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The Educational Needs of Professional Hospice Staff: An Ethnographic Inquiry

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The Educational Needs of Professional Hospice Staff: An Ethnographic Inquiry

by

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Abstract

Hospice care delivered by an interdisciplinary team of professional staff includes care of those individuals with a life-limiting illness and a prognosis of days to a few months. It serves a variety of individuals with a combination of multiple diseases and co-morbidities and provides support for their families. A skilled health workforce is needed to deliver quality hospice and palliative care services. Inconsistencies in hospice staff knowledge and provided education have been identified locally in Alberta and across Canada. In previous studies, hospice nurses have identified knowledge deficits in pain and symptom management, psychological and spiritual care, and communication with dying patients. This research, engaging a focused ethnographic methodology, occurred at a local 26-bed hospice. I immersed myself in the hospice culture and in the research process to understand ways that the culture of hospice care can shape the educational needs of professional hospice staff. Data consisted of semi-structured interviews of hospice staff key participants, observations of interdisciplinary hospice professionals during their daily work, examination of hospice cultural documents and artifacts, and the writing of field notes over three months. The study findings suggest that at the core of the hospice staff educational needs lies three primary themes: communication as an essential foundation of quality care; interdisciplinary collaboration is vital for team cohesiveness and lastly, the central care philosophy utilized by the hospice interdisciplinary team is person/resident and family-centered care. These findings offer suggestions for hospice education and further research. Relational care is foundational for this philosophy, with trusting relationships at the forefront of care.

Keywords:…hospice, hospice professionals, interdisciplinary hospice team, ethnography, palliative care, educational needs

Preface

The desire to pursue a Masters' Degree in Nursing was initially an extension of my passion for palliative care and a desire to advance my knowledge and skills, thus providing an advanced level of end-of-life care through nursing leadership. I work in palliative community care, and this has been my clinical nursing practice specialty for over two decades. I continue to find blessings, inspiration, and meaning in my life through serving those with a life-limiting illness and their loved ones. The knowledge gained through my studies specific to the research process has opened another lens through which I now view nursing practice and leadership. Through this new view, I see how nurses such as myself can make substantial contributions to the communities they live in and the care provided to patients and families through nursing research and educational initiatives. This study and written thesis focuses on the educational needs of professional hospice staff and has given vision to the need for further education and research in additional sites within end-of-life care in Calgary, Alberta, and throughout Canada. The study's findings reveal the beauty and inspiration in hospice culture and the staff journeys in hospice care as individuals, professionals, and interdisciplinary team members. Additionally, the findings show the hospice staff to elicit respect and reverence as providers of quality hospice care and in their openness in describing their educational needs to continue providing such high-level care. As revealed in the thesis, the study findings are immense and unique and motivate me to continue engaging in research specific to end-of-life care.

Acknowledgments

Thank you to my supervisor Dr. Shelly Raffin Bouchal, for her immense passion, knowledge, and experience in end-of-life care. Additionally, her willingness to share her wisdom, research expertise, and support my journey in graduate studies, hospice research, and this thesis's writing have been exceptional. Thank you also to my supervisory thesis committee members Dr. Shane Sinclair and Dr. Lorraine Venturato, for their offered beneficial interest, guidance, and constructive feedback for my research proposal and thesis.

I would also like to thank the interdisciplinary hospice staff for allowing observation of the culture of the hospice and their daily work life. I learned from the hospice staff, cultural environment, and the hospice staff key informants. They allowed me to interview and shadow them, revealing important information about the hospice culture and professional staff educational needs. I was amazed by the hospice staff's dedication toward the hospice residents, their family, and friends, and additionally, to each other as they warmly supported each other as caring colleagues and capable interdisciplinary team. I felt honored as the hospice staff shared their thoughts and stories about being care providers in a hospice, taught me about hospice care and the staff educational needs, and were interested and excited about the research project and its implications for improving the care they provide in the hospice.

Thank you to all the hospice residents, their families, and friends who were so open to allowing me to observe the care provided to them by the hospice interdisciplinary team. It was a privilege to have a glimpse of the formidable physical, emotional, and

spiritual changes faced by hospice residents and the challenges faced by those who love them as they approached the end of their lives. I felt honored as hospice residents, and their loved ones shared stories of their spiritual journeys through both their lives before a life-limiting illness and towards the end of their lifetimes in the hospice.

And finally, I would like to thank my family, friends, and colleagues in palliative community care for their support and assistance, allowing me to complete my graduate studies. The completion of the research at the hospice and the thesis provides a source of pride and accomplishment as I have studied the educational needs of hospice staff. My parents, extended family, and friends have been incredibly encouraging and helpful. They have expressed their pride in me for seeking higher levels of education and wanting to continue to find meaning and purpose in my life through the provision of end-of-life care as I have for over two decades. I am incredibly grateful for my son Luke as he came to the university campus with me one day and encouraged me to pursue higher education beyond a master's degree. As a result, I hope to make him proud as I pursue further research projects specific to hospice and palliative care and continue to seek knowledge through higher education as this is the path he envisions for me.

Dedication

Dedicated to my son Luke. The most magical day of my life was the day I became your mother.

"The miracle is not that we do this work, but that we are happy to do it." Mother Teresa

"It's very easy to give example, but it's very difficult to become an example." Mother Teresa

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Epigraph

- *"The best way to find yourself is to lose yourself in the service of others" Gandhi*
- *"For most of us working in hospice, it is so much more than a job. It's a commitment to making an impact on the lives of the patients we care for and their families." Don Schumacher*
- *"We cannot change the outcome, but we can affect the journey" Ann Richardson*
- *"Education is for improving the lives of others and for leaving your community and world better than you found it." Marion Wright Edelman*
- *"You matter because of who you are. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully but also to live until you die." Dame Cicely Saunders*
- *"Do not count the days; make the days count." Muhammad Ali, Boxer*
- *Perhaps they are not stars but rather openings in heaven where the love of our lost ones pours through and shines down upon us to let us know they are happy. Inuit Proverb*

Chapter One: Introduction to the Study

Hospice care encompasses the physical, psychosocial, and spiritual dimensions of hospice residents' care needs and their family members' psychosocial and spiritual well-being (World Health Organization, 2020). The expertise of health professionals is foundational to manage these complex needs. There is evidence that hospice care teams providing holistic care, including pain and symptom relief for hospice residents, positively affect resident's symptoms, length of stay, patient/family satisfaction, and costs [of care] (Carstairs, 2010). Therefore, team members must be clinically competent in their discipline and be committed to improving their practice through ongoing education. However, inconsistencies in staff knowledge and education in hospice care have been noted in Alberta and across Canada (Alberta Health Services, 2014; Canada, 2018). This research study/thesis will address understanding related to the educational needs of professional hospice staff in an area hospice in Calgary, Alberta, Canada. A literature review preceding this study revealed that international end-of-life palliative/hospice staff had knowledge deficits in six key areas (Kehl, 2014; Ly Thuy et al., 2014; Murray et al., 2004). These six key areas included: pain and symptom management, communication skills, interdisciplinary team collaboration, psychosocial support, cultural sensitivity training, and lastly, spiritual support. In this study, I uncovered educational priorities emerging from practice in the hospice and have described the research and its findings and implications in this written thesis. This introductory thesis chapter opens with an overview of the background and context of the study, followed by the problem statement and purpose of the study. Also included in this chapter are the research question, the

researchers' perspectives, and assumptions, and lastly, I will outline the remaining chapters in this thesis.

Background

Hospice resident support focuses on assisting individuals with a life-limiting illness through the last stages of life with a philosophy of providing comprehensive care (Dobrina et al., 2014). Delivering dying patients with support encompassing medical, symptom management, psychosocial, and spiritual needs is described as comprehensive hospice care (Candy et al., 2011; McIlfatrick et al., 2010). Adequate hospice staff knowledge and competence are essential for the provision of comprehensive care (Chochinov, 2006; Chochinov et al., 2005; Koffman, 2001). The implications of staff knowledge deficits can include hospice care that fails to attend to patient and family's multifactorial needs and is not evidence-based and grounded in evidence-informed practice (EIP) (Chochinov, 2006; Chochinov et al., 2005; Koffman, 2001). Specifically, the consequences of hospice staff knowledge deficits can include increased hospice resident psychological and spiritual distress, reduced pain and symptom management, and diminished levels of patient dignity at the end of life (Chochinov, 2006; Chochinov et al., 2005). Traditionally, an interdisciplinary team approach is delivered to provide comprehensive hospice care (Dyess et al., 2020; Miller & Makela, 2005; Wittenberg-Lyles & Oliver, 2007). The interdisciplinary team's optimal functioning can maximize the staff's competency and promote comprehensive hospice resident care grounded in EIP (Eng, 1993; Kobayashi & McAllister, 2016; Minetti, 2011).

Problem Statement and Context in Alberta

The Canadian Society of Palliative Care Physicians (CSPCP) identifies several non-oncological, life-limiting diagnoses requiring hospice care in Canada. These diagnoses include end-stage organ failures and neurodegenerative diseases such as Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis (MS), Huntington's, and Alzheimer's disease (The Canadian Society of Palliative Care Physicians, 2016). Hospice care in Alberta also encompasses individuals with challenging conditions, often with poorly defined disease trajectories such as frailty (often due to advancing age) and chronic disease. Additionally, those individuals with a life-limiting disease in combination with multiple co-morbidities further intensify hospice care needs in Alberta and across Canada (Alberta Health Services, 2014; Canada, 2018).

Seniors 65 years and older are estimated to encompass 25 % of the total Canadian population by the year 2036. Among seniors, 22% will be diagnosed with cancer each year (Canadian Cancer Society's Advisory Committee on Cancer, 2015). In Alberta, by the year 2030, there will be 27,640 new cancer cases, with 25% eventually requiring hospice care. A projected 85% of the available hospice care services within AHS will be utilized annually by these new cancer cases (AHS, 2014).

The complexity and high care needs of hospice residents in Alberta require support from hospice staff with high levels of knowledge and skills (AHS, 2014). Hospice care differs from hospital care for the terminally ill as the primary focus is hospice resident comfort and not costly diagnostic and life-saving interventions. Also, hospice staff has more training and expertise in providing less aggressive and expensive comfort care than hospital staff, whose knowledge and focus is on more life-sustaining measures (Freeman

et al., 2013). Two studies conducted in Alberta, Bruera et al. (2000) and Fassbender et al. (2005), reported that effective hospice care could provide cost savings by reducing hospitalizations for Albertans in the last stages of their lives. Also, Fainsinger (2008) and Williams et al. (2010) identified the importance of lowering hospice costs by strengthening hospice care providers' effectiveness through targeted staff education. In 2014, Alberta Health Services (AHS) developed the Palliative and End-Of-Life Care Alberta Provincial Framework (PEOLC) AHS (2014) in collaboration with provincial stakeholders. A key issue identified during the framework development was variations in knowledge across several care domains among palliative and hospice care providers in Alberta. An inadequate infrastructure to provide post-licensure education for palliative and hospice care providers across AHS sectors was also noted, further contributing to gaps in knowledge (AHS, 2014). These growing hospice care needs, the cost-effectiveness of hospice care for the terminally ill, and inconsistent hospice care provider knowledge and educational needs warrants further research. Specifically, investigating professional hospice staff educational needs may facilitate more effective hospice staff education programs and comprehensive hospice resident care based on EIP.

Additionally, the assessment of how the culture of hospice shapes the educational needs/priorities of the staff may facilitate initiatives optimizing the functioning of the hospice interdisciplinary team and the overall hospice culture. Of note, the terms professional hospice staff, interdisciplinary hospice staff, and hospice staff, throughout this thesis, will be used interchangeably. Professional hospice staff onsite at the hospice included the Hospice Medical Director (MD), Team Lead (TL) or manager, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Resident Aides (RAs), Registered

Nurse Clinical Nurse Educator (RN CNE), Social Worker (SW), Chaplain, Volunteer Coordinator (VC), and the Volunteers (VOs) that are based both internally and externally to the hospice.

Research Question and Statement of Purpose

In this study, I explored professional hospice staff's educational needs, priorities, and how the hospice culture shaped these needs. Previous literature and the current environment in Alberta suggest knowledge deficits and specific unmet needs of professional hospice staff necessary to provide effective end-of-life care. Furthermore, the impact culture has on shaping the hospice staff educational needs, and priorities emerging from the practice of hospice staff is the aim of this research. Therefore, the following research question was formulated for the study: *How does the culture of hospice care shape the educational needs of professional hospice staff?* Describing the hospice culture and determining the educational needs of hospice staff has several essential research purposes: identifying the educational needs of hospice staff, obtaining rich data regarding hospice culture, and gaining knowledge specific to the influence of this culture on hospice staff education. Additional study purposes include planning hospice nursing education, planning future hospice research, and improving hospice resident outcomes with EIP (Denzin, 1999; Ekblad et al., 2000; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011).

Research Description

Rationale and Significance

The rationale for this study came from the researcher's desire to describe, understand, and discover strategies for professional hospice staff to meet their

educational needs. Multiple factors influence the educational needs of professional hospice staff, including the hospice culture where the staff is employed and the knowledge and competencies of individual staff members (Goepp et al., 2008; Spindler, 2014). The rationale of the study is to reveal the ways hospice leaders, professional hospice staff, and residents and their families interact and perform their everyday work, and through this data, create a picture of hospice care and hospice staff educational needs utilizing a cultural lens (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). The study will add to the existing body of literature, providing an evidence base for hospice education and background for developing educational programs for hospice staff. Additionally, increasing the use of EIP by professional hospice staff, and identifying further hospice research needs, are important potential outcomes of this study (Gerrish et al., 2011; Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Discovering solutions to hospice staff knowledge deficits and educational and interdisciplinary cultural priorities begins with clinical research describing the nature and scope of practice of hospice staff (Gerrish et al., 2011; Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). The proposed research is significant as it encompasses the spirit of inquiry that can raise new questions in hospice care, challenge current and traditional hospice care practices, and facilitate new approaches to issues in optimal hospice care provision.

Additionally, the research can provide the leadership and innovation needed to influence improvements within hospice cultures and educational systems (Gerrish et al., 2011; Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Also, while the PEOLC Alberta Provincial Framework AHS (2014) provides broad recommendations at

a provincial/organizational level and the Canadian Palliative Care Framework Canada (2018), at a national level, this research focuses on a much more detailed and granular level. Specifically, I am looking at factors such as the setting, culture, and hidden hospice staff educational needs, existing educational curriculums, and cultural aspects of influence such as norms, values, and beliefs embedded within this hospice community of practice.

The Role of the Researcher

To gain access to the field and attain the trust of the study participants, I must be passionate about the topic and open to learning from the participants (Hamric et al., 2013; Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). In this openness, I can develop a rapport with the professional hospice staff and allow for the detailed, descriptive data to emerge during data collection (Hamric et al., 2013; Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Therefore, I engaged in this study as a research instrument aligned with ethnographic research traditions and with an open lens and perspective. I was involved in the observation of many aspects of the day-to-day operational and professional interdisciplinary hospice staff care provision embedded in the hospice culture, utilizing an ethnographic research process (Hamric et al., 2013; Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Specifically, I conducted interviews with members of the professional hospice staff, and I also observed aspects of the hospice staff's practice and the hospice culture. These cultural and staff observations included elements of the daily hospice activities such as interdisciplinary rounds, accreditation preparation meetings, team meetings, and staff interactions with the hospice residents and family members and other hospice staff members, including members of

the hospice leadership team such as physicians, team leader (TL) (manager) and educators. Thus, the detailed data and research findings extracted during this study can potentially reveal extensive and valuable information and play a role in future research recommendations, facilitating more effective hospice staff education and comprehensive hospice resident care grounded in EIP (McGregor et al., 2010; Roper & Shapira, 2000; Speziale et al., 2011).

Researcher Assumptions

Researcher assumptions are beliefs, pre-understandings, and researcher perspectives that can either enhance or bias research (Bonnel & Smith, 2013; Polit & Beck, 2012; Roper & Shapira, 2000). These assumptions may arise from the researcher's education, professional training, clinical background, or previous experiences (Bonnel & Smith, 2013; Polit & Beck, 2012; Roper & Shapira, 2000). Thus, a researcher needs to be transparent about their background, values, and beliefs and continuously self-assess the impact these factors may have upon the research findings (Bonnel & Smith, 2013; Polit & Beck, 2012; Roper & Shapira, 2000). I became a Registered Nurse in 1991, initially with a Diploma in Nursing. Later, I obtained a Bachelor of Science Degree in Nursing (BSN), where I had my first experience as an RN on a combined medical-surgical and detoxification unit. I am a 50-year-old Caucasian female, and I consider my religious beliefs more spiritual in nature than religious. Specifically, I am open to any inspiring, sublime ideology from all faiths that are meaningful for my own life and address the collective human reality/condition. Furthermore, I consider my values to be liberal and humanistic, respectful, and open to the intrinsic personhood and humanity of all human beings of all walks of life.

I am an insider to palliative care with over 20 years of direct clinical practice experience, adding a depth of observational understanding to this research. In addition, this palliative care experience is related to direct clinical hospice experience, as I have extensive expertise as a Palliative Community Care Coordinator RN (palliative RN patient & family case manager). Specifically, my clinical role includes working in palliative community care for over 20 years, focusing on patient and family care. Encompassed in this clinical care experience is the direct coordination of patient care interventions. My case management role includes direct case management interventions such as pain and symptom management (including medication management and managements of interventions/concerns needing regular care such as drains and wounds), and coordination roles such as care planning, including coordination of home care service providers, interdisciplinary team care coordination and consultation, and the arranging of patient transfers to both the hospital and hospice setting for diverse care needs. I am also a resource for families following palliative patient deaths as I provide grief support and coordinate referrals to grief support services. I also have directly and indirectly worked with hospice leadership and professionals during patient care transitions from the community to the hospice setting. As a result, I believe that my knowledge and palliative care experience will benefit the research process, engagement with the participants, and the understanding of palliative and hospice care cultural knowledge and the hospice staff's educational needs.

Descriptions of existing knowledge levels and education provided amongst interdisciplinary palliative and hospice staff showed inconsistencies in end-of-life care frameworks developed both provincially and nationally (AHS, 2014; Canada, 2018).

Therefore, I assumed that the current continuing palliative and hospice education model is inadequate, suboptimal, and needs improvement and reform. Additionally, I believed in utilizing an ethnographic lens for the study as I also assumed that cultural learning environments influence learning that is not an individual enterprise.

Additionally, I believe that changes in practice are achieved primarily through the acquisition of knowledge and behavior change. There has been extensive research conducted internationally investigating end-of-life care staff (palliative and hospice) knowledge levels specific to pain and symptom management, communication with the dying, interdisciplinary team collaboration, psychosocial care, spiritual care, and cultural sensitivity. However, there have been no studies focused on the study site hospice previously, or the other six Calgary area hospices, the palliative home care program, or the acute palliative unit at the Foothills Medical Center specific to the educational needs of the staff. The knowledge gained from the study and similar studies will also add to the body of research specific to palliative and hospice professional educational needs and may eventually contribute to improving end-of-life and hospice resident care. I Have over 20 years of experience in the field of palliative care, enabling me to see that some of the six critical areas of hospice educational knowledge gaps revealed in the literature review chapter in this study continue to exist. However, the culture of this hospice has revealed unique educational priorities that have emerged from practice. An in-depth understanding of these educational needs through observation and interviews with hospice professionals has the potential to aid in improved education, hospice professional job satisfaction, and enhanced end-of-life care.

Overview of Thesis

In the introductory first chapter of this six-chapter thesis, I detailed the hospice care culture focus of the research, study background, problem, purpose and rationale, and assumptions regarding the study's significance. Chapter two contains a review of the current state of the literature regarding the educational needs of end-of-life hospice and palliative care staff, emphasizing dedicated hospice and palliative care healthcare environments. Chapter three includes an exploration of essential features of the focused ethnographic research methodology utilized for the study and the appropriateness of this particular methodology in answering my research question. In chapter four, I describe in detail the hospice cultural landscape using an ethnographic foundation, and this contextual and detailed description provides a background for the study findings. I acquired this cultural description from hospice staff interviews, direct field observations, and informal discussions with hospice staff professionals. Chapter five includes a presentation of an exploration of the findings of this study: the ethnographic themes and cultural domains that emerged from the key informant participant interviews, observational data, cultural documents and artifacts, and written field notes about the hospice culture and the professional hospice staff educational needs. Finally, in chapter six, I discuss the findings specific to hospice staff educational needs in relation to the existing literature, and present recommendations for practice, education, future research, and the strengths and limitations of the study.

Summary

The determination of the ways hospice culture shapes the educational needs of hospice staff is studied best with focused ethnography. Hospice care is provided

optimally by competent, knowledgeable staff who provide care grounded in EIP. However, there is still much to learn about the educational needs of professional hospice staff in Alberta. This study offers an opportunity to discover and elicit significant and rich meanings regarding hospice culture and the educational needs of professional hospice staff emerging directly from focused ethnographic data. The information found in this study has the potential to contribute to the improvement of hospice care and increase the knowledge levels of hospice staff**.**

Chapter Two: Literature Review:

Introduction:

This chapter provides an overview of previous and relevant research reviewed revealing the educational needs of hospice and palliative professionals employed in health care sites focused explicitly on end-of-life care. In this chapter, I will familiarize the reader with an exploration of the information I have found in the existing body of literature specific to palliative and hospice professional staff knowledge and skill levels, identifying pertinent foundational concepts and areas of needed further exploration. The focus of this review is a gaining of a thorough understanding focused on relevant concepts, repetitive themes, and areas where further research would be beneficial with the current literature specific to hospice staff educational needs. I undertook a comprehensive literature review to facilitate this in-depth understanding and comprehensively determine current academic information regarding the knowledge and educational needs of dedicated hospice and palliative care staff. In addition, it is crucial to understand the unique needs of professional staff working in hospice and palliative cultures to improve the care for patients and their families at the end of life. Exploring these identified hospice staff educational and cultural needs/priorities forms the primary focus of the study presented in this thesis.

Literature Inclusion Criteria and Search Methods

This literature review permits the gaining of an understanding of the current state of literature focused on the educational needs of hospice and palliative care professional staff. In reading many pertinent articles, five distinct bodies of literature emerged, including palliative care educational needs of nursing home staff, hospital staff,

oncological staff, home care staff, and the educational needs of staff working in designated end-of-life (palliative and hospice care) settings. The focus of this literature review is on the latter. The inclusion criteria for the literature review limited the search to peer-reviewed articles written in English between the years of 2000 to 2020. All articles included have a focus on the professional staff educational needs for dedicated end-of-life settings. These dedicated sites include health care settings such as hospices, general palliative, and oncological palliative specific sites in facilities and based in the community. Although the proposed study focuses on a hospice setting, limited hospice setting-specific research exists, and therefore, I searched in these additional dedicated end-of-life settings. My extensive experience in end-of-life palliative care reveals that drawing from these areas will be beneficial.

For this literature review, I completed a comprehensive search of the following databases and engaged in an additional manual search (See Appendix H for the complete academic literature search details and terms): EBSCOhost and Cumulative Index of Nursing and Allied Health Literature (CINAHL Plus with Full-Text), MEDLINE Complete, PubMed & OVID, PsycINFO, the Cochrane Database of Systematic Reviews (CDSR), Google Scholar, and Sociological Abstracts.

The search terms used for this literature review are hospice, palliative, hospice care, palliative care, knowledge, knowledge deficits, education, educational needs, hospice staff, professional staff, professional hospice staff, staff, nurse, nurses, nursing (truncated), nursing care, nursing education, learning, and learning needs. Applied limitations for the literature search included only articles published in the English language and peer-reviewed journal articles. Additionally, publication date limitations

were applied to discover the full scope of articles available from the years 2000 to 2020. I also utilized the Boolean operators AND and OR to combine keywords to narrow the search.

The search of the databases, a manual search of grey literature, and secondary scans of the bibliographies of included articles revealed several articles: EBSCOhost and Cumulative Index of Nursing and Allied Health Literature (CINAHL Plus with Full-Text) revealed 346 articles. MEDLINE Complete showed 195 articles. PubMed & OVID 197 articles, PsycINFO 312 articles, the Cochrane Database of Systematic Reviews (CDSR) 77 articles, Google Scholar, revealed 1700 articles, and lastly, the Sociological Abstracts database showed 131 articles. Following the removal of duplicate articles, titles and abstracts were screened for relevance, leaving 157 articles. These articles were evaluated further for specificity to health care sites dedicated to hospice and palliative care, excluding seven articles for not meeting these criteria. An additional 94 articles were specific to hospice and palliative care sites; however, they were not specific to staff educational needs and were, therefore, excluded. Fifty-six remaining articles were screened more thoroughly for relevance to the research project and specificity to the research question. Several articles focusing on staff educational needs were not relevant, and others have some data regarding staff educational needs; however, this information did not directly relate to the primary focus of the research study. A total sample of 25 articles included in this review is reflective of the examination of the staff working in dedicated palliative care and hospice settings and their educational needs.

Results

In summary, the literature review revealed four articles with a *mixed-methods design* (Booth et al., 2003; Lansdell & Beech, 2010; Morris et al., 2013; Pawlow et al., 2018). Eight articles with a *qualitative research design* (Bailey et al., 2009; Diver et al., 2003; Selman et al., 2017; Somerville, 2007; Tornøe et al., 2015; White et al., 2013; Whittaker et al., 2014; Zerwekh et al., 2002). Twelve articles are of *quantitative design* (Bernardi et al., 2007; Greiner et al., 2003; Hollen et al., 2000; Kehl, 2014; Ly Thuy et al., 2014; McIlfatrick et al., 2010; Murray et al., 2004; Perri et al., 2016; Schim et al., 2006; Sedillo et al., 2015; Weisenfluh & Csikai, 2013; White et al., 2012). Lastly, one article is a *retrospective documentary study* of a national archive of educational profiles (Astin et al., 2008).

The published articles included in the literature review are from around the world, with the majority, nine of the included studies being from the United States of America (USA) (Greiner et al., 2003; Hollen et al., 2000; Kehl, 2014; Pawlow et al., 2018; Schim et al., 2006; Weisenfluh & Csikai, 2013; White et al., 2012; White et al., 2013; Zerwekh et al., 2002). Seven studies from the United Kingdom (England) (Astin et al., 2008; Booth et al., 2003; Diver et al., 2003; Lansdell & Beech, 2010; Morris et al., 2013; Somerville, 2007). Two studies were from Canada: Murray et al. (2004) and Perri et al. (2016), and two were from Northern Ireland (McIlfatrick et al., 2010; Whittaker et al., 2014). Additionally, several countries contributed one article to the international literature review each including The Republic of Ireland, Bailey et al. (2009), Italy, Bernardi et al. (2007), Norway, Tornoe et al. (2015), Kenya, Sedillo et al. (2015), and

lastly, Vietnam (Ly Thuy et al., 2014). (See Appendices H & I for further details regarding the study literature search & results).

I undertook a systematic appraisal to critique research article quality utilizing various methods for all articles included in the literature review. Specifically, I used the RE-AIM framework (reach, efficacy, adoption, implementation, and maintenance) for evaluation and critical appraisal for the quantitative and mixed methods research articles (Gaglio et al., 2013; Polit & Beck, 2012).

While quantitative research describes study rigor with such terms as reliability and validity, qualitative research describes the precision of investigation with the term trustworthiness (Polit & Beck, 2012; Roper & Shapira, 2000). Data trustworthiness consists of four components credibility, transferability, dependability, and confirmability (Roper & Shapira, 2000; Speziale et al., 2011). The consolidated criteria for reporting qualitative research (COREQ) is utilized for this literature review and is a valuable guide for evaluating qualitative research (Polit & Beck, 2012; Tong et al., 2007).

In summary, the included literature represented in this review is mainly quantitative with 12 articles, eight qualitative, four mixed methods articles, and lastly, 1 article is a retrospective documentary study of a national archive of educational profiles. All reviewed articles had some deficiencies; however, this excluded none of these evaluated studies despite having some demonstrated limitations.

Literature Synthesis

The analysis and synthesis of the selected publications in the literature revealed significant emerging, related, and universal themes. Many hospice care concepts are found in the literature, with substantial bodies of knowledge where further staff education

in dedicated end-of-life settings was needed, justifying this research study. The main findings in this literature review are related to the following themes specific to hospice and palliative professional staff's educational needs: pain and symptom management, communication, interdisciplinary collaboration, psychosocial, cultural, and spiritual care, and support; and lastly, cultural sensitivity in the hospice environment.

Background

Several studies correlate best hospice nursing practice with current staff knowledge and skill levels (McIlfatrick et al., 2010; Moir et al., 2015; Morris et al., 2013; Murray et al., 2004; Steven et al., 2014). Conversely, hospice nurses lacked skills and knowledge specific to finding EIP resources, making EIP decisions, integrating EIP from research into clinical practice, conducting and critiquing research, and facilitating EIP knowledge translation among hospice staff members (Morris et al., 2013). Therefore, determining hospice staff knowledge levels related to comprehensive care is a necessary foundation to expand EIP (Morris et al., 2013). In addition, several hospice care concepts emerged in the literature with significant knowledge areas where expanded hospice staff education was needed justifying further research. These hospice staff knowledge limitations included pain and symptom management, communication skills, psychosocial support, cultural sensitivity training, and spiritual support; further, this literature review revealed hospice staff knowledge levels and educational needs as unresearched in Alberta prior to this ethnographic study. Lastly, the study site in Calgary is unique as this hospice had only been open for approximately two years at the time of the study, and no previous staff knowledge/staff educational needs and cultural assessment had been done (AHS, 2014).

The definition of culture is a group's set of behaviors, goals, beliefs, and knowledge utilized by that group as they engage in daily life (Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011). The quick establishment of definite cultures is necessary to provide quality, safe care in end-of-life healthcare settings (O'Connor et al., 2006; Wittenberg-Lyles & Oliver, 2007). Therefore, even a hospice only open for approximately two years would have a unique set of cultural norms/staff educational needs appropriate for study. The hospice study site is remarkable as it is a Catholic/faith-based facility operated by a private Catholic organization and has an on-site Chaplain. The hospice also has a previously unresearched cultural reality with an interdisciplinary care delivery model, and the effectiveness of this model at this hospice is unknown. The uniqueness of this relatively new hospice site, the Catholic organization's commitment to quality and ongoing education, and the hospice organization's support of the study justify and provide the rationale for the study.

Adequate pain and symptom management, psychosocial, cultural, and spiritual support, and effective communication with the dying and their families are essential aspects of comprehensive hospice care (Chochinov, 2006; Chochinov et al., 2005; Koffman, 2001; Puchalski et al., 2014). Attention to these important aspects of comprehensive care can ensure excellent, cohesive hospice care grounded in EIP (Chochinov, 2006; Chochinov et al., 2005; Koffman, 2001). In addition, understanding the educational needs of professional hospice staff is imperative in preventing care provision that negatively impacts hospice patients and their families across multiple domains (Chochinov, 2006; Chochinov et al., 2005). Specifically, adequate hospice staff knowledge and education are crucial in preventing hospice patient psychological and

spiritual distress, reducing pain, enhancing symptom control, and averting diminished levels of patient dignity at the end of life (Chochinov, 2006; Chochinov et al., 2005).

Literature Review Findings

Pain Management

Adequate pain management is vital for hospice patients as inadequate pain control can decrease quality of life and functional ability (Kelly et al., 2014). Contrarily, health care providers in hospice care settings had deficits and differences in pain management skills in the following studies: Bernardi et al. (2007), Hollen et al. (2000), and Sedillo et al. 2015, and an identified lack of hospice staff knowledge regarding pain control is a barrier to adequate end of life care (Greiner et al., 2003). Several researchers have identified educational needs among hospice providers regarding pain management (Ly Thuy et al., 2014; Murray et al., 2004; White et al., 2012; Zerwekh et al., 2002). In particular, (Bernardi et al., 2007) highlighted inconsistencies between staff perceived and actual pain management knowledge and skills, with hospice team members rating their knowledge higher than actual skill testing. According to two sources, fear related to the administration of narcotics and associated ethical implications is another significant knowledge gap concerning pain management in hospice care (Greiner et al., 2003; Zerwekh et al., 2002). However, nurses who had attended pain management education courses had higher pain management knowledge and skills (Bernardi et al., 2007; Hollen et al., 2000; Sedillo et al., 2015). In addition, a study written by Perri et al. (2016) found that palliative care nurses had inadequate knowledge regarding pain management for patients with non-cancer diagnoses such as end-stage liver disease. This knowledge deficit is specifically related to opioid administration and the side effects of opioids when

patients had underlying liver disease. The research included suggestions for targeted education and quality improvement for palliative care staff managing pain for patients with end-stage liver disease. These deficits in pain management practices in the literature suggest that pain management should be part of the end-of-life staff education competencies and targeted education.

Management of Other Symptoms

Experienced hospice clinicians recognized the management of symptoms such as nausea, vomiting, and constipation as a vital component in providing quality hospice care (Hermann & Looney, 2001; Jablonski & Wyatt, 2005). Accordingly, three studies identified the importance of symptom control for maintaining comfort for hospice patients (Hermann & Looney, 2001; Jablonski & Wyatt, 2005; Nunn, 2014). Six of the studies from the literature review identified symptom management other than pain as a learning need among hospice care providers. Only three of these studies gathered data unique to the focus's specific types of symptom management (McIlfatrick et al., 2010; Murray et al., 2004; Sedillo et al., 2015). A study by Sedillo et al. (2015) demonstrated statistically significant self-perceived symptom management knowledge differences among differing care provider types, specifically in managing nausea, vomiting, and constipation for the hospice patient. Also, nurses identified symptom management as their top-rated core competency or learning need (White et al., 2012). A study by Ly Thuy et al. (2014) showed low nursing scores specific to symptom management, and Greiner et al. (2003) identified knowledge deficits amongst end-of-life care providers about symptom management. McIlfatrick et al. (2010) found knowledge deficits in training and perceived competence for patient symptom management in areas such as

non-malignant conditions and gastrointestinal symptoms. Murray et al. (2004) identified hospice staff educational needs regarding managing specific symptoms such as respiratory congestion, delirium, nausea, and vomiting. Additionally, Murray et al. (2004) identified preferred learning needs for staff working in end-of-life care, including highest to lowest: dyspnea, nausea and vomiting, delirium, and pharmacological methods of symptom management. Finally, Greiner et al. (2003) suggested innovative education regarding hospice symptom management was needed and that a barrier to quality end-of-life care included a lack of hospice staff knowledge about symptom control for hospice patients.

Communication and Interdisciplinary Team Collaboration

Even experienced hospice and palliative staff can struggle with communicating with hospice patients and their families regarding the dying process (Hamilton et al., 2014). Several studies describe the importance of effective communication in providing quality hospice patient care (Clayton et al., 2014; Hamilton et al., 2014; Moir et al., 2015; Murray et al., 2004)**.** Despite this, communicating about dying with hospice patients and their families was identified as a knowledge deficit (Kehl, 2014; Ly Thuy et al., 2014; Sedillo et al., 2015; White et al., 2012). A study by McIlfatrick et al. (2010) identified that hospice nursing staff felt ill-prepared to communicate with terminal patients and families in particularly challenging situations. Difficult situations included the death of a young person's parent and discussing death with a terminally ill young person. Several studies identified interdisciplinary communication amongst hospice team members as a learning need (Astin et al., 2008; Booth et al., 2003; Murray et al., 2004; White et al., 2013). Murray et al. (2004) identified specific communication learning needs in end-of-

life care such as assessment, information sharing, decision support, response to ethical dilemmas, and practical care delivery strategies.

A study by Kehl (2014) found that nurses believed in the preparation of families in advance for death using effective communication. Nurses also identified the development of trust before utilizing the repetition of death preparation information and strategies as necessary for successful preparation for the end of life (Whittaker et al., 2014**).** This literature review also revealed knowledge deficits amongst hospice physicians and advanced practice nursing specific to providing effective hospice clinical leadership (Pawlow et al., 2018; Selman et al., 2017). This potential lack of knowledge is relevant to the study community hospice setting as physicians, and advanced practice nurses are vital for providing quality care in Calgary, Alberta, Canada's palliative and hospice care system. A study conducted in the UK by Selman et al. (2017) identified several educational needs and a general lack of confidence in physicians from the United Kingdom (UK). Included in these educational needs were identifying patients for palliative care, responsibilities, teamwork; after-hours care; having difficult conversations; symptom management; providing care for non-malignant diagnoses, and pediatric palliative care. These same General Practitioners (GP's) from the UK also require education and support in end-of-life care, particularly the management of complex clinical care and counseling. Again, this is relevant to palliative and hospice community care in Calgary as GP's are often the primary care physicians for these patients.

A study by Pawlow et al. (2018) described the educational needs of hospice and palliative advanced practice nurses. These nurses expressed a sense of insufficient

preparation for their advanced practice role, including a lack of understanding of their role and the regulatory, legislative restrictions on the scope of practice for advanced practice end of life specialist nurses such as Nurse Practitioners (NP's) and Clinical Nurse Specialists (CNS's). In addition, many reported a lack of palliative and hospice care content in their graduate programs.

Psychosocial, Cultural and Spiritual Support

Adequate psychosocial, cultural, and spiritual support are essential aspects of quality hospice care. Frequently, hospice patients and families struggle with these areas of care needs and issues, and hospice staff routinely grapple with inadequate preparation to provide care within these dimensions (Boston et al., 2011; Chochinov, 2006; Chochinov et al., 2005; LeMay & Wilson, 2008). Influencing the knowledge levels of hospice nurses are broader social structures and health care systems that can provide practical, efficient, ongoing professional staff education (Chochinov, 2006; LeMay & Wilson, 2008). However, Canada's secular society and end-of-life healthcare settings with rigidity in professional disciplines roles versus interdisciplinary health care models may leave staff lacking skills and knowledge in these realms of care necessary for the holistic care of dying patients (Chochinov, 2006; LeMay & Wilson, 2008). Total pain is a term encompassing physical, spiritual, and mental pain within the end-of-life journey and can cause suffering and ultimately end in palliative sedation or medically assisted dying, according to Booker and Bruce (2020) and Koksvik et al. (2020). This total pain phenomenon experienced by hospice patients can also result in the administration of high doses of analgesics in end-of-life care (Boston et al., 2011; Chochinov, 2006; Chochinov et al., 2005; LeMay & Wilson, 2008). When spiritual or psychosocial distress is present,

the hospice or palliative nurse often consults a psychologist or member of the faith community and therefore may not be directly involved in providing spiritual or psychosocial support (Boston et al., 2011; Chochinov, 2006; LeMay & Wilson, 2008; Puchalski et al., 2009). A hospice chaplain has many roles, including performing spiritual assessments, providing supportive spiritual counseling, and developing spiritual care plans for hospice patients, families, and staff (Williams et al., 2004; Wittenberg-Lyles et al., 2008). The study hospice has an onsite chaplain, and this may enable the interdisciplinary hospice staff to provide a higher level of patient spiritual support than is reflected in the literature review. Also, staff at the study hospice may consider spiritual needs to be essential learning needs because of the faith-based nature of the study hospice organization.

Psychosocial Support

Confronting the psychosocial concerns of hospice residents is an integral part of providing holistic hospice care (Elliott & Umeh, 2013; Neimeyer et al., 2011). Providing psychosocial support for hospice residents has been identified as a staff educational need (Murray et al., 2004; Weisenfluh & Csikai, 2013). Moreover, a study by Ly et al. (2014) showed low scores with perceived self-competence in addressing the psychosocial domains of hospice care. A study by Landsdell and Beech (2010) revealed knowledge deficits identified by the hospice staff participants in talking to patients in denial, discussing a poor prognosis, and asking end of life preferences. Also, the same study following an educational program focused on psychosocial support showed an increase in confidence and knowledge scores in the provision of psychosocial support (Lansdell & Beech, 2010). These deficits in the literature related to hospice staff knowledge specific

to hospice patient psychosocial management practices justify a local study to determine Calgary area hospice staff's psychosocial care management educational needs.

Culturally Sensitive Care

The provision of culturally sensitive care is a critical component of high-quality, socially conscious hospice care (Lu & Havens; Mei Lan et al., 2016). Preparing patients in the hospice setting for the dying process is influenced by the patient's and family's cultural background regarding strategies, tailoring, timing, and content. As a result, cultural competence in hospice care is necessary (Kehl, 2014). However, barriers to quality, culturally sensitive care include limited access to interpretive services and negative hospice staff attitudes and behaviors toward patients and families from an ethnic minority (Diver et al., 2003).

A study by Somerville (2007) identified essential factors in providing quality culturally sensitive hospice care, describing the establishment of genuine relationships, and providing sensitive communication and individualized care as facilitators of culturally sensitive care. Providing hospice care in a culturally sensitive manner was identified as a learning need in several studies (Kehl, 2014; Schim et al., 2006; Somerville, 2007; Weisenfluh & Csikai, 2013). Schim et al. (2006) noted deficits in hospice staff knowledge in obtaining information on which to base culturally congruent interventions and reported infrequent inclusions of cultural assessments in client evaluations, documenting cultural adaptations to care, and using resources to learn about cultural issues. Schim et al. (2006) also reported a significant association between higher education, Bachelor of Science in Nursing (BSN) or higher academic degrees, and cultural awareness and sensitivity amongst hospice staff. Lastly, two studies found an

association between staff diversity training and self-reported cultural competence behaviors in end-of-life care settings (Diver et al., 2003; Schim et al., 2006).

Spiritual Support

Spiritual care and support are essential aspects of quality hospice care. The profound loss of an individual's health may cause physical and emotional symptoms that lead to spiritual questioning (Sinclair & Chochinov, 2012). In addition, the diagnosis of a terminal illness may also cause an individual to experience a loss of meaning in life (Meraviglia, 1999; Sawatzky & Pesut, 2005). Spirituality is described as a sense of connectedness to a personal god or higher force or power and is considered by some to be a larger, more complex construct than religion (Koenig, 2012; McGrath, 2002). Unfortunately, the concept of spirituality is vague, abstract, and inadequately researched, and applied to medical and nursing concepts and care (Steinhauser et al., 2017). Sinclair and Chochinov (2012) described the importance of providing spiritual assessment and support to patients receiving end-of-life care and delivering clinical guidance for end-of-life clinicians concerning patient spiritual and existential needs.

Spirituality, in the literature, is a concept interwoven into the care provided by healthcare staff working in settings such as hospice and palliative care. Additionally, hospice and palliative care are spiritual and existential catalysts for end-of-life clinical providers and are disciplines often described as spiritual callings (Sinclair, 2011; Sinclair et al., 2006). End-of-life care is emotionally charged work, and care providers trained in self-care methods such as meditation experience reduced distress, and palliative care teams similarly educated were noted to have enhanced protective resources for staff (Orellana-Rios et al., 2017; Sansó et al., 2015).

Several studies identify that hospice care staff have difficulty providing spiritual support (Chochinov, 2006; Chochinov et al., 2005; Roze des Ordons et al., 2018; Selman et al., 2018; Tornøe et al., 2015). Also, hospice staff members are hesitant to implement support in the spiritual dimensions (Boston et al., 2011; LeMay & Wilson, 2008; Puchalski et al., 2009; Tornøe et al., 2015). Tornoe et al. (2015) reported that this hesitancy could stem from uncertainty regarding spiritual support competence and fears relating to facing patient and family suffering.

One reviewed study by Ly Thuy et al. (2014) described low hospice staff knowledge scores in providing spiritual support. Also, Bailey et al. (2009) described hospice staff spiritual needs as understanding the concept of spirituality and incorporating this into care practice and spiritual care skills development. Finally, Tornoe et al. (2015) reported that training in spiritual support provision resulted in an increased willingness to provide spiritual care from staff working in end-of-life settings.

Conclusion: Determining Hospice Educational Needs

In conclusion, this literature review included several studies focusing on palliative and hospice staff's educational needs and knowledge gaps. Unfortunately, no local studies from hospices in Calgary, Alberta, Canada, concentrated on the educational requirements or knowledge needs and priorities of hospice professionals were located in the literature. Since there are no studies focused on the educational needs and priorities of Calgary area hospices, there is a hesitancy to assume that Calgary area hospices mirror the educational needs of the hospices discussed in the literature review. The lack of local research focusing on these educational needs of Calgary hospice professionals supports developing a research question, proposal, and study. Educational needs identified in the

literature included pain and symptom management, communication about the dying process, psychosocial support of the dying, and the provision of culturally and spiritually sensitive support. A greater focus was given to pain management among the reviewed relevant studies, leaving other essential learning needs of hospice professionals not fully explored, revealing an additional justification for the study described in this thesis. Researching the educational needs of professional staff in this particular Calgary area hospice may provide the information necessary to plan future research endeavors and educational programs.

Chapter Three: Methodology

Research Design and Rationale

The study of hospice culture and how culture shapes hospice staff educational needs lends itself to an ethnographic research design (Andreassen et al., 2020; Polit & Beck, 2012; Roper & Shapira, 2000). Ethnography is a qualitative research methodology employed by researchers to fully describe the culture of a practice environment (Andreassen et al., 2020; Roper & Shapira, 2000; Speziale et al., 2011). Specifically, the application of ethnographic research in the domain of education reveals the ways hospice leaders, staff, and hospice residents and families interact, thus creating a picture of hospice care and professional hospice staff educational needs utilizing cultural description (Andreassen et al., 2020; Rashid et al., 2015; Reeves et al., 2008).

Ethnography has several different traditional forms, and for this study, I utilized focused ethnography. Focused ethnography is a pragmatic and uniquely applied form of this research methodology that facilitates the study of not only a culture but also a specific phenomenon of interest in healthcare; in this study, the educational needs of hospice staff (Andreassen et al., 2020; Roper & Shapira, 2000; Speziale et al., 2011). The purpose of a focused ethnography (such as in this study) is to reveal the meaning of observed social interactions in the hospice setting (Andreassen et al., 2020; Polit & Beck, 2012; Roper & Shapira, 2000). Further, a focused ethnography centers on a central domain or theme, specifically, for this study, the educational needs of professional hospice staff (Andreassen et al., 2020; Roper & Shapira, 2000; Spindler, 2014). The rationale for choosing ethnography is that ethnographic inquiry legitimizes the study through multiple data collection methods, including the examination of hospice staff interviews, direct staff observation, cultural artifacts, document reviews, and written field

notes (Andreassen et al., 2020; Polit & Beck, 2012; Roper & Shapira, 2000). Furthermore, diversifying the timing of study observations and detailed descriptions of the participants and their relationships also increases the rigor of the research (Andreassen et al., 2020; Roper & Shapira, 2000; Speziale et al., 2011).

Ethnographic philosophical foundations are essential to describe as they support the rigor of the research methodology. Ethnography is a well-established philosophy/methodology of cultural research originating from cultural anthropology, the study of human cultures and societies having immense depth as its origins are centuries old. In recent years ethnography has been applied in focused ways to describe healthcare cultures and areas of interest such as professional hospice staff educational needs as in this study (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). The central philosophical foundations of ethnography include reflexivity, stemming from the emic and etic perspectives, and naturalism and holism, arising from the researcher's immersion in the cultural setting and the researcher's presence as an instrument in the study (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011).

Reflexivity in ethnographic research stems from a complex interplay with the emic or cultural insider's view (in this study, the professional hospice staff) and the etic or cultural outsider's view (for this study, I provide the etic perspective as the hospice researcher). This dynamic requires a researcher to have an ongoing awareness that the culture itself may be influenced or changed through their immersion in the study site's culture. Additionally, a researcher must understand their potential to influence the research observations through their values and bias; this is also an aspect of reflexivity (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Holism in

ethnography is a striving for a wide lens encompassing the beliefs, activities, and knowledge central to those participants or cultural insiders of an ethnographic study (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Ethnographic naturalism is the philosophical stance of cultural observation/research inquiry in the unmanipulated natural study setting. Therefore, situating an ethnographic investigation in the naturalistic, cultural setting is central to the methodological characteristics of this research tradition that includes cultural immersion, fieldwork, and the positioning of the study researcher as an instrument (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011).

Research Setting and Context

The setting of this research study is a free-standing 26-bed hospice facility in Calgary, Alberta, Canada. The hospice is a part of a private Catholic/faith-based health care organization. At the time of this research study, the facility was relatively new, open for approximately two years. The hospice is a privately-run facility; however, it does receive some funding and regulation from AHS. There were seven hospices in Calgary at the time of the study, with one hospice since closing and a new hospice site opening. These Calgary area hospices all utilize an interdisciplinary care model, including physicians, RNs, LPNs, RAs, SWs, and VOs (AHS, 2014). In addition, the study hospice has an affiliation with a Catholic/faith-based religious organization and, accordingly, does have an on-site chaplain. Residents eligible for hospice care in the study hospice setting are diagnosed with a terminal illness, having a prognosis typically less than three to six months in duration (AHS, 2014). Hospice services for residents and their families usually include care for multiple issues surrounding the dying processes such as physical,

symptom/comfort, psychosocial, and spiritual aspects (Baldwin et al., 2011; Chochinov, 2006). The hospice interdisciplinary team provides care, symptom management, spiritual and psychosocial care, and support and communication about the dying process during the final phases of life before death (Baldwin et al., 2011; Chochinov, 2006).

Sample and Recruitment

The study sampling procedure was a nonprobability purposive sample (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Purposive research samples are selected based on characteristics of the study population and the study objectives (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Purposive sampling is appropriate for a focused ethnographic study as participants are often required to have knowledge about the culture and the focus of study. This type of research sampling provides key informants who actively participate in and are knowledgeable about the culture and area of focus for an ethnographic study such as this one. These key informants function as knowledgeable participant representatives who reveal vital information about the study culture and focus of interest specifically, for this study professional hospice staff educational needs (Andreassen et al., 2020; Reeves et al., 2008; Roper & Shapira, 2000). The participants in this study were limited to professional hospice staff who have at least one year of experience in hospice care. This inclusion criterion ensured that the participants had the experience of hospice care provision and exposure to hospice/palliative and end-of-life care to identify specific educational needs of hospice professionals. Potential participants included all interdisciplinary team members, such as hospice leadership, medical staff, hospice educators, RNs, LPNs, SWs, VCs, VOs, RAs, and hospice chaplains. Initially, I considered having members of my

own professional discipline with only nursing staff for the purposive sample; however, members of the diverse interdisciplinary team expressed an interest in the study, and I believed with my extensive palliative experience that end-of-life care is profoundly interdisciplinary and this would be a sample able to provide much depth in perspectives specific to hospice staff educational needs. The study focused on the professional hospice staff perceptions about their educational needs and the hospice culture; hospice residents and their families were observed under the team's care but not interviewed. Participant selection based on first-hand experience is made possible with nonprobability purposive sampling. The study sampling method (non-probability, purposive sampling) aligned with the study research question and the specific phenomenon of interest of the study, in this case, hospice culture and professional hospice staff educational needs (Andreassen et al., 2020; Denzin, 1997, 1999; Roper & Shapira, 2000; Speziale et al., 2011).

The sample size included nine key informants (interdisciplinary staff members of varying professional disciplines). This sample of hospice staff is considered an adequate sample size for ethnographic research due to the significant amount of data generated using this research tradition (Polit & Beck, 2012; Roper & Shapira, 2000). The sample was purposive and non-probability in nature; however, self-determination was honored with hospice staff participation as a key informant being entirely voluntary in nature. The final study key participants all had over one year of experience in hospice care. Also, the sample included seven females and two males with diverse religious/non-religious philosophical ideologies; all participants were Caucasian (which could be a potential limitation for the study). The sample included 2 RNs, one LPN, one RA, one VC, one VOL, one SW, one chaplain, and one RN CNE. Study recruitment took place at the

hospice over a four-week time frame via a third-party email sent out by the hospice clinical TL (manager) to all hospice staff (with a follow-up reminder email sent two weeks later). In addition, I gave a presentation at a hospice team meeting facilitating recruitment. Also, recruitment information posters detailing the research project were placed strategically at the hospice to generate interest in the study. (See Appendix B for the study recruitment email invitation).

Data Collection Methods

The collection of ethnographic data for this study involved my immersion in the inner workings of the study hospices culture (Andreassen et al., 2020; Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Data collection began with my general observation of the hospice environment and staff and an establishment of a rapport with the hospice staff, becoming acquainted with the hospice culture, and gaining the acceptance and cooperation of the staff (Andreassen et al., 2020; Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Data collection methods also included semi-structured interviews in the staff meditation/reflection room where the interviews took place. This room is a calm and serene environment for the staff to reflect on spiritually positive and challenging hospice situations and relax in a healing environment with a massage chair and a fireplace when they had personal time away from hospice care. In addition, the setting of the participant interviews allowed for a comfortable and inspiring place for the interview participants to reflect on their experiences in hospice care provision and on professional hospice staff educational needs. The study interviews took between 60-90 minutes, depending on the individual study participant, and questions included a grand tour question--*Tell me about working in a hospice. Can you describe a*

typical day in your practice as a hospice staff member? Eight additional related questions were also asked of each study participant (see Appendix F for a complete list of interview questions).

I focused on nine hospice staff members or key informants and interviewed and observed these staff members during their daily hospice practice. I documented in written field notes informal cultural field interactions with other staff, hospice residents, and family members and included hospice site conversations, shadowing observations, and shift reports (Andreassen et al., 2020; Polit & Beck, 2012; Reeves et al., 2008; Roper & Shapira, 2000). Shadowing, or following the key informants and other staff during their daily routine, provided rich amounts of data (Andreassen et al., 2020; Polit & Beck, 2012; Reeves et al., 2008; Roper & Shapira, 2000). I also observed the evening and night hospice culture. Much of the hospice's education occurs during the day, resulting in these groups of hospice staff having uniquely unmet needs and an expressed sense of distance from the hospice leadership, educators, and diverse disciplines such as the SW and chaplain who typically work during the daytime hours. Observations in the study were passive for direct hospice resident and family care observation and active in the discussions with hospice staff specific to the inner workings of the hospice culture, staff educational needs, and resident and family care provision. The observations that I made were a privilege and an honor as I had access to the internal culture of the hospice site and the interdisciplinary staff functioning.

I placed posters strategically throughout the hospice informing the general hospice population when the research observation was occurring. Hospice staff and any other individual in the hospice environment made aware of the study observations in this way

could opt-out of participation in the study observations if desired, giving implied consent for the general hospice cultural observations. Specifically, any hospice visitor, family member, resident, or staff member could decline participation at any time if desired. The participant interviews and the observations made of the nine staff participants (key informants) during their care of the hospice residents required the formal written consent of the hospice staff (See Appendix A for study participant consent). Hospice residents also gave verbal consent for the instances when I observed the care provided to them by the hospice staff. When a hospice resident was near to end-of-life, the hospice resident's family gave permission for observation. Hospice residents and their families had a study fact information sheet given to them before I made these care observations. (See Appendix C for the study information sheet). I did not participate in the hospice resident and family care; instead, I observed the staff in their daily work and observed the overall culture of the hospice, writing detailed field notes and collecting information about hospice documents, policies, and cultural artifacts. I maintained a passive stance during observations of the staff providing direct resident and family care within the culture. However, I engaged actively in the hospice environment with the hospice staff, asking clarifying questions and seeking the hospice staff's opinions, thoughts, and experiences after observing the care and following social interactions and cultural engagement.

Field notes are an essential data collection method in ethnography that captures rigorous written accounts for the description and interpretation of the data. I observed the overall hospice culture and recorded this information in the form of field notes. These field notes provided rich and in-depth contextual data offering a first-level analysis and understanding of the everyday vision and mission of the hospice culture. This

ethnographic data provided the landscape of the how, what, and why daily hospice practices unfold as they do, central to the ethnographic research tradition (Andreassen et al., 2020; Denzin, 1999; Polit & Beck, 2012; Roper & Shapira, 2000). First level description and analysis included not only clinical and social observations of the hospice staff culture, care of the residents and families, and participant focused interviews, but also cultural artifacts, background documents, historical records, archives, and written records (Andreassen et al., 2020; Polit & Beck, 2012; Reeves et al., 2008; Roper & Shapira, 2000). Therefore, I wrote detailed field notes (while maintaining resident and family confidentiality) that included relevant documents, archives, and hospice resident records, including charts, care designations, medication records, physicians' orders, and nursing documentation. Also documented in the field notes were the interpretations of these observations with the goal of understanding cultural behaviors, beliefs, rituals, and practices (Andreassen et al., 2020; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011). I wrote field notes immediately following hospice participant and cultural observation with a wide-angle open focus encompassing environmental space, staff perspectives such as goals, and my personally experienced reflections and feelings encountered during fieldwork (Andreassen et al., 2020; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011). Also included in the field notes were my relationships with the participants as they unfolded, any conversations that occurred, initial perceptions, and emerging theoretical details and impressions (Andreassen et al., 2020; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011).

Data Analysis Methods

The focused ethnographic methodology utilized in this study offered a unique method of analysis involving myself as a study research instrument (Andreassen et al., 2020; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011). My complex role in the research project involved an interplay between identifying, analyzing, and interpreting the culture of the hospice setting (Andreassen et al., 2020; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011). This research involved a dynamic process accomplished through participant interviews, observations, and the recording and examining of the culture's physical data such as artifacts and documents (Andreassen et al., 2020; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011). The data analysis involved a cyclical, continuous, and evolving process of interviewing, observing, reviewing materials, analyzing that data, and going back to the research setting to do more interviews, observations, and cultural artifact collection and examination (Andreassen et al., 2020; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011).

The analysis of the ethnographic data obtained during the study involved participant perspectives and my perspectives as the study researcher. Reflexivity is the tension and dynamic interplay/influence unfolding between the researcher and participants during the ethnographic research process. The data revealed also shows emic (from within the social/cultural structure/subject perspective) as well as etic (from the researcher's outsider observational perspective) views from my fieldnotes (Andreassen et al., 2020; Polit & Beck, 2012; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011). Also, the analysis of the data included the verbatim transcription of the recorded

hospice staff/key participant interviews. Coding of all transcriptions, field notes, and cultural documents and observations facilitated identifying the domains, patterns, and themes in the data and the integration of the analyzed data into an understanding of the holistic everchanging nature of the culture. A constant comparative approach was utilized where I asked questions, analyzed, and developed new questions and answers in a repetitive manner as a complete view of the hospice culture emerged (Andreassen et al., 2020; Polit & Beck, 2012; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011). In addition to the inductive nature of ethnographic data analysis, I coded data for each interview and observation, grouping these codes in relation to related domains on a spreadsheet to discover the patterns and themes within the data set. First-level coding included keywords, emerging patterns, memoing (reflective remarks), considering theoretical constructs, and examining any data outliers to ensure a complete picture/understanding of the data. Three main themes emerged in the data with color highlighting of the data codes and related hospice staff quotations, and subthemes were also identified (Andreassen et al., 2020; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011). In synthesizing the data, these three themes included a holistic combination of the cultural landscape, interviews, and fieldnotes interpreted to produce broad perspectives and meanings of the educational needs of the professional hospice staff as they related to and received influence from the greater hospice culture (Andreassen et al., 2020; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011). I then created a thematic map to illustrate the three themes and subthemes, went back to each transcript, and highlighted quotes within the data to ensure consistency between the interviews. Finally, writing a detailed description showed the rich and

complex depiction and interpretation of the themes revealing the professional hospice staff's everyday practices, strengths, challenges, and professional hospice staff educational needs particular to this culture.

Maintaining Trustworthiness

While quantitative research describes study rigor with such terms as reliability and validity, qualitative research describes the rigor of investigation with the term trustworthiness (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Data trustworthiness consists of four components credibility, transferability, dependability, and confirmability (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Multiple data sources and data collection methods facilitate the trustworthiness of this ethnographic study (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). The prolonged ethnographic engagement with the subject matter in this study provides credibility (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). The multidimensional/triangular design of focused ethnography allows for maximum dependability of the study findings (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Also, ethnographic research leaves a significant audit trail with its multilayered data collection and data documentation methods, increasing confirmability for future studies (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). I held attention to trustworthiness as the study included nine staff interviews and field notes detailing observations of the professional hospice staff providing resident and family care and observations of the general hospice culture. The transcribed study participant interviews and detailed written field notes were coded and analyzed thematically to determine the study findings. Lastly, an ethnographic study has

transferability for future studies if the data and findings have contextual resonance with other hospice, palliative, and end-of-life settings and possibly healthcare sites not dedicated to end-of-life care. In qualitative, ethnographic research, defining transferability or fittingness is the likelihood that the research findings resonate or are meaningful to others in similar situations/settings. (Beck, 1993; Polit & Beck, 2012; Speziale et al., 2011). The richness, depth, and detail of the data in this ethnographic study increase the potential for transferability to other contexts by other researchers in the future (Polit & Beck, 2012; Rashid et al., 2015; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011).

Ethical Implications

The moral and ethical values guiding a research study are essential because they direct the degree to which procedures comply with the professional, social, and legal responsibilities honoring the study participants (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Accordingly, the University of Calgary Conjoint Health Research Ethics Board (CHREB) approved this study according to their standards, ensuring proper ethical adherence. Additionally, I had discussions with the hospice leadership team before the study began regarding any potential ethical issues/concerns anticipated during the study from their perspectives. I also obtained support for the research study from the hospice before initiating research at the site (see Appendix E for the hospice study support letter). I had the study key participants sign informed consent forms before completing the semi-structured interviews after ensuring participants had adequate information and comprehension of the study (see Appendix A for the study participant consent). Consent included an understanding that study participants could

voluntarily consent or refuse participation at any time during the study as ethical consent is an ongoing process (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). All observed study key participants provided written consent, and hospice residents and their families that were present during the observation of the staff during their work who had capacity gave verbal consent. When the resident did not have the mental capacity/were nearing end-of-life, verbal consent was obtained from their family whenever possible. I also observed the professional hospice staff, leadership team, and the hospice residents and their families in the open hospice cultural environment. I observed the overall culture gaining a sense of the hospice setting, posting a notification ensuring that all present individuals knew that observation was occurring. This way, any individual not wanting to be observed could speak with me to decline participation. Informed consent was an ongoing process, revisited throughout the time I was at the hospice, upholding the study participant's right to self-determination when hospice staff voluntarily decided to participate in the study (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). To maintain self-determination, I informed staff at the team meeting that participation in the study was voluntary. Maintaining human dignity is essential for any study (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Therefore, I informed participants that they did not have to answer any questions they did not feel comfortable with and could stop the interview or conversation at any time if they thought this was necessary. Additionally, counseling services information was provided verbally through the informed consent process if required.

Confidentiality and anonymity must be maintained whenever possible to protect the study participant’s right to privacy (Polit & Beck, 2012; Roper & Shapira, 2000;

Speziale et al., 2011). The data from the interviews and observations were transcribed and secured in a locked cupboard in my home office. Also, the recorded copies of the interviews were stored in a locked cabinet and deleted after transcription occurred. The names of the participants were kept confidential, further maintaining anonymity; instead, I assigned pseudonyms for both written and recorded data.

Limitations and Delineations

This study has several limitations, including having a small sample from only one hospice site. A focused ethnographic research methodology for this study served to obtain a rich and detailed description of a single hospice however may not be fully representative of the other Calgary area hospices. Studies including multiple end-of-life care sites offering more diverse samples of study participants may be more transferable to all seven Calgary hospices (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). However, focusing on one hospice site is more realistic in scope for a master's thesis project. In addition, the study sample was not racially diverse. This diversity may have brought a unique and different perspective to the study data/findings. All nine key informants were Caucasian individuals.

The study hospice's affiliation with a Catholic/faith-based organization (and AHS for funding and regulation) also may reduce transferability to other non-Catholic hospices. A mixed-methods study may be a superior design for this research study; however, a mixed-methods study may have been ambitious for a smaller scale master's thesis (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011). Finally, individual bias can become a barrier in ethnography, as all persons view social situations

through their cultural lens, with no two researchers describing the culture in the same way (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011).

Summary

The understanding of the ways hospice culture shapes the educational needs of professional hospice staff is best studied with focused ethnography. In this focused ethnographic research, I sought to understand hidden meanings within this culture that may uncover the specific educational needs of professional hospice staff based on the cultural members' mission, values, rituals, and beliefs. In other words, ethnographic research aims to understand what people do and why they do it. Competent, knowledgeable staff are best able to provide hospice care grounded in EIP. However, there is still much to learn about the educational needs of hospice staff locally, provincially, and in Canada. Methods of data collection for the study included key informant interviews and observation and documentation of the culture as a whole and of the interdisciplinary hospice staff as the team went about their everyday practice in caring for dying individuals. The focused ethnographic methods utilized for the study offered an opportunity for significant and rich meanings regarding hospice culture and the educational needs of hospice staff to emerge from the data. This information may ultimately contribute to improving hospice care and enhance hospice team members' job satisfaction.

Chapter Four: The Cultural Landscape of the Hospice

Introduction

An Ethnographic research methodology is tasked in this study to describe a specific healthcare setting and the cultural reality within that particular site. For this research project, the culture of a 26-bed Catholic/faith-based hospice in a city in Alberta, Canada, was the focus of the examination. Ethnography enables the study of groups of individuals specific to their everyday activities and cultural norms. Ethnographers reveal complexities in healthcare cultures via "learning about people by learning from them" (Roper & Shapira, 2000, p. 1). This chapter's purpose is to provide detailed, in-depth, rich descriptions of the hospice cultural environment and interdisciplinary staff culture. The research project is, more specifically, a focused ethnography allowing for the examination of the hospice culture within a specific domain: the educational needs of the professional hospice staff. The focused nature of the project enabled the researcher having many years of palliative care experience, to interpret the culture through a critically informed lens, adding to the depth and the layering of the analysis. This chapter will describe only a portion of the cultural landscape as the hospice space is vast in layout and cultural complexity (see Appendix J & K for hospice setting maps). This description will focus on key aspects of the hospice's cultural background stemming from its Catholic/faith-related purpose and mission, the organizational policies that govern its operations, and the people that reside and work in the hospice to shape the understanding of the comprehensive culture. I will begin this chapter's discussion with the physical and social structure of the hospice.

The Culture of Hospice Care

Hospice care is specialized care with a philosophical focus on providing comfort care with dignity for those nearing end-of-life (AHS, 2014; Canada, 2018). In Calgary, Alberta, the interdisciplinary professional team mix differs between hospices. For example, some hospices have only RNs and not LPNs working (according to revealed information from hospice staff obtained during field discussions and recorded in field notes). Despite a uniform overarching hospice care philosophy of providing dignified and comfortable care AHS (2014), hospice care delivery systems are not uniform or consistent within the Calgary zone (AHS, 2014). I chose to observe one hospice with potentially unique learning needs as part of the distinct hospice culture in this study. My interpretations reveal this environment's artistic, aesthetic, and spiritual nature as part of the personal needs of those residents experiencing death and dying and their families and as being shaped by the unique culture this hospice embodies. The professional hospice staff expressed that hospice care is unique, specialized, and is very different from supportive living (housed within the facility is also a senior's assisted living complex). Overall, the hospice culture and care focus center on the well-being of the hospice residents and families, and this is another foundational hospice care principle.

Hospice residents and their families receive a Hospice Resident & Family Information binder upon arrival to the hospice describing the Catholic/faith-based historical traditions that profoundly provide structure and influence to the hospice care and interpersonal philosophies. Also described in detail in the binder are the history and meaning of hospice care. Specifically, the word "hospice" comes from the Latin

"hospitium," meaning guesthouse and hospitality. It originally described a safe lodge/ shelter for tired and unwell travelers returning from sacred journeys. Also described in the binder is the hospices association with a Catholic/faith-based private healthcare organization and the reverence held within the hospice and its governing organization for the historical contributions and philosophical foundations of care provided by the Grey Nuns (a religious order of nuns providing primary healthcare and social services historically across Canada) (Hardill, 2007; Paul, 1994). The private Catholic/faith-based healthcare facility housing the study setting includes the hospice (located on the lower level of the main building) and a 102-bed supportive living facility. In this facility, there are also seventy studio rooms for residents, eight one-bedroom rooms for couples, and twenty-four Memory Care suites (care focused on those residents with cognitive/memory deficits/challenges). In this chapter, I will describe the structural, social, and aesthetic layout of the hospice. First, I will detail the religious/faith-based and spiritual foundations that shape the hospice's mission, purpose, and everyday working practice and culture.

Faith-Based Influence/Catholicism

"God is calling me home."

The influence of the hospice's affiliation with a private Catholic healthcare association and the Catholic tradition is immediately visible and steeped in every area of the hospice. The Catholic Church has a profound and meaningful history in palliative and hospice care, with many traditions and rituals specific to death and dying (Gray, 2020; O'gorman, 1998). These rituals, such as a Catholic priest participating in bedside prayers and the offering of the Sacrament of the Sick, and other religious symbolism, are

immediately apparent in the artwork placed throughout the hospice. These Catholic/faith-based traditions are also honored at the hospice in spiritually focused care, with the presence of a chaplain and on-call Catholic priests supporting hospice residents in their end-of-life journeys and families in the supportive care of their dying loved ones at the hospice. In addition, chapel services were held in the hospice by Roman Catholic priests for the hospice residents and families in a mass/liturgy. Additional faith-based services held within the hospice include United Church chapel services and the services affiliated with the Baptist Church, further showing respect/reverence to the faith-based philosophy specific to the hospice and its affiliation with Catholicism, religiosity, and spirituality.

An RN hospice staff member discussed the faith-based nature of the hospice and her connection/positioning within the hospices faith-based/Catholic affiliation:

> *Catholicism is really in the background here…I'm not a religious person even though I work at a hospice connected to Catholicism, and I feel that any human being has something to offer the dying even if they are not a religious person."*

Despite the apparent aesthetic, religious presence that I observed in the hospice, I was informed in conversation by many hospice staff members during my fieldwork that Catholicism does not dictate the general/overall care practices or who is eligible to become a resident in the hospice. This openness and acceptance of hospice residents and families of all religious and cultural backgrounds is a prevalent and pervasive philosophy of care in the hospice environment as I engaged in the day-to-day interdisciplinary culture of the hospice staff.

The hospice aesthetic also further revealed a Catholic/faith-based historical association and honoring of the founding Sisters of Charity of Montreal (The Grey Nuns), with artistic artifacts recognizing their significant contributions to healthcare in Alberta (Hardill, 2007; Paul, 1994). For example, as you enter the main building/healthcare facility that houses the hospice (on the lower level), an oil painting is framed in gold of a nun wearing a black and beige habit. The nun had a silver cross around her neck and a halo of light around her head and neck. This nun is one of the founding Sisters of Charity of Montreal (Grey Nuns), and her memory is honored with the painting and in the naming of this Catholic/faith-based healthcare facility. "*This site is named after… foundress of the Sisters of Charity in Montréal, known as the Grey Nuns."* The healthcare site/facility housing the hospice is named after this founding Sister of Charity, further acknowledging the contributions to healthcare in Alberta made by the Gey Nuns.

Additionally, the hospice itself is named after another Sister of Charity (Grey Nun) who traveled from Montréal to Calgary in the late 1800s to open a hospital. I found information about her history, contributions to healthcare in Alberta, and the significance of the name of the hospice in a document found in the hospice cultural environment as described and written in this excerpt from my field notes:

> *Her training allowed her to care for the most vulnerable patients with compassion and comfort as they face their illnesses. The Hospice honors her pioneering spirit and service to those in need. The name of the hospice represents kindness and gentleness, attributes that reflect the care and compassion needed to care for the hospice residents as they journey through end-of-life.*

There is a dedication to a faith-based care culture and philosophy affiliated with Catholicism, religiosity, and spirituality as observed in its artifacts and aesthetics in the hospice. This observed faith culture is throughout the hospice in places such as residents' rooms and the window boxes noted outside each resident's hospice room. The window boxes are symbolic in that they allow each resident to show who they are, including their values and beliefs. The themes of the window boxes are often spiritual, mystical, religious, or inspirational. For example, in a resident's room, the researcher saw three angel crafts on one of the windowsills and a mother-of-pearl angel statue. The window box outside of another resident's room had a picture of flowers in a meadow, three angels, and a placard inscribed with *"angels often come to us as grandmothers."*

The affiliation of the hospice to a Catholic Health Organization has influenced the handling & the lack of the provision of the Medical Assistance in Dying (MAID) procedure on the hospice site and the MAID policies for the hospice. Several documents for residents, families, and healthcare professionals located in this hospice site related to the MAID process. The hospice MAID policy includes a statement that the Catholic health organization *"is committed to the inherent dignity of every human being throughout the entire continuum of life from conception to natural death."* The facility's MAID policy acknowledges in a statement that the hospice *"MAID policy does not apply to other sites, including AHS or physicians working at other sites."* The policy statement that clearly encompasses the Catholic organization's belief regarding MAID is: *"Covenant Care and Covenant Living personnel shall neither prolong nor hasten death."*

In contrast, the same MAID policy indicates, *"An expressed request from the person in our care for MAID must be respectfully acknowledged in a non-coercive and non-discriminatory manner."* One of the RNs interviewed for the study stated that *"she supports MAID and struggles with the hospice policy."* She elaborated further, indicating that she *"supports individual choice, and after all, it is the Canadian law."* This belief may be held by other professional hospice staff members, causing them to explore their own ethical beliefs surrounding MAID. Despite the values and ideas identified in the hospice policy, access to MAID is made available for hospice residents as per Canadian Law. As described by a hospice RN, when residents and families broach a discussion about MAID with staff, and a hospice resident requests MAID, *"MAID forms are filled in, and the resident & family may speak to the MAID team."* The administration of the MAID procedure does not take place at the hospice site; however, the hospice leadership & staff are open to discussions and referrals specific to MAID with hospice residents and families. When a hospice resident has the MAID procedure, the resident either goes to their own home for MAID or goes to another healthcare site, often a long-term care facility for MAID.

The Hospice Mandate, Mission and Vision

The hospice serves residents with a terminal diagnosis, typically with a prognosis of approximately six months or less, and provides additional support for hospice residents' families. The professional hospice staff includes a leadership team with a TL (manager), MD, rotating medical physician staff, and additional input from the palliative consult physician team affiliated with AHS. The nursing team includes the RN CNE,

RNs, LPNs, and RAs. The SW, VC, VOs, and Chaplain also work together closely collaborating to provide optimal hospice care. The hospice is also alive with a multitude of services achieved through engagement (often by the hospice volunteer team) with community-based organizations that contribute to the quality of hospice care provided and the hospice's spiritual and aesthetic beauty.

The hospice's name, mission, vision, values, goals, organizational standards, and structure descriptions are in information binders housed throughout the hospice and recorded in field notes. The defined hospice mission is *"we are called to continue the healing ministry of Jesus by serving with compassion, upholding the sacredness of life in all stages, and caring for the whole person; body, mind, and soul."* The documented vision of the hospice asserts we *"will foster, through leadership and innovation, enriching environments where people find meaningful opportunities to live, work and grow."* Specifically, the values of *"compassion, respect, collaboration, social justice, integrity, and lastly stewardship"* reflect the values of this faith-based organization.

Operational Standards and Policies: Hospice as a Home

Many standards make the hospice a safe yet resident and family-centered environment. Operational practices of the hospice can be a delicate balance with the hospice as an operating facility versus the hospice as a caring home-like community (a duality of hospice care reality). For example, continuing care standards identify that offering hospice residents a shower or a tub bath at least twice per week is an expected routine for hospice staff members. There are several hospice operational policies in an accreditation binder, including operations policy around night checks, encompassing the

refusal of nightly checks by a resident's family and the hospice policy around the resident/family declining recommended care. Accreditation with commendation (accreditation Canada) is held by the hospice, as clearly stated on a placard in the lobby. The skilled hospice interdisciplinary nursing staff (RNs, LPNs, and RAs) provides all assistance with resident mobility challenges and transfers, maintaining the safety of the residents. Operational and communication policies regarding residents' safety with mobility and transfers include a plan of care using information cards in each resident's room. These hospice resident mobilities and transfers policies facilitate safe, smooth hospice operations with descriptions of resident transfers, including one-person, stand-by, two-person transfers, or mechanical lift transfers. There are also operational guidelines to prevent skin breakdown for hospice residents. During my fieldwork, one of the RN's revealed in an informal conversation that she *"worries that the residents are not being turned and repositioned enough in the hospice to prevent skin breakdown. This concern can cause nurses to experience ethical & moral dilemmas."* In my field notes, I wrote that the RN believed that *"high workloads and the level of training of the RAs are dual contributing factors for suboptimal skincare and pressure relief provision."*

The Hospice as a Home

The study hospice environment is comfortable & homelike, with the hospice staff striving for a palpable feeling of peace and calm for the benefit of the hospice residents and their families. These homelike aesthetics are part of the hospice's philosophy and cultural reality, as described in detail in this thesis. In keeping with this philosophy that the hospice is a home, not a healthcare facility, the term hospice resident is used (not patient or client). There are many other practices in hospice in keeping with this homelike

care philosophy. For example, a VO describes that when he wants to speak with a resident, he *"knocks on the door of the resident's room as though he is knocking on a neighbor's door to meet for coffee."*

Additionally, the hospice residents have the freedom to come and go from the hospice just as they would in their own homes. And hospice residents and their families are encouraged to let the staff know as preliminary care support & medication management may be needed when the hospice resident is off-site on a pass. Hospice practices such as these foster resident and family independence and choice, reflecting the resident/person & family-centered care philosophy held within the hospice culture. The descriptions of the significant features of this primary underlying care philosophy in the hospice (resident/person & family-centered care), such as a focus on the end-of-life journey as the hospice resident and their family members envision it, will be found later in the thesis.

The hospice space design is for the care needs and comfort of the residents and their families with a homelike design and aesthetic features. The researcher observed the SW giving a tour, and she informed the new resident's family to *"come early and decorate the room before your family member arrives at the hospice."* The hospice has many lovely seating areas with comfortable chairs, end tables, and fresh-cut flowers and plants placed strategically in the hospice halls. According to a hospice RN, as documented in field notes, the need for seating areas became apparent throughout the hospice as *"families often gathered for support when the hospice residents were receiving care or resting."* These seating areas *"allowed space for the family to relax in*

comfort near their loved one's room." In addition, the seating arrangements offer a *"sense of community within the hospice as family and friends of multiple hospice residents connect through shared experiences of grief and loss."* There are many homelike distractions in the hospice to entertain hospice residents, their family, and friends, including televisions in the resident rooms and lounge area, a sitting room piano, and many available books to read for residents, families, and hospice visitors to pass the time. Food and refreshments are readily available at the hospice for staff, residents, family, and visitors. Also, there is a snack bar near the hospice report room for residents and families to gather, and families can order meals at the hospice and eat with the resident if they so choose. There is also a sizeable kitchen area near the hospice leadership room for staff, residents, and families to make snacks, have coffee or tea, relax while seated in the kitchen, and facilitate communication and support in the hospice.

A VO described how he utilizes the kitchen area to connect with hospice residents, family, and staff to establish rapport and provide social companionship and support. There is a stenciled quote on the wall in the kitchen area with the sentiment *"where life begins; love never ends,"* and there are stencils of flowers and butterflies surrounding the passage. Music is frequently playing in the kitchen area; the musical pieces are calming and soothing, often with moving vocal singing, such as the song Constant Craving by K.D. Lang. In the kitchen, several other quotes are on the wall applied in black stencil adding to the inspiring beauty of the hospice *"a family is a gift that lasts forever"* and *"life takes us to unexpected places"* and lastly, a quote describing how *"love brings us home."* In addition, a children's playroom in the kitchen near the

leadership room is available for the hospice residents and families to allow their children to play and read provided books in that area. The hospice SW having previous experience in the care of children, informed me that she had developed this room when the site opened. This room is another example of the hospice's commitment to providing resident/person and family-centered care that is more homelike than institutional.

Landscape Culture for Professional Staff

There are several rooms throughout the hospice where the professional staff carry out their daily work and interact as a team. The leadership room, the nurses' station, the report room, and the medication room are significant areas where team members make decisions and communicate and collaborate. The hospice staff refers to the cubicle office space of the hospice leadership team as *"the bunker."* This area is a primary information and activity center for the hospice leadership team and staff. The RN CNE, VC, and chaplain offices are all housed in this room; in contrast, the MD and the clinical TL (manager) have their own private offices down the hall. The leadership staff expresses their personalities and hospice care philosophies with unique art and aesthetics at their desks in the leadership room/bunker. The postings at the RN CNEs desk reveal inspirations beautiful to her, relevant to hospice care, and professional information for the hospice staff. She has this information nearby available for her and the hospice staff to view throughout the workday. For example, the educator expressed the importance of "*mindfulness"* in hospice care practice during my field observation and interviewing discussions with her. This personal philosophy is revealed at her desk with the pinned quote, *"The moment you are in is the moment you have."*

Hospice Report Room

The hospice report room has an engaging and positive aesthetic with inspirational, social, educational, and operationally informative artifacts and medical/nursing documentation systems located within the room. The hospice report room is a cultural hub & center for the interdisciplinary hospice staff. Much of the unit interactions amongst the front-line hospice staff and with hospice leadership occur in this room. In the hospice report room, I often saw food and refreshments writing in field notes that this is *"provided by staff members, made by the volunteers, or donated from the community outside the hospice or from hospice residents and families."* In addition, several staff members are noted not to have taken a break and eat their soup/meals in the report room while working. I reflected in my field notes concerns that the hospice staff was *"not taking breaks and not engaging in adequate self-care during their working shifts."*

All hospice staff members from diverse professional disciplines provide frequent reports regarding the hospice resident's needs and condition changes in the report room. The room is the "*report/information room."* Many informative and educational documents are in the report room, including policies, and the tools, and forms used in assessing resident status, are all located in the room. Examples include The Palliative Outcome Scale (POS), Palliative Performance Scale (PPS), Modified Nursing Delirium's Screening Scale (Nu – DESC), the hospice resident care and assessment flowsheet, the fall risk assessment tool, the functional transfer record (FTR), and lastly the Braden Scale, a scale to assess for the hospice resident's level of risk for skin breakdown. Additional official documents in the report room include death certificates, admission document packages, and green sleeves (containing the residents' signed Goals of Care

(GOC) designation). There is a pamphlet in the report room for residents and their families titled understanding the GOC designation. The GOC designation is an official document signed by a physician describing the resident's wishes concerning resuscitation and medical versus comfort focus of care. The GOC is also often with a copy of the hospice resident's personal directive identifying an agent or legal, medical decision-maker for the resident. The report room also has a large whiteboard with temporary black ink information about the resident, such as the physician's name, the room number of the hospice resident, and the resident's name is listed. VO staff information is also on the whiteboard in the report room. Next to the resident whiteboard information are mail folders with each of the regular/resident hospice staff physician's names. A paper labeled "*equianalgesic table for opioids"* is in the report room should the nurses need to calculate opioid rotations/doses and many other clinical documents related to a hospice staff professionals' work.

In summary, most documents about hospice practice, and clinical documents like equianalgesic tables for opioids to promote safer, competent care are available in this room. The hospice staff has the opportunity to engage with each other in the setting of the report room socially and professionally, collaborating in positive ways to provide optimal care for the hospice residents, their families, and friends, and to provide support for all members of the interdisciplinary staff. When in the report room, I made important social and cultural observations and often spent time reading documents, facilitating a shared rapport with the team.

Medication Room/Medications

A central medication room is located behind the hospice nurse's station and next to the report room. It is a primary room for the nurses to gather and prepare meds for administration to the hospice residents. The administration of medications is a hospice activity encompassing most of the hospice nursing staff's (the RNs and LPNs) time and effort impacting the overall culture of the hospice. The administration of medications in the hospice includes the resident's standard medications for chronic conditions such as hypertension or depression; however, much of the medications given in the hospice focuses on resident symptom management. The maintenance of the safety of medication administration was an important topic of discussion in the medication room in the hospice. The study participants in conversation during field observation in the medication room revealed that a concern in their practice specific to medication safety is the frequency of interruptions from other interdisciplinary staff members, residents, and families. Interruptions are also a safety concern in the logistics of medication administration; the RN and LPN medication administrators push medication carts down the halls to give medications leaving a situation where distraction may impact the safety of medication administration. Narcotic medication administration in the hospice is a practice with great significance. Narcotic administration is well monitored and controlled by the Nursing TL (manager), physicians, nursing team (RNs and LPNs), and the pharmacy team for safety. The hospice nursing team spends a significant amount of time managing narcotic meds, perhaps more so than in other health care settings due to the pain and symptom management needs of hospice residents.

Applying medication administration in the hospice to the philosophy of person/resident & family-centered care includes several principles followed to show respect for the residents' health and wellbeing. For example, there is a policy specific to assessing the need to wake residents for their medications when sleeping, ensuring the medications are critical for the resident's comfort. The resident's family does, however, have the right to request that the resident not be disturbed even if medications are due. Another example of person/resident and family-centered care related to medications is the standing order medications for hospice resident comfort, referred to as the *comfort protocol*. The *comfort protocol* includes laxatives such as Senna, Lactulose, and enemas, analgesics such as Tylenol & Advil, nebulizers including saline and Atrovent, and also included in the *comfort protocol* are specific procedures such as urinary catheterization (Xylocaine if needed).

Resident Rooms

Each hospice resident's living space/room design reflects a person/resident & family-centered care philosophy. Further, all resident rooms in the hospice are private rooms which further speaks to the dignity and individualized care given to each resident and their family in the hospice. The resident rooms are often aesthetically beautiful, with most of the décor and inspirational items provided by the VOs and through community engagement. The VOs place bird seeds outside of the hospice so that residents and families can see the birds around the trees as they enjoy looking through the windows of their rooms. In keeping with the hospice's person/resident & family-centered care philosophy, the hospice staff supports families wanting to spend time with the hospice

residents in their rooms with individualized and consolidated care plans. Also, residents and families are encouraged to keep personally meaningful items in their hospice rooms. A document is given to residents and families when they arrive at the hospice, offering a welcome to the hospice and listing personal items that residents can bring when they arrive; these individual items can make their rooms seem more like home. The hospice resident rooms have an abundance of items donated by the VOs, including fresh-cut flowers and green plants in vases and pots, decorative quilts on the wall, hung with curtain rods, and striking knitted Afghans in the rooms for residents and family members use. Adorning the walls of the resident rooms are items such as clocks, paintings of themes such as Alice in Wonderland, motorcycles, photos of the resident's family, friends, and loved ones, and a framed picture of fall colors, trees, and flowers on the shores of a flowing river. Some of the rooms have faith-based symbolic artifacts, including a mother-of-pearl angel statue. In one of the rooms, there was a stenciled black sign *"till death do us part."* There is a small frame with flowers in another resident room and a quote, *"oh Lord, you have examined my heart and know everything about me Psalm 139.1 NLT"*. I spent time in the hospice resident's rooms making observations, and each resident room has a television, and Cable TV is also available to the residents. The residents also can access a phone in their rooms and view a white erasable board with important posted information. This information includes the charge nurse's name, the primary nurse's name, the name of the RA working with the resident and family each day, the phone number in the room, and the date. The staff locks the main door of the hospice after hours, and the code is written on the white erasure board in the resident's rooms as this code is changed often. Residents and families use a donated music player in

their room when it is available. The aesthetics of the hospice resident rooms are in keeping with the openness to faith-based personal expression in the hospice, a person/resident and family-centered care philosophy, and a visionary goal expressed by the interdisciplinary hospice team during the researcher's fieldwork of the creation of a hospice with a home-like environment/presence.

The hospice resident bathrooms are private and located within the resident rooms. The bathrooms design/construction facilitates ease of personal care for individuals with progressively deteriorating health, weakness and that are experiencing reduced independence with Activities of Daily Living (ADL's). This bathroom design provides dignity and consistent quality in personal care for a hospice resident in keeping with the hospice philosophy of person/resident & family-centered care. The resident bathrooms have many care, safety & privacy feature**s** as ensuring safety and privacy in care are essential in the hospice and facilitate resident dignity.

The hospice staff respects the resident's privacy when they are in their rooms. One family requested no door knocking as this startled the resident, and the hospice team honored this resident in respecting this request. Many laminated *respect* signs in the hospice conveyed instructions for respecting the hospice residents' wishes and privacy. The signs are on the resident room doors and give instructions regarding the resident's wishes and ways to be respectful. They are laminated and have graphics with such natural images as birds and flowers. The *respect* signs include directions focusing on the resident's privacy and care needs such as *"please stop at the nursing station prior to entering room," "pet visiting, please knock prior to entering to give us time to place our*

pet on the leash. Thank you" (these signs have explanatory images on them, and this one has pictures of cats and dogs). In addition, there is a *"please keep the door open thank you"* sign, a *"come on in no need to knock,"* sign and another *respect* sign on one of the resident's doors *"personal care is taking place, please respect my privacy."* Further, a *respect* sign on a resident's doors is *"No Housekeeping before 10 AM"*. These *respect* signs reflect the philosophy of person/resident & family-centered care, thus reducing resident and family stress, a primary goal in the hospice and within the hospice core philosophy of person/resident & family-centered care.

However, no visitor signs can cause conflict when posted on hospice residents' doors (perhaps due to differences in family member values related to the number of visitors/length of the visits). For example, a hospice resident's family discussed with the hospice SW conflicting cultural expectations and dynamics within their Hispanic family surrounding family presence/number of visitors during care provision and at the time of the resident death and dying process. Negotiating visitors and family member involvement in care is part of the end-of-life dynamics in the hospice for the staff, residents, and their families. In a conversation, the hospice SW revealed that she believed that *"families often want to protect dying hospice residents and prevent them from being overwhelmed."*

Conclusion

The ethnographic description of the hospice cultural landscape emerged primarily from my fieldwork and field note observations transcribed throughout the study data

collection & analysis. The hospice is a 26-bed unit that has been designed and structured physically, environmentally, and socially to meet the needs of hospice residents with a life-limiting illness and to support the members of the resident's family. The interdisciplinary nature of the hospice staff and leadership team facilitates & enacts a hospice philosophy of person/resident & family-centered care. The hospice team's focus is developing and implementing a person/resident & family-centered care plan. Further, the philosophy of *the hospice as a home* is evident with the aesthetic beauty of the hospice and the attention to home-like details and facilities. The hospice's physical aesthetic layout has a spiritual feel, which possibly inspires residents and their families to mentally and spiritually explore the divine and sublime aspects of their lives and family histories, as their time within the physical world will soon come to a close.

I found that being within the hospice and doing fieldwork was an emotional and inspiring experience. In the richly detailed description in the study field notes, I captured the essence of the hospice cultural landscape that makes hospice unique in the care of residents and families. The distinctive nature of care in the hospice provided attention to a person/resident & family-centered care philosophy steeped in the Catholic/faith-based tradition of the hospice's affiliation with a private Catholic healthcare organization. The values and rituals included within this cultural environment embedded in the homelike environment are where the everyday practice of professional hospice staff reveals specific educational needs. The following thesis chapter will present the themes I found relevant to professional hospice staff educational needs and stemming from this particular hospice philosophy and culture.

Chapter Five: Thematic Findings:

Hospice Professional Staff Educational Needs

Introduction

According to the principles of an ethnographic research methodology, a culture can be explained and understood by examining the emic or insider's cultural values, including norms, viewpoints, beliefs, concepts and practices, languages, and social structures (Andreassen et al., 2020; Polit & Beck, 2012; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011). Therefore, I utilized a focused ethnographic methodology to study the hospice culture for this research and described in the previous chapter the cultural landscape of the hospice. The hospice cultural landscape, in association with participant interviews and cultural documents/artifacts, reveals the specific cultural domains (presented as themes) related to professional hospice staff educational needs (Andreassen et al., 2020; Polit & Beck, 2012; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011).

The thematic findings of this study emerged from a culture of hospice care processes and rituals entrenched and arising from distinct and subtle cultural connections between hospice leaders, professional hospice staff, and hospice residents and families steeped within the hospice mission and values of the Catholic/faith-based tradition. The cultural norms within the hospice stem from the values of the faith traditions of serving others, inclusivity for residents and families, and professional hospice staff functioning as a cohesive and collaborative interdisciplinary team. Also, philosophical and cultural values embody the hospice culture, precisely an all-encompassing and underlying philosophy of person/resident & family-centered care. Finally, Hospice cultural artifacts also impact the study findings revealing professional hospice staff educational needs with examples, including charting documents, policies,

educational materials, and additional existential artifacts that show the impressive features of hospice aesthetics and spiritual and inspirational art.

This chapter presents the key findings from the study data that included in-depth participant interviews and field observations of the hospice culture, documents, and artifacts documented in field notes. In addition, the hospice cultural, environmental considerations written in field notes and described in chapter four, the cultural landscape chapter also provided substantial information revealing the thematic findings of the study. The hospice cultural landscape description is part of the thematic study findings with rich descriptive, cultural observations of the hospice care culture, aesthetics, layout, and hospice professional staff interdisciplinary cultural descriptions and analysis. The study's thematic findings specific to hospice professional staff educational needs emerged mainly from the formal interviews of professional hospice staff. They addressed the following research question: *How does the culture of hospice care shape the educational needs of professional hospice staff?*

Thematic Study Findings:

Several significant themes & subthemes emerged from this study (See Appendix G for a summary of the study findings, themes & primary concepts). A discussion of each theme in connection with participant quotations taken from interview transcripts and observations from field notes offer perspectives of the individual and collective interpretations about the staff educational needs in the hospice environment. The themes are the primary themes encompassing the hospice and interdisciplinary teams' culture, values, norms, and behaviors, and within these central themes, the hospice interdisciplinary staff identified their educational needs. The staff discussed these themes and their importance as a primary focus in their day-to-day work and as educational needs, and these staff reflections and themes further described in the text of this

chapter are: 1) *Communication: the essential foundation of quality hospice care;* 2) *Hospice team cohesiveness: The bond to interdisciplinary collaborative practice; 3) Person/resident and family-centered care: the central care philosophy of the hospice interdisciplinary team.*

Theme One: Communication: The Essential Foundation of Quality Hospice Care

Communication was a prominent theme throughout the study data and within the field observations and participant interviews. Communication in hospice care reduces uncertainty and provides a basis for action so that residents and families can make meaningful decisions at the end of life. Additionally, the hospice interdisciplinary team's authentic and constructive communication and interactions can solve any arising resident and family issues and problems. In exploring the themes, I will use the term interdisciplinary team member interchangeably with professional hospice staff. The data indicates that hospice professionals describe themselves as members of an interdisciplinary team.

In the daily practice of all members of the hospice interdisciplinary team, effective communication characteristics are practiced, such as the importance of providing non-judgmental support and the need to practice cultural sensitivity and mindful communication. Mindful communication in this study involves; being intentional, being fully present, remaining open and non-judgmental, and relating to others with compassion. Additionally, all team members, including the hospice physicians, seek mutual feedback to improve practice and work towards optimal resident and family care provision. Finally, barriers such as heavy workloads emerged as a challenge in maintaining optimal and effective communication in the hospice.

Communication is an Essential Competency for all Members of the Hospice Team

Study participants and interdisciplinary team members identified communication as one of hospice professionals' most crucial competencies and educational needs throughout the

interviews and observations. Additionally, compromised care in the hospice may be present without adequate communication quality, and the RN CNE discussed her thoughts on the importance of communication in the hospice in the following excerpt:

> *I think communication is one of the greatest educational needs…communication is definitely the most important for what we do here. And it applies to everybody. Some of the clinical matters mainly apply to RNs or LPNs, but communication is for everybody. It's communication between the interdisciplinary team and with the hospice residents, too… it is essential to continue learning new and different communication techniques…effective communication and clinical knowledge and skill should be intertwined and not function independently of one another. It's just so two-fold. It's hard to pick one that's more important than the other because they work together.*

The RN CNE further described the focus on communication skills and the development of relationships in the hospice as a staff educational need in the following passage:

> *In staff orientation and annual education, there's a lot of focus on communication, including different modes of communication; what communication looks like… verbal, non-verbal, all the different types of communication, how we say things... we do so much of that and its huge… between staff members, residents, and families…it really impacts how care is perceived, and it impacts the relationships. Such a big part of what we do is relationship building.*

In the following excerpt from my fields notes, I further describe the importance of communication and relationship in the hospice culture: "*a central part of palliative/hospice care is relationship building via effective and compassionate communication. This relationship-building occurs between hospice interdisciplinary care team members and the hospice residents*

and their family members, friends, non-family caregivers, and support systems." Relational Care is more fully described later in this chapter as an essential aspect of a person/resident and family-centered care philosophy.

The RN CNE also revealed that she perceives skilled communication provision as a hospice staff educational need in the following passage:

> *Communication to meet resident needs effectively involves the whole interdisciplinary team working together, including the SW, Chaplain, VC, Vols, and medical leads such as nurses and physicians. Communication amongst the disciplines, learning from one another is vital for optimal resident care. Also, communication education includes formal training and informal mentoring.*

Communication in the hospice often involves team members offering support and reassurance to each other, residents, and families. In written field notes, I described that both the hospice SW and Chaplain view communication as a hospice staff educational need and as occurring from moment to moment, meeting the needs of residents, families, and the front-line hospice staff. Communication, according to the Chaplain, is also "*just hanging out in the report room or in the hallways, paying attention to what's happening in the moment and being available. It includes being in touch when we need each other, always debriefing, always discussing".* Additionally, the Chaplain further describes hospice communication and education as it unfolds formally and informally by virtue of where they are in the day-to-day events that occur in the hospice *"I use whatever opportunity I can to facilitate staff education in effective communication utilizing real hospice situations as a teachable and supportive moment."*

Supportive and Non-judgemental Communication Skills

The communication in the hospice was observed to be generally supportive during my observations that were recorded as field notes. Even amongst challenges related to heavy workloads with new staff on-site, and when the team was under increasing stress because of resident acuity and family grief and suffering, several interdisciplinary hospice staff members commented on the supportive and non-judgmental nature of the communication given by team members. However, they did find providing this ongoing supportive communication challenging for their hospice interdisciplinary team, and the interdisciplinary staff did identify the maintenance of consistently supportive and non-judgemental communication as a staff educational need. Below is an example offered from the hospice RN CNE of how she views the goal of optimal support provision for new interdisciplinary nursing staff with the use of supportive communication:

> *They can feel like they are drowning…we provide support by asking, how are you doing? How are you feeling? How can we support you…we want to keep those great staff members when we get them. It's great that the team supports each other too. The nurses will say to new nurses; you are doing great. Don't worry about it because it's a huge learning curve.*

The RN CNE also describes her role in the provision of optimal supportive interdisciplinary communication and the role of supportive mentorship in hospice staff education specific to communication:

> *Typically, I would come on the floor and participate in initial rounds after report. If staff have questions or concerns and need support about different medications, wound care, or policies and procedures, I jump in there. I try and support staff in a lot of ways and try to*

make contact with residents and families... or in difficult situations, such as difficult family situations, working and communicating together is important.

The Chaplain also identified his role in supportive communication and in his role in providing education in the hospice clinical setting for the interdisciplinary staff in the form of mentorship:

If I'm in the room and I see a certain approach that creates some distress or anxiety, I explore that immediately as a way of determining what was happening for this particular staff member. What was causing difficulties in the room, it's about mirroring, support, and rapport.

The Chaplain also described the importance of supportive communication from the hospice TL (manager) and her role in mentoring and educating the staff about positive communication, accountability, professional autonomy, and leadership.

She doesn't personalize. She doesn't embarrass or attack anybody. She holds us accountable, yet there's freedom to be who we are. And so, I think having our current manager makes the whole team function very well. She is caring, and we all feel supported by her. We are all getting on well, and there is safety because no one's being attacked, and we're all encouraged. She'll put out needs to be addressed, who's going to do it, and we all fight for it. She models leadership. She's taking out the garbage. She's unpacking things. She models it for me.

Communication Practices Involve: Mindful/Culturally Sensitive Communication

Communication in the hospice specific to cultural sensitivity can be related to the cultural diversity noted amongst the interdisciplinary hospice staff and the hospice residents and family. Mindful communication, in practice, is also an essential aspect of maintaining positive

communication in the hospice within the context of cultural diversity related to residents and family and the interdisciplinary team. Mindfulness in communication defined takes an open, not a closed stance or lens, has clear and transparent goals or intentions, is non-judgmental, compassionate, inclusive, and fully psychologically, spiritually, and intellectually present in the current moment (Huston et al., 2011; Jones & Hansen, 2015; Ucok, 2006). Specific to end-of-life care, mindfulness in communication has an intentional lens of focus on hospice and palliative care's central principles and aims (Breitbart, 2006; Fook & Kellehear, 2010; Meghani, 2004). These specialized foci and aims of hospice and palliative care include care based on EIP, culturally sensitive, delivered with compassion and dignity and person and family-centered, with those receiving care able to have care that is in alignment with their wishes and values (Gerhart et al., 2016; Johns et al., 2016; Omilion-Hodges & Swords, 2016). I observed communication with cultural sensitivity in the fieldwork and the hospice staff being mindful of communication practices. However, in the busy and dynamic hospice environment, maintaining cultural sensitivity and mindfulness in practice was difficult and expressed as challenging and an educational need identified by the staff. Additionally, several interdisciplinary team members discussed these concepts specific to communication in the focused interviews.

The hospice RN CNE believes that attention to cultural diversity in communication is an ongoing educational need for the hospice staff, as expressed in the following written excerpt from her participant interview: "*cultural diversity teaching is included as that's a big part of communication too, minding that cultural piece of it and trying to understand some of it*." A VOL also described cultural diversity amongst the interdisciplinary hospice team, the hospice team of VOLs, and the hospice residents and family and how being sensitive and respectful and

knowledgeable of other cultures and informed about the death practices of varying cultural groups are staff educational needs:

> *They all come from different backgrounds...* and *an important aspect of volunteering is respecting other races and religions that are different from your own and trying to understand; this includes the understanding of how different ethnic groups prepare for death.*

The RN CNE additionally described mindful communication and practice at the hospice, indicating in the following passages that mindful communication is a staff educational need: *"it's really difficult sometimes to stop and just be mindful about communication. Mindfulness is a concept closely related to communication."* She views mindfulness as *"central to authentic communication where one is paying attention purposefully and nonjudgmentally."* According to the RN CNE, "*mindfulness is a skill that needs to be taught because it involves self-awareness, something that she tries to teach and discuss frequently with the staff."* The RN CNE further describes mindful communication as an educational need in hospice practice as written in the following interview excerpt:

> *This includes being mindful of your purpose going into that room and knowing what kind of space you want to create, and just stopping even for 5 seconds, rather than rushing from room to room to room to room. Being mindful can be difficult, especially when it's so busy, and you're rushed, feeling overwhelmed, or frustrated, and the hospice is full. It's really difficult sometimes to stop and just be mindful. We try and teach that…and definitely, … one of the greatest educational needs is to keep learning about that and keep learning new and different techniques.*

A hospice VOL also described the educational need of staff mindful communication as the need to be in the moment:

> *Being in the moment during the provision of hospice care, this is their job.... there's nothing to do other than just be in the moment and react to the people that you are visiting with or trying to help and just listen to them.*

A VOL also described a learning principle for hospice staff specific to mindful communication in practice as *"having quality interactions with connections versus a large quantity of interactions that are not as meaningful or helpful."* Providing mindful care arising from a focused approach was expressed by a hospice VOL with the following statement *"an educational need for the volunteers is to understand that every moment at the hospice is about supporting the residents, their families, and the staff, not about your own needs*."

Further, a hospice SW discussed a staff educational need related to the practice of mindful communication as "*the importance of mindful, deliberate, focused communication specific to understanding the personal dynamics and working with staff and how-to best approach some of those situations."*

Transparency and Feedback in Communication is Important to Overall Care

Study participants attempting to facilitate hospice care and communication improvements believed it was essential to display transparency and openness amongst all team members. According to the interdisciplinary hospice team, poor communication patterns complicated the relationships of team members, residents, and families and placed hospice residents at risk. For teams to understand each other, support one another, and learn from one another, communication must be open, transparent, equitable, and fair. The RN CNE describes the importance of optimal communication as a staff educational need written in this excerpt:

An important aspect of holistic hospice care and optimal interdisciplinary functioning… so everybody is on the same page in terms of resident care needs and family situations that are arising or may potentially arise. We want to provide comfort and peace, and safety. And we can't provide that if our communication doesn't' facilitate that.

On a separate occasion, the RN CNE shared her thoughts about the need for staff education specific to quality communication with residents and families in the hospice:

If we don't create an open and comfortable space through communication, through what we say and what we do and how we present ourselves, if we don't create that space of safety, then it's not going to be there, and that's going to impact their experience. During the dying process, we don't want to create a negative experience based on something we say or the way we say it.

I discovered that the study participants believed that feedback amongst interdisciplinary team members was crucial in completing that feedback loop of *how did we do?* Therefore, potential ongoing education for hospice physicians to maintain open lines of communication with hospice staff is an essential need. The RN CNE described the role of interdisciplinary feedback in hospice communication and eloquently shared her experience with the hospice physicians in the excerpt below:

Communication involves all team members, including physicians seeking out feedback from others for optimal care and interventions. The physicians in hospice are just so willing to ask us for our feedback. They will ask us, well, what do you suggest? What do you think is the best thing to do here? The physicians are just incredible at making it a team.

In summary, the data has shown that hospice communication that is culturally embedded and central to quality care and the practical day-to-day functioning of the hospice is an educational need for all team members. There are vital educational strategies such as respecting cultural diversity, mindful communication and ensuring that communication is transparent that fosters effective communication. Communication is highly effective when hospice staff works as a collaborative team, communicating together as a whole.

Theme Two: Hospice Team Cohesiveness: The Bond to Interdisciplinary Collaborative Practice

Team cohesiveness and collaboration are a hospice staff educational need and a cultural theme that emerged from this study, noted in the dynamic daily interactions amongst all hospice interdisciplinary team members. The hospice care team function not as individual members of disciplines, but as a team, as a whole unit, with a shared vision and mission to improve the quality of care given to residents and their families. The cohesive interdisciplinary team at the study hospice solves problems as they mutually learn to accomplish identified goals, purposes, and outcomes. Dynamic, cohesive, authentic, and constructive team interactions and problem-solving evolve in a progressive interpersonal process forming bonds through mutual commitments. Cohesion grows out of effective communication, described previously, builds team identity and inclusivity, and creates a culture of inclusion for all members of the hospice interdisciplinary team and external hospice community such as volunteers, donators, and stakeholders. Therefore, developing and sustaining team cohesiveness and collaboration is an essential hospice staff educational question and need that is a priority for the hospice leadership team and all other members of the hospice interdisciplinary team.

Team cohesiveness fosters positive interdisciplinary team functioning through the hospice values of team member equality. Encompassed in this equality of all team members is the overlapping of roles, the need to navigate and understand roles and boundaries, learning together as a team in practice, engaging the community external to the hospice, and finally creating a safe environment for the team to flourish and be healthy. Hospice staff identified the maintenance of interdisciplinary team cohesiveness and collaboration as an educational need in data from both field observations and participant interviews. In addition, hospice staff revealed that sustaining team cohesiveness is achieved by the hospice staff with personal growth and satisfaction from their practice, replenishing themselves or practicing self-care, and enjoying and trusting in their working relationships together.

Team Inclusivity: Unconditional Respect and Regard for Others.

Team inclusivity (unconditional respect and regard for others) is a central tenant of cohesive interdisciplinary collaboration. The RN CNE described the meaning of inclusivity in the hospice as a staff educational need as documented in the following interview excerpt: *"open giving of respect and honor to the residents and family members and the understanding of one another's role in hospice care and not being afraid to call on one another for help, even if interdisciplinary team roles differ."* To be inclusive, one has to understand their role (discipline) and understand the role (discipline) of others to sustain the team's worth. In other words, the cohesiveness of the team supersedes the individual staff member's role prominence. The VC described this staff educational need in that she *"works with the Chaplin and SW to see how we can collaboratively support our families. Also, the interdisciplinary feeling of inclusivity is important, too."* The central premise is that all hospice team members have worth. The VC

discussed the hospice value and ongoing staff educational need of inclusivity in practice, as described below:

> *Everybody is just as valuable as the doctors, who are often viewed as leaders. The philosophy of the hospice includes inclusive hospice care, inclusive treatment of the interdisciplinary team, and equal interdisciplinary value of the staff. That's a big part of who we are. Even our rounds speak to that. We start with the volunteers or nurses speaking first. Our focus is on the person first during rounds; it's unique to hospice, I think, from what I understand. The focus in rounds is first to learn about the person, then their disease.*

Further, the VC describes the optimal vision of hospice team cohesiveness and collaboration as an ongoing educational need for the interdisciplinary team dynamic in hospice rounds:

> *Perspectives of the Chaplain, SW, VC, RA, LPN, and RN are heard, with the Physicians being the last ones to speak. The focus in rounds includes interdisciplinary participation. They've got to listen to everybody else and learn about the person in rounds.*

The VC discussed the need for showing inclusivity to the VOLs in the hospice specific to honoring educational opportunities:

> *Hospice VOLs are unique to the VOLs in general in the community. They want education. It's important for them to have an education. Many of the VOLs are looking for education. It's important for me to include them. It builds a culture of inclusiveness. They're not separate from us. They're part of our team. They're valuable. So that's my job. To make them not forgotten and to speak on behalf of VOLs in our leadership meetings. And to say hey, let's include them.*

The fostering of interdisciplinary team cohesiveness encompasses working as a team with all other disciplines effectively. In addition, cohesive interdisciplinary relationships offer the opportunity for self-reflection, often regarding the appreciation for the differences and acceptance of colleagues' unique caregiving approach. The SW described this aspect of staff educational needs specific to interdisciplinary team dynamics as written in this passage:

> *We all have our puzzle pieces to put in place. So really only by listening to all of the team and working together can we create a good service for people. So, I think the skill is being open to learning, what is important for a nurse to say to a family caregiver, or what they may see as the most important piece of the puzzle, listening to each other and creating a whole picture together.*

As part of the hospice interdisciplinary team culture, an effective strategy for understanding self, team relationships, and recognizing the balance between personal and professional relationships fosters mutual respect. An LPN described the ongoing educational need to maintain the cohesive culture of the hospice interdisciplinary team she frequently engages with:

> *I think we have a very good team. We help each other. The nurses help each other. The RAs aren't afraid to call us if they need help. We've always instilled that if you need us, call us. We'll come. We support each other, and we're there for each other. Some shifts can be very difficult due to a death. Someone who's been here for a while, you kind of get attached. So, we do a lot of hugging and crying.*

An RA also described the ongoing educational need to maintain interdisciplinary team cohesiveness as a hospice interdisciplinary team approach:

My position on the floor is called a float. I go between both zones. I see to their needs for the day, and sometimes I need assistance and the other team member's help. And my co-workers we help each other out. Typically, the nursing team RN, LPN, and RAs sit down, or at the end of report, we'll say, okay, I'm going to help so and so. How are things? Are you good? I'm always asking, or they ask me if I'm okay. We just work together, and I've always thought everybody brings something to the table.

Navigating Blurred Boundaries and Delineation of Roles

As discussed previously, individual disciplines may have unique expertise. Nonetheless, team members who work closely together sharing their knowledge can achieve greater success in meeting and delivering quality care. However, many barriers within teams prevent them from functioning cohesively. The study findings show that one prevalent barrier to effective teamwork is the blurring or confusion of clear roles for team members. The study data analysis revealed the potential for staff crossing professional boundaries with hospice residents and families, role blurring, overlapping roles, and differences in staff/interdisciplinary values.

The VC describes staff boundary concerns/staff educational needs in the hospice during her participant interview as written in the following passage: *"there are educational needs around knowing how much of yourself to reveal to the residents and families, and it is important to learn how to establish interpersonal connections in the hospice without crossing interpersonal and professional boundaries."* The VC described some of the challenges/educational needs for the VOLs who have had medical training as nurses and that these nurses must recognize the importance of "*not being a nurse while here, having to make that disconnection."* Specifically, as documented in my field notes, she described staff educational needs related to care, role, and medical boundaries: avoiding actions out of the VOL non-medical scope such as *"feeding*

residents with swallowing difficulties and not repositioning clients with musculoskeletal issues such as bone metastasis." Another VOL described this necessary staff educational need in his belief that "*an untrained VOL could cause a resident harm/discomfort by doing something as simple as putting their head up so they can eat breakfast."*

Additionally, a hospice VOL shared her belief that the appropriate maintenance of interpersonal boundaries are a crucial staff educational need and essential for providing emotionally healthy and effective VOL support for the hospice residents and their families "*VOLs must be careful that they are not getting over-involved and too connected to the hospice residents and families."* Further, the VOL believes that "*the VOLs must be taught; don't become over-involved; also, we want you to be very compassionate when you're here but then also to let it go when you leave so you can be an effective VOL on your next visit."* Finally, I documented in my fieldnotes that a VOL described current training practices in response to this staff educational need for the VOLs, indicating that the VOLs get support, education, and guidance from the VC specific to any boundary issues the VOLs encounter in the hospice.

During my fieldwork at the hospice, observations related to the challenges and maintenance of healthy role delineations and fair workload divisions were noted and recorded in the field notes, revealing potential staff educational needs specific to the staff navigation of these challenges. In these written field notes, I documented that the RN staff expressed conflicts between the staff members regarding workload division, role clarity, and scope of practice. According to the RN staff, these workload concerns are especially prevalent between the RNs and LPNs in situations involving poorly communicated division of roles and sharing nursing roles such as hospice resident care assessments, planning of care, assessment of medication needs, and the administration of medications.

I also described in my field notes that members of the nursing staff expressed concern regarding the hospice manager's level of self-care as the manager was on call for the hospice twenty-four hours per day. The RN indicated that she needed to call the manager over an issue related to access to methadone and needing to borrow from another resident's med supply. At shift change, the pharmacy *"went home early "* according to the LPN, so the RN called the manager *"who is on call all the time basically"* An RN also relayed concerns related to being short-staffed with the potential for role strain at the hospice during some shifts; *"we are down one LPN, and we have made a bunch of calls and are unable to replace her."* In addition, the RN staff were often juggling multiple priorities during their shifts at the hospice (sometimes functioning in the hospice charge nurse role and carrying a resident care assignment). Again, this is documented frequently in my field notes. In summary, insufficiently maintained professional boundaries, blurred role boundaries, role ambiguity, and role overload are potential factors impeding staff team cohesion in the hospice and are hospice staff educational needs.

Learning Together and Meeting Educational Needs in Practice

Regardless of discipline, assessing the everyday educational needs of all hospice professionals is mirrored in the complexity of the resident and family experience. Everyday experiences can foster team cohesiveness and are often where learning and educational needs arise and become the focus of attention in the moment of care. The VC discussed the educational needs of VOLs.*"They are often not in the hospice interdisciplinary team's direct line of responsibility but require an understanding gained from working with other team members."* The VC provided an example of this form of learning to meet the resident's needs:

> *I feel the VOLs could go in and see a person in delirium or experiencing other symptoms. The nursing educational approach to learning the symptoms and assessing the symptoms*

[through the contribution of the nurses] *would be applicable to them in the way that they would see things like that. It's hugely important. You know how many times they get asked to go in and sit with somebody during a delirium. Or a resident could have a catastrophic bleed, and just the knowledge and understanding helps. So, a lot of that is done on-site with orientation. And a lot of it is shadowing other VOLs and other team members, working alongside our staff educator, that type of education. So, it's real-time education*.

The study data revealed that each staff member individually possesses specific expertise and assesses their unique educational needs, and also the interdisciplinary hospice team learns together and from one another. These synergistic and interdependent team member interactions are the basis for the hospice team's way of learning. The RN CNE shared this example:

I'd been present at stillbirths at labor and delivery, but I had never seen the process of dying. I didn't know what it looked like. I didn't know about changes in breathing. I didn't know about changes in circulation, like mottling. I didn't know any of that basic clinical knowledge. I gained that through experience and seeing different scenarios and how they played out and talking to physicians and working through scenarios with other nurses, and hearing their experiences. And asking, what medication works best for this symptom? Or what are the different ways that we can manage these other symptoms?

An RN described the importance of knowing your team members and what they bring to the staff learning dynamic. Each interdisciplinary team member has strengths and areas for growth that can be actively communicated and shared:

Learning from each other and reflecting on some areas that I just really need to get better at. It's when you come together as a group and get stronger. Some don't talk, don't

self-educate; they just get the job done, and we love them because they can help other ones that chat a lot. And then there are other ones that are really incredible advocates, and they see the bigger picture, but they're really uncomfortable with conflict. And you're assessing who your team is, and you try and fill in the gaps. I think the educational needs are just complex with so many people like any nursing specialty area or hospice or hospital; there are so many different people with different pieces of knowledge.

It is evident in the culture of the hospice team that educational needs often center around the resident and family care needs to be shared by all interdisciplinary staff members in contributing their knowledge and skill to achieve a greater whole.

Collaborating with Community Volunteers and Stakeholders

In hospice, a staff educational need is the effective forming of a cohesive bond with individuals within the hospice, including interdisciplinary staff, residents and families, and agencies located outside of the hospice facility, and is a critical resource often assumed by VOLs with groups of VOLs frequently working closely together. The VC identified that:

There are seventy-three VOLs, and the different VOLs work closely together. And that's just on-site VOLs. It might be, we have a resident artist that comes in. She paints. It might be delivering trays at mealtime to support the RAs. It might be doing administration work. We have a program where we're doing real-time surveys with families. The VOLs take the lead on that. Our legacy work. It just goes on and on. I mean, the sky's the limit. There are virtual VOLs as well. That would be people doing things off-site to enhance what goes on in the hospice. It includes the community.

Building community relationships is another bond formed to make the hospice environment more meaningful and rewarding, requiring staff knowledge and skills. Hospices do not function without stakeholders in the community. It is these connections with the community that makes a free-standing hospice unique. Engaging the community means broadening the hospice identity to benefit the hospice interdisciplinary team and the hospice residents and their families and is a staff educational need. The VC described collaboration from the perspective of *community engagement.*

> *It's one thing to have a hospice standing here, but if you don't have the community owning it and involved in it, it's just another health care facility. So, I believe that we need to be invested in who we are and what we do, and it brings awareness to end of life. I reached out to the local dental business two Christmases ago, suggesting they might be interested in taking us on as their Christmas charity and buy us Christmas trees for the hospice. So, I asked for six artificial Christmas trees and decorations. Their whole team from the dental clinic came in, decorated the trees, donated them, and then left them. So, we have them now at the hospice. So, every year for the last three years, they come back and decorate the trees, and they've invested in us. We're part of their community now. So that's just one little example of community outreach. This does a couple of things, it invests in us, it saves us money, they bought us our trees, and now they're part of our family. They get invited to VOL appreciation, we go out and thank them, its building relationships. Whether you are in the hospice or the community, that's what community is.*

Creating a Safe, Inclusive Environment for Team Cohesiveness:

The Importance of Self-Care

As discussed previously, creating a safe, inclusive environment for the hospice staff to work in is central to team cohesiveness and is a staff educational need. Personal and professional self-care is an important goal and value at the hospice that facilitates fostering a positive environment for the hospice team. All team members are encouraged to have fun together, providing decompensation from emotionally charged work. Humour and laughter are encouraged and are a part of hospice staff self-care. Team building activities and monthly meetings are frequently offered as an opportunity for staff to connect and deliver care with safety and cohesiveness within the interdisciplinary team; this maintains the strength of individual team members. The hospice philosophy of care and concern and the creation of a positive environment for residents and families as well as the hospice interdisciplinary staff is reflected in the hospice name, mission, goals, vision, and values as transcribed from my field notes below:

> *The stated vision of the hospice asserts we will foster, through leadership and innovation, enriching environments where people find meaningful opportunities to live, work and grow; Specifically, the values of compassion, respect, collaboration, social justice, integrity, and lastly, stewardship reflect the values corresponding with this faith-based organization*.

Guidance from the hospice leadership team and VC plays a prominent role in ensuring the maintenance of staff self-care in response to this staff educational need. The VC described this idea in the following excerpt from the participant interview:

> *I learned something so valuable from my VOLs. We have a wonderful baking program on Saturdays. And they always make extra food for our staff. So, I came down on them a*

little hard that we're spending too much money. Staff don't need all those extra cookies. And they reminded me that caring for our staff is very important. And you know what? I thought you are absolutely right. Just make more cookies. Caring for our staff gets forgotten sometimes. Everybody gets focused on a task. So, some of that is education for our leadership team to remember to take care of the staff.

Self-Care and the Management of Emotional Energy

The management of emotional energy experienced by hospice team members and the recognition of the hospice staff's need for self-care, and the presence of caregiver/compassion fatigue are identified in the study data as prominent hospice staff educational needs. Healthy emotional connections and compassion amongst hospice team members and towards residents and families are fundamental learning needs essential to authentically attend to the complex needs of hospice residents and family members and the hospice staff team members. In addition, the SW discussed the importance of self-care as an educational need for the interdisciplinary hospice staff:

I think self-care is an educational need if you're not doing self-care and you don't have a good understanding of self-care. I'm sure a nurse might say the greatest need might be competency in care. Being a good nurse on the floor is pretty important too. But I think if you're not doing self-care, you can't be a good nurse no matter how much you know. How can you go in and care for somebody if you're not good inside? I really believe in self-care, actually. Part of that self-care is education. But part of it is your culture on the floor. It's us taking care of each other. I mean, is that education? I don't' know. That's good people taking care of each other.

During fieldwork at the hospice, I observed self-care for the hospice staff as a primary educational need. Attention to this learning need and aspect of interdisciplinary staff well-being came in many forms within the hospice environment. Instilling the hospice staff with pride in the beauty of their work is a form of self-care provided to the hospice team members. It is inspiring as this care of the hospice staff's emotions and well-being aligns with hospice care's historical traditions and philosophy. Self-care amongst the hospice team members is encouraged with positive spiritual messages in the hospice. Self-care and resiliency for the interdisciplinary hospice team members are within the inspirational hospice quotes written in the report room on the wall:

> *The most beautiful people we have known are those who have known defeat, known suffering, known struggle, known loss, and have found their way out of the depths. These persons have an appreciation, a sensitivity, and an understanding of life that fills them with compassion, gentleness, and a deep loving concern. Beautiful people do not just happen -Elisabeth Kubler-Ross*.

Staff Self-Care: The Importance of Humour and Fun in the Hospice

It is well known in hospice care communities that hospice professional team members must maintain their spiritual, psychological, and physical wholeness if they are to provide adequate support to others. Preservation of personal wholeness and integrity is vital in preserving role adaptation and intra-personal and inter-professional relationships. Participants discussed this necessary staff educational need as the need to be proactive in their self-care involving many different strategies. Team members must be mindful of maintaining their fitness to practice. They must ensure that they possess the necessary physical, mental, emotional, and spiritual capacity to practice safely and competently. Proactive team activities for individual and team

self-care, resilience strategies, and a healthy work environment are critical to cohesiveness as a team. The RN CNE discussed a focus on this staff educational need as the having fun together as an interdisciplinary team in the following passage:

> *We've recently been trying to do some team-building activities such as fun exercises. We had a water balloon fight in the summer and a pajama day for both staff and residents to foster a team sense of fun… we also have monthly staff and team meetings and try to bring as many people together as possible. I think that's a really important piece of what we do. This work is highly emotionally charged, and so there needs to be some way that we decompress and do some self-care too. We try and laugh together as well as cry together*.

The Chaplain described some of the interpersonal dynamics addressing this staff educational need within the hospice that foster staff self-care specifically, a positive interdisciplinary team culture forged through respectful debriefing, and the building of rapport with the use of humor within the interdisciplinary team:

> *Sometimes the team has the door shut with dark humor as they discuss, debrief, and collaborate. Interdisciplinary staff build a positive rapport with each other through the use of humor. We have good rapport with all the staff here…with humor and with being creative and gentle with each other*.

The hospice interdisciplinary team report room also has many team building and personally encouraging artifacts for the staff, addressing self-care as an ongoing staff support and educational need. These efforts improve team morale and individual self-care for the interdisciplinary hospice staff. As a result, I felt positive energy in the hospice, and the staff feels very welcome in the hospice in providing individual and team self-care. Further, an LPN

described her perspectives about maintaining the professional values, knowledge, and training for staff self-care within professional practice via the provision of positive and supportive psychosocial interactions with the hospice residents:

> *I always feel that anytime you can have fun with the terminally ill or make them laugh, it's a very positive and uplifting nursing intervention for them, and this helps to build rapport and puts the resident at ease and makes them forget their situation for some time. Any amount of time that a patient feels happiness and forgets about his/her situation, even for a short period, is favorable. So, I do not view this as unprofessional I see this as the staff providing a sense of fun to help the patients with their coping*.

In summary, attention to the hospice's cultural value and staff educational need for self-care and caring for others is pervasive. The team at the hospice showed a sense of joy in countless activities and ways that they care for themselves and their residents. Self-care is a significant educational need necessary for creating a safe, inclusive environment for team cohesiveness and quality hospice resident and family care.

Theme Three: Person/Resident and Family-Centred Care: The Central Care Philosophy Utilized by the Hospice Interdisciplinary Team

Person/resident and family-centered care is a significant hospice cultural theme and staff educational need that emerged during the study data analysis. A central principle of hospice care is that dying is a unique experience belonging to the hospice resident and family. They are indeed in control and directing their care and experiences. A person/resident and family-centered care philosophy is prominent in everything hospice staff do during their day-to-day care provision. Holistic person/resident and family-centered care (care that meets all resident and family/significant other's needs, including physical, psychosocial, and spiritual needs), through

compassion and empathy, is provided to uphold resident and family dignity and quality of living. Finally, relational care is the foundation of this care philosophy, with the building of trusting relationships at the forefront of this philosophy of care and in the provision of person/resident and family-centered care.

Honoring Person/Resident and Family-Centered Care Needs

Much of the expression of the existential focus of the hospice environment and care values are in the spiritual and profoundly inspiring aesthetics present in the hospice environment. This aesthetic in the environment evokes sublime, spiritual, and existential reflections of human needs, where the finding of meaning and purpose in living and dying is often a highly valued dimension of one's personhood for hospice residents and families at the end of life. Thus, attention to the existential and spiritual nature of the hospice resident's personhood and honoring the person who is lost is at the forefront of care for family grieving and well-being following a hospice residents' death and is also an educational need expressed by the hospice staff. This is shown with the following excerpt from my field notes of the hospice culture and is related to the special focus of honoring deceased residents during a memorial service as the Chaplain recounts the memories of the hospice residents who have passed on:

> *Tender moments of getting together with one another, family-supporting other families in the hospice. Care, love, and support in powerlessness* [states the Chaplain]. *We hope our staff have helped your loved ones honor the journey of your loved ones;* [the Chaplain says] *in God's name Amen*.

The SW also speaks about loss and grief at the resident memorial service giving educational direction and support for the hospice staff and residents and families with the following poignant quote: *"you are brave and full of strength even if you don't feel it."*

The hospice and staff interdisciplinary cultural attention to the staff educational need of honoring the unique personhood of the deceased hospice residents is also revealed in this excerpt from my observational field notes from the hospice resident memorial service:

> *Violin music is again played by the violinists in the corner of the memorial room near the window. The hospice resident's names are called by the staff, and the loved ones come up and light the candle at the candle table. The service is very moving, and many tears are shed in the room. One family became very emotional as they placed their lit candle on the candle table and heard the calling out of their loved one's name. The paper candle lights are turned on and placed on a mirror with rose petals and a larger lit candle. It is a very beautiful memorial for the families of the residents of the hospice who have passed on.*

Modeling the Values of the Hospice in Person/Resident and Family-Centered Care

The end-of-life brings many challenges as the resident/family adapts to their illness, dying and bereavement, and unfolding grief processes. How they choose to live this experience reflects the diversity of their individual life experiences, values, and beliefs. Person/resident and family-centered care must respect these values and needs in offering care and thus, is a staff educational need according to the hospice RN CNE:

> *We always bring it back to the resident as a person. What are their needs? What are the complexities of that person and their family together? The physicians consult the resident*

or family before they even make any medication changes. The focus of all care goes back to the resident. Always we bring it back to them, and our care plans are very resident-specific, and we try and do everything that we can that's important to them. We try and facilitate all of their goals. Even if it's just something as simple as I want ice cream for breakfast every day. It's realizing that every individual and family journey is different. Being aware of our own values and beliefs in order to keep those in check. I teach a lot about that during orientation and annual education, too; my idea of well-being and what would create well-being for me is not necessarily the same as my residents. So, I can't assume that my idea of a good death would be the same as, as theirs. And you only get to do it once.

The philosophy of person/resident and family-centered care is prominent in all aspects of hospice resident care needs, equally so for families, and is also a staff educational need. This sentiment is expressed below by the VC:

VOLs often provide respite care for burned-out families so they can take the family's place for an hour or two while they slip out to wash their hair. That's a big part of what we do. Or even just going in and speaking with our families because a lot of time, our residents are too sick to talk. We're there for the families. So, a lot of VOL work is done with families.

The SW additionally describes this staff educational need and the interdisciplinary team and her role in-person/resident and family-centered care:

Hospice staff also strive to understand the person from a medical and emotional comprehensive and inclusive picture. So, we all have our little pieces, and at the end of the day, we really understand what's going on physically, mentally, spiritually, and we're

able to provide better care that way. If there's a family that needs a lot of my involvement with them, sometimes I get behind on meeting the new people. So typically, it's reviewing their legal documentation. Looking to make sure resources are in place, such as palliative blue cross medication coverage. Then it's the practical and the therapeutic piece where you're assessing the whole picture. What are the relationships in the family? What are the dynamics? Are there any potential areas of concern? Are there people who are potentially aggressive, or maybe we're watching for depression in some people? Or we're always looking at the whole picture and seeing how we can support a family. So, I think as a SW, it's understanding the personal dynamics and sometimes working with staff and how to best approach some of those situations.

The hospice SW also shared her perspectives on her and the hospice interdisciplinary team's role in this staff educational need and the provision of person/resident and family-centered care as being unique to each individual:

I designed the children's play area and believe in the hospice priority of person/resident and family-centered care and being resident-focused. Starting where they are and understanding their needs as opposed to what we may think they need. The belief of freedom of expression and choice and the belief that quality of life is more important and understanding what's important to them and what brings quality to their life? What makes this the best possible experience for them? I like to believe that we all look at it that way, and we are assisting them in one of the most difficult journeys that they'll have in their whole life.

A philosophy of care in the hospice that is a staff educational need and closely associated with the philosophy of person/resident and family-centered care identifies the *hospice as a home.*

This philosophy provides another layer to person/resident and family-centered care. A VC participating in the study discusses the role of the hospice VOLs in fostering a home-like atmosphere in the hospice:

> *It's our bakers baking, and you walk into the kitchen…that smell of home, and it brings home back and, and it's a good thing. Then conversations start around the person or things they're feeling…so, VOLs do a lot of good work.*

Hospice Care Provision with Dignity: The Essence of Person/Resident and Family-Centred Care

In holistic person/resident & family-centered hospice care, preserving and maintaining human dignity within the care provided in the hospice and treating hospice residents and families with dignity is paramount. The concept of dignity is integral to personhood and central to the care offered by the interdisciplinary team. Skilled communication, listening skills, respect, along with an approach imbued with empathy and compassion are core attributes and educational needs of the hospice team members. When dignity is absent from care, residents are more likely to feel devalued; and that they lack a sense of control and comfort. Thus, hospice staff needs to ensure that attention to dignity is at the forefront, and this is a staff educational need. For example, care with dignity often includes attention to symptom management and simple measures such as respecting the resident's sleep during the night shift. In addition, standing orders, as discussed in the landscape chapter, are available for the hospice professional nursing staff, specifically, *comfort protocol* orders for ease of the provision of symptom management for the hospice residents.

Many examples of dignity in this hospice are revealed directly in the care provision, how it is delivered, and the person providing it. For example, an RA described interdisciplinary care

focused on dignity as being related to individual characteristics specific to the values of the staff members and as a staff educational need. This RA has delineated these different types of team members and how they function in their workday at the hospice; *"learning to work together with staff that are focused on dignity comes from the inside versus the population of caregivers now that are very task orientated. Nothing wrong with that."* Hospice care provided with values centered on dignity-focused care is central to person/resident and family-centered care. A hospice RN describes it as a learning need to be shared amongst hospice staff members "*Find out these things that are very unique to the person, and you bring that back to the team, and you help to make the person-centered care plan*."

The care from hospice team members at the resident's end of life, significantly impacts the resident /family's sense of dignity and is a staff educational need. The hospice VOLs play a role in maintaining residents' and their family member's dignity following death, such as the "*covering of deceased residents with a blanket when the funeral home picks them up from the hospice."* Another VOL remembers the respect shown to the body, as dignity after death: "*after death, the hospice staff will stand in the hallway and pay their respects, and the family will walk with the mortician as the body is being removed and they leave the hospice."* Finally, the VOL revealed that the dignity of the resident and family is maintained as "*deceased residents and their families leave via the front door of the hospice."*

The RN CNE described a hospice focus and staff educational need specific to the provision of dignity-centered care in this way; "*it's always brought back to the resident. And so, this is about them…we focus a lot on dignity. Preserving dignity in any way that we can."* The RN CNE also addresses the unique focus that hospice care offers to ensure dignified, holistic care as meeting priority needs of the hospice residents and families:

Nurses focus on prioritizing patients based on their symptoms or who has the greatest need to get their meds right away following report. Usually, I focus on pain meds first, just to make sure that everybody is settled. Or if there's somebody who's actively dying, and family support is required. That takes priority. The learning needs and priorities of staff can be different. It's a very different area. The skills and competencies are very different here than they would be in areas like acute care. So, our population does influence the educational needs greatly.

The RN CNE also describes *a focus on compassion and empathy* present in the hospice and that this hospice focus is a staff educational need. And specifically, the RN CNE revealed: "*a focus on empathy has a huge presence in hospice education in addition to a primary focus on whatever values are most important to that resident.''* The VC expressed a similar focus on *compassion and empathy* with her description of the VOL role/training needs in the hospice *''the VOLs often hold the hands of dying patients and comfort dying individuals and their families.''*

The hospice staff must provide care to residents and families that is compassionate and respects the dignity of hospice residents and families. Providing this type of care is a professional hospice staff educational need. It reflects rituals and practices steeped in philosophies that offer dignity and compassion in the study hospice and its vision of care. A gift of compassion is given to each hospice resident in the spirit of dignity and compassion in hospice care and described in my field notes in the following passage*:*

Decorated stones are given to the residents and families. There is a card attached to each stone with the following written on the card: Compassion Stones by '…Carolyn Post c…'

always gifted-never sold. This stone was inspired from my heart and loving hand-painted for YOU. May it bring you love, peace, and joy.

Each compassion stone has a message written on the stone. For example, a specific resident's compassion stone' has a spiritual and existential message that may provide comfort; *"may angels watch over you."*

During my ethnographic fieldwork, I observed the hospice providing compassionate and empathetic care for the hospice residents and their families. However, this is a staff educational need as the intensely dynamic nature of hospice care may make it challenging for staff to always keep these values at the forefront of care, which is a necessity in hospice care provision. The hospice staff provided this type of care in the resident memorial services for deceased resident's families (described previously in this chapter concerning the hospice philosophy of person/resident and family-centered care) and the monument table honoring deceased hospice residents. I describe the monument table below in this excerpt from field notes written during hospice observation:

A memorial table compassionately honors the deceased resident. It has a placard with the hospice resident's first name printed with beautiful background graphics such as a sunset for 24 hours after the resident's passing. These memorials to the passing of the hospice residents show compassion, empathy, and a concern for the grief of the families and friends of the deceased hospice residents.

Attention to grief support is also an essential educational need and part of compassionate care at the hospice. All team members share the responsibility for providing compassionate grief support for the hospice residents and families. I observed this focus on grief support in team

dynamics and artifacts discovered in the hospice during fieldwork and described hospice grief support in field notes as below:

> *Grief and bereavement responsibilities are shared by the different disciplines of the staff, including RAs, LPNs, RNs, SWs, the VC, VOLs, and the spiritual advisor/chaplain, and all of these interdisciplinary team members are recognized and valued as providers of grief support in the hospice. In addition, there is an information sheet in the hospice entitled, Communicating with Dying Persons, and one about what not to say versus what to say to dying and grieving people; additionally, there is also information about helping children cope with grief.*

Written in my fieldnotes, the SW described a story revealing how she and the Chaplain work together to provide supportive and compassionate grief care to residents and families during the time before death. This narrative reveals the importance of this staff educational need as identified by the SW and Chaplain.

> *The SW described how a resident's wife didn't want to cry in front of her husband as she didn't want to upset him because he was nearing death. The SW revealed that she and the Chaplain used music and sang and played guitar in the room. The spouse became overwhelmed with vulnerability and ran out of the room, and then she came back into the room, and they all cried together. The song they played is entitled Water is Wide. The SW and the Chaplain then discussed this beautiful moment in hospice care together, and they seem to both cherish the memory.*

Relational Care: Building Trusting Relationships are at the Forefront.

In each resident and family's hospice and palliative care journey, person to person, experience to experience, the responsibility of the hospice interdisciplinary team is to assist

individuals and families in healing emotionally within the dying experience, the meaning of which may be different for each person. Relational care respects personal and family values, preferences, and expressed needs. The hospice team values resident and family autonomy, dignity, and worth as a foundation of their relationships. Through these relationships, hospice team members come to know the true meaning of life, death, and suffering. The RN CNE described this hospice staff educational need and positive interactions with the dying as relational within death and the journey of dying as the staff provides care and support during the dying process at the hospice:

> *It's a sacred space. And to be invited into that sacred space, you know that's a privilege. It's an honor for me. Treating it with that respect and treating every opportunity with that sacredness is important to me personally as a hospice nurse. And we do our best to teach and foster that with all the staff. And model that. So that's…the values that you're teaching the staff…the staff modeling this, so I think our values, goals, our beliefs are always to be client-focused or resident-focused.*

The hospice team is always learning to offer the best possible hospice care as members are encouraged to reflect on their relationships with dying residents and families, explaining their interactions with persons' interpersonal and intimate nature. This staff educational need is unique and individualized as each team member has a special relational connection with the interdisciplinary hospice staff and the residents and families. A staff SW described relationships in the hospice as being a "*team effort."* as further detailed in the text below:

> *Sometimes what we'll do because the relationship is so important, we may…tag-team a little bit. So, if the Chaplain has a really good relationship with the people in room 120, I may back off on that one a little bit. So, there is a connection; we don't need to double*

connect with families as long as they have one person that can provide them support if they're having problems. Or if they're having a challenging day. So, we're always liaising with families.

The VC further described the staff learning dynamic in the hospice specific to relational connections in the hospice and their influence on hospice care provision*:*

I work closely with the SW. Sometimes a family clicks with me. Sometimes a family clicks with her. So, it just depends on what's going on with families. She might be busy with another family, and I can go in and chat with families or see what their needs are. The other person, of course, is your Chaplain. We work together. You know he might be busy on the floor, and somebody needs somebody, so either I support them or send a VOL in…working together.

Further, the SW describes in a participant interview the staff learning dynamic with the provision of a skilled set of eyes focused on relationship building. Some staff members with natural skills at forming relationships in the hospice have the potential to mentor other staff about optimal interdisciplinary team dynamics and hospice and relational care:

We're coming at it as new eyes as well. So, I think that's a lot of what we do. Provide that relationship. I look often to nurses or people providing care to assist me in understanding what's going on medically so I can explain it to the family. I believe that some hospice staff are naturally really good at this work. There are people who are naturally good at building those relationships or putting a person at ease when they walk into a room.

Learning to Give Relational Care

Caring for dying individuals and their families can be stressful, emotional work that requires a supportive hospice environment. Team members share their humanness, are familiar

with each other's philosophies of life and death, and accept one another's strengths and weaknesses. Together they work as a team drawing strength and power from each other's resources. These qualities, as a hospice team, foster a relational approach with residents and families. Mutual respect and attentive listening build relationships where trust can develop between the hospice interdisciplinary team, residents, and family members. This hospice staff educational need is grounded in respectful interactions, and there is a role for staff mentorship in optimizing relational care in the hospice.

I asked the VC the following question: *"Do you feel that there's any education that goes on in the hospice around forming those kinds of positive and supportive relationships with the families and the residents?"* The VC responded as described below:

> *I don't know exactly how everyone is educated. But… there are people who have a natural gift when they do this work. There are people who are naturally good at building those relationships or putting a person at ease when they walk into a room. And it starts at the door. You knock, and you wait till someone can say come in. Unless…maybe they're sleeping or something, and you tiptoe in. So how even you walk into a room is the beginning of a relationship. So, for me, I always feel like there is more education needed around how to be with people in a very respectful way. How you speak to them if you're looking for something, that you just don't open their closet door. You ask permission, and you just really understand that that's their space, and we're just there. We're in their space… I'd like to see a little bit more around how to be with someone in a way that's positive for them and maybe more understanding of how to see the whole picture.*

How to approach suffering hospice residents and families is an educational need that emerged from the data. Team members must develop the relational skills necessary to facilitate family conversations and sense resident's and families' emotional and spiritual needs. And, most importantly, being visible as a person, giving of the self, exposing oneself to one's vulnerability, and the resultant need for adequate self-care. In doing so, team members follow the hospice resident's and families' cues regarding pacing and setting aside the notion that we are central characters in the relational process.

A hospice SW discussed staff educational needs related to grief and suffering in the participant interview. This attention to grief and suffering can only be observed, and care provided via the establishment of the therapeutic relationships:

> *…how to see grief reactions. For example, some people can be or seem really upset or angry…to me. If I see that, then I know it's probably a good indicator of their suffering or what they just experienced before I walked into the room. So always being aware of the larger piece.*

The resident's story can also be a vital hospice staff educational tool for learning relational care and fostering relational interdisciplinary team collaboration. The SW reflected on establishing therapeutic relationships by gaining the resident's narratives as described below:

> *I think an ability to look at a larger system, at the ability to understand or to be able to pull out of a situation the real story. The real richness of what's actually happening in that room. We have lots of incidents where people present a certain way, and then we find out all this other stuff is laying below the surface. I think what I feel that I'm good at is building a safe space for people. And a place where people can be honest with me about what their experiences have been, whether*

positive or negative or challenging. Then how I can use that information and present it to the staff in a way that's not necessarily telling everything I know but telling what needs to be known. So that they can be with that person in a way that's helpful. So, I think, for me, that's the most important skill… that's the kind of skill that is being open to learning, what may be important to a nurse to say or to a caregiver, or what they may see as the most important piece of the puzzle. So, I think it's just listening to each other and creating a whole picture together.

In relational care, hospice staff team members share qualities as a team, hospice values of mutual respect, and bearing witness to the suffering of others. By bearing witness, they listen attentively to the stories of the hospice residents and their families. In addition, hospice staff is attentive to grief support in remembering the stories of the hospice family member's loved one's passing. Careful listening and receiving cues from residents & families are potent ways to gain and build relational understanding and trust between the hospice team, residents, and families in care at the hospice and are a staff educational need. In valuing person/resident & family-centered care, fostering dignity, and entering relationships, hospice team members choose to pursue the best relational care given their potential and the context of the situation. They follow the vision & mission of the hospice of fostering the well-being of others, including staff, residents, families, and other loved ones of the hospice resident.

Conclusion

The interdisciplinary hospice culture has informal and formal values, norms, and philosophies that have influenced the themes and hospice staff's educational needs discovered during the data analysis for the study. In summary, the three prominent overarching themes encompassing the hospice staff educational needs revealed in the

study data analysis are 1) *Communication: the essential foundation of quality hospice care;* 2) *Hospice team cohesiveness: The bond to interdisciplinary collaborative practice; 3) Person/resident and family-centered care: the central care philosophy of the hospice interdisciplinary team.*

A central premise found in the study is that communication is a foundation for hospice staff education, effective resident and family-centered hospice care, and hospice care provision from the hospice interdisciplinary team. Effective, transparent, equitable, and fair hospice communication reduced uncertainty, provided a basis for meaningful decision making, was foundational in solving care issues and concerns, and for resident and family care planning. I observed a conscious effort by the staff to provide optimal communication with the characteristics of openness and transparency within the daily practice of the interdisciplinary hospice team members. However, hospice environmental/workload challenges within hospice staff dynamics impacted hospice communication. In this observation, I found communication a critical educational need for all hospice team members, notably the importance of providing non-judgmental support and the need to practice cultural sensitivity and mindful communication. Further, all team members, including the hospice physicians, must have continued education to seek feedback from each other to improve evidence-informed practice and work towards optimal resident and family care provision. Finally, hospice systematic/operational concerns such as heavy workloads emerged as a challenge in upholding optimal and effective communication in the hospice.

Team cohesiveness is a theme that emerged from this study encompassing hospice staff educational needs, specifically amongst all hospice interdisciplinary team members.

I noted teamwork and intensive collaboration between interdisciplinary professionals as essential aspects of palliative and hospice care philosophy. The hospice care team members function not as individual members of their unique professional discipline but as a whole team. This dynamic includes a shared vision and mission to improve the quality of the care plan provided for residents and their families, and hospice staff identified this optimal team functioning as a staff educational need.

The hospice interdisciplinary team strives to achieve positive resident and family care planning and provision by accomplishing mutually identified goals, purposes, and outcomes within the interdisciplinary team dynamic, allowing the hospice team members to grow professionally. I observed the hospice interdisciplinary team bonding cohesively in supportive and healthy ways. Team members commit to engaging in authentic and constructive ways to solve issues and concerns in an ever-evolving team process. Interdisciplinary team cohesion and connectedness grow out of active and positive communication, building a distinct team identity and vision. This dynamic creates a hospice culture and philosophy of inclusion for all members of the hospice interdisciplinary team and external hospice community, such as donors and stakeholders. Developing and sustaining team collaboration and cohesiveness is an essential educational concern that is a priority for the hospice leadership team and all other members of the hospice interdisciplinary team. I observed the hospice staff building a healthy interdisciplinary hospice team dynamic with optimal cohesiveness and clinical competence.

Further, the team creates this interdisciplinary infrastructure utilizing a complex interplay of team support, connectedness and cohesion, inclusivity, and the overlapping

of staff disciplinary roles. This dynamic allows for high-quality hospice interdisciplinary team functioning that is positive in tone as the team develops, grows, and flourishes in the hospice. Also crucial for the well-being of the hospice interdisciplinary team is the need to circumvent, navigate and understand roles and boundaries. The hospice staff learns together as a unified hospice team to provide the best and evidence-based practice, engage the community external to the hospice, and finally create a safe, inclusive environment that values equality for everyone. For this connectedness and cohesiveness to be maintained and sustained, the interdisciplinary members must replenish themselves or practice self-care and sustain, value, enjoy, and trust their working relationships together.

Lastly, *person/resident and family-centered care* is a significant cultural theme with related hospice staff educational needs that emerged during data analysis. Central principles and philosophical assertions of hospice care are that dying is a unique and profoundly individual experience belonging to the hospice resident and family. A person/resident and family-centered care philosophy and goal within the day-to-day hospice resident and family care planning are prominent in everything the interdisciplinary hospice team does during their regularly carried out resident and family care provision. Holistic person/resident and family-centered care in the hospice meet all resident, and family needs, including physical, psychosocial, and spiritual needs. The interdisciplinary team provides this care in the hospice through a lens of dignity, compassion, and empathy, upholding and allowing for the ease of delivering resident and family dignity and quality of living within the end-of-life experience in the hospice. Finally, *relational care is the foundation of this core philosophy,* with the building of

healthy, positive, and trusting relationships at the forefront of this philosophy of care and the provision of person/resident and family-centered care.

This chapter has described the significant themes and embedded cultural practices that shape the educational needs of professional hospice staff. The three significant thematic findings: 1) *Communication: the essential foundation of quality hospice care;* 2) *Hospice team cohesiveness: the bond to interdisciplinary collaborative practice; 3) Person/resident and family-centered care: the central care philosophy of the hospice interdisciplinary team w*ill be applied to and interwoven with current relevant literature specific to hospice and palliative care and hospice and palliative staff educational needs in the subsequent discussion chapter.

Chapter Six: Discussion and

Implications for Education and Research

Introduction

The study findings showed an embedded hospice cultural landscape within the hospice site and the staff interdisciplinary team dynamics. Additionally, the findings revealed the following themes specific to the hospice interdisciplinary staff's educational needs: 1) *Communication: the essential foundation of quality hospice care. 2) Hospice team cohesiveness: the bond to interdisciplinary collaborative practice. 3) Person/resident and family-centered care: the central care philosophy of the hospice interdisciplinary team.*

Educational needs of the interdisciplinary hospice staff in this culture are complex, shaped by communication and experience and the working and personal relationships of the hospice staff and their leaders, guided by a philosophy of person/resident and family-centered care that is the foundation of the hospice culture. Interdisciplinary team cohesiveness is a formed bond through which learning, problem-solving, and accomplishing identified goals, purposes, and outcomes may occur as a team. Facilitators and challenges exist for all hospice staff team members for the provision of optimal hospice resident care requiring the acquisition of educational and training opportunities to meet their needs. In this chapter, I will discuss the study findings in relation to the relevant literature. Additionally, I will provide recommendations for hospice interdisciplinary team learning needs and suggest implications for education and future research.

In this study, the first cultural theme, *communication,* has been identified by hospice interdisciplinary team members as an essential aspect of effective hospice care and an

opportunity to build and form trusting relationships with all team members. I found in the study that the knowledge and skills needed to provide effective and therapeutic hospice communication for the hospice residents, their families, and optimal interdisciplinary team functioning are prominent staff educational needs. These findings specific to effective communication throughout the hospice environment are consistently threaded throughout the hospice culture, appearing in the study data connecting and unifying all thematic findings. Throughout the cultural landscape, I found that communication is essential for optimal hospice care for the residents and their families and for cohesive interdisciplinary team functioning. In essence, communication is an educational need for all team members that impact the hospice's quality of care and practical day-to-day functioning.

Further, cultural values such as respect for all in the hospice environment, being non-judgmental, respecting cultural diversity, and the use of mindful communication foster effective communication. However, organizational challenges were also identified, such as heavy workloads that can make communication challenging. These study findings echo the reviewed literature demonstrating the characteristics of effective hospice communication. In the literature, effective communication occurs when hospice staff work as a collaborative team, communicate together as a whole and seek each other’s feedback with a shared vision and mission to improve resident and family quality of life, ultimately resulting in the team's satisfaction.

In this study, the hospice team participants expressed communication as a crucial competency and educational need for all hospice professionals. This finding mirrors the frequent description of communication in the reviewed literature as an essential foundation of quality hospice care. This research finding has also been reflected in several studies specific to team

collaborative functioning via effective communication related to the dying process with hospice patients and their families (Clayton et al., 2014; Hamilton et al., 2014; Moir et al., 2015; Murray et al., 2004)**.** In addition, a study by Moore et al. (2016) found a correlation between the level to which an interdisciplinary hospice team provides high or inadequate quality care and how effectively they communicate within the interdisciplinary team and with patients, caregivers, and families. Further, ineffective communication can inhibit the quality of hospice care.

Communication at the end of life is a critical skill that requires an individualized (for hospice residents, families, and staff learners) respectful approach to care at very sensitive moments for hospice residents and families as they make the memorable and challenging end-of-life decisions. Participants in this study spoke about never taking the significance of these conversations lightly and never fully feeling prepared to have a difficult discussion but learning to take the cues from the hospice residents and families. There are many complex ethical conversations that occur at the end of life, and experience in having these conversations does not equate to having a prepared script. A study by McIlfatrick et al. (2010) identified that hospice nursing staff felt ill-prepared to communicate with terminal patients and families, particularly in challenging situations. Difficult situations included the death of a young person's parent and discussing death with a terminally ill young person. In addition, communicating about dying with hospice patients and their families was identified as a knowledge deficit in several studies (Kehl, 2014; Ly Thuy et al., 2014; Sedillo et al., 2015; White et al., 2012). When combined with the results of this study, this suggests that the provision of effective communication is a significant hospice staff educational need. Specifically, the quality of communication can impact the process of the needed preparation for death with attention to the holistic spiritual and psychological needs of the dying hospice resident and their families and loved ones.

In the study data analysis, I found that intentional, mindful and supportive communication is essential in relationship building amongst the hospice interdisciplinary staff members and for developing therapeutic relationships with the hospice residents and their family members. Pangborn (2017) revealed the importance of narrative stories and open dialogue in ways that humanize communication and relationships amongst staff members providing end-of-life care with the hospice residents and their family members. I found that creative and authentic communication in the hospice included aesthetic arts, music, and storytelling opportunities for hospice residents and families, which are meaningful care approaches. Therefore, hospice staff must have traditional communication skills training and education provided to them in the delivery of additional innovative communication mediums. These forms of staff training will enable hospice staff to assist hospice residents and their families in finding transcendent and sublime meaning in the end-of-life journey and allow staff to provide spiritual, existential, and psychological support for hospice residents and their families. This staff education will have a profound impact on the quality of the provided clinical care.

Foundational characteristics of effective communication within the interdisciplinary team included the provision of non-judgmental support and the need to practice cultural sensitivity and mindful communication. Mindfulness facilitates intention, being present, self-awareness, and creating a purpose; this is achieved with a shared vision and mission to improve resident and family quality of life, ultimately resulting in the team's satisfaction. Omillion-Hodges and Swords (2016) proposed mindful communication practices by palliative care leaders. These included knowing your audience, asking questions, discarding scripts, and recognizing your communication and care role. Further, Wittenberg et al. (2016) found that a focused communication training program for end-of-life care teams with attention to mindful

communication improved communication processes and increased awareness of communication with family caregivers.

The literature also revealed that the provision of culturally sensitive communication is a critical component of high-quality, socially conscious hospice care (Lu & Havens; Mei Lan et al., 2016). For example, Somerville (2007) identified essential factors in providing quality culturally sensitive hospice care, including establishing a genuine relationship, providing culturally sensitive communication, and establishing individualized care. Additionally, cultural competence related to communication in hospice care is described as necessary for quality hospice care in the literature and identified as a learning need in several studies (Kehl, 2014; Schim et al., 2006; Somerville, 2007; Weisenfluh & Csikai, 2013).

Communication is not the sole responsibility of an individual or the responsibility of one discipline. Rather, it is essential for all hospice staff team members to communicate with each other and with hospice residents and families. In this study, interdisciplinary hospice staff team members revealed how they would often ask other members how they might approach or what they would "*say"* in certain situations. The advice and feedback from all team members, including the hospice physicians, are often sought to optimize and improve team communication. Relevant literature also identified the shared interdisciplinary nature of hospice communication to improve care (Kobayashi & McAllister, 2016; Moore et al., 2016; Washington et al., 2020). In summary, maximizing the care of hospice residents and their families is achieved with skilled, mindful team communication specific to care needs and situations vital for smoothing end-of-life transitions. This essential practice of optimal communication amongst all hospice staff members and the residents and families they care for daily can be improved/refined with constant feedback/support amongst all interdisciplinary team members.

Poor communication patterns can complicate the collaborative relationships of hospice team members and the relationships of the hospice staff with residents and families and place residents at risk. Suboptimal communication may result in care that is less than comfortable, peaceful, and safe. Additionally, poor communication can result in a lack of a safe space and negative experiences for families during the dying process of their loved ones. A study by Brereton et al. (2020) examined reviews of hospices in the US and found that the public identified themes of suboptimal communication, such as the perception of communication that was inauthentic and without a genuine interest in providing care and comfort to their family and loved ones. In addition, the study found that a deficiency in internal communication amongst hospice staff negatively affects the quality and cohesiveness of their loved one's care. Participants in the study identified the importance of optimal communication amongst the interdisciplinary team, hospice leadership, residents, and their families. Communication was expressed by the study participants and during field observation to specifically be optimized through interdisciplinary support amongst team members and mindfulness and cultural sensitivity in communication with hospice residents and families. In summary, communication is a foundational skill and educational need that all hospice team members share. Effective communication is necessary for optimal team-collaboration and mindful, culturally sensitive care that enhances the quality of hospice care.

Hospice Team Cohesiveness: The Bond to Interdisciplinary Collaborative Practice

Teamwork and intensive collaboration between interdisciplinary professionals are integral in palliative and hospice care and its relevant philosophies (Dyess et al., 2020; Kobayashi & McAllister, 2016; Minetti, 2011; Pangborn, 2017; Wittenberg-Lyles & Oliver, 2007). Team cohesiveness among interdisciplinary hospice members is a central theme, crucial in delivering quality holistic hospice care. A study by O'Connor et al. (2006) identified that effective palliative interdisciplinary team dynamics improved patients' insight into their illness, pain and symptom management, quality of life, and satisfaction with healthcare disease management and communication. This same study found that palliative interdisciplinary team functioning was not without the potential for improvement and refinement, specifically within the realm of the provision of effective psychosocial care. The study findings show that sustaining high-level interdisciplinary team cohesiveness to provide optimal hospice care is an essential hospice staff educational need.

Similarly, a study by Kobayashi and McAllister (2016) showed that education was needed for hospice staff interdisciplinary team members to maximize both individual and team functioning. This educational need was primarily due to profession-based differences in language, descriptions, perceptions, and understanding of effective teamwork and its barriers. The study findings showed that team cohesiveness is a dynamic interpersonal process in which team members address issues and concerns at the hospice with an open, genuine, and sincere commitment to each other in constructive and authentic collaboration and communication. As described previously, cohesiveness develops from effective communication and fosters hospice staff team identity and hospice staff inclusivity. Also, this cohesiveness encourages a culture of inclusion for all members of the hospice staff interdisciplinary team and external hospice community such as donors and stakeholders. A study by Asinas-Tan et al. (2016) revealed that

suboptimal team unity and effective working towards common goals across healthcare specialties resulted in a disorganized care delivery plan, operational processes and protocols, and healthcare delivery and practice inconsistencies. Cohesiveness is the bond that allows the hospice staff (interdisciplinary team members) to gain knowledge and skills from one another to identify goals and purpose in their practice and to facilitate successful care outcomes. According to the study findings from the information described by the hospice staff participants, for team cohesiveness to continue to flourish, the interdisciplinary hospice staff team members must experience personal growth and satisfaction and replenish themselves for practice (self-care) and have positive, enjoyable, and trusting collegial relationships together.

In summary, team cohesiveness involves all hospice staff members, both within the hospice and with stakeholders in the community. In addition, meeting educational needs may be discipline-specific and often expanded across disciplines as a collective opportunity for all to grow personally and professionally. Finally, creating a safe, inclusive environment for the hospice staff to work in is central to team cohesiveness. A hospice staff team that works collaboratively and addresses individual and group wellness will be resilient and sustainable, despite hospice staff team challenges and changing dynamics of the working environment. Most importantly, the hospice staff team will be rewarded with the professional satisfaction of delivering quality hospice care.

Team Inclusivity: Core to Team Cohesiveness

The study findings show that hospice staff team culture engages in staff inclusivity as unconditional respect and regard for others and considers this dynamic essential for effective hospice staff team collaboration. A study by Oliver and Peck (2006) found that respect, team building, good communication, trust, and administrative interest and support fostered team

mutuality and collaboration in hospice. Conversely, the study found that team mutuality and collaboration challenges included large patient workloads, focusing on a medical model, conflicting personalities, and team conflict. Pease and McMillin (2018) described a similar need for the interdisciplinary team and family member inclusivity and cohesiveness with end-of-life discussions in the pediatric population. Conversations around death and dying were most effective when approached with an inclusive interdisciplinary lens, including physicians and all other team members and patients and family members.

Respecting and understanding one another's role in hospice care and not being afraid to call on one another for assistance, even if interdisciplinary hospice staff team roles differ, encompass hospice staff team dynamics and are a significant study finding. To be inclusive, one must understand both their role and the role (discipline) of other hospice staff members to allow the team's worth to flourish. Essentially, the hospice staff adheres to the values of interdisciplinary team inclusivity and cohesiveness. In doing so, establish an interdisciplinary cultural norm that the best interests of the hospice team hold precedence over the prominence of the role of the individual hospice staff members. The central premise is that all hospice staff members have worth and an equal chance to contribute to the hospice care and interdisciplinary dynamic, give and receive help to others during times of increasing workloads, and receive vital education to improve their hospice practice.

Challenges to Team Cohesiveness

Many challenges were felt to exist within interdisciplinary hospice staff team collaboration and cohesiveness in the findings of this study. A frequent challenge in the provision of effective teamwork is the blurring or confusion of interdisciplinary professional

hospice staff roles and responsibilities, resulting in the formation of role boundaries. Such examples include where a volunteer may have previously been a health care professional and has difficulty maintaining boundaries as a volunteer, or issues of conflicts that have occurred between the hospice staff regarding workload division, specific to role boundaries, and the maintenance of appropriate scope of practice, especially between the RNs and LPNs. A study by Reese and Sontag (2001) described potential barriers to the full use of all interdisciplinary team members in collaboration to provide optimal holistic hospice care. These barriers include lack of knowledge of the expertise of other disciplines, role blurring, value conflicts, and theoretical base differences amongst interdisciplinary professionals, negative team culture, patient stereotypes, and administrative issues. Additionally, identified as a finding in this study is the prevalent barrier to effective teamwork: the confusion of clear roles for hospice staff team members, role blurring, overlapping roles, and differences in values.

Psychosocial and spiritual care are dimensions of care offered by many hospice staff members in the hospice; nurses, physicians, SWs, the VOL team, and spiritual care providers all attend to these hospice care domains. I also have observed this shared care of these holistic care dimensions in my clinical practice amongst the interdisciplinary palliative community care team. This team dynamic exists because of the mutual humanness we experience as caregivers. Effective communication between individual hospice staff team members is needed to respect shared accountability of care between disciplines. Flexibility with responsibilities and roles amongst interdisciplinary hospice staff team members reflects respectful and trusting relationships for hospice staff members. Providing psychosocial support for hospice patients has been identified as an interdisciplinary professional practice and educational need in many studies (Murray et al., 2004; Weisenfluh & Csikai, 2013). I observed during this study that the hospice

staff team embraces and values professional role diversity rather than firmly dividing their roles, which positively impacts this team's cohesiveness and collaboration.

Spiritual support is another crucial aspect of quality hospice care provided by multiple members of the hospice staff interdisciplinary team, as the profound loss of an individual's health may cause physical and emotional symptoms that lead to spiritual questioning or the loss of meaning in life (Meraviglia, 1999; Sawatzky & Pesut, 2005). The study hospice has an onsite chaplain who mentors other interdisciplinary hospice staff members to provide spiritual care. Of note, the social worker and the chaplain worked closely and cohesively together, and both offered psychosocial and spiritual care effectively and collaboratively. Additionally, they identified psychosocial and spiritual care as a learning need for the other hospice staff interdisciplinary team members.

Learning Together in Practice: Addressing Educational Needs

It is clear from this study that identifying and meeting the hospice staff's educational needs in this hospice often emerges from their working together in the direct care of residents and families. In the study, data, and analysis, I identified that learning together as a team, in practice, and mutual mentorship is a satisfying and effective strategy in sustaining hospice staff team cohesiveness and meeting the educational needs of all hospice staff team members. However, gaps remain in meeting some hospice staff interdisciplinary team member's educational needs. Spiritual care is one example of care where the training of professionals is inconsistent and thus a priority educational need for many hospice staff team members. Sinclair and Chochinov (2012) described the importance of spiritual assessment and support for patients receiving end-of-life care and providing clinical guidance for end-of-life care providers concerning patient spiritual and existential needs. Several studies identified that hospice care

staff have limitations specific to spiritual support provision (Chochinov, 2006; Chochinov et al., 2005; Roze des Ordons et al., 2018; Selman et al., 2018; Tornøe et al., 2015). Also, hospice staff is often uncomfortable and hesitant to implement support in the spiritual dimensions (Boston et al., 2011; LeMay & Wilson, 2008; Puchalski et al., 2009; Tornøe et al., 2015). Tornøe et al. (2015) reported that this hesitancy may stem from uncertainty regarding spiritual support competence and fears relating to facing patient and family suffering. In this study setting, a hospice chaplain onsite regularly mentored staff as spiritual needs emerged for hospice residents and families. Like in the literature, training in spiritual support provision resulted in the hospice staff feeling increasingly confident to provide spiritual care.

Educational Needs and Team Cohesiveness Arise through Community Engagement.

Further thematic findings specific to interdisciplinary hospice staff team collaboration and cohesiveness include community volunteers and stakeholders in hospice, working with individuals and agencies located outside the hospice facility. Volunteers and groups of volunteers who work closely together often assume this essential resource. Community building in the workplace can create a meaningful and rewarding work environment. Morris et al. (2017) found that hospices need to develop volunteer communities and strategies through community engagement and involvement. This expansion into the community can foster hospice education, recruitment, and increased awareness. The VC described hospice collaboration with the greater Calgary community from the perspective of community engagement as essential in that stakeholders in the community broaden hospice identity. Stakeholders give to hospice because they recognize the value of working with the dying as they have often experienced loss. The extent of community involvement is what makes a free-standing hospice unique.

Awareness of Emotional Energy and Self- Care Needs

The awareness of emotional energy, self-care needs, and caregiver fatigue are identified in this study as prominent hospice staff educational needs. According to descriptions in several studies, a primary difficulty and challenge for hospice and palliative interdisciplinary staff is caregiver fatigue (Frey et al., 2018; Melvin, 2012; Whitebird et al., 2013). Many vulnerabilities may occur, such as fatigue, distress, and other traumatic stress symptoms, if the hospice staff is not self-aware and reflective of their health and wellness needs. Melvin (2012) found identifiable physical and emotional health consequences for health professionals providing hospice and palliative care over long periods of time. Whitebird et al. (2013) reported that poor mental health placed hospice staff at risk for burnout. Hospice staff revealed high levels of stress in their work with moderate to severe symptoms of depression, anxiety, compassion fatigue, and burnout. Emotional connection and compassion are essential to authentically attend to the hospice resident, family, and other hospice staff members. Frey et al. (2018) described drawing upon *"psychological capital"* for hospice professionals to maintain well-being as they care for patients with life-limiting illnesses. This maintenance of hospice staff well-being included previous palliative care education, psychological empowerment, and the individual's commitment to maintaining psychological hardiness and overcoming challenges. Whitebird et al. (2013) also found that hospice staff managed their work stress through social support, both personal and with coworkers, and through physical activity.

Creating a safe, inclusive environment for hospice staff is central to team cohesiveness; personal and professional self-care is a vital hospice goal and value that fosters a positive environment for the hospice staff team. All hospice staff team members are encouraged to have

fun together, providing compensation for emotionally charged work. Humour and laughter are encouraged and are a part of hospice staff self-care. A study by Harris (2012) described the stress of hospice work and the role of coping strategies for the hospice professional. The study found that hospice staff reported that social support, humor, and prayer, as well as meditation, were the most effective coping mechanisms for hospice professionals. The study concluded that hospice organizations have a responsibility and opportunity to provide their staff with coping strategies and that further exploration into useful programs for staff to deal with stress, burnout, and fatigue in their work as hospice care providers is needed.

Team building activities and monthly meetings are frequently offered in this hospice culture as an opportunity for hospice staff to connect and deliver care with safety and cohesiveness within the hospice staff interdisciplinary team; this maintains the strength of individual hospice staff team members. In the hospice, hospice staff members know that they must maintain their spiritual, psychological, and physical wholeness to provide adequate support to others. Preservation of personal integrity is a vital factor in preserving role adaptation and intra-personal and inter-professional relationships. Hospice staff study participants discussed the need to be proactive in their own self-care involving many different strategies.

Team cohesiveness involves all hospice staff members both within the hospice and with stakeholders in the community. Although hospice staff perceived educational needs may be discipline-specific, achieved learning is across disciplines as a collective opportunity for all hospice staff team members to grow personally and professionally. Finally, creating a safe, inclusive environment for the hospice staff to work in is central to team cohesiveness. A team that works collaboratively and addresses individual and group wellness will be resilient and

sustainable, despite team challenges and changing dynamics of the working environment. Most importantly, the hospice staff team will be rewarded with the professional satisfaction of delivering quality hospice care.

Person/Resident and Family-Centered Care

The philosophy of person/resident and family-centered care is central to the care philosophy utilized by the hospice staff interdisciplinary team. A fundamental principle of hospice care is that dying is a unique experience belonging to the hospice resident and family. They are indeed in control and directing their care and experiences. Imbued in this study is person/resident and family-centered care in upholding the integrity of personhood, the wholeness or intactness of the person in all aspects of care. Throughout this discussion, threaded within the educational needs of the hospice staff team is the interdisciplinary hospice staff team caring for the entire person in honoring their dignity and suffering and being a compassionate and empathetic presence through relational care.

Maintaining the Integrity of Personhood

The care provided in a hospice has a concern and focus centered with the whole person, a person's body, mind, and spirit, and includes the family as the unit of care. Person/resident and family-centered care are prominent in everything hospice staff do to ensure whole-person care. The hospice staff team focuses on aspects of hospice resident living and dying and how this affects their family, which impact their personhood. Finding purpose and meaning both in life and death is often a highly valued dimension of person-centered care (personhood) for residents and families at the end of life. Attention to the existential and spiritual nature of the hospice

resident's personhood is paramount in the dying experience and honoring the person(s) who have lost their loved one and are grieving. A study by Tornøe et al. (2015) described spiritual and existential care as a vital aspect of holistic, comprehensive, and compassionate care. Spiritual and existential care includes care provided by hospice staff as they aim to facilitate a peaceful and harmonious death for the hospice residents at the end of life. Hospice staff help residents and their families achieve this positive spiritual tone in the dying process through acceptance, resolving practical needs, and achieving reconciliation with their past, loved family and friends, and a higher being if a part of their belief system.

Central to hospice care is the provision of holistic care in the findings from this study and many studies in the literature; however, study findings also acknowledged knowledge deficits in the provision of adequate psychosocial, cultural, and spiritual support. Frequently, hospice residents struggle with issues related to these areas of need, and often, hospice staff receives inadequate preparation to provide care within these dimensions (Boston et al., 2011; Chochinov, 2006; Chochinov et al., 2005; LeMay & Wilson, 2008). This results in total pain or spiritual and mental pain-causing suffering and ultimately ending in palliative sedation or the administration of high doses of analgesics in end-of-life care (Boston et al., 2011; Chochinov, 2006; Chochinov et al., 2005; LeMay & Wilson, 2008). Broader social structures and health care systems in our secular society and some health care models with rigid boundaries between the care provided by differing professional disciplines may value care that encompasses the spiritual, psychological, and cultural dimensions. However, according to the reviewed research, holistic care provision that includes spiritual, psychological, and culturally sensitive care remains elusive. Practical, efficient, ongoing professional hospice staff education in the cultural, spiritual, and psychosocial dimensions is needed to provide holistic hospice care. This study hospice has an onsite chaplain,

enabling the hospice to provide a higher level of resident spiritual support than is often reflected in the above-cited studies. I have described in the landscape chapter that spiritual care is provided daily in the hospice. This spiritual care is in conjunction with the foundational faith-based mission and vision of the hospice staff values and the hospice staff living spirituality in everything they do in the hospice. One example documented in my field notes of a spiritual ritual routinely practiced is that all hospice residents receive a gift of compassion, a stone with a spiritual/existential message that may provide comfort, such as *"may angels watch over you."* In this hospice culture, spirituality is considered an essential practice, a learning need, and a part of the faith-based nature of the hospice organization.

Relational Care

Relational care is a foundation of hospice care and is a significant study thematic finding where the building of trusting relationships is at the forefront of providing person/resident and family-centered care. Canning et al. (2007) found that forming therapeutic relationships between palliative care teams and dying patients and their families is a primary domain of end-of-life clinical practice and inextricably interwoven with all other care domains. In this type of hospice culture, relational care respects person and family values, preferences, and expressed needs, which may differ for each person. The hospice staff team offers the best care possible when they are encouraged to reflect on their relationships with dying residents and families, explaining their interactions with persons' interpersonal and intimate nature. Each team member has a unique relational connection. However, it is essential to consider that not all hospice staff have naturally occurring gifts in building those relationships or putting a person at ease when they walk into a room. Therefore, in this study's findings, learning to give relational care emerged as an educational need for the interdisciplinary hospice staff.

In *relational care,* hospice staff team members share the qualities and values of mutual respect and the bearing of witness to the suffering of others. By bearing witness, they listen attentively to the stories of the hospice residents and their families and are fully present to hear as families remember the stories of their loved one's passing. Wittenberg-Lyles et al. (2007) suggested educational needs specific to relational care for end-of-life practitioners focused on healthcare providers and patient narratives. This education should include relational care, specifically relational intimacy with the dying, spirituality, the desire for control expressed by caregivers, and the authentic revealing of emotion amongst palliative care providers. Attentive listening and receiving cues from residents and families are potent ways to gain and build relational understanding and trust between the hospice team, residents, and families in care at the hospice. A study by Broom and Kirby (2013) revealed dying as a profoundly relational process, with the dying individual's family dynamics playing an emotional and critical role in the dying process. Indeed, a relational model of spiritual care provision can effectively aid the dying to address their spiritual yearnings specific to the meaning of their life (Callahan, 2013). Additionally, individual patient factors and appropriate spiritual care planning can optimize end-of-life experiences. When listening attentively, the hospice staff interdisciplinary team shows that the human spirit is sacred and to be respected and honored, a connectedness to the person valuing their experience and acknowledging their suffering.

Honoring Dignity

In findings from this study, hospice care provision with dignity is the essence of person/resident and family-centered care. In valuing person/resident and family-centered care, fostering dignity, and entering relationships, hospice staff team members followed the vision & mission of the hospice. The hospice staff interdisciplinary team provides care for hospice residents and their families in ways centered within dignity by maintaining a sense of autonomy at the end of life and giving care delivered with respect in the dying journey. Skilled communication, listening skills, respect, and an approach imbued with empathy and compassion are core attributes of hospice staff team members.

Dignity is a concept related to hopefulness, a sense of self, acceptance, and generativity. Dignity is integral to personhood and central to the dignity-conserving care the hospice staff interdisciplinary team offers (Chochinov et al., 2005). Hemati et al. (2016) described the characteristics of care of the dying that promote dignity as overall respect in care provision, respect for privacy, and a focus on hope and spiritual peace. When healthcare providers give patient and family dignity attention, there is an increased sense of peace as death nears and more peaceful deaths with a sense of patient comfort and privacy. Esteves Franco et al. (2019) identified that caregiver's and health professionals' competence and care presence influenced the perception of the provision of dignity in care. A study by McDermott (2019) also reflected the importance of a focus on dignity to help hospice patients feel that their clinicians had genuinely heard them and that hospice staff had an increased understanding of the patient's needs and levels of compassion in the hospice care provided.

During this study, in fieldwork conversations with hospice staff and in the literature review, I found that when dignity was absent from care, individuals were more likely to feel devalued; and that they lack a sense of control and comfort. Care with dignity was revealed to include attention to symptom management and simple measures such as respecting the hospice resident's sleep during the night shift. In addition, professional hospice staff (nursing: RNs and LPNs) often utilized standing orders, specifically *comfort protocol* orders, for ease of the provision of symptom management for the hospice residents.

In summary, hospice staff team members develop the skills to provide effective relational care. The hospice staff provides this relational care with a focus on facilitating family conversations, sensing the emotional/spiritual needs of hospice residents and families, and, most notably, being visible as a person. The hospice staff achieves this relational caregiving by giving of the self and exposing oneself to one's vulnerability (necessitating adequate self-care for the hospice staff). In doing so, interdisciplinary hospice staff team members follow the resident/family cues regarding pacing and setting aside the notion that they are central characters in the relational process. Further, the interdisciplinary hospice staff team establishes relationships and rapport with the hospice residents and their families by conveying respect during their interactions. This relationship and rapport building can include giving full attention, support, and affirmation to build trust, establish connections, and provide relational care that facilitates hospice care with dignity, empathy, and compassion.

Implications for Education and Further Research

In conducting this study, I aimed to explore the educational needs of professional hospice staff and how hospice culture shaped these needs. Previous palliative and hospice care literature

and the context of these environments provincially and nationally AHS (2014) and Canada (2018) suggested that there are knowledge deficits and particular educational needs of hospice staff professionals not being met to provide effective end-of-life care. I utilized the following research question in guiding this study: *How does the culture of hospice care shape the educational needs of professional hospice staff?* Describing the hospice culture and determining the educational needs of hospice staff has revealed a fresh outlook on the significance of culture in shaping the provision of education and the hospice staff educational requirements that are foundational to hospice care. Specifically, I found in the study an emphasis on communication, building, and sustaining interdisciplinary team collaboration and cohesiveness, and person/resident and family-centered care as fundamental practices and educational needs for hospice staff necessary to provide quality hospice care. These findings from the study show many previously known concepts specific to hospice and palliative care provision, culture, and hospice staff educational needs; however, they also offer some surprising and novel ideas. Specifically, hospice staff prioritize relational rather than instrumental aspects of care and identify hospice staff educational priorities accordingly. The hospice staff recognizes a need for professional education in communication, relational care, and team works. These educational needs are unique findings compared to the educational needs found in the literature review described in earlier chapters. The literature review analysis revealed educational requirements that were more clinical and instrumental and suggested that hospice and palliative staff need education related to pain and symptom management using expertise in medication administration. I noted that conversely, the hospice study findings highlight a different way of thinking about hospice staff education by focusing on a unique lens of hospice and staff interdisciplinary team culture and related staff educational needs. Exploring these aspects of

hospice culture and staff team dynamics has revealed the importance of leaders in the hospice to meet these educational needs, maintaining the sustainability of the hospice staff interdisciplinary team and the self-care of its members. Additionally, the study findings revealed that the hospice staff interdisciplinary team embraced the values and mission of the hospice, namely putting the person/resident and family-centered care philosophy first.

Implications for Education

The educational needs of hospice staff identified in this study and similarly in other provincial, national, and international studies are essential foundational educational needs of hospice and palliative care professionals. Communication is a central thread that precedes all others, including the thematic findings of team collaboration and cohesiveness and person/family-centered care. Without communication, none of these would be effective. Driving implications for further study/research stem from the remaining central question: Why do these foundational practices continue to be educational needs often experienced as intimidating and challenging for palliative and hospice staff professionals today? The following are educational recommendations that may be helpful for hospice leaders, educators, and hospice staff interdisciplinary team members that would cross the central themes identified in the study findings:

- Leadership is necessary from universities and government bodies to ensure the implementation of hospice and palliative care curricula across all health care professionals such as medicine, nursing, social work, chaplaincy, and others. This study has identified some potential curricula needs and future focuses for the implementation of the findings. Furthermore, this education should be interprofessional due to the nature of team collaboration, where effective, quality hospice and palliative care is delivered.

- Continue to develop hospice and palliative care competencies and standards for all interprofessional healthcare staff implemented in curricula and practice. These would be

considered minimum standards of hospice and palliative care to support curricula and practice. In addition, competencies would address core domains such as communication, team collaboration, self-care, and relational care.

- Consider palliative and hospice competencies beyond rote "skills"; instead, communication and compassion are core techniques that are relational and require reflection and self-awareness beyond traditional scripts and videos. Tailoring education for individual palliative and hospice staff specific to previous experience, previous education, and specific learning needs is valuable to ensure staff participation and benefit from the education. A new awareness and implementation of the use of mentors for end-of-life staff education as an effective method of teaching taking place in the clinical setting immediately as educational situations and needs unfold.

- Palliative and hospice communication should focus more significantly on professionalism, sensitivity to cultural diversity, and being mindful of others' viewpoints and beliefs.

- Consider a greater emphasis on mindful (purposeful, intentional, and contemplative) communication in palliative and hospice care to help address holistic care that encompasses aspects such as spiritual, psychosocial, empathetic, and compassionate care.

- Consider best practice models that integrate palliative and hospice care training and education for interdisciplinary teams that include volunteers.

Implications for Research

I believe that changes in practice are achieved primarily through the acquisition of knowledge and behavior change. Sustained research is vital for the long-term and continuous improvement of palliative and hospice care. Evidence is needed to address knowledge gaps, overcome current challenges and drive innovation in current palliative and hospice care practices. Extensive knowledge has been gained internationally about palliative and hospice staff proficiency specific to pain management, symptom management, communication with the dying, and psychosocial and spiritual care. However, there has been minimal research to understand palliative and hospice interdisciplinary team members' core, optimal domains in practice, and educational needs. The understanding of palliative and hospice care culture gained

from this study through interviewing and observing hospice professionals has the potential to aid in improved palliative and hospice staff education, professional job satisfaction, and enhanced end-of-life care. The findings of this study specific to the educational needs of hospice staff have raised the need for further research and exploration into evidence that drives improvements and supports new models and approaches to care. Additional research needs include those in the following areas:

- A systematic review of palliative and hospice culture and educational needs, including an understanding of what makes the hospice culture unique to other palliative care settings

- Research/literature reviews focused on the critical palliative and hospice conceptual findings from the study, such as holistic care, person/resident and family-centered care, and providing hospice care with optimal communication, mindfulness, dignity, compassion, empathy, and cultural sensitivity.

- Research into how establishing trustful relational care is achieved by palliative and hospice staff and maintained at the forefront of palliative and hospice care. I found in this study that trusting, relational care is necessary to advance the quality of hospice and palliative care provision.

- Research specific to interdisciplinary palliative and hospice team functioning and relevant themes is needed to ensure quality end-of-life care provision in hospice and palliative care settings. Some examples include effective communication, collaboration, and cohesion maintenance within the palliative and hospice settings and with external community and stakeholders, navigation of professional role boundaries, boundary maintenance with residents and families, and palliative and hospice staff self-care (to prevent compassion fatigue and burnout). Further, research focusing on maximizing volunteers' role within the hospice and palliative care systems and translating these concepts effectively into educational programs for staff working in these care settings will be valuable.

- Research at the remaining 6 Calgary hospices, unit 47 (palliative intensive care unit) at the Foothills Medical Center and Palliative Home Care focused on the cultures of these sites and the educational needs of hospice and palliative care staff working at these end-of-life care provision settings.

- Research specific to the educational needs of staff caring for patients at end-of-life working in non-dedicated palliative and hospice care settings may be valuable. This future research would include provincial and national sites AHS (2014) and Canada (2018), and for example, include general hospital units, intensive care units (ICU), nursing homes, and oncological care.

- The palliative and end-of-life care provincial framework (AHS, 2014) reveals described inconsistencies in Alberta's staff education and knowledge levels specific to end-of-life care. Additionally, the more recent Health Canada Framework on Palliative Care in Canada (Canada, 2018) suggested national research and educational deficits and goals specific to palliative and hospice care in Canada. Therefore, expanding the research and educational initiatives described to include other communities both provincially and nationally is needed.

Limitations

The described hospice study has several limitations, including having a small sample from only one hospice site. A single hospice site sample may not be representative of other hospice staffing in a transferable manner. A more diverse sample of study participants from multiple palliative and hospice healthcare sites may offer a more transferable view applicable to all seven Calgary hospices (Andreassen et al., 2020; Polit & Beck, 2012; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011). However, focusing on one site was more realistic in scope for a master's thesis-level project. Next study steps could later include other hospices and dedicated palliative care sites.

Additionally, the study sample is not racially diverse, which may have brought a unique and different perspective to the study data and findings. Specifically, all nine key informants were Caucasian individuals. Also, despite the hospice association with AHS for funding and regulation, the hospice affiliation with a Catholic organization may reduce transferability to other non-Catholic hospices and dedicated end-of-life care settings. Finally, individual bias can

become a barrier in ethnography, as all persons view social situations through their cultural lens; no two researchers will describe the culture in the same way (Andreassen et al., 2020; Polit & Beck, 2012; Reeves et al., 2008; Roper & Shapira, 2000; Speziale et al., 2011).

Conclusion

I utilized an ethnographic methodology for this study to explore the educational needs of professional hospice staff and how hospice culture shaped these needs. An explanation emerged that attempts to explain the cultural patterns of healthcare professionals' educational needs in a hospice setting. I discovered that the study findings show that the educational needs of hospice staff identified in this study are important foundational educational needs of palliative and hospice care professionals identified in many other studies nationally and internationally. However, the study also shows some innovative ideas as the staff express relational rather than operational aspects of care and identify educational needs based on these priorities. The hospice staff recognizes a need for professional education in communication, relational care, and team functioning. These staff learning needs are a unique finding compared to the more clinical and instrumental educational needs found in the previously described literature review. This study highlights a new way of thinking about hospice staff education by focusing on a specific lens of culture. Exploring the hospice culture and educational themes has revealed the importance of the interdisciplinary team, team self-care, and the interdisciplinary team embracing the values and mission of the hospice, namely putting a person/resident & family-centered care philosophy first. The findings highlighted that communication is a central thread that precedes and facilitates all others, including team collaboration/cohesiveness and person/resident and family-centered care. Without communication, none of these would be effective.

Central questions remain and stem from why these foundational practices continue to be educational needs often experienced as intimidating and challenging for healthcare professionals working in end-of-life care today. I believe these questions remain central and drive further research and educational implications. I found that the themes revealed in the study findings realize unique and important concepts as the hospice culture shapes the practice and education of the interdisciplinary hospice staff. The central core of caring for dying individuals and their families is holistic and embodies the prominent engagement of interdisciplinary team members, including volunteers and community stakeholders.

Profoundly infused in the cultural landscape of the hospice is the faith-based/religious tradition of Catholicism. However, there is an openness and acceptance of all religious and cultural backgrounds, prevalent and pervasive in the hospice environment, related to each hospice resident's beliefs and values surrounding death. Person/resident and family-centered care is the focus of care, with the values and wishes of the hospice residents and their families at the forefront of decision making. The unique and inspiring aesthetics of the hospice exemplify the liberal hospice values of cultural equality and inclusion and a just hospice culture. The hospice environment also has a spiritual feel to the cultural climate/landscape. This spiritual tone/presence in the hospice may inspire hospice residents and their families to mentally and spiritually explore the divine and sublime aspects of their lives and family histories now that their time together within the physical world is coming to a close.

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Appendix A: Study Participant Consent

UNIVERSITY OF CALGARY

Consent form for Observation and Interview

TITLE: The Educational Needs of Hospice Staff: An Ethnographic Inquiry.

INVESTIGATORS:

Dr. Shelley Raffin Bouchal
University of Calgary, Faculty of Nursing
Associate Professor, Associate Dean (Graduate Programs)
(403) 220-6258

Andrea O'Brien, RN, BSN (Master of Nursing Student)
University of Calgary, Faculty of Nursing
Master of Nursing Program
(403) 813-6237

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

Effective hospice care has been shown to contain costs by reducing hospitalizations for Albertans in the last stages of their lives. Also shown is the importance of reducing hospice costs by strengthening the effectiveness of care provided by hospice care providers; this is accomplished through through targeted staff education. The 2014 Palliative and End-of-Life Care (PEOLC) framework development revealed variations in knowledge within several care domains among hospice care providers in Alberta. An inadequate infrastructure to provide education for hospice care providers across AHS sectors was also noted, contributing to gaps in knowledge. The educational needs of hospice staff are influenced by multiple factors including the culture of the hospice where the staff is employed and the knowledge and competencies of individual staff members. This study will explore the educational needs of frontline hospice professional staff.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of the study is to explore the educational needs of frontline professional hospice staff. Through interview and observation of hospice staff in their everyday practices, it is proposed that unique educational needs will be revealed, which may provide information useful for future educational workshops and programs. In addition, enhancing the potential for using

Appendix B: Study Recruitment Invitation

Email Invitation

Subject: Invitation for Study Participants: Covenant Care

Dulcina Hospice Staff

Good day,

Researchers from the University of Calgary are seeking **Dulcina Hospice Professional Staff** to participate in a confidential study to better understand the ways the Dulcina Hospice culture shapes the educational needs of hospice staff members. Professional staff members with a minimum of 1 year of experience working at Dulcina hospice are eligible for participation in the study. The study involves observations of professional hospice staff in everyday practice and the sharing of hospice care experiences in 1:1 interviews to examine educational needs.

To become a part of this research project, or to learn more please contact Andrea O'Brien (Master of Nursing Student) by phone at 403-813-6237 or via email at andrea.obrien@ucalgary.ca. This project has received ethical approval from the Conjoint Health Research Ethics Board (REB 17-0740).

With warm regards and thanks,

Dr. Shelley Raffin Bouchal

University of Calgary, Faculty of Nursing

Associate Professor, Associate Dean (Graduate Programs)

(403) 220-6258

Andrea O'Brien RN BSN (Masters in Nursing Student)

University of Calgary, Faculty of Nursing

MN Thesis Program

(403) 813-6237

Appendix C: Hospice Resident Study Fact Information Sheet

UNIVERSITY OF CALGARY

Faculty of Nursing
University of Calgary
2500 University Drive NW
Calgary, AB T2N !N4

Study Fact Sheet

Title: The Educational Needs of Hospice Staff: An Ethnographic Inquiry.

This Patient Information is provided to you because a Master of Nursing Student (Andrea O'Brien RN BSN) may request your verbal consent to allow the observation of care provided to you by one of the hospice professional staff members. The focus of the study is on the educational needs of the hospice staff and the ways that the culture of the hospice influences the educational needs of the hospice staff. This information should give you the basic idea of what the research is about and what being observed by the student researcher will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

Background: Effective hospice care has been shown to contain costs by reducing hospitalizations for Albertans in the last stages of their lives. Also shown is the importance of reducing hospice costs by strengthening the effectiveness of care provided by hospice care providers; this is accomplished through targeted staff education. The 2014 Palliative and End-of-Life Care (PEOLC) framework development revealed variations in knowledge within several care domains among hospice care providers in Alberta. An inadequate infrastructure to provide education for hospice care providers across AHS sectors was also noted, contributing to gaps in knowledge. The educational needs of hospice staff are influenced by multiple factors including the culture of the hospice where the staff is employed and the knowledge and competencies of individual staff members. This study will explore the educational needs of frontline hospice professional staff.

Study design: Qualitative study using observation and 1:1 interviews with hospice health care professionals

Areas of exploration: a) explore the educational needs of frontline professional hospice staff., b) perceptions of hospice professionals unique hospice educational needs and c) how the aspects of hospice culture shapes their educational needs

Who is being interviewed/observed? Eligible health care professionals are:

- English-speaking;
- 18 years of age or older;
- a hospice health care professional for 1 year or more

How many will be recruited? We estimate about 10 hospice care professionals in total

Where will participants be recruited from? Covenant Care Dulcina Hospice

Appendix D:

Definitions of Key Terminology:
1) **Anthropology:** A science committed to the exploration and description of humanity, including societal, cultural, and behavioral phenomenon (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011).
2) **Communication:** The movement of information (may include elements such as facts, emotions, opinions) between two or more individuals via written, telephone, or one-on-one, face-to-face contact (Afriyie, 2020; Moore et al., 2016).
3) **Compassion in Hospice Care:** Hospice care provided with the empathetic expression of unconditional caring that embodies genuine concern and takes action to lessen the suffering of hospice residents and their families (Kayser-Jones et al., 2005; Taylor et al., 2017).
4) **Culture of Hospice Care:** A key term in any ethnographic study; specifically, the culture of the hospice environment is of primary importance for this study. Hospice staff lives within complex cultural systems with the shared activities and values of a particular physical and social environment. Culture encompasses such aspects of a health care facility such as a hospice, including shared missions or goals, beliefs, values, behavioral norms, knowledge, language, artifacts, and customs (Cameron, 2017; Munro, 2016; Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011).
5) **Culturally Sensitive Care:** Hospice care that is provided with respectful knowledge, acceptance, and awareness of resident's spiritual, socio-cultural, and religious backgrounds, and the integration of this aspect of personhood into the daily practices in hospice care (Mei Lan et al., 2016; Pentaris & Thomsen, 2020).
6) **Dignity in Hospice Care:** The interdisciplinary hospice team provides care that values aspects of hospice resident and family care specific to dignity, such as respect for cultural diversity, individual justice, adherence to human rights, freedoms, and care focused on truth and individual autonomy in its provision (Choo et al., 2020; Coventry, 2006).
7) **Embodiment:** A central concept in ethnographic research and refers to the absorption of the researcher into the cultural environment under study. This absorption places the researcher in that specific world on a physical, conscious, and spiritual level. Further, the embodiment of the culture under study is described by the researcher in a way that fully expresses the nuances of that specific culture (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011).
8) **Emic Perspective:** Ethnographic research refers to the view the cultural insiders have regarding their world, in this instance, the view the hospice staff participants have regarding the hospice and the staff educational needs (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011).
9) **Emotional energy:** The effects of hospice care provision on the interdisciplinary team and the need to regulate and support the emotional inner life (self-care) of all the hospice team members (Barnett et al., 2020; Sansó et al., 2015).

10) **Ethnography:** This research tradition is the study of cultures grounded in the science of anthropology. Ethnography is one of the oldest research traditions, having specific terms that apply to this type of qualitative research. The collection of ethnographic data involves unique researcher and participant perspectives described as reflexivity, and emic (insider) as well as etic (outsider) views (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011).

11) **Etic Perspective:** This is the perspective of the culture's outsider; precisely for this study, the researcher's view of the culture of the hospice and staff educational needs (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011).

12) **Hospice Care:** Encompasses a patient who is close to the dying process, has high care needs involving specialized communication, teaching, and care support for both the patient and family related to the patient's imminent passing (Batchelor, 2010; Teitelbaum et al., 2013).

13) **Hospice and Palliative Care:** These two terms are often used interchangeably; however, they have slightly different meanings. The differences are often related to the patient's status on the terminal disease trajectory, and the level of care needs to be required by the patient, with palliative being the term utilized for patients earlier on the terminal trajectory and hospice patients being closer to end of life (Batchelor, 2010; Teitelbaum et al., 2013).

14) **Inclusivity in Hospice Care:** Hospice Care and interdisciplinary team functioning that support equal acceptance and treatment, including care provision and support to all members (Pangborn, 2017; Wilson & Lemon, 2019).

15) **Interdisciplinary Cohesiveness:** The level that the hospice interdisciplinary team members can work effectively towards the attainment of team goals (Pangborn, 2017; Thompson et al., 2015).

16) **Interdisciplinary Collaboration:** The cooperative working together of a healthcare site's professional team (comprised of many different professional disciplines) to achieve common goals for the benefits of their hospice patients and their families (Reese & Sontag, 2001; Wittenberg-Lyles et al., 2010; Wittenberg-Lyles & Oliver, 2007).

17) **Interdisciplinary Team Model of Care:** An essential aspect of understanding hospice organizational culture is understanding the interdisciplinary team model of care in hospice care facilities. This model of care involves the collaboration of multiple hospice professionals from diverse disciplines with the shared goal of providing optimal patient care (Eng, 1993; Kobayashi & McAllister, 2016; Minetti, 2011).

18) **Interdisciplinary Role Boundaries in Hospice Care:** The challenges and the blurring of the many different interdisciplinary roles and professional concerns of the members of the hospice team who are of differing professional disciplines (O'Connor et al., 2006; Sanders et al., 2012).

19) **Moral Values Hospice Care:** The shared goals of the hospice interdisciplinary team focused on the common good and well-being of the hospice residents and their families. Morality in hospice care provision is the underlying principles and

expectations for appropriate care that does no harm within a hospice team and hospice site culture (Coventry, 2006; Salloch & Breitsameter, 2010).
20) **Pain & Symptom Management:** The management of comfort in end-of-life care is holistic and includes the relief symptoms such as pain, nausea and vomiting, dyspnea, respiratory secretions, delirium to include restlessness and agitation. Pharmaceutical, psychological, spiritual, and alternative therapies are often tried to relieve pain and symptom management issues (Hermann & Looney, 2001; Nunn, 2014).
21) **Palliative Care:** Often involves the maximization of symptom control, quality of life, and level of functioning in the client's journey toward their eventual passing (Batchelor, 2010; Teitelbaum et al., 2013).
22) **Personhood:** The quality of being an individualistic human being to include intrinsic human rights, self-awareness, spirituality, and psychological health; also included are the social and cultural realities that an individual interacts with during the lifespan (Hemati et al., 2016; Kabel & Roberts, 2003).
23) **Person/Resident and Family-centered Care:** A hospice philosophy that values and considers the concerns, needs, preferences, and involvement of both hospice residents and their families in hospice decision-making and care policies. This philosophy shows respect and reverence to the value of the personhood of all residents, families, and visitors to the hospice (Coventry, 2006; Kiwanuka et al., 2019).
24) **Psychological Care:** Hospice care of the dying individual and their families focused on the condition of the emotional self, mind, and mental functioning specific to the psychological crisis of end-of-life and how this influences behavior and coping (Chochinov et al., 2005; Payne & Haines, 2002).
25) **Reflexivity:** A concept encompassing the self-evaluation of the researcher's preconceived notions, biases, and preferences in research participation. Reflexivity also refers to the relationship and interactions of the insights of both participant and researcher and the impact this duality has on the study data and outcomes (Polit & Beck, 2012; Roper & Shapira, 2000; Speziale et al., 2011).
26) **Relational Care**: A style of hospice care focusing on a genuine interest in the individual and those important to them from a holistic, respectful, and compassionate stance and in finding out what is most important to an individual and their life experiences, quality care is provided (Broom & Kirby, 2013; Bulk et al., 2020).
27) **Mindfulness in Hospice Care:** Hospice care provision with interdisciplinary care team members fully present in the care moment and focused on the concerns of the hospice resident and their family members. This practice of mindfulness reduces the focus on the hospice care provider's inner and outer environmental concerns and more on the interactive relationship and care planning with the hospice resident and family members (Ricci-Allegra, 2018; Tsai-Ling et al., 2016).
28) **Self-Care for the Hospice Interdisciplinary Team:** The care of the inner spiritual, psychological and physical well-being of the hospice professional interdisciplinary team members that is needed to prevent burnout and compassion fatigue due to the emotionally charged and stressful nature of hospice work (Orellana-Rios et al., 2017; Sansó et al., 2015; Smit, 2017).

29) **Spiritual Care:** Hospice care focusing on the dying individual and their families' deeply held beliefs regarding the sublime, infinite aspects of dying and, in some cases, religious beliefs and their social and cultural implications (Bailey et al., 2009; Batstone et al., 2020; Callahan, 2013).
30) **Trusting Hospice Relationships:** Hospice care where the interdisciplinary team works together to foster a reciprocal interaction with hospice residents and families wherein they have confidence in the truth-telling, abilities, and reliability of the hospice care team (Baik et al., 2020; Bulk et al., 2020).

Appendix E: Hospice Study Support Letter

Andrea O'Brien RN BSN
Master's of Nursing Student
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403-813-6237
2500 University Dr. NW, Calgary, AB. Can. T2N 1N4
May 8, 2017

Carol Lefebvre, RN, BN, GNC (C)
Clinical Leader
Dulcina Hospice
Carol.lefebvre@covenantcare.ca
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110 Evanspark Manor NW
Calgary, AB T3P 0N4

Dear Andrea O'Brien RN BSN

The Dulcina Hospice: Covenant Care supports the efforts of Andrea O'Brien RN BSN in conducting the research study: The Educational Needs of Hospice Staff: An Ethnographic Inquiry. Certainly, this research effort may be of value to determine the educational needs of the Dulcina Hospice staff. We believe one of the many benefits of the research project is to improve hospice patient care through determining evidence-informed nursing practice. We recognize the need for continued research regarding hospice cultures, and the educational needs of hospice staff. This research can offer insight into hospice care that may be utilized to develop program initiatives and educational programs for hospice staff.

Sincerely,

Carol Lefebvre, RN, BN, GNC (C)

Appendix F: Focused Interview Questions

• **Grand Tour Question:** *Tell me about working in a hospice. Can you describe a typical day in your practice as a hospice staff member?*
• *Tell me about your team in hospice. Who are the members? How do you work together?*
• *What are the shared goals, values, and beliefs of your hospice team that shapes the educational needs you have as a hospice team?*
• *From your perspective (as a Chaplain, Registered Nurse, Social Worker, etc.), what are your most important educational competencies?*
• *What are the unique educational competencies specific to working as an interdisciplinary team in the hospice environment?*
• *How are the hospice team members educational needs/competencies met? What are some of the challenges you face in making sure your educational needs are met?*
• *Who in the hospice care setting and culture determines what educational needs are in need of addressing?*
• *How do you feel the hospice care setting influences educational needs?*
• *What do you consider the greatest educational needs within your workplace? For you personally?*

Appendix G:
Study Findings: Themes/Primary Concepts

Theme 1: Communication: The Essential Foundation of Quality Hospice Care/Optimal Interdisciplinary Hospice Team Dynamics.
• *Communication is embedded in hospice culture*
• *Communication is essential for all members of the interdisciplinary hospice team*
• *Transparency and feedback in communication is important to overall care*
The essential qualities of hospice communication/educational needs
• *Communication is supportive and non-judgmental*
• *Communication practices cultural sensitivity and mindfulness*
• *Mindfulness in communication/practice is an essential aspect of maintaining positive communication in the hospice setting*
Factors influencing hospice communication
• *Communication is made difficult with heavy workloads*
Theme 2: Hospice Team Cohesiveness: The bond to interdisciplinary collaborative practice
• *A foundation of quality care: hospice team cohesiveness/collaboration*
• *Team inclusivity: unconditional respect and regard for others.*
• *Collaborating with community volunteers and stakeholders*
• *A shared moral hospice community: embracing values and caring for self*
Learning together: educational needs that cross all disciplines
• *Creating a safe, inclusive environment for working together as a team*
• *Navigating challenging role blurring/boundaries*
• *Awareness of emotional energy and self-care needs*
Theme 3: Person/Resident and Family-Centered Care: The Central Care Philosophy Utilized by the Hospice Interdisciplinary Team.
• *Honoring person/resident and family-centered care needs*
• *Modeling the values of the hospice in-person/resident and family care*
Person/resident and family-centered care: educational needs
• *Hospice care provision with compassion, empathy & dignity: The essence of person/resident and family-centered care*
• *Relational care: Building trusting relationships are at the forefront/ Learning to give relational care*

Appendix H: Literature Search Details

Databases

- *CINAHL Plus with Full-Text, MEDLINE Complete, PubMed, Google Scholar, EBSCOhost, ProQuest, CDSR, Sociological Abstracts, PsycINFO, OVID*

Keywords

- *Hospice, Palliative, Hospice Care, Palliative Care, Knowledge, Knowledge Deficits, Education, Educational Needs, Nurse, Nurses, Nursing (truncated), Nursing Care, Nursing Education, Learning, Learning Needs, Educational Needs, Nurse, Nurses, Nursing (truncated), Nursing Care, Nursing Education, Learning, Learning Needs*

Search Limits

- *Full-Text, Peer-Reviewed, Published in English, Published: 2000 to the Present,* Boolean Operators *AND as well as OR Used to combine keywords to narrow the search*

Yields of the Search

- *The search did not reveal any systematic reviews. Only studies from specialized/dedicated hospice/palliative sites included. Yielded 50 articles: quantitative and qualitative design focusing on the educational needs of those providing end-of-life care.*
- *No studies focusing on the knowledge deficits and educational needs of hospice/palliative staff in the Calgary, Alberta, Canada area were found.*
- *Twenty-five studies met the final inclusion criteria following a second updated literature review (post data collection/analysis and full texts were retrieved and analyzed).*

Appendix I: Literature Search Results Table:

First author, year, country where study was conducted	Theory/conceptual framework	Sampling method including: Where/how recruited. Inclusion/exclusion criteria	Sample size; # and size of groups. attrition	Study design; description of intervention, if appropriate	Data Collection/Measurement (give the name of scales and psychometrics). List Dependent and Independent Variables	Strengths and Limitations	Results of Study
Murray, M., 2004. Canada.	Two frameworks are utilized for this study: 1) The Canadian Palliative Care Curriculum (CPCC) 2) The Canadian Hospice Palliative Care (CHPCA) Square of Care Framework.	-All 22 staff nurses in a residential hospice were invited to participate. – The survey purpose and procedures are discussed at a staff meeting. -A letter explaining the survey purpose, the voluntary nature of responses and assurances of confidentiality was attached to each survey. -22 surveys are distributed in the hospice nurse's mailboxes. -A self-sealing envelope was provided with each survey.	-The sample size was 12 participating nurses. -No groups identified. -No attrition is described.	-The study was a cross-sectional multiple method survey approach focusing on the learning needs of hospice nurses.	**Data Collection:** -A palliative care fellow nurse completing a 12-month postgraduate fellowship conducted the learning needs assessment during an advanced practice placement at the hospice. - Interviews, a focus group, a survey, and clinical observation is conducted. - Participants have contributed to all or some of the need's assessment components. (Unspecified in the article). - The nurse fellow also maintained field notes throughout her clinical placement and participated in a retrospective chart review of the last 48 hours of	**Strengths.** 1)Utilized two frameworks. 2) Implications for nursing practice well described. 3) Multiple methods utilized for the study. **Limitations.** 1) Small sample size. 2) Relatively Homogenous group. 3) Representation of a single setting. 4) Limited generalizability of the assessment findings. 5) Nonexperimental methodology precludes hypothesis generation. 6) Tool reliability not established. Survey Questionnaire is modified from a previously developed	**Results:** **(Summary of results from the mixed methods).** 1) Learning needs of the Hospice Nurses were identified as, assessment, information sharing, provision of decision support, and practical care delivery strategies. 2) Primary knowledge and clinical Skill development needs identified were pain evaluation and management. 3) Physicians and secondly nurse colleagues is identified as the hospice nurses' primary source of information. 4) Monthly educational in-service sessions were the preferred instructional delivery method.

First author, year, country where study was conducted	Theory/conceptual framework	Sampling method including: Where/how recruited. Inclusion/exclusion criteria	Sample size; # and size of groups. attrition	Study design; description of intervention, if appropriate	Data Collection/Measurement (give the name of scales and psychometrics). List Dependent and Independent Variables	Strengths and Limitations	Results of Study
		-Explanatory posters were posted in the unit communication book and on the staff bulletin board. **Inclusion:** -All 22 staff nurses in the residential hospice. **Exclusion:** -No specified exclusion criteria.			care for all deaths in the previous 12 months (n=99) **Survey Questionnaire:** -Modified from a previously developed tool. States validated and used in several Canadian and Chinese studies. No further details, however, the tool is referenced to another study. No psychometric information provided in the article. **Scale:** -Included % of the time on a scale of 0-10 that hospice nurses adequately assessed, documented, and treated pain and the extent that this is usual hospice practice. **Statistical Analysis:**	tool. States validated and used in several Canadian and Chinese studies. No further details were given; however, the tool is referenced to another study. No psychometric information provided in the article. 7) Data analysis is poorly described in the article. 8) Participants may have contributed to all or some of the needs assessment components; this may result in data gaps. The specifics of the hospice nurse's participation in the study methods is not described in the article.	5) Improving communication facilitation, providing psychosocial support for patients and families, response to ethical dilemmas, and establishing stronger linkages with the larger palliative care community were identified as educational needs.

First author, year, country where study was conducted	Theory/conceptual framework	Sampling method including: Where/how recruited. Inclusion/exclusion criteria	Sample size; # and size of groups. attrition	Study design; description of intervention, if appropriate	Data Collection/Measurement (give the name of scales and psychometrics). List Dependent and Independent Variables	Strengths and Limitations	Results of Study
					- Descriptive Statistics were used to analyze the survey results. -Content analysis and identification of themes were undertaken for all other data sources. **Dependent Variable:** -The learning needs of nurses at a residential hospice. **Independent Variables:** -The demographic variable analysis included: demographic, academic, and practice profile information. -Study variables: 1) Symptom control. 2) Provision of psychosocial support. 3) Ethical issues. 4) Quality Assurance. 5) Clinical integration.		
Bernardi, M., 2007. Italy.	No Theoretical or Conceptual framework is utilized for this study.	**Sample Method:** --The head hospice nurse from 9 hospice units in the north,	**Sample:** -66 hospice nurses completed the questionnaire and	**Study Design:** -A cross-sectional descriptive study.	**Instrument:** 1)The Italian version of The Nurse's Knowledge and Attitudes Survey	**Strengths.** 1) The study was nationwide/multiregional and multi-site.	**Results:** 1) Significant differences in the level of nurse's pain knowledge noted among

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		center, and south of Italy were given a questionnaire to provide to all hospice nurses at their site. **Inclusion:** -Hospice nurses from Northern/central/ and southern Italy comprised the sample. -1 or 2 hospitals from each region were included to provide a representative sample. -Also recruited were nurses from 24 inpatient hospice units. - Units were chosen per their "relevance and importance as hospice units in the specific region." **Exclusion:**	comprised the sample. (66.6% response rate). **Groups:** -None identified. **Attrition:** -No attrition described.	-utilized a questionnaire focusing on knowledge and attitudes regarding pain management and predictors of nurse's pain management knowledge.	(NKASRP). (English version). 2)Demographic tool. **Psychometrics:** 1) (NKASRP) content standards of pain management established from the American Pain Society, World Health Organization, and Agency for Health Care Policy and Research. 2) Content validity was established by a review of pain experts. Construct validity of the original version was established by comparing the scores of nurses at various levels of pain management expertise. 3) Internal consistency for the English version was reported at 0.70, and the test-retest reliability as 0.80.	2) The study utilized a preexisting assessment tool with prior psychometric analysis. 3) Substantial sample size with 66 participants. **Limitations.** 1) Varied Psychometrics strength among the three-general analysis listed. 2) No sample size power analysis. 3) No limitations listed in the study. 4) Demographic data tool not validated/assessed. 5) No framework utilized. 6) The use of the English version of the study instrument could have affected the results when the sample included Italian nurses. 7)The significance was listed as p = .05 not p <	differing Italian regions, years of hospice nursing experience, and among different graduates in nursing. 2) The nurses who had attended pain management education courses had higher survey scores. 3) More than 30% of hospice nurses underestimated the patients' pain, and they did not treat the pain in the correct way, and they had an incorrect self-evaluation about their pain management knowledge. 4) Only 27.3% of the nurse has administered the correct dosages of MS to relieve the pain. 5) For the 39 pain knowledge questions assessed, the mean number of the correctly

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		-No specific exclusion criteria were described in the article.			4) Tool psychometrics differed for different countries. Internal consistency (Cronbach alpha)/ Test-retest reliability (Pearson r). USA .70/0.80, Greece .88/0.68, Italy .69/0.97. -To increase the reliability of answers on the demographics, the questionnaires were anonymous and confidential. **Scale:** -(NKASRP) contains 22 true/false questions, 13 multiple choice questions, and 2 case studies with 2 questions each, for a total of 39 questions. -Demographic tool included 10 questions. **Statistical Analysis:** -Knowledge scores for each item in the NKASRP	.05. (Usual standard of significance). 8) Detailed data analysis procedure.	answered question was 24.4 (SD = 4.2), with a range of 15 to 35 items correctly answered. The correct answer rate for the entire scale, on average, was 62.7% (SD = 28%).

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					were calculated by giving ‘‘1’’ for each correct answer and ‘‘0’’ for each incorrect answer. -Totals were then added, and the mean scores for total pain knowledge were then calculated. -The percentages of correct answers for total scores were also calculated. -Mann-Whitney and Kruskal-Wallis tests (nonparametric comparisons) were used to compare the differences of nurses’ knowledge per demographic groups. - A significance level of P = .05 was used. -The data were analyzed using the Statistical Package SAS System version 8.2 **Dependent Variable:**		

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					-The knowledge and attitudes of Italian hospice nurses about cancer pain management. **Independent Variable:** 1)Predictors of nurse's pain management knowledge 2) Pain assessment, 3) Pharmacologic and nonpharmacological interventions, and 4) Attitudes about pain management. -Demographic items included age, nursing education, working place (north, middle, south of Italy), number of years of experience as hospice nurse, prior pain management education, prior pain management education, pain experience with a significant other, the self-		

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					evaluation of knowledge, and prior experience of underestimated and overestimated of pain.		
Hollen, C., 2000. The United States.	No Theoretical/Conceptual framework was identified as being utilized in the study.	**Sample Method:** -Seven adult hospital oncology units and 11 community hospices within an urban county in a southcentral state. -All facilities with eligible nurses were invited to participate. -State Associations provided a complete list of hospices and hospitals within the regions. -Unit/hospice capacity ranged between 14-30 beds. -140 surveys were distributed. -Nurse managers distributed the lists	**Sample:** The sample size was 64. This is a response rate of 46%. **Groups:** -Hospice nurses (n=30). 53% -Hospital oncology nurses (n=34). 41% **Attrition:** -No listed attrition, however, missing data from unanswered questions led to a sample size of 29 hospices and 33 hospital nurses, respectively.	**Design:** -Descriptive, cross-sectional comparative survey. -The study focuses on identifying knowledge strengths, weaknesses, and misperceptions about cancer pain management. -The study compares registered nurses in the hospice and hospital oncology settings.	**Instrument:** -The North Carolina Cancer Pain Initiative (NCCPI) survey and a demographic survey. -Cronbach's alpha for knowledge component was 0.71, opioids were 0.61, scheduling was 0.61, the general pain was 0.21, and for the attitudes subscale 5 Likert scale items the result was 0.51. -The tool was modified from the Wisconsin Pain Initiative Survey. **Scales:** -Total knowledge and knowledge subscales - correct answers were scored 1, and incorrect answers were scored 0. A higher score showed a	**Strengths.** 1) The sampling method was detailed and well described. A sizeable sample of 64. 2) Diverse sample with 2 comparison groups. 3) Study write up well organized. 4)Study utilized a pre-existing tool with psychometric analysis discussed in the article. **Limitations.** 1) The reliability of the tool not particularly strong. Internal consistency of the knowledge test was only 0.71. Internal consistency of other domains was low at 0.61, 0.61, 0.21, and 0.51. The tool may	**Results:** 1)Hospice nurses scored significantly higher than hospital oncology unit nurses regarding overall pain management knowledge, opioids, scheduling, and liberalness. 2)Hospice nurses also reported more pain education and a higher frequency of pain guidelines review requirements than hospital oncology unit nurses. 3)The most prevalent knowledge deficits concerned opioids for both hospice and hospital nurses. Hospice nurses were more knowledgeable regarding opioids than hospital oncology nurses.

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		for 3 of the oncology units. -The same investigator delivered the surveys to all eligible nurse's work mailboxes within three days. -The cover letter was attached and described eligibility and advised participants that their responses were voluntary and anonymous. -Four weeks later, the surveys were distributed again using the same procedure. The cover letter indicated that repeat survey completions were not needed. **Inclusion:**			higher level of participant pain management knowledge. -Knowledge test ranges were: Total knowledge: (0-31), opioids (0-10), scheduling (0-9), and general pain (0-12). -The range of scores for the attitude's subtest was (5-22). Higher scores indicated higher levels of liberal pain management attitudes. -Demographics included 27 questions. **Statistical Analysis:** -Significance was set at an alpha level of 0.05 - "descriptive and inferential procedures were used" but were not fully described in the data analysis section. -ANOVA was utilized to compare the relationship between pain education,	also lack sensitivity due to the small number of questions. 2) Nurse managers delivered the surveys where no mailboxes were available. This may have led to selection bias. 3) Urban location of the study may limit generalizability to nurses in rural areas. 4) "descriptive and inferential procedures were used" but were not fully described and identified. 5)Condensed demographic tool may result in missed variables. 6)Missing data reduced the sample size. No plan for missing data was discussed.	4) Practice setting and prior pain education may influence knowledge and attitudes regarding pain. 5)10 times more of the hospice nurses than the hospital nurses correctly answered that the oral route was the preferred method 7) For both groups, more than 16 hours of pain education resulted in higher pain knowledge levels. 8)100% of the hospice nurses had 1-16 hours of pain education. Twice as many hospice than hospital nurses had more than 16 hours of pain education in the past 2 years. 9)Three times as many hospice nurses had to review pain guidelines than hospital nurses but this did not affect pain knowledge or attitudes.

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		-Public, private, and teaching facilities, community-based hospices, oncology units in acute care were included. -RN's who had worked a minimum of 20 hours per week in hospice or oncology for at least the preceding six months. -80% of the participant's professional practice must involve patient or family care. **Exclusion:** -No exclusion criteria specified.			opioid knowledge, and liberalness. -Student-Newman-Keuls Post-hoc test for opioid knowledge as well as liberalness and pain education was utilized. **Dependent Variables:** - Hospice and Hospital oncology unit nurses. **Independent Variables:** 1) Knowledge about basic pharmacologic cancer pain management. 2) Attitudes about basic pharmacologic cancer pain management. 3)Demographic variables: Age, work setting, hours of pain education prior two years, personal experience with cancer pain, and yearly review of pain guidelines.		
White, K., 2012. United States.	**Framework/Conceptual Model:**	**Sample method:** -Convenience sample survey of nurses from	**Sample:** -The sample size was 1,234 completed surveys	**Design:** -Cross-sectional descriptive design.	**Instrument:** -The survey was described as "having been used in	**Strengths.** 1) Large sample size from diverse geographical	**Results:**

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	No Theoretical/Conceptual framework was identified as being utilized in the study.	the Hospice and Palliative Nursing Association (HPNA). -The sample was taken in April 2010 from members of the HPNA who had given permission for their addresses to be released. -A total of 4,022 nurses. (40.8% of total HPNA membership) from 50 states, Puerto Rico, and Washington, DC was sent recruited for the study. - Respondents varied greatly by state ranged from one in North Dakota to 93 in Florida. -Recruitment involved a letter mail out with study information, a survey instrument,	-This was a return rate of 31.15%. **Groups:** 1)Hospice Nurses (n=566) 2)Palliative Care Nurses (n=260) 3)Long term care nurses (n=102) 4)Hospital nurses (n=73) 5)Research/management (n=96) 6)Other (n=133) **Attrition:** -No Attrition was identified.	-The study focused on end-of-life care competencies and perceived gaps in palliative continuing care education.	two other previous research efforts.” And having been developed per ‘‘Clinical Practice Guidelines for Quality Palliative Care’’ and with “EOL core competencies representative of the National Consensus Project Domains ‘‘Clinical Practice Guidelines for Quality Palliative Care’’ -No other information given regarding validity/reliability. No psychometric information given. **Data Collection:** -The survey was sent out in late July, 2010. Data collection continued through September 2010 as surveys continued to be received back to the researchers by mail. **Scale:**	areas. Substantial return rate of 31.15%. Substantial # of respondents from hospice/palliative specific settings. Hospice (n=566), palliative (n=260). 2) Reminder postcard sent out 2 weeks after initial mail out. May have Increased the response rate. Postage was paid this may have also increased the response rate. 3)Numerous independent variables utilized in the study providing a richness of study data. **Limitations.** 3) No theoretical/conceptual framework. 2) Sample is homogenous nurses are	-Palliative care continuing education was important to nearly all respondents. -Nearly 80% of the respondents had 7 or more hours of specific continuing education in the preceding 2 years. -Ninety-six percent of the respondents believe they are adequately prepared to effectively care for an individual with a life-limiting condition. -Symptom management was the top-rated nursing core competency. - Pain management and how to talk to patients and families about dying were also frequently selected. - HPNA nurse respondents are comfortable with the quantity and

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		and a postage-paid return envelope. - A reminder postcard was sent two weeks after the initial mailing. **Inclusion:** 1) HPNA RN's who specialize in hospice and palliative nursing across a wide range of organizational and geographic settings. 2)HPNA RN's working in roles and settings that deliver direct care to palliative/hospice patients. 3)RN members of the HPNA who had given permission to release their addresses. **Exclusion:**			-Twelve EOL competencies were rank ordered from 1-12 in order of importance for nursing practice. -The scale was a "standard 5-point Likert Scale". No other details were given regarding the Likert Scale. **Statistical Analysis:** -Data analysis included: measures of central tendencies, Chi Square test & ANOVA. -When certain Likert scale categories had few responses, the responses were collapsed to simplify the analysis. **Dependant Variable:** -Core practice competencies considered most important by HPNA members. **Independent Variable:**	more experienced and educated than the general population. 3) Overlap with some having specialty certificates in areas such as oncology. 4) The sample may be biased as the nurses may be more motivated to seek education/certification. 5) Survey responders are underrepresented by staff and overrepresented by management. 6)Minimal details regarding the study instrument provided. No psychometric data regarding validity/reliability of the tool provided. 7)Likert scale poorly described.	quality of orientation and continuing education within their scopes of practice in palliative care. -HPNA members report a high level of motivation for education. -High level of satisfaction in their abilities to care for patients and their families at the EOL period. -42 % of the respondents reported caring for patient populations varying from the very young to the very old.

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		-None specifically identified in the article.			1)Interest and involvement in EOL Care. 1)Continuing educational preparation. 2)Organizational commitment to EOL care 3)EOL care core competencies 4)Demographic variables including: -Gender -Geographic region -Highest level of formal nursing educational preparation. -Age -Race -Number of years as an RN. -Certifications (basic or advanced). -Practice setting. -Type of practice population. -Nursing role.	8)No missing data plan described responses "were collapsed to simplify the data". This may have been like attrition in that data from certain participants was missing. 8)Convenience sample no randomization effecting the generalizability of results. Increased risk of bias, the sample may not be a true representation of the population. (Respondents were skewed to more experienced nurses).	

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					-Organizational ownership of employer (nonprofit or for profit).		
McIlfatrick, S. 2010, Ireland.	**Theoretical/Conceptual Framework.** No Theoretical/Conceptual framework was identified as being utilized in the study.	**Sample Method:** - All the palliative care link nurses (*n*=80) in a large integrated health and social care trust in Northern Ireland were invited to participate in an audit. -The audit was undertaken in June 2009. - A questionnaire was distributed to all the palliative care link nurses who attended the first workshop of the project. -Completed	**Sample:** -A total of 71 completed questionnaires were returned. - This is a response rate of 89%. **Groups:** -No groups were identified. **Attrition:** -No identified attrition.	**Design:** -The design was a cross-sectional descriptive mixed methods questionnaire.	**Instrument:** - The study questionnaire was adapted from one previously used by Whittaker et al (2006). -Mixture of open and closed questions. -No information regarding psychometric analysis was listed. **Data Collection:** - A questionnaire was distributed to all the palliative care link nurses who attended the first workshop of the project. -Completed questionnaires were left in a box at the end of the workshop day. **Scale:**	**Strengths:** -89% response rate from the questionnaire. Substantial sample with 71 returned surveys. -The instrument (questionnaire) had been utilized in a previous study. -Surveys distributed at a workshop. Completed questionnaires were left in a box at the end of the day. These efforts may have maintained the high survey completion rate. -Survey had open and closed questions providing a richness to the data (quantitative and qualitative). -Mixed methods studied are considered to	**Results:** -Participants demonstrated a clear commitment to and enthusiasm for their role. -More than two thirds of the participants had already completed some form of palliative care training and considered themselves to already possess the necessary skills, confidence, and competence to be palliative care link nurses. -Competence tended to relate more to skill-based elements and less towards practice issues. -Participants revealed that they became palliative care link nurses because of their desire to increase their

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		questionnaires were left in a box at the end of the workshop day. **Inclusion:** - All the palliative care link nurses who attended the first workshop of the project. **Exclusion:** -No specific exclusion criteria was listed.			-No scales listed/described in the article. **Statistical analysis/Qualitative analysis:** - The quantitative data from the questionnaire were subject to descriptive analysis on all closed variables using SPSS (VS 11). -The qualitative information was transcribed and subjected to content analysis. Then sentences with identical or similar meaning were clustered together and summarized into themes. **Dependant variable:** -The educational needs and level of knowledge of palliative care link nurses. **Independent variables:** 1) Educational needs.	provide more valid results than single method studies. **Limitations:** - The use of closed questions to assess educational needs can be problematic as it limits the possible responses. Interviews may be considered for further studies. - it is unclear whether the participants' knowledge and confidence in their abilities were based on actual expertise, as no research was undertaken to observe staff in clinical practice. - This was a small study undertaken in only one area of the UK, which may limit its generalizability.	knowledge or skills base, to improve the practice environment, and to optimize the welfare of the patient. -There is a need to facilitate more practice-based learning, as opposed to replicating the content of formal programmes and modules.

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					2) Reasons for becoming a palliative care link Nurse. 3)Competence and confidence levels relating to the palliative link nursing role. 4)Knowledge and understanding of palliative care. 5)Formal training in palliative care. 6) Views on palliative care. 7) Issues related to discussing death and dying 8)Suggestions to improve palliative care provision. 9)Demographic variables including: -age -level of education -professional data -reasons for becoming a palliative link nurse	-No psychometric information regarding the instrument was described in the article. -A survey can generate a low response rate. -No power analysis for sample size. -No Theoretical/Conceptual framework was identified as being utilized in the study. -No scales for the study instrument were described. -Data analysis (statistical) was poorly described only stating “descriptive analysis on all closed variables” -Many independent variables listed providing a richness to the study data.	

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Booth, K. 2003, United Kingdom.	Macmillan Framework based on clinical leadership principles relevant for palliative nurse specialists.	**Sampling Method:** -The study population was 1500 identified Macmillian post holders, the majority were nurses 1048(91.6%). -Postal questionnaires were sent to 1144 Macmillan post holders in England, Scotland, and Wales. -3 focus groups with a total of 21 respondents were also used as a secondary form of data collection. -The questionnaire was sent out in three mailings with a freepost return. Non-respondents were sent reminders. **Inclusion:** - Macmillian post holders, the majority	**Sample:** --Total sample completed returns 1144 (75.7% return rate). -1511 questionnaires sent out. 1203 (79.6% return rate) returned. Uncompleted returns 59 (3.9% return rate). -3 focus groups with a total of 21 respondents **Groups:** -No identified groups.	**Design:** -Mixed methods quantitative (postal survey) and qualitative (focus group) research design. -Study focused on the study participants practice development support needs.	**Instruments:** **-**The development of the postal questionnaire instrument was based on "previous reports in the literature." No further information given. -The instrument was designed and piloted in three phases, with the extensive consultation of clinical experts. -The finalized instrument included combined closed questions and Likert scales. As well as multiple responses to open questions. **Data Collection:** -Postal questionnaires were sent to 1144 Macmillan post holders in England, Scotland, and Wales. -The questionnaire was sent out in three mailings with a freepost return.	**Strengths:** -Large sample and a high response rate for the survey. -Convenience sample. Generalizability thus may be questionable. -Respondents were from multiple disciplines and from three different countries, providing a richness in the study data. -The questionnaire was sent out in three mailings with a freepost return. Non-respondents were sent reminders; this may have led to the high survey response rate. -Mixed methods study. This has strength within the hierarchy of evidence. -The focus groups allowed for further exploration than could	**Results:** -Practice development needs substantial and include needs with respect to development needs (organizational support and guidance) educational support, resources, and access to evidence. -Nurses indicated unable to engage in improving care unless initiatives were supported in practical ways by their organizations. -Need for organizational support enabling practice development was the most important need when respondents asked to identify most important unmet need. -Most popular educational activities included: attending study days (98%0, reading professional literature (93%), discussing issues with colleagues (93%), acting as a

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		were nurses 1048(91.6%). **Exclusion:** -Individuals who were not Macmillian post holders.			Non-respondents were sent reminders. -3 focus groups with a total of 21 respondents were also used as a secondary form of data collection. -Focus group interviews were held to allow participants to expand on their responses from the questionnaire. **Scale:** -A Likert scale was used for the questionnaire, but the scale was not well described in the study article. -Respondents asked to identify the most important practice need from a list of seven statements. **Statistical Analysis/qualitative analysis:**	be provided with the questionnaire only. -The themes from the focus group arose from the questionnaire and validation of those themes was explored by the respondents in the focus groups. **Limitations:** -Findings may be somewhat limited to the respondent's perceptions. -No details were given regarding the psychometrics of the study instrument. -Uncompleted survey returns 59 (3.9% return rate). No intent to treat/missing data analysis plan provided or carried out. This reduced the potential sample size.	resource for others (90%), undertaking education for oneself (89%), reflecting on practice (88%), and networking (88%). -Least popular educational activities were: Using appraisal systems (44%), persuading managers to resource improvements (41%), conducting research (30%), and involvement in curricular development (28%). -Practice development is hindered by lack of time, poor organizational support, resources, and workload pressures per respondents.

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					-All questionnaire responses were analyzed using SPSS for Windows (1997) and descriptive statistics were produced. -Mann-Whitney U-test Z=-6.35 p=<0.001 to analyze satisfaction with practice development. -Focus group interviews expanded on concepts from the questionnaire. -Data was thematically analyzed and a coding frame was developed from pilot data. -Inter-rater reliability was achieved for the categories being coded. The total % agreement scores ranged from 85-92% throughout the analysis period. **Dependent Variable:** **-**The practice development and support needs of Macmillan	-The study may be difficult to replicate due to likely high cost. Mixed methods design as well as large number of mailed out surveys and reminders. -Focus group sample small with only 21 respondents this may limit the generalizability of the qualitative results. -Minimal demographic information was obtained or perhaps simply not described in the article.	

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					cancer and palliative care specialists. **Independent Variables:** 1)Perceived need for help with practice development. 2)Factors that would help an individual improve practice. 3)Factors preventing improvements. 4)Practice development activity undertaken by the respondent/identifying most helpful activity. 5)Satisfaction with current ability to meet practice development requirements of the post. 6)Variables/categories from the qualitative data included: -Evidence and information needs -organizational support and resources, and time and workload.		

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					6)Demographic data. -Length of time employed in cancer or palliative care. -Employment identification (Ex. Macmillan nurses). -Previous educational development.		
Kehl, K. 2014. United States.	**Theory/Conceptual Framework.** Martin's theory of Critical Thinking of Nurses is based on models by Benner and Paul and Binker.	**Sampling Method:** -Hospice and Palliative Nurses Association (HPNA)members were invited to participate. -Questionnaires were mailed to 1537 hospice RN's and postcards to 1169 palliative care RN's. -From the 8500 HPNA members 2706 met the inclusion criteria and were contacted.	**Sample:** -Total sample was 1434 (53.1%). **Groups:** 1)1434 nurses (53.0%) 2)880 HNs (61.4%) 3)554 PCNs (38.6%). **Attrition:** -No attrition listed.	**Design:** A cross-sectional descriptive, comparative study using a self-report questionnaire. to gather data from hospice and palliative care RNs.	**Instrument:** -A questionnaire was developed by the study researcher and was based on the results of a qualitative study of hospice staff perceptions about preparing families for dying. (23 questions) -No details given regarding the tool development. -The questionnaire was reviewed by an expert panel for content validity. - The final version contains 23 questions	**Strengths:** -Large study sample, with a substantial response rate (53.1%). -Sound data collection methods: Surveys could be completed via paper or online. Two weeks after distribution of the questionnaires, a reminder was sent. Four weeks after the initial distribution, the survey was sent out a second time. These data collection measures all likely increased the	**Results:** -Nurses believe families can be prepared in advance for death and identified trust and repetition as important strategies. -There are significant differences based on population regarding nurses' beliefs about patient and family preparation for death including strategies, tailoring, timing, and content. -Nurse's tailor the delivery and content of their preparation to family.

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		-Mailed surveys were utilized due to available contact information for participants. -Additional nurses asked about online availability of the survey, as a result, PCNs were sent postcards with the option of receiving the survey via mail (n = 920) or online (n = 249) via Qualtrics Survey Hosting Service. -Two weeks after distribution of the questionnaires, a reminder was sent. -Four weeks after the initial distribution, the survey was sent out a second time. - Completed responses were			and takes about 15 to 20 minutes to complete. -No Psychometrics were described. The scales within the instrument were not described. **Data Collection:** -Mailed surveys were utilized due to available contact information for participants. -Additional nurses asked about online availability of the survey, as a result, PCNs were sent postcards with the option of receiving the survey via mail (n = 920) or online (n = 249) via Qualtrics Survey Hosting Service. -Two weeks after distribution of the questionnaires, a reminder was sent. -Four weeks after the initial distribution,	sample size and relatively substantial response rate. -no problem identified with multicollinearity in the data as assessed in the study. -A previously utilized conceptual theory was used for the study backdrop. -The sample was diverse leading to a richness of data. Both hospice and palliative nurses were included in the sample for comparison. -No attrition or missing data was identified. **Limitations:** -Limitations to the study include potential sampling bias (convenience nonprobability sample with no randomization may have limited	Tailoring is influenced by cultural background, perceived educational level, what families want to know, and lastly the patient's symptom profile. -Nurses preparation with respect to tailoring differed based on the nurse's certification status. -More hospice than palliative nurses believe that family members can be prepared for death. -Hospice nurses place a higher importance on consulting the multidisciplinary team than other study participants.

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		received from 1434 nurses (53.0%), 880 HNs (61.4%) and 554 PCNs (38.6%). **Inclusion:** -Current HPNA membership, RN, listed ‘‘hospice’’ or ‘‘palliative care’’ as their primary practice and gave permission to be contacted by other organizations. **Exclusion:** **-**No specific exclusion criteria listed.			the survey was sent out a second time. **Statistical Analysis:** -Data was collected from Qualtrics and assessed using SPSS 20.0 (IBM, Armonk, New York). -In an effort to ensure reliability, 10% of the surveys were compared with the data entered in Qualtrics. There was 99.0% reliability between the paper surveys and the database, and all errors were corrected when found. -Frequencies were analyzed with the study Likert Scales. -Dichotomous data comparisons were calculated using Pearson Chi Square. -Ordinal logistic regression was used to explore the likelihood	generalizability/may not be an actual representation of the population). -This survey was limited to HPNA members and does not represent the beliefs or practices of nonmembers. This limits the generalizability of the study results. -The total number of nurses who provide care for hospice or palliative care patients is unknown, making it impossible to determine the proportion of certified to noncertified. nurses or the number of HPNA members to nonmembers. -It was also not known if non-CHPNs had been certified in the past, which might be a confounding factor.	

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					that nurses' beliefs and practices could be predicted by certification Status. -Multicollinearity was evaluated by examination of tolerance and variance inflation factor. All tolerance values were greater than 0.1 (range, 0.996-0.998), and the variance inflation factor was less than 10 (range, 1.002-4). This indicated no data issues. **Scale:** The Likert scales in the instrument were not described in the paper. **Dependent Variable:** -The relationship of patient population and nurse's certification statuses on nurse's practices in preparing	-Nurses self-reported, which introduces the possibility of recall bias and social desirability bias. - The number of analyses conducted may result in a risk of increased type I statistical error. - This was an exploratory study designed to stimulate further research, as a result, the type I error rate was not controlled. --No details given regarding the tool development. -No Psychometrics were described. - The scales within the instrument were not described.	

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					families for the end of life. **Independent Variable:** **1)Demographic variables:** -location of employer -education/certifications. -Age -Gender -Ethnicity 2)Nurse's beliefs about family preparation tailoring/timing.		
Ly, T. 2014. Vietnam.	No Theoretical/Conceptual framework was identified as being utilized in the study	**Sample Methods:** -The study included registered nurses (RN) working in three oncology hospitals in the capital of Vietnam. All three institutions have palliative care units that train new staff in palliative care. - The study package contained a participant	**Sample:** -A total of 251 RN responses was obtained (71.7% response rate). **Groups:** -No groups were identified. **Attrition:** -No listed attrition.	**Design:** -Cross-sectional Descriptive Survey.	**Instruments:** -The study utilized 3 validated instruments: 1)The Expertise and Insight Test for Palliative Care. (Included 18 items from the Palliative Care Quiz for Nurses (PCQN) and 18 newly developed items). Cronbach's alpha was listed at 0.718. 2)The Attitude Toward Care of the Dying Scale B. (This scale consists of 30 items,	**Strengths:** 1)Moderately sizable sample from multiple hospital sites with a good response rate of 71.7%. 2)The study utilized 3 instruments providing a large amount of information/a richness of the data. 3)The statistical data analysis was detailed and sound. SPSS was utilized as well as a standard level of results	**Results:** -Low scores in nurses' palliative care knowledge related to pain and other symptom management and psychological and spiritual aspects of care. -Discomfort in communicating about death and establishing therapeutic relationship with oncology patients who require palliative care.

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		information sheet, a self-administered questionnaire and envelopes -The package was left with the head nurse of each oncology unit for distribution to staff. -Information about the study was also placed on the nursing office board. - Participants could deposit the survey in a sealed envelope, in a box located in the nursing offices of each ward. -The box was sealed to maintain participant Confidentiality.			15 of which were worded positively and 15 negatively. Positive items were scored from 1 (strongly disagree) to 5 (strongly agree). For negative items, these scores were reversed. Possible scores ranged from 30 to 150. Cronbach's alpha value is 0.716. 3)The Palliative Care Nursing Self-Competence Scale. A comprehensive instrument with 10 dimensions. Scale ranged from 1 (not at all competent) to 6 (highly competent). The Cronbach's alpha value was 0.97. **Data Collection:** - The study package contained a participant	significance ($p < 0.05$). multiple tests used to include ANOVA (see measurements section). 3)The Palliative Care Nursing Self Competence Scale used in the study was very reliable with a Cronbach's alpha value of 0.97. 4)Participant confidentiality was maintained with a sealed envelope/sealed box for data collection. **Limitations:** 1) Convenience, non-probability sample (no randomization) and thus the study may have limited generalizability. 2) The palliative care knowledge questionnaire does not comprehensively assess	-Low scores in perceived self-competence when providing pain management and addressing social and spiritual domains of palliative care. -Nurses who had higher palliative care knowledge scores demonstrated attitudes which were more positive and expressed greater perceived self-competence. -The study nurses with a 4-year bachelor's degree had higher palliative care knowledge and attitudes displaying more comfort towards caring for the dying than secondary nurses or nurses with a 3-year bachelor's degrees. -Nurses employed in palliative care had a significantly

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					information sheet, a self-administered questionnaire and envelopes -The package was left with the head nurse of each oncology unit for distribution to staff. and attached. -Information about the study was also placed on the nursing office board. - Participants could Deposit the survey in a sealed envelope, in a box located in the nursing offices of each ward. -The box was sealed to maintain confidentiality. **Statistical Analysis:** -The Statistical Package for Social Sciences (SPSS) version 21 for Windows was used to analyze the data.	nurses' knowledge regarding the provision of palliative care. 3)The sample may be biased as only those interested in the subject manner chose to participate in the study. 4) The study design did not involve collecting information about nurses' actual practice; thus, the data may reflect the nurses self-perceived competence rather than their actual skills. 5)The tools in the study varied greatly in reliability. Cronbach's alpha was only 0.716 & 0.718 for two of the instruments and 0.97 (Very reliable for one of the instruments).	higher palliative care knowledge score than the other participants. -Nurses employed in chemotherapy and radiotherapy departments reported themselves as having lower perceived self-competence compared with nurses from other clinical areas. -Nurses with more clinical experience demonstrated less positive attitudes towards the care of dying patients and their families. -nurses working in direct care with the dying had more positive attitudes towards care of the dying than those who did not consistently work in this area. -Palliative care education, 'being older' and 'having more experience' were

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					-The level of significance for all analyses was set at less than 3.05 ($p < 0.05$). - Frequencies and percentages were calculated for each of the variables and the data were verified. -The Kolmogorov-Smirnov (K-S) test was employed to determine the normality of total scores of the three factors (palliative care knowledge, attitudes and perceived self-competence). -Bivariate analysis (students t-test for two groups; ANOVA (analysis of variance) for more than two groups of independent variables; Pearson's correlation for continuous independent variables) was used to		identified as important factors contributing to perceived self-competence among study participants.

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					explore the associations between background characteristics and total score of each factor. -Pearson's correlation was performed to identify relationships between these three factors set at less than 3.05 ($p < 0.05$). -Frequencies and percentages were calculated for each of the variables. **Dependent Variable:** -Palliative care knowledge, attitudes and perceived self-competence of nurses working in Vietnam. **Independent Variable:** 1) Pain management 2) Other symptoms management. 3) Psychological care 4) Social care 5) Spiritual care		

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					6) Care associated with functional status 7) Ethical and legal issues 8) Interprofessional collaboration and communication. 9) Personal and professional issues related to nursing care 10) End-of-life care 11)Demographic data: 1)Gender 2) Close family/friend with a life-limiting illness 3) Education 4) Palliative education 5) Practice setting. 6) Percentage of work involved in caring for the dying. 7) Age 8) Nursing Experience 9) Oncology experience. 10) Palliative Care Experience.		
2003, Greiner. United States.	No Theoretical/Conceptual framework was	**Sample Methods:** -Surveys were mailed to all Wisconsin health	**Sample:** -This was a total of 318 (36%) returned surveys. **Group Sizes:**	**Study Design:** -Cross-sectional, descriptive survey.	**Data Collection/Measurement:** 1) Survey response data was calculated for the	**Strengths:** 1)Fairly substantial sample with 318 returned surveys.	**Results:** 1)The three most prevalent end-of-life care services were A) A program to

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	identified as being utilized in the study.	care institutions. -Institutions were identified by their individual state parent associations. - Parent organizations. including the Wisconsin Hospital Association, the Wisconsin Association of Homes and Services for the Aging, the Wisconsin Health Care Association, and Hospice of Wisconsin all assisted in identifying member institutions. -All institutions received a survey and a letter of introduction. The letter included detailed instructions to forward the survey	hospitals (n = 208), hospice agencies (n = 48), long-term care facilities (n = 200), home health care agencies (n =180), and other health care institutions (n = 245). **Attrition:** -No attrition was identified.	-The survey was developed to assess palliative care provision in several domains. (See independent variables).	total sample and for the type of sample institution. 2)Data was also analyzed using frequencies, measures of central tendency and dispersion, and cross tabulation. 3) The instrument (survey) was pretested on specific representatives of health care organizations (n = 5). -The survey instrument included: 1) an 8-item demographic section. 2) 45 items in 4 sections assessing current services, staff education programs, barriers to care provision, and any resources that may be useful to the institution to improve palliative care. and 3) An open-ended question to identify palliative care resources currently available in the	2)Multiple sites with palliative patients were included with multiple disciplines of professionals this revealed diverse types of data. 3)No attrition or missing data identified. 4)The instrument was pretested prior to the study. This practice prevents unexpected costly research issues. -Steps were taken to ensure an adequate response rate 1) A stamped, self-addressed envelope was provided for use in returning the survey. 2)The allotted time frame was 3 months after the distribution of the survey for all responses to be returned. **Limitations:**	promote advance care planning B) A contractual relationship with one or more hospice programs, and C) An interdisciplinary care program for end-of-life patients. 2) Pain management and advance directives were the two most common educational offerings in the past year. 3) Barriers to good end-of-life care included a lack of knowledge among patients/families, a lack of provider knowledge about pain and symptom control, and poor reimbursement for end-of-life care. 4)Resources that specific institutions felt would be useful included newsletters, a speaker's bureau, and information about establishing quality

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		to the individual within the institution who could best respond to the survey questions. -A stamped, self-addressed envelope was provided for use in returning the survey. -The allotted time frame was 3 months after the distribution of the survey for all responses to be returned. **- Included** were, Hospitals, hospice agencies, long-term care facilities home health care agencies, and other health care institutions. **Exclusion:**			institution or community. -No Psychometric information regarding the instrument was given. -A stamped, self-addressed envelope was provided for use in returning the survey. -The allotted time frame was 3 months after the distribution of the survey for all responses to be returned. **Scales:** -No scales were identified in the study article. **-Dependent Variable:** The provision of palliative care in Health Care Institutions in Wisconsin. **-Independent Variables:** 1) Services currently provided 2) Staff education programs offered in the previous	1)No identified theoretical/conceptual framework indicated in the study. 2)Low response rate. This may indicate a selection bias of respondents leading to a lack of addressed palliative care service indicators. May result in reduced generalizability of the study. A second reminder to potential respondents was too costly for the study budget. 3)The survey instrument was highly subjective and open to interpretation by the respondent. No psychometric evaluation of the instrument was described. 4)The brief nature of the survey unlikely to capture the diversity of palliative care provision	improvement programs for end-of-life care. 5)The availability of specialists in palliative care is currently limited. 6) Hospice and combined hospice/ home health agencies offered the greatest number of services in end-of-life care. Majority of deaths occur in the hospital away from these settings with the most resources. 7)The most frequently identified staff education program was on the topic of pain management. 8) A lack of knowledge among patients & families were a barrier to the delivery of good end-of-life care. 9) A lack of adequate reimbursement for end-of-life care services is a significant barrier to the

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		-No specific exclusion criteria was identified.			Year 3) Barriers to the delivery of palliative care, and 4) Resources that would be useful to the participating institutions. 5)Demographic information including: Geographic setting, type of institution, region of the state, JCAHO accreditation, & title of the individual completing the survey.	across a variety of service departments. 5)Study sample from only the state of Wisconsin. This may lead to sample bias, low level of generalizability to other states.	delivery of good end-of-life care. 10)20% of the respondents worked in areas caring for care combinations: long-term care, hospice, home health. The survey may not be able to capture the nuances of this reality.
2015, Sedillo. Kenya/United States.	**Framework:** -Study framework is based on the shared theory of self-competence. This concept combines a Social Cognitive Theory with a Self-care Model and examines both nursing and patient concepts in palliative care impacting the therapeutic relationship	**Sample Methods:** - All hospice staff providing palliative care services (n = 25) were invited to participate in the study. - The recruitment of eligible Kimbilio Hospice clinical and support staff was initiated by the research team from	**Sample:** The final sample was 24 hospice staff members as one individual did not speak English and was excluded. **Groups:** 1) Clinical staff (including nurses and clinical officers). (n=5) 2)Support	**Design:** - A descriptive cross-sectional pilot study. -Study purpose was assessing hospice care provider self-competence in both clinical care and patient and family interactions as	**Data Collection.** - Surveys were conducted with each individual participant in a private room. - The researcher read the questions out loud ensuring accuracy and participation of all literacy levels. - Likert scale responses were recorded by the investigator on the survey	**Strengths:** 1)24 of the 25-hospice staff participated in the survey. (96%). 2)A detailed, previously utilized framework was used for the study. The framework was clinically relevant for the population. 3) The study may provide preliminary data to	**Results:** -Statistically significant differences amongst provider types were found in 5 self-competence variables: performing a basic pain assessment, use of oral opioid analgesics, assessment, and management of

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	between nurses and patients with life-threatening illnesses.	the University of California, San Francisco (UCSF), School of Nursing. - Surveys were conducted with each participant in a private room. - The researcher read the questions out loud ensuring accuracy and participation of all literacy levels. **Inclusion:** -All hospice staff providing palliative care services were invited to participate in the study. -Included were: 1)Adults at least 18 years old. 2)Hospice staff who provide palliative care services at Kimbilio Hospice based on	staff (including social workers, chaplains, physical therapists, and community health workers). (n=8) 3)Caregivers (those who aid with activities of daily living in a role similar to certified nursing assistants in the United States). (n=11). **Attrition:** -No attrition was listed.	well as priorities for education. -A quantitative survey was utilized to obtain study data.	instrument prior to being submitted for analysis. **Measurements:** -Survey with Likert scale Is the ‘‘Self-assessment of Clinical Competency and Concerns in End-of-Life Care’’. -The survey instrument was adapted from a questionnaire, ‘‘A Survey of Competencies and Concerns in End-of-Life Care for Physician Trainees’’ - The instrument has not been formally validated with an original audience, and psychometrics have not been reported. **Statistical Analysis:** -The means and Standard deviations were determined for each question in each domain.	inform future studies in Kenya. 4) The study could be replicated by administering the survey at other hospices and palliative care services throughout Kenya and other sub-Saharan African countries. 5)A research team from the U.S. a developed country conducted the research, and this may offer a level of expertise/education to a developing countries palliative program. 6)The sample was multidisciplinary so gathered information from multiple professions. This increases the richness of the data. 7)Surveys were completed with the	nausea/vomiting and constipation, and discussing an end-of-life prognosis with a patient’s family member (P < .05). -Sixteen participants (66%) selected pediatric palliative care as their top priority for future education. -The findings support the hypothesis that palliative care providers have varying levels of self-competence. -Non-clinical staff as expected showed less competency with clinical skills such as pain assessment, constipation management. - Higher self-competence in the use of parenteral opioid analgesics; use of adjuvant analgesics; assessment of pain in the nonresponsive or confused patient; or

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		scope of practice and job descriptions, able to give informed consent, and able to speak English fluently. **Exclusion:** 1)Children 2)Individuals unable to give consent. 3)Individuals who do not speak English.			-Non-Parametric Kruskal-Wallis test to compare between mean scores. -Statistically significant differences were found in the 5 self-competence variables. ($P < .05$). **Scale:** **-Section #1-** A Likert scale was used to assess self-competence (1 = need further basic instruction, 2 = competent to perform with minimal supervision and coaching, 3 = competent to perform with team consultation, 4 = competent to perform independently) 5 ‘‘not applicable to my role’’ **-Section #2-** Participants were asked to rate their priorities for 10 palliative care	researcher in the room, this could improve rates of survey completion. 8)No attrition or lost data mentioned. **Limitations:** 1)Small sample size (n=24). Questionable generalizability of this study. 2)No Psychometric testing available for the instrument. **3)**Subject bias as participants may have responded in ways that would encourage the researchers to provide/find future training for the hospice. 4) Many of the study participants answered ‘‘not applicable to my role’’ this influenced the power of the statistical analysis and the generalizability of the	the assessment and management of pediatric pain, terminal delirium, terminal dyspnea, or fatigue was surprisingly not higher for clinical staff when compared with other staff. This finding raised some scope of practice concerns at the hospice. -The clinical staff had more training than the support staff so had higher scores in the domains of pain assessment and discussing end of life prognosis. -The providers who had less than 1 year of palliative care experience. had higher self-competence than did those with more experience across all provider types.

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					education and training topics using a Likert scale (1 = not at all a priority, 2 = somewhat a priority, 3 = a priority, 4 = definitely a priority). -Then participants were asked to highlight their top 3 priority topics for future education and training. **-Section #3-** In section II, participants were asked to rate their priorities for 10 palliative care education and training topics using a Likert scale (1 = not at all a priority, 2 = somewhat a priority, 3 = a priority, 4 = definitely a priority). -Participants then were asked to highlight their top 3 priority topics for future education. - A section eliciting providers 'priorities for	results to the inpatient hospice staff. 5) The results of the study may not generalizable beyond the setting of Kimbilio Hospice in Western Kenya. 6)Researchers may inflict their own ideas/bias onto the participants/results as they are from a developed country. 7)Surveys were completed with the researcher in the room, this could inflict researcher bias onto the participants. 8) Convenience sample, non-purposive design. This may lead to poor levels of results generalizability. 9)The survey was in English so this may inflict	

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					future education were also added to the original survey. **Dependent Variable:** -Palliative Care provider's self-competence and educational priorities. **Independent Variable:** 1) Competencies and comfort in end-of-life communication topics. 2) Management of end-of-life medical issues. 3) Comfort with treatment withdrawal. 4) Ethical concerns in common end of-life scenarios.	cultural bias or reduce comprehension of the instrument for the respondents. One employee who did not speak English was excluded.	
Schim, 2006. United States.	-A conceptual model using the analogy of a three-dimensional (3-D) jigsaw puzzle, with pieces representing provider elements was utilized for the study.	**Sample:** -A convenience nurse represented sample of 107 nurses from 5 different hospice agencies, and a subsample of hospice employees and volunteers	**Sample:** **-** The overall response rate was 95% for the hospice nurses. (n=107). **Groups:** **1)**Hospice nurses (n=107)	**Design:** - A cross-sectional descriptive design was used to examine variables associated with cultural	**Data Collection:** -Surveys were returned in unmarked envelopes to maintain participant anonymity. -Completion and return of the survey constituted informed consent.	**Strengths:** 1)Psychometric analysis of the instrument included. 2)Sample size power analysis performed to support the regression analysis.	**Results:** 1) Significant association between higher education and cultural awareness and sensitivity. (BSN or higher academic degrees). 2) Lower scores related to the nurse soliciting

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		represented the sample. - Participants were approached before the start of hospice meetings and asked to complete a paper-and-pencil survey. -Potential participants were advised that participation was completely voluntary and the survey would take 20 -30 minutes to complete. - An information sheet on the cover of the survey detailed the study purpose and indicated that participants could choose not to	**2)**Hospice employees (number of participants not specified). **3)**Hospice volunteers (number of participants not specified). **Attrition:** -None Listed.	competence among hospice nurses. A survey instrument was utilized for the study.	**Measurement (Scales, Psychometrics):** -The Cultural Competence Assessment (CCA) tool. --Internal consistency reliability for the CCA has been reported previously at over 0.80. -Construct, content, face validity, and test-retest reliability have been previously established. -In the current study, CAS subscale reliability was reported at 0.72 and the CCB subscale reliability was 0.88. **Scale:** -Tool scale is a 26-item instrument with a 5-point Likert Scale. = "strongly agree, agree, disagree, strongly disagree, and no opinion." -A subscale for cultural competence behavior (CCB) of "always, often, at	3)Substantial sample size with 107 nurses. 4)The 5 hospices from which the sample was drawn represent a broad range of diverse communities. **Limitations:** 1)The overall participant response rate was 95%, however, the nurse-specific response rate (versus hospice employees and volunteers) could not be calculated. 3) The use of a convenience sample of hospice nurses limits the generalizability of the findings. 4) Recruitment of nurses from only five agencies in one state limits the	specific information on which to base culturally congruent interventions were noted. 3) Behavioral Subscales indicated that the hospice nurses reported infrequent inclusions of cultural assessments in client evaluations, documenting adaptations to care, and using resources to learn about cultural issues. 4) An association between diversity training and self-reported cultural competence behaviors

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		participate/withdraw/ stop at any time. -Surveys were returned in unmarked envelopes to maintain participant anonymity. -Completion and return of the survey constituted informed consent. **Inclusion:** -None specified, however, hospice nurses, hospice employees and volunteers were included. **Exclusion:** -None specified.			times, never, and not sure." was also included. For both scales, no-opinion and not-sure responses were coded at the midpoint (3 of 5). **Statistical Analysis:** -All analyses were performed with SPSS for Windows 13.0 (SPSS, Chicago, IL). -Significance was set at ($p < 0.5$). -Standard multiple regressions were used to determine the variance for independent variables. -The Tabachnick and Fidell formula ($N = 50 + 8m$) for a medium-sized relationship between the four independent variables and the dependent variable for each regression analysis	generalizability of the findings. 5)The study was cross-sectional and only assessed the nurses at one specific point in time. 6)87 % of the participants were white-non-Hispanic. This may limit the study to other minority groups.	

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					assuming on a level of .05 and P of .20, a sample size of 82 would have been sufficient for the analysis. Thus, the sample of 107 was deemed to have adequate power to support the regression analysis. **Dependent Variable:** -Cultural competence among hospice nurses. **Independent Variables:** 1) Cultural awareness and sensitivity. 2)Cultural Competency behaviors. -Demographic variables on the CCA included: 1) age, 2) Prior cultural diversity training (yes/no), 3)Self-identified race or ethnicity, and 4) level of educational attainment (associate, bachelor, graduate degree).		

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					5)Gender was not identified in this study.		
Diver, 2003. United Kingdom.	-No identified theoretical or conceptual framework described.	-Sample from a day-care unit of a large palliative care facility of a university hospital in central England. -Provides palliative care services to a population of over 650 000 people. --Sample purposively recruited with the assistance of a senior staff member. **Inclusion:** Experienced palliative care staff. **Exclusion:**	-5 palliative care staff. -No groups identified. -No identified attrition. -Sample included two hospital Macmillan nurses, one E grade inpatient nurse and an auxiliary nurse from day care. There were 4 female participants and one male participant.	Qualitative Design, Phenomenology: semi-structured interviews.	**Data Collection:** **-**Senior staff gave out participant information sheets and collected the names of staff interested in participating. -Staff who volunteered to participate were then contacted and the interview time and location were arranged. -The library, treatment rooms or interview rooms at the hospice were used. -Quiet times during the shift were selected and the interviews were undisturbed. **-**Interviews were audiotaped following	**Strengths:** 1) Interviews were transcribed as soon as possible, as this enabled the researcher to remember the fine details of the interaction and recall unclear pieces of recorded speech. **Limitations:** **1)** The step-by step approach of phenomenology was not followed as the study goal was not to develop theory. 2)Small sample size only 5 participants.	**Results:** 1) Staff showed awareness of inter-cultural diversity and the importance of individualized care. 2) Staff did not possess ethnocentric attitudes. 3) Facilitators of multicultural care included training, learning from experience, the use of culturally specific literature and resources, and effective communication channels in the team. 4) Barriers included limited interpreting services, and some staff and other patients' negative behaviors

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		-Inexperienced palliative care staff.			consent, and then transcribed as soon as possible. -Warming up questions and probing were used. **Data Analysis:** **-**Based on Burnard's (1991) stages for analyzing interview transcripts in qualitative research. -A consideration of the phenomenological orientation also maintained. Steps included making 'memos' throughout the process about data categorization methods. -The categories were grouped together under higher order categories	3) The difference in interview locations may have limited the consistency of the interviews. 4)The researchers were inexperienced in interview techniques. 5) The cultural background of the researcher may also have had a subtle influence on the conversation with the participants and thus have affected the quality of the data.	towards ethnic minority patients. 5) Four sub-themes lead to the overall theme of 'philosophies of care'. Including intercultural diversity, individualized assessment, lack of ethnocentrism and cultural awareness.

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					and repetitions were removed to produce a final list.		
Astin, 2007. United Kingdom.	- No theoretical or conceptual framework identified.	-Macmillan nurses (Nurses employed as CNS's across palliative and cancer care services. -Content analysis of 159 educational profiles of Macmillan Nurses included. -No specific exclusion criteria was identified.	-The sample size was 159 educational profiles of Macmillan nurses. -No identified groups. -No identified attrition.	-Retrospective Documentary Study. -Content analysis.	-Content analysis of 159 educational profiles. -To enhance trustworthiness, two researchers analyzed data independently to develop a coding frame for subsequent analysis. -QSR NVivo version 2.0 was used to organize and retrieve data.	**Strengths-** **1)** Large # of educational profiles analyzed (159). 2)Ethical approval was obtained. 3)Detailed thematic analysis with 7 themes identified. **Limitations-** 1) No limitations listed in the study. 2)The nurses were not interviewed. Their educational profiles only were reviewed. 3)The study was retrospective not current.	**Results-** **-**Seven major themes identified in participants' profiles as key areas for education and development. -One barrier to the development of their multiple roles was the magnitude of their clinical workload. **-The seven themes included:** 1)To function as a specialist, developing and maintaining knowledge, skills and expertise. (Resources not always available). 2)To participate in educational activities. (Wide range of activities documented).

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							3)To identify career plans and personal development opportunities. 4)To develop teaching and dissemination skills. (Felt ill equipped to teach, wanted formal teaching experience, a teaching qualification and presentation skills). 5)To develop leadership and management skills. (Included project management, conflict and change, human resources, occupational health issues, service development and policy, effective time management, & caseload management). 6)To develop and streamline existing services. *referral criteria, documentation, strategic direction, set standards, working effectively, raise awareness about services).

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							7) To engage with role transition and development. (lack of role clarity and role conflict).
Bailey, 2009. Republic of Ireland.	- Analysis using Burnard's framework for thematic concept analysis.	-50 nurses from a palliative unit invited. **Inclusion:** 1)Nurses from palliative site 2)Working at the site for a minimum of 12 months. **Excluded:** 1)Nurses from other healthcare sites. 2)Nurses not working at the site for a minimum of 12 months.	-22 nurses in a palliative setting. -No identified groups or attrition.	-Qualitative descriptive design. -Identifying educational needs and deficits relating to spiritual care.	-Semi-structured one-to one interviews and content analysis. -Data collected over an 8-week period. -Adjustments made after a pilot study. -Interviews lasted 30-45 minutes. -Post interview: Field notes, tape-recordings transcribed verbatim. -Transcripts given a code number. -Identifiable material excluded to maintain confidentiality. -Analysis using Burnard's framework for thematic concept analysis. -Strategies to ensure trustworthiness utilized. -Transcripts	**Strengths: -** 1)Adjustments made after a pilot study. 2) Post interview: Field notes, tape-recordings transcribed verbatim. **Limitations:** 1)Small sample size. 2)Study is a convenience sample from only one site this may limit generalizability. 3)Study only focused on nurses. 4)Coding dependent on the correct interpretation of the language used. 5)Respondents mostly Roman Catholic and this may have influenced individual perspectives and experiences.	**Results:** 1)One major theme and 5 subthemes. -Major Theme-Spiritual tapestry. -Subthemes included: understanding spirituality; the art of nursing in spiritual care; education and learning; the challenge of spiritual caring; and the dimensions of time. Educational needs: 1)Understanding the concept of spirituality and incorporating this into practice. 2)Spiritual care skills.

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					were independently analyzed by the researchers. -Transcripts returned to randomly selected participants for verification and comment.		
Morris, 2013. United Kingdom.	No theoretical/conceptual framework was identified by the authors.	**Sample:** **Inclusion:** -59 staff members invited to take part. -6 managers invited to participate. **Recruitment:** -Potential participants sent a letter with the questionnaire and study purpose. -Reminder sent out 2 weeks after the first mailing. **Exclusion:** -No specific exclusion criteria listed.	**Sample Size:** -48 staff members (81% of the staff). -6 Managers. -No identified groups or attrition.	**Study Design:** -A mixed methods approach was used. -Survey assessing the staff attitudes to and skills in using evidence. -Self assessment tool for senior managers regarding the readiness of the organization to embrace an evidence-informed focus.	**Data Collection/Measurement.** -Research assistant available for any questions and to collect completed questionnaires. -Workshop held at one of the Hospice sites and took place over a 3-hour period. -Workshops facilitated by the authors to answer any questions. -Three sub-scales with all items rated from 1 to 7, with a higher score indicating a more positive response.	**Strengths:** 1)Ethics approval by the Hospice senior management team. 2)Mixed methods design. 3)81% of the staff involved in the study as well as 6 managers. This is a high response rate. 4)Participation was voluntary. 5)Gaps in knowledge and skills regarding EBP identified and may be applied to future research/education. 6)Cronbach's alpha 0.85/0.79/0.91 with an	**Results:** 1)Staff were committed to the principles of evidenced-informed decision making. 2)Lacked needed knowledge and skills. 3)Over 80% indicated that EBP is important and they had changed their practice because of it. 4)Workload issues significant factor in keeping up with EBP. 5)Participants frequently attempted to find EBP evidence, however, identified a lack of knowledge/skills in doing so.

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					-The three sub-scales included six items that measured the frequency with which an evidence-based approach was applied to an individual patient's care over the past year. four items that measured attitudes toward using research-based evidence. -14 items measuring perceived competence with EBP skills. -Workshop included a validated self-assessment tool with 2 sections. -First a self-assessment tool focusing on 4 key areas. Items rated on a scale of 1-5. -The second section asked participants to consider the results from the self-assessment. **Data Analysis:**	overall alpha of 0.87 for the study tool. **Limitations:** 1)Study only involved one facility, and thus, generalizability may be limited. 2)Small convenience sample. 3)No theoretical/conceptual framework utilized.	6)Managers indicated that a priority was developing an evidence-informed decision-making culture focusing on education, training and policy development. 7)Participants identified deficits in integrating EBP from research into actual clinical practice. 8) Participants identified deficits in knowledge translation of researched EBP to staff members. 8)Lack of knowledge identified by participants regarding how to conduct and critique research.

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					-Descriptive Statistics. -SPSS Version 19. -Score data used to facilitate discussion re; change/areas of improvement.		
Sommerville, 2007. United Kingdom.	**Conceptual/Theoretical Framework.** -Lincoln and Guba's (1985) criteria were used to demonstrate the trustworthiness of this study.	**Sample:** **Inclusion:** -The sample was a purposive sample randomly selected from staff who volunteered to participate. -Sample from nurses working in areas of high ethnic diversity. --Participants varied in ethnicity and grade and length working in palliative care. **Exclusion:** -No specific exclusion criteria described.	**Sample:** -Sample size of 10 palliative care nurses. -Purposive sample of 5 community palliative care and 5 hospice-based nurses working in areas of high ethnic diversity. -No identified groups. -No identified attrition.	**Design:** -Qualitative modified grounded theory approach. -Semi-structured interviews.	**Data Collection/Measurement.** -Semi-structured interviews (45 min. in length and carried out in a quiet room) were tape-recorded and transcribed verbatim. -Two initial pilot studies were carried out to ensure that the data collected was of a high quality. -Analysis of emerging data. -Data numbered line by line. -Constant comparison. -Open, axial, and selective coding. -The researcher described	**Strengths:** 1)Interviews tape recorded and transcribed verbatim. 2)Interviews were carried out in a quiet room where no disruptions would occur. 3)Ethics approval was obtained from the appropriate ethics committee. 4)Consent obtained before interview. 5)Time allowed for debriefing surrounding the interviews and counsellor was available. 6)The author carried out the analysis increasing dependability.	**Results:** 1)Palliative care across cultures is paradoxical. In treating everyone equally, everyone was treated as individuals. 2)Intense efforts made by nurses to transcend cultural and language barriers. 3)The nurses gave of themselves when caring for the patients, but their endeavors were impeded by limited resources and a lack of education. 4) The theory of cross-cultural endeavor in palliative nursing was developed to explain how palliative care nurses care

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					and interpreted her experiences in a reflexive research journal throughout the study.	**Limitations:** 1)Small sample size from one location generalizability may be limited. 2)Modified grounded theory method used. 3)Participants volunteered so this group may be more positive/highly motivated group than the overall population.	for patients from cultures other than their own. 5)Seven theoretical constructs emerged: Genuine relationship, individualized care, communication, providing care, limited resources, self-awareness, education and training.
Lansdell, 2010. United Kingdom.	-No theoretical/conceptual framework identified.	**Sample:** **-**All staff at the hospice received a copy of the education prospectus and the first ten to apply for a place on the psychosocial education program were recruited. -Each participant recruited two patients for an audio-	**Sample:** -9 participants from multi-professional teams. **Groups:** -No identified groups. **Attrition:** Initial sample was ten. One withdrawal for personal reasons.	**Design:** -Mixed methods study. -Between methods triangulation.	**Data Collection/Measurement:** **-**Data collection included a self-rated confidence questionnaire, knowledge questionnaires, audiotaped interactions, observation, and a focus group. -A confidence questionnaire was completed by participants at the start of day one and a month	**Strengths:** 1)Mixed methods design allowing for a deeper exploration of the topic. Overcomes bias from adopting a single method. 2)The study was approved by the local ethics committee. 2)Participation was voluntary and confidential. **Limitations:**	**Results:** 1)Increased confidence scores for all participants (psychosocial care). 2) Audiotaping and observation of an interaction was found to be valuable when applying theory, and participants reported a change in their practice. 3) Attendance on the 3-day programme has increased the

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		taped interview: one after day two and one after day three. Eligible patients included those who could comprehend the information sheet and provide written consent to participate.			after day three. -10-point Likert scale, ranging from 1: 'not at all confident' to 10: 'very confident'. Eighteen items were included. -The scores were subject to descriptive statistics, and mean scores compared before and after the three day programme. -Participants completed a short questionnaire before and after each day of the programme. -Data were reviewed for key words, noting the frequency and range of words reported. -Reviews and reflections on the interviews were performed. -Some interviews were observed by the researcher.	1)Small sample size may limit study generalizability. 2)Did not fully detail the patients experiences i.e., semi-structured interviews.	health professionals' understanding of psychosocial care and their confidence in providing psychosocial care in the clinical setting. 4)Knowledge deficits identified by the participants in talking to patients in denial, discussing a poor prognosis, and asking end of life preferences. 5)Deficits in psychosocial terminology pre-education had improved after the education program.

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					-Data was analyzed separately and the results reviewed to link qualitative and quantitative data by considering patterns of relationships.		
Tornoe, 2015. Norway.	**Theoretical/Conceptual framework:** **-** Pragmatic and functionalist epistemological starting point. -Practical focus rather than the ontological questions related to the conceptual framework of spiritual care.	**Sample:** -The team members were Norway's first and only mobile spiritual and existential care teaching team in end-of-life care. -The team was invited to participate in a focus group interview. **-**Team members had the following characteristics: 1) Expert hospice nurses 2) Several years of experience as supervisors in end-of-life care 3) Were	**Sample:** -3 team members. -No groups. -No attrition.	**Design:** -Qualitative focus group. - The interviews were analyzed using a phenomenological hermeneutic method.	**Data Collection/Measurement:** -The interviews lasted 80 min. and were designed as a narrative approach, with one open-ended question, followed by clarifying questions when necessary: - The data was analyzed using Lindseth & Norberg's phenomenological hermeneutic method for researching lived experience. - To ensure rigour, the authors performed	**Strengths/Limitations:** **Strengths-** 1) To ensure rigor individual structural analyses were performed. Interpretations were compared to strengthen validity. 2) The team members assessed in the study had extensive knowledge and skills. 3)Focus group interviews are an effective way to obtain data. 4)Ethics approval obtained from the Norwegian Social	**Results:** 1) The mobile teaching team perceived that the care workers became more courageous in addressing dying patients spiritual and existential suffering following the training in spiritual and existential care. 2)Three themes emerged through the structural analysis: Fear and uncertainty, bedside teaching, courage, and competency. 3)Reluctance to discuss spiritual/existential concerns with patients as participants due to fear and uncertainty regarding how to discuss

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		between 55 and 61 years old 4) Had from five to fifteen years' experience with hospice nursing 5) Broad range of nursing expertise and having advanced nursing degrees. -No other recruitment or inclusion/exclusion criteria was given.			individual structural analyses. -The interpretations were compared to strengthen the validity of analysis. -The themes were compared with the naïve reading to validate the structural analysis. -The themes were consistent with the naïve reading. This strengthened the validity of the analysis.	Science Data Service (NSD). 5)Participants gave their written consent. **Limitations:** 1) Small sample size, no assessments performed to describe what an effective sample size would be 2) The care workers were not asked for their assessment of the training. This could perhaps be a future study. 3)The interview process is lengthy lasting 80 min.	concerns and facing suffering.
Weisenfluh, 2012. United States of America.	-No theoretical/conceptual framework identified.	**Sample:** **-**Respondents were recruited through several social work professional list serves and websites. -The survey was posted to the NHPCO	**Sample:** **-**1169 practicing hospice and palliative social workers.	**Design:** -Quantitative study. Internet based survey. -Participants provided info. Regarding practice activities and agency	**Data Collection/Measurement.** **-**The survey instrument was designed specifically for this study of hospice. -Responses were indicated on a 5-point Likert type scale from 1	**Strengths:** 1)Large sample size. 2) The sample was not random and so the results are not generalizable to all hospice and palliative care social workers. **Limitations:**	**Results:** 1)Educational needs included: learning about the psychological and social needs of patients and families and psychosocial interventions.

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		e-groups via My.nhpco. -Several other active end-of-life social work list serves were also willing to post the survey, including the Social Work Hospice and Palliative Care Network (SWHPN) and a hospice and palliative care list serve maintained by personnel at Beth Israel Hospital. -Hyperlinks were provided for response to the survey and social workers were encouraged to send the link to other practicing professional social work individuals and groups.		characteristics, professional affiliations and certification, and ongoing educational needs.	not important to 5 extremely important. -The survey had a total of 40 questions and took approximately 15 minutes to complete. No surveys were excluded due to missing data.	1)Unable to calculate the response rate due to the multiple recruitment methods. 2)Selection bias as respondents from lists are often the most interested in staying current with the issues in the field and improving their practice.	2) Less than one-half (45.3%) of respondents indicated that they had attended a national conference related to their current work in hospice/palliative care. 3) The preferred educational formats for most were local or regional conference/ Workshops. Many also preferred printed materials and online courses. 4) Barriers to participating in continuing education were cost (84%), an inability to take time away from work to attend (50%), and lack of social work-related content in courses offered (32%). 5)Resources that these social workers used most often to enhance their current work were staff education (in-service workshops), locally sponsored workshops/

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		-The survey was available for a 3-week period during the month of July 2010.					conferences, journal articles, books, and online training. 6) The three content areas with greatest perceived need for continuing education and other educational programs in the field were the psychological and social needs of patients and families; psychosocial interventions that can ameliorate distress; the influence of dying on family dynamics; and cultural differences that impact the death experience.
White, 2013. United States of America.	-No theoretical or conceptual framework identified in the study.	**Sample:** In August 2010, a validated and replicated survey4,5 was mailed to 4022 HPNA members in all 50 states, Puerto Rico, and Guam.	**Sample:** -Total of 1234 completed survey's -Return rate is 31.2% - Of the 1234 completed surveys, 353 respondents, or 26.8%, provided qualitative responses.	**Design:** -Qualitative design. - inductive thematic analysis utilized. -Focus is gaining understanding of palliative nursing practice and competencies to	**Data Collection/Measurement.** **-**Data from members of the Hospice and Palliative Nurses Association (HPNA) in a larger survey project that examined nurse perceptions of palliative and EOL nursing practices was utilized.	**Strength:** 1)Large sample size. 2) Cohen 0, which is used to assess interrater agreement, was at least 0.89 for each theme for question 1, and at least 0.80 for each	**Results:** **-** Palliative nurses view end-of-life and palliative nursing competencies as a toolkit they draw upon based on the customized needs of patients and families rather than a ranked list of important skills.

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				learn more about the issues, concerns, and needs of these nurses.	- 2 open-ended survey questions aimed to better understand nurses' perceptions of palliative care practices, needs, and concerns. -Survey focus on symptom management, pain control techniques, how to talk to patients/families about death and dying, knowledge of palliative care, knowledge of hospice, dealing with your own feelings, recognizing impending death (physiological changes), ethical issues (pertaining to nurse's role), advanced directives, dealing with angry dying patients/families, legal issues (pertaining to nurse's role), and religious and cultural perspectives.	theme in question 2. The 0 scores exceed the recommended threshold required to demonstrate coder agreement. **Limitations:** 1)No identified theoretical or conceptual framework. 2)Large sample size, however, the return rate is rather low at 31.2% and for qualitative responses only 26.8%.	- Palliative nurses place importance on interpersonal skills on working with patients and families, physicians, and as a health care team. -Participants reported concerns about the level of palliative and end-of-life education of their health care professional colleagues. **Question #1** -5 major themes were identified: (1) ranking difficulty, (2) clinical knowledge and guidelines, (3) family training, (4) physician skills and relationship management, and (5) teamwork. -3 remaining themes included interpersonal competencies, including how to work with physicians, teamwork, and

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					-Responses were coded using NVivo 9 software with at least 2 members of the research team coding each question. -Multiple researchers conferred/contributed to data collection/analysis.		how to work with patients and families. **Question #2** -themes were categorized into 3 overarching areas: (1) concerns and needs, (2) intrapersonal and reflective statements, and (3) feedback from the field regarding organizational and regional practices and efforts related to EOL and palliative care. -Distinct themes emerged from this overarching category: (1) education concerns, (2) physician issues, and (3) access to care and other barriers.
Whittaker, 2014. Ireland.	-No theoretical or conceptual frameworks were identified.	**Sample:** **-** A purposive sample was taken from a freestanding Hospice in Northern Irelands Hospice's population of 33 community PC-CNSs.	**Sample:** **-**Final sample of 17 community PC CNS's.	**Design:** -A qualitative enquiry with a descriptive exploratory approach was used.	**Data Collection: Measurement:** **-**Researcher attended team meetings to discuss the study. **-**Packets given to participants including consent form and	**Strengths:** 1)Informed consent from all participants prior to the study. 2)Confidentiality was maintained as a unique identification code known only to the	**Results:** -3 main themes emerged from the analysis: influence of organizational culture, influence of the individual, and learning and development solutions.

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		Exclusions: -Those on maternity leave, retiring within the next 6 months, or working 15 hours per week or less were excluded. -To avoid selection bias, there were no other exclusions.		-Semi-structured interviews.	stamped, addressed envelope. -Interviews were audio-recorded, transcribed verbatim, and thematically analyzed. -A pilot test with one participant preceded the main study and some adjustments were made. -Data was coded with full researcher collaboration.	researcher was allocated to each participant. 3) Data was stored on a password-protected computer and written information was kept in a locked cabinet accessible only to the researcher. 4) In accordance, with the Data Protection Act (1998) and University of Ulster policy, the data will be destroyed in 10 years' time. 5)Approval to undertake the study was obtained through arrangements for Research Governance at the University of Ulster. -Permission to recruit staff for participation was obtained from hospice management. All local research governance procedures were adhered to.	- Having increased knowledge and skills enhanced their confidence and improved their working relationships with GPs. - Resource management affected the time available for the effective fulfilment of the role and the use of learning and development opportunities. -Identified personal characteristics either challenged or enabled individuals to priorities and value their own continuous learning and development needs. -Up-to-date evidence-based specialist knowledge and skills were deemed essential to working collaboratively, confidently, and competently.

First author, year, country where study was conducted	Theory/conceptual framework	Sampling method including: Where/how recruited. Inclusion/exclusion criteria	Sample size; # and size of groups. attrition	Study design; description of intervention, if appropriate	Data Collection/Measurement (give the name of scales and psychometrics). List Dependent and Independent Variables	Strengths and Limitations	Results of Study
						Limitations: 1)Small sample from one Hospice site may limit generalizability. 2)Insider knowledge may have impeded full disclosure of information by some. 3)Managers were not interviewed regarding their perceptions.	-Learning needs must be individualized in a cost-effective manner. -Learning was facilitated with experiential learning in practice settings, putting theory into practice, learning from others through role modelling, as well as gaining more role experience. -Formal education helped to consolidate and validate existing knowledge, skills, and experience and build confidence to fulfil all aspects of the role.
Zerwekh, 2002. United States of America.	-No identified theoretical/conceptual framework.	**Sample:** **Inclusion:** 28 Hospice nurses and supervisors were interviewed.	**Sample:** **-**28 Hospice nurses.	**Design:** **-**Qualitative Grounded Theory. -Constant comparative analysis.	**Data Collection:** **Measurement:** -Open ended interviews were tape-recorded and transcribed into written narrative. **-** Constant comparative analysis of interviews following transcription.	**Strengths:** 1)Sizable sample for a qualitative study. 2)Grounded Theory can provide theory development. 3)Authors described implications for future palliative education.	**Results:** -5 initial categories were identified. Barriers within the patient, physician, family, nurse, and within the healthcare system. -Two psychosocial processes were identified as

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					-Themes and subthemes were identified. -Preliminary categories were identified, and open coding was performed.	**Limitations:** 1)Demographic data for 3 nurses was lost. 2)One site only assessed may limit generalizability. 3)Ethical adherence was not described. 4)Limitations were not described by the authors.	foundations for the barriers: fear, and avoidance behaviors. -Difficulty qualifying pain due to impaired thought and attention. -Difficulty with narcotic pain management due to dynamic state of pain and side effects. -Challenges with the pain philosophies of the physician/family and nurse, as well as the healthcare system.
Perri, Giulia-Anna MD, 2016, Canada	-No identified theoretical/conceptual framework.	**Sampling Method**: - The sample comprised 35 PCU nurses working at a continuing chronic care facility in Toronto, Ontario, Canada. Inclusion: Thirty-one PCU nurses were included for the analysis.	**Sample Size:** 35 PCU nurses Attrition: 1	**Study Design:** single-center, descriptive, cross-sectional self-administered survey design Quantitative survey	**Data Collection:** - Ethical approval from the research ethics board at the CCC facility was obtained for this study. - The unit manager of the PCU explained the aim of this study and encouraged voluntary and anonymous completion within 2	**Limitations:** - Despite having a high survey response rate, the sample size was single centered, small and restricted to patients older than 55 years, thus reducing the generalizability of the results. - Perhaps the study was underpowered, as	**Results:** - continuing education related to pain management in ESLD is more important than years of experience or education level when it comes to pain management for patients with ESLD in a PCU. - Regardless

First author, year, country where study was conducted	Theory/conceptual framework	Sampling method including: Where/how recruited. Inclusion/exclusion criteria	Sample size; # and size of groups. attrition	Study design; description of intervention, if appropriate	Data Collection/Measurement (give the name of scales and psychometrics). List Dependent and Independent Variables	Strengths and Limitations	Results of Study
		Exclusion: - Questions regarding pain management in children, postoperative pain, and intravenous interventions were omitted because they didn't reflect current practices in the PCU - A small focus group of voluntary PCU nurses (n = 3), who were not included in the final sample of 35 nurses, developed survey items related to pain management knowledge for patients specifically with ESLD. - The m-NKASRP tool was subsequently pilot tested with another small group of voluntary PCU			weeks for all 35 nurses in the PCU. - Thirty-five empty paper surveys were made available in the PCU, with an information sheet attached to the survey explaining the aim of this study in written form. - Permission was given to the participants to withdraw participation at any stage. Measurement: -Data on the knowledge and attitudes of the nurses regarding pain management in patients with ESLD, was obtained using a modified version of the ''Nurses Knowledge and Attitudes Survey Regarding Pain'' (NKASRP) tool – as developed by Ferrell and McCaffery. Independent Variable: Included Sample	evidenced by the lack of significant findings concerning differences in scores by both experience and education level.	of years of experience or education level, interventions about pain management, even specifically for nursing in palliative care seems warranted. - PCU nurses have an inadequate level of knowledge and attitudes regarding pain management for patients with ESLD - The findings of this study provide important information about the inadequate knowledge and attitude in nurses regarding pain management for patients with ESLD - It is suggested that targeted educational programs and quality improvement initiatives in pain management for patients with ESLD could improve

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		nurses (n=3). The 3 pilot test survey results were not part of the final analysis.			Dependent Variable: nurses' knowledge and attitudes toward pain management		knowledge and attitudes for PCU nurses.
Pawlow, Patricia MSN, ACNP-BC, 2018, USA	No theoretical or conceptual frameworks were identified.	**Sampling Method:** Because of the difficulty in identifying and contacting HPC APRNs, we used several methods for recruiting respondents. First, we sent an email invitation to members of the HPNA Advanced Practice Nurse Special Interest Group (SIG) listserv (ca.1700 members) and the Pediatric SIG listserv (ca. 500 members). We also sent a link to the Hospice and Palliative	**Sample Size:** 556 Survey Responses. Respondents were mostly female (89.7%) and white (87.1%). Almost 60% were 50 years or older, and most (63.0%) had more than 20 years of nursing experience	**Study Design:** Online Survey Descriptive statistics were used to summarize multiple-choice responses	**Data Collection:** - We developed a 31-item online survey in consultation with experts in palliative care and APRN education. It covered the following domains: (1) work experience, (2) educational preparation, (3) licensure and certification, (4) practice population, and (5) barriers to practice. The authors piloted the survey among 5 APRNs to evaluate the clarity of the questions, determine the length of time for completion and address logistical issues with the online format.	**Strengths and Limitations: Limitation** -This study has important limitations. =Although we recruited respondents through several methods, we cannot be sure that our sample is representative of the HPC APRN workforce. = Using an electronic survey format distributed through emails to a professional organization may yield a sample bias. = New-to-practice APRNs may not yet qualify for certification and may not be associated	**Results of Study:** The workforce includes very experienced APRNs who are new to specialty HPC practice. Many respondents reported that their graduate education. did not provide adequate preparation for their HPC role, and they have sought additional education most commonly through professional organizations. - Most of these APRNs did not report barriers to becoming credentialed, obtaining a job in HPC, or state licensing for practice in their HPC role.

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		Credentialing Center's Certificate SIG listserv (ca. 1600 members). Recipients of the email link were encouraged to forward it to colleagues who were eligible to participate. Last, the survey email link was also distributed through the HPNA Graduate Nursing Faculty Council to alumni of graduate level palliative care programs (usually specialty tracks within a master's or Doctor of Nursing Practice program). Reminders were sent up to 3 times via the list and twice in the HPNA newsletter, which is			- Data were automatically entered and stored securely in an online Qualtrics (Qualtrics LLC, 2017) survey and database. Data were analyzed using the statistical package SPSS Statistics 24. Descriptive statistics were used to summarize multiple-choice responses. Content analysis was used to examine free-text responses. Two members of the research team first coded all narrative data independently, and then both reviewers looked at data together to identify common patterns and key themes.	with a professional organization so, this group may be underrepresented. - This survey was limited to NPs and CNSs because they are the only APRN roles that are currently recognized as qualified for specialty certification through the ACHPN certification examination. It is possible that APRNs in other specialty areas may have been missed Thus, despite efforts to recruit broadly, we do not know how representative our sample is. **Strengths** This national survey provides much needed baseline data for the HPC APRN workforce. Although these specialty	- Clinical nurse specialists were proportionately more likely to report barriers. -The most common challenges for both CNSs and NPs relate to the lack of understanding of the HPC role and regulatory/legislative restrictions on scope of APRN practice.

First author, year, country where study was conducted	Theory/conceptual framework	Sampling method including: Where/how recruited. Inclusion/exclusion criteria	Sample size; # and size of groups. attrition	Study design; description of intervention, if appropriate	Data Collection/Measurement (give the name of scales and psychometrics). List Dependent and Independent Variables	Strengths and Limitations	Results of Study
		sent to all Association members. The survey was anonymous; however, to encourage participation, we offered respondents the opportunity to participate in a random drawing for a paid 2-year HPNA membership. Respondents who wanted to be entered into the drawing provided an email address, which was not linked to their responses on the survey. Data were collected from October 2016 to January 2017. All procedures and measures were				APRNs face challenges similar to the larger APRN population, they have unique educational and regulatory challenges.	

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		approved by the University of Pennsylvania Institutional Review Board to ensure ethical conduct of research. 596 responses were received, of these 40 were blank and were excluded. Total 556 survey responses.					
Selman, Lucy Ellen 2018, England	No theoretical or conceptual frameworks were identified.	**Sampling Method:** **- Inclusion criteria** were practicing as a GP or training to be a GP. **How Recruited:** Practicing GPs were recruited in two ways: advertisement in the electronic bulletin to the CCG mailing list, and in-person by the researchers at the event on cancer in primary care.	**Sample Size:** 28 focus groups participants in five focus groups. - Mean length of the groups was 55 mins (range 35-82 mins). Participants comprised 18 trainees (8 ST1s, 3 ST2s, 7 ST3s) and 10 GPs (median years in practice 109, range 3-45). The majority were women (79%), with a median age of 32 (range 27-63)	**Study Design:** -qualitative focus-group study -Face-to-face semi-structured focus groups were con ductedwith trainee and qualified GPs.	**Data Collection:** Focus groups were facilitated by experienced researchers with academic backgrounds in palliative care and health psychology and an interest in the education of health care professions (LS or LB), following best practice [28]. Another researcher or research administrator (LB or LK) attended each focus group to take field	**Strengths and Limitations:** **Strengths:** - Our findings support other studies in highlighting the limitations of current end of life care education for GPs and their lack of confidence in this area, as well as educational needs relating to out-of-hours care, symptom control, non-cancer diagnoses, and	**Results of Study:** Four major themes emerged: (1) why education is needed, (2) perceived educational needs, (3) learning references, and (4) evaluation preferences. End of life (EoLC) care was perceived as emotionally and clinically challenging. Educational needs included: identifying patients for palliative care; responsibilities and teamwork; out-of-hours

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		Trainees were recruited in-person by the researchers during the away days. Maximum variation sampling aimed to capture diversity of age, years of experience, gender, and ethnicity. Exclusion: Data collection continued until data saturation was reached. Data saturation was reached after five focus groups, totaling 28 participants. **-Where Recruited:** Participants either worked at a CCG or were trainees completing their specialist training in a large UK city. Focus groups were held at			notes on environmental factors and non-verbal behaviors during and immediately after each group. The researchers and administrator were not known by participants and introduced themselves as academic researchers unconnected to the CCG or their training program. Guidelines including maintaining confidentiality, allowing all participants to speak and there being no right or wrong answers, were explained at the beginning of each focus group. The research was part of a wider study generating data to inform future training in palliative and EoLC and its evaluation. We defined EoLC broadly as care of	counselling. Where we add to the evidence is in identifying the need for practice-based mentorship and/or apprenticeship models in education in end-of-life care. We also describe specific educational needs around the identification and referral of patients for palliative care; roles, responsibilities and team working; local services and systems; and in pediatric palliative care. - A strength of this study is the diverse sample: clinicians ranging from junior trainees to experienced GPs, good representation from both genders, and participants of diverse ethnicities. **Limitations:**	care; having difficult conversations; symptom management; non-malignant conditions; and pediatric palliative care. Participants preferred learning through experience, working alongside specialist palliative care staff, and discussion of real cases, to didactic methods and e-learning. 360° appraisals and behavioral assessment using videoing or simulated interactions were considered problematic. Self-assessment questionnaires and patient and family outcome measures were acceptable, if used and interpreted correctly. - GPs require education and support in EoLC, particularly the management of complex clinical care and counselling. GPs value mentoring, peer-

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		convenient times and locations around existing events so as not to interfere with work or study schedules: one took place at a conference center where an event on cancer care in primary care was being held, one at the research department in line with the schedules of interested participants, and three at a residential conference center where an away day for trainee GPs was scheduled.			patients with incurable, progressive and life-limiting disease, and palliative care as a holistic approach to EoLC in line with the World Health Organization definition The topic guide was based on gaps in the existing literature and revised with input from the project team and lay advisory group (one patient with advanced disease and four family caregivers). To prompt discussion, during the focus groups participants were given handouts listing the topics covered in a current two-day training on palliative and EoLC held in a local and asked to reflect on which of these would be relevant or not for GPs. The focus groups were	- Participants were recruited in a major city, so the findings might not be directly transferable to non-urban areas or other countries, where access to education and educational needs will differ - GPs who participated in this study may also have had a particular interest in EoLC, and GPs with less interest may report different needs and experiences. In particular, GPs who did not attend due to lack of interest or time constraints may have even greater unmet and unknown needs. - Differences in the views of experienced GPs and GP trainees were identified and discussed; however, the study was	support, and experiential learning alongside EoLC specialists over formal training - Participants in general felt they had had sufficient communication skills training, despite still finding conversations about dying to be difficult. Perhaps what is needed is not more communication skills training, but qualitatively different communication skills training

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					recorded, transcribed verbatim and anonymized. Participants also completed a brief demographics form. - Transcripts and associated field notes were analyzed within a minimal realist paradigm using thematic analysis to describe the data and explore emerging patterns. This process comprised five stages: (1) Familiarization with the data and inductive coding of five transcripts to generate a draft coding frame. (2) Refinement of the coding frame with input from academic and clinical members of the project team; (3) Application of the final coding frame to all data.	not designed to compare these groups in detail;	

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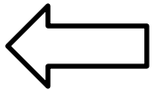
					(4) Independent dual coding of a sample of two transcripts by academic and clinical team members to assess inter-rater reliability and refine the coding frame. (5) Review of all coding and generation of a narrative summary, paying attention to deviant cases within each theme and differences between trainees and qualified GPs. Analysis was managed in QSR NVivo 10		

Elevators

Hospice in the

Basement

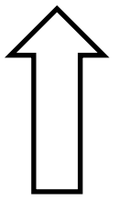


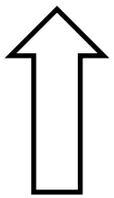
Chaplain Offices

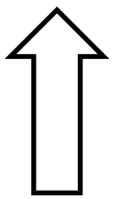
Multi-Faith

Chapel

Appendix J: Main Building Entrance/Lobby Map:

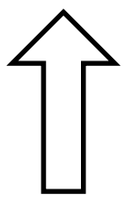




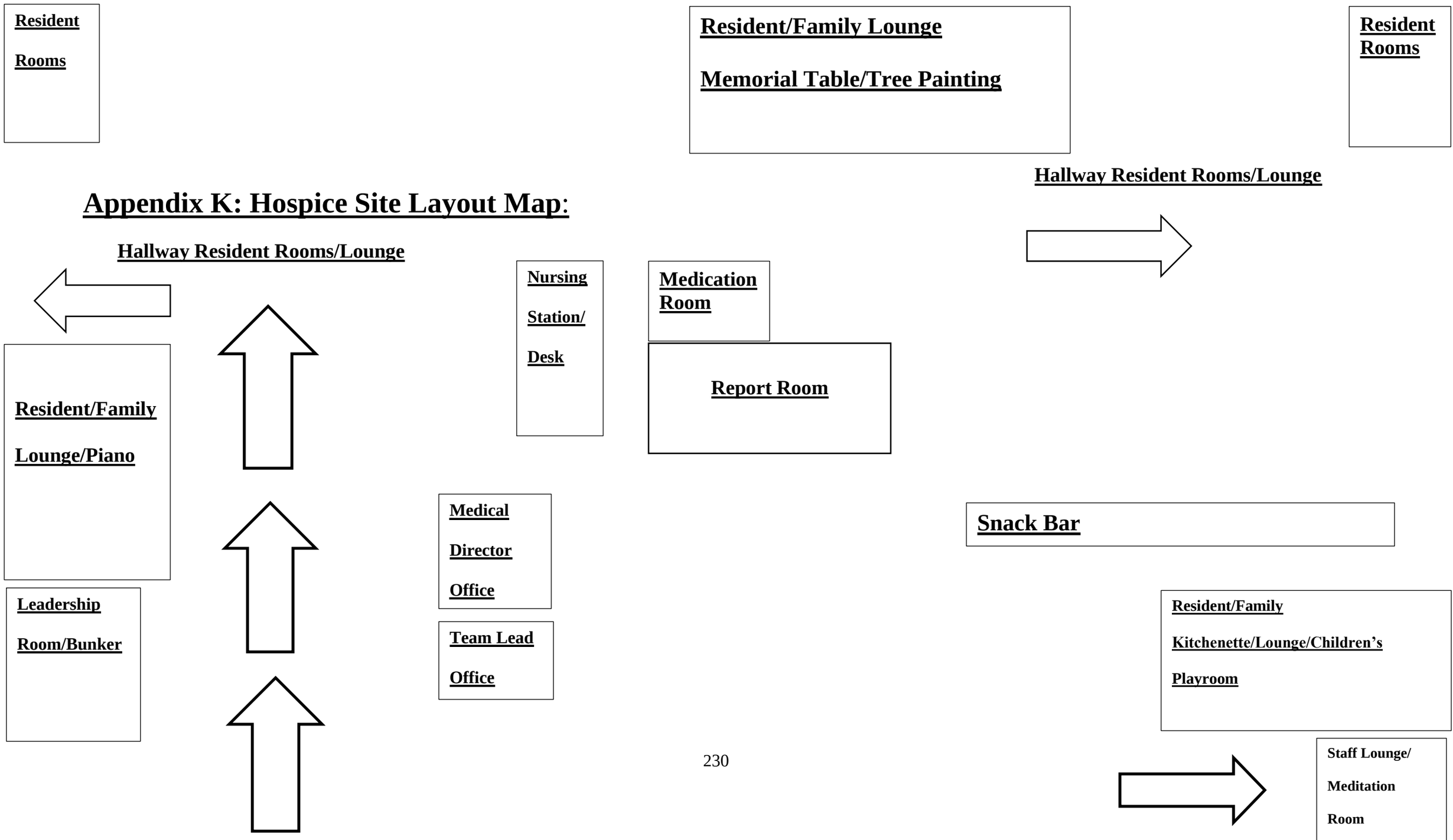


Lounge/Sitting Area

Front Desk/Reception



Appendix K: Hospice Site Layout Map:



Appendix L:

Recommendations for Education and Research

- **Education:**
- ***Interdisciplinary Team Collaboration***
  - Focus from the leadership of universities and government bodies.
  - Ensuring palliative/hospice care curricula are implemented across all health care professionals.
- ***Palliative care competencies and standards***
  - Continuous development for all palliative/hospice interprofessional health care professionals
  - Implementation in palliative/hospice curricula and practice/core competencies
  - Domains of focus such as communication, team collaboration, self-care, and relational care.
  - Beyond rote "skills." Communication and compassion are relational and require reflection and self-awareness beyond using traditional scripts and videos. Role for mentorship/individualization in end-of-life education.
  - Best practice models that integrate palliative/hospice care training and education for interdisciplinary teams that include volunteers.
- ***Communication***
  - Greater focus in palliative/hospice care on professionalism, sensitivity to cultural diversity and being mindful of others' viewpoints and beliefs.
  - Emphasis on mindful (purposeful, intentional) /contemplative communication to focus on holistic care (end-of-life) addressing aspects such as relational/spiritual and compassionate care.
- **Research:**
- ***Systematic Review***
  - Hospice/palliative cultures
  - Educational needs including understanding of what makes the hospice culture unique to other palliative care settings.
- ***Literature reviews: Palliative and Hospice Care Conceptual Findings***
  - Holistic care
  - Person/resident and family-centred care/relational care
  - Optimal communication
  - Mindfulness
  - Dignity
  - Compassion
  - Cultural sensitivity.
- ***Interdisciplinary hospice team functioning***
  - Effective communication, collaboration, and cohesion maintenance: within palliative and hospice communities and with the external community and stakeholders.
- ***Local multi-site research: End-of-life care cultures/ staff educational needs***
  - 6 Calgary hospices, unit 47 at the Foothills Medical Center and Palliative Home Care
  - Non-dedicated end-of-life care settings such as general hospital units, intensive care units, nursing homes, and oncological care sites.
- ***Expansion of research to other communities in Alberta and Canada. Needs identified in provincial and national palliative/end-of-life frameworks (AHS, 2014; Canada, 2018).***

Appendix M:

▶ **Study Conclusions:**
▶ **Focused Ethnography: to explore hospice staff educational needs via a cultural lens.**
▶ **The study revealed:**
▶ Well-known Palliative/hospice staff learning needs.
▶ Innovative relational educational needs instead of operational needs based on these specific priorities.
▶ **Educational needs of the hospice staff included:**
▶ Communication being a central thread that precedes all other educational needs.
▶ Relational care, and hospice staff team functioning including self-care of the team members.
▶ The central philosophy of resident and family centered care is a hospice primary focus and educational need.
▶ **Unique finding: Hospice culture shapes the educational needs/practice.**
▶ Care provided involves all hospice staff interdisciplinary team members.
▶ Includes volunteers and community stakeholders.
▶ **Profound features from the hospice culture:**
▶ Liberal values such as equality & inclusion
▶ Spiritual aesthetic beauty in the hospice inspires the dying/families to explore the divine/sublime aspects of life and family histories as time on earth ends.