

Cultural and Structural Shifts Towards Early Palliative Care: Stakeholder Perspectives on Implementing Palliative Care Identification and Needs Assessment Tools in a Hospital Setting - A Focus Group Study from Denmark

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Abstract

Background

Early identification of palliative care needs is essential for patients with life-limiting illness to enhance their quality of life. Despite the recognised benefits of systematic identification and needs assessment tools, consistent implementation within hospital settings remains a challenge. This study aimed to explore healthcare stakeholders' perceptions of barriers and facilitators to the implementation of palliative care identification and needs assessment tools, while eliciting stakeholder-driven perspectives on potential implementation strategies within a hospital setting.

Methods

This pre-implementation qualitative study utilised a purposive sampling strategy. Four homogenous focus group interviews were conducted in November 2024 with eleven stakeholders (leaders, physicians, nurses, physio- and occupational therapists). Data were analysed abductively, drawing on Critical Realism to explore underlying generative mechanisms. Subsequently, findings were deductively mapped onto the Consolidated Framework for Implementation Research

Results

One overarching theme: *Cultural and Structural Shifts Towards Early Palliative Care*, and five sub-themes were identified: (1) *The Need for Standardisation and a Shared Language*; (2) *Unstructured Palliative Practice and Interprofessional Discrepancies*; (3) *Attitudinal Hesitation and Knowledge Gaps*; (4) *Practical and Structural Implementation Challenges*; and (5) *The Critical Role of Leadership and Vision*. Key barriers included a knowledge gap regarding general palliative care and a hesitation to discussing future care. Stakeholders suggested that implementation could be facilitated by a shift from person-dependent practices toward standardised workflows, integrating tools into electronic health records, proactive leadership, and the de-stigmatisation of palliative terminology through targeted education.

Conclusions

The findings indicate that implementation of tools could be facilitated by a coordinated, systemic shift beyond superficial compliance toward a shared interprofessional responsibility. The study highlights the potential necessity of visionary leadership to foster interdisciplinary integration and address cultural and structural changes. These insights provide a stakeholder-driven foundation for developing targeted implementation strategies in a hospital setting.

BACKGROUND

Palliative care aims to enhance the quality of life for individuals facing serious, life-limiting illnesses, focusing on symptom management and holistic support [1]. Applying a multidisciplinary approach addresses the physical, emotional, social, and spiritual needs of both patients and caregivers [1]. As populations age and the prevalence of chronic conditions like heart failure, chronic obstructive pulmonary disease, and dementia increases [2], the demand for palliative care is expanding across healthcare settings [3]. This underscores the need to integrate an early palliative approach throughout the illness trajectory [4].

Proactive and early identification of palliative care needs, facilitated by using validated identification and needs assessment tools, is essential for delivering timely care [5], and offers potential advantages, including reduced hospital admissions, decreased reliance on aggressive and futile treatments, and improved adherence to patient preferences [5, 6]. Conversely, delayed identification impedes referrals to specialised services, which can lead to adverse outcomes for patients and caregivers [7]. Therefore, the consistent use of identification and needs assessment tools within hospital-initiated general palliative care is considered vital for proactive care planning [8–10]. Despite international recommendations and the availability of validated tools, such as the Supportive and Palliative Care Indicators Tool (SPICT)[11], and Patient-Reported Outcomes (PROs) like the EORTC-QLQ-C15-PAL,[12] a significant implementation gap persists [13]. For the purpose of this study, these identification and needs assessment tools are collectively referred to as tools.

Research indicates that the systematic use of tools remains suboptimal, largely due to professional knowledge gaps and inadequate education [10, 13]. However, these barriers are frequently rooted in deeper organisational and cultural complexities [14–17]. Examining these underlying mechanisms is fundamental to ensuring equitable identification and assessment of palliative care needs, regardless of diagnosis or trajectory [18–20]. While the individual barriers to using tools are well-documented, there remains a lack of knowledge regarding how these factors interact within the unpredictable context of hospitals. The aim of this study is twofold: first, to explore stakeholders' perceptions of barriers and facilitators of the implementation of tools in a hospital setting, and second, to elicit stakeholder-driven perspectives on potential strategies to support this implementation.

The research question was: *Which barriers and facilitators do healthcare stakeholders perceive as dominant, and which potential strategies can be derived from stakeholder perspectives to support implementation of palliative care identification and needs assessment tools in a hospital setting?*

METHODS

This qualitative study represents a pre-implementation phase, forming a component of a co-created intervention and feasibility test of palliative care tool implementation strategies in a hospital. To ensure the trustworthiness of this study, we addressed the criteria outlined by Lincoln and Guba; credibility, confirmability, dependability, and transferability [21]. The reporting of this study adheres to the

Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines [22], ensuring methodological transparency.

Theoretical approach

This study was guided by Critical Realism (CR) [23], a meta-theoretical position developed by Bhaskar that distinguishes the empirical, the actual and the real, the last comprising the underlying structures and generative mechanisms that produce observable events [23]. CR maintains that this reality exists independently of our knowledge of it, while our access to it remains fallible and shaped by interpretation [23]. Because social phenomena such as implementation are produced by these mechanisms rather than surface events alone, CR was well suited our aim: it allowed us to treat stakeholders' accounts as manifestations of deeper structural and cultural mechanisms, and to ask what conditions would have to exist for the barriers and facilitators to arise [24]. This orientation directly shaped the analysis, in which retroduction was used to move from participants' descriptions toward the generative mechanisms underlying them. CR also complemented the Consolidated Framework for Implementation Research (CFIR)[25]: whereas CFIR organised the determinants of implementation, CR provided the explanatory depth to interpret why those determinants operated as they did within this hospital context.

Setting

The study was conducted at a large university hospital in Denmark with approximately 1020 beds and 6000 employees. The specific department where this study took place specialises in pulmonary and infectious diseases, providing treatment for a diverse patient population, including individuals with and without cancer. Prior to this study, the department had no established experience or formalised routines regarding the use of systematic identification and needs assessment tools in clinical practice. The study was situated within the Danish healthcare system, which is characterised by universal access and tax-based financing.

Participants and sampling

A purposive sampling strategy was employed to recruit healthcare stakeholders to the focus groups. In this study, stakeholders are defined as individuals who are directly involved in or affected by the clinical workflow of the department and whose professional engagement is critical to the successful implementation of tools. Furthermore, these stakeholders were recruited with the intent of involving them in the subsequent co-creation and development of a tailored implementation intervention. Healthcare stakeholders were identified by their respective ward managers or heads of department based on their clinical roles and experience. The first author then invited these selected individuals to participate via email. None refused to participate.

The study ultimately included four focus groups comprising a total of eleven stakeholders (seven female, four male). The participants had a median age of 42 years and a median of 18 years of professional experience. To mitigate professional hierarchies and foster a conducive environment for open dialogue, focus groups were structured homogeneously by professional affiliation (3 leaders, 3 physicians, 2 nurses, and 3 therapists, specifically physio- and occupational therapists)[26]. This approach aimed to facilitate the sharing of experiences and perspectives specific to their professional roles regarding the implementation barriers and facilitators of palliative care identification and needs assessment tools. Participant characteristics are presented in Table 1.

Table 1
Characteristics of focus groups and participants

Data collection		
Focus group	Participants, n	Duration, min
FG1	3	47.5
FG2	3	47.1
FG3	3	29.5
FG4	2	44.4
Participant characteristics (N = 11)		
Gender, male / female, n	4 / 7	
Age, years – median (range)	42 (40–63)	
Professional experience, years – median (range)	18 (5–34)	
Eleven stakeholders participated across four focus groups. Duration is reported per group; the mean group duration was 42 minutes. Age and professional experience are summarised at the participant level (n = 11).		

Data collection

Focus group interviews were conducted in a hospital office during November 2024. The specific time of day for each session was chosen by the managers of the participating professional groups to facilitate maximum attendance. The discussions were moderated by the first author using a semi-structured interview guide informed by the CFIR (see supplementary) [25]. Discussions were guided by prompts structured around key CFIR domains, to explore stakeholder perspectives on: *Innovation* (e.g., perceived advantages of tools); *Individuals* (e.g., motivation for implementation); *Inner Setting* (e.g., organisational culture, available resources, and the perceived tension for change); *Outer Setting* (e.g., external policies); and *Process* (e.g., perceptions of how implementation could be planned, executed, and supported within daily routines) [25]. While the Process domain was not a standalone heading in the interview guide, it was integrated through questions on future workflows and roles, allowing stakeholder-suggested

strategies to be interpreted within this domain during analysis. Each session commenced with open-ended questions designed to initiate discussion around current practices and perceptions of implementation of early palliative care using tools. The last author was present as an observer in all focus groups to balance participation and taking field notes. Participants had no working relationship with the researchers prior to the study and were unaware of the first author’s specific research interests. Participants were informed about the first author’s background as a nurse and a PhD-student. The focus group sessions ranged in duration from 29 to 47 minutes (mean: 42 minutes), as detailed in Table 1. All discussions were digitally recorded and transcribed verbatim by the first author.

Table 1: Characteristics of focus groups and participants.

Data analyses

Data analysis followed an abductive workflow combining inductive reflexive thematic analysis with a subsequent deductive CFIR mapping, underpinned by CR to explore underlying generative mechanisms [23, 25, 27]. Guided by the principles of Braun and Clarke, the analysis followed a recursive, six-phase approach [27]. To ensure analytical rigour and acknowledge our active role in meaning-making, investigator triangulation was employed, the first and last author independently performed initial inductive coding, systematically labelling meaningful segments based on shared semantic patterns. Through iterative discussions, these codes were clustered into broader categories. To align with CR, this phase used retroduction to look beyond surface-level descriptions, examining how specific factors and experiences functioned as potential causal mechanisms shaping the perceived barriers and facilitators to implementation. Following this inductive phase, the generated sub-themes were deductively mapped onto the five CFIR domains [25]. The resulting categories were collaboratively reviewed and refined by all authors to ensure depth, consistency, and confirmability. This process culminated in an overarching theme that conceptually linked the five sub-themes. An illustrative example of the coding process is presented in Table 2. Throughout the process, reflexivity was consistently practised to foster awareness of our pre-existing assumptions and their influence on the interpretations.

Table 2

Example of a Coding Tree. Cultural and Structural Shifts Towards Early Palliative Care, with deductive mapping onto CFIR domains

Quotes	Codes	Sub-themes	CFIR domain
<i>"It's simply about us needing to have a common language so we can communicate that a patient has palliative care needs."</i> (FG1) <i>"We need a common understanding of what palliative care is. We call it all sorts of different words."</i> (FG2)	A common language is missing	<i>The Need for Standardisation and a Shared Language</i>	Innovation; Inner Setting
<i>"How well the patients' palliative needs are met... depends heavily on the perspective that the clinician they meet has."</i> (FG2)	Practice is not uniform	<i>Unstructured Palliative Practice and Interprofessional Discrepancies</i>	Inner Setting
<i>"I think it's a professional challenge, and I believe most nurses go home with a stomach ache because of perceived overtreatment."</i> (FG4)	The emotional burden on staff		
<i>"I also believe many people experience a sense of attitudinal hesitation. We need to address that treatment has an entirely different goal. It is also crucial to align expectations timely to avoid those difficult conversations at 3 AM."</i> (FG1)	Attitudinal hesitation	<i>Attitudinal Hesitation and Knowledge Gaps</i>	Individuals
<i>"When the senior physician leaves, the junior doctor is left in charge without the experience or courage to initiate palliative care. The nursing staff are often the ones highlighting that the current approach no longer makes sense. It boils down to knowing when enough is enough, and when to respect the patient's wish to forgo further diagnostics."</i> (FG2)	Physician reluctance		
<i>"...palliative care plans are often not acted upon by general practitioners; this undermines the purpose of early identification."</i> (FG2)	Cross-sectoral fragmentation	<i>Practical and Structural Implementation Challenges</i>	Outer Setting; Inner Setting
<i>"I think that there's a lack of resources for it [implementation of tools]. It's not just money, it's also time and space."</i> (FG4) <i>"One thing is having a tool, another thing is having the time."</i> (FG3)	Resource and time constraints		
<i>"Without strong leadership engagement, implementation efforts would remain wasted and random."</i> (FG1) <i>"It's about management having to recognise that this [implementation of</i>	Leadership is essential		

Quotes	Codes	Sub-themes	CFIR domain
<i>tools] is an area that we must prioritise and train staff for.” (FG2)</i>			

Table 2: Example of a Coding Tree.

RESULTS

The analysis led to the construction of one overarching theme, *Cultural and Structural Shifts Towards Early Palliative Care*. This theme captured the necessity of transforming both individual mindsets and organisational workflows to embed early palliative care using tools in the patient disease trajectory. It was supported by five sub- themes: *The Need for Standardisation and a Shared Language*; *Unstructured Palliative Practice and Interprofessional Discrepancies*; *Attitudinal Hesitation and Knowledge Gaps*; *Practical and Structural Implementation Challenges*; and *The Critical Role of Leadership and Vision for Implementation*.

Collectively, these sub-themes clarify current structural challenges, explicit barriers, and key facilitators for future tool implementation. Table 3 presents illustrative examples of the findings, including verbatim quotes analysed as barriers, facilitators or proposed implementation strategies. While these quotes are not exhaustive, they serve to exemplify the empirical grounding of the broader sub-themes presented in the following sections.

Table 3
Illustrative quotes of barriers and facilitators categorised by CFIR domains

CFIR Domain	Barriers	Facilitators
Innovation	<i>"The tools can't be complicated, it needs to be easy for staff to understand and use, otherwise it won't succeed." (Nurse)</i>	<i>"The use of tools needs to be structured, like a guideline or a standard for when to consider palliative needs. We need a screening modality to identify eligible patients and ensure it's done for everyone." (Physician)</i>
Outer Setting	<i>"The process within the municipality has become so complex that we cannot make an immediate referral. All such actions must now be meticulously planned." (Nurse)</i>	<i>"A political mandate to prioritise a specific goal is beneficial, as it ensures that the necessary resources are allocated." (Therapist)</i>
Inner Setting	<i>"We tend to prioritise blood tests over conversation and curative treatment over a shift to palliative care. I question how we are going to change this mindset." (Physician)</i>	<i>"I believe our profession is currently making this transition [to early identification of palliative care needs]." (Nurse)</i>
	<i>"I frequently experience pressure from the nursing staff, who state that it is unethical to proceed with treatment. However, I find myself unable to make a decision." (Physician)</i>	<i>"I hope the tools can help establish a common language to facilitate this shift in care earlier." (Leader)</i>
Individuals	<i>"I did not receive any training on palliative care during my education, which is completely absurd." (Physician)</i>	<i>"Sending patients a PRO form could normalise the discussion. The topic would be seen as a routine part of care." (Physician)</i>
	<i>"A primary barrier is that physicians must first become comfortable with informing a patient that they may die. The term palliative itself is also a significant barrier." (Leader)</i>	<i>"A tool can help us to initiate palliative care conversations... shifting the focus from a retrospective view... to a proactive effort." (Nurse)</i>
Process	<i>"We are currently lacking a key driver for the implementation of tools [while the specialist nurse is on maternity leave]." (Leader)</i>	<i>"I believe the most effective approach is the use of mandatory fields within the electronic patient record. This forces us to take a position." (Physician)</i>

Table 3: Illustrative quotes of barriers and facilitators categorised by CFIR domains.

The Need for Standardisation and a Shared Language

Within the CFIR-domain of *Innovation*, a pronounced demand for a structured, uniform approach to identify patients with palliative care needs emerged as a facilitator for implementation, driven by the limitation of current fragmented practices. Stakeholders with a nursing background were the only group aware of any existing tools (SPICT and EORTC-QLQ-C15-PAL), though they reported no practical

experience in their application. Nurses highlighted that in the absence of established clinical standards, implementing standardised tools would function as a tangible structural way to reduce the person-dependence characterising current practice. Physicians emphasised the clinical necessity for systematic patient identification, advocating for tools characterised by simplicity and clear, actionable guidance. They envisioned a workflow where nursing staff performed the initial identification and proactively notified the physician, thereby ensuring timely clinical intervention. All focus groups viewed standardisation as a crucial facilitator to improve early identification, providing a degree of prognostic safety against retrospective criticism of care decisions. Furthermore, all stakeholders acknowledged that the lack of a shared interdisciplinary language currently generated workplace conflicts, that standardised use of tools was anticipated to mitigate.

Unstructured Palliative Practice and Interprofessional Discrepancies

Examining the CFIR *Inner Setting* domain, stakeholders described current palliative practices as being shaped by an ad-hoc, person-dependent logic, reflecting an underlying absence of formalised routines within daily clinical workflows, a foundational institutional barrier to the implementation of tools. The lack of a uniform approach to identify patients with palliative care needs created communication barriers between nurses and physicians, routinely resulting in conflicting clinical assessments. These discrepancies functioned as a causal mechanism for a negative clinical climate and moral distress. For instance, nurses experienced emotional and physical strain due to the perceived overtreatment of patients. Across all stakeholder groups, participants highlighted operational barriers such as severe time pressure, high-stress shifts, and rapid turnover among junior medical staff, which collectively reinforced a fragmented practice to discussing prognosis and future treatment early in the disease trajectory. Therapists felt marginalised within this fragmented structure, noting that despite their expertise regarding activities of daily living and quality-of-life, they were often excluded from daily decision-making due to structural barriers requiring a formal medical referral. Consequently, the quality of palliative care currently relied heavily on individual initiative rather than sustained organisational systems.

Attitudinal Hesitation and Knowledge Gaps

In relation to the CFIR-domain of *Individuals*, a primary barrier to tool implementation was the foundational knowledge gap regarding general palliative care. Stakeholders reported that their initial professional training had not adequately prepared them for the complexities of early palliative care, leaving some without the professional self-efficacy required to initiate future care conversations. This educational deficit directly shaped attitudes; some physicians, particularly senior consultants, maintained a narrow interpretation of palliative care as strictly synonymous with terminal care and end-of-life care. Consequently, the very terminology of palliative care functioned as a barrier. This conceptual limitation operated as a core source of resistance to using identification tools early in the disease trajectory, with some physicians preferring to “let fate decide.” To mitigate interpersonal discomfort, a physician suggested using PROs as a psychological buffer, allowing patients to report symptoms from

home. While junior consultants and nurses generally held a broader clinical view of palliative care, they also experienced a shared reluctance and emotional toll when initiating future care conversations, particularly with younger patients. Despite these challenges, junior consultants expressed a strong desire to prioritise early palliative care. Stakeholders argued that the successful use of tools required moving beyond superficial box-ticking compliance toward a fundamental shift in individual attitudes and clinical culture.

Practical and Structural Implementation Challenges

Looking at the *Outer Setting* in CFIR, a significant structural barrier highlighted in the focus group discussions was the systemic void between the hospital and primary sectors. Stakeholders described the primary care sector as inadequately structured to support patients identified with palliative care needs post-discharge. A central barrier noted was the lack of integrated electronic documentation systems; palliative care plans generated in the hospital were often neither visible nor acted upon by general practitioners, undermining the clinical purpose of early identification. Physicians argued that identifying needs within the hospital felt futile if no sustained external support, such as outpatient palliative care teams or sub-acute ambulatory clinics, existed in the wider healthcare system. Finally, stakeholders emphasised that actual cross-sector collaboration was needed in practice as a key facilitator to secure the long-term resources required for sustainable tool implementation.

The Critical Role of Leadership and Vision

Finally, regarding the CFIR *Process* domain, stakeholders affirmed the vital importance of translating leadership vision into concrete initiatives led by a dedicated project driver. Physicians and nurses stressed that without active leadership engagement, implementation efforts would remain isolated and random, identifying leadership buy-in as a critical facilitator. One nurse leader specifically stated that this driving role relied on a specialist nurse, while physician leaders emphasised the need for senior consultants to act as key drivers in educating and mentoring junior staff. To structurally support this process, stakeholders suggested that integrating the tools into the electronic health record (EHR) was a critical strategy. Specifically, some physicians proposed that the use of reminder prompts and mandatory hard stops within the EHR would be an effective mechanism to enforce compliance and ensure that the new workflows become embedded in the daily routine. While leaders viewed their own role as primarily structural, centred on resource allocation and process stabilisation, therapists emphasised that leadership must actively foster interdisciplinary integration to cultivate collaboration. Collectively, participants called for a fundamental paradigm shift, moving the implementation of tools away from managing death toward a proactive quality-of-life framework that honours patient and caregiver preferences.

DISCUSSION

This study investigated healthcare stakeholders' perspectives on existing clinical practices to identify the barriers and facilitators, as well as stakeholder-suggested strategies, impacting the forthcoming

implementation of early palliative care using tools in hospitals. The findings demonstrate a profound tension between the current state of unstructured, person-dependent practice and a shared professional aspiration for a standardised, proactive palliative care approach using tools. By moving beyond a descriptive categorisation of these challenges, this discussion synthesises how individual attitudes, institutional structures, and systemic voids operated as interconnected mechanisms, while outlining the potential implementation strategies identified from stakeholders' perspectives to navigate these dynamics.

When examining the individual-level determinants of this implementation landscape, a dominant barrier to future implementation was the deep-seated attitudinal hesitation and foundational knowledge gap regarding general palliative care. This professional reluctance, captured in the sub-theme *Attitudinal Hesitation and Knowledge Gaps*, was frequently rooted in a narrow interpretation among certain stakeholders, particularly senior consultants, who viewed palliative care as strictly synonymous with terminal, end-of-life care. This conceptual limitation led to a defensive preference for “*letting fate decide*,” a finding consistent with Sommerbakk et al., who identified perceived philosophical barriers as key impediments to quality improvement in palliative practices [28].

To mitigate these individual-level determinants, stakeholders highlighted the need for an educational approach, emphasising that successful implementation required targeted training that actively reframes palliative care as a parallel care model rather than an alternative to curative treatment [29]. Interestingly, this highlights a central paradox within the implementation process regarding whether a clinical culture must be transformed before a tool can be introduced, or whether the tool itself can act as the initial mechanism to disrupt practice. The pronounced desire for a structured and uniform approach, exemplified by the sub-theme *The Need for Standardisation and a Shared Language*, suggested that stakeholders do see immediate utility in structural support. This is consistent with Crespo et al., who noted that clinicians value instruments that facilitate comprehensive assessments without disrupting clinical flow [30]. The tool should not be understood merely as a rigid bureaucratic requirement, but as a supportive clinical anchor that has the potential to gradually alter underlying cultural practices by providing a new, shared structure for interprofessional action.

Shifting the focus from individual attitudes to the wider clinical environment, the lack of a uniform institutional approach functioned as a generative mechanism for profound interprofessional discrepancies and operational strain. This internal complexity, manifested through *Unstructured Palliative Practice and Interprofessional Discrepancies*, echoes the recent work of Bergholtz et al., who identified interdisciplinary complexities as central challenges when strengthening general palliative care in hospital settings [31]. Nurses in the present study experienced severe emotional and physical strain due to the perceived overtreatment of patients. As found by VanderWeele et al., if such strains become persistent, they can transition into moral distress or even moral injury, characterised by profound guilt and a loss of trust in the organisational system [32]. This crucial link underscores that the forthcoming implementation of tools is not merely a technical task to improve workflow efficiency, but a potentially

vital structural facilitator to improve the professional work environment and clinician well-being by providing frontline staff with a formal framework to guide care trajectories.

To structurally enforce compliance and ensure uniformity across high-pressure shifts, stakeholders proposed a technical implementation strategy of integrating the identification tools directly into the EHR through automated reminder prompts and mandatory hard stops. While stakeholders viewed these technical constraints as necessary drivers to overcome daily operational drift, existing literature warns that the practical viability of this strategy must be carefully weighed against the risk of alert fatigue [33]. As demonstrated by Ernecoff et al., excessive digital prompts can lead to workflow disruption and contribute to clinician burnout rather than supporting high-quality care [33]. This reinforces the notion that technical fixes alone cannot substitute for a shared clinical vision, structural enforcement through the EHR must be balanced with relational support to ensure tools do not degenerate into superficial box-ticking.

This need for a shared vision becomes even more critical when looking beyond the hospital walls, where a significant structural barrier highlighted by participants was the cross-sectoral disconnect between the secondary and primary sectors, which created a sense of futility among hospital physicians. Stakeholders highlighted that identifying early palliative needs within the hospital felt pointless if the wider healthcare system lacked the infrastructure, such as outpatient palliative teams and intermediate care facilities, to act upon those plans post-discharge. This systemic void is consistent with Sørensen et al., who highlighted the lack of clear cross-sectoral care plans in the Danish context [34]. This systemic fragility points toward a deeper structural issue regarding the tendency for palliative care initiatives to be driven almost entirely by an isolated clinical champion or project driver. It is remarkable that palliative care implementation so frequently relies on the momentum of a single individual, suggesting that the underlying institutional system itself is fundamentally unprepared to absorb these tasks into routine care [35, 36]. Relying on a solitary agent severely threatens long-term sustainability, as supported by Pettersen et al., who concluded that appointing a champion as a solo agent is often unsuitable, instead, organisations should utilise multiple champions with clear mandates and dedicated time [37].

To bridge this cross-sectoral void, stakeholders proposed for formal collaborative protocols to ensure that patient documentation is not merely transmitted, but actively processed and acted upon across sectors. Successful models, such as the INTEGRATE Project [38], demonstrate that implementation is entirely contingent on embedding models into existing workflows and leveraging external partnerships. This necessity for a collective, integrated effort aligns with the subtheme *The Critical Role of Leadership and Vision*, as well as the work of Albers et al., who describe implementation support as a relational task [39]. It is argued that implementation support practitioners facilitate change by instilling trust and spanning boundaries between stakeholders, thereby creating a sense of safety that allows staff to experiment [39]. In this study, such relational insights can be applied to leadership practices, by moving the implementation of tools away from managing death toward a proactive quality of life paradigm, leadership can foster interdisciplinary integration and create a sense of psychological safety. Ultimately, the findings suggest that while tools can be implemented despite existing challenges, ensuring long

term sustainability may require the establishment of formal collaborative structures that support healthcare professionals both within and beyond the hospital.

Strengths and Limitations

A primary strength of this study is the application of CR and CFIR, which ensured a structured exploration of both surface-level barriers and underlying causal mechanisms. Grouping participants by professional affiliation helped mitigate hierarchical power dynamics, facilitating more candid reflections. Furthermore, to enhance the trustworthiness and validity of the findings, all participants were given the opportunity to review and comment on the preliminary results, ensuring that the analysis accurately reflected their perspectives. While the inclusion of eleven healthcare professionals from one department constitutes a relatively specific group, the data provided high information power to robustly address the research question. Rather than aiming for traditional data saturation, sample sufficiency was achieved through the deliberate inclusion of key stakeholders with vast and diverse clinical expertise, combined with the depth of the abductive analysis. Finally, the recruitment strategy relied on ward managers identifying key stakeholders. While this approach is a methodological strength that secured highly experienced healthcare professionals crucial for the subsequent co-creation and sustainability of the implementation, it introduces a specific nuance, the perspectives of less experienced staff or those less visible to leadership may not be fully represented in these findings.

Conclusion

The findings from this pre-implementation study suggest that integrating palliative care identification and needs assessment tools into hospital settings requires a coordinated and systemic approach. The analysis points to several stakeholder-suggested strategies, including enhancing professional self-efficacy, establishing formal interprofessional workflows, and integrating the tools into electronic health records. Our study indicates that successful implementation may depend on moving beyond administrative box-ticking toward reframing general palliative care as a proactive, parallel care model rather than a terminal intervention. Importantly, the perspectives of these clinical stakeholders highlight the role of leadership in fostering interdisciplinary integration and supporting the necessary cultural and structural changes. These insights provide a stakeholder-driven foundation for developing tailored implementation strategies within hospital settings.

Clinical Implications

To support the implementation of palliative care identification and needs assessment tools in hospital settings, the following actions should be considered:

- Establish systematic procedures for early identification and needs assessment to reduce reliance on individual clinicians' initiatives or interests.

- Develop shared workflows that actively involve all relevant healthcare disciplines, ensuring that diverse professional insights are utilised in clinical decision-making.
- Introduce educational initiatives that reframe general palliative care as a proactive approach rather than terminal care, thereby addressing attitudinal hesitation and de-stigmatising the terminology.
- Engage clinical leadership and dedicated project drivers to secure the necessary organisational support and foster a collaborative, interdisciplinary culture.

Declarations

Ethics approval and consent to participate

This study adhered to the ethical principles outlined in the Declaration of Helsinki. In accordance with national research regulations in Denmark, formal ethics committee approval was not required for this qualitative study. The study was approved by the regional data protection authority (Region Sjælland, Forskningsfortegnelsen: REG-128-2023, EMN-2023-09955). Written informed consent was obtained from all participants prior to their involvement. Participants were fully informed about the study's purpose, their right to withdraw at any point without consequence, and the measures taken to ensure data confidentiality. Additionally, approval for the study's conduct was obtained from the hospital management.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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Author Contribution

TR was responsible for data collection, initial analysis, and drafting the manuscript. HMB, CLE, and VØS contributed to the study design, iterative analysis, and interpretation of findings. All authors contributed to the critical revision of the manuscript and read and approved the final version.

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Data Availability

The datasets are available from the corresponding author on reasonable request

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