

Before starting my hospice clinical. I expected to work with patients who were actively dying—mostly bed bound, receiving comfort care only. In a way, that expectation was met. There were some patients nearing the end of life, but I was also surprised to see one who was walking around the hallways. I remember feeling confused about why he was even admitted to hospice. It made me realize that hospice isn't just about the last few hours of life, but about managing symptoms and planning end of life care at different stages.

Overall, my experience was a mix of observation and learning. I didn't feel emotionally moved in the way I thought I would, but I did gain a better understanding of what hospice nursing looks like. It was slow paced focus on comfort, symptom management, and planning. A lot of what I saw involved discharge coordination, family dynamics, and different levels of care that I hadn't thought much of before.

One patient that stood out to me had garbled speech, constant cough, and an SpO<sub>2</sub> of 75%. I know that is below the normal range, but I didn't know if that was okay considering the patient was nearing the end of life. She said no and started him on oxygen and the nurse also eventually got suction. We gave an opioid to suppress the cough. The doctor was discussing with the social worker whether he had capacity which I learned means being able to make his own decisions regarding care. The team seemed caught between symptom control and financial/legal limitations – he didn't have insurance, and his green card had expired, which made things more complicated. They were trying to keep him in hospice by switching up the symptoms he was being treated for. For example, I heard someone suggest to say “aspiration pneumonia” so he could stay longer. This was the first time I saw the behind the scenes conversations and how much social work and financial factors can impact care, especially in hospice.

Another thing that stood out to me was how different medication passes were. There was no bedside MAR, no scanning system, and no ID bands. Nurses would pass medications, then go back and chart them later. That really made me question patient safety. In the hospital there are so many checks built into the system: scanning, ID confirmation, real-time charting. In hospice, it felt a little loose. I understand the environment is different, and the patients have different needs, but I couldn't help thinking there's a high potential for medication errors. It's ironic that the med pass isn't stricter because I feel like these patients were receiving way more medications around the clock versus at the hospital it might just be am/pm (BID). In addition, there were no IV drips, and the bedroom showers didn't work if someone wanted to take a shower. Many things that could be updated.

Another takeaway is the importance of patience and effective communication in hospice. One patient had a sister who was a retired nurse, and she would often interrupt and answer on behalf of the patient. The patient seemed anxious around her family and wasn't getting a chance to speak for herself. It reminded me that even in end-of-life care, autonomy still matters. Nurses need to advocate for the patient, even if it means setting boundaries with family members. The nurse I was with did this; she always referred the questions back to the patient. If the sister said she needed to take a shower and wash her hair, the nurse asked the patient if that was what she wanted.

I also learned more about what the different levels of care entailed. I didn't realize how patients could move between levels. I knew what respite was, but I wasn't familiar with routine home care. The nurse explained that with those patients you apparently don't always need to do vital signs and assessments. Like I previously mentioned, I thought everyone who came into hospice was there until the very end unless it was respite. Seeing how patients are stabilized and sometimes discharged helped shift my understanding of what hospice involves.

One thing that did bother me was when I heard that once patients no longer qualify for GIP, they must leave or pay privately around 300 dollars per day. I wonder how there is no other way. I remember thinking to myself at one point, "it's always about the money."

Overall, I learned a lot during my hospice clinical, even if I didn't feel super emotional like I thought I would. It was more about learning how nurses work in a different way—slower, more focused on comfort (most of my day consisted of passing pain and anxiety meds) and dealing with families. I still have questions, but I left with a better understanding of hospice and the palliative care.