

Hospice nurse reflections on a palliative care educational intervention in long-term care: An inductive content analysis

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Abstract

Abstract Background: Older people in long-term care facilities are at a greater risk of receiving care at the end of life that does not adequately meet their needs, yet staff in long-term care are often unprepared to provide palliative care. The objective of the study was to explore hospice nurse experiences regarding the barriers and facilitators to the implementation of a palliative care educational intervention, Supportive Hospice Aged Residential Exchange (SHARE) in 20 long-term care facilities. **Methods:** Reflective logs (465), recorded over the course of the yearlong SHARE intervention by the three hospice nurses, who were the on-site mentors, were qualitatively analyzed by two researchers utilizing inductive content analysis. **Results:** Categories emerging from the logs include the importance of relationships, knowledge exchange, communication, and the challenges of providing palliative care in a long-term care setting. **Conclusion:** Evidence from the logs indicated that sustained relationships between hospice nurses and staff as well as reciprocal learning were key factors supporting the implementation of this palliative care educational intervention. Challenges remain however in relation to staffing levels, which further emphasizes the importance of hospice presence as a point of stability.

Background

As one of the most disadvantaged and vulnerable groups in industrial societies (Armstrong et al., 2012), older people in long-term care facilities are at a greater risk of receiving care at the end of life that does not adequately meet their needs.(1) In New Zealand, the Health Needs Assessment for Palliative Care conducted under the auspices of the Palliative Care Council concluded that almost all long-term care facility residents would require palliative care at the end of their life.(2) Furthermore, 50% would benefit from specialist palliative care advice and support, while the other 47% could be managed by the long-term care facility, given the capabilities and resources to provide a generalist level of palliative care.(3)

Research has indicated that staff in long-term care facilities are often unprepared to provide palliative care.(4) For example, they feel ill-equipped to undertake Advance Care Planning (ACP)(5), a process of discussion and shared planning for future health care that assists the individual to identify their personal beliefs and values and incorporate them into plans for their future health care (Ministry of Health).(6) There is also evidence that long-term care facility staff feel inadequately supported in coping with multiple bereavement experiences.(7) Addressing the palliative care skills deficit of long-term care facility staff is therefore of critical importance to delivering quality healthcare in this setting .(3, 8, 9)

However, a major challenge continues to be the translation of educational interventions to the reality of the long-term care environment.(10) The negative impact of burnout on education uptake and the lack of consideration of organisational factors (e.g. low staffing levels, time pressures), may present obstacles to sustainable change.(11, 12) Furthermore, conflicts may arise between hospice and long-term care facility staff hindering the delivery of quality care.(13) The provision of complex, quality health care requires effective relationships among multidisciplinary team members, as well as the ability to learn together and adapt to change.(14-17)

Education initiatives developed to date have focused on short training programs concentrating on the traditional “chalk and talk” format.(18, 19) However, there is minimal evidence that staff knowledge gained from this format is sustained in the long term.(10) Adults learn best from direct experience.(20) As quoted from Confucius “Tell me, and I will forget. Show me, and I may remember. Involve me, and I will understand.” It is within this context that the need for a new model of education delivery has been identified that supports “hands-on” learning which is a vital component of the sustained transfer of new knowledge into practice.(21)

The Supportive Hospice Aged Residential Exchange (SHARE) intervention provides a means to package and systematically support knowledge exchange between hospice staff and long-term care facility clinical care staff on-site at the facility, with the goal of improving palliative care delivery.(22) The SHARE model is supported by research evidence indicating that that clinical coaching, role modelling and debriefing provided by specialist palliative care nurses can achieve sustained knowledge transfer.(23-25) SHARE implementation involved the identification of residents who would benefit from a palliative approach through a review process conducted by a hospice nurse in conjunction with a facility nurse.(22) The purpose of the review is to provide the basis for ongoing monitoring of resident palliative care need and to create a “Goals of Care” plan for those on the registry. The review process is outlined in Figure 1.

[Insert Figure 1 here]

SHARE was implemented and evaluated in 20 long-term care facilities for one year in two district health boards. The goal of the larger evaluation was to determine if the intervention was contextually appropriate and sustainable. This study explores the hospice nurses’ views and experiences regarding the barriers and facilitators to the implementation of SHARE in long-term care facilities.

Methods

The objective of the study was to explore hospice nurses’ views and experiences regarding the barriers and facilitators to the implementation of a palliative care educational intervention (SHARE) in long-term care facilities. The study forms part of a larger yearlong mixed methods evaluation of SHARE in 20 long-term care facilities.

Participants

All of the hospice nurse specialists were female and between 40 and 55 years of age. Two hospice nurse specialists had between six to ten years of experience in age care while the third had over eleven years of experience. Given the small number of contributors, identifiers for quotes have been omitted to maintain the confidentiality of both the hospice nurses and the facilities.

Process

The extensive reflective logs, recorded over the course of the yearlong SHARE intervention by the three hospice nurses, who were the on-site mentors, were qualitatively analyzed. The hospice nurses were asked to keep a weekly journal for each of the 20 facilities. The journals included sections on resident care as well as a section for reflective comments about their perceptions of how the intervention protocol supported the goal of improving palliative care knowledge among staff in long-term care facilities. This report focusses on the reflective section. Four hundred sixty-five reports (average of 23/facility) were submitted by the hospice nurses over the one year of SHARE implementation. All data collection took place between September 2017 and November 2018. The start of SHARE in facilities was staggered across the period. Significant information can be derived from written journals that the author may have difficulty in recalling later.(26)

Analysis

All logs were imported into QSR NVivo 12 for analysis. The process of inductive content analysis was utilized.(27) The researchers (RF, DB) read all logs several times. Open coding headings were used to describe all aspects of the content. Headings were listed on a coding sheet and categories were created. Following open coding, the categories were grouped together into higher order headings by combining categories with similar content. Higher order headings were refined as the analysis process progressed through in-depth discussions between DB and RF. The names of the categories were selected based on their ability to represent the overall sense of the logs. Sub categories were identified through the process of abstraction.

Results

Four categories were isolated. These categories included connections, knowledge exchange, communication, and challenges. Categories and subcategories are portrayed in Figure 2.

[Insert Figure 2 here]

Relationships

A common topic from all the logs was the building of relationships – of facility staff with residents, and with families, connections among facility staff, and for hospice nurses, the importance of building a strong connection with the facility staff in order to build trust.

Relationships between hospice nurses and long-term care facility staff- The establishment of relationships between the hospice nurses and long-term care facility staff, helped develop a sense of both trust and understanding of the role and scope of hospice in the care of residents. Having a dedicated hospice nurse visiting regularly allowed the staff to build a key relationship, and encouraged them to share the gaps in their knowledge as well as to ask for support in working with families.

SHARE helped the long-term care facility team and myself developing a better rapport. Particularly my relationship with care staff, they would share with me about their wedding anniversaries and family's struggles. I sensed that there was added meaning to their work somehow.

I always say "hello [staff member name]" and have contributed no more than a couple of sentences. However, calling his name to acknowledge him in my regular visit is significant apparently1...But this taught me how important I [SHARE nurse] had become a 'Regular' in the facility.

Relationships with residents and families - The following quote highlights the need for the reinforcement and support provided by the hospice nurses as illustrated by this example of the isolation within which facility nurses often work.

Long-term care facility nurse was working in such a lonely environment. I could see the joy in the eyes of RN's [registered nurses] [name] and [name] when I listened to them. When I gave RN [name] my honest praise about her kindness and compassionate care to her elderly resident, she actually had tears. She was very humbled and said, "I was doing my job. I thought I was doing what everyone does!" Such beautiful and caring nurses!

The hospice nurses also encouraged the adoption by managers of a variety of new methods to improve interactions with both residents and families. The methods ranged from greater involvement of volunteers to liaising with the local library to provide talking book resources.

We [hospice nurses] talked about involving the volunteers at the facility with some of the dementia residents. Discussed using memory boxes, downloading music that they may enjoy, contacting the local library to get some talking books or discuss with family and look at downloading short podcast series on items of interest. Encouraged her [facility manager] to explore different options for some of her residents with sundowners and to talk with families about what resources they may have at home that could be beneficial.

Relationships between staff and managers – Support for SHARE on the part of managers fostered close and ongoing relationships between staff members. The support and respect of the manager for staff, in turn, facilitated greater collaboration with the hospice nurse:

One [health care assistant] in particular whom I found to be very prickly when I first started visiting [facility] and how her demeanor had changed over the last 12 months. When I walked in today, I could hear her laughing and joking with the staff and she even came up and gave me a hug. I put that down to the way that [manager] has been managing and supporting the staff and the improvements she has made within the facility.

Relationships among staff members - Opportunities for staff participation in activities encouraged socialization between staff members and between staff and residents. These activities provided a mutual feeling of "family" that fostered the development of collaborative relationships, a key prerequisite for SHARE success.

It was clear which facility did want to involve residents 'family.' When Nurse Manager A announced Christmas decoration competition in individual Suites I could hear that the focus was about the dignity for residents...Looking at the staff involvement in their own party and the trolley filled with Secret Santa, I felt this place was full of love...If staff were not happy, they wouldn't bother to participate in Secret Santa or Share lunch.

Knowledge Exchange

Reciprocal learning -The sharing of knowledge and skills between the hospice nurses and the long-term care facility staff and growth in hospice nurses understanding of geriatric care was evident in the logs. The hospice nurses' perspectives on care in long-term care facilities revealed new understandings of geriatric care and the palliative care trajectory of chronic illness with all of its uncertainty.

The learning from SHARE discussions with [name] [RN] has been most beneficial to inform my knowledge to a broader level of the "strength of the human spirit to survive when the body and mind are dying" especially with reference to those who have dementia and advanced frailty.

Situated contributions -There is considerable evidence of situated interventions by the hospice nurse where the hospice nurses' deliberate presence in the long-term care facility created plentiful moments where discussion, learning, teaching, and changes in practice have been documented.

It was quite rewarding to see RN [name] come up with the resident for Palliative Care Register. This RN team worked quietly and never showed any excitement on the SHARE visit. Thus, when they voluntarily gave me a name "[Hospice Nurse], I think this resident was ready for palliative care approach..."I was quietly joyful. Without SHARE, this facility had not been offered palliative care education in the past and (a hospice) community team had not been in touch for at least two years.

Other insights for the hospice nurse indicated areas for further education. This was particularly true in regards to maintaining ongoing communication with families about changes in their relative's condition and care needs.

I was surprised that the predominance of residents reviewed was by default as "For Resus" [resuscitation]...RN/facility under the impression of the resident is unable to cognitively decide rendered them as 'resuscitatable' rather than working with family as part of ACP [advance care planning] process.

Communication

Quality - Confidence in communication skills as well as the quality of communication between staff and residents and staff and families improved in some facilities. One hospice nurse reflected on both the improved palliative care knowledge and communication skills of a nurse:

The long-term care facility team had been very caring for him [resident] and kept close communication with him [resident] and his son. RN [name] was able to share with me that resident [name] and his son discussed funeral arrangement on the last 48 hours. She felt particularly proud of able to recognise dying and facilitate communication amongst resident and his son.

Early palliative care need identification -The logs also provided evidence of better documentation of residents with palliative care needs. Better identification allows for proactive care planning before the terminal stage.

When I was preparing for the resident's information for a research report, I realised that all recent deceased residents were enrolled onto Palliative Care Register.

Barriers - Communication problems persisted in some facilities particularly in relation to future care documentation. The hospices nurses in the SHARE study documented practices that they found troubling concerning palliative care and especially unnecessary hospital admission.

A new nurse was on duty and there were no clear easy to access guidelines in residents notes about her future plan of care. Therefore, by default, she went to the hospital where she spent 24 hours, was commenced on oral antibiotics and then returned to the facility.

Challenges of providing palliative care in a long term care setting

Key themes reflected throughout the logs included the detrimental effects of resource constraints and increasing staff turnovers. These factors not only influence palliative care education and delivery but also staff well-being.

Staff turnover, & under-resourcing -The level of reference to staff turnover, insufficient staffing & staff changes (especially RNs coming in from overseas who use the long-term care sector to bridge into work in district health boards) is troubling. This, in turn, led to very challenging circumstances in which to provide staff education in a traditional classroom sense, making the physical presence of the hospice nurses even more significant in sharing knowledge and practice between the long-term care facilities and the hospice nurses.

Lead clinical nurse in the Dementia Unit has left. Find this unfortunate as she appeared to us to be very knowledgeable in the care of those with dementia. They do not have someone to replace her as yet.

The continuing staff shortages serve as a further indicator of the need for an alternative to traditional didactic methods of teaching. Staff shortages translate into a lack of staff available to attend sessions, as indicated in the following reflection:

Even CCM [clinical charge nurse manager] A could honestly share that she was constantly orientating a new group of nurses. They were not in any shape to take on [education] training at all.

Discussion

A number of factors supported the educational intervention, Supportive Hospice Aged Residential Exchange (SHARE) as perceived by the three hospice nurses. In the first instance, the relationship that the hospice nurses forged with facility staff appeared to have a huge bearing on the success of the uptake of the learning. Developing a connection and acceptance of the hospice nurse by staff was key – i.e. that the hospice nurse needed this relationship to be developed in order to feel her role was effective. Indeed, previous research has indicated a relationship between improved student outcomes and the development of a trusting teacher-student relationship.(28) Having a dedicated hospice nurse visiting on-site regularly allowed the staff to build a key relationship, encouraging them to share the gaps in their knowledge, as well as to ask for support in working with families. Comments on the personal support that the hospice nurse gave indicate that along with providing specialist palliative care knowledge, they became a source of comfort for many stressed registered nurses. Trust has also been associated with increased sharing and collaboration.(29) In fact, trust and collaboration reinforce each other.(29) Ongoing contact between the parties (in this instance, hospice nurses and staff), creates the opportunity to increased trust, leading to enhanced motivation to learn.(30) This increased motivation, in turn, supports a willingness for continued collaboration. In other words, with ongoing contact, the hospice nurse gained acceptance within the facilities and was in turn welcomed as part of the “staff family”. The development of a trusting relationship where nurses felt “safe” to ask for help with caring for residents with palliative care needs was a key component of the SHARE model. Relationships among staff members were also key to hospice nurse perceptions of improved resident and family care. Previous research has indicated that the quality of the relationships and communication among staff members is a key predictor of health care quality.(31)

Drawing on Lave and Wenger (32), learning within long-term care facilities is a situated and collaborative activity, a process of participation in “communities of practice.” Learning is context-bound, shaped by the sociocultural practices of the organization. Indeed, research indicates that setting, activities, and artifacts also play a key role in learning, particularly in tasks that require higher-order knowledge.(33) According to Billet (33) “the adaptability of the knowledge that has been learned is premised upon its discernible applicability to particular situations” (p. 389). Findings also point to evidence of reciprocal learning with hospice nurses gaining new knowledge and understanding during the interactions with residential care staff. Previous research has indicated that mentoring is linked to personal and professional development for mentors.(34) Hospice nurse mentors appeared to have expanded their views to include a deeper understanding of long-term care staff member perspectives.(35) In essence, the hospice nurse and the nurses in the long-term care facilities developed a peer learning partnership – a reciprocal learning relationship between parties of equal status who share a common goal.(36) Findings indicated that staff interactions as part of the SHARE role increased the hospice nurses respect for the care provided by the facility staff as well as their own knowledge and skill to care for frail older people. The partnership thus

facilitated knowledge exchange between the hospice nurses and clinical care staff with the goal of improving palliative care delivery within the long-term care facilities. This, in turn, helped to establish a trusting relationship built on mutual respect.(37)

Evidence from the hospice logs indicated both a recognition of improved communication about changes in resident condition with family members. Excellent palliative care occurs when interdisciplinary team members communicate effectively and collaborate on care plans.(38) Therefore, it is necessary for all health care providers (including health care assistants) to become more effective at interpersonal communication and collaborative skills.(39) Mentoring by the hospice nurses appears to have enhanced interpersonal communication skills for residential care staff. Barriers to communication persisted, however, particularly in relation to the identification and documentation of residents who would benefit from a palliative approach to care. There is a significant relationship between advance care plans and quality of dying (40) as well as a relationship between the care received at end of life and patient preferences.(41) As in previous research, lack of willingness to document palliative care need may stem from prior uneasiness with discussing Advance Care Plan related issues with residents or families.(42)

The level of reference to staff turnover, insufficient staffing, and staff changes was highlighted by hospice nurses. This led to very challenging circumstances in which to provide staff education in a traditional didactic format.(18, 19) Low staffing levels and the associated time pressures create barriers to the uptake and application of new knowledge.(43) Previous research has indicated a staff preference for interactive, hands-on applied learning (44) making the physical presence of the hospice nurses even more significant in sharing knowledge and practice. Furthermore, traditional training and education methods in palliative and end of life care have previously required nurses to leave the clinical environment to attend study days and training sessions (45) creating more staffing pressures for long-term care facilities. In contrast, SHARE does not pull staff away from the bedside and therefore does not require “more time” to attend teaching sessions. Hospice nurses work alongside care staff supporting and coaching as they work and may, in fact, support care staff to provide better care.

Recommendations

In the first instance, findings indicated that one-off education is not sufficient to promote sustained learning. Long-term care facility staff benefit most from hospice nurses being present and demonstrating a willingness to exchange ideas. The frequency of the visits is vital to the long-term success of the intervention.(46) It was also very noticeable in the log accounts how often the hospice nurses were working with newly employed registered nurses – nurturing new relationships, sometimes every week. Dealing with high staff turnover in long-term care will require hospice nurses to constantly invest in developing new connections with nursing staff, which are based on mutual respect of the knowledge, and skills each person brings to the relationship.(47) The creation of genuine connections, even in brief encounters, can result in greater trust and opportunities for teamwork to develop.(47) Finally, given the turnover in the workforce, findings from this study highlight the need for a palliative care orientation

package for new residential care staff, which can be used as a supportive tool alongside the mentoring, coaching and reciprocal learning, principles which underpin SHARE. The package, while providing information on palliative care delivery, will supply crucial links for new staff to the SHARE staff nurse and hospice nurse contacts (representing palliative care knowledge integration into practice).

Strengths and Limitations

The findings and consequent discussion are based solely on the perceptions and observations of the hospice nurses. The views and opinions of others involved in the evaluation, such as the long-term care facility nurses, managers, and residents, have not been included. However, because the logs were maintained over the course of a year, emerging patterns were revealed which may not have been observable with other methods. Furthermore, both contextual and recall biases were significantly reduced as logs were created as events unfolded.(48)

Conclusion

The overall impression of the hospice nurses was that SHARE has improved communication between staff and residents and staff and families and alerted registered nurses to be vigilant in assessing the palliative care needs of their residents on a regular basis. Furthermore, evidence from the logs indicated that the more hospice nurses interacted with long-term care facility staff, the better the knowledge base for the hospice nurse and the residential care staff. Challenges remain however in relation to staffing levels and support the need for innovative education initiatives that do not demand additional staff time. Engaging with nurses at the bedside using SHARE principles along with supportive palliative care educational resources for staff needs further development.

Declarations

Ethics approval and consent to participate

Ethical approval for this component of the larger evaluation was obtained from the University of Auckland Human Participants Ethics Committee (ref. 020075). Written informed consent was obtained from all participants.

Consent to publish

Not applicable

Availability of data and materials

The dataset used and/or analysed during the current study are available from the corresponding author on reasonable request in a de-identified form.

Competing Interests

None declared.

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Authors Contribution

RF, DB, MB, JR and MG were involved in the conception, design, and implementation of the research. RF, DB, were involved in the data analysis and interpretation, and RF, DB, MB, JR and MG were involved in the drafting of the paper. RF, DB, MB, JR, and MG were involved in the review and approval of the final article for publication.

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Figures

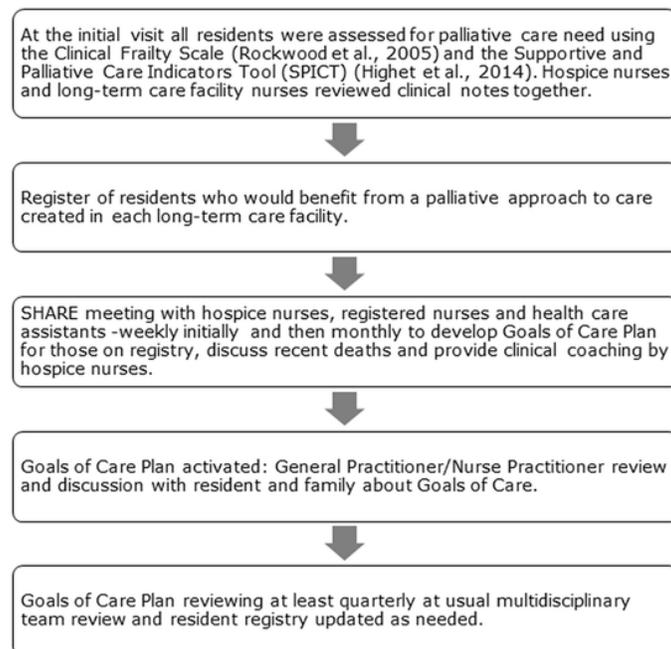


Figure 1

Supportive Hospice Aged Residential Care (SHARE) ongoing review process (22)

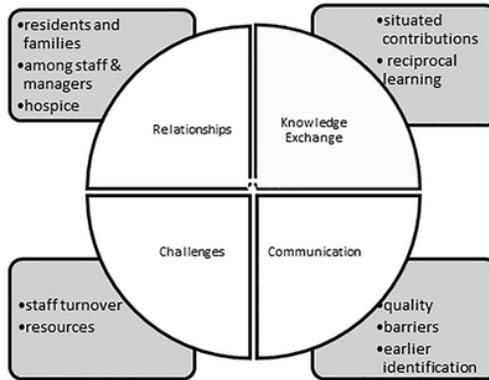


Figure 2

Categories and sub-categories identified within the log texts