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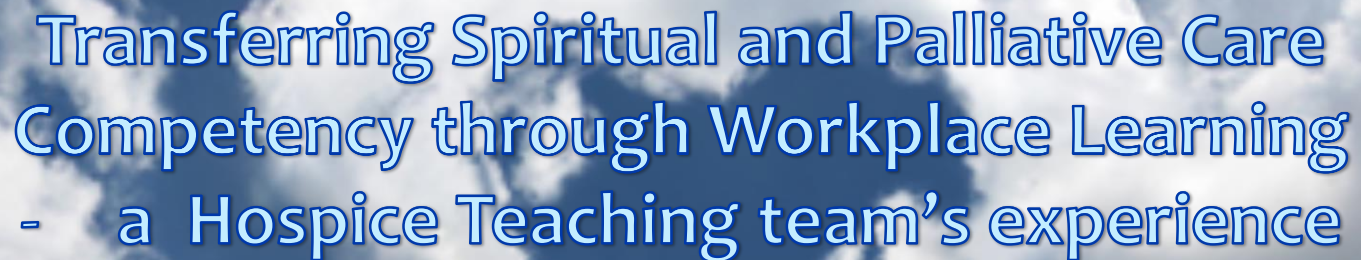

EC RSH 2014 Malta

The aim of the study

1. To explore a norwegian pioneering hospice teaching team's experience with transferring palliative and spiritual care competency to nursing staff across specialist, non-hospital and community based services.

1. To explore their experiences with spiritual care

* Focus group interview with teaching team consisting of 3 expert hospice nurses

* Data were analysed using a qualitative Phenomenological- hermeneutical method (Lindseth and Norberg 2004)

Health care systems under pressure

International trend:

* Ageing populations and Reduced wellfare budgets

* Need to reduce healthcare expences

(Euclid Network 2012, WHO 2002)

The Norwegian health care reform of 2012: ”The Coordination reform”

Cutting healthcare costs:

- Downsizing specialist health care, and increasing patient turnover
- Increasing use of outpatient clinics, nursing homes and home care solutions (Romoren et al 2011)

To Well!
FOR FRISK!
SYKE HUSET

!

To sick!
FOR SYK!
HJEMME SYKE PLEIEN

Unskilled Nursing staff

* International trend towards larger numbers of unskilled care workers in long term care (Colombo et al 2011)
* Registered nurses must spend more time supervising unskilled staff to ensure high quality care for the dying (Colombo et al 2011)
* In Norway: 1/3 of nursing staff in nursing homes and home care nursing consists of unskilled labour. (Norwegian Ministry of Health and Care Services 2012 -2013)

Spiritual needs

* Research indicates that a significant number of dying patients long for adequate spiritual or existential counseling (Grønvold et al 2006)
* Spiritual and existential care may have a positive impact on the patients quality of life (Balboni et al 2013, Edwards et al 2010, WHO 2013).
* Health care professionals often feel anxious and insecure about spiritual and existential care(Back et al 2009, Bosma et al 2010, Noble and Jones 2010)
* Widespread need for staff education and training in spiritual care (Holloway 2011)

The Hospice teaching team

* Created in 2010: Collaboration between a major hospice and nurse administrators in nursing homes and home care
* Provides "On the job" teaching and supervision in nursing homes, home care nursing and specialist health care
* **Objective: to improve nursing staffs' palliative, spiritual and existential care competency**
* Experienced hospice nurses: 9 – 36 yrs of nursing, advanced degrees in nursing: such as in oncology, palliative care

Religion in Norway

Nominal religion in Norway is mostly Evangelical Lutheran with 77% of the population belonging to the former “state church”. Separation of church and state in 2012.

* Low church attendance, (3%), except for christenings, confirmations, weddings, funerals and Christmas Eve.
* Most Norwegians are either atheist or agnostic.
* The least religious country in Western Europe (gallup international survey 2005)http://en.wikipedia.org/wiki/Religion_in_Norway#cite_note-kirke_stat_2011-1

KEY FINDINGS

Experience based spiritual care

”WE WORK WITH OUR HEART”: Integrating clinical competency, good communication skills, personal courage and empathy

* SPIRITUAL CARE IS DEEPLY EMBEDDED IN OTHER CARE PRACTICES. TACIT NATURE OF SPIRITUAL CARE

Spiritual care practice

* ”Acting as door openers” to create oportunities for safe and meaningful dialogue about thoughts and feelings. Patients rarely take the first step to talk about existential or spiritual distress
* Being a ”listening presence” more important than ”giving the right answers” about ”the meaning of suffering”
* Conveying consolation by sharing the silence and supporting the patients’ way of meaning making.

”It’s our tone of voice, it’s how we relate to the patient’s moods and existential needs while we are providing physical care and doing other things for the patient. It’s about getting involved and allowing oneself to be touched”.

Spiritual and existential themes

- Dealing with feelings of grief and sorrow
- Dignity and hope in the face of despair
- Wishes and needs related to treatment and symptom alliviation
- How the patient wishes to spend the rest of his life

- The nurses had a ”Person centered understanding of spirituality”. They related this to ”the individual’s deep personal core”
- The nurses felt more competent about existential aspects of spiritual care, assisting the patient in ”existential meaning making.
- Often refering to hospice chaplain if patients have religious issues.
- Religion issues are considered to be private matters in secular scandinavian societies

  (Lacour 2008, DeMarinis 2008)

Nursing staff's competency needs

* Fear of adressing dying patients' existential and spiritual concerns.
* Afraid of not knowing what to say if the patient asks difficult questions about suffering
* *"They need to be able to use themselves as an instrument, becoming more courageous, daring to investigate the patients' experience."*

Transferring spiritual and existential care competency

Traditional lecturing

”Bedsid teaching”: participating in nursing care with staff. Emphasizes ”learning by doing:

- **Acting as rolemodels:** *”Sometimes they need to hear the questions I ask and see how I relate to the patient.”*
- **Stimulating critical reflection** through reflective dialogues before and after bedside situations
- **”Walking in step”** with the staff and communicate on their wavelength
- ***”Many just need a ”little push”*** *and encouragement to talk with the patient alone, using me as a conversation partner to reflect on how they handled the situation.”*

- **Supervision themes during ”Bedside teaching:**
- How to bring hope into a hopeless situation
- How to talk with the patient about death and dying
- How to be present in the *”Room of death and in the patient’s suffering”*
- How to identify the patients needs
- Daring to sit down and be quiet with the patient
- Using opportunites during physical care to identify the patients needs, for example by asking *”How has your night been?”*

Improved competency

* The teaching team observed that staffmembers gradually became more courageous and skilled in talking with the patients about death and dying, including existential and spiritual issues:

* *”I see that they dare to involve themselves in the situation, exposing their vulnerability. And they are able to ask some of the difficult questions. I see that they have become braver.”*

* The nurses experienced that ”bedside teaching had a greater impact on staff’s competency development than lecturing in palliative and spiritual care.

* This is in line with educational research:
* Benner(1984): Much clinical knowhow can only be demonstrated when a particular situation arises.

* Lave and Wenger (1991): Learning in practice is a matter of acculturation, of joining a community of practice, rather than learning decontextualised skills and principles.

Conclusion

* Spiritual and existential care is a deeply relational and personal practice
* Workplace teaching and learning strategies may be efficient to improve nursing staffs' palliative and spiritual care competency
* Employers should support experienced nurses to develope their skills and roles as teachers and supervisors in the workplace.

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