CONTINUING EDUCATION IN PALLIATIVE CARE NURSING: AN EXPLORATION OF PERCEIVED OUTCOME AND FACTORS INFLUENCING APPLICATION OF LEARNING

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ABSTRACT

Many inadequacies have been identified in the delivery of palliative care in the acute hospital setting and in the provision of palliative care education. The provision of such education has tended to be sporadic and uncoordinated. Recently, more structured courses for nurses have been available. However, little attempt has been made to evaluate the outcome of formal teaching in this area.

This study explores the perception of outcome of registered nurses who have undertaken the Professional Studies II Course in Care of the Terminally Ill Patient. Questionnaires, semi-structured interviews and the Critical Incident Technique were used to collect data on the application of learning and factors which influenced this.

Most participants considered that the course was very beneficial to their own personal development and to their clinical practice. The confidence derived from their perception of enhanced knowledge of symptom control and communication skills were the main enabling factors. They perceived an increased ability to respond to and cope with the expression of intense emotion. They also acquired the confidence to act as an advocate for patients and relatives. As such they were able to ensure that symptoms were more adequately controlled and that information needs were met.

Factors which limited their ability to apply learning and influence practice were mainly related to lack of interest and support in the work environment. The ability to argue their case from a sound knowledge base succeeded in swaying the opinion of some medical staff. However, in some respects there was more resistance from nursing colleagues.

The study concludes that the impact of Continuing Professional Education in Nursing could be enhanced by:

1. identification of a 'facilitator' in the work environment. This person could ensure that the objectives of the potential candidate and the institution were compatible and help to prepare the candidate for attendance. They could also provide support and encouragement to apply and share their learning on return from courses;

2. development of closer links between the facilitator or manager and these course providers;

3. more preparation of the participants by the course providers to institute change and cope with conflict.

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AUTHOR'S DECLARATION

The author declares that this thesis contains no material previously published or written by another person except where due reference is made in the text of the thesis. Part of this work has been presented at the 1992 meeting of the Palliative Care Research Forum. Apart from acknowledged collaboration the work reported in this thesis was solely performed by the author.

LIST OF ABBREVIATIONS

CANO	Chief Area Nursing Officer
CIT	Critical Incident Technique
CPE	Continuing Professional Education
CRMF	Cancer Relief Macmillan Fund
DNE	Director of Nurse Education
ENB	English National Board for Nursing, Midwifery and Health Visiting
NBS	Scottish National Board for Nursing, Midwifery and Health Visiting
NHS	National Health Service
OPCS	Office of Population Censuses and Surveys
PREPP	Post-registration Education and Practice Project
PSI	Professional Studies One
PSII	Professional Studies Two
UK	United Kingdom
UKCC	United Kingdom Central Council
WHO	World Health Organisation

CHAPTER 1 - INTRODUCTION

This study is concerned with the outcome of a post basic nurse education programme in care of the terminally ill. The stimulus to study such an area arose mainly from personal experience of Continuing Professional Education (CPE) programmes in nursing and of nursing dying patients in acute hospital wards.

Attending continuing education courses often left me feeling frustrated at being unable to instil the same enthusiasm in my colleagues or to make lasting changes in practice. I also thought that the integration of theory and practice might be easier if follow-up support for staff undertaking CPE was available.

Examination of the outcome of CPE in general is a very broad area. For practical reasons I decided to concentrate on a specific area of nursing for the purpose of this study.

Care of the terminally ill became the focus for several reasons. First, it was caring for those patients who were dying which I had found the most demanding and difficult while working as a gynaecology/oncology clinical nurse specialist. Such situations aroused feelings of inadequacy. Attempting to meet the needs of dying patients and their families seemed particularly difficult in an acute care environment.

Secondly, I recognised the important role that education would have to play in ensuring that quality of care for the dying patient is available in all care settings.

Thirdly, palliative care is a very recent but rapidly developing speciality. Consequently, there has been a great demand for education in this field, little of which has been evaluated. Shortly before the project began, one of the Glasgow Colleges of Nursing mounted a CPE programme in Care of the Terminally Ill Patient. This was the first course of its kind to be approved by the Scottish National Board for Nursing, Midwifery and Health Visiting (NBS), the regulating body for

all nurse education in Scotland. This course became the focus of this study.

I hoped that this study might demonstrate the extent to which the course was successful in influencing this complex area of practice. I also hoped to identify ways in which the introduction of newly acquired knowledge and skills into practice could be facilitated. This could be very beneficial to both practitioners and managers in maximising the potential of staff and the cost effectiveness of CPE.

Terminology

Although the course title refers to terminal care, this should be seen as part of the philosophy of palliative care. The difficulties in defining these terms are discussed in the text. It should be noted also that much of the research in relation to palliative care has concentrated on the cancer patient. However, many non-cancer patients require a similar approach to care.

CHAPTER 2 - LITERATURE REVIEW

2.1 INTRODUCTION

The following literature review explores three main areas - palliative care nursing, education and application of learning. Within these areas there are several key topics.

Palliative Care Nursing

In view of the extensive influence of the hospice movement on the way dying people are cared for, the first section gives a brief history of the origins and concept of the modern day hospice movement. Some attempts to evaluate hospice care are also reported.

The following section draws on the literature in relation to the nature of palliative care as it has developed from the hospice movement. This serves to illustrate the complex nature of palliative care nursing. It also demonstrates the ideals to be achieved in palliative care education. The provision of palliative care is discussed with particular reference to the hospital setting. This reflects the important role of the acute hospital in the provision of palliative care and is particularly appropriate in view of the fact that the study was stimulated by the author's experience of caring for dying patients in acute hospital wards.

Education

The third section explores the need for palliative care education and the adequacy of the current provision in response to growing demand. Mainly drawing from American literature, CPE for nurses is then discussed in a more general sense. Evaluation of CPE, the approaches adopted and some of the associated difficulties are explored. Methods of evaluating the impact of CPE on practice are reviewed with the purpose of providing a framework for the study.

Application of Learning

The degree to which the content of educational programmes is applied in the clinical setting determines the success of CPE. Yet there has been little attempt to study this, particularly in the UK. A small number of studies examining factors affecting application are discussed. Reference is also made to the literature in relation to implementation of change, especially as it pertains to the integration of newly acquired knowledge and skills.

2.2 THE HOSPICE MOVEMENT

The word "hospice" is derived from the Latin "hospes" meaning both a host and a guest. Originally "hospice" was the term used for a place of refuge and rest for weary travellers. The term first became associated with care of the dying in France in the mid nineteenth century (Lewis, 1989). In 1879 the Irish Sisters of Charity opened a home for the dying in Dublin. They called it a hospice because they considered death to be the beginning of a journey (Lamerton, 1983).

The same order of nuns later opened St Joseph's Hospice in London in 1905. It was here that the pioneer of the modern hospice movement, Cicely Saunders, was appointed as the first Medical Officer. Trained as a nurse, then a social worker before becoming a doctor, she went on to establish St Christopher's Hospice in 1967. This was the first research and teaching hospice (Lewis, 1989).

Employment as a social worker at St Luke's Home for the Dying was Saunder's first meaningful professional experience with dying patients. This made a major impact on her thinking regarding terminal care. It was here that she learned the two principles which provided a basis for the delivery of care in St Christopher's. First was the value of regular administration of analgesia to prevent pain. Secondly, she learned from the nuns that "Feelings are facts in this house" (du Boulay, 1984; p72).

It was here also that she developed a close friendship with David Tasma, a dying patient. She recognised that he needed skills which

were not available then. Even more he needed a sense of belonging. The two had long discussions about the need for homes for people who were dying. When he died, he left £500 to be "a window in your home" (du Boulay, 1984; p58).

Close observation and involvement with her patients and the Sisters of St Luke's and St Joseph's taught Cicely Saunders many things. As a result, she pioneered improvements in pain management, control of other distressing symptoms, family support and the use of volunteers, especially in bereavement support (Lamerton, 1983). It was in recognition of her work at St Christopher's that she later received the honour, Dame of the Order of the British Empire.

Caring for David Tasma and other experiences with dying patients shaped the philosophy of St Christopher's and the modern hospice movement. Dame Cicely listed the principles on which her hospice was firmly established (Saunders, 1978). These are summarised below.

- Maximising potential - enabling patients to live until they die, independently and in control.

- Place of choice - delivering care in the most appropriate setting for each individual.

- The patient and family as the unit of care - not only supporting the whole family but also welcoming them as an integral part of the caring team.

- Bereavement follow-up of those identified as having special need.

- Competent symptom control - allowing time left to be used to the full and leaving pleasant memories for the family.

- A clinical team experienced in symptom control and supportive interventions.

- Supportive team nursing - with confident and supportive leadership to plan and maintain excellence in symptom control to the end.

- An interprofessional team - to meet the wide variety of needs.

- A home care programme - of skilled support in the community bringing increased confidence and flexibility.

- Methodical recording and analysis - to evaluate clinical experience and develop soundly based practice.

- Teaching in all aspects of terminal care - to stimulate interest, pass on specialised knowledge and skills and allow experience to be gained.

- Imaginative use of the architecture available - to meet the patient and family need for privacy, space to walk around and for staff to take 'time out'.

- A mixed group of patients - who need more personal and less technical care than is given in the acute general ward.

- Supportive administration - instilling confidence of patients, families and staff.

- The search for meaning - with opportunities to share the strain and questions which cause much emotional pain among patients, families and staff.

Dame Cicely acted as the catalyst for the birth of the modern hospice movement in Britain. She was aided by the prevailing social and political climate. The philosophy proclaimed by St Christopher's in 1967 was a much needed antidote to the disillusionment felt by many at that time. A "relentless pursuit of cures" by the medical profession and a tendency to neglect the incurable fuelled this need (Hillier, 1983; p320).

There was also an upsurge in literature in relation to death and dying around this time. Most of these writings originated in America, giving rise to what has been termed the "Death Awareness Movement" (Kastenbaum, 1981). The prevailing attitude, that death was a taboo subject, was challenged by writers such as Kubler-Ross (1970) and Feifel cited by Mount, Jones and Patterson (1974). Feifel coined the term "conspiracy of silence" in describing the tendency to withhold information from people who were dying. He advocated that "Honesty and a sustained sense of reality tend to be more supporting and beneficial to the patient than deception and denial". Such an approach is fundamental in the hospice movement.

Contribution of others

Other inspired individuals have also had an important part to play in developing services for dying patients. In 1911, Douglas Macmillan founded the National Society for Cancer Relief following the death of his father from cancer (Lewis, 1989). The Society set out to provide help and support for cancer sufferers. It later became known as The Cancer Relief Macmillan Fund (CRMF). In 1972 the Douglas Macmillan Home was opened in Stoke-on-Trent. This was the first hospice to be backed by the charity. Many more were to follow.

Another important development was the establishment of the Marie Curie Memorial Foundation in 1948. Squadron Leader Bernard Robinson founded the charity with the help of friends (Lewis, 1989). The idea for the Foundation grew from a conversation between Robinson and Winston Churchill. This concerned the number of British lives lost throughout the Second World War - relatively small by comparison to the numbers dying from cancer annually (Hodgkin, 1985). Robinson decided to accept the daunting challenge to take on cancer as the new enemy. A fund was set up to help in the battle. The first task of the Foundation was to investigate the existing care of cancer patients and to determine where the need was greatest. As a result, an urgent need for residential homes was identified.

This report also influenced Cicely Saunders. She used the findings to strengthen her arguments for establishing St Christopher's Hospice, quoting them in her paper entitled "The Need" (du Boulay, 1984).

The development of the hospice movement has been supported by numerous, sympathetic charitable organisations such as the Marie Curie Memorial Foundation and CRMF. All have worked towards meeting needs which were being ignored by the statutory services and avoided by the general public who preferred not to think about death (Young 1981). The hospice movement has shown that patients, for whom cure is not possible, are more than merely end products of medical failure (Ainsworth-Smith and Speck, 1982).

St Christopher's effectively demonstrated what could be achieved. "Its impact on the care of the dying has been dramatic both in terms of the number of patients helped and of doctors and nurses inspired (Hillier, 1983 p322). Today it is acknowledged world-wide as a centre of excellence and teaching in care of the terminally ill.

Hospice Care Today

The hospice environment tends to differ in appearance from that of traditional hospitals. In the latter, managers have only recently recognised the therapeutic effect of pleasant surroundings (Mohun, 1989). Hospices are more likely to be bright, cheery, homely and relaxed, lacking in hustle and bustle, technical equipment and charts. "Large windows ... give a feeling of unity with the living world" (O'Connor and Gleeson, 1989; p235). The environment is likened to an extension of home (Campbell, 1989). The atmosphere is intended to be therapeutic for patients, relatives and staff. However, the ambience of the hospice is not only due to the decor. "The essence of good care .... is in the attitude of the staff who provide it" according to Ford (1978;p177).

Those who work with the hospice movement are anxious to stress that a hospice is not just a building. It represents a way to care; a philosophy "rooted in honesty, open communication, sensitivity to the needs of patient and family .... and a willingness to sometimes 'be

with' patients, rather than always needing to 'do things' for them" (Stott, 1986;p30). It requires that someone who is dying be treated with the same respect and consideration as would a healthy person. A hospice has been defined as "a community of people devoting their time exclusively to the care of dying patients, and sometimes the frail elderly and chronic sick or disabled as well" (O'Connor and Gleeson, 1989; p234).

Consequently, the provision of hospice care is not restricted to the confines of a building. It reaches out to wherever there are patients who need this special type of care. It therefore takes many forms, depending on the local need. These include the following services (Directory of Hospice Services, 1991).

- Inpatient units run independently and funded by charitable monies or by the National Health Service (NHS), or a combination of both. Fifteen inpatient units currently provide 263 beds in Scotland.

- Home Care Services extend the availability of expertise to the community. Staff who are specially trained in aspects of symptom control and in meeting the psychosocial needs of cancer patients and their families complement the care provision of the Primary Health Care Team. Such staff are generally nurses but may comprise a multidisciplinary team. There are twenty such services in Scotland.

- Hospital Support Teams function in a similar advisory and supportive role within five Scottish hospitals. Most teams comprise two or more nurses and many are multidisciplinary.

- Day Hospices in ten units allow patients to remain at home while having continuing contact with the facilities and expertise of the hospice. They also provide some respite for caring relatives.

The charitable organisations have had considerable influence in the expansion of hospice services. CRMF, which plays a vital role in the

planning and provision of services to patients with cancer and their families, works alongside the professional carers. CRMF is perhaps best known for its establishment of Macmillan Nurse posts. These were introduced in the early 1970s. There are now over 800 Macmillan Nurses in the UK (figures not yet published). Some of these are developing new roles in specialised areas or in different care settings. CRMF also provided the initial funding for the first Regional Nurse Adviser posts in 1988. The advisers' remit is to review and plan cancer care for particular regions (Scott, 1989).

The Marie Curie Memorial Foundation also plays a key role in this field. It now manages eleven homes, providing skilled nursing and rehabilitation for cancer patients. Marie Curie nurses are vital contributors in care of dying patients at home. They provide much needed services such as sitting with and caring for patients during the night to allow relatives some respite (Lewis, 1989). Financial support for cancer patients and their families is also a function of the Foundation.

Just as the principal charities supporting hospice type care are associated with cancer patients, this is the group of patients mainly served by hospices. It is recognised, however, that the intensive nursing and interpersonal skills involved in hospice care are applicable to more than only patients with cancer. Therefore, many units accept patients with other diseases which are severe and progressive, for example motor neurone disease. In the 1991 Directory of Hospice Services, 65% of hospice inpatient units in the United Kingdom and Northern Ireland indicated a willingness to care for patients with motor neurone disease. Nevertheless this acceptance is sometimes only extended to short term respite care (Goddard, 1990).

The benefit of hospice care has been acknowledged in a number of reports (Wilkes, 1980; Taylor, 1983). Although in an ideal situation to study the strategies employed in caring for dying people, systematic evaluation has been undertaken infrequently. This is particularly true in relation to nursing care. Thomas (1988) implies that this may be because nurses feel that research is incongruous with the philosophy of hospice care and may be distressing to dying patients. Several

researchers argue that the converse is true. Hinton (1963) observed patients to be relieved by sharing their concerns and cheered by the companionship of the researchers during interview sessions. Likewise, bereaved relatives who were interviewed in Parkes' study (1978) appeared "glad of the opportunity to talk about this period of their lives".

The hospice movement has been accused of complacency and failure to systematically evaluate the outcome of interventions in terms of which are most appropriate in different situations (Vachon, 1988). Poor documentation and an apparent lack of clear and measurable objectives in relation to psychosocial aspects of care was reported by Vachon.

While acknowledging the need to evaluate the provision of care in the hospice setting, Mount and Scott (1983) argue that the value of such evaluation is limited. Their rationale is that no tools exist which can effectively measure its impact in terms of, for example, the sense of personhood it can bring, likening it to measuring the value of a smile.

Evaluation of hospice care has tended to be reductionist in nature. Isolated components have been examined, rather than the impact of the whole. The limited research undertaken suggests that hospice care is superior to conventional care in terms of controlling pain (Mount and Scott, 1983). This is not consistent with more recent findings (Parkes, 1985). Control of pain by the hospice was significantly better than that of hospitals when studied in 1967-69. Little difference between the two was evident ten years later. Parkes considers this to be an indication of successful dissemination of pain management skills from the hospice to other settings.

Hinton (1979) reported hospice patients as being less depressed and anxious, preferring the more open communication of the hospice setting. This was concluded following interviews with 80 married patients who were receiving care in either a home for cancer patients, a hospice or a group of four radiotherapy wards. The three settings were selected because of their reputations for high quality care. Therefore, they were not representative. The study sought to measure levels of patient

anxiety and depression in each setting. As a result patients with physical distress were excluded from the study. Hinton's findings have been supported by more recent research (Kane, Wales, Bernstein, Leibowitz and Kaplan, 1984).

Care of patients in the hospice setting has not been shown to be better than that provided elsewhere. However, the hospice has been rated higher consistently in terms of patient and relative satisfaction (Kane et al, 1984; Parkes, 1985; Dawson, 1991; Seale, 1991). In addition, an assessment of grief resolution in bereaved spouses demonstrated significantly better adjustment in those whose partner had died in hospice when compared to those dying in hospital. After a period of one year the hospice group were less depressed and anxious and less socially isolated (Ransford and Smith, 1991).

In comparing hospice with hospital care, it is important to remember that the hospice has some distinct, basic advantages. Hospice staff have been chosen for their specific qualities in this area and for their motivation. The concentration of terminally ill patients in one area allows further development of these qualities and expertise. There are no conflicting demands of acutely ill and dying patients. The workforce tends to be stable. The therapeutic environment, supportive management and good relationships with colleagues who understand the difficulties, help staff to cope with the effect of numerous losses (Hillier, 1983).

Care provided in the hospice setting is generally believed to be of high quality (Parkes, 1985; Johnson, Rogers, Biswas and Ahmedzai, 1990). However, wide variations in the services performed by units classed as hospices have been reported. In terms of throughput and discharge rates, the variations were so wide that the authors wondered if the only common factor was the title of hospice.

However, hospice placement is available only to a minority of dying patients. It may be undesirable for others. Approximately 7% of all deaths (Lunt, 1982) and 7% of cancer deaths (Walsh and Kingston, 1988) occur in the hospice setting. This has not altered over the years as a

deliberate restriction on bed numbers in each unit has enabled hospices to maintain a homely, therapeutic environment.

Further increase in the number of specialised units which are separate from the mainstream of healthcare is considered undesirable (Wilkes, 1980). Wilkes argues that this may inhibit the dissemination of knowledge and skills to other areas and that there is "something unhealthy with any society which felt the need to hide dying patients away in separate institutions" (Wilkes, 1980; p9).

Although not the only institution which undertakes care of the terminally ill, hospice care is the only specialty which provides comprehensive terminal care in a concerted fashion (Levy, 1988). By serving as a model of care the hospice has challenged the predominantly negative attitudes to care of the dying (WHO 1989).

Summary

The modern hospice movement has grown rapidly since it began with the opening of St Christopher's in 1967. Services have expanded and developed in response to patient need and public demand.

Hospice care has become firmly associated with care of the dying (Nahat, 1991). It has significantly influenced the way dying patients are cared for in all settings (Hillier, 1983). Even so, it is recognised that the care involved is appropriate not only for those who are very close to death. Many aspects of hospice type care can be incorporated into curative management of disease (WHO, 1990). There is a need to identify the nature of care involved. There is also a need to dissociate it from the idea of imminent death. This has perhaps been one reason for the increasing use of the term 'palliative care' in preference to 'hospice' or 'terminal' care. The next sections look at the concept of palliative care, its development as a speciality and the response of health care professionals.

2.3 PALLIATIVE CARE

Definition

The origins of palliative care are firmly rooted in the hospice movement (WHO, 1990). However, palliative care is a term which has come into regular usage only in recent years. Numerous attempts to define it have failed to produce a universally agreed definition (Scott, 1988). The word "palliate" is derived from the Latin palliare, meaning "to cloak". It is defined in the Concise Oxford English dictionary as "to alleviate without curing".

One of the difficulties in discussing palliative care is the tendency to use the terms terminal care, palliative care, hospice care and care of the dying interchangeably. The problem in agreeing definitions does not lie in the type of care involved; a similar philosophy applies to each. The difficulty arises in perception of the timespan involved. For example if someone has an incurable and progressive disease, appropriate palliation may enable them to live a relatively normal life for months or even years. Describing such a person as dying or terminally ill would be inappropriate. It has been suggested that an illness should only be defined as terminal when death can be expected "within an anticipated period of time" (Nahat, 1991;p6). The appropriate time scale suggested being within twelve months.

Palliative also tends to be used to reflect a more positive, active approach than is suggested by use of the word terminal. However, terminal care or care of the dying could be considered to be part of the continuum of palliative care.

For the purpose of this study the definition of palliative care is accepted as that offered by a World Health Organisation (WHO) Expert Committee (1990). "Palliative care is the active total care of patients whose disease is not responsive to curative treatment" and in which the "control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount", the goal being "the best possible quality of life for patients and their families" (WHO, 1990; p11).

Philosophy of Palliative Care

The same basic philosophy is common to both palliative care and hospice care. Any differences reflect the organisation of care within the hospice institution. Therefore, when referring to the values and standards which form the basis of the philosophy, the term palliative care will be used in this study.

The components of the WHO definition which capture the somewhat nebulous concept of palliative care are first the "active" nature of management. Palliative care is not considered a poor substitute for curative treatment. One does not wait passively for the patient to die. The essence of palliative care is to encourage maximum independence and control within the patient's capabilities by setting realistic, achievable goals in conjunction with the patient and family (Lunt and Neale, 1987).

The second important point is the "total care of patients". Endeavouring to meet the needs of the body, mind and soul in unison is the cornerstone of palliative care (Charles-Edwards, 1983). The individualised, holistic or whole person approach is person rather than disease-centred.

Thirdly, that the patient's "disease is not responsive to curative treatment" identifies the patient group with which palliative care is concerned. So often writings on palliative care focus on the cancer patient. That no specific disease is mentioned is in keeping with the principles of hospice care (Saunders, 1978). Levy (1988) also states that "it is the special needs and conditions surrounding the care of this patient-family unit that makes palliative care a distinct discipline or specialty", not the disease itself.

Fourthly, "the control of pain, of other symptoms, and of psychological, social and spiritual problems" draws attention to the need for therapeutic intervention. This stresses the active approach to care of all aspects of the patient. Such intervention requires a clearly defined strategy. Also needed are assessment skills, a high degree of knowledge of the often complex underlying pathological

mechanisms and the appropriate strategies for management and open communication with the patient and relatives (WHO, 1989).

The goal of the "best possible quality of life for the patient and family" reflects the need to actively increase the capacity to enjoy life. The perception of quality in life is very individual and will only be achieved by attainment of patient and family-centred goals (Calman, 1987).

Finally, the inclusion of the family in the definition signifies the importance of their role. The family also need care and support during the patient's illness and continuing into the bereavement period. Family and friends provide an invaluable source of support to the patient. This can be enhanced by encouraging them to feel they are an integral and valued part of the caring team (Saunders, 1978; Hampe, 1975).

Another important feature of palliative care not specifically mentioned in the definition is that of a multidisciplinary approach. Palliative care has always been considered an important part of nursing. In the past, when cure was no longer deemed a reasonable expectation, medical interest often declined, leaving the care to nursing staff (Saunders, 1978; du Boulay, 1984). This tendency still persists in some quarters (Mills, 1983).

Palliative care follows an holistic nursing model which emphasises care of the whole person and of the family. This is most effective when carried out by a well co-ordinated, multidisciplinary team (Scott, 1988). To meet the multitude of needs likely to be identified and to achieve whole patient care, the skills of many professionals and disciplines may require to be incorporated (Saunders, 1978). Consequently, care of the whole family and the role of the nurse within the context of a multidisciplinary team are important themes of the PSII modules (Appendices 7,8 & 9).

The large body of writing concerning the philosophy of palliative care is based upon many years of experience in caring for dying patients and a willingness to learn from such patients and their families. The

complexity of palliative care makes it difficult to explain in a few words. Perhaps the most simple and concise description of the aims of palliative care are captured by Scott (1988) when he writes that it should provide "freedom from pain, emotional and spiritual tranquillity, a sense of worth and dignity, and, finally, at the end, a hand to hold".

Palliative Care Provision in the Acute Hospital

Evaluating the care of dying patients in the hospital setting is problematic in several ways. Selection of patients is a problem because, outwith the hospice setting it can be difficult to determine prognosis or to define "dying" (Mills, 1983). In addition, patients in the hospital setting are not confined to one area. Each ward may have one or two dying patients at any one time (O'Neill, 1989). Any research has to be carried out over a wide area and there may be difficulties in controlling variables or in making comparisons.

Another problem which is common to all care settings is that as the patients die, the numbers under study are continually being depleted. These difficulties may provide some explanation for the dearth of research in this area. Another contributory factor may be related to attitudes to death and dying being perceived as a low priority in the acute care setting. However, further exploration was not possible as part of this study.

Nonetheless, research suggests that those with an illness which is not responsive to curative therapy experience more or exacerbated difficulties than those whose disease is amenable to cure. In addition, the needs of patients with a terminal illness are more likely to remain unmet, even in an environment with professional carers readily available.

In Hinton's study (1963), 102 patients considered likely to die within six months were interviewed weekly while in hospital. Most of the patients within this study group had malignant disease. A control

group, comprising the same number of patients who were expected to recover, were also interviewed. Each patient in the study group was paired with a patient who was under the care of the same consultant and was being cared for in the same ward. As far as possible patients were comparable in terms of age, social circumstances and the site of the disorder. For example, a patient with bronchial carcinoma might be paired with another with bronchiectasis. The severity of the illness was also considered. Some of the control group were seriously ill. Three of these died during the course of the research.

The symptoms which predominated were pain, dyspnoea, nausea or vomiting, malaise and persistent cough. Physical distress of all kinds was more predominant in patients who were not expected to recover. Not only did symptoms occur more frequently, but they were much less likely to be relieved. There was a tendency for such symptoms to increase in the last week of life. Contrary to other findings (Cartwright, 1991), most unrelieved physical distress was experienced by those patients dying of heart failure and/or renal disease (57%) and not cancer (26%).

In terms of psychological distress, the dying patients had a significantly higher incidence of depression and anxiety than the control group. Depression was more common when there was physical distress, particularly of a prolonged nature.

A number of other studies have reported inadequacies in provision of palliative care in hospital settings. These have been in relation to poor symptom control, pointless overtreatment and uncaring attitudes (Wilkes, 1984), disclosure of information (Wilkes, 1984; Townsend, Frank, Fermont, Dyer, Karran, Walgrove and Piper, 1990) and lack of knowledge regarding available support (O'Neill, 1989).

A more recent study involved the examination of problems experienced by patients with terminal cancer in a university hospital. This led to the introduction of a Hospital Support Team in an attempt to overcome the inadequacies identified (Simpson, 1991). A medical and nursing team carried out interviews with 78 patients who had "malignant disease where treatment has moved from curative to palliative". During the interviews patients were asked to rate their pain and whether there had

been an improvement since admission. They were also asked to list the three problems which distressed them most. The patient records were examined to determine the treatment which had been given.

This study had the advantage of being prospective, involving the perception of the patients themselves and the ability to check treatment details in the notes. The findings support others in the incidence of multiple, unrelieved problems (Hinton, 1963; Hockley, Dunlop and Davies, 1988). Only one symptom was reported by 15% of patients. Two or three were reported by 44% and four or more by 36%. Pain proved difficult to control in 63% of patients, other symptoms in 60%. In most of these cases it was considered that control could have been greatly improved by very simple measures, such as increasing the dose of analgesia or by administering analgesia on a regular basis.

Many distressing problems went unnoticed or untreated by staff. Fewer than half the patients who complained of nausea or vomiting were prescribed antiemetics. Only half of the patients on regular opiates, known to cause constipation, were prescribed laxatives and of the twenty-one patients complaining of constipation only six were treated. The research team concluded that there was a total lack of a coordinated service in the hospital for patients who were terminally ill and an apparent deficiency in education in staff of all levels.

A pattern of under-reporting symptoms by dying patients has also been observed by Maguire (1978) and Doyle (1984) who claim that symptoms reported by the terminally ill are the "tip of the iceberg". Greer (1985) suggests that anxiety and depression in cancer patients often goes untreated because many doctors view these symptoms as natural, understandable consequences of the disease and thus not reasons for intervention.

It has been postulated that failure to identify and address the problems of dying patients is related to the use of distancing tactics by staff as a coping mechanism. Faulkner (1984) and Maguire (1978) suggest that feelings of inadequacy in dealing with difficult questions or problems which may be identified if the opportunity is given, cause staff to deliberately block meaningful dialogue with patients.

Grof and Halifax (1977; p7) state that "The contemporary medical approach to a dying person is dominated by a determined effort to conquer death and delay its advent by all means possible" and that death is a "a painful reminder of the limits of our ability to master nature". The professionals' own fears and inability to accept death as anything other than failure have been contributory factors in the complicated games of charades and silent conspiracies which are associated with dying (Jeffree, 1990).

While nurses may be less inclined to view dying as failure, Mills (1983) reported a strong tendency for hospital nursing staff, including the ward sister to follow the consultant's example in how dying patients were cared for. The wards used in Mills study were selected as suitable by nurse managers and therefore may not be representative of acute care wards, but were spread throughout six major hospitals. It is to be hoped that their selection was not on the basis that they were thought to be examples of good care in view of the disturbing findings. Most qualified nurses distanced themselves from dying patients when the consultants demonstrated less interest, which was apparent with ten of the fourteen doctors observed.

The distancing tactics of nursing staff were also evident at other times. There was little patient contact by staff for anything other than carrying out nursing procedures, which were also seen to be lacking. Communication, when it did take place was generally of less than five minutes duration. Most of the care and communication was carried out by unqualified staff with little guidance or support from trained staff. Some of the trained nursing staff had no contact with the dying patient in an entire duty span.

The inadequacies of care could not be entirely explained by lack of time or need in view of the evidence of greater need in these patients. Mills noted that dying patients received fewer visits, less time and less nursing care than those with a positive prognosis. American literature also suggests that dying patients are afforded less attention as death approaches and that nurses have been reported as taking longer to answer the call bell of a dying patient than one who is expected to recover (Mount, 1976).

Anyone with serious illness faces many problems - of the effects of the illness itself and also the emotional, social, spiritual and financial ramifications on themselves and their families. These problems may be more acute when the patient is dying. In the acute hospital setting, staff endeavour to meet the needs of dying patients as far as they are able, although the difficulty in marrying the curative and caring roles is often apparent (Mount, 1976; Jeffree, 1990).

As palliative care has gained recognition as a specialty, the role of the acute hospital in terms of palliative care has often been overlooked. Hospitals are considered to be places where ill people go to have treatment and hopefully be restored to good health. However, the hospital has an important role in caring for those who cannot be cured. The trend towards fewer deaths occurring at home and more people being admitted to hospital when death is expected, has been apparent for many years. In 1869 over 90% of deaths took place in the home, but had fallen to 35% in 1969 (Cartwright, Hockley and Anderson, 1973). Since 1969 the figures have not altered dramatically and despite the growing number of hospice placements, the percentage of home deaths remain around 30% (Griffin, 1991).

Griffin (1991) suggests this is related to the increasing numbers of people requiring palliative care and a declining number of family members who are available and physically able to care for dependent family members. Caring for someone with a progressive illness at home may be difficult if:

- there are no close relatives, or family living nearby;
- the main carer is elderly or infirm;
- the patient's symptoms are of a distressing nature (Cartwright et al, 1973; Wilkes, 1973; Griffin, 1991).

The significance of all these factors is evident when the reason for admission to institutions is examined. In a group of 126 patients with terminal cancer, Walsh and Kingston (1988) reported that the reason for the last admission, during which the patient died, was absence of

carers in 28% and family inability to manage the problems of a seriously ill patient in 33%.

In any event, the caring rather than curing role has become even more important as a result of multiple changes in society which have influenced health care needs. Moreover, the demand for palliative care services is likely to increase. Therapeutic advances, combined with socioeconomic change, have improved many aspects of health. Advances which have increased the availability of life sustaining resources have also brought a different set of problems, requiring new approaches to care (Hillier, 1983).

For example, the development of antibiotics and vaccines, together with improved social conditions, have virtually eradicated infectious diseases in the Western World. Once the most common cause of death, infectious diseases accounted for only 0.4% of deaths in the UK in 1989 (OPCS, 1989). As a result of such progress, life expectancy is steadily increasing (Cartwright et al, 1973).

However, increased lifespan has led to a growing proportion of elderly in the population. This has been accompanied by a corresponding rise in the incidence of degenerative diseases. In the UK, chronic debilitating diseases are the most common causes of death. Cardiovascular and malignant disease accounted for 46% and 25% of deaths respectively in England and Wales in 1989 (OPCS, 1989). Similar figures have been reported in Scotland (Scottish Office, 1991).

In considering malignant disease alone, there is substantial need for palliative care. One in three people are predicted to develop a malignancy. Approximately half of these will require palliative treatment from the outset. The other half will receive potentially curative treatment. Of these, 60% will relapse, also requiring palliative care (WHO, 1989).

Development Of Palliative Care As A Specialty

The anticipated increase in demand for palliative care services and the awareness of the particular needs of dying patients have drawn attention to inadequacies in existing care provision. As a result, palliative care is now being taken very seriously and not only in respect of nursing care. In 1979 the Standing Sub-Committee on Cancer formed a working group to look at the organisation of terminal care services. The subsequent report acknowledged the problem of unmet needs but recommended that further expansion of hospice inpatient units should be undertaken cautiously and only with thorough planning by the authorities in conjunction with voluntary bodies. The preferred option was to encourage the dissemination of appropriate attitudes, knowledge and skills throughout the health service to "ensure that every dying patient has access to professional staff who can provide the appropriate care" (Wilkes, 1980).

Interest in palliation is such that palliative medicine is now recognised as a medical sub-specialty by the Royal College of Physicians. It is therefore an examinable subject in medical schools. In 1987 the first journal concerned solely with palliative care issues was introduced in Britain. Entitled "Palliative Medicine" it is aimed at a multidisciplinary readership.

Another innovative step was taken when the Scottish Partnership Agency in Palliative and Cancer Care was established in response to the document "Proposal for Partnership" (Scott, 1989). The aims of the agency include the facilitation of communication and cooperation amongst all those professional and voluntary bodies involved in palliative cancer care to work together for the benefit of patient care. The number of professional associations who are actively involved in the agency is an indication of the level and extent of interest in palliative care.

The Professional Associations Group includes representatives from the following associations:-

- Palliative Care Physicians
- Hospice Matrons
- Nurse Teachers in Palliative Care
- Hospice Social Workers
- Hospice Chaplains
- Hospice Administrators
- Hospice Voluntary Worker Co-ordinators

Summary

Palliative care embodies an active approach to maximising the quality of life of patients whose disease is not curable and to support their families. In an area of health care in which there are no second chances to improve on a patient's care, it is disturbing that there is so much evidence of inadequacy in care provision. Lack of knowledge and skills in relation to strategies for relieving pain and other symptoms appears to be partly responsible. However, a major factor is the repeated failure of staff to identify or respond appropriately to the needs of dying patients and their relatives. There is little doubt that this has much to do with the tendency to avoid communication or close contact with dying people.

There is also little doubt that many people will require palliative care before they die and that much of this will take place in the hospital setting. Hospitals also have a major part to play in educating and shaping the attitudes of a variety of health professionals. The need for high quality palliative care to be made available in the acute care setting is well recognised, but frequently falls short of what is possible (Wilkes, 1980).

The next section looks at the role of palliative care education in helping to overcome the problems which have been identified in existing care provision. It also discusses the extent to which the educational needs have been met.

2.4 EDUCATION IN PALLIATIVE CARE

The Need For Education In Palliative Care

As discussed in previous sections, care of dying people has undergone many changes in the past thirty years. So too have nurses' experiences of caring for dying people. Degner and Gow (1988a) point out that the trends toward hospital, rather than home death and the predominantly curative approach of hospitals, have resulted in nurses being less likely to observe "effective nursing models of comfort-oriented care", despite their important role in terminal care.

However, realisation that care of the dying could be improved has followed in the wake of the expanding hospice movement. There are numerous reports of health professionals expressing concern regarding the inadequacies of their abilities and training in this area (Wilkes, 1984; Kennedy, 1984; MacDonald and MacNair, 1986; Lyons, 1988; Hockley, 1989).

The basic nurse education programme leading to registration lays the foundation for the provision of high quality terminal care. However, the report of the Working Group on Terminal Care (Wilkes, 1980) recommended that greater emphasis be afforded to psychological aspects of care and to counselling skills. The time given to topics related to care of the dying or to interpersonal skills in basic nurse education has been difficult to determine as they are recurring themes in many parts of the curriculum (Field and Kitson, 1986).

Degner and Gow (1988a) also found that most colleges of nursing favoured the approach whereby teaching related to care of the dying was integrated into various parts of the basic education programme. Such classroom teaching was rarely supported by assignments to relevant clinical placements. This lack may detract from the value of the classroom based teaching as it is well recognised that theory requires reinforcement by appropriate learning experiences (Geddes, 1968). The reverse is also true. Exposure to dying patients without supporting education has been said to result in negative attitudes and anxiety

concerning death, leading ultimately to withdrawal from caring interactions with the dying (Quint, 1967).

Withdrawal from caring interactions, or the use of distancing tactics by staff, has been observed frequently (Kastenbaum, 1981; Mills, 1983; Maguire, 1985). Maguire (1985) reports that such patterns of behaviour are now recognised as coping mechanisms which are effective in protecting staff from the emotional pain of involvement with dying patients and their families. On the other hand, it has been suggested that personal involvement on the part of staff is a pre-requisite of real care for the dying (Scott, 1986).

Lack of education, particularly in relation to interpersonal skills, and support for all staff have frequently been cited as reasons for nurses having to resort to distancing tactics (Lyons, 1988; Faulkner, 1981; Kennedy, 1984). The need to reinforce theoretical learning with appropriate clinical experience has been well established. Inconsistencies between what is taught and what is learned in the clinical environment may have very negative consequences. McGuinness (1986) observed that nurse learners began to stifle their natural responses to the death of a patient and to the reactions of bereaved relatives when they witnessed the "model of controlled behaviour provided by more senior nursing staff".

The same senior staff recognised that more junior colleagues demonstrated a greater awareness of the needs of bereaved relatives than they did at a comparable stage in their careers. Even so, they did not consider such awareness a skill which could be developed or taught. MacLeod Clark and Tomlinson (1989) have also encountered the attitude that communication skills are considered innate and could not be taught.

A later study by Lyons (1988) also indicated training needs in qualified staff. The sample used was small but suggested that a number of trained ward staff experience difficulty in discussing impending death with patients and relatives (56%).

Lack of knowledge of the grieving process was perceived by 39% of trained staff, with 95% expressing a need for further training in grief counselling. All of the staff concerned were involved in caring for dying people on a regular basis. Yet 33% felt that the stress of this aspect of their work rendered them ineffective as teachers / role models for nurse learners.

This supports the view that trained staff who may not have had the benefit of appropriate formal training may lack the necessary skills and understanding to support more junior nurses in what can be a very stressful aspect of care (Field and Kitson, 1986). The working party (Wilkes, 1980) also recognised inadequacies in the clinical settings. It recommended that training in the delivery of terminal care should be a priority for key personnel, e.g. the ward sister. This was to encourage dissemination of skills by example. Practical experience in a hospice or specialist setting was seen as a vital component of this training.

Despite a recognised need for post basic education in several aspects of palliative care, provision has been largely on an ad hoc basis until very recently. From the outset, St Christopher's Hospice in London provided a focus for education and research for all health professionals, opening its study centre in 1973 (Parkes, 1985). Similar opportunities in education and training have now been extended to other units, with 70% of hospices surveyed in 1990 offering training to professionals outwith their own establishment (Smith, 1990).

However, Webb (1990) stated that the provision of palliative care education had been neither systematically planned nor sufficient to meet demand. Prior to her study in 1988 there had been no attempts to assess the educational needs or initiatives in palliative care despite the huge demand for such education. In addition, many nurses had difficulty in gaining access to post basic education in palliative care even when available. Reported problems were related to obtaining funding and study leave. Attendance was only made possible for some by the generosity of charitable organisations and willingness to attend courses in off duty time.

In terms of nurse education, specialist courses in terminal care nursing, such as the ENB Course 931, have been available from a number of hospice units in England. These courses are of four to six weeks duration, although a longer course was previously available (Simms, 1985). Only one equivalent course has been offered in Scotland (Doyle, 1982). This was discontinued in 1987 as plans for a new type of post basic course were being developed.

Even these recognised courses developed haphazardly with very different emphases (Simms, 1985). There are few attempts to evaluate such educational programmes reported in the literature. Watts (1977) suggests this is a common problem when the subject matter, in this case palliative care, is relatively new and teaching is offered prior to systematic objective testing.

In addition to the education programmes addressing the broad issues of palliative or terminal care there are two topics which are often offered separately to help health professionals enhance their care of dying patients. The first of these is sometimes referred to as "death education" (Lyons, 1988). The second topic concerns the teaching of communication/interpersonal/counselling skills specific to palliative care. Although not well-researched, there have been more attempts to evaluate each of these than there have been of the more general palliative care education programmes.

Death Education Programmes

Death education is based on the assumption that assisting health professionals to come to terms with death and their own mortality will reduce the distress of caring for dying patients (Simpson, 1975). Staff will then display less death-related anxiety and more positive attitudes to caring for those who are dying. The intended outcomes are that staff become more willing to have close involvement with such patients and employ fewer distancing tactics. Most reports of this type of education originate in America (Watts, 1977; Dickinson and Pearson, 1980-81; Degner and Gow, 1988b; Miles, 1980).

Some workshop programmes of this nature have been offered in the U.K. by a variety of independent bodies (Trevelyan, 1990). Reports of formal evaluations in this country have not been found. However, via the nursing press, Trevelyan invited readers to give their views. Several respondents appeared to have attended workshops of this nature and reported them to have been very positive experiences. The workshops generally involved the provision of a safe and supportive environment in which the participants could openly discuss death/their death-related experiences and feelings and also their own death.

Communication Skills Teaching

Effective communication is the basis for all therapeutic interaction. It is the aspect of care with which patients are most often dissatisfied according to the annual reports of the Health Service Ombudsman. In palliative care also, inadequacies in communication are frequently reported (Wilkes, 1984; Mills, 1983; Townsend et al, 1990; Hockley et al, 1988). Scott (1986) states that communication in palliative care requires a fundamental shift from talking to listening to give patients space and time to speak about their fears and concerns. Such an apparently simple strategy, he acknowledges, can be painful, difficult to learn and requires a willingness to become personally involved with dying patients and their families.

MacLeod Clark and Tomlinson (1989) point out that a need for the teaching of communication skills to nurses in the UK has only been generally accepted since the early 1970s. They believe that two major factors in this change were the overwhelming evidence of inadequacies in nurse-patient communication and developments in the philosophy of nursing towards individualised patient care.

Colleges of Nursing have made various attempts to meet the educational needs in these areas amidst demands from other sources for space in the ever-expanding curriculum. Formal teaching on care of the terminally ill and in interpersonal skills is now receiving serious attention, often in great detail and by means of a variety of teaching methods according to Field and Kitson (1986).

However Faulkner, cited in MacLeod Clark and Tomlinson (1988) had previously found that although Nurse Tutors and Directors of Nurse Education perceived the teaching of communication skills to be important, less than five percent of curriculum time was given to the subject, either in its own right or incorporated into other topics. Fewer than five percent of tutors felt adequately prepared to teach communication skills. In Scotland it was disturbing to find that almost half of the tutors involved in teaching communication skills did not feel that they had any preparation for this.

Webb's (1990) survey of all disciplines working and teaching in palliative care confirmed that large numbers of teachers felt inadequately prepared in this area. Yet the same group believed the teaching of communication by a teacher who was experienced and skilled in this aspect to be very important.

Communication and counselling skills teaching was high on the list of priorities of staff working in palliative care in Webb's study. These skills were seen as pre-requisites for the provision of psychological care and support by 85% of those responding. A model for teaching communication skills to health professionals has now been developed by Maguire and Faulkner (1988). Since the demand for these courses far exceeds the provision, an initiative is being developed and monitored to facilitate doctor/nurse teams to teach the necessary skills locally (Webb, 1990).

Other Educational Opportunities

Other educational opportunities in terminal care nursing beyond basic training were offered only by the voluntary sector until very recently. While providing a valuable source of information these have often been limited to sporadic lectures and study days and have depended upon the willingness of nurses to attend such programmes in their own time. Opportunities for clinical practice and training have been strictly limited.

More innovative attempts to meet educational needs have been made possible by funding from several charitable organisations. Palliative

care lectureships and tutorships have been established in several key areas to identify local needs and develop education accordingly. By 1991 there were nine such posts known to the author in Scotland. That only two of these were in existence when this study began is an indication of the rapid development now taking place.

At a local level, CPE in Glasgow in relation to palliative care was very limited until 1987. There were no specialist lectureships or tutorships. There were no clinical placements in hospices available to nurses. Lectures by the medical staff of a local hospice were much in demand, but were sporadic and uncoordinated. In an attempt to meet the demands for education, a planned course in Care of the Terminally Ill Patient for registered nurses was introduced by the health board in that year.

This concentrated mainly on increasing awareness of services available for dying patients and gaining an understanding of the role of other appropriate health professionals. Aimed towards those nurses with an interest in terminal care as part of their wider remit and with no possibility of practical experience in clinical placements, its impact must be understandably limited.

The new CPE was also in modular form and was offered at two levels, called Professional Studies I (PSI) and Professional Studies II (PSII). PSII modules were generally more advanced and concerned with specialist areas of nursing. In September 1987 the first PSII Course in Care of the Terminally Ill was introduced by one of the Glasgow colleges. This course became the focus for the present study.

2.5 CONTINUING PROFESSIONAL EDUCATION AND ITS EVALUATION

Education is a complex phenomenon which is not easily defined (Peters, 1966). One definition offered by Jarvis (1983;p19) is that "Education is any planned series of incidents, having a humanistic basis, directed towards the participant(s)' learning and understanding."

Learning is not a single event, but an ongoing process. In Peters' discussion of education (1979;p8), he states that "to be educated is

not to have arrived; it is to travel with a different view". This is the foundation of professional education. Not only is it considered important to produce individuals with sufficient knowledge and skills to practise, it is also necessary to have a desire for further learning and a commitment to ensure that good practice is maintained (Jarvis, 1983) Del Bueno (1979;p135) stated that "The first step in the process (education) is an awareness by the individual that there is a need for acquiring knowledge or skills or that there is a need for looking at a situation differently. The individual must feel uncomfortable about her current practice, knowledge base, or value system."

The concept of education as a process, rather than a means to an end is important in professional education. Yet it is a relatively recent discovery in nursing. The traditional, 'apprenticeship' approach to nurse training which existed until the 1970s, concentrated on equipping participants with practical skills which were considered sufficient for a lifetime of practice. However, it was not until the introduction of the modular basis of nurse education in 1980, which was described as a foundation programme on which to base further learning, that continuing education became formalised.

The more recent recommendations in the Report of the Post-registration Education and Practice Project (PREPP) by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC, 1990) reflect the high priority with which CPE is held. Besides emphasising the need for professional education to be a continual process, it stresses that the individual must assume responsibility for maintaining and developing their own professional knowledge and competence and keeping a record of the same. The report's proposals also include the introduction of mandatory CPE for nurses.

This is intended to encourage a partnership approach to CPE. The employing authority will be required to provide support by releasing members of staff for the necessary study leave. Registered nurses will be required to maintain a profile of their ongoing educational development and experiential learning which will be self-directed.

The importance of CPE in nursing cannot be denied. In view of the ever-increasing bank of available knowledge and technological developments, continual learning is necessary to maintain existing levels of knowledge. The half-life of nursing knowledge is said to be between two and five years, depending on the specialty involved (Ferrell, 1988). However, there is more to CPE than "getting the latest information to the nurse in the fastest way possible" (Oliver, 1984).

It is generally accepted that CPE in nursing should result in improved delivery of care. The American Nurses' Association, cited by Oopson (1980;p8) define continuing education as "Planned, organised learning experiences designed to augment the knowledge, skills and attitudes of registered nurses for the enhancement of practice, education, administration and research, to the end of improving health care to the public."

Evaluation Of CPE

"Evaluation has two main purposes: to prove that worthwhile activity is taking place; and to improve on the quality of that activity" (Gorman, 1991).

Evaluation of education in general has been problematic. Education may be about a process of learning. Yet, teaching is not synonymous with learning. Educational input does not necessarily equate with a positive learning outcome. Nor can it be proven, beyond all doubt that education is responsible for a particular outcome, only that it is likely to be the case. This is especially true in adult education (Kidd, 1973). Adults organise and integrate new information according to their past experience, self-concept and perceived learning needs (Knowles, 1984). Learning is therefore highly individualistic and subjective. The idea of learning being a unique experience is important and often problematic when attempting to evaluate education.

An additional difficulty arises when one considers that learning is a mental activity. As such it is not always observable. Moreover, as learning occurs over a period of time, it is subject to the influence

of many extraneous stimuli. As a result, it may be impossible to determine any direct links with educational input and behaviour.

Bell and Bell, cited by Cooper (1982;p119) identified six areas which may be evaluated in CPE;, some of which are more difficult to measure than others. These are:

- Cognitive skills.
- Attitudes.
- Psychomotor skills.
- Job performance.
- Cost-benefit analysis.
- Patient improvement.

Of the above, cognitive skills are the most easily and therefore the most regularly evaluated aspects of education. Attainment of knowledge is readily assessed by means of examinations or course work and therefore is often given the highest priority.

Psychomotor skills can also be relatively easily evaluated. Methods developed by Tyler in the 1940s, based on the achievement of objectives which are specific, observable and measurable are reliable in evaluating competence following the teaching of specific skills and behaviours. Nonetheless, possession of knowledge and skills is no guarantee that they will be used (Sanazaro, 1983).

The use of these traditional methods of evaluation is limited in demonstrating a positive outcome in terms of practice (Warmuth, 1987). Warmuth has criticised this approach as being reductionist and oversimplistic in evaluating the complex interactions involved in nursing care. In addition, it is teacher rather than learner centred. The educator determines what is to be learnt and how it will be used.

Attitude measurement has also been used to evaluate educational outcomes, on the assumption that developing more positive staff attitudes to specific client groups or aspects of care will result in improved delivery of care. However, it has not always been possible to demonstrate corresponding care improvements when attitudes have been

shown to be more positive as a result of education (Harrison and Novak, 1988). This reflects the lack of consensus as to whether attitudes are reliable indicators of behaviour or merely expressions of what the subjects consider to be socially acceptable responses.

Although attitude change may be an unreliable indicator of behaviour change when considered in isolation, it may be useful in conjunction with other evaluation strategies. An interesting example of this is seen in a study by Keiser and Bickle (1980). The findings of this research demonstrated a positive correlation between the degree of attitude change towards primary nursing and the likelihood of adopting behaviour relating to its implementation.

However, the increased motivation to implement primary nursing was only one element signifying change in behaviour. The other factors were knowledge, psychomotor development and resources. The authors suggest that deficiencies in any one of these elements reduces the likelihood of successful CPE and should not be viewed in isolation.

Evaluating Impact Of CPE

The impact of education has been particularly difficult to demonstrate, which may explain the paucity of research in nursing literature in this area. Yet it is the most important part in demonstrating successful CPE. Few reported attempts to evaluate the impact of CPE in nursing have originated in the UK. This may be because evaluation of education which involves measuring behaviour change can be very complex, time-consuming, expensive and therefore impractical (Gosnell, 1984). Other problems may be related to the learning being of a developmental nature, rather than immediate or because intended outcomes are not amenable to direct observation (Murgatroyd, 1987).

An additional problem is the limited use of any evaluation tools which are developed. Owing to the unique nature of CPE programmes, the evaluation methods also require to be very individualised. Therefore it is rarely possible to replicate studies. Two examples of the complexity and uniqueness of CPE evaluation are the studies by Alexander (1990) and Connors (1989).

In the first of these by Alexander (1990), a very comprehensive evaluation of a training programme in Breast Cancer Nursing was undertaken. A combination of nine different research tools were used. These were as follows:

- Cognitive test.
- Attitude Rating Scale.
- Two behavioural impact questionnaires - one at the end of the programme, one at eight weeks later.
- Satisfaction scale - evaluation of objectives and their importance.
- Satisfaction scale - regarding the programme.
- Patient perception of care questionnaire.
- Breast Cancer Quiz.
- Multiple Affect Adjective List.

The findings were that the programme increased the knowledge of the thirty-three participants, stimulated more positive attitudes, was perceived by participants to be useful to their practice and improved patient care. The latter was concluded on the basis of comparing a group of nine patients receiving care prior to the introduction of the programme with a study group of nine different patients afterwards. The study group reported higher levels of patient satisfaction with care, more knowledge of their condition and less depression and hostility than those in the control group.

The patient groups in this study were small and not representative. Alexander also acknowledges that patient outcome can only be readily addressed when the focus is on specific care problems. However, the self-appraisal of the usefulness of the programme to clinical practice was considered to be a reliable indication of change of practice by the researcher.

The second example, by Connors (1989) concerned the impact of an educational programme to improve case management skills of community nurses. Connors used a pre- and post-test competency behaviours inventory to measure the extent to which participants valued the relevant skills and their perception of how well each could perform

them. Three instruments were developed and used: a demographic questionnaire, pre- and post-cognitive assessments, and a Competency Behaviours of Case Managers Inventory of 68 statements.

Connors concluded that the educational programme under study made a significant impact on the participants' perceived skills. This was based on the findings that the skills were more valued and the participants felt better prepared to perform them after completing the programme.

This study represents a very thorough attempt to evaluate CPE for case managers in the community in the United States. However, the time required to develop the sophisticated research instrument, which would not be transferable to other areas of practice was considered to be a major disadvantage by the researcher.

Measuring the value of the skills taught and their performance as perceived by the participants themselves was based on Peters' theory of education (1966), which states that for learning to occur, the individual must perceive the knowledge to be valuable. Self-perception has been used increasingly to evaluate learning as nurse education has begun to adopt approaches to teaching based on the theory of adult learning (Knowles, 1984).

Androgyny, the art and science of adult education, is now the approach favoured by many nurse teachers, especially in continuing education. Didactic teaching has become less pervasive and teachers have more frequently adopted the role of facilitator to support students and encourage self-directed learning. One example of this is contract learning (Norton, 1989). This involves the learner drawing up a document in conjunction with the teacher/facilitator which identifies the learning needs, how and within what timespan this will be achieved and how it will be evaluated. This system shifts the responsibility for setting and pursuing the objectives to the learner. Teaching is then truly learner-centred.

As a natural extension of self-directed learning, Burnard (1988) advocates self-evaluation. He argues that the learner is the

individual most suited to the task in view of the very personal, subjective nature of learning. It is also an important aspect of self-awareness, which like learning, is an ongoing process.

The view that self-evaluation is a valid and reliable method of determining the effectiveness of education in terms of behavioural change, is supported by Fuhrmann and Weissberg (1978). They suggest that participants' perceptions of knowledge gained, attitude change and performance achievements are more reliable than the actual measurable differences in any of these aspects. They also suggest that perceptions of increased self-confidence may be useful predictors of behaviour because of the close relationship between perceived abilities and confidence.

Although the value of self-perception in relation to adult learning has been stressed by Gosnell (1984), she warns against the tendency to rely on "happiness indexes". These are the superficial evaluations carried out during or immediately following the educational input which concentrate on the participants' satisfaction with the content and structure of the course.

A more effective use of self-perception was used by Warmuth (1987) to measure the utilisation of learning. By focussing on what and how learning was used by the participants it was possible to determine which aspects of the education programme had been selected according to the perceived needs of the individuals. The need to learn, what is perceived as useful to each individual, is an important characteristic of adult education (Knowles, 1984).

The study involved 34 registered nurses who had undertaken a single study day on Care of the Patient with Chronic Obstructive Pulmonary Disease. The participants were contacted six months after the educational programme, initially by letter. Collection of data was by interview. None of the nurses had prior knowledge of the study and therefore their behaviour could not have been influenced by knowing that the evaluation would take place. Two nurses declined to take part.

Only three respondents said they had not utilised the content of the day in their practice. However, they did report having learned from it. The reasons for non-utilisation were not reported in the study. One of the three was no longer a practicing nurse. The twenty-nine participants who reported using the content of the course listed an average of five behavioural or conceptual aspects of learning which they had incorporated into their practice. These aspects were categorised into five main areas of change as follows:

- Nursing practice.
- Nursing thinking / rationale.
- Nursing perspective, eg better self-concept, more confidence.
- Teaching others.
- Uses outwith work.

One of the advantages of this method of evaluating impact is its ability to identify unanticipated positive outcomes, for example educational initiates of the participants. This was supported by the results in a small study by Sakalys and Carter (1986). Not only did participants report using the learning in their own practice; several also used it to implement their own teaching programmes, develop educational materials and establish support groups.

A variety of strategies have been used to determine utilisation of course content by learners. These include unstructured interviews (Hughes, 1990), completion of statements related to care of particular patients and direct enquiry regarding use of equipment (Farley, 1987). The findings by Hughes were less convincing than those of Warmuth (1987) but the sample was very small. Farley reported positive outcomes but also experienced problems in sample size and low response rate.

Other methods of CPE evaluation reporting positive outcomes have included appraisal by superiors. Bignell and Crotty (1988) used this method, partly to validate the self-reported changes in practice of participants. They concluded that the questionnaire developed for both the participants themselves and their managers was effective and

reliable in determining areas in which effectiveness and efficiency was improved. These areas were predetermined by the researchers and so did not allow for unanticipated benefits to be reported.

The results showed utilisation of learning and improvements in practice. No areas of discrepancy were evident between the improvements as perceived by the participants or observed by their managers. However, it was interesting that the participants rated their improvements less highly than did their managers.

Record analysis was the method chosen in a small study by Dickinson, Holzemer and Nichols (1985) indicating that patient assessment was more thoroughly carried out and documented following an education programme. A similar attempt by Sakalys and Carter (1986) was unable to substantiate this largely on account of poor overall record-keeping practices.

The foregoing examples of educational evaluation cover a wide spectrum of educational offerings. However, there has been little systematic evaluation of palliative care education. This reflects the recent development of palliative care as a specialty and the relatively underdeveloped status of appropriate formal education. The lack of evaluation in this area was evident in a survey by Webb (1990) in which palliative care teachers reported using observation and immediate verbal feedback as their main methods for determining the effectiveness of their teaching.

Only two studies evaluating palliative care education could be found in the literature. The first was a retrospective study by Simms (1985). This involved indepth interviews with twenty participants of the ENB Course 930 and Course 284 (now discontinued). The focus of the study was participant satisfaction. Responses were mainly positive with some reservations. The opportunity to observe and participate in terminal care in the hospice setting was seen as the most beneficial aspect of the courses.

Negative comments related to the courses having been centred too much on hospice care. An unmet need was also expressed for more help in

implementing the skills taught and in assertiveness training. A majority of the nurses expressed a need for ongoing education, tailored to their individual needs. One nurse who had undertaken the course four years previously, sadly reported that the details of her course were "lost in the mists of time".

The sample in this study were drawn from participants of courses run by fourteen hospices over a number of years. The total number this involved, or the method of selection was not stated. It was essentially a pilot study and the findings do give some insight into the difficulties experienced by the participants. However, it is not possible to draw any conclusions from the results.

The second study by Morgan (1990) also involved participants of the ENB Course 930. Twelve nurses were interviewed six months after completing the course. Benefits were perceived in terms of increased confidence in their practical and psychological skills and in their ability to cope with dying patients and their relatives.

The only other relevant studies reported originated in the United States and were related to death education programmes.

In a review of studies evaluating death education programmes in the United States, undertaken by Degner and Gow (1988a), most were reported to be effective in reducing death anxiety and improving death attitudes. Degner and Gow questioned these findings on account of the numerous problems in the study designs, including small sample size, failure to report response rate and absence of control groups or randomisation. They then designed their own research, attempting to overcome the identified difficulties in methodology (1988b).

A longitudinal comparison was made between two approaches to death education. The experimental group of nursing students received 72 hours of teaching on topics related to care of the dying over two terms, i.e. three hours per week. This was supported by appropriate supervised clinical practice for six hours per week. One control group comprised nursing students who received the standard teaching on care of the dying integrated throughout their basic education programme,

with no specific related clinical practice. A second control group comprised non-nursing students who received no death education.

This research concluded that death anxiety was reduced by both types of education and that ultimately the level of positive attitudes converged. Such attitudes were quicker to develop in the experimental group. However, the experimental group felt more adequate in caring for dying patients and claimed to adopt more open communication with the patients and families.

Summary

In view of the early development of palliative care as a specialty and the related education, there is an urgent need to examine palliative care more thoroughly. It is also vital that evaluation findings are reported to allow further educational development to have a sound basis. Many individual educationalists may have satisfied themselves that their provision of palliative care teaching is worthwhile and effective. This experience needs to be shared with other teachers and managers, both in terms of the outcome and the methods used to evaluate the outcome.

In considering the subjective nature of learning and Rae's assertion (1986) that fully objective evaluation is not always possible, it may be that self-perception is the most reliable and cost-effective method of evaluating the impact of CPE. The learners perceptions must be determined on more than their enjoyment of the course. The most revealing aspects in terms of impact of education would appear to be the learners perception of:

- value of the learning and its usefulness to clinical practice;
- knowledge gained;
- utilisation of the learning;
- change in themselves and in their practice;
- enhanced self-confidence.

Positive perception of the above by the learner is likely to be a reliable indicator of successful CPE. However, there may be external factors which inhibit change of practice. These are discussed in the next section.

2.6 APPLICATION OF LEARNING IN THE CLINICAL SITUATION

The concept of professional education was discussed in the previous section as a continuing process which seeks to stimulate commitment to further learning and maintenance of good practice. According to Del Bueno (1979), the first step in this process is taken when an individual practitioner feels uncomfortable with an aspect of her knowledge or practice, thereby identifying learning needs. CPE endeavours to build upon the existing knowledge and skills of the individual to enable her to improve practice. However, it has also been stated that increased knowledge and skills do not necessarily result in improved practice.

Several studies have been carried out to explore the reasons for inability or failure to apply the content of educational programmes to the clinical setting. An example of this is Warmuth's study (1987) of impact of CPE which has already been discussed. Warmuth sought to establish the participants' perceptions of factors which had either encouraged or discouraged the utilisation of their learning. Responses could be grouped into three categories - the individual, the education, the work environment.

Difficulties in these three categories which have been reported in this and other studies are listed below.

Individual	-	lack of commitment/motivation (Keiner and Hentschel, 1989), feelings of powerlessness (Ramprogus, 1989).
Education	-	task complexity/insufficient skill gained (Keiner and Hentschel, 1989).

Work environment	-	follow-up reinforcement (Oliver, 1984), lack of time, resources, administrative support (Keiner and Hentschel, 1989; Ramprogus, 1989) resistance from other staff (Ramprogus, 1989).

Factors perceived to encourage change in practice have been reported in the same areas.

Individual	-	commitment (Keiner and Hentschel, 1989) increased self confidence (Brown, Brown and Bayer, 1987).
Education	-	knowledge gained (Keiner and Hentschel,1989).
Work environment	-	an environment conducive to learning and change, administrative support and positive reinforcement of behaviours (Lawler, 1987) peer support, administrative support/resources, and networking (Keiner and Hentschel, 1989).

It is essential that the educational content and presentation is of a high standard and able to meet the needs of the learners. When change in behaviour is the desired outcome of education, it has been suggested that short education programmes have a very limited effect; that time is required for old ideas to be unfrozen, new knowledge and skills learned and refrozen (Lawler, 1987).

Nonetheless, in light of the theory of adult education, it would appear that the controlling factors in respect of the application of learning lie with the individual and the work environment (Ferrell, 1988). Lawler (1987) states that "change basically begins from within: that it is intrinsically motivated, yet extrinsically reinforced".

The outcome of education cannot be predicted by the teacher as "Learners react to all experiences as they perceive them, not as

someone such as a teacher presents them." (Thompson, cited by Pennington, Allan and Green, 1984;p38). This is especially relevant in adult education as adults have wide ranging experiences on which to base their perceptions.

The importance of the work environment as the other key element in the application of learning has been suggested by several studies (Lawler, 1987; Brown et al, 1987; Peden, Rose and Smith, 1990). Unfortunately, the negative impact of the work environment is most often apparent, being reported three times more often as a discourager than an encourager in Warmuth's study (1987).

This was not the case in a study by Brown et al (1987) which attempted to explore the barriers to utilisation of learning. The study was concerned with the outcome of a CPE programme on "Increasing Physical Assessment Skills for Nursing". A questionnaire was developed and sent to 359 nurses who had undertaken the course. The response rate was 41%. Most respondents reported using the skills learned in their clinical practice. Therefore, it is possible that the motivation for returning this questionnaire had been a perceived utilisation of skills. Those who felt otherwise may have been less motivated to respond.

Changes in nursing practice were measured in terms of increased confidence, improved attitudes, enhanced peer relationships and reports of increased initiation of independent nursing actions or referrals. Where learning was reported as seldom or never used, subjects were asked to identify the reasons. Surprisingly, lack of support from colleagues, superiors and medical staff accounted for non-utilisation of skills in only five percent. The main barrier was lack of confidence (24%). There findings should be accepted with caution since the seldom or non-users accounted for only 21 of the subjects. To some extent they do support the findings by Fuhrmann and Weissberg (1978) that self-confidence is closely related to implementation of skills. On the other hand, they do not corroborate the belief that managerial support is a major factor in successfully implementing change.

What is clear is that nurses do not practise in isolation. Many internal and external factors influence behaviour. Ongoing support and resources are required to enable the individual to maximise the benefits of learning. The various elements which synergistically achieve successful CPE were developed into a model by Keiser and Bickle (1980) to facilitate evaluation. This stressed the importance of factors other than educational input. Their theory was that behaviour is a function of knowledge, plus skills or psychomotor development, plus motivation, plus resources, each being interdependent. This was represented as an equation as follows:

$$B = f\ (K + PD + M + R)$$

According to the authors, the absence of the desired behaviour change following education reflects a deficiency in one of the four elements. If improvement in practice is considered necessary, the source of the deficiency must be identified and addressed. In other words, where a negative attitude exists, increased knowledge or enhanced resources are unlikely to result in change. In the same way, lack of resources, including managerial support, could undermine any benefit which may be obtained from increased motivation. Keiser and Bickle suggest that efficiency and cost effectiveness can only be achieved by assessment of both the behavioural deficiency and the causal source(s) of the deficiency.

It has also been suggested that the best way to harness all four elements and maximise the effects of CPE is by greater collaboration between the individual nurse and her managers. Unless organisational goals and individual development are closely linked, CPE is likely to be ineffective (Gorman, 1991). Identification of learning needs and the setting of goals should be an exercise undertaken by the individual in conjunction with her superior/employer (Del Bueno, 1979; Gorman, 1991).

Goal setting in CPE is vital to provide direction and provide a basis for evaluation, which should be incorporated from the outset (McLemore and Bevis, 1979). In addition, del Bueno (1979) states that both the individual and her manager must hold the expectation that the content

of a CPE programme will be utilised. Thereafter, the application and use of the learning must be rewarded and reinforced to ensure it becomes established practice.

Rather than being an expensive luxury, CPE should be seen as an investment by management (Gorman, 1991). One might expect that managers would wish to be closely involved in protecting and maximising that investment. Yet a number of studies have demonstrated apathy or even resistance from Nurse Managers in response to attempts by individuals to apply learning in the clinical environment (Ramprogus, 1989; Keiner and Hentschel, 1989).

Nurse Managers are generally responsible for releasing staff for CPE programmes which aim to "improve health care to the public" (Oopson, 1980). This implies that not only is the participant of CPE expected to alter her practice in light of the knowledge and skills gained, she is also expected to influence the practice of colleagues, acting as a change agent.

Change has been defined by Wright (1989;p6) as "an attempt to alter or replace existing knowledge, skills, attitudes, norms and styles of individuals and groups." Implementing change is a difficult task. The sheer size and complexity of the NHS, with its many powerful and often incompatible groups has been said to mitigate against successful implementation of change (Handy, 1985). Resistance to change may occur simply because all change is stressful. It creates uncertainties, requires risks to be taken and may be seen as implying criticism.

Change may also be resisted on the basis of personality conflicts, parochial self-interest, or the nature of the change itself (Rogers, 1983). The change agent must have credibility and the respect of those whose behaviour is to be altered. The suggested change must be perceived as beneficial, practical and not too difficult to understand or introduce.

The type of behaviour involved in initiating change is also relevant. For example change related to knowledge or information was found easier to achieve, than those which involved attitudes or behaviour, Yura and

Young cited by Fradd (1988). Handy (1985) also reported more rapid diffusion of innovations when equipment was involved rather than procedures.

Clearly, implementing change can be fraught with difficulties. Without the sanction and support of managers, McLemore and Bevis (1979) suggest that change has little or no chance of succeeding. Wright (1989) stresses the need for an understanding of the nature of change and a structured plan of action. While McLemore and Bevis (1979) stated that the first task of planned change is the establishment of support systems.

The three main factors identified by Wright (1989) which can effectively destroy enthusiasm and prevent change were obstructive management, unsupportive educators and resistant colleagues. Successful application of learning and implementation of change is therefore multifactorial. Determinants of success involve the individual, the nature of the learning/change itself and the working environment in which the change is intended to occur.

Evaluating and enhancing the impact of CPE clearly does not begin and end with the education programme. It must be incorporated into the planning for education and followed up. Just as learning is individualised, so must the evaluation be specific to the situation. The effort, time and expense involved in such exercises may explain why so few studies have been carried out in this country. It may very well be impractical to evaluate every course in detail. However, it would seem an appropriate time to look closely at the provision and effect of teaching in relation to palliative care, in view of the early stage and rapidity of its development.

While there may be increasing demands for educationalists to demonstrate the value of the course which they offer, it is important to consider the other relevant factors in the equation as described by Keiser and Bickle (1980). Without identifying and addressing the deficiencies in all areas, CPE in nursing is unlikely to be a sound investment for managers. Nor is it likely to have any benefit in recruiting and retaining staff. If staff are stimulated to improve

practice by education and then prevented from utilising knowledge and skills gained by other obstacles, frustration and apathy are more likely to be the outcome (Downe, 1990).

2.7 SUMMARY OF LITERATURE REVIEW

By reviewing the literature, a clearer picture was obtained of the current perspective of palliative care and the need to prepare nurses who are skilled in this aspect of health care. To meet the complex needs of dying patients and their families, nurses require a high degree of knowledge and skill. In addition, they need to be skillful communicators who are willing to explore the patient's feelings, identify their needs and respond accordingly.

The rapid development of palliative care in the past 20-30 years has been in response to needs and demand from the public. The mainstream of health care professionals were slow to recognise the needs and the special skills involved in meeting these needs. Consequently, the development of services and the provision of appropriate education have been largely uncoordinated and underevaluated.

Given the complexities and demands of palliative care, it is of particular value to attempt an evaluation on an educational programme designed to increase skills in this area. Moreover, with the financial constraints on health care on one hand and the demand for improved care provision on the other, the need to ensure efficiency and cost-effectiveness in CPE has never been greater. Before embarking on further developments in palliative care education, it would seem appropriate to test the effectiveness of the current provision. The course which provides the focus for this study was the first of its kind in Scotland and the first to be approved by the NBS for Professional Studies Two. The future of such courses may be insecure unless they can be shown to be effective as it will always be a temptation for managers to choose less expensive options.

The effectiveness of CPE has been shown to depend on more than educational input. Therefore, evaluation must also consider other relevant factors in the individual and the work environment. The

literature also indicates a need for an individualised approach to CPE and its evaluation. In terms of identifying learning needs, assessing usefulness of the learning and the extent to which it is utilised, the learner is the expert. It follows that the learner must be central to any evaluation.

The broad aim of the study was to evaluate the PSII Course in Care of the Terminally Ill Patient. Undertaking the literature review also led to refinement of the research objectives. The objectives of this study became to:

1. explore the outcome of the PSII course in Care of the Terminally Ill Patient;

2. determine the benefits of the education programme as perceived by the individual nurses who have participated;

3. examine the factors which were perceived by the nurses to either facilitate or hinder the integration of the knowledge and skills gained into their own practice;

4. identify strengths and weaknesses in the programme and in the clinical environment;

5. make recommendations for evaluation of future education and support of nurses participating in CPE.

To achieve these objectives a variety of research methods were considered. These are discussed in the next chapter.

CHAPTER 3 - LITERATURE PERTAINING TO THE METHOD

In this chapter various approaches and research methods are discussed. These include those which were utilised and also those which were considered.

3.1 QUANTITATIVE AND QUALITATIVE APPROACHES

In the field of educational research both quantitative and qualitative approaches have been employed. Each seeks to advance various types of existing knowledge by differing means. Quantitative research uses deductive reasoning to test or support theories derived from existing knowledge and predict outcomes. Qualitative research aims to generate theory inductively from the data to further the understanding of human experience (Cormack, 1991).

One school of thought considers the main difference between quantitative and qualitative research to depend on whether description or quantification is required (Powers and Knapp, 1990). Powers and Knapp suggest that this is simplistic and misleading since these aspects can be common to both.

The second school of thought considers the difference to be epistemological ie. in the way knowledge of the world develops in the individual. The quantitative approach reflects the realist or "received view" of the natural sciences (Putnam, cited by Powers and Knapp, 1990). The received view is that a real, objective world exists which can be known as it really is through the human senses and logical enquiry. Moreover, all events have a cause which can be determined (Cohen and Manion, 1986). Therefore, all data can be measured objectively. Leininger (1985,p8) described this as "a mechanistic, static conception of the world" which takes no account of how individuals might influence knowledge or the world.

Qualitative researches are said to have an idealist or "non-received view". This philosophy believes that knowledge of the world is shaped by the differing perceptions and subjective understanding of human beings. The meaning which individuals attach to experiences are as

important as the experiences themselves (Leininger, 1985). Furthermore, the two cannot be separated.

Both quantitative and qualitative approaches are relevant to nursing research. Moreover, they are not mutually exclusive. Qualitative research is sometimes used to generate theory as a precursor. Following this, data may be tested using a quantitative approach (Morse, 1991). Qualitative research findings may be useful in adding richness and meaning to quantitative findings. However, it has been suggested that using both methods together may lead to contamination or dilution of the findings (Leininger, 1985). Both approaches are discussed in more detail below.

Quantitative Research

Quantitative research has emerged from the physical sciences. It has tended to be viewed as the scientific and therefore the only valid approach to research (Leininger, 1985). It is mainly concerned with data which can be expressed in numerical terms and statistically interpreted. Precise, objective measurement of systematically controlled and regulated observation is used. It frequently seeks to demonstrate relationships between certain phenomena, enabling predictions to be made. In this way it goes from the general to the particular (Powers and Knapp, 1990).

In demonstrating such relationships, extraneous variables which may influence the outcome must be controlled and manipulated. Subjectivity is excluded. The research instruments must be valid, and reliable. The validity of a research instrument is defined as its ability to measure what it purports to measure. Reliability refers to the ability of an instrument to produce the same results consistently over time, regardless of who uses it (Oppenheim, 1966). Credibility of quantitative studies also depend on the subjects being representative of the population (Powers and Knapp, 1990).

Quantitative research approaches have been used often to determine the effects of particular education programmes. For example some studies have used experimental designs in which the researcher deliberately

controls one aspect of education to determine its effect on another (Cohen and Manion, 1986). Pre- and post intervention testing of knowledge, skills and / or attitudes (Alexander, 1990) have all been used in this way. Alternatively, the subjects being studied might have been compared with a control group which had not had the benefit of a particular educational input (Degner and Gow, 1988b).

However, quantitative research has limitations particularly in relation to human behaviour (Leininger, 1985). The tendency is to study people in terms of how they react to a specific, controlled situation or circumstance. Leininger (1985) suggests that such study is taken out of context and removed from reality. Therefore, it fails to take account of the complex, unpredictable nature of human behaviour (Cormack, 1991).

Harden (1986) also suggests that experimental research in education merely serves to reinforce assumptions and is unlikely to uncover facts which have not been considered previously. In addition, quantitative researchers tend to base their work on established theories. These are sometimes only assumed to be correct. An example of this is seen in Metcalfe's study of patient allocation organisation of nursing care (1983). Although assumed to be better than a task allocation system, the researcher acknowledged that this theory was unsupported.

Qualitative Research

Qualitative research has its origins in the social sciences. The traditional "scientific" methods only considered observable entities. The limitations imposed by this view stimulated the development of qualitative approaches. These were based on the belief that human beings not only react to the environment; they act on it (Cormack, 1991). This interaction is dynamic - constantly changing and developing. Qualitative research takes into account that which has gone before and that which follows events in the situations under study. In this way, data obtained is detailed and in context. However, this also means that generalisation to other circumstances is not possible (Cormack, 1991).

The aim of qualitative research is to describe and interpret human experience in ways that promote understanding, provide insight or challenge existing beliefs (Powers and Knapp, 1990). Whereas quantitative research is said to be reductionist, qualitative research is expansionist (Leininger, 1985). Qualitative research seeks to preserve the whole dimension of the phenomena under study. Although data may be manipulated and interpreted, validity depends on the meaning remaining intact. This enables the reality of the situation to be described.

However, it requires a broader view than that of the scientific approach. Human experience must be studied holistically to capture the "totality of how events, situations and experiences fit together and form the people's viewpoint" (Leininger, 1985;p7). Cormack (1991) suggests that the task of analysis is not to describe every piece of the jigsaw, but to stand back and present a clear picture of the whole.

Qualitative Methodology

There is not one single method in qualitative research. Methods vary according to the orientation. This may be anthropological, sociological or philosophical (Powers and Knapp, 1990). There are many approaches within each discipline. Examples of these include ethnography (Evaneshko, 1967), symbolic interactionism (Field, 1989) and phenomenology (Benner, 1985).

The variety of strategies which have been developed to analyse qualitative data reflect the awareness and legitimacy of different perspectives of human experience (Anderson, 1991). However, Morse (1991,p15) considers that overmodification and mixing of the methods produces a "sloppy mishmash". On the other hand, Powers and Knapp (1990) express the view that attempting to adhere to prescribed methods may stifle the creativity and interpretative ability of the researcher.

Indepth interviews and detailed observation are methods frequently used to collect qualitative data. In the latter, the researcher is also frequently a participant (Leininger, 1985). Common to most qualitative methods is an holistic approach to data gathering and analysis. An

example of this is Benner's analysis of narrative text or "stories" obtained in the course of her research interviews (1984). Benner stressed an holistic approach to data gathering and analysis in which the 'whole' story is considered in context to reflect the reality of the situation. The whole text (paradigm case) is compared with analysis of textual components (exemplars) and other whole texts for similarities and differences. In this way new questions, understandings and themes emerge (Benner, 1985).

Minimising Error

In qualitative research accurate measurement is not the aim. Nevertheless, it is important to minimise error and ensure authenticity as far as possible. There are many potential sources of error. These may be related to the study population, the research instruments, researcher bias or faulty interpretation of results (Oppenheim, 1966). Error in any part of the study can affect its validity and reliability. Thus the ability to achieve results which are real and true may be compromised (Brink, 1991).

Validity And Reliability

In qualitative studies controls for bias are generally built into the research design. However, the terms validity and reliability are considered in different ways.

Validity in qualitative studies is concerned with the accuracy and truth of the data presented. Methods used to ensure validity include the cross-checking of data by the informants themselves, detailed record keeping and memos of the researcher's actions and impressions and critical self-reflection (Powers and Knapp, 1990).

Reliability is judged by the clarity of the research report. If the method can be followed and replicated by another researcher and similar conclusions drawn, the research is considered reliable (Powers and Knapp, 1991). Inter-rater reliability is the extent to which two or more individuals examining the data independently agree on the scoring/judgements made. This technique is used to demonstrate

objectivity in the analysis of qualitative data. On the other hand, Chenitz and Swanson (1986) suggest that where analysis is dependent on the researcher's skill, creativity and analytical ability, that no two analyses will be the same.

Triangulation

Triangulation is a term originating from the fields of surveying and navigation. Various views are expressed as to its meaning in relation to research. It may be considered as the use of two or more methods of data collection in one study (Cohen and Manion, 1986). Knafl and Breitmayer (1991) describe it as the combined use of quantitative and qualitative methods. The use of more than one researcher, bringing different perspectives to a study may also be considered as triangulation.

The aim in all three cases is to provide a more detailed picture of the phenomena under study. Triangulation is especially appropriate when a more holistic view is desired or when studying complex phenomena (Cohen and Manion, 1986).

Triangulation may also be seen as a way of cross-checking or cross-validating to counteract the bias of any single method (Knafl and Breitmayer, 1991).

The Role of the Researcher

In qualitative research it is impossible for the researcher to be a detached observer. To obtain the necessary depth of data sought, data collection methods tend to include personal involvement of the researcher with the subjects (Powers and Knapp, 1990). Indepth interviewing and detailed descriptions of observations are methods frequently employed. The researcher becomes part of the data by interacting with it in a reflective and intuitive way.

Reduction of subjectivity and bias on the part of the researcher is of major importance in qualitative studies. Providing the researcher is aware of any possible effect their own attitudes and behaviours may

have on the subjects and does not attempt to manipulate, the relationship between the researcher and the researched can be advantageous (Bergum, 1991). The empathy which can be demonstrated by the researcher who shares common experiences and concerns may help the subjects to verbalise experiences and thoughts. This in itself may give rise to problems. Buckeldee (1990) described the dilemma of being unable to act on the information elicited from subjects once encouraged to verbalise feelings.

3.2 METHODS OF DATA COLLECTION AND ANALYSIS RELEVANT TO THE STUDY

Descriptive Research

Descriptive research is a method frequently used in relation to education. Concerned with what has already occurred, descriptive studies have been termed as developmental research studies because they seek to describe how things are and how they change over time. Three types of descriptive research are described - longitudinal, cross-sectional and trend studies. All are important in educational research because of the process of development which education seeks to achieve (Cohen and Manion, 1986).

Questionnaires

"Questionnaires are designed to elicit information through written responses of subjects" (Cormack, 1991). The questionnaire has the advantage of being a relatively inexpensive and efficient data collection method (Hoinville and Jowell, 1978). Postal questionnaires allow subjects to be reached who would be inaccessible for interview. The cost in terms of time and travel to diverse locations is avoided. Hoinville and Jowell (1978) suggest another advantage of the postal questionnaire is the opportunity afforded the subjects to give more considered opinions.

Sources of error in the postal survey method are limited to the sample and the instrument (Cohen and Manion, 1986). For these reasons the questionnaire must be unambiguous and understandable to the population.

The study population must have the intellectual ability and motivation to complete the questionnaire truthfully (Oppenheim, 1966).

In general, the response rate to questionnaires tend to be poor (Oppenheim, 1966 ; Cohen and Manion, 1986). The other main disadvantage is the inability to clarify or explore the respondents' answers (Hoinville and Jowell, 1978; Cohen and Manion, 1986). Therefore, questionnaires are most appropriate for obtaining fairly superficial information from large numbers of respondents (Fox, 1982).

Interviews

The purpose of the research interview is to elicit information by means of direct interaction between the researcher/interviewer and the subject (Cohen and Manion, 1986). Such interaction allows for flexibility and deeper exploration of responses. The interviewer has a measure of control over the depth of responses (Fox, 1982). The degree of control depends on whether the interview is structured, semi-structured or unstructured.

Structured interviews are used to ensure no vital details are missed. A uniform approach to questioning is used to limit or control the response. Such restrictions are generally undesirable in qualitative research (Leininger, 1985).

In contrast, unstructured interviews allow the interviewee total flexibility to pursue any avenue. It allows the subjects to relate their "stories" in their own way. Although questions are determined by the research purpose, there is minimal direction by the researcher (Leininger, 1985). This approach is best suited to situations which involve complex attitudes or of which existing knowledge is limited (Cohen and Manion, 1986).

Semi-structured interviews represent a compromise between a structured and unstructured method. This allows both specific and unanticipated information to be obtained (Leininger, 1985). The interviewer must have knowledge of the situation to be able to pick up cues and prompt

for more information where gaps are identified. A prompt schedule or guide is usually used to ensure specific objectives are achieved.

The interview method is very costly and time consuming in terms of data collection and the subsequent analysis. Fox (1982) suggests that it should only be used when the required data could not possibly be obtained by simpler measures. The other main potential disadvantage is the risk of bias and subjectivity of the interviewer.

Kitwood (cited by Cohen and Manion, 1986) suggests that the interview can be considered:-

1. a simple transfer of information in which a skilled interviewer can eliminate bias, or

2. a transaction in which bias is inevitable and must be recognised and controlled, or

3. an encounter with many features of everyday life, including the inability to control all aspects.

All three concepts are used in research interviewing depending on the purpose of the study.

Diaries

The diary technique in research is used to obtain an accurate record of specific activities of the respondents over a period of time (Oppenheim, 1966). It is particularly useful for obtaining rich, detailed data which may be forgotten if not recorded immediately. In a study of the work of primary school teachers, Nias (1991) considered the diary technique useful in corroborating data obtained through interviewing. However, she considered interview data to be more reflective and detailed than that obtained by diary recording.

The technique is very arduous and time consuming for the subject to record and for the researcher to analyse. There is also a risk that the subject's behaviour will be influenced by the exercise (Oppenheim,

1966). There is no way of knowing if the selected time span is representative. Oppenheim (1966) suggests that there are so many problems associated with the diary method that it should only be used if absolutely necessary.

The Critical Incident Technique

The Critical Incident Technique (CIT) is now a standard research tool within the social sciences. It involves the gathering of factual information based on first hand observation. It aims to gather precise information and keep generalisations to a minimum. The technique was first developed by Flanagan (1954) to systematically collect and organise direct observations of significant human behaviour. The purpose of collecting such data was to help solve practical problems specifically in relation to selection procedures for air crew in the United States Army Air Force in World War II.

As part of the aviation psychology programme, Flanagan sought to analyse the specific reasons for failure in learning to fly. Instructors' reports on failed pilots frequently described them as being of unsuitable temperament or having poor judgement. These statements gave very little useful information and provided no basis for further selection since it was unclear what was a suitable temperament.

The work of Flanagan and others, cited by Flanagan (1954), led to the formulation of critical requirements for success in specific jobs or assignments. An example of this was the problem of combat leadership. In an attempt to differentiate between effective or ineffective behaviour, combat veterans were asked to recall incidents which they had observed that "involved behaviour which was especially helpful or inadequate in accomplishing the assigned mission". They were asked to describe the officer's action by simply asking "What did he do?" From this a set of categories was obtained which described the critical requirements of combat leadership.

This was followed up with similar studies in an attempt to refine the technique (Flanagan, 1954). Studies involving the comparison between

the CIT and the daily recording of performances in a diary showed similar patterns. It was concluded that the CIT could be relied upon to provide an accurate account of job performance.

Over the years, the CIT has been modified for use in a wide variety of situations and by many different professions. Forest (1983) used this approach to determine training needs of qualified nurses. He asked the subjects to recall a situation which "posed her some concern, either because she did not know what to do or because she did something she felt was incorrect, inappropriate, or ineffective". This approach by Forest allowed categories of need to emerge from the data and avoided preconceived ideas. Used as a basis for identifying situations where all was not well, it was considered more reliable than simply asking individuals what they thought they needed.

The CIT has since been used to evaluate the performance of student nurses (Flanagan, Gosnell and Fivars, 1963 ; Sims, 1976 ; Newble, 1983) and dietetic students (Ingalsbe and Spears, 1979). It has also been utilised to determine teacher effectiveness (Weitzenfield, Watson, Argo and Chapman, 1982), to assist in curriculum development for medical students (Hayes, Fleury and Jackson, 1979) and to determine competencies in nursing (Bailey, 1956), in medicine (Sanazaro and Williamson, 1968) and pharmacy (Dunn and Hamilton, 1986).

The CIT had generally been used to identify attributes and inadequacies in performance. However Flanagan (1954) suggests that "it should be thought of as a flexible set of principles which must be modified and adapted to meet the specific situation at hand". While Flanagan's subjects were generally reporting observations of the behaviour of others, the observers have also been participants in the events in other studies (Dunn and Hamilton, 1986).

Few studies report on the shortcomings of the CIT. However, a study by Dachelet, Wemett, Garling, Craig-Kuhn, Kent and Kitzman (1981) to identify factors which influenced learning in the clinical situation drew attention to the problems of:-

1. failure of recall;

2. distortion of facts when information may be sensitive;

3. under-representation of more frequent, but less spectacular experiences;

4. subjective classification of incidents;

5. reported incidents being unusable or unrelated to the purpose of the study;

6. the variable degree of interest and specificity of those reporting the incidents.

Sims (1976) warns about misunderstandings over the term "critical" when the subjects are health professionals. Sims also experienced difficulties in convincing nurses of the worth of the exercise. Obtaining precise details rather than global comments proved to be a difficulty for Newble (1983).

Content Analysis

Content analysis is "a procedure for the categorisation of verbal or behavioural data, for purposes of classification, summarisation and tabulation" (Fox, 1982 ;p391). This can be taken to several levels. The most superficial would be determining the frequency of particular words or concepts without any interpretation by the researcher. These may be ascribed "feeling tones". It may involve the identification of categories and units of analysis. These are determined and sorted by the researcher and will be peculiar to particular studies. Thorough explanation of the rationale and methods used in this process are required.

Content analysis has been criticised as being more appropriate to quantitative research (Powers and Knapp, 1990). This is on the basis of the reduction of data to numerical terms and of distortion of the data by stripping it of its context (Leininger, 1985).

Identification Of Themes

Identification of themes or categories is often used in qualitative studies to avoid distortion of data. Thematic analysis involves the identification of pieces of data which may be mean little in isolation, but can be grouped together in a meaningful way (Leininger, 1985). Benner (1985) used the identification of common themes in her interview transcripts together with excerpts to illustrate these. She suggests this approach serves to discover and to present the common meanings in the data.

CHAPTER 4 - THE METHOD

A qualitative approach was considered to be most appropriate for the purposes of this study. This was consistent with the concept of holism and individuality which had been evident throughout the literature review. The essence of palliative care is to respond to each patient as an individual, encompassing his whole being and those close to him. Meeting the needs of the patient's body, mind and soul in unison is considered to be the cornerstone of palliative care (Chapter 2.3).

It was also clear from the literature that the ability to deliver such care depends on more than knowledge and skills. It requires the adoption of the whole philosophy of palliative care and a certain attitude of mind.

An holistic, individualised approach was discussed also in terms of adult education. Learning was described as a highly individualised activity which involved more than the transmission of knowledge. The learner should be considered important as an individual. Learning is influenced by past experience, existing knowledge, relevance to the learner's situation and the desire to learn. The application of learning to clinical practice is also influenced by several factors. These are related to the individual's knowledge, skills and motivation, the nature of the learning/change and the resources available within the clinical environment.

In this study, the subjects' experiences of learning and delivering care were likely to be shaped by many factors. Therefore experiences could be expected to be individual and subjective. Isolation of single aspects would have failed to capture the reality of the situation for those concerned.

It was important to preserve the meaning of the individuals' experiences in attempting to integrate newly acquired knowledge and skills into practice. This required a broad, holistic view of the data. A qualitative approach was considered most appropriate to capture the reality and complexity of the experiences. Nonetheless, it

was anticipated that some quantitative aspects would be incorporated into the collection and analysis of the data where appropriate.

An experimental approach was not considered suitable because:

- the total population had to be included to obtain a sample of sufficient size. As this would be include past participants it would not be possible to gather data prior to the educational input.

- the population from which the sample would be drawn lacked homogeneity.

- adequate control of the learning experiences would not be possible.

- information not previously anticipated could have remained undiscovered.

The choice of research methods was also influenced by the literature in relation to adult learning (Knowles, 1984; Peters, 1979), the reliability of self-perception as an indicator of effect (Fuhrmann and Weissberg, 1978; Warmuth, 1987; Burnard, 1988; Alexander, 1990) and the importance of factors other than educational input (Keiser and Bickle, 1980). Consequently, certain assumptions were made.

First, the participant was the common factor in the theoretical input, the clinical placement and the work experience before and after the course. No other person could reflect on the total experience. Participant opinion was therefore assumed to be that of the "expert" for the purposes of determining the outcome of the modules.

Secondly, self-perception of enhanced knowledge and skills, utilisation of learning and increased self-confidence would be reliable indicators of outcome.

Thirdly, the ability to implement change would depend on numerous factors related to the nature of the change itself, the individual, their environment and the support of management and colleagues.

Therefore, the outcome of education was likely to be highly individual, even if the input had been well controlled. Attempts to describe the outcome of education in terms of standard achievements and tasks would fail to capture its true value. A wider focus would be required to identify all the factors involved and to understand the process of integrating learning into practice.

4.1 DATA COLLECTION

Constraints of time and limited experience on the part of the researcher precluded the use of in depth interviews or detailed observation required by methodological approaches such as phenomenology or ethnography. It was not possible to undertake data collection of this scope or level. The descriptive survey approach which was selected reflects the exploratory nature of the study. The intention was to capture an overview of the participants' perceptions of the outcome of the PSII Modules. This would be supported by a more detailed examination of the experiences of a subsection of participants.

To achieve this, three methods of data collection were developed; a structured questionnaire; a semi-structured interview; the CIT. The questionnaire was intended to gather mainly quantitative data. The interviews and gathering of Critical Incidents were intended to illuminate these data by allowing more detailed expression of the subjects' experiences. It was anticipated that richness would be added to the data by combining these methods. It was also hoped that a fuller, more complete picture of the participants' experiences could be achieved in this way. It also represented an attempt to compensate for inadequacies of each data collection method.

The Questionnaire

A questionnaire technique was considered appropriate for the first part of the study to obtain:

- simple demographic data from the whole participant population;
- an overview of certain opinions and experiences from the whole participant population;
- baseline information which could be expanded in an interview situation with participants. Interviews could then be kept as brief as possible.

The questionnaire (Appendix 1) was produced using guidelines for maximising response rate of postal questionnaires (Hoinville, Jowell and associates, 1978). Attention was paid to the appearance and layout. Coloured paper was used. Questions were well spaced. Questions relating to particular topics were grouped together. Related questions were sublettered to create an appearance of brevity. Wording of questions and instructions was kept as simple and clear as possible. 'Tick' responses were requested to most questions to simplify the respondent's task and minimise time required for completion. This was also intended to facilitate analysis. At the end of the questionnaire, respondents were thanked for their cooperation.

Content of Questionnaire

A number of important themes were identified as a result of the literature review and involvement in peer group discussion. The development of these themes was facilitated by the work of Keiser and Bickle (1980) and Warmuth (1987).

Keiser and Bickle's model (1980) for evaluating outcome of CPE is based on the theory that Behaviour is a Function of Knowledge plus Psychomotor Development plus Motivation, plus Resources, i.e. $B = f (K + PD + M + R)$. Warmuth (1987) stressed the importance of the

participant's self perception of the value and utilisation of learning. In addition, failure to apply learning was found to be related to three areas - the individual; the education; the work environment.

In light of these studies the questionnaire was constructed to incorporate the following themes:

- The participant's motivation and expectations/ perceived learning needs.
- Nurse Manager support and involvement in staff development.
- The participant's perception of the impact of the course on their practice.
- Factors affecting ability to apply learning or implement change.
- Acceptance of expertise/attitudes of colleagues.
- Strengths and weaknesses identified by participants in the course and in the clinical environment.

The questionnaire was constructed to incorporate these themes at a superficial level. Most questions were closed, but some open questions concerned the content of discussions between the participants and their Nurse Managers. Questions related to discussions prior to attending the module(s) represented an attempt to determine the extent of Nurse Manager interest in staff development. Secondly, an indication of the degree to which the Nurse Managers helped participants to identify learning needs was sought. It was hoped that evidence would emerge of Nurse Managers enabling the participants to clarify their aims and lay the foundations for improved patient care.

Participants were also requested to state which, if any, plans they had for improving care following the module(s) and if these were discussed with the Nurse Manager. This was intended partly to indicate the level of support and interest of the Nurse Manager in facilitating change in

practice. It was also to determine if the participants had any clear ideas or plans to utilise their learning which could be used as a basis for evaluation of outcome.

Semi-structured Interview and Critical Incident Technique

Interviewing was to be undertaken to allow a deeper level of questioning than was possible in the questionnaires. A semi-structured format was to be used to maximise the ability to introduce probing questions, while still confining questioning to specific topics. Another advantage of interviewing was considered to be the opportunity to clarify and expand on information already given in the questionnaire. Each interviewee was to be shown her questionnaire responses and asked to comment or expand on relevant parts.

A prompt schedule was developed for the interview (Appendix 2). This was designed to allow respondents to expand or clarify responses to the questionnaire. It would also serve to further explore various themes.

Two independent teachers of similar PSII modules were asked to review the schedule. They were asked to comment specifically on whether there was any part which they perceived to be difficult for nurses who had completed such modules to answer. They anticipated no difficulties.

The CIT was considered a useful method for enabling the subjects to focus on specific aspects of their experiences in applying learning to practice. Much of the learning on the modules was experiential. All aspects of care were involved - physical, spiritual and psychosocial. There was concern that some abstract concepts would be difficult to articulate in response to direct enquiry. It was hoped that sources of facilitation and difficulty in application of learning could be identified by encouraging detailed descriptions of particular incidents as examples of their experiences.

Suitable incidents were defined as events which led to particularly satisfying or unsatisfying consequences. In an attempt to avoid implied criticism of the subject, the focus was to be on the event, rather than the individual. The events were to be described by the

individuals who were best placed to describe them. Therefore, the observers were also the participants in the events. In seeking out the reality of the situations, each would be individual. Therefore, it would not be possible to generalise findings.

4.2 DATA ANALYSIS

Questionnaire

A master recording sheet was prepared on which a range of possible responses to closed questions were assigned a numerical code. All codes were entered into a computerised database. Codes could not be assigned to the open questions until all questionnaires had been returned. Once these data were gathered, a coding frame was to be designed. This was intended to be a simple categorisation of content. Three other independent researchers/teachers were to be asked to check this analysis. However, it was anticipated that the questionnaire format would avoid the likelihood of having to analyse lengthy pieces of text.

Interviews and Critical Incidents

Clearly identified methods of analysing qualitative data such as grounded theory were not entirely appropriate for this study because of limited time. However, it was intended that the approach should remain faithful to the spirit of qualitative research. The aim was to capture an understanding of the whole experience of the participants' efforts to apply learning to practice. Common themes and patterns would be identified and examples provided to illustrate these.

The interview questions would explore various themes. It was anticipated that other themes may emerge, particularly from the Critical Incidents which would allow the interviewees to describe experiences of their choosing. Sections of the data relevant to each of the themes would be separated. Taking each theme in turn, the data would be examined. Significant phrases or sentences would be marked and assigned a code word or phrase which conceptualised each piece of data.

Reference would be made continually to all the sources of data to obtain a fuller and clearer picture of the participants and their experiences. Themes and categories which were considered to capture the essence of the data would be identified and developed. Each would be contrasted and compared. Random samples of the interviews and Critical Incidents would be examined by an independent expert together with the researcher's notes. This would help to ensure that the observations were a true representation of the data and that no relevant issues were omitted.

CHAPTER 5 - PILOT STUDY

A pilot study is defined by Fox (1982;p43) as a "miniature of some part of the actual study, in which the intended instrument is administered to subjects drawn from the same population as will be used in the research, or a similar population". Fox (1982) acknowledges the constraints of time which can result in omission of a pilot study or pre-testing of selected parts only. Treece and Treece (1986) suggest that it should be a complete ministudy to identify weaknesses in the design. It should differ from the main study only in terms of numbers of subjects. Limitations of time in the present study made it necessary to follow Fox's definition and restrict piloting to certain parts of the study. However, the pilot work begins at a much earlier stage to give general impressions of the subject area (Oppenheim, 1966).

5.1 EXPLORATORY WORK

Informal discussion with colleagues took place over a period of several months. These included past recipients of CPE, researchers and general or palliative care nurse teachers. In the main study it was intended that indepth information be obtained regarding relevant experiences of nurses who had undertaken the modules. Two methods of data collection were initially considered for this purpose. The first involved keeping a 'diary' for three consecutive shifts. The requirement was to record all involvement with dying patients or their families and relevant contact with other staff during these shifts.

In the second method, two Critical Incidents were to be recorded pertaining to care of terminally ill patients, their families, or staff caring for them. The Critical Incidents were to reflect situations in which the nurse was able to use something learnt on the course to positive effect (positive Critical Incidents) and situations in which it proved difficult to do so (negative Critical Incidents). This exercise was also to be carried out on three consecutive shifts.

5.2 PRE-PILOT STUDY

Two subjects were approached and asked to help with the testing of the diary method and the CIT method. These individuals had been identified by the course tutors as being sufficiently motivated and capable of undertaking such exercises. Permission to approach the testers was obtained from the relevant senior nurse. Initial approach was made by telephone. The tasks were further discussed in person, at their place of work. The guidelines issued to both parties can be seen in Appendix 3 & 4. Both nurses expressed a willingness to give their assistance. One nurse was asked to test the diary method. The other was asked to undertake the recording of Critical Incidents. They were then excluded from the main study.

The nurse who tested the CIT expressed the opinion that recording so many incidents was "quite an onerous task". Writing the 'negative' incident had been particularly difficult but the nurse was unable to explain why.

The nurse who had agreed to undertake the diary exercise failed to complete this task, despite numerous reassurances that even if incomplete, her comments regarding the difficulties would be helpful. It is not possible to be certain of the reason(s) for noncompliance. The onerous, time consuming nature of the exercise may have been an important factor for someone working in a busy, acute care setting. However this is only speculation.

As a result, it was decided to include a modified form of CIT in a more formal pilot study.

5.3 FIRST PILOT STUDY

The purposes of the pilot study were fourfold. These were:

(1) to test the Participant Questionnaire (Appendix 1) for ambiguity in question phrasing;

(2) to provide the researcher with experience of interviewing;

(3) to determine the effectiveness of the Critical Incident Technique as a method of data collection;

(4) to provide a framework for an interview schedule.

In view of the small sampling frame for the main study, there was reluctance to remove any potential subject for a pilot study. When such a difficulty arises Oppenheim (1966, p30) suggests that a group is used which is "comparable in their knowledge and ways of thinking". A decision was made to use a comparable group of subjects in a different geographical location. Both the pilot and study group consisted of registered nurses with widely varying degrees of knowledge and skills. Both groups had been seconded to a course on care of the terminally ill which had been approved by the NBS for PSII. The philosophy and much of the content were similar in both courses.

The course in the pilot study differed from that of the main study in that only one module was offered, rather than three. The one module in the pilot area attempted to cover the same content by means of encouraging self-directed and contract learning. It also differed in that all of the clinical experience was either hospice-based or in the community with Macmillan Nurses. Some of the clinical experience in the main study area was gained in hospital wards which had been approved as suitable learning environments. However, an exact match was not thought to be necessary to fulfil the aims of the pilot study.

Access to the subjects in the pilot study was discussed informally with the course tutor and written permission gained from the Director of Nurse Education (DNE) in March 1990 (Appendices 5 & 6). The course

tutor then approached the subjects on behalf of the researcher to request their assistance with the project at a later date. This approach was made during the course of the module. Six subjects agreed to complete a questionnaire. This was sent to them in July 1990 when they had returned to their own working environment.

Four questionnaires were returned. Three respondents agreed to be interviewed. The data gained were not formally analysed but the responses were examined for evidence of misunderstandings or difficulties in answering the questions. These findings were then discussed with the course tutor and an independent researcher.

Problems Identified by the Pilot Study

The problems identified as a result of the pilot study were first that the tone of the questionnaire may have been too formal and not "user friendly". Secondly, the instructions regarding the Critical Incidents were not sufficiently clear. Subjects had been requested to consider one positive and one negative critical incident. The guidelines for this were included in the questionnaire to enable subjects to give some thought to the exercise prior to the follow-up interview. They were then asked to relate the incidents verbally.

It was also considered that the explanation of the interview at the end of the questionnaire could have been perceived as implying criticism of the subject's ability to effect change.

Much of the information yielded in the interviews was superficial and incorporated many sweeping statements. An initial difficulty in obtaining precise information became less pronounced as experience in interviewing was gained. It was also evident that subjects who had appeared somewhat reticent about submitting their opinions and ideas to paper had no such difficulty in expressing themselves verbally. This may have been a natural reluctance to commit ideas to paper. However the formal tone of the questionnaire may have contributed to this.

The subjects obvious willingness to discuss their successes and difficulties at great length created problems with timing from the

point of view of both the subject and the interviewer. Some of them had so much to say, either because they were so full of praise for the course or because they had experienced considerable difficulties in their work situation and seemed to need to unburden themselves. When a particular problem was raised, some subjects clearly wanted to give as many examples as possible to illustrate the difficulty. The researcher may have been fulfilling an important need of the interviewees when this occurred.

At these first interviews, the opportunity was taken to ask the subjects for comments on the questionnaire. In general they were pleased to have the opportunity to offer such feedback. The only negative comments related to the explanation of the interview and the Critical Incidents. There was a lack of understanding of what was required of them. Consequently, it had been ineffective in allowing the subjects to come to the interview prepared to relate two Critical Incidents.

Alterations as a result of the Pilot Study

Following the first pilot study the wording of the questionnaire was altered in parts to appear less formal. Some existing questions were made more specific. The number of open questions was reduced in favour of set options. These were derived from the pilot study responses. The opportunity to add other responses to these was retained. Two questions were added. One of these related to the value of the pre-course interview with the Nurse Manager which had been omitted from the first questionnaire. The second related to the perceived strengths and weaknesses of the module(s).

The range of options was altered for the question relating to the perceived benefits of the course. The column indicating that they had been helped 'a moderate amount' was removed to encourage more definite responses between 'a little' and 'a lot'. One other column was added to allow an indication of those aspects in which the respondents felt that they were already knowledgeable or experienced prior to the module(s). It was recognised that such a response could only indicate the subject's perception of their own knowledge and skills and may not

be wholly accurate. However it did avoid negative responses which failed to identify a level of knowledge which was perceived as adequate and which unintentionally reflected badly on the module(s).

The final alteration to the questionnaire involved the deletion of the explanation and request for interview. This was replaced by a simple question regarding their willingness to provide further information to the researcher. If so, they were requested to provide a contact telephone number. This allowed the respondents to choose if the point of contact was their place of work or home.

It was evident from the pilot study that interviews required to be more specific and structured. Whilst there was no desire to inhibit the interviewees, some measure of control was required to obtain detailed, in-depth information about one incident rather than opinions of experience in general. Use of the CIT did seem to be a useful way of focussing the subjects attention on particular points.

Although no formal analysis of the pilot study questionnaires and interviews was undertaken one particular theme occurred frequently. The extent to which interest was shown and support offered by Nurse Managers, appeared to be an important issue for the participants. Consequently, it was decided to attempt to obtain data on the Nurse Managers' perception of their role in staff development. While the Participant Questionnaire and interviews were being piloted for the second time, a questionnaire was developed for Nurse Managers (Appendix 7). Unfortunately constraints of time prevented the piloting of this instrument. In view of this, results can only be considered suggestive and not conclusive.

5.4 SECOND PILOT STUDY

Following modifications, a second small pilot study was carried out with another group of subjects who had undertaken the single module. This allowed further interview experience and a test of the modifications. On this occasion five questionnaires were sent, three of which were returned. One of the nonresponders had moved away with an unknown forwarding address.

Two respondents had agreed to provide further information and had given a contact telephone number as requested. When the contact was made they were thanked for their assistance and asked if they would be willing to be interviewed informally. It was explained that part of this would involve clarification of some of their questionnaire responses where necessary.

It was also explained that the main purpose was to ask about two situations or events which had occurred in their work environment and which reflected attempts to utilise what they had learnt on the course. These were to involve either a patient who was dying, the patient's family or another member of staff who had been involved in caring for the patient. One incident was to represent a situation which they considered to have a positive outcome. The other was to be an example of a situation which had not turned out as they would have wished. This may have been because their input had not had the desired effect or because they had been unable to implement the care which they felt to be appropriate.

Following this second pilot study a few minor alterations were made to the wording of some sections of the questionnaire and the interview schedule. Since no major changes were considered necessary and time was limited, it was decided to proceed with the main study.

CHAPTER 6 - MAIN STUDY

6.1 FOCUS OF THE RESEARCH

To facilitate understanding of the research approach and findings the philosophy and structure of the course will be explained in detail.

The PSII course in Care of the Terminally Ill Patient was introduced in September 1987 by the Glasgow South College of Nursing. It was significant in that it was the first course of its kind to be approved by the NBS. It was also first to offer planned clinical experience as part of the course. The course was also unique in that it provided nurses with the opportunity to function in a supernumerary capacity while undertaking indepth study of terminal care nursing.

Rationale of the Course

"To increase the knowledge and skills of the nurse in care of the terminally ill patient." (Course Information)

Aims and Objectives of the Course

The aim of the course in "Care of the Terminally Ill Patient" is:

> To prepare the nurse to provide the best quality of life for the patient with a terminal illness, whether at home, in hospice, or in hospital, and to enable him/her to give appropriate support to the relatives and friends during this period and throughout the subsequent bereavement period. (Course Information)

Specific learning objectives are laid down for each module which encompasses cognitive, affective, behavioural and attitudinal components (Appendices 8,9 & 10).

Structure of the Course

The course is offered as three separate, autonomous modules:

Module One	-	Attitudes to Death and Dying
Module Two	-	Quality of Life
Module Three	-	Coping with Loss

Modules can be taken singly or in combination with modules of a different nature. However, for nurses who already hold PSI Certificates, undertaking all three modules leads to attainment of the Diploma of Professional Studies.

Each module is of 45 days duration. In each, there are ten days of theoretical instruction and 35 days on clinical placements. Clinical experience during Modules One and Two is gained in the hospice setting and in an environment similar to the participant's own place of work. Experience in Module Three was initially divided between the participant's own clinical area and a placement in a hospital or community setting different from their own; for example, nurses normally working within a hospital setting would have the opportunity to gain experience in the community and vice versa. In November 1989 this was altered. At present, no part of the clinical experience is spent in the participant's own clinical environment (Appendix 11).

Entrance to the Course

To gain entry to the course two criteria are required. Candidates' names have to be entered on the current UKCC, register in parts One, Three, Five or Eight. Secondly, candidates are required to have a minimum of eighteen months post registration experience if qualified before 1983. Those qualified after this date are required to have completed PSI.

Application to the course may be made by the candidate directly. Alternatively, the Nurse Manager with line management responsibility for the candidate may apply on their behalf. A maximum of twelve candidates are accepted for each module.

Course Content

The ethos of the course is grounded in the philosophy of palliative care (Chapter 2.3). Quality of life, role of family and friends and staff support are core themes.

Teaching Strategies

Teaching methods are varied and learner centred. Course participants are drawn from a wide range of clinical settings. Each may have a very different knowledge base, personal and professional experience. In the classroom setting considerable time and attention are given to sharing and exploring feelings, ideas and values. The small number of nurses accepted for each module is intended to encourage active participation. In this way learning from the valuable and varied experience of each individual may be facilitated. The group dynamics, with adequate opportunities to discuss experiences and support each other, is considered to be a vital component of the PSII Course.

Learning Strategies

Reflective and self directed learning are important components of the course. To provide nurses undertaking the modules with the time for reflection in the clinical placements, they are afforded supernumerary status. Weekly meetings of the participant and their clinical supervisor are scheduled to discuss progress, review competencies and identify learning goals for the coming week.

Assessment of Learners

Two main methods of assessing learning are utilised. These are written assignments and formative assessments of clinical competence. Written assignments are used to assess:

- knowledge gained;
- evidence of private study;
- application of learning - on clinical placement or considered for own work environment;
- presentation skills.

In Modules One and Three, assignments take the form of extended essays relevant to the content of the modules (Appendices 12 & 14). The requirement for Module Two is the production of a nursing care profile and symptom control package (Appendix 13). The subject matter is determined by the learner in consultation with the course tutor.

Clinical competencies are evaluated by means of continuous assessment by clinical supervisors. Achievement of specific objectives appropriate to each module are required. Others may be set by the learner in conjunction with the supervisor to meet individual learning goals.

Evaluation of the Course

Participants are requested to complete an evaluation form at the end of each module. Comments are invited on the:

- pre-course information;
- theoretical programme;
- clinical experience;
- assessments.

No further follow-up was carried out by the College of Nursing.

After the Course

The existing methods of evaluation have been able to satisfy the Course Organisers that the required levels of knowledge and clinical competence have been achieved by those participants who have successfully completed the modules. However, it has not been possible to ascertain the extent to which the knowledge and skills gained have been integrated into practice. Nor is it known what difficulties have been encountered by participants who have attempted to apply their learning to clinical practice.

Nurses who undertake the modules are absent from their clinical base for a period of between nine and 27 weeks, depending on the number of modules taken. During this time, it is anticipated that their

knowledge and skills will be enhanced. However, the staff with whom they work may have little understanding of this process. Likewise, the work of their ward or unit would goes on, perhaps undergoing change, from which they have been excluded.

These circumstances may influence the extent to which learning is integrated into practice. In the literature review, the work environment was one factor implicated in determining the extent to which change could be implemented. Other factors were linked with the individual and with the nature of learning and change. This study seeks to gain an understanding of the experiences of the participants in their attempts to integrate newly acquired knowledge and skills into clinical practice.

6.2 RESEARCH OBJECTIVES

The research objectives have already been stated following the literature review. However, they are reiterated below as an introduction to the description of the main study.

The objectives of the study were to:

1. explore the outcome of the PSII course in Care of the Terminally Ill Patient;

2. determine the benefits of the education programme as perceived by the individual nurses who have participated;

3. examine the factors which were perceived by the nurses to either facilitate or hinder the integration of the knowledge and skills gained into their own practice;

4. identify strengths and weaknesses in the programme and in the clinical environment;

5. make recommendations for evaluation of future education and support of nurses participating in CPE.

6.3 POPULATION AND SAMPLE

The study took place in three parts. The sample differed for each part.

Sample One

The study population consisted of 55 registered nurses who had completed one, two or three modules of the PSII Course in Care of the Terminally Ill Patient offered by Glasgow South College of Nursing and Midwifery. In view of the small numbers involved it was considered legitimate to seek the opinions of the whole study population. It was recognised that as the numbers were small, no generalisations could be made. However, as an exploratory study the possibility existed that certain trends might emerge. The timespan involved course participants from the introduction of the course in September 1987 until November 1990 inclusive. This sampling frame was obtained directly from the college records. Two individuals were excluded as they had been involved in assisting with testing data collection methods early in the study. A total of 36 participants volunteered to take part in the study.

Sample Two

The second sampling frame consisted of the 36 participants who had volunteered to take part in the study. Sample selection was made on the following criteria.

- Subjects should have indicated a willingness to be interviewed.

- Subjects should have been seconded from a hospital environment.

- Subjects should have worked in the same clinical area but not necessarily in the same ward or in the same capacity, since undertaking the module(s). This took account of those staff nurses who had gained promoted posts in the interim.

- Subjects should be employed full time either on day duty or a day-night rotation. Those employed part-time were to be rejected on the basis that this would have introduced another variable.

- An equal number of subjects were to be included from the grade of staff nurse and ward sister/charge nurse.

The decision to restrict the selection of the sample to those nurses who worked in a hospital setting was based on several factors.

1. Personal experience, supported by reports in the literature indicated that implementing palliative care philosophy in the acute care setting can be difficult.

2. Most of the course participants were hospital based.

3. Excluding other care settings reduced the number of independent variables.

The above criteria also excluded Community Nurses, Macmillan Nurses or any subjects in a specialist role. The rationale for this was the assumption that by working in relative isolation, their experiences of integrating learning and practice may have been quite different from those who worked closely with others and in perhaps a more restrictive environment. This would have been an interesting area to explore, but was outwith the scope of this study.

The optimum number to be selected for interview was set at twelve. If it was not possible to obtain adequate numbers fulfilling the above criteria, subjects whose clinical area had changed, were to be

considered for inclusion. Even so, it was not possible to obtain a sample of twelve. A total of eleven subjects took part.

Interview Selection - Charge Nurses

A total of five Charge Nurses were interviewed. Of the eight Charge Nurses who responded to the questionnaire one did not wish to be interviewed. Subjects were not requested to state their reasons for refusal. One further interviewee was held in reserve because of a failure to respond to the question regarding a willingness to provide follow-up information. Three of the remaining Charge Nurses were excluded because of career changes which meant they no longer met the criteria for selection.

Only three Charge Nurses who fulfilled the criteria remained. Two of these continued to work within the same hospital/clinical area in the same capacity. The other had changed setting but continued to function in the same capacity.

Having failed to obtain six participants of Charge Nurse grade who met the criteria, the list of other respondents was examined. Two participants who had been Staff Nurses at the time of undertaking the module(s) had been promoted to Charge Nurse grade within the same clinical area prior to the study. Both of these were subsequently included in the Charge Nurse group.

A letter and reply slip was then sent to the respondent who had not indicated either a willingness or refusal to be interviewed. The reply confirmed that the individual did not wish to be interviewed. Consequently, only five subjects were suitable for inclusion in the Charge Nurse Group. All five were employed full-time on day duty.

Interview Selection - Staff Nurses

A total of six Staff Nurses were interviewed. Of the fifteen respondents who were willing to provide further information, six were excluded because of career changes. Of the remaining nine , five were employed in the same hospital, three in one ward and two in another.

Therefore it was decided, to avoid organisational difficulties and in keeping with the wishes of Senior Nurses, that only one Staff Nurse from each of the two wards (one surgical and one medical) be selected for interview. These two interviewees were selected randomly by an independent person.

Sample Three

The population for the third sample comprised 26 Nurse Managers with line management responsibility for the course participants.

The sampling frame was dictated by the list of nurses who had completed the Participant Questionnaire. The number of subjects were fewer because some Nurse Managers were responsible for more than one respondent.

A total of 25 Nurse Managers voluntarily took part in the study.

Negotiations for Access

This study evolved from a larger project concerned with developing education in palliative care. For the main project a steering committee was formed. This included the Chief Area Nursing Officer (CANO) for Glasgow and the DNE for Glasgow South College of Nursing and Midwifery. The PSII modules selected for the study were based at this College. The support and guidance of the CANO and the DNE were vital to the project throughout. The idea was originally discussed informally with the DNE. She and the Course Tutor were very supportive and offered valuable advice on the conduct of the proposed study. The limited scope of the existing informal evaluation of the modules was acknowledged. A more indepth study was welcomed.

Gaining access to the participant sample was discussed informally in March 1990. The DNE considered it unnecessary to make an initial approach to the subjects or for contact to be made via the College. The reasons being that the subjects would recognise the researcher as a nurse having both expertise in the area of terminal care and the sanction of the College of Nursing and Midwifery.

Consequently, access to the study application file was gained. Initial contact with students was made directly to their home address. It was thought that this would achieve the highest response rate as the current place of employment could not be ascertained.

The CANO, Glasgow, was fully informed about the study via the steering committee. CANOs of other health boards and the Unit Nurses of Glasgow had also been aware of the project and had previously given permission to approach staff. This was confirmed by letter in April, 1990 (Appendix 15).

A similar letter was sent to senior nurses in May, 1990. This identified the staff members to whom a questionnaire would be sent. The plan to interview a small number of willing respondents at a later date was also indicated. Since this number could not be determined at the outset, it was decided that a formal request for access should be sought when that sample could be identified. The staff time involved could then be assessed more accurately.

In November 1990, the Nurse Manager Questionnaire was sent to Senior Nurses for approval together with a request that it be given to Nurse Managers for completion (Appendix 16). Relevant Nurse Managers were considered to be those with line management responsibility for nurses who had both completed the relevant module(s) and had participated in the study. The identity of those completing the questionnaire therefore remained anonymous.

Access for Interviews

The subsample of participants for interview was to be self-selected initially . Respondents to the Participant Questionnaire were requested to indicate their willingness to provide further information by supplying a telephone number at which they could be contacted. They would provide a home or work number as preferred. Once identified, permission was sought again from the CANO and the Senior Nurses to arrange an interview with the subjects (Appendix 17).

Nonresponders

It was planned that a reminder be sent to each nonresponder of the Participant and Nurse Manager Questionnaire five to six weeks after the initial contact. No further attempts were to be made regarding the Nurse Managers since their participation was complementary, but not vital to the main study. A third attempt was to be made with the non-responders of the Participant Questionnaire. A duplicate questionnaire would be sent to their place of work. This was also the course of action to be taken should the original correspondence be returned by the Post Office indicating they were no longer at their known address. One Nurse Manager and 17 participants failed to respond.

6.4 DATA COLLECTION PROCESS

Participant Questionnaire

The Participant Questionnaire was sent late in November 1990 to all participants excluding the six who were undertaking a module at that time. These were delayed until the end of January 1991. All questionnaires were sent to the participant's home address. They were accompanied by a brief explanation of the study. Assurance was given regarding confidentiality. It was also stressed that the study did not form any part of the course assessment. A short covering letter was enclosed to request the participant's assistance (Appendix 18). This also informed respondents of:

- the identify of the researcher and the sponsoring body;
- the relevance of the study;
- how the information gained would be used;
- the legitimacy of the study, i.e. it was with the full knowledge and agreement of the course organisers;
- the intention to provide feedback on completion of the study.

At the end of the questionnaire, respondents were asked if they would be willing to provide further information. A contact telephone number was requested from those who agreed.

As questionnaires were returned, respondents were sent a letter of thanks. They were also advised at this time that some of those willing to provide further information would be contacted by telephone within three months.

Nonresponders

The original questionnaire was returned by nineteen participants (36%). A further eight (15%) were returned unopened via the Post Office as they were no longer at that address. When this occurred, the correspondence was sent to their last known place of work. This action yielded another six responses. Twenty-six nonresponders were sent a reminder letter with duplicate questionnaire six weeks after the initial correspondence. If no response was received from this, it was again sent to their last known place of work. Eleven more questionnaires were returned as a result. The final response rate was 36 (68%).

Arranging Interviews

Those participants selected for interview were contacted by telephone. They were thanked for completing the questionnaire and for agreeing to provide further information. It was explained that an informal interview lasting thirty to forty-five minutes was required. They were given an opportunity to withdraw at this point. A simple explanation for the critical incidents was given. The term "critical" was avoided because of the meaning which nurses may have attached to this (Sims, 1976; Wilde, 1988).

Respondents were asked to give some thought prior to the interview about two situations which had occurred since completing the module(s). One of these incidents was to reflect a situation in which they felt able to use what they had learned on the module(s) to the benefit of a patient, relative or member of staff.

The second incident was to be an example of a situation in which they found it difficult to take the action they would have wished in caring for a dying patient, his or her family, or staff caring for them. It could also involve incidents in which their actions had seemingly failed to achieve the desired effect.

A date and time for the interview was arranged which was convenient for the interviewees. The choice of venue for the interview also rested with the interviewee. The interviewees were given a telephone number at which the researcher could be contacted should circumstances require the arrangements to be changed. This occurred on one occasion only. However, on another occasion when the researcher arrived at a ward for an interview the nurse was too busy and had to reschedule the appointment.

The interviews were carried out between August and December 1991. Arranging two interviewees each week had been the intention. It was considered that this would give sufficient time to summarise the data and make personal notes on each interview while the experience was fresh and before undertaking the next interview. In practice, it sometimes took considerable time and several telephone calls to make contact with the interviewees because of off-duty, holidays and sickness leave.

Location of Interviews

With one exception all interviews were carried out at the place of employment. All but one of these took place in the privacy of the duty room or a single room. Despite attempts to ensure privacy during the interviews, it was difficult to achieve complete freedom from interruptions. On most occasions there was at least one interruption - the telephone ringing or a member of staff entering. In the main, these did not appear to be detrimental to the interview.

Recording of Interviews

Before embarking on the interviews, a request was made to record the interview using a small unobtrusive dictaphone. It was explained that

this was to avoid copious notetaking by the researcher which may have resulted in vital data being missed. They were reassured that once it had been played back and notes taken from it that the recording would be destroyed. All were relatively happy about a recording provided that no-one else would be listening to it. Interviewees were again reassured regarding confidentiality and sensitive utilisation of data.

Only one difficulty arose with recording, due to equipment failure or human error. Following an interview one side of the tape was found to be blank. Some notes were made from memory. A repeat interview was arranged to allow the interviewee to check these and to "fill the gaps". However, some valuable data in terms of the critical incidents did appear to be lost.

Interview Process

The interview schedules were used as a guide and not adhered to strictly. The ordering of questions or the wording was sometimes adapted to suit the occasion and the subjects. Every attempt was made to put the interviewees at ease. If a question seemed to cause some difficulty it was rephrased. Simple prompts were used to encourage the interviewees to be specific about situations described. Responding sensitively to the subjects' feelings and experiences was considered important. On the other hand, expression of personal opinion or reactions which may have influenced the subjects were avoided.

The most common problem was in encouraging detailed descriptions of single events, rather than global statements or numerous superficial examples of one perceived problem. This difficulty has been reported by other researchers (Newble, 1983). A series of direct questions regarding the first incident mentioned was used to focus attention on one example.

Another difficulty arose in determining the actions of the individual nurse. They would often say "we did this or that", referring to the ward team. Sometimes there appeared to be a reluctance to take credit or responsibility for initiating actions. To the researcher, continued

probing on these occasions often seemed to be labouring the point. However, following such an experience, one nurse remarked, "You don't realise what you have achieved until you are encouraged to think about it".

The interviews were not transcribed entirely verbatim from the recorded text. For example, words and phrases which represented stop gaps while the interviewees thought about the question were excluded. The transcription and notes of researcher observations were carried out as soon as possible after each interview. This was usually immediately after each interview. It was always before another interview was undertaken to avoid confusion.

The researcher always ensured that sufficient time was allowed prior to interview in case of difficulties in finding the location or unanticipated delays. So, each interview could be approached calmly and in a consistent manner.

To ensure that the transcription of interviews by the researcher presented the data accurately, four interviewees were asked to review the transcription. All of these were satisfied that no parts had been misinterpreted or misrepresented.

Interview Problems

Eliciting data from interviewees was problematic on only one occasion. This particular individual was not very forthcoming and was unable to think of a specific incident which represented either satisfying or dissatisfying outcomes. The overall negative effect may have been created by several factors. It may have arisen from a reluctance to be interviewed in spite of prior agreement. It may also have been related to constraints of time or failure to establish rapport by the researcher. An unsuitable environment was certainly one factor. This demonstrated the problem of interviewing at the subject's place of work.

It is also possible to speculate on a variety of reasons for this based on information given in the questionnaire and in other parts of the

interview. A contributory factor may have been that only the module on "Coping with Loss" had been undertaken. This has a large psychological component. It may have been difficult for the individual to think of concrete examples of utilisation of learning in relation to the module. This was a sentiment expressed by several interviewees.

Limited attempts to utilise knowledge and skills may also have contributed to inability to give examples. There were references made to continuing feelings of inadequacy, not really trying to change things as such and lack of support for any efforts. In addition she appeared to relate the course content to the period only around the patient's death. This narrow view of the possible applications of knowledge and skills surprised the researcher as the course tutors endeavour to broaden the issues to include all aspects of loss.

Critical Incident Difficulties

Several subjects expressed the view that it was difficult to think of specific, positive incidents as they considered their learning to be incorporated into their everyday practice. Despite this, ten positive incidents were related as opposed to only six negative incidents. In addition to the interviewee discussed above, four others were unable to think of specific incidents with which they were dissatisfied.

Two of these interviewees had undertaken only one module. One perceived that she had limited opportunities to apply learning as the modular content was not very relevant to her clinical environment. Another interviewee had not attempted to alter practice as she felt she had not gained from attending the course.

Role of the Researcher

The researcher was known to the subjects as a nurse experienced in the area of terminal care nursing. A teaching session on the broad issue of research in terminal care by the researcher had involved most subjects. A lecture on the pathophysiology of pain by the researcher had also been delivered on one module. This prior relationship appeared to be useful in the interview situation. Most interviewees

quickly realised that the researcher had an understanding of the issues involved. Consequently they talked very openly about these experiences.

The researcher's previous experience of counselling was also helpful. The ability to be accepting and non-judgemental, to empathise while being non-interventionist proved extremely valuable. Added to the knowledge of terminal care, these skills were utilised to obtain detailed descriptions of the interviewees' experiences.

In addition, it was likely that the interviewees view of the researcher as someone outwith the mainstream of health care encouraged openness in the interview situation. Most subjects were eager to help in providing information. Those who held particularly strong views appreciated the opportunity to relate them.

It is impossible to be completely objective in an interview situation. All are approached in a slightly different way. An attempt was made in all interviews to be aware of subtle differences in the researcher's attitude or behaviour and the effect this had. Notes to this effect were made as soon as possible after the interview.

Nurse Manager Questionnaire

The Nurse Manager Questionnaire was sent out at the end of November, 1991. It was sent with a covering letter to the Senior Nurse of the unit or hospital concerned (Appendix 16). The letter requested that the Nurse Managers responsible for staff who had undertaken the relevant modules be asked to complete the questionnaire. Information and instructions given were similar to those given in the correspondence to participants. However, the Nurse Manager respondents were anonymous. So it was not possible to offer any direct feedback to respondents.

The format of the Nurse Manager Questionnaire was designed to restrict the time required for completion to a minimum. It consisted of a list of statements with which respondents were asked to agree or disagree. They were also asked to complete two sentences regarding how they could best help their staff who had undertaken a Professional Studies Course.

Reminders and duplicate questionnaires were sent to nonresponders in mid January, 1992, in case the originals had gone astray in the Christmas mail. The Senior Nurse was also encouraged to involve the Nurse Managers concerned even when the participant had left their employment.

6.5 DATA ANALYSIS

Participant Questionnaire

Responses to closed questions were assigned numerical codes which were entered into a computerised database. Designing a coding frame for responses to open questions was more difficult. Responses to each question had to be handled separately. These were examined and roughly categorised by the researcher. To achieve maximum objectivity, the list was set aside for a few days and then recategorised on two separate occasions.

Using the first question in part two of the questionnaire as an example, coding was carried out in the following way. The question asked respondents to list topics discussed with their Nurse Manager prior to attending the module(s) regarding what they hoped to gain from attending. Seventeen respondents stated a total of twenty-seven topics. These were listed, studied and roughly categorised. Assigning categories to the data was more complex than anticipated. Some were extremely general or vague. One respondent stated "What I aimed to achieve and gain from the course". While this confirmed that achievement of aims was discussed, it provided no useful information regarding the content. This response was assigned to a category for general comments.

When all the data had been categorised, an uncoded copy was sent to a nurse researcher and two independent teachers of palliative care nursing. A list of the categories which had been identified was also sent. All three raters examined the data and assigned codes based on the list of identified categories independently.

Next, all four categorisations of data were examined by the researcher and supervisor. Each category was assigned a score between one and four indicating the extent of agreement between the four raters. A score of four indicated no discrepancies between the raters. A score of three indicated that one person had either not coded a particular piece of data or had assigned a different code.

Again the first question may be used as an example. From the twenty-seven pieces of data coded by the researcher, eight discrepancies occurred. These were examined further by the researcher and supervisor. In light of this, some of the original coding was altered, but the majority remained unchanged. Those which presented a particular difficulty were left uncoded. It was decided to discuss these individually in the findings.

To provide an indication of the degree of inter-rater reliability, the score for each piece of data was added together. This was presented as a percentage of the optimal figure of four for each category. Prior to adjustments, there was a 92% agreement for the first question. The degree of inter-rater reliability for each question is shown in Table 1.

QUESTION	AGREEMENT
1	92%
3	95%
4	92%
5	94%
6	100%
7	83%
10, part 1	93%
10, part 2	85%
Average	93%

TABLE 1. EXTENT OF INTER-RATER AGREEMENT

It can be seen from Table 1 that question 7 revealed the highest number of discrepancies. This was mainly because several responses were not directly related to that particular question. Respondents had been asked to state in which aspects they felt they had achieved some measure of success in changing or influencing others and with whom this had occurred. Some of the data obtained referred more to the way change was introduced or to the difficulties experienced in attempting to introduce change. An example of this was one response that change was "difficult, as I was moved to another area during the course". Such data was left uncoded and discussed with the findings in relation to the factors affecting implementation of change.

Nurse Manager Questionnaire

A similar approach was taken with the Nurse Manager Questionnaire. Only two questions required decisions on rating. The extent of agreement for these was 76% and 77%. There was one main source of disagreement in each question. Both involved making a decision

regarding the extent of involvement. For example, comments by the manager concerning help and support had two elements. Some clearly indicated the offer of active help, e.g. "giving help with caseload" or "assisting them in introducing relevant changes". Others suggested a more passive type of support, e.g. "encouragement to utilise skills and knowledge for better nursing practice" or "supporting new initiatives". The decision to code these as active support or giving encouragement had to be clearly defined. As a result, some items were recoded and checked by the supervisor.

Interviews

Each interview transcript was read in total several times to get a feel for the data. Parts of the text were then studied in detail. Key points extracted from the parts were compared with the whole transcript and the questionnaire responses. This allowed a greater understanding of the whole in relation to the parts. Common themes and patterns were identified and examples provided to illustrate these.

The interview questions had explored various topics. However, the data could not simply be assigned to particular questions. In answering one question, responses to others were sometimes expanded. Some responses were applicable to more than one topic.

Sections of the data relevant to each of these topics were separated into a number of envelopes. Parts which were relevant to more than one topic were copied and inserted in all the appropriate envelopes. Each piece of text was coded to allow identification of all the extracts from each subject. Taking each topic in turn, the data were examined. Significant phrases or sentences were highlighted. Alongside these, a code word or phrase was inserted which conceptualised each piece of data.

A copy of each complete transcript, questionnaires and researcher's notes were also kept to hand. Continual cross-referencing being made to all the sources of data helped to obtain a fuller and clearer picture of the participants and their experiences. Apparent conflicts in the transcripts could often be explained by referring to the

questionnaires. This cross-referencing led to the code words being changed several times as greater understanding was achieved.

To show how this worked in practice, the following is an example of data analysis in relation to motivation. All interview text which had any bearing on each subject's wish to undertake the module(s), identified learning needs or expectations was extracted. All relevant phrases and sentences were highlighted and assigned a code word or phrase. For example, from the interview text of one nurse the following was extracted.

> Prior to doing the course, I don't think I would have asked about MST (opiate analgesic). It was always a no go area. The doctor was the one who prescribed and although there were times when I felt someone should have something else, I wasn't awful sure about how much they should give and I suppose like most nurses I was a bit afraid. I remember giving diamorphine and a patient dying shortly afterwards and feeling I had killed them. That hung on for a lot of years.

The whole paragraph had been extracted to ensure it was kept in context. The nurse had explained that although medical staff were responsible for prescribing analgesia, she sometimes felt the prescription was inappropriate or inadequate, but was unable to challenge the doctors' decisions. The fear expressed was not fear of the doctor, but fear of hastening a patient's death by administering strong analgesics as a result of a previous distressing experience.

Initially, simple notes written beside this extract were simply : (1) knowledge sought; (2) fear; (3) lack of assertiveness; (4) relationship with medical staff. Once all of the extracts had been similarly dealt with, they were examined again. There were a number of references in the text about feelings of inadequacy in a number of areas. In the main, these were related to knowledge, skills or confidence. Specific incidents from the past featured strongly as a motivating factor for some nurses.

On reflection, some of the original notes made were thought to be of limited relevance to the topic of motivation. Although reference was made to her relationship with medical staff, this was not considered to be a motivating factor in itself. However, her inability to challenge medical decisions because of lack of knowledge and confidence was clearly identified. The quote was then recoded. (1) identified need - knowledge/confidence; (2) previous experience.

When all text concerning identified needs was coded including the type of need, another code was assigned to it to indicate the subject. In the example given this was PAIN CONTROL. The whole interview text and the questionnaire of this particular nurse was then re-examined. It was searched for any further data pertinent to motivation or which might illuminate the interpretation of the text. In this case there was no further alteration in coding. However, it was useful to note that the clinical area was care of the elderly. This may have accounted for a reluctance to prescribe opiates.

The same process was applied to all the excerpts related to motivation. The next step was to compare data and codings pertaining to that topic by all the interviewees. Similarities and differences were noted. Some codes were unique to a particular individual. However, some recurrent themes begin to emerge. At this point some adjustment was made to the coding to ensure there was no overlap in the identified themes. The example given early was finally coded thus: (1) exposure; (2) need - pain; (3) specific. This indicated that motivating factors were: (1) repeated experiences of caring for dying patients; (2) awareness of need for knowledge/skills in relation to pain control; (3) a particular incident may have been a significant influence.

The coded excerpts, the complete transcripts and questionnaires and a description of the themes identified by the researcher were made available to an independent expert in palliative care. Random parts of the data were examined to ensure that no important points had been omitted and that the researcher had interpreted the data truthfully and without embellishment.

Critical Incidents

The critical incidents allowed the interviewees to describe experiences of their choosing. These often, but not always, represented examples of issues which had emerged during the course of the interviews or in the questionnaires. In view of this, the CITs were analysed separately.

Some of the interviewees had difficulty in recalling a specific incident when asked. However, they were often able to describe such incidents spontaneously when they were given an opportunity at the end of the interview to add any relevant comments. In this event, these examples were analysed as a Critical Incident. Two interviewees related more than one Critical Incident, in which case only the example related first was included.

Although considered separately, the analysis approach to the Critical Incidents was similar to that taken with the rest of the interview data. Each incident was read and reread many times. Notes were made on each reading until the researcher considered that all the themes were extracted. The incidents and researcher notes were then examined by the independent expert to ensure the observations were a true representation of the data and that no relevant issues had been omitted.

Thereafter, the themes identified in each incident were contrasted and compared with each other and with the whole text and questionnaires.

6.6 ETHICAL ISSUES

All subjects were volunteers to the study. However, once included there were three main ethical issues involved - having access to the home address of subjects, confidentiality and encroachment on time.

It was recognised that approaching subjects via their home address could have been considered an invasion of privacy and was of concern. Contact via the place of employment would have been ethically preferable. This was discussed at length with the DNE and and was

rejected for three reasons. First, the DNE considered a direct approach most suitable. Secondly, it was considered likely that the place of employment would have changed for some subjects since undertaking the module(s). Therefore, it was anticipated that the highest response rate would be obtained by contacting subjects at their home address.

Thirdly, the researcher had been introduced to most of the subjects during the course of a talk on research in terminal care in Module One and was likely to be accepted as a nurse with experience in this area. In addition, subjects were free to choose whether or not to enter the study. The frontispiece of the questionnaire ensured that the study was not mistaken for an official assessment of their progress. No objections were raised by the subjects with regard to this approach.

Written assurances of confidentiality were given in the questionnaire sent to Sample One (Appendix 1). All subjects were initially assigned a code number which permitted anonymity. However, this could not be assured for those who agreed to be approached for further information. When the subsection of this group was selected for interview their names were retrieved to allow contact to be made. At the time of interview they were again reminded that their responses would be held in confidence and where necessary every attempt would be made to sensitively report their responses in a way which would not allow them to be identified without their permission.

The indirect method of approaching the sample of Nurse Managers virtually assured their anonymity.

Some of the Senior Nurses were concerned about the time factor required for data collection and were anxious that excessive demands were not made on staff. Of particular concern was the time which might be required for the interviews. It was anticipated that these would take place in the work setting, although the choice rested with the subjects. It seemed equally important to keep the demands made on the interviewees to a minimum whether encroaching on work or leisure time.

Attempts were made to keep the interviews concise, while giving the interviewees opportunities to expand on relevant issues. In selecting subjects for interview, efforts were also made not to overburden any particular hospital/unit.

All subjects in Sample One who responded to the questionnaire were assured that they would be informed of the outcome of the study in due course.

CHAPTER 7 - PRESENTATION OF THE FINDINGS

7.1 RESPONDENTS' DETAILS

Response Rate - Participant Questionnaire

The study population of 53 course participants comprised 12 Charge Nurses, 35 Staff Nurses, two Macmillan Nurses, one Community Nurse and one Clinical Nurse Specialist. The overall response rate was 36 (68%). Eight (69%) of the Charge Nurses and 24 (67%) of the Staff Nurses responded to the questionnaire. Therefore, the sample was representative of both of these groups.

Age Range of Respondents

The age range of respondents spanned approximately 30 years. Most of these were in the 25-35 age group (Figure 1).

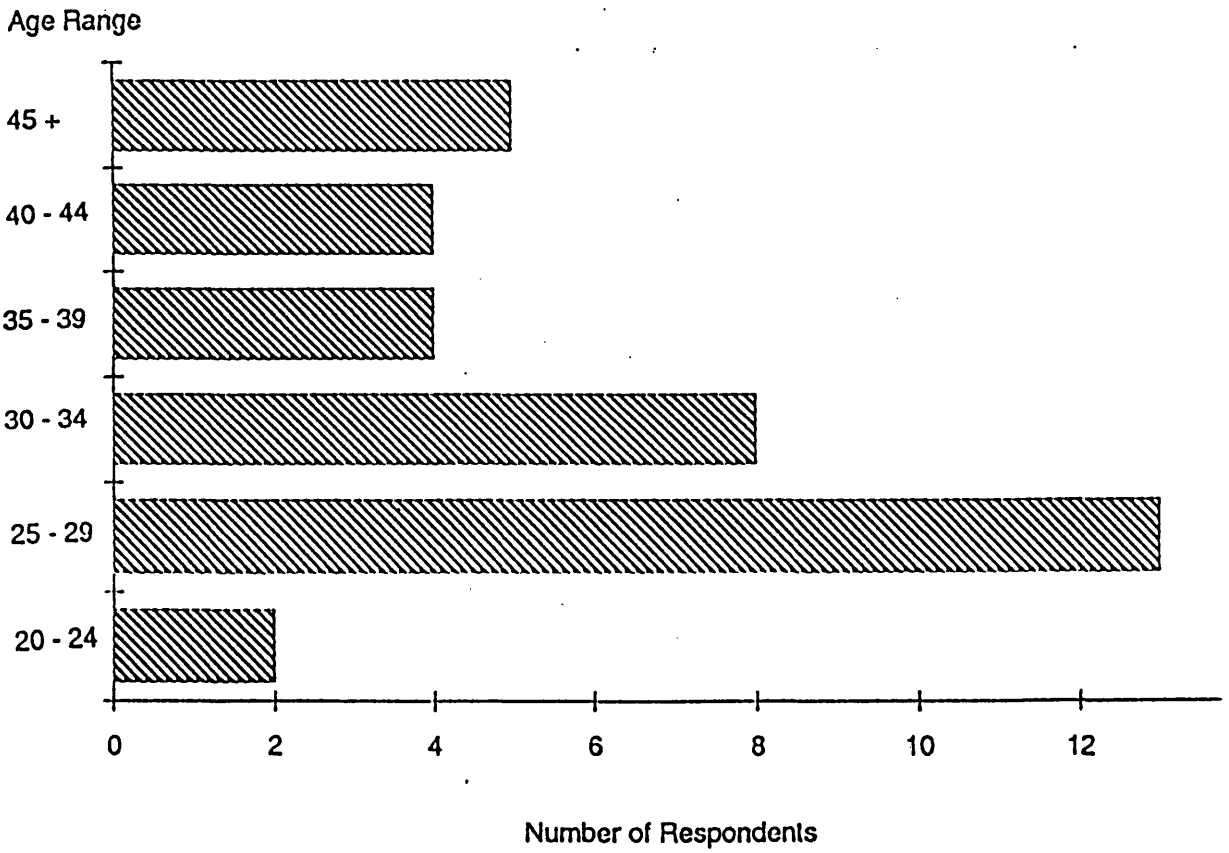

FIGURE 1. AGE RANGE OF RESPONDENTS

Previous Professional Education of Respondents

The respondents represented a wide range of professional education experience. Eleven had registered in more than one branch of nursing. A further ten had been awarded certificates in specialised areas of nursing. Four had taken nursing degree courses, one an Open University degree and one had taken Open University credits. Twelve had taken at least one PSI Module. In short, most of the subjects were well qualified and could be described as being highly motivated in terms of professional development as can be seen in Figure 2.

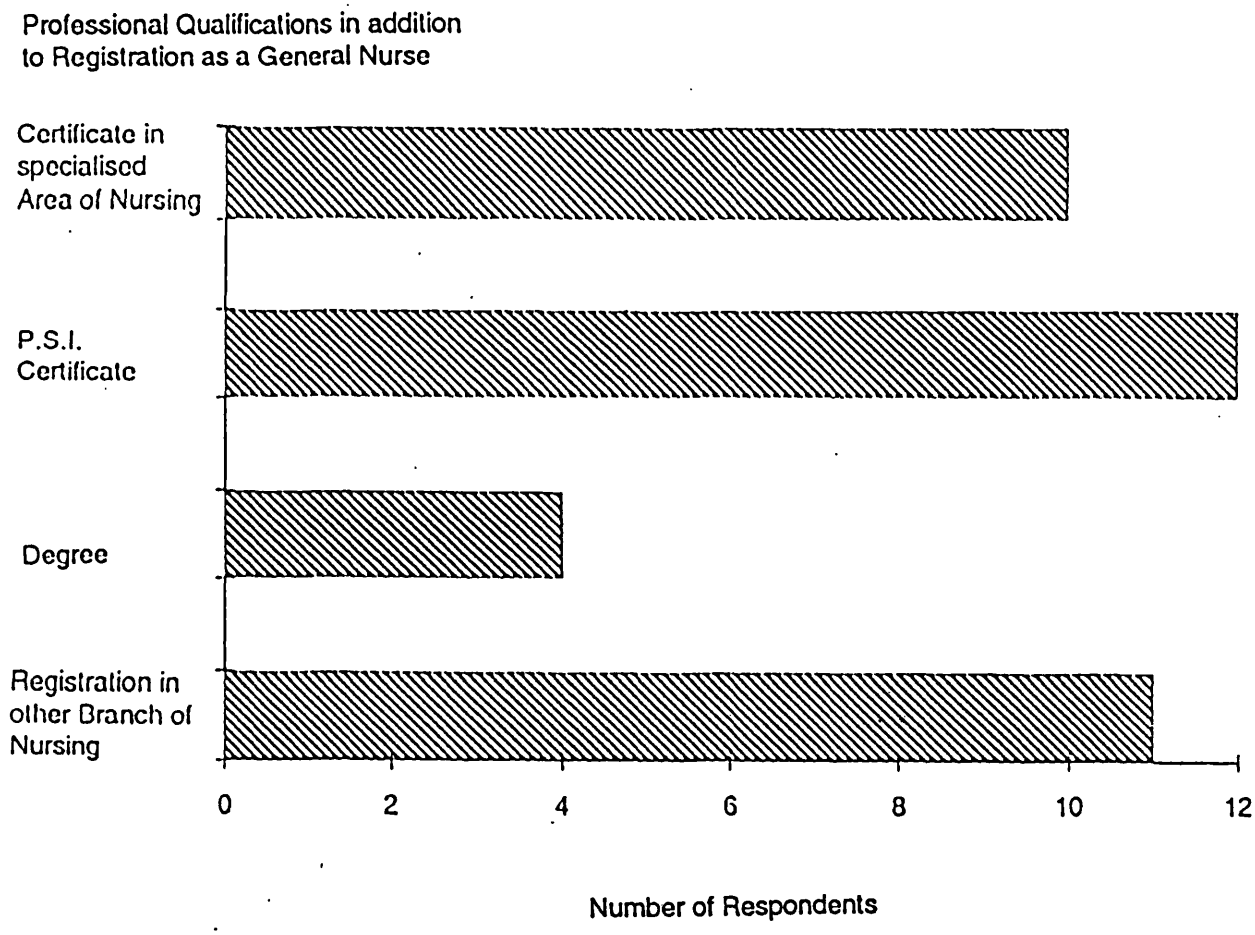

FIGURE 2. PREVIOUS PROFESSIONAL EDUCATION OF RESPONDENTS

Current Clinical Environment of Respondents

At the time of the study the majority of respondents were working in a hospital setting (75%), mostly in acute medical and surgical wards. Eight subjects worked in the independent sector (hospices). One worked in the community, one in a mental handicap setting and the remaining seven in care of the elderly/psychogeriatric settings. Table 2 indicates the working environment of each grade of nurse.

	GRADE OF RESPONDENT			
CLINICAL ENVIRONMENT	CHARGE NURSE	STAFF NURSE	OTHER	TOTAL
COMMUNITY	-	-	1	1
HOSPICE UNIT	1	5	2	8
HOSPITAL				
MEDICAL/SURGICAL	2	17	-	19
ELDERLY/PSYCHOGERIATRIC	4	2	1	7
MENTAL HANDICAP	1	-	-	1
TOTAL	8	24	4	36

TABLE 2. CLINICAL ENVIRONMENT OF RESPONDENTS AT TIME OF STUDY

Respondents' Attendance of Modules

All three modules had been attended by 17 respondents. A single module had been taken by 15 and two modules were taken by four respondents as shown in Table 3.

RESPONDENTS OF PARTICIPANT QUESTIONNAIRE	Total n = 36	Charge Nurse n = 8	Staff Nurse n = 24	Other n = 4
All 3 modules taken	17	6	9	2
Module 1 taken alone	5	1	3	1
Module 2 taken alone	5	1	3	1
Module 3 taken alone	5	-	5	-
Module 1 & 2 taken	2	-	2	-
Module 1 & 3 taken	1	-	1	-
Module 2 & 3 taken	1	-	1	-

TABLE 3. PATTERN OF ATTENDANCE ON MODULES

7.2 PARTICIPANT QUESTIONNAIRE RESULTS

Pre-modular Discussions with Nurse Managers

An opportunity to discuss what they hoped to gain from the modules with their Nurse Manager was reported by 21 (58%) of the participants (Table 4). Thirteen participants initiated this discussion themselves, twelve of whom found it useful. All but one of the seven whose discussion was initiated by the Nurse Manager found it useful also.

All 15 participants who had no opportunity for prior discussion with their Nurse Managers felt that such a discussion would have been useful. Of the ten Staff Nurses who would have liked such a discussion but were not afforded the opportunity, five felt that the Nurse Manager was the most appropriate person and five their Charge Nurse, with one being happy with either of the two.

PRE-MODULAR DISCUSSIONS WITH NURSE MANAGER	NO. OF PARTICIPANTS
ACTUAL	21 (58%)
INITIATED BY NURSE MANAGER	8 (22%)
INITIATED BY PARTICIPANTS	13 (35%)
NO OPPORTUNITY GIVEN	15 (41%)
TOTAL	36 (100%)

TABLE 4. PRE-MODULAR DISCUSSIONS WITH NURSE MANAGER

Content of Pre-Modular Discussions

The most frequently reported topic of this discussion was related to the perceived benefits of attending the module (ten). Some of these were extremely general, seeming to reflect a fairly superficial discussion. For example "Nurse Manager stated that she thought I would enjoy it and find it useful for future work".

Meeting the needs of the individual nurse was discussed with the Nurse Manager on six occasions. Specific mention was made about the subjects ability to enhance patient care following the module by a further six participants. These may represent attempts by the Nurse Managers to match organisational and individual goals. The following represent examples of the content of such discussions with their Nurse Manager.

1. "Benefits of incorporating knowledge learnt on the course to my own work area".

2. "Mainly centred around the needs of the ...unit... I was also keen because this was different".

The participants' needs for support following the module(s) was discussed and/or offered in three cases. Practical arrangements related to the secondment were included in three discussions. In two of these, the discussions appear to have been limited to the practicalities alone. For example the "date of prospective course" was the only item mentioned by one.

Other topics reported by the participants included symptom control, attitudes, psychological care, dealing with relatives, bereavement, and answering difficult questions. Subjects were only requested to list the topics which they recalled being discussed. No conclusions can therefore be drawn with regard to their value in helping the subjects to set aims and objectives. Four gave no indication of the content of the discussion.

Post-Modular Plans

On return from the module(s) 32 participants (89%) had plans for improving care. In ten cases these were reported in very general terms. All others mentioned specific areas in which they hoped to make improvements. These areas are diverse and may reflect the wide remit of palliative care.

Improvements in physical care delivery were the objectives for nine participants. The interpersonal and supportive aspects were the aim of 20 participants. Two specifically mentioned enhanced staff support as an objective. None of the Charge Nurses stated support of staff as an objective and only three Charge Nurses mentioned staff education.

Post-Modular Discussions with Nurse Managers

Opportunities to discuss knowledge and skills gained with their Nurse Manager arose for 24 participants (67%). These mainly occurred within two weeks of completing the module(s). Of the 12 (33%) who did not have such an opportunity, one commented that it was still too early for this. However eleven felt they would have benefited from such a discussion. One remarked that her Nurse Manager was disinterested. Four of those who did have a discussion did not find it a useful exercise, one stating that it was merely a superficial enquiry.

Content of Post-Modular Discussions

Once again the topics of the conversations were diverse and often not specific. The effect of the learning on the individual was discussed in four instances and the value and content of the course in general in five. This may represent attempts by the Nurse Managers to informally evaluate the module(s). Improving care in general was discussed by four, specifically in relation to pain management by three and in psychological aspects by four. The areas of staff education or support were again discussed by only a small number of Staff Nurses.

Perceived Benefits of Attending Module(s)

The overall view of respondents was that attending the module(s) had been very useful in enhancing their practice. Taking all 26 listed aspects of practice together, 50.4% were reported to have helped a lot. A further 36.2% were reported to have helped a little. A small number (3.7%) were not at all helpful. A further 9.4% were aspects in which some participants already felt sufficiently skilled. The complete results of this question can be seen in Appendix 19.

Participants had been asked to indicate the three aspects of practice which had been most influenced by attending the module(s). Each of the 26 listed aspects was indicated by at least one participant. This again reflects the individual nature of learning and its utilisation. The aspects most influenced by the modules were:

1. the ability to question the way things are done (nine);

2. meeting patients' psychological needs (nine);

3. being able to identify own weaknesses (nine);

4. communicating with patients (six).

Two respondents did not rate any aspects. One did add a comment that she had been disappointed in the course overall and had felt very demoralised on return to her own clinical area.

Twenty-three participants perceived they had gained additional benefits from the course. These were related to three main areas.

1. Widening of Experience. The opportunity to share ideas and experiences with colleagues in the classroom setting and on clinical placements was considered to be very valuable by ten respondents. One nurse expressed this as "knowledge gained from listening to course participants of situations experienced and how they were handled, which opened up discussion eg how better this may be dealt with".

2. Personal and Professional Development. Nine participants benefited from the sense of achievement and increased self-awareness and self-confidence which was stimulated by the course. It helped to identify further learning needs for some.

3. Enhanced Knowledge and Skills. Four participants mentioned specific areas of their practice which they felt had been enhanced.

Application of Learning

Success in changing practice or influencing colleagues in relation to care of the terminally ill was reported by 23 respondents (64%). However these perceived improvements frequently involved a change in the attitudes of colleagues. For example "Now patients not automatically moved to single room once diagnosed or when condition deteriorates". Another nurse commented "With colleagues - in helping them understand that relatives and patients react to dying in a variety of different ways. Their attitudes toward nursing staff are their defences about a situation they are finding difficult, eg guilt, anger, etc."

Symptom control was reported to have been influenced by seven participants. Four of these mentioned pain control specifically. Improvements in psychosocial aspects of care were cited by eleven. These included helping junior staff "to feel more at ease in answering awkward questions" or encouraging them "to participate more in the psychological needs of patients and their families in learning to cope with loss".

Few of the respondents indicated which colleagues they had successfully influenced. Four cited junior staff. The same number mentioned medical staff and nurse learners. One Nurse Manager was perceived to have been influenced.

Factors Perceived to Facilitate or Hinder Application of Learning

Two main factors were perceived by participants as helping them to improve care following attendance of the course. These were increased knowledge and skills and increased confidence. The main factors perceived to hinder attempts to improve care were shortage of staff and lack of support. Tables 5 & 6 summarise all the responses.

FACILITATORS OF LEARNING APPLICATION		No. (n = 36)
Enhanced Knowledge/Skills		35
Enhanced Confidence		31
Support		11
- Nurse Manager	4	
- Charge Nurse	10	
- Medical	4	
- Other	3	
Other Factors		3

TABLE 5. FACTORS PERCEIVED TO FACILITATE APPLICATION OF LEARNING

The "other" support was specified by only one respondent. In this case it represented nurses in the ward who had also undertaken some of the modules. The "other" facilitating factors were:

- the participants own enthusiasm;
- increased awareness of other staff - the reason for which was unspecified;
- a change of clinical area.

INHIBITORS OF LEARNING APPLICATION		NO. (N = 36)
Shortage of Staff		22
Lack of Support		17
- Nurse Manager	9	
- Charge Nurse	6	
- Medical	8	
- Other	3	
Negative Attitude		14
- Nurse Manager	6	
- Charge Nurse	2	
- Medical	8	
- Other	3	
Lack of Resources/Equipment		11
Lack of Time		9
Lack of Knowledge/Skills		5
Lack of Confidence		1

TABLE 6. FACTORS PERCEIVED TO HINDER APPLICATION OF LEARNING

Participant Perception of Strengths of the Modules

Most positive comments were made in relation to the teaching on the modules. This was seen as a particular strength by 17 respondents. Within this category, the theoretical content was mentioned by 12 respondents and the teaching staff/lecturers by five. Four referred to the organisation and methods. These related to the informality of the classroom setting and the use of group work and role playing. In some respects these could be related to two other categories. First was the group dynamics. Six respondents considered the "comradeship" and support of the other class members particularly helpful. The small numbers accepted on each module enabled the sharing of ideas and experiences.

Support from staff in the college and in the clinical placement was recognised as a strength by five participants. Four considered the clinical placements to be very beneficial. In addition, three specifically mentioned the opportunity for supernumerary status on the placements as being valuable. The opportunity for reflection was mentioned by five respondents. This was categorised separately because it was unclear whether it related to the class setting or to the clinical placement, or both.

Participant Perception of Weaknesses of the Modules

In identifying weaknesses, the organisation of the modules was criticised by 14 respondents. However, comments reflected the variability of individuals and the difficulty of meeting the needs of even small groups. Three respondents felt the course was too short. Two of these had only completed one module. The other had completed two. Most criticisms were related to the balance of components.

Dissatisfaction was expressed with regard to overlaps in the content of modules by two respondents who had completed all three modules. The distance which two participants were required to travel to clinical placements was also a concern in respect of the organisation.

Five criticisms of the teaching were made - one in respect of staff, four in relation to content. One suggested that the input on spiritual care was unsatisfactory, but gave no details. Two were general. For example "some lectures poor standard". The fourth and most constructive comment was that "increased input of implementation of ideas to change and improve nursing practice" was required.

Dissatisfaction was expressed with the clinical placements (three) and support and guidance while on placement (eight). One problem which has now been rectified was the difficulty of placement time being spent in own clinical environment. Inadequate support during Module One was perceived by one participant. However, three participants felt this was lacking in Module Three, which involved community placements. One nurse complained of feeling isolated during this experience, especially

since the "placement supervisor was unsure of assignment content and was unable to be of assistance".

Three participants did not feel their particular needs were met. One felt the teaching was focussed on young dying patients and would have preferred more input related to care of elderly people. One hospice based nurse felt the course was geared towards hospital care. The third, a Macmillan Nurse felt it was not appropriate for specialist nurses.

Another problem which although identified by only one respondent should perhaps be highlighted. It concerned the nurse being "unable to go 'against' hospital and UKCC policy, eg resuscitation". This draws attention to the ethical difficulties which could arise for the individual nurse if trying to implement the philosophy of palliative care in the acute care setting.

7.3 NURSE MANAGER QUESTIONNAIRE

Response Rate

Twenty-six Nurse Managers Questionnaires were sent out. Twenty-five responded (96%).

No background information was obtained regarding the Nurse Managers.

Nurse Manager Opinions on Pre-Modular Discussions

It was surprising that only eight Nurse Managers (32%) initiated a discussion with the participants prior to the module(s) in view of the corresponding findings from the Nurse Manager Questionnaire. The Nurse Managers indicated a strong belief (92%) that such a discussion should take place. Moreover, only three Nurse Managers (12%) felt that it should occur at the request of the participant.

The Nurse Manager responses did suggest some possible reasons for the discrepancies between what was felt should happen and the reality. A small number of Nurse Managers (16%) felt that the responsibility for

such a discussion lay with the Charge Nurse when the participant happened to be a Staff Nurse. The same number believed that nurses generally did not wish to discuss prior aims with their Nurse Manager. Only one Nurse Manager agreed that lack of time prevented such discussions. However, eight (32%) considered that they may feel uncomfortable in discussing prior aims in relation to a subject in which they had little experience.

Post Modular Support by Nurse Managers

The majority of Nurse Managers (76%) claimed that it was their usual practice to encourage nurses to set out an action plan on completion of Professional Studies Modules. Embarking on change too quickly was said to be discouraged by 13 (52%). Despite a willingness to provide this sort of advice, there were mixed feelings regarding their input. For example, eleven thought that staff should be responsible for their own learning and development. Three of these felt that guidance and encouragement were also necessary. Thirteen disagreed that responsibility rested with the staff themselves.

Insufficient time to acquaint themselves with the content of courses attended by their staff was perceived by seven Nurse Managers (28%).

Nurse Managers as Facilitator

Despite being cited as an inhibiting factor more often than a facilitator by the participants, Nurse Managers appear to consider that they have an important role in facilitating change. In completing the statement "When a Ward Sister/Charge Nurse returns from a PS Module, I can best support them by....", 14 Nurse Managers stated discussion of implementation of learning and how this could be facilitated. Many of these suggested a very positive and active Nurse Manager response. For example, "...working with them (the Charge Nurse) to set out an action plan and supporting them in the implementation of change". Although such an active role was not suggested by all the Nurse Managers, the responses were generally very positive. Almost all responses involved listening, encouraging, offering support/advice or enabling.

Completion of the same statement in respect of Staff Nurses was also in a very positive vein. Eleven Nurse Managers mentioned the facilitation of implementation of learning as how they could best help their Staff Nurses. As one might expect, there was a tendency to consider their role to be less involved with Staff Nurses than with Charge Nurses. However, seven considered that they were in a position to enable or encourage relevant discussions between the Staff Nurses and their Charge Nurses. Five also mentioned that they could support and advise the Charge Nurse in how best to support Staff Nurses who had undertaken such education.

7.4 PARTICIPANT INTERVIEWS (Appendix 2)

Response Rate

Although 33 participants were willing to provide further information, only five at Charge Nurse grade met the criteria for selection. These five, together with six at Staff Nurse grade were approached and all eleven agreed to be interviewed. Ten positive and six negative Critical Incidents were related by the interviewees.

Interviewee Details

At the time of the interview, four of the Staff Nurses and two of the Charge Nurses were working in the same post as when they had attended the module(s). Career changes which had occurred in the interim included the following:

- two Staff Nurses had been appointed to more senior grades in different wards within the same unit.

- two Charge Nurses had been promoted within their unit from Staff Nurse posts.

- one Charge Nurse had left her NHS post to take charge of a hospice ward but agreed to provide information on the basis of her NHS experience.

Clinical Environment

Of the Charge Nurse group, two worked in medical wards, three in care of elderly/psychogeriatric wards. Two Staff Nurses worked in medical wards, four in surgical areas.

Attendance on Modules

Four of the Charge Nurses and three of the Staff Nurses interviewed had undertaken all three modules. The remaining Charge Nurse had taken only Module Two. One Staff Nurse had taken only Module One and two had taken only Module Three.

Presentation of the Interview Data

The Critical Incidents related by the interviewees tended to serve as examples of issues which had been raised in the main body of the interview. Therefore, both sources of data are utilised in conjunction where appropriate to present the findings. To allow the reader to distinguish between the two, all data obtained from the Critical Incidents will be headed as such.

All interviewees had experienced some successes and some disappointments. To maintain a realistic view, examples of positive experiences will be presented alongside those illustrating negative experiences where appropriate.

7.5 INTERVIEW FINDINGS

Participant Motivation - Pre-Modular

Six interviewees had a particular interest in terminal care prior to undertaking the module(s). Four of these had either specifically requested to take one of the "Terminal Care" modules, or had made their interest in this area of care known to their Nurse Managers. Where such interest was expressed, there tended to be an expectation of change as a result of attending the module(s). It was viewed in terms

of acquiring knowledge that could be passed on to others or be used to influence practice.

Five nurses had no special interest in this area of care. In fact, four considered undertaking the modules very much in terms of furthering their career. One requested to take the course, viewing it as an appropriate "stepping stone" to District Nurse training.

Others were informed by their Nurse Manager that they were being seconded to the course. Reactions to this differed. Absence of request to attend did not necessarily equate with lack of motivation. Despite no previous interest, the opportunity for professional development was generally welcomed and was accompanied by a determination to gain as much as possible from the course.

Some saw it as a means of gaining the PSII Diploma; the type of module was unimportant. Only one nurse considered the course to be irrelevant to her clinical environment and did not wish to attend.

Those who had not expressed a specific wish to attend the modules had one factor in common. They embarked on the module(s) with no clear idea of what to expect or what they wished to gain from it.

Participant Motivation - Post-Modular

Despite a number of nurses having no specific expectations or interest prior to undertaking the course, most returned with clear ideas for implementation of learning. Only two did not have specific aims.

Motivating Factors

For those participants who had been highly motivated to attend the course, frequent professional encounters with dying patients and their families were strong motivating factors. Their experiences had often left them feeling frustrated and inadequate. The feeling expressed by one nurse that "I felt often that there should be more we could do for these patients, but didn't know quite what" was referred to by all six nurses.

A need to acquire knowledge and/or skills to enable improvements in care of dying patients was perceived. Particular aspects of care in which a need was identified were pain management, coping and communicating with dying patients and their relatives. The inadequacy felt, particularly in relation to coping and communicating, was expressed repeatedly. So too was the tendency to employ distancing tactics as a result of this inadequacy. For example, "I wanted to learn more about coping with loss from a personal point of view and from the point of view of relatives. We had previously had a lot of dying patients and nobody knew how to cope. I saw nurses walking by rooms, avoiding going in to dying patients".

Specific past experiences had triggered a determination to enhance relevant knowledge and skills for some nurses. For one, an acutely distressing personal experience of inadequate symptom control provided the impetus. Another related the following incident.

> We had a patient with pain which was difficult to control. I suggested trying a nerve block. The Consultant immediately started telling me why a nerve block wouldn't work. However, I had previously done anaesthetics and probably knew more about nerve blocks than he did. So I argued my case. He eventually said to refer the patient to the pain clinic. Consequently, they did a nerve block which significantly helped his pain.
>
> However, on the same day, a student nurse asked me how panadol worked. I didn't know. I thought, that is why medical staff don't listen to nurses. We don't have the knowledge.

Existing knowledge and assertiveness enabled achievement of a positive outcome in this case. However, the nurse perceived her knowledge to be lacking in some areas. She also considered that enhanced knowledge would increase her ability to influence medical staff.

Course Content - Perceived Strengths and Weaknesses

Perceived strengths of the course greatly outweighed the weaknesses for all but one nurse. Several participants considered that there was nothing lacking in the content of the course. Those aspects of practice to which the interviewees considered the course to have added little, tended to be areas in which they perceived no learning need.

Parts of the course content which had caused difficulty were those which one interviewee described as "the airy fairy ones". These included "meeting patients' spiritual needs" and "understanding ethical issues involved". This was usually thought to be due to personal difficulties with the topics or lack of religious commitment, rather than a failure of the course. However, some constructive comments were made, particularly with regard to organisational aspects of the course.

Supernumerary Status - Perceived Strengths and Weaknesses

In general, the nurses felt their supernumerary status was beneficial but found it difficult initially. They were able to focus their attention on a small number of patients, with time to communicate and develop relationships with them and their relatives. This helped them to identify needs, systematically plan care using an holistic approach and reflect on the effect of interventions. They were also able to take time out for themselves when their intense involvement with patients became stressful, or to work on their assignments.

Some participants felt uncomfortable; like "an outsider and not part of the team". This was particularly apparent when the clinical placement was in a busy, acute hospital ward. There were some feelings of guilt aroused by seeing the regular ward staff so busy.

On the other hand, the participants became so involved with 'their' patients that some felt a degree of resentment when the regular ward staff interfered by changing the plan of care or withheld information from them. Some of these difficulties may have been the result of uncertainty regarding the participant's role. The course was new and

the supernumerary status was an unfamiliar situation for staff and participants alike.

The supernumerary status and a perceived tendency to focus on hospice care in the theoretical part of the course caused some participants to complain that it was not based on reality.

Other Criticisms of the Course

Most other criticisms made were individual, often representing relationship difficulties which would require to be resolved at a local level. For example, some supervisors were perceived to be lacking in knowledge or unsupportive. Nonetheless, the following is an example of a criticism which although being expressed by only one, may be true of other new education programmes.

The nurse felt totally demoralised when she returned to her own clinical environment. This was ascribed partly to being a participant on the first occasion the course was offered. It was her view that it was important to the organisers that the new course be seen to be successful. As a result, the participants were being constantly reminded that a lot was expected of them. The teaching methods, with a stress on reflection and examining personal beliefs and attitudes, caused her to question her own abilities to such an extent that she had lost her confidence. She felt very pressurised and as if she had "been put under a microscope and systematically taken apart".

Another participant who had undertaken only one module felt frustrated that some really interesting discussions were cut short. This was sometimes because the topic was covered in more detail in another module. On the other hand, duplication of content was a criticism made by one nurse who had undertaken all three modules.

Perceived Benefits of the Course

The course made a significant impact on all but one interviewee. The variable learning needs of individuals are reflected in the different aspects which were identified as being particularly useful and

beneficial. Some recurrent themes did emerge. These included knowledge and skills gained, personal development and enhanced confidence. Although discussed individually, it had been their combined effect which had made the impact.

Personal Development

The course aims to foster more positive attitudes to death and dying and to facilitate personal growth. Therefore, examination of personal values is encouraged. The success of this was evident in the participants' strong perception of having gained personally by undertaking the module(s). This was true of all but one interviewee. It was sometimes expressed in terms of having altered attitudes, being more tolerant of others, recognising their own strengths and weaknesses and being more confident generally. Some nurses had difficulty in describing the personal impact of the course in concrete terms. As one explained:

> When I came back from the course it was difficult to explain to people what I had learned because it was not on a practical level. However, it made me look at myself, what I thought and how I felt about things. From an inner point of view I could cope better.

The development of self awareness was recognised as having an influence on all aspects of their professional and personal lives. References were made to their enhanced insight into the experience of all patients, not only those who were dying. An improved ability to cope with and support friends during crises was also perceived.

Interpersonal Skills

Closely related to personal development was the acquisition of interpersonal skills. The enhancement of communicating skills was perceived as considerable by eight of the eleven interviewees. These skills, enabled the participants to develop closer relationships with patients. It also tended to make dealing with dying patients and their relatives less stressful. They felt more able to cope with awkward

questions and became less fearful of expressions of intense emotion. Only one nurse expressed feelings of continuing inadequacy when dealing with grief.

The positive effects also extended to their relationships with colleagues, especially medical staff. They were more inclined to discuss patient management with medical staff as an equal and were more prepared to question medical decisions. As such they have adopted the role of patient's advocate.

Increase in Knowledge

The knowledge acquired has improved the participant's abilities to identify, understand and meet the needs of patients, relatives and staff directly. Their increased knowledge of pain and symptom control enhanced their confidence and ability to challenge medical staff decisions.

Resources

The questionnaire responses indicated that enhanced knowledge, skills and confidence were perceived to be the most important factors in facilitating attempts to improve practice. The interview findings strongly supported this perception of internal resources being the most important facilitators. The questionnaire also suggested that external resources were the most significant inhibiting factors. In descending order of important these were shortage of staff, lack of support, negative attitudes of colleagues and lack of equipment.

During the interviews, shortage of staff and time featured as a problem on only one occasion. Lack of equipment was not mentioned. Lack of support and negative attitudes in the work environment featured much more strongly. The following section summarises the participants' responses to specific questions about discussions with their Nurse Manager and the extent to which various colleagues accepted their expertise.

Nurse Manager Support

The assumptions made from the questionnaire responses regarding lack of support from Nurse Managers was borne out by the interviews. Opportunities for discussion with their Nurse Managers had occurred for five of the eleven interviewees prior to attending the course and for six following completion of the module(s). Despite this, there seemed to be no comprehensive staff development strategy.

There was little effort to identify how knowledge and skills gained could benefit delivery of care, far less support its integration into practice. Nonetheless, two Nurse Managers and two Charge Nurses were perceived to have been supportive and open to suggestions.

The experience of one nurse serves to demonstrate the possibilities. It could also serve as a model for maximising the organisational benefits of CPE. On return from the course, the nurse had felt that her Nurse Manager really wanted to hear her views about the course and had been asked to speak to other staff about it. It had also been agreed that she should spend time in each ward within her unit "so that they could all benefit from the course".

There was no indication that this particular Nurse Manager devoted more time to staff development than any of the others who had discussed the course with their staff. However, the nurse's perception of being supported was far greater. The Nurse Manager's attitude and ability to convey a sense of support seems more crucial than active involvement.

Another important factor appeared to be the Nurse Manager's knowledge of her staff and their individual need for support. For example, one Charge Nurse reported that her Nurse Manager "was very good and very supportive ... she was very keen that I go ahead with any ideas ... She really just stood back and let me get on with it and didn't put me under any pressure. She didn't interfere".

It was not possible for some Nurse Managers to know their staff sufficiently to be aware of their needs. Some participants returned to their clinical area to find that they had a new Nurse Manager. One

nurse had three different Nurse Managers within a two year period. Several nurses expressed an understanding of the difficulties experienced by Nurse Managers which may have diminished interest in the educational development of their staff.

Nonetheless, most nurses perceived their Nurse Managers to be disinterested and unsupportive. Some Nurse Managers had made no enquiry about the course at all. This left one nurse feeling that "I had done it and that was the end of it and nothing was even asked". Other Nurse Managers had asked for a written report and/or had read the nurse's project work, but gave no feedback.

The negative reaction of the Nurse Managers perceived by some nurses was overt in only one situation. The nurse involved was bitterly disappointed to be told that there was no place for what she had learned in the unit, which was for elderly long stay patients. "She has never discussed it from that day to this and it has been very difficult trying to get her to discuss it. It's really as if I have never gone". Fortunately, such extreme attitudes were not the norm. A few Nurse Managers did encourage the nurses to share their expertise with colleagues, both formally and informally.

It was interesting to note that the two Staff Nurses who perceive their Charge Nurses as being supportive were seconded from wards where the Charge Nurses acted as supervisors for the course. Therefore, they had an interest and understanding of what was involved. Other Charge Nurses showed little interest in what the Staff Nurse may have been able to contribute to patient care.

Acceptance of Expertise/attitudes of others

Junior Nursing Staff

In general the participants' expertise was accepted by junior nurses. Most interviewees felt very positive about their experiences with junior nursing staff. "Junior nurses usually come and ask questions. Once they know I have done the course the first thing they ask is how to deal with patients or relatives".

Medical Staff

The extent to which medical staff valued the expertise gained by the participants varied. The personality of the individual doctor or nurse seemed to be an important determinant of this. For example, one nurse experienced very different reactions from two consultants when she returned to her ward.

The first asked where she had been as he had missed her. On being told that she had undertaken a course in care of the terminally ill his reply was "Why did you need to do that? You have been dealing with terminal care patients for years and you have done fine. That was a waste of money!" He returned later to apologise, but could not be convinced there was any value in her attending the course. The nurse also reported "If I tried to persuade him to do anything differently I had to wait my moment and do it in a round about way and make him feel it was his idea. But I could do that before I went on the course".

This same nurse was told by another consultant that:

> He would love to go on the course because he deals with all the patients with bronchial cancer. He says what he wants to do is run past the door and not tell them. He thought it would be great having me in his ward. So I told him that he was passing the buck and that he should learn how to do it. He said 'But I could listen to what you were saying and learn from you'.

Besides reflecting the differences between personalities, this demonstrated the wide variation in attitudes towards terminal care. The first consultant did not recognise terminal care as involving specialist skills which could be learnt. The second was envious of the opportunity to learn some of these skills, which he valued. These represent two extremes.

The medical staff were perceived as being more likely to respond to the requests of a Charge Nurse than a Staff Nurse. This was reported as a source of frustration by several Staff Nurses and also by Charge Nurses

who had gained promotion since undertaking the course. Some Critical Incidents indicated a positive change in how the nurses were perceived by their medical colleagues.

Critical Incident

Following a battle to have a patient's pain control improved, success brought a change in the relationship between one nurse and a consultant. After that, he asked each day if she felt the analgesia was adequate or if adjustment was required. It also led to other improvements, because he would regularly ask her opinion on other matters. Therefore, not only did the negotiations end the unnecessary suffering of one patient, it paved the way for a team approach and utilisation of the nurse's knowledge in other situations.

Nursing Colleagues

A broad spectrum of attitudes were also evident amongst nursing colleagues. Some colleagues responded very negatively, some were ambivalent, but little active support was evident.

Some participants felt that colleagues accepted their expertise to a limited extent. This was generally qualified by a statement indicating a reluctance to change or accept new ideas, such as "There are always some people who have their own opinions and don't want anyone else to intrude on them". Others felt there was a general apathy. This tended to be applicable to education in general, not only palliative care.

Others were perceived to be more hostile, seeming to resent a colleague having a bit more knowledge in some areas. A feeling was expressed by several of the participants that nurses are sceptical and are unwilling to accept advice "from one of their own". One comment made to a Charge Nurse by a colleague was "Why did you do a terminal care course? What has that got to do with geriatrics? All these Professional Studies courses are a waste of time anyway".

Fortunately, the majority of participants considered that they had at least one ally who had an interest and asked about what they had

learnt. A few found that colleagues from other wards would occasionally call to ask for information on an informal basis. Some considered that acceptance had developed with time.

Application of Learning

All participants considered that they utilised at least some aspects of what had been learnt on the course. Learning depended on the particular module(s) undertaken and the perceived learning needs. Utilisation was also selective. The ease with which certain aspects were incorporated into practice had some bearing on this. Three participants considered that practical aspects were easier to implement because the result can be observed. Two others thought that use of communicating skills was easier because it depended only on themselves.

There was a perception that learning had been integrated into all aspects of practice, not only in respect of dying patients, but also in respect of patients who were not terminally ill. However, not all attempts to apply learning were successful. Six of the interviewees experienced disappointment and frustration because efforts to utilise their learning have been thwarted. On occasions, this has been the result of having no clear strategy or because unhelpful strategies to institute change had been used.

Staff Support and Education

Participants perceive themselves to be more aware of the needs of staff for support and many attempt to provide this. All have become involved in teaching staff formally and informally. Some are used as a resource within their clinical area. Although the extent of their teaching is variable, all consider that they have been able to influence staff in some ways. A regularly reported example of alteration in staff attitudes was a move away from the automatic isolation of dying patients by means of removal of their beds into side rooms.

There also appeared to be an increased awareness of the needs of colleagues. One nurse saw colleagues avoiding dealing with dying patients and their relatives, as she had done previously. She stated

that "Now I don't want to side step it. I am comfortable dealing with it. If I notice that there is a problem and others are not coping with it, I will offer to deal with it".

Another nurse recognised a need for support in two student nurses who were upset, following the sudden death of a young patient. She sought them out and spent time with them. They were embarrassed and felt that they shouldn't be showing their feelings.

Critical Incident

> I tried to explain to them that it was only natural, because I could feel it as well - the lump in my throat and tears in my eyes. I said that it was better to let it out now than go home and worry about it. I think if I hadn't had the experience on the module that I probably wouldn't have gone to look for them and left them to their own devices. I was glad I was able to give them some support and not just ignore it, pretending there was nothing wrong.

Disclosure

In addition to adopting more open communication themselves, participants' attempts to encourage openness in others were generally perceived as successful. They reported a tendency to have more discussion with medical staff regarding the patients' and relatives' needs for information. This was accompanied by encouragement and empowerment, particularly of relatives, to ask for further explanations if they wished. This is demonstrated in the following.

Critical Incident

One nurse had considered a doctor's explanation of a patient's illness to the patient's wife as inadequate. She encouraged the lady to return and ask questions if there was anything she wished clarified. When the lady returned with some queries, the nurse called the doctor. She discussed with him the lady's questions and her apparent need for further information before he spoke to her. The relative came back to

the nurse and talked over her feelings. She had realised there was something seriously wrong with her husband and it had been preying on her mind. She felt better "knowing what they were up against". The nurse stated that previously she would not have offered the relative the opportunity to discuss the situation again. Nor would she have attempted to influence the information given by the doctor.

Pain and Symptom Control

Eight interviewees felt that considerable benefit to patients was achieved as a result of their ability to secure better pain and symptom management. This was related to their ability to discuss management with medical staff from a sound knowledge base. However, even when successful, good symptom management was not always so readily achieved. The following described the struggle experienced by one Charge Nurse to improve a patient's pain control.

Critical Incident

> I fought a battle for a long while to have a particular patient prescribed something stronger. The patient was in a lot of pain. He was lying in bed everyday, moaning. I spoke to the doctor repeatedly. He had prescribed Coproxamol, then changed it to DF118 and then tried something else. Eventually I brought in my literature from the course and we sat down and discussed putting him on MST (opiate). He said "It might made him drowsy. It might make him this or that." So then I came out with my facts and figures and said that it wouldn't.
>
> So he was very good. He just sat there and read through all this and said "Well OK, Sister. We'll let you have your way this time. Let's go and we'll see what happens". The patient then went on proper pain control. I felt quite pleased because the patient was pain free. He was able to get up and about and do what he wanted.

Increased knowledge of analgesia and confidence in that knowledge enabled her to justify her requests. It also demonstrates a successful strategy in the management of change. She persisted in her assessment of the patient and used sustained argument to influence medical opinion in a constructive way.

Attempts to improve symptom control were not successful on every occasion. The same nurse also experienced failure.

Critical Incident

This was extremely frustrating experience. It concerned a patient who was close to death and had a very moist chest. The nurse had suggested that a particular drug might be useful in drying up secretions. The doctor had declined to prescribe it because it would dehydrate the patient. This is a practice which is common in the hospice setting. It avoids the distress of oropharyngeal suction for the patient and the distress of listening to the "death rattle" for the family.

Her failure in this instance was partly related to limitations of time. The patient was dying and she had not time for the persistent persuasion which had been successful in the previous situation. However, the situation was not totally negative. Although the doctor declined to prescribe the drug on this occasion, he did agree to look into it. The nurse had not had an opportunity to discuss it further with him prior to the interview, but intended to ask him about it the following day. Therefore, from a seemingly negative experience, it is possible that she may have influenced his future prescribing practice.

Only one participant who had undertaken the Quality of Life module which deals with symptom control felt that she did not use that particular aspect of learning. She considered that she had not kept her knowledge of analgesia up to date and therefore lacked confidence in that respect. However, this appeared to have been the result of selectivity of utilisation of learning, according to the perceived needs in her clinical area. The main focus of her attention was the use of interpersonal skills and support of staff.

Confronting Emotion

Confidence in their communication skills gave six of the interviewees courage to confront situations involving intense emotion such as anger or grief, which they would have previously avoided. One nurse related a conversation with a patient who had been admitted for mastectomy and whose husband had recently died.

Critical Incident

> I spent some time with her yesterday and found that I could talk quite openly to her about it, which I don't think I could have done before, knowing that she had been bereaved. I took time to speak to her. I went over things about her surgery and asked how she felt about it. She said she wasn't really apprehensive because she had other things on her mind. I asked if she wanted to talk about it. She talked about the death of her husband.... She said she got angry with other people being concerned about her having breast cancer, instead of being concerned that she had just recently lost her husband. I felt quite good in myself, because I could speak to her like that. Before it would have been more of a general chitchat on a superficial level. I think the woman appreciated someone who was prepared to listen to her and talk about her bereavement, rather than focus only on her surgery.

This illustrates a common theme of increased awareness of the patient's needs. It also shows the use of communication skills at a meaningful level, demonstrating that the nurse was sufficiently confident and comfortable to allow herself to be led by the patient's agenda.

Advocacy

Adoption of the role of patient or relative advocate by the participants also resulted from the increased confidence in communication skills, linked with knowledge. Strategies for persuading the medical staff to adopt a particular treatment are evident. Thus

their knowledge of symptom control is being used for the benefit of patients and their families.

A different example of advocacy was described in the following incident. Although the desired outcome was achieved, the means were undesirable and left the nurse feeling very unhappy about the situation.

Critical Incident

It involved the care of a very elderly man with severe cardiac problems. He suffered a lot of chest pain on the slightest effort, despite medication via a variety of intravenous infusions. At home, he was limited to movement from bed to commode. He was exhausted and didn't want to be dependent on machines for the rest of his life. Attempts to persuade the consultant to discontinue active treatment failed.

> I tried speaking with him (the consultant) several times and even asked the man to tell the doctor how he felt, but there was no way he would listen. When the patient had spoken to the consultant about how he felt about the machines and his condition, the consultant had said, "I'm not God. I have to do my best." It was hopeless. The man was angry. Every now and again he would pull out his IV and we would have to reinsert it. His family couldn't bear to see him suffer. All the staff were quite angry at the situation and felt he was suffering needlessly. All the doctor had to do was not restart the drips, give him his oral medication and let nature take its course. He didn't have to do anything actively. I felt frustrated - so frustrated.
>
> Eventually we had to go behind his back and when he was off for a few days we spoke to his senior registrar about it. He agreed that enough was enough. We didn't like doing what we did in going to the senior registrar. However,

> nothing more was said about the incident. The consultant never questioned it when we told him the man had died.

This demonstrates not only the ethical problems of discontinuing active treatment, but also the difficulties which arise when there are conflicting perceptions of responsibility. It is possible to speculate that the consultant's stance may have been related to avoidance of issues related to dying. Whatever the reason, the nurse found herself having to adopt an undesirable strategy to circumvent an attitude problem which could not be addressed. It is unfortunate that such an inability to achieve a mutual understanding of each others reasoning may allow misunderstandings and conflict to be perpetuated.

Conflict Stimulated by the Interviewee

Conflict of various types was a major theme which emerged, particularly from the Critical Incidents. On some occasions the individual participant herself was the source of conflict. Trying too hard to change practice had brought some participants into conflict with their colleagues. Three participants have now adopted different strategies to achieve change in light of this awareness.

The course had evoked a greater awareness of patient and relative needs in the participants. It had made them more assertive and willing to act as an advocate. The intense enthusiasm of some participants mitigated against their suggestions being accepted initially. However, by modifying their approach and exercising patience, some have found their suggestions for change have been accepted to a certain extent. As one nurse said:

> I wanted to change attitudes in the ward. At first I didn't get the chance, if I said black they were away doing the opposite. Nobody wanted to know. I think they felt I was a threat to them .... but subtly things have changed.

Another nurse was aware that initially she "was constantly fighting about things related to symptom control". In time "I just stopped voicing my ideas and did things very quietly, trying to make

suggestions look like other people's ideas". She perceived that her aggressive approach was a direct result of the enormous impact made by the course. She wanted to change everything at once.

> The course makes you acutely aware of the patient and the patient needs. I think its because you are supernumerary and only looking after a few patients. It is really very unrealistic. You are so involved with that one patient and what is right for them, your priorities are different and you are not really aware of the demands of the rest of the ward, staff or patients. You are so full of the theory of caring for the dying, at least I was .... I used to focus in on the patients who were terminally ill and try to make my own diagnosis. I kept thinking back to everything I had learned on the course because it made a really big impact. I was fighting against other people in the way I wanted to do things for the patients.

Perhaps, if the participants had been equipped with more knowledge of the process of change from the outset, some of these painful experiences could have been avoided.

Theory/Practice Conflict

The theory/practice conflict was exacerbated by the focus on hospice care. The participants were exposed to innovative practices which are accepted within the hospice movement, but foreign to staff working in an acute care setting. Consequently, the nurses have returned to their own clinical environment with greater knowledge in some aspects of symptom control than the medical staff whom they were trying to influence. The prescription of certain drugs for pain and for drying up bronchial secretions are two examples of this which have already been illustrated in the Critical Incidents.

Conflict - The Role of the Nurse

The following incident is an example of conflict between differing perceptions of the nurse's role. It involved an aspect of care

traditionally considered to be the responsibility of medical staff, but in which the nurse was more skilled.

Critical Incident

> Although we had a syringe driver on the ward, at first the medical staff didn't want to use it. They preferred the old intravenous pump. When they decided it should be used, they wanted to set it up which was stupid because half of them didn't know how to do it. To start with they were setting it up intravenously. The nurses had to show them that it worked just as well subcutaneously. When they saw that, they let us get on with it. It suited them because the young doctors weren't being called out at night. After a while it became practice on other wards too. Then an edict came from the Health Board saying that only medical staff could set them up.
>
> I discussed this with my Nurse Manager. Then I remembered that while on hospice placement during the course, I was given a certificate to show that I had been taught to use the syringe driver. I gave it to my Senior Nurse, who discussed it with the consultant. That piece of paper made all the difference. I was the only sister in the hospital who was allowed to set up syringe drivers. I then instructed my staff officially and they were allowed to do it too.

Although the outcome was positive, numerous difficulties had to be overcome through dogged persistence. A syringe driver is the safest, simplest and most comfortable method of administering drugs to patients who are unable to take oral medication. In the hospice setting, nursing staff are responsible for setting up, monitoring the function and effect, changing and recalibration of these pumps. The nurse was the only staff member in her unit with the knowledge and technical know how to operate the equipment safely and effectively. Consequently, it was used inappropriately on a number of occasions.

Strategies used to achieve her aims were negotiation, assertiveness and demonstration of the benefits to the patients and the doctors. These were aided by drawing on past experience and confidence in her own knowledge and abilities. Despite her expertise being accepted by her nursing and medical colleagues the Health Board directive meant that she could no longer take professional responsibility for her actions. Her skills had not been in question, but bureaucracy demanded a piece of paper to legititise these skills.

Conflict - Advocacy

Conflict also arose on a number of occasions because of the willingness of the participants to act as an advocate and to challenge the opinions of others. This was not always related to medical prescriptions. It involved all staff. It was sometimes related to entrenched attitudes to terminal care, the role of the nurse or to disclosure of information.

The following is an example of a nurse who utilised the communicating skills which she acquired on the course. The resulting conflict which occurred with her nursing and medical colleagues illustrates the difficulties which face staff in an unenlightened environment.

Critical Incident

The situation had involved a young patient with whom the nurse had developed a trusting relationship. He had an advanced tumour and had been through a lot of treatment and suffering. He had been offered a choice by the Senior Registrar, between going home and letting nature take its course or trying one more treatment.

> I walked into his room and the first thing he said was "Hi,.... Tell me something - am I going to die?" Immediately I responded with "What makes you think that?" So he explained what the doctor had said. He wanted to know from me what his chances were if he took the treatment. I said that I didn't think he should make any

> decision then, but should discuss it further with the medical staff the next day.
>
> He interrupted me and said "Look, I want to know what is happening here". I said I didn't know what type of treatment the medical staff had intended using, but obviously there is always the possibility that the situation would remain unchanged. He wanted to decide that night and wanted to speak to the doctor. I 'phoned the doctor on call and explained what had happened. She 'phoned the senior, who happened to be the one who had spoken to him that day about the choice. She refused to come in and said that I had absolutely no right to have said anything that I had said to that patient, that it was terrible that I had even entered into a conversation with him in that way.

The patient died two days later in hospital having decided to have no further treatment. However, that was not the end of it. The Ward Sister had confronted her when she returned from nights off. The Consultant had been extremely angry that she had discussed treatment with the patient and also that the Senior Registrar had given the patient a choice.

> They were not willing to listen or understand. I got into terrible rows for it, terrible, terrible rows, because they had this idea that I had gone in and told him to go home and say cheerio to his wife. They didn't think I might have tried to discuss it with him, or tried to put him off making his decision. I got absolutely hammered about it and all the staff thought I was in the wrong. Every single one of them thought I had no right to be honest, to confront someone with what they already knew, to help them sort out their choices. I had absolutely nobody to go to for support.

Fortunately for the nurse involved, another Staff Nurse went on the course several months later. On returning from the same learning

experience, the Staff Nurse said she could then understand how right she had been to act as she did. Although she felt sure she had acted correctly, this comment brought considerable relief.

Although this is a fairly extreme example of reaction from the other members of staff, it is not unique. It serves as an example of a paternalistic attitude in the medical staff and a perception by nursing and medical staff of the nurse being subservient. Few nurses would have been able to survive this personally or professionally. The nurse in question was very anxious afterwards about the effect of her career and her relationships with colleagues.

Application of Learning without Conflict

Not all attempts to apply their learning brought the participants into conflict with their colleagues as the following demonstrates.

Critical Incident

Following the death of an elderly lady, the Ward Sister expressed a reluctance to break the news to the lady's daughter, with whom she had established a relationship. The interviewee, who was a Staff Nurse, offered to deal with this for her. This offer was gratefully accepted and the Staff Nurse dealt with the immediate situation.

> After all this, Sister was able to come in and sit with the family and hold her hand, because the acute situation was over. We talked about it afterwards. She felt that she couldn't have told the daughter without having been upset and because she was trying not to be emotional, may have come across as being a bit stand-offish. But she said I was very natural and relaxed.

The increased confidence in her own communication skills enabled the nurse to deal with a situation which a colleague perceived as difficult. Moreover, she was able to do this in a natural and relaxed way. She had the courage to confront the grief and emotion of both the relatives and staff. Her skills were used appropriately to support

both parties. She did not automatically expect the Ward Sister to be able to deal with it because of experience and seniority. Her handling of the situation enabled a more senior person to confess and overcome their difficulties. The Ward Sister clearly accepted the Staff Nurse's expertise. It is also possible that the Ward Sister may have learnt from the experience.

CHAPTER 8 - DISCUSSION ON THE FINDINGS

8.1 LIMITATIONS OF STUDY

Palliative care is a specialty which is in its infancy. Consequently, there is a dearth of well-structured educational programmes in this area. When the study began, the PSII Course on Care of the Terminally Ill Patient offered by Glasgow South College of Nursing was the only one of its kind in Scotland to offer theoretical teaching combined with planned clinical experience. Despite including all participants, the numbers were small. Moreover, participants were drawn from a variety of different clinical environments. Therefore findings cannot be generalised.

Time and limited experience on the part of the researcher were also constraining factors. With such small numbers, a more detailed examination, based on a firm theoretical framework, may have added to the study. Alternatively, a prospective study, even with smaller numbers may have been more valuable. This would have provided opportunities to further explore the perceptions of the participants and their managers regarding the purpose and content of their pre- and post-modular discussions.

Failure to pilot the Nurse Manager questionnaire because of limited time meant that the results could only be considered suggestive. In addition, had an attempt been made to analyse the pilot study results, some problems with analysis of the interviews could have been avoided.

It was not until the interviews for the main study were carried out that it was discovered that not all participants had requested or wished to attend the modules. Had this been foreseen, it might have been addressed within the questionnaire. It may have been useful to explore the factors which motivated attendance of the whole sample and if this had any bearing on the perceived outcome.

It should be borne in mind that the results are dependent on the perception and recall of the participants. Some participants had completed the module(s) two years prior to receiving the questionnaire. Therefore, it must be assumed that some of the reported findings have suffered distortion. In addition, it was not possible to check details of the incidents related.

8.2 SUMMARY OF THE FINDINGS

Despite its limitations, this study highlights are number of issues in palliative care education and staff development. If education is to be effective in improving practice, these issues must be addressed.

There is a recognised need for improvement in the delivery of palliative care, particularly within the hospital setting (Wilkes, 1984; Simpson, 1991). The development of appropriate attitudes, knowledge of symptom management and communication skills are vital in achieving such improvements (Wilkes, 1980). However, education is only one part of the equation (Keiser and Bickle, 1980). Knowledge and skills gained are not necessarily incorporated into practice (Sanazaro, 1983). The individual practitioner must have a desire to improve practice (Jarvis, 1983) and must be adequately supported to do so (Lawler, 1987).

Pre-Modular Preparation

It had been assumed that all participants had been enthusiastic attenders of the modules. During the course of the interviews, it had emerged that this was not so. A small minority of participants and Nurse Managers appeared to view attendance of the modules as no more than a means of extending qualifications. There was also evidence that the modular content was inappropriate for the learning needs of some individuals and for the needs of their clinical areas. Yet it has been suggested that identification of learning needs appropriate to the individual and the organisation are important if CPE is to be effective (Gorman, 1991).

Even in those with an expressed interest, the commitment to learning often lacked a clear focus. Few participants embarked on the course with specific learning goals. Although more than half of the participants had discussions with their Nurse Manager regarding their objectives this was not always considered to be at a level which was useful or meaningful.

In the absence of clear objectives, many participants lacked direction. Yet, in view of the belief that the outcome of adult education is unique to the individual, the learning objectives of each individual provide the basis for evaluation (McLemore and Bevis, 1979).

These problems raise the question of whether the course organisers should undertake to interview potential participants. This could ensure that only those whose learning needs could be met by the course would be accepted. It could also have important ethical and financial implications for the course organisers if it resulted in a reduced number of participants on the course. In any event, maximum benefit from CPE requires that managers ensure staff attend appropriate courses.

The Education

Overall, participants evaluated the course very positively. They reported enhancement in many areas of clinical practice and personal development. However, selectivity of learning was demonstrated by a number of interviewees. As would be expected in adult education, areas of practice in which the participants perceived themselves to be already knowledgeable and skilled were given little attention by the participants (Knowles, 1984). The same was true of areas which were not considered applicable or useful to their own clinical area.

Most learning needs of participants were met by the course. Such criticisms as were made regarding insufficient input in some areas, or too much in others, were individual. Perhaps the use of contract learning might have enabled the course organisers to tailor the content to the specific needs of these individuals (Norton, 1989).

Another criticism which has also been made of other palliative care courses was the tendency to focus too heavily on care in the hospice setting (Simms, 1985). This may well have been intentional to illustrate the ideal scenario. However, perhaps some participants would have benefitted from more guidance on how to translate this to their own clinical area.

There may also be a need to examine the approach to some specific aspects of course content. The ability to meet the spiritual needs of patients and to address the ethical issues in palliative care were two common areas of difficulty. There may be a need to modify the way these areas are presented. It may be that more research is required in general, to identify effective approaches in the education of these topics.

In general, the course increased the participants' sensitivity and understanding of the needs of dying patients and their relatives. It also equipped participants with strategies for coping with the emotive issues. As in Simms' study (1985), some participants felt that they might have been better prepared for the conflicts which arose when attempting to integrate learning into practice. In view of the difficulties encountered, it may be useful to address these issues during the course. Enabling participants to identify potential deterrents to the application of learning may help them to minimise their effect.

Discussion of strategies for and plans for implementation of change has also been suggested as essential to avoid failure (Wright, 1989). Although most participants did return to their clinical area with plans for improving care, these did not appear to be very structured. Indeed, for some participants, the intensity of the course stimulated a missionary-type zeal to change everything at once, which was not well received by colleagues.

Supernumerary Status

The supernumerary status of participants was generally perceived as valuable. The difficulties in adjusting to working in this way were

more apparent in those who had undertaken the course in its earlier stages. Presumably, this resulted from lack of familiarity of this approach among the supervisors and staff in the clinical placements. For some participants the supernumerary status added to the reality shock when they had returned to their own clinical area.

The Outcome

Most participants reported some degree of success in improving practice or in influencing colleagues following attendance on the module(s). The extent to which this was achieved appeared to be variable, it may also be underestimated since at least three participants did not appear to recognise their achievements until they were encouraged to relate their experiences in the Critical Incidents.

Despite Del Bueno's assertion (1979) that recognition of a need to improve an aspect of practice is an important first step in the learning process, this was not supported by the present study. Absence of pre-existing interest in palliative care did not always equate with lack of motivation to learn. Moreover, once selected to the course, most participants were committed to learning and utilising as much as they could from it . This enthusiasm and commitment seem to have been important factors in encouraging individuals to apply learning to practice. This supports previous findings by Keiner and Hentschel (1989). Perhaps this indicates that the individual's acceptance of responsibility for their own learning was more important than prior interest.

Application of Learning - Facilitating and Hindering Factors

In keeping with the findings of Keiner and Hentschel, (1989), the acquisition of knowledge was most frequently reported by participants as facilitating the application of learning. This was closely followed by enhanced self-confidence, supporting the findings of Fuhrmann and Weissberg (1978). The questionnaire responses indicated shortage of staff to be the most important factor which inhibited the application of learning. Yet, in the interviews it featured only once. Even then,

it was suggested that shortage of staff or time was sometimes a convenient excuse for not spending more time with patients.
The credibility and authority of the participants was recognised as having considerable influence on their ability to effect change. Staff Nurses were perceived to have more difficulties than Charge Nurses in trying to influence the behaviour of other nursing and medical staff. However, there were examples of medical staff responding to the nurse's ability to justify requests regardless of her position in the hierarchy. The ability to do this arose from the perception of enhanced knowledge and increased self-confidence. Nonetheless, it may be useful for course tutors to be aware of the additional difficulties which more junior staff may experience in similar situations.

Support in the Clinical Environment

The most frequently cited factor inhibiting the application of learning to practice was lack of support and negative attitudes in their own work environment. This comes as no surprise. Several other studies have demonstrated this, apparently to no avail (Keiner and Hentschel, 1989; Ramprogus, 1989).

Junior Nurses

In general, participants were encouraged by the response of junior nurses who appreciated any support and guidance offered.

Nurse Managers

Responses of Nurse Managers polarised. A few were very supportive and encouraging, clearly valuing the contribution which the participants newly acquired knowledge and skills could bring to the unit. One reacted very negatively, perceiving the learning to be a waste of time. The majority lay somewhere in between.

Although some Nurse Managers provided active and appropriate support to their staff, a greater number were perceived to be unsupportive. A quarter of the participants had no opportunity to discuss the module(s) either before or after their attendance. If the discussions which were unhelpful are also taken into account, there would appear to be a considerable number receiving little support or encouragement from their Nurse Managers. The Nurse Manager responses suggest possible reasons for this may relate to

- lack of time;
- lack of knowledge and understanding of the content and aims of the module(s);
- a wish to conceal own ignorance or inadequacies;
- lack of appreciation of need for support for staff learning and development.

In some cases, the problem may simply be apathy. It was disturbing to find a number of Nurse Managers appearing to believe their responsibility for staff development ended with the release of a staff member to a course. These Nurse Managers seemed to show little concern that the content would be utilised. It is interesting that the Nurse Managers' opinions suggested that they adopted a more active role in staff development and support than was perceived by their staff.

Despite the strength of opinion in respect of lack of managerial support, this featured very little in the Critical Incidents related. It may be that while Nurse Manager support is important to the morale of the individual, it is much less important to the actual application of learning. Alternatively, this may simply reflect the small number of Critical Incidents related.

Charge Nurses

When the participant was a Staff Nurse, some Nurse Managers considered the responsibility for staff development and support should rest with the Charge Nurse. In view of the tendency to devolve more managerial responsibility to the Charge Nurse, this seems perfectly reasonable. However, few Charge Nurses appeared to be equipped or willing to undertake this role. It may be that such responsibility had not yet devolved to this group of Charge Nurses or that they did not perceive staff development as part of their remit.

In any event, few Charge Nurses seemed to adopt an active role in facilitating their staff to implement what they had learnt. Some appeared unwilling to accept that a more junior colleague may have expertise which they lacked. Indeed, some were perceived to resent the suggestion. They were unable to see their staff as a resource, which they could help to develop.

The role of the Charge Nurse is undergoing change. It is becoming more management-orientated. In the future, the clinical experts are likely to be senior Staff Nurses, co-ordinated and managed by a Charge Nurse. Consequently, fewer Charge Nurses are likely to attend such purely patient-centred courses. Therefore, it is vital that Charge Nurses receive adequate preparation for this additional responsibility.

Medical Staff

The responses of senior medical staff were as diverse as those of the Nurse Managers. These ranged from respecting and valuing the participant's expertise to extremely negative or paternalistic views. Nonetheless, relationships between nursing and medical staff appeared to be critical to patient care. The Critical Incidents frequently involved situations in which the participants were required to take risks with their relationships with medical staff. Successful outcomes appeared to be aided by the use of constructive strategies. The exercising of patience, gentle but firm persistence, negotiation, presentation of evidence and demonstration were all successful strategies. Whereas argument and confrontation led to failure.

Colleagues

The insight gained from the interview data concerning the attitudes of colleagues suggested that disinterest and apathy were predominant. There were some exceptions to this attitude, mainly from individuals who were interested in attending the course themselves. Some demonstrated resistance to participants' attempts to influence their practice. The nurses in Ramprogus' study (1989) also reported this. There was little to suggest that colleagues looked upon the participant's attendance on the course as an opportunity to extend their own knowledge and skills. This is a sad reflection on the nursing profession and is perhaps indicative of professional immaturity.

The Critical Incidents

The reporting of Critical Incidents appeared to be appropriate to the study. The incidents served to illustrate the experiences of the participants in a way that straightforward reporting could not have achieved. It was also interesting that they reflected the wider issues of nursing, including the role of the nurse and advocacy.

Although asked to relate negative and positive incidents, most contained elements of both. Some reported as negative incidents demonstrated valiant attempts by the nurse to improve the situation. On the other hand, some incidents with supposedly positive outcomes were achieved at great cost to the nurse.

The frustration felt by some nurses who knew their knowledge and skills were not recognised or valued by others was apparent in the Critical Incidents. The examples of patients who suffered needlessly serve to reinforce the need for education in palliative care. Often this was because others had neither appropriate knowledge, skills, attitudes nor the ability to recognise their own inadequacies.

Also clearly illustrated was the vulnerability and professional isolation of nurses who were trying to integrate the principles of palliative care into practice in the acute care setting. In view of

the difficulties encountered, it is surprising that so much was achieved. This was especially so among those who felt that there was no-one to whom they could turn for support.

Nevertheless, the Critical Incidents highlighted the contribution of the course in developing interpersonal skills and enhancing knowledge of symptom control. Thus, participants were better equipped to identify and meet the needs of dying patients, their families and the staff caring for them.

8.3 CONCLUSIONS

Palliative care is a complex issue with no clear boundaries or skills peculiar to that area. Education in palliative care involves more than the acquisition of knowledge and skills. It also requires a change in attitudes and the development of self-awareness. The necessary thawing of old attitudes and their replacement with new knowledge and ideas takes time (Lawler, 1987). This deeper learning cannot be achieved in single study days. Although short education programmes have their value, they cannot be realistically expected to achieve alterations in practice.

In the current financial climate, all aspects of health care are coming under scrutiny. Continuing education for nurses is no exception. It is very tempting for managers to fulfil their responsibility for staff development by opting for the short, cheap alternative. This may be a short-sighted view but it is difficult to demonstrate conclusive evidence that CPE has a significant impact on practice. This may be particularly true of palliative care education when the effect may take time to develop and be internalised.

In view of existing knowledge in relation to adult learning, it must be accepted that the outcome of any educational programme will be unique to each individual participant. An evaluation tool sufficiently flexible to demonstrate the impact of education in a variety of situations does not yet exist. Until such an instrument can be devised, evaluation of outcome must be tailored to the individual situation. This would be a difficult and impractical exercise for the

educators alone to undertake. Evaluation of education should begin with the identification of learning needs in order to achieve specific objectives. Successful outcome is more likely to be achieved if participants' objectives are compatible with those of the clinical area. Therefore, this would suggest that the clinical manager should not only be taking a more active role in the selection and preparation of staff for courses; they are also in the best position to evaluate the outcome in terms of these objectives being met. Nonetheless, this could be more easily achieved with the help and support of the educators.

By using an individualised approach, this study sought to explore the outcome of the PSII Course in Care of the Terminally Ill Patient and the benefits as perceived by the participants. No attempt was made to prove the course had achieved its aims. However, variable degrees of success and considerable benefits were perceived by the participants. Studies have suggested that these are reliable indicators of educational outcome (Warmuth, 1987; Connors, 1989; Alexander, 1990).

The study also sought to examine the factors which were perceived by the participants to either facilitate or hinder the integration of newly acquired knowledge and skills into practice. The purpose of this was to make recommendations as to how the impact of the education could have been enhanced. The findings suggest that the only way to achieve this is by greater collaboration between education and service staff and willingness of both to address the difficulties.

No amount of education will compensate for the absence of a supportive work environment. There also needs to be a bridging of the education/practice gap by course organisers. Evaluation must be incorporated at the outset. Potential participants and their managers could be helped to identify needs and set goals to give direction and a basis for evaluation. Managers would then see for themselves whether or not particular education programmes were cost-effective. Nurse educators must also be willing to offer continued support as part of the education package to managers.

8.4 RECOMMENDATIONS

This study highlights a number of areas which require further exploration as a means to optimising the outcome of CPE. These include:

- reviewing the selection criteria for course participants;
- identification of a mentor or facilitator in the clinical area to guide and support participants;
- greater collaboration between the potential participant, their Nurse Manager/facilitator and the course organisers, before and after the course;
- creation of an environment which encourages and develops the individual practitioner's ability to identify her own learning needs;
- enabling the individual to set clear objectives which complement those of the clinical area;
- use of a framework for evaluation based on the agreed objectives;
- increasing the familiarity of Nurse Managers regarding the content of CPE programmes;
- ensuring the learning needs of the individual are achieved, possibly by means of learning contracts;
- preparation of participants to plan and manage change;
- creation of a supportive work environment which values education and the individual expertise of staff members;
- preparation of Charge Nurses to take a more active role in staff development and in facilitating change;

- the establishment of support networks for participants of specialised courses.

In addition to the above, the researcher believes that courses in palliative care nursing which incorporate both theoretical and practical components, should be more readily accessible to nurses in the acute care setting. On the other hand, there should be further evaluation of the current provision of palliative care education. There is a need to determine the best approach and such details as the optimum length of education programmes.

Continuing education of staff should be viewed as an investment to ensure high quality care. It may not be necessary to increase that investment. However, this study highlights an urgent need to protect the current investment. There could be substantial savings from ensuring the appropriate secondment of staff to courses. An expectation that learning would be utilised should be held by the participants, their managers and their colleagues. Thereafter, utilisation of learning should be supported to ensure that it becomes established practice. To achieve this, comprehensive staff development strategies require to be introduced. This should help to secure a more profitable return on the investment into CPE.

APPENDIX 1

INSTRUCTIONS

This questionnaire is being issued to participants of Professional Studies II Modules in Care of the Terminally Ill. It is part of a study to examine the difficulties of integrating new knowledge into practice, and to explore ways in which course participants might be helped to use what they have learned in their own work environment.

ALL THE INFORMATION THAT YOU WILL BE PROVIDING WILL BE TREATED IN THE STRICTEST CONFIDENCE

Please also note that this questionnaire in no way forms any part of your Professional Studies assessment.

Thank you for your help.

Margaret Sneddon
Macmillan Research Nurse
University of Glasgow
Department of Postgraduate Medical Education
7 Lilybank Gardens
GLASGOW
G12 8RZ

DQUES27.11

PART 1

1 NAME _____

2 TITLE OF MODULES UNDERTAKEN AND DATE OF COMMENCEMENT

_____

_____

_____

3 AGE (please circle) 20-24 25-29 30-34 35-39 40-44 45+

4 POST (e.g. S/N; W/S; Part/Full time; Day/Night duty, etc.)

_____

5a CLINICAL AREA FROM WHICH YOU WERE SECONDED (e.g. surgical, acute psychiatry, etc.)

_____

5b CURRENT CLINICAL AREA (if different from above).

_____

NB <u>If you have changed jobs since completing the module(s) please complete this questionnaire on the basis of the post held when seconded.</u>

6 HEALTH BOARD _____

7 How long have you held your present post? _____years _____months

8 Have you undertaken any other Professional Studies modules? Please specify which modules.

_____

_____

9a The following list consists of some of the Parts of the UKCC register of nursing qualifications. Please indicate your year of qualification, by those which you possess:-

PART 1 (RGN) _____ PART 5 (RNMH) _____

PART 3 (RMN) _____ PART 8 (RSCN) _____

9b OTHER QUALIFICATIONS (e.g. Degree, Diploma, Certificate, etc.)

(please specify) _____

PART 2

In this section please tick the most appropriate response.

1. Before attending did you have an opportunity to discuss what you hoped to gain from the module(s)?

[] YES [] NO

If yes - with whom did you discuss it?

[] Ward sister/charge nurse
[] Nurse manager
[] Other

Who initiated this discussion? [] You [] the other person

Was this discussion useful? [] YES [] NO

Please list any topics you recall being discussed.

If you answered NO to this question, would such a discussion have been useful?

[] YES [] NO

Whom do you feel would have been in the most appropriate position to discuss this, if you had the opportunity?

[] Ward sister/charge nurse [] Nurse manager
[] Other - please state who

PSII Modules are designed to increase the participants knowledge and skills and so enhance their ability to provide high quality care. They may also enable participants to have a positive influence on the practices of others. Some aspects are more difficult to change or influence than others and many factors may be involved. The following questions relate to these.

3. On completion of the module(s), did you return to your post with specific plans for improving care?

[] YES [] NO

If yes, please list which aspects this involved.

4. Have you had an opportunity to discuss the knowledge and skills gained in the course of the module(s) with your nurse manager?

[] YES [] NO

If YES, was this useful? [] YES [] NO

When did it take place?

Within 2 weeks of returning to work situation []
3-4 weeks after returning to work situation []
More than 4 weeks after returning to work situation []

Please state any specific topics which you recall being discussed at this time.

If you did not have this opportunity, would such a discussion have been useful? [] YES [] NO

5. To what extent do you think that the following aspects of your job have been helped by undertaking the modules? Please insert a tick in the column which most accurately reflects your opinion. If you feel any particular aspects were not enhanced by the course because you were already knowledgeable or experienced in that area, please place your tick in the right hand column.

	A LOT	A LITTLE	NOT AT ALL	ALREADY KNOWLEDGEABL EXPERIENCE
a) Assessing patients' needs	[]	[]	[]	[]
b) Assessing relatives' needs	[]	[]	[]	[]
c) Meeting patients' physical needs	[]	[]	[]	[]
d) " " psychological needs	[]	[]	[]	[]
e) " " social needs	[]	[]	[]	[]

	A LOT	A LITTLE	NOT AT ALL	ALREADY KNOWLEDGEABLE/ EXPERIENCED
f) Meeting patients' spiritual needs	[]	[]	[]	[]
g) " " relatives' needs	[]	[]	[]	[]
h) Understanding the needs of staff	[]	[]	[]	[]
i) Understanding ethical issues involved	[]	[]	[]	[]
j) Improving standards of care	[]	[]	[]	[]
k) Evaluating care given	[]	[]	[]	[]
l) Being able to identify your strengths	[]	[]	[]	[]
m) Being able to identify your weaknesses	[]	[]	[]	[]
n) Responsibility for your own learning	[]	[]	[]	[]
o) Communicating with patients	[]	[]	[]	[]
p) Communicating with relatives	[]	[]	[]	[]
q) Increase in enthusiasm for this aspect of your job	[]	[]	[]	[]
r) Reduce the stress involved in this aspect of your job	[]	[]	[]	[]
s) Ability to question the way things are done	[]	[]	[]	[]
t) Supporting staff	[]	[]	[]	[]
u) Teaching junior staff	[]	[]	[]	[]
v) Bereavement care	[]	[]	[]	[]
w) Influencing practice of nursing colleagues	[]	[]	[]	[]
x) Influencing practice of medical colleagues	[]	[]	[]	[]
y) Implementing change	[]	[]	[]	[]
z) Encouraging a multidisciplinary team approach	[]	[]	[]	[]

If you responded "NOT AT ALL" to any of the above, was this because:

[] it was not covered in the module(s) you have undertaken

[] it was inadequately covered in the module(s)

[] other reasons. Please state.

6a. From all the aspects of your practice listed in question 5 which three have been most influenced by the course.

1

2

3

6b. Were there any other benefits gained from attending the modules?

7. Change does not necessarily mean major upheaval. It may be a subtle alteration in thinking, approach, decision making or behaviour. If you feel you may have had any success in changing or influencing others, can you briefly say with whom, and in which aspects?

8. Since completing the course, have any of the following factors been of any help to you in trying to improve care.

e.g. [] Increase in own knowledge/skills
[] Increase in confidence
[] Support of nurse manager
[] Support of ward sister/charge nurse
[] Support of medical colleagues
[] Other source of support
[] Other factors. Please state which.

9. Since completing the course, have any of the following hindered you in any way from trying to improve care.

e.g. [ ] Lack of confidence
[ ] Lack of time
[ ] Shortage of staff
[ ] Insufficient knowledge in some areas
[ ] Lack of resources/equipment
[ ] Other factors

Lack of support from:
[ ] Nurse manager
[ ] Charge nurse
[ ] Medical colleagues
[ ] Other

Negative attitudes of:
[ ] Nurse manager
[ ] Charge nurse
[ ] Medical colleagues
[ ] Other

10. In your opinion, were there any particular strengths or weaknesses in the PSII Module(s) you have undertaken.

If so, please indicate what these were in the appropriate column.

STRENGTHS	WEAKNESSES

11. Would you be willing to provide further information if it is required?

[ ] YES [ ] NO

If yes, would you please give a telephone number at which you can be contacted?

_____

Thank you for your cooperation.

APPENDIX 2

PSII SEMI-STRUCTURED INTERVIEW SCHEDULE

Thank you for taking the time to complete the questionnaire and for agreeing to this meeting. It has been arranged to further explore some of your answers in the questionnaire and some of your experiences in caring for the terminally ill since undertaking the Modules.

1. Check details of demographic information in Part 1, if necessary. If the present post differs from the one from which the participant was seconded, how long did they stay in post after completing the module(s)? Explore reasons for changing job.

2. Before starting the Modules, had you given much thought to what you hoped to gain from them?

   If yes, what was this?

3. In your questionnaire you stated that you had been given an opportunity to discuss the knowledge and skills gained in the course of the Modules with your superior.

   Was this at an appropriate time?

   In what way was this useful/not useful?

4. Discuss plans - were they asked to plan their action?

5. In your questionnaire you stated that undertaking the Modules had helped only a little in the following areas - show questionnaire. Can you say why?

6. How could you have been helped more in these areas?

7. Is your expertise accepted by others?

   a) Junior nurses
   b) Nursing colleagues
   c) Medical colleagues
   d) Your superior

   Do others come to you for advice/information? If so, what kind, who requests it, and is it taken?

   Any course is liable to raise expectations in the participants. There are many reasons why things learnt are difficult to implement. This study is intended to identify areas of difficulty and explore ways in which they may be overcome.

8. Are there particular types of knowledge/skills gained easier to implement than others?

   If so, which? (Ref Question 4) e.g. nursing/medical attitudes, ward routine.

9. Are there any types of change (Ref Question 5) which are easier to implement than others?

10. Since completing the questionnaire can you recall any situation in which you utilised the knowledge and skills gained on the Modules to the benefit of a patient, relative, or member of staff.

    Can you tell me what happened?

    What did you do or say?

    Why did you take this action?

    What happened then?

    How did you feel?

    How did your action or reaction differ from the way you would have behaved prior to undertaking the Modules?

11. Since completing the questionnaire, can you recall a situation in which you found it difficult to take the action you would have wished in caring for a dying patient, his or her family, or staff caring for them?

    Can you say what happened?

    What do you feel should or could have been done in this situation?

    Why were you unable to take this action?

    How do you feel about this situation?

    Would you have felt differently prior to taking the Modules?

12. Have you any other comments that you would like to add?

APPENDIX 3

CRITICAL INCIDENT RECORDING - GUIDELINES

EVALUATION OF EDUCATION IN PALLIATIVE CARE

Subjects: Participants of Professional Studies II (PSII) modules in Care of the Terminally Ill.

Aims of the exercise

To determine what aspects of your practice have changed as a result of participating in the above modules.

To determine areas in which you recognise that you did not take the action you would have wished in caring for a dying patient, his/her family or staff caring for them.

To explore reasons for the above.

Method

On each of 3 consecutive shifts, record 2 incidents or situations pertaining to care of terminally ill patients, their families or staff caring for them.

Where possible, one of these should represent a situation in which you utilised the knowledge or skills gained on the above modules. The other should represent a situation in which you did not use this knowledge of skills for whatever reason. Try to give reasons for not taking this action. If no such situations present themselves, you may extend this period until 3 of each type can be reported. In this case please give the dates of each incident.

APPENDIX 4

DIARY RECORDING - GUIDELINES

EVALUATION OF EDUCATION IN PALLIATIVE CARE

Subjects: Participants of Professional Studies II (PSII) modules in Care of the Terminally Ill.

Aims of the exercise

To determine what aspects of your practice have changed as a result of participating in the above modules.

To determine areas in which you recognise that you did not take the action you would have wished in caring for a dying patient, his/her family or staff caring for them.

To explore reasons for the above.

Method

For 3 consecutive days maintain a diary of all dealings with terminally ill patients, their families and staff caring for them.

Record in particular the following:

- any opportunities taken to utilise the knowledge and skills gained on the above modules.
- instances in which you have acted or reacted differently from the way you might have done prior to undertaking the above modules
- situations in which you did not take the action you felt you could or should have. Attempt to give reasons for your inactions.

APPENDIX 5

PILOT STUDY - REQUEST FOR ACCESS

14 March 1990

Dear

I am a nurse currently funded by Cancer Relief Macmillan Fund to undertake a piece of educational research. My project involves past participants of the Professional Studies II modules on Care of the Terminally Ill, offered by Glasgow South College.

As you are aware, the numbers attending each module are small, and carrying out a pilot study would further reduce the number of available subjects. In view of this, I would be most grateful if you would permit me to approach the participants of the module which you are offering on this subject. I am aware that the content and methods are somewhat different, but I am sure the aims are similar. The following are my objectives for the study:-

1. To examine the extent to which education in the form of PSII modules in Palliative Care are perceived to change attitudes and nursing practice of the individual participants.

2. To explore the role of the nurse manager in supporting and facilitating the participants as perceived.

3. To elicit which factors in the workplace were or are perceived to either encourage or inhibit the participants from effecting change.

4. To compare any differences in the participants' ability to effect change, depending on whether they are seconded from a hospice or an acute or long stay hospital setting.

The methods involved would, in the first instance, be a questionnaire issued to each participant, followed by a semi-structured interview to a sub-group, excluding any Macmillan nurses and district nurses. This will not be ready until June or July of this year.

I have the full support of the Director of Nurse Education from Glasgow South College. If you require any further information, please do not hesitate to contact me. Alternatively, I am sure the Director would be happy to discuss it with you.

Thanking you in anticipation.

Yours sincerely

APPENDIX 6

PILOT STUDY - GRANTING OF ACCESS

C O P Y

22:3:90

Ms M Sneddon
Macmillan Research Nurse
University of Glasgow
Research Unit
Dept. of Postgraduate Medical Education
7 Lilybank Gardens
GLASGOW G12 8RZ

Dear Ms Sneddon

Thank you for your letter of 14th March, 1990.

You will probably be aware that the Professional Studies II Module in Caring for the Terminally Ill and Support of Carers is a joint project between this College and St. Columba's Hospice.

I understand that you have had some contact with the Tutor at St Columba's Hospice and, for my part, I have no objection at all to you carrying out a pilot study with participants of the Module as I am sure you will find this helpful in your research.

I will pass your letter to the tutor and would be grateful if you could contact her direct in this matter.

Yours sincerely

Mr S Walker
Director of Nurse Education.

c.c. Education Officer, St Columba's Hospice.

APPENDIX 7

QUESTIONNAIRE FOR NURSE MANAGERS

The following questionnaire relates to the perception of the nurse manager's role in staff development. It is to be used as part of a study of palliative care education for nurses. It has been kept very brief, requiring mainly tick responses, although any comments on the topic or the questions will be most welcome.

All responses will be confidential.

Thank you for your help.

PART 1

This section concerns your views on the discussion of aims prior to undertaking a Professional Studies Module.

	Agree	Disagree
A prior discussion of aims should always occur with the participant and the nurse manager.	[]	[]
A prior discussion should only occur with the nurse manager at the request of the participant.	[]	[]
If the participant is a staff nurse, any prior discussion is the responsibility of the charge nurse.	[]	[]
Although desirable, I rarely have time for a discussion of prior aims.	[]	[]
I would feel uncomfortable in discussing prior aims with a participant if I was inexperienced in the subject of the course.	[]	[]
Nurses generally do not wish a prior discussion of aims with their nurse manager.	[]	[]

PART 2

This section relates to the value and outcome of Professional Studies Modules.

	Agree	Disagree
The main value of seconding staff on courses is to maintain their morale	[]	[]
Courses often only serve to frustrate staff	[]	[]
Improved patient care usually results from staff attending courses	[]	[]
Increased motivation is usually short-lived following attendance at a course	[]	[]
Skills taught on courses are usually put into practice	[]	[]
Staff nurses who have undertaken such courses generally do not stay in post very long but move on to other things	[]	[]
Increase in self confidence is an important effect of attending a course	[]	[]
Attending courses is valuable in extending knowledge	[]	[]
Attending courses rarely motivates staff to make changes in nursing practice	[]	[]
Seconding staff below charge nurse level is rarely cost effective	[]	[]
Medical staff often obstruct nursing staff attempts to improve care	[]	[]

PART 3

This section concerns your views on the nurse manager's contribution following a member of staff's completion of a PS Module.

	Agree	Disagree
I usually encourage participants to set out an action plan when they have completed a course.	[]	[]
I usually discourage staff embarking on change too quickly after a course.	[]	[]
If staff wish help in implementing change, they will ask for it.	[]	[]
The main help expected of a nurse manager is the provision of extra staff.	[]	[]
I would like to be more involved in helping nurses to implement change.	[]	[]
Most charge nurses would not welcome more involvement from me in implementing change.	[]	[]
I don't have as much time as I would like to support staff in trying to improve care.	[]	[]
Staff development is the responsibility of the continuing education department.	[]	[]
I lack sufficient skills to assist staff to implement change.	[]	[]
I have insufficient time to acquaint myself with the content of courses attended by staff	[]	[]
All staff should be responsible for their own learning and development	[]	[]

PART 4

Please complete the following sentences:

1) When a ward sister/charge nurse returns from a PS Module I can best support them by .....

2) When a staff nurse returns from a PS Module, I can best support then by .....

Thank you for your cooperation

Margaret C Sneddon
Macmillan Research Nurse
Research Unit
University of Glasgow
Department of Postgraduate Medical Education
7 Lilybank Gardens
GLASGOW G12 8RZ

APPENDIX 8

COURSE AIMS AND OBJECTIVES - MODULE ONE

GLASGOW SOUTH COLLEGE OF NURSING AND MIDWIFERY

PROFESSIONAL STUDIES II

CARE OF THE TERMINALLY ILL PATIENT

MODULE 1: ATTITUDES TO DEATH AND DYING

Aim

To review with course members the attitudes of society to death and dying and to consider the role of the nurse in the changing approaches to care.

LEARNING UNIT 1: CHANGING ATTITUDES TO DEATH & DYING

General Objectives

To assist the course member to understand the influence of society's attitude to death upon the provision of care for its members.

Specific Objectives

Following experience in this unit, the course member will be able to:-

1. Discuss the development of attitudes in society to death and dying.

2. Distinguish between the related rituals, religious practices and local customs associated with various religions and cultures.

3. Discuss moral, ethical and legal issues, relating to the dying patient.

4. Discuss the philosophy underlying current practices for the care of the dying patient and his family.

5. Identify provisions currently available in society for the patient with a terminal illness.

LEARNING UNIT 2: THE TEAM APPROACH TO CARE

General Objectives

To develop the course members' awareness to the team approach to caring for the dying patient.

Specific Objectives

Following experience in this unit, the course member will be able to:-

1. Recognise the unique function of the nurse in the "Caring Team".

2. Develop professional confidence and authority to examine critically the care and treatment and if necessary express the perceived need of the patient.

3. Establish good relationships, to be able to participate as a member of the multidisciplinary team.

4. Discuss the role and contribution of voluntary workers in the caring team.

5. Describe the role of ministers of religion as members of the caring team.

6. Outline the possible professional dilemmas of all the members of the caring team.

7. Recognise the inevitability of death and accept that the death of the patient does not represent failure.

8. Demonstrate an ability to express feelings appropriately when involved in death and dying.

9. Demonstrate an ability to assist colleagues in the expression of their feelings.

APPENDIX 9

COURSE AIMS AND OBJECTIVES - MODULE TWO

MODULE 2: QUALITY OF LIFE

Aim

To prepare the nurse to provide the best quality of life for the patient with a terminal illness and to enable her to give appropriate support to the relatives and friends during this period.

LEARNING UNIT 1: PHYSICAL & PSYCHOSOCIAL NEEDS OF THE DYING PATIENT

General Objectives

To assist the course member to recognise the physical and psychosocial problems associated with death and dying.

Specific Objectives

Following experience in this unit, the course member will be able to:-

1. Outline the physical and psychological problems associated with dying.

2. Recognise the varied reactions of the patient to diminishing quality of life and the prospect of death.

3. Outline the patho-physiological changes that occur in advanced disease relating to the:

   Gastrointestinal system
   Respiratory system
   Cardiovascular system
   Urinary system
   Neurological system
   Endocrine system
   Skin

4. Discuss the theories of pain perception.

5. Describe the psychological and physical strategies influencing perception of pain.

6. Describe the factors which influence the reaction to illness and disability.

7. Identify and assess the social needs of the patient.

LEARNING UNIT 2: MAINTENANCE OF THE QUALITY OF LIFE

General Objectives

To enable the course member to identify the factors which constitute quality of life and act accordingly.

Specific Objectives

Following experience in this unit, the course member will be able to:-

1. Discuss the concept of quality of life.

2. Outline therapeutic strategies of conventional and alternative medicine relating to patients with terminal disease.

3. Discuss the implementation of research findings in the management of the terminally ill patient.

4. Describe the nursing strategies related to physical symptoms associated with dying.

5. Discuss the nursing implications of the management of the patient with pain.

6. Demonstrate an ability to deal with the specific psychological problems associated with dying.

7. Demonstrate an awareness of the key role of relatives/friends in the provision of care.

8. Critically evaluate her own contribution to the total care of the patient and his family.

APPENDIX 10

COURSE AIMS AND OBJECTIVES - MODULE THREE

MODULE 3: COPING WITH LOSS

Aim

To prepare the nurse to provide the appropriate support for the patient with a terminal illness and assist the relatives and friends during this period and subsequent bereavement.

LEARNING UNIT 1: LOSS AND INDIVIDUAL

General Objectives

To assist the course member to understand the concept of loss.

Specific Objectives

Following experience in this unit the course member will be able to:

1. Discuss the dynamics of grieving and the associated emotional responses relating to:

   The child
   The adolescent
   The adult
   The elderly

2. Outline the different bereavement reactions and the complications which may be experienced by those who are bereaved.

3. Outline the risk factors which predispose abnormal grieving.

4. Discuss the practical and social problems associated with bereavement.

5. Compare religious and cultural practices and associated grieving responses.

LEARNING UNIT 2: INTERVENTION STRATEGIES

General Objectives

To assist the course member to provide support for those facing loss.

Specific Objectives

Following experience in this unit the course member will be able to:-

1. Describe the support which may be initiated in crisis situations.

2. Demonstrate enhanced human relationship skills.

3. Identify voluntary and statutory resources available to the bereaved.

4. Support team members to cope with loss.

APPENDIX 11

CLINICAL EXPERIENCE

Module I	40 days (4 weeks in Hospice) (4 weeks in a clinical environment similar to own environment	) includes 5) study days
Module II	40 days (4 weeks in Hospice) (4 weeks in a clinical environment similar to own environment	) includes 5) study days
Module III	40 days (8 weeks in community or hospital	) includes 5 study days

If Community background, clinical placement will be in a hospital

If Hospital background, clinical experience will be community based with either District Nurse or Macmillan Nurse.

APPENDIX 12

ASSIGNMENT - MODULE ONE

PROFESSIONAL STUDIES TWO

MODULE ONE - ATTITUDES TO DEATH AND DYING

ASSIGNMENT

By the end of week seven of this module the course participants must submit a written assignment of between 4,000 and 5,000 words on a relevant topic based upon the theoretical objectives of this module.

The assignment will take the form of an extended essay and the topic must be approved by the course tutor.

All participants must submit their assignment on or before the required date. Failure to submit without good cause will be considered as a failure. Late submission will be allowed only in exceptional circumstances and each case will be considered on its merits.

The pass mark is 50%, participants who do not meet the required standard will be counselled and allowed to resubmit the assignment following a period of not more than four weeks from notification of results. A second or subsequent failure to submit or meet the required standard will result in the Certificate of Completion of a Module being withheld.

Assignments will normally be marked by the person(s) responsible for the teaching of the syllabus and all are monitored by an external assessor.

MARKING SCHEME

MARKS WILL BE ALLOCATED FOR:

Evidence of knowledge gained during this module	10
Evidence of private reading	20
Discussion of how knowledge gained might be applied to clinical setting	30
The relevance of the material	20
The logic and sequencing of the material	10
Overall presentation	10

APPENDIX 13

ASSIGNMENT - MODULE TWO

GLASGOW SOUTH COLLEGE OF NURSING

PROFESSIONAL STUDIES II
Module: Quality of Life

Assignment

By utilising theoretical input and experience gained in the clinical area and by showing evidence of further research/reading, the course participant is expected to submit no later than .....a patient related symptom control package (minimum, 4,000 words) to include the following.

1. A Patient Profile

   This should if possible be about a patient with whom you have had at least two weeks contact and should include:

   a) how the patient perceived his/her symptoms;
   b) how the nursing staff perceived his/her symptoms;
   c) how the medical staff perceived his/her symptom s;
   d) the treatment selected for control/relief of symptoms;
   e) the outcome.

2. It is anticipated that the course participant will also consider potential problems which might arise due to the progression of the disease process and other influencing factors.

Guidelines

A HOLISTIC APPROACH should be maintained throughout this assignment.

The course participants may wish (dependent upon the patient selected) to consider PHYSICAL SYMPTOMS under the following headings.

Clinical Features
Gastro-intestinal symptoms
Respiratory symptoms
Genito-urinary symptoms
Neurological symptoms
Dermatological symptoms

OR

A System Approach
Gastro-intestinal
Respiratory
Renal
Neurological
Skin
Cardio-vascular
Endocrine

PSYCHOLOGICAL ASPECTS have an influence upon patients' perceptions of symptoms and should therefore be included.

APPENDIX 14

ASSIGNMENT - MODULE THREE

PROFESSIONAL STUDIES 2

MODULE 3 - COPING WITH LOSS

ASSIGNMENT

By the end of week seven of this module the course participants must submit a written assignment of not less than 5000 words and not more than 6000 words.

The assignment will take the form of an extended essay and the topic must be approved by the course tutor. A holistic approach should be maintained throughout this assignment. Guidance for the assignment will be given at the beginning of the module.

The topic should focus on EITHER

A. Losses experienced during a terminal illness. Where possible this should be based on your own experience with a patient you are nursing during your clinical placement.

OR

B. You may compare and contrast two of the following topics listed below. Where possible one of the headings should be based on experience gained during your clinical placement.

Sudden death
Suicide
Child death
Violent death
Protracted death
Still birth
Cot death
Death of a parent
Death of a handicapped person
Death of a close friend
Death in a Long Stay Unit
Death of an adolescent
Death of a spouse
Death of an elderly person

APPENDIX 15

MAIN STUDY - REQUEST FOR ACCESS

5 April 1990

Dear

It is with much regret that I inform you that I am no longer proceeding with the planned research project. I would like to take this opportunity to thank you for your interest and support in this project. I am sorry that your efforts have not been rewarded.

An alternative project is, however, being planned. I now aim to examine the extent to which the Professional Studies II (PSII) modules in Palliative Care, offered by Glasgow South College, effect change in practice, and to identify which factors either facilitate or hinder such change. If any of your staff have undertaken any of the relevant modules, I would appreciate your permission to approach them via the appropriate nurse managers, whose names you have already given me, later this year. The study is likely to involve the completion of a questionnaire and possibly a follow-up interview of past participants and a sub-sample of their immediate superiors. Please advise me if this meets with your approval.

I look forward to hearing from you.

Yours sincerely

Margaret Sneddon
MACMILLAN RESEARCH NURSE

APPENDIX 16

NURSE MANAGER QUESTIONNAIRE - COVERING LETTER

27 November 1990

Dear

I am currently undertaking a research project funded by Cancer Relief Macmillan Fund related to palliative care education for nurses, and I am writing to request your help with a small part of the study.

The main purpose of the project is to determine the effect of the Professional Studies II Modules in Care of the Terminally Ill on nursing practice. In addition, I also hope to explore the role of the nurse manager in facilitating staff to integrate newly acquired knowledge and skills into practice.

Since a member of your staff, . has previously undertaken one of more of these modules, I would be most grateful for your assistance with this matter. The help which I seek is that the nurse manager responsible for the participant be asked to complete the short questionnaire enclosed and return it to me in the envelope provided.

I appreciate that this is a very stressful time in nursing and your support would be most welcome.

Thanking you in anticipation.

Yours sincerely

Margaret Sneddon
MACMILLAN RESEARCH NURSE

APPENDIX 17

INTERVIEWS - REQUEST FOR ACCESS

date

Dear Unit Nurse

You may recall from previous correspondence that I am undertaking a research project funded by Cancer Relief Macmillan Fund, exploring the long term outcome of post basic nurse education in palliative care.

The first part of this study is now complete. This involved participants of the PSII Modules in Care of the Terminally Ill at Glasgow South College, who were asked to complete a questionnaire. For the second part I am hoping to collect more detailed information from past participants of the modules by means of an interview which might last 30-40 minutes. The information which I would be seeking is detailed in the enclosed interview schedule.

I am aware that nursing staff are currently under tremendous pressure of work and would therefore be most appreciative of your permission to approach the relevant senior nurses and hopefully in turn the participants themselves (names and clinical areas listed below) to arrange a meeting at their convenience.

Thank you for the support you have already given to my efforts with this project. I look forward to hearing from you.

Yours sincerely

Margaret Sneddon
MACMILLAN RESEARCH NURSE

APPENDIX 18

PARTICIPANT QUESTIONNAIRE - COVERING LETTER

27 November 1990

Dear

As a nurse who has completed one or more of the Professional Studies II Modules on Care of the Terminally Ill, I am writing to ask for your assistance in a research project.

The project is funded by Cancer Relief Macmillan Fund to look at various aspects of palliative care education for nurses. The main aim is to determine the effect of the modules on nursing practice and to identify areas of difficulty in implementing newly acquired knowledge and skills.

The project is being carried out with the full knowledge and approval of the Course Organisers and all responses will be confidential. The results of the study may influence the future development of such courses and feedback will be given to participants at the end of the study.

I would be very grateful for your help in completing the enclosed questionnaire and returning it to me in the envelope provided.

Thanking you in anticipation.

Yours sincerely

Margaret Sneddon
MACMILLAN RESEARCH NURSE

APPENDIX 19

A LOT	A LITTLE	NOT AT ALL	ALREADY KNOWLEDGEABLE/ EXPERIENCED	NO RESPONSE	ASPECTS OF JOB ENHANCED BY ATTENDING THE MODULES
16	15	0	5	0	Assessing patients' needs
22	9	0	5	0	Assessing relatives' needs
13	12	0	11	0	Meeting patients' physical needs
25	10	0	1	0	" " psychological needs
15	15	1	5	0	" " social needs
14	17	3	2	0	Meeting patients' spiritual needs
20	13	2	1	0	" " relatives' needs
21	9	0	4	2	Understanding the needs of staff
21	14	0	1	0	Understanding ethical issues involved
17	15	1	3	0	Improving standards of care
16	12	0	8	0	Evaluating care given
24	11	1	0	0	Being able to identify your strengths
25	10	1	0	0	Being able to identify your weaknesses
24	7	0	5	0	Responsibility for your own learning
20	8	2	6	0	Communicating with patients
20	7	1	7	1	Communicating with relatives
27	4	1	4	0	Increase in enthusiasm for this aspect of your job
13	20	3	0	0	Reduce the stress involved in this aspect of your job
21	12	1	2	0	Ability to question the way things are done
22	9	0	4	1	Supporting staff
19	12	0	4	1	Teaching junior staff
24	8	3	1	0	Bereavement care
10	22	3	1	0	Influencing practice of nursing colleagues
7	22	6	1	0	Influencing practice of medical colleagues
6	24	4	2	0	Implementing change
10	22	2	2	0	Encouraging a multidisciplinary team approach

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