Quality End of Life Care for All (QELCA ©): A national pilot of a nursing workforce development initiative – Evaluation Report

Liz Bryan, St Christopher's Hospice
Jane Manns, St Christopher’s Hospice
Angela Thavaraj, St Christopher’s Hospice
Marie Cooper, Help the Hospices
Chris Sutcliffe, NHS Improving Quality
Introduction

St Christopher’s has designed and evaluated a training programme which not only role-models end of life care to the participants but equips and empowers them to deliver better care to patients on their return to practice. There is evidence that it also motivates them to introduce care for self and their teams back into their organisations and to lead change in culture. It integrates a work-based learning experience with facilitated classroom reflection and the model is designed to be delivered by specialist clinicians who have undertaken the QELCA© ‘Train the Trainers’ programme.

Background

The Department of Health has concluded that the health and social care workforce across settings needs to develop the necessary attitudes and skills in order to deliver consistently high quality, compassionate care for people approaching the end of life and is looking for beacons of best practice in relation to practice development initiatives (DoH, 2008). In the current economic climate it will also be important to ensure that any local workforce development funding for end of life care training and education is spent effectively and will have a significant impact upon patient experience.

QELCA©, an end of life care education programme, was designed by St Christopher’s Hospice, to be delivered by hospice nurses to nurses working in acute hospitals. Teams of acute nurse clinical managers from the same department spend 5 days based at the hospice in small groups of three or four. This ensures that all of the clinical nurse managers from one team or care group share the same or equivalent experience. Using the hospice setting as a learning resource, nurses are offered a first-hand experience of observing and being alongside specialist nurses as they deliver expert care to patients and their families at the end of life. In addition to this practice experience the 5-day programme combines classroom discussion and reflection facilitated by experienced specialist palliative care nurses. The programme then continues with six months facilitated Action Learning Sets (ALS) (Bryan et al, 2011) so that action plans for self, team and organisation, formulated by the participants on the final day of their hospice experience, can be supported in practice and learning from the programme consolidated.

Preliminary evaluation has suggested that the style of delivery of the QELCA© programme allows for a connection to be made between facilitators and students through shared reflective exercises and the intimacy of the small group. This connection was developed and maintained throughout the week and continued through the action learning process. The aim
of the reflective exercises is to find meaning or make sense of experience and also to enable participants to consider blocks to delivering sensitive and appropriate care for the dying person and their family. The process of facilitated reflective learning empowers participants to take a more active stance and helps them to overcome the tendency to be passive when confronted by the pressures of the workplace.

In partnership with St Christopher’s and Help the Hospices, the National End of Life Care Programme (NEoLCP) invited acute hospitals, through the Transform Programme (NEoLCP, 2013) to participate in a pilot and evaluation of QELCA© across England with a completion deadline of May 2013 (Figure 1).

Figure 1 – National Pilot of Quality End of Life Care for All (QELCA©) - Timeline
Aim

The aim of this pilot was to evaluate the impact of a complex educational intervention on the practice of nurses caring for patients approaching the end of life in acute hospitals.

Methods

Between April 2012 and April 2013 QELCA© was piloted across 17 sites by 21 hospices (see Appendix) (some smaller hospices worked in partnership) to a total of 137 acute nurses. Local governance approval was secured from all 17 trusts prior to commencing training. Training in how to deliver QELCA©, course resources and support and supervision were provided by St Christopher’s for identified trainers from all the participating hospices.

Evaluation data were collected at four stages across the pilot timeline from recruitment to the programme to completion of the Action Learning (AL) (Figure 1) using mixed methods comprising, survey questionnaires, semi-structured questionnaires and focus groups.

Summary of Findings

Key findings will be presented under three headings;

1. The Acute Trusts (n=17)

- 15 of the 17 trusts completed a brief preliminary questionnaire at Stage 1 of the pilot evaluation. Only 5 trusts returned post-programme questionnaires at Stage 4.
- Apart from using national audit tools most of the trusts also monitor complaints to measure the quality of end of life care.
- The most common complaints relate to how nurses have communicated with relatives. However, lack of information given and apparent lack of recognition of dying were also cited.
- The respondents perceived that the primary concern for nurses related to end of life care would firstly be, time pressures related to juggling the needs of acutely ill patients alongside the needs of the dying and secondly, lack of confidence in communicating with patients about end of life issues.
- Of the 5 who responded at Stage 4 all reported observable changes in the practice of those who had attended QELCA© following the programme. However, it was

---

1 St Christopher’s would like to acknowledge, with thanks, the grant awarded by ‘The Daisy Foundation’ to enable the development of the QELCA© ‘Train the Trainers’ programme.
generally felt that any positive outcomes are as a result of a combination of national end of life care initiatives (including QELCA©) implemented within their trust.

- All but one trust agreed that working with the local hospice had been a positive experience. It was suggested that in future, hospice trainers should be aware of and emphasise the need to make change within the existing clinical guidelines of the trusts recognising the impact and constraints of the acute environment.

2. The Acute Nurses (n=137)

2a) The 5-Day Hospice Experience

The impact of the 5-day hospice-based component of the programme was evaluated by collecting and analysing exercises which are integral to the QELCA© programme (Stage 3). Nurses attending the course are asked for three personal learning objectives on Day 1 and ‘three things I have learnt’ on the Day 5. Each exercise was analysed separately, first by categorising the data into knowledge, skills or attitudes and then by identifying themes that emerged.

i) Day 1 - Personal objectives

Of the nurses’ potential total of 411 personal learning objectives (n(137) x 3) less than 10% were related explicitly to learning involving attitude. The remainder were equally spread across knowledge and skills (Figure 2).

Figure 2 – Personal Learning Objectives and Perceived Learning on 5-Day Hospice Placement.
ii) Day 5 - Perceived Learning

Of the nurses’ potential total of 411 ‘things I have learnt’ (n(137) x 3), less than 10% referred directly to skills. However, over 50% now related explicitly to learning involving attitude and the remainder to knowledge (Figure 2). The majority of nurses referred to an increase in confidence in delivering some aspect of care whether it was in their knowledge of medications or in communicating with patients, families or medical colleagues.

The main themes that emerged under attitudinal learning included;

**The Dying Patient:** Several nurses stated that they now realised the importance of taking time to see the patient as a whole and as an individual and of taking time to be with patients to listen and identify what is important to them, for example, respecting the patient’s choice to decline treatment. They also identified and recognised communication as a major part of delivering care as this enables exploration of patients’ needs and preferences.

**The Family:** The importance of involving the family was frequently mentioned, for example, “families are to be embraced not feared”. It was identified that it was important that relatives perceive their loved one’s death as “a good death” including the importance of care of the patient and relative after death.

**The Multi-professional Team:** The increased learning also increased confidence in the nurses’ ability to question and challenge decisions with regard to end of life care for their patients with their medical colleagues and in feeling more empowered to do so. Not only did the experience influence the care of patients but brought about a realisation of the importance of staff well-being including self to enable the delivery of more sensitive end of life care.

**End of Life Care in the Acute Setting:** The attitudinal changes identified also include realising the importance of quality of life and that end of life care is not just about dying but about good nursing. There was also an emphasis on self-awareness. Change was acknowledged as being needed to enable the delivery of sensitive and compassionate end of life care within the acute setting.
2b) Changes in Practice on Completion of the QELCA© Programme (5-Day Hospice Experience Plus 6 Months Action Learning (AL))

Only 44 of the 137 acute nurses (32%), from 12 of the 17 sites, completed and returned questionnaires on completion of the programme at Stage 4. Of these;

- 42 agreed that QELCA© has changed their nursing practice.
- 42 claimed to be more confident now to raise issues for discussion with medical colleagues
- 40 said they are more confident in the management of symptoms at end of life.
- 40 are more confident to communicate with patients about their preferences at the end of life.
- 40 are more confident to communicate with families and offer support and
- 39 believe themselves to be more aware and sensitive to the needs of patients approaching the end of their lives.
- 15 admitted to having experienced blocks to implementing changes in practice. Examples given of blocks to change were “being a lone voice”, “organisational issues and the time things take to change”, and lack of suitable environments to care for patients and families with privacy and dignity.
- 43 nurses would recommend QELCA© to others. Suggestions as to who might benefit, ranged from health care assistants (HCAs) to junior doctors. One nurse wrote, “All areas need facilitators to champion excellent end of life care, the course has much to offer even the most experienced ward staff.”

3) Hospices (n=21).

9 of the 21 hospices were represented at the final trainer event, to participate in focus groups, and a further 2 sent apologies and contributions in writing.

- Preparation and support to deliver QELCA©: Overall hospice trainers fed back that the ‘Train the Trainers’ had adequately prepared them to deliver QELCA© and that they had appreciated the on-going advice and support from the St Christopher’s APT during their first experience of delivering the programme.

It was acknowledged that becoming QELCA© trainers had been far more demanding than they had first envisaged and that hospice managers must be made aware that trainers, many of whom are clinicians rather than teachers, need protected time to prepare as well as deliver the programme, especially the first time.
• **Trainers’ perceptions of the issues of most concern for the acute nurses regarding delivery of end of life care.** Lack of time and inadequate staffing levels were top of the acute nurses concerns. The next issue of concern was communicating with patients and families when prognosis was poor or people were distressed especially in the light of media attention on the LCP. Many lacked confidence or felt they did not have the authority to initiate conversations or give answers if asked questions. Overall, many lacked confidence generally in how to use syringe drivers or how to implement the LCP. Some felt that palliative and end of life care was of low priority within their trusts and therefore the environment was often not conducive to providing privacy and dignity and junior doctors often delayed decision-making over weekends regarding the LCP or prescribing anticipatory medications. Some expressed concern that they felt little support from hospital management to implement change where there appeared to be conflicting priorities. Several acute nurses also referred to the pressure from bed managers to discharge patients before care packages were adequately set up causing stress to staff, patient and relatives and often resulting in re-admission. Nurses had expressed concern that multidisciplinary working could be better utilised.

• **Impact of QELCA© perceived by trainers.** Any impact QELCA© appeared to have on the nurses was somewhat dependent on whether participation was voluntary or individuals had been co-opted with little warning or preparation. For those who engaged with the programme, however, the most noticeable impact observed by the trainers over the period of the programme was increased confidence and motivation to challenge accepted practice. The style of facilitation empowered participants to be honest in their reflections. This gave them the opportunity to acknowledge how emotionally demanding they found end of life care. Overall confidence to initiate conversation increased significantly over the whole period. This was evidenced by stories shared at ALSs. For some, the QELCA© experience affirmed the delivery of good care, for which nurses expressed appreciation. Several trainers commented on the impact of the exercise on Day 1, ‘What would I want if I was dying?’ and described this as a ‘light-bulb’ moment for many of the acute nurses.

• **Evidence of change in practice on completion of Action Learning included:**
  - Bereavement resource box with information for relatives and follow-up bereavement cards
  - Provision of tea/coffee/biscuits for relatives
✓ Setting up death review/reflection/debriefing either as nursing team or at MDT meetings
✓ Setting up ‘Soul Space’ for staff – 10 minutes for calm/reflection
✓ Butterfly symbol utilised – to indicate to all staff that a patient is dying in ward/bay area
✓ Communication tool to inform staff when someone has died
✓ Pocket size check list for process following patient death
✓ Clarification of trust requirements for using additional care pathways when patient on the LCP e.g. falls assessment, fluid balance
✓ Provision of screens in ward areas for privacy/dignity
✓ Changes to the environment including creating a relatives room.
✓ Rapid discharge pack
✓ ‘Comfort’ packs for relatives.
✓ Referral criteria for palliative care ward.
✓ Nurses supporting one another inside and outside classroom.
✓ Staff resource file.
✓ Joint training sessions between hospice and hospital specialist team.
✓ Presentations to the trust.
✓ Involving pharmacy in mouth care guidelines.
✓ Increasing timely checking of CDs.
✓ Engagement of ITU.
✓ Improved and more appropriate referrals to hospice.
✓ Other clinicians can identify which wards attended QELCA©!!!

- **Specific challenges to delivering QELCA effectively.** Overall attendance at ALSs was poor. Trainers who sent AL summaries said that nurses attended on average between two and four of a possible six AL sessions. However, many sessions were cancelled due to staffing issues (levels of staff and staff movement around the trusts.) Two trusts struggled even to release nurses for the 5 days at the hospice and one had to send community nurses to make up the numbers. Some acute nurses appeared not to be supported to attend and therefore implementation of change was challenging. Attendance of the hospital palliative care team at ALSs was valuable when it happened but some trainers found it difficult to engage the hospital team.

- **Outcomes (positive or negative) for trainers, hospices or the acute trusts as a result of involvement in the QELCA pilot project.** As well as empowered and more confident acute nurses, positive outcomes included increased networking,
better working relationships and a raised profile both of the hospital palliative care team and the role of the hospice leading to more appropriate referrals. Learning at the hospice was a 2-way process with hospice staff benefiting greatly from working with the acute nurses, not least, by increasing their appreciation of their roles/challenges in the acute setting. One hospice commented that the QELCA© programme had improved confidence for HCAs in the hospice and that all the trainers remarked on the personal sense of achievement of delivering QELCA©. More negative outcomes included frustration of poor links with the acute trust and no response to emails resulting in loss of contact with some participants. Some trainers were concerned about sustainability now that AL has finished and were attempting to implement some on-going practice development support.

- **The core and essential elements of an effective QELCA programme as perceived by the trainers were:**
  - Delivery in hospice setting by specialist palliative care practitioners.
  - A safe and ‘caring’ learning environment.
  - A flexible, student-centred approach.
  - Attendance/visibility of acute trust support e.g. End of Life Care Facilitator.
  - Focussed/managed discussion, but allow time to listen.
  - Adequate preparation and information given to hospice staff about QELCA/Route to Success process and purpose.
  - Well planned practice placement.
  - Commitment from both trust and hospice.
  - Mixture of classroom and practice learning.
  - Support from St Christopher’s helpful and essential.

- **Suggestions as to how QELCA might be more effective:** Several trainers reported, that the acute nurses had been given very little warning by their managers that they would be attending the QELCA© programme or information about it. The overall conclusion of the trainers was that in future the hospices must be much more involved in the recruitment and preparation of the acute nurses selected to attend the programme and that it will be essential to be flexible about timing of delivery to accommodate acute trust staffing issues. The strongest message from the trainers to future trainers is; “Take time to establish a face to face relationship with key people within the trust before taking the first acute nurses at the hospice for training.”
Conclusions

1. QELCA© does impact on the practice of acute nurses and improvements are made to the manner in which they deliver end of life care. However, the impact is affected by the quality of the collaborative working between the acute trusts and the training hospices. Acute nurses need to be supported in their attempts to bring about positive cultural change. It is apparent that this support needs to be undertaken in close partnership between hospital managers and the hospice trainers, from initial expression of interest of the trust, through recruitment of acute nurses and negotiation of timing of the training, to supporting sustained changes in practice.

2. Involvement in the pilot has increased the hospices' awareness of the experience and 'pressures' on acute nursing colleagues and has opened opportunities for closer collaboration with their local acute hospital.

3. Perhaps the most interesting finding, which is consistent with previous evaluations, is the attitudinal shift made during the 5-day hospice experience (Figure 2). Nurses are focussed on acquiring knowledge and skills when they arrive at the hospice and yet when they reflect on their learning on Day 5 they recognise that it is their perspective that has changed giving greater confidence to take initiative on ensuring more sensitive and appropriate care in their own setting. It is this attitudinal change which will motivate and sustain real change within hospital culture.

4. It has been our assertion that an experienced and competent palliative care specialist nurse will have the necessary attitudes and skills to facilitate small group learning using a person-centred approach in much the same way as he/she would provide support to a family or a patient or carer group (Costello, 2007). This was supported by our findings when initially designing the QELCA© programme (Bryan et al, 2011). Findings, especially those related to the impact on the nurses of the 5-day hospice component of the programme, further support this claim. In addition, the more active participatory approach to learning offered by QELCA© enables nurses to develop confidence in the necessary communication skills required to improve practice.

5. The primary weakness of this pilot evaluation was the poor response rate at the final stage. Initial responses from the trust were promising and participation and feedback from the hospice trainers has been generally good, especially in providing data from 100% of the acute nurses during attendance on the 5-day hospice component of the
programme. However, responses from both acute trust managers and the QELCA© participants were latterly disappointing due to movement of staff and staff shortages. This reflects the nature of the NHS working environment during a time of economic constraints and restructuring. Future evaluation design will seek to ensure that contact is maintained by emphasising to hospices the importance of developing closer face to face relationships with acute nurse managers, negotiating clear expectations and by taking personal contact details of participating nurses.

**Recommendations**

1. **Further Development and Dissemination of QELCA© for Nurses:**

   St Christopher’s, in partnership with Help the Hospices and NHS Improving Quality (NHSIQ) (formally the National End of Life Care Programme (NEoLCP)) will continue to offer training to hospices and to evaluate the impact of QELCA© on end of life care nursing practice. Content of the ‘Train the Trainers’ will acknowledge the importance of establishing a relationship with acute managers before embarking on QELCA© training of acute nurses.

2. **Further Development of QELCA© for Other Settings and Disciplines:**

   Specialist palliative care units should recognize that they are a valuable resource for empowering and enabling generalists to improve patient care at end of life and should consider replicating the QELCA© programme or an adapted programme based on the underpinning principles. There seems little reason why QELCA© might not be developed for nurses from other settings or for other disciplines. St Christopher’s have already delivered it to several teams of community nurses and to the senior nursing staff of a large South London care home. As suggested by some of the acute nurses, QELCA© might also be valuable for small groups of junior doctors.

3. **Quality Assurance of QELCA© Training:**

   QELCA© is copyrighted to St Christopher’s Hospice and anyone claiming to deliver the programme must be registered as a QELCA© trainer. The register will comprise trainers (as opposed to employers) who have attended the ‘Train the Trainers’ run by the St Christopher’s Hospice APT and who have delivered at least one programme under supervision. Registration will entitle trainers to access all the learning resources online. QELCA© trainers will be asked to inform St Christopher’s every time they deliver a programme and if more than 2 years pass without delivering QELCA© their name will be removed from the register.
4. **Implications for Workforce Development:**

Educators and commissioners need to work collaboratively to find the most effective ways of enabling NHS staff to improve the quality of end of life care within current resources. In his executive summary Francis states that one of the aims of the recommendations resulting from the inquiry into the Mid-Staffordshire NHS Foundation Trust is to “Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do.” (Francis, 2013a:p.5). The full report stated that “The ward manager’s role as leader of a unit caring for patients is universally recognised as absolutely critical.” (Francis, 2013b: p.1518). QELCA© targets senior ward nurses and is proven to be cost-effective in providing learning that changes not only their practice but empowers them to lead change within their teams and in their organisations.

5. **Role of Hospices in Future Workforce Development:**

NHS education commissioners should actively seek to invest in training which has a proven impact on end of life care, looking wherever possible to local specialist care providers, the majority of which are voluntary sector, to work in partnership with them. There are 220 hospices with inpatient units in England. Although not all hospices will have the resources to deliver the programme alone, pairs or clusters can work collaboratively to provide a valuable learning experience for small groups of clinical managers from their local acute hospitals. QELCA© provides high impact training and could prove to be a valuable resource for workforce development. It is recommended that Health Education England (HEE) and Local Education Training Boards (LETBs) work with senior nurse managers and specialist palliative care providers to consider ways to commission the delivery of the QELCA© programme to small groups of clinical managers within their acute trusts.
References


## Appendix

St Christopher’s, Help the Hospices and NHS Improving Quality gratefully acknowledge the participation of the following acute trusts and hospices, without whom, this pilot evaluation would not have been possible.

<table>
<thead>
<tr>
<th>Trust</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hinchingbrooke Healthcare NHS Trust</td>
<td>Sue Ryder St Johns Hospice, Moggerhanger</td>
</tr>
<tr>
<td>University Hospitals of Leicester</td>
<td>LOROS</td>
</tr>
<tr>
<td>North Tees &amp; Hartlepool NHS Foundation Trust</td>
<td>Hartlepool and District Hospice</td>
</tr>
<tr>
<td>Northumbria Healthcare NHS Foundation Trust</td>
<td>Marie Curie Hospice, Newcastle</td>
</tr>
<tr>
<td>County Durham &amp; Darlington NHS Foundation Trust</td>
<td>St Cuthbert's Hospice, Durham</td>
</tr>
<tr>
<td>Gateshead Foundation Trust</td>
<td>St Oswald's Hospice, Newcastle</td>
</tr>
<tr>
<td>Salford Royal Foundation Trust</td>
<td>St Clare's Gateshead</td>
</tr>
<tr>
<td>Blackpool Victoria Hospital</td>
<td>St Ann's Hospice, Little Hulton</td>
</tr>
<tr>
<td>Heatherwood &amp; Wexham Park Hospital</td>
<td>Trinity Hospice, Blackpool</td>
</tr>
<tr>
<td>University Hospitals of Southampton</td>
<td>Countess Mountbatten, Southampton</td>
</tr>
<tr>
<td>Basingstoke &amp; North Hampshire Foundation Trust</td>
<td>Thames Hospicecare</td>
</tr>
<tr>
<td>Brighton &amp; Sussex University Hospitals</td>
<td>St Michael's Hospice, Basingstoke,</td>
</tr>
<tr>
<td>Poole Hospital NHS Trust</td>
<td>Countess of Brecknock Hospice, Andover</td>
</tr>
<tr>
<td>Weston Area Health Trust</td>
<td>Martlett's Hospice, Hove</td>
</tr>
<tr>
<td>NHS Worcestershire Acute Hospital Trust</td>
<td>St Peter's and St James' Hospice, West Sussex</td>
</tr>
<tr>
<td>Leeds Teaching Hospital Trust</td>
<td>Forest Holme Hospice, Poole</td>
</tr>
<tr>
<td>Doncaster &amp; Bassetlaw NHS Foundation Trust</td>
<td>Weston Hospice Care</td>
</tr>
<tr>
<td></td>
<td>St Richard's Hospice, Worcester</td>
</tr>
<tr>
<td></td>
<td>St Gemma's Hospice, Leeds</td>
</tr>
<tr>
<td></td>
<td>St John's Hospice, Doncaster</td>
</tr>
</tbody>
</table>