

The Building Rural Research Capacity Program Final Report

A comparative study looking at the effectiveness of two different teaching methods used to improve the integration of the Palliative Approach into Rural Residential Aged Care Facilities

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‘To be educated is not to have arrived at a destination; it is to travel with a different view’

(Peter R in MacLeod R 2004)

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Thank you

Claudia

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Executive Summary

As our population ages Residential Aged Care Facilities (RACFs) are caring for an older, frailer population of people with often complex co-morbid conditions. The care of this group is unique and challenging, often managed by a team that predominately consists of assistant nurses. How to ensure equitable access to excellence in palliative care remains a challenge with the Department of Health and Ageing starting to address this through releasing Guidelines for a Palliative Approach in Residential Aged Care (2006). Adopting these guidelines however is pivotal to their success and this study looked to investigate how best to integrate the palliative approach to care into rural RACFs through comparing two teaching methods (in-servicing and case conferencing).

The researcher conducted a 12 month program of in-services and case conferences across five RACFs in the Central West of NSW. She used both quantitative and qualitative research methodologies, employed simple comparative statistics (Chi Square), descriptive statistics and thematic analysis to inform the discussion and conclusions made.

This study demonstrates that case conferencing was more effective than in-servicing in relation to:

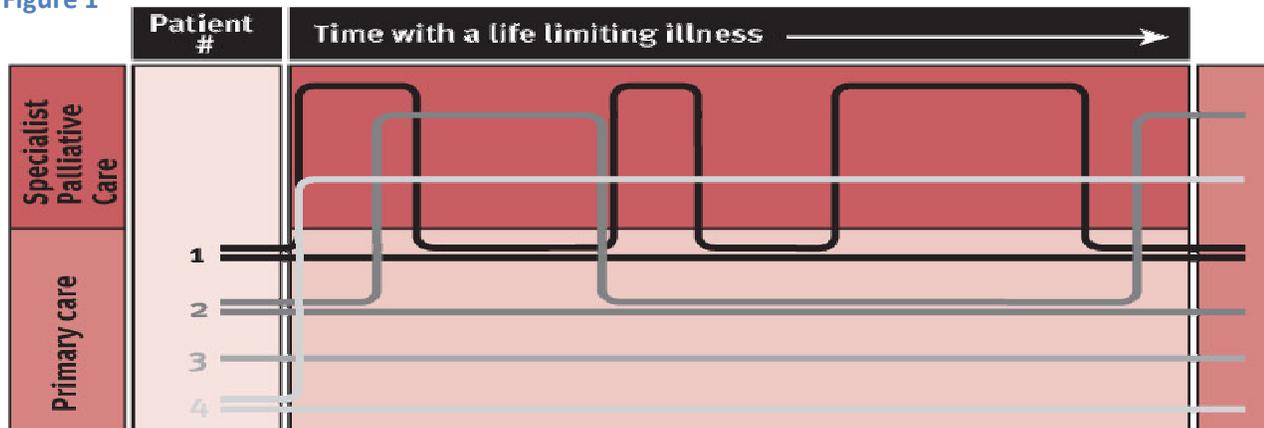
- Increasing and enabling clinically appropriate referrals to specialist Palliative Care services
- Increasing the understanding of the role of the specialist Palliative Care team
- Creating practice changes
- Increasing communication between team members

Palliative Care by its very nature is a broad area where people requiring such care will have unique needs, differing illness experiences and different support needs. Therefore, empowering staff to problem solve, identify issues, communicate effectively and refer for specialist support when needed will allow the successful integration of the Palliative Approach in practice. Case conferencing supports this through the development of a supportive learning environment, responsive to student need, relevant to real time practice and through fostering problem-based learning. Case conferencing seeks to empower staff with the ability to form alternate views in their workplace, to troubleshoot and discuss as a team best practice principles. It values the skill of all those in the team, is inclusive and productive, therefore ideal for a RACF setting. Case conferencing in this study was more effective than in-servicing in integrating the Palliative Approach into Rural RACFs.

Background

Palliative Care, throughout Australia, continues to evolve as a specialty (Department of Health and Ageing, 2004). Palliative Care Australia (PCA) describes a model of care whereby Specialist Palliative Care providers consult with Primary Care providers for patients with complex Palliative Care needs (PCA, 2005). It is clear that not all people with life limiting illness require Specialist Palliative Care input, but they will all require a palliative approach to their care (PCA 2005). Figure 1 displays this concept well (PCA 2005).

Figure 1



Episode of care scenarios to meet palliative care needs.

(PCA 2005 p.17)

As our population ages and medical advances continue, Residential Aged Care Facilities (RACFs) are caring for an older, frailer resident population who often face complex co-morbid conditions (Department of Health and Ageing, 2004; Visser G, Klinkenberg M, Broese van Groenou M, Willems D, Knipscheer C and Deeg D, 2004). It is clear that staff in these facilities require skills and knowledge to provide a palliative approach to care for their residents. Specialist Palliative Care overlaps with, but should not be confused with the palliative approach. This aims to 'promote both physical and psychosocial well-being in all patients. It is a vital and integral part of all clinical practice, whatever the illness or its stage, and is informed by a knowledge and practice of Palliative Care principles.' (Higginson, in Faull, Carter and Woolf, Eds., 1998, p.4) Such an approach is founded in an open attitude towards death and dying, facilitating greater end of life care planning (Department of Health and Ageing, 2004).

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In recent years there have been considerable changes in links between Aged Care and Palliative Care (Department of Health and Ageing, 2005) with many national programs targeting the delivery of the palliative approach in RACFs. Such programs include the production of 'Guidelines for a Palliative Approach in Residential Aged Care', grants for equipment and educational opportunities. However, at the Inaugural Palliative Care Nurses Australia Conference (Sept, 2006) several delegates spoke of difficulties experienced in the adoption of the palliative approach in Aged Care. Reasons given included: staffing levels, skill-mix and other workload issues, lack of knowledge and skills within Palliative Care and having time to deliver such care. Alongside this were strong reports of a willingness of RACFs to learn these skills, to provide optimal care for their residents (PCNA Conference Sept 2006).

It is also relevant that RACFs face unique care challenges as resident's may suffer from dementia and/or many co-morbidities, are often highly dependant and some lack family support (Department of Health and Ageing, 2004). As a result distinct needs are evident within Aged Care, supporting the value of adopting a palliative approach for all older persons with a life-limiting illness or who are dying as a consequence of the ageing process (Department of Health and Ageing, 2004, p. 4).

'Undoubtedly, the need to provide clinically relevant, focused and substantive education programmes to meet the challenge of palliative practice remains high on the agenda for educators' (Vlieger M, Gorchs N, Larkin P and Porchet F, 2004, p.401). Specialist palliative care providers aim to support RACFs with the skills to deliver confident care, founded in the palliative approach to care, with a strong recognition of when to refer for specialist advice. This builds strong links between primary care providers and specialist services enhancing the model of Palliative Care, as endorsed by PCA. The effectiveness of teaching methods used to integrate the Palliative Approach to care in rural RACFs has not been closely analysed and this study seeks to explore this so as to inform future planning in this area.

Literature Review

Search Strategy

Two main search strategies were used in order to complete the literature review for this study. A search was conducted regarding Palliative Care Education within Aged Care and then also in regard to adult education needs.

An electronic search was conducted for English language articles in peer review journals from 1990 to present publications. Further searches were conducted with librarian support from Charles Sturt University. Government and non-government publications, standards of care and existing guidelines and reports to government were also conducted.

Search terms included Palliative Care, Education, Residential Aged Care Facilities, Aged Care, Geriatrics, Rural, Remote. Searches were conducted on Medline, Cinahl, Cochrane Library and CareSearch. Once general themes were established from literature content, a process for identifying, assessing and evaluating and eliminating material in the literature review process was developed. Themes emerged as:

- The need for the Palliative Approach to Care in RACFs
- Training needs for staff in RACFS in relation to Palliative Care
- Adult Education
- Provider issues
- Rural issues
- Evaluated teaching styles used in Palliative Care

Inclusion and exclusion criteria were established for initial decision-making on articles and abstracts.

- Inclusion criteria: English language, relevance to working in rural RACFs, relevance to adult education and palliative care, research based articles as well as expert opinion and literature reviews
- Exclusion criteria: Articles written prior to 1995 were not considered (although 2 seminal texts from prior to this date were included). Non-english language articles.

Limitations to this review include the fact that much research in Palliative Care has occurred in European countries and is therefore often not published in English. Also, most English articles published are from first world countries and therefore may not reflect the full variety of issues present amongst differing socioeconomic climates. Studies not available via electronic databases were not identified. Abernethy, A., Currow, D and Butler (2002) report that electronic databases miss approximately 30% of the palliative care literature. Time constraints also meant that preliminary assessment was made based on title and abstract only.

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The need for the Palliative Approach in Residential Aged Care facilities

There is overwhelming evidence from the literature to support the fact that residents of Aged Care facilities will benefit from a Palliative Approach to their care. This literature describes the fact that the population within RACFs is increasingly frail (AIH&W 2008; Department of Health and Ageing, 2006) with unique and complex needs (AIH&W 2008; Davies E and Higginson I (Eds). 2004; Department of Health and Ageing, 2004; Hudson et al, 2007; Visser G, Klinkenberg M, Broese van Groenou M, Willems D, Knipscheer C and Deeg D, 2004; Wilson and Daley, 1998) and that this population is predicted to increase by 70% over the next 30 years (Giles, L.C., Cameron, I.D. and Crotty, M. 2003). The fact that such conditions seen within the Aged Care Facility population are not amenable to cure but do require effective symptom management, supports the need for facilities to adopt a palliative approach to care (Davies E and Higginson I (Eds). (2004); Department of Health and Ageing, 2006; PCA 2005). Furthermore several authors suggest that the unique and complex needs seen within RACFs are inadequately addressed (Davies E and Higginson I (Eds)., 2004; Harris D, Richard B and Khanna P 2006; Hudson et al, 2007; Rice K, Coleman E, Fish R, Levy C and Kutner J, 2004) and many die without palliative care intervention (Katz, Komaromy and Sidell, 1999; Stillman D, Strumpf N, Capezuti E and Tuch H., 2005). Davies E and Higginson I (Eds). (2004) therefore ask for 'palliative care to be part of the overall health policy for older people and to be an integral part of the services they receive' (p7).

Statistically we know that of those admitted to a RACF in Australia, 62% die within their first year (Hudson et al, 2007) and 31% die within six months (AIH&W, 2003) and that by 2020 approximately half of all deaths are expected to occur in nursing homes (Sheehan D and Schirm V, 2003). Therefore, death and caring for those who are dying is a common experience within RACFs (Amella E, 2003; Philips J, Davidson P, Jackson D, Kristjanson L, Daly J and Curran J, 2006; Goodridge D, Bond J, Cameron C and McKean E, 2005; Hudson et al, 2007)

The literature suggests a model of palliative care within RACFs that involves Specialist Palliative Care simply augmenting a Palliative Approach to care with focused, intermittent and specific interventions as required (Department of Health and Ageing, 2006; PCA 2005). The transition from curative care to palliative care in aged care is often unclear (Lo, R and Woo, J, 2001) and so the model of adopting a palliative approach to care allows for care based within holistic care principles (Edwards A and Hirst P, 2005; Hallberg I 2006; Jones A and Johnstone R 2004; Mathews K and Finch J, 2006) thereby enabling the possibility of a good death for more older persons (Amella E, 2003). Avis, M., Jackson, J., Cox, K and Miskella, C, 1999 also describe the reduction of potential distress caused by transfer to acute settings for residents through the use of a palliative approach to care. At present there is evidence to suggest that this care model is not yet integrated into practice within RACFs (Nair B., Kerridge I., Dobson A., McPhee J and Saul P 2000) with their study showing that less than 0.2% of resident's had any documented treatment wishes.

The literature clearly documents a population of older, frailer residents requiring more complex care, within Aged Care Facilities. In addition to these facts, authors comment on the fact that currently people within RACFs are not receiving adequate palliative care. Palliative Care Australia describes a model of specialist A comparative study looking at the effectiveness of two different teaching methods used to improve the integration of the Palliative Care Approach into Rural Residential Aged Care Facilities

palliative care supporting the palliative approach within RACFs in order to address the above disparities and the literature reviewed, supports this view. Therefore, it is clear that RACFs need to adopt a Palliative Care approach in order to enable optimal care for residents.

Training needs for staff in Residential Aged Care Facilities in relation to Palliative Care

The literature explains clearly that staff in RACFs require additional training in Palliative Care (Davies E and Higginson I (Eds)., 2004; Department of Health and Ageing, 2006; Edwards A and Hirst P, 2005; Harris D, Richard B and Khanna P, 2006; Hudson et al, 2007; Jones A and Johnstone R, 2004; Katz, Komaromy and Sidell, 1999; Mathews K, 2006; Mathews K and Finch J, 2006; NSW Department of Health 2006; Rice K, Coleman E, Fish R, Levy C and Kutner J, 2004 Sheehan D and Schirm V; 2003). In addition to this, there is acknowledgment in the literature of the need to transfer skills between aged care and palliative care providers (Davies E and Higginson I (Eds). 2004; Hudson et al, 2007) and that there is a unique factor for consideration with RACF staff due to their staff skill mix, with particular note of the fact that many unskilled workers deliver care in RACFs (Edwards A and Hirst P, 2005 Hudson et al, 2007; Jones A and Johnstone R , 2004; Stillman D, Strumpf N, Capezuti E and Tuch H 2005). The high turn over of staff is described by Stillman D, Strumpf N, Capezuti E and Tuch H 2005, who suggest therefore that a culture change within RACFs is required. Jones A and Johnstone R (2004) and Mathews K (2006) also describe the issues related to staff development due to recruitment and retention issues. The Department of Health and Ageing, 2006 suggests having an RN (preferably) with formal Palliative Care training as one member of the aged care team.

Other factors impacting on the ability for staff to adopt the palliative approach (outside of direct needs for training and education) include the death denying culture pervasive in our culture (Department of Health and Ageing, 2006; Hudson R and O'Connor, M, 2007). Harris D, Richard B and Khanna P, 2006 suggest that education provision needs to include staff, residents themselves and their families, in order to integrate a Palliative Approach to care successfully.

In Australia, national guidance is given for RACFs to adopt a palliative approach to their resident's care but 'there is currently no evidence-based document to guide health care providers who are endeavouring to implement a palliative approach in RACFs' (Department of Health and Ageing, 2006, p15) and little is known about the ability and capacity of RACFs to support such a model of care (Philips J, Davidson P, Jackson D, Kristjanson L, Daly J and Curran J, 2006). As a result the Department of Health and Ageing have released Guidelines for a Palliative Approach in Residential Aged Care (May 2006). Philips et al, 2006 comment that 'the provision of enhanced palliative care educational and networking opportunities for nurses and care assistants.... augmented by a supportive organizational culture, would assist in the adoption of a palliative approach to service delivery..' (P423)

Adult Education

A review of the literature pertaining to adult education was conducted. Lin Y and Che C, 2007 state that nursing education should involve learning through problem posing, instead of lectures 'to foster an interactive relationship between teacher and student that is characterised by critical thinking and active dialogue' so as to support the development of interpersonal, knowledge acquisition, task accomplishment and personal development skills (Lin Y and Che C, 2007 p.16). Kingsbury and Lymn, 2008 support this view.

Knowles (Knowles M 1980) describes the differing needs for adult education (andragogy- the art and science of helping adults to learn) as opposed to education for children (pedagogy-the art and science of teaching children). The shift from teaching to learning began and continues to be discussed. In practical terms, andragogy means that instruction for adults needs to focus more on the process and less on the content being taught. Knowles' theory (Knowles M 1980) can be stated as four simple postulates:

1. Adults need to be involved in the planning and evaluation of their instruction (Self-concept and Motivation to learn).
2. Experience (including mistakes) provides the basis for learning activities (Experience).
3. Adults are most interested in learning subjects that have immediate relevance to their job or personal life (Readiness to learn).
4. Adult learning is problem-centered rather than content-oriented (Orientation to learning).

Knowles (1980) also states that 'as people grow and develop they accumulate an increased reservoir of experience that becomes an increasingly rich resource for learning – for themselves and others' (p44) Also, people attach more meaning to learning from experience than passive acquisition of knowledge. Critics of Knowles work focus on him taking too much of a simplistic view of andragogy V pedagogy. He discusses a world perhaps where such methods are distinct from each other. 'This hostility toward pedagogy had two negative outcomes: On a strategic level, scholars of adult education could make no alliances with the colleagues from pedagogy; on a content level, knowledge developed in pedagogy through 400 years could not be made fruitful for andragogy' (Reischmann, Jost 2004)

Sullivan A., Lakoma M., Billings J., Peters A and Block S, 2005, describe a study where pedagogical techniques alongside clinical skill development are utilised and discussed as differing techniques. Their study overwhelming indicated that both nursing and medical professionals need to move away from didactic teaching methods and they offer a model they feel is worth considering, based on one week programs, delivered twice over a one year period. They state that 'despite overwhelming evidence of their ineffectiveness in producing behaviour change, lecture-based and other primarily noninteractive methods persist as the prevailing methods of education' (p666).

Many other authors describe differing teaching methods to support student's learning. O'Shea, E (2003) states that not all students are self-directed and a variety of teaching methods need to be used. However, when self-directed learning is supported potential benefits include increased confidence, autonomy, motivation and

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preparation for lifelong learning. Coffman S (1996) states that adults 'learn best when they can select from a variety of learning modalities with the goal of completing a task' (p260). Bigge E and Higginson I 2006 feel that 'Multifaceted education, which includes the use of various media, and which is personally tailored is most effective' (p102). Weissman D and Blust L 2004 state that adults learn best when there is some educational tensions, that is, where there is a need to know something. 'To facilitate changes in attitude, trainees must feel it is safe to discuss their fears and concerns with respected mentors and peers who can normalize their fears and offer alternative or reframed concepts' (168).

Therefore, the literature explains the need to stop and think about educational techniques used to change practice within care settings. We know that greater knowledge with regard to the palliative approach to care is needed within RACFs in order to facilitate this care. The above literature demonstrates the need to consider the unique needs adults have regarding their learning, so as to optimise education opportunities and impact on practice in the longer term.

Rural Issues

There are very few articles discussing the needs of rural RACFs with regard to Palliative Care. However the Department of Health and Ageing, 2006 states that some RACFs in rural settings do not have access to enough support from Specialist Palliative and a South Australian study found rural RACFs were less likely to offer Palliative Care Approach (Hunt, R., Fazekas, B., Luke, C and Roder, D, 2001).

Telehealth facilities have been described as a method of supporting rural RACFs in their delivery of Palliative Care (Department of Health and Ageing, 2006) with Boxel P, Anderson K and Regnard C 2003, finding that there were no significant differences in learning when comparing face to face education with videoconferencing.

It is clear that further research into the needs of rural RACFs is needed to better understand their requirements in being able to adopt the palliative approach to care for their residents,

Provider Issues

When looking through the literature relevant to this project it became clear that health care provider issues in Aged Care have some unique factors that ought to be considered. These issues relate to the population changes inherent within the elderly population, staff training and retention issues within Aged Care and staff support needs.

Davies E and Higginson I (Eds). (2004) state that the number of older people is increasing alongside population changes in society, affecting the care of older people. Furthermore they express that 'it takes more than knowledge and good will or good intentions to translate this into action. Achieving better palliative care for older people requires a willingness to listen to them and their families, imagination, and a determination to remove barriers at all levels of health care systems.' (p33). In addition to this Amella E (2003) writes about the fact that older people tend to die over a longer period of time and thus may experience a multitude of
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symptoms. Often older people experience a small decline in capacity, facing many losses and continue to require a higher level of care. 'Consequently, health professionals need to address not only issues associated with the dying process, but also fundamental problems associated with joint pain, loss of hearing and vision, and perhaps fatigue' (p41).

Staff training and retention issues are important considerations (Brazil K, Bedard M, Krueger P, Taniguchi A, Kelley M, McAiney C and Justice C, 2006). Stillman D, Strumpf N, Capezuti E and Tuch H 2005 state that 'the long-term care industry faces many challenges, including high turnover, few professional staff with training in geriatrics or palliative care, and intense regulatory oversight focused on functional outcomes' (p263). Mathews K (2006) also describes the impact of blurred financial responsibilities and unique staff skill-mix and believes that 'education is the key to the delivery of high-quality palliative care but it has huge implications in terms of time and cost' (p39). Furthermore, Sheehan D and Schirm V (2003) discuss that often obstacles to effective palliative care were hierarchical and involved failure to recognise the futility of curative treatments, difficulties in communication amongst those making decisions about care and a lack of agreement among all those involved about care plans. They describe that ongoing communication and involvement of all concerned in decision making is required.

Staff in RACFs work with residents over significant periods of time and in some ways become that resident's family, affecting how they may cope following a resident's deterioration and death (Amella E 2003). Yates P, Clinton M and Hart G (1996) also state that health care providers describe a great deal of stress when working with people with palliative care needs and that looking for effective support and education in this way is therefore essential.

The literature supports the fact that we need to conceptualise unique education methods to support the varied skill mix working within RACFs, in order to successfully allow the integration of the palliative approach to care.

Evaluated Teaching Styles used in palliative care

Significant work has been done evaluating the impact of various teaching methods within Palliative Care, some of which has had a focus on work within RACFs. Important to note, education itself (in any format described) does have a positive impact in enabling greater knowledge within palliative care (Spiegel M, Meier D, Goldhirsch S, Natale D and Morrison S 2002). Bigge E and Higginson I 2006 and MacLeod R 2004, conclude that multifaceted education, utilizing various media is most effective. Whereas Parks S, Haines C, Foreman D, McKinstry E and Maxwell T (2005) found their program (five in-service lectures with accompanying take home modules) improved end of life care knowledge that was maintained for up to one year. Reflective practice is described and concluded as a useful medium to educate staff (Fryer-Edwards K, Arnold R, Baile W, Tulsy J, Petracca F and Back, A 2006; MacLeod R 2004; Rosser M 1995; Yates P, Clinton M and Hart G 1996). Sociodrama and a 'book club' approach are also reviewed positively (Jones C 2001; Franklin M 2001; Ring J and Reilly J 2003) enabling richness of learning and discussion. Telehealth options are reviewed with Dosser I,

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Lockhart K and Black P (2007) describing a web based degree incorporating both theoretical content and experiential learning via clinical practice scenarios. This is yet to be evaluated. However Denham S, Meyer M, Rathbun A, Toborg M and Thornton L (2006) found their computer based training for nurse's aides was both low cost and meaningful (this work was evaluated on a rural sample).

A recurring theme is evident from the literature in relation to the need to move away from pedagogical techniques alone (Andrew M 1996; MacLeod R 2004; Skinner B in MacLeod R 2004; Stillman D, Strumpf N, Capezuti E and Tuch H 2005; Sullivan A., Lakoma M., Billings J., Peters A and Block S 2005; Yates P, Clinton M and Hart G 1996) Indeed Sullivan et al (2005) state 'despite overwhelming evidence of their ineffectiveness in producing behaviour change, lecture-based and other primarily noninteractive methods persist as the prevailing methods of education' (p666).

The process of reviewing cases in order to learn has been positively described by many authors (Abernethy A 2008; Bellamy, A., Fiddian, M and Nixon J 2006; Franklin M 2001; Fryer-Edwards K, Arnold R, Baile W, Tulsy J, Petracca F and Back, A 2006; Greenhalgh T, Collard A and Begum N., 2005; Howell D, Prestwich C, Laughlin E and Giga N 2004; Tomey A 2003) These authors describe the fact that case conference approaches issues collaboratively amongst those present, encouraging team management and communication. Bellamy, A., Fiddian, M and Nixon J (2006) state that the 'collaborative case-review process is seen as a way to bring colleagues together in an environment that enables communication and encourages the development of best practice. It also supports palliative care philosophy, which promotes multiprofessional working and a holistic approach to patient and family care' (p158). Furthermore they describe the increase in mutual trust and respect between team members evident after case conferencing - 'there is evidence that the case-review process has been used to aid understanding of professional roles and boundaries' (Bellamy, A., Fiddian, M and Nixon J., 2006, p.162). Greenhalgh et al (2005) describe the benefits of reviewing cases are evident due to stories holding universal appeal, memorability, holistic perspectives, ethical dimensions and potential for multiple interactions and input.

This literature review clearly demonstrated the need for greater clarity of thought regarding the education approach used to affect Palliative Care knowledge within rural RACFs and supports the need for this research study.

Study Aims

This study aims to investigate the effectiveness of two different teaching methods used to improve the integration of the Palliative Approach into Rural Residential Aged Care Facilities. Comparison between in-service education and case conferencing education will be made. Changes in knowledge, attitudes and views to Palliative Care will be measured quantitatively across this 12 month program. Qualitative information will also be obtained to assist in understanding staff views about the program.

Methodology

Study Design

Two teaching styles were used: in-servicing and case conferencing. These two teaching styles were chosen because the researcher noted that most often teaching was delivered within RACFs and other health care settings, in the in-service format, utilizing pedagogical teaching strategies. A pre and post study design of the two teaching styles was used.

In-service education in this study refers to formal didactic teaching where the presenter prepares a topic and delivers education alongside this. Topics were chosen after a teaching needs analysis was completed and included: Communicating with dying patients and their families; Management of Anxiety and Distress; Pain Management; Caring for Carers; Bowel care/ Management of constipation; Terminal Care Management of breathlessness; Management of a Syringe Driver; The role of the Palliative Care Team; End of Life Care Planning; Management of confusion and delirium; Management of Nausea and Vomiting. Participants were invited to ask questions as required throughout all sessions and an evaluation was given after each session.

Case conferencing in this study refers to a more informal method of teaching where staff at the RACF would chose a resident they would like to discuss. A team member from the facility would present an overview of the resident's care needs and the educator would then lead this discussion and use a problem solving framework to enable participants to apply theory to reality. The educator used a flip chart to document issues raised and categorized these into medical history, personal/social history, physical symptoms and psychosocial/spiritual symptoms. She then tried to use this format to teach a style of systematically considering issues alongside the full picture of a resident's care. Eg, if pain was an issue, what was causing this and what else impacted on this – allowing staff to start to problem solve both throughout the session and when next faced with a similar issue. Participants were encouraged to share their own experiences, relevant to each role. All sessions were held monthly, for 1 hour.

At the commencement of this study the researcher visited all five participating RACFs and discussed the project. Consent for participation was obtained. A teaching needs analysis was completed with the RACFs who were having the in-service education (Appendix 1). Dates were sought for all monthly visits and times allocated. Timing was chosen predominantly by each RACF however, due to travelling needs (researcher to each RACF) some flexibility was required for this. The teaching needs analysis informed topics chosen for the 12 month in-service program. Five RACFs were chosen because this represented two towns in which the investigator worked and both towns had expressed interest in Palliative Care education provision.

The Guidelines for a Palliative Approach in RACF (Department of Health and Ageing, 2006) were used to help prepare all the above sessions. Attendance was voluntary with staff informed of all sessions via a memo sent throughout the RACFs. Attendance records were kept and are displayed in the results section (Table 3).

Sampling

RACFs from two rural towns were chosen (a total of five RACFs) and all staff from each facility invited to participate. One town was chosen to receive case-conferencing and the other to receive in-servicing. Participant information sheets (Appendix 6) and surveys (Appendix 3) were circulated with staff payslips. Surveys were completely anonymous and confidential. The questionnaire was to be returned to a designated folder in each facility. Education programs across all sites continued unchanged and staff attendance was voluntary. Tool 2.1 from The Rural Palliative Care Program Evaluation Tool Kit was redistributed 6 months after the administration of the previous tool. That is, tools were completed at 6-month intervals. Again this tool was attached to staff's pay slips.

Staff were invited to participate in interviews to further discuss the acceptability of the teaching style they had and whether this met their needs. This was also discussed in the Participant Information Sheet (Appendix 6). When interviews were due, staff were informed of this (via a reminder memo on the pay slips) and could phone the researcher to arrange if interested.

Data Collection

Following a literature review and analysis of available tools, Tool 2.1 from the Rural Palliative Care Program Evaluation Toolkit (Centre for Health Service Development, University of Wollongong) was chosen to be the tool of choice for statistical analysis. 'This tool was designed to measure confidence about knowledge and skills, attitudes towards palliative care and perceived educational need among providers.' (Quinsey K et al 2007, p.60) This was given out to all staff (attached to their payslips) with requests to complete and return. Completion of the questionnaire was entirely voluntary and data obtained fully confidential. Questionnaires were given at baseline or 0 months, 6 months and at the completion of the program or 12 months. Treatment of data was entered onto an excel spreadsheet. Descriptive statistics and simple comparative statistics such as Chi Square were performed. Treatment of data was entered onto an excel spreadsheet and descriptive and simple comparative statistics such as Chi Square were performed.

Field notes were taken by the principal researcher at every session provided (both in-service and case conference) and an evaluation was completed by those attending in-services (Appendix 2). Field notes included attendance records and changes in referral patterns from the RACFs to Specialist Palliative Care Services. Field notes were collated for use in results analysis. Evaluation forms from the in-service education were collated for review and further discussion.

Structured interviews were held with each RACF who participated in the program. These included group interviews with Assistants in Nursing as well as individual interviews with an RN and a Director of Care/Care Manager for each RACF. All interviews were transcribed and thematic analysis performed.

Ethics Approval

Approval was sought and obtained from the Greater Western Area Health Service Human Research Ethics Committee (GWAHS HREC Reference number 2007/27)

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Results

Demographic Data

Over the 12 month period, 191 questionnaires were returned, from a potential 1062 (18%).

Baseline surveys:

Response from Case Conferencing group: 29 from a possible 81, therefore:

- response rate of 35.8%

Response from In-Servicing Group: 55 from a possible 273 , therefore:

- response rate of 20.1%

6 month surveys:

Response from Case Conferencing group: 36 from a possible 81, therefore:

- response rate of 44.4%

Response from In-Servicing Group: 22 from a possible 273 , therefore:

- response rate of 8%

12 month surveys:

Response from Case Conferencing Group: 34 from a possible 81, therefore:

- response rate of 42%

Response from In-Servicing Group: 15 from a possible 273 , therefore:

- response rate of 5.5%

Of these the following demographics were shown:

Gender: Females 185, Males 11, not recorded 2

Training (including qualification level and/or on the job training):

Comparison between in-service and case conferencing groups at 0, 6 and 12 months

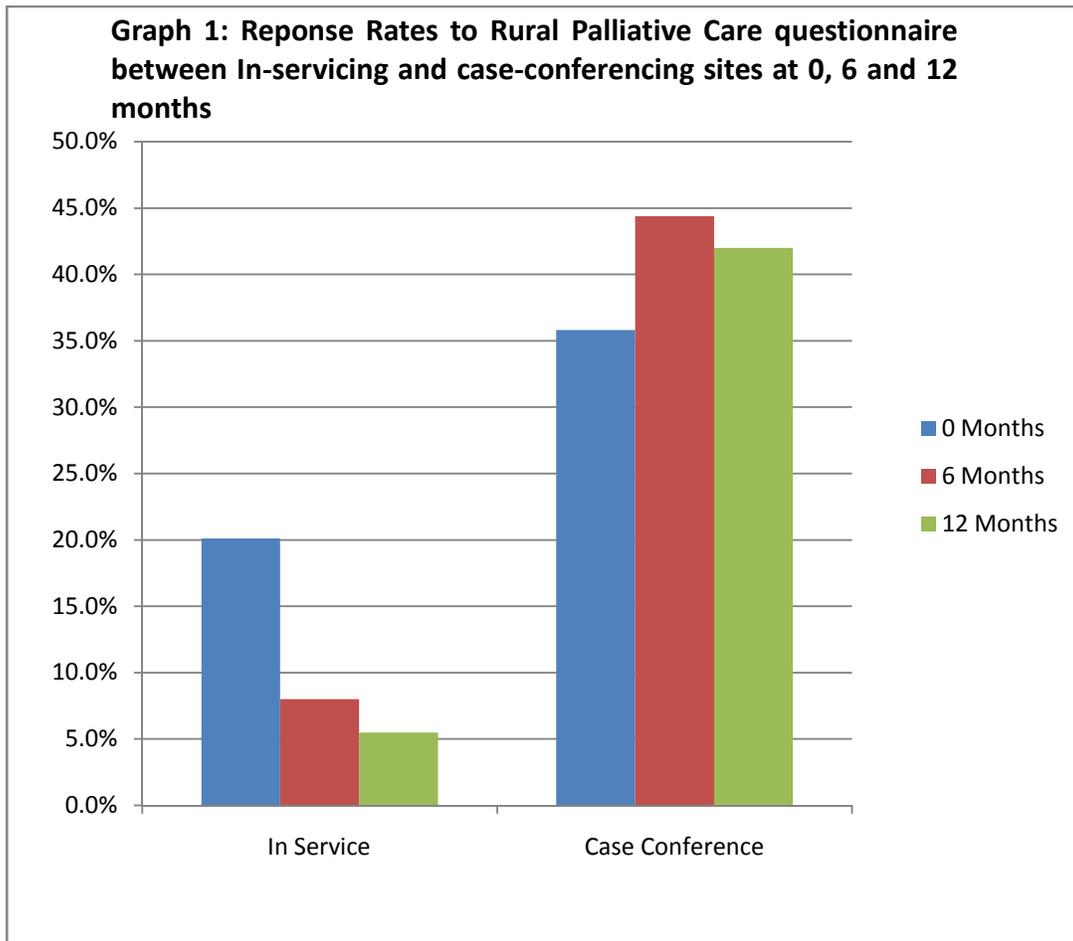
At 0 months, $X^2 = 1.47$ with 1df. $0.250 < p < 0.100$. p is not significant

At 6 months, $X^2 = 1.17$ with 1df. $0.500 < p < 0.250$. p is not significant

At 12 months, $X^2 = 0.109$ with 1df. $0.750 < p < 0.500$. p is not significant

Therefore throughout the project term, there was no statistically significant difference between the qualification levels of the groups.

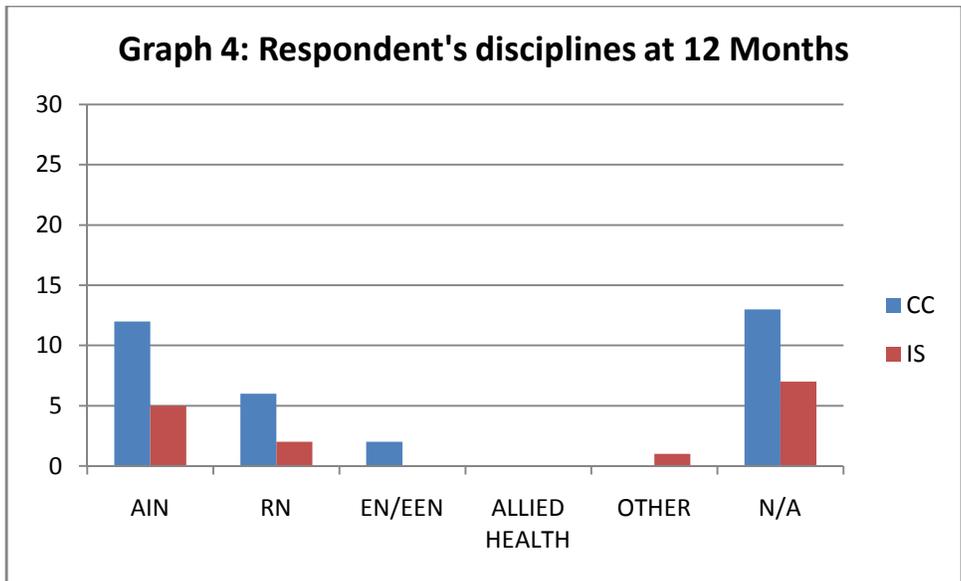
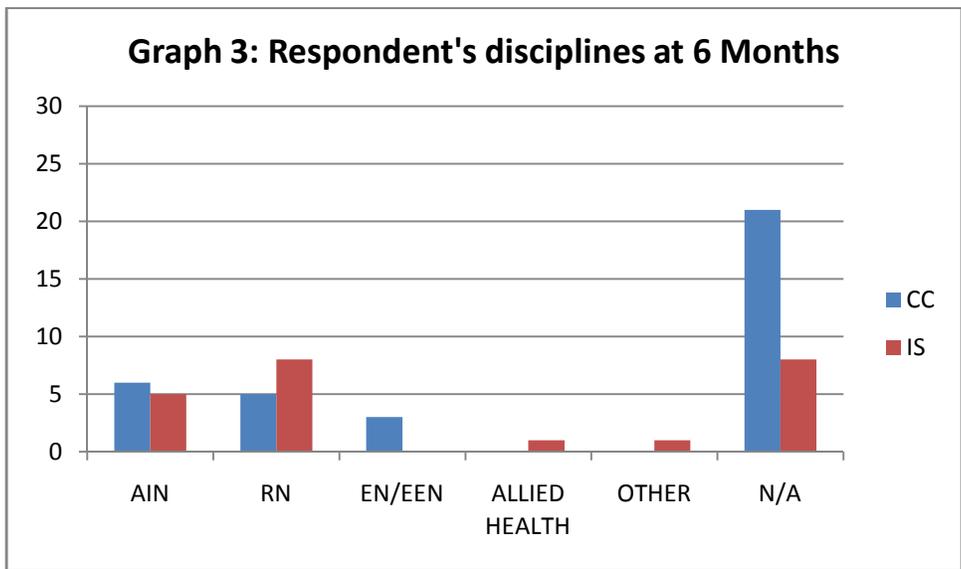
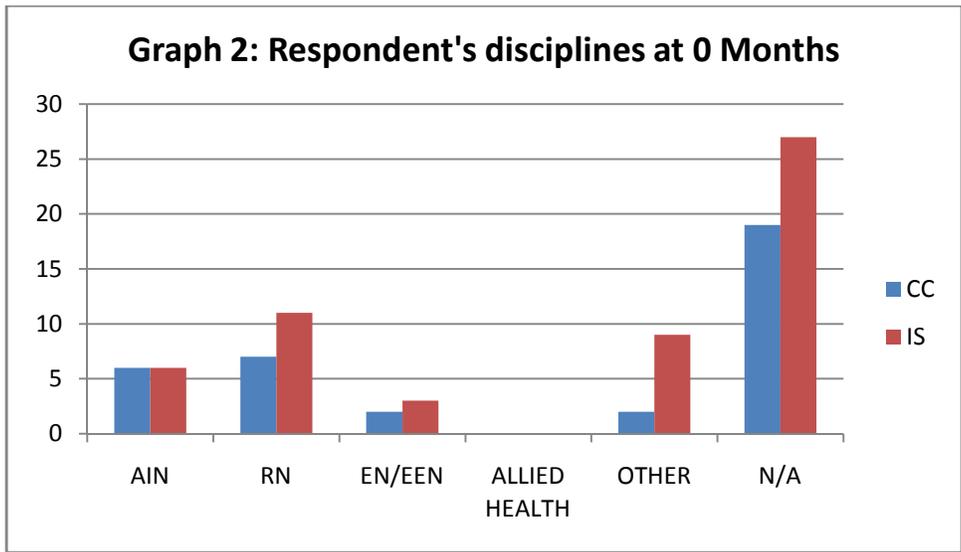
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Response rates in the in-servicing (IS) group were significantly lower than in the case-conferencing (CC) group.

Eight respondents indicated that they are an Aboriginal or Torres Strait Islander (4%) and six respondents identified with an ethnic minority (3%)

Comparative analysis was done between the case conferencing group and the in service group based on respondent's age. All surveys were collated and responses analysed, $\chi^2 = 3.93$ with 1 df. $0.050 < p < 0.025$. p is not significant. Of note, 16% of the sample did not complete this question, leaving their age blank. Also of note, 31% of the sample were older than 51.



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Descriptive Statistics

Table 1: In Servicing – Numbers who attended over 12 month program

Month	Nursing Home A	Nursing Home B	Nursing Home C
April 07	23	16	8
May	7	7	0
June	9	11	7
July	6	8	11
August	5	10	8
September	4	6	7
October	3	6	8
November	5	7	5
December	0	5	5
January 08	0	7	0
February	0	8	0
March	0	8	8

Table 2: Case Conferencing - Numbers who attended over 12 month program

Month	Nursing Home A	Nursing Home B
March 07	11	13
April	7	12
May	5	0
June	6	9
July	10	6
August	7	4
September	6	0
October	7	7
November	6	7
December	7	7
January 08	5	9
February	5	5

About views on palliative care:

Initially the results were analysed as a group for questions 1 – 12. Confidence was rated as a score (in total for all 12 questions) of >26. The author chose this score alongside reasonable responses expected from someone from an AIN training level.

There was no significant difference in overall confidence levels in regard to ‘views on palliative care’ in either the Case Conferencing or In-servicing groups at 12 months compared to baseline.

CC0 V CC12 $\chi^2 = 0.04$ with 1 df. $0.900 < p < 0.750$. p is not significant

IS0 V IS12 $\chi^2 = 1.75$ with 1df. $0.250 < p < 0.100$. p is not significant

When analyzing each question there was also no statistically significant difference either between groups or between time periods (ie case conferencing at 0 months and at 12 months).

Views about death and dying

Initially the results were analysed as a group (q1 -10). Most correct was given for those with an overall score higher than 38.

There was no significant difference in levels of correct/not correct in regard to ‘views about death and dying in either the CC or IS groups.

CC0 V CC12 $\chi^2 = 0.43$ with 1 df. $0.250 < p < 0.100$. p is not significant

IS0 V IS12 $\chi^2 = 0.52$ with 1df. $0.750 < p < 0.500$. p is not significant

When analyzing each question there was also no statistically significant difference either between groups or between time periods (ie case conferencing at 0 months and at 12 months).

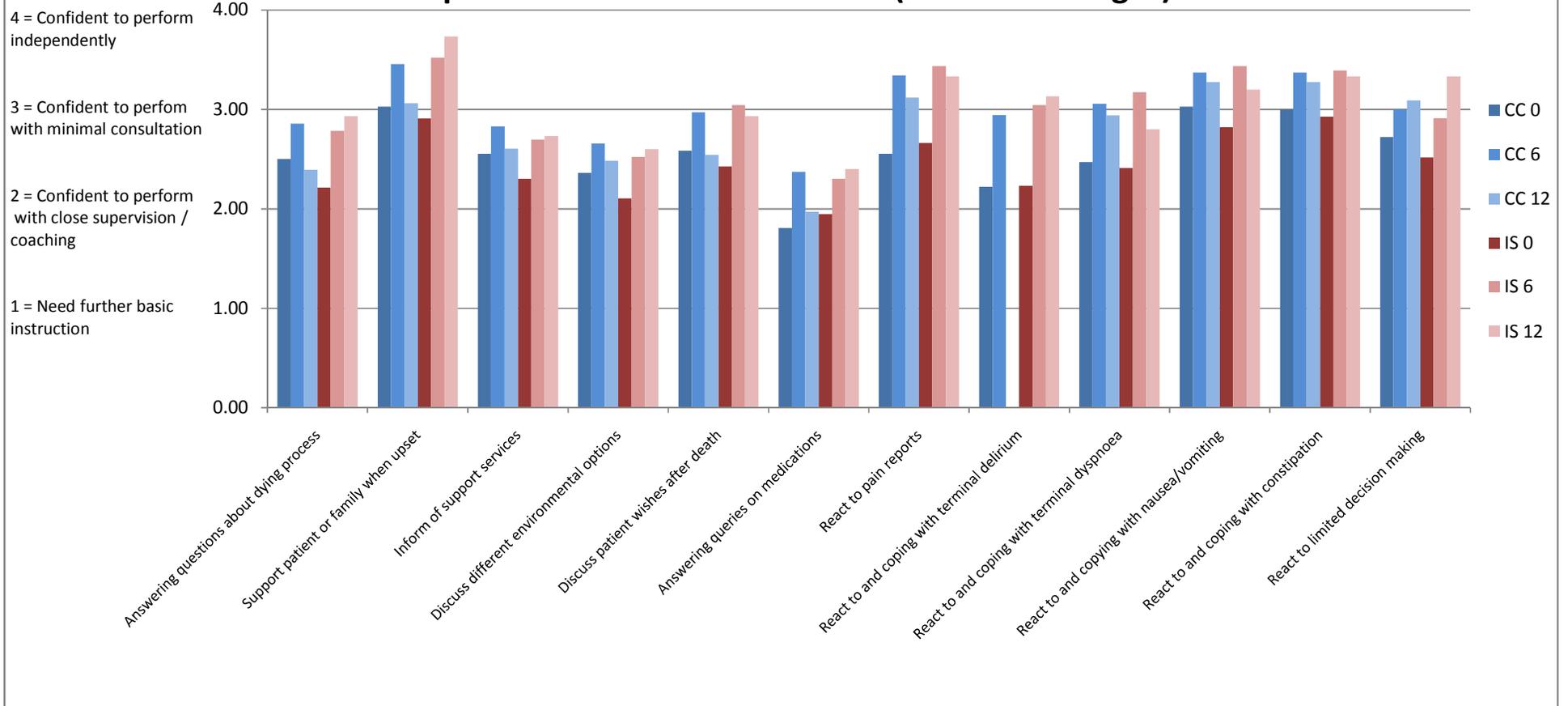
Attitudes towards Palliative Care

It was not possible to statistically analyse this data as an entire group. Therefore analysis on each question was done.

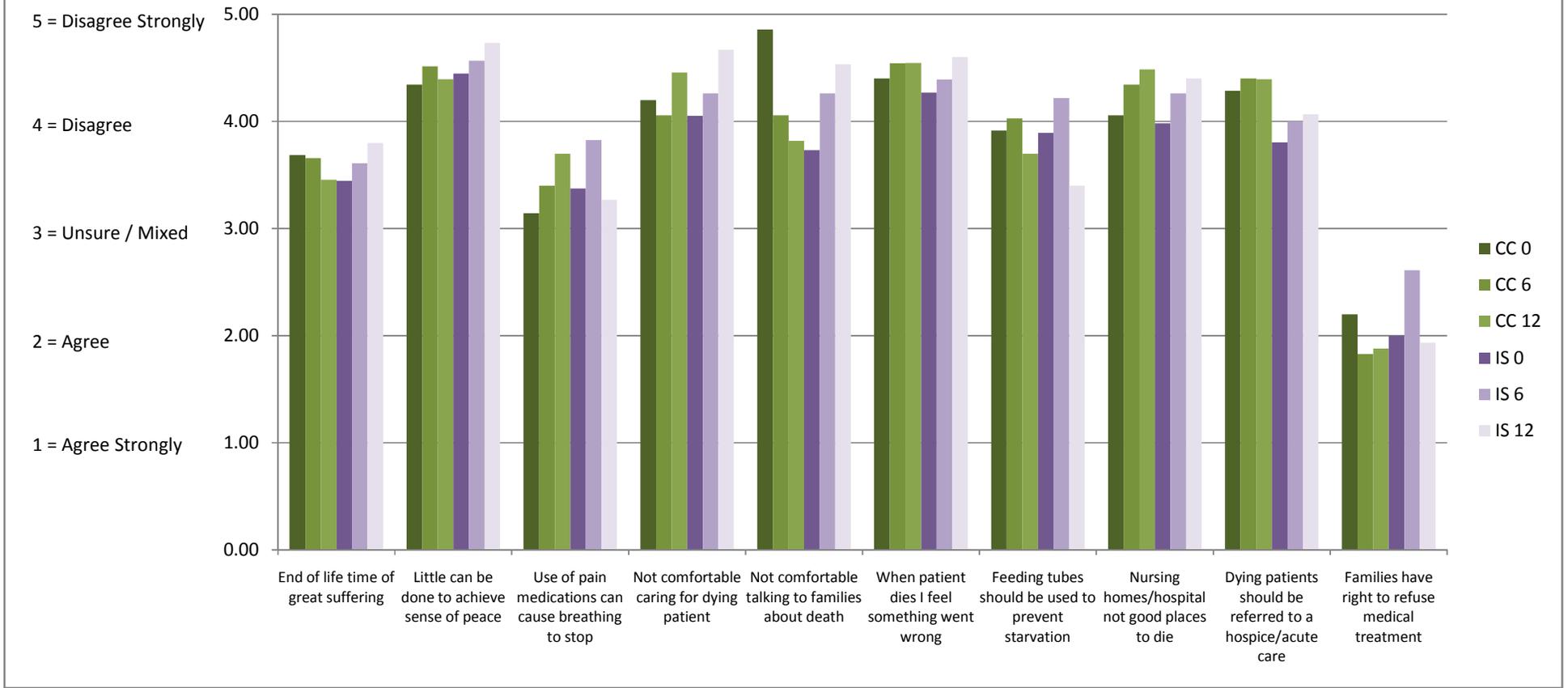
There was no significant difference seen over the 12 months on any of the questions, for each group measured across time.

All data was analysed for averages found across groups at each time interval (Graphs 5, 6 and 7) to assist with descriptive statistical analysis. No notable evidence was found with the comparative analysis, however, this information is of note in describing attitudes and views held by staff at these facilities in relation to Palliative Care issues. For example, most staff felt nursing homes are an appropriate setting to care for someone who is dying and that referral to a hospice is not required.

Graph 5: Views on Palliative Care (Scale of averages)

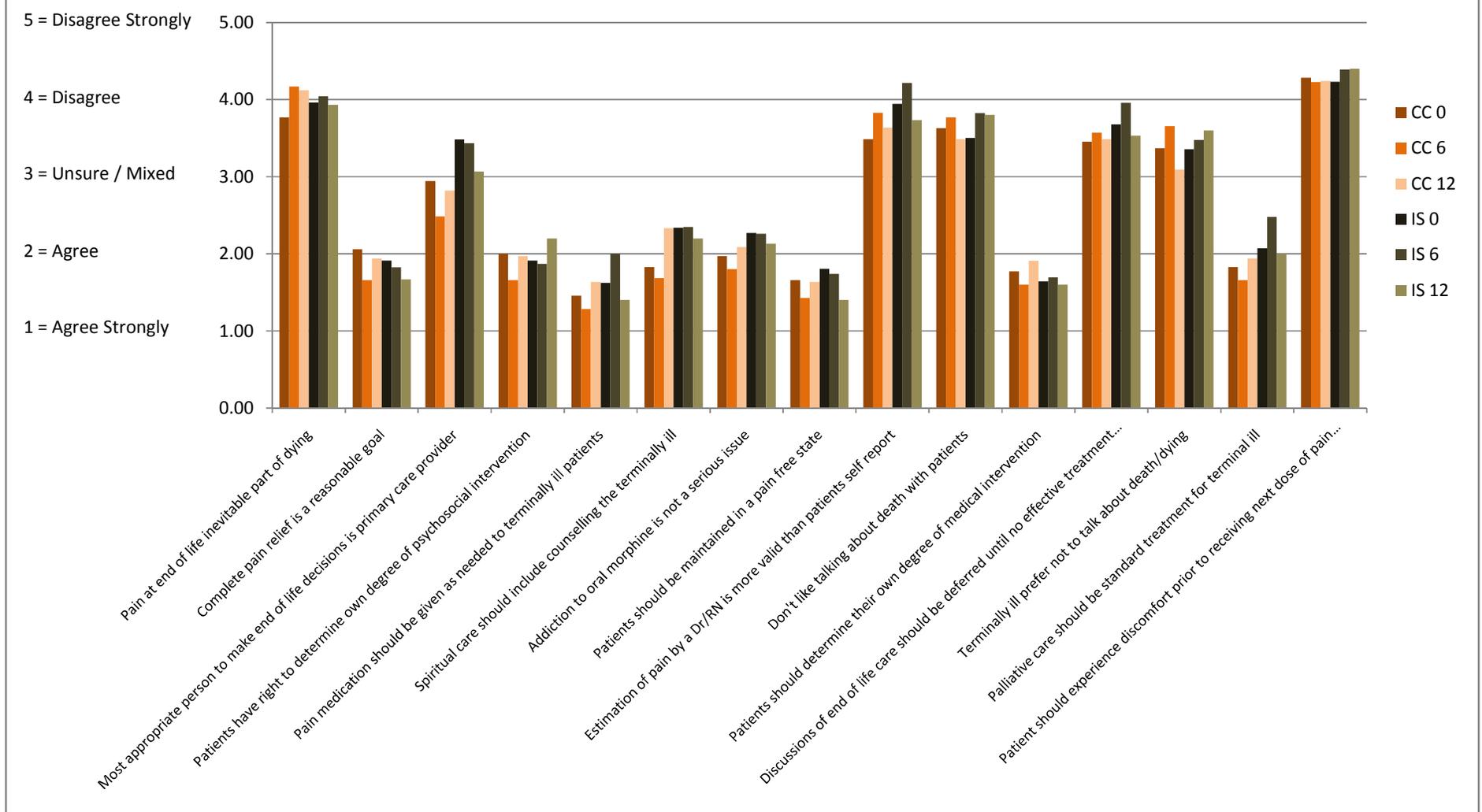


Graph 6: Views on Death & Dying (Scale of averages)



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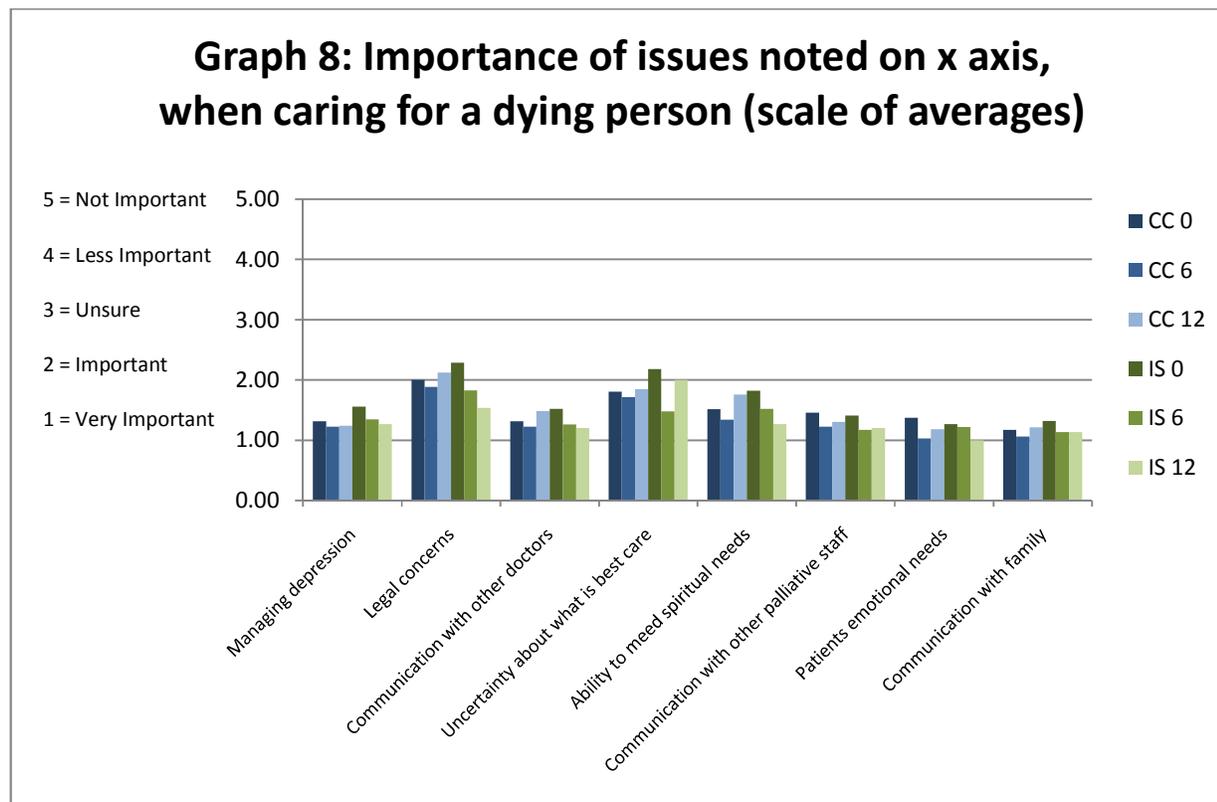
Graph 7: Attitudes towards Palliative Care (Scale of averages)



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Importance of issues

Data was coded by participants as either important or less important across both groups, across the entire programme and results from this are shown below (Graph 8).



Education Topics

Respondents were asked whether they would like future education around specific topics at the conclusion of the questionnaire. Table 3 summarises responses at baseline as compared with Table 4 which displays the results obtained at 12 months (albeit from a much smaller sample). Chi Square analysis of this data shows no significant change across time with regard to education needs.

Table 3: Education needs identified at baseline (0 months)

Values	Column Labels		
	CC	IS	Total
Pain Assessment & Management	33	37	70
Dealing with Nausea & Vomiting	12	29	41
End of life ethics	15	40	55
Use of intravenous hydration	14	31	45
Dealing with constipation	15	25	40
Dealing with Terminal Dyspnea	15	31	46
Dealing with Terminal Delirium	20	33	53
End-of-life communication Skills	21	43	64
Spirituality & Cultural Aspects	11	37	48

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Table 4: Education needs identified at completion of project (12 months)

Values	Column Labels		
	CC	IS	Total
Pain Assessment & Management	16	7	23
Dealing with Terminal Dyspnoea	11	5	16
Dealing with Nausea & Vomiting	7	4	11
Dealing with Terminal Delirium	15	7	22
Dealing with constipation	7	4	11
End of life ethics	12	9	21
Spirituality & Cultural Aspects	7	10	17
Use of intravenous hydration	16	7	23
Other	3		3
End-of-life communication Skills	18	13	31

Table 5: Evaluation results for in-services

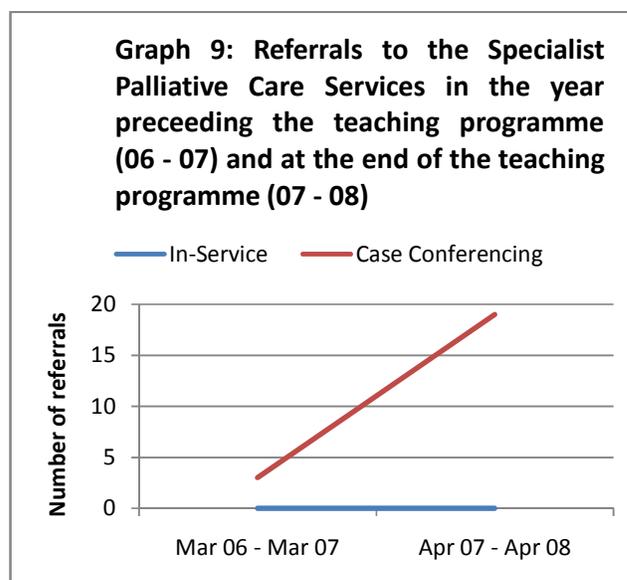
Month	Topic	Improved knowledge?	Improved skills?	Changed Practice?
1	Communication at End Of Life	92%	89%	86%
2	Management of Anxiety & Distress	100%	93%	80%
3	Pain Management in Palliative Care	100%	100%	88%
4	Self care & support	79%	79%	68%
5	Bowel care	100%	100%	100%
6	End of Life Care Plan Strategies	100%	100%	100%
7	Management of breathlessness	100%	100%	100%
8	Management of syringe drivers	100%	88%	82%
9	Role of the Specialist Palliative Care Team	100%	100%	100%
10	End of Life care planning	100%	100%	100%
11	Management of Confusion & Delirium	100%	100%	100%
12	Management of Nausea/Vomiting	100%	100%	92%

Evaluation surveys were given to those who had in-service education only (were not administered at the end of case-conferencing). Participants of an in-service education were asked to complete these at the end of each session, with the presenter collecting these at the time.

Table 6: Referrals to the Specialist Palliative Care Services

In-service	March 06 - March 07	0
In-service	April 07 - April 08	0
Case Conferencing	March 06 - March 07	3
Case Conferencing	April 07 - April 08	19

A dramatic increase (over 600%) in referral to specialist palliative care services (all clinically appropriate referrals) was seen in the group receiving case conference education.



Interview Data

Interview prompts used (Appendix 4) and interview schedule with attendance details (Appendix 7) are provided.

All those interviewed indicated that Palliative Care education (in either teaching style) did help to improve and/or validate their knowledge, skills and practice in this field, confirming the work of Spiegel et al 2002. The in-service evaluation questionnaires also support this statement for the in-service group.

‘The main thing I want to think about and say- this needs to continue’ (CC)

‘We are doing it better than we did and I think it’ll only get better’ (IS)

All interviews were taped and the interviewer also kept field notes to add to the audio taped records. All interviews were transcribed and then content analysis used to enable emergent themes. The researcher colour coded transcripts so that all data obtained was analysed and moved to relevant themes. Any information that was difficult to hear and therefore couldn’t be accurately transcribed, was discarded.

Themes emerged regarding the increased understanding of what ‘Palliative Care’ means and which patient population this refers to. Palliative Care is a care model appropriate to anyone who has a life-limiting illness. Often people believe Palliative care is only relevant to people with cancer. Following this education program (both the in-service group and the case conferencing group) a theme emerged where staff broadened their awareness of what Palliative Care means and what patient population this care refers to. The impact of either teaching method in this study confirms the work of Spiegel et al 2002. Importantly, staff explained an increased understanding of Palliative Care having broader relevance, not purely being related to terminal care.

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'It probably made us realize, or made me realize, that each of our residents here are in here for a level of palliative care, not always the end stage of palliative care...you know a lot of our dementia people, they need that sort of care as well, even though they may not be at the terminal stage of dying..' (CC)

'I think it broadened my knowledge and that of others as well, in that we were thinking of palliative care as being just the last few days of dying whereas I think that education opened our minds to some of dementia being in palliative care and probably most of the nursing home so I think that was a very good part of the education, it just broadened our whole minds to palliative care' (IS)

Another theme emerged regarding the impact the teaching programmes had on practice within the RACFs. It is important to analyse any practice change as a result of education. Staff were asked whether they had any changes in their care following the education programmes and the case conferencing group commented more throughout the interviews with respect to this point. They felt they did see a practice change occur. This was not the case with the inservice group from the interview data.

'we are more proactive to look out there for palliative care and the palliative care team' (CC)

'I think also it has opened up, we talk more about it now as a team, we embrace it a lot more, we are looking more at end of life directives plus we are also still looking at people as individuals' (CC)

'Not considerably but validated what we were doing' (IS)

A further theme emerged regarding the communication between team members. RACFs have a varied skill mix present within their care teams. The interview data suggested that the communication pattern throughout the team improved for those in the case conferencing group. This was not the case for those from the inservice group with no comments made in relation to this point.

'Definitely, yes and I think it also gives the AINs a bit more confidence to ask questions and not just think the RNs are in charge and she's got more knowledge so I just do as I'm told. With this now they actually put forward suggestions on how to manage someone because after all they've got the hands on care.' (CC)

'It gave us a better voice and more confidence. And actually the AINs are now pushing that pain management a lot more, there has been a change with this' (CC)

'Before the case conferences we were a bit more reluctant to speak up because you are not sure of your role whether you can say what you think..' (CC)

Communication with families emerged as a theme whereby those who were in the case-conferencing group felt this skill was enhanced for them, following such sessions. This was not mentioned by the group who received the in-services.

'Before when we had difficulties with one of the families who just hadn't come to terms with the resident's, their relatives condition, we had a palliative care case conference and then I contacted the family and since then we have had a case conference with the two family members who were fantastic' (CC)

Case Conferencing as the preferred teaching style for staff emerged as a very strong theme from the interviews. This was the case for both the case conferencing group and the in-service group. For the in-service group, they spoke from experience from other case conferencing exposure they may have had or spoke based on their opinion or simply reflected their views on in-services.

'Fantastic. I love it and even today we went to a lecture on pain management and it's no where near as relaxed and I love that when we have case conferencing everyone has input..' (CC) *'Yeh I felt the same way, it is much better than a general in-service, because you are dealing with the people who you had problems with, it was fresh, it wasn't something you had to remember for many weeks and so I thought it was good..' (CC)*

'Looking at the person, looking at someone we can identify with. I mean I feel it is heaps better than just an inservice on no one- yeh a general inservice. I felt staff could relate to the symptoms, to the treatment, to the management process.' (CC)

'The lectures were great but you know you go away and not that you forget it but it is just hard to put it into practice sometimes.' (IS)

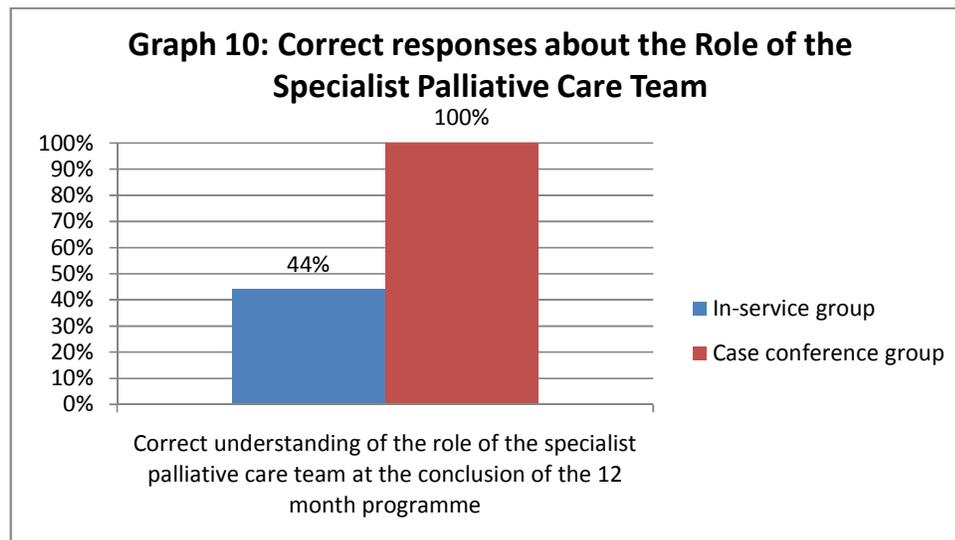
'through case conferencing you show us another way to deal with a problem' (CC)

Understanding of the definition of Palliative Care

There was no difference between groups at interview (12 months) in regard to the definition of Palliative Care. In both research groups, on 2 occasions each, AINS referred to Palliative Care as being terminal care. Answers to this question were marked alongside the World Health Organisation Definition of Palliative Care (Appendix 5).

Understanding of the role of the Specialist Palliative Care Team

There was a difference evident between the groups at 12 months in regard to understanding the role of the Specialist Palliative Care Team. All respondents, 100%, who had been involved with case conferencing answered this correctly. However only 44% of the in-service group was able to describe correctly the role of the specialist palliative care team. The incorrect responses indicated that the specialist palliative care team are only used for people with cancer and people in hospital or the community. All those interviewed answered this question and the researcher marked their responses against the Palliative Care Australia guidance and definition of the role of the Specialist Palliative Care Team.



'They deal with cancer care and that role and because they know about syringe drivers they can educate the patients and help people stay at home longer' (IS)

When asked about referring to the Specialist Palliative Care Team – response – 'Not really, no never.' (IS)

Supports identified as needed to improve Palliative Care provision in RACFs

Infrastructure – single rooms with space for relatives

Information - *'Information, handouts, keep it basic, don't overwhelm us, but just simple information that way we can think ok we'll try this' (CC)*

Staffing - More staff, more time, ability to move away from 'the assembly line' approach to care. A Palliative Care RN employed 1 day a week to review residents and assist in care planning

Medical staff – Easier access to medical review and relevant medication changes.

Planning- greater planning of care

Equipment – spankos, concentrators, syringe drivers

Case conferencing – *'regular times of case conferencing' (CC)*

'The main thing I want to think about and say- this needs to continue. What we have started, don't let it die. You know and some days I will have thought about a pt and just think, I'll give Chris a ring now and I want to keep that going and I want the team to know that that is how we work here.' (CC)

More input with families – *'the type of support that you are able to give us, that we are not just here alone that there are other people out there support services out there that we can tap into.'* (CC) *'A united front for the family, all talking the same language' (IS)*

Personal professional development

Education -*'Be good to have the RNs just by themselves for a talk because I think that some of them are very hesitant to give things like morphine etc...'* (IS)

Discussion

This study recounts the views of those who are predominantly female (93%) and not from an ethnic minority group (93%). In addition 31% of the sample were women aged over 51 years, raising issues regarding workforce into the future. This sample is not able to be generalized from widely as many other RACFs in metropolitan centres describe a multicultural workforce. It may be representative of a rural RACF.

Response rates from participants in the in-servicing group were poor, starting with 20% at baseline but moving to only 5.5% at the conclusion of the 12 month programme. This creates great difficulty with performing accurate comparative analysis.

Comparative analysis of all the variables from Tool 2.1, revealed no significant difference between groups, over time. However, several issues impact on this data which make it difficult to reliably assert that such a statement is accurate. These issues include:

1. Poor response rate overall
2. Markedly different response rates from the in-service group as compared with the case conferencing group
3. Tool 2.1 did not track respondents over time (methodological design flaw). That is, the survey was administered to all staff at each time interval and no tracking codes were used. Therefore true changes in views and attitudes at an individual level are not captured. Changes as a group are captured, however this also has difficulties in interpretation as the groups were not static and indeed staff attendance was variable and workforce changes frequent
4. Tool 2.1 was administered to all staff. Analysis was not performed with regard to discipline with each variable. Coding for data analysis then had to account for staff with the lowest level of training to ensure requirements in survey responses were reasonable. However, reasonable expectations for an AIN as opposed to an RN are very different. Analysis according to discipline was not possible as a large number of respondents did not complete their discipline on the survey (49% at baseline, 50% at six months and 42% at 12 months). This perhaps relates to poor instrument design and poor instrument choice

Therefore unfortunately the data derived from Tool 2.1 is not helpful in forming conclusions regarding the effectiveness of in-service education as opposed to case conferencing to improve the integration of the Palliative Approach in to Rural RACFs. The descriptive statistics, field notes and interview data is much more helpful in this regard.

Attendance records (Tables 1 and 2) show clearly that attendance was maintained for those attending case conferencing and not maintained within the in-service group, for two of the three RACFs. Three months after commencing the in-service programs at three RACFs, reminder phonecalls regarding the sessions were required at two out of the three in-service RACFs. Despite such phonecalls from nine months into the program, frequently sessions at these two homes were cancelled or no staff were able to attend (Nursing Home A cancelled four sessions, Nursing Home C cancelled three sessions). In comparison, the two RACFs having case conferencing education never required a reminder and cancelled on two occasions (Nursing Home B) over the 12 month program. When cancelling, Nursing

Home B would ring ahead of time and explain why this could not be avoided. The case conferencing nursing homes were expected to appoint a case they would like to review and have the relevant paperwork in order for this. This occurred throughout the program and shows a level of commitment to this teaching strategy. It was clear throughout the 12 month program that a greater commitment was seen with the case-conferencing group, in fact they described this through the fact that they would wait for this in order to inform care planning and look forward to this session to enable this (from field notes). Nursing Home B from the in-service group showed great commitment to the program also, maintaining good attendance and not requiring reminders. However, they described and asked to have case conferencing instead of in-servicing if possible (from field notes). All RACFs involved described a huge willingness to learn and felt palliative care education was integral to allowing their work to continue in an optimal way.

Case conferencing allowed for a dramatic change in understanding of the role of specialist palliative care working in conjunction with aged care. This is clearly demonstrated through the referral patterns noted throughout this project period. Referral data was taken for the year preceding this study and at the conclusion of this study. This data was looking at referrals to specialist palliative care from nursing home staff. Residents transferred to a RACF who were already known to the palliative care service were excluded as the researcher was interested to know about RACF initiated referrals. The in-service group initiated no referrals to specialist palliative care in the year preceding this project and no referrals by the conclusion of the project. The case conferencing group initiated three referrals to specialist palliative care in the year preceding this project and 19 by the conclusion of the project. This represents an increase of 633% which is highly clinically significant.

It appears that case conferencing allowed for a much greater understanding of professional roles and how staff can work together for the care of residents. This data is further supported by interview data where all staff interviewed were able to adequately define palliative care but when describing the role of the specialist palliative care team, all those interviewed from the case-conferencing group were able to answer this correctly, whereas only 44% of the in-service group were able to correctly describe the role of the specialist service. This is a highly significant finding – case conferencing allows for a greater understanding of the role of Specialist Palliative Care and how they may support staff and residents in rural RACFs. In facilitating a greater understanding of this role, it could be interpreted that a greater understanding has also occurred with regard to the Palliative Approach to care. The researcher did request data regarding the appropriateness of the 19 referrals made to the specialist service – all were appropriate suggesting a good understanding of primary care as opposed to specialist input.

Interview transcripts continue to support the preference of case conferencing as opposed to in-servicing in order to improve the integration of the Palliative Approach into Rural RACFs. Despite this it is clear that all the education provided was helpful (according to staff and evaluations throughout the project) and contributed to a broader applicability of palliative care within rural RACFs. This confirms work described by Spiegel et al 2002.

'I think it broadened my knowledge and that of others as well, in that we were thinking of palliative care as being just the last few days of dying whereas I think that education opened our minds to some of dementia being in palliative care and probably most of the nursing home so I

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think that was a very good part of the education, it just broadened our whole minds to palliative care' (IS)

Practice changes correlated more highly with the case conferencing groups with all interviewees describing changes in practice. The in-service group stated that they did not see practice changes but felt validated by the education provided.

'we are more proactive to look out there for palliative care and the palliative care team' (CC)

'I think also it has opened up, we talk more about it now as a team, we embrace it a lot more, we are looking more at end of life directives plus we are also still looking at people as individuals' (CC)

Of note, communication between team members was improved following case conferencing and this was not changed by in-service education, confirming statements made by Bellamy et al 2006. Interview data clearly describes these differences with the in-service group stating there is no change in this area whereas the case conferencing group stated the team discussed care planning together a lot more.

'Definitely, yes and I think it also gives the AINs a bit more confidence to ask questions and not just think the RNs are in charge and she's got more knowledge so I just do as I'm told. With this now they actually put forward suggestions on how to manage someone because after all they've got the hands on care.' (CC)

'It gave us a better voice and more confidence. And actually the AINs are now pushing that pain management a lot more, there has been a change with this' (CC)

'Before the case conferences we were a bit more reluctant to speak up because you are not sure of your role whether you can say what you think..' (CC)

Overall case conferencing was the preferred teaching style for those staff that were interviewed (both from the in-service group and the case conferencing group). A clear theme emerged where staff felt they learnt more from a relaxed conversation style session relating directly to current issues with a resident. This confirmed statements made by Bellamy et al in 2006.

'Looking at the person, looking at someone we can identify with. I mean I feel it is heaps better than just an inservice on no one- yeh a general inservice. I felt staff could relate to the symptoms, to the treatment, to the management process.' (CC)

'The lectures were great but you know you go away and not that you forget it but it is just hard to put it into practice sometimes.' (IS)

'through case conferencing you show us another way to deal with a problem' (CC)

The interviews and data obtained from field notes throughout the project strongly supports case conferencing being more effective than in-servicing for the integration of the Palliative Approach into Rural RACFs. Practice change occurred, demonstrated by referral data, in the groups attending case conference education, supporting the assertion by Bellamy et al (2006) that case reviews allows a

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greater understanding of professional roles and boundaries. In addition case conferencing increased the understanding of the role of specialist palliative care, impacted on practice changes and improved staff communication.

Strengths and Limitations of this study

Strengths

The interview data obtained has provided some powerful evidence to substantiate this project's conclusions.

Limitations

Tool 2.1 (Appendix 3) was not the correct analysis tool to use given the methodology employed for this study. The researcher distributed this tool across sites, across time periods. She did not code each questionnaire in such a way that respondent's could be recognised over time. Therefore, those who may have responded at the commencement of the study, may not have responded again at all- therefore tracking any change in knowledge, skill or attitude is lost. In addition to this, Tool 2.1 uses a measure of 'most correct' for each response and due to the varied skill mix present it became difficult to determine 'most correct' responses across disciplines, that is what is 'most correct' for an RN as opposed to an AIN is different and therefore running statistical analysis based on such a premise is not accurate. Furthermore, it was not possible to break down the statistics into discipline groups as a large number of respondents did not complete their discipline on the survey (49% at 0 months, 50% at six months and 42% at 12 months). In addition to the above, it is difficult to derive any true results from the use of Tool 2.1 due to the poor sample responses at six and 12 months.

Implications for practice

This study shows that case conferencing led by a specialist palliative care nurse, improves the understanding of the role of the specialist palliative care team within rural RACFs. In addition, it improved the interface between the RACFs and the specialist team, evident by the increase in clinically appropriate referrals. Therefore, it is an appropriate education model to utilize, and an efficient use of resource. This study recommends changing our education approach to incorporate case conferencing at regular intervals to support the changed practice within RACFs of the palliative approach to care. This change in practice (referring to the specialist service and discussing the holistic health care needs of residents) is significant as it could be inferred that the outcomes of such a change would enable excellence in palliative care for all residents of rural RACFs as staff would identify needs appropriately and refer through for specialist support, as required.

Conclusion

In order to effectively integrate the Palliative Approach into Rural RACFs many competing priorities must be acknowledged including societal attitudes to death, staffing levels, skill mix, management support, funding support structures, access to medical and allied health support and staff knowledge base. This study seeks to comment on staff knowledge development and how this may be maintained over time. It also reflects on how change management may be affected in a sustainable manner.

All staff working in RACFs will be adults. Therefore, to continue to disregard clear evidence in relation to adult education is to the detriment of educators and staff alike. Palliative Care by its very nature is a broad area where people requiring such care will have unique needs, differing illness experiences and different support needs. Therefore, empowering staff to problem solve, identify issues, communicate effectively and refer for specialist support when needed will allow the successful integration of the Palliative Approach in practice. Case conferencing supports this through the development of a supportive learning environment, responsive to student need, relevant to real time practice and through fostering problem-based learning. Through careful and skilled facilitation, case conferencing supports the adult learning theory espoused by Knowles (1980) where focus for learning moves to the process of learning, rather than purely content.

This study demonstrates that case conferencing was more effective than in-servicing in relation to:

- Enabling appropriate referral to specialist Palliative Care services
- Increasing the understanding of the role of the specialist Palliative Care team
- Creating practice changes
- Increasing communication between team members

‘To be educated is not to have arrived at a destination; it is to travel with a different view’ (Peter in MacLeod, 2004). Case conferencing seeks to empower staff with the ability to form alternate views in their workplace, to troubleshoot and discuss as a team best practice principles. It values the skill of all those in the team, is inclusive and productive. Case conferencing in this study was more effective than in-servicing in integrating the Palliative Approach into Rural RACFs.

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Appendix 1

Palliative Care Education

The Palliative Care Service is currently planning an education strategy for all nursing staff, in relation to Palliative Care issues. We appreciate as many staff as possible filling out the following survey to assist us in this project. Thankyou for your time.

- 1) Name (optional) _____
- 2) Facility _____
- 3) Specialty area _____
- 4) Designation (NUM, Nurse Educator, CNS, RN, EN, AIN, student) _____
- 5) How many years experience do you have in nursing? _____
- 6) Do you feel you have adequate knowledge to provide good palliative care? Yes/ No
- 7) Would the following sessions be helpful for your practice?

1. Pain Management	Yes / No
2. Terminal Care	Yes / No
3. Communicating with dying patients and their carers	Yes / No
4. Management of nausea and vomiting	Yes / No
5. Bowel care/ Management of constipation	Yes / No
6. Oral care	Yes / No
7. Pressure Area Care	Yes / No
8. Management of breathlessness	Yes / No
9. End of life care planning	Yes / No
10. The role of the Palliative Care Team	Yes / No
11. Management of anxiety and distress	Yes / No
12. Spiritual Care	Yes / No
13. Caring for the carers	Yes / No
14. Use of hydration and feeds in end of life care	Yes / No
15. Management of confusion and/or delirium	Yes / No
16. Management of a syringe driver	Yes / No

- 8) Which of the above sessions do you feel are most useful for your practice? (Use numbers from the above table)

9) How would you like this education to be delivered? (Please circle)

30 min in-services / 2 hour education sessions / education days

10) Are there any other topics you would like teaching on or comments you would like to make?

Thankyou for your time in completing this survey



PALLIATIVE CARE EDUCATION EVALUATION FORM

- 1. Please state your job classification and specialty (NUM, Nurse Educator, CNS, RN, EN, AIN, student)
2. Please state your area specialty (Medical, Surgical, Aged Care etc)
3. Has this session improved your knowledge in palliative care? Please give details (even if answered no)

YES [] NO []

.....
.....
.....

- 4. Do you think this session has improved your skills to provide palliative care in your facility? Please give details (even if answered no)

YES [] NO []

.....
.....
.....

- 4. Do you think your practice will change as a result of this session? Please give details (even if answered no)

YES [] NO []

.....
.....
.....

Thankyou for completing this evaluation

Views about death and dying

Please indicate how much you agree or disagree with each of the following statements, by ticking the box that best describes how you feel. (There are no right or wrong answers).

No	Statement	Agree Strongly	Agree	Unsure / Mixed	Disagree	Disagree Strongly
1	The end of life is a time of great suffering.					
2	Little can be done to help someone achieve a sense of peace at the end of life.					
3	The use of strong pain medication can cause the person to stop breathing.					
4	I am not comfortable caring for a dying patient.					
5	I am not comfortable talking to families about death.					
6	When a patient dies I feel that something went wrong.					
7	Feeding tubes should be used to prevent starvation at the end of life.					
8	Nursing homes/hospitals are not good places to die.					
9	Families have the right to refuse a medical treatment, even if that treatment prolongs life.					
10	Dying patients should be referred to a hospice or acute care.					

Attitudes towards Palliative Care

No	Statement	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Disagree Strongly
1	Pain at the end of life is an inevitable part of the dying process					
2	Pain medication should be given as needed to terminally ill patients					
3	Spiritual care should include counselling the terminally ill patient					
4	I do not like talking about death and dying with patients					
5	Palliative care should be the standard medical treatment for patients who are suffering from a terminal illness					
6	Patients should have the right to determine their own degree of medical intervention					
7	Addiction to oral morphine is not a serious issue given that terminally ill patients have a short time to live					
8	Opening discussions of end-of-life care should be deferred until there is no further effective curative treatment available					
9	Estimation of pain by an MD or RN is a more valid measure of pain than patient self-report					
10	Complete pain relief is a reasonable goal even when the pain is not caused by a terminal condition such as cancer					
11	Patients have the right to determine their own degree of psychosocial intervention					
12	The most appropriate person to make end-of-life decisions is the patient's primary care provider					
13	A patient should experience discomfort prior to receiving the next dose of pain medications					
14	Patients should be maintained in a pain-free state					
15	As a rule, terminally ill patients prefer not to talk about death and dying					

Please indicate the importance of the issues below in terms of the problems they create for you in caring for a dying patient by ticking the box that best describes your feelings. (There are no right or wrong answers).

No	Statement	Very important	Important	Unsure	Less important	Not important
1	Control of pain					
2	Managing depression					
3	Legal concerns					
4	Ability to meet spiritual needs					
5	The patient's emotional needs					
6	Communication with family					
7	Communication with other palliative care staff					
8	Communication with (other) doctor/s					
9	Uncertainty about what is best care					
10	Other (please describe)					

Please tick the boxes to indicate whether you would like future education on any of the following topics:

Pain assessment and management	Dealing with terminal delirium	
Dealing with nausea and vomiting	Dealing with terminal dyspnea	
Dealing with constipation	Use of intravenous hydration and/or non-oral feeding in end-of-life care	
End-of-life communication skills - giving bad news, talking with family, discussing prognosis, discussing various treatment options	End-of-life ethics: DNR orders, advance directives, decision-making capacity	
Spirituality and cultural aspects of end-of-life care	Other (please specify below)	

Please list any other topics here

*This is the end of the survey. Thank you for your time.
If you wish to make any further comments, please do so over the page*

Other comments:

Project

Title: A comparative study looking at the effectiveness of two different teaching methods used to improve the integration of the Palliative Care Approach into Rural Residential Aged Care Facilities (RACFs)

Interview Prompts

- Please state your job role
- Regarding the Palliative Care education sessions held this year,
 - Do you feel they improved your knowledge in Palliative Care? Give details.
 - Do you feel they improved your skills in working with residents with palliative care needs? Give details.
 - Have they changed your practice? Give details. (For managers, also asking whether they observed any changes in practice from the teams in relation to Palliative Care issues. Look for key drivers of change)
 - Was the education style (case conferencing/in servicing) appropriate? If not, give details (good/bad points)
 - Was the timing of the sessions appropriate? If not, give details.
- What is your understanding of Palliative Care?
- What is your understanding of the role of the Palliative Care Team?
- What support do you feel is needed to better enable you to work with residents requiring Palliative Care?

WHO Definition of Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

(Accessed from <http://www.who.int/cancer/palliative/definition/en/>)

Title: A comparative study looking at the effectiveness of two different teaching methods used to improve the integration of the Palliative Care Approach into Rural Residential Aged Care Facilities (RACFs)

PARTICIPANT INFORMATION SHEET

(1) What is the study about?

You are invited to take part in a research study to investigate the effectiveness of two different teaching methods used to improve the integration of the Palliative Care Approach into Rural Residential Aged Care Facilities (RACFs). As our population ages and medical advances continue, RACFs are caring for an older, frailer resident population who often face complex co-morbid conditions. Not all such residents require specialist Palliative Care but they will need a Palliative Approach to their care, facilitating greater end of life care planning. This study aims to compare two models of teaching in order to establish which one produces a greater impact on staff knowledge, attitudes, confidence and behaviour in regard to Palliative Care.

(2) Who is carrying out the study?

The study is being led by Claudia Giugni, Clinical Nurse Consultant Palliative Care (Southern and Eastern Clusters), Greater Western Area Health Service

(3) What does the study involve?

If you agree to participate in this study:

- You will be asked to attend the Palliative Care Education provided at your facility (voluntary)
- You will be asked to complete an anonymous 4 page survey (voluntary)
- You will also be invited to participate in a one-on-one interview, which may be conducted either face to face, or by phone. You are not obliged to be involved in an interview if you choose not to.

(4) How much time will the study take?

- The education sessions run for 45 mins every month
- The survey takes 10 – 15 minutes to complete
- The interviews will run for 30 mins

(5) Can I withdraw from the study?

Being in this study is completely voluntary - you are not under any obligation to consent and your decision whether or not to participate will not affect your future relations with your facility or the Greater Western Area Health Service. If you decide to participate, you can withdraw your consent and discontinue participation at any time. The study is looking at staff as a group and not individuals. Any information you offer either in the survey or at interview will have no ramifications in terms of your employment or relationships with GWAHS staff.

(6) Will anyone else know the results?

The surveys completed are completely anonymous and therefore results obtained cannot be identified. If you take part in an interview, you will be provided with a transcript of your interview for verification, and participants will be also be provided with a summary of the report. Any information from interviews will be de-identified and coded. You can request a copy of the final report. A report of the study will be presented to the Rural Institute of Clinical Services and Teaching and to GWAHS with recommendations based on the outcomes of the study. A report of the study will be submitted for publication or presentation at conferences, but individual participants will not be identifiable in such a report. Copies of the final report can be obtained by contacting Claudia Giugni on 02 6363 8036 or claudia.giugni@gwahs.health.nsw.gov.au

(7) Will the study benefit me?

One of the desired outcomes of this study is to improve your knowledge and confidence in delivering Palliative Care. In addition this study seeks to identify improved models of education to further support staff at RACFs in the future, in regard to Palliative Care.

(8) Can I tell other people about the study?

Yes, you can tell others about the study.

(9) What if I require further information?

If you would like to know more at any stage, please feel free to contact Claudia Giugni on 02 6363 8036 or claudia.giugni@gwahs.health.nsw.gov.au

The ethical aspects of this project have been approved by the Human Research Ethics Committee (HREC) of the Greater Western Area Health Service. If you have any concerns or complaints please contact: The Executive Officer, PO Box 143 Bathurst NSW 2795 or telephone (02) 6339 5601

Thank you for considering this invitation. This information sheet is for you to keep.

Appendix 7

Interview Schedule

Case conferencing:

Interviews were held at the two nursing homes who had been involved with the project. The researcher chose to hold an interview with three levels of professional staff:

- AIN/EN/ EEN (2 group interviews)
- RN (2 individual interviews)
- Director of care (2 individual interviews)

Attendance numbers therefore with case conferencing were:

Six AINs, two EENs, one EN, two RNs and two Director's of Care

In-servicing:

Interviews were held at the three nursing homes who had been involved with the project. The researcher chose to hold an interview with three levels of professional staff:

- AIN/EN/EEN/DT/domestic and admin staff (3 group interviews)
- RN (3 individual interviews)
- Director of care (3 individual interviews)

Attendance numbers therefore with in-servicing were:

Eleven AINs, three Diversional therapists, one admin staff member, one EEN, one EN, three domestic staff, one Spiritual Care Worker, three RNs and three Director's of Care