REVIEW ARTICLE

Preventable Issues in Home-Based Palliative Care by Core Nursing Theory - Narrative Review

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Abstract

Home-based palliative care HBPC provides a compassionate, patient-centred approach for individuals with life-limiting illnesses, aiming to enhance their quality of life. It delivers in familiar, comforting surroundings, offers a more personalized experience, and reduces the risk of preventable health issues. The study explores avoidable problems faced by patients and families in home-based settings through the lens of Lydia Hall's Core Nursing Theory, which emphasizes patient-centred care supported by a multidisciplinary team. This review article examines common preventable issues in palliative care through the lens of Lydia Hall's Core Nursing Theory, which emphasizes the 3C model—Core, Care, and Cure—and advocates for multidisciplinary, patient-focused care. To identify key challenges, a literature review was conducted across PubMed, Google Scholar, Scopus, and Cochrane databases, with references managed *via* Mendeley. Out of 2,446 articles published between January 2019 and January 2025, 82 English-language studies were selected from both national and international contexts. Among 82 studies analysed, the most frequently reported preventable issues included infections, pressure ulcers, falls, contractures, constipation, depression, abuse, and nutritional deficiencies. These findings were primarily drawn from studies investigating causes of hospital readmissions among palliative patients. The study concludes that empowering families and healthcare teams through evidence-based practices and compassionate care, as Core Nursing Theory emphasizes, can significantly improve the palliative care experience. By proactively addressing preventable issues with the framework Core Nursing Theory provides, patients can spend their final days with greater comfort, dignity, and peace. This review suggests that integrating Core Nursing Theory into HBPC protocols may reduce preventable complications.

Keywords: *Palliative care, home-based, health issues, nursing theory, prevention.*

INTRODUCTION

Palliative care is a specialized, patient-centred approach designed to enhance the quality of life for individuals facing life-threatening illnesses [1]. It addresses physical, emotional, social, and spiritual needs, while also offering essential support to families and caregivers during the most challenging stages of illness [2]. Although palliative care is provided in various settings—such as hospices, community facilities, and hospitals—Home-based palliative care (HBPC) has become increasingly prominent [3]. HBPC provides patients with a more personalized and comforting environment, which helps minimize the likelihood of preventable health complications. In this context, preventable issues are understood as a palliative care approach aimed at enhancing the quality of life of patients and their families by preventing and alleviating suffering. This is achieved through early recognition, timely assessment, and comprehensive, holistic treatment [3]. When such issues are not addressed proactively, they can result in unnecessary suffering and increased hospital readmissions [1, 3].

In the 20th century, the concept of palliative care gained visibility, with Lydia Eloise Hall emerging as a pioneer, mentor, and advocate for nurses throughout their careers. She was a strong proponent of care for individuals with chronic illnesses and worked to engage communities in addressing public health concerns [4]. The reason to use Hall's theory is that it aligns with a humanistic, multidisciplinary approach. Secondly, there is minimal literature on applying Hall's theory to address preventable issues in palliative care.

While most existing literature focuses on specific health-related problems, few studies have comprehensively addressed multiple issues within a single framework. Therefore, this review aims to compile and discuss the most common health-related issues in palliative care [4]. Specifically, it explores avoidable problems faced by patients and families in home-based settings through the lens of Lydia Hall's Core Nursing Theory, which emphasizes patient-centred care supported by a multidisciplinary team [4]. By examining recurring challenges and discussing strategies to prevent them, healthcare professionals can improve patient outcomes and uphold the core values of palliative care in non-clinical environments.

Hall's Core Theory

This paper is structured around Lydia Hall's Core Nursing Theory—a foundational and insightful framework that offers a valuable perspective on the importance of palliative care and the need to address preventable health conditions effectively and on time in home-based settings [4]. Lydia Hall, a groundbreaking and influential nursing theorist born in 1906, made a lasting contribution to the profession by developing the Core, Care, and Cure model [5]. Though conceptualized decades ago, this model remains highly relevant in today's healthcare

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landscape, especially within holistic and patient-centred care approaches.

Hall's theory is built on three interconnected components: the "Core," the "Care," and the "Cure." The "Core" represents the patient—not merely as a clinical case, but as a unique individual with emotional, psychological, spiritual, and social dimensions. This aspect emphasizes the importance of understanding the patient's values, beliefs, experiences, and personal goals, which guide the care process [5]. The "Care" component highlights the nurturing role of nurses, underscoring the need for compassionate, empathetic, and personalized support that promotes comfort, dignity, and emotional well-being [5]. Nurses play a vital role in building trust, advocating for patient needs, and offering continuous emotional support—especially critical in palliative care, where psychological comfort is as essential as symptom management [4]. The "Cure" refers to therapeutic interventions provided by a multidisciplinary team, including physicians, pharmacists, physiotherapists, dietitians, social workers, specialized nurses, and other allied health professionals. Their collective goal is to alleviate suffering, manage symptoms, and maintain or improve the patient's quality of life [4, 5].

METHODOLOGY

To investigate preventable problems in palliative care, a comprehensive literature review was conducted using PubMed, Google Scholar, Scopus, and Cochrane databases. Reference management was handled through Mendeley. The following MeSH terms were used: "palliative care," "palliative patient," "home-based palliative care," "readmission," "causes of hospitalization," and "rehospitalization." Out of 2,446 articles initially identified, 82 were selected for review. The issues examined were derived from studies exploring the causes of hospital readmissions among patients receiving palliative care [6, 7].

Inclusion Criteria

- Publications dated between January 2019 and January 2025. The study uses the last 5 years of data to incorporate COVID-19 learning in HBPC.
- Studies involving all age groups and genders
- Articles published in English only

Exclusion Criteria

- Studies focused on drug-based or medical interventions were excluded

According to the literature, commonly reported preventable problems in palliative care include abuse, pressure sores (also referred to as pressure ulcers or bedsores), infections (including sepsis), contractures, constipation, depression, nutritional issues, and falls. The total number of records on 'abuse' among palliative care patients was 1,891, with five articles available as open access. Similarly, the reported cases were 360 for 'falls,' 65 for 'infections/sepsis,' 48 for 'depression,' 44 for 'nutrition,' 15 for 'pressure sores/pressure ulcers/bedsores,' 15 for 'contractures,' and 8 for 'constipation.' Among these, the number of full-text articles available was 17 for falls, 15 for infections/sepsis, 11 for depression, 19 for nutrition, 6 for pressure sores, 5 for contractures, and 4 for constipation. Abuse was the most frequently identified issue (1,891 records), while constipation was the least reported (8 records). All reviewed literature was drawn from both national and international sources, and the details are summarized in Table **1**.

Table 1: Summary of preventable problems in HBPC.

Problem	Total Records in Database	Full-Text Articles Available
Abuse	1,891	5
Falls	360	17
Infections / Sepsis	65	15
Depression	48	11
Nutritional Issues	44	19
Pressure Sores / Ulcers / Bedsores	15	6
Contractures	15	5
Constipation	8	4
Total	2,446	82

Note: List of preventable issues mentioned with the database record in quantitative data.

RESULTS

This study identified a range of preventable problems in palliative care across diverse populations, encompassing variations in age, gender, and nationality. The findings from the literature review are summarized below:

Abuse

Multiple forms of abuse were documented in palliative care settings, including domestic violence, psychological harm, coercive control, and financial exploitation—with financial abuse noted as particularly widespread [8]. Nearly one-third of female primary caregivers of paediatric patients reported experiencing partner violence, which included psychological, sexual, and physical abuse [9]. Elder abuse was found to affect one in six older adults globally, yet it remains significantly underreported [10]. Additionally, studies revealed that LGBTQ+ patients often encountered disrespectful treatment, inadequate care, and breaches of confidentiality within palliative care environments [11, 12]. Collectively, these findings highlight abuse as a serious and frequently overlooked issue in palliative care, underscoring the need for heightened awareness and proactive intervention by healthcare professionals [13].

Falls

Falls represent the third most frequently reported safety incident in inpatient palliative care units, posing a significant concern for healthcare providers. Approximately 10% of individuals receiving palliative care experience at least one fall during the final 30 days of life, most commonly while attempting to use the toilet [14]. Even minor falls can lead to considerable

discomfort, emotional distress, reduced mobility, and loss of confidence—ultimately compromising quality of life and independence during an already vulnerable period [15]. Contributing factors include gait instability, adverse medication effects, and unmanaged cardiovascular conditions, with falls often serving as early indicators of health deterioration [14]. Older adults are particularly at risk, especially when mobility aids are poorly fitted, inadequately maintained, or used without proper gait training [16]. Additional risk factors are frequently multifactorial, encompassing polypharmacy, age-related decline, delirium, and a history of previous falls [17].

Infections

Nosocomial infections were found to be highly prevalent in palliative care units, with reported rates reaching up to 74.3% [18]. The most frequently documented types included urinary tract infections, bloodstream infections, respiratory infections such as pneumonia, and skin or soft tissue infections [18]. Key contributing factors included prolonged hospital stays, use of invasive medical devices, and compromised immune function [19]. Additionally, frequent antibiotic use was shown to promote resistance and extend hospital admissions—an outcome that contradicts the core philosophy of palliative care, which emphasizes comfort over curative interventions. As a result, aggressive antibiotic therapy is often deemed inappropriate in many palliative scenarios [19]. Infections remained a leading cause of hospitalization, with significant variability in management practices across nursing homes, particularly regarding the misuse of antibiotics [20]. Preventive strategies such as early detection, minimizing device use, and implementing strict infection control protocols proved effective, especially for elderly and immunocompromised patients [21].

Depression

Depression and anxiety were found to be highly prevalent among patients receiving palliative care, underscoring the importance of routine psychological screening and targeted interventions to improve quality of life [22]. Vulnerable groups included newly diagnosed individuals, older adults, and those with reduced functional capacity [22]. The literature also highlighted the frequent overlap between spiritual distress, hopelessness, and clinical depression—conditions that are often difficult to differentiate [23]. Early identification facilitated timely access to psychotherapy, such as cognitive behavioral therapy, while the use of antidepressants required careful consideration due to potential adverse effects in advanced illness [24, 25]. Mental health outcomes were influenced by factors such as age, gender, sociodemographic status, and the availability of social support. Integrative approaches—such as psychotherapy, relaxation techniques, meditation, yoga, and selective pharmacological treatments—demonstrated significant benefits in alleviating psychological distress and enhancing emotional well-being [24].

Nutrition

Nutritional support in palliative care was identified as essential yet highly individualized, requiring close collaboration among healthcare providers and open communication with patients and families. Oral intake with nutritional supplements was preferred when tolerated, while tube feeding or enteral nutrition was considered when oral intake proved insufficient [26]. Parenteral nutrition was reserved as a last resort, typically when the digestive system was no longer functional [27]. Anorexia was frequently observed and often signalled advancing illness, prompting a shift in nutritional goals toward comfort and dignity rather than life prolongation. Artificial nutrition and hydration offered potential benefits in carefully selected cases, depending on clinical status, patient preferences, and family values [28]. Open dialogue within the care team was emphasized to ensure that nutritional decisions remained aligned with the core philosophy of palliative care [28].

Pressure Injuries

Pressure injuries—also referred to as bedsores, pressure sores, or pressure ulcers—were reported with a prevalence of 12.4% and an incidence of 11.7% among palliative care patients [29-31]. Key risk factors included neurological impairment, immobility, malnutrition, and anemia, particularly in elderly individuals with chronic illnesses [32]. These injuries were more common in palliative care settings than in the general population due to prolonged illness duration and multiple comorbidities [32]. Pressure ulcers were closely linked to increased morbidity and mortality, making early identification and preventive nursing care critically important [32]. Although treatment in palliative patients is often complex and resource-intensive, effective management plays a vital role in preserving comfort, dignity, and overall quality of life [32, 33].

Contractures

The permanent tightening of muscles, tendons, or skin was identified as a common yet preventable complication associated with immobility in palliative care. They contribute to reduced functional capacity, increased dependence, and a diminished quality of life [34]. In long-term care facilities, the prevalence of contractures was reported to increase annually by 0.7-3.2% in the upper limbs and 0.3-6.0% in the lower limbs during the first five years of admission [35]. Key risk factors included prolonged immobility, extended bed rest, muscle weakness, and unmanaged pain [36]. Early identification and training of care staff were emphasized as critical steps to ensure timely intervention and appropriate referral to physiotherapists. Evidence indicated that specialized palliative physiotherapy significantly improved mobility, comfort, and dignity;

however, consistent implementation remained a challenge, particularly in resource-limited settings [37].

Constipation

Constipation was frequently reported among palliative care patients and was commonly associated with immobility, low dietary fiber intake, inadequate hydration, and the use of medications—particularly opioids and anticholinergics [38]. A notable gap was observed between patient self-reports and standardized diagnostic criteria, such as the Rome IV guidelines (https://theromefoundation.org/rome-iv/rome-iv-criteria/), resulting in underreporting and misinterpretation [39]. Evidence supported the effectiveness of non-pharmacological interventions—including acupressure, abdominal aroma massage, and self-management education—in enhancing patient comfort and quality of life [40, 41]. Additionally, the use of prophylactic laxatives, guided by proper clinical assessment, was identified as a cost-effective strategy for preventing opioid-induced constipation, reducing hospital admissions, and improving overall well-being [42, 43].

Overall, the findings reveal that preventable problems in HBPC—ranging from abuse and falls to infections, depression, and nutritional deficiencies—are multifactorial and deeply interconnected. Each issue compromises patient comfort, dignity, and quality of life, yet remains addressable through timely, coordinated, and compassionate care. By recognizing these challenges through the lens of Core Nursing Theory, healthcare professionals can implement proactive strategies that uphold the values of holistic, patient-centered palliative care.

DISCUSSION

In this study, preventable health problems have been systematically categorized within the 3Cs model (**Fig. 1**), providing a structured lens for interpreting and addressing these challenges. The intersection of Core, Care, and Cure reveals a critical insight: many issues encountered in HBPC are not inevitable but can be prevented through coordinated, compassionate, and evidence-informed practice.

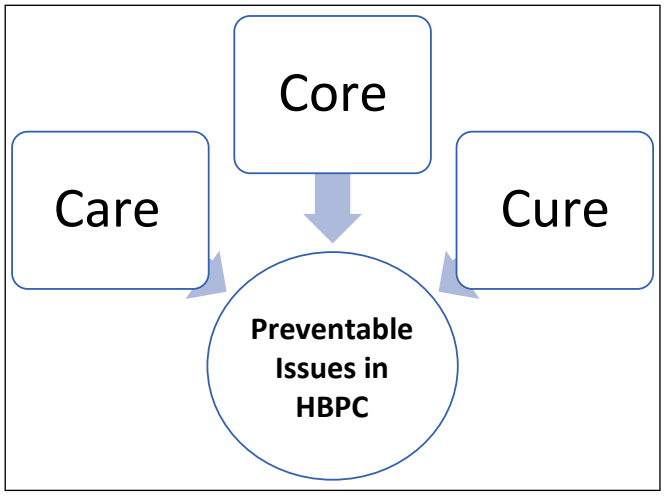

Fig. (1): 3C model.
Note: The relationship between the 3C model and preventable issues in HBPC.

Placing preventable issues at the center of the Core-Care-Cure model allows for a clearer understanding of the problems and facilitates the development of practical solutions.

Abuse The Core-Care-Cure Circle emphasizes the importance of addressing abuse as a critical component of palliative care. Abuse—defined as the mistreatment that causes physical or psychological harm—can severely undermine a patient's dignity and well-being [44]. Forms of abuse include physical, sexual, emotional, and psychological mistreatment, as well as exploitation, neglect, self-neglect, and abandonment [45]. Vulnerable populations at heightened risk include children, the elderly, individuals with chronic illnesses or disabilities, those with communication barriers, veterans, racial and ethnic minorities, LGBTQ individuals, victims of human trafficking or sexual violence, incarcerated individuals and their families, migrant workers, people with chronic mental health disorders, and those experiencing homelessness [46].

Recognizing and addressing abuse requires healthcare providers to build trust and demonstrate respect. Abuse is not only a violation of human rights but also a significant threat to the emotional and physical well-being of both patients and their families [47, 48]. Immediate interventions should focus on ensuring safety, reporting incidents, and providing emotional support [8].

Falls are events in which a person unintentionally comes to rest on the ground, floor, or another lower level. They are a significant public health concern, with an estimated 684,000 fatal falls occurring globally each year. Approximately 80% of these incidents occur in low- and middle-income countries—Southeast Asia alone accounts for nearly 60% of these fatalities. The average healthcare cost associated with fall-related injuries ranges from US$1,049 to US$3,611, while effective preventive measures could save up to US$120 million annually [49].

The Core-Care-Cure model plays a pivotal role in fall prevention by fostering collaboration among healthcare providers. Falls are hazardous for terminally ill patients, often triggered by medication side effects, muscle weakness, or improper use of assistive devices [16]. Preventive strategies should include home safety assessments, regular medication reviews, and patient education. These interventions, when coordinated by nurses and other healthcare professionals, are essential for minimizing fall-related injuries and improving patient outcomes.

Infections occur when harmful microorganisms—such as bacteria, viruses, fungi, or yeast—invade and multiply

within the body. Depending on the site of infection. While a healthy immune system can often combat infections [50], palliative care patients are particularly vulnerable due to weakened immunity and frequent exposure to invasive procedures or prolonged hospital stays [51-56]. Infections remain a leading cause of hospital readmissions among palliative patients.

Home-based care offers a lower risk of infection than institutional settings. However, maintaining proper hygiene and implementing rigorous infection control practices are essential. Nurses and other healthcare providers play a crucial role in educating patients and caregivers about hygiene practices, monitoring for signs of infection, and ensuring timely follow-up with physicians through outpatient services [51, 52].

Through the lens of Hall's model, coordinated care integrating emotional support, nursing vigilance, and medical oversight can significantly reduce infection rates in palliative care. This not only improves patient comfort and safety but also reduces the financial burden associated with hospital readmissions.

Depression is a significant concern in palliative care, profoundly affecting a patient's emotional and mental well-being. Also known as depressive disorder, it is characterized by persistent low mood, loss of interest or pleasure in activities, and a range of cognitive and physical symptoms [22]. Within the Core-Care-Cure model, the Core component emphasizes understanding the patient's emotional needs and providing compassionate support. Caregivers play a vital role in providing continuous emotional care, communication, and comfort, often through interventions such as counselling and antidepressant therapy [23]. These efforts prioritize symptom relief and aim to improve the patient's overall quality of life [24, 25]. By integrating the Core, Care, and Cure elements, this model facilitates a multidisciplinary approach that ensures depression is managed with empathy, dignity, and clinical effectiveness.

Nutrition is another critical aspect of palliative care, involving the intake of appropriate nutrients to maintain bodily function and support healing. Good nutrition not only reduces the risk of disease but also enhances mental health and physical comfort [57]. In palliative care, challenges such as anorexia, dysphagia, and altered taste perception often lead to reduced oral intake and increased risk of malnutrition [27]. Addressing these issues requires a coordinated effort from dietitians, nutritionists, physicians, pharmacists, and nurses. Together, they assess nutritional needs, monitor intake, and provide education and emotional support to both patients and families. Managing food-drug interactions and tailoring nutritional plans to individual needs are essential to maintaining strength and dignity [28]. Health education remains a cornerstone of informed care, empowering patients and families to actively participate in nutritional decisions and collaborate effectively with the healthcare team.

Pressure ulcers, also known as bedsores or decubitus ulcers, are injuries to the skin and underlying tissue caused by prolonged pressure, particularly over bony areas such as the heels, hips, and tailbone [58]. These wounds are a significant source of pain and infection and can develop within hours or days in patients with limited mobility. Preventive strategies—including regular repositioning, skin assessments, and the use of pressure-relieving surfaces—are essential components of nursing care [30]. Nurses, in collaboration with physiotherapists, wound care specialists, and other members of the multidisciplinary team, play a pivotal role in implementing these measures [31]. Their efforts not only prevent complications but also support the Core of Hall's model by preserving the patient's comfort and dignity in the home setting.

Contractures, which involve the tightening and stiffening of skin, muscles, joints, or tendons due to scarring or fibrosis, can significantly impair mobility if left untreated [59]. These complications often result from prolonged immobility and can be prevented through physiotherapy, range-of-motion exercises, and early mobility interventions tailored to the patient's condition [34]. Nurses, alongside physiotherapists, occupational therapists, and physicians, are instrumental in developing and executing these plans. A collaborative approach involving the patient, family, and healthcare team ensures that contractures are managed effectively [36]. Health education is crucial in this context, enabling families to understand the importance of mobility and actively participate in care strategies that uphold the patient's functional independence and quality of life.

Constipation is a common gastrointestinal issue in palliative care, often characterized by infrequent, painful, or difficult bowel movements. It is particularly prevalent when induced by medications and can significantly affect patient comfort [60]. Effective management requires regular monitoring, individualized laxative regimens, and non-pharmacological interventions such as abdominal massage [38, 40]. Nurses, in collaboration with physicians, pharmacists, and dietitians, play a central role in assessing and addressing constipation through a comprehensive, patient-centered approach. Complementary, evidence-based theories can be helpful. Their coordinated efforts ensure that bowel health is maintained, contributing to the overall well-being and dignity of patients receiving care at home [43].

LIMITATION

This study is limited to open-access literature and proposes solutions to preventive health issues in HBPC through the lens of Lydia Hall's Nursing Theory.

CONCLUSION

The study concludes that empowering families and healthcare teams through evidence-based practices and compassionate care can significantly improve the palliative care experience. By proactively addressing preventable issues, patients can spend their final days with greater comfort, dignity, and peace. Applying Lydia Hall's Core-Care-Cure Nursing Theory enables healthcare providers, particularly nurses, to adopt a holistic, person-centered approach that addresses these concerns with empathy and clinical precision.

RECOMMENDATIONS

- Nurses can operationalize the theory in HBPC through a family training module and an Early risk assessment, and these must be considered for inclusion in the Nursing curriculum.
- Research should also evaluate best practices in HBPC across all genders (including LGBTQ+ individuals) to promote equitable, culturally sensitive, and patient-centered approaches to all (including persons with disabilities).

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CONFLICT OF INTEREST

The author declares no conflict of interest.

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In this study, author made limited use of ChatGPT (GPT-4, OpenAI) for minor proofreading and language suggestions. Author reviewed and edited the content as needed and takes full responsibility for the manuscript content.

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