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ORIGINAL ARTICLE

Learning, support and communication for staff in care homes: outcomes of reflective debriefing groups in two care homes to enhance end-of-life care

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Background. Nursing care homes are increasingly the place where frail older people die. However, training in end-of-life care is not statutory.
Aims and objectives. To develop strategies to promote quality end-of-life care in nursing care homes.
Design. Action research was used to work collaboratively with the managers and staff in two nursing care homes to develop end-of-life care.
Methods. There were three overarching phases: an exploratory phase, feedback/planning of actions and a summative evaluation. Two main actions were inductively derived. One of the actions, reflective debriefing groups following a resident's death, is reported.
Results. Ten reflective debriefing groups, led by the researcher (a specialist palliative care nurse), were undertaken. The groups facilitated learning at three different levels (being taught, developing understanding and critical thinking) and enabled staff to feel supported and valued.
Implications for practice. The use of reflective debriefing groups is a useful mechanism to support experience-based learning about death/dying in care homes.

Key words: action research, end-of-life care, experience-based learning, nursing homes, older people, reflection

Hospices and specialist palliative care are being encouraged to disseminate their palliative care knowledge to support people dying of non-malignant disease (DH, 2008). Care homes, and nursing care homes in particular, with up to 19% of the UK population dying in these settings (DH, 2012), are a prime area for palliative care training. However, care homes pose a very different context to that of hospices (Badger *et al.*, 2009; Kinley *et al.*, 2013). Innovative training methods in relation to care of residents and their families at the end of life, reported in this article, may not only help support care home staff but also provide a creative way of in-house training enhancing teamwork. This article reports one of the actions (reflective debriefing for staff following a death) of an action research study undertaken in two nursing care homes to develop high-quality end-of-life care as part of a PhD (Hockley, 2006). The subsequent development of a reflective debriefing tool is also reported.

What does this research add to existing knowledge in gerontology?

- Reflective debriefing groups are a mechanism to develop end-of-life care in care homes.
- The groups can build relationships between specialist palliative care and gerontology.

What are the implications of this new knowledge for nursing care with older people?

- The effect of reflective debriefing groups on staff's confidence to speak about death and dying could enhance communication with dying residents and families.

How could the findings be used to influence policy or practice or research or education?

- End-of-life care training needs to be considered as part of statutory training for care home staff – reflective debriefing groups could be one way of providing this training.
- The reflective debriefing tool subsequently developed is freely available for use (www.stchristophers.org.uk/care-homes).

Background

Care homes with nursing (NHs) now provide care for increasingly frailer people with complex healthcare needs – the majority of whom will die within 12 months of admission to the home (Kinley *et al.*, 2014). Traditionally, care homes have developed from a culture of rehabilitation with the majority of residents being sent to hospital to die (Komaromy *et al.*, 2000; Hanson *et al.*, 2002). As a result, often the dying process is not recognised, and there is a danger that dying becomes peripheral to the care home culture (Hockley, 2006).

The introduction of frameworks such as the GSF (www.goldstandardsframework.org.uk/carehomes) and the Liverpool Care Pathway for the Dying (www.mariecurie.org.uk/en-GB/Commissioners-and-referrers/Partnerships-and-innovations/liverpool-care-pathway/) has been produced to help introduce systems to improve standards of palliative care in care homes (Hockley *et al.*, 2005). However, for many young untrained staff, talking about and caring for people who are dying is frightening and a powerful trigger to their own unresolved grief (Holman *et al.*, 2011). Improving NH staff's confidence in end-of-life care and creating a learning culture in care homes towards a greater palliative care approach is complex. It requires a balance between training initiatives that support both the care home system and the staff (Froggatt *et al.*, 2011).

Reflective practice has long been a tool to help individuals increase self-awareness and confidence (Gibbs, 1988; Mezirow, 1991; Johns, 1998) and help reduce anxiety in first-year student nurses (Davies, 1995). Gamble (2001) found group debriefing following a cardiac arrest not only reduced stress following CPR attempts but led to improved coping mechanisms in individuals as well as improved team cohesion.

Group debriefing has historically been set within the battle context (Pearson & Smith, 1985). Research looking at the effect of group debriefing of soldiers exposed to combat reveals better group cohesiveness and reduced anxiety as a result of the group debrief (Shalev *et al.*, 1998; Deahl *et al.*, 2001).

Huggard (2013) explores the process of group debriefing within specialist palliative care for support of staff highlighting the difference between organisational support and the emotional/psychological support for staff when caring for dying people and their families. The GSF programme advocates the use of 'after death analysis' if you are part of their programme but primarily as an audit tool (Thomas *et al.*, 2012). However, there is no empirical research on the role of 'group reflection/debriefing' as a way of encouraging experience-based learning around end-of-life care in care homes. This article reports on data collected from ten reflective debriefing groups following the deaths of the residents in two nursing homes that were part of a larger action research study (Hockley, 2006). As a result of ongoing practice development using the findings of this action research study, a reflective debriefing tool has recently been developed and is also presented.

Method

Design

The study used an action research design to explore and develop quality end-of-life care in two nursing homes. Action research requires a flexible design because the whole process is driven collaboratively with those in the setting where the research is being carried out. The researcher characteristically engages in spirals of planning, action, observing and reflecting both individually and collaboratively (McNiff & Whitehead, 2002; Reason & Bradbury, 2008).

The context of the study

In the early 1990s, care for frail older people in the UK changed from being provided by the National Health Service to being provided by 'private' care homes (NHS Community Care Act, 1990). The provision is a mixture of 'for profit', 'not for profit' and 'charity' organisations. Further legislation 10 years later (The Care Standards Act, 2000) did away with the distinction between residential homes (no on-site nursing) and nursing homes (employing nurses and healthcare assistants). Instead, all homes were to be called care homes. The majority of care homes are care homes providing personal care; a quarter of homes are care homes with nursing (NHs). No care homes have physicians on-site. The average size of a care home is between 40 and 80 beds (Laing, 2012).

When this study was undertaken (2001–2006), <10% of NH residents in the UK had a cancer diagnosis with less than half of residents having a formal diagnosis of dementia (Hockley, 2006). Since then, the NH context has changed considerably with as many as 80% of NH residents having a degree of dementia or significant memory impairment (Alzheimer's Society's, 2013) and the majority of all residents dying within a year of admission (Hockley *et al.*, 2010; Kinley *et al.*, 2014).

Study setting

Ethics approval was given by South East Scotland Research Ethics Committee because of the sensitive nature of the subject. However, in the UK at the time of the study, research in private NHs did not require ethical approval.

Managers/owners of two private 'for profit' NHs volunteered to take part having responded to a local end-of-life care survey of 73 local NHs (Hockley, 2006). They and their staff agreed to come up with actions to improve the quality of end-of-life care which would then be implemented and evaluated. Nurse managers gave 'gatekeeper consent', that is, overall consent; staff gave consent for participating in focus groups but otherwise gave ongoing verbal consent throughout the action research study. An information sheet about the study was freely available on the office notice board in each NH.

Two main aims and objectives from the wider action research study are relevant for the reporting in this paper:

- To identify problems that staff experience in caring for a resident who is dying and how these problems impact on the provision of high-quality end-of-life care for older people in NHs.
- To examine with staff what actions could successfully be implemented in order to promote high-quality end-of-life care, and to evaluate the impact of these actions.

Data collection

A broad outline (consisting of an exploratory phase, action phase(s) and a summative evaluation phase) framed the larger study from the beginning. During the 3-month exploratory phase in each NH, the researcher worked alongside staff caring for the frailest residents alongside undertaking focus groups, interviews and the recording of fieldnotes through the use of reflective diary. Thematic analysis of this exploratory phase found two overarching themes (Hockley, 2006):

- Context issues in managing end-of-life care in NHs – including themes concerning time constraints and low morale and the need for a culture of learning.
- Clinical issues concerning death and dying – including themes concerning closed communication in relation to death/dying; lack of psychosocial care for resident/family in relation to dying; symptom control at the end of life; and anticipating the dying phase.

Data were formally and informally fed back to both NHs in order for staff to come up with suggested actions. The first inductively derived action which is the subject of this paper was the setting up of reflective debriefing groups (RdBGs) following a resident's death.

Aims of the reflective debriefing groups [RdBGs]:

- To use the experience of caring for a resident who had died as a basis for learning about end-of-life care.
- To be a place where 'death and dying' could be safely and openly discussed.
- To construct knowledge about end-of-life care of frail older people dying in NHs.

The RdBGs were led by the researcher (nurse specialist in palliative care). The sessions followed a structure for group reflection outlined by Pearson and Smith (1985) (see Box 1). The researcher verbally introduced the four main questions for the reflection. No specific written reflective debriefing tool was used; the intention was to encourage open dialogue using the oral tradition of healthcare assistants. There had been no plans for the RdBGs to be tape-recorded in order to create the least threatening atmosphere possible. However, after a number of sessions in one of the NHs, a night nurse was disappointed not to be able to attend the reflection on a particular resident. A suggestion was made that the session could be audio-taped. Staff unanimously agreed and gave their consent for all ten subsequent sessions to be transcribed and analysed as part of the research.

Box 1 Outline of verbal format for the RdBG session (adapted from Pearson & Smith, 1985: p. 72)

1 Brief résumé of resident/family whose death was being discussed
2 What happened?
  (i) Description of own and other peoples' actions/ involvement
  (ii) Different times, shifts, experiences
3 How did the participants feel?
  (i) Exploration of personal + interpersonal feelings
  (ii) Anticipation of unexpected expressions of emotion
  (iii) What was 'good' ...what was 'bad'?
4 What does it mean?
  (i) What can we learn ... how does practice need changing?

The RdBGs were held at the commencement of the afternoon shift 5–10 days following the death of a resident. This enabled staff from both the morning and afternoon/ evening shift to attend as well as night staff if they were on days off; staff that stayed on after their shift or staff that came in on their days off were financially reimbursed for their time by management.

Data analysis

Data from the ten tape-recorded RdBGs were transcribed verbatim and read and re-read to extract themes following each session. A summative evaluation capturing the whole project was undertaken using interviews for management and a questionnaire posted to all staff. For this paper, specific analysis has been made of the evaluation questionnaire with respect to the RdBGs. This analysis was compared to the emerging themes from the transcripts of the ten RdBGs. The initial coding from the RdBGs was then re-examined for content relating to themes/comments from the questionnaires and collapsed under three emerging categories.

Results

Thirty-four different staff members attended one or more of the ten RdBGs. There were never fewer than four people at a session; they mostly included six or seven staff. The sessions lasted around 40 minutes. A myriad of topics including different dying trajectories were discussed (see Table 1).

Analysis of data from the RdBGs and the summative evaluation questionnaire highlighted three core outcomes, namely an educative role, a supportive and communicative role (Table 2).

Educative role of the RdBGs

Themes from the transcripts revealed three levels of learning, namely being taught, increasing mutual understanding and becoming critical with the result that staff felt able to challenge the status quo. This third element highlighted aspects specific to the dying process of older people within the NH context.

Individual learning and gaining of knowledge by 'being taught'

Different group members took the opportunity to share their knowledge about certain aspects of palliative care including death and dying. More often than not, this was either the clinical lead, one of the trained nurses or myself taking the opportunity to pick up on an issue being discussed and directly teach about it.

'Dying' was one of the topics frequently raised. Staff wanted to know the mechanism by which frail older people came to die. McCue (1995) highlights the importance of seeing dying in old age as a natural process at the end of an older person's life that is independent of underlying disease (s). Many staff did not realise that pneumonia is commonly associated with the dying process and had not heard of it being talked about as 'the old man's friend' (a phrase coined by the physician Sir William Osler 1849–1919). Through describing actual deaths, the process of dying was regularly explored. Staff were learning from each other as they told their stories or talked about their concerns:

> ..and we noticed that his peripheries were really purple...and as we turned him over he had that sort of mottling...that purple mottling...and I just thought, 'I think he is going to die'. [Night nurse, RdBG.2.004]

Being able to talk in this way helped to make dying part of the NH culture. Staff were less scared and gradually recognised dying as a process with different stages. With trained nurses now speaking openly about these things, care assistants were learning directly from colleagues.

Many staff did not realise the importance of pro-actively talking to and supporting families through the dying process. For those families with whom it was easy to form relationships, this was not so difficult. But in many situations, staff needed encouragement to engage with different family members in order to emphasise the seriousness of the situation:

Table 1 Reflective debriefing groups

RdBG	Nursing home (NH)	Age of resident + time in NH	Topics discussed	Staff present at RdBGs
No 1	NH1	97 years [3 years; 5 months]	Dwindling trajectory; dying process; family involvement at end-of-life (EoL) decision-making; incontinence at EoL; 'natural' dying; no need of EoL medication; speaking with family but still closed communication with other residents; increasing dependency of residents	6 (nurse manager, nurse × 1, HCA × 4)
No 2	NH1	88 years [2 weeks]	Respite admission & sudden death; guilt; need of staff support; recognising dying; dying process; taking responsibility; learning through 'reflection'; breaking bad news over phone; honesty; using the word 'dying/died'; sitting with the dying	5 (nurse manager, nurse × 2, HCA × 2)
No 3	NH1	78 years [3 weeks]	Gangrenous pain; complex pain control; importance of having medical background on resident; rehabilitative vs. palliative care culture; evidence of increasing knowledge of strong opioid use; continuity of care; importance of involving the full multi-disciplinary in care	4 (nurse manager, nurse × 2, HCA × 1)
No 4	NH1	81 years [1 year; 11 months]	Dying process; premonition of death; resident dignity/choice; learning how to use 'out of hours' pharmacy for E of L drugs; importance of a clinical expert as nurse manager; taking responsibility – communication with family; sitting with a dying resident; highlighting the importance of 'dying'; appropriate use of opiates at E of L; dehydration & dying	3 (nurse manager, nurse × 2)
No 5	NH2a	88 years [1 year; 9 months]	Dwindling trajectory; anticipating dying; dying process; taking responsibility; communicating about dying; supporting young healthcare assistants (HCAs); marking the dying process; antibiotics at EoL & end-of-life decision-making; natural dying; constipation & dying; dehydration & dying; GP continuity; pain vs. agitation when dying and use of anxiolytics	6 (nurse manager, senior nurse, nurse × 2, HCA × 2)
No 6	NH2a	93 years [1 year; 10 months]	Speaking to relatives; seeing resident & family as unit of care; dying & constipation; pain assessment/management; sitting with the dying; fear of new things – drugs to control symptoms at E of L; going to funerals; pharmacists getting E of L drugs	6 (senior nurse, nurse, HCA × 3, domestic)
No 7	NH2a	98 years [1 year; 11 months]	'Unexpected' but timely deaths; premonition of death; death as celebration; natural dying; support of staff; working as a team; HCAs fear of death in NH; person-centred care; residents as 'family'; telling other residents about a death	6 (nurses × 2, HCA × 4)
No 8	NH2a	81 years [2 years]	Terminal restlessness; end-of-life decision-making & family; pneumonia as 'old man's friend'; quality of life; fentanyl patches; dehydration & dying; importance of staff communication; speaking about dying with resident despite dementia; coordinating removal of body; open communication – telling other residents; saying 'good bye'	6 (nurse manager, nurse, HCA × 3, activity coordinator)
No 9	NH2a	87 years [7 months]	Sudden death; shock/guilt; support of HCAs +; isolation of some residents – 'those who do for themselves are left to themselves'; breaking bad news of sudden death	7 (senior nurse, nurse × 2, HCA × 4)
No 10	NH2a	86 years [1 year; 9 months]	Sudden death; resuscitation; support; honesty when breaking bad news; taking responsibility; guilt over being immune to 'buzzers'; rehabilitative vs. palliative care culture; involving families in communication over end-of-life decision-making; pain	7 (senior nurse, nurse × 2, HCA × 4)

The other thing I learnt from [this situation] was the difficulty that sometimes you have to get through to the family. I mean, I spoke to her daughter on a number of occasions and she couldn't accept the fact that things were serious. And she said, 'She has had two strokes before and she's having another one – she'll be fine!' …. eventually I had to speak to the brother on the phone…he came up and spent a lovely week-end & brought the grandchild … I am so glad because it was only a couple of days after that that she died. But it was very, very difficult to speak to these people. [Management, RdBG.4.012]

Table 2 Core outcomes of reflective debriefing groups (RdBGs)

CORE OUTCOMES of the reflective debriefing groups	
Educative: experience-based learning	1 Individual learning and gaining knowledge – *'being taught'* 2 Mutual understanding of end-of-life care –*'developing understanding that influences practice'* 3 Critical knowing & adding to a theory of end-of-life care – *'challenging the status quo'*
Supportive	Opportunity to share together some of the difficulties surrounding death & dying
Communicative	Aiding communication across the nursing home among the different personnel involved in the care of the very old at the end of life

There was considerable teaching, during the RdBGs, on symptom control during the last days of life. Many of the nurses taking part in the sessions thought that an opioid was the only drug used. This meant that often agitation in a dying resident was treated inappropriately with an opioid rather than an anxiolytic. The RdBGs became a forum for this knowledge to be shared and misunderstandings corrected.

Mutual understanding of end-of-life care: 'developing understanding'

The RdBGs were a place where increasing understanding of end-of-life care was expressed. Nurses became aware of their pivotal role to orchestrate good end-of-life care. Even when a nurse had not questioned the doctor, it was felt that being able to verbalise feelings about what one should have done was embedding new thoughts of how to do things differently in future:

> ..my instinct was that he was going to die because as soon as I had seen this mottling on his back I thought, 'Now that is his peripheries'. . .you know. I really did think. . .and I nearly said to the doctor, 'Don't you think he is going to die?'.. . .but I don't know why I didn't. Maybe I thought, she knows best! . . .I wish I had actually. . ..I wished I had afterwards. I should have. [Night nurse, RdBG.2. 007]

Staff began to understand more readily the importance of taking responsibility and to anticipate dying within the deteriorating trajectory. It happened in both NHs:

> 'You see in the past what has been different is that the doctor has suggested something and we go along with it. . .. That's the big difference. *We* should now be thinking, 'Right, what is our opinion of what should be happening?' [Nurse, RdBG.3.026]

Staff were being given the opportunity to learn together, not just about the resident's needs, but also about those of the family. It was rewarding to hear care staff say quite spontaneously in the RdBGs what they had been learning from the impact of the wider study:

> Yeh! I think that is something that I have picked up with this. . .project. . .is the relatives. You know, appreciating Hilda's daughter, you know. . .because you can get involved in the resident. . .you are caring for them, and you say, 'Oh yes, come in' but when it comes to talk. . .I used to think I'll just get out the way and go away. But . . .no, no, I'll stand and I will speak now rather than just going on. I'm just sort of thinking about it now. [Care assistant, RdBG. 1.014]

Once learning is internalised, it is more likely to impact on the individual's practical work (Johns & Freshwater, 1998). Because there was this sense of analysing and reflecting back on a resident's death, staff in the groups (including myself) were gradually beginning to critically analyse a number of assumptions and issues. We were building knowledge together about end-of-life care that was specific to frail older people rather than imposing a model from specialist palliative care.

Critical knowing – 'challenging the status quo in end-of-life care'

In some of the RdBGs, there was a clear indication that those present were beginning to re-think critically the care given to those of their residents who were dying. Subjects were being discussed that began to challenge the end-of-life care culture within the NHs. One such aspect was the use of the word 'dying' (see Box 2).

This discussion, started by a young care assistant, had an enormous impact not only on the group and their reaction or non-reaction when a resident was dying, but also on me. I was beginning to see the importance of using the word 'dying' within the care home setting.

The use of antibiotics for chest infections and especially pneumonia in frail older people with advanced dementia gave mixed messages about dying. Gradually, staff themselves were beginning to find confidence to challenge their use:

> I worry about the amount of antibiotics given in this home. . ..I know that there are different situations, but I really feel that certain people whose condition is not. . ..hasn't got a good quality of life. . . I feel we are just prolonging the agony. . .. . ..I do worry about the amount of antibiotics. . .when I am taking report – I am only in one night a week – there will be six or so people each week on a new antibiotic. . .for the 4th. . .5th time. [Night nurse, RdBG.8.007]

Antibiotics were not the only resuscitative measure that was queried. There was no resuscitation equipment in either

Box 2 Developing 'critical thinking'

CA1 : We were told that she was deteriorating, but we weren't told she was actually 'dying'. So I mean. . .that was a shock to me because I've just been off for 2 days, I have just come back today.

JH : So, it is something about using this word 'dying' that is quite important?

CA1 : It is for me!

CA2 : . . .for everyone to use the word 'dying'

SN : I thought she was just declining

CA1 : Even when you think someone is deteriorating, you think they are just going to 'bounce back'

CA2 : For me 'deteriorating' & 'dying' are two different things. [RdBG.5]

NH. Some care assistants verbally acknowledged they found it difficult to accept that someone with advanced dementia should not be resuscitated if they unexpectedly collapsed and died from a heart attack. Many staff had not considered dementia as a terminal illness.

The use of opiates was also being challenged:

> I felt she didn't need oramorph – she didn't appear in pain. But even if she did settle when [the GP] came in I wanted something that she could have if she needed it. So she had Diazepam 2 mg.. . .. . .I know you were going along the lines of oramorph but I thought I don't want to 'zonk' her out completely and not have her drinking at all. Whereas the diazepam – a small amount settled her and it was enough to settle her to let her lie.. . .. . ..and [two care assistants] sat and read to her all afternoon.' This resident died 12 hours later. [Nurse, RdBG. 5.021]

It was encouraging to witness the skill of an experienced staff nurse who had worked many years with frail older people. Morphine was often what GPs wanted to prescribe and often what came first to my mind because of my work in specialist palliative care. However, I realised how important it was for this nurse to be challenging its use. An opioid in an elderly dying resident, especially someone with advanced dementia who had no pain and was likely to be dehydrated, was a significant threat to a peaceful death.

Supportive & communicative role of the RdBGs

There was evidence that, as well as fulfilling an educative role, the RdBGs fulfilled both a supportive *and* a communicative role among team members. Many staff benefited from being able to open up about personal losses. In one particular case, the nurse manager had previously tried unsuccessfully to encourage one of her staff to attend professional counselling because of a previous unresolved bereavement. Through regularly attending the RdBGs, the staff member in question felt safe enough to gradually open up about his own situation with considerable benefit to both him and the rest of the staff.

Three RdBGs were held following a 'sudden' death (see Table 1). These took on a different stance where there was a greater emphasis on staff needing to talk about their feelings, and share the awfulness of certain situations. There was a sense that re-telling the story formally to others gave staff permission to 'let go'. There was the need to try and make sense of the situation for those who had been faced with such an ordeal. Some nurses carried a sense of guilt when they felt there was something that they might have done differently, even thinking that perhaps they could have been able to do more:

> 'But I must admit I felt. . . I have to be honest. . .I felt a bit . . ..like. . .she died without us being able to do something for her. I did feel initially that maybe I should have. . .could have done something else, but there wasn't anything else to do.' [Nurse, RdBG.1.013]

Part-time and night staff found the communication aspect of the RdBGs extremely helpful. Many appreciated the sessions because of finding out in detail what had happened to a specific resident and how they had died. After a very difficult situation where a resident reacted to a sedative being used in the last few days of her life, one of the night staff nurses came to the session specifically to find out what had happened. She had needed to know that the resident in question had in fact died very peacefully and commented on her evaluation questionnaire:

> 'It was helpful to attend the debriefing so that I could hear that she had become more settled at the end of her life even though I didn't see her.' [Night nurse, evaluation questionnaire]

Evaluating the summative questionnaires

In one of the NHs, there was a large staff turnover and only nine questionnaires were sent out; however, a good percentage of questionnaires (78%) were returned. In the other NH, 35 questionnaires were sent out with a 54% response rate. Out of the usable questionnaires returned, 22 evaluations concerning the RdBGs were complete. Forty-five per cent of staff (10/22 staff) felt that the RdBGs were extremely effective rating the sessions between 8 and 10/10 (see

Table 3). Four nurses rated them as 4/10 with two of the nurses commenting that they did not feel they needed support as they felt that a resident dying was a natural part of life. Many care assistants found that the RdBGs provided a legitimate opportunity where time was given to share ‘feelings’. The word ‘feelings’ was a word repeatedly used in the evaluation questionnaires (see Box 3).

Box 3 Quotes from healthcare assistants (CA) concerning supportive nature of RdBGs

> I feel it was really helpful to be able to talk about our feelings before and after. It was a great relief [CA3, evaluation questionnaire, NH2a]
>
> Being able to discuss events leading up to death and death itself. Realising that one is not alone with these feelings [CA1, evaluation questionnaire, NH1]
>
> It gave me a chance to express how I felt after a resident had died [CA1, evaluation questionnaire, NH2a]

Initially, not all staff were confident about the RdBGs when they were first introduced. One nurse declined to come to any of the sessions saying that she knew about death/dying. One area of conflict that arose in one of the NHs, both in the returned questionnaires and in fieldnotes, was the time allocated to RdBGs. One senior nurse found that ‘many sessions were very lengthy and that the time given to the sessions detracted from the care of current residents’. When only 10 minutes was given to the daily handovers between shifts, a 45-minute RdBG seemed a very long time to speak about one resident’s end-of-life care. However, in the same NH, the owners, neither of whom had a nursing background, reported:

> ‘Those [RdBGs] were good! That has been the big thing, and they have…we have had one since the last two [residents died]…I think it was [senior nurse] that got it organized… that is one thing that I would definitely like to encourage, because I think that helps. I think it gives the care assistants in particular and some of the RGNs…er…the confidence that they are doing the right thing. It is one thing ‘thinking’ you are doing the right thing – it is another thing ‘knowing’ you are doing the right things…It is reviewing that depth. And if somebody has got a feeling that, ‘well, I think that we should have done [such and such]..’ they get the chance to say it. I like them to be involved….you know…and it makes me feel that they are being given the chance to say their bit…everyone wants to say their bit’. [Management 001, evaluation interview]

A senior nurse who came regularly felt the sessions gave an important opportunity to show staff that they were valued for the work they did. Being involved in the groups helped her understand more fully how staff were really feeling over the death of a resident:

> ‘[They] gave a valuable opportunity to the manager to hear first hand from a group of workers their thoughts and feelings on a death. It gave scope for reflection on practice and provided a safe environment for staff to make their views known. From this future training/planning could be formulated. It also valued staff which I feel is extremely important in this field of work’. [Management 002, evaluation interview]

Discussion

This study reports two important findings: firstly, the different levels of learning that occurred within the RdBGs and, secondly, the emotional support that staff experienced as a result of the RdBGs enabling them to speak more openly about dying.

Pearson and Smith (1985) discuss ‘group debriefing’ within a context of experience-based learning. They suggest that, depending on the way the group is facilitated, there are three different ways people learn (didactic, experiential and critical thinking). In this study, the researcher was an experienced nurse specialist in palliative care and was able to draw out all three ways of learning into the RdBGs. However, a less skilled person might find this difficult.

Table 3 Summative evaluation of RdBGs

	Trained nurses responding to summative evaluation of RdBGs				Care assistants responding to summative evaluation of RdBGs				
Score	10/10	8/10	6/10	4/10	10/10	8/10	6/10	4/10	Total number of staff
NH1	–	1	3	–	2	–	1	–	7 staff
NH2a	2	2	1	4	3	–	3	–	15 staff
Total	2	3	4	4	5	–	4	–	22 staff

Casey *et al.* (2011) highlight the importance of an open culture towards death and dying in care homes in order to provide good end-of-life care. The RdBGs not only enabled a greater openness towards death and dying, but encouraged staff not to use euphemisms such as 'deteriorating' or 'more poorly'. If such euphemisms are used when a person is really dying, staff believe the resident will 'bounce back' and subsequently families can receive confusing messages. There is still much fear in using the word dying. The recent independent review by Neuberger *et al.* (2013) of the Liverpool Care Pathway (LCP) – More Care Less Pathway– is a case in point. The committee found that the word 'LCP' or 'putting them on the pathway' had often been substituted for an open discussion about death/dying.

The opportunistic learning that occurred during the RdBGs around a myriad of relevant aspects would unlikely be covered through a regular teaching course. Care assistants in particular found the groups relevant to their immediate practice with the oral tradition of untrained care assistants being harnessed (Braun & Zir, 2005). Nolan *et al.* (2008) highlight the benefits of in-house training in care homes creating a sense of ownership and shared vision. Storytelling, which was very evident in the RdBGs, is an ideal medium for individuals and group learning (Foyle, 2010). The RdBGs not only enabled staff to tell their stories but also enabled staff who had experienced distressing incidents to leave them within the group rather than holding on to them.

This study highlights that most staff valued the opportunity to formally discuss deaths of residents they had cared for, opening up about their emotions and helping staff clarify personal and cultural beliefs about end-of-life care. Many care home staff still avoid discussions about death and dying (Wowchuk *et al.*, 2007; Österlind *et al.*, 2011) often believing that death is a failure to care. Young people, attracted to NH work, often do so from a desire to help older people – to wash, dress and help them with their meals. However, work in NHs is considerably more demanding. Gone are the days when residents admitted themselves to a home for companionship. NHs are now places where a fifth of the UK population die (DH, 2012; Shah *et al.*, 2013). It is a surprise that end-of-life care is not part of the statutory training for care homes. The RdBGs helped young carers to grasp the importance of end-of-life care. They encouraged staff not to shy away from such responsibility and to seek support from others.

The RdBGs could have unwittingly been a substitute for the lack of inclusive team handovers in both NHs. Hopkinson (2002) highlights the vital role handovers play in the support of staff caring for dying patients. The RdBGs appeared to directly challenge the often task-orientated focus of care which militates against the person-centredness of many care assistants who work in care homes. Caring for frail residents over many months strengthens an emotional bond between resident and carer that is unique to care homes (Hanson *et al.*, 2002).

Different ways of using reflection to increase knowledge and help bring about change, such as action learning sets (McGill & Brockbank, 2004), had been considered for this study. Action learning has been used to provide appropriate end-of-life care training and support in care homes (Hewison *et al.*, 2011). However, action learning would have limited the number of people who could have attended. In this study, the exploratory phase had highlighted the need of support and learning for nurses *and* care assistants. Care assistants play an important part in end-of-life care because they have often cared for the resident(s) for many months, even years. They can feel excluded when nurses 'take over the care' when a resident is dying (Hockley *et al.*, 2005). Being inclusive of all staff, the RdBGs not only addressed a gap in staff's knowledge about death and dying but helped to increase cohesion across the whole care home team. Further research to see whether RdBGs have the potential to reduce staff turnover as a result of staff feeling more supported would be interesting.

There were limitations to this study. The sessions were led by someone with many years experience in specialist palliative care, addressing any topic that emerged without difficulty and thus promoting palliative care knowledge within each group. If they were led by a nurse manager or someone with less palliative care experience, the content/angle of the RdBGs would likely be different. Nonetheless, the supportive and communicative aspect of the groups would still help staff feel valued for this important work that they do. Secondly, this was an action research study in just two NHs, and although the RdBGs were inductively derived by the staff, the results are not generalisable. Further testing using the tool developed subsequently would be useful. A further limitation is that care home shift patterns are changing. Many NHs now have 12-hr shifts because of increasing financial restraints – this may make in-house training during the afternoon more difficult. Finally, the number of evaluation questionnaires returned was limited because of the transience of staff. The reliability of using questionnaires in care homes as a way of collecting data has also been questioned (Redfern *et al.*, 2002).

As a direct result of this study and the further use of RdBGs in practice, a reflective debriefing tool has been created (see Box 4). The tool incorporates the Gibbs model of reflection (Gibbs, 1988) and Pearson & Smith's experience-based learning model (1985). It is currently being used by the Care Home Project Team at St Christopher's Hospice across the 71 NHs in their catchment area (www.stchristophers.org.uk/care-homes).

Box 4 Reflective debriefing tool

REFLECTIVE DEBRIEFING

Adapted from Gibbs' Model of reflection (1988) & Pearson & Smith experienced-based learning model (1985)

Reflection no:………..   Date:…….…………

Reflective debriefing is the process whereby clinical practice can be re-examined to foster the development of critical thinking and learning for improved practice. The process is on-going with each debriefing and should be viewed as an aid to lifelong learning rather than single processes.

1. Describe the person/event.
Encourage all in the group to recall their memory about the person/event – such as:
Person: What were they like, what did they like to do? Did they have family? Who was important to them? What did they like/dislike? Were they humorous/serious/sad/angry? What were their perspective on what was happening? Were their fears/anxieties?
Event: What was the event? who was involved?

2. What happened leading up to the death/event?
Describe what happened for individuals on the various shifts that led up to the death or event

3. How do staff feel things went?
What went well? What didn't go so well? How did people feel about this?
Both positive and negative feelings should be described and owned. Feelings can be a very useful guide to how learning is progressing so whilst it is important to be honest it is also important to respect others feelings.
Look in detail at the decisions that were made – this will help you to understand what else could/couldn't be done. Opinions of others will help in this process. Remember to reflect on what was hoped and planned for, the original aims and objectives i.e. in the event of death was the LCP used, anticipatory drugs in place, symptoms controlled, family supported and informed, spirituality addressed - were they in the place of their choice, was the DNaCPR and ACP completed.

4. What could have been done differently?
Existing knowledge can be built on or restructured by theorising about what could have been done differently. In order for this to be effective critical thinking in a safe learning environment is essential with a 'no blame' attitude.

5. What do we need to change as a result of this reflection?
Key learning points can be listed and any action plans needed to enhance learning/more appropriate care. This might be a change in or re-writing of a policy, further chats with GP/CNS in order that in the future the problem being discussed does not occur again, or it may highlight a need for training. It is essential that these learning points are not just logged but acted on.

Each reflection can inform practice and should be used not only as a building block to learning but as a celebration of good practice. Reflection is not a passive contemplation but an active, deliberate process that requires commitment, energy and a willingness to learn as a team.

1. **Pen portrait of person or event**

2. What happened leading up to the death?

3. How do staff feel things went?
a) What went well?

b) What didn't go so well?

4. What could we have been done differently?

5. What do we need to change as a result of this reflection?

Further research using this tool and its subsequent effect on practice and staff support/tenure would be useful.

Conclusion

This article details the use of reflective debriefing groups (RdBGs) following the death of residents as part of a wider action research study in two nursing care homes. The groups provided a unique way of learning, giving staff the opportunity through reflection to 'tell the story' of what happened to residents during their last days. The learning that took place occurred at three levels: being taught, increasing understanding and critical thinking. Formally exploring together different feelings and ideas about individual deaths began to change the way death and dying was managed providing an opportunity for support and training. Such RdBGs, led by a local palliative care nurse, may be a good way of building relationships and supporting staff in care homes without on-site nurses. As a result of the success of ongoing groups, a specific reflective debriefing tool has been developed.

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Implications for practice

- Reflective debriefing sessions help support care home staff in their care of residents at the end of life which may in turn help reduce staff turnover in care homes.
- Learning from practice through reflection can be a powerful teaching tool.
- Involving specialist palliative care to help lead reflective debriefing sessions may bridge the gap between care homes and hospices.

Contributions

JH was the responsible for the whole study design, data analysis and manuscript preparation. Deborah Holman helped to design the RdBG tool in Box 4.

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