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Author(s)	O'Shea, Eamon; Ní Léime, Áine
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Dying well: Factors that influence the provision of good End of Life care for older people in acute and long stay care settings.

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3 **Dying well: Factors that influence the provision of good End of Life care for older**
4 **people in acute and long stay care settings.**
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7 **Word Count -5,000**
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9 **Data Collection Period:** 2007-2008
10

11 **Abstract:**

12 The aim of this study was to explore key stakeholders and direct care managers'
13 perspectives on the current provision of end-of-life (EoL) care for older people in acute
14 and long stay care settings and to construct a mode of these.
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16

17 **Background:**

18 Although the literature reveals a number of factors that impact on EoL care no study has
19 examined staff perceptions concerning the provision of good EoL care for older people in
20 an Irish context.
21
22

23 **Research Design;**

24 Grounded theory was utilised. Semi structured interviews were employed to collect data
25 between 2007 and 2008.
26
27

28 **Sample:**

29 A purposive sample of 33 staff involved in the delivery of EoL care to older people
30 working in six sites were selected.
31
32

33 **Findings:**

34 A model of the factors that influence provision of EoL was developed. The core category
35 was 'dying well'. The potential to 'die well' was influenced by three interrelated factors,
36 namely philosophy, culture and organisation of care, knowing the person and physical
37 environment and resources.
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39

40 **Conclusions**

41 People are living longer consequently acute and long stay care setting will increasingly
42 become places where older people die. This study presents a model of the factors that
43 influence the provision of good EoL care for older people. Mobilising resources to ensure
44 that these factors are considered is crucial to ensuring that, regardless of where older
45 people die; they will receive the highest standard of care that nurses can provide.
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50 **What is already known about this topic:**

- 51
- 52 • There is a lack of clarity in relation to the meaning of End of Life(EoL) care
 - 53 for older people
 - 54 • Staff working in acute and long stay care facilities face many challenges in
 - 55 providing good quality EoL care to older people.
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What the paper adds:

- This research provides a mode which identifies the factors that influence the provision of EoL care for older people living in acute and long stay care facilities
- A clear set of interrelated factors are identified that expand our understanding of what is required to enable for older people to 'die well'.
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Implications for Nursing Practice

- Nurses require specific education and training focusing on palliative care for older people if they are to provide good EoL care.
- Nurse Managers play a key role in shaping the ethos and organisation of care and creating supportive environments which facilitate the establishment of open communication and meaningful relationships with older people at EoL.

Review Copy

Introduction and Background

Worldwide people are living longer (Bartlett 1996) and older people want to die at home (WHO 2004). However in Ireland only 20% of older people actually do die at home (CSO 2006). In reality older people are more likely to die in acute hospital settings, private/public nursing homes and other public long-stay care facilities. Yet very little is known regarding end of life (EoL) care across these different settings.

End-of-Life Care:

There is a lack of clarity as to the meaning of 'end-of-life care' leading to varied interpretations which has implications on the care delivered (Froggatt and Payne 2006; Payne et al., 2002). EoL care refers to "any time in the final period of life where issues (physical, social, emotional, and spiritual) arising from an individual's death and mortality" need to be addressed, (Froggatt et al., 2006, p 46). In addition quality care at EoL is characterised by individualised care, "...shared decision-making and clear communication that acknowledges the values and preferences of clients and their families", (Steinhauser et al., 2000, p. 2482). However there are many factors that affect the delivery of good quality care at EoL.

Factors that influence the provision of good EoL care for older people

A number of studies have explored staffs perceptions of EoL care in long stay care (Katz 2001; Cartwright 2003; Brazil 2005; Froggat & Payne 2006; Hanson et al 2002; Palan-Lopez 2007; Phillips 2006; Phillips et al 2007; Watson et al 2006). Others have focused on staff perceptions of EoL care in more specialist hospital palliative care settings

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2
3 (Anslem et al 2005) or in acute settings (Costello 2001; Costello 2006; Clarke & Ross
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5
6 2006; Parish et al 2006). Irrespective of the setting a number of common elements are
7
8 pivotal to good EoL care.
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12 Knowing the person, following their wishes and providing individualized care is
13
14 considered key to good quality EoL care (Hanson et al 2002; Costello 2006; Froggatt and
15
16 Payne 2006; Palan-Lopez 2007). Staff emphasise the importance of offering residents
17
18 choices and control over decision making (Payne et al 1996; Steinhauer et al 2000;
19
20 Aspinal et al 2006). In long stay units residents become 'like family' members to the
21
22 nurses caring for them (Cartwright and Kayser-Jones 2003; Hanson et al. 2002; Phillips
23
24 et al. 2006). In such relationships staff are sensitive to the needs of the dying person,
25
26 display kindness and take the time to listen (Aspinal 2006; Costello 2001; Steinhauer et
27
28 al. 2000). In contrast when staff fail to get to know the client a poor relationship exists
29
30 making a good death less likely (Costello 2006). In this context staff circumvent
31
32 developing close relationships to avoid emotional engagement (Costello 2001; Hanson et
33
34 al. 2002) and emotional exhaustion (Clarke and Ross 2006; Katz et al. 2001; Palan-Lopez
35
36 2007). Staff may therefore resort to using superficial communication, and use blocking
37
38 techniques (Watson et al 2006) ignore cues or change the topic when clients attempt to
39
40 discuss death/ dying (Costello 2001).
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51 Studies also reveal that staff are often reluctant to discuss death/dying with older clients
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53 due to certain cultural and religious values surrounding death (Watson et al. 2006;
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55 Anslem et al., 2005) and the existence of an institutionalized policy of non-disclosure of
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3 information about death/dying based on protecting clients (Costello 2001). Such policies
4 create a closed awareness around death, where everyone knows the client is dying but it
5
6 is not openly discussed (Glaser & Strauss 1965; Costello 2001). This closed awareness
7
8 may also extend to the period after death when staff follow a number of procedures to
9
10 conceal death (Komaromy 2000). An ethos of open communication between staff and
11
12 clients regarding bad news, prognosis and treatment options are therefore important for
13
14 good EoL care (Phillips et al., 2007).
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21
22 Studies report that good quality EoL care is also dependent on the culture, philosophy and
23
24 organisation of care in particular a culture of learning where staff feel supported, is vital
25
26 (Watson et al., 2006; Froggatt and Payne, 2006; Clarke & Ross (2006). Some studies
27
28 found that organisational routines and the general busyness of the facility meant that
29
30 caring for the dying was difficult (Costello 2001; Katz et al 2005). Hopkinson et al
31
32 (2003) explored EoL care in the acute setting and revealed a tension between what nurses
33
34 felt care should be and the reality of practice where there was limited time and competing
35
36 demands. Clarke and Ross (2006) found that nurses working in palliative care devoted
37
38 time listening and talking with clients as this was considered a key element of their role,
39
40 in contrast nurses on the general medical ward prioritised the physical aspects of care.
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49 Other studies report lack of multidisciplinary team work, and role ambiguity (Anselm et
50
51 al. 2005; Hanson et al. 2002; Watson et al. 2006); staff shortages (Ling, 2005; Cartwright
52
53 and Kayser-Jones 2003; Costello 2006; Costello 2001; Hanson et al. 2008); high staff
54
55 turnover (Stillman et al., 2005); financial constraints (Ling, 2005); time constraints
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3 (Clarke and Ross 2006; Costello 2006; Hanson et al. 2002) work overload (Anselm et al.,
4 2005) short-term relationships in busy acute settings, lack of support (Anslem et al.,
5 2005); and poor communication between nurse and physician (Palan-Lopez 2007; Parish
6 et al. 2006) all impact negatively on EoL care. Furthermore in acute hospitals ensuring
7 privacy when access to single rooms is limited can be difficult (Clarke and Ross 2006;
8 Daaleman et al. 2008).

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20 The literature also reveals a lack of palliative-care and EoL training and education for
21 staff (Hanson et al 2002; Anslem et al., 2005). These include the need for medication
22 management (Phillips et al. 2007; Watson et al. 2006); and symptom management (Field
23 & Froggat 2003; Watson et al., 2006; Parish et al 2006; Ling 2005; Froggat & Payne
24 2006).

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34 In summary the literature reveals that knowing the person and their family, the
35 organisation and ethos of care, and the physical environment and resources influence
36 provision of good EoL care for older people. As staff are central to the delivery of this
37 care it is important to extend prior work by examining staff perceptions concerning the
38 provision of good EoL care for older people in Ireland.

39 40 41 42 43 44 45 46 47 48 **Aims and Methods**

49
50 A grounded theory approach was used, and the aim of the study was to explore key
51 stakeholders and direct care managers' perspectives on the current provision of EoL for
52 older people in Ireland. This approach was deemed most appropriate as the focus of the
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3 study was on the meaning of events for people and the underlying social processes that
4
5 shaped interactions (Glaser 1978; Chenitz & Swanson, 1986, Smith & Biley, 1997)
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10 **Sample**

11
12 A purposive sample of 33 staff involved in the delivery of EoL care to older people
13
14 working in six sites representing the distribution of places of care in which older people
15
16 die were interviewed (Table 1). To capture a range of experiences maximal variation
17
18 sampling for gender, age, educational level, rural /urban settings were undertaken (Table
19
20 2). Interviewees also had to have worked consecutively for at least three months in the
21
22 facilities to ensure they had both knowledge and experience of care services therein.
23
24 Initially senior nurses were invited to suggest direct care staff who could be interviewed.
25
26 In later interviews sampling decisions were guided by data analysis and the emerging
27
28 categories (Strauss and Corbin, 1998). Theoretical sampling continued until theoretical
29
30 saturation was reached
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40 **Data Collection Methods**

41
42 Semi structured interviews with the use of an interview guide were used to collect the
43
44 data. Data were collected over a 6 week period and interview lasted between 45 minutes
45
46 to 60 minutes.
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49

50 **Ethics**

51
52 Ethical approval was obtained from the University Research Ethics Committee. Informed
53
54 consent in writing was obtained from all interview participants 24 hours in advance of the
55
56 interview. Confidentiality was ensured by the removal of all identifying material. All
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3 participants were assured of their right to withdraw from the study at any time without
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5
6 fear of repercussion and that their anonymity would be preserved.
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10 **Data analysis**

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12 Data from all interviews were recorded and transcribed verbatim. Concurrent data
13
14 collection and analysis were undertaken. A computerised qualitative data analysis
15
16 package (Atlas Ti) was used to manage the data and a grounded theory approach to data
17
18 analysis was employed. This involved the use of the constant comparative technique,
19
20 (Glaser & Strauss, 1967). First level or open coding (Strauss and Corbin, 1998) was then
21
22 undertaken allowing similar facilities s to be grouped together into categories. After the
23
24 principle categories were established axial or second level coding was undertaken.
25
26 Finally selective or level three coding was completed, where all the categories and
27
28 subcategories were united to form a core or over arching category (Charmaz, 1990; Bluff,
29
30 2005).
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39 **Rigor**

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41 The criteria developed by Lincoln and Guba (1985) - credibility, dependability,
42
43 conformability and transferability - were employed to maintain rigour. All interviews
44
45 were transcribed verbatim. A sample of participants were presented with a copy of their
46
47 interview transcription to ensure that their interviews had been transcribed accurately.
48
49 The data was then independently coded by two researchers and the comparisons of
50
51 coding frameworks revealed overall agreement. Comments were also invited from
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3 experts in the field who confirmed that the findings were consistent with their
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5 experiences.
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10 **Findings**

11
12 A model of the factors that influence the provision of EoL care for older people was
13 developed from the findings (Figure 1). The core category was 'dying well' as this was
14 the outcome that could be expected when good EoL care was provided. This model
15 consists of three interrelated factors that govern the provision of good EoL care namely,
16 philosophy, culture and organisation of care, knowing the person and physical
17 environment and resources.
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28 **Philosophy, Culture & Organisation of care**

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30 This factor focuses on elements of the philosophy, culture and organisation of care, which
31 shaped staff's approach to EoL care.
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38 Most participants interpreted palliative care to mean care for people who were dying from
39 cancer. They did not perceive that they had a key role to play in EoL care and were
40 unsure as to whether they could to take on this role. These participants felt that palliative
41 care should be provided by the hospice and palliative care teams:
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48 *...I associate it more with hospice and cancer, I think that's where I could have,*
49 *respite care... we've palliative care here I suppose to a certain extent, I think I*
50 *would have associated it more with hospice (PIX048 Staff 3).(Private Nursing*
51 *Home)*
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53

54 When asked to describe the philosophical focus of EoL care within their facility. two
55 main descriptions emerged. The first emphasised comfort and dignity in physical care
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3 terms. They perceived that the focus of EoL care was to make people as happy and
4 comfortable as possible and believed that discussion of death was unsettling for residents
5 and therefore not encouraged. The second description stressed the need to prepare a
6 person for dying and emphasised the need for holistic individualised care. It was
7 recognised that this was not easy but was an essential part of their role. In these facilities
8 care was structured around clients' needs and there was recognition of the importance of
9 clients' choice:

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20 *"We are dealing with patients who are dying you know, and we are giving the best*
21 *possible care that we could, meeting their needs... we usually use the patient*
22 *centeredness, ...if the patient wishes to get up at this what time, so you could give*
23 *him a chance not like you will decide on your own like..." (BLW004 Staff 3)*
24 *(Extended Care Unit)*

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26
27
28 Participants also described the support that they could expect within their facility when
29 caring for people who were dying. Some felt supported by their managers and efforts had
30 been put in place to provide formal counselling if required:

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35
36 *There's a counselling service available to staff for every issue here. I think it's*
37 *fairly new but they're pushing the awareness of it now a lot, it's a great thing*
38 *(SAZ012 Staff 2).(Acute Hospital)*

39
40
41
42 For other participants however the ethos within their facility was "carrying on" and
43 containing emotions. It was evident that there was little support or understanding given to
44 staff who were emotionally distressed, but the emotional labour of care was very evident:

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51 *...but sometimes it could be hard if you get really attached to the patient which*
52 *you should not suppose to you know, really close attachment you know*
53 *sometimes you might be, you might like this patient really you know because he*
54 *was really good you know but and you know him by time and most of them are*
55 *getting close to you but you have to be strong (BLW004 Staff 3).(Extended Care*
56 *Unit)*

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4 The problem for staff in these facilities was that they often felt unsupported and they
5
6 therefore felt they were less able to give support to others.
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10
11 The organisational routines in care facilities varied. It was evident from some participants
12
13 that it was difficult to prioritise the needs of the dying within their workload. Participants
14
15 suggested that time to “be with” the dying person were key to good EoL care. However
16
17 they described the difficulties in giving that time as they lacked sufficient staff and their
18
19 day-to-day work was so busy. There was therefore a tension between what participants
20
21 believed to be best practice and the reality of care delivery. This tension resulted in stress
22
23 and anxiety for staff:
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29 *Somebody dying needs more like one-to-one care, like they have upstairs (in*
30 *the specialist unit) and here they have what - something like 10 nurses for 70*
31 *beds. That means at night you might have only one nurse to 24 beds. With that*
32 *kind of staffing, you just can't have the kind of care you need when somebody*
33 *is dying (GRT005 Staff 3). (Long stay unit attached to palliative care*
34 *centre/Hospice (LSUAPC/H)*
35
36
37

38 In some facilities therefore the routine prevailed which often meant the dying person did
39
40 not get the care that participants felt they should. A few participants suggested however
41
42 that time and staffing levels were not the only issues in providing best EoL care, they also
43
44 emphasised that there was a need to examine the way in which nurses' work in order to
45
46 provide best care:
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49

50 *...sometimes we get it wrong because again the focus anyway is always about*
51 *staffing...sometimes it's about you know what might need to be done in a different*
52 *way to provide another way of looking at things, you know it's always a lot of the*
53 *issues, you know get us more staff but a lot of my work this year is about trying to*
54 *get nurses to look differently about how their doing things, how they're working*
55 *with patients (BLW004 Staff 7)...(Extended Care Unit)*
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5 In some facilities a learning culture existed where staff shared information and
6
7 knowledge. Staff participants from overseas described how they were unfamiliar with
8
9 catholic death practices but they learnt from other members of staff or the ward manager.
10
11 It was evident however that not all facilities s shared this team ethos. A few participants
12
13 who were care assistants felt that they were not given sufficient information about client's
14
15 conditions or needs. While this was now changing one care assistant described how she
16
17 felt "locked out" when information was not given:
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19

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21
22
23 *... when I started here three years ago and whenever you asked a question*
24 *about a patient they'd say 'sorry it's none of your business...I think they were*
25 *probably protecting confidentially, but you always felt you were sort of locked*
26 *out, and I think that's changing now (BLT004 Staff 1) (Extended Care Unit)*
27

28
29 It was evident therefore that there were perceived differences in the learning culture
30
31 within facilities.
32
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35
36 Participants also described a number of organisational practices and rituals they adhered
37
38 to when a client was dying or died. Overall participants reported death rituals and
39
40 practices relating to religion, in particular to Catholicism. In such instances reciting
41
42 prayers at the bedside, putting a crucifix in the room and lighting candles were important
43
44 considerations when a client was dying. A common practice routinely undertaken, as a
45
46 mark of respect for the dying and their relatives, was the switching off of televisions and
47
48 radios. In addition when a client died on a shared ward the curtains were pulled around
49
50 the other beds just prior to dying and left in place until the body was removed. It was
51
52 clear that these rituals were undertaken in an effort to protect clients and to reduce their
53
54 anxiety. However participants recognised that clients were probably fully aware as to the
55
56 purpose of this strategy:
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3 *QS5 ...we have to be very sensitive...now they know that when the curtains are*
4 *being pulled around they know why...they know exactly why but it's just not to be*
5 *pushed in to their face you know.*

6
7 *P 6: BLT006 QS2. (Extended Care Unit)*
8
9

10 In summary the philosophy culture and organisation of care influenced the way in which
11
12 EoL care was delivered. Across all facilities there was an ethos of spending time with
13
14 those who were dying. However lack of time, staff shortages, lack of support and the
15
16 organisational routines and procedures often hindered staffs ability to provide good EoL
17
18 care.
19
20

21 22 23 **Knowing the Person**

24
25 Participants felt that 'knowing the person' and creating a close relationship at the
26
27 individual level was a key determinant of quality EoL care. Many indicated that they did
28
29 indeed form close attachments:
30
31

32
33 *"You get attached to them and then all of a sudden they're not there anymore and*
34 *you still, we still mention (name), she's dead about two or three years, something*
35 *would come up, 'oh do you remember (name) doing this.'" (BLT6, Staff 02,*
36 *Extended Care Unit)*
37

38 In particular participants felt that 'knowing the person' allowed them to interpret
39
40 treatment and care wishes when communication with a client was no longer possible:
41
42

43
44 *"... you get to know the person's likes, dislikes, qualities...and then when it comes*
45 *to the EoL, you have a good picture of what that person likes or the person*
46 *doesn't like." (PIX48, Staff 04, Private Nursing Home)*
47

48 Participants also described how getting to know the person enabled them to distinguish
49
50 between normal behaviour patterns and episodes of distress that warranted referral and
51
52 intervention.
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3 Across all facilities it was evident that participants were very sensitive to the needs of
4
5 people who were approaching EoL and the needs of their families. They described
6
7 meticulous attention to certain aspects of care, for example holding a hand or talking to
8
9 the person. Ensuring that the person was well groomed was also highlighted as important
10
11 as this demonstrated respect for both the needs of the client and of the family.
12
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16 *it's,...the simple things, so simple that you nearly overlook them, a sip here, a*
17 *word of encouragement... hold his hand for a few minutes you know if you get a*
18 *chance... always cleanly dressed and shaved and that they would look well...its*
19 *important BLW004 QS5. (Extended Care Unit)*
20
21

22
23 However, although 'knowing the person' was highlighted as important, most participants
24
25 rarely openly discussed death and dying with clients and in many instances they
26
27 described the use of blocking techniques that closed down the potential for any
28
29 discussion. Strategies such as keeping cheerful, distracting clients and offering
30
31 reassurance that they would be fine were used
32
33

34
35 *Oh I am just try to reassure 'no its nothing, no don't think like that'...And even if*
36 *I know they have an hour left or whatever left, I keep on reassuring them*
37 *like...'you will be fine, you will see, you will be fine', yeah so try to reassure*
38 *them... So you know to try reassure that there is a tomorrow there, and I know its*
39 *not....but I try to reassure (PIQ048 QS4).(Private Nursing Home)*
40
41

42
43 Some participants reported that lack of knowledge and skills was a key factor that
44
45 prevented them from discussing death and dying. Others described instances where it was
46
47 difficult to discuss death and dying with clients as the families didn't wish them to know
48
49 they were dying or vice versa. While a few participants reported that engaging clients in
50
51 a discussion re death and dying was just not done:
52

53
54 *QS4 Actually we don't discuss dying with them at all to be honest*
55 *(P 8: BLT006 QS4.(Extended Care Unit)*
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5 Predominantly, although participants recognised and knew clients were dying they tended
6 to shy away from discussing this topic. A system of 'closed awareness' was in operation
7 whereby staff didn't discuss dying with clients and clients were not give an opportunity
8 to discuss dying with the staff, yet both parties appeared to know that death was
9 imminent. Overall it appeared that the acknowledgement of death was largely reserved
10 for the time shortly before death and exhibited through the caring response of direct care
11 staff rather than a discussion prior to the terminal phase of life. In addition participants
12 reported that little formal EoL care planning which reflected an engagement with clients
13 was undertaken.
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29 Knowing the person therefore was viewed as crucial to good EoL care and to dying well
30 and across all facilities staff demonstrated sensitivity to the needs of the dying. However,
31 few staff openly discussed death/dying with clients and used various techniques to
32 circumvent such conversations.
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41 **Physical Environment & Resources**

42 Participants reported that the physical environment and adequate resources were an
43 important issue in EoL care. In particular the availability of a single room was deemed to
44 be paramount as it helped to maintaining privacy and dignity of the client and family.
45
46
47
48

49 *"...To have the dignity to die in a room on their own, I think would be very important.*
50 *Because you can't grieve or say what they want maybe when there's other*
51 *people in the room you know. (GRT005 S 4) (LSUAPC/H)*
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3 However few facilities had single rooms and participants reported that they often found
4 that these rooms were needed for other clients with an infection, which took precedence.
5
6 In such instances participants went to great lengths to meet the needs of families by
7
8 procuring either mattresses to enable families to be with their dying relative:
9
10

11
12 *... the last few people that died we had mattresses that could just, throw on the*
13 *floor and sleep in the room with the people themselves ... (GRT005 QS7)*
14 *(LSUAPC/H)*
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20 Some participants felt that the death of a client in the same room was quite traumatic for
21 other clients. However others felt that moving a person to a single room may be
22 inappropriate when s/he was used to living in shared accommodation.
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29 Palliative care education and training was another key resource identified by all
30 participants as central to providing good EoL care. A range of needs were identified
31 including symptom management, pain management use of syringe drivers, counselling
32 and psychosocial care. Access to educational opportunities however differed across
33 facilities. Some participants reported that there were good training resources and
34 opportunities while others suggested that these were not always available:
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43 *“...nurses need more education on palliative care and pain control. We should be*
44 *sent by our hospital management to the hospice or whatever for one day, two*
45 *days... I think we need it here in the care of the elderly as much as anywhere*
46 *else” (BLT006 Staff 4).(Extended Care Unit)*
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49 Participants also suggested that the increasing ethnic diversity of the population raised
50 particular challenges for EoL care. They felt unprepared to give EoL care to people from
51 different ethnic groups and felt strongly that this need should be addressed. In addition
52 staff participants from overseas described how they learnt appropriate cultural EoL care
53 from their colleagues:
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“We just find out and we just ask what should be done...Normally [from] the manager ...So when I first came into this country, I didn't know what the rules were...But I find out what needs to be done so I know if they are Catholics I would put the beads, in their hands ...” (PIQ048 Staff 4). (Private Nursing Home

Physical environment and resources influenced EoL care. In particular access to single room accommodation and palliative care training and education hindered staffs ability to enable clients to die well.

Discussion

This study developed a model of the factors that influence the provision of good EoL care for older people living in acute and long stay care settings. While other studies have identified these factors as important, this study found the interrelationship between these factors was as important as the factors themselves, in contributing to good quality EoL care and enabling resident to 'die well'. The model (Figure1) illustrates how factors overlap and influence each other.

In this study participants were cognisant of the needs of the dying and their families and described examples of providing practical, sensitive and appropriate care. This was also a finding in other studies (Costelll 2001; Katz et al 2005). A key factor governing the provision of good EoL care revolved around building relationships and getting to know the person as an individual. This factor is also highlighted in other studies (Costello 2006; Froggatt and Payne 2006; Palan-Lopez 2007; Cartwright and Kayser-Jones 2003; Hanson et al. 2002; Phillips et al. 2006) Knowing the person however, makes little difference to good EoL care if the facility lacks a care philosophy of open communication

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3 regarding death/dying. As in other studies (Costello 2001), in this study, in an attempt to
4 protect clients a system of closed awareness dominated, whereby staff colluded and kept
5 clients “in the dark” regarding their terminal status (Glaser & Strauss 1965; Costello
6 2001). This closed awareness often continues after death, where staff hide the death of a
7 client attempting to maintain an atmosphere of normality believing that it would be
8 upsetting for other clients (Katz et al 2005). This was also evident in this study where
9 staff seemed to engage in a ‘professional performance’ to conceal death (Komaromy
10 2000) despite the fact that they knew that people were well aware of what was happening.
11 These practices prohibit open discussions regarding death/dying and preclude the
12 establishment of meaningful relationships. There is an urgent need therefore to change
13 such practices which deny clients the right to prepare themselves and their families for
14 the last major event in their lives.
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34 Similar to other studies (Costello 2001, Katz et al 2005; Hopkinson et al 2003; Clarke &
35 Rosse 2006) this study found that the culture, philosophy and organisation of care
36 governed staffs approach to EoL care. In settings where the philosophical focus was
37 holistic and individualised, care was orientated around clients needs and preferences
38 (Hanson et al 2002; Costello 2006; Froggatt and Payne 2006; Palan-Lopez 2007). It is
39 likely that the ethos is influenced greatly by the ward manager and in the absence of a
40 clear philosophy the study found that clients were given little choice. Nurse Managers
41 need to work with staff to establish a clear understanding as to the care philosophy
42 underpinning their work and how the terms EoL care and palliative care are interpreted,
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3 and operationalised in practice. In this way staff may be more confident in providing
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5 good quality EoL care with less room for ambiguity
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10 Lack of resources in terms of time and staff have a negative impact on staff ability to
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12 deliver quality EoL care (Ling, 2005; Cartwright and Kayser-Jones 2003; Costello 2006;
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14 Costello 2001; Hanson et al. 2008; (Clarke and Ross 2006; Costello 2006; Hanson et al.
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16 2002). However, communicating and discussing sensitive topics with clients do not
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18 require more time, what it does require is a new way of working (Clark & Ross 2006;
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20 Costello 2004). As suggested by participants in this study, the way in which time is
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22 allocated and care is prioritised requires a fundamental shift in thinking and a change in
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24 approaches used if the dying person is to get the care they need and that staff clearly feel
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26 they should receive.
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34 Not being able to offer the dying person the choice of single room accommodation is
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36 mentioned in the literature (Clarke and Ross 2006; Daaleman et al. 2008) and it was also
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38 a real concern for many participants in this study. The use of single room
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40 accommodation and the actual physical structure of all elderly care facilities therefore
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42 should be reviewed and as recommended by Health Information & Quality Authority
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44 (HIQA 2008) these facilities must endeavour to include more single rooms.
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51 The lack of education training and skills in EoL care is well documented (Field &
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53 Froggat 2003; Ling 2005; Anslem et al., 2005; Parish et al 2006; Phillips et al. 2007;
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55 Watson et al. 2006). Likewise in this study lack of education and training was identified
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3 as one of the main factors preventing staff from providing good EoL care. Indeed only
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5 twelve participants in this study had attended specific palliative care training. The lack of
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7 palliative care education may be another reason why staff avoided and emotionally
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9 disengaged from older people at EoL. NICE (2004) stipulate that nursing staff should be
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11 educated in EoL care and in particular communication skills. There is an urgent need
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13 therefore to ensure that all staff caring for older people receive adequate EoL education
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15 not only in how to discuss death/dying but also in terms of symptom control and
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17 management.
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24 The study also reveals the need for multicultural education focusing on the EoL beliefs
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26 and needs of different ethnic groups. Traditionally Ireland was predominantly catholic
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28 however recently there has been an influx of migrant workers working in the care of older
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30 people. Recent statistics reveal that 43% of nursing staff and 32% of all staff in private
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32 nursing homes are migrant workers (INHO 2006). Nurse curricula therefore need to
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34 address these changes. Furthermore overseas staff require induction programmes, which
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36 include EoL practices and needs of different ethnic groups.
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43 **Conclusion**

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45 People are living longer consequently acute and long stay care setting will increasingly
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47 become places where older people die. However there is compelling evidence that older
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49 people at EoL have several unmet needs. There is an urgent need therefore to develop
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51 health care settings and quality care strategies responsive to these needs. This study
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53 presents a model of the factors that influence the provision of good EoL care for older
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3 people. Mobilising resources to ensure that these factors are considered is crucial to
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5 ensuring that, irrespective of where older people die, they will do so while receiving the
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7 highest standard of EoL care that nurses can provide.
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Table 1: Study Sites

Facility	Urban	Rural
Acute Hospital	1	
Extended Care Unit	1	1
Private Nursing Home	1	1
Long stay unit attached to Palliative care centre/Hospice (LSUAPC/H)	1	

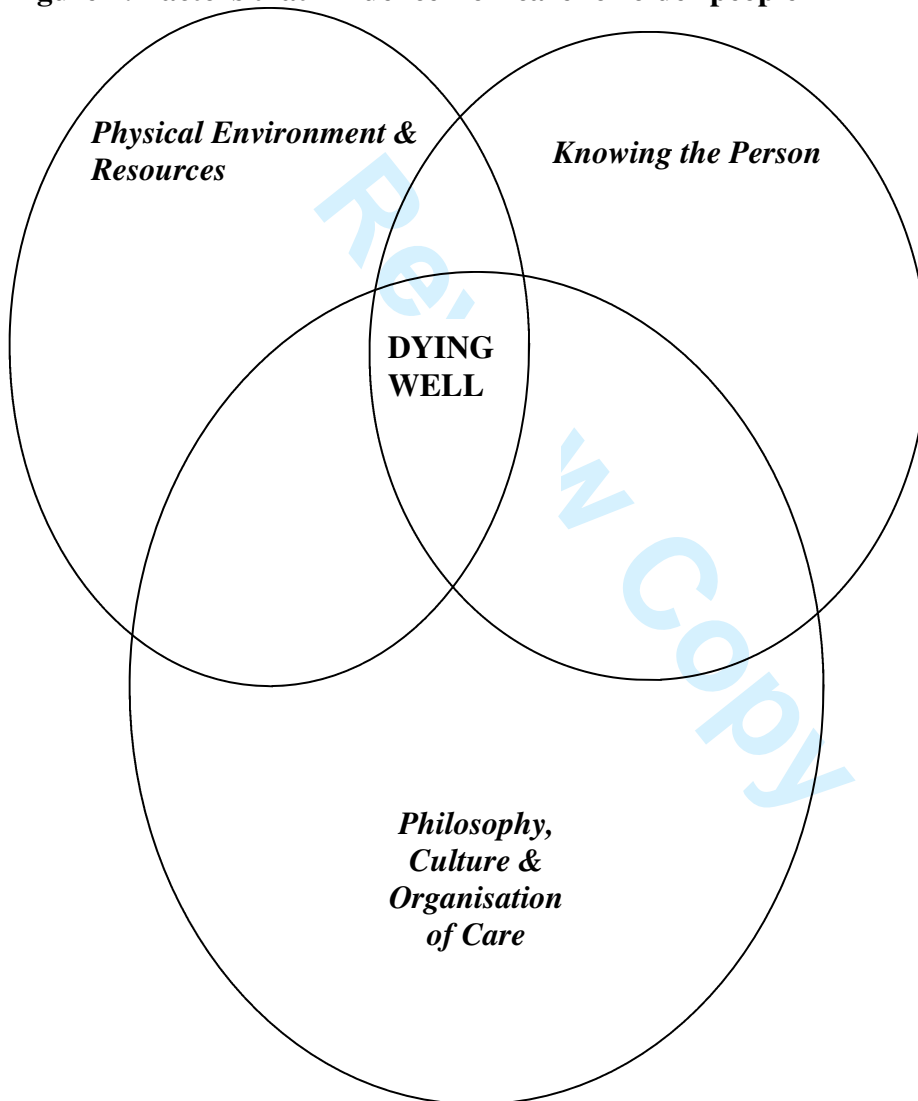
Table 2: Demographic profile of interviewees

Occupation	Gender	Length of time in current position	Highest Educational qualification	Attended a specialist course or study day in Palliative care
Clinical Facilitator	Male	0-5 years	Higher Diploma (Nursing)	No
Clinical Nurse Manager	Female	0-5 years	Certificate (Nursing)	No
Clinical Nurse Manager	Female	0-5 years	Masters (Nursing)	Yes
General Practitioner	Male	0-5 years	MD	No
Health Care Assistant	Female	0-5 years	FETAC*	No
Health Care Assistant	Female	0-5 years	FETAC	No

Health Care Assistant	Female	0-5 years	FETAC	No
Health Care Assistant	Female	0-5 years	FETAC	No
Health Care Assistant	Female	0-5 years	FETAC	No
Health Care Assistant	Female	0-5 years	Post Primary Certificate	Yes
Occupational therapist assistant	Female	0-5 years	Certificate (Nursing) obtained outside the EU	No
Physiotherapist assistant	Female	0-5 years	Degree (Psychology)	No
RGN	Female	0-5 years	Degree (Nursing)	No
RGN	Female	0-5 years	Degree (Business studies)	No
RGN	Female	0-5 years	Degree (Nursing)	No
RGN	Female	0-5 years	Degree (Nursing)	No
RGN	Female	0-5 years	Certificate (Nursing)	Yes
RGN	Female	0-5 years	Certificate (Nursing)	Yes
Clinical Nurse Manager	Female	11-15 years	Diploma (Counselling)	Yes
RGN	Female	11-15 years	Certificate (Nursing)	Yes
RGN	Female	16-20 years	Certificate (Nursing)	Yes
General Practitioner	Male	21-30 years	MD	Yes
RGN	Female	21-30 years	Certificate (Nursing)	Yes
RGN	Female	31-35 years	Certificate (Nursing)	No
Health Care Assistant	Female	36-40 years	Post Primary Certificate	No
RGN	Female	6 months	Degree (Nursing)	No
Clinical Nurse Manager	Female	6-10 years	Certificate (Nursing)	No
Clinical Nurse Manager	Female	6-10 years	Postgraduate Diploma (Nursing)	Yes
Clinical Nurse Manager	Female	6-10 years	Certificate (Nursing)	Yes
Clinical Nurse Manager	Female	6-10 years	Postgraduate Diploma (Nursing)	Yes
Health Care Assistant	Male	6-10 years	FETAC	No
Health Care Assistant	Female	6-10 years	Certificate (Nursing)	No
RGN	Female	6-10 years	Certificate (Nursing)	No

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3 *FETAC- Further Education and Training Awards Council. This is a Level 5 Certificate
4 in Healthcare Support for healthcare assistant, which focuses on core competencies
5 needed to provide direct/indirect patient care, following allocation by and under the
6 supervision of an RGN or RNM.
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14 **Figure 1: Factors that influence EoL care for older people**



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