526104106

Received: 18 February 2026 UTC
Revised: 9 June 2026 UTC
Accepted: 10 October 2026 UTC

Keywords:
advance care planning; Delphi study; end-of-life communication; nursing staff; older people

Corresponding author:
Fran B.A.L. Peerboom;
Email: f.peerboom@zuyderland.nl

Abstract

Objectives. Perspectives on advance care planning (ACP) and the perceived roles of healthcare professionals in ACP can differ across cultural and national contexts. As part of a larger study, a theoretical framework of the fundamentals (important aspects) of end-of-life communication by nursing staff with older people was previously developed. We aimed to refine and achieve consensus in an international context on the theoretical framework of end-of-life communication by nursing staff as part of ACP with older people.

Methods. A 2-round online Delphi study was conducted with experts in palliative care, care for older people, end-of-life communication, and nursing. Participants evaluated the importance and clarity of the framework's 20 fundamentals (e.g., self-efficacy, using intuition, and being silent) using a 4-point Likert scale and suggested improvements.

Results. In the first round, 48 experts from 15 countries participated, and 46 in the second. Most had nursing or research backgrounds and lived in Europe. All fundamentals were refined based on the experts' feedback, which focused on the fundamentals' applicability to diverse individuals and their suitability for both formal and informal conversations. Consensus with high agreement (≥90%) was reached on 17 fundamentals and consensus with agreement (≥80%) on 2. Two agreed-upon fundamentals were combined into 1.

Significance of results. This study resulted in a refined theoretical framework with broad applicability across diverse individuals and contexts. It deepens understanding of end-of-life communication, provides guidance for nursing staff, and informs education and research. Further research is needed to confirm validity beyond Europe and to inform implementation.

Introduction

End-of-life communication as part of advance care planning (ACP) with older people involves proactive and timely informal and formal conversations between an older person, their family caregiver, and a healthcare professional about, for example, future end-of-life care, the transition to the end-of-life phase, and death and dying from a holistic perspective (Rietjens et al. 2017; Sudore et al. 2017; Schüttengruber et al. 2022). ACP encompasses 5 goals: respecting individual autonomy, improving quality of care and life, strengthening relationships, preparing for the end of life, and reducing overtreatment (Fleuren et al. 2020). Rather than focusing exclusively on making decisions and completing advance directives, ACP emphasizes an ongoing communicative process that supports mutual understanding and preparedness for future healthcare decisions (Rietjens et al. 2017; Sudore et al. 2017). ACP is particularly relevant for older people,

© The Author(s), 2026. Published by Cambridge University Press. This is an Open Access article, distributed under the terms of the Creative Commons Attribution licence (http://creativecommons.org/licenses/by/4.0), which permits unrestricted re-use, distribution and reproduction, provided the original article is properly cited.

as they often experience frailty, multimorbidity, and decisions regarding end-of-life and palliative care. Nevertheless, they may engage less in ACP conversations due to vulnerability, limited ACP awareness, or difficulties discussing future decline and dying (Mohammadpour et al. 2018; Hopkins et al. 2020).

End-of-life communication as part of ACP is widely recognized as an essential component of healthcare, where it is actively promoted and integrated into routine practice (Rietjens et al. 2017; Chiang et al. 2021). However, ACP models differ across settings and populations, resulting in variation in the timing, content, and processes of end-of-life communication. At a more interactional level, recent conversation-analytic and discourse-focused literature has examined how these discussions are enacted in practice and shaped through interaction between patients, family caregivers, and healthcare professionals (Parry 2024; Wu and Zhang 2024; Jia and Wu 2025). In addition, attitudes toward ACP and its implementation into routine clinical care differ across cultures and countries. In many Asian cultures, for example, decision-making is often family-centered, and open discussions about death may be considered inappropriate or taboo (Chiang et al. 2021). In East Asian and Middle Eastern contexts, avoiding discussions about death is sometimes seen as a way to maintain hope or to protect emotional well-being (Evans et al. 2012; Brooks et al. 2019b). In contrast, Western societies typically emphasize individual autonomy, which supports more open and direct conversations about end-of-life care and ACP (Gómez-Vírseda et al. 2020). Moreover, variations in national healthcare systems influence how ACP is perceived, valued, and implemented (Sable-Smith et al. 2018), and the roles of specific healthcare professionals, such as nursing staff, in ACP may differ accordingly (Rietze et al. 2024; Wilkin et al. 2024).

Nursing staff are uniquely positioned to play a central role in end-of-life conversations adapted to cultural and individual preferences and needs, given the trusting relationships they often build with older people and their family caregivers (Phillips et al. 2020). However, many nursing staff face difficulties when initiating or engaging in end-of-life communication, such as feeling uncomfortable or lacking clear guidance (Phillips et al. 2020). End-of-life conversations require specific skills and must be tailored to the unique needs of older people (Hemsley et al. 2019; Phillips et al. 2020). Understanding the fundamentals of holistic and person-centered end-of-life communication by nursing staff can support nursing staff in overcoming these barriers and enhance nurse education, research, and practice. In this study, fundamentals refer to the key elements or "building blocks" of end-of-life communication, including the necessary prerequisites, competencies, activities, and values involved in preparing for, carrying out, and evaluating holistic, person-centered conversations. They provide a foundation for guiding nursing staff in addressing sensitive topics in a manner that respects the preferences, needs, and values of older people and their family caregivers.

We have developed a theoretical framework on the fundamentals of end-of-life communication by nursing staff with older people, largely from a Dutch perspective (Peerboom et al. 2023, 2024, 2025a, 2025b) (Box 1). To be able to use the theoretical framework internationally, refinement and validation of the framework by incorporating the insights and opinions of international experts is needed. Once validated, the theoretical framework can support nursing staff to be aware of, learn about, prepare for, carry out, and evaluate end-of-life communication. In addition, the framework could enhance nursing education and international scientific research and can be translated into interventions that empower nursing staff in end-of-life communication. Therefore, the aim of this study was to refine and achieve consensus in an international context on the theoretical framework of end-of-life communication by nursing staff as part of ACP with older people.

Methods

A Delphi study was performed (Figure 1) (Jünger et al. 2017) to assess the content validity of the LISTEN (Learning about the essentIal fundamentalS of end-of-life communicaTion in palliative nursing care) framework through expert review. Content validity was prioritized as the first step in a phased validation approach, given that the framework was initially developed from empirical studies involving nursing staff, other clinicians, older people, and family caregivers (Peerboom et al. 2024, 2025a, 2025b). Establishing content validity through international expert consensus was considered a necessary precondition before proceeding to external or real-world validation, which is recommended as a next step in future research. We conducted 2 online Delphi rounds. In each Delphi round, the panel members' opinions on the fundamentals of the theoretical framework were recorded.

Participants

International experts in the field of palliative care, care for older people, end-of-life communication, and nursing were invited after selection by the research group. Their expertise was assessed based on available scientific publications, online biographies (e.g., biographies of universities they were affiliated with), and previous collaborations. As the framework specifically targets nursing staff, we aimed to include primarily, but not exclusively, experts with a professional background in nursing. We also specifically selected members of the European Association for Palliative Care board of directors 2023–2027 who have a professional background in nursing and the first and last authors of the studies we included in our previous scoping review (Peerboom et al. 2023). None of the participants in our previous interview studies were included (Peerboom et al. 2024, 2025a, 2025b). We aimed to include at least 30 participants.

Recruitment

A total of 80 potential Delphi panel members from 18 countries were first approached by email between April 22 and May 2, 2025, by a member of the research group who had the potential panel member in her professional network. F.B.A.L.P. approached those who were not in the research group's network. The invitation email consisted of information about the study, a consent form, and a personalized hyperlink to the questionnaire. If they agreed to participate, they were asked to confirm their consent digitally by checking a box at the beginning of the questionnaire in the first round.

Data collection

Data were collected through an online questionnaire in Qualtrics (Qualtrics, Provo, Utah, USA). This questionnaire was pilot-tested by 3 researchers with a background in nursing who were not included in this study.

Demographic data (country, profession, and field of expertise) were collected at the beginning of the questionnaire in the first

https://doi.org/10.1017/S1478951526104106 Published online by Cambridge University Press

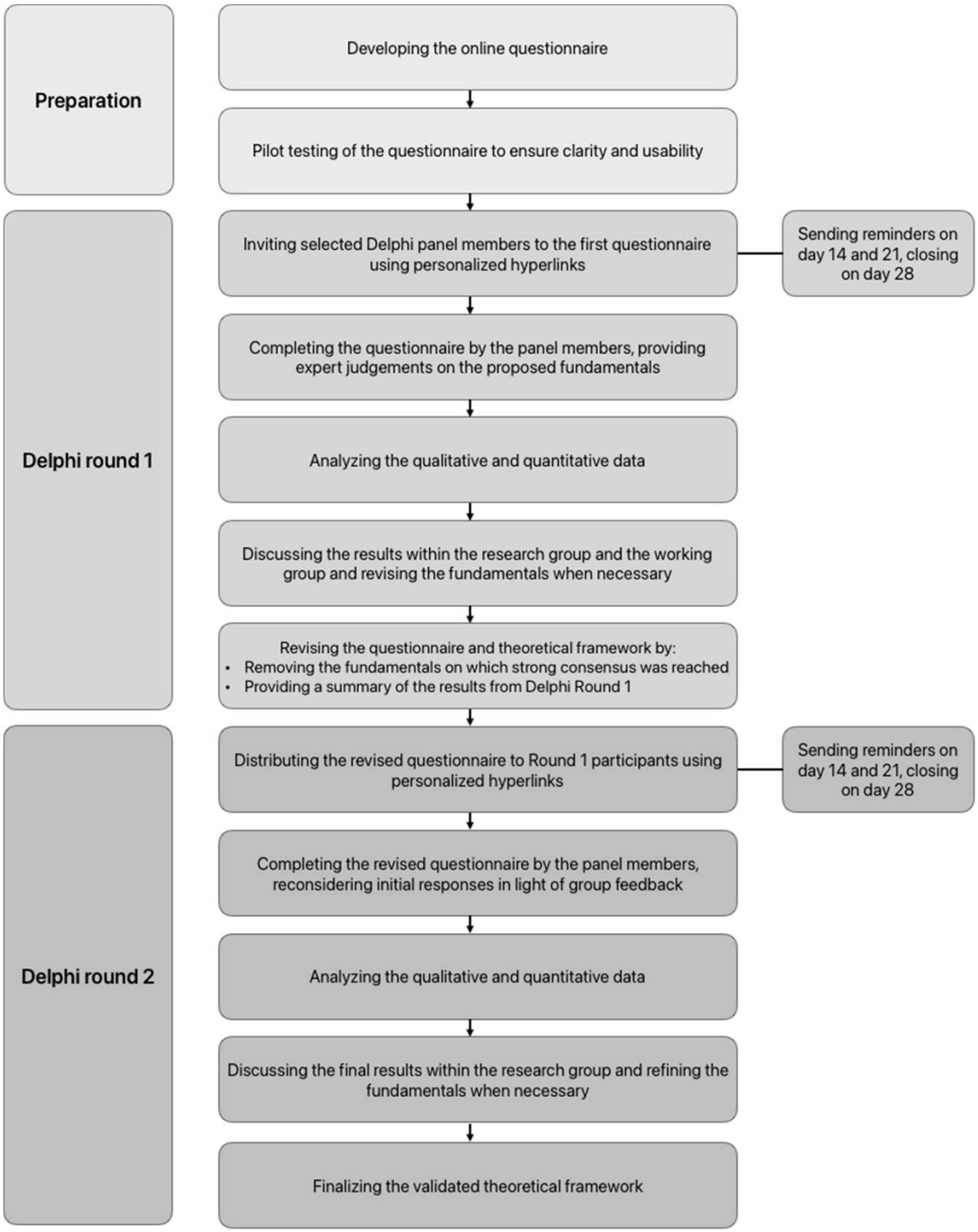

Figure 1. Flow-chart of the procedures in each Delphi round.

round. In each round, panel members were asked to rate the importance of the fundamentals using a Likert scale ranging from 1 = not important to 4 = very important. We used a 4-point Likert scale to avoid a neutral response option and to encourage stronger agreement or disagreement (Fink 2024). We included free-text fields to allow panel members to provide additional comments, allowing them to elaborate when necessary.

In the second round, the panel members received a new questionnaire including a summary of the results of the first round (i.e., percentage agreement, median, and interquartile range [IQR]) and the reasons for revising the fundamentals. The panel members also received an overview of the individual scores they had originally assigned to the fundamentals. Fundamentals that already achieved consensus with high agreement were not presented again.

https://doi.org/10.1017/S1478951526104106 Published online by Cambridge University Press

The personalized hyperlink each panel member received was linked to their email address. This allowed F.B.A.L.P. to monitor whether the personal reminder was needed and to link responses across rounds.

Data analysis

We analyzed the responses of each Delphi round with descriptive statistics. To evaluate consensus, a priori developed conservative criteria based on median, IQR, and percent agreement were used (Hohmann et al. 2025). Fundamentals were deemed to have achieved consensus with agreement if they received a median score of ≥3, an IQR ≤ 1, and at least 80% of participants rated the fundamental 3 or 4. Consensus with high agreement was defined as a median score of 4, an IQR ≤ 1, and ≥90% of participants rating the fundamental 3 or 4. A directed content analysis was adapted to the free-text fields (Hsieh and Shannon 2005). Participants' answers were extracted into a Microsoft Excel file. Responses were cut into small text segments and coded and summarized by 2 researchers (F.B.A.L.P. and J.H.H.M.F.-S.) based on the fundamentals and themes in the framework. The results of the analysis were then discussed with the research group. Then, we adjusted, refined, or excluded fundamentals when necessary.

Results

Participants

Of the 80 invited experts, 48 experts (60%) from 15 countries completed Round 1 (Table 1). Most participants had research or nursing background, were based in Europe, and their field of expertise was palliative care. Most of these experts (46 of 48; 96%) also completed Round 2. Participants and non-participants appeared broadly similar with respect to stakeholder group and geographic distribution based on information available during expert identification.

Table 1. Characteristics of Delphi panelists ($n = 48$, Round 1)

	n (%)
Professional background (more possible)	
Researcher	38 (79%)
Nursing	27 (56%)
Medicine	8 (17%)
Spiritual or psychological care	7 (15%)
Education	4 (8%)
Ethicist	2 (4%)
Other	4 (8%)
Field of expertise (more possible)	
Palliative care	43 (90%)
Advance care planning	26 (54%)
Nursing care	25 (52%)
Communication	22 (46%)
Care for older people	17 (35%)
Spiritual care	8 (17%)
Other	11 (23%)
Residence (15 countries)	
Europe:	
Western Europe: The Netherlands (17),	
England (4), Belgium (3), Ireland (3),	
Switzerland (2)	29 (60%)
Southern Europe: Italy (3), Portugal (2)	5 (10%)
Eastern Europe: Romania (1)	1 (2%)
Northern Europe: Finland (1)	1 (2%)
North America: USA (3), Canada (2)	5 (10%)
Asia: Japan (3), China (1), Taiwan (1)	5 (10%)
Oceania: Australia (2)	2 (4%)

Round 1

In Round 1, participants rated 20 fundamentals. Sixteen fundamentals achieved consensus with high agreement, and 3 fundamentals achieved consensus with agreement (Table 2). Consensus with agreement was not reached on 1 fundamental, "Trusting intuition" (73% agreement, median = 3, IQR = 2) (Table 3). Each fundamental was revised and refined based on the experts' comments and suggestions (Supplementary File 1). The primary feedback centered on how well the framework applies to a diverse range of individuals, including those from LGBTIQA+ communities and various cultural or religious backgrounds, as well as to both formal and informal conversations. For example, experts mentioned that not all end-of-life conversations need to be natural, open, or comfortable, as communication styles may vary across cultures (e.g., preferences regarding directness or eye contact, and whether limiting the number of people present is appropriate). Some also noted that recommendations such as minimizing distractions to create a calm atmosphere may be more relevant to formal than to informal conversations.

Round 2

In Round 2, we included the fundamental that failed to reach consensus with agreement (73%) and the 3 fundamentals that achieved consensus with agreement (≥80%). Based on the feedback on the fundamental "Taking a seat to seek connection," we integrated this fundamental into "Creating a calm atmosphere."

Two fundamentals achieved consensus with agreement in Round 2, while 2 fundamentals achieved consensus with high agreement. The primary feedback concerned the wording and cultural sensitivity of several fundamentals. In particular, "Fostering a natural and open conversation" was considered potentially misleading, as it could imply that end-of-life conversations should be easy or non-confrontational; experts therefore suggested using the term "authentic" instead. Concerns were also raised that an emphasis on intuition in "Verifying intuition" might suggest a simplistic approach, whereas participants stressed that end-of-life communication requires trained skills and the ability to recognize and interpret subtle cues. Each fundamental was revised and refined based on the experts' comments and suggestions (Table 3 and Supplementary File S1). Figure 2 and Supplementary File S2 display an overview of the final theoretical framework.

https://doi.org/10.1017/S1478951526104106 Published online by Cambridge University Press

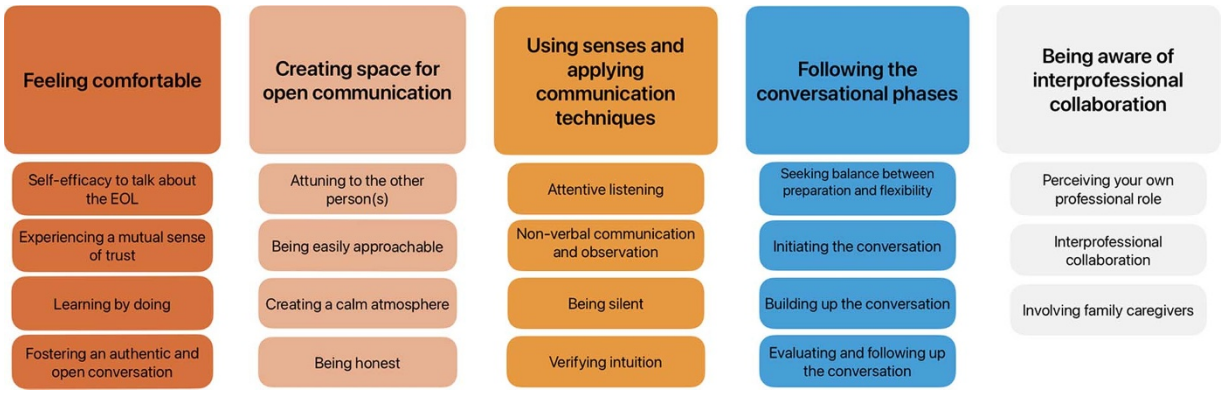

Figure 2. Final theoretical framework.

Discussion

Through a structured, 2-round Delphi process involving 48 experts, this study refined the theoretical framework of end-of-life communication by nursing staff as part of ACP with older people, achieving international consensus on the content of the framework. The feedback we have received on the framework's fundamentals in both Delphi rounds primarily focused on their applicability to diverse individuals, including those from LGBTIQA+ communities and various cultural or religious backgrounds. Although end-of-life communication is widely recognized as an essential component of healthcare, attitudes toward ACP and its integration into routine clinical care can vary significantly; not only across cultures and countries but also based on factors such as sexual orientation and gender identity. For example, this Delphi study showed that behaviors such as being honest and direct, sitting down during the conversation, maintaining eye contact, and the number of people present are highly sensitive to cultural context and should be carefully considered in end-of-life communication. We have incorporated this feedback into the framework but also emphasize that these considerations have direct implications for the practical usefulness of the framework. In its current form, the framework reflects a predominantly Western European perspective on end-of-life communication, in which individual autonomy, openness about dying, and direct communication are generally valued. In cultural contexts where family-centered decision-making, avoidance of explicit death talk, or indirect communication styles prevail, some fundamentals may need to be revised. This does not diminish the framework's value but underscores that it should be treated as a flexible starting point rather than a universal standard.

These findings are also reported in other studies, which further explain how to address them in end-of-life communication and end-of-life care (Jünger et al. 2012; Brooks et al. 2019a, 2025; Lambert et al. 2023). Brooks et al. (2025), for example, highlight the importance of healthcare professionals examining their own cultural values, beliefs, and assumptions, as these can influence communication with patients or family caregivers from diverse backgrounds. They argue that awareness of one's own cultural identity is a necessary foundation before attempting to understand others' cultural perspectives (Brooks et al. 2019b), as also emphasized in the framework. In line with this, Stinchcombe et al. (2017) and Rosa et al. (2023a) highlight the important role healthcare professionals play in fostering positive care experiences for older people by becoming knowledgeable about the unique needs of this population and being unassuming and accepting of individuals' sexuality. One such need is having the opportunity to disclose their LGBTIQA+ identity in a safe clinical environment (Rosa et al. 2023a). While the validated theoretical framework in this study already addresses certain cultural aspects, cultural and LGBTIQA+ sensitivity requires ongoing self-awareness and attunement to the other person, even before a conversation begins. This is reflected in the fundamentals "Attuning to the other person" and "Self-efficacy to talk about the end of life."

Another point of feedback we have received in this Delphi study regards the concern that some fundamentals might unintentionally imply that natural end-of-life conversations should be imposed, despite the inherently complex and sometimes confrontational nature of end-of-life conversations. In our previous interview study with older people and their family caregivers, we found that they particularly value feeling comfortable, safe, seen, and heard in open, natural, and human conversations (Peerboom et al. 2025b). Engel et al. (2023) found in a systematic review that open and honest communication is highly valued in palliative care, while also emphasizing the importance of allowing patients and relatives time to process information. Similarly, Chen et al. (2022) and Ibañez-Masero et al. (2019) highlight the value of open, natural, and person-centered dialogues in end-of-life communication. Despite the strong preference among older people and their family caregivers for such conversations, a natural approach is not always appropriate or preferred. For example, during acute deterioration requiring urgent decisions, a more direct approach may be needed. Similarly, some older people may prefer structured, checklist-based discussions focused on specific care preferences. These diverse perspectives and possible preferences are now better integrated into the framework's fundamentals. End-of-life communication, like culturally sensitive communication, requires adaptation to individual preferences and contextual factors (Fakhri et al. 2016).

Our Delphi panel revealed divergent views on the role of intuition in end-of-life communication. While the majority of participants strongly supported the importance of validating intuition in these conversations, some cautioned that relying too much on intuition could overshadow the importance of trained communication skills. A growing body of evidence supports the fundamental role of intuition in nursing practice. Valenzuela and Marcos (2019) describe nursing intuition as personal knowing based on knowledge, clinical experience, and the nurse-patient relationship, enabling interpretation of health and illness in context. Similarly, Melin-Johansson et al. (2017) define intuition as a cognitive process

https://doi.org/10.1017/S1478951526104106 Published online by Cambridge University Press

Table 2. Total results of the Delphi rounds

Fundamentals[1]	Percentage agreement	Median (IQR)
Theme 1: Feeling comfortable		
Achieved consensus[2] without revision in Round 1		
Self-efficacy to talk about the end of life	100%	4 (0)
Experiencing a mutual sense of trust	98%	4 (1)
Learning by doing	96%	4 (1)
Achieved consensus[2] after revision in Round 2		
Having a natural and open conversation *(Round 1)*	92%	3 (1)
Revised into after Round 1: Fostering a natural and open conversation	83%	3 (1)
***Revised into after Round 2:** Fostering an authentic and open conversation*		
Theme 2: Creating space for open communication		
Achieved consensus[2] without revision in Round 1		
Attuning to the other person(s)	100%	4 (0)
Being easily approachable	98%	4 (1)
Being honest	100%	4 (1)
Achieved consensus[2] after revision in Round 2		
Creating a calm atmosphere *(Round 1)*	96%	4 (1)
Taking a seat to seek connection *(Round 1)*	83%	4 (1)
***Revised into after Round 1:** Creating a calm atmosphere (covers "Taking a seat to seek connection")*	94%	4 (1)
Theme 3: Using senses and applying communication techniques		
Achieved consensus[2] without revision in Round 1		
Attentive listening	100%	4 (0.75)
Non-verbal communication and observation	96%	4 (0.75)
Being silent	90%	4 (0)
Achieved consensus[2] after revision in Round 2		
Trusting intuition *(Round 1)*	73%	3 (2)
***Revised into after Round 1:** Verifying intuition*	80%	3 (1)
Theme 4: Following the conversational phases		
Achieved consensus[2] without revision in Round 1		
Seeking balance between preparation and flexibility	92%	4 (1)
Initiating the conversation	94%	4 (1)
Evaluating and following up the conversation	96%	4 (1)
Achieved consensus[2] after revision in Round 2		
Gently building up the conversation *(Round 1)*	88%	4 (1)
***Revised into after Round 1:** Gently building up the conversation*	91%	4 (1)
***Revised into after Round 2:** Building up the conversation*		
Theme 5: Being aware of interprofessional collaboration		
Achieved consensus[2] without revision		
Perceiving your own professional role	94%	4 (1)
Interprofessional collaboration	92%	4 (1)
Involving family caregivers	94%	4 (1)

[1]This table lists the titles of the fundamentals, with any changes to those titles noted. Each fundamental was accompanied by a description, which was revised in each round. Details of these description revisions are provided in Table 3 and Supplementary File S1.
[2]Fundamentals were deemed to have achieved consensus with agreement if they received a median score of ≥3, an IQR ≤ 1, and at least 80% of participants rated the fundamental 3 or 4. Consensus with high agreement was defined as a median score of 4, an IQR ≤ 1, and ≥90% of participants rating the fundamental 3 or 4.

grounded in knowledge, self-awareness, and experience, complementing evidence-based practice and supporting clinical decision-making. This highlights that the use of intuition in end-of-life communication does not replace the need for trained communication skills but rather complements and enhances the skills nursing staff already possess or develop, ultimately supporting the quality of this uniquely sensitive form of communication. Still, it remains important that specific interpretations are verified by nursing staff to ensure that it reflects the thoughts, feelings, experiences, and needs of the older person.

The added value of the framework does not lie in introducing entirely new communication techniques, but in structuring the specific conditions, tensions, and professional awareness required for end-of-life communication within ACP. Recent conversation-analytic and discourse-focused research has illuminated how end-of-life discussions are interactionally organized in practice, including how sensitive topics are introduced, how uncertainty is communicated, and how patients and professionals jointly navigate emotionally complex moments (Parry 2024; Wu and Zhang 2024; Jia and Wu 2025). While this body of work offers valuable descriptive insights, it addresses a different question than the one this framework is designed to answer. Rather than analyzing conversational sequences, the framework makes explicit the professional, relational, and reflective dimensions that nursing staff need to develop to engage meaningfully in end-of-life conversations across both formal and informal encounters and in their dual role of initiating and sustaining communication over time.

In this sense, the framework complements rather than competes with conversation-analytic approaches and addresses a practical gap that descriptive interaction research alone cannot fill. The framework is not intended as a checklist, nor are all fundamentals required in every conversation. Instead, the fundamentals are designed to promote awareness, self-awareness, learning, preparation, and reflection on the key dimensions of end-of-life communication. By addressing complementary aspects of communication practice, the framework provides flexibility and relevance for the diverse realities and sensitivities that nursing staff encounter in end-of-life care.

The fundamentals can be translated into nursing practice through targeted interventions and training programs that prepare nursing staff to take an active and central role in person-centered end-of-life conversations, both in initial education and continuing professional development. Integrating the framework from the

https://doi.org/10.1017/S1478951526104106 Published online by Cambridge University Press

Table 3. Details of the re-assessed fundamentals in Round 2

Initial fundamental	Revised fundamental after Round 1	Revised fundamental after Round 2
Theme 1: Feeling comfortable		
Having a natural and open conversation - Older people and their family caregivers should feel comfortable, safe and should be reassured; - The conversation should feel natural, open and light-hearted, and should emerge naturally.	*Fostering a natural and open conversation* - Older people and their family caregivers should feel safe in end-of-life communication and they should be reassured; - This may help the conversation feel natural and open for everyone involved, which is especially appreciated by older people.	*Fostering an authentic and open conversation* - Fostering authentic and open communication to help older people and their family caregivers feel safe in end-of-life communication (e.g., by being open to discuss any topic, without judgement, and using a person-centred approach).
Summary of the feedback in Round 1 presented to participants in round 2: There was considerable discussion about this fundamental regarding the fact that it is not appropriate, preferable or necessary for every end-of-life conversation to be natural, open, light-hearted and comfortable. This is also strongly influenced by cultural factors.	**Summary of the feedback in Round 2:** Some feedback indicated that this fundamental might imply natural conversations should be imposed, while end-of-life conversations can sometimes be confrontational. Additionally, the term 'natural' caused confusion; several panel members suggested using 'authentic' instead. The note that older people especially appreciate this fundamental was seen as irrelevant.	
Theme 2: Creating space for open communication		
Taking a seat to seek connection - Creating equality and calm; - Taking a strategic seat (e.g., so that the other person can see you all the time if there are several people present).		
Summary of the feedback in Round 1 presented to participants in round 2: There was considerable discussion about how this fundamental applies to informal conversations across various settings and cultures, for example, in cultures where direct eye contact is not preferred. It was suggested to merge this fundamental with another fundamental: "Creating a calm atmosphere". We have adopted this change.		
Creating a calm atmosphere - Taking enough time and showing that you have enough time; - Limiting the number of people in the room; - Minimising distractions (e.g., by turning off digital devices, closing bed curtains (in hospitals)).	*Creating a calm atmosphere* - Taking enough time and showing that you have enough time; - Limiting the number of people in the room; - Minimising distractions in case of formal conversations (e.g., by turning off digital devices, informing colleagues, closing bed curtains (in hospitals)). - Considering taking a seat during an end-of-life conversation to create equality and calm, but adapt this approach based on the context, setting, and cultural preferences.	*Creating a calm atmosphere* 1 Taking enough time and showing that you have enough time for end-of-life conversations as part of the process of advance care planning; 2 Limiting the number of people present, if culturally appropriate; 3 Minimising distractions, especially in case of formal conversations (e.g., by turning off digital devices, informing colleagues, closing bed curtains (in hospitals)). 4 Considering adopting the same physical height as the other person(s) (e.g., by taking a seat) during end-of-life conversations to foster a sense of equality and a tranquil atmosphere, while also considering the context, setting, and cultural preferences.
Summary of the feedback in Round 1 presented to participants in round 2: There was some confusion about the applicability of minimizing distractions to create a calm atmosphere to informal end-of-life conversations.	**Summary of the feedback in Round 2:** 'Taking a seat' was seen as too specific and not suitable for all types of end-of-life conversations. Participants suggested changing it to 'adopting the same height.' They also noted that 'limiting the number of people present' is culturally dependent. Additionally, it was recommended to emphasize that advance care planning is a process rather than a single conversation.	

(*Continued*)

https://doi.org/10.1017/S1478951526104106 Published online by Cambridge University Press

Table 3. (*Continued.*)

Initial fundamental	Revised fundamental after Round 1	Revised fundamental after Round 2
Theme 3: Using senses and applying communication techniques		
Trusting intuition - The approach to end-of-life communication is often intangible; - Sensing what a conversation should be about (i.e., what might be on the other person's mind) can make the other person feel seen.	*Verifying intuition* - The approach to end-of-life communication is often subtle and intangible, as it requires attuning to the other person and relying on intuition; - Sensing what a conversation should be about (i.e., what might be on the other person's mind) can make the other person feel seen. - Nursing staff should validate their intuition by checking with the other person to ensure it reflects their experience or meets their needs.	*Verifying intuition* - Adopting a subtle and intangible approach in end-of-life communication, as it requires attuning to the other person and substantiating intuition when appropriate; - Sensing what a conversation should be about (i.e., what might be on the other person's mind) can make the other person feel seen. - Validating intuition by checking with the other person to ensure it reflects their thoughts, feelings, experiences and needs is important.
Summary of the feedback in Round 1 presented to participants in round 2: There was considerable discussion about the risk of making assumptions based on intuition, particularly when that intuition is not verified by checking whether it aligns with the other person's experience or needs.	**Summary of the feedback in Round 2:** Some participants expressed doubts about encouraging the 'simple' use of intuition. They felt this fundamental overlooks the fact that effective end-of-life conversations require learned skills. Rather than relying on intuition, they emphasized the importance of recognizing and responding to specific signs or interpretations.	
Theme 4: Following the conversational phases		
Gently building up the conversation - Starting conversations lightly and slowly building towards "heavier" topics (e.g., death and dying), attuning to the other person's readiness; - Prompting questions add depth to a conversation; - Emphasising that decisions do not have to be made immediately and can be reconsidered at any time; - Striking a balance between gathering information to provide good care, providing information and allowing the other person(s) to vent.	*Gently building up the conversation* - Starting conversations lightly and slowly building towards topics that may be sensitive (i.e., death and dying), attuning to the other person's readiness and to what is important to the other person; - Conversations can develop dynamically - at times exploring topics that may be sensitive, then shifting back to less sensitive ones; - Prompting questions add depth to a conversation; - Emphasising that decisions do not have to be made immediately and can be reconsidered at any time; - Striking a balance between gathering information to provide good care, providing information, addressing fears and concerns, and allowing the other person(s) to vent.	*Building up the conversation* - Starting the conversation gently and building up towards topics that may be sensitive (i.e., death and dying), while adjusting the pace based on the other person's readiness and to what is important to them; - Prompting questions add depth to a conversation; - Emphasising that decisions do not have to be made immediately and can be reconsidered at any time; - Striking a balance between gathering information to provide good care, providing information, addressing fears and concerns, and allowing the other person(s) to vent.
Summary of the feedback in Round 1 presented to participants in round 2: Additional reasons for and ways to gently build up end-of-life conversations were mentioned.	**Summary of the feedback in Round 2:** Some feedback raised concerns that this fundamental might suggest that end-of-life conversations should always be gentle, which is not necessarily the case. There was also confusion about what was meant by "dynamically developing" end-of-life conversations, and its added value was questioned compared to the first bullet point.	

start of their careers helps position end-of-life communication as a fundamental nursing skill. Training can focus on raising awareness of the fundamentals and coaching nursing staff in applying the fundamentals in daily practice, not only during formal end-of-life conversations but also in informal conversations. By incorporating methods such as reflection, role-play, and feedback, education can support nursing staff in recognizing and strengthening their own communication patterns while developing the confidence and sensitivity needed to respond effectively to the needs of older people and their family caregivers (Fuoto and Turner 2019; Laranjeira et al. 2021). The framework may also strengthen international research on end-of-life communication. The fundamentals can be translated into outcome measures, which help to observe and analyze complex communication processes.

Although the framework provides considerable opportunities for translation into nursing practice, education, and research, it may entail a risk that introducing its structured fundamentals into clinical practice may inadvertently formalize what are naturally informal conversations. Once nursing staff become more aware of the key elements involved, there is a risk that such conversations are approached more purposefully. Although this increased awareness generally has positive effects (e.g., enhancing confidence, sensitivity, and person-centeredness) (Peerboom et al. 2023, 2024), it may also reduce the spontaneity of informal conversations, making

https://doi.org/10.1017/S1478951526104106 Published online by Cambridge University Press

them feel more structured or even formal. The extent of this risk likely depends on the clinical setting and on individual experience with end-of-life communication. In healthcare, increased formality has been shown to reduce spontaneity and a person-centered approach, leading to a more reserved and depersonalized environment (Montgomery et al. 2024). Patients, in turn, report feeling most comfortable and best able to share personal values when healthcare professionals communicate with empathy, informality, and openness (Zwakman et al. 2018). Informal end-of-life conversations can be valuable for older people when they are not yet ready to engage in more formal conversations and decision-making (Bergenholtz et al. 2020; Mikaelsson et al. 2025). Because these conversations often feel less pressured and more open-ended, they enable older people and their family caregivers to begin reflecting on their values, wishes, and preferences at their own pace (Peerboom et al. 2023, 2024, 2025a). To address the potential risk of inadvertently formalizing what are naturally informal conversations, nursing education and training should highlight the importance of preserving flexibility and responsiveness. Reflective exercises and guided supervision can help nursing staff balance the use of the framework's fundamentals with the informality that often makes these conversations meaningful.

Strengths and limitations

This study has several strengths. First, both Delphi rounds had relatively high response rates, and most fundamentals reached consensus with high agreement, strengthening the reliability and credibility of the findings while minimizing attrition bias. Second, providing participants with summaries of group results, individual responses, and rationale for revisions improved the transparency and rigor of the Delphi process. Several limitations should also be noted. First, although the Delphi panel comprised experts from 15 countries across 4 continents, most participants were from Western Europe. This may limit the global generalizability of the findings and create uncertainty regarding the framework's applicability in settings where the perceived role of nursing staff differs from that in Western Europe (Ng and Wong 2021). Recruitment was based on purposive selection through the research group's professional networks and publicly available scientific profiles, which inherently reflects existing collaborative ties and may have introduced a geographic bias toward Western Europe. Broader representation was actively sought, but achieving proportional global representation within the scope of this study was not feasible. This geographic imbalance should be considered when interpreting the findings, and future validation studies in non-Western contexts are recommended. In addition, approximately half of the experts reported experience in nursing care, ACP, or communication. As participants may have indicated only their primary area of expertise, other relevant experience across domains may not have been fully captured. Nevertheless, this should be considered when interpreting the findings, as these areas are central to the study topic. Second, language and cultural differences may have led to varying interpretations of the fundamentals, potentially affecting consistency in responses. Third, although we strengthened the content validity of the framework, this does not constitute full validation in real-world settings. While the framework shows strong potential, further empirical research is needed to examine how it can be applied in clinical and educational contexts and to evaluate aspects such as usability, reliability, and its contribution to supporting nursing end-of-life communication.

Future research

Several areas for future research can be identified. First, although the framework emphasizes the need to adapt end-of-life communication to individual, social, contextual, and cultural factors, further refinement may be appropriate. Empirical studies could develop and test practical guidance and illustrative examples to strengthen its applicability to culturally and LGBTIQA+ sensitive communication. Second, given the focus on the Western European setting, the generalizability of the present findings could be limited. Future research could therefore examine the framework's validity in other geographical contexts. Finally, translational research is needed to operationalize the theoretical framework into specific nursing interventions. As the framework itself is not an intervention, future studies should first translate its fundamentals into educational or practice-based approaches tailored to nursing staff needs, followed by feasibility, implementation, and effectiveness studies in clinical practice.

Conclusion

This Delphi study refined and validated a theoretical framework for end-of-life communication by nursing staff, resulting in a set of fundamentals grounded in both clinical and academic expertise. The framework contributes to a deeper understanding of both formal and informal end-of-life communication and offers practical guidance for nursing staff, care assistants, and nurse practitioners working with older people. While designed as a flexible framework to raise awareness and support person-centered end-of-life communication, its effective use depends on thoughtful application, cultural sensitivity, and professional judgment. Future research should confirm the validity of the framework in broader geographical contexts beyond Western Europe and inform its implementation in nursing education and clinical practice.

Box 1. The LISTEN project

This study is part of the LISTEN project, which aims to build and validate a theoretical framework of the fundamentals of end-of-life communication between nursing staff (i.e., nurses, care assistants, and nurse practitioners) and older people (i.e., 65 years or older and receiving care or palliative care in home care, nursing home, or hospital settings [e.g., due to frailty or chronic illness]). The previously developed theoretical framework is based on a scoping review (Peerboom et al. 2023), 2 interview studies with nursing staff (Peerboom et al. 2024) and older people and family caregivers (Peerboom et al. 2025b), and a focus group study with multiple disciplines (Peerboom et al. 2025a). The theoretical framework consists of 5 themes ("Feeling comfortable," "Creating space for open communication," "Using senses and applying communication techniques," "Following the conversational phases," and "Being aware of interprofessional collaboration") and 20 fundamentals (Supplementary File S1).

The framework emphasizes that nursing staff should feel comfortable to talk about the end-of-life, in both private and professional contexts. For example, experiencing a trusting relationship and learning by doing can help nursing staff feel comfortable and engage in natural and open end-of-life conversations. In addition, nursing staff can create space for open communication by, for example, attuning to the other person and being easily approachable. When engaging in the conversation, nursing staff may use their senses and apply appropriate communication techniques, such as by attentive listening and trusting their intuition. Although end-of-life communication does not need to follow strict phases, certain phases may be identified. Nursing staff seek balance between preparation and flexibility in the conversation and gently build and evaluate the conversation as part of a continuous process. Interprofessional collaboration is important in each part of the communication process. Nursing staff should be aware of their own role in end-of-life communication and work together based on

https://doi.org/10.1017/S1478951526104106 Published online by Cambridge University Press

these roles. In addition, family caregivers should be actively involved while ensuring that the older person remains central to the care process.

Supplementary material. The supplementary material for this article can be found at https://doi.org/10.1017/S1478951526104106.

Competing interests. This work was supported by the Netherlands Organization for Health Research and Development (ZonMw, grant number 10040022110005).

Ethical approval. The study was approved by the Research Ethics Committee of the Faculty of Health, Medicine and Life Sciences (FHML-REC) of Maastricht University (FHML-REC/2024/073).

References

Bergenholtz H, Missel M and Timm H (2020) Talking about death and dying in a hospital setting-a qualitative study of the wishes for end-of-life conversations from the perspective of patients and spouses. *BMC Palliative Care* **19**(1), 1–9. doi:10.1186/s12904-020-00675-1

Brooks LA, Bloomer MJ and Manias E (2019a) Culturally sensitive communication at the end-of-life in the intensive care unit: A systematic review. *Australian Critical Care* **32**(6), 516–523. doi:10.1016/j.aucc.2018.07.003

Brooks LA, Manias E and Bloomer MJ (2019b) Culturally sensitive communication in healthcare: A concept analysis. *Collegian (Royal College of Nursing, Australia)* **26**(3), 383–391. doi:10.1016/j.colegn.2018.09.007

Brooks LA, Manias E, Rasmussen B, *et al.* (2025) Practice recommendations for culturally sensitive communication at the end of life in intensive care: A modified eDelphi study. *Intensive and Critical Care Nursing* **86**, 103814. doi:10.1016/j.iccn.2024.103814

Chen W, Chung JOK, Lam KKW, *et al.* (2022) End-of-life communication strategies for healthcare professionals: A scoping review. *Palliative Medicine* **37**(1), 02692163221133670.

Chiang F-M, Wang Y-W and Hsieh J-G (2021) How acculturation influences attitudes about advance care planning and end-of-life care among Chinese living in Taiwan, Hong Kong, Singapore, and Australia. *Healthcare* **9**(11), 1477.

Engel M, Kars MC, Teunissen SC, *et al.* (2023) Effective communication in palliative care from the perspectives of patients and relatives: A systematic review. *Palliative & Supportive Care* **21**(5), 890–913. doi:10.1017/S1478951523001165

Evans N, Meñaca A, Koffman J, *et al.* (2012) Cultural competence in end-of-life care: Terms, definitions, and conceptual models from the British literature. *Journal of Palliative Medicine* **15**(7), 812–820. doi:10.1089/jpm.2011.0526

Fakhri S, Engelberg RA, Downey L, *et al.* (2016) Factors affecting patients' preferences for and actual discussions about end-of-life care. *Journal of Pain and Symptom Management* **52**(3), 386–394. doi:10.1016/j.jpainsymman.2016.03.012

Fink A (2024) *How to Conduct Surveys: A Step-by-step Guide*. California, USA: SAGE Publications.

Fleuren N, Depla MF, Janssen DJA, *et al.* (2020) Underlying goals of advance care planning (ACP): A qualitative analysis of the literature. *BMC Palliative Care* **19**(1), 27. doi:10.1186/s12904-020-0535-1

Fuoto A and Turner KM (2019) Palliative Care Nursing Communication: An Evaluation of the COMFORT Model. *Journal of Hospice & Palliative Nursing* **21**(2), 124–130. doi:10.1097/NJH.0000000000000493

Gómez-Vírseda C, De Maeseneer Y and Gastmans C (2020) Relational autonomy in end-of-life care ethics: A contextualized approach to real-life complexities. *BMC Medical Ethics* **21**, 1–14. doi:10.1186/s12910-020-00495-1

Hemsley B, Meredith J, Bryant L, *et al.* (2019) An integrative review of stakeholder views on advance care directives (ACD): Barriers and facilitators to initiation, documentation, storage, and implementation. *Patient Education and Counseling* **102**(6), 1067–1079. doi:10.1016/j.pec.2019.01.007

Hohmann E, Beaufils P, Beiderbeck D, *et al.* (2025) Guidelines for Designing and Conducting Delphi Consensus Studies: An Expert Consensus Delphi Study. *Arthroscopy: The Journal of Arthroscopic & Related Surgery* **41**, 4208. doi:10.1016/j.arthro.2025.03.038

Hopkins SA, Bentley A, Phillips V, *et al.* (2020) Advance care plans and hospitalized frail older adults: A systematic review. *BMJ Supportive & Palliative Care* **10**(2), 164–174. doi:10.1136/bmjspcare-2019-002093

Hsieh H-F and Shannon SE (2005) Three approaches to qualitative content analysis. *Qualitative Health Research* **15**(9), 1277–1288. doi:10.1177/1049732305276687

Ibañez-Masero O, Carmona-Rega IM, Ruiz-Fernández MD, *et al.* (2019) Communicating health information at the end of life: The caregivers' perspectives. *International Journal of Environmental Research and Public Health* **16**(14), 2469. doi:10.3390/ijerph16142469

Jia N and Wu Y (2025) Discourse analysis in end-of-life communication: a systematic review. *Health Communication* **40**(8), 1387–1402. doi:10.1080/10410236.2024.2400815

Jünger S, Payne S, Brearley S, *et al.* (2012) Consensus building in palliative care: A Europe-wide Delphi study on common understandings and conceptual differences. *Journal of Pain and Symptom Management* **44**(2), 192–205. doi:10.1016/j.jpainsymman.2011.09.009

Jünger S, Payne SA, Brine J, *et al.* (2017) Guidance on Conducting and REporting DElphi Studies (CREDES) in palliative care: Recommendations based on a methodological systematic review. *Palliative Medicine* **31**(8), 684–706. doi:10.1177/0269216317690685

Lambert E, Strickland K and Gibson J (2023) Cultural considerations at end-of-life for people of culturally and linguistically diverse backgrounds: A critical interpretative synthesis. *Journal of Clinical Nursing* **34**(12), 5050–5069.

Laranjeira C, Afonso C and Querido AI (2021) Communicating bad news: Using role-play to teach nursing students. *SAGE Open Nursing* **7**, 23779608211044589. doi:10.1177/23779608211044589

Melin-Johansson C, Palmqvist R and Rönnberg L (2017) Clinical intuition in the nursing process and decision-making—A mixed-studies review. *Journal of Clinical Nursing* **26**(23–24), 3936–3949. doi:10.1111/jocn.13814

Mikaelsson Å, Eriksson LE, Stenfors T, *et al.* (2025) Proactive end-of-life conversations in residential care homes: A qualitative interview study exploring residents' and family members' experiences. *BMC Geriatrics* **25**(1), 279. doi:10.1186/s12877-025-05916-7

Mohammadpour A, Sadeghmoghadam L, Shareinia H, *et al.* (2018) Investigating the role of perception of aging and associated factors in death anxiety among the elderly. *Clinical Interventions in Aging* **13**, 405. doi:10.2147/CIA.S150697

Montgomery A, Lainidi O and Georganta K (2024) Why talking is not cheap: adverse events and informal communication. *Healthcare* **12**(6), 635. doi:10.3390/healthcare12060635

Ng SY and Wong EL-Y (2021) The role complexities in advance care planning for end-of-life care—nursing students' perception of the nursing profession. *International Journal of Environmental Research and Public Health* **18**(12), 6574. doi:10.3390/ijerph18126574.

Parry R (2024) Communication in palliative care and about end of life: A state-of-the-art literature review of conversation-analytic research in healthcare. *Research on Language and Social Interaction* **57**(1), 127–148. doi:10.1080/08351813.2024.2305048

Peerboom FBAL, Friesen-Storms JHHM, van der Steen JT, *et al.* (2024) Fundamentals of end-of-life communication as part of advance care planning for older people: An interview study with nursing staff. *Geriatric Nursing* **60**, 59–69. doi:10.1016/j.gerinurse.2024.08.042

Peerboom FBAL, Friesen-Storms JHHM, van der Steen JT, *et al.* (2025a) Conceptualizing end-of-life communication by nursing staff as part of advance care planning with older people: A multiple discipline focus group study. *International Journal of Nursing Studies Advances* **100436**, 100436. doi:10.1016/j.ijnsa.2025.100436

Peerboom FBAL, Friesen-Storms JHHM, van der Steen JT, *et al.* (2025b) What matters in end-of-life communication with nursing staff: An interview study among older people and their family caregivers. *BMC Nursing* **24**(1), 1205. doi:10.1186/s12912-025-03882-4

Peerboom FBAL, Friesen-Storms JHMH, Coenegracht BJEG, *et al.* (2023) Fundamentals of end-of-life communication as part of advance care planning from the perspective of nursing staff, older people, and family

caregivers: A scoping review. *BMC Nursing* **22**(1), 363. doi:10.1186/s12912-023-01523-2

Phillips J, Johnston B and McIlfatrick S (2020) *Valuing Palliative Care Nursing and Extending the Reach*. In: SAGE Publications Sage UK. London, England.

Rietjens JA, Sudore RL, Connolly M, ***et al.*** (2017) Definition and recommendations for advance care planning: An international consensus supported by the European Association for Palliative Care. *The Lancet Oncology* **18**(9), e543–e551. doi:10.1016/S1470-2045(17)30582-X

Rietze LL, Stajduhar KI, Purkis ME, ***et al.*** (2024) The challenges of advance care planning for acute care registered nurses. *Canadian Journal of Nursing Research* **56**(3), 293–302. doi:10.1177/08445621241244532

Rosa WE, McDarby M, Buller H, ***et al.*** (2023a) Communicating with LGBTQ+ persons at end of life: A case-based analysis of interdisciplinary palliative clinician perspectives. *Psycho-Oncology* **32**(12), 1895–1904. doi:10.1002/pon.6237

Sable-Smith A, Arnett KR, Nowels MA, ***et al.*** (2018) Interactions with the healthcare system influence advance care planning activities: Results from a representative survey in 11 developed countries. *Family Practice* **35**(3), 307–311. doi:10.1093/fampra/cmx113

Schüttengruber G, Großschädl F and Lohrmann C (2022) A consensus definition of end of life from an international and interdisciplinary perspective: a Delphi panel study. *Journal of Palliative Medicine* **25**, 1677–1685. doi:10.1089/jpm.2022.0030

Stinchcombe A, Smallbone J, Wilson K, ***et al.*** (2017) Healthcare and end-of-life needs of lesbian, gay, bisexual, and transgender (LGBT) older adults: A scoping review. *Geriatrics* **2**(1), 13. doi:10.3390/geriatrics2010013

Sudore RL, Lum HD, You JJ, ***et al.*** (2017) Defining advance care planning for adults: A consensus definition from a multidisciplinary Delphi panel. *Journal of Pain and Symptom Management* **53**(5), 821–832.e821. doi:10.1016/j.jpainsymman.2016.12.331

Valenzuela JP and Marcos M (2019) Theory of nursing intuition and its philosophical underpinnings. *International Journal of Nursing Science* **9**(1), 19–23. doi:10.5923/j.nursing.20190901.03

Wilkin K, Fang ML and Sixsmith J (2024) Implementing advance care planning in palliative and end of life care: A scoping review of community nursing perspectives. *BMC Geriatrics* **24**(1), 294. doi:10.1186/s12877-024-04888-4

Wu Y and Zhang X (2024) Examining conversation analysis in palliative care: A systematic review. *Health Communication* **39**(13), 3072–3083. doi:10.1080/10410236.2023.2301202

Zwakman M, Jabbarian L, van Delden JJ, ***et al.*** (2018) Advance care planning: A systematic review about experiences of patients with a life-threatening or life-limiting illness. *Palliative Medicine* **32**(8), 1305–1321. doi:10.1177/0269216318784474

https://doi.org/10.1017/S1478951526104106 Published online by Cambridge University Press