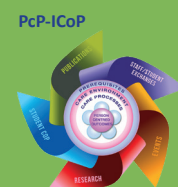


International Practice Development Journal

Online journal of FoNS in association with the IPDC and PcP-ICoP (ISSN 2046-9292)



ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Improving caregivers experience: enhancing end-of-life care for residents

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Submitted for publication: 21st January 2019

Accepted for publication: 8th April 2019

Published: 15th May 2019

<https://doi.org/10.19043/ipdj.91.005>

Abstract

Background: Global demographic changes are resulting in an ageing population with increasingly complex needs and comorbidities. The nursing home sector will increasingly play a critical role in the care of people at the end of life. Education for staff in this sector is variable in nature, with little evidence of its impact on practice. Practice development aims to enhance person-centred and evidence-informed cultures.

Aim: To develop and evaluate participants' palliative and end-of-life care knowledge, enabling them to develop and transform care practices in the homes.

Methods: A practice development programme for registered nurses and care assistants in two nursing homes was undertaken. Evaluation data were collected at the start of the programme and six months after its completion, via focus groups, self-assessment, record reviews, reflective diaries, one-to-one manager interviews, and evaluations and notes from meetings and sessions. Data also informed activities within the programme and its evaluation. A creative hermeneutic approach was adopted for overall data analysis.

Findings: The findings confirm the strength of adopting a practice development approach to underpin a staff education programme. Integrating registered nurses and care assistants in the learning environment enhanced working relationships and translated to a more healthful workplace culture and enhanced person-centred end-of-life care.

Implications for practice:

- Integrating practice development into staff education for nursing home staff is an effective means of developing their knowledge and skills and seeing this integrated into practice
- As global demographics change, this sector will play a major role in end-of-life care, so a more systematic approach to the development of nursing home staff is required to enhance person-centred end-of-life care in this sector

Keywords: Palliative care, end-of-life care, practice development, nursing homes, person-centred, education

Introduction and background

Global demographic trends are changing, with an aging population and an increased life expectancy for people living with life-limiting illnesses. Furthermore, it is estimated that every year more than 40 million people will require palliative and end-of-life care (World Health Organization, 2018). In the UK, it is estimated that by 2035 more than 20% of the population will be aged 65 and older, and the number of those living beyond 75 years will increase from around five million in 2010 to eight million in 2030 (Office for National Statistics, 2017). As the population ages, people are more likely to be living with conditions such as cardiovascular disease, cancer, chronic obstructive pulmonary disease and dementia, which will require a palliative care approach (Department of Health, 2008; National End of Life Care Intelligence Network, 2012).

Palliative and end-of-life care for older adults aims to support and comfort individuals and is based on a philosophy of care that promotes a holistic, multidisciplinary approach to enhance quality of life (NICE, 2011). It is suggested that nursing homes will play a critical role in its delivery for many older people (Finucane et al., 2013; Mitchell and Twycross, 2016). The sector currently provides more beds for older people with complex healthcare needs than NHS hospitals, and is already a major provider of end-of-life care (National End of Life Care Intelligence Network, 2012; Care Quality Commission, 2016).

The importance of good quality end-of-life care provision for older people in nursing homes is well recognised within the international literature (World Health Organization, 2011; Clark et al., 2012). Residents in nursing homes who are entering the end stage of an illness must receive high-quality care reflecting a palliative care philosophy, enabling them to die in the place of their choice and avoid inappropriate admissions to hospital (Booth et al., 2014). It is therefore important that nurses and care assistants are enabled to develop and enhance their confidence and skills in palliative and end-of-life care, and have access to robust training and education programmes (Department of Health Social Services and Public Safety, 2010; Guidelines and Audit Implementation Network, 2013). There is no legal requirement for such training for nursing home staff in the UK and complaints from relatives of residents in some homes highlight that staff's lack of knowledge and skills have resulted in their loved ones dying in distress and in pain (Bloch-Budzier, 2018). There are, however, minimum standards for nursing homes in Northern Ireland that underline the need for staff training that includes person-centred end-of-life care (Department of Health Social Services and Public Safety, 2015). Furthermore, Mitchell and Twycross (2016) and Dean (2018) suggest the lack of education in this setting has been well documented and that, even where provided, the education was varied in nature. Dobbie et al. (2016) went further, highlighting the differences in the length and content of available education programmes, and suggesting the perfect model of training and its success have still to be defined. Of particular concern has been the lack of evidence of any sustained changes in practice or in culture within the nursing homes following education sessions (Kelly et al., 2011; Anstey et al., 2015).

Healthcare practitioners are required to undertake continuing professional development (CPD) with the expectation that they will continue to develop their practice throughout their career. This implies that CPD results in the development of practice. However, enhancing knowledge and skills does not always result in practice change (Manley et al., 2013a). Brown and McCormack (2011) also suggest that traditional training alone does not bring significant improvements in practice or in staff confidence. Practice development is an internationally recognised and sustainable approach that encourages people to work and learn together, exploring their own values and beliefs to enable a continuous process of developing person-centred and evidence-informed cultures (Dewing et al., 2014). However, practice development is not the same as CPD; more accurately, practice development activities are underpinned by transferable principles and methods. This type of engagement has been shown to encourage teams to work with shared values, develop their knowledge and skills, and learn in and from practice, changing the culture and organisation of care (Brown and McCormack, 2011; Manley et al., 2013b).

This article will present a practice development programme run collaboratively between one healthcare organisation and private sector nursing homes. It will address the challenges associated with the education and development of person-centred palliative and end-of-life care in the nursing home setting. The development of the programme, its content and evaluation will be explored and the findings discussed.

Context and programme design

Within one health and social care trust (hereafter 'the trust') the community palliative care education facilitators (CPCEFs) provide education and support to nursing home staff, with the aim of improving quality of care for residents and reducing inappropriate admissions to hospital at the end of life. Thus far, a traditional approach to education has been delivered, with little in the way of evaluation of its effect on care delivery. The literature would suggest that traditional training alone does not have a significant impact on improving practice and staff confidence (Brown and McCormack, 2011). Local evidence, including feedback from district nurses and community hospice nurse specialists – mainly relating to problems with symptom management – would suggest this has been the case with education delivered to nursing home staff in this trust.

To enhance education, a palliative care link nurse group was established. Within this group, the CPCEFs worked with the link nurses in three key areas: communication, syringe pump management and end-of-life care. However, only around 30% of homes engaged with the group, and in the homes where there were no link nurses, the CPCEFs felt they were firefighting. This, alongside the feedback from community staff, in particular relating to syringe pumps and symptom management, resulted in the education facilitators questioning the effectiveness of their approach. They discussed their options in supervision with their manager, specifically considering how education could be delivered differently, in a way that could impact on service provision and the culture in nursing homes. The approach would need to work for the providers and managers, and actively engage the nurses and care assistants. A programme that would provide end-of-life care education using practice development methods and tools was considered. The trust manager wanted evidence that an additional investment would improve the quality of palliative and end-of-life care, so any new approach needed to be evaluated in a robust way.

A working group was established that included nursing home managers, the CPCEFs, a research/practice development nurse and a GP palliative care facilitator. This group became the project team, who met to plan and subsequently develop and manage all aspects of the initiative. The result was a one-year practice development programme developed and run collaboratively between the trust and two private sector nursing homes. Its aim was to enhance participants' palliative and end-of-life care knowledge, enabling them to develop and transform care practices in the homes. In contrast to previous education offered by the CPCEFs, care assistants – who are often the direct care providers in this sector – were fully included as programme participants alongside the registered nurses.

Overview of the programme

Enhancing knowledge and translating this into developments in end-of-life care was the core focus. Practice development was the underpinning methodology that guided the overall programme. The integration of a practice development approach, with its collaborative, inclusive and participative methods and tools (McCormack et al., 2006), aimed to create the conditions in which new knowledge and skills would be applied in practice. The practice development methods used included: working collaboratively to agree roles and responsibilities and the focus for staff and practice development; being person-centred and exploring this in the practice context; clarifying values, focus and vision; working collaboratively; and developing relationships to encourage participation in the homes (McCormack et al., 2013). These methods were intended to promote ownership of the developments in the nursing home setting, thereby creating the drive to sustain and promote a culture where palliative and end-of-life care for residents would continue to develop after the end of the programme.

The education element of the programme was delivered in six half-day sessions over six months. Participants were asked to undertake practice development activities in their nursing homes in between the sessions. The project team developed an outline plan for the educational content using the regional direction for palliative care education. Programme activities gave the project team, and the CPCEFs in particular, an idea of the participants' level of knowledge and skill, education needs and insight into the culture of care, enabling them to adapt the content accordingly. The education sessions used a mixture of practice development tools and approaches, traditional slide presentations, and group discussion and reflection to encourage a person-centred approach to planning and providing care. An overview of the education sessions and associated activities making up the programme can be found in Table 1.

Table 1: Themes within the education programme and practice development tools used

Session	Topic	Examples of activities
1	Principles of palliative care	Use of cards
2	Communication	Chinese whispers, observation of practice
3	Holistic assessment	Expression using paints and collage
4	Advanced care planning	What's important to me, values and beliefs
5	Symptom management	Case studies with reflection and discussion groups
6	End-of-life and bereavement care	Case studies with reflection, discussion and care planning

Integrated research evaluation: methodology and methods

Having previously adopted a traditional approach to education, the CPCEFs wanted to explore if the integration of practice development with end-of-life care education would have the desired impact on practice and care. Therefore, the research evaluation was initiated to enable a systematic analysis and a better understanding of the impact of a practice development approach in this programme – in particular, to determine if this approach would enhance person-centred end-of-life care, and improve the experience of the caregivers in terms of acquired knowledge, skills and confidence in offering this care. The CPCEFs were also interested in the sustainability of the outcomes of the programme over time, in order to reassure key stakeholders wanting evidence of the 'worth' of the programme and its impact in terms of practice change.

Research question

How does a practice development programme enhance the caregiver's experience of providing end-of-life care?

Objectives

1. To determine how a practice development programme affected caregivers' experience of providing palliative and end-of-life care within the nursing home setting
2. To understand how practice development impacts on the knowledge, skills and expertise of caregivers and how this is evidenced in their practice
3. To measure the sustainability of the outcomes from the practice development programme over time in line with objectives 1 and 2

Two homes that met the initial inclusion criteria (being within the trust locality and having an identified palliative care link nurse) were identified and invited to take part. The management team within each home had to commit to all aspects of the programme: the education sessions, supporting practice development activities and the accompanying research evaluation. Each home began the study with eight participants: four registered nurses and four care assistants.

Ethics

Approval for the research was received from the participating nursing homes and from the trust (SET/15/60). Ethical principles were adopted for all aspects of the programme and the research. The evaluation was unique to the particular programme and is therefore unlikely to be generalisable to a different setting. However, rigorous and systematic approaches were adopted to ensure transferability, transparency, credibility and dependability of this study (Parahoo, 2011).

The project team comprised staff from the participating nursing homes and the trust, meaning there were 'insiders' and 'outsiders' to the care setting. In such a context, adherence to particular principles is important; the practice development principles (McCormack et al., 2013) and authentic facilitation (Heron, 2006) were used to support participant interactions during all activities associated with the programme. The chief investigator (MR) and other members of the team had previously facilitated practice development and research programmes in health and social care and so had relevant experience. Reflexivity was used to manage any potential researcher bias.

Consistent with the practice development approach, the project team made every attempt to build trust with the participants, ensuring all were treated equally and placing their needs at all times before the evaluation. Written consent was obtained from all participants. Confidentiality is imperative throughout research (Bowling, 2001), and ground rules were developed to agree the meaning of the terms confidentiality and anonymity, and ways of working at the beginning of each focus group and within the education sessions. It is difficult to ensure full anonymity in this sort of research or in practice development activities, as participants work together over a period of time and get to know each other well. As a result they may recognise responses made by others. Confidentiality was maintained by coding all data collected and ensuring no names were used in any reports. At the outset, participants were made aware that only the project team would have access to data generated, that all information collected in relation to the proposed study would be kept in a locked cabinet in a locked office and that all e-documents would be encrypted and held on a password-protected computer.

Data collection

Data to answer the research question were gathered via a range of methods. Much of the data were also used to inform the overall programme and associated education and practice development activities.

- Focus groups were undertaken, two before the education sessions started (month zero) and two six months after completion of the education programme (month 12). Separate groups were held for nurses and care assistants
- Nurses were asked to complete a self-assessment adapted from the National End-of-life Care Programme (2012) before starting the programme (month zero) and again at month 12. The purpose of this was to record knowledge, skills and attitudes both pre- and post-education sessions to ascertain if these had changed as a result of the programme
- Residents' notes were reviewed before the education sessions began, and again six months after they were completed. Topics were identified from best practice as recommended in regional guidelines (Guidelines and Audit Implementation Network, 2013), and the regional End-of-life Care Operational System Model (Orr and Elder, 2012), with specific review of the documentation of palliative and end-of-life care provision
- Evaluations from the education sessions and notes from project team meetings were maintained throughout the programme
- One-to-one interviews were scheduled with the home managers six months after the education sessions were completed to identify any changes in practice as a result of the programme (note that this was only conducted with one manager; the other left post during the programme and her replacement was not interviewed as they were not as familiar with the programme)
- Members of the team maintained a reflective diary throughout the study. This was used to capture thoughts and feelings during the planning phase, after the focus groups and education sessions. This was done to facilitate collection of notes, memos, hunches and any ideas that arose during the lifespan of the study

Data analysis

The purpose of data analysis is to organise, structure and gain meaning from data. Data were gathered through the range of methods described above, which, taken as a whole, provided the overall evaluation findings. Data underwent two stages of analysis. Each dataset was initially analysed by the team member responsible for collection of those data and informed activities within the programme. Second-level analysis (of the already analysed data) was subsequently undertaken at the end of the programme by the project team, using creative hermeneutic analysis (Boomer and McCormack, 2010). Table 2 provides an overview of data collection and analysis methods, and how they informed activities within the programme and its associated evaluation.

Table 2: Overview of data collection and analysis

Dataset	Details	Method of analysis
Focus groups	<ul style="list-style-type: none"> • Four groups: two at month zero and two at month 12 • Separate groups run for nurses and care assistants • Themes from month zero to inform training, action and practice development activities 	<ul style="list-style-type: none"> • Thematic analysis (Newell and Burnard, 2011)
Competency tool	<ul style="list-style-type: none"> • Nurses completed self-assessment adapted from the National End-of-life Care Programme (2013), at months zero and 12 • Initial analysis would inform education and development activities linked to staff needs 	<ul style="list-style-type: none"> • Comparison of data from month zero and month 12, to identify self-perception of developments in knowledge, skills and attitudes
Review of residents' records	<ul style="list-style-type: none"> • Review of residents' notes at months zero and 12 for documentation of palliative and end-of-care provision • Audit tool developed from best practice guidelines (GAIN, 2013, Orr and Elder, 2012) 	<ul style="list-style-type: none"> • Descriptive statistics and comparison of pre- and post-programme data to understand changes
Reflective records/diaries	<ul style="list-style-type: none"> • Research team kept reflective dairies throughout life of the project 	<ul style="list-style-type: none"> • Thematic analysis (Newell and Burnard, 2011)
One-to-one interviews with home managers	<ul style="list-style-type: none"> • Undertaken at month 12 to ascertain practice and cultural changes from the programme • Only completed with one manager; the other manager left and was replaced after the project 	<ul style="list-style-type: none"> • Thematic analysis (Newell and Burnard, 2011)
Evaluations and notes	<ul style="list-style-type: none"> • Evaluations from the education sessions and notes from project team meetings were maintained 	<ul style="list-style-type: none"> • Thematic analysis (Newell and Burnard, 2011)



Secondary analysis

Themed data from focus groups, competency tool, review of residents' records, reflective diaries, one-to-one interviews, evaluations and notes analysed using hermeneutic data analysis (Boomer and McCormack, 2010)



Overall project themes

Findings

The second-level analysis gave an understanding of the whole, providing overall themes and enabling the team to draw conclusions. One overarching theme was identified, namely an improvement in the confidence of staff to provide care – specifically in terms of communication, symptom management and acquired knowledge and skills. Importantly, a translation of learning into changes in practice was evident. These overall findings will now be presented.

Communication

Across the datasets, a significant outcome was the level of improvement in the communication skills of staff. Nurses and care assistants were more aware of the importance of communicating with each other, the wider healthcare team and, most importantly, with residents and their families. This is evidenced in the post-project interview with one of the nursing home managers, who reported relatives describing how they believed that residents were loved and cared for and that they had confidence in the team. Families also commented on how well they were kept informed about their relative's condition.

Participants believed that their interpersonal skills were enhanced, thus enabling the provision of holistic palliative care, open and honest communication and authentic engagement with the residents in their care. One participant said:

'I have improved my communication skills and I have learned how to listen. I do like to listen to their stories, go into the rooms – and they have photos I go and see' (Focus group 3, participant 8).

This was further evidenced in the self-competency tool completed by nurses, which demonstrated a significant improvement in open and sensitive communication skills. The review of notes also reflected that communication, and its documentation, had generally improved. One very encouraging finding was an improvement in the documentation of conversations with residents' families about end-of-life care, demonstrated in the review of notes by a 27% improvement in one of the nursing homes and 14% in the other.

These improved communication skills had a significant impact on the care assistants' confidence in their ability to provide high-quality end-of-life care. In focus groups at the start of the project, care assistants had highlighted a 'them and us' culture with the nurses that left them feeling undervalued and, in many cases, simply doing the tasks they were asked to do. They did not challenge the nurses or ask them questions about the residents' care. However, this changed, as illustrated by one participant in the focus group at month 12:

'I think if we really want to know something we must ask, it's the only way you will find out' (Focus group 4, participant 6).

Following the education programme, there was evidence of increased understanding and respect among participants for each other's knowledge and experience, regardless of their role. Subsequently the relationship between the nurses and care assistants also improved.

Knowledge and skills and symptom management

The self-competency assessment tool completed by the nurses demonstrated a dramatic improvement in competencies across all domains: overarching values and beliefs; communication skills; assessment and care planning; and symptom management. There was also a significant improvement in knowledge, skills and attitude. The data as a whole corroborated this self-assessment. This was also evident in terms of the translation of knowledge into practice, notably with the nurses' approach to holistic assessment and care. The review of notes demonstrated a substantial improvement in the documentation of holistic assessment, with a 95% improvement in one home and 84% in the other at the month 12 review.

The manager's interview also highlighted the positive impact of the programme. She believed this was demonstrated through the increased knowledge and appropriate use of end-of-life tools and guidelines, improved assessments and symptom management. This enhancement of knowledge, skills, and consequently confidence, encouraged the translation of learning into changes in practice. There was also evidence of staff recognising the importance of completing care plans, recording preferred places of care/death and identifying when residents were deteriorating and needed input from the wider multidisciplinary team. Overall, both nurses and care assistants were much more proactive in the care they provided to the residents.

Discussion

Achieving a good death experience is the aim of palliative and end-of-life care (NICE, 2015). This will not be achieved solely through policy and guideline implementation (Yalden et al., 2013), or indeed staff training and education (Brown and McCormack, 2011; Manley et al., 2013a). This programme aimed to develop participating staff's knowledge and skills, see this translated into practice and enhance a person-centred culture within the respective homes. Lannie and Peelo-Kilroe (2017) demonstrate the relevance of the person-centred framework for planning and the subsequent provision of person-centred palliative care. Drawing from and building on their work, we will discuss our findings in relation to the following:

- Sympathetic presence – specifically 'being with', 'recognising the resident as a person' and enhanced communication to provide holistic care for residents and their families
- Improving staff relationships, thereby developing a more healthful workplace culture

As these are explored we will also demonstrate how the use of practice development enabled and enhanced person-centred palliative and end-of-life care.

Sympathetic presence

Being sympathetically present is about being attentive, available, present and visible, although it moves beyond these simplistic terms; ultimately it is being available in the moment while recognising the uniqueness and value of the individual (McCormack and McCance, 2010). To be present, there is a need to know the resident as an individual, their wishes, hopes and choices about their prognosis and care, as highlighted in the UK context by NICE (2015). To realise this there is the need to get alongside the resident, building a rapport with them and those close to them. This is challenging in all healthcare contexts, although it could be assumed that the longer-stay environment of nursing homes would provide more opportunity to develop meaningful relationships with residents and knowledge of their individual wishes. Providing holistic care for residents and their families at the end of life requires being with and recognising the resident as a person (Lannie and Peelo-Kilroe, 2017). Participants in this programme discussed the importance of being able to empathise with residents and their families, and appreciate the loss of future that they may be feeling.

Interestingly, programme participants recognised that, on occasion, they felt they were only truly caring for residents when they were providing physical care. However, during the session that focused specifically on end-of-life and bereavement care, the participants realised that just being there – often sitting in silence – could be more powerful than trying to fill the moment with words or actions. This was reflected by one participant at the end of the programme:

'Basically it's not going in and saying stupid things like "everything is going to be ok" when you know basically it's not, which probably I would have done at the start... but now I do have that wee bit of understanding round the families not to say stupid remarks' (Focus group 4, participant 6).

The evaluation demonstrated that participants were more confident in having end-of-life conversations and understood the importance of allowing residents and their family members to express how they were feeling. There was recognition that if care was to be person-centred, there was a need to get to know the resident and their family, and to be able to engage emotionally with them.

Choice emerged as key in an exploration of what was important to people at the end of life and after death, specifically in terms of place of care and death, pain control and the involvement of family and those close to them (The Choice in End-of-life Care Programme Board, 2015). Participants were encouraged through discussion and reflection on their practice to consider what would be important to them if they were in a nursing home and in the last stages of life. This enabled the recognition that they would want to be treated as an individual and that those looking after them would need to know what was important to them to ensure their wishes were achieved at the end of their lives.

Participants identified how they could engage in a more meaningful way with residents and families, specifically discussing use of the *This is Me* document (Alzheimer's Society, 2013). This document had previously been introduced by managers in the homes without involving the nursing team, with the result that it had not been well received or actively used in practice by participants. However, they had begun using this tool to help give them a better understanding of the residents and what was important to them. This highlights the well-rehearsed argument that top-down approaches are not always successful in achieving change. It is recognised that for change to be embraced and new initiatives to be successful, the views and opinions of staff must be taken into account, and care should be planned using a person-centred approach (McCormack and McCance, 2010). This demonstrates that if staff are enabled to see the meaning of a tool or initiative then it can become something they want to use in their practice. This significant change reflected that staff had a greater interest in their residents as individuals and were providing more person-centred care.

Staff must recognise their own values and beliefs around care provision if the goals of good palliative care are to be achieved. Exploring values and person-centred end-of-life care saw participants in this programme acknowledge the emotional aspects of their work and consider how this translated into care for residents. The challenges faced by staff when providing end-of-life care are well documented in the literature (National Council for Palliative Care, 2016). Emotion cannot be removed (Lannie and Peelo-Kilroe, 2017), and in this programme participants described how they often became emotionally attached to residents who were in their care, particularly if they had been in the home for many years.

The importance of a person-centred approach in healthcare is advocated in policy for palliative and end-of-life care (Department of Health Social Services and Public Safety, 2010). Taking all aspects of care provision into account, it is important to recognise that good communication skills are also necessary to establish rapport and trust with patients and their families at this very difficult and emotionally charged time in their lives (Department of Health, 2014). Staff need to be able to uncover and understand the concerns of residents and their families to enable a truly holistic assessment to take place. In this study, participants came to recognise that the emotional and spiritual parts of assessment are of equal importance to the physical assessment. These difficult conversations require sympathetic presence and advanced communication skills.

Improving staff relationships: developing a more healthful workplace culture

McCormack and McCance (2017) argue that if the care environment is not conducive to person-centred ways of working it will be challenging to realise the potential of teams and to develop person-centred cultures of care. It is recognised in the literature that workplace culture has an impact on care, for staff as caregivers and patients/residents and their families (Manley et al., 2013). The most recent iteration of the Person-centred Practice Framework has as its central outcome a healthful culture (McCormack and McCance, 2018, personal communication). However, this can only be achieved through the interaction of the elements and constructs within the framework. The findings presented in this article suggest that the programme had most impact on the sharing of power and effective staff relationships within the care environment construct of the person-centred framework (McCormack and McCance, 2017) – ultimately helping to develop a more healthful (workplace) culture through the development of more effective communication between staff groups, and appreciation of what each role offers.

Consistent with other studies, challenges with communication were highlighted by the care assistants and nurses. The care assistants felt at the outset that they were not listened to by the nurses; that on occasion, if they offered an opinion about a resident's condition they were ignored. Moreover, they felt they were not given important information about the residents that could have influenced the care they were providing. Interestingly, the nurses commented that the care assistants did not understand the amount of administrative duties they had to complete in their role. They did recognise that they relied on the care assistants to do much of the personal care. This highlights that an understanding of other team members' roles and responsibilities is important for effective staff relationships and the provision of person-centred care (McCormack and McCance, 2017). Communication has a role not only in getting to know each other, 'being truly connected in a person-centred relationship' (McCormack and McCance, 2017, p 33) but also in engaging in conversations about care as a core element in provision of holistic care to residents and their families. There was a greater appreciation from care assistants at the end of the study of the amount of paperwork the nurses needed to complete. The relationship was much better, with both groups of staff feeling listened to and valued.

To realise a good care experience it is important that working relationships are fostered and developed, enabling staff to feel valued and respected for the job they do. In this programme, the use of creativity enabled project participants safely to share that they needed to be listened to, and work together to achieve optimum care. This highlights the role of creativity and its potential in enabling staff to consider and develop their workplace culture so that staff, residents and families work together, involving everyone in the planning of care.

Inconsistencies in communication were noted by nurses and care assistants; as a result of the programme, staff realised the need for more regular communication to update others on the residents' condition. One home changed the way handovers were given in an attempt to be more inclusive of the care assistants, adopting informal handovers throughout the day in a similar way to the safety briefs commonly used in acute care settings. All these outcomes translated into a happier place to work, where communication had improved between staff, as summed up by one care assistant in the focus group at month 12:

'I think in our nursing home, it has improved communication between staff' (Focus group 3, participant 1).

One of the nursing homes introduced a communication book in each resident's room, which could be used to pass important information about care between residents' families and staff. The other home introduced large picture boards where residents and carers were encouraged to display pictures or information about life events that had been important to the resident. Both are simple but effective changes that impact positively on the care experience.

Through the observations of practice, undertaken between sessions three and four of the programme (see Table 1, page 4), the participants were able to see how they really worked together and also how they interacted with residents. Participants realised that, on occasion, they were very noisy around residents; Shannon and Peelo-Kilroe (2012) highlight that reducing the level of staff-generated noise creates a more therapeutic atmosphere for end-of-life care. Issues with confidentiality also emerged; through the observation of practice, participants became aware that sensitive information was often shared in corridors. This highlighted the issue of how space is used within a care environment, for example for private conversations with residents and families, and also for staff and team communication. The participating homes realised that there was a need for a dedicated private area, and appropriate areas were identified in the homes.

How did practice development make a difference?

It could be argued that any educational input with regard to palliative and end-of-life care could have a similar effect on improving participants' confidence in providing care. McLaughlin et al. (2013) demonstrated a marked improvement in acquired knowledge and skills in nursing home staff who attended a three-day palliative and end-of-life care programme. Likewise, project ECHO (Extension for Community Health Care Outcomes), which used teleconferencing technology to support and educate nursing home staff, reflected an improvement in knowledge and skills of the staff (All Ireland Institute of Hospice and Palliative Care, 2017). Importantly, neither of these studies demonstrate changes in practice within the participating nursing homes. This practice development programme did, however, demonstrate changes in practice and in the culture of care in both participating homes. This is evidenced by the outcomes of the action plans participants developed as part of the programme, which detailed the changes they wanted to make in the homes. The focus on making small changes, initiated and led by the participants themselves was a core element of the programme, creating ownership of the practice development, increasing collaboration and providing evidence of the transfer of learning into practice.

Interestingly, despite care assistants providing most of the personal care to residents, the majority of education programmes for nursing home staff appear to be limited to nursing staff. Having nurses and care assistants attend all education sessions together proved to be of great benefit in this programme. Themes from both staff groups were very similar, which validates the project team's rationale to increase collaboration within the learning setting.

Limitations

This was a small programme involving two nursing homes and 16 participants. Retention of staff was an issue, with two staff members moving to other jobs during the programme timeframe. The nurse manager of one home resigned halfway through the programme and her replacement was not as familiar with all aspects of the programme. Residents and their family members were not included in the evaluation.

Conclusion

This article provides a transparent audit trail that allows others to decide on the worth of the evaluation should they wish to replicate the programme for their own setting. The programme and its evaluation achieved the original aim of developing participants' palliative and end-of-life care knowledge and transforming care in the homes. The results demonstrate that adopting a practice development approach to a staff training initiative significantly improved the caregivers' experience of providing care. The overarching theme was one of enhanced confidence, alongside a growth in participants' knowledge and skills. The evidence presented here would suggest that the improvements made are now embedded in practice. Significantly, ongoing work with the homes by the community palliative care education facilitators allows them to see these developments sustained in practice, with benefits to residents' care despite the ongoing staff turnover issues in this sector. Overall, participants considered that their involvement in the project was a valuable experience, as reflected by one participant:

'Being honest, during this project I didn't know that I was learning something day by day but now at the end of the project when I look back, I realise that this lesson really helped me and I improved all my skills and I am feeling very, very confident with what I know' (Focus group 3, participant 3).

Fuelled by the impact from this programme, the recommendations are now being implemented by the trust and the programme has been adapted and implemented in other practice settings. Most important, however, has been the positive feedback received by staff from family members of those residents who have been cared for at the end of life in the homes.

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Acknowledgements

A special thank-you goes to the staff in the two homes for their active participation in the programme and for sharing their experiences with us in the evaluation. The authors would also like to thank the management of the Care Circle Group and the South Eastern Health and Social Care Trust for their valuable support, guidance and encouragement, and the RCN Foundation Rae Bequest Fund for the grant awarded.

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