

How do hospice nurses prepare to give end-of-life care? A Grounded Theory study of nurses in one UK hospice

Abstract

Background: Very little evidence currently exists informing how hospice nurses become prepared for delivering end-of-life care.

Aim: To investigate how nurses in one UK hospice have become prepared to deliver end-of-life care.

Methods: A classic Grounded Theory approach was used to investigate the experiences of 22 registered nurses, to discover how they felt they had become prepared for their role. Seventeen individual interviews and one focus group were conducted. Constant comparison of data and member checking were performed to establish validity.

Findings: Findings were synthesised into five categories: the 'shared ideal', feeling good at the job, making a difference, experience/exposure to hospice work, and the importance of role models. The shared ideal formed the core category, which explained how hospice nurses feel a sense of 'fit' with their work.

Conclusion: The feeling of 'fit' to the work was the identified core element to nurses feeling of preparedness.

Key words

Nursing, Palliative care, prepared, competent, end-of-life care

Introduction

End-of-life care first came to national prominence in the UK with the publication of the End of Life Care Strategy [EOLCS] (Department of Health [DH], 2008). The aim of the EOLCS was to improve end-of-life care for all. Just seven years after publication, an international report studying the quality of palliative care in 80 countries, ranked the UK highest, based largely on the quality of the palliative care services and the training and availability of health care and support staff (Economist Intelligence Unit, 2015). An achievement such as this, suggests that staff, including nurses who spend the most time at the bedside of dying patients, must be well-prepared for their role in end-of-life care.

Making such an assumption appears to be flawed, contradict other evidence. For example, because a report from the National Palliative and End of Life Care Partnership [NPELCP], published in the same year, highlighted six key areas which still needed addressing to improve care of the dying (NPELCP, 2015). The fifth of these 'ambitions' in the NPELCP report aimed for all paid staff to be 'prepared to care' (NPELCP, 2015). This may suggest that staff were already adequately prepared, but would benefit from further preparation. However, an examination of the literature further emphasises the notion that nurses are not yet adequately prepared to care for the dying. For example, Cavaye and Watts (2014a; 2014b), the RCN, (2014), the National Council For Palliative Care [NCPC] (NCPC, 2016) and Zheng et al. (2016) all report that nurses are woefully unprepared to give end-of-life care. Furthermore, there is limited evidence that undergraduate nursing curricula have included sufficient, if any, time for students to learn about end-of-life care. The NCPC (2016) also

highlighted that there are no national guidelines on how nurses can become prepared for this important aspect of their role.

This need to better prepare nurses to deliver end-of-life care is not unique to the UK and has been identified as a European and global priority (Pereira et al., 2020; Malloy et al., 2018). If this need is to be met, it is first important to ensure clarity about how nurses can become prepared to deliver end-of-life care. This research investigates how registered nurses in one UK hospice felt that they had been prepared to care for the dying. The research question posed was: How do registered nurses in the hospice under study feel that they have become adequately prepared to give palliative and end-of-life care? As a Grounded Theory study, the focus was on the processes that the nurses felt had been important in this development. The main objective was: to identify and explain influences that make sense of palliative and end-of-life patient care. By better understanding how these nurses came to feel prepared, it was hoped that strategies could be highlighted that might inform the preparation of other nurses to deliver end-of-life care, wherever it is needed.

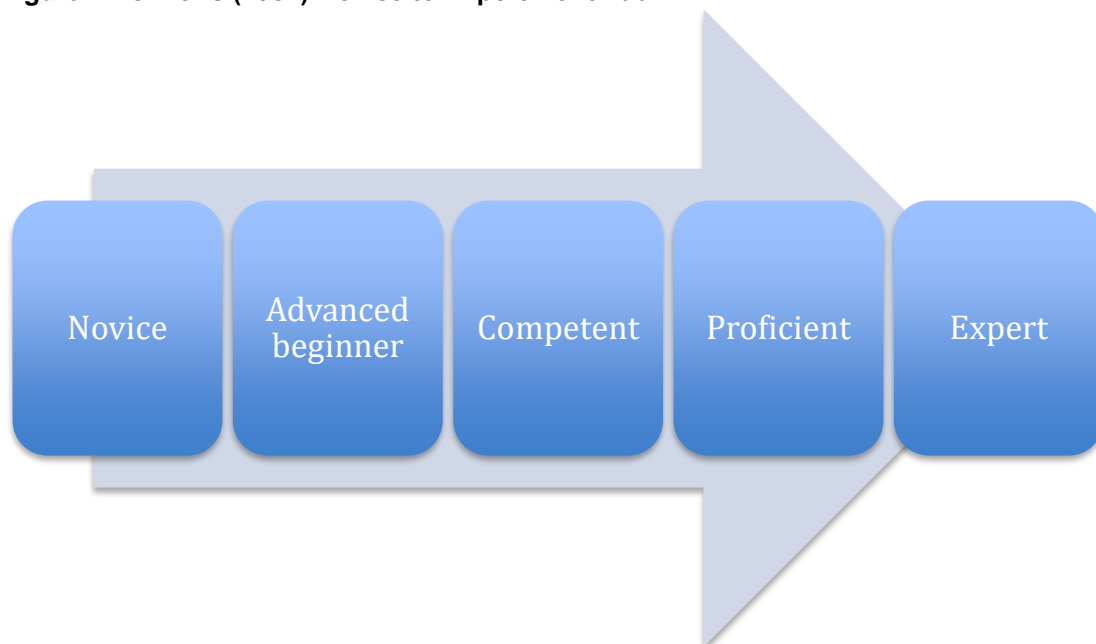
Background and literature review

Before one can identify what it takes to become prepared to deliver end-of-life care, it is first necessary to define 'prepared' and to understand the qualities that a 'prepared' nurse might display. This is a complex undertaking because it is often perceived that hospice nurses are experts in palliative and end-of-life care, or that they practice at an advanced level (Dixon, 2018). However, this contradicts the findings of the Democratic Society's (2015) survey of how

education and training support care delivery to dying patients, which highlighted that there are a limited number of hospice nurses with expert level knowledge. Dixon (2018) claims that hospice nurses have undertaken specialist training, but this is difficult to quantify because there is currently no national or standard qualification required for nurses to practice in a hospice setting, even at Clinical Nurse Specialist level. Again, this issue is not unique to the UK (Hökkä et al., 2020). Furthermore, with palliative care not listed as a discrete specialism, there is also no data available reporting on qualifications held by palliative care nurses (NCPC, 2016). Nevertheless, being prepared suggests a level of practice well beyond being a novice.

Benner's (1984) seminal work first presented the idea of nurses evolving, over time, from novice to expert. Benner's continuum outlined five stages (See Figure 1).

Figure 1 Benner's (1984) Novice to Expert Continuum



Benner's framework has been used extensively to rationalise the level at which nurses practice in many clinical settings, and the knowledge and expertise required at each level. What is less clear is where the nurse prepared to deliver end-of-life care might fit in this continuum. However, they are probably going to be beyond 'advanced beginner.' It is also difficult to know if someone adequately prepared for this caring role could ever achieve expertise. This will be further explored in this paper.

A concept analysis sought to offer some clarity to the idea of being prepared by defining 'prepared' in the context of end-of-life care (Griffith, 2018). The concept analysis identified that 'competent' can be used as a surrogate term for 'prepared,' but this highlights a further complication, because measuring competence has yet to be adequately refined to make it useful in practice (Frey et al., 2011). Moreover, there is no standard qualification or nationally agreed competency framework for hospice nurses, making it difficult to explore or reliably 'measure' how nurses experience preparedness for this role. This research is the first to explore nurses' preparedness to deliver end-of-life care by exploring nurses' experiences of this process .

Prior to commencing the study, the existing literature was examined to ensure that this area had not been investigated previously. See Box 1 for search terms and strategy. omprehensive discussion of the literature reviewed and the full concept analysis, Griffith 2018). The main findings from the concept analysis, and the antecedents to being prepared, were established to be:

- having a willing attitude toward care of the dying,

- acceptance that cure was not possible,
- having education on end-of-life care,
- having experience of caring for dying people,
- having exposure to care of the dying.

However, what was not clear in the existing literature studied, was exactly how these five areas could be achieved, particularly regarding feeling willing and accepting death.

Aim

To investigate how the processes through which nurses in one UK hospice have become prepared to deliver end-of-life care.

Methods

The focus for this research was to explore and interpret the experiences of nurses working in a hospice setting about how they felt prepared for their role in delivering end-of-life care. This research clearly required a design, which would allow the researcher to be close to the participants and to obtain an in-depth account of their experiences of practicing as a nurse in end-of-life care. Grounded Theory is based on the interpretivist tradition and forms an excellent approach for interpreting people's descriptions of their experiences (Topping, 2015). Grounded Theory is also inductive, and the best methodology for creating a new theory in an area which has not been studied before (Harris, 2015). Using a Grounded Theory methodology, also requires a choice of

methods which allow the researcher to become close to the participants and to gather in-depth data on their experiences. Moreover, it offers the opportunity to explore those accounts and not just to accept and report the experience as described. Therefore, semi-structured interviews with individual participants, and follow-up focus groups, creates the ideal situation for this to occur.

Sampling

The first two participants were chosen by the researcher, as a starting point for theory generation. Subsequently, participants were theoretically sampled, by the researcher guiding gatekeepers towards approaching nurses who would help to build the emerging theory (Glaser and Strauss, 1967; Holloway and Galvin, 2015). The gatekeepers asked potential participants if they would be interested in participating in the research study, without the researcher knowing their identity, to protect their anonymity at that stage, in case they chose not to participate. Inclusion criteria were to consider all registered nurses who would help to inform the emerging theory. Excluded from this study were all other health professionals and non-registered clinical staff. This was simply to ensure that an in-depth study could be made of one professional group in the first instance. It would be interesting to follow this up with a study of other health professionals and non-registered staff in the future. In total seventeen interviews, and two re-interviews, with individual registered nurses from across the whole hospice were conducted, and one focus group of seven.

Data collection and analysis

The individual interviews and focus group were held in a classroom in a separate building from the patient area, to avoid distractions and provide a safe

space. An audio recorder was used to record the interviews, which allowed the interviewer to focus on body language of participants and to make field notes, without trying to transcribe at the same time. Rubin and Rubin (2012) recommend that in-depth interviews are semi-structured, with no previously assembled firm questions, and follow the leads of the interviewee, rather than the direction of the interviewer. Therefore, only an interview guide was used to ensure that some basic areas were covered, if they did not spontaneously arise. Interviews began with the interviewer asking 'tell me about your experiences of hospice work and how you feel that you became prepared for this?' The interviewees' leads were then followed up with probing questions.

Congruent with a Grounded Theory approach, the interviews were transcribed and analysed as each one was conducted (constant comparison). This informed the choice of the next participant (theoretical sampling), and ensured that data collection continued until theoretical saturation was reached (Holloway and Galvin, 2015). Using a classic Grounded Theory approach meant that the data was coded by hand, with a print out of each transcript, and pencil to mark in the margins (Glaser and Strauss, 1967). This was performed line-by-line to ensure that nothing was missed. Original words and phrases were used to create descriptive labels (Willig, 2013). Field notes and memos were used throughout the course of the research study to strengthen the analysis and also to help counter subjectivity (Elliott and Lazenbatt, 2005). Figure 2 demonstrates the data collection and analysis process.

When data saturation was deemed to have occurred, a focus group was held with seven nurses. Two of these nurses had been individual interviewees, and

five were new to the study. After seventeen interviews, and two re-interviews to probe areas which had not been explored in early interviews, no new data was emerging from individual interviews. The purpose of the focus group was, therefore, two-fold. Firstly it allowed for the rapid collection of more data, and ideas to be expressed and explored in ways which may have been missed in individual interviews (Goodman and Evans, 2015). Secondly, the focus group gave an opportunity to 'member check' the findings at that point (Lincoln and Guba, 1985, p.134). Having new and previous participants facilitated this dual process, with the focus group conducted in two halves: firstly an open discussion to gather any new data, and the second part for the interviewer to present the emerging theory to ensure that participants could identify with it, and validate the interpretation. With no new information emerging in this group, it confirmed data saturation, giving the opportunity to check the accuracy of the evolving theory with previous interviewees.

Trustworthiness

Member checking in this way strengthens the trustworthiness of the developing theory (Elliott and Lazenbatt, 2005). To enhance trustworthiness, the emerging theory was also presented at national and international conferences and to several other individual participants. Additionally, reflexivity, or critical self-examination of the research process (Topping, 2015), was conducted using the Alvesson and Sköldberg (2018) framework, to ensure rigour and trustworthiness of both the process and the interpretation of data.

The data was coded by hand, in the original way (Glaser and Strauss, 1967), using an iterative and interactive approach. The words and phrases of the participants formed the early codes, which were then used to generate categories. Field notes and memos strengthened the data analysis. Figure 3 gives an example of the coding process. The analysis process led to the establishment of five categories

Ethical considerations

Ethical clearance from the Faculty of Research and Ethical Panel at the University, and Research Ethics Committee approval from the hospice where the study was conducted were granted prior to data collection. Participants were given a participant information form explaining what was entailed, and signed an informed consent form prior to interview. Explanation was given on how their data would be anonymised and stored, to protect their identity. Participant's right to withdraw was also explained.

Findings

Twenty-two nurses participated in this research, including 18 females and four males, all with a mean age of 38 years (see Table 1 for more details about the participants). Participants were all assigned pseudonyms to protect their anonymity. Five categories emerged from a thorough analysis of the data. The categories were:

- The Shared Ideal
- Making a difference
- Feeling good at the job

- Experience/exposure
- Role Models

There is considerable overlap between the categories. The 'Shared Ideal' was apparent in every interview and formed the core category, which was found to be a central phenomenon, connecting all of the other categories (Holloway and Galvin, 2015).

The shared ideal

The basis of the shared ideal category was that participants all felt that there had to be more to nursing than they felt was possible in other settings. Central to this feeling is: a) being able to give good and holistic care; b) understanding and being comfortable with the knowledge that death is not failure and that cure is not always possible, and c) striving for people to have a 'good death.' Having enough time to care well for the dying in a non-hierarchical team was central to this. There was also a feeling that hospice nurses prefer to work with others who feel the same and somehow just 'fit' the work and the environment.

In demonstrating this personal desire to work in a clinical environment where they might feel they are able to make a difference, one respondent, Steve, commented:

"... people say 'well why not A&E [Accident and Emergency] or surgery, or something like that,' and I didn't really feel comfortable in that environment ... I wanted somewhere I could give quality of care and really make a difference."

Eugenie used very similar phrasing:

“In ITU I felt I never really got to know the person or the family. They either died suddenly and you hadn’t got to know them, or they improved and went to the ward – so you still didn’t get to know them. This made me think there had to be more to it.”

Claudia also realised that an acute setting did not offer what she wanted from nursing:

“... I recognised that I wanted to be able to do more on a longer scale in terms of building up the relationships and making more of an impact than you can do in A&E.”

It was clear from these excerpts that part of making a difference was being able to build relationships with patients and families.

Two participants had considered leaving nursing but changed their minds after they began work at the hospice. As Tracey observed:

“... here everyone wants it (to give good care) and makes sure it happens ...”

Moving to the hospice convinced them to continue in nursing, but only if they could give good, holistic care in the way that they felt dying people and their families deserved.

The participants felt that they had to be comfortable with death and dying, and knew from experience that in acute settings this was often not the case for many of their colleagues. Fern commented on her prior experience of an oncology ward:

“ ... and so I found early on, that there is the treatable side, and having the chemo and things wasn't really where I felt confident, I felt much more at home on the palliative side, and there was a bit of a divide with the staff on the ward. You found that they very much either preferred doing the palliative or chemo ...”

Flo also noted that not only were some of her colleagues not comfortable with death and dying, but at times the potentially curable patients seemed to take priority:

“... palliative care ... became a back burner, not a priority, because I think a lot of people thought, because they were dying, that was one less person to worry about.”

Fern identified that not only did some nurses feel less comfortable with talking to the dying, but also felt this was less valuable:

“They feel that if they are giving chemo they are doing something worthwhile.”

Macey realised that this cure focus formed a need to ‘fix’ people, noting that colleagues would say:

“I couldn't do your job, I am a surgical nurse, I need to fix things ... I fix people ...”

It was not only the need to accept death and not feel that this was failure, but also the need to strive to help people to have a good death that was central to the shared ideal.

Participants described their shared ideal as having a good ‘fit’ to the work, the patients and their colleagues. For example, Quinn noted:

“... for me I’d say they [the palliative patients] were a better fit with my personality, or, the way I nurse, I’m not quite sure how to describe it, but I felt that I did a better role with them than I would do, for example, when I occasionally went onto a surgical ward.”

Other participants noted this fit, and described it as ‘sitting with their personalities.’ For example, Fern noted:

“I don’t know if that is where it sort of sits with me ... I find it difficult to put into words, but there was just something in me ... You can actually see that ... you are making a difference.”

Fern’s comment also denotes how the shared ideal category overlaps with being able to make a difference.

Making a difference

All participants highlighted the importance, to them, of being able to make a difference. Fi noted:

“ ... the hospice was attractive because I had always wanted to do something where I was making a difference.”

Eugenie recognised how making a difference helped her to feel good too:

“I think sometimes it is the little things that make you feel good, so it can be sitting with someone, looking at a photo, striking up a conversation, reading a poem, or going out in the garden.”

Ella also noted how satisfying this can be:

“... and that is what is so rewarding ... even if somebody is dying, probably the traditional thought of a nurse is to make somebody better, but if somebody is dying and you still make a difference and make that not quite so horrific, then it is almost more special really ...”

Ella's quote indicates that making a difference is possible if you feel that you are good at the job.

Good at the job

The feeling of being good at the job emerged in the second interview, and almost every interview thereafter. It appeared to be central to the feeling of 'fit.'

Fern commented:

"It was important for me to feel that I was doing a good job – even though it felt quite minimal at times. I felt that was the path I wanted to choose."

Similarly, Ollie noted:

"... they'd be like, oh, this person is dying, give that person to Ollie, and they'd feel nervous around them, and I never [did] ..."

Whilst Ayla added:

"I had something within me, something that was good at communicating, good at listening and being with people."

Ella identified that age might be a factor:

"I found that I was quite good at it, I think because I was older ... I really warmed to it ... built up some really good relationships with people, and found that I was able to communicate with them and was able to support them and I think my managers recognised that ... and gave me the palliatives to visit ... because I found that I was good at it, I enjoyed it, and it gave me confidence ..."

Ella's comment suggests that this skill was identified, or even developed, through experience, and being exposed to dying patients, which was also found to be important in this study.

Experience/exposure

Prior experiences, which were attributed with helping to prepare the participants, included community, oncology and haematology placements, particularly if these were management placements at the end of the participant's' training.

"... after my pre-management placement, I just fell in love with it." (Flo).

Fern, however, was concerned that her sensitivity would be a problem, until she tried oncology:

"I am a sensitive soul, I am going to cry all of the time, ... and the first two or three shifts into it, ... I felt that was the one I enjoyed the most, and that is where I stayed for four or five years, before coming here."

Perhaps unsurprisingly, only one participant had received a significant amount of teaching in her undergraduate nurse training. For this one participant her twelve-week module on end-of-life care made a big difference, allowing her to study this in-depth. Those who had done a post-graduate degree in palliative care also found this invaluable, although for them this came much later in their careers, and usually when they had selected to move in to hospice work.

Several participants attributed their life experience to helping them to be prepared. However, some also noted that they would have been adequately prepared when younger, or had younger colleagues who were very capable.

Ella, in her fifties, noted:

"I think my age probably... life experience, the fact that I had lost somebody close to me, that I had witnessed other not such traumatic losses, and life – you know – I was able to not be too shocked at things I think, and I guess that comes with age really doesn't it?"

Lesley, also in her fifties, noted that she may well have been ready when younger:

“It is hard to know if I would have been ready at 21, but when I look back at myself at that age, I can see that I might have been ready. I have worked with a lot of nurses who are a lot younger, in their twenties, and they are very good at what they do as well.”

Lesley’s comment also endorses the perception that sometimes people just ‘fit’ with hospice work, regardless of age. Certainly, several of the participants were in their twenties or thirties, as seen in Table 1. Important experiences in the workplace that helped to prepare the participants were working alongside role models.

Role models

Very early in the analysis it became apparent that working alongside good role models was very influential in preparing people for end-of-life care. Lydia summed this up:

“They always had qualities that I wanted – I hold you up there – you have got something I want to get ... They all had a passion for it – and that prepared me.”

Similarly Claudia noted:

“... and the senior nurses ... are working alongside you all of the time ... and you see how they work and pick up their skills first hand.”

Likewise, Lottie commented:

“ ... it kind of moulds you doesn’t it? I don’t think you learn from one person, you pick out things from all different people, ... and then you use all of those different things and you kind of mould yourself.”

Whilst Macey added:

“I just watched how she spoke to her, and I admired her because she allowed her to really explain what was going on ... and now I see it, because I have the same conversations with my patients ... it is things like that, that have changed the way I am as a nurse...”

Macey’s comment demonstrates clearly how this role modelling changed her own practice.

However, a really important part of having good role models, was not just observing them, but having their support, as a kind of ‘safety net.’ Lottie summed this up:

“... the co-working and working alongside the CNSs, we learnt masses, probably more than we actually realise ... and being with them on some really difficult cases, you can see how they kind of deal with things, and then you would dip in and out as you felt comfortable, so your confidence kind of grew, with the support.”

The findings from this one study, are strengthened by integration with the existing literature.

Discussion

The findings presented so far, alone constitute what Glaser (2004, p.e2) dismissively refers to as ‘Qualitative Data Analysis’ (QDA). Glaser (2004) continues that many researchers stop at this stage, which therefore, precludes their studies from being called Grounded Theory. Instead, the findings should be developed into a substantive theory (Glaser, 1978) that includes integration

of relevant literature, which may then form a conceptual framework for the study. A conceptual framework can be described as an internal structure, which is applied to research to support the theory developed, aiding the researcher in recognising the link between the data and existing literature (Leshem and Trafford, 2007). Hallberg (2006) recommends that the core category is integral to the development of a conceptual framework. As noted previously, the core category of this research study – the shared ideal – represented the participants' feeling of 'fit' to the work. This feeling of 'fitting' constituted a major element of how the participants felt they had become prepared, particularly the element of being 'willing' to work with the dying.

The large body of work on Person/Environment Fit (PE Fit), dating back over nearly one hundred years, was examined and compared to the findings of this study. Much of this work has been performed in the fields of organisational employment and work stress (Edwards et al., 1998), but still has great resonance with the findings of this study. There is no single comprehensive theory of PE Fit (Harrison, 2007), and as a concept it is still poorly defined and misunderstood (Kristof-Brown and Billsberry, 2013). Instead, it can be viewed as an umbrella term, made up of five elements of fit (see Figure 4). Table 2 offers succinct descriptions of these types of fit. Table 3 demonstrates how the findings of the current study fit into eight of the ten categories and sub-categories of fit, as defined by Edwards and Billsberry (2010). The findings will be discussed under these headings.

Person/Vocation (P/V) Fit

In the current study, participants highlighted how important it was to work with people who were aiming for the same goals as themselves. Participants explained that this involved being able to give good, holistic care, spend time getting to know people, make a difference to people's lives and enable what they perceived to be 'good deaths.' Participants found this could most easily be accomplished if colleagues worked as a non-hierarchical team, accepted that patients in their care would die, rather than making futile attempts to try to cure them, and valued spending time being with, and talking to, patients and families. This also involved feeling that it was special work that not everyone could do, and was in fact a vocation, not just a job.

It is proposed that having a shared ideal, which epitomises the group's values, helps people to identify as members of a special group. Yu (2014) identifies this as people feeling happier working with others whom they trust and understand. Therefore, to attain this, it could be surmised, people will choose organisations that they perceive to share their personality profiles (Kristof-Brown and Guay, 2011). In sharing characteristics, such as values, they are able to define themselves and to validate their own beliefs (Kristof-Brown and Guay, 2011). Edwards and Shipp (2007) observe that people also prefer to help others who they perceive to be similar. The findings from Resick et al.'s (2013) extensive meta-analysis endorse this, identifying that people find similar individuals more likeable.

Interestingly, this was also reflected in Hopkinson et al.'s (2003) study of 28 newly qualified hospital nurses, in which an identified theme was the 'personal

ideal,' which encompasses the good death, having enough time to care for people and doing the job the way it should be done. Similarly, Kent et al.'s (2012) survey identified a key theme of being 'able to make a difference.' Thirty-three of 174 respondents in that study reported that the most important things to them were satisfaction with the nursing care they could give, and taking pride in the meaningful connections they were able to make with patients and families. Being able to provide 'comfort care' to dying patients was also a recurring theme (Kent et al., 2012). Likewise, in Ablett and Jones (2007) Interpretive Phenomenological Analysis of the experiences of ten hospice nurses, making a difference was a central theme. Being able to make a difference was also cited as partially explaining why the nurses had chosen to work in a hospice, which endorses the idea of hospice work being vocational.

It is easy to see why participants in the current study left previous workplaces when they felt they were no longer able to make a difference, either because there was too little time, other patients were given priority, or because colleagues did not support them in giving quality end-of-life care. Salvage (2010) describes these as 'push' factors, which ten participants in Salvage's study identified as reasons for leaving the acute setting. In contrast, 'pull' factors, which attract people to the hospice, include having the opportunity to give holistic care, getting to know patients and getting away from the fast turnover of the acute hospital. This illustrates the power of the PE Fit theory to explain why nurses in the current study felt they fitted into a hospice more than an acute hospital setting.

Person/Organisation (P/O)Fit

PO Fit and PV Fit are sometimes categorised together (Chuang et al., 2016). However, it is possible for people to feel that they fit the hospice ideal, but do not feel a sense of fit with an individual hospice. Cable and DeRue (2002) explain that a person may not relate to the organisation's values, if these values do not match their own. Several participants in the current study mentioned the 'conveyor belt culture' of acute settings, which was also identified in Gott et al.'s (2011) study. This culture prevented participants from getting to know their patients and caring for people the way they wanted to. Having time to build relationships with patients has been found in other studies to be important to palliative care nurses (Sekse et al., 2018). Furthermore, time is vital to establish trust, whilst permission to spend time with people forms a central tenet of the palliative ideology (Evans and Hallett, 2007). As well as permission, Johnston (2002) found having the ability to be alongside dying people is viewed as an essential quality of a good palliative care nurse.

Illustrating this quality, one participant of Peterson et al.'s (2010, p.183) study commented:

“My time [is a concern]. I want to be attentive to all my patients, and when one is actively dying, they deserve one-to-one care.”

Another participant demonstrated the need to care for families too, and the struggle sometimes to choose between the dying and potentially curable patients, noting:

“I wish I could take care of dying patients on a one to one so I can be there for the family. ... if I have another patient that's crashing then I obviously can't give them all the time I want to give.” (Peterson et al.,

2010, p.183).

The challenges of this differential between the care nurses want to give, and that which they are actually able to give, creates a tension between professional obligations and personal values, which in turn causes stress. Nurses in Udo et al.'s (2013) study identified a feeling of discontentment when they were not able to follow their own caring instincts. Discontentment can be classified as a feeling of not fitting well with the environment, and can, therefore, be a cause of stress in the workplace.

Conversely, Edwards et al. (1998) note that sustained levels of good PE Fit can produce positive health outcomes. This is explained in one of the early theories of PE Fit (French et al., 1974), and endorsed in Ablett and Jones' (2007) study of hospice nurses' experiences, which revealed that the hospice nurses had lower levels of stress than other health service workers. Ablett and Jones (2007) attribute this to Person/Job Fit being influential in reducing stress. Similarly, Edwards and Shipp (2007) advocate that there are several mechanisms by which P/E Fit can reduce stress in the workplace. These include the development of supportive relationships with like-minded others, which supplies the affiliation needs of employees, and the buffering effect that working in a supportive team can have against stress.

Furthermore, Soto-Rubio and Sinclair (2018, p.1431) assert that being able to deliver true compassionate care in a self-congruent way protects nurses against both 'emotional contagion,' and helplessness, which reduces stress and sustains people. McCourt et al. (2013) found that whilst stress and fatigue

were common themes in the research reports they studied of general nurses caring for dying patients in the acute setting, being comfortable with death and dying was itself a buffer against stress.

Person/Group (P/G) Fit

Many of the participants in the current study commented that they wanted to work with like-minded people who shared their understanding that cure was not possible for palliative patients. Encompassed within this is the knowledge that caring for the dying is equally important to care of those receiving curative treatments, and being able to 'fix' people is not the only goal of nursing care. Zimmermann (2012) identified acceptance as part of the unifying philosophy of palliative care. Participants recognised that, although they were not alone in this ambition, they were often in a minority group in acute settings, and sharing this approach was part of what drew them together.

In the UK, as in many countries in the developed world, there is a national lack of willingness to talk about dying and consider death to be a normal part of life (Dying Matters, 2020). This is reflected in medicine and nursing. Gardiner et al., (2012) note that nurses often find the transition from curative to palliative care a difficult time. Unsurprisingly, Chan et al. (2017, p.3) refer to this as a 'philosophical divide.' Results of Gott et al. (2011) and Chan et al.'s (2017) studies demonstrate a bias in the approach of clinicians caring for dying patients in acute settings towards life-prolonging interventions, resulting in the dying receiving inferior care, just as the participants of the current study noted. Costello (2006, p.599) attributes this to the prevalence of the curative ideology, resulting in death in acute settings being perceived as a 'terrifying threat.'

However, Costello (2006) suggests this threat can be mediated when it is recognised that there is no hope of cure. This could be why hospice nurses feel less stress than their cure-focussed colleagues.

Concurring with the participants' experiences in the current study, McCourt et al. (2013) found that the curative patients were given priority over palliative patients, and also that inappropriate active treatments were given to the terminally ill, in a form of denial that they were dying. The issue of care versus cure is also highlighted in Peters et al.'s (2013, p.19) literature review, where the conflict of dividing time between 'rescuable' and palliative patients is noted. Finfgeld-Connett (2008) reasons that a major antecedent to nurses giving good care, is having an environment that is conducive to its achievement. Having a job that allows hospice nurses to care solely for terminally ill patients takes away the stress of colleagues trying to cure people, and the limited resource of time being concentrated on curable patients. Person/Job (P/J) Fit

According to Caplan (1987), there are two aspects of people fitting their work environment. These are demands-abilities fit, and needs-supplies fit. Demands-abilities fit concerns whether the person has the abilities to accommodate the demands of their work role, whereas needs-supplies fit involves whether the needs of the person can be supplied by the organisation. If both of these aspects are not matched between the person and their job, or work environment, then either some adjustment is required by the person, or employer, or the person needs to find alternative work. Fit of the person to the job is exemplified by the fact that the amount or type of work may be large or difficult, but if it fits the person's needs or desires from a job, then it is not too

great or too hard (Caplan, 1987). People may vary in how much misfit they are prepared to accept in their work life between their own perceived needs and those of their job. If people have a strong vocational fit, and therefore, a desire to remain in a workplace, it could be postulated that they will tolerate a higher level of misfit than if they work in a large industrial company to which they have no personal allegiance.

Edwards and Shipp (2007, p.18) also note that people feeling good at their jobs is an important part of PE Fit theory, asserting:

“when the person is able to fulfill job demands, he or she is likely to experience a sense of competence that serves as a supply for the need for competence.”

Student nurses in Hopkinson et al.'s (2005) study similarly expressed that positive feedback helped to sustain their feeling of well-being.

Having experience of caring for, and exposure to dying patients, was revealed as an important way of becoming prepared to give good end-of-life care in the concept analysis (Griffith, 2018). It is unsurprising then, that most participants in the current study mentioned that caring for end-of-life patients in previous jobs was influential in preparing them for hospice nursing. The most frequently discussed experiences were caring for patients in the community and on oncology wards, where a higher number of expected deaths occur than in most other settings. The one nurse who had no previous post-registration experience had also benefited from her time as a carer in a nursing home. This mirrors the findings of King-Okoye and Arber's (2014) study, where prior experience of being a Health Care Assistant helped to prepare two of the participants.

Similarly, respondents in Nguyen et al.'s (2014) study reported that daily contact with dying patients, combined with underlying education, gave them an advantage over their colleagues who did not have such regular exposure to the dying. Benner (1984) also recognised that experience is a requisite for expertise. More controversially though, Benner (1984) asserts that it takes about five years of experience in one area to develop expertise and begin to work at the expert level of practice, which was not endorsed by the findings of the current study.

Person/Person (P/P) Fit

PP Fit is recognised to be a dyadic fit between the person and a significant other in the organisation (Kristof-Brown and Guay, 2011). Although this is often referred to as Person/Supervisor Fit, it can be between any two people in the organisation (Kristof-Brown and Guay, 2011). In the current study, a main theme of the findings was the identification of role models as significant people within the organisation whom participants respected and often wanted to emulate. Quinn commented that this is how all nurses learn, which makes this almost axiomatic.

Certainly, the idea that we learn everything from role models, including our behaviour, is not new. Bandura's (1977), theory of social learning is widely credited with being the first to recognise the importance of people learning in this way (Perry, 2009; Gibbs and Kulig, 2017). In nursing and medicine respectively, the concept has been further highlighted in the works of Benner (1984), Baldwin et al., (2014) and Benbasset (2014) among others. Bandura (1977) asserts that nearly all learning resulting from direct experience, occurs

by vicariously observing other people's behaviour and the effects of that behaviour. Without this, Bandura (1977) suggests, we would learn by trial and error, which would take far longer and potentially have undesired consequences.

Participants of this study noted that they were drawn to the hospice by their interactions with inspirational role models. Jansen and Kristof-Brown (2006) observe that a robust dyadic fit between an employee and a role model will have a strong influence on vocational choice. Supporting this, Pullis (2013) recommends that student nurses should have scheduled clinical time with expert role models, in order to develop competence and a caring attitude toward the dying. Jansen and Kristof-Brown (2006) also note that when people are paired with role models who share similar values and attitudes, they report greater job satisfaction and evaluate each other more highly than when paired with dissimilar people. In Bucher and Stelling's (1977, p.155) seminal text on becoming professional, the word 'fit' is used to explain how people are influenced by the traits that they identify in a role model and the professional image they desire for themselves. This assertion confirms how the shared ideal is the central theme of both the findings of this study and the PE Fit theory, combining PP, PV, and PJ Fit in this one outcome.

Strengths and Limitations

This study has strength in being the first of its kind to study how hospice nurses feel that they have become prepared for their role in end-of-life care. The meaningful substantive theory developed could be built on, which can make a

starting point for other studies across UK hospices and international settings in future. Grounded Theory studies do not set out to be generalisable, but rather, to offer transferability and a starting point for other studies to develop or apply the theory generated. The findings of one study must, therefore, be applied with caution to any other dissimilar site. The participants in this study were also all white, with only two non-UK nurses included. This was typical of the site studied, but limits direct transferability to all other sites.

Implications for practice

This research study has identified some key areas which could help to guide the preparation of nurses new to hospice and end-of-life care. Firstly, the benefit of a placement in a hospice was very clear, to offer exposure to death and dying, and for student nurses to experience giving end-of-life care. It was clear that having good role models was also very important and formative. A hospice is a good place for nurses to work alongside expert role models, but not exclusive in this aspect. Care homes, acute wards caring for frail and elderly people, community and oncology wards also have very experienced nurses who can equally role model good communication and care at end of life. Offering a 'safety net' for novice nurses to practice their newly acquired skills in the presence of an expert, would also be beneficial. Careful choice of mentors from this group would make a difference to a student or novice nurse's preparation. Clearly, more education on end-of-life care needs to be included in pre-registration curricula, and post-qualifying opportunities for further education provided by expert palliative care nurses can also make a difference

to a nurse's preparedness. This research also has implications for selection of new staff, by assessing their 'fit' to the hospice ideology.

Furthermore, as a substantive theory developed in one hospice, this study could be used as a starting point to guide further research in more diverse areas, to develop the theory into a formal theory.

Conclusion

A meaningful substantive theory has been developed, which explains the findings of this study. The substantive theory identifies that the participants felt a strong sense of identity with other nurses in the hospice who shared their ideal way to care for dying patients. This strong sense of PE Fit has been shown to be a superordinate fit to all five of the key areas of fit identified by Kristof-Brown and Billsberry (2013). Furthermore, the feeling of PE Fit was identified to be the element that made these nurses feel prepared for hospice work, particularly from the point of view of their willingness to do the work, and acceptance of death.

Further research needs to be undertaken in end-of-life care to explore how being prepared to deliver care to those at end of life might impact on the quality of care being delivered, and how patients and families experience that care.

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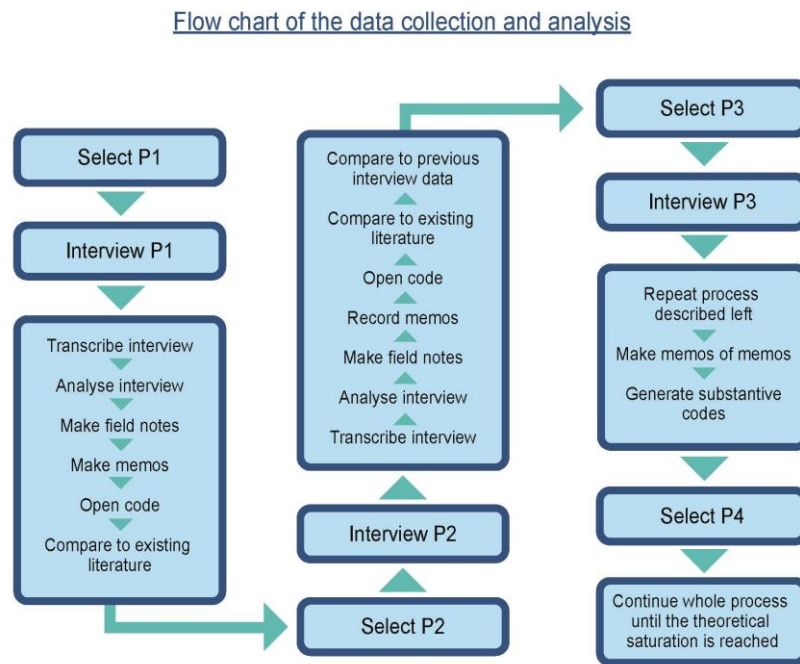
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Figure 2 Flow chart of the data collection and analysis process



Code: P = Participant

Figure 3 example of the coding process

An example of the stages of in-vivo coding, beginning with open codes from the participants' own words, through early codes, to categories and then development of the core category

<u>Open coding</u> Lines	Codes
1. It's the little things you do for people	1. Little things matter
2. It's my desire to make people comfortable at the end of their life	2. Comfort at end of life

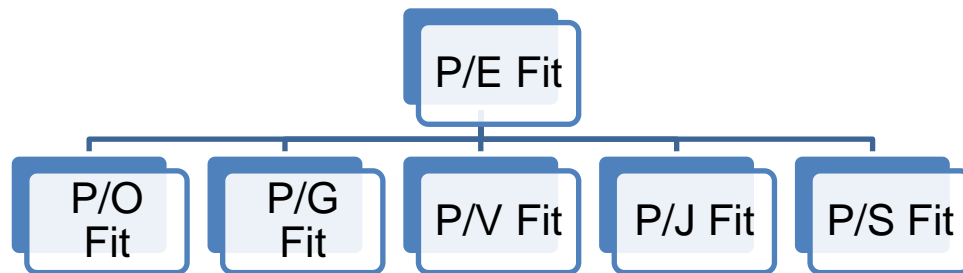
<u>Category development</u> Initial code	Category
Giving good care It's the little things that make a difference	Making a difference

<u>Categories</u>	<u>Core category</u>
Making a difference Feeling good at the job Experience/exposure Role models Shared ideal	Shared ideal

According to Glaser and Strauss (1967) the core category:

- Is a central phenomenon occurring in the research findings, and links all other categories
- Occurs frequently in the data
- Is not forced and emerges naturally
- Has the power to explain variations in the data
- Is discovered toward the end of analysis

Figure 4 PE Fit according to kristof-Brown and Billsberry (2013)



P/E Fit =

Person/Environment Fit

P/O fit = Person/Organisation Fit

P/G = Person/Group Fit

P/V = Person/Vocation Fit

P/J Fit = Person/Job Fit

P/S = Person/Supervisor Fit

Box 1 literature search strategy for the literature review

Search terms: Death, Dying, Nurs*, Hospice, Hospice AND OR Nurs*, Palliative AND Care, Palliat*, Educat*, Training, End-of-life, End-of-life Care, End of life, Prepar*, Competence, Competency, Readiness

Boolean operators AND and OR were used to focus and combine searches using these terms, limiting the number of unhelpful hits.

Truncation was used, for example nurs*, prep*, prepar* to widen the search and capture all possible variations.

Inclusion criteria:

- Publications from 2000-2020
- Articles and books published in English
- UK PhD theses available through EThOS
- Studies relating to adult care
- Studies with a focus on, or applicable to, the UK
- Studies focussing on how nurses (including student nurses) have become prepared for end-of-life care. These were included due to the lack of anything relating directly to UK hospice nurse preparation.

Exclusion criteria:

- Articles published in any language other than English
- Studies conducted in countries with very different healthcare systems, which would mean that findings could not relate to how UK hospice nurses are prepared
- Studies relating to children
- Studies of interest, but not relevant to how nurses have become prepared for end-of-life care

Databases searched:

- Cumulative Index to Nursing and Allied Health Literature (CINAHL),
- Allied Health including Occupational Therapy, Physiotherapy, Complementary Therapy and Palliative Care (AMED),
- PubMed,
- Psychology, psychiatry, child development, psychological aspects of illness and treatment (Psychinfo),
- United States Library of Medicine (Medline),
- British Nursing Index (BNI),
- OpenGrey.

Table 1: Demographic details of all 22 participants

<u>Participants</u>		
Individual interviews	Female	n = 13
	Male	n = 4
Focus group	Female	n = 6
	Male	n = 1
Second interviews	Female	n = 2
Total participants (two people were involved in individual interviews and the focus group)	Female	n = 18
	Male	n = 4
Age range	Range mean age	25-63 years 38 years
Qualifications held	RN or equivalent	n = 22
	Diploma in Nursing	n = 9
	BSc (Hons) Palliative Care (PC)	n = 7
	Undertaking BSc (Hons) PC	n = 2
	Some PC modules completed	n = 4
	Post graduate certificate	n = 1
	MSc (not in PC)	n = 4
	PhD (not in PC)	n = 1
Length of time since qualifying	Range	3-42 years
	Mean	14 years
Length of time in Palliative Care	Range	4 months-27 years
	Mean	7 years
Previous work in oncology		n = 10
Previous work in community		n = 6
Current role	Community PC RN	n = 5
	Inpatient Unit (IPU) RN	n = 6
	Clinical lead	n = 2
	Clinical Nurse Specialist	n = 6
	Manager	n = 2
	Lecturer	n = 1

Table 2 Descriptions of the different types of fit

Type of fit	Description of type of fit
Person/Vocation Fit	This fit is based on matching people with careers that meet their interests. It suggests that people will make adjustments if their needs are being met by their occupational environment.
Person/Organisation Fit	Based on the principle that individuals will be most successful in organisations that share their ideals. It therefore, addresses the compatibility of people with entire organisations.
Person/Job Fit	Based on the principle that employees' knowledge, skills and abilities are commensurate with what the job requires. An employee's desires, needs or preferences are met by the job they do.
Person/Group Fit	This fit examines the fit between people and the group of people they work with – co-workers and the rest of the team. Whilst some research has focussed on demographic variables such as race, gender and age, others have concentrated on values and goals.
Person/Supervisor Fit	This theory examines the dyadic relationships between employees and others in their workplace, but rather than co-workers, it examines relationships such as supervisors and their subordinates.

Table 3 How the findings fit into the subsections of PE Fit

Type of fit (As defined by Jansen and Kristof-Brown (2006) and Edwards and Billsberry (2010))	Findings	Sub-category of fit (as defined by Edwards and Billsberry (2010))
Person/Vocation Fit	The Shared Ideal The good Death Being able to make a difference	Vocation
Person/Organisation Fit	Having enough time to do the job well Opportunities for growth and development Less stressful environment	Organisational values Opportunities for growth and development Physical work environment
Person/Group Fit	Shared understanding that cure is not possible Working in a non-hierarchical team	Colleagues
Person/Job Fit	Feeling good at the job Job satisfaction Experience/Exposure	Skills and knowledge Nature of the work
Person/Person Fit	Role Models	Relationships