Preparing palliative home care nurses to act as facilitators for physicians learning : evaluation of a training programme

Reference:

Pype Peter, Mertens Fien, Wens Johan, Stes Ann, Van den Eynden Bart, Deveugele Myriam.- Preparing palliative home care nurses to act as facilitators for physicians learning : evaluation of a training programme
Palliative medicine - ISSN 0269-2163 - (2015), p. 1-6
DOI: http://dx.doi.org/doi:10.1177/0269216314560391

Preparing palliative home care nurses to act as facilitators for physicians' learning: evaluation of a training program.

Abstract:

Background. Palliative care requires a multidisciplinary care team. General practitioners often ask specialised palliative home care teams for support. Working with specialised nurses offers learning opportunities, also called workplace learning. This can be enhanced by the presence of a learning facilitator.

Objectives. To describe the development and evaluation of a training program for nurses in primary care. The program aimed to prepare palliative home care team nurses to act as facilitators for general practitioners' workplace learning.

Design. A one group-posttest only design (quantitative) and semi-structured interviews (qualitative) were used.

Methods. A multifaceted train-the-trainer program was designed. Evaluation was done through assignments with individual feedback, summative assessment through videotaped encounters with simulation-physicians and individual interviews after a period of practice implementation.

Results: Thirty-five nurses followed the program. The overall satisfaction was high. Homework assignments interfered with the practice workload but showed to be fundamental in translating theory into practice. Median score on the summative assessment was 7 out of 14 with range 1-13. Interviews revealed some aspects of the training (e.g. incident analysis) to be too difficult for implementation or to be in conflict with personal preferences (focus on patient care instead of facilitating GPs' learning).

Conclusions. Training palliative home care team nurses as facilitator of general practitioners' workplace learning is a feasible but complex intervention. Personal characteristics, interpersonal relationships and contextual variables have to be taken into account. Training expert palliative care nurses to facilitate general practitioners' workplace learning requires careful and individualised mentoring.

Keywords.

Palliative care; train-the-trainer; workplace learning; program evaluation; primary health care; inter-professional relationship; inter-professional collaboration

What is already known about the topic?

- Inter-professional collaboration and inter-professional learning go hand in

hand

- Team members can act as facilitators for other team members

What this paper adds?

- Nurses can be trained to be a facilitator for team members' workplace learning
- Nurses can act as facilitators for physicians' learning
- The implementation of this new role requires careful mentoring of the nurses

Implications for practice, theory or policy

- Health care professionals should be trained to act as facilitators for other team members' workplace learning
- This role is independent of a professional role (one can facilitate the learning of someone from another profession)

INTRODUCTION

Most palliative patients want to stay at home until death.[1] General practitioners (GPs), generally accept the responsibility to deliver palliative care[2,3], but report knowledge gaps and learning needs[4-7], not always fulfilled by continuing medical education.[8] Literature on inter-professional collaboration and workplace learning (WPL) shows that

working together leads to learning with, from and about each other.[9,10,11] Although efforts are being made to improve WPL through facilitation by collaborating professionals, WPL is often unscheduled and implicit.[12,13] In Belgium GPs collaborate with specialised palliative home care teams (PHCTs) who's main task it is to support and advise the regular healthcare professionals. In light of this collaboration it is worthwhile considering if these nurses could act as facilitators of GP's learning.[14] Literature suggests that the following aspects are important: detecting learning opportunities during collaboration, addressing them adequately and stimulating reflective practice.[15,16,17] We did not find any publication reporting on a training program for nurses to act as facilitators for physicians' learning.

AIM AND PURPOSE OF THE STUDY

This study describes the evaluation of a training program for PHCT nurses to act as facilitators of GPs' workplace learning.

METHODS

A one-group post-test only design.

This study is part of a RCT exploring the learning impact of inter-professional collaboration in primary palliative care (Belgian Registration Number: B67020123863).

Baseline measurement of the trial showed that all professionals stated to learn from others but in an opportunistic way (e.g. by listening and observing). More efficient learning strategies were not used (e.g. providing feedback and learning from mistakes).

Therefore we decided to train the PHCT nurses to introduce these strategies in daily practice. Of the fifteen PHCTs covering the Dutch speaking part of Belgium, twelve agreed to participate. After randomisation, the six PHCTs from the intervention group received the training program described below.

The primary outcome of the trial is the GPs' report on PHCT nurses' communication behaviour.

Data collection is done by quantitative and qualitative measures from November 2012 until April 2013.

THE PROGRAM

The program encompassed: 1) recognising learning opportunities; 2) shifting specific questions to generic ones; 3) giving positive and negative feedback; 4) analysing clinical incidents; 5) debriefing the collaboration.

The program consisted of a full day's training and a half day booster session. During the three months between the sessions, participants implemented the skills in practice

while completing homework assignments and progress reports. The homework and progress reports fit in the models of self-directed, experiential learning and reflective practice. Meanwhile an individual Skype call was held with each participant to give fine-tuning advice.

Table 1 shows the program's details

Evaluation and outcome measures

Summative assessment consisted of a video-recorded consultation from each participant with a trained simulation GP on the final session.

Qualitative evaluation was done by analysing participants' progress reports and by interviewing the participants, exploring the barriers and facilitators for skills implementation into practice.

Data analysis

Homework and progress reports were analysed using content analysis with the program components as an analytical framework. The video-recordings of consultations with simulation GPs were scored independently by two scorers. A scoring system to capture the educational outcomes of the training has been created for this purpose. Scores per item were 0 (participant did not address the item), 1

(address was incomplete or inadequate) or 2 (address was complete and adequate). The scoring system has been tested for content validity, and inter-rater agreement was calculated by the Intraclass Correlation Coefficient and Cronbach's alpha. Influence of nurses' demographics on scores was calculated using Mann-Whitney U-test (gender) and simple linear regression (age and years in practice). The interviews were transcribed verbatim and analysed independently by two researchers according to the principles of constant comparative method and using Nvivo software.

The rigour of the study has been preserved by coding and analysing every result by two researchers independently. Disagreements have been discussed with a third researcher.

Ethics approval

Ghent University Hospital approved the study (B67020123863). Informed consent was obtained.

RESULTS

Process evaluation:

Thirty-five nurses were enrolled (8 males, age mean=46.3 (SD=7.8); years in PHCT practice mean=6.7 (SD=5.1)). Thirty-three completed their homework. Eighteen wrote

progress reports. Twenty-one did the interview, 25 participated in the final session. The main reason for not participating in one or more components was a high workload.

Quantitative evaluation: Summative assessment

Twenty-five participants took part in the video-assessment (6 males; age mean=45.8 (SD=7.3); years in practice mean=7.7 (SD=5.2)). Median score 7/14; range 1-13. The inter-rater agreement between the scorers was high for all components (Cronbach's alpha 0.847 - 0.987 and Intraclass Correlation Coefficient 0.732 - 0.974).

Female nurses had significantly (p=0.05) higher total scores (mean=7.5; SD=2.5) than males (mean=4.5; SD=2.7). There was no significant difference in scores for age (p=0.762) and years in practice (p=0.959).

Qualitative evaluation:

Participants were able to recognise the learning opportunities in the assignments. They made comments and suggestions on how to address them. The progress reports showed that giving positive feedback and asking explorative questions were handled confidentially. The most difficult items to implement were the clinical incident analysis (time consuming) and the 'turning specific questions to generic ones' (some did not

understand how this works). Participants valued writing personal experiences and receiving individual feedback as fundamental for a deeper understanding of the training's content.

Twenty-one nurses were interviewed (3 males, age mean=46.0 (SD=7.7); years in PHCT practice mean=6.8 (SD=5.3)). All interviews took 30 to 60 minutes.

General results

Participants recognised the program content as characteristic for difficult practice situations. The training was experienced as 'the most practical and useful' in years. Participants stated that their way of interacting with GPs has changed. Before, contacts used to be one-direction with nurses receiving orders. Now, they reported to be a more active listener and better responder. Simultaneously this changed the nurses' attitude: nurses consider GPs more as part of the team and 'take care of them as team members'.

The communication with other professionals has changed equally. Some reported that community nurses were excellent for a try-out of the skills since there was no hierarchical interference.

Factors influencing the implementation of the trained skills

a. Personal factors

Being used to the role of clinical expert sometimes hindered the assimilation of the new facilitator role. One nurse who described himself as a real doer had a hard time waiting for the GP's reflection and keeping himself from answering a question promptly.

b. Interpersonal factors

Some nurses hesitated to address less known GPs and felt obstructed by a GP's perceived lack of interest.

Nurses' fear of irritating the GPs and the fear that GPs would question their expertise if they did not came up with solutions straightaway, were experienced obstacles.

c. Team support

The support of the PHCT team was a strong promoting factor. Observing colleagues and providing each other with feedback induced self-confidence. Preparing a difficult conversation together is very helpful.

d. Contextual factors

Time was seen as a major barrier for preparing a conversation as well as having a conversation in a learning-facilitating way.

Table 2 shows the themes discussed during the interviews illustrated with participants' quotes.

DISCUSSION AND CONCLUSION

The results show that training PHCT nurses to act as a facilitator of GPs' WPL is a feasible but complex intervention. The median score on the summative assessment seems low though no benchmark was available.

It seems important to participate in all training components. Personalised support and mentoring is required for the role transition from clinical nurse expert to facilitator of others' learning. [12,18,19] This is confirmed by literature indicating that an individual approach fosters professional development.[20, 21]

Personal characteristics, interpersonal relationships and contextual variables have to be taken into account to optimise the implementation of new skills. Personal characteristics influence the ease and comfort to broaden professional roles. The interpersonal relationship between nurses and GPs influences the way nurses address them. As nurses depend on GPs' collaboration in delivering patient care, they are

reticent to harm their relationship. Nurses report higher self-confidence when difficult conversations are prepared with colleagues. As such, PHCT members are monitoring and discussing each other's functioning which has been called a core item of teamwork and an effective learning method.[22,23] Time restraints are the most important contextual factors influencing the application of the new skills.

Two other results are noteworthy. Firstly, although the training was focused on the interaction with the GPs, nurses also applied the same communication skills with other professionals Secondly prejudices against doctors were abandoned and interchanged by a belief in doctors' overall good intentions resulting in an openness to listen and collaborate.

Strengths and limitations

The mixed-method evaluation with attention for the context, the process and outcome of the program reveals a deeper understanding of the way things work and thereby facilitates transferability to other settings.[24]

A limitation of the study is the one-group post-test only design. As there is no control group or pre-testing, the effect of the study is difficult to quantify. Another limitation concerns the summative assessment immediately after the training. As a result, our study does not allow to make any statements on long term effects.

Further research is needed to evaluate effects on GPs' learning or quality of patient care.

CONFLICT OF INTEREST

No conflicts reported.

ACKNOWLEDGEMENT

Funding was received for this study by the Vlaamse Liga tegen Kanker

REFERENCES

1. Gomes B, Calanzani N, Gysels M, et al. Heterogeneity and changes in preferences for dying at home: a systematic review. *BMC Palliat Care* 2013; 12: 17.
2. Mitchell GK. How well do general practitioners deliver palliative care? A systematic review. *Palliative Med* 2002; 16: 457-464.
3. Seow H, Brazil K, Sussman J et al. Impact of community based, specialist palliative care teams on hospitalisations and emergency department visits late in life and hospital deaths: a pooled analysis. *BMJ* 2014; 348:g3496. doi: 10.1136/bmj.g3496.

4. Slort W, Schweitzer B, Blankenstein A et al. Perceived barriers and facilitators for general practitioner-patient communication in palliative care: a systematic review. *Palliat Med* 2011; 25: 613-29. doi: 10.1177/0269216310395987.
5. Sanderson C and Tieman J. CareSearch - online palliative care information for GPs. *Aust Fam Physician* 2010; 39: 341-343.
6. Beccaro M, Lora A, Scaccabarozzi G et al. Survey of Italian general practitioners: knowledge, opinions, and activities of palliative care. *J Pain Symptom Manage* 2013; 46: 335-44. doi: 10.1016/j.jpainsymman.2012.08.020.
7. Hirooka K, Miyashita M, Morita T et al. Regional medical professionals' confidence in providing palliative care, associated difficulties and availability of specialized palliative care services in Japan. *Jpn J Clin Oncol* 2014; 44: 249-56. doi: 10.1093/jjco/hyt204.
8. Pype P, Stes A, Wens J et al. The landscape of postgraduate education in palliative care for general practitioners: results of a nationwide survey in Flanders, Belgium. *Patient Educ Couns* 2012; 86: 220-225.
9. Parboosingh JT. Physician communities of practice: where learning and practice are inseparable. *J Contin Educ Health* 2002; 22: 230-236.
10. Li LC, Grimshaw JM, Nielsen C, et al. Evolution of Wenger's concept of community of practice. *Implement Sci* 2009; 1: 4-11.

11. Eraut M. Informal learning in the workplace. *Studies in Continuing Education* 2004; 26: 247-273.
12. McClure E, Black L. The role of the clinical preceptor: an integrative literature review. *J Nurs Educ* 2013; 52: 335-41.
13. Kashiwagi DT, Varkey P, Cook DA. Mentoring programs for physicians in academic medicine: a systematic review. *Acad Med* 2013; 88: 1029-37.
14. Pype P, Symons L, Wens J, Van den Eynden B, Stes A, Deveugele M. Health care professionals' perceptions towards lifelong learning in palliative care for general practitioners: a focus group study. *BMC Fam Pract* 2014; 19; 15:36.
15. Kilminster S, Cottrell D, Grant J, et al. AMEE Guide No. 27: Effective educational and clinical supervision. *Med Teach* 2007; 29: 2-19.
16. Andrews CE, Ford K. Clinical facilitator learning and development needs: Exploring the why, what and how. *Nurse Educ Pract* 2013; 13: 413-417.
17. Ramani S, Krackov SK. Twelve tips for giving feedback effectively in the clinical environment. *Med Teach* 2012; 34: 787–791.
18. Weidman N. The lived experience of the transition of the clinical nurse expert to the novice nurse educator. *Teach Learn Nurs* 2013; 8: 102-109.
19. Ellinger A, Cseh M. Contextual factors influencing the facilitation of others' learning through everyday work experiences. *JWL* 2007; 19: 435-452.

20. Cangelosi P, Crocker S, Sorrell J. Expert to Novice. Clinicians Learning New Roles as Clinical Nurse Educators. *Nurs Educ Perspect* 2009; 10: 367-371.

21. Melton J, Forsyth K and Freeth D. The Individual Practice Development Theory: an individually focused practice development theory that helps target practice development resources. *J Eval Clin Pract* 2012; 18: 542-466. doi: 10.1111/j.1365-2753.2010.01618.x.

22. Bedwell W, Ramsay P, Salas E. Helping fluid teams work: A research agenda for effective team adaptation in healthcare. *Transl Behav Med* 2012; 2: 504–509.

23. Veloski J, Boex JR, Grasberger MJ, et al. Systematic review of the literature on assessment, feedback and physicians' clinical performance: BEME Guide No. 7. *Med Teach* 2006; 28: 117-28.

24. Craig P, Dieppe P, Macintyre S, et al. Developing and evaluating complex interventions: The new Medical Research Council guidance. *Int J Nurs Stud* 2013; 50: 585–592.