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THE EXPERIENCE OF HEALTHCARE ASSISTANTS IN PROVIDING END OF LIFE CARE IN A CONTINUING CARE UNIT
This study was carried out to explore the experiences of healthcare assistants in providing end of life care to individuals with life limiting illness and their families within older person care services.
Over two thirds of deaths in Ireland are of people aged 65 and over, one third of which occur in community hospitals and nursing homes.

Life expectancies are increasing resulting in greater numbers of older people in society that will subsequently require healthcare, continuing care and end of life care.

People are living longer with multiple co-morbidities.

There’s been a sociological shift in how people are cared for, i.e previously, care was provided at home by families but for different reasons (crowding, isolation, poor nutrition and increasing no of females taking up employment) more formal care was, is and will be required.

Caring for older people and death is now more medicalised.
Standards addressing end of life care for older people in Ireland have only in recent years been published:

- Health information & Quality Authority National Quality Standards for residential Care Settings for Older People in Ireland (2009).
- Hospice Friendly Hospitals, Quality Standards for end of Life Care in Hospitals (2010).

Healthcare assistants under the direction of the R.G.N carry out the majority of personal care and are key and experienced workers in providing end of life care to older people.

Negative ageist perceptions to older people and gerontological care exist.

Not seen as a good career choice.
Quality of life in continuing care settings (Leas cross).

Ageing workforce- FETAC qualifications. HCAs not able to explicate their roles - all encompassing.

Communication - life experience, cultural differences among staff, families requiring information, who gives it??

HCAs often left out of essential communication.

Support often lacking from RGNs and management- delays in delivery of care
HOW WAS THE STUDY CARRIED OUT:

- Qualitative descriptive design.
- Purposive sampling was used.
- Gatekeeper was used and post box
- 10 HCAs were interviewed
- Interview guide was used
  - Quality of life.
  - HCA role in providing end of life care.
  - Communication
  - Support
  - Training and development
- Interviews were recorded and transcribed.
- Content analysis was used - Miles & Huberman (1994) data analysis to identify codes, categories and themes.
Participants spoke about relationships and bonds formed with residents:

“you get close to them when you’re dealing with them on a daily basis”

Person centred family care was evident through the caring relationships formed with family members which also developed over an extended period of time.

“they’d like when they tell you about their mother or their father... I enjoy that though when they tell you stories about before cos then you get to know them ...”
There was often a sense of humour that became apparent between the carers and the resident that appeared to contribute to residents’ quality of life.

“...you’ll be having the craic with them doing their hair if it’s a lady d’ya know what I mean and she’d be laughing push it back this way or that way so you get to know them like you don’t just go in and say right this is project A lets get it over and done with and then go to project B...”

Healthcare assistants use humour to get to know residents and family members likes and dislikes.

They use these opportunities to develop and nurture a working, caring relationship.

Humour is an effective and beneficial therapeutic technique that can help reduce anxiety, depression and embarrassment among both patients and carers.
An element of journeying with and supporting family members was evident.

“... they’re going through a very difficult time... it can be really worse for them in a sense you know they’re watching they’re still in their full senses and they know what’s going on ...”

Relationships were seen to be sustaining for the resident and the healthcare assistant however the professionalism that must prevail was also seen.

“...we have to be professional ... some care staff they cry... if you cry they mean you couldn’t control your emotions and eh the relative they may think ... they emotional ... how could they provide care to my family”
Healthcare assistants expressed that the nurse has a role in educating others and that the nurse provided a sense of security.

“...information is always there for you and the support is there for you too like you don’t have to go in to the resident on your own and do anything there’s always a nurse available to go in ...”

However there was a reluctance in accessing that support

“..there’d be no trouble in contacting the staff nurse but em you know she has her own stuff to do ...”
However healthcare assistants also often expressed feeling frustrated with the nurse.

“...I’ve talked to my nurse and they say oh I’m busy just leave it for a while but then after 1 hour I still saw my work undone. I feel really bad...”

The nurse was seen to place a significant amount of trust in healthcare assistants.

“...they’ll just tell you what to do and go off”
The multicultural society that exists in Ireland was evident and was seen to impact personally on healthcare assistants, creating a lonely environment for them to work.

“It’s really not nice when … two persons are talking and then you couldn’t understand and you’re not included”

Overcoming cultural differences was important and seen to be possible in the working environment.

“...body language and ... that calm approach and attitude you know and soft gentle simple words so they can understand...”
Healthcare assistants expressed being aware of the privacy needs of residents and their family members.

“you should have to close the door first …”

Person centred, family care was also evident.

“...the family can stay day or night there’s beds made available for them, they get their dinners or lunches or teas anything they like”

Participants displayed evidence of attending to spiritual needs

“I would just sit with them & I’d hold their hand and have their rosary beads in their arms & I’d say either a decade of the rosary or I’d say some sort of prayer with them”
The reciprocal role of caring through religion was also seen.

“If … old people pray for you that is the way to happy so when they pray for me it’s like they give me money so I really I say God this prayer let it work for me so it makes me happy to be able to help them”.

Healthcare assistants can benefit on a higher level from the work they carry out, thus indicating the shared caring relationship that exists.

The spiritual dimension of care was seen to extend beyond religion though.

“I’d see how they’re feeling about if death is on them … and have they a fear and talk with them … or if there’s any other wishes that they would like before they would pass away”
Healthcare assistants are aware and actively care for the whole person thus creating an open environment where spiritual end of life care is provided to older people.

“The whole nursing home when someone dies seems to drop down to this quiet level where the bells don’t go as much that day and everyone’s quite calm”

“being there as a person, your presence, the presence is very important...”
EXPERIENTIAL LEARNING

- Healthcare assistants expressed how they learned from experience

  “...my 1st time really freaked me out you know I was kind of scared which is really stupid you know cos I had never been with somebody who died before & eh now over the years it comes natural to me I know it’s a way of life and that...”

  “...the only way I know is through what I’ve seen...”

- The human impact of death was evident from participants

  “...when a resident passes you kind of the shock hits you and the first few days you’re like Oh my God...”

- This impact was sometimes seen to last for a period of time.

  “...when they do actually pass away then it is it does affect you you know eh in a certain way you know you’re down and you come into work expecting to see the person still there and it takes a couple of weeks to to get used to not having them here”
The death of a resident was seen to evoke other personal memories also:

“... it reminded me ... about my mum ...”

Participants displayed using a “veil of protection” in order to guard themselves from the emotional effects endured.

“...I’m giving 100% care but as a person I’m not giving my 100% because if I put eh myself 100% then died it’s very hard for me”
requiring some form of debriefing

“...to go and have a talk with somebody afterwards especially if you’ve cared for somebody for a good few years it would be a good idea...”

“I’d like to learn ... and really know how to cope with it ...”
Participants expressed having some knowledge of the nuances of dying

“... they start breathing heavier and their skin ... they get thinner as well a lot of the time and they kind of eh they won’t really walk…”

Health care assistants also identified gaps in their knowledge.

“I wouldn’t understand what happens when someone dies, perhaps you know just eh a little background information to know what happens to the body and kind of signs…”

There was also a certain lack of confidence in abilities too.

“...I wouldn’t always understand ...I didn’t know how to handle it... I didn’t want to do something that would have been wrong…”
The complex nature of end of life care was displayed.

“End of life care is from the beginning too we’re all on end of life care even when we’re born we live to die”

There is an uncertainty as to when the focus of care changes.

“… before I know that she’s on palliative care the care that we’re giving is still the same”

The lack of confidence, doubt and unclear pathway of care subsequently results in confusion upon the death of a resident

“I panicked...everyone was busy there was nowhere to look and it was a bit of uh oh then kinda going … where do ya go what happens like how responsible are you? … should I leave should I stay should I press the call bell”
1. Collaboration with all team members is required to create clear pathways of care.
2. Healthcare assistants should be encouraged to continue providing spiritual care that enhances the care environment.
3. Promotion of positive culture development should be fostered, with nurses being instrumental to this.
4. Consideration should be given to implement team debriefing or death reviews upon the death of a resident.
5. Further research on the topic is indicated using other approaches and a larger sample, to obtain more detailed data.
6. Healthcare assistants should continually engage in education that provides a clear curriculum that addresses the nuances of end of life care.
7. Further research attempting to clarify the role of the nurse and healthcare assistant in continuing care settings is recommended.
CONCLUSION

Healthcare assistants play a worthwhile role in:

1. Forming sustaining relationships
2. Creating an environment conducive to “a good death”
3. Through displaying the complex nature of end of life care for older people

Nurses are identified as being key healthcare workers who can

1. Educate
2. Support
3. Promote a positive culture