Highlights

- Supportive Hospice and Aged Residential Exchange (SHARE) integrates specialist palliative care nursing into aged care facilities.
- Pilot results indicate that the intervention overall is seen by staff as a success.
- Building relationships with key stakeholders is essential for model implementation.

The Supportive Hospice and Aged Residential Exchange (SHARE) programme in New Zealand

Introduction

International literature has demonstrated that residents of aged residential care facilities have high palliative care needs (Katz and Peace, 2003, Kapo et al., 2007, Badger et al., 2009). Yet, previous research has also noted deficiencies in staff palliative care education in aged residential care (Marshall et al., 2011, Unroe et al., 2015, Frey et al., 2016a). For example, they feel ill-equipped to undertake Advance Care Planning (Ministry of Health (New Zealand), 2011b, Silvester et al., 2012), a process of discussion and shared planning for future health care that assists the individual to identify their personal beliefs and values and incorporate them into plans for their future health care (Ministry of Health (New Zealand), 2011b). There is also evidence that nurses and health care assistants feel insufficiently supported in coping with the multiple bereavement experiences they have when residents die (Whittaker et al., 2006, Freyer, 2013). Addressing the palliative care skills deficit of aged residential care staff is therefore of critical importance to delivering quality healthcare in this setting (Froggatt, 2000, Kenny, 2001, Strumpf et al., 2004). In collaboration with a local hospice, this project piloted an innovative context specific psycho-educational intervention - Supportive Hospice and Aged Residential Exchange (SHARE) - designed to enhance in-house expertise in the delivery of palliative care amongst aged residential care staff.

Background

Research has demonstrated a link between a well-educated workforce and quality of care (Froggatt, 2000, Kenny, 2001, Strumpf et al., 2004). Within aged residential care, a skilled workforce improves resident outcomes, for example by reducing acute hospitalisations which are potentially hazardous for frail older people (Gill et al., 2004, Ouslander et al., 2010). Internationally, education has been seen as the most effective way of optimising palliative care provision in this setting (Phillips et al., 2006, Ronaldson et al., 2008, Latta and Ross, 2010). However while necessary, is palliative care education alone sufficient to meet the growing demand for palliative care delivery within aged residential care? Education initiatives developed to date have focused on short training programmes emphasising didactic methods (Quinn et al., 2008, Raunkiaer and Timm, 2013). New Zealand is following this trend (e.g. Fundamentals of Palliative Care) (Hospice New Zealand, 2012). Although this work represents a great leap forward, it is well known that education alone may not change the practice reality. The failure of interventions can often be attributed to the negative impact of burnout on education uptake and the lack of consideration of organisational factors (e.g. time pressures, low staffing levels), both of

which influence sustainable change (Frey et al., 2014).The context of aged residential care requires a more 'hands on' collaborative approach to enhancing clinical care (Aylward et al., 2003).

Aged residential care palliative care delivery in New Zealand

Internationally, New Zealand has the highest number of reported deaths in aged residential care (38%)(Broad et al., 2013). A prospective follow-up study of 6828 aged residential care residents in 152 facilities reported that 861 residents (12.6%) died six months after aged residential care entry (Connolly et al., 2014). aged residential care facilities in New Zealand are thus increasingly the place of death for older people and have been argued to be acting as de facto hospices (Broad et al., 2013, Connolly et al., 2014). Palliative care is defined in this context as defined as: "care for people of all ages with life-limiting conditions" (Ministry of Health (New Zealand), 2011a). There are currently excellent examples of palliative care integration into aged residential care facilities from many hospices, yet there are few consistent models of care throughout New Zealand. This has led to a rather 'ad hoc' approach to the integration of specialist palliative care in aged care facilities. There is also a current lack of gerontology expertise for palliative care specialists who may have limited experience with the complexities of care for those with frailty and dementia (over 65% of aged care residents have some form of cognitive impairment) (Boyd et al., 2011).

Supportive Hospice Aged Residential Exchange (SHARE)

Working in collaboration with one urban hospice, the intervention was designed to provide a mechanism to package and systematically foster palliative care knowledge transfer to clinical care staff with the goal of improving palliative care delivery within aged residential care facilities. Drawing on previous research (Gill et al., 2004, Ouslander et al., 2010, Latta and Ross, 2010, Boyd et al., 2014) the key components of the intervention are:

- Clinical coaching by a palliative care nurse specialist through direct (for complex needs) and indirect (not so complex needs) patient consultation

- Role modelling of Advance Care Planning   conversations (including documentation with residents, families and GP's)

- Debriefing amongst all aged residential care staff following a resident's death

A full description of the SHARE model components is outlined in Figure 1

REVIEW AND ASSESSMENT OF GOALS OF CARE

- **Weekly visits to intervention facilities**
- All existing residents, and those recently discharged from hospital were reviewed by the senior aged residential care nurses and Palliative Care Nurse Specialist for palliative care needs at the weekly meeting using the Gold Standards Framework "Surprise Question" (Thomas K, 2011).
- The list of residents identified as having palliative care needs (and likely to be in their last year of life) became the basis for discussion at subsequent meetings. These residents were not be automatically referred to the hospice UNLESS the resident had a level of complexity in their care needs that were not able to met by aged residential care staff working together with the palliative care nurse specialist. Regular meetings with the aged residential care facility provided an opportunity for facility staff to raise any concerns they had about the palliative care needs of any resident within the facility.

RECIPROCAL CLINICAL COACHING AND ROLE MODELLING

- **Clinical coaching and role modelling** of palliative care skills and knowledge is a key component of SHARE. This is a reciprocal process of shared learning between palliative care and aged care. The palliative care nurse specialist in partnership with healthcare assistants, registered nurses and general practitioners developed and updated a goals of care plan to reflect new or changing palliative care needs (See Appendix A: Goals of Care Summary).

EDUCATION PLANNING

- Palliative care skills and knowledge vary between facilities. The Palliative Care Nurse Specialist worked in partnership with staff to facilitate a discussion on the specific learning needs of each facility identifying the priorities for staff in terms of palliative care knowledge and skills.

ROLE MODELLING OF ADVANCE CARE PLANNING CONVERSATIONS

- The Palliative Care Nurse Specialist reviewed with the facility registered nurse opportunities for discussions regarding advance care planning for any resident within the facility. The Palliative Care Nurse Specialist provided guidance and role modelling for the nurses in relation to advance care planning conversations including documentation, discussions with the General Practitioner and with the family. The developing relationship between the Palliative Care Nurse Specialist and facility staff provided opportunities for effective care coordination.

DEBRIEFING AND REFLECTION

- Debriefing was offered for each death that occurs within the facility, facilitated by the Palliative Care Nurse Specialist in partnership with a senior nurse from within the facility. This was an opportunity for staff to reflect on the care provided whilst acknowledging the emotional impact of caring for people at the end-of-life.

Figure 1

SHARE intervention components

Aim

The aim of the current study was to explore the impact of SHARE in improving staff perceptions of confidence in palliative care delivery.

Methods

A mixed-model design was used to guide the data collection (Creswell and Clark, 2007). *Phase One* adopted a quasi-experimental pretest-posttest design for a survey measuring changes in staff confidence in palliative care delivery. *Phase Two* employed a qualitative approach using post-intervention interviews to examine staff perceptions of the impact of SHARE.

Sample

Two small privately owned aged residential care facilities (< 70 beds) were recruited from the 68 aged residential care facilities within one urban district health board. Small privately-owned facilities were purposively selected as they represented the majority of aged residential care facilities within the district health board (Eldernet Ltd., 2016). The intervention took place over a six-month period (April to September 2015).

Context

Facility One is a 40-bed private hospital level facility offering long and short term care including dementia care. A certification audit (Ministry of Health (New Zealand), 2014b) in 2014 reported staff numbers that included nine registered nurses and twenty health care assistants. Facility Two is a 52-bed private hospital level facility. Two of these beds are designated as rest home level beds. Staff included eight registered nurses and 21 healthcare assistants (Ministry of Health (New Zealand), 2014a).

Phase One – pre-test/post-test questionnaires

Utilising a validated tool (National Audit Office, 2008) adapted from the palliative care education questionnaire administered to clinical care staff in an acute hospital setting in New Zealand, (Frey et al., 2013). The staff survey measured changes in perceived confidence in palliative care skills on three tasks (identifying palliative care residents, hospice referral, and palliative care delivery) (Frey et al., 2013). Each item was measured on a scale from 1 "not confident at all" to 10 "extremely confident." Previous results utilising the perceived confidence measures found significantly higher scores for palliative care delivery confidence for those

clinical staff with formal palliative care education (Frey et al., 2013). Three secondary measures of staff wellbeing were included in the questionnaire. Hakstian and McLean's (1989) Brief Screen (BSD) (4 items) was used to assess depression (depressive affect). The Cronbach's alpha estimate of reliability was .89 for scores on this scale. Stamm's (2010) Professional Quality of Life scales were used to examine compassion satisfaction (gratification from effective work performance)(Stamm, 2010), burnout (cumulative non-traumatic stress) (Malach-Pines, 2005) and secondary traumatic stress (compassion fatigue)(Figley, 2013). ProQOL is composed of three discrete scales not designed to produce a composite scale score (Stamm, 2010). Cronbach's alphas for these five-point scales were .81, .67 and .85 respectively. Spreitzer's (1995)12-item Empowerment scale (7 point response format) was used to measure psychological empowerment (defined as employees' perceived control over their work life) (Spreitzer, 1995). The Cronbach's alpha coefficient for the total scale was .95. Demographic information (e.g. gender, age, ethnicity, role, time in aged residential care), previous palliative care experience and education items were also included. Paper questionnaires were distributed to healthcare staff (registered nurses, healthcare assistants) in each facility. A second administration of the questionnaire took place one month post-intervention in both facilities.

Phase Two – Interviews

Semi-structured interviews with seven staff (registered nurses, healthcare assistants), management (2) and two (2) hospice nurses post-intervention (Oct-November 2015) were utilised to assess the acceptability and necessary refinement of the SHARE intervention. The interview schedule covered topics including any previous education in palliative or end-of-life care, palliative care experience, as well as benefits and areas of improvement for SHARE. Interviews were conducted at the two aged residential care facilities.

Data analyses

The study resulted in the generation of both quantitative (Phase One) and qualitative (Phase Two) data. *Quantitative data sets* consisted of the pre-test/post-test surveys of facility clinical staff. Staff survey outcome variables in the administered questionnaires were measured at baseline before the intervention and at a follow-up one month after the intervention. Quantitative data were imported into SPSS version 21 for analyses. Both descriptive (frequencies, mean, SD) and inferential (paired sample t-tests) statistics were utilised. The *qualitative datasets* comprised transcripts of semi-structured interviews with staff, management, and hospice

nurses. With the consent of participants, interviews were audio recorded and transcribed verbatim. Interviews averaged one hour in length. Analysis of the text generated from Phase Two followed the principles of the National Centre for Social Research 'Framework' approach, involving a structured process of 'sifting, charting and sorting material' according to key issues (Ritchie J. and Spencer L., 1994). Analyses were conducted by the research assistant (SF), together with (RF) who worked together to ensure data quality (for example, using double-coding). Subthemes were considered in relation to pertinent literature.

Ethical considerations

Ethical approval was obtained from the University Ethics Committee (Phase One ref 013501, Phase Two ref. 014462). All Phase One and Phase Two participants were given the opportunity to consider their participation and choose whether to opt in.

Results

Phase One demographic overview

Staff participants were most often female (92.6%) worked as health care assistants (48.1%) and reported English as a second language (66.7%). Staff predominantly listed Pacific (44.4%) or 'Other' (44.4%) (e.g. Filipino, Indian and Chinese) as their ethnic identification. Six participants (22.2%) reported a Bachelor's degree or higher while five (18.5%) reported a Certificate as the educational qualification responsible for their employment in their current position. Participants most frequently reported (29.6%) over 10 years' experience in aged residential care (Table 1).

Table 1: Staff Overview

Staff Participant Characteristics		Frequency	Percent[a]
Gender	*n = 27*		
Female		25	92.6
Male		2	7.4
Age	*n =25*		
17-25		1	3.7
26-35		6	22.2
36-45		3	11.1
46-55		9	33.3
56+		6	22.2
English First Language	*n = 26*		
Yes		8	29.6
No		18	66.7
Ethnicity	*n = 27*		
NZ European		2	7.4
Māori		1	3.7
Pacific		12	44.4
Other *(inc. Asian, Southeast Asian, African, Middle Eastern, European, British, North American and Australian)*		12	44.4
Role	*n = 26*		
Health Care Assistant		13	48.1
Registered Nurse		5	18.5
Charge Nurse/Senior Nurse		1	3.7
Care Coordinator		1	3.7
Manager		1	3.7
Allied health (PT,DT, etc.)		4	14.8
Educational Qualification	*n = 17*		
Bachelor's degree or higher		6	22.2
Certificate Course/Work Training		5	18.5
Other		2	7.4
None		4	14.8
Formal Palliative Care Education	*n = 27*		
Yes		10	37.0
No		17	63.0
Fundamentals of Palliative Care	*n = 27*		
Yes		9	33.3
No		18	66.7
Last Days of Life	*n = 27*		
Yes		10	37.0
No		17	63.0
Liverpool Care Pathway	*n = 27*		
Yes		5	18.5
No		22	81.5
Further palliative care training	*n = 27*		
Yes		18	66.7
No		9	33.3
Years in Aged Residential Care	*n = 21*		
< 12 months		3	11.1
1-3 years		4	14.8
4-10 years		6	22.2
10 + years		8	29.6
Frequency of observing End-of-life Care	*n = 26*		
never		2	7.4
1-3 times		10	37.0
4 or more times		14	51.9
Frequency of giving bad news	*n = 26*		
never		9	33.3
1-3 times		8	29.6
4-9 times		6	22.2
10 or more times		3	11.1
Frequency of discussing End-of-Life Care	*n = 25*		
never		9	33.3
1-3 times		9	33.3
4 or more times		7	25.9

Clinical staff palliative care experience and education

Clinical staff members recorded categorical responses concerning 1) the percentage of time observing end-of-life care (2) frequency of giving bad news and (3) frequency of having discussed end-of-life care management with colleagues. In all, 51.9% of clinical staff members selected the category of" 4 or more times" as indicative of the frequency of observing end-of-life care. In contrast, the majority of participants (62.9%) had given bad news either 1-3 times or never and likewise had not discussed or rarely discussed (1-3 times) resident end-of-life care management with a colleague (66.6%).

Turning to formal palliative care education 10 (37%) of the participants had undertaken palliative care education. However, 66.7% of respondents reported that they would like formal education. Of those who had undertaken palliative care education nine (33.3%) had completed Fundamentals, 10 had completed Last Days of Life (37%) and five (18.5%) had previously completed the Liverpool Care Pathway. Clinical staff members (11) most frequently mentioned topics to be included in future formal palliative care education: care of the dying (14.8%) and dealing with family (7.4%) .

Pre-test confidence in palliative care delivery

Participants reported (1–4 scale) how prepared they felt, professionally to care for a patient with a life-limiting illness. Respondents most frequently reported a mean score of 3.19 (SD = .74) "reasonably prepared" to care for someone with a life-limiting illness. Clinical staff also rated their confidence in the delivery of three palliative care-related tasks from 1 (not confident) to 10 (extremely confident). The mean confidence scores were as follows: (1) identifying when to begin palliative care ($\overline{x}$ = 7.36, SD=1.93); (2) referral to specialist palliative care ($\overline{x}$= 7.04, SD=2.16); and (3) providing palliative care ($\overline{x}$=7.32, SD=2.33). The Confidence in Palliative Care Delivery (an additive scale of the three items) mean scale score was 21.91 (SD=5.45) (Table 2).

Staff wellbeing

ProQOL baseline measures for compassion satisfaction (pleasure derived from being able to do work well)(Adams et al., 2008), secondary traumatic stress (work-related, secondary exposure to extremely or traumatically stressful events)(Stamm, 2010) can be found in Table 2.   Respondents reported a mean score of 41.61 (SD = 4.75) for Compassion Satisfaction and a mean score of 24.59 (SD = 7.52) on the STS indicating an average level of secondary traumatic stress (Stamm, 2010). The mean score recorded for burnout was 22.3 (SD = 3.40) indicating a low degree of burnout. Staff recorded an average score of 15.29 (SD = 6.76) for depression (Table 2). Scores above 21 distinguish clinical levels of depression (Fischer J and Corcoran, 1994). The mean score for psychological empowerment was 77.14 (SD = 6.36).

Table 2 *Pre-test (T1), Post-test (T2) changes in mean Confidence, Depression Professional Quality of Life and Psychological Empowerment scores*

Measure	n	T1	T2	t
Confidence in identifying a palliative care resident	11	6.72 (2.05)	7.63(1.36)	-2.19
Confidence in identifying when to refer to hospice	8	6.70(1.88)	5.37(1.68)	0.85
Confidence in palliative care delivery	11	6.63(1.96)	7.63(1.74)	-2.62*
Brief Screen for Depression	12	15.00(7.28)	7.58(9.28)	2.61*
Compassion Satisfaction (ProQOL)	10	39.4(5.94)	41.10(4.88)	-1.03
Burnout (ProQOL)	10	22.30(3.40)	19.7(3.91)	2.26
Secondary Traumatic Stress (ProQOL)	11	22.45(7.40)	20.90(4.65)	0.71
Psychological Empowerment	7	77.14(6.30)	73.28(9.81)	0.93

* $p < .05$

Changes over time

Twelve respondents (45%) completed the second questionnaire at the conclusion of the intervention.

Confidence in palliative care delivery

A repeated measures *t*-test was conducted to analyse changes in perceived confidence in palliative care delivery. Perceived self-confidence scores ($\overline{x}$ = 7.63 SD = 1.74) after the six month SHARE intervention were significantly higher than those scores recorded pre-intervention ($\overline{x}$ = 6.63, SD = 1.96). There were no significant differences in confidence identifying a resident with palliative care needs or confidence in knowing when to refer a resident to hospice ($p > .05$) (Table 2).

Staff wellbeing post-test

Results of repeated measures *t*-tests indicated that there was a significant difference ($p < .05$) in mean depression scores between T1 and T2. The mean Brief Screen for Depression (BSD)(Hakstian and McLean, 1989) score post-intervention ($\overline{x}$ = 7.58, SD = 9.28) was significantly lower than the mean BSD score ($\overline{x}$ = 15.0, SD = 7.28) pre-intervention. Although not statistically significant ($p = .05$) the mean burnout score post-intervention ($\overline{x}$ = 19.70, SD = 3.91) was lower than the pre-intervention mean score ($\overline{x}$ = 22.30, SD = 3.91). There were also no significant differences over time ($p > .05$) in Compassion Satisfaction or Secondary Traumatic Stress (Table 2). Finally there were no significant differences ($p > .05$) in psychological empowerment between T1 and T2.

Phase Two overview

Eleven (11) interviews were conducted (managers, nurses and healthcare assistants, hospice nurses). The majority of staff members were non-European in ethnicity and all were female. The time in current role ranged from new graduates with less than one year experience to 22 years. Relevant participant demographic information is presented in aggregate to protect the participant identities (Figure 2).
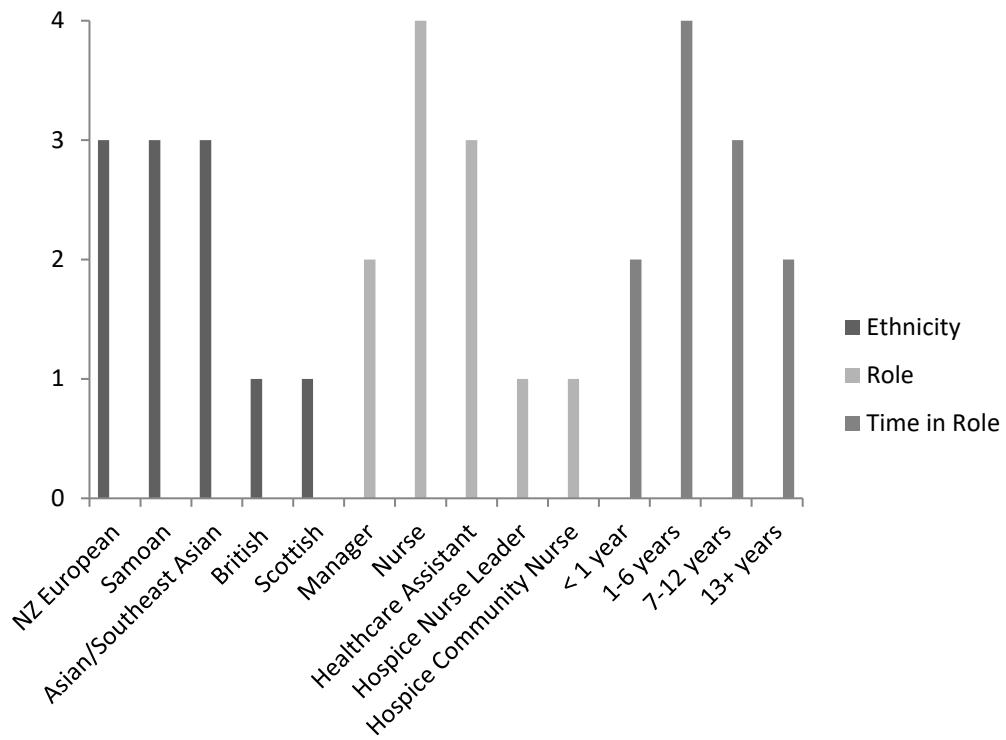
Figure 2   *Selected Staff Demographic Characteristics (Frequency)*

Key Themes

Four overarching themes emerged from the manager and staff interviews. These included: documentation, communication, relationships and mutual knowledge exchange.

Documentation

The manager of Facility One felt SHARE had been a great success – particularly surrounding their documentation. Prior to the intervention, no consistent recording of weight was carried out by staff, and this has now been rectified by the introduction of a nutrition sheet and regular weighing. One of the nurses (Facility One) said that one of her patients was losing weight, and now they talk about it in the morning meeting, and it resulted in her having a conversation with the kitchen staff about the diet.

We're just recording it, but we don't keep it on track and why this patient is losing their weight. And whether they're in stable BMI [Body Mass Index] range or stuff like that, but after we're doing the assessment with that form, we know whom we have to focus on about the nutrition. And we were talking about that in the meeting, and we're discussing with the chef how he has to prepare the meals for particular patients. Nurse Facility One

The manager also commented on how useful the resident file review had been as it forced her to look at the care of the patient in a holistic way rather than moving from one six-month review to another. This will now be done on an annual basis in the future. Enduring Power of Attorney and Advance Care Planning information previously held in the front office had now been transferred to the resident's file. In contrast hospice, nurses reported staff difficulties in identifying people that have less than 12 months left to live at Facility Two, leading to problems in communicating with families and subsequent documentation of cardiopulmonary resuscitation status and Enduring Power of Attorney. The hospice community nurse reported the following regarding Facility Two:

My gut feeling is they're struggling with identifying people that have less than 12 months left to live. They're not very confident with communication, with talking to relatives say, coz I had this discussion last week with them, around CPR[Cardiopulmonary resuscitation]status and who is EPOA [Enduring Power of Attorney] they've acknowledged that.

Hospice Community Nurse

Relationships

Possibly the most frequent theme from all interviewees was the recognition of the importance of relationship – of staff within the facility with patients and also their families, and for Hospice nurses the importance of building a strong connection with the nurses in order to build trust. For example, the Manager at Facility Two had initially demonstrated mistrust of the hospice nurses:

And I think we felt it was a bit like we were being audited again. But it certainly highlighted gaps that perhaps we needed to address. That we had such a big problem and it's looking at what was more an issue of resident life, as opposed to our statutory obligations.

Manager Facility Two

The healthcare assistants at Facility One felt that intervention had helped them to have conversations with families and for those who had English as a second language they realised that sometimes they did not talk to families because they lacked confidence in their English language skills. The hospice nurses helped them to talk to families as they were caring for the patient. All three Facility One healthcare assistants are extremely experienced caregivers and expressed their care for their patients. They felt the intervention had not changed their care but more increased their knowledge base.

After they talk to us, you've got the knowledge. You can walk in the room, and you say I've got, learnt something from yesterday's talk. So I walk in from that knowledge, and I know exactly what will I use for this person. Healthcare Assistant Facility One

For Facility Two the bond between the hospice nurse and the registered nurses at the aged residential care facility ,who were new graduates and unsure of the "next step," became essential. They were both very grateful for the relationship they had, and this made it easier for them both to ring hospice when they were stuck.

I think having the hospice nurse leader, or hospice community nurse here has been really beneficial. Having just a face, you know having them there you wouldn't typically, you might not phone nurse leader or the hospice community nurse with advice but they're there anyway, so we'll just grab you. What do you think about this, which to me is a far more pro-active approach than waiting until we actually have to refer someone for palliative care for Hospice care shall we say, or end-of-life care.

Manager Facility Two

Communication

Communication and relationship go together. However, it is interesting how the two facilities deal with communication around difficult conversations differently. At Facility One, the nurse manager takes responsibility for the difficult conversations with families around Enduring Power of Attorney and Advance Care planning, and the recording of these is clear and up to date. It also fosters a relationship between the nurse manager and the families who then, in turn, trust the care their relatives receive. For the Korean and Chinese nurses, these are difficult conversations to have due to both cultural and English as second language challenges, hence why the Nurse Manager has assumed the responsibility   For example one nurse, her English was quite limited because she was from another country.

And she's polite, but she just tries not to use her language to communicate to the residents.   But I remind her communication is very important, so she's starting to use her   communication skills, even though her English is bad. Then the family and her relationship were a bit better. Nurse Facility One

At Facility Two, the hospice nurses report that the manager is not comfortable holding the conversations around Enduring Power of Attorney   or Advance Care Planning, and consequently, she does not have the same relationship with families as Facility One.

Mutual knowledge exchange

Another issue that became clear from the interviews is the different knowledge bases of the facilities and of hospice. There were differing definitions of palliative care – hospice regarded palliative care as providing quality care to their patients rather than talking about a time frame while the facility staff indicated that they were talking about the last months of a person's life. The nurses at Facility Two reported that the relationship with the hospice nurses was critical to their change in attitude towards palliative care. They previously felt that palliative care was end-of-life care, but now see it in more holistic terms and over a longer period. One healthcare assistant   commented:

I learnt every, what I mean is a different stage, like coming to the patient and yourself, what are you

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expecting at the time that, you know that you never experience from. And you get it from there, right

there in front of your face when the patient is dying. And not only that the care that you're gonna give

to that patient, that person, end-of-life... And also the stuff in the family.

<div align="right">Healthcare Assistant Facility One</div>

The Hospice nurses stated clearly that they learnt as much as the facility staff about the care of older people as the facility staff gained from them. One area was around nutrition – the nutrition form was provided by the Gerontology Nurse Specialist from the district health board, not hospice who said: "why would you bother?" But they learnt that weight gain or loss in the elderly can be an indicator of diet and well-being rather than being seen as a side effect of the disease. Secondly, they found it very hard to identify when an older person is in their last year of life as there were so many co-morbidities. They found that the facility staff members were able to identify these people much better than themselves as they not only knew the patient but also understood the trajectory of illness better. It would appear that the more the hospice nurses interact with aged residential care, the better the knowledge base would be on both sides. A hospice nurse leader reflected the following:

I'm learning how difficult it is to work out, I guess, the trajectory of frail elderly. You know

when they're going to be end-of-life. Because, you know, we've been, they've been a couple of

weeks between visits and patients have died at that time and then other patients who weren't

identified as being likely to die in the next twelve months have died as well. So it is difficult to

know, to work out well it's difficult to know when these patients are likely to die.

<div align="right">Hospice Nurse Lead</div>

Discussion

This pilot project is a first step in the development and implementation of a new consult model of palliative care education for aged residential care staff. Building on the results of previous research (Boyd et al., 2014, Frey et al., 2015, Frey et al., 2016b) SHARE could be described as being effective especially in relation to keeping notes well documented and alerting nurses and healthcare assistants to weight gain and loss. The results

of this preliminary study also highlight the importance of adapting the intervention to fit the organisational culture within each facility. Facility One for example already has excellent communication and has clear policies and processes for residents when they are dying. These were not so apparent at Facility Two and may reflect the manager's ambivalence towards documenting the advance care directives noted in the staff interviews. The results of this study also underscore the importance of the role modelling of advance care planning conversations to reduce staff discomfort in holding these conversations with residents and families. In particular, English as a second language staff had difficulty in communicating with families. This is particularly vital given the increased reliance on an immigrant aged-care workforce in Western industrialised societies (Callister et al., 2014, Bourgeault et al., 2010, Cangiano and Shutes, 2010). Role modelling effective communication styles rather than the use of written information (a cognitively demanding activity) (Abriam-Yago et al., 1999) has been shown to provide confidence to English as second language staff to engage in needed conversations (Kataoka-Yahiro et al., 2016).

Relationships between hospice and facility staff, and consequently facility staff and patients and their families are seen as the key to the success of the intervention. Previous research indicates that the provision of complex quality health care requires good relationships among team members as well as the ability to learn together and adapt to change (Jordan et al., 2009, Lanham et al., 2009, Crabtree et al., 2011, Nutting et al., 2011). Overall, a deeper understanding of the roles of both facility staff and also hospice staff has fostered an appreciation of how the two can work together to create a richer care experience for residents. The intervention thus conceptualizes learning as a *shared* rather than individual activity (Boud, 2001). Staff and hospice nurses build on each other's understandings. Pre-test-post-test questionnaire results in relation to increased confidence and decreased depression concur with the results of the staff qualitative interviews pointing to the effectiveness of the SHARE intervention. Drawing on research by Gray-Stanley et al. (2010) SHARE may impact on worker depression by providing a source of external support.

Limitations and Recommendations

These results are a summary of only two facilities and as such are not generalizable. However, the convergence of both qualitative and quantitative results supports the usefulness of SHARE within the facilities. The implementation time frame (six months) was of short duration. A longer implementation period may establish a level of trust to the point where information flows freely from one care area to the other. In addition, while a direct link between improved collaboration and better resident care was not demonstrated, most respondents felt SHARE would support effective care delivery. A larger evaluation incorporating outcome

measures for residents is recommended (Hall et al., 2011).

Conclusion and Way Forward

Built on a consult model SHARE is designed to strengthen relationships between aged residential care and Hospice through mutual respect and sharing of knowledge between services. Key lessons learnt from for the development of any palliative care intervention within aged residential care include the importance of reciprocal learning, as well as the necessity of a strong partnership with key stakeholders including the University, Hospice, Hospital and aged residential care facilities.

Conflict of interest

None declared.

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