An Evaluation Study of Palliative Care Education: Linking Theory and Practice

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CHESHIRE HOSPICES EDUCATION

A development centre for
palliative care education

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Abstract

In the United Kingdom the demand for palliative care education is increasing. This is in part both due to an increasing demand for palliative care, and the need for nurses and other health care professionals to keep up to date with a growing, dynamic speciality. However, education in whatever speciality is costly, it should therefore be effective, efficient and make a difference to the practice of those who receive it. It should therefore be evaluated. At the beginning of this study in 1998, there was little if any evidence in the literature of the evaluation of palliative care education. Indeed there was and still is to a lesser extent, a lack of consistency in the quality and content of palliative care courses, despite there being a wealth of centres of excellence in the provision of palliative care in the United Kingdom.

The aim of this research was to determine whether palliative care education made a difference to the practice of those who received it. My intention was to clarify those 'experiences' of the 'process' of education and to identify how such processes affected the outcomes. In addition, I was interested in the levels of confidence and competence expressed by these experienced practitioners before, during and after the period of education. This work serves to fill a gap in the evidence base of palliative care education, and perhaps also nurse education by providing an appropriate framework for evaluation.

This study took place in a hospice education centre in the north west of England; stakeholders were invited to take part in the study, which was multi-collaborative and participative. An action research approach was chosen in order to assist in the development of a multi-method evaluation framework. Such methods included one to one and group interviews, observation, survey, case studies and the use of focus groups.

The results from the study concluded that education in palliative care does make a difference to practice (which was sustained). These findings were initially self-reports from the research participants; however, managers, mentors and others who

encountered the participants in their practice also validated them. Teachers visiting the participants in their clinical placements were able to verify changes to practice and recognize some important but often imperceptible changes, for example: changes in values and beliefs the participants had previously expressed.

The study findings have implications for the ongoing development of palliative care education. An educational model has been developed which incorporates some fundamental aspects, which I believe help to provide evidence of 'best practice'. Palliative care education may have some privileges not always afforded in other educational settings, for example smaller class sizes; such advantages can and should be used to explore creative ways of enabling learning. A robust evaluation strategy can assist in this by providing good evidence of what works best, ultimately this serves to enhance the care provided to patients and their families.

The results of this study also indicated that effective education involves the student being able to apply the knowledge and skills learnt to their own practice. One way of doing this is to work alongside them in their own setting. Such a strategy assists the teacher in maintaining her credibility as a practitioner, and helps ground the education in the reality of practice. Education in palliative care with an integrated evaluation strategy can make a difference to the personal and professional development of practitioners, and ultimately, to the care that patients and families receive.

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Lindsey has acted as a mentor and friend and I couldn't have done it without her. Indeed she has fostered in me the desire to continue to explore how evaluation can change practices, and push the boundaries in new and creative ways of thinking. We have also together developed a credible pub quiz team as part of our down time, with and without Stuart, and one day we will win the jackpot!

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Finally but most importantly, I would like to thank all the students who participated in this study over the years. You have contributed so much to my personal and

professional development, but most significantly you have made a difference to patients and families when they were at their most vulnerable. This work is a tribute to all of your talents.

Lesley J Kenny – June 2004

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AUTHOR'S DECLARATION

I declare that the work contained within this document is my own,

Unless otherwise stated in the body of the text.

L J Kenny (Mrs)

June 2004

Confidentiality Clause:

The participants in this study have been given numbers and pseudonyms to protect their identity, they have given permission for their comments and evaluation data to be included as part of the study.

Permission was given by the organisation Cheshire Hospices Education, for the study, and for it to be identified as such within this thesis.

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Glossary

AHP's Allied Health professionals, includes speech therapists, occupational therapists, art therapists. Were previously known as PAM's professions allied to medicine.

CHE Cheshire Hospices Education – the organisation involved in this evaluation project. It is a palliative care education centre based in Winsford Cheshire. It is supported by three hospices: St Luke's Hospice Winsford, East Cheshire Hospice Macclesfield, and Hospice of the Good Shepherd Chester.

CNS Clinical Nurse Specialists – Experienced nurses who are working in specialised fields and who have (usually) had extra training/education purporting to that field.

ENB The English National Board for Nursing Midwifery and Health Visiting. A regulatory body who were responsible (at the time this study took place) for the education and training of nurses. This organisation ceased to be operative in March 2002 and its functions have been replaced by the Nursing and Midwifery Council also abbreviated to NMC.

MMU Manchester Metropolitan University who validated the diploma module the students were undertaking at CHE.

NCHSPCS The National Council for Hospice & Specialist Palliative Care Services. The representative body for hospice and palliative care in England, Wales and Northern Ireland. It is a charitable body that was established in 1991 to promote the extension and improvement of palliative care services. It develops policies to promote better collaboration and co-ordination between the voluntary, health and local authority sectors. It offers advice and guidance to hospices and provides a forum for the sharing of experiences. It encourages improved professional education and research in all aspects of palliative care. Representatives of the council sit on key

government working groups developing policy and quality standards across the spectrum of palliative care and within National Service Frameworks (NSF's).

Preceptorship A term used in nursing to denote a period of supervision provided to newly qualified nurses. The amount of time allocated to this activity varies between hospitals and trusts but approximately six months is considered to be appropriate by most nurse managers. Sadly there is anecdotal evidence to suggest that poor staffing levels may affect the quality and amount of preseptorship; with some newly qualified nurses not receiving any at all.

Q.A.A. Quality Assurance Agency responsible for the setting of and maintenance of standards within higher education.

U.K.C.C. United Kingdom central Council for Nursing Midwifery and health Visiting. This was the statutory regulating body for nurses, midwifes and health visitors (until March 2002). It held registration details for all practising professionals and was responsible for upholding and maintaining the standards of professional conduct expected of a registered practitioner. It was a publicly accountable body. It was replaced in March 2002 by the Nursing & Midwifery Council (NMC).

WHO The World Health Organisation

CHAPTER ONE

Palliative Care: Education, Research & Practice.

1.1 Introduction

The overall purpose of this study was to determine whether education in palliative care is effective not just in the classroom, but also in the way it may benefit students' future practice. As a nurse teacher, I was interested in the views and 'lived' experiences, of these recipients of the educational process. In addition, this study aimed to provide evidence to contribute to the theory and practice of evaluation research within palliative care. It was carried out between 1998-2003, in a hospice education centre in Cheshire, United Kingdom. This first chapter describes the contextual background of the study, and identifies the nature of palliative care and the reasons why educational programmes are necessary. It is proposed to examine some of the available literature procured as a consequence of an extensive literature search reviewing journal publications both national and international within the last 10 years. In addition, a number of book publications relevant to the field of palliative care are reviewed in order to extract issues of relevance to palliative care education.

1.2 Aim of the Study

This evaluation project was undertaken in order to determine whether education in palliative care made a difference to nurses' practice, i.e. did it improve nurses' palliative care skills. A participatory action research framework was utilised within this study.

1.3 Objectives of the Study

- To identify perceived levels of knowledge, confidence, and competence pre and post education.
- To describe the participant's and stakeholder's views and experiences of the 'process' of education in palliative care.
- To make recommendations regarding the provision of effective palliative care education.

1.4 Structure of the Thesis

The rationale for this study came about because of the lack of evidence of the effectiveness of palliative care education in terms of practice. As a service provider of palliative care education, CHE was keen to ensure that any educational programmes it delivered were effective and that ultimately they make a difference to practice. A review of the literature suggested a lack of evaluation frameworks of educational programmes, this study attempted to fill that gap.

This study was very complex and involved numerous stakeholders at different levels of engagement (see table 1 below).

Table 1 - List of stakeholders involved in this evaluation study

Stakeholder	How Involved in this Study	Level of Engagement in this Study
46 students (all qualified nurses) undertaking a 13 week course of study –(the programme)	As participants of the educational programme being evaluated	High – taking part in evaluation activities before, during and after the programme delivery
Director of Education at CHE	Had overall responsibility for the planning & implementation of the educational programme at CHE. Reporting to trustees. Part of the core teaching team and my line manager	High – assisting with evaluation exercises as part of the teaching team, participating in discussions about the data and actions as part of the action research process.
The Trustees of CHE: Chairman –Local businessman Treasurer – Retired bank Manager Company Secretary Accountant Plus 3 trustees from each hospice (St Luke's, East Cheshire & Hospice of the Good Shepherd). These included a retired palliative care consultant and the Dean of a School of Nursing plus other people who participated in a variety of hospice activities especially fundraising	Responsible for the ongoing funding and future directions of CHE	Low involvement initially, although were supportive of the need for evaluation by agreeing to allow the study to take place and in allocating some funding to the project. I was required to submit ongoing evaluation reports to the trustees at meetings which were held bi-monthly. As the project began to demonstrate value in providing information that could be utilised for other purposes (i.e.in helping with funding bids) the trustees became more interested. One trustee participated in the focus group meetings of the students as an observer and helped in the validation of the findings.

Stakeholder	How Involved in this Study	Level of Engagement in this Study
Staff from CHE, teachers & administrative staff	**Day to day running of the programme being evaluated.**	**High – due to contact with course participants. Also collected evaluation information and evidence from others e.g. mentors.**
Clinical placement staff including mentors	**Involved in course delivery of theory & practice, supporting students whilst in practice, assisting them meet their learning contracts**	**Medium- practice placements were a mandatory part of the course. Information from mentors assisted in the ongoing quality mechanisms and development of the programme**
Macmillan Nurses & other Clinical Nurse Specialists	**Involved in teaching mentoring & supporting students whilst on the programme**	**Medium- participated in team & planning meetings. Keen to participate in evaluation activities.**
Managers in the community & local hospital trusts who supported students during the course	**Participated in planning meetings, attended AGM and provided funding/time for student's study**	**Very Low – I reported the activities of CHE to them, they were aware of the research project. One community manager was especially supportive and was interviewed informally as part of the evaluation evidence. As a consequence of what she saw as 'good education' she sponsored her staff to do any relevant courses that CHE subsequently offered.**

Chapter two, commences with the emic perspective and reflects how my ontological views influenced the chosen research framework. An outline of the main research paradigms is offered along with a critique of action research. The rationale for using an action research approach is discussed, in particular its use as a collaborative approach with an emphasis on change. Evaluation as a concept is considered. Particular attention is paid to the way the discipline of evaluation has evolved; and how it is increasingly being recognised as an

effective means of providing useful information about services, which goes beyond simple measurement. The differences and similarities between research and evaluation are considered. The concept of multi-collaborative evaluation being more likely to provide realistic valid results about services is offered. Chapter three describes the research design and evaluation framework used in this study, together with an outline of the evaluation tools used.

In chapter four, the formative evaluation results are discussed and how these contributed to the development of a model of palliative care education (stage 1). An audit trail of the results of the evaluation study is mapped against the research methodology to demonstrate how I analysed the results and how emerging themes led to the development of the final model. One of the methods used to corroborate my findings was the focus group, chapter five discusses in some detail the planning conduct and results of these focus groups.

Finally, chapter six explores the linking of theory and practice both in the conduct of the research, considering the reality of the researcher role; and in the challenges encountered within this project. The changes made to the model of palliative care education are described with supporting rationale. Recommendations regarding the future provision of palliative care education are made. This includes using multi-collaborative evaluation strategies to provide evidence of effectiveness.

1.5 The Setting of the Study - Cheshire Hospices Education

Cheshire Hospices Education (CHE) is a charitable organisation that was set up in 1988 as a tripartite venture between three hospices in Cheshire. St Luke's Hospice, Winsford; East Cheshire Hospice, Macclesfield; and Hospice of the Good Shepherd, Chester. The aim of CHE is:

> *"to provide high quality education, in theory and practice, which will improve the quality of palliative care wherever it is given".*
>
> (Cheshire Hospices Education Mission Statement, 1998).

CHE was set up in response to both the local demand for education (which each individual hospice was unable to fully meet), and the overall philosophy of hospices to provide outreach educational programmes to their local communities (NCHSPCS, 1996; Reeves, 1996). As hospices are themselves mostly funded from charitable donations the amount of money that can be spared to provide education is severely limited (e.g. the total budget for education at St Luke's Hospice in 1997 was £500, this budget was to include statutory training and was for all employed staff, not just nurses). The pooling of resources from each individual hospice (including local staff expertise,) therefore seemed a more realistic approach to the problem of providing education. In addition, the matrons of each hospice had worked informally together for five years and were keen for such a collaborative venture to begin. CHE was set up as an individual charitable company funded by equal contributions from each hospice on an annual basis. Trustees were appointed, with a management team consisting of representatives from each hospice, an accountant and the Director of Education, all responsible for the ongoing management of the company.

CHE offers a variety of educational programmes, to both multi-professional and non-professional personnel (see appendix 1 for a full list of courses). These programmes range from study days, workshops, conferences, to short courses and a diploma level module. A full diploma in palliative care was commenced in October 2002, validated by Manchester Metropolitan University. It is anticipated that students will in the future be able to undertake degree studies at CHE. Details of the participants who were the focus of this study will be more fully explained in chapter three.

Students who study at CHE are from a variety of work settings, and roles, and are predominantly based in the North West of England. The majority of them are qualified nurses, however a substantial number are health/social care assistants, which reflects the current changes in health and social care provision (Komaromy et al., 2000). Other people attending courses include allied health professionals (AHP's), teachers, and receptionists working in acute, or community settings.

1.6 The Educational Programme

This section describes the specific nature, content, learning, and teaching approach of the CHE programme, which was being evaluated in this study (See also appendix 1 for module handbook).

The educational programme was called: The Principles & Practice of Palliative Care incorporating ENB 931- Continuing Care of the Dying Patient and Their Family, (Abbreviated hereafter to '931' course).

It was a level 2 (diploma) module, which generated 20 academic credits. It was accredited by Manchester Metropolitan University being part of their portfolio of modules at level 2 run by the faculty of Community Studies, Law and Education, and the Department of Health Care Studies.

The rationale for running the course was based on the need for education in palliative care (NCHSPCS 1996) and that educational development should be seen in the context of a recognised need for an increase in palliative care services (DoH, 2000).

Module Aims

1. To enable students to develop a critical understanding of physical and psychosocial well being in palliative care.

2. To enable students to develop expert practical skills in relation to physical and psychosocial palliative care.

Learning Outcomes/Objectives

At the end of this module, students will be able to:

1.Critically consider how the philosophy of palliative care can adapt and improve care in a variety of health care settings.

2. Analyse theories of grief and loss.

3. Analyse issues surrounding communication-enhancing skills.

4. Critically compare approaches to symptom management in palliative care.

5. Utilise skills of moral reasoning to enhance decision-making.

6. Critically review support mechanisms for maintaining professional growth and development.

7. Through critical reflection, act as a catalyst to influence change in practice.

8. Explore personal and societal feelings and attitudes to death and dying; recognising how these can influence approaches to and management of care.

Structure of the Course

The course was equivalent to 31 days, including 13 taught days, 10 days in practice and 8 days reflective practice in their own work setting. It was organised so that students attended CHE for one day per week over a period of 13 weeks; plus there were 10 days allocated to a palliative care specialist practice setting, in weeks 7 and 8 of the course.

An introductory preview half day was held about a month before the full study days commenced. The purpose of this was, to allow the students to begin to get to know each other and to form a cohesive group. A group learning contract was also devised. The rationale behind this activity was to get the group to start to take responsibility for what was to happen in the classroom, both in terms of how they wanted to be treated; but also in helping them to formulate ideas about the content and mode of delivery of future sessions.

In addition, at this initial meeting, the students were provided with further information about the course and allocated to their clinical placement base. This was usually done on a geographical basis in respect of their home address and which nearest hospice was available to provide clinical placements. Sometimes students would have a particular request as to where they were placed, and this was accommodated wherever possible. They had the

opportunity to meet with their clinical placement mentor and to start to plan their placement activities and begin to devise an individual learning contract with help from their mentor and tutors (see appendix 11). This learning contract was one of the ways that students were able to make a judgement about the value of their clinical placement and it also contributed to the overall academic assessment of the course.

The final stage of the course was a review day, which was held approximately three months after the course was completed.

Figure 1. Principles & Practice of Palliative Care Example of Module Format

One month prior to course commencing	Preview day
Week One	Two days taught input
Week Two	One day taught input
Week Three	One day taught input
Week Four	One day taught input
Week Five	One day taught input
Week Six	5 days practice placement
Week Seven	5 days practice placement
Week Eight	5 days practice placement
Week Nine	One day taught input
Week Ten	One day taught input
Week Eleven	One day taught input
Week Twelve	One day taught input
Week Thirteen	One day taught input
Three months after course completion	Review day

This totals 13 days taught input and 10 days practice placement.

Students were expected to attend a minimum of 80% of the taught input and 100% of the allocated hours for practice (Mandatory ENB requirements).

Course Content

The following themes and topics were explored in the course:

Definitions and perceptions of palliative care, the differences between palliative and terminal care, stereotyping and the difficulties in diagnosing when in the disease trajectory the term palliative is appropriate. Attitudes, and fears of patients and carers in relation to palliative care and dying. Quality of life, what it means, who assesses it, methods of assessment. The psychosocial and spiritual impact of a life-threatening illness. Moving palliative care forward, and the future of palliative care as a speciality.

The nature and incidence of cancer, including risk factors, and different treatment modes. The NHS cancer plan and how policies affect the provision of care. Common neurological disorders for example multiple sclerosis, motor neurone disease.

The meaning of pain, including the physiological and psychosocial manifestations. How pain can be assessed and managed. Symptoms that palliative care patients exhibit, their meanings, assessment and management. Consideration of practical tips that may be of use to patients and carers in dealing with symptom management. The experience of loss and grief and how that affects society in general. Normal and abnormal patterns of grief including anticipatory grief. Attitudes to death and dying including consideration of different cultural patterns, taboos in society and professional expectations. The concept of spirituality is explored in a workshop where participants consider what they understand the term to mean for them, and identify the use of artefacts to explore how it may be experienced by patients and carers.

Reflection on practice, using reflective diaries and journals, management of change in practice and the challenges to changing practice. Multi-professional approaches to care including the use of integrated care pathways for the dying (ICP's).

Communication issues - skills, barriers, breaking bad news, dealing with collusion, handling difficult questions and challenging situations. Multi-professional communication, working in and between teams. Ethics and ethical dilemmas that professionals experience when working in palliative care.

Personal and professional development planning - including study skills, presentational skills, using literature and academic writing. Application of taught principles to an individual's practice.

<u>Teaching Styles</u>

<u>Our beliefs about palliative care education (CHE student handbook)</u>

- Learning is a dynamic and lifelong process.
- Education needs to be flexible and meaningful to encourage students to enhance and improve their clinical practice.
- Education should be stimulating and motivating.
- It should empower the student so that they reflect on and analyse their practice.
- It should increase self-awareness, self-confidence and competence.
- It should promote and support the continued personal and professional growth of individuals.
- It should be easily accessible.

- It should be provided in an environment which is supportive and which respects the uniqueness and value of each individual.

A variety of teaching methods were used within the course including lectures, tutorials, seminars, and group work However, the approaches used by all teachers were to encourage students to explore their own values, attitudes, feelings and previous experiences. Interaction with each other and the learning material was emphasised, the aim being to facilitate the professional and academic development of the student. There was a specific focus on reflection and reflection on practice, (Ghaye, et al., 1996; Ghaye & Lillyman, 2000), students were encouraged to question and challenge themselves and each other. Such teaching strategies often required more than one teacher to be available in order to ensure the safety of students, for example when discussing loss and bereavement issues students may disclose uncomfortable feelings they had experienced which may have been detrimental to themselves or others in the group, teachers needed to be sensitive to this. It is my opinion that all teachers in any situation need to be sensitive to their students. However, when teaching about palliative care it perhaps triggers sensitive issues more often for students than when teaching other less sensitive subjects. For example: during this study, one student disclosed that she had deliberately chosen to qualify as a midwife because she had had a bad experience as a student nurse when a patient had died. She thus spent most of her early nursing career delivering babies rather than addressing her feelings. After a break from nursing to have her family she returned to work as a district nurse and as a result of dealing with patients requiring palliative care felt that she needed to personally *"confront her demons"* and deal with the uncomfortable feelings, hence her enrolment on the course.

Due to the emotive nature of palliative care, a fair amount of the teaching required teachers to challenge students to go that bit further in their thinking, developing a more critical view. For example: using debates about issues from practice like euthanasia or the withdrawal of treatments allowed students to offer their opinions in a safe setting and more often than not helped them to really think through some controversial issues. Providing the appropriate theory served to assist them in decision making in later situations.

Finally, as part of their own professional development the teachers at CHE have all attended communication training workshops which have dealt specifically with helping to assess patients' psychological states. During these workshops specific experiential techniques devised by Dr Peter Maguire (a leading psychiatrist in the cancer field) were utilised (Maguire & Faulkner, 1988, Maguire et al., 1996). As a team, we have now adopted this method with our students. It involves the use of tape recorders and specific role-play exercises carried out in a systematic manner. It has proved to be very challenging for students (and teachers) but is one of the sessions that students have commented favourably about, noting that the techniques they have learnt in the 'safe' setting of the classroom they have since been able to apply in practice.

1.7 Palliative Care - A Review of the Literature.

The following exploration of palliative care literature is not intended to be an exhaustive critical review but to highlight some of the major themes and current tensions within the practice of palliative care. It is anticipated that this will provide some background for the

reader as to the 'climate' in which palliative care education is provided. The literature reviewed analyzed aspects of palliative care within the following broad themes: -

- The history and philosophy of palliative care.
- Palliative care practice in the 1990's and beyond.
- Palliative care education - theory and practice.
- Researching palliative care education.

1.71 The History and Philosophy of Palliative Care.

According to the World Health Organisation (WHO, 1990) palliative care is defined as:

"the active total care of patients and their families by a multi-professional team when the patients' disease is no longer responsive to curative treatment. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is the best possible quality of life for patients and their families." (p. 11).*

The term includes specialist practice and principles and approaches developed by WHO.

The NCHSPCS defines such an approach to palliative care as:

"...to promote both physical and psychosocial well-being. It is a vital and integral part of all clinical practice, whatever the illness or its stage, informed by a knowledge and practice of palliative care principles" (p5).

(National Council for Hospice & Specialist Palliative Care Services 1995a).

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* The WHO has revised its definition of palliative care since this study began, the full text can be seen in appendix 2

Twycross (2001) stated that palliative care is:

"the technical term for comfort care at the end of life"

(Foreword in Abu-Saad & Courtens 2001).

However, such definitions relate to palliative care within the last few decades in the United Kingdom. Abu-Saad & Courtens (2001) identify that palliative care was provided as long ago as the fourth century to sick and exhausted travellers. Hospices were later set up by the Benedictine monks in the sixth century providing the link between religions and caring for the terminally ill. The term hospice is derived from the Latin word *'hospitium'* which translates as:

" the warm feeling between host and guest"

(Abu-Saad & Courtens 2001, p4).

The French translation of this Latin word is hospice, this term remains in use today and signifies places where: -

"Multi-disciplinary teams strive to offer freedom, dignity, peace and calm at the end of life"

(St Christopher's Hospice Information Service 2004).

The term palliative is derived from the Latin word *'pallium'*, meaning cloak or shield. Authors have interpreted this in a variety of different ways, for example as being symbolic, in 'cloaking' the patient in warmth and protection by care givers, (Francke et al., 1997 cited in Abu-Saad & Courtens 2001). Or, a 'cloaking' of the symptoms the patient experiences (Twycross, 1997). Meanwhile, Morris (1997) suggests the term is more pejorative, and

may indicate a covering up, and/or disguising of symptoms whilst ignoring the disease.

George and Jennings (1993) propose the term palliation was used in medicine as long ago as the 16th century to describe the alleviation of suffering. Doyle (1998) suggests that before advances in medical technology, doctors carried out 'palliative care' because they lacked modern analgesics and treatments; it was therefore an accepted part of their traditional medical practice.

Hospices were first established in the United Kingdom and Ireland in the nineteenth century at the same time as many large hospitals were built. However, Dame Cicely Saunders is credited with founding the modern hospice movement in 1967 at St Christopher's hospice in Sydenham, United Kingdom. The philosophy was very much about caring rather than curing, whilst providing comfort and hospitality for those who were dying, and their relatives (Saunders, 1965). St Christopher's is now recognised as an international centre of excellence in palliative care. It's website indicates that death is a *"natural part of life"* and that hospices *"care for the whole person"* at home, in (hospice) day care facilities, and in the hospice.

(St Christopher's Hospice Information Service, 2004).

However, the hospice movement is not without its critics. James & Field (1992) suggested that the hospice movement is characterised by charismatic leadership, a narrow focus and a predominantly Christian ethos. It also had a *'socially homogenous group of founder members'.* (p1364) In my experience, the people involved in hospices today; fundraisers,

trustees and volunteers all appear to belong to a fairly similar narrow social group, (characterised as white middle class). Gunaratnam (2000) identifies that the way hospices have developed in relation to people with cancer has also

> *"meant that relatively small groups of people from 'ethnic minority' groups have used palliative care services in Britain."* (p148).

Randhawa & Owens (2004) have identified that the current provision of palliative care services to minority ethnic groups may be regarded as *"Culturally insensitive"* (p20) for a number of reasons including:

> *"History and perception of palliative care services as only being available to white, middle-class patients" (ibid).*

Gatrad & Sheikh (2002) stated:

> *"Hospices conjure up visions of secular or Christian organizations. There is thus a need to ensure that all communities are aware of hospices and their role in providing palliative care for all patients, irrespective of their religious beliefs."* (p597)

These authors also indicated there have been some '*improvements in awareness of services*' and possibly service provision in the last few years. It remains a challenge to ensure there is equity of access for all service users regardless of colour or creed.

Thomas (2003) identified the emergence of the "*palliative care movement*" (p19) as being due to concerns being raised about 'care at the end of life' either at home, or in institutions. In addition, she states this growth of the palliative care movement was about the medical profession responding to the increasing demand for euthanasia; a point also made quite

forcibly by Lawton (2000) when she states

> *" ...proponents of hospice and palliative care are fundamentally opposed to euthanasia."* (p179).

In line with this view doctors working in hospices have responded to patients in pain by developing new ways of administering analgesia, so that patients can remain alert and make 'choices' (Twycross,1997). Multi-disciplinary team working has been instigated so that other professionals like social workers, counsellors and clergy are utilised to provide a 'holistic' approach to patient care (Faull & Woof, 2002). The palliative care movement therefore sought to differentiate itself from mainstream health care (which it viewed as paternalistic and not working).

Authors within the field of medical sociology have long debated the role of the medical profession within society. The most radical criticism was from Ivan Illich (1976) who argued that the wider influence of medical ideology in society has medicalized such human experiences as birth and death. One way this has been demonstrated is by the large numbers of people who now die in hospitals or institutions rather than at home which would have been normal in Victorian times (Field & James, 1993). Other writers also suggest that death and dying have become taboo topics within western society. Gorer (1965) wrote about the *'Pornography of death'*, which he described as society's increasing distancing from death as a natural reality. Philip Ariès (1974, 1981) also examined attitudes towards death from the middle ages onwards. He suggested that within modern society death has become hidden away and forbidden, unlike in Victorian times when it was a normal

accepted part of everyday life. Ahmedzai (1993) writes of the paradox of our western society with an ageing population, where nobody dies of old age, but of a medical diagnosis! Thus, the primary activity around dying people has been (and still is) medical. The hospice and palliative care movement has evolved in order to demystify death and according to Kellehear (1999) to

> *"restore the fallen, disempowered, and lonely figure of the dying person"*(p175)

Lawton's (2000) study of patient's experiences of palliative care is critical of the whole notion of hospices and palliative care per se, to be able to truly alleviate suffering. She reports that much of the literature about hospices has been written by hospice professionals, (though this is changing) and that this literature presents a somewhat romanticised view of patients resting comfortably in bed and dying with dignity. This view is in direct contrast to the reality of death she witnessed where patients were despondent, incontinent, disengaged from their bodies and supported by burnt-out, exhausted relatives. She indicates that the *"bodily realities of dying"* (p179) can have such a devastating impact on the patient that it is impossible to die with dignity. She recognises the need for people to think of death as peaceful and dignified. However, there is a danger if the professionals also hold this view, in that they see themselves as the 'elite' and as 'specialists' in their field.

Doyle (1998) alludes to this when he suggested that the growth of the 'speciality' of palliative care has offended some people, particularly those who view it as simply an emphasis on the principles of traditional medicine; i.e. we are doing it already (Field, 1998). Doyle counters this argument by stating that we live in an age of increasing specialization.

He also identifies that when creating a specialism, with the resulting body of knowledge; expertise and experience should enhance the skills of those working in other disciplines, particularly if the specialists acknowledge their responsibility to share their knowledge and skills through education and training (Doyle, 1998).

An interesting point to consider here is that the term palliative care is inextricably linked to the growth of the modern hospice movement; this may account for some of the perceived tensions within the speciality relating to 'exclusivity' and 'specialism'. Such tensions exist when specialists suggest to other practitioners that they are 'better' at caring for palliative care patients (Thomas, 2003). This results in practitioners feeling de-skilled or undervalued and the resulting squabbling between professionals at the expense of patients and families. Doyle (1998) states that one of the obstacles to the provision of palliative care may be that some nurses (those who have undergone specialist training!) see it as an exclusive nursing responsibility. One student during the course of this study suggested she had come across a *'form of tribalism'* amongst community nurses. This manifested itself as an unwillingness to refer patients to specialist services (like Macmillan nurses) because they could look after *'their patient'* adequately. This is perhaps related to the term used by Nyatanga (2002a) 'professional ethnocentrism' which he concludes is the

> *"belief that one's own professional group is superior and better than all the others"*

and, that it is characterised by *"the need to create professional boundaries"* (p316).

In this instance community nurses would see Macmillan nurses as 'specialists' rather than nurses. Such tensions between palliative care specialists (be they medical or nursing) continue to exist and possibly mirror the tensions in other areas of health care between

specialities e.g. care of the elderly versus cardiology. Tensions also exist between and within settings e.g. community, acute hospital, and hospices, and may be partly attributable to funding anomalies, and financial constraints affecting the provision of services and caseloads.

Despite these tensions within and between disciplines, UK policies and government initiatives are becoming a driving force for change in palliative care. The Supportive Care Strategy in England and Wales (2002) led by Professor Mike Richards, includes provision for the education of community nurses in palliative care and the phased introduction of the 'Gold Standards Framework' (GSF). The aim of the GSF is to

> *"Support, encourage and enable primary healthcare teams to develop improvements in the supportive care of patients in the last stages of life"* (Thomas, 2003, p177).

The GSF has been piloted in 12 GP practices in Yorkshire and is now being rolled out to others across the United Kingdom (Thomas, 2003). One of the benefits has been the shared working between palliative care specialists and generalists and a real commitment to improve communication and team working. This can only advantage patients and families and may prove to help eliminate some of the historical problems within palliative care relating to exclusivity, and a lack of knowledge amongst generalists.

According to Thomas (2003), 75% of in-patient hospice units are voluntarily and charitably funded. There is currently a funding crisis and many hospices are being forced to close beds and turn patients away.* Hospices are now actively trying to discharge patients; the

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* During this study two of the three hospices supporting CHE experienced considerable financial difficulties resulting in cutting of services and reduced numbers of beds.

average length of stay is now 2 weeks (NCHSPC, 2003). A further contention around hospice care has arisen regarding the way patients are accepted (or not) for admission. Most hospices have a small number of in-patient beds and cannot possibly provide this for all those who need it. Lawton (2000) recognised similar changes in admission procedures whilst she was carrying out her study, stating that the hospice appeared to be treating the more difficult cases requiring symptom management and that there were economic tensions in attempting to discharge patients. Hospices try to provide outreach services in the form of day care and education so that the hospice philosophy is transferred to other settings such as the home. However, a recent National Patients Survey has identified many inequities around the provision of palliative care services (Cancer Voices Programme & Cancerlink www.macmillan.org.uk). In addition, with hospices being selective about which patients they will accept (some will not accept patients unless they have a cancer diagnosis) it has been suggested that hospices may be seen as elitist because they have had a lower proportion of patients from the lower social classes.

Higginson et al., (1999) investigated whether social factors affected where people die (in relation to cancer deaths) in the United Kingdom. The results demonstrated a small inverse correlation between social deprivation and home deaths. Grande et al., (1998) also considered whether certain groups of patients were at a disadvantage when it came to accessing palliative care services. Their results demonstrated that patients in higher socio-economic groups were more likely to die at home and to access palliative home care. Other studies have focussed on the provision of specialist palliative care to different ethnic groups (NCHSPCS, 1995; Firth, 2001; Jack et al., 2001; Randhawa & Owens, 2004) with recent

studies offering recommendations for the provision of *'culturally sensitive palliative care'* (Nyatanga, 2002b, p246).

White (1999) argued that advances in medical treatments and technology have caused a shift to a more interventionist approach within palliative care which in turn may *"direct the focus away from the fundamental philosophy of holistic care"* (p108). If palliative care returns to a disease-centred medical model then the initial values and philosophy inherent within the speciality will be lost. Lawton (2000) has already identified the stress caused to hospice staff of having to reconcile their goals of providing a *"safe haven"* (p 20) with managerial objectives of cost effectiveness and efficiency.

1.72 Palliative Care Practice in the 1990's & Beyond

In May 2001 NCHSPCS produced a briefing paper entitled *"What do we mean by palliative care?"* This was in response to recent government papers such as the NHS Cancer Plan for England (DoH, 2000) and other initiatives such as National Service Frameworks (NSF's), which will affect how care is delivered, and organised. The NCHSPCS adopted "*new approaches to defining services*" (p2) and concentrated on defining what should be provided. This paper stated that the WHO (1990) definition of palliative care was still relevant but adds that this is also applicable to patients with a

"Non-cancer diagnosis, as well as those with cancer" (p3).

In addition, this paper made a distinction between general palliative care and specialist palliative care.

"General palliative care can be defined quite simply as palliative care provided by the patient and family's usual professional carers as a vital and integral part of their routine clinical practice. It is informed by a knowledge and practice of palliative care principles" (NCHSPCS, 2001, p3).

This statement recognised that many health professionals provide palliative care in a variety of different settings as part of their everyday work. In contrast to 'specialist palliative care', this was now defined as:

> *"palliative care provided by health and social care professionals who specialise in palliative care and work within a multi-professional specialist palliative care team"* (ibid).

Nurses working in a hospice setting and Macmillan nurses would therefore be defined within this category. The NCHSPCS have also issued a briefing paper to discuss the provision of palliative care for adults with non-malignant disease (Addington-Hall, 1998). This is in response to the growing demand for palliative care services (Thomas, 2003).

The rapid growth of palliative medicine in the United Kingdom reflects the great increase in patients requiring palliative care, similar increases have been noted worldwide (Billings, 2000; Singer & Wolfson, 2003). Lloyd-Williams & Field (2001) indicated that over 90% of hospital beds in the United Kingdom are occupied by patients with a disease other than cancer which is life threatening and chronic, these patients require palliative care.

There is a danger however of palliative care becoming a two-tier system as reported by

Dicks (1999); cancer deaths account for only 25% of the total deaths (in the United Kingdom); with the majority of people dying from other causes not accessing palliative care services. Suggested reasons for this include:

- Fears that existing services would be overwhelmed with referrals.
- In-patient beds would be blocked by chronically sick people rather than the acutely dying.
- Independent hospices who rely on charitable donations may find it difficult to fund raise for less emotive (than cancer) conditions; and
- fears that the needs of cancer patients would be neglected.

(Dicks, 1999. p133.)

Dicks does agree with the reasons for such concerns nevertheless she is adamant that

"All patients in need of palliative care expertise should receive it" (p134).

Her suggestion is that there is a difference between those who require the 'palliative care approach' and those who require 'palliative care services'. If the former group had access to a palliative care expert who would provide time limited consultations, then this may be sufficient to meet their current needs; whilst allowing those with longer term or chronic needs to access more comprehensive palliative care services.

The House of Commons Health Committee is currently inquiring into the provision of palliative care by the NHS and independent services in England (2004). There will be a cross-party committee of MPs, which is independent from government. Areas to be examined include: issues of patient choice; equity in the distribution of provision; financing of services.

(Source: New inquiry - Palliative Care. The United Kingdom Parliament: Press Notice, 23rd January 2004

HospiceUK [hospiceuk@hospiceinformation.info])

A final point to consider is that as the amount of money and time spent on palliative care increases it is in danger of being subsumed under the auspices of 'cancer care'; which has already been identified by government policies as high priority. This threat has been highlighted by various pressure groups including NCHSPCS (2001). To alleviate this threat, all those working with patients and families who require palliative care need to have a good knowledge of what determines palliative care, what services are available and to be able to provide them effectively and efficiently. Putting this into practice requires ongoing education.

1.73 Palliative Care Education - Theory & Practice

The term "*palliative medicine*" was not recognised as a medical speciality in the United Kingdom until November 1987 despite the history of the hospice movement and subsequent educational programmes developed by hospices in-house (Scott et al., 1998). Since 1987, there have been recognised training programmes in palliative medicine and a higher profile in undergraduate medical education in the United Kingdom (Smith, 1998). Conversely, according to Lloyd-Williams & Field (2002) there is little evidence of palliative care teaching to undergraduate and diploma level nurses. In fact, the paper further asserts:

> *"Medical students appear to be receiving more teaching and training in palliative care, nursing students appear to be receiving less"* (p592).

The NCHSPCS (2002) has expressed concern about the paucity of palliative care education in pre-registration nursing programmes and made some recommendations of the minimum elements to be incorporated into programmes of basic nursing education. These include nurses being made aware of the role and functions of the palliative care team; and a basic understanding of the psychological support needs of palliative care patients and their carers. Ingleton & Seymour (2004) note that palliative care education is inadequate in undergraduate training in the UK and that as the need for it increases due to the growing demand for care

> *"For those patients with chronic, life-limiting diseases, palliative care education should take greater prominence than at present"* (p581)

Faull & Woof (2002) identified the importance of the *"palliative care approach to patients"*(p.vii) and noted its increasing prevalence for example as a taught and examined subject in the medical curriculum. The Cancer Relief Macmillan Fund established in 1911 has played a vital role in helping to develop cancer and palliative care services by providing funds for education and training, which are available to both doctors and nurses. This charity continues to fund education, training and research programmes as well as specialist nursing posts throughout the United Kingdom (Macmillan, 1999). In 1990, Macmillan set up a national network of Macmillan general practitioner clinical facilitator posts (GPCF's). These posts were accepted by experienced GP's whose role was to work as an educational resource in primary health care teams (Cox et al., 1995). The impact of this role has been evaluated both nationally (Shipman et al., 2003) and locally (Noble et al., 2003). Both evaluations indicated the need for the continuing education and support of those providing

palliative care.

According to Coles (1996)

> *"Theory and practice are not separate within palliative care: they are integrated"* (p97).

Education is a dynamic process. In collaboration with a variety of health care providers, CHE offers students undertaking educational courses the opportunity to undertake periods of supervised practice in placements where specialist palliative care is provided. Students may already be providing general palliative care in their own work setting. However, offering an opportunity to work with specialist palliative care practitioners enables them to broaden their knowledge and skills base, and network with a variety of different people from the multidisciplinary team. Evidence from previous research (Macleod et al., 1994; Cantillon & Jones, 1999) suggests that this is essential if students are to make sense of education and apply it to their own practice.

CHE believes that education in palliative care is a necessity for all those involved in caring for palliative care patients in any setting (CHE, 1998a). Good clinical practice is inextricably bound to education, so one cannot develop without the other. Some palliative care education programmes in other areas of the country (particularly those to qualified nurses), are unable to offer specialist practice placements (Langton et al., 1999). The philosophy of CHE is that the practice components of the course have an equal value with the theoretical components. This philosophy is supposedly widespread within nurse education, although in my extensive experience with several higher education providers this

philosophy is often only paid lip service to, and does not easily translate into the everyday work of nurse teachers. An education commission chaired by Sir Leonard Peach (UKCC, 1999) stressed the importance of integrating theory and practice in the education of pre-registration nursing students. I would suggest this is equally relevant to qualified nurses undertaking education, because nursing is a practice-based profession.

Governing bodies such as the United Kingdom Central Council for Nursing Midwifery & Health Visiting (UKCC) agreed that the ***practice*** of nursing is as important as the theoretical components (1999). The English National Board for Nursing, Midwifery & Health Visiting (ENB) was responsible for accrediting pre-and post registration nurse training programmes (up to March 2002) and stipulated the number of hours that must be spent in clinical practice settings. However, the emphasis for qualified nurses has traditionally been on obtaining academic qualifications. Nursing has moved from a more practice based training programme to one with a more academic basis. This was due to the changes in nurse education instigated by the 1984 UKCC project concerning nurse education and training, which became known as Project 2000 (James & Jones, 1992). Implementation of the project 2000 training programmes for nurses began in the early 1990's. This shift from practice to theory has led to criticisms by some nurses that practice has become devalued (UKCC, 1999). In practice, in my experience, many higher education post-registration nursing courses offer little experience of practical placements, on the premise that the nurses who attend are practising nurses anyway. In this way assumptions are made about the 'quality' of their practice settings i.e. the assumption being they are supportive learning environments, which is not always the case (*ibid*).

Within palliative care education, it appears to be even more difficult to obtain practice placements due to the specialist nature of the practice, a point made by Langton et al., (1999). In higher education, the importance of practice was highlighted by the Dearing report (1997), which stressed that higher education should properly prepare all students with the skills and knowledge for the environment in which they would ultimately work, thus increasing their employability. Up to date relevant skills and knowledge are especially important for those working in health care settings, where multi disciplinary teams are required to work together to deliver quality care; which will ultimately benefit patients and their families (DoH, 1998).

The CHE approach to practice is to recognise the student's experience, and to organise a practical placement, which is individually tailored to that student's learning needs. This has two demonstrable effects, one being to raise the profile of practice and the other to recognise that students are often working in highly stressful/pressured working environments. Therefore learning needs to be seen (by the student themselves) to be meeting their individual needs. Visiting a new area can help students reflect on how theory is applied to practice whilst being away from the stresses and strains of their own job. This affects unqualified staff (who are also offered placements) as much as qualified nurses. In my view, such approaches to palliative care education must be evaluated, to ensure that they are improving the care; which is delivered to patients and their families.

1.74 Researching Palliative Care Education

In 1994, Webber stated that in the field of palliative care, research to benefit practice and education was only just beginning to emerge. Reasons put forward for this paucity of research include a lack of resources, lack of knowledge e.g. few of the staff involved in palliative care had the exposure to research assumptions and methods. In some cases there was a feeling that:

> *"Key research should be conducted outside the area of late stage disease and its palliation"* (Ford, 1996, p182).

This morality argument about whether it is ethical or not to conduct research on dying subjects, still exists and is one argument which continues to be put forward by practitioners who fail to carry out research projects (Field et al., 2001). Wilkes (1998) examined research in palliative care in the United Kingdom over a ten-year period and noted the importance of recognising the skills and expertise of nurses in this area; and of demonstrating a link between the care nurses give and patient outcomes. More recently Froggatt et al., (2003) examined qualitative research in palliative care between 1990-1999 and noted that:

> *"...qualitative research in palliative care has the potential to make significant contributions to practice."* And *"The development of practice can be enhanced through qualitative methodologies and further endeavours should be made to develop this approach within palliative care research."* (p104).

Corner (1996) established a strategy for palliative care research, she noted it needed to be collaborative, multi-method and engage consumers of services, research subjects and professionals in all aspects of the research. This study strives to meet this challenge.*

Doyle (1996) stressed that palliative care is the *"right of every patient"* (p 91) and that appropriate education and research is required in this field. The question being, what is considered as 'appropriate' education? This question has not really been fully explored by writers in the field of palliative care education either nationally or internationally; although recent studies have identified some common themes such as it being multi-professional and collaborative (Langton, et al., 1999, Dowell 2002). This study aims to fill the gap as to what might constitute appropriate education, particularly in relation to what can be expected to be achieved. Froggatt (2002) stated:

> *"Some initiatives (Kenny, 2001) with a clear educational focus do address this in choosing strategies that are explicitly collaborative with the participants and integrating practice experience with the theoretical input, but these are the exception"* (p158).

Interestingly in England the NHS Cancer Plan (DoH, 2000), established a need for basic palliative care education for district and community nurses to enable more patients with advanced cancer to be nursed in their own homes. A total of £6m over three years has been made available to fund educational programmes in 34 cancer networks across

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* In this study I have taken 'consumers of services' to mean students who were consumers of education at CHE, as opposed to patients.

England. A national evaluation of the project is being carried out over a three-year period funded by the Department of Health and led by a team at King's College London (DoH, 2002).* That evaluation project is similar to the study reported here in that it considers the views of participants and stakeholders, and aims to assess outcomes of the education (Shipman, 2002). It differs, in that it seeks to identify the *'support and resources'* needed by district and community nurses in providing palliative care.

One assessment of the impact of these educational programmes will be by the proportion of cancer patients dying at home, in hospitals and hospices *(ibid).* A criticism would be that place of death, may not always explain the "choices" available to patients. For example: a patient may wish to die at home but the support services may not be available, including social care as well as nursing care. A frequently reported problem encountered by community staff is the difficulty in accessing out of hours drugs and equipment (DoH, 2002). Additionally, not all patients choose to die at home, although the evaluation team acknowledges this fact, in the initial report (DoH, 2002). The impact of the programme would also be assessed on the knowledge, confidence and perceived competence of district nurses, although how this would be done has not yet been publicised. It should be noted that this is the first national evaluation of palliative care education programmes in the United Kingdom; the final report will be completed in summer 2004.

This national evaluation programme will try to:

> *"Identify and categorise the range of educational models and methods of*

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* See final chapter, as a result of this PhD study I am now leading the Greater Manchester & Central Cheshire cancer networks' evaluation strategy of the district nurses' education pilot project.

delivery" (DoH, 2002; p16).

as well as, outlining the participant's and local stakeholder's views. It fails to explain the purpose of identifying what is currently available, or whom that information will be made available to. The NHS Cancer Plan (DoH, 2000) acknowledges the importance of meeting local needs for cancer treatments, and education and training, therefore it may be assumed that current local education and training provision is aimed at meeting local needs.

Sheldon & Smith (1996) suggested that evaluation of the outcomes and processes of palliative care education *"was in its infancy"* (p104). The World Health Organization (1989) stated that palliative care should be a compulsory part of courses leading to basic professional qualifications, (including medicine, nursing, health and social care). In addition, the Calman-Hine report (1995) indicated that education is a vital component in the delivery of palliative care. Therefore, provision must be made for it in a network of cancer care services in England and Wales. Hillier & Wee (2001) argued that as most people who die have some contact with health professionals, all health professionals should therefore have ***some*** education in palliative care. They also suggest that the responsibility to provide such education lies with the specialists who are practising it. A point agreed in principle by the stakeholders and trustees of CHE (Cheshire Hospices Education, Mission Statement; 1998). Cooley (2003) indicated that:

"People with palliative care needs are nursed in every clinical setting by every level of nurse. Expertise in palliative care is probably one of the most

important skills in nursing and should be core to every nursing curricula" (p5).

Thus, there is a need for education in palliative care and it is a growing and developing speciality. Sentilhes-Monkam & Serryn (2004) state:

> *Research into palliative care is essential to improve both the care provided by, and the technical and interpersonal skills of, healthcare professionals"* (p23)

The need for palliative care is increasing due to demographic changes, i.e. the increasing age of the population, plus the higher incidence of cancer and other chronic diseases in older people (Calman-Hine 1995). The importance of palliative care is being recognised amongst health care professionals as principles of care, which can also be utilised with clients suffering from other chronic diseases apart from cancer (Faull & Woof 2002, NCHSPCS, 2003; Thomas, 2003). Therefore, the demand for palliative care education is also growing. However, Sneddon (2001) warns against the provision of more education requiring additional funding. She states quite simply that education needs to be more "*effective*" in order to improve palliative care. Sneddon (ibid) indicates effectiveness may relate to prolonged courses of study, which enable deep and critical reflection, and the sharing of ideas with others. In addition, the development of effective communication skills (seen to be a basis for good practice) requires education **and practice**, with feedback over a period of months. Prolonging education may cause conflict with managers who are under increasing pressure to demonstrate higher numbers of employees with relevant qualifications (including palliative care), to fulfil government targets and

reduce current vacancies. Interestingly, Sneddon further comments that practitioners and managers share the *"same responsibility,"* in ensuring that the educational goals of a programme meet the needs of the service. This is one way of assisting practitioners in implementing any future changes to their practice as it quite rightly suggests managers need to be supportive of educational goals and possible future changes.

1.8 A Justification for Evaluation of Education in Palliative Care

The crux of the problem seems to be how will we know whether education is effective or not? Currently, quality assurance within higher education in the United Kingdom is regulated by the quality assurance agency (QAA). Conversely, as funding arrangements are based on the achievement of QAA standards, some questions have been raised about the rigour of such procedures in some establishments (Daily Telegraph, 2001). The bureaucratic nature of the current inspection procedures and the need to offer consumers of services some objective measures of quality; reflects the reality of the problems of attempting to demonstrate robust standards. Such difficulties have been grappled with by evaluators in the field of education over many years (Aspinwall et al., 1992; Popham, 1993). Equally, educational establishments, who are linked to, or part of, higher education provision, do not always provide palliative care education. Therefore, the question is who would be deemed responsible for regulating the quality of education provided by these establishments, given that higher education has no jurisdiction here?

Rigorous evaluation strategies need to be developed, that will provide accurate evidence

about the standard and quality of palliative care education programmes (Robbins, 1998). An important point to note however is that education may, in itself, be regarded as insufficient. Educational programmes can have the highest standards and be of excellent quality but unless what the student has learnt is **put into practice,** essentially the education could be deemed to be of little use. This is particularly relevant in the National Health Service where there is a drive for evidence-based practice in health care, through such initiatives as clinical governance, audit and national service frameworks (DoH, 1997). Jordan et al., (1999) identified a:

> *"Lack of empirical data supporting the links between taught courses and clinical effectiveness"* (p797).

They further suggested that as educational courses proliferate, stakeholders require the results of reliable, relevant, and valid evaluations to inform their purchasing decisions. Wilkinson (1998) purports:

> *"Palliative care patients have as much right as others to receive the most appropriate care"* (p160) and that such care is evidence-based.

Clark (2000) writes about the remit of educationalists, nurse managers and practitioners to create a 'research culture'. She also considers that nurse educationalists have a particular responsibility to assess the needs of students, outcomes of education and evaluate the teaching and learning strategies they use. She acknowledges the use of 'goal-free evaluation' research to answer these questions and identifies it as a holistic, creative

approach that takes time and is costly. I consider my responsibility to provide evidence that teaching is effective as part of my role as a teacher, this evaluation study partly came about because of my belief in the value of this.

This study investigated whether students have put into practice what they have learnt and whether such practice was sustained. Effectiveness was deemed to be the practitioner's views of how they have made changes in how they practise and what new skills they can perform. (Such evidence needed to be corroborated and I will identify how this was done). Improvements may be demonstrated as cognitive, motor or affective skills. It was anticipated that students would be able to identify improvements in all three domains, as the curriculum encouraged them to critically reflect on their development. A further important aspect was the potential to encourage greater confidence and personal growth in the students through participation in education,

> *"Which can have a positive impact on care provision".*
>
> (Loftus & Thompson, 2002 p.354).

Ingleton & Seymour (2004) identify there is little evidence of the effectiveness on practice of palliative care education. However, they have recognised the difficulties of conducting such studies due to the '*methodological challenges'* researchers face in conducting any research in palliative care. They articulate the view that

> *"Perceptions of increased knowledge, self-confidence and attitude change are more reliable (and meaningful) than measurable differences, there is substantial evidence to support the effectiveness of education in palliative care (Kenny 2001; Dowell*

2002)" (p584)

Much of the research about palliative care education has focused on medical students and doctors (Lloyd-Williams, 2001), although evaluation of palliative care education has been undertaken with both medical staff (Macleod et al., 1994) and qualified nursing staff (Faulkner, 1992; Faulkner & O'Neill, 1994; Hopkins & Field, 1997). Conversely, these studies have tended to concentrate on enhancing communication and collaboration between hospital and community based staff, or in demonstrating differences in confidence when dealing with physical or psychological symptoms. None of these studies considered the effects of education over a significant time period i.e. more than three months. An evaluation study by Webber in 1991 used a qualitative approach to assess nursing student's perceptions of the value of palliative care education. There were some attempts to integrate theory and practice however there was no evidence of whether the student's reported perceptions could be corroborated (Langton et al., 1999). A more recent study of education in palliative medicine by Rawlinson and Finlay (2002) also strongly advocated the use of formal evaluation for educational programmes as well as for clinical interventions. Wilkinson et al., (1999) reported on a longitudinal study of the impact of communication skills training workshops, which had significant benefits on the participants' abilities to communicate more effectively post training. A later paper (Wilkinson et al., 2002) identified an *'integrated approach'* to skills training being used and that opportunities for *"reflection and self-critique"* (p737) seemed to be important factors in improving the confidence of the participants.

MacDougall et al., (2001) described an evaluation of an interprofessional palliative care education programme which attempted to:

> *"Explore the main issues in delivering care to individuals with palliative care needs and their carers"* (p 29).

One of the evaluation tools used in that study was a pre and post course reflective diary where participants had to reflect on their practice with an emphasis on their communication skills. However, this was voluntary and the authors noted:

> *"evidence from the reflective diaries was difficult to evaluate, not least because only eight participants took part in the first exercise* (pre-course) *and of these, only two participants took part in the second* (post-course) *exercise."* (p 27).

The results from the above study indicated an increased knowledge about palliative care, more confidence and competence in collaborating with other health professionals and an enhanced ability to communicate with service users. The evaluation recognised the continuing need to provide flexible and creative educational programmes to meet the needs of participants. Interestingly, the authors recommended that in future the reflective diaries should be a compulsory element of the programme, thus recognising the importance of reflecting on practice, to identify improvements that participants may make to their own practice. The educational model devised from this evaluation study (see

page 234) encompasses both of these elements i.e. meeting the needs of participants and developing reflective practitioners.

Froggatt (2000), reported on an evaluation study of a palliative care education programme for qualified staff in nursing homes in the North West of England. Froggatt's recommendations indicated that further evaluative work:

> *"which is methodologically rigorous and where possible gathers baseline data is essential."* (p.146).

This study meets those recommendations, and commenced sometime before Froggatt published her work. It is interesting to note that other authors in this field have highlighted the very real problem of putting education into practice. Hutchinson (1999) purports the link between education and practice is the:

> *"most difficult link to make"* (p1268).

The uniqueness of this study is in tackling the challenges of providing meaningful reliable measures that will inform the debate about evidence-based practice in palliative care education.

Billings & Block (1997) reporting in an American Journal identified a number of principles relating to palliative care in undergraduate medical education. Principle 15 stated:

> *"Educational programs should be evaluated using state of the art methods"* (p737).

However, the one paragraph related to the above statement identified student outcomes, patient and family satisfaction with care, and costs, as the things which should be evaluated (measured). Plus:

> *"descriptions of and course materials from successful educational programs should be broadly disseminated"* (p737).

There are no suggestions as to what makes a successful course, nor how this evaluation would be carried out, or what state of the art methods would be used! Machin (1997) stated that all educational initiatives should be evaluated. Whilst, Jodrell (1998) and Robbins (1998) identified that there are a lack of systematic evaluations of palliative care educational programmes. Jodrell (ibid) suggested this may be due to the fact that palliative care is an emerging field. Robbins further states the importance of research:

> *'to advance a sophisticated and rigorous approach to palliative care evaluation'* (p147).

Froggatt (2002) has identified the need to:

> *"evaluate the evidence being offered within educational courses"* (p158).

Therefore, this study researching palliative care education will become part of the evidence base of palliative care itself.

A key finding from the research project of Langton et al., (1999) was that there is a lack of reliable studies providing valid evidence as to the effectiveness of palliative care (and cancer care) education and its subsequent impact on patients. A recommendation from that study was that further empirical work was needed, to assess the longer-term effectiveness of educational programmes. This study will endeavour to meet that need.

A further review of the international literature has revealed a Canadian pilot study, (Kristjanson et al., 1997), which has some initial similarities with the intentions of the study reported here. That pilot study was concerned with the evaluation of an interdisciplinary training programme to improve the quality of care of patients with H.I.V. Three aspects of the programme were evaluated:

> *1. The effect of training on knowledge and attitudes of health professionals.*
>
> *2. The effect of the training programme on *<u>care practices</u> of health professionals trained.*
>
> *3) Satisfaction of the volunteers with the volunteer component of the training programme.*
>
> (Kristjanson et al., 1997, p9). **(* My emphasis).**

However, on closer examination the target group, setting, and emphasis on quantitative data collection is different to that of the study described here. The changes in ***'care practices'*** were not discussed in any detail either.

1.9 Key Issues Which Affect Palliative Care Education.

A review of the literature has indicated how palliative care has developed and the way this development has been closely linked with the hospice movement. However, the demand for palliative care is escalating due to an increasing ageing population and advances in medical technology, but also to changes in the way palliative care is defined. Newer

definitions of palliative care encompass a much wider range of diseases and conditions, (WHO, 2001), this creates an increase in demand for the provision of palliative services. The need for healthcare to be accountable and for services to be efficient and effective is a prerequisite of clinical governance. So too is the need to provide equitable access to services for all users.

Stjernsward (1996) indicated the need for high quality palliative care to be freely available to the population and further states it is a key responsibility of service providers to provide such education. As the demands for palliative care services increase so too will the demands for quality education to support practitioners. However, the provision of more education is potentially unlikely to make a difference to practice as outlined by Sneddon (2001). Therefore, the emphasis needs to be on providing '*more effective programmes*' of education. Effectiveness like quality is a term that can mean different things to different people; however, if educational programmes are to meet the needs of stakeholders they need to be properly evaluated. As already indicated, there is lack of reliable studies providing valid evidence as to the effectiveness of palliative care (and cancer care) education and its subsequent impact on patients (Langton et al., 1999, Ingleton & Seymour 2004).

Corner (1999), has identified that nurses are:

> *"particularly well placed to take a lead role in the emerging research and practice development agenda for palliative care"* (p185)

I would suggest this study may become part of the practice development of education in palliative care, for several reasons:

- It provides sound reasons for the need to evaluate education in palliative care.
- It identifies how to do that by providing a model of palliative care education which can be used as an evaluation framework.
- It has been tried and tested on stakeholders involved in palliative care education.
- It mirrors the philosophy of palliative care itself in that it is multi-professional in orientation, multi-modal in delivery and emphasises process and outcomes of care because of the emphasis on the application of transferable skills to practice.

1.10 Cheshire Hospices Education as a Palliative Care Education Provider

As a service provider, CHE has taken on board the challenge to provide education in palliative care; whilst recognizing the need to provide appropriate evidence of effectiveness. I was appointed as evaluation project leader and have been instrumental in developing multi-collaborative evaluation strategies in order to determine whether educational programmes are effective. This appointment was undoubtedly influenced by the good working relationship already established between the CHE team and myself. I acted in a 'link nurse teacher' role, over a number of years at one of the hospices, and had previous experience of working as a teacher with the Director of Nurse Education at CHE. Furthermore, I had already demonstrated effective research skills in my work completed at masters' degree level on evaluation.

A variety of evaluation tools were used for this research study, the evaluation strategy adopted will be discussed in detail in chapter 3. The rationale for the research perspective chosen i.e. action research is considered in the following chapter, which also considers

how evaluation has evolved as a discipline. This serves to identify the philosophical stance, which has been adopted in this study and sets it in a paradigmatic context.

Summary

- Palliative care is a growing speciality due to demographic changes and the increasing numbers of people who are dying from chronic and terminal illnesses. The World Health Organisation (WHO) and National Council for Hospice and Specialist Palliative Care Services (NCHSPCS) have provided definitions of palliative care and the palliative care approach. (1990, 2001). These definitions are used to guide practitioners in the planning and delivery of care to patients and their families.
- Some of the tensions within palliative care have been outlined such as the development of a speciality which may be seen as 'exclusive' and the need to provide accessible equitable care to all ethnic groups.
- The purpose of this study was to determine whether palliative care education is effective, particularly in how it affects student's practice. A review of the literature suggests evaluation of palliative care education has been minimal, and to date has been lacking reference to long-term practice. There is a lack of methodological frameworks for conducting such evaluations.
- This study is unique in attempting to provide meaningful reliable measures about the effectiveness of palliative care education in both theory and practice. It is envisaged that this work will inform the debate about evidence-based practice within palliative care education.

- It provides sound reasons for the need to evaluate education in palliative care and provides an evaluation framework in which to do it.
- A paper describing this study has been published in an international journal (Kenny, 2001), and papers and posters have been presented at various United Kingdom nursing and education conferences describing the evaluation strategies in use at CHE (see appendix 3).
- I have a history of successfully working as a nurse teacher supporting student nurses working in a hospice setting and have a relevant background in research and evaluation. Cheshire Hospices Education (CHE) has appointed me as their evaluation research officer to provide evidence that the education offered by them is effective; if not to suggest recommendations as to how to make it so.

CHAPTER TWO

The Research Perspective:

Action Research / Action Learning & Evaluation

2.1 Introduction

The purpose of this chapter is to provide further context for the study reported here. Such context includes the emic perspective, i.e. the "insider view" or, "voice" of the researcher. In order to do this an autobiographical account is presented, which seeks to demonstrate the interdependence of the disciplinary perspective of myself as the researcher with the research question. In any research, it is important for the researcher to clearly justify their reasons for choosing the particular approaches that move them from the research question to the study itself. It is necessary to outline the philosophical stance taken and how it has been applied. These points will be clarified and the justification for using an action research approach will be outlined.

This chapter additionally considers the concept of evaluation theory and practice identifying the way it has developed in health care and education. This assists in embedding the concept of action research into evaluation practice, which is what this study was concerned with.

2.2 Autobiographical Account - The Emic Perspective

I have been involved in nurse education for twenty years as a practising nurse teacher. In

order to qualify as a nurse teacher it was necessary for me to become a registered nurse demonstrating competence clinically, as well as undertaking specific teacher training. I also possess a degree in health promotion and a masters' degree in health. My masters' thesis looked specifically at evaluation in health care and the need for further education/training in this subject for health care practitioners.

My philosophy of education was initially influenced by my late mother; she believed passionately in the value of all education and encouraged me to learn in my formative years, I am most grateful. Later, I was influenced by the work of Friére (1972, 1976) Rogers (1967, 1983) and Heron (1973, 1977, 1978, and 1981). Friére believed in the ability of education to emancipate people and to significantly change the relationship between teacher and students to one where both have responsibility for learning. Carl Roger's (1983) work was important in providing me with a framework through which to value the contributions of students and it enabled me to recognise my development as a 'humanistically orientated teacher'. This allowed the 'facilitation' of learning to become a priority within my teaching, i.e. a consideration of the process rather than merely the end result. The relationship between teacher and student becomes more of a partnership with recognition that both learn from each other. This notion of 'student centred' learning recognises that students are capable of planning, implementing and evaluating their own learning. This is an important skill for student nurses to learn, as they will be eventually responsible for planning, implementing and evaluating care. Heron's work on the conscious use of the self enabled me to develop interpersonal skills, which were an asset to me both clinically (in nurse patient interactions) and in classroom situations developing experiential learning activities.

Throughout my teaching career I have had a tendency to gravitate towards the 'why not?' questions and been willing to take risks in developing learning activities which would prove meaningful as well as memorable to students. For example: I introduced team building exercises early in the curriculum for new student nurses. This had the effect of raising important questions about working as part of a team, something the majority of them would be actually doing, as qualified nurses. Equally, it assisted them in their new role of "student" by helping them to get along with others in their group. I have been attempting throughout my teaching career to allow students to think more creatively about the tasks that nurses do, moving away from stereotypical images to the actual reality of the job.

This practical slant and urge to make learning meaningful is I am sure about nursing being a practice-based profession. Nurses do things to and with patients and their family, so the application of theory to practice has always been a high priority of mine. It is a driving force and a personal philosophy that learning should serve to enhance the care that patients receive.

I have also been lucky to work with a variety of colleagues and peers who acted as supporters or mentors. My involvement with qualified nurses, who were studying again after a long absence, enabled me to practice my facilitation skills. They were highly motivated yet anxious and uncertain as to whether they could cope academically. I was able to reflect on my own journey along the path of lifelong learning, looking for similarities with them. Learning to reflect has proved to be a very useful skill, which has

helped me to grow both personally and professionally (Schön, 1983, 1987; Gibbs, 1988; Johns, 1995). The use of 'reflection' has been a significant part of this study, and this will be explored in more detail in Chapter three.

I find interactions with students highly satisfying and aim to stimulate in them a questioning approach to the subject. Practising nursing is about 'valuing' people, treating them as individuals and helping them to achieve their potential. I believe the same qualities are required in teachers and that having those qualities assists students and teachers to learn from each other and hence make the most of all learning encounters. I also believe that learning should be fun for all those involved and that it is a lifelong task. These beliefs affect how I teach, both in the choice of methods and approaches used and how I behave in the learning environment, whether as a teacher or as a student.

My past and present experiences in nurse education and clinical settings are continuously shaping the way I interact with the world of nursing. Such beliefs also affect me as a researcher. The choice to undertake action research was most definitely influenced because it is a method, which blurs the boundaries between researchers and researched, with collaboration and co-operation as key themes (Waterman, 1995a). It is also primarily about:

> *"doing, and is an approach which has the potential to generate knowledge about, and promote change in nursing practice and service delivery"*
>
> (Mathieson 1995, p3).

Furthermore, Titchen (1997) makes the claim that action research should help nurses to empower themselves, and that it is part of the professional role of nurses to research one's own practice. Although practising predominantly as a nurse teacher, I continue to practise as a nurse with specific practice hours set aside thus; I also have a responsibility to enhance my practice as a nurse and a nurse teacher.

2.3 Paradigms of Research

This section discusses my understanding of the research process, and attempts to explain the methodological reasoning for choosing action research for this study.

Thomas Kuhn, first mooted the term paradigm, in 1970. He suggested that paradigms might be loosely described as schools of thought, which determine beliefs, values and how questions should be answered. He identified that one paradigm is essentially dominant in any era. He used the term "scientific revolution" to describe when the dominant paradigm in science is replaced by a new science which then itself becomes dominant until it is challenged. The dominant paradigm in the natural sciences for a long time was based on a positivist quantitative philosophy, which states the existence of an objective reality, which human beings can discover once they set aside their personal biases.

Science in this traditional form has been concerned with defining knowledge, which can be objectively and independently verified, through a systematic process known as the "scientific method". This method is sometimes referred to as "logical positivism", it seeks to measure (quantify), analyse and replicate findings. Philosophers such as Descartes viewed human beings as existing in a world of objects; there was a belief in a mind-body

split sometimes known as subjective-objective dualism (Koch, 1999). The underlying belief systems of those who carry out positivist research suggest that all entities can be explained by cause and effect, and context free generalisations are possible. The process is intended to be reliable, valid and rigorous (Streubert & Carpenter, 1999). This positivist approach to research has been very successful hence its popularity. Within health care systems (particularly bio-medicine) in the western world it has been, and still is, considered the "gold standard", for example: the use of randomised controlled trials (RCT) used in medical/drug research projects. However, difficulties in measuring or explaining some phenomena particularly those involving human behaviour, have led scientists to look for other ways to approach their studies (Streubert & Carpenter, 1999, Robson 2002).

Philosophers and social scientists have led the way to explore alternative views of science in thinking about and conducting research. Loosely grouped under the term interpretive or qualitative these differing ways suggest that human beings can never be completely objective and that new knowledge is subjectively constructed. Such subjectivity is acknowledged and valued as part of, rather than apart from, the scientific inquiry. Systematic and rigorous methods still need to be employed in order that such studies can be accepted as "scientific" data (Wilson & Butterworth, 1998). According to Streubert & Carpenter, (1999):

"Research must be based on a philosophical commitment to discover knowledge using the means that most appropriately explains the phenomena of interest" (p13).

Robson (2002) indicates that doing research on human beings requires the researcher to

explore the meanings, ideas, and motivations behind the behaviours of the research participants. He also states quite rightly in my opinion that

> *"Different approaches are alternative ways of looking at the world and should be simply described, rather than evaluated in terms of their predictive power, explanatory value or truth value"* (p.25).

This approach also known as relativist recognises that reality is represented through the eyes of the participants. The morals and beliefs of the researcher influence the choice of theoretical frameworks and the role of language is stressed because it is the central instrument in which the researcher represents the world of the participants. Researchers working within a relativist framework are also required to explore the context in which experiences and subsequent behaviours of the participants are rooted.

Constructivism is another term used to describe the qualitative research paradigm, this label is useful in that it serves to identify one of the "basic tenets of the approach" (Robson, 2002, p27), which is that reality is socially constructed. Constructivist researchers try to construct the reality of their participants and use such methods as interviewing, and observation to allow them to develop multiple perspectives. With such multiple perspectives the researcher needs to have a flexible research design as Anastas & Macdonald (1994) so eloquently noted:

> *"Flexible qualitative methods have traditionally included the researcher and the relationship with the researched within the boundary of what is examined."* (p.60)

Also;

> *"Because all methods of study can produce only approximations of reality and*

incomplete understanding of the phenomena of interest as they exist in the real world, the findings of flexible method research can be seen as no more or less legitimate than those of any other type of study" (ibid).

Koch (1999) indicated that researchers must identify their philosophical position on inquiry in order to help us to understand the research process. The ontological position we hold helps us to understand what happens when we research and how we collect and make sense of data (including what analytical frameworks we might use in the analysis of data). My ontological view has been inadvertently clarified by carrying out evaluation work within health care using the framework of fourth generation evaluation identified by Guba & Lincoln (1989). They argue that reality is a social construction of the mind, and that it exists in multiple forms. The best one can hope for is to report the findings of an investigation as the results of interactions between researcher and participant. They have identified a:

> *"resonance between an inquiry paradigm that proposes a hermeneutic/dialectic methodology and an evaluation model that depends exactly on such a process to substantiate its claim of responsiveness"* (p44).

Hermeneutics according to Robson (2003) is the *"art and science of interpretation"* (p196). Its early use was by theologians who were attempting to interpret the bible; they needed to consider the meaning of the written word and its context. Robson further asserts that as all social science needs to be interpreted, hermeneutics can offer some guidelines. Thompson

(2000) however moots a wider definition suggesting hermeneutics is a "*science of the person*" (p51) focusing on the experiences of people and the experiential dimension. This study was about the learning experiences of the participants, (me included) and how those experiences affected the practice of nursing. However, it has not been specifically labelled as a hermeneutic study, rather as in Robson's view as guidelines for interpretation.

Within nursing, many writers have identified the need for good quality research projects, the primary goal being to improve the care that patients and their families receive (Briggs, 1972; Getcliffe, 1993; Parahoo, 1997). As nursing is essentially an activity involving human subjectivity and interpretation, it makes sense therefore to utilise a research paradigm that embraces this. The dominant philosophy within current nursing practice embraces a holistic, humanistic, patient centred approach to care (Streubert & Carpenter, 1999). Nurses are encouraged to be non-judgemental and to put aside their personal prejudices in order not to influence their professional judgement. Equally, they are expected to respect and promote their clients' rights. Koch (1999) states that asking interpretive questions in nursing can assist the researcher to make sense of what is happening and that this aids reflection.

Interpretive qualitative research methods have a focus on the experiences and behaviour of people. This perspective is informed by a concern to understand the world at a level of subjective experience from the frame of reference of the participant rather than that of the observer (Rodwell, 1998). Data collection occurs in the natural environment of the participants, recognising the importance of how culture and social factors might influence

the research process (Parahoo, 1997). Of equal importance is the way that interpretive approaches to research values the respondents' views and seeks to understand their 'world view'. It was therefore highly appropriate to use this paradigm in this particular study, which required participants to share their beliefs, values, and experiences of their educational process at CHE.

According to Denzin & Lincoln (1994), qualitative research offers the opportunity to focus on finding answers to questions that centre on social experience, how it is created and how it gives meaning to human life. Learning how to care for people is a social experience, creating changes which improve practice has also proved to enable practitioners to reflect on their own, and the practice of others (Kenny, 2001). Rolfe (1993) indicates that as nursing is essentially a practice-based discipline the purpose of nursing research should be to develop nursing practice. Robson (2002) identifies that professionals working with people in any capacity are likely to have a set of skills which are important when carrying out research. These skills include having an

> *"open and inquiring mind, being a good listener, general sensitivity and responsiveness to contradictory evidence."* (p168).

Robson also comments that professionals working as insiders have much to contribute as researchers. Nursing writers such as Field & Morse (1985) would argue that nursing research should contribute to nursing knowledge. I would suggest that research in health care per se, should contribute to theory **and** practice. One way of doing this is to use action research.

2.4 Action Research

There are many different definitions of action research, this section aims to provide a critique of this method and locates this evaluation study within an action research framework. Kurt Lewin is credited with the early use of the term action research in the mid 1940's. There was a growing belief that positivism with its reductionist, depersonalised approaches was failing to provide adequate answers to social and scientific questions. Lewin (1946) believed strongly that by participating in action research participants would learn about themselves as well as their practice. Action research has been used successfully within organizations and industry to promote organizational development (Peters & Waterman, 1982; Argyris, et al., 1985). It has also been extensively used in educational settings where early action research projects were carried out by external researchers (Robson, 2002).

Action research has been defined as:

> *" .. a systematic investigation which aims to contribute to knowledge as well as solve a practical problem"*
>
> (Ovretveit, 1998; p.14).

Kelly & Simpson (2001) noted that action research can produce insights into *'previously taken for granted situations'* (p 655) and that individual and organizational goals can be achieved in ways that are more beneficial. Carr and Kemmis (1986) suggested

> *"Action research is a form of self-reflective enquiry undertaken by participants (teachers, students or principals, for example) in social (including*

educational) situations in order to improve the rationality and justice of a) their own social or educational practices, b) their understanding of these practices, and c) the situations (and institutions) in which these practices are carried out." (p162).

Bell (1999) identified action research as an approach which educators have found particularly useful because of its practical problem solving emphasis. Whilst Frost (2002) states action research is

> *"..a process of systematic reflection, enquiry and action carried out by individuals about their own professional practice"* (p 25).

The shortest definition I encountered was by John Elliott (1991) whose work at the Centre for Applied Research in Education, at the University of East Anglia is considered to have been highly influential in the action research field in education (Altrichter et al., 2003). He suggested:

> *"action research is the study of a social situation with a view to improving the quality of action within it"*
>
> (Elliott, 1991 p 69).

Finally, Costello (2003) identified action research as a flexible spiral process, which is cyclical. On closely examining these definitions, it can be seen that action research is referred to in many different ways; as a process, a method of enquiry, and cyclical. Several authors refer to it as having a problem solving or practical emphasis, and it is carried out by

professionals and educators with an aim to improve practice. Costello (2003) reminds us it is:

> *"Undertaken to understand, evaluate and change."* (p5).

In this way action research may be seen as similar to formative evaluation (which is discussed in the next chapter) in that it is concerned with change.

Action research draws upon reasoning and "praxis" (doing) by allowing individuals to question whether a course of action should be encouraged, rather than simply whether or not it will be effective (Kelly & Simpson, 2001). It is an approach that has become increasingly popular in the professions of education, health, and social care (Grbich, 1999). Within the discipline of nursing, action research projects have included studies helping nurses to be more effective in their roles (Titchen & Binnie 1993). A more recent study explored the notion of *"Idealism in palliative nursing care"*, using action research (Taylor et al., 2002).

In action research, the role of the researcher is different to that of other types of research because there is an attempt to empower subjects of the research to bring about change (Karim, 2001). Waterman (1995b) suggested that adopting action research as a method means that research findings are more likely to be incorporated into practice. This supports my intentions in trying to implement changes within palliative care practice through education. In addition, Grbich (1999) stated:

> *"Evaluation is now an intrinsic part of action research, while action research*

approaches (involving interventions for change) are seen as a desirable outcome of evaluation" (p 193).

Waterman et al., (2001) in an overview of health care action research projects aimed to provide a definition of action research and possible guidance for future action research studies. The lengthy definition they provided acknowledges the complexity of the term in both how it has been used, and the process of doing it.

"Action research is a period of inquiry, which describes, interprets and explains social situations while executing a change intervention aimed at improvement and involvement. It is problem-focused, context specific and future orientated. Action research is a group activity with an explicit critical value basis and is founded on a partnership between action researchers and participants, all of whom are involved in the change process. The participatory process is educative and empowering, involving a dynamic approach in which problem identification, planning, action and evaluation are interlinked. Knowledge may be advanced through reflection and research, and qualitative and quantitative research methods may be employed to collect data. Different types of knowledge may be produced by action research including practical and propositional. Theory may be generated and refined, and its general application explored through the cycles of the action research process (p11).

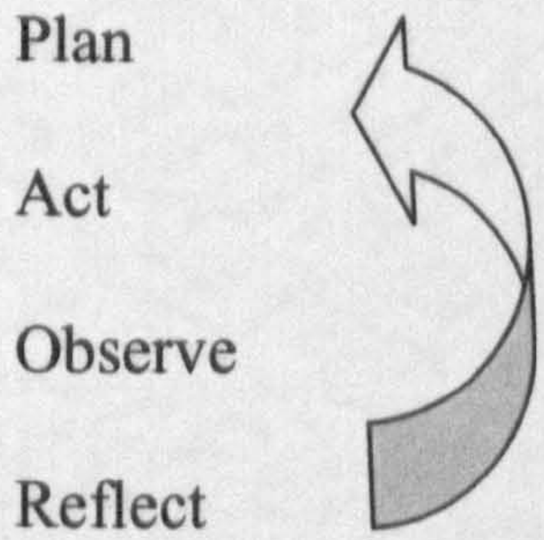
This protracted definition fits the purposes of this study, the 'social situation' (CHE), the 'change intervention' (palliative care education - the course) aimed at improvement (care of patients). It recognises the importance of reflection as a way of improving knowledge as

well as being 'involved' as empowering. Theory may be generated or refined thus in this study adding to the 'knowledge' about the effectiveness or otherwise of palliative care education.

2.41 Models of Action Research

On reviewing the literature concerning action research there are several diagrammatic representations of action research models. The following model in figure 2 is based on Lewin's work (1946) and is illustrated here because it is one of the most simple. It involves deciding on a focus for the research, planning to implement the activity, doing it (acting), observing any outcomes, reflecting on what happens, and then planning future actions.

Figure 2 A Basic Action Research Model : (after Lewin 1946)



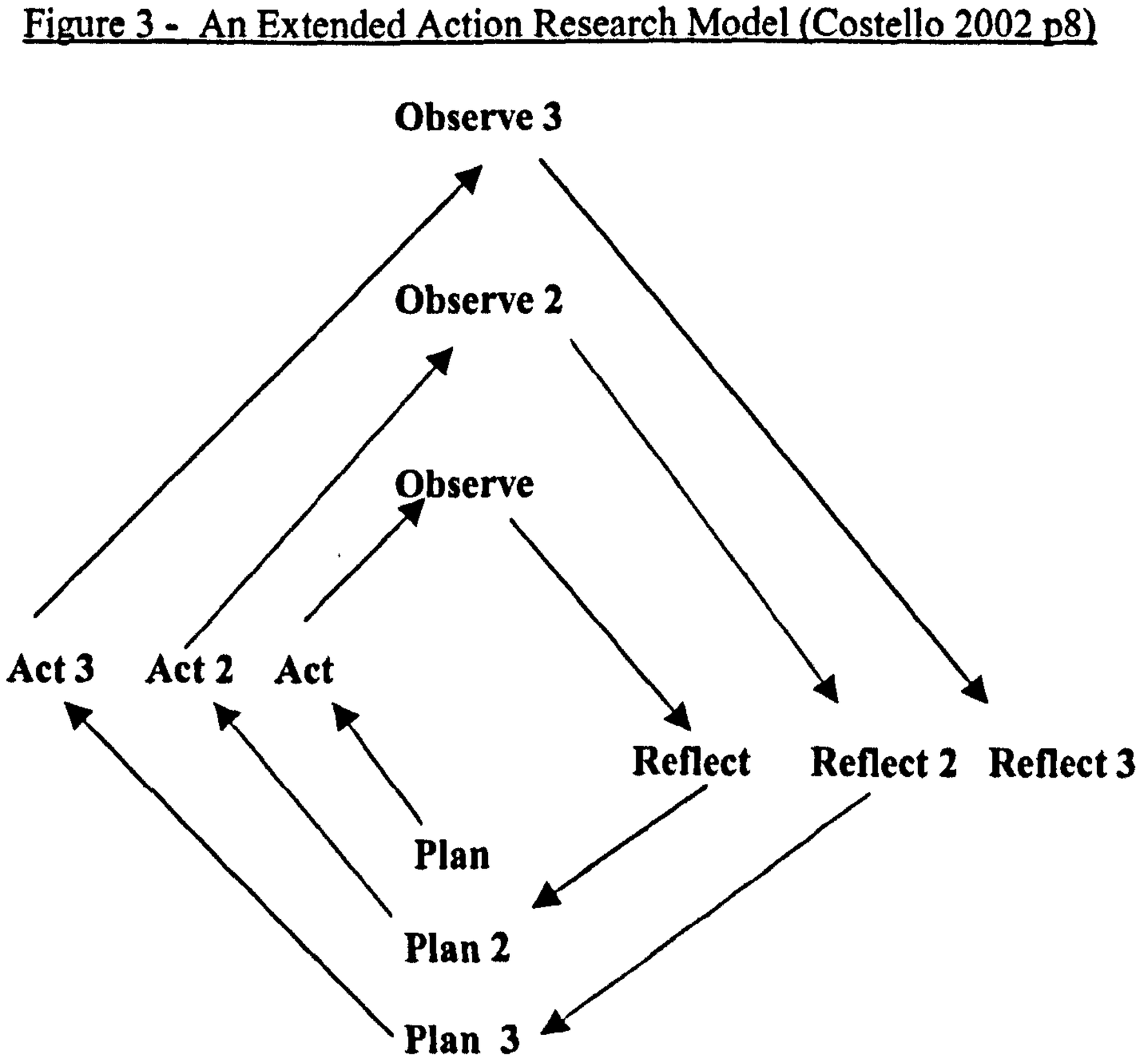
Costello (2002) offers an extended action research model, which I believe demonstrates the cyclical nature of the process and is similar to the model used in this study, it is illustrated in figure 3 overleaf. In this study, the students involved in the educational process were planning for their practice placements using a learning contract see appendix 11 (PLAN), they then went to the clinical placement(s) (ACT) and observed practice, (OBSERVE) in the classroom they then used reflection facilitated by me (REFLECT). This led directly to

them considering their future practice and engaging in thinking about what they wished to change or develop further, leading to another cycle.

In addition I as the researcher was also involved in this cycle, planning the design of the study, (Plan) when to collect information (Act) and observing when and how the student's behaviour changed, I then reflected on this and this led to further action for example checking out my findings with students.

Some authors (Winter & Munn-Giddings, 2001; Williamson & Prosser 2002) refer to this cyclical nature of action research as a spiral framework, whilst recognising it should not be a rigid framework but it should be flexibly applied. Winter & Munn-Giddings (2001) also emphasise that action research is about critical personal reflection.

Figure 3 - An Extended Action Research Model (Costello 2002 p8)



2.42 An Action Research Framework for this Study

The choice of what kind of action to be taken in an action research project depends on the way participants 'read' or 'judge' the context in which it operates. As a teacher and researcher, I read the learning environment as a social arena that students come to in order to learn useful things that they can apply in their work with patients and families. I also view education as emancipatory, in that it helps provide students with the reasons why things happen or need to change. Dewey (1933), Winter (1989) and Elliott (1991) are all proponents of the notion of 'practitioner research' in education i.e. using reflection to investigate their actions as teacher / researchers. Practitioner research is also an important concept in nursing with practitioners being increasingly expected to reflect on their practice. John's (1996) has indicated the importance of nurses reflecting on practice in order for them to develop their practice. Waterman et al., (2001) suggested that action research has the potential to be useful in developing innovation, improving health care and developing knowledge and understanding in practitioners as well as involvement in users and staff.

Action research has the potential to close the 'theory practice gap', with the collaboration of researcher and practitioners being paramount to its success (Parahoo, 1997). Hart & Bond (1995) identify the strengths of action research as being educative, involving individuals as part of social groups, problem focused, context specific and future orientated. In addition, they recognise the importance of the cyclical process of action research which links research with action and evaluation*. This perspective was very important in this evaluation study; the aim of any education is about change. Within nurse education, such changes may be related to knowledge, skills and attitude. The education at CHE is related to all three

* My emphasis

aspects, improving knowledge whilst increasing skill development and encouraging appropriate (positive) attitudes to palliative care.

Noffke & Brennan (1997) identified the way action research has developed historically and politically. They noted some tensions between projects which have a primary focus of social justice/emancipation, and those with interests in professional growth and development. In taking the latter focus and applying it to this study, the focus would be personal (me as the teacher/researcher) looking for changes which are within my control to affect; within the classroom setting. This somewhat restricted view would certainly constitute action research i.e. a study of my teaching and looking for ways to improve the practice of teaching. However, the aims of this project were to consider the affect of learning on students' practices and to verify whether CHE could be considered as providing 'effective education'. Therefore, although any changes (the students made) may be seen from the students' viewpoint as personal and professional, from my stance as a researcher the project would be viewed more broadly as emancipatory. I would however suggest that this project could be considered as both emancipatory and professional development action research (Kember et al., 2001).

As the debate so far has considered my stance as a researcher it is equally important to consider how and where the participants of this study fit in relation to action research. In reviewing the literature, there are agreements and disagreements about the nature of action research (Costello, 2003). Denscombe (1998) makes the point that practitioners are the crucial people in the research process and have an active role. However, Dick (2000) rejects the view that action research should be participative, and he states it is more about

the cyclical nature of the process with action and research being its "*defining characteristics*".

The role of students in making changes to their practice as a result of learning could also be linked to the notion of action learning as described by Revens (1993). He suggested that there is no learning without action and no action without learning; and reported ways of enhancing learning through working in 'action learning groups' to facilitate change. To clarify, I was using action research as a systematic investigation in to how the process of action learning worked. The students were partners in this process, I was the driver. We met at various stages of their learning where I was able to collect data for reflection and analysis. These meetings undoubtedly did act as a trigger for students to consider their progress in learning about palliative care, and how that may affect how they practised. I am able to make this statement as a result of the many conversations I had with students over the course of the research period.

However, this study was not just about students it was also concerned with other stakeholders (see table 1 page 3) and the evaluation of whether palliative care education was effective or not was broader than just the views of the major stakeholders (students). I have chosen to use the term 'action research/action learning' because the project was very complex, and contained elements of both action research and action learning. Whilst the methodology of action research as explored in the literature is applicable, it does not truly solely reflect the multifaceted nature of the project.

46 participants in this study were students undertaking a course of education at CHE, (see

page 102 for more information); however there were in addition other stakeholders who were approached for evaluation information. It is fair to say that these 'other stakeholders' (for example trustees) were not participating in action research as described above, but they were receiving evaluation reports from myself which influenced decisions they made about CHE. This point will be returned to further in the final chapter.

Holter & Schwartz-Barcott (1993) identified some fundamental characteristics of action research to differentiate it from other kinds of research, (see table 2 below). These characteristics of action research resonate with the aims and objectives of this study as described earlier (page 2).

Table 2
Fundamental characteristics of action research
(Holter & Schwartz- Barcott, 1993

A search for solutions to practical problems.*
Collaboration between researchers and practitioners.
Implementation of change as part of the research process.
The development of theory using reflection and reflexivity.

*Note nursing researcher's classify problems as practical when they pertain to a particular clinical practice situation or setting.

Within this study the practical problem is:
What constitutes effective palliative care education?

To explain this further:

- Students were looking for solutions to issues they encountered with patients requiring palliative care.
- Managers were looking for educated practitioners who were effective and

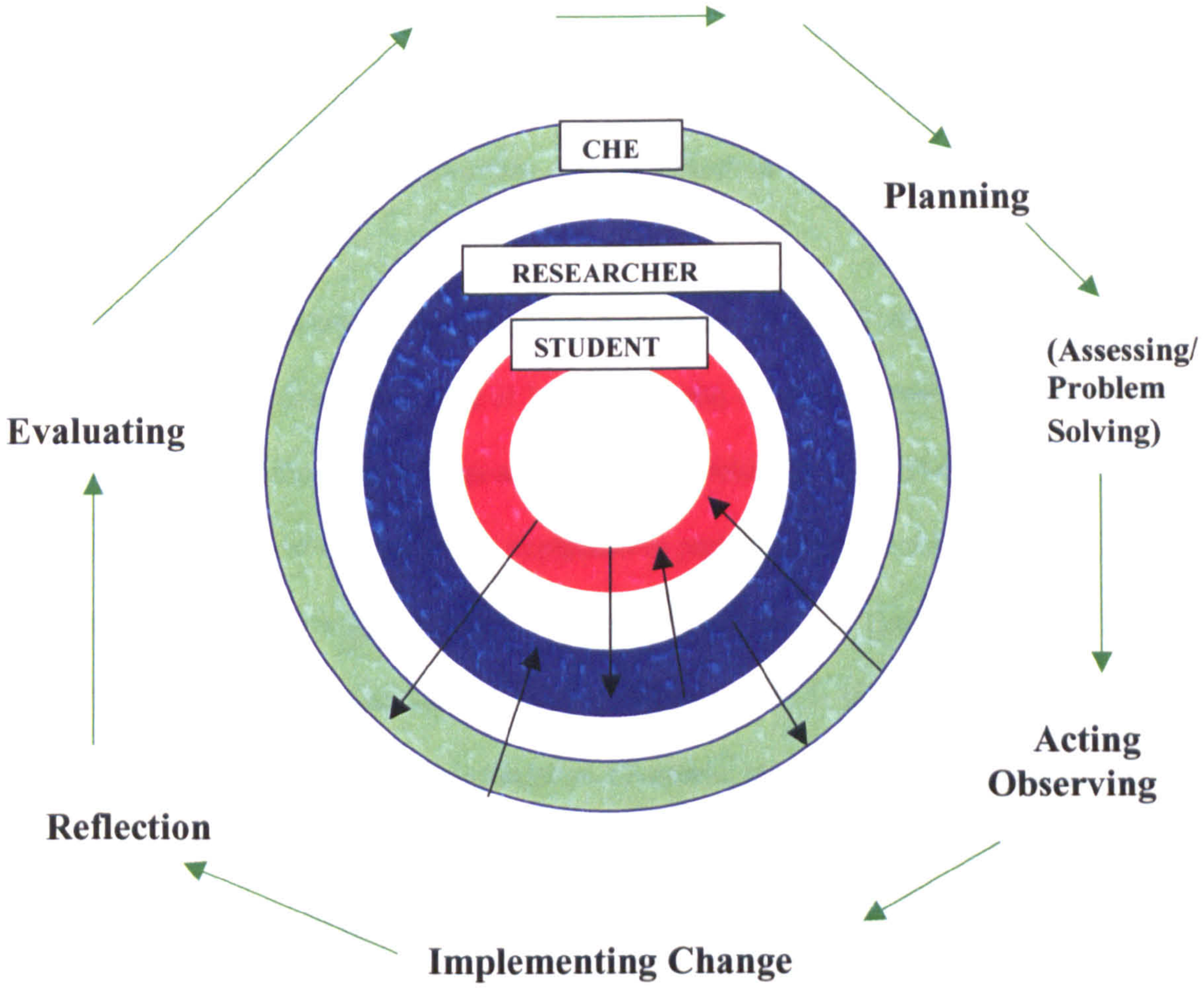
knowledgeable.

- Teachers were looking for students who were able to apply their learning to the practice situation.
- Mentors were looking that students were able to benefit from practice placements and fulfil their learning objectives.
- Trustees were looking for the continuing viability of CHE and that the education offered was able to meet the demands of the market group.

Collaboration between researchers and practitioners occurred when I as the researcher met stakeholders, but equally as the students themselves acted as researchers in developing skills and changes to their practice. The development of theory using reflectivity and reflexivity came about during the data collection and analysis process i.e. collecting evaluation information and making sense of it.

The following diagram (figure 4) is included in an attempt to demonstrate how action research was occurring at both the micro and macro level in this study, i.e. I was doing action research, the students were doing action research and the organisation CHE was part of the action research cycle because evaluation information was provided, which resulted in decisions being made/action taken. The black arrows from the coloured circles in the diagram indicate the flow of information between me (the researcher), the organisation (CHE), and the research participants (students), during the action research cycle.

Figure 4 The Action Research Process in this Evaluation Study



In this study as the evaluator, I used an action research approach to determine whether palliative care education made a difference to practice. In using action research in this way, I was observing change from three perspectives:

1. The students- how they behaved in class, what they said, what they did, data from evaluation activities.

2. The researcher (me) - learning about the various research methods, interpreting results, what data to include and omit.

3. The Organisation (CHE) - How the evaluation study influenced the stakeholders (including the trustees and fund holders) and what effects that had on the organisation itself.

2.5 Ethical Considerations When Using Action Research

In adhering to research governance, ethical approval for this study was required. Approval was granted by the ethics committee at Liverpool John Moores University, permission had been given by the management team and other stakeholders (trustees) at CHE to carry out the study. The nature of the study was explained to participants both verbally and in writing and the participants were given a consent form to complete. The nature of the consent gained from participants was that of process consent which is discussed more fully in chapter three. However, the characteristics of action research itself poses some ethical dilemmas for even the most expert researchers, this section identifies those dilemmas associated with this study and the action taken to ensure participants 'came to no harm'.

Ethics may be seen as the principles of good human behaviour; philosophers have written about ethics in an attempt to guide us in appropriate ways to behave. Conducting research may present ethical dilemmas, therefore the World Medical Association devised a code of conduct for those undertaking biomedical research involving human subjects. It is known as the declaration of Helsinki and was published in 1964, a variety of amendments and updates have been issued since. An early edition of the declaration stated:

"It is unethical to conduct research which is badly planned or poorly executed"

(cited in Greenfield, 2002 p42).

Lathlean (1996) specifically describing action research identified four ethical principles that researchers must consider:

- Respect for participants.
- Prevention of harm.
- Assurance of confidentiality or anonymity.
- Maintenance of privacy.

I shall now identify how those principles were upheld in this study.

2.51 Respect for Participants.

This was demonstrated by my professional manner, in how I liaised with participants, and provided them with information about the study, before, during and after it. It was about ensuring that what I included as data in the study was seen and approved by them, and that such data remained unchanged from the original, i.e. I used their words. It was also about me being seen to 'value' participants and their experiences. This was established by how I presented myself with them in class, particularly when I was involved in asking them to reflect. I tried always to enable them to see something positive in their reflections and to value themselves and their experiences to date.

Respecting and valuing students was also an inherent way in which CHE operated (and is part of the philosophy of the organisation), students were encouraged to be part of the planning process and were encouraged to individualise learning to meet their needs, and thus they were able to customise their practice placements depending on their learning

needs.

2.52 Prevention of harm

It is important that those participating in any research come to no harm, as a consequence of being involved in the study. As the researcher, I needed to consider the potential risks (physical or emotional) that may affect the participants in this study. I believe there were no inherent physical risks. Emotional risks of being involved in the study in my opinion centred mainly on the notion of reflection and reflexive practice and students feeling pressured to make changes to their practice. I was asking students to look at their own practice and rationalise why they did or did not do things, doing this could potentially cause them some conflict. It may also have had the effect of disempowering them and making them temporarily feel 'less skilled'. In order to address this I looked to the supportive mechanisms set up within CHE, for example: students were allocated a personal tutor and a mentor to whom they could take their concerns. Asking students about whether they had clinical supervision systems in process was another strategy which I used; and whether it was useful to discuss issues raised on the course with their clinical supervisor and or manager if they were experiencing difficulties. This had the effect of demonstrably valuing students' contributions but equally of empowering them to take some responsibility for their feelings about practice. The expression of negative comments/emotions by students was certainly something I and the other teaching team members were observing for so that appropriate support could be offered.

According to Kember et al., (2001) the affective dimension of reflective thinking should not

be under estimated. I would suggest that a greater awareness of practice issues is not in itself inherently harmful to practitioners, otherwise the whole notion of 'lifelong learning' is undermined. However, raising issues about practice may be uncomfortable, this always requires sensitive handling.

A further concern was the possibility of the students feeling 'under pressure' to make changes to their practice and perhaps feeling despondent if they were unable to make any such changes. Although I was aware of this as the researcher, the course the students were doing emphasised the need to look at and develop their practice, this was explained to them in the course literature and at interview; so the students were in effect under that pressure anyway. What I did do was to discuss the benefits of education on practice with them and that I was looking for them to disclose any changes at all, and that even what they might consider to be a small change may have a potentially very big impact on patients, families, or colleagues. The students appeared happy with this explanation. On reflection, discussing with students what they saw as minor or inconsequential changes proved to be empowering for them as they began to value their skills and abilities. It also served to 'lighten the load' (of the course) as they began to see that several small changes often had a ripple effect and they were able to begin to develop both their own practice and act as a role model to others which frequently caused further changes.

2.53 Assurance of confidentiality or anonymity & respect for privacy.

The student participants in this study gave their consent in writing to take part in this study (see appendix 5). Other stakeholders i.e. the management team and trustees gave

permission for CHE to be identified as the organisation involved in the study. An ethical dilemma occurs in the presentation of data, in ensuring that participants' confidentiality is not breached. This includes the original thesis and any publications, and papers given at conferences. I gave the students numbers when they were completing the pre and post questionnaire (although several students were conversely unhappy with this and wanted to put their names on them!) I ensured that data collected was securely held i.e. not left lying about and any tape recordings I made in the early part of the study were for my hearing only. Data was discussed with the teaching team and my supervisory team as part of the research process (and participants were aware of this), however actual student names were not disclosed.

Williamson & Prosser (2002) have indicated that giving consent to participate in action research is problematic in itself because participants do not always have a realistic understanding of what it is they are consenting to! Project aims and goals may be unclear and indeed change as the project moves forward. This was perhaps not quite so relevant in this study because participants were explicitly being asked to look at their practice, so they did know what the goals were, what was perhaps less obvious to them was how looking at their practice might cause them to feel initially less skilled and effective. The nature of action research being participatory can be a strength in changing behaviour (and practice) but may be an ethical weakness (*ibid*).

Mason (1996) indicates that qualitative researchers grapple with many issues relating to the data that they collect, and that they have to think in complex and sophisticated ways about

handling the issues of confidentiality and privacy. One of my concerns was that in publishing data I wished to identify the students' setting in which they worked. It would not take too much detective work by people who had access to the thesis to make an accurate guess as to whom some of the participants were. This concerned me a great deal, and was the subject of many a discussion with my supervisor. I grappled with the benefits of disclosing the work setting or not; and decided from the data collected that it did often have an impact on the things students said and did. I never fully resolved the issue, but did show those participants (who I felt could be more easily identified) the specific information I wished to include (particularly the case studies) and verbally sought their permission to do so. On reflection, I could also have asked for this permission in writing and would do so in similar future circumstances. I also told them where a copy of the thesis would be held locally and that if at any time in the future they wished me to remove data pertaining to them I would do so. Seymour (2001) refers to parallel ethical dilemmas in her study of death and dying in intensive care. She was concerned about other people identifying both the places (intensive care units) and the people (staff) involved in her study. She posits a theory that the research community should

> *"agree not to attempt, or encourage, detective work of this kind."* (p32).

Whilst I concur with her sentiments, I am not sure that inexperienced researchers would necessarily understand the ethical issues involved in them exploring who the participants were; and I think the main responsibility remains with the researcher in maintaining confidentiality and privacy. This does however continue to present some challenges as outlined above.

Williamson & Prosser (2002) offer a potential solution to some of the ethical dilemmas of action research suggesting that trying to meet ethical codes in carrying out action research is neither practical nor philosophically reliable. Instead, they offer the idea of

> *'professional morality in nursing, and the idea of transparency through external scrutiny'* (p45)

Professional morality in nursing means adhering to professional behaviour and research governance and codes of practice. Transparency involves being open and honest about what is happening and being subject to external scrutiny. In this study I was subject to external scrutiny by my research supervisors, in addition evaluation feedback information was available in stakeholder meetings; some evaluation comments were also available on the CHE website. I was also subject to external scrutiny by my peers when I engaged with the research community via conference presentations and journal publications.

Other ethical issues, particularly relating to me as a researcher are discussed in later parts of this thesis. The next section discusses evaluation as a concept and how the theory of evaluation influences how it is practised. This evaluation study used an action research approach which was collaborative and involved learning, this links well with the cyclical nature of evaluation; which itself involves learning and action.

2.6 Evaluation the Development of Theory and Practice

Previous sections have considered the rationale for this study and the research perspective taken. This section highlights the development of evaluation theory and practice with

particular reference to health care and education. A review of the literature both nationally and internationally will demonstrate how the practice of evaluation has been influenced by the need to provide 'purposeful', more 'user friendly' evaluation reports (Patton, 1981, 1982, 1990, 1997; Hawe et al., 1990). The notion of *'evaluation research'* is explored from Robson's (1993) claim that evaluations are:

> *"essentially indistinguishable from other research in terms of design, data collection techniques and methods of analysis"* (p174).

Consequently, purposeful ***evaluation research*** may provide a systematic framework, which aims to contribute to knowledge and allow practitioners to make changes to their practice (Ovretveit, 1998). This concept is ideal for this ***practice-focused*** study in palliative care education, which aims to contribute to the evidence base of palliative care theory and practice. To avoid confusion from now on this work will be referred to as an **evaluation study**, which has taken the stance of providing a high quality evaluation using my research skills in the design, analysis and recommendations.

2.61 Defining Evaluation

Evaluation is the term used to describe a process that involves making judgements of worth (Long & Wilkinson, 1984). Rossi et al., (1999) identify the term in its broadest sense as being concerned with placing a value on events, things, processes, and people. Evaluation uses tools derived from the social sciences to systematically investigate the effectiveness of programmes (ibid). Within the discipline of health, evaluation enables practitioners to

judge the merits of a programme or service against a standard or baseline of acceptability (Suchman, 1967). Shaw (1993) identifies higher public expectations as one of the driving forces to introduce quality assurance, audit and evaluation into health care. The ever expanding costs of providing health care require practitioners to provide evidence of efficiency, effectiveness and value for money. Unfortunately as a result evaluation has sometimes been viewed negatively, as a costly process which takes a great deal of time and energy and frequently results in the loss of, or rationalisation of services (Springett, et al., 1995, WHO, 2001).

Historically, evaluation has tended to concentrate on simply making judgements of worth through measurement, for example: how far targets have been achieved. This preoccupation with measurement was evident when various attributes of school children were first measured in the early 1930's including IQ testing, to tests that measure actual performance against set criteria (Guba & Lincoln, 1989). This obsession with evaluation as measuring continues today, as the results of such tests are used to 'rank' individual schools and higher education providers for effectiveness. The publication of these league tables subsequently affects student numbers and ultimately funding, within education. Interestingly, within the field of health care, league tables of hospitals and health care providers are now being published; with criteria such as waiting times for appointments to see a consultant, hospital admissions, and numbers of operations performed by speciality, being listed. This is ostensibly part of the effectiveness debate i.e. what is effective health care? What is effective education? A wealth of information exists within the health promotion literature about measuring the effectiveness of health promotion programmes

and services, (Kemm & Close, 1995; Baric, 1996; Ovretveit, 1998, 2001). However, as Rootman et al., (2001) note:

> *"There is a danger that, if measurement dictates the aims of an initiative, only quantifiable objectives will be pursued"* (p28).

Twycross (2001) acknowledges that evaluation of palliative care is fraught with difficulties due to the nature of palliative care itself, he identifies:

> *"the bureaucratically unsatisfactory conclusion that all that can be measured is not relevant and much that is relevant is not measurable"*
>
> (Foreword in Abu-saad, 2001).

Early evaluation studies were concerned with measuring (as described above) Guba & Lincoln (1989) called this 'first generation evaluation'. The philosophical underpinnings of this approach to evaluation can be traced to the scientific paradigm based on 'objective' (and outcome driven) knowledge, derived from a systematic process 'the scientific method,' also known as logical positivism. The problem with this approach is that it rests heavily on formal quantifiable data generated by hypothesis testing, variable control and statistical analysis. This positivist paradigm suggests that what cannot be measured does not exist, data must be value free and strict controls put in place so that results can be generalisable, thus ensuring rigor and reliability. This approach fails to take account of the context and process of evaluation; it suggests that evaluators merely report what they find (the facts) without interpretation. It fails to answer the "why" questions. Guba & Lincoln (1989) have suggested that to treat evaluation scientifically is to:

".. miss completely its fundamentally social, political, and value orientated character" (p7).

On finding limitations in using pure measurement approaches to evaluation, evaluators began to try to add descriptive statements to the evaluation process. These descriptive statements were used to determine how far certain objectives had been achieved. Guba & Lincoln (1989) define this objective orientated approach as *"second generation evaluation"*. This kind of evaluation was about more than just evaluating people; it allowed other aspects of programmes to be evaluated; including such things as methods of teaching, materials used and the organisation of programmes. *"Third generation evaluation" (ibid)* was to then make judgements about the evaluation. The inherent problem with this was who was to be the judge? Against what standards? Moreover, how could those standards be value free?

It is worth noting here that even the most effectively conceived objective or standard (to be measured) is not value free. Evaluation can be very powerful if we pretend it provides "truth" and is the "right thing to do". This way of thinking may also lead to the assumption that the evaluator is not responsible for the findings nor to what uses such findings may be put.

The nature of evaluation can be determined by observing how it is practised. Hawe et al., (1990) note that evaluation involves two different kinds of processes, observing and measuring being one process. The second process involves comparing what you have observed with some form of criterion or standard. This may be set by the evaluator themselves or be against some form of benchmark. (The term benchmarking is used

extensively in management literature and means "best practice"). This in itself is open to question, what best practice is. How do we know? Are we comparing like with like and in what context?

Much of the literature and theories of evaluation were generated in America. People like Ralph Tyler working in the field of management and education was instrumental in recognising that evaluation was a process. Nevertheless, it is Michael Quinn Patton, who has probably had the greatest influence on the practice of evaluation. Patton (1981, 1982, 1990, and 1997) was keen to move the process of evaluation from merely a theoretical exercise to one that is valuable and useful.

> *"The central tenet to professional practice remains - doing evaluations that are useful and actually used"* (Patton, 1997, p. xiv).

He identifies the many purposes of evaluations and the desire to assist in the improvement of whatever is being evaluated (Patton, 1997).

Kazi (2003) uses the term "realist evaluation" to identify an emerging evaluation paradigm first developed by Pawson & Tilley (1997) which seeks to investigate what works best, for whom, and under what circumstances. It also considers the importance of not just the outcomes of the evaluation but also what mechanisms have produced those outcomes. Kazi states:

> *"There are no complete published realist evaluations of human services; and*

to date, no account of dedicated methodologies that can be applied to investigate what works, for whom and in what circumstances"

(Kazi, 2003, p 6).

This new paradigm identifies the need to:

" ...address teacher-learner relationships with practitioners"

(Kazi, 2003, p28),

and also how programmes affect practice. Therefore, this evaluation study would quite naturally begin to fit this emerging paradigm of a realist evaluation, although unintentionally so.

2.7 Evaluation as Research

Robson (1993) suggests that evaluation is *"..a purpose not a strategy"* (p170).

He further stresses the importance of evaluation as "*applied research"* i.e. using tried and tested research methodologies to systematically collect information. In addition, evaluation may be seen as applied research because it attempts to define *"real world problems"* and offer potential solutions (ibid). This latter perspective is important in the growing field of evaluation theory and practice in that it demonstrates a shift in thinking. From that of merely producing an evaluation report; to producing a report which offers suggestions of how to improve a service, or reduce uncertainties. In turn, this broadens the view of evaluation from just meeting someone's objectives to demonstrating wider findings such as the unintended aspects of a programme or initiative (Owen & Rogers, 1999).

Within an action research paradigm, an intervention, its' development and evaluation, can

be seen to be inextricably linked. Meanwhile, Koch (1994) describes the term evaluation research as:

> "*.. investigative activities that employ a problem solving process*" (p1148).

She further asserts that much of these activities have developed uncritically (in health care) as a response to quality assurance procedures. In response to this kind of criticism authors from the discipline of evaluation like Patton (1997) and Ovretveit (1998; 2001), have attempted to look for new ways of carrying out evaluation that are both rigorous and practical.

Ovretveit (1998) uses the term *"evaluation for action"* to discriminate between evaluation, clinical audit and quality assurance. He states that pure and fundamental research is simply about increasing scientific knowledge, whereas evaluation is about making informed practical decisions. There is also a difference in the use of terms within and between countries (ibid) hence causing further confusion. According to Ovretveit, (1998) the essential difference between most types of audit, quality assurance and evaluation is one of *purpose.* Some types of research may be evaluative and some types of evaluation use research methods hence the growing uncertainty surrounding terms.

2.8 Evaluation Practice

Traditionally evaluation has been carried out summatively, i.e. at the end of programmes (Springett et al., 1995). Newer approaches to evaluation (Patton 1997; Ovretveit, 1998,

2001) encompass collaborative working with those involved in the service being evaluated, in order to identify multiple perspectives. This is known as formative evaluation and is a useful method with new and innovative services as it allows adjustments and changes to be made as the need is identified (Owen & Rogers, 1999). Stakeholders are involved in the process of evaluation, so that vested interests and different agendas can be acknowledged. Beattie (1991) identified the concept of *'portfolio evaluation'* where evidence is collected from multiple stakeholders to inform the evaluation process. This is important in that it serves to provide a more balanced view and helps alleviate the problems of bias and serves to demonstrate the trustworthiness of the findings. This approach has subsequently become more common in the discipline of evaluation; and has been adopted within this study. In traditional research projects, triangulating methods of data collection is often used to test the trustworthiness of the data. This means data is collected from different sources and methods, the rigor and validity of the results are demonstrated when similar findings are produced.

Ingleton et al., (1998) identified the difference between summative and formative evaluation as one of purpose. They also identify that formative evaluation pays attention to the social and political contexts of services. Noting that evaluators are actively involved in the design, data collection, and analysis, rather than being 'at a distance'. Moreover, the work of Ingleton et al., (ibid) is set in the field of palliative care thus recognizing the specific contextual nuances of that situation, hence its relevance to this study. The paper, clearly documents the sound reasons for formative evaluation in palliative care. It demonstrates the process of conducting this type of research and describes how illuminative

data using triangulated approaches can be systematically collected. In the evaluation of a new service, (such as palliative care education at CHE) this is just the sort of information required by stakeholders, particularly those with responsibility for ongoing funding.

The nature of evaluation can be determined by observing how it is practised. Guba & Lincoln (1989), describe the evolution of the discipline of evaluation as generative steps forward culminating in what they term *"fourth generation evaluation"*. The aim of fourth generation evaluation is to move towards evaluation strategies where negotiation occurs between those involved. This stance has been adopted for this study because it is collaborative and fits with the emerging paradigm of co-operative experiential inquiry identified by Reason & Rowan (1981). Reason (1988), further explains this new approach to research as:

> *" .. a way of doing research in which all those involved contribute both to the creative thinking that that goes into the enterprise ..... But also contribute to the action which is the subject of the research"* (p.1).

The work of Guba & Lincoln (ibid) is especially relevant because it is from the field of education, thus it is highly applicable to the context of this work.

2.9 The Evaluation Role

Finally, the role of the evaluator is important in any evaluation process. There is much written in the literature about who does the evaluation, (Everitt & Hardiker, 1996; Patton,

1997; Owen & Rogers, 1999). Should it be someone within the organisation or an outsider? There are advantages and disadvantages to both approaches. Insiders (internal evaluators) according to Owen & Rogers (ibid), are less costly, understand the nuances of the organisation and can have a strong credibility with stakeholders thus influencing them to utilise evaluation findings. Limitations include being biased, and working in a public relations mode rather than programme improvement. Conversely, outsiders (external evaluators) commissioned to accomplish evaluation tasks, are often expensive. Owen & Rogers (1999) noted that external evaluations are more likely to be perceived as objective. However, the unethical use of external evaluators to provide evidence that programmes are not working, resulting in the rationalisation and subsequent loss of services, (particularly in health, government and education sectors) has made staff more wary of co-operating with such evaluation activities (Springett et al., 1995, Owen & Rogers, 1999).

Shaw (1999) writes extensively about the notion of practitioner evaluation. His argument is that evaluation has historically been about models and theorists, who when they present their reports to practitioners fail to make a difference to how those practitioners practice. This essentially continues the argument that evaluations should be purposeful and utilization focused, offered by Patton (1997). Shaw (ibid) however, argues further by questioning whether practitioner evaluation is about research and evaluation, carried out by practitioners, as 'participatory research'. Or, whether evaluation by practitioners is about evaluating in-practice using reflective inquiry as a tool. This is where the debate about action research can be revisited; because action research within the discipline of nursing has essentially developed because of the increasing frustrations of practitioners, when

traditional research fails to improve practice (Hart & Bond, 1995). Robson, (2000) adds to this debate by using the term *'practitioner-centred action research'*, which:

> *"puts practitioners in charge of all aspects of the evaluation"* (p21).

Robson also indicates that the role of the evaluator is that of a 'consultant'. The study outlined here fits somewhere between these two approaches; the evaluator was acting as an evaluation consultant for the trustees of CHE. However, the practitioners (the students) were not in charge of all aspects of the evaluation because it was multi-collaborative and therefore other stakeholders were involved. This is further explained in the following section.

2.91 The Role of the Evaluator in this Study

The study reported here uses an insider (me!) as evaluator, some of the reasons for this are explained below. Ingleton et al., (1998) suggest that:

> *"Underpinning formative evaluation is an acceptance that evaluators are part of the social world they are examining"* (p201).

In order to understand the social world of palliative care and palliative care education, I would suggest that an evaluator needs to have a good working knowledge of both fields. A significant part of this study was to assess whether participants have made changes to their practice, influenced by the educational process. As a nurse teacher, I am competent in

evaluating nurses in both formal and informal learning environments, including clinical practice. As part of the study involved self reported claims from the research participants, a working knowledge of nursing practice was necessary to allow the evaluator to ask probing questions and thus verify the validity of answers to questions. An outside evaluator would possibly be unable to do this. In addition, the insider evaluator is able to become part of the "team" within the organisation. This means that there is access to all stakeholders, (not just those funding the venture), this is an essential part of working collaboratively. Ford (1998) identified that a crucial theme of palliative care education is that students are able to explore and discuss their own values, attitudes and beliefs about palliative care. As part of the teaching team, I had access to this information as disclosed by students, which was used as part of the data collection and evaluation process. The analysis of this information is discussed in more detail in chapter four.

Due to the complex nature of this evaluation study, an eclectic approach to evaluation/research was used. There was collaboration between evaluator and stakeholders (including students), the evaluator acted as a 'consultant' as defined by Robson (2000) in some instances helping students facilitate changes to their practice. It is my premise that the students were acting in the role of *"practitioner-centred action research"* as identified by Robson (2000, p21) however they were never *"totally in charge of all aspects of the evaluation"* (ibid) nor was I. Equally, there was much evidence of "*evaluation in- practice"* using reflective inquiry.

2.10. Differentiating between Evaluation, Evaluative Research and Action Research.

This section is included in an attempt to clarify some subtle differences between the above terms, and to demonstrate how I have utilised them in this study.

Research is a systematic and rigorous process involving the study of phenomena, collection and analysis of data and the public reporting of findings. Exposing it to the scrutiny of others allows for replication of the findings as well as verification and possible falsification (Parahoo, 1997). Making public the results of research projects does not necessarily mean they will be utilised, although I concur with Hammersley's (1992) claim that there is little justification for

> *"research especially for publicly funded research that does not make some contribution to the needs of non-researchers".* (p137)

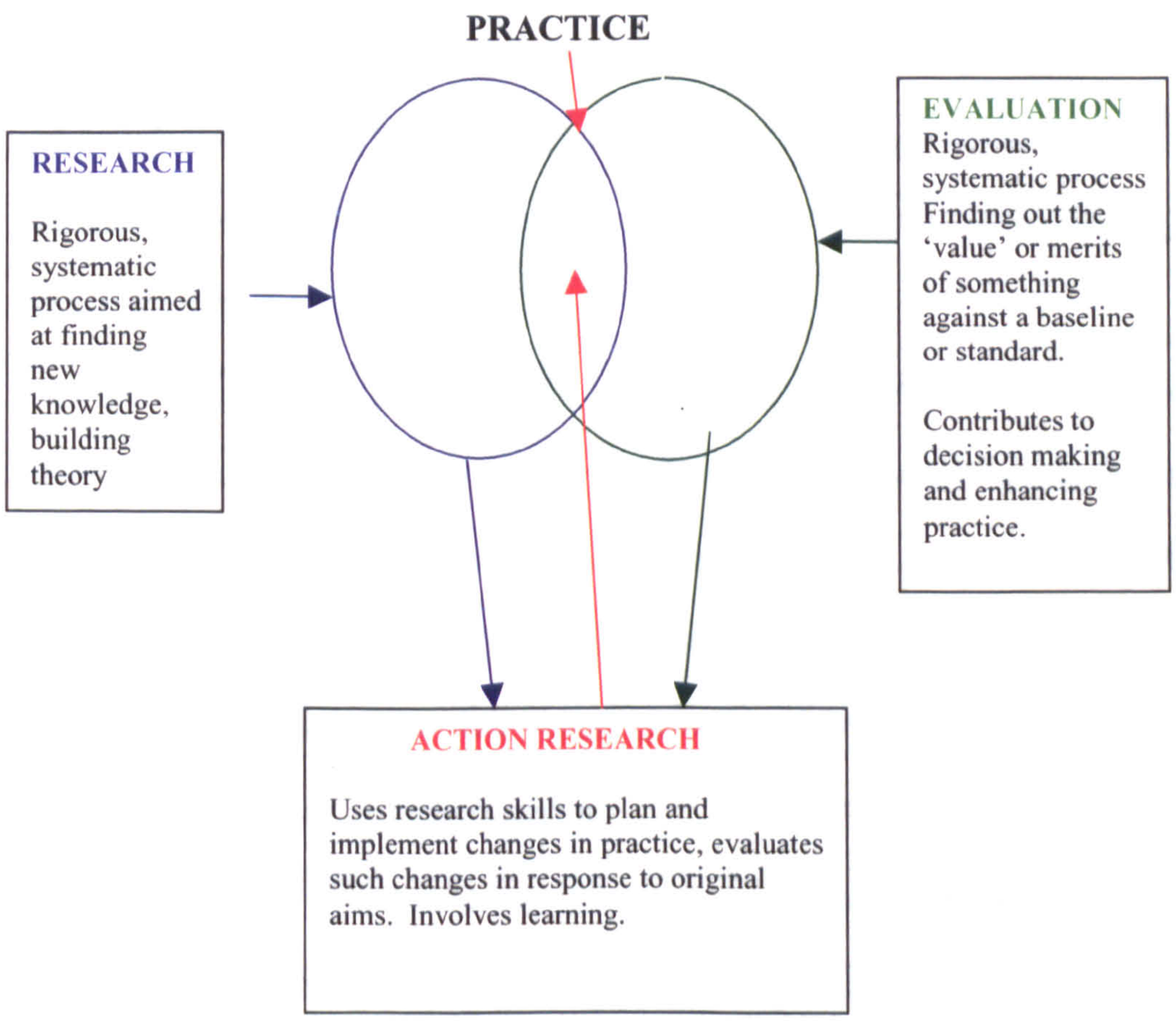
Research has traditionally been about furthering knowledge. Nursing research generally tends to have an 'applied focus' (Bond, 2000) but research per se need not have; since its prime purpose is to add to understanding and knowledge. Equally, early evaluation studies have been about measuring and finding out about programmes or services. The growing demand for evaluation has led to the demand for evaluation reports to be user friendly and utilised to change practice. Changing practice requires that the evidence on which those changes are based needs to be valid and accurate, hence the need to use research tools within the practice of evaluation. Well designed and implemented evaluation studies can reveal not just the effects of programmes or services but also reveal the circumstances in which they are effective and explain why. Bond, (2000) eloquently describes evaluation research as:

> *".... evaluation research straddles the twin ideals of generating knowledge and also informing decisions...."* (p228)

Action research is concerned with using research skills to plan, implement and evaluate change in practice alongside others; hence there is an overlap between the above terms.

The following diagram (figure 5) is an attempt to illustrate these points in this study

Figure 5 – How Research, Evaluation & Action Research Overlap in this Study



Summary

- My beliefs and values are stated, in order to demonstrate my 'world view', and to provide some context to the research. It has been identified how this view closely matches the philosophy of nursing, adult education and qualitative research.
- A critique of action research is presented with a consideration of some of the historical and political influences. The notion of action research resulting in some change to practice is offered as the reason for its use in this study.
- Some ethical challenges regarding the use of action research as a method are considered in particular: ensuring no harm comes to the participants, respecting them and ideas about maintaining confidentiality, anonymity and privacy.
- The introduction of the phrase action research/action learning is explained, as within this study there were elements of both. A diagrammatic model of action learning for this project is included.
- Previous studies within palliative care have recommended formative evaluation as the most appropriate way of evaluating services. The reasons for "insider/internal" evaluation in this particular study are identified. In particular, the need to get 'close' to the research participants, to recognise/verify changes to their practice. It was anticipated that this insider view would provide valuable information as to the effectiveness of palliative care education.
- The similarities and differences between the terms research, evaluative and action research have been discussed, and their use within this study.

CHAPTER THREE

Study Design & Evaluation Framework

3.1 Introduction

Previous chapters have identified the need for this evaluation study and I have attempted to set the study in context within the field of nurse education, palliative care and evaluation. This chapter focuses on the development of the evaluation framework, which enabled decisions to be taken about the evaluation methods and sampling strategy. It mirrored the steps in the research process involving the purposeful planning and design of the study. In designing any research study the most important issue for researchers is that the research strategy and methods used are appropriate to answer the research question (Robson, 1993, 2002; Parahoo, 1997; Streubert & Carpenter, 1999; Grbich, 1999). This statement is also applicable to the design of an evaluation study in that the chosen methods must be appropriate for the evaluation questions asked (Robson, 2000, 2002; Ovretveit, 2001).

3.2 Evaluation Design

The evaluation design was based on the principles of multi-collaborative participative evaluation (Patton, 1997). It was acknowledged when formulating the design that using one single research method to systematically collect data may be limiting, therefore a variety of methods were used. Using a variety of methods known as 'triangulation' also helped to ensure the trustworthiness and rigor of the findings. The emphasis was on

collecting qualitative data, thus collecting evidence of how palliative care education was 'experienced' by students/stakeholders. This demonstrated the importance of the paradigmatic stance taken to the nature of palliative care education, and the philosophy and values of humanistic enquiry (Reason, 1988). I was attempting to 'get under the skin' of the participants and describe their experiences in a meaningful way. At the same time I was looking to whether the participants were making changes to their practice whilst being involved in the educational process (and afterwards, up to the review day of the course).

This study was both inductive looking for themes and patterns to emerge during the data collection process; and deductive at the focus group stage when themes and categories had started to emerge (Biddle, et al., 2001) and therefore it was important that its' design was flexible. Measuring changes in practice was a developmental, iterative process and the methodological tools selected, were chosen to reflect this process. Chapter two has already discussed qualitative and action research, this chapter will consider the actual methods used in more detail. It will describe who the research participants were, how they were selected for this study (including consent,) and how ethical issues relating to confidentiality, and anonymity were achieved. These were important matters to consider as they could have affected the reliability and validity of the participant's responses. Of equal relevance to the discussion within this chapter is the identification of the limitations of this study in order to provide context and clarification for any future work to be undertaken in this area. The evaluation tools selected for each stage of the research study are identified, together with a rationale for their inclusion. For reasons of clarity table 3 page 96, identifies an overview of the research design used in this study.

In my role as evaluator I kept a research diary, containing autobiographical writing about specific events and for ongoing reflection throughout the period of this study. Some extracts from this including information about the content and structure are included in chapter 5 which considers analysis of the data. It was initially used because I had been involved in teaching about reflection and was familiar with using reflection as an aid to learning (Kember et al., 2001). However, it became a very important tool in the research process, at both a macro and micro level. For example: it was used to record specific research activities, such as writing up notes from classroom observations. I also used it reflexively because it allowed me to identify further issues to discuss with the research participants which then stimulated further questions for me about the study (see appendix 7 sample from diary). It became both a record of research activities carried out and an ongoing research tool, which assisted in providing evidence of validity. The last part of this chapter will consider the use of reflection in this way within this study.

Table 3 An Overview of the Research Design of this Study

Method	Pre-course	During the course	Review day Held 3 months after course completion	Post course 6-12 months after review day
One to one interview	X	X		X
Survey	X *(Preview day)*		X	
Observation	X	X (this occurred in any sessions the evaluator was present with students)	X	X
Group interviews		X	X	X
Questions about practice, in all encounters with students but especially after practice placement	X	X	X	X
Focus group Interviews Teachers/mentors July 2001				X
Focus group Interviews Students Sept/Oct 2001				X

In addition, ongoing meetings with other stakeholders such as the management team and trustees of CHE, mentors, clinical managers of participants and other educationalists from other palliative care education provider settings were held. (See table 1 page 3 for stakeholder information)

It was important at these meetings for me to update people on the progress of education at CHE. At these meetings, I was careful to discuss broad issues rather than provide detail

which may have broken confidentiality. Sometimes managers raised issues that participants had already disclosed to them. One particular manager discussed how her member of staff had complained about the long distance she had to travel to her placement. This was about the limited number of placements we were initially able to offer students, plus this student had enrolled late to the course. We had already taken action to identify and educate more mentors so that students could be offered a wider variety of placements by the time this issue was raised in a public meeting.

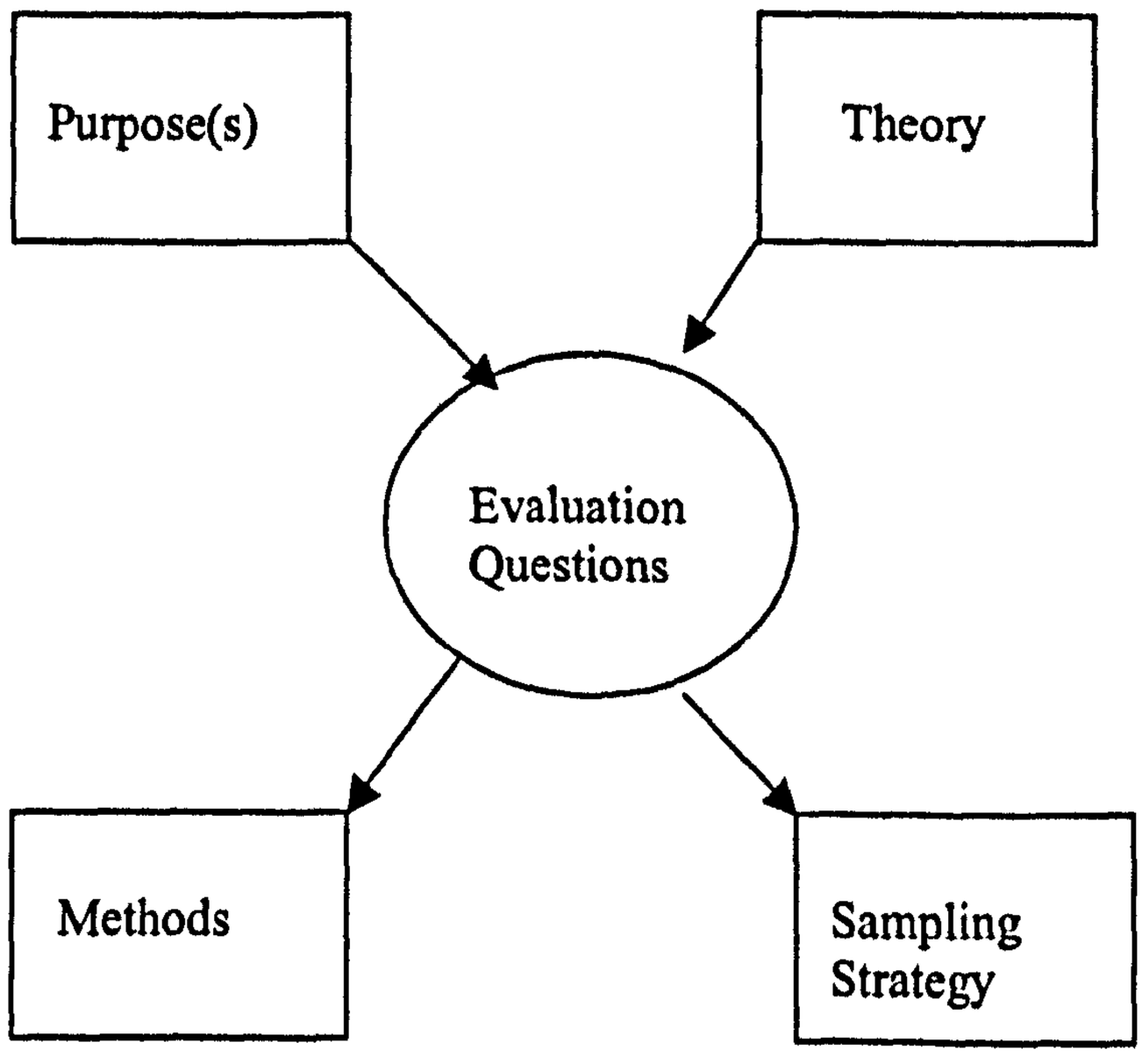
3.3 An Evaluation Framework

Robson (2001) suggested that many of the attempts to display evaluation designs:

> *"bear little resemblance to the complex, messy and interactive nature of what actually goes on"* (p79).

However, he does provide a simple model, which relates to the task of designing an evaluation (see figure 6 below).

Figure 6 Framework for Evaluation Design (Robson 2001, p80)



Whilst this model does not explain the context of the study, the role of stakeholders or what sort of data is collected, it was chosen as a starting point because of its simplicity. Using the model as a template enabled some clarification as to where to start in designing this evaluation. For example: the purpose of the study was to find out whether education in palliative care made a difference to the *practice* of students. This then determined the evaluation questions to be answered, some of which also emerged during the study. Evaluation questions included what knowledge, skills and attitudes students were able to identify pre and post course. Specific questions focusing on practice were asked at the end of the course and following the review day, which was held three months after the course had finished. Those students who were involved in the focus groups were also asked how their practice had been affected immediately following the course of education, and whether any changes had been sustained.

Robson (2001) identified the 'theory' part of the above framework as being able to '*mean many things*' (p80). However, he also stated it is one aspect which may help focus the evaluation by helping the evaluator think of the ideas or hunches behind the programme. In this study, many of the ideas and hunches behind the study were derived from my background in teaching and learning. Some of these ideas related to what might be termed 'good educational practice' for example: treating students as individuals, valuing their contributions, being cognisant of the appropriateness of the learning environment and teaching methods used (Minton, 1997; Reece & Walker, 1997). Others rested more on my experiences as a teacher, trying to challenge students to move away from more traditional ways of learning towards action learning approaches, where the students are responsible for

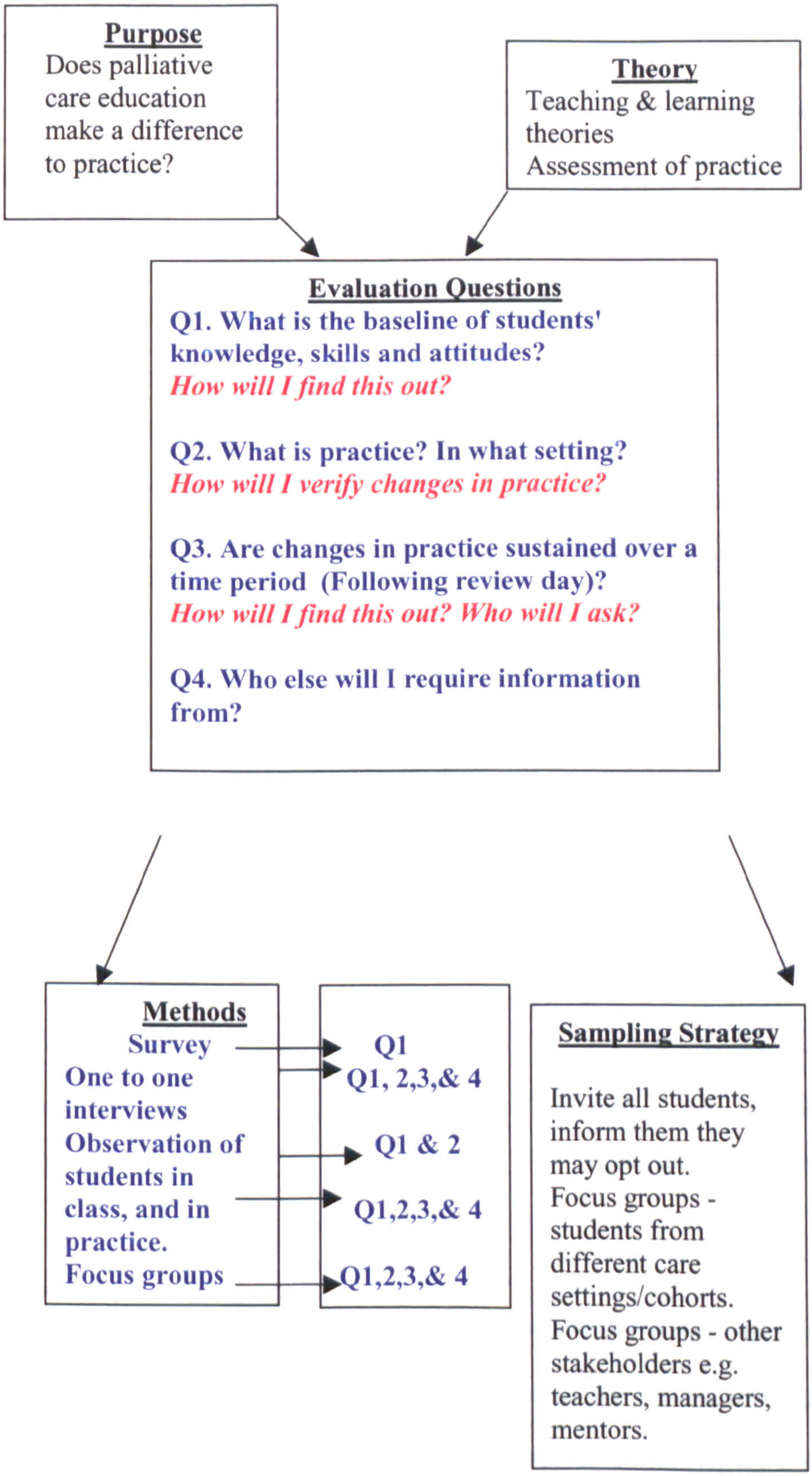
what and how they learn (Kember, 2000; Kember et al., 2001).

The evaluation questions were mainly concerned with practice including how to verify any self-reported changes about their practice, as disclosed by students. Methods of obtaining answers to evaluation questions therefore included one to one interviews with students, group interviews, telephone conversations with managers, mentors and others whom the students had encountered in practice. One limitation of this study is that the views of patients and relatives were not included; and there is certainly a need for further work to be done involving service users, see the final chapter.

When there was actual physical evidence of changes in practice, for example: one student had changed the assessment protocol in relation to oral care; this was seen and then recorded in my field notes. Managers were keen to discuss with the evaluator how the course had affected students; indeed the continuing popularity of the course and demand for places may be seen as further evidence of effectiveness or awareness of the benefits of education in palliative care. For example: one community manager identified a more effective use of 'out of hours services' for patients and families, by nurses who had undertaken the course at CHE (Vickers, 2001). This manager has now block booked places for her staff on future courses.

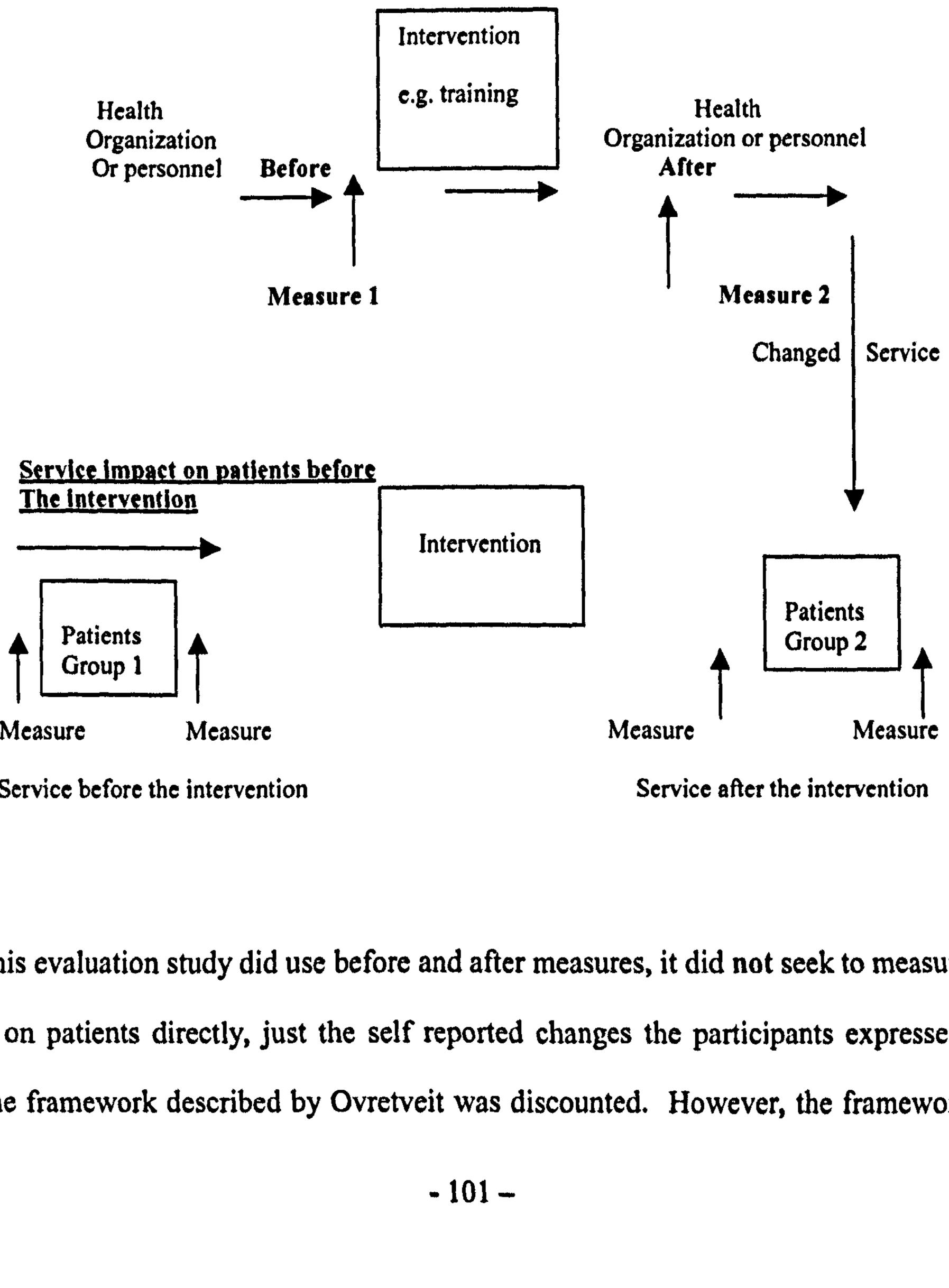
Figure 7 (page 100) illustrates the use of Robson's (2001) evaluation framework as applied to this study and provides some examples of the types of evaluation questions, which were generated. The questions in italics demonstrated the issues I had to consider, and dictated to some degree the methods that were used.

Figure 7 -Evaluation Framework for this Study, (based on Robson's 2001 model)



Ovretveit (1998) also offers an evaluation framework that was briefly considered for this study, which describes a framework for considering the impact of a service on patients. It is depicted in figure 8 below:

Figure 8 Intervention to a Service: Impact on Patients (Ovretveit 1998 p 287)



Although this evaluation study did use before and after measures, it did **not** seek to measure the impact on patients directly, just the self reported changes the participants expressed; therefore the framework described by Ovretveit was discounted. However, the framework

may be a useful one to adapt to use as a follow up to this study.

3.4 The Research Participants

As previously explained, CHE offers a variety of educational programmes to those involved in caring for patients with palliative care needs in any setting. These programmes range from half/full day workshops to diploma module courses. Those who undertake courses at CHE may be qualified health care practitioners such as nurses, physiotherapists, social workers; or unqualified staff such as receptionists, care assistants, and volunteers. As evaluation project leader for CHE it is my responsibility to evaluate all courses. However, for the purposes of this study the information presented here related to qualified nurses who have completed the ENB 931 Course, Principles & Practice of Palliative Care. The course was validated by Manchester Metropolitan University, and attracted a credit rating of 20 credits at level 2. This diploma module was held over 13 weeks and consisted of 13 theory days and 10 days spent in a specialist clinical practice placement.

3.41 Sampling

Sampling is the term used to denote the selection of individuals who take part in a research study. There are a variety of different techniques used to do this depending on the research question and the stance taken by the researcher. In this study, **all** students in each cohort were automatically invited to take part in the research project ***(n = 46)***.

The reasons for this being, each cohort had small numbers of students (*n =up to 12*), plus the students were from a variety of different care settings. I felt it would therefore be desirable to study all students initially and then follow up a smaller number

over a longer period. The purpose of the research was to try to find out whether or not students could make changes to their practice following their education at CHE. One of the potential questions to consider was whether the setting in which students worked affected their ability to make changes. For example: the course attracted many nurses from community settings who often work alone (although part of a team set up); some nurses came from acute hospital settings where staff shortages were common, and others from private nursing homes or hospitals. Each cohort therefore had students from a variety of settings but in small numbers. I had envisaged if students were unable to make changes to their practice one reason could be the setting in which they worked. If so, because the study was carried out over the duration of three years, a pattern may begin to emerge by using all the students in each cohort. It was also a potential question for inclusion in the focus group interviews, involving students from different cohorts, which were to be part of the study, (see chapter five).

It is recognised that changes in practice often take a considerable amount of time, and that organisational factors and other health professionals also influence changes in practice (Cantillon & Jones, 1999). The students in this study worked a variety of different hours full to part time, comprised of nursing grades from D to G and came from the following settings:

- 14 Community Nurses.
- 11 Hospice Nurses.
- 14 Nurses from an acute hospital (From a variety of wards and departments).
- 2 Nurses from a community hospital.

- 2 Nurses from nursing homes.
- 3 Nurses working as Bank Staff.

Total number = 46

45 of the students were female, the other male. The age range was from 25 years to 58 years. It is interesting to note that most of the students had qualified prior to project 2000 training, one had a master's degree and three held a nursing degree. There was a large range in the academic abilities of students, based on the qualifications of the students at interview (which in my experience is not unusual in such an eclectic mix of students).

One disadvantage was that a large number of these students needed to 'learn how to learn', i.e. they had a great amount of practical experience as nurses and were knowledgeable about their practice (although frequently found they were not as knowledgeable or up to date in their thinking as they had expected!) However, they were not confident about learning and needed to master new skills such as how to read literature critically and to find up to date information more effectively.

It is important to note here that CHE only takes small numbers of students annually on their longer courses. Because **all** students who were registered for this module between October 1998 and April 2001 participated in the research study, I was therefore unable to utilise a bigger sample.

3.42 Consent

The study was explained to the students both verbally and in writing. They were then asked

to sign a consent form (see appendix 5) and were informed at all stages of data collection that they could 'opt out' or ask for any information which they had disclosed to be excluded. One potential pitfall of this approach was my dual role i.e. being seen as a teacher, (part of the course team), and the evaluator. Williamson & Prosser (2001) noted the potentially conflicting roles of action researchers, suggesting that 'insider' action researchers mean that participants may not be clear to whom information was being disclosed; in my case I was a teacher, researcher, and evaluator. They also suggest that this dilemma is

> *"unavoidable when researcher's work in their own organisations"* (p43)

When designing the evaluation, the role of the evaluator was considered very carefully in this respect, the arguments for an insider knowledgeable evaluator outweighed the benefits (and costs) of an external evaluator.

It may possibly be seen as a limitation of the study that course participants could have felt intimidated by the researcher being part of the course team; and therefore felt unable to 'opt out' of the research process. Equally, they may have felt concerned that the researcher could have affected their successful completion of the course assessment processes. However, my personal view is that the students were adults and professionals, the aim of the study was made clear to them and there was a genuine desire on my part to work with the students in a participatory way that would be beneficial to both parties. There were many opportunities for students to opt out, or ask their comments not to be recorded. This view concurs with that of Johnson (2003) who identifies the *"assessment of benefits versus harms"* (p167), as being what ethical approval for research should be concerned with. This study involved methods such as reflection, which assisted participants in identifying the

benefits of education to them and their practice. Being able to reflect on their own practice and that of others should ultimately be more of a benefit than harm to students. Conversely, I do recognise that for some students reflection can be a negative experience leaving them feeling de-skilled; therefore, who ever is facilitating the reflection process needs to be appropriately skilled, this fact is highlighted by many authors who have written about reflection (Johns, 1996; Ghaye et al., 1996; Ghaye & Lillyman, 2000; Kember et al., 2001).

In this study, there was also the problem of the evaluation being viewed as inherently biased. To overcome this, careful explanation was given to every student on an individual basis as well as in the classroom setting. This explanation involved stressing the neutrality of the role of the researcher and the fact that the students' evidence was only one part of the evaluation process, (evidence being collected from multiple perspectives, i.e. all stakeholders).

A further tactic used in attempting to avoid bias was that evaluation information from students was collected at various times during the course and not always by the evaluator; i.e. other members of the teaching team carried out evaluation exercises (directed by me) and the information became part of the evaluation documentation for that cohort. For example: it was not possible for me to visit every student in his or her practice placement. Such visits were shared, between all members of the teaching team. In order to provide some semblance of integrity of evaluation information, the teachers all asked the same questions of students and mentors about the placement. The quality of the evaluation was also maintained, as the teaching team was so small. Information was then shared between

all members of the teaching team *(n = 4)* and discussed so that any necessary action could be taken. This way of working had the added effect of demonstrating to students that evaluation was everybody's responsibility, not merely the evaluation project leader. It also assisted the mentors and clinical staff in sharing their experiences of working with students, both good and bad.

In my experience as a nurse teacher obtaining good feedback from practice mentors has sometimes been problematic. Going out to meet with students and mentors on their 'turf' helped to demonstrate the teacher's values in recognising the importance of learning in practice situations. Sadly, this has not always been the case in nurse education; in recent years the academic theoretical aspects of nursing, have been given greater priority and more emphasis than the actual practice of nursing (UKCC, 1999).

The philosophy of the teachers currently employed at CHE is that theory and practice have equal merit, and this therefore has been adopted as an integral way of working. Students became used to being asked evaluative type questions during all aspects of their course programme by a variety of different people. Indeed, by the end of their course they were frequently seeking out the evaluator to offer unsolicited extra evaluative information! As much as possible of this was recorded in my research diary (see appendix 7).

3.5 Using Case Studies to Collect Research Data

Case study is one type of research design where the researcher explores a phenomenon, be that an individual 'case', group, or set of circumstances (Parahoo, 1997). Cresswell (1944),

cited in Parahoo (1997) remarks the case is bounded by:

> *"time and activity (a program, event, process, institution, or social group) and collects detailed information by using a variety of data collection procedures during a sustained period of time"* (p149).

Whilst Stake (1995) suggests case study is:

> *"expected to catch the complexity of a single case" (p.xi).*

Taking note of these and other writers such as Yin (1994); it was apparent to me that case study, as a research strategy was an appropriate method for this study. Using this approach the case may be the institution (CHE), the educational process, the cohort of students, or an individual student. A variety of data collection methods, were used to assess the impact and value of the educational process. Including, one to one interviews, group interviews, questionnaires, observation and analysis of student's written work, and focus group interviews. This data collection was carried out during the period 1998-2001. In this study each individual student ($n = 46$) was, in effect, a mini case study for the purposes of evaluation research. According to Stake (1998) case study methodology allows the focus to be one of uniqueness relating to the individual taking part, it explores their issues and tells the story from their viewpoint. This was an important part of the methodology in that it acknowledges the importance of the individual's experience and may be helpful in helping them to feel valued; (see page 160 where case study examples of individual students are discussed).

Within the discipline of education, case study research is extremely popular, and Aspinwall et al., (1992) used this method to describe how they managed evaluations in education. Smith & Topping (2001) used a *'multi-method case study approach'* (p341) in their search for empirical evidence that continuing professional education within nursing is of any benefit. Ellis (2003) utilised a case study approach in her study of the continuing professional development of nurses working with elderly clients. She also developed a

"new and alternative approach to the study of continuing professional development" (p49) using a method called illuminative case study design. This method uses illuminative evaluation, which was specifically developed for use in educational settings. Additionally, in the field of palliative care, Ingleton et al., (1997, 1998) identify the use of case studies as a method of choice when:

"studying a unique situation in a changing context" (1998, p198).

Education and palliative care are both dynamic concepts, which are affected by social, financial and political constraints (Souter 2003). Grbich (1999) identifies that case studies can provide:

"thick ethnographic description and theory generation" (p188).

In addition:

"powerful stories to illustrate particular social contexts" (ibid).

Therefore, the use of case study as a research strategy for this project can be well supported.

A further benefit of using case study as a strategy in this project was that it allowed the use

of multiple methods and sources of evidence to ensure rigour. This is known in research terms as 'triangulation' and is derived from the field of navigation, when two independent points are used to fix the location of an object (Richardson, 1996). When applied to research this term is used to demonstrate different methods or sources of information to answer the same question. In this study, evidence was obtained from a variety of different stakeholders to ascertain whether education makes a difference to practice (see page 3 for list of stakeholders involved). Asking different people assists in the rigor of the evaluation and helps to reduce bias.

In order to assess the impact of the educational module, the knowledge, skills and attitudes of the participants were investigated before and after the course using a variety of different methods. A repeated measures design with students acting as their own controls was developed. Information was collected at different stages of the course and verified with each student at each stage as to its accuracy and reliability. As the evaluator I worked closely with students collecting data and analyzing themes, which emerged. Students were encouraged to reflect on their experiences with a focus on their practice. Such reflections took place at various points before, during, and after the course (see table 4 page 111). In order to pursue a rigorous approach to the study, interpretations I made were checked with the participants to ensure they were correct and valid (Grbich, 1999). This involved the participants reading field notes relating to them, and interview transcripts as soon as possible after the interview so that they could correct them as necessary. Participants were encouraged to add any extra comments they wished to make.

Further discussion with other stakeholders for example: trustees, was extremely valuable at this stage so that they were able to contribute to the evaluation process and become actively involved (Robson, 2000). These discussions enabled all those involved (including the evaluator) to clarify the purposes of the evaluation and what could realistically be achieved in the timeframe available. This collaboration and planning contributed to the eventual success of the evaluation strategy adopted by CHE, and is further discussed in the final chapter.

Table 4 Identification of the Evaluation Processes Used in this Study

Event	Time	Evaluation Tool	Questions Asked	Analysis
Selection interview.	Held any time before preview day Usually 2/3 months In advance.	Interview, observation, field notes	Reasons for wanting to do the course, experience of palliative care.	Identifying individual learning needs and objectives of students, which could be verified at the end of the course.
Preview day	Held 4 weeks before the course starts.	Pre-course questionnaire. (Appendix 8) Observation of group dynamics	Sample question: "I feel confident when communicating with patients who are terminally ill" Agree-------- Disagree Scale Hopes & fears about the course done in the group setting.	Scoring of the questionnaire provided a baseline for each individual student for post course testing. Identification of any group learning objectives.
Course Commences	Week 1	Continued classroom observation	How students are feeling, how Palliative care concepts fit with	Assessment of knowledge, skills and attitudes (for teaching purposes).

Event	Time	Evaluation Tool	Questions Asked	Analysis
			their practice experiences	
Practice Placement (10 days)	Week 7&8	Visit to practice area by evaluator or other teacher	Discussion with student and mentors	How learning contract is being utilised / evidence of learning.
Assessment Strategy 1. Student presentation 2. Written assignment & Completed learning contract	Week 11 & 12 Handed in 4 weeks after course ends.	Observation/field notes student self report of identified learning & changes to practice. Student & practice mentor's comments	Has this student demonstrated achievement of his/her individual learning outcomes?	Documentary analysis marks allocated to 1 & 2. Identification of evidence provided which supported completion of individual learning outcomes
Final Theory Day	Week 13	Group discussion, set questions relating to theory and practice. University devised evaluation form addressing quality issues concerning the educational experience (audit tool) appendix 11	Review of hopes and fears. Learning objectives, have they been achieved how do we know? Teaching environment, mentorship, library facilities, quality of teaching and support, clinical placement.	Group analysis of learning as identified by students. Note taken of individual student comments, compared with previous data about that student. Identification of any negatives and any necessary action required.
Focus groups Teachers	Between 6 months and 18	Focus group interviews, set questions	Questions differed	Categorisation of responses to set questions relating to emerging themes and concepts (above).

Event	Time	Evaluation Tool	Questions Asked	Analysis
practitioners Students *Managers *Other stakeholders as equired e.g; trustees [Author's note *3 & *4 although originally planned did not occur see Chapter 5]	months after course finishes	set questions relating to theory, practice and evidence of changes made in practice.	according to which group of people in the focus group. For teachers/mentors sample question: Can you identify any differences in students at the end of the course? This would then be discussed further.	Discussion of proposed model of palliative care education (stage 1) Clarification of responses with Focus group participants. (Member checking)

3.6 Interviews

In using interviews as a means of collecting data, my intentions were to attempt to find out the perceptions of the participants in the study and later to check out with them my interpretations. There are many studies within nursing practice where interviews have been used to provide accounts of practitioner's views (Webb & Pontin, 1996; Biley & Smith,1998; Driver et al., 2003); or patients, (Haddock & Burrows,1997; Mitchell & Koch, 1997; McLoughlin, 2002). Interviewing is a method commonly used in the social sciences and can range from a highly structured process to one which is unstructured where the researcher is letting a conversation develop with the subject (Robson, 2002). Pontin (2000) identified that interviews are a good way of finding out people's perceptions or opinions on specific matters. In this study I was trying to find out from the students their perceptions of providing palliative care and whether or not the course had influenced them and subsequently affected how they practise.

For the purposes of this study the interviews were informal and often carried out on an ad-hoc basis i.e. when I had access to students, but in addition to the specific data collection points I had identified. This initially came about when students had disclosed something in the classroom and I wanted to find out more. It was sometimes inappropriate for me to ask further questions at that time as the information was required by me in my research capacity, rather than as part of the overall learning experiences for the cohort of students. I was mindful that my research questions should not adversely affect their learning and it was about keeping a balance between my research needs and their learning needs. I did use reflective sessions in the class to develop a deeper understanding of students' perceptions but it was not always appropriate to question them further. I recorded in my research diary my thoughts and if I wished to speak further with a particular student (see appendix 7). Pontin (2000) alludes to the differences between interviewing in quantitative studies and qualitative studies. He suggested that in qualitative studies interviewers will

> *"be open to unforeseen avenues of enquiry opening up during the encounter with the interviewee. They may follow this new development and ask further questions – testing out what other interviewees have said about things to see if this corresponds with the experience of the person at hand"* (p294)

According to Hammersley & Atkinson (1995) this ensures the interviewees talk about what is meaningful to them rather than what is meaningful to the interviewer, which was my intention when choosing this tool.

Robson (2003) suggests that interviewing is a flexible method of finding things out and that it can be a useful way of seeking answers to research questions. He also notes face to face

interviews offer a way of "*following up interesting responses*" (p272) which is how the method was used in this study. I was able to ask particular students questions as the data collection proceeded and was influenced by the ongoing findings. One of the problems was actually remembering to record conversations I or other teachers had with students. For example, a teacher reported to me what a student had said to her about a practice placement experience which had been after the official feedback session in class. I was conscious of constantly writing snippets of conversations with students and other colleagues' involved in the project. My colleagues were aware of me saying "*Did you write that down?*" especially in the early part of the project. A further difficulty was students saying things very informally and of me trying to decide if it was relevant or indeed ethical to use their comments. In the end, I became very skilled in asking if I might use their comments as part of the research process even if they had been made very informally. On reflection, it appears that many such comments were made at coffee or lunch breaks and perhaps reflects the complexity of the project and my dual role as researcher and teacher. It also reflects the intricacy of this action research project and one of the issues for all action researchers about when the project ceases. Sometimes this may be very clear, i.e. when a specific goal has been achieved, but in this complex project, it was less so.

3.7 The Questionnaire

The students completed a pre-course questionnaire to act as a baseline about what it was CHE was trying to achieve (see appendix 8) and to stimulate discussion amongst the students. This questionnaire was devised in discussion with various stakeholders, (mainly experienced clinical practitioners and teaching staff). In order to find out information about

the students knowledge, skills and perceived levels of confidence before and after the educational intervention, the survey method was used. My intention in using this method was to seek to demonstrate some discussion with the students after the intervention (the course), although there was never the intention to prove conclusively that such changes were as a **direct result** of the course. It was therefore used as a learning tool within the classroom setting. It made them think about what they knew and didn't know at the start of the course and assisted some in considering how they might go about improving their knowledge and developing their learning contracts for practice.

The questionnaire needed to be fit for purpose. An essential aspect of that purpose in this study was as a tool to generate thinking about learning for the students. The questionnaire was also found to be a useful tool for the students in providing them with a form of self-reported measurable evidence of how they had changed following the course.

3.71 Design of the questionnaire

The purpose of the questionnaire was to collect written information from the students' pre and post course. The aims were:

- To ascertain the students' level of knowledge or information about palliative care.
- To identify their perceptions of their confidence related to palliative care situations; and their opinion and feelings, which may be related to levels of self-awareness.

According to Carter (1996), a questionnaire should measure what it purports to measure thus making it a valid tool; it should also be reliable. Reliability refers to the consistency of the method in measuring the same phenomena (Parahoo, 1997). Ross et al.,

(1996) developed a tool in Canada to measure nurses' knowledge of palliative care, the palliative care quiz for nursing (PCQN). However, this 20 item quiz only tests knowledge, and although some of the questions may have been useful to this study, others were not. The author's do highlight the usefulness of the quiz to:

> *"fill the gap in instrumentation available for teaching and research initiatives aimed at improving the quality of education received by health care providers and ultimately the quality of palliative care received by those who are dying and their families"* (p134).

Whilst it would have been useful to be able to use a questionnaire that had already been piloted, in this instance it was inappropriate to all of the aims of this part of the study. Carter (1996) also states:

> *"even though an instrument has been previously tested in another study, it is advisable to retest it as it has been shown that neither reliability nor validity is constant and both can change over time"* (p181).

It was therefore decided to write a new questionnaire, which was specific to this study and would meet its purpose. It is interesting to note that whilst this study was in progress the Association of Palliative Medicine has devised a self-rating questionnaire for undergraduates studying palliative medicine. It is published as an appendix in a small core textbook (Faull & Woof, 2002). The questions cover the disease process, symptom control, pharmacology, psychosocial aspects, communication skills, grief, religious and cultural aspects, ethics, teamwork and organizational skills. The scoring system was divided into

knowledge skills and attitudes. Medical students are encouraged to complete the questionnaire as a guide to helping them realise what they need to learn to enable them to competently care for palliative patients. This approach is similar to the one used in this study and further demonstrates the need to have some way of measuring or evaluating educational interventions and their subsequent effect on practice.

In conjunction with colleagues and clinical staff, I developed a new questionnaire for this study. The aims and objectives of the course were identified, and discussions took place about what was expected of students following the course. Of equal importance in developing the questions, was to find out what these *experienced palliative care practitioners* felt, were some of the challenges and difficulties; faced by health professionals when working in palliative care. It was considered that issues relating to pain and symptom management should be included, together with questions asking about students' confidence, as students who had been interviewed for the course had already raised this. (The questionnaire was developed in September 1998 with the first students completing it in October 1998).

The challenges in palliative care situations were perceived, (by those developing the questionnaire), to be most frequently related to communication issues. For example: dealing with relatives, answering difficult questions and dealing with collusion by patients, families and fellow professionals, so these aspects were formulated into questions. There is also plenty of evidence in the literature to support the statement that practitioners working in the field of palliative care find communication issues one of the most challenging

(Maguire & Faulkner, 1988; Wilkinson, 1994; Buckman, 1996; Bailey & Wilkinson, 1998; Wallace, 2001) An important further point made by Cantwell & Ramirez (1997) cited in Wilkinson et al., (2002) was that:

> *"Communication skills do not reliably improve with experience alone".*
> (Wilkinson et al., 2002, p732).

A view shared by Jarrett & Maslin-Prothero (2004) who identify that effective communication skills *"are assumed to be innate in the caring professions but the evidence can be contrary"* (p142)

3.72 The Questions

In view of the fact that the evaluation sought to ascertain students opinions about their levels of knowledge, confidence and competence, it was decided to use closed questions with a Likert type rating scale. The language, wording of questions and perceived ease of completion are vital to the success of any questionnaire. For this reason they should be tested on a pilot sample and revised in the light of such experience until they appear to be meeting the researcher's requirements (Barker, 1996). In this study, the first cohort of students (October 1998) acted as the pilot group. Because of their comments, the instructions were changed slightly to ensure that subsequent students marked the questions actually on a grid line rather than in between.

In developing the questionnaire, the researcher was looking at being able to measure some sort of change post education. Individually this was easy to do simply by looking at each student's two questionnaires side by side and seeing whether there had been a positive or negative move for each question. There were two questions 15 & 16, which were expected

to elicit a negative response as an improvement because they were negatively phrased questions. They were thus recorded as a positive (because it was an improvement). In addition questions 8 and 21 were asking about students' personal beliefs and feelings and could be considered neutral questions as they may or may not have changed following the educational experience. Therefore, students who recorded a negative change in these questions post course may simply have changed their beliefs or feelings. The full questionnaire can be seen in appendix 8.

3.73 Administration of the Questionnaire

The questionnaire was to be used as a before and after measure i.e. before and after the course. It was therefore given to students to complete on the preview day and on the review day. The purpose of the evaluation study was explained to them verbally and in writing and students signed a consent form agreeing to participate (see appendix 5). It was important that students understood that the first questionnaire was to be used as a baseline assessment for them, also it was not a test; merely an indicator of their perceived abilities at that time. They were reassured about how this information was to be stored and that names would not be disclosed. Students used their initials and cohort name on the front sheet of the questionnaire so that when they completed the 2nd questionnaire on the review day (held three months after course completion) the data for each student could be compared.

Following practice placements group discussion took place between the evaluator and the students, to elicit information about what they found useful and least useful, about their period in clinical practice. Information was also collected at the end of the course and three

months following course completion. At that stage the students were asked to complete the same questionnaire they filled in on the preview day. Students were then able to compare their pre and post-course answers. I recorded in my field notes any specific instances I wished to discuss with individual students and noted against each student whether they had recorded themselves as improving or not. In this way I was able to note that 45 students in total had identified some improvements in the post- course questionnaire. The remaining student Paula* is the subject of one of the case studies see page 165.

3.8 Other Evaluation Tools Used

A variety of methods have been used to collect data including one to one semi-structured interviews, focus groups (n=3), survey (to promote discussion) and non-participant observation of group discussions and classroom activities by the evaluator. In addition, information was obtained from mentors during placement feedback sessions, managers, and peers of those involved in the educational process. The evaluator also read the students' written assignments, which were reflective accounts of a critical incident involving palliative care. By using reflection as a tool the students were encouraged to consider any alternative actions and future learning needs. Many of them were able to formally reflect in writing on how they had changed their practice as a result of their education at CHE, although it could be argued that those were the students who were able to write well. Students also gave seminar presentations as part of the assessment process, which I attended and was involved in assessing. Such presentations frequently proved to be unexpected good sources of evidence for this study, demonstrating that students had benefited from their education in palliative care. For example: students confirmed they were able to discuss

* Pseudonym

palliative care more knowledgeably, appeared more confident and competent in their ability to problem solve and sometimes even demonstrated new skills, for example: one student demonstrated how lymphatic drainage was used for patients with lymphoedema. Another student working in a hospice setting identified the need for changing the oral hygiene practices for patients who were dying, with reference to recent research she had read and evaluated (Candidate L. J, 1999).

Some of the evaluation tools used in this study are discussed in greater detail e.g. focus groups, which have a whole chapter devoted to it. The reasons for this were twofold; firstly some of the tools were also an inherent part of my role as a teacher i.e. group discussion, reflection, observation of group dynamics. The researcher and teacher roles thus often merged and it was sometimes difficult to separate the two. Secondly, focus groups and to a lesser extent case studies, were new to me and therefore required a thorough understanding before they could be utilised as part of the study. The focus groups were held towards the end of the study and served to confirm my initial hunch that education made a difference to practice; they therefore perhaps unfairly have been given more credence. In addition, in any study the researcher has to decide what to include and what to omit, the inclusion of case studies and focus groups were about me attempting to demonstrate learning and the value to future evaluation studies of these tools.

3.81 Observation of Group Dynamics

Observation was another tool used to provide evaluation information within this project. Much has been written in the literature about the pros and cons of using observation in any

research activity (Cormack, 1996; Parahoo, 1997; Polit & Hungler, 1999; Robson, 2002). In this evaluation study my intention in using observation was to attempt to understand the behaviours and experiences of students in the classroom and where possible the clinical setting. It was also about gaining rapport and trust with the participants so that they would disclose information to the evaluator, their mentor and other teachers.

As a teacher, observation of group dynamics is part of the ongoing task of teaching in order to adjust the session and take action to enable learning to take place. As a researcher, I was interested in how students perceived themselves in the classroom; self awareness has been linked to the ability to communicate with dying patients, (Wilkinson et al., 1999; Souter, 2003). In addition, listening to students talk about their practice, often in a very critical way influenced the development of teaching strategies to attempt to assist students to value their practice and ongoing experience. Robson (1993) indicates the value of using observational research methods for nurses in that it can help nurses analyse events as they occur in 'real life' situations. For me as the researcher the real life setting in the classroom was an indication of how students might behave in situations with patients. Equally it was possible to consider what situational factors might change by manipulating the environment through experiential learning, for example dealing with challenging situations through role play.

Observation was unstructured; it provided material for my research diary particularly in relation to how students expressed feelings related to confidence, lack of knowledge, or challenging situations. The way they asked questions, what kinds of questions and how they interpreted their placement experiences were noted. All groups of students are

different and it was interesting to notice who offered strongly held views about issues (such as euthanasia and spirituality) and indeed who appeared not to want to debate them. One student in particular openly expressed her anger following a teaching session about spirituality. She said:

> *"I couldn't stop thinking about it all night, and all the next day. I even asked some of my staff what they thought."* (Hospital Nurse).

This student was angry that her previously strongly held beliefs and views had been challenged, she felt vulnerable and initially deskilled. She later reported that the course had been *"fantastic"*, she has since attended a further palliative care course at CHE.

In using observation as a tool as a novice researcher I had not really thought through how I would record my observations other than by taking field notes. I have noticed that my field notes did change throughout the study. Initially I wrote <u>everything</u> down, later I wrote less but explored things in more depth, I also cross referenced and utilised highlighter pens and colour to assist me with analysis. However, as I reviewed my early notes it was clear that I had already started to attempt to classify my observations as the example below illustrates:

<u>Extract from Research diary -16th Sept 1998 (October cohort preview day)</u>

Very nervous, had to go to Chester to meet the group. First try of questionnaire, need to ensure I don't influence the group in any way.

Met students – mixed age range and ability and from variety of settings.

Surprised at expressed <u>lack of confidence</u> of even those who are relatively senior nurses. I wonder why? These people are dealing with pall care pts all the time.

Even hospice nurses seem to <u>lack confidence</u>.

All appear enthusiastic about being on the course, good! ? have hospice nurses been sent on the course because of CHE.

? perhaps need to find out from interview notes whether participants have elected to do the course or been sent by manager ? will this affect their motivation/ ability to change practice, how will I know?

How will I measure attitude? One student in this group definitely got a 'problem' is insensitive, brusque, wonder how SPJ will deal with this?

Hopes and fears exercise – lots said they were worried about assignments (presentations) suppose that is to be expected. 8 out of 12 identified they want to learn specific skills. Communication skills identified. I was unsure how SPJ would deal with 'fears' but she just allowed them to be expressed. This was a good exercise because it helped the group see how similar their feelings were and ? 'bond'.

At this first period of observation I had identified confidence, communication and skills as issues. Undoubtedly this then influenced what I was looking for in the next observational sessions and with other cohorts; because I was interested to see whether the groups were similar in their behaviour and development throughout the evaluation study. The problem of course in this ad-hoc way of using observation is of missing something I was not actively looking for. I did discuss my field notes with other members of the teaching team and my supervisor and was willing to reconsider in the light of their perceptions (especially when they had also been with me at the time of observation). In this way I was able to explore my perceptions of the situation and also that of others. Questions from my supervisor made me continually revisit my data in an effort to ensure I had truly looked at the data from as

many perspectives as possible.

Some of the criticisms of the use of observation as a tool to collect data centres on the argument that merely being there (to observe) changes the situation (Mason, 1996). However one could also logically argue that how would you know what the behaviour would be like if you had not been there to observe it? (Robson, 2002). In this study observation was used to complement data collected from other methods (interviews, focus groups). My dual roles as teacher and researcher meant that I had many opportunities to collect research data by merely being with participants, for example participants would disclose things to me at coffee or lunch breaks. These discussions were frequently triggered by events in class, whether I had been present or not!

A key feature of my use of observation was my belief that to explore the perceptions of the participants I needed to be a part of their social world. To notice their use of language particularly how that related to their palliative care knowledge, and to further question them as necessary as I began to form any opinions about the effectiveness (or otherwise) of their educational experiences.

3.82 Group Discussion

Group discussions were utilised in the classroom to answer evaluation questions. This was particularly relevant following the practice placement when students were asked to answer questions about their placement. They were given the questions:

- What has been most useful about the practice placement?
- What has been the least useful about the practice placement?
- What if anything, can you take back to your own practice setting?
- Any other comments.

The students worked in pairs, writing their answers on a flip chart and then they were discussed in turn with the whole group. This activity promoted much discussion amongst the students as they asked each other questions like:

"How did you cope with that?" "Why do you think ----- was successful?"

"How could we do that in my area?"

Discussions such as this proved to be a rich source of material for evaluation and allowed me to 'test out' hunches, particularly around the value of the practice placement. I noted which practice placements were highly rated by students and attempted to find out through further questions, why they were so highly rated. I was also able to compare what different cohorts said about the same practice placement, this was important for evaluation purposes in that it helped me to look at the overall benefits of practice and where more resources might be required. One reflection from practice event demonstrated that a previously well evaluated placement area had less than positive comments from the current group of students. On further investigation, it was found that there had been an extensive staff reorganisation within the hospice and that in the future more mentors would be required. CHE was able to support the placement area by offering to train new mentors to support future students. Thus the evaluation helped CHE to be proactive rather than reactive.

Extract from research diary relating to review of practice May 1999

(April Cohort)

** *Hospice well evaluated by both students.*

LK "Why do you think this placement was so good?"

CS. " Well, everyone was keen to support us and interested in why we were there"

PB "It seemed friendly the moment we got there, you know the atmosphere and everything"

LK "What exactly was it about the atmosphere then?"

CS "Well you just knew that they enjoyed having students, nothing was too much trouble, my mentor had a programme of things all arranged for me but she asked me if it was ok first, not just going off and doing it on her own like.. I felt like she really cared about us having a good placement"

PB " For me it was about them understanding we felt like a spare part but also that we were nurses too and had something to offer them, my mentor wanted to know about nurse prescribing and what the course was about".

LK " Do you think that being able to share your practice experiences like that was useful?"

PB "Yes very"

Entry from later cohort (October 1999 groupB) review of practice placement

2 students (EG & JB) attended ** hospice – rated as not very successful (by the students – although interestingly they had both fulfilled their learning contracts!)

EG "My mentor was away, no one seemed to know what was expected of us".

LK – "Did you not meet with them on the preview day?"

EG – "No they were unable to come"

JB "My mentor attended the preview day but she was off sick for the first week of my placement and no-one was allocated to replace her".

LK "So what exactly happened?"

JB " Well we arrived as planned and did get to do and see things we wanted but I think it was more by luck than anything else, I was glad to finish the placement"

LK "Was that about you rather than the placement?"

JB "Well er maybe... I admit I didn't really want to go ...but we weren't well looked after"

EG "We did spend a lot of time whingeing in the car on the way home!"

(Lots of laughs from the rest of the group here)

LK – to whole group (10 students) How important do you think mentors are in your practice placements?

Replies – all suggested mentors were very important, the rest of the students in this cohort had experienced good placements and mentorship.

As a result of this exchange the question of mentorship was discussed at the team meeting and we discussed what to do if student's mentors were less than effective, or unable to attend preview days. CHE instigated new mentorship preparation workshops and annual update sessions; we thus are able to maintain a live register of mentors and try to ensure that mentors are appropriately supported. This has been as a direct result of feedback from students.

Feedback from mentors assisted in the planning of future courses and in the provision of

information to students about practice. Mentorship update sessions are offered annually, and have been useful in the ongoing development of CHE as an organisation as we have a willing group of clinical practitioners with whom we can debate new ideas.

3.9 Using Reflection/Reflexivity in the Research Process

Reflection to enhance learning is not a new idea. Hancock (1999) suggested it is:

> *"akin to Aristotle's concept of deliberation"* (p37).

A leading pioneer in the value of reflection and learning by experience was John Dewey, who in the 1930's defined reflection as:

> *" An active persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusion to which it tends"* (Dewey, 1933; p9).

Dewey identified that individuals learn from and through experiencing, and he subsequently wrote about how reflection is enhanced by experiential learning. Other educationalists such as Kolb (1984) identified reflection as part of his model of learning. Later Gibbs (1988) developed a cycle of reflection which is similar to Kolb's learning cycle but with key questions, see figure 9 overleaf

Figure 9 Kolb's Learning Cycle (1984)

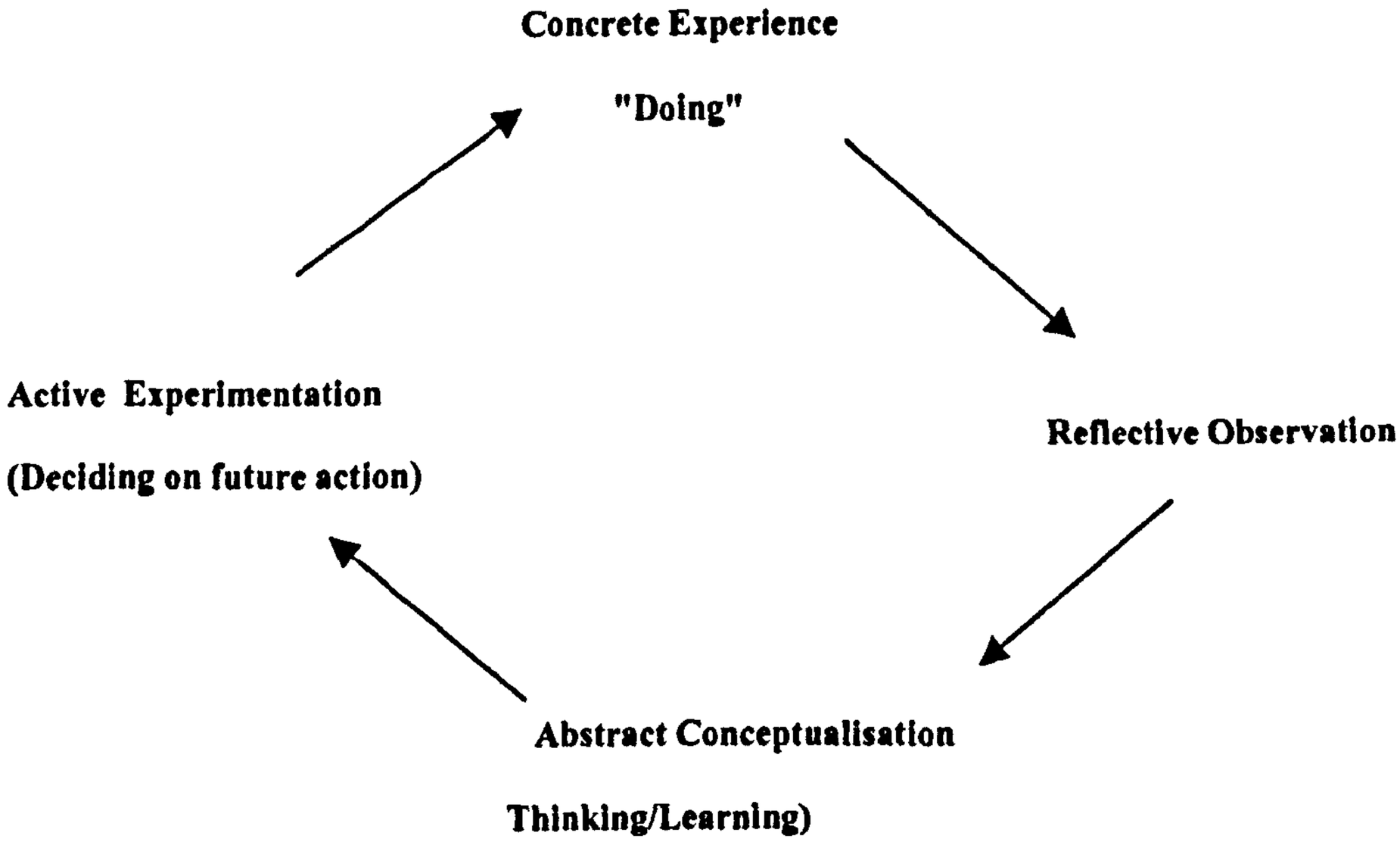
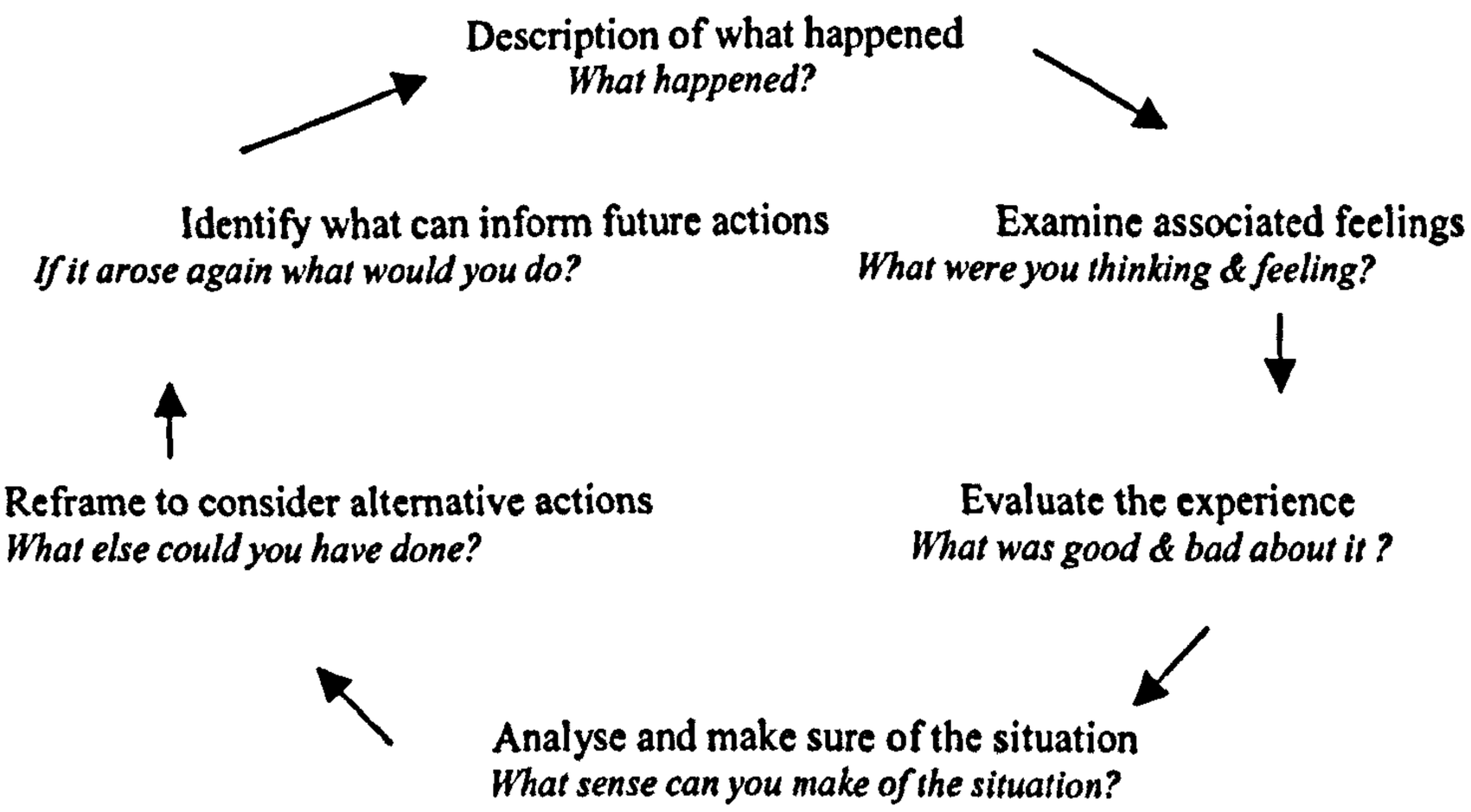


Figure 10 - Gibbs Cycle of Reflection (1988)



The use of reflection as a means of enhancing professional (nursing) practice has been influenced by Schön (1983; 1987). He suggested that the empirical approach (theory) had dominated professions, and that it was imperative to recognize that the lived experience can be used to develop knowledge. Schön (ibid) noted that whilst nursing was seeking academic credibility, it was in danger of becoming dominated by the scientific approach at the expense of developing the intuitive artistry (practice) of the expert practitioner.

Benner (1984) supported Schön's views that scientific knowledge alone is not adequate. She focused her theories on the artistry of nursing, by charting the progress of nurses from *'novice to expert'*. Benner did not discard the value of theory, in fact, she suggests that knowledge enables practitioners to ask the right questions and look for problems that promote learning from practice. However, her theories do question the view that if scientific knowledge is applied to practice, correct nursing action will always result. Benner promotes the value of experience and explains the importance of guiding the practitioner towards an intuitive use of accumulated past experiences and focussing on 'whole' situations. Benner also pointed out that not all knowledge which stems from experience, can be immediately embedded in theory. Equally, theoretical knowledge which is learnt in a classroom cannot always be applied to the practical setting; this being one of the great challenges nurse teachers face in making learning meaningful to practice (UKCC, 1999).

Within nursing, there is a growing interest in the value of reflection and reflective practice to enhance personal and professional learning. Schön (1983, 1987) identified different

kinds of reflection. 'Reflection on-action' that happens after the event, and 'reflection in-action', which happens during the event, thus influencing any decisions made. Due to my familiarity with the concept of reflection and reflective practice I used both of these strategies within this research study. Reflection in-action during the data collection process i.e. individual encounters with students and focus groups, and reflection on action when attempting to analyse and make sense of the wealth of information collected.

From the extensive literature written about reflection in nursing practice there appear to be some key points raised; these include the idea that reflection is thought to create the opportunity for improving practice through learning (Schön, 1983, 1987; Boud et al., 1985, Shields, 1994; Palmer et. al., 1994; Ghaye et al., 1996; Ghaye & Lillyman, 2000). There is also the suggestion that reflective practice is good for personal development in that it increases self-awareness (Johns, 1995; Johns & Freshwater, 1998; Rolfe et. al., 2001). This aspect was highlighted by Howell (1999), who when writing specifically about palliative care nursing stated:

> *"personal knowing through self-reflection is one of the most challenging elements of reflective practice. Yet it may also be one of the most important elements for palliative nurses in recognizing their feelings and fears in caring for a terminally ill person"* (p212).

Souter (2003) stated the essence of palliative care involved "*genuinely caring practice*" (p12) and personal change, which is enhanced by reflection.

In this evaluation study, I used reflection to enhance my learning (about research) and the learning of those involved in the study. The process of reflection was actively used to enhance learning amongst students throughout their studies at CHE. This was either on a one to one basis with a student in the form of tutorials, or as a group activity as 'collective reflection', for example: on return from their practice placement. Several writers have reported the benefits of such 'action learning' groups (Haddock, 1997; Scanlon & Chernomas, 1997; Kember, 2000; Kember et al., 2001; & Knowles et al., 2001). Therefore, reflection was used to assist students to learn about their practice and hopefully, improve it. It also assisted the teaching team in learning about students (and assessing students' progress). Equally, the teachers continued to develop their own skills through reflection in this way (Kember, 2000; Kember et al., 2001).

For the purposes of this evaluation study reflection about the research process itself (reflexivity) was very much a component of the study. This was in part due to my ongoing use of reflection as a tool professionally (as described above). However, reflection is also a necessary part of the methodology of qualitative and collaborative research. Ongoing reflection within the research process known as reflexivity is defined as:

"The process of self-examination. In reflexive analysis, the investigator examines his or her own perspective and determines how this perspective has influenced not only what is learned but how it is learned" (DePoy & Gitlin, 1994, p 277).

In research terms reflexivity is a technique, which may be used in an attempt to ensure rigour. Researcher bias is impossible to eliminate but being reflexive highlights any such bias and it may therefore be identified and examined further in the light of the data collected (Parahoo, 1997). However, it is not easy for researchers to recognise their own prejudices, therefore in this study the data was further discussed with the teaching team, my supervisor and with the participants (member checking) to further validate the interpretations. Carr & Kemmis (1986) suggest that reflective self-inquiry is part of action research in order for participants to improve their practice, (which was the ultimate aim of the course they were undertaking). In my view, this is equally true for researchers themselves, to enable them to reflect on their progress as researchers.

Summary

- In designing this research strategy, it was important to ensure that the most appropriate methods were used to answer the research question. Therefore, a variety of methods, were employed at different stages of the project; including observation, one to one interviews and focus groups. The evaluation design itself is based on the principles of multi-collaborative participative evaluation (Patton, 1997).
- The use of case study as a research strategy is explored and the rationale for its use in this work is provided.
- All available students were automatically co-opted, to the research project (*n = 46)*, because each cohort contained a number of students from different work

settings.

- Students from different cohorts but similar work settings were invited to focus groups. This allowed for the fact that the setting may have influenced whether or not students were able to make changes to their practice. Thus the potential to investigate any themes and patterns relating to this was there if the need arose.

- My dual role as evaluator and nurse teacher has been explored as a potential limitation of the study, whilst also recognising its strengths, such as being aware of the context and sensitive nature of the work.

- The role of reflection is emphasised as an integral part of the research activity for both the researcher and the research participants. Reflective self -inquiry is part of action research and assisted the participants in looking at their practice and how it could be improved.

- Reflection for me as the researcher involved reflexivity and a consideration of how my role in the research process may have influenced it. This is very similar to the argument of the role of the evaluator as an insider. In terms of professional development, reflection enabled me to consider my ongoing learning and developing skills as a researcher.

- A discussion of the difficulties of using some of the chosen research methods identified some of the challenges of qualitative research including which comments to include from students and how to validate ongoing findings.

CHAPTER FOUR

Evaluation Results: Formative and Summative. The Development of a Model for Palliative Care Education (Stage 1)

4.1. Introduction

This chapter discusses the findings of the data collection from the period October 1998 to April 2001. Data was collected from four cohorts of students (*n = 46)*, as well as teachers and other stakeholders. As the information became available, and was analysed, certain recurring themes became evident. This led me to consider how these preliminary findings should be reported and to whom. Initial results proved to be very positive with students reporting evidence that they had changed their practice. Therefore, a decision was made to publish these early results (Kenny, 2001 see appendix 3), even though the study was only halfway through. These early results led me to consider whether a model of education could be developed which would reflect the findings and thus be advantageous to others involved in teaching palliative care. A preliminary model was developed (stage one), it was piloted with focus groups, and later amended following feedback from those groups.

This chapter describes the model and discusses how the results of the data influenced the components of it. Evaluation theory also informed the analysis of the results, as the intention was to provide *'utilization focused'* evaluation reports (Patton, 1997). The analysis sought to find evidence of whether education made a difference, i.e. was education effective. For the purpose of this chapter mini case studies are used which comprise of data

from individual students, to illustrate how they have changed their practice, as a consequence of their educational experiences at CHE.

4.2 Discussion of the Formative Evaluation Process, Results, and Deductive Findings

The evaluation processes have been described in Table 3 page 96. This section will summarise the data realised at each stage of the process and attempt to explain the reasoning of the researcher in arriving at the conclusions.

4.21 First Evaluation Encounter - the Selection Interview

A selection interview for the 931 course was necessary, to exclude participants who would be deemed unsuitable to participate in the course due to recent personal bereavement or losses (CHE, 1998b). Academic criteria and qualifications were identified as appropriate from the application form, before the candidates were asked to attend for interview. The purpose of the interview was stated to the candidates, as a means of 'getting to know them' and telling them about the course, before they commenced the programme of study. In addition, it was about being able to discuss the practice component of the course so that a suitable placement could be organised. It was also an opportunity for the student to ask any questions. During the period of this study, only two candidates were rejected at interview stage, (one due to a recent bereavement, the other was not working sufficient hours and was therefore unable to meet the course criteria set by the ENB as a minimum of 18 hours in practice).

From a research perspective, this was my first encounter with participants and it was important to clearly explain my role and gain their consent to my presence at the interview.

Sometimes I had experienced previous contact with many of the students who applied to do this course, in either a clinical or academic setting. Consent did not appear to be a problem (it had been stressed to the student that their acceptance or not on the course had nothing to do with the research). The interviews were tape recorded initially, see appendix 6 for transcriptions. However, not all candidates agreed to the tape recorder feeling it made them *"more nervous"*. This was discussed with my research supervisor as an issue for clarification. From a research perspective the questions were the same with or without the tape recorder and I felt it did not particularly add any extra benefit; its use was then discontinued. Students' answers to questions were recorded in writing anyway as part of the interview process.

All students were asked the following questions at interview:

- ***Why do you want to do this course?***
- ***What do you hope to gain from the course?***
- ***How do you think the course might affect your practice?***

In addition they were asked questions about their current role, previous study, and how they kept up to date professionally; where they would like to be based for their clinical placement (i.e. a hospice in their geographical area) and what they thought they might find most challenging about the course, including how they might address this. Content analysis of field notes and transcripts of tape recordings (Grbich, 1999) taken during encounters with students at this time, enabled the identification of themes relating to why students wanted to undertake palliative care education, and what their expectations were.

Table 5 Summary of Data Obtained Following the Selection Interview with Students

Event	Evaluation Tool	Analysis	Researcher's Summary
Selection Interview	Interview, observation, field notes, analysis of tape recorded transcripts - see appendix 6	Identifying individual learning needs and objectives of students to act as a baseline.	**THEMES** Wanting to be more **confident** in the delivery of palliative care, wanting more **knowledge**, being able to **cope in 'difficult' or challenging** situations. Specific **practical skills.**

4.22 Evaluation Results following the Selection Interview

Although reasons for wanting to do the course varied between students, there were common themes. It is not unreasonable; to predict that by attending an educational course all of them wanted to improve their knowledge about palliative care! This proved to be so! Many also stated specific practical skills they wanted to learn such as setting up a syringe driver, specific bandaging skills for dealing with patients with lymphoedema, and assessment skills.

All students in this study mentioned at the initial interview, one or more of the following

themes:

- **Wanting to improve their communication skills (particularly in relation to dealing with difficult situations).**
- **Wanting to become more confident and competent in caring for patients and their families.**
- **Improving their knowledge and practical skills in relation to palliative care.**

Of particular significance to the researcher was that **all** students identified the need to:

"improve their confidence" or *"become more confident"*.

This was regardless of their experience, or level of seniority (grade). When challenged about how they would know this they said that having more knowledge would help them be more confident especially if they had to challenge medical or more senior colleagues.

It appeared therefore that the students in this sample, who were caring for patients with palliative care needs, recognised that they needed help in dealing with situations that provoked feelings of conflict. In addition, there was an expressed need by some students *(n= 33)* to improve their communication skills. Therefore, when designing a model of education for palliative care (see model page 233) the application of theory into practice needed to be explicit. For this reason theory and practice were given equal weighting within the model. This goes someway to perhaps redress the balance of the 'theory practice gap' within nurse education, and values both equally, rather than what happened in the 1990's when theory appeared to have a higher profile than practice (UKCC, 1999).

4.23 Evaluation Encounter:- The Preview Day

The preview day was held approximately four weeks before the course started. Its purpose was to formally register the students and complete the relevant paperwork. In addition, it was devised as a way of helping the students identify any hopes and fears about the course, and to start to get to know each other and the teaching team. The nature of the course material was deemed to be sensitive and the group would be working closely with each other therefore the group dynamics were important. This initial get together before sensitive course material was presented, allowed the teaching team to start to create a conducive learning environment. The students completed the pre-course questionnaire at this time before any teaching about palliative care had begun, (see page 116 for discussion of the questionnaire design). The purpose of this was for the first questionnaire to act as a baseline of the student's knowledge and self-reported confidence and competence. This would then be compared with the results from the same questionnaire, which would be completed by the students on the review day of the course. Comparing the two questionnaires in the classroom setting enabled discussion with the students about what they had learnt or not and where they saw improvements to their practice, thus the questionnaire was used as a learning tool and to promote discussion. The preview day also provided students with an opportunity to meet their practice mentors; this allowed dialogue to commence between the two parties about the learning contracts for practice.

Table 6 Summary of Data Obtained Following the Preview Day.

Event	Evaluation Tool	Analysis	Researcher's summary
Preview day	Precourse questionnaire (appendix 8)	Reading of questionnaire to observe how students had self scored, whether there were any high or low scores	Each question given a score according to where answer placed on the scale. An average score per person was collated for comparison post course. Many students although experienced nurses gave themselves low scores particularly around competence, knowledge and confidence questions.
	Hopes & fears exercise.		Hopes around **knowledge, acquisition of new skills, confidence and competence**, giving "better quality care" Fears around academic writing, giving presentations "being able to cope" "Current workload and not being able to cope with more
	Observation of group dynamics	Identification of any group learning objectives	

4.24 Evaluation Results following the Preview Day: The Questionnaire

A student scoring a low score when first answering a question (preview day) meant that they tended to agree with the statement.

As the researcher I was somewhat surprised by how many of the students had given themselves scores at the lower end of the questionnaire at this initial stage, (*n=31).* This surprise related to the fact that they were all registered nurses some with many years of experience; who had been in contact with patients and families requiring palliative care during this time. The UKCC Code of Conduct (1992) for nurses (since replaced by NMC Code of Conduct 2002) expressly stated that nurses should keep themselves up to date and

recognise any limitations in their competence to practice. However, research in cancer and palliative care education identified that many nurses do not have specific training in palliative care in their pre-registration training programmes (Copp, 1994, Lloyd-Williams & Field, 2002), and that post-registration training has been somewhat ad-hoc (Langton et al., 1999). This fact alone serves to demonstrate the need for continuing professional development for all nurses and for specific general training in palliative care as all nurses (and other healthcare professionals) are likely to come into contact with dying patients at some stage in their career (Hillier & Wee, 2001). It may also be significant that nurses who are perceived as 'experts' in their field may find it difficult to disclose their lack of knowledge or competence, as they may feel that by virtue of their grade/position that they are 'expected to know'. (A large number of nurses in this sample were graded E and above *n= 32).*

4.25 Hopes & Fears Exercise Preview Day

On the preview day the students were asked to identify their hopes and fears (anonymously on post it notes) these were then collected in and arranged on a large piece of flip chart paper. The purpose of this exercise was to allow students to express their hopes and fears in (optimistically) a safe setting. It allowed the students to identify any common issues, of which there were many. More importantly, it highlighted to the teaching team any issues that would need to be addressed in the forthcoming weeks. This provided further evidence to me of the need for the student to be involved in the planning (however informally) of the educational programme. Hence, the inclusion of the student, at the planning stages

highlighted within the model and that the planning was therefore 'needs' led.

4.26 Evaluation Encounter: Reflections following the Practice Placement

The practice placement of 10 days occurred in weeks 7 & 8 of the course. The students were allocated to a hospice base and a named mentor provided, in conjunction with that mentor they then identified their learning needs and how these could be met, (see appendix 12 example of learning contract). The amount of time actually spent at the allocated hospice varied between students, some spent all their time there others spent a few days with visits organised to other settings (such as oncology or radiotherapy clinics, with other nurse specialists, or with other members of the multidisciplinary teams). Students identified in their evaluation sessions, this flexibility within the practice setting, as important, in helping to address individual learning needs.

Following practice, the students returned to the classroom and a total of four hours was spent reflecting on this practice placement. The sessions were structured and all cohorts were asked the same questions. The evaluator took notes during these sessions and written records were made from the flip charts the students created. Discussions with the teaching staff who were present during these sessions were also recorded in the evaluator's field notes. The students were asked the following questions:

- ***What has been most useful about your practice placement?***
- ***What has been the least useful?***
- ***What if anything, can you take back to your own practice setting?***

The students working in pairs answered these questions recording the answers on pieces of flip chart. During the feedback discussion they were then able to clarify any points or add things in. It was important for the evaluator to be present at these sessions because the students provided much more detail and examples during the discussion phase, above and beyond, what they had written down on the flip charts. I was able to ask questions for further clarification. Taking field notes of these discussions also served to provide a rich source of data for later analysis.

Table 7 Summary of Data Obtained Following the Practice Placement

Event	Evaluatior	Analysis	Researcher's Summary
Feedback following practice placement. Week 9 of the course	Group discussion with questions. Questions specifically related to skills development, cognitive and affective, as well as the perceived ↑ or ↓ in confidence.	Identification of emerging themes for individual students and the group. Consideration of what students may change and how to verify this in the future.	All students noted that practice had been beneficial, even if they had been unable to achieve all their learning objectives. There were some initial problems with mentorship. Those who had never visitied a hospice before found it beneficial to be able to pass on specific information to patients and their families. **Theme - knowledge confidence** Specific skill development was identified, being knowledgeable about pain & symptom management. **Theme skills development** The ability to use new equipment and see different services in action; eg: lymphoedma therapies, day care, complementary therapies.

4.27 Evaluation Results following the Practice Placement

Without exception, all students found the practice placement beneficial. Some of them had been highly anxious before going into practice, and had been quite vocal about this in the classroom! The practice placement was particularly challenging for students who worked part time or night duty and had to make special arrangements for child care or other personal concerns. In every student cohort there was at least one student who noted this in the feedback session. Mention was made of the need for good organisational skills and extra support these students required from their families and to a lesser extent the teaching team. Generally students were allocated to a hospice within reasonable travelling distance of their home or work setting, but this was not always possible for example one student had a 75 mile round trip to undertake for 10 days (although this was an exception). Students were also allocated to a hospice in pairs so that they could travel together if they so wished. This was evaluated by the students as beneficial from both a personal and professional (learning) perspective as they utilised this travelling time together to informally reflect on their experiences.

Students identified positive things about being in a hospice setting, this was a theme acknowledged in all the feedback sessions, especially by those students who had never visited a hospice before. There were essentially two issues for the students about working in a hospice setting:

1. That they felt 'valued' and easily became part of the team, and
2. It provided them with knowledge about services available to patients and their families.

Student related comments included:

> ***"Now that I have visited the hospice myself, and know the staff I am better able to prepare patients who may fear going there"*** **(Community Nurse).**

Another said:

> ***"I have telephoned the hospice several times before for advice, but it is great to meet the staff and put a face to a name. I have been reassured that it is ok to phone at any time and will continue to do so"*** **(Hospital nurse, acute care).**

Students indicated a variety of things they considered '*least useful*' to them including:

> ***"Attending to the hygiene needs of patients"*** **(Community Staff Nurse).**
>
> ***"Sitting in on case conferences when we didn't know the patients"***
>
> **(Hospice Nurse).**
>
> ***"Doing the drug round"*** **(Community Nurse, Sister).**

Interestingly, these comments had also been given in the '*most useful*' category by other students! Other '*least useful*' comments related to the amount of time spent in a particular setting, some students felt placements of one weeks duration would be better, others wanted more! Travelling was also highlighted as least useful, travelling to new places, especially if there was a long distance involved.

'*Things to take back to practice*', **all** students said 'new knowledge', this related to specific things from their individual learning contracts, information about pain and symptom management being a particular theme. Four students particularly highlighted 'attitudinal'

aspects of practice they had noted:

> ***"I watched** (name) **admit a patient and was impressed with how she spoke to that patient and his family. I shall try and copy her approach particularly in relation to assessment"*** **(Hospital Nurse).**
>
> ***"I was there when** (name) **died, the staff were so kind to the family, I felt quite humbled to have witnessed such a 'good' death."*** **(Nurse working in a residential home).**
>
> ***"I observed my mentor give bad news to a family, she was really skilled and gave them lots of time and comfort, afterwards she told me how hard she finds it"*** **(Community Nurse, Sister).**
>
> ***"I really learnt to listen to patients, in all my nursing career I don't think I have been listening properly,** (name) **showed me how it is done."***
>
> **(Community Staff Nurse Night Duty).**

Other students had specific examples of things they had observed that they thought might be easily transferred to their own setting including:

- Using soda or tonic water for oral hygiene.
- Using vitamin C tablets for oral hygiene.
- Writing on dressings the date they have been changed.
- Using nicotine patches for patients who are no longer able to smoke but are craving a cigarette.
- Hand massages for patients and relatives.
- Ensuring staff get clinical supervision.

4.28 Evaluation Encounter: The Assessment Strategy

The students undertaking this course at CHE were being awarded 20 academic credits at level 2 by Manchester Metropolitan University therefore they had specific academic criteria to achieve. The assessment of the learning outcomes of the module was by a written assignment, a presentation and evidence of achievement of their practice learning outcomes. For this evaluation study, I was less concerned with the achievement of academic goals (an outcome measure) and more concerned with the process of the education. Therefore, the data collection and subsequent analysis at this stage was limited to whether or not students achieved the pass mark.

Table 8 Summary of Data Obtained Following the Assessment Strategy

Event	Evaluation Tool	Analysis	Researcher's Summary
Assessment strategy *1.Student presentation **2. Written assignment ***Completed learning contract	Observation/field notes Student self report of identified learning and changes to practice. Student and practice mentor's comments	Documentary analysis: Marks allocated to *1. & **2. Identification of evidence provided which supported completion of individual learning outcomes outcomes.	Marks attained. Perceived ↑ in confidence, students talking & writing more knowledgeably about palliative care. Achievement of learning outcomes ***.

4.29 Evaluation Results following The Assessment Strategy

44 of the 46 students in the study successfully completed both parts of the assessment and a practical learning contract. This enabled them to be granted the award - *Principles & Practice of Palliative Care Incorporating ENB 931 - Continuing Care of the Dying Patient & Their Family*. Of the remaining two students one, (student no 43) was referred for the second time in the written component of the course and was therefore unable to be given the award. Of interest to me as a teacher and evaluator is that this student identified herself as having ***"improved significantly"*** in the post course questionnaire (see later results) and in her practice; yet she failed to demonstrate achievement of the written educational outcomes of the course. Perhaps this is an indictment of the 'value' of written assessments being the only way a course is measured. However, conversely it can be seen from the data that in this self-rating questionnaire this candidate had marked herself significantly lower than others at the beginning of the course, her pre course average mark was 3.6; which was in fact the lowest score of all the students. I noted that this participant was an enrolled nurse working in an elderly care setting and perhaps her starting educational level was less than that of other students. There was an expectation that all students on the course would be able to write at level 2 and some of them did struggle.

The other student failed to submit her written work twice, despite having completed her presentation and learning contract; (there were no known extenuating circumstances). She was therefore unable to demonstrate the achievement of the learning outcomes and was ineligible for the certificate or academic award. Interestingly, the teaching team in their evaluation identified this student as having demonstrated ***"great positive attitudinal***

changes" by the end of the course. This was demonstrated by her comments in class, which had been seen early in the course as inappropriate, insensitive and somewhat questionable. By the end of the course she had identified for herself how much she had changed and saw this as very positive. As a result of this increased self- awareness she opted to take a break from nursing because she had identified she felt "burnt out". If the evaluation measure was simply the successful completion of the course then this student would be deemed to demonstrate a negative outcome. However, from a pragmatic viewpoint this student was working with vulnerable clients and feeling burnt out, I would suggest her recognition of this fact as a result of doing this course was highly beneficial; both personally, and professionally.

Two students were referred in one part of the assessment at their first attempt (one the written work, the other the presentation) however both students were successful in their second attempt.

4.2.10 Evaluation Encounter: The Final Theory Day.

On the final theory day of the course, the students completed an evaluation form devised by MMU. Results from this were collated and discussed with the teaching team and information provided to MMU for the end of year board of studies. For this study observation of students and informal discussions occurred in the classroom setting. At this stage of their course although they had completed the taught days and their formal presentations they still had to complete a written assessment which was submitted four weeks after the last taught session. Consequently, many of them were anxious about this particularly those who had not previously studied at this level.

Table 9 Summary of Data Obtained on the Final Theory Day of the Course

Event	Evaluation tool	Analysis	Researcher's summary
Feedback on final theory day of the course.	Group discussion, set questions relating to hopes and fears exercise carried out on the preview day	Group analysis of learning as identified by students. Note taken of individual student comments compared with previous data about that student	Students were usually very positive at this stage of the course; although they had not yet handed in their assessments and had therefore not completed the course. Hopes and fears exercise produced some recurrent themes: fears around being able to "pass" the course and cope with studying. The methods of assessment caused anxiety particularly the presentation. However all cohorts could identify the benefits of doing it (afterwards!)
	University devised evaluation form addressing quality issues concerning the educational experience (audit tool).	Teaching team discussion about comments made on evaluation forms	Data from this event alone produced some interesting comments about the perceived quality of support received from both teachers and clinical mentors.

4.2.11 Evaluation Results: The Final Theory Day.

In reflecting on field notes made at this time for each individual cohort there is a recurrent theme of students feeling supported by the teaching team and that they had enjoyed the course even though it was hard. The written evaluation forms also demonstrated this and

explicitly asked the students about their learning experiences:

" this was the best and hardest course I have ever done" **(Hospital Nurse).**

"I thought at first I wouldn't be able to do it, but the support from the teachers has been second to none. Thank you so much" **(Community Nurse).**

"My mentor helped me so much, I couldn't have done it without her"

(Nurse from a Nursing Home).

"I am really sad the course is over, I have learnt so much.

All nurses should do this course" **(Community Nurse).**

"I thoroughly enjoyed the course, even though it was hard work, all of the teachers were supportive and I enjoyed the sessions with the specialist nurses"

(Hospice Nurse)

At this stage of the course the students had not submitted their final assessed work, so the feedback was that the course was not yet over. Action was taken about course content and structure where appropriate and the students were informed of this on the review day. The teaching team also provided the students with an evaluation of how they thought the course had progressed see example below:

4.2.12 Teacher's Reflections of the Principles & Practice of Palliative Care (October 1999 - Cohort)

What was good about the course?

The enthusiasm, interest and dedication shown by students.

Students being willing to share challenging palliative care situations that

they had found themselves in.

A good rapport was evident both with each other and between students and the teaching team.

The variety of subjects chosen and the quality of student presentations.

The support from the team including admin staff who helped everything go smoothly.

What was not so good?

The venue had its moments!

(Author's note: This mostly related to noise from building work and problems with car parking).

There were some problems with placements.

(Author's note: this was about the quality of mentorship and certain clinical placement experiences which were not able to be arranged in time).

The angst experienced by students over the presentations and written assignments which was at times significantly out of control in some students.

4.2.13 Evaluation Encounter: The Review Day

The review day was held three months after the theory days had been completed, it was a mandatory part of the course and 44 students attended, *(n=46 in sample)*. At this stage, the students written work had not been through an academic board so they did not know whether they had successfully completed the course. I contacted the 2 students who were unable to attend in writing and by telephone to enable them to have their comments

included in this study, one student declined to offer any further comments but all students completed the post-course questionnaire.

For the first cohort of students I asked them to complete the post-course questionnaire without them seeing the results of their first questionnaire. When these questionnaires were then compared with the pre-course results this seemed to be an obvious error on my part. These first results seemed to be quite dramatic in demonstrating a positive shift in knowledge, skills and confidence. Consequently, for subsequent cohorts the pre-course questionnaires were made available for the students to compare with their post-course results there and then on the day of completion. This exercise thus gave way to a richer source of data as the students themselves wanted to discuss their results. I was able to clarify student responses and answer their questions. In addition, the teaching team requested to continue to use the questionnaire for other cohorts who were not part of this research study. These later students kept the pre-course questionnaire and were encouraged to bring it with them to the review day and utilise both questionnaires as evidence in their professional portfolios (UKCC, 2001).

A further development has been the use of an adapted form of this questionnaire for evaluating some palliative care education for district nurses being carried out as a pilot study for the Greater Manchester and Central Cheshire Cancer Network see final chapter.

Table 10 Summary of Data Obtained on the Review Day

Event	Evaluation Tool	Analysis	Researcher's Summary
Review day held three months after the final theory day	Post course questionnaire (appendix 8)	Comparison of results with pre course questionnaire by both student and researcher	There were significant measurable achievements demonstrated by the questionnaire. Students were surprised how far they had moved along a particular continuum and although they could vocalise it, seeing it in black and white was an interesting exercise for them as well as the researcher. Common themes were: ↑ in **knowledge** about palliative care in particular pain & symptom management. More effective **communication skills.** Feeling more **confident** about their **skills and knowledge.**
	Group discussion What if any changes have you made in your practice in caring for palliative care patients and their families?	individual student comments compared with previous data about that student	Able to deal more effectively with complex and challenging situations relating to palliative care. Real examples from **practice** which students offered as 'evidence' which could be verified from care plans or discussion with colleagues

4.2.14 Evaluation Results from the Review Day: The Questionnaire

The questionnaire was analysed by just looking at the pre and post scores of each student side by side. Visually it was easy to see whether students had increased or decreased their rating. It provided material for a lot of discussion in the classroom when students considered where they had made changes and why.

Some candidates had scored themselves low pre-course, (meaning they agreed with the statements in the question) therefore they had less room to demonstrate a large improvement. For example: student number 8 was an experienced ward sister working in an acute hospital setting, she would therefore have perhaps more experience/confidence and her initial results demonstrated this.

The questionnaire provided some positive feedback for students in that it enabled them to see some sort of 'measure' of their abilities pre and post course. A number of students *(n=3)* identified they had marked themselves lower post-course in some areas than they had pre-course. This was discussed and they came to the conclusion that it was about having a ***"better level of knowledge".***

One student said:

> ***"You don't know what you don't know and I have a much better understanding of palliative care now, but there is still so much I need to learn. I thought I knew about it before, but I clearly didn't"***
>
> **(Hospital Nurse, Sister Acute Care).**

When students in the study were asked about the relevance of the questionnaire they all felt

it was a useful tool, particularly in identifying/quantifying areas of learning when they felt they had ***"learnt such a lot"***. One student disclosed she had discussed her questionnaire results with her manager formally in her professional development review. Another had utilised it for further discussion of her progress in a new post in clinical supervision.

4.2.15 Discussion of How Students Felt That They Had Changed Their Practice as a Result of the Course.

In the discussion on the review day students were keen to provide examples from their practice of how they had changed. This ranged from them actually implementing new skills to identifying what they termed a "problem case" and how they had dealt with it. Many of these scenarios reflected the challenges that palliative care patients present to health care professionals. Some of the topics raised related to symptom management, dealing with collusion, helping families to cope, dealing with difficult questions and supporting colleagues. For me and members of the teaching team the review day always proved to be extremely satisfying as students demonstrated not only learning but **real application of that learning to their practice.**

In order to verify student comments, I asked them to provide examples in the form of written evidence whenever possible. This was relevant for changes to policy or protocols and I was able to verify the existence of such things as resource files the students had collated. However, it was beyond the remit of this study (and ethical approval) to ask for examples of case notes/care plans. The students were encouraged to identify and write up such information themselves as evidence for their professional development portfolios

(UKCC, 2001).

Rolfe (1993) has indicated that new knowledge does not necessarily lead to changes in practice. However, Dyson (1997) suggested that a gain in knowledge and a positive attitude should lead to an impact on practice. The course that the students were undertaking at CHE had a strong emphasis on the development of appropriate (positive) attitudes to the care of patients and families. The role of the multi-disciplinary team in providing palliative care in all settings was stressed, as were the benefits of multi-collaborative working practices.

4.3 Case Studies

This section provides more detailed evaluation information from four students in the form of case studies. The work of Lawton (2000) and Seymour (2001) influenced the construction of these case studies. Both of these authors have used case studies in the context of palliative care to illustrate incidents, which arose during their fieldwork, which may illuminate issues with a more general applicability. My thoughts having read these authors works was that the case study approach illustrated some of the complexities of their research and provided both breadth and depth. One of the difficulties action researchers face is to 'tell it like it is' whilst maintaining rigor. In this study, these case studies help to demonstrate some of the themes which arose from the data collection period as well as the richness and 'individual variability' of the data obtained. Pseudonyms* have been used for reasons of confidentiality and all of these students gave permission for me to include this amount of detail about them. I was thus able to discuss the information with these students and the discussions assisted me in clarifying my interpretations with the participants. I also

discussed at length the case studies with my research supervisor who was able to question why I had chosen each case study and how each different case study might add to the data I had collected as a whole. The four cases were chosen because these students represented a variety of different care settings. They also demonstrated some good examples of changes in the differing evaluation tools used, for example:

- Caroline provided some profound comments to the evaluator and later changed her job to work more directly in palliative care.
- Paula's written academic work was weak, she was referred on her first attempt at the assignment yet her practical skills were excellent; in addition she very quickly made substantial changes to her practice following the course
- Janet had significant self reported changes pre and post course as measured by the questionnaire and is a good example of a student whose "*confidence increased significantly*" as a result of undertaking the course.
- Heather was an average student academically however following the course she showed strong evidence of using/applying the knowledge and skills she had gained during the course. She became the palliative care link nurse for her area of practice.

If just one measure had been used to identify the 'effectiveness of education' then some rich data would have been lost. Using a variety of tools in this qualitative study helped to illustrate the individual students' perspective. The student who scores highly academically (one measure of the effectiveness of educational courses) does not always apply that learning to her practice. Equally, education is multifaceted and with different styles of teaching and learning it would be naïve to suggest one measure truly captures the 'essence'

of the educational experience. The case studies are structured in such a way that demonstrates the data I obtained from them at each evaluation encounter. I therefore reflected on all the available data I had for each participant, the chosen comments here imply just a snapshot of that data and was chosen because in my view it represented a fair and accurate picture of each participant. In addition my reflections as a researcher about each case study are included in an attempt to illustrate my thinking about the data.

The extract from the first case study 'Caroline' demonstrates a typical CHE student – a mature student with family commitments who qualified as a nurse prior to changes in nurse education (project 2000). It was chosen because it illustrates some of the ethical tensions when students actively participate and seek to change practice as a result of being involved in action research /education.

4.31 Case Study One - Caroline

Caroline worked as a staff nurse night duty (E grade), in a local hospital on an acute surgical ward. She had trained and worked in Yorkshire before marrying and moving to Cheshire. She had taken a break from nursing whilst her children were young and she then completed a 'Back to Nursing Course' in September 1998 before being appointed to a permanent night duty staff nurse post in May 1999. She had therefore recently undertaken some academic work at level 2 but lacked confidence in her academic abilities, she was however very motivated and enthusiastic. She was a member of the April 2000 cohort in this study, and participated in the focus group interviews.

1st Evaluation encounter -at interview

Her reasons for wanting to do the course included:

"Wanting to make her nursing care the best it could be for people who were dying" In addition, she wanted to *"ensure her practice was research based and to be up to date with current thinking around pain management".*

Comments relating to ongoing classroom evaluation.

Caroline was a quiet student who was keen to participate on the course, she was able to share some key issues from her practice that concerned her, these were often related to the fast pace of the work on her ward and the difficulties of finding time to be with patients. She found the communications day useful and was able to use some of the taught strategies with patients and families.

Evaluation of practice and assessment strategies

Her practice placement was in the local hospice where she was able to find out what services were available for patients. She enjoyed the placement and noted how the staff had *"Put the theory into practice".* Her presentation was about hypnotherapy for which she received a mark of 85% Her written work received a mark of 64%. Her post course questionnaire results were positive and she was pleased to see how she had evaluated her learning.

Review day evaluation

On the review day she identified she had *"improved her communication skills and assessment of patients particularly in the management of symptoms"*

She had also challenged a member of the medical staff about medication for a patient's pain with a satisfactory result. She was however distressed that she could not put into practice more of the things she had learnt on the course and was actively seeking a new post.

Final(unplanned) Evaluation encounter

3 months later Caroline had secured a post as a staff nurse D grade, in the local hospice where she had enjoyed her practice placement. She has since been promoted to E grade and is now undertaking a diploma in palliative care at CHE.

Researcher's reflections - Caroline

Caroline was a very committed student; she was interested in palliative care and keen to make changes to her practice. In this respect she was an asset in the classroom because she felt able to challenge things she did not agree with whilst being open minded about new concepts. From an evaluation perspective she had so many ideas she wanted to put into practice yet found it very difficult to do so working in an acute ward environment with others who were unreceptive. Herein lie some of the challenges of action research, as a participant in a research study Caroline may have felt a compulsion to change practice and very real distress when she couldn't. I believe that Caroline did feel she must change her practice but that was as a consequence of her accepting her accountability as a nurse (who had improved her knowledge) rather than because she was involved in a research study. I discussed with her actions she could take to relieve her distress (clinical supervision, documenting issues she was concerned about and discussing them with her ward manager). She was very self-aware and concluded that if she could not change the system; she could remove herself from it! One of the more positive things she did was to join the nurse bank at the hospice before she left her job, this meant she could see for herself what working in the hospice was like and they too could see how she fitted in with the team.

Caroline was a good example of the concept of '*influencing own and others practice*',

which is part of the final model, proposed in this study. Although she eventually left her night duty post to work in a specialist palliative care setting she was able to discuss how she had attempted to influence the practice of others. She encouraged some of her colleagues to enrol on the course emphasising how she felt it had been such a positive experience. Indeed she later acted as a mentor to other students involved in palliative care education.

I have inadvertently been able to keep track of Caroline's progress since completing the course because she is now working at the hospice where CHE is based. She has commenced her diploma in professional studies (palliative care), and reflects positively on her first learning experience at CHE.

The second case study represents a student who was working in a specialist palliative care setting (a hospice) and was initially unsure whether the course would have any benefits for her. She is a good example of how using reflection helps to improve confidence in students, which assists them in changing their practice and that of others.

4.32 Case Study Two - Paula

Paula was a staff nurse in a local hospice, where she had worked for a number of years. She had previously been a second level (enrolled) nurse but had completed her conversion course to become a registered (first level) nurse. This conversion course was at level 1 (certificate level), before conversion courses were available at diploma level. Paula was another student who entered the course with very little academic experience. She was a

mature student with a grown up family and grandchildren, she had significant input to the care of an elderly relative as well as working full time.

1st Evaluation encounter -at interview

She said *"I am not really sure whether I should be doing this course as I have worked in the hospice for some time and I am sure there are other people who need it more than me"* Her manager had proposed she did the course. (This qualification is considered as the basic requirement of those working in specialist palliative care settings). She did however feel she had *"something to offer other students"*

See also appendix 6 for extracts from interview, where Paula expressed these and other concerns.

Comments relating to ongoing classroom evaluation.

In the classroom Paula related well to others and identified similar hopes and fears about the course, hers were mainly to do with the academic part of the course. She identified she *"lacked confidence"* about her knowledge of palliative care (despite working in a specialist palliative care setting) and was keen to improve this.

Evaluation of practice and assessment strategies

She went to a different hospice for her practice placement and spent some time with the community Macmillan nursing team. She was *"not looking forward to practice, yet found it useful"*. She identified there were some differences in procedures that she wanted to implement in her own work setting.

Her presentation was about the use of aromatherapy for palliative care patients and received a mark of 70%, her written assignment was referred at the first attempt but subsequently passed at the second attempt.

Review day evaluation

Her post course questionnaire overall showed **on average no improvement** although she has **changed her practice,** which has had a **significant effect** on service delivery.

Following the course Paula has helped implement complementary therapy sessions in the hospice day hospital for patients, carers and staff. Instead of day sessions where patients come to the hospice for a variety of treatments, and activities a 'Complementary Therapies Day' has been introduced. This means that patients come for specific complementary therapies (a variety are offered such as aromatherapy, reiki, massage, reflexology, yoga, hypnotherapy). In addition, carers and staff can also take advantage of these sessions. This has been so well evaluated as a service, that the way the day hospice was organised has been changed to meet the increased demands*.

Day hospice staff have also noted an increase in the number of younger patients (who did not take up hospice services before) who are happy to come to the hospice for a shorter time and who see it as beneficial. This has the advantage of allowing patients to partake of some of the hospice services before they are very ill, get to know the staff and perhaps alleviate potential future problems by early planning of appropriate care.

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* Since January 2004 the day hospice have increased this service from one to two days because of increased demand from patients and carers thus reflecting a changing need from previous day services offered.

Researcher's Reflections:- Paula

Paula demonstrated no significant change between her pre and post course questionnaire, yet had obviously experienced some benefits in doing the course. She achieved a high mark of 70% for her presentation, which was about the practical application of complementary therapies in palliative care. She found the written work difficult; indeed she had identified this as one of her challenges on the course. She was able to implement some changes to her practice very quickly after completing the course. This may have been because the course gave her more confidence in her own abilities. She had already discussed with the evaluator how she felt she *'didn't have a lot to learn'*. This is perhaps a common feeling with post registered nurses who have a wealth of experience in a particular field. However, there is always the danger of knowledge becoming dated and nurses finding themselves in a rut (albeit a comfortable one!) Paula felt vulnerable because she felt she was "*expected to know*", in my experience as a teacher, well-qualified experienced staff may feel vulnerable and under pressure to perform well on courses and consequently feel deskilled. Using reflective practice can assist them in recognising what they are good at and what experience they already have in order to improve their learning.

For Paula, the course enabled her to take a fresh look at her practice in a non-threatening way and perhaps gave her a 'push' to make some changes, which she had been talking about for some time. In a one to one conversation, she expressed that she had felt quite 'vulnerable' because she already worked in a hospice, and that other students might expect her to know more than she did. She was also aware that as one of the hospice nurses she would be expected by the matron to share her knowledge with her colleagues on return

from the course. As a researcher, it was ethically important for me to identify these 'vulnerable feelings' in one of the participants and take some action to ensure she '*came to no harm'*. Again, it is my belief that Paula would have felt vulnerable whether the research was taking place or not simply because she was on a course. In some ways, it could be argued that being a participant in this study provided both the impetus for her to change her practice but also the underlying support to enable her to do so. This is illustrated by her comments about the evaluation project; ***"it encouraged people to make changes, because we knew you would be asking questions!"*** The students were supported in the way the course was organised by the inherent philosophy of CHE, (which was about valuing students); and by me as a researcher and teacher encouraging them and challenging them. Paula had discussed her ideas for change with me, tentatively asking advice on how she might persuade her manager and colleagues of the benefits of her proposed changes. In this way the collaborative nature of the action research process were experienced by us both.

Although Paula was referred in her first attempt at the written assessment she did demonstrate an improvement in her learning skills overall. This has subsequently assisted her when searching for relevant information concerning her complementary therapies project. She also asked me to speak to her colleagues about how they could evaluate the new service, and a strategy was subsequently developed. This is a further example of how action research can influence the practice of the participants and those they are in contact with in the practice setting. It is also part of the evidence, which influenced the components of the educational model developed as a result of this evaluation study.

Following the data collection period I have been in contact with both Caroline and Paula. This has facilitated evaluation dialogue in continuing above and beyond the time of the initial project. This has enabled me to continue to see and hear how these students have developed their practice. In mentioning this I have reflected on the difficulties of completing an action research project. By its very nature it is cyclical and therefore perhaps is never ending? Although the 'official' data collection period ceased as indicated, I was cognisant of further changes in participants, whom I encountered after the research period had ended. I did not include this data as part of this study but it did reinforce my understanding that changes were ongoing. Additionally it made me consider what other changes the participants I no longer had access to, may have made. Further, it also continues to validate the findings of this study in that changes were sustained above and beyond the official life of the project, (see final model - changing practice).

The third case study is from a student who worked in the community and although part of a team she described her role as 'fire fighting' and she often felt 'alone' and troubled by some of the decisions she faced. She recognised that palliative care patients had less access to other services in the evenings and at night. This led her to believe that her practice must be exemplary because these patients were "vulnerable". Her learning needs were identified specifically around "*symptom management*" but also "*dealing with difficult situations and communicating more effectively with the multi-disciplinary team*".

4.33. Case Study Three: - Janet

Janet was a community nurse who worked on the evening service. She had worked in the community for five years and had undertaken a specific post registration qualification in community nursing. She was academically able and had a keen interest in continuing her studies for the benefit of her patients. She was a team leader and aware of her responsibilities in disseminating new knowledge to the other members of her team.

1st Evaluation encounter -at interview

Her reasons for wanting to do the course were *"to improve my knowledge and skills around palliative care and to help me cope better when relatives become distressed".*

Comments relating to ongoing classroom evaluation.

In class Janet was able to draw on her vast experience of nursing palliative patients and discussed some of the difficulties, she experienced trying to cope with urgent referrals at night. She found working with other students useful because she identified she often felt she was *'working in a vacuum'* and was able to express her frustrations about the organisation of care. She was also able to reflect on the similar challenges experienced by those students working in acute settings.

Evaluation of practice and assessment strategies

Although based at a hospice for her practice placement she also went to the local oncology clinic to which many of her patients are referred and spent time in the chemotherapy centre of a large specialist cancer hospital. "*I learnt about the care patients receive at the hospital and this will help me explain to patients and relatives just what to expect. I feel more confident about dealing with patients who have hickman lines inserted*".

Her presentation was about insomnia in palliative care patients- receiving a mark of 80% and her written assignment was marked at 77%.

Review day evaluation

Her post course questionnaire scores were significantly higher than the pre-course and she said " *this course has really helped me gain confidence, that what I was doing was right even though I didn't always know why. It has helped me deal with student nurses more tolerantly and I hope demonstrate to them more effective ways of communicating*".

Since the course, Janet has helped design an information leaflet for patients and their families about the evening service. She has also acted as a mentor for students undertaking diploma studies at CHE. She is shortly to undertake further studies at CHE.

Researcher's Reflections:- Janet

Janet is a good example of a high scoring student in the post questionnaire. However, her comments were probably of more value from an evaluation perspective. She identified that her practice was appropriate but she did not always know why. This course therefore helped

students like Janet to value their intuition and past experiences, which would now be labelled as 'experiential learning'. The course encouraged her to link theory and practice and apply that theory to her practice situation. Due to the nature of her post (night duty) Janet felt that she did a lot of 'fire fighting' that is dealing with crisis situations in the middle of the night. This is a very challenging role anyway and requires highly skilled practitioners who can problem-solve and make good nursing assessments often with little or no information in advance. Janet identified there was a gap in knowledge in some of her colleagues relating to palliative care patients and that this meant appropriate care was not always given. She also identified that sometimes patients and particularly 'worried relatives' may self refer to the night service. In order to improve the situation for patients and their relatives she has produced an information leaflet that the day staff can routinely leave with families. This assists with communication between nursing staff and the patient and family, at a time when they may be feeling under enormous stress.

Janet demonstrates how being involved in action research can enable practitioners to look at what needs changing in practice and go ahead and do it. Janet was a team leader and highly skilled in her practice. She knew there were gaps in the services she provided and reflection enabled her to consider what the gaps were, why they were there and what she could do about it. Being involved in the research study was *'exciting for me'* as she was eager to assist others in her team improve their own practice through education. She recognised that she had learnt other skills which would enable her to support her team members in their own professional development. She was keen to use reflection as a way of debriefing with her team and felt it was a useful way of considering how to audit good practice.

The final case study is included because I observed how the nature of the learning environment facilitated the personal and professional development of Heather. She was a very quiet student who did not share a great deal about herself with other students and was quite happy to *'just listen'*, She was not confident about her knowledge or abilities; academically she achieved good grades and *'enjoyed her placement'*. In effect, there was nothing particular in the data that made her stand out as an example to share. However, she went on to become the palliative care link nurse for her area and has been tireless in her promotion of palliative care at a level beyond her own practice.

4.34. Case Study Four – Heather

Heather was an enrolled nurse working on an orthopaedic ward in a local hospital. One of her concerns was being able to *'do the course'* and pass the assignment at diploma level, as she had never studied at that academic level before.

1st Evaluation encounter -at interview

She wanted to do the course because *"we seem to have a lot more palliative patients on the ward now and they often die with us. I have always been interested in palliative care and would like to know more so that I can share that knowledge with my colleagues". "I feel as if we could do better in caring for palliative patients I want to know how to do that."*

Comments relating to ongoing classroom evaluation.

Heather was very quiet in class and initially appeared somewhat overawed by the students in her group; she lacked confidence and said very little. However following her practice placement she seemed to gain in confidence.

Evaluation of practice and assessment strategies

"Practice was excellent, I felt I had time to really talk to patients and try to understand how they might be feeling. My mentor was very supportive and let me listen when she had to break some bad news to a relative that was really useful to me"

Heather's presentation received a mark of 57%, and her written work 58%-.

Review day evaluation

In her post course questionnaire, she scored more highly on questions relating to confidence and communication skills.

Following the course Heather has been appointed as the palliative care link nurse in her area. She has also successfully completed her enrolled nurse conversion course. *"Having passed this diploma level unit I knew I could study again, it gave me confidence to go for the conversion course which I had been putting off"*

Researcher's Reflections:- Heather

Heather was a very shy student who did not say very much, she found the academic nature of the course somewhat difficult (although achieved reasonable marks). However, she

made significant changes to her practice. She opted to become the palliative care link nurse in her area regularly meeting with other nurses with an interest in palliative care with the intention of improving practice in a local hospital trust. She also gained confidence in her ability to study and has since achieved a first level nursing qualification. I have met Heather since the data collection for this study was completed; at a study day run by CHE. She appeared more confident and knowledgeable, contributing significantly to the discussions about palliative care patients.

This case study demonstrates how the philosophy of CHE was of benefit to students like Heather. She did not participate very much in class, when I asked her about this she said:

"at first I didn't think I knew very much and didn't want to feel stupid, then later when I felt more confident I didn't feel the need to, .. you know ...like it was ok not to say anything because the group were supportive of each other. I knew I could say anything and people wouldn't put me down... it made me feel good and I know that next time I join a group that I do have something useful to say and will feel more able now to join in. This has helped me more than I can tell you er...I mean explain."

On the review day I asked Heather about any changes in her practice and was delighted to hear that she had been asked to be the palliative care link nurse in her area she said:

"I volunteered for this you know, I mean you can't do a course like this and not share all that information with others. Some of things we learnt like tips on symptom management even the small things made such a big difference. I have also talked to some of the nurses about dealing with some of the junior medical staff, you know when they are new and you are trying to get them to write up some drugs for palliative patients. I sort of get them on my side now, and approach them totally differently. I realise they are probably as scared as

I am of getting it wrong. Now I do the link role I attend meetings with the other link nurses and the Mac nurses and we discuss some of the difficult cases, I have been able to offer my opinion which I couldn't do before"*

Undertaking the course and volunteering for the new role of palliative care link nurse is not in itself unusual, after all as her manager I would expect someone who has undergone specific education to be able to take on such a role. Of more specific importance is the fact that Heather felt more confident to take on the role in that the course had prepared her for it and that she felt that she was operating at the right level.

4.4 Validating Research Data With Students

From an evaluation stance the students in this study were acting as co-researchers and common evaluation questions asked of them were:

"How will you know?" and ***"How do you know".***

This was in particular related to improvements in confidence.

It was discussed individually and with groups of students and was a recurring theme throughout the course. Asking this question assisted me and frequently the student, to clarify what they meant. This is an important aspect of this kind of research ***"Have I got it right" "Is my understanding of your understanding the same?"*** Such member checking adds to the reliability and validity of the research process. A common entry in my research diary was similar ***"How do I know?"*** and led to frequent encounters with students as I attempted to check out findings. This question was often identified around what may be perceived as the more nebulous concepts such as confidence and attitudes, knowledge and skills being much easier to measure and quantify.

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* Mac nurses refers to Macmillan Specialist Palliative Care Nurses.

I was concerned with investigating exactly what it was, that occurred for students during the educational process that enabled them to make changes to their practice. This thinking was triggered by several students (from various cohorts) who had repeatedly stated that courses at CHE were '*different*' to those they had undertaken in other educational establishments.

When asked to identify how or why courses were different, most answers related to what can only be described as good educational practice (Reece & Walker, 1997). For example, students stated:

"That they were listened to". "Their opinions counted".

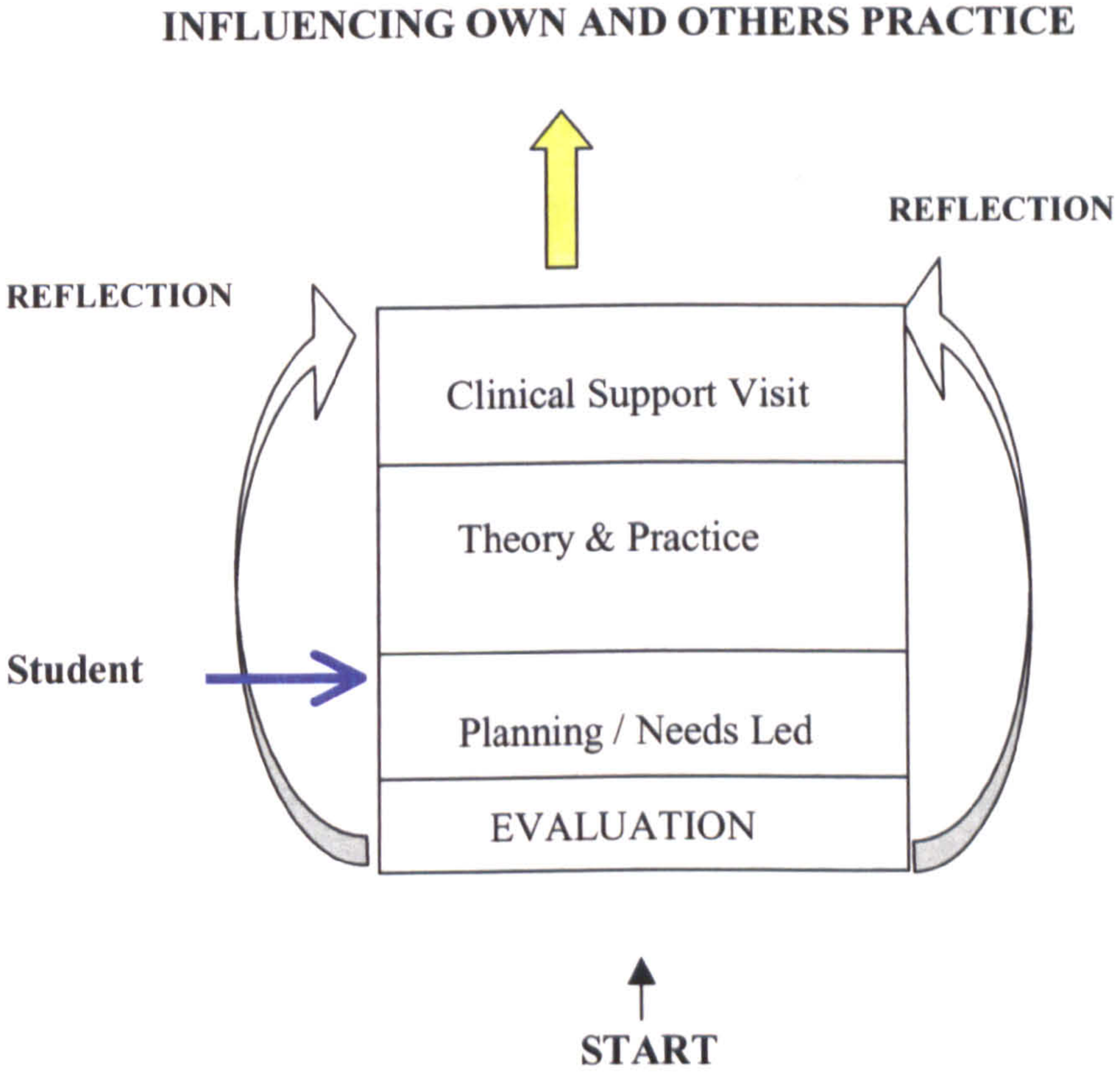
"Tutors were interested in us, enthusiastic and supportive". "They were valued".

"They felt comfortable disclosing personal issues and difficulties surrounding their practice".

On reflection, noting what students had said about their previous educational experiences, it appeared that a significant number had experienced poor teaching and support on other courses. Given that palliative care is provided to what could be considered the most vulnerable of client groups (Faull & Woof, 2002); it is essential that those receiving palliative care education receive quality education. Those providing palliative care education have an obligation to demonstrate evidence of efficiency, effectiveness and value for money; it must therefore meet the needs of practitioners and make a difference to service users. The following model was envisaged in an attempt to explain how the main themes derived from the data collection could be utilised in an effective way to demonstrate how quality palliative care education may be delivered.

4.5 A Model of Education for Palliative Care: (Stage One)

Figure 11 A Model of Education For Palliative Care- Stage One



4.51 The Components of the Model:- How They Were Derived.

Evaluation

The model rests on a foundation of evaluation. Evaluation enables judgements to be made about the merits of a programme or service against a standard or baseline of acceptability. The ever expanding costs of providing health care require practitioners to provide evidence of efficiency, effectiveness and value for money. The same argument

applies to palliative care education, it must meet the needs of practitioners, be effective and value for money. Evaluation is therefore a vital element in helping to ensure the quality of education. It assists in making appropriate changes to programmes because of good evidence, and not just as a reaction to students or teachers comments. Beattie (1991) identified the concept of *'portfolio evaluation'* where evidence is collected from multiple stakeholders to inform the evaluation process. Using stakeholder evaluation strategies serves to provide a more balanced view. It ensures a voice for all who are involved in the educational process, thus helping to alleviate any bias, whilst demonstrating the trustworthiness of the findings. Systematic evaluation studies of educational programmes will help provide relevant information to all stakeholders as well as providing an evidence base of good practice.

Planning:- needs led

Education in palliative care in the past has been limited within the curricula in pre-registration nurse education (Copp, 1994; Yates et al., 1996; Lloyd-Williams & Field, 2002; Dowell, 2002), and has until fairly recently been rather ad-hoc for qualified staff (Langton et al.,1999). The inclusion of the student at this stage is essential so that the content of educational programmes is relevant and meets the varying needs of students. In practice, this may be difficult to achieve particularly before programmes run. However, it is not impossible, as planning is a dynamic process occurring at different stages of all educational programmes. At CHE, a high level of commitment to the planning process is encouraged from both prospective and former students. Clinical staff of all grades and from a variety of disciplines, are also part of this planning process. As

an experienced nurse teacher, I had been used to the notion of student involvement at various planning meetings. However, at CHE there has been a **greater emphasis** on this involvement, with a real desire to engage with students and a willingness to experiment and try out new ideas.

The study from which this data is derived, comprised of qualified nursing staff of various grades and experiences, **all** stated that they wished to improve their knowledge about palliative care. With such diverse experiences and learning needs, it therefore becomes essential that the students are involved in the planning process, in order to make their learning relevant. This is also necessary if the educational programmes are aimed at multi-disciplinary teams rather than just nurses, something the NHS Cancer Plan (DoH, 2000) identifies as an important way of improving services. Providing students with the necessary tools to assist them to identify their learning needs is part of a committed student centred approach. Involving students at the planning stage also demonstrates a willingness on the part of the teachers to really listen to student's concerns and a more equal power relationship where teachers act as facilitators of learning.

<u>Theory / Practice</u>

In line with recent reports about nurse education per se (UKCC, 1999), I acknowledge the importance of theory **and** practice. The model seeks to demonstrate an equal weighting between theory and practice. According to Langton et al., (1999) the opportunity for practice placements in palliative care has been limited, particularly for post registration students. Educationalists **must** address the issues relating to providing high quality

practice placements where students are well supported, and learning opportunities maximised. Otherwise, courses will be seen as *academic* and unrelated to practice, thus widening the so-called *theory practice gap.* This study was essentially about education having a positive effect on practice (or not). Nursing is about practice and it is my intention that students should be able to see the relevance of theory to their practice at any educational event they attend.

Reflection

Is shown in the model as commencing at the evaluation stage, (which requires reflection), and developing through each component so that eventually the student is able to influence their own and the practice of others. Reflection is a process rather than a one off event. From the extensive literature written about reflection in nursing practice, the common line of reasoning is that reflection is thought to create the opportunity for improving practice through learning (Schön, 1984, 1987; Boud et al., 1985; Shields, 1994; Palmer et al., 1994; Ghaye et al., 1996; Ghaye & Lillyman, 2000).

Reflection occurs at all stages of the model, and is inherently linked, to both education and evaluation. However, as Wong et al., (2001) so eloquently stated:

"*the attainment of reflective learning is developmental*" (p55) and, the development of reflective learning is *"unique to that person" (ibid);* it is therefore an integral part of the educational model devised. The intention being that once students have learnt to reflect on their own practice (the good and the bad) they can then help others to reflect on practice. This is equally about the personal and professional development of students, which ultimately contributes to the ongoing development of

practice settings. As a result of the experience of explicitly using reflection as a tool for learning, a further paper has been published that describes a method of using reflection in palliative care education (Kenny, 2003a, see appendix 3).

Clinical support/visit

A named mentor supported the students in their clinical placements. These mentors worked with the students to identify how they could help them achieve their individual learning outcomes (as identified in their learning contract see example appendix 11) in practice. The mentors were all qualified nurses working in a specialist palliative care setting (a hospice) and had undertaken preparation for their mentorship role either with CHE, or another higher education establishment. The mentors were invited to attend the afternoon of the preview day of the course to meet the student and commence working with them on the learning contract. Mentors were invited to an annual updating and feedback meeting with the team at CHE and were seen in practice when members of the teaching team met with them and their student. Some mentors participated in the focus groups used in this study. Student feedback stated that the quality of this mentorship was a very important part of the learning experience.

A member of the teaching team visited all students at least once during their clinical placement. The purpose of this was to ascertain whether the student was making relevant progress with their learning contract and to offer any additional support and academic advice. This aspect was included in the model because this visit was well received by the students and mentors, and enabled the teaching team to be seen to value practice. It

provided good opportunities to visit a variety of different practice settings over a wide geographical area and assisted with the planning of other educational events at CHE. Teachers were able to talk directly with practitioners and hear their views and expressed educational needs.

Influencing own and others practice

The ultimate goal of palliative care education must be to influence, improve or change practice, so that it benefits patients and their families. High quality education improves knowledge, skills and attitudes, more importantly it produces confident competent practitioners who question their own and the practice of others. This aspect of the model is about recognising the need to disseminate and share good practice, whilst acknowledging the responsibility of all practitioners to be accountable for their practice. Recognising the work of Knowles (1984) that education should recognise the individual learning needs of students, then it should also change the way they perceive and respond to situations. If the goal of palliative care education is to improve care for patients then the student must be able to apply what they have learnt to their practice. Sneddon (2004) confirms this when she states:

> *"specialist professional education should seek to enable participants to deliver best clinical practice"* (p638)

Lifelong learning is beginning to be part of the culture of health care, but such learning needs to be meaningful for all stakeholders i.e. managers, students, teachers, patients and families. Including this as an explicit part of the model was intentional and about demonstrating the responsibilities of the students to disseminate information and share

their learning with others.

4.52 Researchers Reflections – Model of Palliative Care Education (Stage 1)

As previously explained the model of education was derived from the data collected during the study. It was my intention to use the model as a way of explaining to others how education at CHE had influenced palliative care practice and to offer it as a framework for others to follow. On reflection, the process was not quite as simple or explicit as that. This section is included in an attempt to clarify what is 'new' about the model, how it was derived from the data, what was already there and what I learnt.

CHE operates within some philosophical principles, which were identified in the student handbook (see appendix 1). An important key principle is that of valuing the student. One aspect of the model identified is that the student is involved in the planning this was already implicit in the way the course was designed and in how it was operationalised. However, it is my belief that students did not necessarily recognise the extent of this, nor their power to really influence things. They elected a student representative to speak on their behalf at the course committee and were encouraged to select the content of lectures. In fact, the teaching staff gave great priority to ensuring that the students had a 'voice' and that material was relevant. The nature and content of sessions were negotiated and changes made following discussions, students were encouraged to bring their 'issues from practice', which were then utilised as part of teaching sessions. For example: one student described a difficult situation involving a patient whose wife did not want any nursing input from the community nursing team, they were then called in when there was a crisis.

This example provided an abundance of material for consideration of patient choices [place of death], ethical issues about permission for care, the role of the professional, autonomy versus paternalism, as well as symptom management the session in which it was first raised. Using student's experiences in this way in teaching is nothing new however, the extent to which this happened was very high and was part of the emphasis on the 'reality of practice'. As a teacher, this way of working demonstrably encourages reflective practice, which is one of the things CHE was trying to do. In addition, several writers have identified parallels between the philosophy of palliative care and the palliative care education (Sheldon & Smith 1996; Dowell 2002; Sneddon, 2004). Comparisons have been made between the difficulties patients face on their 'illness journey' and the difficulties students face in responding to new sometimes challenging experiences; according to Sneddon (2004)

> *"respect for their choices and feeling valued as an individual is important for each within their own context"* (p639)

When discussing the model at the focus group interviews (more detail is provided in chapter six); students expressed surprise at being included as part of the planning process. Clearly, they had not been cognisant of that fact at the time they were students; despite agreeing that they had been able to influence the way the course was structured and delivered! It is therefore included explicitly as part of the model because I think students should be explicitly made aware of their responsibility to be involved in the planning of their education. Furthermore, it acknowledges a shift in the power relationships of students and teachers to one that is more facilitative.

When I was interviewing students as part of this study a continuing comment was how they felt that the teachers on the course were '*in touch with what really happens in practice'* and how they felt that by using examples from their own practice they were able to *'reinforce our learning'.* The organisation (CHE) has identified the importance of practice demonstrated by teachers spending part of their time working in practice settings as nurses. Inherent within the ENB course practice placements were mandatory. The students were aware that in order to successfully achieve the ENB award they were **required to attend 100%** of practice placements and 80% of theory sessions.

My decision to include theory and practice as part of the model was centred around the idea of both being equal in value. In subsequent conversations with students, they valued the practice placements highly and sometimes the theory less so! Others were anxious about practice placements wondering why they were included. Although in this course the practice placements did not equal 50% of the course, it was my intention in the model to have them as equal weighting. This is in line with recent thinking in nurse education, particularly pre-registration training. In my view, nurses need to value their practice as much as the theory, which underpins it. This was confirmed by my conversations with students following their practice placements.

One of the challenges I experienced during this study was how to get 'from' the data I had collected to articulate what was happening to the research participants. Decisions of how the model should 'look' were complex, although I had some idea of the 'components' of

the model (derived from the data as previously explained); I had no idea of how to put them together visually. My first attempt depicted the model as a set of jigsaw pieces (the components), then I decided on a more linear approach because I wanted to demonstrate the 'process'. Evaluation as a first step was because I was doing an evaluation study and from my knowledge and understanding of that concept, I wanted to depict it as the 'foundation' or beginning of the model.

The clinical support visit was initially included as an attempt by teachers to check out that practice placements were progressing smoothly; especially with the early cohorts. CHE was a new organisation running a new course with practice placements in settings over which CHE had no control. However, the visit soon became more than just merely checking things were ok, mentors approached teachers for information and advice and students asked teachers for educational guidance particularly relating to assignments. Students were also able to consider how they were progressing in meeting their clinical learning objectives and in discussion with teachers and mentors identify their achievements to date. In my role as researcher, I was using this visit to practice settings to collect data from participants, mentors and managers. It was included as part of the model because it serves to underline the importance of teachers and practitioners working collaboratively. It also demonstrates the importance of the practice setting as a learning environment, in my opinion this has been somewhat undervalued by students, practitioners and teachers. Additionally it helps teachers recognise the realities of practice and hence tailor make lessons to meet the demands of practice.

4.6 Mapping the Action Research Process in Relation to the Evaluation

The following diagram figure 12 page 190, is an attempt to demonstrate how the data derived from and during the action research process influenced the evaluation process and vice versa. It also demonstrates how/when the research had an influence on practice.

The reader is asked to consider how at various stages of the educational process the course participants were influenced by the action research process and how such triggers then went on to affect their practice (demonstrated in the diagram by arrows linking to practice and to education). For example at the pre-course interview in addition to providing them information and negotiating consent for them to participate in the study the students were already being asked about their current practice and what they might gain from the course. Whilst I would consider this is perhaps a common enough question for any student expecting to take on further studies the very fact that part of this study involved some ongoing evaluation of the course, the team, the organisation and the students in some way seemed to provide the students with an added impetus to do well.

When I explored the importance of evaluation with various student cohorts they recognised that CHE *"does more than pay lip service to the notion of quality education" (October 1999 student).*

> *"Being involved in the research made me want to do well for CHE as well as for me" (April 1999 student).*

> *"I knew you would be asking me questions, it sort of helped keep my enthusiasm high, especially as it was a new course" (October 1998 student).*

> *"It was interesting being part of the whole thing, you know, you looking at the organisational elements as well as us as a cohort and indeed me as an individual. I didn't understand how research/evaluation could have such a positive influence until I was involved" (April 2000 student)*

Figure 12 Mapping Action Research & Evaluation

Educational Processes START ▼	**Action Research/Evaluation**	**Practice**
Pre course interview	↔ Consent to study Negotiated with course participants	Thinking about palliative care placement Data about confidence competence, skills
Preview day	Developing learning contracts ↔	Identifying current knowledge and skills and any gaps
Classroom activities during the course. Including feedback from Practice placements.	Feedback* Observation, reflective practice Feedback ↔	Data –communication Skills gaps How does this affect my practice now? What have I learnt? Data –value of practice
Assessment	Reflective practice Feedback Feedback ↔	Using critical incident from practice for written assignment. Data ↑ practical skills communication, confidence Identify topic to research for presentation To inform practice
Review Day	Feedback ↔	Verification of Changes to practice
	Model of Education (stage1) Feedback ▼ **REVISED MODEL OF EDUCATION** ↔	Data from Focus Groups ←

KEY ↔ Evaluation affecting both the educational process and practice.

* Feedback points where I as the evaluation project leader gave information to others about the progress of the research study, others = other stakeholders as well as participants (students)

Figure 13 Mapping Action Research Data to Model of Palliative Care Education Stage 1

Data derived from the Action Research	Components of the Model of Palliative Care Education (Stage 1)	Rationale / Comments
Lack of confidence, competence, poor practical skills especially communication and dealing with complex/ challenging situations	EVALUATION	This allows a baseline to be identified. It encourages all participants to ask the question what do I need to know and why? It means that programmes of education can be flexible to meet practitioners needs.
Feelings of being de-skilled, Not knowing what or how to learn. Feeling anxious about returning to study. Low self scores in baseline measures.	PLANNING NEEDS LED	Allowing students to be involved in the planning of education enables it to be relevant and realistic. It also helps them to feel valued.
Using experiential methods in the classroom assisted the students to 'have a go' and try out difficult scenarios in a 'safe' setting. The value of clinical practice placements supported by appropriately skilled mentors. Students & mentors questions in practice	THEORY & PRACTICE CLINICAL VISIT	The value of practice is well documented in the literature, it was my intention to demonstrate that practice placements need to be well supported by appropriately qualified mentors and that teachers also need to be credible practitioners, and in touch with practice. Hence the need for both to be considered of equal value.
Students becoming more questioning, challenging each other. Bringing experiences from practice to discuss in the classroom. Demonstrating their ability to apply what they have learnt to new/ different situations.	REFLECTION	The importance of reflection was an inherent part of the course. However students noted its value in helping them to change their practice and how it assisted them when questioning others. It helped them to look at alternative ways of working and be more flexible.
Students taking action, changin own practice and that of others	ACTION PHASE	Demonstrates the 'transferability' of Learning to new situations.

NB: The reader is now directed to read the paper in appendix 3

<u>Education in palliative care: making a difference to practice?</u>

Which was published in August 2001, as formative results became available from the data collection.

Summary

- The data collected is summarised at each stage of the evaluation process, and the context and results discussed. Individual student comments are offered as case studies to illustrate how and why I came to a particular conclusion.
- I have discussed how the question *"How do you know?"* influenced the analysis of data and acted as a check on the validity of the information presented.
- Early positive results from the data collection suggested that education in palliative care did make a difference to student's practice; this led me to consider the development of a model of education – stage 1
- Recurring themes from the data included an increase in confidence of students, recognising they had improved their knowledge and skills relating to palliative care and that they were able to apply this to their practice.
- Diagrams have been used to explain how these themes from the data link to the proposed model of education.
- Evaluation processes facilitated learning back into the educational process and also to practice (figure 12), for students and the organisation CHE.

CHAPTER FIVE

The Utilisation of Focus Groups In This Evaluation Study

5.1 Introduction

Focus groups were used, as a method of gaining information from the research participants in this study. They were held towards the end of the study so that I could check out with the research participants my findings up to that point. Also, as the preliminary model of education had been devised from data already obtained, there was a wish to validate its' components with the students and other stakeholders and ask for their comments. The intention was to utilise such information to change the model if necessary.

This chapter is sub-divided into three main parts. The first part describes the theoretical background to focus groups as a method, including the historical perspective. A detailed commentary on the use of focus groups in research settings is presented in order to provide some academic context. The discussion also highlights the rationale for using this method within this study. The second part contains an explanation of the planning, organisation, and conduct of the groups used in this study. Information, which was obtained from these groups, is explored in relation to the research question. This was also a method of ensuring trustworthiness of the data, which had been generated earlier in the study. Finally, a description of the learning, which occurred for the researcher, in relation to both the methodology and the content of the focus groups, is provided. This serves to demonstrate both the powerful and sensitive nature of this particular research study and the benefits of this strategy to elicit real *'experiences'* from the participants.

5.2 Theoretical Perspectives

5.21 Focus Groups – Historical Influences

Kitzinger (1994) identified that focus groups were first mentioned as a market research technique in the 1920's and have been used in social sciences research since the 1950's. Although according to Bloor et al., (2001) focus groups as a research method were instigated by Paul Lazarsfield and Robert Merton working at the University of Columbia in the 1940's within the field of market research. This early work aimed to investigate the public's response to radio programmes and wartime propaganda. Later this technique was used by food manufacturers, to target the marketing of their products to certain groups of people to gain responses to different kinds of packaging. Researchers from other fields, particularly the social sciences, saw that focus groups would enable them to get information from a wider range of people in a short time frame (Grbich, 1999). Focus groups have also been extensively used in political research (Kitzinger, 1994).

5.22 Defining Focus Groups

Focus groups are essentially group discussions where the interaction between participants is part of the data collection process (Owen, 2001). Kruegar (1994) defines focus groups as carefully planned discussions, which are concerned with obtaining the perceptions of a specific subject in a non-threatening environment. The researcher is not necessarily looking for consensus but merely reporting the experiences of the group. Instead of asking questions of each person in the group, focus group researchers encourage the group to talk to one another. Kitzinger (1995) explains this method is therefore useful for exploring people's knowledge, and experiences as well as how and why people think in a particular

way. Focus groups allow researchers to not only consider group meanings but also group processes and norms (Bloor et al., 2001). For example: in this evaluation study the focus groups were used to ask questions about the clinical practice placement that students undertook as part of their course. The focus group became a legitimate occasion for students to really question the value of the placement, away from the 'classroom setting', where the teachers had already provided their opinion of how valuable the placement was. Kevern & Webb (2001) indicate that all the definitions of focus groups within the social sciences literature share *'common elements'* (p323); such as a small group of people, who possess certain characteristics, which meet for a focussed discussion. The discussion itself provides the qualitative research data.

5.23 The Advantages of Using Focus Groups

According to McHugh & Thoms (2001), focus groups can be used to collect in-depth data, which cannot be achieved by other research methods. They may be seen as effective and economical in terms of time and money, and have been suggested by some researchers, (Barbour & Kitzinger, 1999) to be a useful way of facilitating changes in organizations. Bertrand et al., (1992) stated that focus groups offer a number of practical advantages as they can be conducted in a short space of time and with limited resources. The findings may also be more readily acceptable to decision makers because they can be presented as a 'narrative' rather than statistics and complicated analytical tables (Bertrand et al., ibid).

Focus groups are different from group interviews because of the overt way group interactions are used as research data (Morgan, 1998; Kitzinger, 1994, 1995); the nature of

these interactions is important too. For example: Milburn et al., (1995) also identified that focus groups can reveal *'social processes in action'* (p353) because the researcher can examine how ideas develop in a social context. In this study considering the effectiveness of palliative care education, conducting focus groups enabled me to observe those students discussing the **reality of practice issues about real patients;** what the students did or did not do, and how their attitudes as well as skills and knowledge had changed with reference to palliative care. This 'reality of practice' is difficult to replicate in a classroom situation and for the participants the focus group was a 'safe' environment in which to discuss their practice. It was important to provide a safe environment and I intentionally used a meeting room rather than a classroom, to enable the students to identify me in my researcher role rather than as a teacher. In addition, the researcher was not expecting to meet with the students again (in a teaching capacity), nor were they expected to meet up with each other (other than in a professional capacity), thus, confidentiality was established.

Using focus groups in this study gave me the opportunity to report information from students, from their perspective, as accurately as possible. This helped to validate data already collected and provided further research information to work with; for example: one student identified that following the course she now felt better equipped to deal with grieving relatives. On further questioning, it became clear that she had received little information/preparation for this previously but that she had also been able to recognise *'good practice'* whilst attending her clinical placement. She had further discussed with her placement mentor some strategies she might adopt in her own working environment, and since then successfully tried them out. From a research perspective this incident

highlighted the problem of when to actually collect information from students and how long to leave it. In fact, I felt that I never really resolved this question during the research process! However, students were asked to contact me if they were tackling any new projects because of the course, or indeed making any organisational changes. A large number (10), students, did this prior to the data collection period being completed, and I have since identified changes students have made outside of this time period. Three students actively changed their employment and found posts working in specialist palliative care settings (hospices), one student carried out an audit of palliative care services provided to patients in two community districts, because she suspected there were inequities regarding service provision. Both she and her manager informed me of this during evaluation encounters. Many students (from different settings) identified a lack of knowledge regarding pain and symptom management within their teams and the focus groups allowed them to discuss what they could realistically do about this. The focus groups allowed for both individual and group responses.

Bloor et al., (2001) considered focus group discussions to provide:

"rich data on the group meanings associated with a given issue" (p7),

and that the focus group *"may give privileged access to in-group conversations" (ibid).* (This point has already been made in the discussion of the merits of the insider v the outsider evaluator, chapter two page 86.) Kitzinger (1994) identified the benefits of bringing focus group participants together from pre-existing groups because they bring to the interaction comments about shared experiences, which may promote further discussion and debate. This was an intended outcome of the sampling strategy for this study, all the

focus group participants belonged to a pre-existing group, be that nurse/student, teacher, or mentor.

Owen (2001) described the use of focus groups within health care services as a useful method of obtaining the:

> *"views of clients, care-givers and service providers about health and health care"* (p652).

Focus groups have been used for this purpose in the field of health education (Weiss, et al., 1993) and health promotion (Higginbottom, 1998.) The study described here obtained the views of a wide variety of stakeholders within palliative care education in order to contribute to the knowledge base of what constitutes effective palliative care education and how such education ultimately benefits patients and their families who require palliative care.

Wiles (1996) commented that focus groups used to obtain information about patient satisfaction with services, might provide better quality data than just using survey methods. This is because being part of a focus group helps participants feel they belong and have something to offer; they feel part of the service they are being questioned about. Although this does also depend on how well they are facilitated. Researchers and service providers in order to effectively promote good services, which meet the needs of clients; can use this 'empowering' nature of focus groups. This reflects the ongoing debate about incorporating focus group methods into:

> *"participative public decision making"* (p.6).

highlighted by Bloor et al., (2001). Interestingly, within the United Kingdom, focus groups have also been used in the evaluation of nurse education by distance learning (Macintosh, 1993), and the evaluation of the assessment and supervision of nursing students (Clark, 1996).

Barbour (1999) argued that focus groups used in conjunction with other structured research tools might be an appropriate tool for studying organizational change. Morgan & Krueger (1997) described how focus groups are useful for studying the success or failure of particular programmes, are well suited for pilot studies and, if used in a longitudinal research design enable participants to comment as the programme unfolds. The focus groups under discussion in this study were used with both of these comments in mind.

Bloor et al., (2001) identified the usefulness of using focus groups in research studies primarily when used as an adjunct to other methods. They suggested that focus groups could be used in pre-pilot studies to provide context, as an extension to survey and other methods, as an interpretative aid and to gain insights to findings. Finally, they can be used to communicate findings to the research participants. In this study, the focus groups with the teachers involved in the project were carried out before the focus groups with the students. This enabled me to check out some initial ideas with the teachers and to pre-test some of the findings with the teachers before asking the students; for example: the perceived increase in confidence of students after the clinical practice placement. The educational model stage 1, (see page 179) was also presented first to the teachers, although

the same model was then presented to the students (with and without the teacher revisions, which related to specialist practice, rather than just practice). Written information was sent after the focus group meeting to individual participants to comment upon, in order to verify the data information, which had been collected. This information consisted of the questions and answers provided by the participants (with their names) plus an overall summary of the discussion. The participants were asked to verify they had said what was written down, was there anything missing from the written information and did they have anything further they wished to add either about the conduct of the session, the content, or their part in the research study. Therefore, focus groups in this study were used in the middle and towards the end of the project, to check out findings and as an interpretive aid in gaining insight to how the educational process was perceived by both students and teachers. They were also used to provide information to research participants about the progress of the study and were an ancillary method to other methods, thus contributing to the triangulated approach of methods to help provide an accurate representation of reality (Depoy & Gitlin, 1994). The evidence from the focus groups added a depth and richness to data already collected, which was beneficial in confirming previous findings.

From my viewpoint in this study, the use of focus groups as a strategy was deliberate because they were a form of participatory evaluation in themselves. According to Shaw, (1999), this is especially relevant where there are power differentials between the researcher and research participants. In this study as well as being a researcher, I was also a teacher and some of the focus group participants were students. Focus groups allowed the students to act as co-researchers in this project and lead the discussions in potential new directions.

This was a powerful co-learning experience for all those involved. The teachers and guest speakers also reported this 'powerful' quality of being involved in the focus groups, one participant said it had confirmed she was *'doing a good job'*.

5.24 Disadvantages of Using Focus Groups

Focus groups have been reported in research literature as useful methods of exploring sensitive topics such as sexual behaviour and attitudes (Wellings et al., 1994) and HIV (Kitzinger, 1994). However, conflict may occur when people hold very different views, this may inhibit discussion and can be distressing for individuals (Hudson, 2003). Bloor et al., (2001) noted the need to ensure that participants disclosing sensitive information 'feel safe' and that they may require an individual debriefing to ensure no harm occurs. A research ethics committee should be involved and advice taken accordingly. For the purposes of this study, ethical approval was sought and gained from Liverpool John Moores University ethics committee. I was required to describe how the research was to be carried out, whom the participants were and how confidentiality of information obtained was to be maintained. It was unnecessary to inform the local ethics committee of the study as patients or relatives were not involved.* All participants of educational courses at CHE were aware of the study as were managers and other stakeholders, indeed it helped to raise the profile of CHE with fund holders who were keen to acknowledge the importance of the process of evaluation.

It is important to consider what groups of people are invited to form a focus group. Those

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* (The author is aware of new 'research governance' directives that have been instigated since this study and of the continuing need to ensure participants come to no harm as a result of any research project).

focus groups comprising people from relatively homogenous groups may have nothing to say or all appear to agree. However, Shaw (1999) writing about the use of focus groups in evaluation studies suggested that current:

> *'best practice is to work with homogenous groups'* (p 155).

He noted this produced information in greater depth than by using heterogenous groups. A further problem of focus groups according to Crawford & Acorn (1997) is that the group may feel the need to try and reach a consensus rather than discuss their own individual beliefs and views. Therefore, the selection of participants to the group and the ongoing facilitation of the group require careful attention.

As previously stated focus group discussions reflect group processes and informal and formal group structures. Bloor et al., (2001) identified a focus group conducted in a health centre where the nurses deferred to the general practitioners thus reflecting their hierarchical working relationships. To overcome this problem in this study the students who met in the focus groups came from different cohorts, (thus reducing the influence of the pre-existing group norms). In addition, students came from different work settings i.e. they were not work colleagues and although many were of differing nursing grades (thus the potential for hierarchical status existed), as far as I could ascertain, this did not appear to be a problem.

Shaw (1999) warned against the use of group interviews being labelled as focus groups regardless of how they are conducted. He noted they should not be used as a vehicle to

improve communication or group process skills; neither should they be used for 'therapeutic purposes' a point also made by Bloor et al., (2001). Silverman (2001) considered some qualitative interview studies (like focus groups) might merely provide *'anecdotal insights'* (p293) rather than a rigorous analysis. I was aware of this as a potential problem within this study. To overcome this it was important to be continually questioning about the information provided. One interesting aspect to this study was whether what students were saying about changes to their practice, immediately after their clinical placement and again on the review day could be corroborated or not. Indeed that itself was a challenge, both in terms of resources, and issues relating to confidentiality. I was looking for evidence to confirm that education had made a difference to the way students nursed palliative care patients, whilst also being aware that if they had changed their practice it may affect other patients not just those requiring palliative care.

The success or otherwise, of focus groups rests heavily on the skills of the focus group facilitator. Those skills require the facilitation of the group, not control of it. Facilitation involves ensuring all participants' views can be heard and that no one person dominates. It may also require the refocusing of questions so that participants actually answer the questions the researcher need answering. Therefore, a disadvantage would be the unskilled facilitator who was judgemental, posing as an 'expert', in their field or one who made assumptions. Facilitators also need to be able to think on their feet to clarify ambiguous statements and ensure that potentially interesting points are explored.

Only a limited number of questions can be explored in a focus group setting. It has been

argued that it may be impossible to explore questions in detail or follow up interesting leads (Grbich, 1999). However, from personal experience in this study I would argue the focus should be on getting a few questions right and thus allowing the discussion to develop according to the participants' views. In retrospect, the experience of participating in educational courses at CHE is all about valuing students and ensuring that they feel they can have their say. Conducting focus groups was an extension of that philosophy.

Since the completion of this study Hudson (2003), has identified that although there are recognised general approaches to the conduct of focus groups there has been little in the way of exploring the issues of focus groups with palliative care topics/populations. He further asserts there is a need to report any ethical or practical considerations for further debate, in order to add to and enhance the utilisation of this method within the field of palliative care.

5. 3 The Planning, Organisation & Conduct of Focus Groups in this Study

Planning/organisation

As previously stated there was a deliberate intention on the part of the researcher in choosing focus groups as one of the methods of data collection in this study. That intention was around the perceived learning potential of focus groups, for all participants (including the researcher), and the evaluative nature of focus groups. Equally, it was about valuing the participants and attempting to inform participants about the progress of the study

(particularly those who participated in the first part of the data collection in 1998). This serves to demonstrate the underlying philosophy of this evaluation study, which was collaborative and participatory.

5.31 Focus Group with Teachers/Guest Speakers (Pilot study)

Running a focus group was a new experience for me, therefore, it was important to spend some time considering what sort of questions needed to be asked and what information was to be disclosed to the participants. The first focus group was held with a group of teachers/guest speakers who had been involved with all the courses since 1998 *(n= 6)*. This first group proved to be very much a 'pilot study' and test of both the content i.e. questions to be asked, and the process, i.e. the way the focus group is facilitated.

At this stage in the data collection, there was already a wealth of information obtained from questionnaires, individual student interviews and group reflections about practice before and following the course, (see summary from reflective diary appendix 7) This information supported the premise that education in palliative care (provided by CHE), did make a difference to the way nurses practised. Students had identified they had more confidence, had greater skills in symptom management, and felt more able to question colleagues, especially medical staff, about treatment regimes for patients. Many students had identified particular skills they had learnt or developed further whilst participating on the course. Such skills included the setting up of syringe drivers (this was a particular theme from community staff that has to use this equipment in patient's homes but may not use it on a regular basis and so often lack confidence in their abilities); using complementary therapies

and helping patients cope with fungating wounds.

I therefore spent some time trying to devise questions, which were unambiguous and would provide information to explore the above findings. Essentially, the focus groups were about providing more detailed information, from the research participant's own perspectives; whilst checking out some of my initial thoughts, which had been gained from being reflexively immersed in the data. Finally, from the analysis of data obtained up to this point, I had developed a proposed model for palliative care education, which I wished to share with the group (see page 179). It was important to find out if this model truly reflected the experiences of the educational processes they were involved in at CHE and whether they felt some important aspect had been missed. This was true collaborative research as I was not a specialist in palliative care nursing, but all of this group of teachers/practitioners were.

It was deemed wise by the researcher to personally invite participants (and thus gain consent), to the first focus group meeting. This involved careful explanation as to the purpose, place and suggested times of the meeting. The purpose of the meeting was to find out their views of the educational process, and how they perceived the students at the beginning and end of the course, whether they noted any obvious differences especially related to confidence. Information was also provided in writing to the participants and they were offered a variety of dates/times to choose from. At this stage, a sample of the proposed questions had been given to each individual participant to reflect upon before the focus group meeting. In part, this was due to time constraints of getting all relevant participants

together at the same time. Plus, the time available for the meeting was quite short and the researcher wanted to provide something, which would stimulate and create reflective thinking for the participants in advance of the actual focus group. On reflection, this worked well for all parties as it allowed the participants to think about the questions prior to them being asked, it also allowed the researcher to acknowledge how 'busy' the participants were and that the focus group was taking them away from their clinical practice. This strategy was an attempt to lessen the time they were away from their 'work' whilst maintaining a rigorous research protocol. A limitation is that by providing the participants with a prior list of questions this may have taken away any spontaneity from the discussion.

When the participants arrived at the meeting, some ground rules were debated and agreed upon. These were: to share information with each other in the focus group, to be open and honest, maintain confidentiality by not naming students they were discussing and agreeing to receive and comment on a transcript of what was said at the meeting. Participants were reminded of the purpose of the meeting i.e. it was part of the research project and what would happen to the information provided. As the number of people at this first meeting was small (*n=6),* it was decided not to use a tape recorder as it was felt (by the participants) that this would be too intrusive. Instead, I made a written record during the meeting. Each participant was later asked to comment on these notes made as a transcription, to check that what had been written was what they had said; and also whether they agreed it was a true record. Several participants then added extra comments such as:

'I didn't realise we had said so much.'

'Yes, I said all that but the discussion was very animated and all of us seemed to

be on the same wavelength, have you got that? ' I enjoyed taking part, Thank You, it was very powerful wasn't it?'

' Great to feel we are doing a good job, and making a difference'.

The participants of this group were well known to the researcher as they had been working with her for some months. However, following the advice of Krueger (1998) in developing focus group questions, the opening questions were concerned with introducing the topic and helping the participants feel comfortable. Less time was spent on this than with later focus groups because the participants knew and worked with each other and had already seen the questions. Kruegar (ibid) also identified the importance of developing key questions, such questions *'drive the study'* and *'require the greatest attention to analysis'* (p25). A key question for this focus group was:

'Have you identified any differences in the students, in how they are at the beginning of the course to how they are at the end of the course'?

Some of the participants were with the group of students every week during their course, for example the teachers; others such as guest speakers (clinical staff) had less frequent contact but did see the students at different stages of the course and also in practice. The response to this question was a definite yes from all participants. The interesting thing from the research view is the depth and quality of the answers which were given to this question, this serves to demonstrates the value of focus groups in eliciting participant's views and allowing them the opportunity to reflect, perhaps more critically in this instance, on their role.

Responses to this question included:

<u>Example 1- A guest speaker - Deputy Matron at one of the Hospices.</u>

'Yes, I have taught at various stages of the courses, I come in and out at different times. I have noticed that their questions are ***more informed.**** *It's a nebulous thing really and we as teachers are trying to demystify palliative care, it is something they can do and they can make a difference'.*

<u>Example 2 - Course Leader - Director of Education/Practitioner at CHE.</u>

'Groups tend to be a bit more reticent at first - not used to each other. There is a physical focus - emphasis on practical things they can do or see/physical.

After the communication and spirituality workshops there seems to be a ***more broader view about the people they care for.**** *They talk about "I've started to think differently when I go into my patients". This thinking differently is reflected* ***in how they look at patients****, I have seen them do this in practice'.*

Both of these responses provided further discussion amongst the other participants and provided cues for the facilitator to probe further (indicated by bold type and *). This provided more in depth answers with specific examples, which in turn led to other respondents to offer their own suggestions and examples. This demonstrates the way focus group participants can be influenced by each other as they are in real life. It also demonstrates the interactive nature of this method of enquiry, which produces a large amount of data in a small amount of time.

A further key question was:

'Have you noted any changes in students that you see in practice?'

Again, this question was about eliciting examples and participants did provide plenty of concrete examples of things students did differently before, during and after the educational process. The benefits of the practice placement were also outlined in particular by one respondent who commented:

'Practice enables them to observe in a 'safe' way, they can see how things work and then try them out for themselves with appropriate support from the mentor'.

An important key question (in my mind) for this focus group was to investigate whether or not being involved in the course had informed their practice. The reason why I was particularly interested in this question was I believe very strongly that theory informs practice, and that practice informs theory. As a newly qualified nurse teacher some years ago, I found to my shock I did not know as much as I thought about what I was supposed to be teaching merely from being a nurse practitioner! Becoming a teacher then informed how I practised as a nurse because in order to teach credibly I needed to become more informed and knowledgeable. Equally, the skills I had learnt as a nurse in practice, especially communication skills and having a rapport with patients, were transferable to the classroom setting. This principle thus informed the final model of education (see page 233) so that theory and practice has equal merit. Asking this question thus enabled me to check out the validity of this principle, rather than merely just using personal experiences and anecdotes.

<u>The model of education stage 1 (see figure 11 page 179)</u>

The participants were happy with the model as presented:

"Yes that seems to explain what we do".

"Not sure of how you can depict it visually, this perhaps needs working on but the ideas are right".

Participants also felt that the nature of the practice should be made more explicit, i.e. that practice should be in ***"specialist palliative care settings"*** and that students should be mentored by those with"***specialist knowledge"***. This is in fact what happens at CHE, I agreed with this point and as a result, the final model incorporates this aspect more explicitly.

5.32 Lessons Learnt From the Pilot Study

Recruitment to this focus group was not a problem because the participants were all on-site, although the timing of the group was difficult to get right. It was held by consensus, at mid-morning. I was aware however that it might be more of a problem for the other focus groups to be held at a time and date, which was convenient to all. Therefore, future invitations were sent out to 20 participants with two possible dates, asking them to reply, this eventually resulted in 2 focus groups being held with 10 in one group and 6 in the other. Morgan (1995) acknowledged the difficulties in recruiting to focus groups and suggested to always invite more people than needed, a principle Iconcur with.

It was important to be clear about the goals and purposes of the focus group therefore thinking in advance about the questions to be asked was important. The pilot study allowed

me to ask the questions whilst checking whether they were phrased correctly, and in the right order. Subsequently, a slight change was made as it became clear that the answer to question 3, also answered question 4. Some of the questions asked of the first group were particular to them as teachers and not relevant to the later focus groups.

The facilitation of this first focus group was easy, the respondents knew each other and were keen to be of help with the research project. I am skilled at leading groups but was aware of the need to let the discussion roam as the participants wanted it too, whilst being aware of the need to collect relevant data. The key principle regarding facilitation is therefore that the questions asked need to fulfil the needs of the researcher in generating appropriate data, whilst also meeting the needs of the participants for discussion. The difficulties encountered were around listening whilst making notes, and how to record the nuances of conversations, (one participant used a lot of gestures whilst speaking which were eventually recorded as +++ signs). This group tended not to talk all at once but did talk in long sentences, individuals often adding a bit more to their answer after someone else had spoken.

A debriefing was carried out following the focus group; I gave all participants a written record of the meeting and asked them to comment on it. This was useful in two ways; it helped maintain an interest in the process of the research amongst the participants and it helped me to check out the validity of recorded information. This strategy was useful but it may not always be possible asking participants to meet a second time. With the other groups, this checking out of validity was done during the written recording of the focus

group, although written information was also sent out to the participants for their comments. The amount of information generated by the group was substantial, and although the information was not tape recorded by request of the participants it would have been useful in the analysis to have been able to rerun a tape. However, with a small group such as this, the focus group strategy was effective and it provided the data required and stimulated discussion amongst the participants.

5.4 Focus Groups with Students

As with the previous focus group meetings with teachers, students were invited to participate in a focus group meeting. Number of participants = 16 in two groups, group 1 = 10 students, group 2 = 6. This invitation was by letter and offered the student a choice of dates. The venue was the education centre at Winsford, which is situated approximately half way between Chester and Macclesfield. It was more difficult with this group of people to actually get them together, a choice of dates was offered and it was my intention to mix the cohorts up. In reality, this wasn't always possible due to off duty and students' prior commitments. Unfortunately in the second group, there were three participants from the same cohort, which may have affected the results. However, on rereading the information that these students provided, they were disparate, in their views and keen to add their comments to what proved to be a lively discussion. In addition, these three students were from the first cohort studied. It was refreshing to note how evaluation comments previously made by them and subsequent students, had made a significant impact on the educational process already, as relevant changes to the course had been made.

My intentions in using focus groups for students were the same as for teachers in that it was about gaining insight into the student's perceptions of the educational process at CHE and to find out how it may have affected their practice. Again, the educational model devised (stage one) was presented to the students for their comments. Unlike with the teachers who were well known to the researcher and each other, the students in the focus groups did not know each other, (although some may have had professional contact with each other for example a ward nurse liasing with a community nurse). Therefore, the introduction and opening questions were structured differently, because their purpose was to enable the participants to feel comfortable with each other and introduce the topic and purpose. Written information had been sent to the students and they had all participated in other kinds of data collection with the author at various points in the course. All freely consented to attend and those who could not expressed their disappointment and asked that they be informed about the progress of the study. Unlike the teachers, this group did not have the questions in advance. Again, this was a purposeful decision as it was hoped that there would be deliberation and discussion between participants who did not know each other. There was also more time available and more questions to be answered, than with the first group of teachers.

The opening question for this group asked them to introduce themselves including where they worked and what they enjoyed doing most when not at work. A tape recorder was not used in these sessions either at the request of the students. Although I am aware that this meant that it was more difficult to accurately record what was said in the focus group. To

alleviate this to some extent the questions were written in advance on flip chart paper, one per sheet. I then recorded what was said during the session, which was checked with the participants at the time. During the second student focus group an observer was present (with the students' permission) who was one of the trustees of CHE, recorded information was also checked with her when the students had departed. In addition I made field notes straight away following each focus group meeting in order to record the nuances, atmosphere and any relevant thoughts. These were reflected on later when the analysis took place. Silverman (1993) notes there can never be a perfect transcription of a tape recording, whilst Kruegar (1994) states that transcription is not always necessary. However, Bloor et al., (2001) disagree, and suggest that for a detailed and rigorous analysis a thorough transcription of the tape recording of a focus group is required. This could be considered a limitation of this study, however as a variety of other methods were used and the focus groups were being used to verify data already obtained from the participants it was considered appropriate to not tape record those sessions.

<u>Examples of questions asked in the student focus group sessions.</u>
<u>(See appendix 9 for further information).</u>

- *What does good quality palliative care mean to you?*
- *What in your view makes a good (educational) course?*

These two questions were about context, understanding what students (who had completed the course at this stage of the data collection) perceived to be good palliative care and their experiences of education. In previous feedback sessions, several students had suggested that

this ENB 931 course was *'the best they had ever done'* or *'very different to other courses I have attended'*. There are many post registration courses available to qualified nurses. It was important from an evaluation perspective to find out whether we were meeting the needs of our customers; as in did our ENB 931 course constitute a 'good course'?

- *Has the ENB 931 course changed your practice?*
- *If so, how?*

These were key questions and the researcher was looking for specific examples (which could be verified in some way).

- *Is there anything specific that has helped you to apply theory to practice?*

This question was designed to get students to consider the practice placement in more depth, including the role of mentors. The researcher was aware from previous feedback that going to a new practice area was often stressful for students who felt out of their depth or lacking in confidence. At this point in the data collection process, both students and mentors had already rated practice as important. Practice was therefore a significant part of the educational model I developed, hence the relevance of this question.

- *Has participating in the course influenced any peers that you work with?*
- *Has it made a difference to the way you practice now?*

These questions were important in that several of the students who participated in the focus groups had completed the course over 12 months previously, so these questions were about whether changes made in practice were sustained over a lengthy time period; and not merely in the first flush of enthusiasm following an enjoyable course. Equally the educational model developed suggests that students should be able to influence their own and the practice of others hence the relevance to of this question.

Finally, the group were shown a diagram representing the model of palliative care education stage 1 (see page 179) which had been devised by the researcher. The reasons for development of the model were explained to the students and they were encouraged to ask questions about any aspect of it. They were asked the following questions:

'Does the model of education reflect how you perceived the educational process at CHE to be ?

'Is there anything you would like to add to it or remove from it'?

Each focus group ended with a summing up of what had been said and asked the participants whether in their view anything had been missed that they felt should have been included. I also asked for feedback on my performance as a facilitator explaining to them about being a novice at running focus groups, whilst sharing the learning experiences with the participants. Both student groups had a wealth of relevant information to disclose, were highly enthusiastic and demonstrated a willingness to continue their education in palliative care. Two students who had not previously met each other prior, to this focus group

meeting arranged to meet with each other subsequently, to share their experiences of a change in practice currently being experienced and assist each other in future learning. One of the challenges for me at the student focus groups was completing them in the allocated time-period! Some valuable comments were made by students in the car park afterwards (although not included in the study!)

Other focus groups were to be held with trustees and managers as participants. These were scheduled to run after the student focus groups. However, I already had information from mentors and managers, which supported the premise, that education at CHE made a difference to practice. Therefore, with the support of my supervisor who agreed data saturation had been reached, these later focus groups were cancelled. The information about the model of education was shared with mentors and managers at meetings, which I already attended as part of her evaluation role, and comments were invited.

5. 5 Analysis of Results From the Focus Groups /Audit Trail

It is important for researchers using focus groups to explicitly demonstrate how the data they collected was analysed. One way of doing this is to provide an audit trail, which explains all the steps used in the analysis.

For this study the audit trail of the focus groups is illustrated in table 11 overleaf.

Table 11 - Audit Trail of the Focus Groups

Evaluation Tool	Analysis	Researcher's Summary
Focus Groups Pilot teachers/mentors	Content analysis - words/themes Enabling students to 'see' or 'view' things differently. 'Valuing' students both as individuals and their professional work. Students becoming 'more informed & knowledgeable' 'Becoming more reflective' Providing evidence of ways students interacted on placements with patients becoming more confident, utilising their knowledge in the practical setting	This group were really positive about the learning experience they perceived students had at CHE. All felt that the education had made a difference to practice and were able to provide examples of this. The group readily answered questions with a high level of interaction with each other. They reported feeling 'energised' by being part of the process.
Focus groups 2 & 3 Students	<u>Words /Themes.</u> Quality of life, symptom control, holistic care, support, flexibility, team/collaborative approaches. Motivation, enthusiasm, support, instilling confidence. Talking to relatives, better at communicating, especially listening. Challenging others. Practical skills, symptom management Must stress support is needed for all aspects of the course. Continuing education and reflection on practice.	All students were able to articulate what good quality palliative care meant (which could infer they had learnt something on the course in itself) Good education - students feeling safe & valued, there was a lot of discussion around what specifically students saw as a 'good course'. Also many examples of how their practice had changed as a result of doing the course. Educational model - some issues about what the term 'student-led' meant. Discussion around clinical facilitation as a method of support. How longer term educational support around palliative care may be accessed by students.

Content analysis is one method of analysing focus group data. By the time the focus groups were run common identified themes had been inductively generated from the evaluation data already collected, these were:

- Improving communication skills.
- Wanting to feel more confident and competent in caring for patients and families.
- Improving knowledge and skills in relation to palliative care.
- Making changes to their own practice.
- Quality of support received from clinical staff and academic staff.
- Dealing more effectively with complex/challenging situations.

Therefore during the analysis of field notes I was looking for words* which fitted into these 'loose' categories; plus, examples students provided of how they had changed their practice. Thus, the themes generated from the focus group data were therefore deductive. The focus groups were about trying to understand the participant's views of the educational processes they had undertaken at CHE and to explore their views of the model of education as presented to them. (See annotated notes in appendix 9).

5.6 Researcher's Reflections of the Focus Groups

The focus groups of students and teachers/mentors confirmed my premise that education at CHE made a difference to practice. There was opportunity for me to verify how students had changed their practice and to consider what it was about the educational process that enabled students to make changes. The focus group participants were able to bring their

experiences of being involved in the educational process at CHE and discuss their perspectives. By displaying the preliminary model of education (stage 1, page 178) I was able to examine with participants how there are a number of factors, which need to be in place to facilitate the application of theory to practice. Although these factors may be seen as just 'good educational practice,' my experiences and those of student's suggested that they are not always paid sufficient attention to. The model of education was designed to enable those involved in palliative care education whether that is in planning, delivery or as a student, to apply learning to practice. The focus group participants were able to make changes to the model of education based on their experiences, this final model is presented in chapter 6 page 234.

Summary

- Focus groups were initially used for the purposes of market research, but have since been embraced by researchers especially in the social sciences because they are useful for exploring people's knowledge and experiences; as well as how and why they think in a particular way.
- Focus group discussions may provide rich data on group meanings associated with a given issue, whilst allowing the researcher privileged access to in-group conversations. This was demonstrated by the quality of information offered by the participants in this study.
- They are useful for studying organizational change and the success or failure of programmes, hence the use of them in this study.
- Focus groups can be used as a form of participatory evaluation; and were chosen in

this study, to help reduce the power differentials, which may have existed, between the researcher and some of the participants (students).

- Unless properly conducted and analysed focus groups may be perceived to lack methodological rigour and merely provide 'anecdotal insights'. The data from the focus groups in this study was analysed by comparing it with themes already identified from data previously collected. This new data confirmed the previous findings thus adding to the validity and rigour of the study.
- Key questions were developed for the focus groups in this study and a pilot of those questions and the facilitation of focus groups were carried out.
- Carrying out a pilot study of the questions and process allowed me to make some changes to the questions and become more confident about my ability to facilitate a focus group.
- A possible limitation of this study is that the focus groups were not tape recorded for analysis. However, a rationale is provided for this, with a description of how information obtained from the participants was verified as accurate.
- Focus group participants were asked to comment on a preliminary model of education for palliative care (stage1), which I had devised. These comments were discussed during the focus groups and contributed to the final model of education produced for this study.

CHAPTER SIX

Discussion: Linking Theory to Practice: A New Model for Palliative Care Education.

6.1 Introduction

This chapter demonstrates learning from both a micro and macro perspective; it encompasses both the organisational learning and changes, which occurred because of this evaluation study at CHE; and my personal learning and development. The differing roles I undertook during the research study are highlighted in order to demonstrate the complex, sometimes chaotic, nature of multi-collaborative evaluation.

The chapter also identifies the final model of palliative care education, which has been developed from the research findings. The model aims to ensure education in palliative care is effective, efficient and enables practitioners to make changes to the way they deliver care. The assumption that by attending a course and gaining new knowledge automatically results in changing practice has been challenged (Dyson, 1997; Hutchinson, 1999; Sneddon, 2001; Froggatt, 2002). This model of education therefore incorporates some fundamental characteristics, which need to be present in order for education to make a difference to practice. It also highlights some of the underlying principles of good educational practice, making them explicit rather than implicit. The intention being to empower students in their work setting to be able to make changes following a period of education, this is true whatever the setting.

The chapter further explores how the underlying philosophies of this model of education are transferable and could be utilised in other specialities and settings. (It is however recognised that palliative care education at CHE has some 'privileges', which are not always apparent in other nurse education settings, for example small class sizes). Finally, a summary of the study is offered and some broad recommendations for future scholarly review and practice are provided.

6.2. Discussion - An Overview of the Evaluation Research Process

The purpose of data analysis in any research study is to impose some sort of order on a large collection of information in order to synthesise, interpret and communicate findings (Polit & Hungler, 1999). Unlike in quantitative research where analysis commences at the end of the data collection, qualitative research requires the researcher to look for important themes and concepts as soon as the study begins. Indeed, the researcher acts as an instrument of the research, spending long periods engaged in fieldwork and becoming immersed in the data until saturation point is reached.

This study was complex and chaotic in nature and my role as an evaluator was to try to bring some sort of order to that process in order to discover whether education did indeed make a difference to the practice of the students (and whether such differences were sustained). There were many stakeholders in the project (not least myself who as a teacher in the organisation was also under scrutiny). Others who were funding CHE had a vested interest in whether the organisation delivered effective quality education so that we would build a credible reputation and that students and managers would want to subscribe to our

courses. Consequently, I held a somewhat privileged role in the organisation that is I was charged with evaluating the quality of the organisation whilst also being a part of it. I have discussed the advantages and disadvantages of insider/outsider evaluators elsewhere in this study (see page 86). For me, the reporting of things "as they were" was also about my personal ethical codes of professional integrity and honesty. Safe guards about any misrepresentation of the project data were built in, as participants and colleagues read evaluation information and were able to question me as did trustees and my supervisor. Additionally some of the evaluation comments from students were put on our website and therefore in the public domain and open to scrutiny. The following section identifies some of the roles I played as a researcher/evaluator during this study and some of the issues I had to consider.

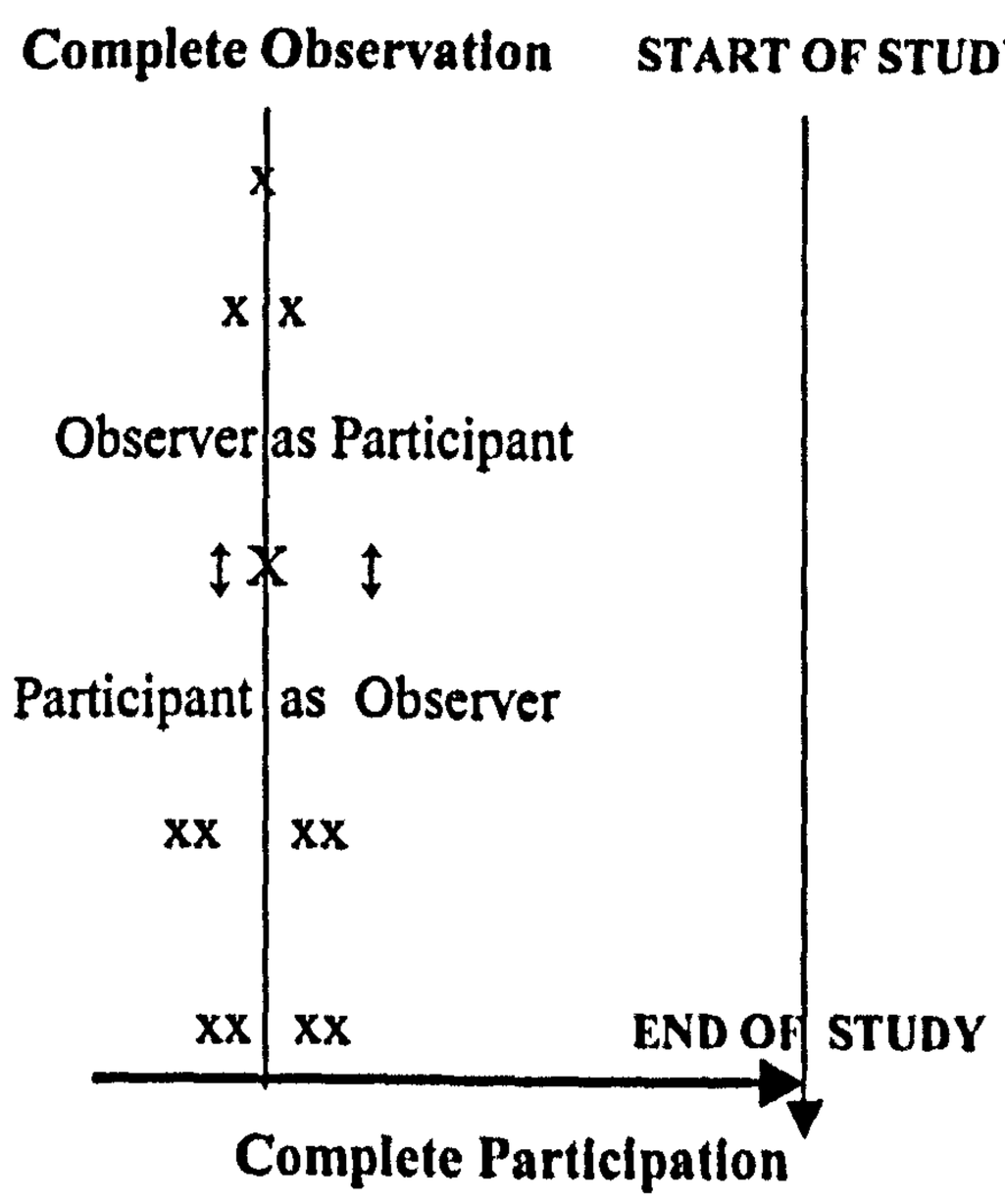
6.3 A Continuum of Researcher Roles

In making these roles transparent, I have attempted to demonstrate the realities of evaluation research in practice. The data analysis was used to inform the focus group meetings, (see chapter five) which were held towards the end of the study in order to verify findings, inform participants about the research process and ask for their perceptions of my inferences. As described in chapters two and three respectively, this action research project involved a number of different techniques for eliciting data from the research participants. These techniques included observation, interviews (both one-to-one and group), participant observation, survey, focus groups and case studies. In addition, I kept field notes as a reflective diary, systematically recording encounters with research participants and the data itself. Clark (2001) indicates it would be rare within a palliative care research study for the:

> *"…. researcher to adopt a purely observational stance in relation to the research setting"* (p59).

He also indicated that merely being present in the setting, such as a hospice, might involve some unintentional form of participation on the part of the researcher. Thus, a *'continuum of roles'* is identified where the researcher may be operating in a number of different research roles. The following diagram (figure 14) illustrates the continuum of roles I operated within whilst undertaking this study. On reflection, these roles were blurred, and this demonstrated the complexity of the study. The evaluation process itself is offered as a means of legitimizing the emerging data of the study, and therefore answering questions about validity and trustworthiness (Biddle et al., 2001).

Figure 14 Continuum of Researcher Roles Practiced within this Evaluation Study



Complete observation/observer as participant

I sat in as an observer during interviews with potential candidates who wished to attend the 931 course, at CHE. For the very first interview I merely sat in the same room, however I felt that subsequent interviews should be tape recorded for future analysis, with the student and interviewers permission. The very act of asking for permission involves the researcher to a greater degree (although permission was already sought to be present in the room). In addition, the teacher actually interviewing also felt I could have a beneficial role to play in the interviewing process. This therefore moved my researcher role very quickly from observer to observer/participant.

One of the difficulties identified in this early involvement in the interview process was to ensure that participants felt able to say 'No' to being involved in the research study. As this was also the beginning of the study, I was additionally attempting to identify the nature of the setting; early concepts about palliative care education at CHE and promote feelings of 'partnership' with all those involved in the study. One of the strengths of the study in my view was this early engagement with research participants, although conversely it could also be seen as a weakness when issues such as consent are considered.

On reflection, the issues of consent at this stage of the research were not dealt with as well as they could have been. This was in part due both to my enthusiasm (for the study), and my inexperience as a researcher. The participants were provided with both a written and a verbal explanation as to my evaluation role at CHE (see appendix 5). They were asked

their opinion about the course information they had received, (whether it could have been improved), and about the actual interview process. However, the troubling issue of the researcher being in a more 'powerful' role than the participants may have precluded them from refusing permission to be involved in the research at this stage. Although I was aware of this issue and did attempt to address it in my careful explanation to the prospective student, consent to participate may have been given (at this stage) prompted by a fear of not being accepted on the course. I had discussed this point at length with the course interviewer; when we both were looking for evidence that the candidate was unhappy with the decision to allow me to be involved in the interview process. Discussions with my supervisor about this point were also reflected in some entries in the research reflective journal, regarding uncomfortable feelings about this aspect (see entry marked ** appendix 7). Equally, many of the participants who applied to the palliative care course at CHE already knew me from my previous teaching/nursing roles and were quite open about the fact that they were happy to be involved.

<u>Observation as participant/participant as observer</u>

This next point on the research role continuum arose as described above and then on the first day of the course when I was actively involved with the participants in the classroom setting administering the pre course questionnaire. On reflection, the participants probably perceived me in either of these roles, whether carrying out research or not, as both fit in well with the teaching/facilitation role. A potential difficulty for the participants was this perceived blurring of the two roles. This was to some extent addressed by me by viewing consent to participate in the research as a process, rather than a one off single event

occurring at the beginning of the project. Polit & Hungler (1999) suggest it is sometimes difficult to obtain meaningful consent at the beginning of a qualitative study, because the research design emerges during the data collection and analytical process. Therefore, '*process consent*' is used where the researcher continually renegotiates the consent:

> *'... allowing participants to play a collaborative role in the decision-making process regarding their ongoing participation'*
>
> (Polit & Hungler,1999; p141).

Collaboration in this manner was a strong theme throughout the evaluation process. Students were expressly asked if their comments could be used, (comments having been checked with them previously to ensure they were correct). They were also used for a variety of different purposes although all under the guise of evaluation. For example: comments were included in a published article (Kenny, 2001). In addition, evaluative comments have been disclosed to trustees and others responsible for the ongoing funding of CHE. Two comments have been deleted from field notes at the expressed request of participants, although both were happy to have other comments they had made included.

Complete Participation

I facilitated the focus groups as a participant observer, asking questions and writing down responses. However, as the students began to discuss the proposed model of education the discussion began to include me as the focus group participants sought clarification. There was a definite shift in emphasis from being apart /excluded from the conversations to now being part of the conversation. This shift was particularly noted with both student focus

groups and is illustrated by the following narratives:

Context: Showing the model of education on an overhead projector.

Facilitator - *"This is a proposed model for palliative care education. I have devised it as a suggested way of demonstrating how to carry out effective education. I would like you to think about it and consider whether it is a true reflection of the educational processes you experienced at CHE".*

Student JL

" Yeah, I thoroughly enjoyed the course and there was all that in it, but then you knew that didn't you? How did you arrive at all those bits to put into the model?".

Student SG

" I think so, but tell us more about it".

Student CT

" It was a very personal course, small groups enable students to build a supportive relationship with each other and teachers, like we have here, you (teachers) were very much a part of that for me. The personal nature of the course needs to be stressed, like you did at the beginning in helping us feel comfortable with each other".

Student AB

" So when you're famous and get this published we will be able to say we were part of it then?".

Facilitator

"Not sure I want to be famous! (much laughter) *However, yes you have all been a very important part of the study and have influenced the outcomes. Your willingness to take part has been much appreciated, thank you all".*

Hudson (2003) identifies that focus group moderators although passionate about their topic should not:

> *"influence outcomes in keeping with his or her personal views"* (p205).

On reflection, at this stage in the study, it was difficult not to influence the students (when talking about the model of education) because I was so enthusiastic about it! However, student's views were recorded exactly as stated and verified; thereby ensuring trustworthiness. A member of the trustees was present at one of the groups and I spent some time in discussion with her about what had been said, to check my perceptions and see whether she had anything to offer from her view as an observer. The focus groups were also run towards the end stage of the study. I never quite reached the "complete participation stage" as depicted on the research continuum although it was close! This position illustrates well the nature of collaborative evaluation work and action research, working with/alongside research participants.

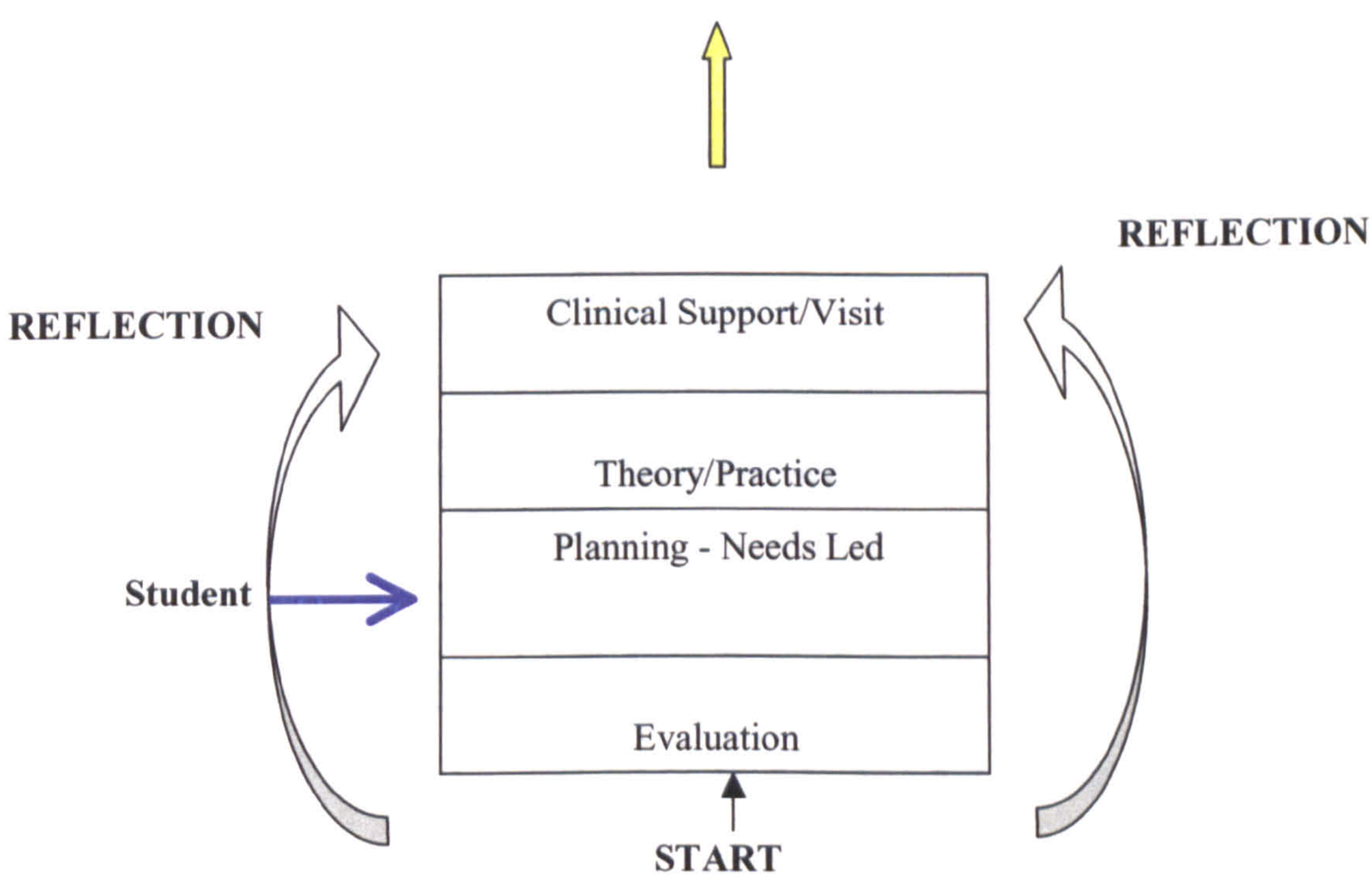
The criteria I utilised to legitimize the action research/evaluative processes in this study included triangulation of methods and member checking of the results. Collaborative evaluation practice itself requires evaluators to disclose evaluation results to stakeholders and to take any necessary agreed action. This study has utilised a new emerging research approach not only in the methodology but also in how it has been presented. I have attempted to 'tell it as it was' from my longitudinal involvement with participants in what is essentially a 'practice based profession'. Sometimes the language used in this study has veered towards the positivistic paradigm in seeking to legitimize this work. This is in many

ways due to the lack of a sophisticated research language amongst the research participants and health care in general which is based on practice based evidence. Biddle et. al., (2001) identify different ways of writing as different ways of knowing and call for qualitative researchers to consider *"new ways of representing their endeavours"* (p802). This study is my way of representing the views of my research participants in a study which is important to nursing and to palliative care education; and not least to those recipients of palliative care patients and families.

6.4 Models of Education for Palliative Care

This section considers the final model of palliative care education devised as a result of this study. It demonstrates how the new model has changed from the first proposed model (stage One) and why those changes have been made.

Figure 15 A Model of Education for Palliative Care (Stage One)



6.41 A Revised Model for Palliative Care Education

The final model in figure 16 has two distinct changes from that shown above, (model of education for palliative care education stage 1). The new model looks different, as a result of developing it for publication (Kenny, 2003b) see appendix 3.

The changes are the inclusion of the terms **'specialist palliative care practice '** and

'clinical facilitation' (by an experienced palliative care practitioner) which replace the categories 'practice' and 'clinical support /visit' respectively. The reason for these changes is further explained below.

Figure 16. The Revised (final) Model for Palliative Care Education

Changes to the Model: Practice to Specialist Palliative Care Practice

During the discussion with the focus group participants, it became clear that practice the students had undertaken on the course was with skilled practitioners in specialist palliative care practice settings. This was felt to be particularly important by both students and teachers/mentors. One participant said:

"I really benefited from being with skilled practitioners in palliative care; they knew what

the problems were and were extremely helpful in helping me to work out how I could help my patients".

All of the teachers/mentors believed that specialist palliative care placements were necessary to enable students to develop confidence in their own general palliative care skills. This would also help them to know when and how to refer patients with problems to specialist services. On reflection, after completing this study I agree with that view. The teachers' statement was subsequently borne out by a community nurse manager who stated that she had noticed that staff who had received palliative care education at CHE were more skilled at assessing palliative care patients, and hence specialist practitioners were being utilised more effectively (Vickers, 2001). The National Council for Hospice and Specialist Palliative Care Services (1996) also supports the provision of education by specialist practitioners, as does the cancer charity Macmillan; both groups have a vested interest in the provision of 'excellence' in palliative care services.

<u>Changes to the Model: Clinical support/visit to clinical facilitation</u>

Nursing practice is about being with patients and their families, facilitation of learning in the clinical setting (called clinical facilitation in the model) is a new aspect to the model. It recognises that theory and practice have equal value, but until practitioners are able to apply what they have learnt to their practice, learning may be of little value to practice.

Birchenhall (2001) noted that the process of clinical facilitation enhances the ability to apply theory to practice. Educationalists would argue that facilitation is an:

"essential component of learning through practice".

(Birchenall, 2001; p249).

Clinical facilitation is a relatively new term, which is being used in this instance within the model to describe the process of working with students in their own clinical setting, with a particular focus of helping the student **apply** what has been learnt in the classroom. In addition, it can assist in overcoming barriers to change (Kenny & Partington, 2002).

Froggatt (2000) indicated the need for palliative care educational interventions to promote changes in practice. One way of supporting this is to work with the students in their own workplace after the course has been completed, to help them to apply the principles of palliative care to their practice. A key feature of effective learning is if students are able, to make changes to their practice as a result, of what they have learnt and whether such changes are sustained. Clinical facilitation therefore acts as a 'reminder' to students when the enthusiasm about the course may have waned and they return to the responsibilities of their own workplace. (This was seen in students from other courses run at CHE where clinical facilitation was first piloted).

For qualified nurses this type of facilitation is practically unheard of, although there are well-documented reports of preceptorship schemes (for newly qualified staff), and more recently, the commencement of clinical facilitator posts, to introduce skills development in clinical settings (Nichol & Glen, 1999; Kelly & Simpson, 2001). As a result, of this study (and other projects undertaken at CHE where facilitation was offered as an integral part of courses and well evaluated), it was decided to include clinical facilitation explicitly as part

of the proposed palliative care educational model for use in all courses offered at CHE. This was discussed at the focus group meetings and an explanation of how it had been run for other courses offered to the participants. The idea was well received; many students recognised the difficulties of making changes to their practice once they were back in their own work setting. Students also felt it would act as a reminder to themselves and more importantly to colleagues/managers of the 'value' of education and the need for it to inform their practice. Appendix 13 offers some guidelines for putting clinical facilitation into practice, these demonstrate how facilitation has been successfully carried out at CHE, informed by an ongoing evaluation strategy (Kenny & Partington, 2001).

Following on from this study, the effectiveness of clinical facilitation is to be the topic of a PhD ethnographic study by a fellow member of the teaching team at CHE. This relates to specific educational programmes CHE is offering to qualified nurses working in nursing homes. It will address how facilitation is perceived by the students and also attempt to track any long term changes. This demonstrates how an aspect of my study will be taken forward in more depth.

Other writers specifically in palliative care have identified the need for this support in the workplace including Wilkinson, (1991) Booth et al., (1996) (both in respect of improving communication skills). Whilst Seymour et al., (2002) considered the need for clinical supervision to assist practitioners in developing fully their roles. Froggatt & Booth (2004) discuss the need for flexible ways of providing education including taking education to the workplace; facilitation is one way of providing this. In palliative care education, it is important that the clinical facilitator is provided by an experienced practitioner in palliative

care, this should enable the participants of the educational process to deliver *"best clinical practice"* (Sneddon, 2004 p 638). A study by Seymour et al (2002) has noted that many specialist practitioners have been inadequately prepared for their teaching role, however the more recent standards for specialist practitioners set out by the Nursing and Midwifery Council should go some way to improving this situation.

6.5 The Challenges of Adopting this Model of Palliative Care Education

All teachers in whatever field would wish to believe that their teaching '*made a difference*'. This model explicitly demands that teachers look for evidence of this through evaluation. It requires a clear understanding, by all stakeholders as to just what measures constitute a successful programme. To students, that may mean passing an assignment, to their manager more effective use of services, to teachers more confident practitioners who are able to challenge and question why things are being done. Multi-collaborative evaluation will provide data from a variety of sources, which are valid and rigorous. All of this data should be collected and systematically examined. Such evaluation is costly and time consuming and to the uninformed may be seen as merely collecting information. Evaluation information must be <u>put to use</u>, informing and supporting the ongoing planning of education; enabling decisions to be made on the basis of good evidence. This requires a framework within which evidence can be utilised.

<u>6.51 Making Changes Explicit: Recognising the Unintended Benefits of Evaluation</u>

Teaching and learning are dynamic and changes will be made to the content of programmes and the methods of delivery, evaluation enables those changes to be made more explicit and

rationalised. It also allows teachers to be more confident about what works and what does not. In this respect, unintended outcomes of the educational process may also become more visible. In this project, the students in each cohort were chosen from a variety of different care settings; because palliative care is provided in all settings, (not just hospices). In the evaluations from all cohorts, students noted how beneficial this mixing of settings was. It allowed them to see other nurse's perspectives and relate more closely to different care settings. It also provided students with the opportunity to challenge each other's perspective within the safety of the classroom. They were thus able to acknowledge the difficulties they encountered in their own setting and realise how similar difficulties existed in others. This helped them in attempting to problem solve and work out how they could help one another, when back in their own care settings thus improving communication and networking skills.

Although the students had been chosen from different settings in order to set up networks and assist them to work together, the teaching staff may have under-estimated the intensity and longevity of these networks. Students informed the teaching team up to two years after course completion that they still met with colleagues from the course, some had visited each other in practice and many of them continued to telephone each other for advice about patients. Being reflexive about the choice of students to any course has led me to discuss with the teaching team how we need to continue to endeavour to ensure we do have a mix of students from different settings and professions (where possible); in order to extend the richness of the student experience. The teaching methods used at CHE and the nature of palliative care demand much from students therefore having a less homogenous group can help them see different perspectives. As the demand for palliative care education rises, this

mix of professionals and settings could in the future be of real influence on the perceived quality of the courses we offer at CHE.

Evaluation is everyone's responsibility but is often not realised in practice. The organisation needs to develop a culture where evaluation is inherently built into every activity (Pawson & Tilley, 1997). Changing an organisational culture can take time and doesn't happen overnight, never-the-less if there is commitment to evaluation from senior managers and a dynamic enthusiastic person to take the lead; significant progress can be made. Evaluation generates more questions and is fairly time consuming. Consequently, it may be seen as costly in the short term; however, the cost of ineffective inefficient education; is considerably more expensive.

6.52 Evaluation Information Supports the Planning and Delivery of Courses

Planning for all educational interventions at CHE involves a variety of staff, including the prospective participants (students), teachers, specialist practitioners and mentors. This requires flexibility on the part of the planning team in order for staff to be released from the clinical areas; inevitably, it takes quite a long time. However, it is very important and something that students noted as helping them to feel valued, which is an essential part of the philosophy of CHE.

Evaluation activities also provided information for the ongoing planning of courses. This was particularly helpful as the teaching team developed more experiential teaching sessions and was keen to assess their worth from the students' viewpoint. There was sufficient

flexibility built into each module for the students to have some choice in the content of sessions and how they might be taught. This is a challenge in itself when palliative care is such a vast subject; there is a tendency to want to fill each session.

Teachers need to be aware of the research, which states that students frequently have difficulty with the psychological support of patients and families (Morize et al., 1999), teaching sessions, which address this, are therefore essential. Such sessions require confident, competent teachers who can facilitate experiential learning and provide ongoing appropriate support. Not all teachers are comfortable with this style of teaching and learning, and therefore may lose the opportunity to adapt programmes sufficiently to meet learner's needs. Ongoing professional development of teachers is required; evaluation data can help support this in the following ways:

- By identifying what works well in the programme, including why.
- By drawing attention to any gaps in the knowledge, and skills, of teachers.
- In fostering creativity, as teachers become more willing to try new things because they have ongoing evidence of what works and what does not.
- Used as evidence that further training/education is needed to keep up with the demands of service users.

6.53 The Application of Learning into Practice, through Clinical Facilitation

Clinical facilitation was added to the educational model because it had been developed for other courses run at CHE and was proving to be successful. Those students indicated that it helped them to reflect on the course after it had finished, it also became part of their ongoing professional development. It proved to be a very effective evaluation tool as teachers could see first hand how students had changed their practice. For example: teachers observed how students communicated with patients and relatives, how they recorded care, how they referred on to other agencies and how they recognised their limitations and sought further advice when they felt out of their depth.

In reality, a qualified teacher visiting every student in their workplace for a set number of hours is costly; both in terms of time and resources. The teacher has to be very skilled, aware of her limitations and realistic about what can be achieved. By adopting this strategy of working with students in their own setting, the CHE teaching team have noted the benefits of increased access to areas where there has been limited teaching provided on-site (such as nursing homes). Such benefits have included: good networking and information exchange between all parties. Plus an added appreciation of the difficulties staff face in trying to deliver palliative care in care homes where resources may be inadequate; and effective external partnerships with relatives, primary care, social services and other specialist palliative care providers may be tenuous (Parker & McLeod, 2002)*.

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* **This information has been particularly important in the planning of a new educational programme at CHE specifically aimed at nursing home staff.**

Clinical facilitation has also helped to market the organisation (CHE) and the courses it offers. This has subsequently led to the demand for more education, an aspect small organisations need to be aware of; as there is a danger in losing the quality of what is provided; if trying to meet the increasing demands of the market place with the same resources.

6.6 Transferable Philosophies - Using the Model in Other Settings

The model of education presented here is based on a personal philosophy that education should empower students, that it should be enjoyable, and that learning is an ongoing process. It also recognises that practice is as important as theory (i.e. has equal weighting) and that evaluating learning helps to maintain quality.

Being open to learning requires students who are interested, enthusiastic, and motivated about what they are learning. The subject, course and curriculum need to be relevant to them. One way of ensuring relevance is to identify individual needs through learning contracts and to have the recipients of education involved at the planning stages. In either a participant or provider of education role, I believe there is a responsibility to ensure that any education informs my practice; and where applicable, the practice of others. Using reflection as a tool can assist in this process. The model expressly demands that those involved consider how they can apply learning to their practice by emphasising the need to disseminate information and influence practice.

All of the above points are transferable to any setting within health care, and I would argue in education per se, particularly where education involves the application of practical skills. Higher education establishments need to ensure learning is applicable to the workplace and that students emerge at the end of the course with more than just a certificate or degree. This concept has already been highlighted in the Dearing Report (1997). However the model has been developed specifically for palliative care education and would benefit from further research in other settings.

6.7 Evaluation as Research/Research as Evaluation

The differences between evaluation and research have been identified earlier in this work (chapter two). This study illustrates the similarities between research and evaluation rather than the differences. Both activities require a systematic approach and careful analysis of evidence. In taking part in this study, I have honed my research skills and been able to assist other members of the team to develop evaluation skills. These skills include the deliberate questioning of the merit or worth of activities, and the search for evidence of effectiveness. However, evidence may not be easy to find immediately and its' credibility needs consideration.

I have to acknowledge that the information presented here is very 'positive' and that evaluation reports I presented were positive. This is because they reflected the opinions and practices of the participants involved in the study, and have been verified by them. I have merely "told it as it was". I was continually challenged by the trustees, my supervisors, and indeed the examiners of this study to ensure that I was able to be critical and include all

relevant data, even if that data was in opposition to my views and or expectations. Questions I grappled with and which other researchers might ask included:

"How was I able to get close to participants whilst still maintaining a capacity for analytical scrutiny?"

My desire to get close to participants necessitated abandoning the conventional "*dichotomy between objectivity and subjectivity*" (Grbich, 1999 p130), however I have tried to document clearly my research role and how and when I collected data. One of the problems is the complex, chaotic nature of the process, which was not necessarily linear. For example: I first met the participant at interview, yet three or four of them also attended a CHE workshop I ran (Study Skills), before commencing the palliative care course. I knew they were attending the palliative care course and my teaching on that workshop was influenced by that. Although I did not consciously collect data from those participants on those occasions I did attempt to make them feel valued and welcomed their input. This may have then affected how they behaved with me when they started the course.

Another question: *"What role did I play when immersed within the group being studied?"* has to some degree been answered by my explanation of a continuum of researcher roles depending on the time of the project (see page 225, section 6.3). It was interesting to reflect on how the participants saw me and this was the subject of many a conversation with my supervisor. There was inevitably some role tension/conflict for me during this project. I was fortunate to have a research supervisor and a clinical supervisor plus a supportive team with whom I worked to help me cope with the tensions. The constructivist and relational nature of this work required that as a researcher I acknowledged that the findings and

resulting actions came about through the personal relationship of myself and the research participants. Some personal bias based on my background and aspirations may have influenced this relationship and hence the direction of the study.

I have to admit to an initial feeling of surprise that the study went so well, although on reflection there were many challenges in getting stakeholders on board for the project to even commence, concerns about the availability of resources and these things took longer than I had anticipated. Actually, delivering high quality course material and supporting students was an inherent way in which the teaching team worked anyway. The strength of this evaluation study was perhaps in making that more explicit to other stakeholders by providing evidence that education was effective. The trustees (apart from one) and some of the other stakeholders do not have an educational background and are sometimes unaware of the very real challenges, of education in palliative care. The model of education provided demonstrates the need for a more equal relationship with students which are enabled by asking them to be part of the planning process, developing learning contracts and valuing theory and practice.

It is important to consider the merit of any evaluation information and when to take action. For example: poor student evaluation of a lesson may be due to a variety of factors such as: the content, teaching style, learning outcomes, learning environment, individual students learning styles, student expectations. The same lesson could also be evaluated more positively by another group of students. To avoid being reactive to such situations multi-collaborative evaluations provide more than one viewpoint, in this case the teacher would

also be asked to evaluate the session, and it must be recognised that sometimes things do not go well for a variety of reasons. Appropriate evaluation strategies prevent 'knee jerk' reactions and enable those involved to consider issues in context. In addition, the evaluator is responsible for asking the type of questions, which assist people to make constructive criticism; as well as making any suggestions of how to improve.

The benefits of formative evaluation have been highlighted elsewhere in this study, formative evaluation can be likened to qualitative research with the researcher identifying themes during the data collection. Formative evaluation can also demonstrate themes as they occur; in this study, those themes were confidence and competence. Students wished to change some aspect of their practice and be able to utilise their improved communication skills when dealing with difficult issues concerning patients and relatives.

Working at CHE it has been possible to implement an evaluation strategy which is multi-collaborative, that is not to imply that participation has been total and perfect but that there is a will to engage with others in the evaluation process. Most importantly the results of evaluations are taken note of, and serve to inform the planning process and ongoing work that is carried out. Such evaluations to inform practice are vital if the practice of evaluation is to have credibility amongst stakeholders. The feedback of evaluation results rests with the evaluator and this can be done in the form of written informative reports and or presentations. At CHE trustees are informed of ongoing evaluation activities in bi-monthly meetings, students have both formal and informal means of obtaining this information and the evaluator meets with clinical staff and mentors. Some evaluation information is also

available on the website of CHE: http://www.che.org.uk/eduhosp

6.8 Personal Learning and Development

This evaluation study offered me much scope for personal learning. At the onset, merely writing the research proposal was a difficult though necessary undertaking. The task of applying for ethical approval raised many questions before approval could be sought. This process though long and sometimes tedious, ensured I was serious about the project and could defend my plan of work. It also provided a learning opportunity for future events such as meetings with trustees of CHE and other stakeholders; who were keen to ask searching questions about the study. The personal experience of submitting a proposal for ethical approval was later shared with a colleague who was also considering undertaking a research project.

Planning and implementing an evaluation strategy was new to me although I had been involved in evaluation activities before, I had never been involved from the beginning. This was exciting, and a great challenge. I was introduced to the CHE Trustees as "*someone who is passionate about evaluation*" this was, and remains so. However, it may have given the impression I was an 'expert' in evaluation, something I do not claim to be. On the other hand, it was apparent that I had more knowledge about evaluation than the other stakeholders did and they agreed, some reluctantly because of funding, to let me take the lead. The wide range of literature I was able to access about the nature of evaluation was applicable to all stages of this project and some useful tips were gained. In addition, my

supervisor's experience of evaluation ensured I did not give up on the project particularly in the early days when other stakeholder support was limited or none existent. The valuable lesson here was about being tenacious!

My first task was to get people on board with the concept of multi-collaborative evaluation, to make them feel that they were part of it, thus transferring ownership. The learning for me at this stage was about whom I could be open and honest and share things with and how I could get people on board without seeming to coerce them. This aspect took a long time. To be fair to stakeholders they had other things on their mind than just my project, evaluation is often not seen as a priority (until afterwards!) and it was my job to convince them both of the worth of evaluation and the need to be involved in the strategy. The challenge was to get stakeholders to acknowledge evaluation as a priority. I did this by regular reporting of the progress of this study and the ongoing evidence that evaluation was providing.

Patton (1997) identified the need for good communication between the evaluator and stakeholders, I was very aware of this and endeavoured to attend all relevant meetings and if I could not attend, I always submitted a written report. The information was also explicitly tailored to meet their needs, for example: I asked some students to attend the Annual General Meeting of CHE in June 2000 to feedback on their experiences of studying at CHE. A manager of the local community trust was also invited to speak at this meeting about her experiences of sending her employees to CHE for education (Vickers 2000). Both of these strategies proved very successful by providing stakeholders with information

from the students themselves and from the manager's perspective; it demonstrated the value of multi-collaborative evaluation in an unbiased way. From the trustees perspective I may have been perceived to be biased, in both the selection of information to present and in my reporting of events, simply because I was the evaluation project leader. However, I was held to scrutiny by the trustees at regular meetings and was frequently asked to defend data I presented to them.

A further benefit was that evaluation evidence was collated formatively, this ongoing process provided evidence, which was subsequently used to support bids for funding. Trustees were delighted when such bids proved to be successful. The fact that CHE had an evaluation strategy proved an organisational strength, when submitting bids.

The colleagues with whom I was working were supportive throughout the study and although knew little about evaluation at the beginning they were influential in enabling CHE to adopt an evaluation culture. This was evident as CHE grew and began to employ more staff and develop other palliative care education courses. Evaluation strategies became integral to all aspects of the work of CHE. Evaluation contributed to the bidding process when new contracts were sought and was evident in the success of the organisation in developing new courses to meet local demands. For example: a three year county wide collaborative project was set up with the aim of improving the education of staff in relation to HIV/AIDS, sexual health, and palliative care. The trustees of CHE began to see the results of the evaluation strategy (such as that described) and are now wholeheartedly behind the concept of evaluation. New evaluators need to be reminded that getting such

important stakeholders on board is a time intensive though vital process.

The study required me to constantly change roles from being a researcher, to a teacher, evaluator and back again. I found this a continual challenge. Early in the study, I was very rigid in my approach in a perhaps misguided effort to maintain the quality of the research. For example: I had said I would tape record the student interviews. One candidate said she did not wish me to but was happy for me to write everything down. I worried about affecting the rigor of the research and was unhappy that a participant had said "No" even though I had allowed for this. When I compared my written notes of this student's interview with the taped transcripts from other interviews, I had sufficient information to be able to make a comparison between both methods. The comparison was that there was little difference in the quality of information obtained between my note taking, and a taped recorded analysis, because the interview was highly structured. On reflection, this was about my inexperience as a researcher. Later in the study, I became more comfortable with changes to my original plan and lively discussions with my supervisor convinced me that if I could justify why I was changing and was open and honest about reporting these changes, this was acceptable.

The evaluation project proved successful in a number of ways. It fostered a spirit of creativity, as the CHE team attempted new initiatives knowing that evaluation strategies were in place to provide evidence of their effectiveness, or not. It encouraged students to question themselves and others, either in the classroom or practice. Co-operative working with managers helped the organisation gain important support from fund-holders; this was

vital in ensuring the early success of the organisation. Managers and other stakeholders then started to ask the team to be involved in other projects relating to palliative care. Evaluation added to CHE's reputation in delivering quality courses, which were meeting the needs of local practitioners. I was invited to apply for a post to lead Research and Practice Development within the three hospices that support and fund CHE. Raising the profile of practice helps to ensure that practitioners feel valued. Providing them with the resources to question and develop their practice and that of others, can ultimately benefit patients and their families.

The final paper in appendix 3 was published at the end of this study in order to share good practice by disseminating the model of education to other palliative care education providers. The paper was peer reviewed, prior to being accepted for publication; a selection of reviewers comments are quoted below.

Comments from reviewers for: International Journal of Palliative Nursing (22nd April 2003).

A Model for Education in Palliative Care

"Simple and comprehensive, incorporating in one structure key features of effective education. Although many of these features are well-known I think the emphasis on evaluation as a foundation, and the inclusion of clinical facilitation, make the model particularly robust".

"Overall I think this is an interesting and well-constructed paper which makes an important contribution to the literature on education for effective practice in palliative care".

"This is a well written article of a high standard and worthy of publication... it presents a useful model which the international audience could usefully learn from".

6.9 Conclusions / Recommendations

Finally, I am required to reflect on the original aims of the study, and identify how the research findings can add to the knowledge base of palliative care education. The demand for palliative care is rising due to both an increase in the elderly population who are more likely to suffer from cancer and chronic diseases, and a redefined definition of the nature of palliative care (WHO, 2002). Additionally, patients and families appear to be utilising palliative care services earlier in the disease trajectory (Sepulveda, et al., 2002; NCHSPCS, 2003a; Thomas, 2003). The evidence in the literature to date suggests that many qualified nurses still do not have specific training in palliative care in their pre-registration training programmes (Copp, 1994; Lloyd-Williams & Field, 2002), and that post-registration training has been somewhat ad-hoc (Langton et al., 1999). Furthermore, there has been little evidence of the rigorous evaluation of such educational programmes.

As more people require palliative care, (indicated by an ageing population and wider definition of what constitutes palliative care); then those who provide it will require ongoing effective education; which enables them to become competent, confident practitioners. Sneddon (2001) conversely made the point that more education does not necessarily mean improved practice. This study has therefore highlighted a **gap in the provision of rigorous evaluation strategies for palliative care education.** I suggest this perceived gap might be due to a lack of evaluation frameworks suitable for palliative care education.

Furthermore, palliative care is a rapidly changing field. With the increasing specialisation of the subject and emergence of specialist palliative care practitioners; nursing staff may lose confidence in their abilities to provide general palliative care. There is some research evidence to suggest that nursing and medical staff may become deskilled by the provision of clinical nurse specialists (CNS) in palliative care (Jack, et al., 2002). However, the same study reported how junior staff perceived the CNS's as empowering them to deliver care. England's chief nursing officer Sarah Mullally, has recently stated that the increasing numbers of specialist nurses in all fields should be used to improve care to specific groups of patients and not deskill more generalist nurses (Parish, 2003).

The philosophy of CHE is to widen the provision of palliative care education so that it is available to people from all care settings. Whoever provides palliative care; appropriate education to inform their practice is required. Such education must be rigorously evaluated and in this way, evaluation can be used as a tool to ultimately improve and change palliative care practice. The effectiveness of education in palliative care on care practices must continue to be questioned. One way of doing this is to involve stakeholders including students, in the evaluation of educational programmes. Measuring the 'worth' or 'value' of education to them, and their practice, in the wider context of collaborative professional development, seeks to improve the delivery of care, by enabling the application of learning to practice.

6.91 Aims and Objectives of the Study

This evaluation project was undertaken in order to determine whether education in palliative care made a difference to nurses' practice, i.e. did it improve nurses' palliative

care skills. The results from the research indicate that education (at CHE) did make a difference to the way students' practised in palliative care and that such differences were sustained. However, this study was equally concerned with investigating just what it was about the education; that enabled students to make changes to their practice. The evidence that the education was effective came from a number of sources (not just students themselves), and tools. It was also ongoing, checking with participants whether changes in practice had been sustained; thus adding to the rigor of the findings.

Palliative care education at CHE has a number of advantages:

- A stable dedicated team of highly enthusiastic teacher/practitioners who are well motivated and passionate about the importance of practice.
- Having small groups of students so that teachers can get to know them and value openly their contributions, nurturing their learning and fostering collaborative working styles.
- Having access to specialist practitioners to assist in the teaching and mentoring of students.
- Providing an environment in which creativity and innovation are encouraged.

I would conclude that in this study such advantages fostered a genuine partnership between students and teachers, which enabled learning. It also allowed students to be challenged in a 'safe' environment, thus they permitted themselves to consider their own beliefs and values and become more self-aware. I would like to suggest that nurse education in general could benefit from similar advantages, to openly demonstrate, the 'valuing' of students and their practice. This may be about reducing class sizes; a difficult

decision when there is a national shortage of nurses and a government drive to train more. In my personal opinion, students of nursing whether qualified or unqualified, could ultimately benefit from closer interactions with each other in a safe classroom environment; where they can participate in well-facilitated experiential learning exercises, to increase self-awareness. This in itself is worthy of a further research study.

One of the objectives of the study was to identify the perceived levels of knowledge, confidence, and competence pre and post education. This was achieved by establishing good communication with the students and by using various research tools observation, one to one and group interviews and focus groups. All of these methods required a clear rationale for their use and good explanations to the students. I recognise alongside other palliative care educators that it takes more than just education to change practice (Sheldon & Smith, 1996; Sneddon, 2001, 2004); however Sheldon & Smith (*ibid*) also argues that using quantitative approaches to measure the impact of education is pointless when the best evidence of personal growth comes from the participants themselves. Therefore using the model of education presented here encourages the valuing of students and provides an environment where personal and professional growth is encouraged.

Lessons learnt in describing the participant's and stakeholder's views and experiences, of the 'process' of education in palliative care, were about the requirement to be clear about what information was required and from whom. It was also necessary to keep good research notes from the field and a reflective journal was invaluable in being able to refer back to, when trying to analyse the wealth of information collected. Some of the research

participants also almost self-selected to provide more data simply by approaching me with further evaluative information. It could be argued that these participants would have changed their practice anyway but it was pleasing to see that they were keen to share this information, valuing it as an important part of their professional and self –development.

This study used an action research approach because it was a collaborative empowering process. It stressed the importance of the involvement of participants, in this case, students (plus other stakeholders), rather than some 'expert researcher'. It also aimed to contribute to knowledge and enable individual and organizational goals to be met. It was noted that students' ownership of the evaluation project encouraged them to make changes to their practice. Robbins (1998) highlighted the importance of staff being part of the evaluation of palliative care (to help establish an evidence base) including recognising their professional development needs. The way this study was conducted enabled students to assess their learning needs in relation to palliative care and thus identify the gaps. They were then encouraged to think how to fill the gaps and ensure learning was appropriate to their needs. In this way, learning and professional development is demonstrated as being ongoing. Similarly, students were exposed to the notion of theory and practice being considered of equal value, one informing the other.

In this study, the term evaluation has been utilised as a form of applied research, where the tools of research have been used to find out about the effectiveness of palliative care education in the stated setting. The role of the evaluator has been explained and sound reasons provided for being an internal evaluator in this project. The understanding of the

nature of nurse education and practice, and the complexities of palliative care; were considered more important qualities in the evaluator than perhaps could be gained by an impartial neutral outsider doing the evaluation. The reflexive nature of the study ensured all participants (including the evaluator) were able to provide reasons for their actions and any subsequent decisions made.

Although not an original aim of the study, the questionnaire which was used as an aid to learning, allowed student's results to be compared with each other. This proved interesting because those scoring higher than the average (apart from one student), all worked in a community setting. The reasons for this would be worth exploring further. The participants in the study who were community nurses (in the focus groups), all of whom had worked at one stage in hospital acute care settings; suggested that working independently one to one with patients in their own homes, made it easier to identify and try out changes in their own practice. It was felt that the organisation of work in hospital settings made change more difficult.

A further comment made by one of the community nurses was the perceived increase in patients requiring palliative care in their workloads. As more patients are diagnosed as palliative, earlier in the disease trajectory, then it would be expected that they would have an increased contact with health care services/personnel where ever care is provided. The drive to provide more community based services is an ongoing part of the NHS Cancer Plan (DoH 2000; DoH, 2002). Other students in the group (from settings other than community) may not have had as much opportunity to practice their new skills with

palliative care patients. A further point to note here is that sometimes nurses in all settings appear to have difficulty applying the term 'palliative' to a patient unless they have been diagnosed as 'terminal' by a doctor. The wider definition of palliative care to include those patients with chronic, non-cancer diseases and the fact that the principles of palliative care nursing are transferable to all patients in whatever setting, is unfortunately not always recognised.

The use of focus groups towards the end of this study assisted in checking out the validity of the data obtained to date; and ensured that the final model of education was truly collaborative whilst reflecting the participant's experiences of the process of education at CHE. The model therefore is promoted as a working example of how palliative care education can be provided to meet participants needs. Further work is necessary to assess the effect on patients and families. With the increasing need for evidence to inform practice, clinical audit and user involvement, practitioners and researchers will need to ask patients and carers their views. Bradburn (2003) identifies that palliative care user involvement is an area that requires more development. Enabling practitioners to be more confident, providing effective, efficient education which meets practitioners needs should allow them to begin to address gaps in their knowledge and skills which currently prevents them from asking patients and relatives their views.

One of the benefits of using the model was the organisational change at CHE, which occurred because of the evaluation process. This change involved improved working relationships between stakeholders. There was more clarity and focus relating to

organisational goals, and positive feedback; which helped to nurture creativity and the implementation of new ideas and projects. Providing stakeholders with evidence of how a service is working (or expected to work) is good practice and can assist with ensuring there is continuous support and ongoing funding for the service. Evaluation also helps identify any unintended benefits of a project. In this study unintended benefits included:

- Manager's being able to directly identify the benefits of the education when looking at the wider service provision of palliative care in their areas (Vickers, 2000)
- The ongoing networking of students with each other, after the course had finished which further facilitated better working relationships between different care settings.
- Developing creativity in how courses were planned and delivered.
- Adopting an evaluation culture, which became an inherent part of CHE. Although I expected this to happen, as a result of stakeholders being involved in the evaluation study, once they were on board the positive change in attitude towards evaluation was marked.

The model of education presented here may be applicable to education in other settings and this would be worth further study. It is has proved in this study to be particularly relevant in helping to make learning meaningful for students i.e. their learning agenda rather than the teachers, thus education being more likely to meet student needs. It also demonstrates learning as an ongoing process rather than a one off event. It helps students learn how to learn by using reflection and encourages them to apply what they have learnt

to their practice. James & Macleod (1993) identified that the interpersonal aspects of palliative care are more important to patients than their physical problems. If nurses are to be taught to address these psychosocial aspects of care then they must give freely of themselves and become more self-aware. Palliative care education programmes must enable students to achieve their personal potential and help them to respond to patients as fellow human beings. The palliative care teacher must allow the student time to develop knowledge of their strengths and weaknesses whilst encouraging confidence in their skills. A trusting relationship needs to be developed and a safe environment in which students can share their experiences within comprehensive programmes.

The inclusion of clinical facilitation recognises the reality and challenges of practice; it assists both students and teachers ground practice with theory. Teachers working in clinical areas with students can experience what practice is like for those students and tailor the learning experience to suit the context of practice. The experience is equally good for teachers enabling them to keep up to date with practice (a professional requirement), and helps them be seen as credible practitioners by students. Bringing teaching to a practice setting encourages ongoing learning and helps students to utilise different styles of learning. It clearly makes the patient the focus of the learning experience, and in my experience, patients and the practice setting provides ample quality teaching materials; for example: patient's views, experiences, case notes. Working with a teacher in their own practice setting may provide the opportunity for the student to identify areas for practice improvement and also her strengths that would perhaps not be revealed in a classroom setting.

6.10 Recommendations regarding the provision of palliative care education

- Patients requiring palliative care should receive the highest quality care to meet their needs. The National Institute for Clinical Excellence (N.I.C.E.) is expected to publish some guidelines next year for palliative care, the underpinning theme of those guidelines will be:

- *"the provision of good supportive and palliative care should be an integral part of every health and social care professionals role"* (NCHSPCS, 2003b p12) This means that those who care for these patients should be properly educated.

- Palliative care education should be effective and meet the needs of practitioners and other stakeholders. To ensure this, it should be evaluated to provide tangible evidence of what works and what doesn't work. Such evidence should be widely disseminated as evidence of 'best practice'.

- It is suggested that the model of palliative care education developed in this study would be a helpful evaluation framework. The model explicitly demands that stakeholders evaluate whether education makes a difference to practice. It does this by using evaluation as a foundation and ensuring that stakeholders involved in education (be they teachers, students, managers, or fundraisers) have a clear focus about what that educational process, may be expected to achieve.

- Using an evaluation framework such as that suggested by Ovretveit (1998), (page 100 of this study), it might be possible to measure the impact of education on

service users. I suggest that if education makes a difference to the way nurses practice then they should be more able/willing to identify omissions in services and attempt to gain service user views to ultimately improve practice.

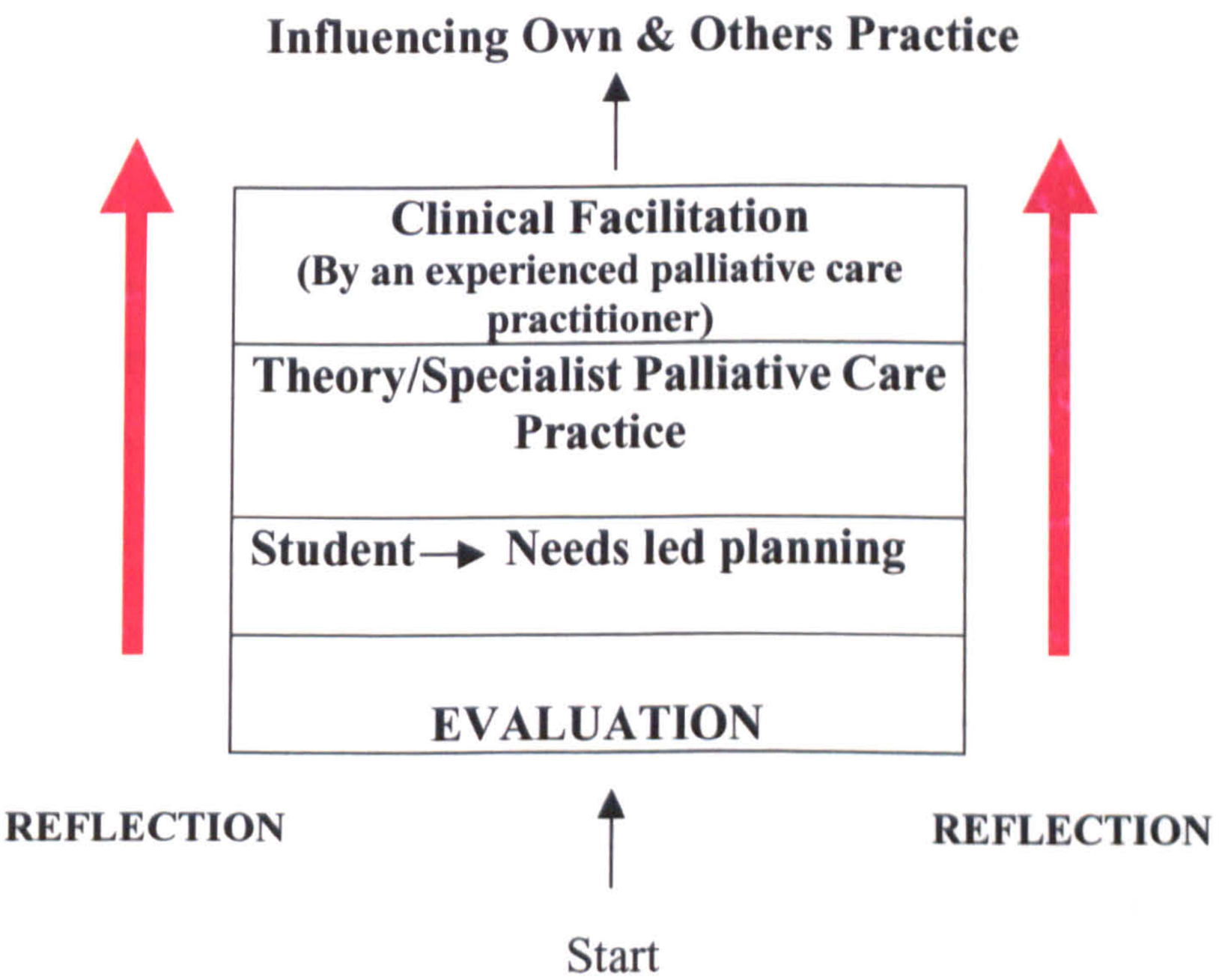
- It is important that teachers of nursing in whichever field of speciality teach in a variety of settings including practice. Providing support for students in their practice setting encourages the ongoing professional development of both teacher and student in a partnership approach; and the application of theory to practice.

Finally, through this research project it has been possible to demonstrate that evaluation strategies have something to offer palliative care education. A framework for evaluation as suggested by the model devised in this study can help palliative care education move forward and demonstrate best practice. As palliative care currently has a high political agenda, due to the National Cancer Plan (DoH, 2000; 2002) it will be interesting to see whether as palliative care services develop, evaluation strategies become integral to those development plans.

I propose that in the past evaluation has had a low profile. It has been 'added on' at the end of projects, almost as an after thought, with little preparation and training of those responsible for actually doing the evaluation. It may also be perceived, as expensive. The true expense lies in the potential added costs of ineffective, inefficient projects. The time has come to demonstrate the benefits of multi-collaborative evaluation practice

through well thought out, well run evaluation strategies, the results, as in this project will speak for themselves. I offer the following model as an approach that is useful for palliative care education. It provides a framework to follow which is based on evaluation and brings together concepts of good educational practice to enable students to apply what they have learnt to their practice. In addition it has helped to demonstrate to the students involved in this study that the support they have received has been influential in assisting them to challenge previously held assumptions and practices.

A Model for Palliative Care Education



End Note:

I have been part of a working group in the Greater Manchester & Central Cheshire Cancer Network to identify and provide education and training for community nurses in order for them to provide general palliative care. In line with the national strategy, each cancer network was provided with funding to make available education in palliative care to community nurses. As a direct result of this PhD study I was asked to lead a project to evaluate this education across four pilot sites, one of which was central and east Cheshire.

The evaluation strategy was multi-collaborative, and used pre and post course questionnaires, (adapted from the one used in this study) teacher/facilitator evaluations and individual one to one interviews. The evaluation report was completed in March 2004. The results are to form part of the national evaluation project of palliative care education for community nurses, led by Dr Cathy Shipman at Kings College Hospital London.

In addition, colleagues at CHE are similarly involved in the delivery of palliative care education to community nurses in Ellesmere Port and Chester (part of the Merseyside and Cheshire Cancer Network) and are also contributing to the national evaluation programme.

* March 2004 - The pilot study was deemed to be successful and the portfolio of learning has been adopted by the Greater Manchester & Central Cheshire Cancer Network as the strategy for the ongoing palliative care education for all its community nurses.

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Appendix One

- **List of educational programmes and courses offered at Cheshire Hospices Education & Students Course Handbook for ENB 931- Principles & Practice of Palliative Care.**

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Appendix Two

- **World Health Organisation Revised Definition of Palliative Care (2002).**

Appendix 2

Palliative Care: The World Health Organization's 2002 Definition

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

Palliative care:

- Provides relief from pain and other distressing symptoms
- Affirms life and regards dying as a normal process
- Intends neither to hasten or postpone death
- Integrates the psychological and spiritual aspects of patient care
- Offers a support system to help patients as actively as possible until death
- Offers a support system to help the family cope during the patient's illness and in their own bereavement
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- Will enhance quality of life, and may also positively influence the course of illness
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications

The World health Organization (WHO) has broadened its approach to palliative care. Whereas before, a disease specific approach was used, now the similarities and opportunities for cooperation among those working with different diseases are emphasised. In particular, the need for collaboration between those working with HIV/AIDS patients and those working with patients with other chronic diseases is noted.

The earlier WHO definition of palliative care stressed its relevance to patients not responsive to curative therapy. This statement might be interpreted as relegating palliative care to the last stages of care. Today, however there is a wide recognition that the principles of palliative care should be applied as early as possible in the course of any chronic, ultimately fatal illness. This change in thinking emerged from a new understanding that problems at the end of life have their origins at an earlier time in the trajectory of the disease. Symptoms not treated at onset become very difficult to manage in the last days of life.

The WHO approach to palliative care has also been extended, such that, while pain relief is still an important component, it is by no means the only consideration. The physical, emotional, and spiritual needs of the patient are all considered important concerns in palliative care. In addition the WHO consideration of palliative care has broadened in that it no longer considers just the patient, but includes considerations of the health and well-being of family members and of the carers working with the patient. It extends beyond the period of care for the patient, and includes a consideration of the need to support and counsel those who have been bereaved.

WHO also has a palliative care definition explicitly for children.

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World Health Organization (2002) ***National cancer control programmes: policies and managerial guidelines***. 2nd edition Geneva World Health Organization.

Appendix Three

- **Published articles:**

Education in palliative care: making a difference to practice?
International Journal of Palliative Nursing - August 2001.

Using Edward de Bono's six hats game to aid critical thinking and reflection in palliative care.
International Journal of Palliative Nursing- March 2003.

An evaluation -based model for palliative care education: making a difference to practice.
International Journal of Palliative Nursing - May 2003.

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Appendix Four

- **Papers and Posters presented at Conferences.**

Palliative care education making a difference in practice? Abstract of Poster Presented at:
Cancer Care 2000, Clatterbridge Centre for Oncology NHS Trust in conjunction with the Royal College of Nursing 4th & 5th February 2000 Chester

Fourth generation evaluation in palliative care education - Abstract of Paper Presented at:
Turning the Tide: Collaborative Cancer Care 2000
RCN & Plymouth Oncology Centre, Plymouth Hospitals NHS Trust 1st & 2nd June 2000.

Collaborative working In palliative care education. Abstract of Joint Paper Presented at:
Cancer Care 2001, Clatterbridge Centre for Oncology NHS Trust in conjunction with the Royal College of Nursing 2nd & 3rd February 2001

Clinical facilitation in the workplace: old problems new solutions? Abstract of Joint Paper Presented at:
Royal College of Nursing Education Forum Conference, Blackpool 14th & 15th February 2002.

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Appendix Five

- **Information given to participants explaining about the research study and consent form.**

Appendix 5

Evaluation information given to students, including consent form

CHESHIRE HOSPICES
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Dear

The team at Cheshire Hospices Education (CHE) take evaluation seriously it is therefore an integral part of our work and an ongoing activity. We carry out both formative and summative evaluation and our evaluation process is multi-professional and collaborative. We aim to seek the views of <u>everyone</u> who is involved in our educational activities i.e. students, teachers, clinicians, managers, and administrative staff, in order to produce a 'portfolio of evidence' as to the effectiveness and quality of our courses. This information is used to improve what we do and inform our future planning. It is also used as evidence to our fund holders and other stakeholders that we are providing education that meets the needs of those who attend.
My role is to collect this information I am therefore writing to you to explain how you are likely be involved/affected by this process.

If you are a student you will see me being involved in teaching and classroom activities. I will be asking your opinion of things relating to the course and your practice. All information will be recorded and checked with you as to its accuracy. Such information is being used as part of a research study I am undertaking at Liverpool John Moores University. This information is anonymous and your name will **not** be identified anywhere in the study. Because this study is taking place over a three-year period I may ask you to participate in further evaluation activities relating to this course in the future. You may of course wish to **opt out** of the study **at any time** or ask for any of your comments **not to be recorded/utilised.**

If you are unsure about any of the comments in this letter please speak to me in person, I will be happy to discuss this further with you at any time.

Lesley J Kenny (Mrs)

Evaluation Project Leader

CHESHIRE HOSPICES
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Form of Consent To Take Part As A Subject In A Research Project

Title of project/procedure: Palliative care education: evaluation of theory and practice.

I ..... agree to take part in the above named
(Subject's full name)

project, the details of which have been explained to me and described in writing.

Signed..... Date .....
(Subject)

I .....certify that the details of this project
(Investigator's full name)

have been fully explained and described in writing to the subject named above and have been understood by him/her.

Signed..... Date.....
(Investigator)

I ..... certify that the details of this project
(Witness full name)

have been fully explained and described in writing to the subject named above and have been understood by him/her.

Signed ..... Date
.....*(Witness)*

NB. The witness must be an independent third party

Appendix Six

- **Transcriptions of interview data from participants prior to commencement of studies at CHE.**

Appendix 6

Transcript of some of the tape recordings of interviews with students prior to them commencing the ENB 931 Course at CHE

The students were all asked the same questions prior to them commencing the course. Their answers were documented in their student records. Students were interviewed by a member of the teaching team and a clinical practice mentor whenever possible. The author as researcher initially observed (and tape recorded these sessions). Later the author was involved in her teaching capacity as an interviewer. 8/2/99

Student LC

Consent obtained

Present SPJ, KP (Practice mentor from Chester hospice) and myself.

SPJ- ' Hello LC how are you?'

LC ' very well Thank-you'

SPJ 'If you would just like to take a seat here, I'd like to introduce KP who is one of our practice mentors, of course practice is integral to the course and we like to involve the practice mentors in the interview process.'

LC ' hello, pleased to meet you'

KP 'hello'

SPJ ' I'd just like to explain the purpose of the interview, it is about us getting to know a little bit about you and gives you the opportunity to ask us questions about the course. So, I will ask you a few questions and then KP will ask some then I will finish and you will have the opportunity to ask us any questions you may have is that all right?'

LC nodding head 'mm'

SPJ ' Ok then perhaps you would like to start by outlining your present role and responsibilities'. (Q1)

LC ' I am a staff nurse in the community working nights, the night sitters ….. er are you familiar with the system? (to KP)

SPJ and KP'yes we are'

LC ' well we have acute patients who are terminally ill and chronic patients, I have to check that they are alright or whether they need anything. There are different methods

of referral, of course the day staff GPs and sometimes even the ambulance staff will refer patients ..... You need good communication skills.'

SPJ ' How long have you been doing that for?

LC '2 years, previously I was a practice nurse, then part time night duty, then full time 2 years ago'.

SPJ ' Why have you applied to do this course'? (Q2)

LC ' Personal self-development, fulfilment, I want to know more share with others develop my knowledge, it is the ultimate care research based. To enhance care with the patient and their family to improve the care.'

SPJ ' What do you hope to gain from the course?' (Q3)

LC ' Achievement, knowing that I know. It makes your voice louder, not literally if you understand what I mean but to give me confidence.'

KP 'What aspects of palliative care do you find the most satisfying?' (Q4)

LC ' Knowing the patient is comfortable ... everything else develops from there if the patient is settled it helps the relatives. The family copes better. I think this is most important .....

KP ' What do you find most difficult or demanding about palliative care situations? ' (Q5)

LC ' It is difficult when there is inadequate pain control, not every patient has good pain control, ... demanding ? er.. well I think you can sort most things out with a good GP'

KP 'Are you able to do that ?'

LC ' yes I think so, most of the time'

KP ' How do you think doing this course will benefit your practice'

LC ' The confidence to know that I know. To have succeeded in the course .. it gives you confidence, and to do more .. research ....'

SPJ ' Have you had any thoughts about where you would like your practice placements to be during the course, as you know there are ten practice days to be organised and we like to start planning for those as soon as possible?' (Q7)

LC ' Well the Macmillan nurses community and hospital, plus I'd like some time here in the hospice.'

SPJ' We try to tailor make placements for each student .. although there are no promises, if a place wasn't available here at the hospice could you travel?'

LC ' No problems I have my own car'

SPJ ' What do you feel you have to contribute to the course'? (Q8)

LC ' well , myself cos I care, the standard, the high standard which the patient may gain. My knowledge and experience I already have. I have good communication skills and empathy, empathetic skills to share with others on the course. Meeting a variety of people.'

SPJ ' Have you any specific expectations/objectives other than you have already mentioned?' (Q9)

LC ' Pain control and more knowledge, I'm doing a bit of a literary no literature search at the moment – into breakthrough pain ...'

SPJ ' yes there has been a good article recently about that ...'

LC ' Yes well I have been doing a staff nurse development programme and I'm looking at syringe drivers and breakthrough pain for that .. '

Salll ' Have you any concerns or worries about the course ' (Q10)

LC ' Presentations! Just coping with it, no not really !'...

SPJ ' Have you any questions ?' (Q11)

LC ' well I was going to ask about audit seeing as how important it is these days ....'

SPJ ' Yes well it is important, clinical governance I'm just getting my head round all that ... Our course is an ENB course...

LC ' it says incorporating ENB .....'

SPJ ' Yes, it is an ENB course validated through Manchester Metropolitan University, they of course have their own quality measures which we are required to follow. In addition we have a course committee meeting about halfway through the course, on that committee is myself, JC the representative from MMU and a student representative from the group. We discuss how the course is going and any concerns that students have, in this way it is ongoing. Good question that.

Result:

Offered a place, also given info about study skills workshop.

PB Hospice Nurse (St Lukes) 8/2/1999

Consent obtained for research.

Present:SPJ, KP (Practice mentor from Chester hospice) and myself LJK

SPJ Gave explanation as to the interview format and introduced practice mentor.

SPJ 'Well PB for the benefit of KP and LJK perhaps you could explain a little bit about your present role and responsibilities.' (Q1)

PB ' I am an E grade staff nurse working in the hospice, well perhaps I need to explain a little bit about my background. I came to the hospice originally as an enrolled nurse, then I did a course to register, staff nurse, RGN, not really conversion a retake, then I was interested in aromatherapy and wanted to take this further. I do half a day a week in practice as an aroma therapist although it is sometimes difficult to separate the nursing and I would really like to do more, to develop the aromatherapy side to include outpatients who, have gone home.

SPJ ' Why have you applied to do the course?' (Q2)

PB ' Well I did wonder whether after 8 years in practice in a hospice it was a bit of a waste of time really, I don't want to be seen to be wasting the hospice's money, however at my development interview recently it was suggested I do this and I knew when I first came I would be expected to do it, I just did the aromatherapy aspect first. Now I feel Matron would like me to do it.

SPJ ' What do you hope to gain from the course?' (Q3)

PB ' Reassurance that I am doing the right thing, help others professionals want to be more confident in passing on information.

SPJ ' What aspects of care do you find most satisfying ?' (Q4)

PB 'One to one – having time to listen and get close – getting it right you don't get a second chance with these people .. it's very rewarding. I do feel I am good at my job I get a lot back.

KP ' What aspects of your job do you find the most demanding?' (Q5)

PB ' I always wonder if I am saying the right thing to patients and relatives. ... sometimes I doubt myself. I worry about that.. especially with relatives .. it stays with people for a long time. It's little things .. it's more than just a job ....'

KP 'Yes we all feel like that I know what you mean about saying things, I found it hard at first not to say anything just to be quiet ...

In what way do you think doing this course will benefit you? (Q6)

PB 'Lots of ways really .. it will reassure me mixing with others is always good I think you can gain a lot from others .. new views... being with the same members of staff for

eight years means you can get stagnant views..... Keeping up to date you know, you get a lot of things from other people.

SPJ ' what about practice .. what placements would you like?' (Q7)

PB ' Aromatherapy definitely as you know I want to incorporate my aromatherapy skills into practice, I'd like to see how other places do it....'

SPJ Can I just ask whether you have had any bereavements or losses within the last year, this course contains a lot of sensitive material that may not be appropriate for people who have had a recent loss. We would want to negotiate a better time for them (Q8)

PB "No nothing"

KP - How do you think you will cope with the studying you will need to do on this course? (Q9)

PB "Well I know it is going to be hard and I am not very good at that sort of thing but I am willing to have a go. All my colleagues have said they will support me. I will just have to buckle down and get on with it won't I ?

SPJ "Is there anything you want to ask us"?

PB Well actually ehhmm this sounds awful I have a holiday booked in ..... what do I do about time off?

SPJ - Well obviously that is not ideal however the regulations say you can miss up to 2 days of theory but no practice, practice has to be made up. We will look at that with you on an individual basis to see what you will be missing and how best to help you catch up.

Appendix Seven

- **Excerpts from research journal/diary that I kept during this study.**

Appendix 7

Research Journal Entry Examples

The following extracts have been taken from the (extensive) field notes/ reflective journal kept by me. They have been included here as examples of how the research progressed and some of the issues tackled. Obviously only a few examples are provided, many were at the beginning of the project where as a new researcher I struggled with issues relating to consent, ethics, my role as a teacher and researcher and trying to make sense of a whole range of ideas.

Reflecting on the research journey at the end I am now aware that this journal records many of the issues other researchers face. Reading the literature may make novice researchers aware of some of the challenges but actually getting on and doing it helps you work out the answers. Something about theory and practice informing one another comes to mind!

My thoughts (reflexivity) are recorded in blue italics where applicable.

September 1998

Unable to attend the preview day to administer the pre-course questionnaire.

Feel like I have failed at the first fence!

Action: Discuss with SPJ exact protocol for questionnaire administration.

October 1998 -

First meeting with group (precourse questionnaire completed on preview day administered by SPJ in my absence).

LK Thoughts. I need to be present at future preview days and administer the questionnaire. ? validity issues and rigor.

Introduced to group by SPJ, explained my role and reiterated consent issues. Found I knew some of the group. *Felt a bit concerned students would feel coerced into taking part.* Need to check this out carefully.

Action: Ask SPJ, discuss with supervisor. Continue to discuss consent with students when I visit them and are involved in classroom sessions. Read up about process consent.

Initial thoughts, students were very positive both about the course and the study!

December 1998

Observation of group following practice placements.

Discussion of 'realities' of practice.

Group much more vocal!

Student VH. ? attitude problem, *(How do I know ?)* yet clearly demonstrated she has learnt from practice. Talked about being able to improve on her listening skills. Very negative student but positive about the course!

Student AC*. A high flyer academically, thinks very carefully yet able to put forward her views in an articulate manner. Talked about 'inequalities in services between different community settings. *(Useful to follow up this student in the focus group to see if this high enthusiasm and commitment to changing practice is sustained).*

Some issues re: quality of placements SPJ and I to discuss. -

Action taken re preparation of mentors, earlier notification of students name to clinical area and requests for mentors name.

(*Author's note student AC did participate in the focus group held towards the end of the project).

Process evaluation - making changes to our practices as a result of feedback.

LK ? what's in it for the mentors?

What is the mentorship experience really like? How can I find this out?

How do they cope with busy clinical areas and a student with a learning contract?

Need to explore this in more depth.

Can we make it any easier?

What changes do they notice in students they mentor?

Action: Questions for mentors at focus group, how do they know? what changes do they see in student? What evidence is available?

Problems with one clinical area (DM) mentors not available - (on holiday). Student coped quite well considering, but this was not an ideal learning environment.

January 1999

Involved with interviewing students for next 931 course. Used tape recorder. Interviewed with SPJ, asked about tape recorder re consent. All agreed.

Same questions for all interviewees, *important issues for evaluation purposes* i.e.

Why do they want to do the course?

Are there any trends?

If using own words how will I identify trends/broad themes?

Transcript of taped interviews x 2 lots of information. See Appendix*

LK's Thoughts: Rich set of data, difficult to observe and think without getting involved!

Lots of non-verbal communication too, ? is it relevant.

People seem to find it difficult to think what they might have to offer as a course participant. *Is this a 'confidence' issue?*

Have identified who this is (PB)so that I can perhaps use case study analysis, refer back to this candidate at a later stage not sure at this stage……

Author's note: I did in fact use this student as an example in the case study (Paula).

Third candidate asked me not to use the tape recorder, if I am to keep to research protocol I need to do one or the other. ? usefulness of tape recording when we have set questions.

Action: Decision made to cease tape recording this initial interview following discussion with supervisor and teaching team

Later entry, (September 2000) identified broad themes were apparent as now had more data these were:

- Wanting to improve communication skills
- Being more confident and competent in caring for patients and their families
- Improving their knowledge and skills in relation to palliative care
- Finding out research based evidence to inform practice

LK Thoughts _ How will they know they are more confident? -what evidence?

How will I know? How will I measure this?

Action: Keep asking the questions!

March 1999

During discussion with ST about her assignment she disclosed how much more confident she was feeling both about her improved knowledge but also about how she could utilise what she had learnt in her daily work. She was quite evangelical and stated she would push for more of her colleagues to do the course as she felt it was "*the minimum people should know about palliative care*"

LK – This conversation came out of nowhere! Unprompted by me and provided useful info

re my research. ? Is it valid, can I use this?

Discuss with supervisor.

Following discussion with my supervisor it was agreed I needed to keep a careful note of when, what and how these conversations came about and that they may prove useful at data analysis stage.

May 1999 Review Day

LK - quite nervous how will I know whether students have benefited from the course.

What am I looking for?

Administered post course questionnaire, some students had not filled it in correctly,

Need to reconsider instructions to ensure they mark a point on the line, also I wasn't there on preview day. Action : Change instructions on questionnaire

Got lots of data - very interesting shifts along continuum.

Learnt a lot from this first group. Need to take care how I ask questions - not leading them on or is that ok to do?

Check with Supervisor, what if SPJ asks a leading question does that make a difference?

Gave them the questionnaire and then took them away for analysis.

On reflection why did I not let them see their original answers? This would perhaps have allowed them to see there own progress (for some students it was very marked from one end
of the scale to the other).

?Would this have created more discussion, ? richer data.

My naivety as a researcher, not wanting to skew the results in any way.

A bit patronising acting as if it was my data rather than theirs.

I need to address this.

Action: discuss with supervisor.

Discussed, agreed it is ok to change the way I go about things provided I have appropriate rationale and not just changing things for the sake of it.

Keep good records in field notes and then will be able to identify changes made along the way when I come to write up.

June 1999

Still not really got trustee support for the project - think they agree in principle but don't want to pay anything!

Attended CHE AGM- did a joint presentation with SPJ re our progress, able to use some student comments from evaluation data collection as evidence.

Action: Keep trustees informed - evaluation info powerful.

August 1999

Spoke to student JL. She asked me about the progress of the research. Said she felt that the education at CHE was excellent and she had really benefited from it. She had been waiting to see me to tell me this.

LK thoughts - is this an example of 'participative research' i.e. student approaching me?

Trustees also asking more questions seem more interested in the project.

April 2000

New cohort of students definite themes reoccurring as to why they want to do the course.

LK thoughts - Increase in confidence, more knowledge and particular skills around things like syringe drivers, pain and symptom management. Lots of concerns about "doing it right" wanting evidence.

June 2000

Good feedback from practice placements Need to ensure positive feedback gets back to mentors.

Discussion re: improving confidence with students CT and SG, one is a hospice nurse, the other working in acute care, both feel their confidence has improved yet both in senior positions and experienced practitioners.

LK thoughts – what is it that is happening here? How different from other education? Is it different? Is it the course, teaching, support, or students or a mixture?

March 2001

There appears to be enough evidence now to suggest the education is making a difference to practice. Discussion with supervisor about positive results, suggests I try and get something published. International Journal of Palliative Nursing interested.

June 2001

CHE AGM- asked some students to speak and one of the community nurse managers. Very powerful, the students talked about the challenges of education and some of the difficulties they had experienced. Trustees now on board!

LK - It took a long time to get the Trustees on board re evaluation, but this meeting seemed to be a turning point. ? about bias, did they see me as presenting biased information? Only the positive? On reflection maybe so. GF asked on several occasions about "the negatives"

Appendix Eight

- **Copy of the questionnaire which was used pre and post course.**

Appendix 8
The Questionnaire

CHESHIRE HOSPICES
EDUCATION

Student Evaluation

Part of our responsibility is to evaluate this course; therefore in order to provide us with baseline information please complete the attached proforma.

There are no right or wrong answers and we are interested in your current perceptions of yourself.

The information will be collated anonymously for statistical purposes.

Additional information will be collected at the end of the course & some students will be invited to participate in further evaluation activities.

This information may be of value to your professional portfolio and will be returned to you when the data has been collated..

Thank-You.

Lesley J.Kenny

Participant Number ☐

Cohort ☐

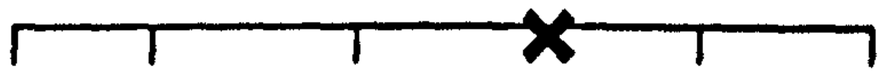
Please tick the relevant box below to indicate when you are completing this form.

Preview day ☐ Review day ☐

Read the statements below and indicate your perception of **yourself today.**

Please rate each of the statements using the scale provided. Place a cross along the line at the point, which most closely represents your views.

Example: ***"I am competent in managing a patient who is experiencing severe pain".***

Agree  **Disagree**

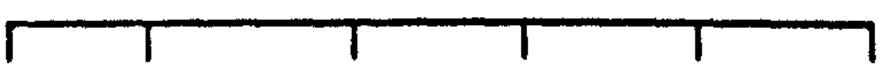
1. I am able to respond appropriately to patients when they ask difficult questions.

Agree Disagree

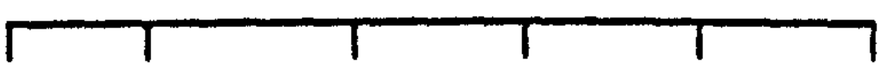
2. I am knowledgeable about a variety of pain control methods.

Agree  Disagree

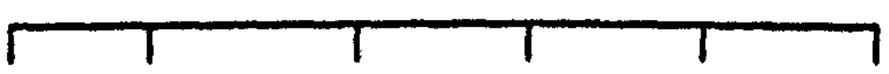
3. I am confident in acting as an advocate for patients who are receiving palliative care.

Agree  Disagree

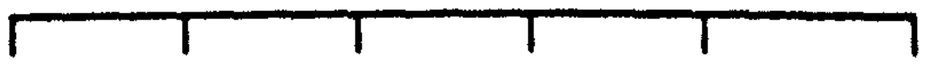
4. I am confident when dealing with bereaved relatives.

Agree  Disagree

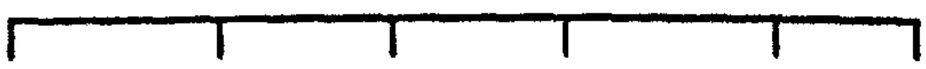
5. I am able to constructively support patients who are in 'denial' about their diagnosis.

Agree  Disagree

6. I am able to respond appropriately to relatives when they ask 'difficult' question.

Agree  Disagree

7. I feel confident in assessing and managing patients with difficult symptoms.

Agree  Disagree

8. I am uncomfortable when talking about my own death/dying.

Agree  Disagree

9. I feel confident when communicating with patients who are terminally ill.

Agree ⌐——┬——┬——┬——┬——┬——¬ Disagree

10. I am able to confidently teach others about the principles of palliative care.

Agree ⌐——┬——┬——┬——┬——┬——¬ Disagree

11. I am confident when dealing with relatives of patients who are terminally ill.

Agree ⌐——┬——┬——┬——┬——┬——¬ Disagree

12. I feel comfortable when patients talk to me about death and dying.

Agree ⌐——┬——┬——┬——┬——┬——¬ Disagree

13. I am competent in assessing a patient who has severe pain.

Agree ⌐——┬——┬——┬——┬——┬——¬ Disagree

14. I am competent in assessing and managing a patient with chronic pain.

Agree ⌐——┬——┬——┬——┬——┬——¬ Disagree

15. I feel uncomfortable when relatives talk to me about their loved ones death/dying.

Agree ⌐——┬——┬——┬——┬——┬——¬ Disagree

16. I lack confidence when challenged by colleagues about patients who are receiving palliative care.

Agree ⌐——┬——┬——┬——┬——┬——¬ Disagree

17. I am able to respond appropriately when collusion is a problem for:-

a) Patients

Agree ⌐——|——|——|——|——| Disagree

b) Relatives

Agree ⌐——|——|——|——|——| Disagree

c) Professionals

Agree ⌐——|——|——|——|——| Disagree

18. I am confident when using reflection as a tool to enhance my own or other peoples' nursing practice.

Agree ⌐——|——|——|——|——| Disagree

19. I respond appropriately when dealing with patients who are receiving bad news.

Agree ⌐——|——|——|——|——| Disagree

20. I am knowledgeable about the availability of bereavement support services.

Agree ⌐——|——|——|——|——| Disagree

21. My beliefs and values influence the care I give when nursing patients who are receiving palliative care.

Agree ⌐——|——|——|——|——| Disagree

22. I am able to offer positive contributions in discussing palliative care with colleagues.

Agree ⌐——|——|——|——|——| Disagree

Appendix Nine

- **Information from focus groups held with teachers/mentors and student participants.**

Appendix 9

Data from Focus Groups

Teacher Focus Group (Pilot)

Focus group data (teachers)

Present: GM, SPJ, LP, LPP, AH (KP unable to come) LJK

Q1 Have you identified any differences in the students in how they are at the beginning to how they are at end of the course?

GM:
Yes, I have taught at various stages of the courses, I come in and out at different times.
I have noticed that their questions are more informed.
It's a nebulous thing really and we as teachers are trying to demystify palliative care, it is something they can do and they can make a difference.

SPJ:
Groups tend to be a bit more reticent at first - not used to each other. There is a physical focus - emphasis on practical things they can do or see/physical.
After the communication and spirituality workshops there seems to be a more broader view about the people they care for. They talk about "I've started to think differently when I go into my patients". This thinking differently is reflected in how they look at patients

GM:

I agree, they seem to have a more rounded view -they seem to be able to generalise e.g. MS patient been in bed for 24 years - thinking more deeply about the patients/carers needs, not just physical.

SPJ:

Less judgemental - not making superficial judgements on what they see. They seem to be more open, more 'connected'

GM:

I think we have to remember that they may be feeling demotivated - but things are not always about resources, we can empower them.
There is something about being valued - maybe a "down" on experience. We can show what they do is valued - valuing their role.
Asking them what their views are - it may be different to ours but is not necessarily wrong.

LPP:

Making them feel valued in their role too - what they are returning to.
Helping people see that they do good work.

Q 2 Have you noticed any changes in students that you see in practice?

SPJ:
Practice - is extraordinary what they say after practice. I am aware that it may increase their frustration.

LPP:

Lots of concrete examples, when they say they have done specific things.

AH
Having more knowledge, - informing. Sharing this with others

GM:
Practice enables them to observe in a 'safe' way, they can see how things work

Q3. Has teaching on the course affected how you practice?
Q 4 Can you identify any benefits from being involved in the course.

LK - These 2 questions sort of merged into one as everyone said Yes to the first! Hence I have recorded them here like this.

AH

Yes, I reflect more, look into things more and think about things more.

SPJ:

Yes - my communication skills I have increased my awareness, the way you teach it - reflect on.
I think about examples from practice to use in teaching I am aware of my shortfalls and gaps in my knowledge. I need to learn more, not as up to date as I should be - I see this as a positive effect making me want to know more.

GM:

"Ask the why" it has given me more confidence. I haven't got as much time to be reading as I should but have to read in order to teach so it helps me to keep up to date. Also teaching with people from other disciplines. We can be very precious about hospice sometimes seeing what students bring to the classroom and practice helps me to learn too.

AH:
It is not always easy.

LPP:
Have to know more
Explaining it to others.
It has given me more of a thirst for knowledge
It has increased how I am - helped me to become more self aware.

How you explain things and talk to people - I analyze more when I am talking to patients and relatives.

There have been benefits to me of having the seconded post- developing me.

AH:

Taking a step back - self reflective bit.

Showed model of palliative care education stage 1, explained how it has come about and was there anything they wished to add to it.

There was some debate about whether there should be something about the 'experience' of palliative care - *LK I would say that is contained within the reflection as students and teachers are encouraged to reflect as an integral part of evaluation activities.*

Also whether the model could include palliative care research practice and that it should reflect that palliative care specialists are involved in the teaching.

LK I would suggest that those things would be inclusive in that teaching about palliative care needs to be research based anyway, we do include specialist palliative care practitioners in the planning and delivery of courses. Worth noting though.

The information was written up and then given to the teachers for their comments, see chapter 6 for more detail.

Student Focus Groups (2 groups)

Q. What does good quality palliative care mean to you?

Group 1- 10 participants
Good symptom control to facilitate quality of life.
Person/Patient centered - time to find out exactly what they want.
Individualised care.
Being there, for patients and families.
Knowledgable practitioner able to meet patient's needs.
Empathic.
Flexible in your approach.
Equality. Research based.

Team approach.
Collaboration. Communication.
Respect - non judgemental.
Holistic care, really doing the best you can, what ever the circumstances
Pulling out all the stops.
Utilising all services to meet patient and family needs.

Group 2 - 6 participants
Good symptom control. Psychological support.
Quality of life - getting the most out of their time.
Ultimate comfort & dignity of the pt. Family support. Pt choice.
The right to have care from a qualified practitioner (specialist). The environment being right.
Giving them what you would like to. Respite care - support for family. Day care.
Feeling that you have done the best you can for them. It is not what we wnat,it is what the pt wants.
Being there. The pt having no "if onlys".

Q. What in your view makes a good educational course?

Group 1
Motivation - students- teachers- staff.
Enthusiasm - teacher and students.
Structured.
Good feedback from students to others.
Content - level right for student.
Time to share ideas.
Way things are delivered.
Environment.
Relevance to practice.
Different disciplinnes learning from other's experiences, and other members.
Link between community & hospice.
Informing pts/families about hospice.
Changing perceptions/ professionals.
Instills confidence - confirms what you know informs if you don't. presentations.
Placements~ bonus - shift in thinking
LK at this point I felt the students were answering questions about our course rather than just generally.

Group 2
Good teacher. Teaching methods - good variety.
Participation of students - "feeling safe". The quality & relevance of the information given.

Support - from other students as well as teaching staff
Able to discuss problems/worries.» Adult learners are often scared so need to have someone to turn to.

LK I asked this group then specifically about whether the ENB course was good.
It gave me confidence - doing things right.
I liked the small group. It made it our course - there was a feeling of belonging.

Pt/learner focused. Helped me relate to practise.

Q. Has the ENB course changed your practice /if so how?

Group 1

It made me question things - research practice.
Making assumptions - I don't do that now. I ask "What's your biggest problem?" I get a good response to that, this is working to the patients' agenda.
Being there - not having to have all the answers I can just be with pts now.
Talking to relatives (unless they ask) - gave me courage (confidence) to talk. eg: daughter of a relative who was dying ... talk to her about her problems before I would have brushed it aside.
Dealing with ethical dilemmas - collusion with patients/relatives/& GPs.
Questioning analgesia doses now.
Care pathways - educating the multi-disciplinary team
I have a different relationship with people I'm working with now. Listening to pts/staff I consider where are they coming from?
I am more vocal "bolshy" inform others.
Increased knowledge= able to allay pts fears better - refer on to hospice.
I couldn't change things so I changed jobs!
One student said how a night staff nurse on a surgical ward said he didn't think palliative care had anything to offer their patients! She moved jobs to work in a hospice.

Group 2

Yes/ To some degree.

How?

I am more questioning now. It reaffirms what I was already doing (hospice nurse).
Confidence building - knowledge to question or instigate a change. I question doses of analgesia, I can suggest a drug or options for treatment/prescription.
I am able to challenge - GP's Able to answer questions. GP's ask my opinion especially about pain control.
I am more prepared to "go there" with patients. Knowledge helps you not be vulnerable. Not being afraid to say "I don't know" or no answer. Not feeling threatened any more.
Listening - I know how important it is now just to listen.
It made me want to find out more » (student went on to do the diploma course)
Gave me practical skills - IV fluids, drugs, syringe drivers etc. Analgesia & constipation.
Passing on info to my team.
I like to say I have done the qualification (Community nursing teams looking very closely at skill mix and what qualifications members of the team have).

Q. Is there anything specific that has helped you to apply theory to practice?

Group 1

Placement - seeing it being done
Spirituality session.
Talking to others - seeing how they did it.

Group 2

Placement - I saw what went on elsewhere.
Time - to put into practice what had been taught & seen in practice.
New skills seeing them being done. Having more confidence.

Q Has participating on the course influenced any peers you work with?

Group 1
Yes - they all want to come on the course (This student was from Wales).
Palliative care pts get referred to me for my opinion.
It has forged a link between hospices (St Rocco's)
Influence of CHE
Being a role model for them. Expectations raised of what we can achieve.
I have used my presentation again. Presentation skills, helping others with theirs and other assignments.

Group 2
Being used as a resource.
Recognition of my skills and new knowledge.
Making people think about things differently eg: syringe drivers.
People assume we have specialist knowledge & skills which we now have. Ii have more to offer patients ~ choices about things ~ informed choices.
Work force planning ~ skill mix.
There is more discussion about patients with colleagues and I feel a part of it, that I can contribute effectively.

Q Has it made a difference to the way you practice now?

Yes. *LK this was really answered previously.*
Group 2 not asked this question.

Q Can you identify the benefits of the methods of assessment used on the course?

Group 1
Presentation skills - being an expert on something.
Reflection +++ what it is and how to use it.
Further work - further study.

Group 2
Sharing presentations.
It gave me the opportunity to look at something I wanted to look at in more depth.
Deciding what to do a problem! Getting information and doing a literature search was very hard
(LK this student was on the 1st course when there was less help available re study skills).
It gave me the confidence to do other studies. New ways of studying.

Discussion of model of education how it might be changed.

Group 1

"Student led " - I'm uneasy about that, students need direction it can't all be student led.
Does the student know the right questions to ask? *LK I think that was about student misunderstanding of what was meant by the term student-led.*

This course was a very "personal" course.
Small groups make it personal, building up a relationship with tutors and students.
Being supportive of each other when talking about very emotional things.
Enabling supportive. Need to put that into the model.
Safe environment - connectedness.
I got more out of it than I was planning to.

Group 2
LK gave info about need for support stressed by group 1 This was agreed with wholeheartedly and discussed in some depth.
What kind of support? It was considered to be 'professional' support and there was much discussion around the notion of the academic support required and support in placements and during the course when things come up for students.
There were also issues about accessible support - 2 students felt support could have been improved as there was only 1 teacher at the time of their course and she experienced a bereavement thus taking some time off (1st course).
It was suggested that reflection and analysis & support be more intertwined in the model. It was also said that reflection and analysis goes on before during and after the course.
LK - I can only agree! Thus, in the final model of education reflection is depicted as alongside all the activities

Appendix Ten

- **Evaluation form from Manchester Metropolitan University.**

APPENDIX NOT COPIED

ON INSTRUCTION FROM

UNIVERSITY

Appendix Eleven

- **Student learning contract for clinical placement.**

APPENDIX NOT COPIED

ON INSTRUCTION FROM

UNIVERSITY

Appendix Twelve

- **Guidelines for putting clinical facilitation into practice.**

Appendix 12

Guidelines for Putting Clinical facilitation Into Practice

- Each student is allocated a number of clinical facilitator contact hours in their own practice setting. The number of hours is included in the course structure/planning and is therefore seen as an inherent part of the course rather than an 'add on' extra. Managers are made aware of these hours as being part of the course.
- Managers are informed of the process of facilitation and meet with the clinical facilitator prior to the student commencing the course, this helps managers understand and support the process.
- The student and facilitator agree on a learning contract/action plan for practice, this includes what can be achieved in those hours, and how it will be achieved. Managers and colleagues are also part of this agreement.
- The student takes responsibility for contacting the facilitator to arrange dates for facilitation visits.
- The facilitator works with the student, in his or her own work setting, as agreed in the action plan. The agreed hours are utilised to suit the individual student, therefore one student may choose to work over a whole shift with the facilitator; another may ask for a number of shorter visits.
- Both student and facilitator critically reflect on the process and whether or not the learning contract has been fulfilled. These reflections are written down and are part of the written evaluation records for that student cohort.
- The student is encouraged to keep a reflective diary relating to palliative care patients and this is used as a basis for discussion of practice issues.

- Following the period of facilitation the student is encouraged to discuss the process with his/her manager and identify possible future learning needs. This activity thus complements performance review and ongoing professional development.

With thanks to my colleague Mrs Lynne Partington who has been the pioneer of clinical facilitation at Cheshire Hospices Education.