Providing End-of-Life Care in Care Homes for Older People: A Qualitative Study of the Views of Care Home Staff and Community Nurses

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Abstract
The study aimed to explore the views of care home staff (CHS) and community nurses (CNs) on providing end-of-life care (EOLC) in care homes. Participants were randomly selected and qualitative interviews conducted with 80 CHS and 10 CNs. Themes emerging from the data included the following: The meaning of EOLC; starting EOLC; dying in the care home; stress of providing EOLC; improving EOLC; and the role of the CN. CHS felt that planning for the end of life was important before residents reached the dying phase, which some found difficult to determine. Although CHS wished to avoid residents being transferred to hospital to die, they acknowledged that improvements in their skills and the resources available to them were needed to manage EOLC effectively. CNs were critical of the EOLC provided in some care homes, reporting tensions over their relationship with CHS. As the number of older people who die in care homes increases, there is a need to overcome these barriers to provide good EOLC.

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Introduction
In view of the worldwide ageing of the population, an increasing number of older people will be cared for, and die, in care homes, giving these institutions an important role in the delivery of end-of-life care (EOLC). According to U.S. data, which are reflective of patterns observed in other developed countries, 40% of the population can be expected to die in a care home, a rise from 25% in 1994 (U.S. Department of Health and Human Services (HHS), 2001). Furthermore, increasing numbers of residents who are frail and suffering from a multiple range of complex medical conditions are being admitted to care homes (National Care Forum, 2006). The prevalence of cognitive impairment is high, and the number of people with dementia requiring EOLC in long-term care settings is rising (Reilly et al., 2006). There has been a growing recognition that providing EOLC is relevant for older people residing in care homes (Hallberg, 2006; Kristjanson, Walton, & Toye, 2005). End-of-life care for older adults has been described as follows:

. . . an active, compassionate approach that treats, comforts and supports older individuals who are living with, or dying from, progressive or chronic life threatening conditions. Such care is sensitive to personal, cultural and spiritual values, beliefs and practices and encompasses support for families and friends up to and including the period of bereavement (Fisher, Ross, & MacLean, 2000).

Based on the high levels of frailty, cognitive impairment and complex medical needs of older people living in care homes, meeting the EOLC needs of this population is a high priority.

Despite this, there is concern over the standard of EOLC in care homes. This is an international issue, as studies from the United Kingdom and the United States have suggested the quality of care for older people living in care homes is inadequate, and that residents have unmet needs at the end of life (Addington-Hall & Higginson, 2001; Fahey, Montgomery, Barnes, & Protheroe, 2003; Reynolds, Henderson, Schulman, & Hanson, 2002). In the United States, previous research in this area has shown that symptom management at the end of life is suboptimal in care homes for older people (Hanson et al., 2008). Similar issues, particularly related to pain management, have been reported in the United Kingdom (Barber et al., 2009; Kinley & Hockley, 2010). Moreover, it is well documented that EOLC knowledge is often limited in care homes (Katz, Komaromy, & Sidell, 1999; Komaromy, Sidell, & Katz, 2000; Wowchuk, McClement, & Bond, 2007).
Managing the needs of older people reaching the end of life in care homes is a major international challenge. It is important to understand the differences and specific challenges concerning EOLC in the different types of care homes. In the United Kingdom, there is a distinction between long-term care facilities that provide nursing care and those that provide personal care only. One important difference is that care homes providing personal care only are likely to be highly dependent on the support of community based health care professionals visiting the care home, for example, community nurses, who can make an important contribution to EOLC in these settings (Davies & Cripacc, 2008; Goodman & Woolley, 2004). However, little is known of their views on EOLC in care homes. The aim of this study is to explore the views of care home staff (CHS) and community nurses (CNs) on providing EOLC in care homes for older people.

**Method**

**Participants**

34/38 (90%) of care homes providing care for older people (65 years or older) in two London boroughs took part in the study: 16 registered for personal care only, nine for nursing care (one was an National Health Service Community Unit), and nine dual registered (care homes providing both nursing and personal care). Care home size ranged from 4 to 128 beds. Interviews were conducted with 80 CHS: 33 managers (one managed two care homes), 29 care assistants, and 18 nurses employed by the care homes. Interviews were conducted with 10 community nurses who visited care homes for older people in the area. The research was approved by the King’s College Hospital Research Ethics Committee (REC Ref: 07/Q0703/89). Informed consent was obtained from all participants.

**Procedure**

We randomly selected care assistants and nurses from staff lists. If an individual declined to take part, another was randomly selected from the list until there were no more names on the list. We were unable to recruit five care assistants and two nurses employed by the care homes during the data collection period of the study.

For the 14 care homes with personal care only, managers provided contact details of the centre from which CNs who visited the care home worked. We asked centers to provide a list of all CNs that visited the care home and we randomly selected CNs to take part. If no CNs were available from a particular centre, we invited them from other CN centers. We made follow-up calls to potential participants who did not respond within a week.
Data Collection

In-depth semistructured qualitative interviews were conducted, covering the following: (a) views on EOLC; (b) initiation of EOLC; and (c) perceived improvements and barriers to providing EOLC. A topic guide provided a flexible framework for interviewers to explore participants’ views. Interviews ranged from 30 to 60 min, and for the CHS, took place in the care home in the most private place available. For CNs, interviews were conducted in their place of work (the CN centre where they were based). Interviews were usually conducted face-to-face, however three participants preferred telephone interviews. Most interviews were audio recorded and transcribed verbatim, however nine participants preferred not to be recorded. In these cases, detailed notes were taken by the researcher during the interview, which were later validated by the participant.

Analysis

The framework method of qualitative analysis (Ritchie & Spencer, 1993) was used to explore the views of participants. This comprised five stages: (a) familiarization; (b) identifying a thematic framework; (c) indexing; (d) charting; and (e) mapping and interpretation (Table 1). The authors selected quotes for inclusion within the findings that best captured the essence of the theme presented.

Findings

The response rate for care assistants was 29/50 (58%), for nurses employed by the care home 18/28 (64%) and for community nurses 10/20 (50%). A number of themes regarding views on EOLC emerged, which were grouped under six categories: (a) the meaning of EOLC; (b) when to start EOLC; (c) dying in the care home; (d) stress of providing EOLC; (e) views on how to improve EOLC; and (f) the role of the CN.

The Meaning of EOLC

Many CHS from both types of homes (nursing and personal care only facilities) felt that constant care and attention for residents who were at the end of life should be central to their care provision. There was recognition that dying residents have greater needs and they wanted to give “their very best” by increasing observation and monitoring of a resident’s condition. Management of the physical symptoms and ensuring comfort in those final days was considered important, in particular
effective pain relief. The prevention of pressure sores and dehydration was also discussed by some, along with the nutritional requirements of residents and maintaining personal care at the end of life:

I mean for us here, when somebody is dying, not that all the time you don’t focus on them, but at that time they are our number one priority, to make sure that they are comfortable, you wet their lips to give them the good fluid, turning them when they should be turned. And we continue to monitor them so the standard doesn’t drop (Manager, home with personal care only, CM9).

This was echoed by the CNs, who felt that high-quality care focusing on the management of pain and other symptoms was needed.

Table 1. Stages of the Analysis

(a) Familiarization: The transcripts and field notes were read thoroughly by the authors.
(b) Thematic framework: The thematic framework was developed when the first 20 interviews had been conducted. All authors repeatedly read these interview transcripts. The authors met to discuss the possible themes emerging and created an initial thematic framework. This was developed inductively (themes arising from the participants views). Initially, to establish the reliability of the framework, the 20 transcripts were indexed by two authors independently using Nvivo 7, who later met to compare the indexing. Where the coding differed, the authors discussed these differences until agreement was established on where the particular text should be indexed. At this point, the thematic framework was modified, themes were reviewed, resulting in similar themes being clustered together accordingly for a higher abstract level of analysis. Based on discussions, new themes were created. This provided the basis for the rest of the analysis.
(c) Indexing: The thematic framework was then systematically indexed to all data, and as a further measure to establish the reliability, another author checked the indexing. The authors met and discussed any disagreements until agreement was established on where particular text should be indexed.
(d) Charting: Charts were created for each of the themes identified. These contained participant’s quotes to enable comparisons between participant views, and allowing a visual aid to better organize the analysis and establish patterns within the data. This analysis was an iterative process, as modifications were made to the coding framework, both at the indexing and charting stages.
(e) Mapping and interpretation: Finally, the findings were interpreted and linked back to the literature.
Many CHS across the different care homes described a compassionate and devoted style of care, where staff engage and connect more intensely with dying residents: “. . . if somebody is dying, you definitely need to give them love” (Care assistant, nursing home, CA5). The emphasis on tender loving care was strong, and staff described spending more time with dying residents: “. . . I think we get a good rapport with the resident and just give tender loving care, like my carers on this floor, somebody’s dying, they would be there with that resident all the time” (Nurse, dual-registered home, N13). The Key Working system operating in some care homes (CHS allocated to provide care to a specific resident) was seen to facilitate the close connection that developed between staff and residents.

Emotional support for relatives was seen as important across the different care homes, both during the dying phase and in their bereavement. Staff described trying to ease relative’s fears and anxieties and simply being available to listen when necessary:

Relatives want to talk, and I tend to do the listening and let them talk. So it’s like they are telling you all the wonderful things that the person was like in their life, and now that they have gone to rest they probably feel “well I need to talk to somebody” (Manager, nursing home, CM23).

CHS also discussed practical support for families, such as offering them facilities for overnight stays and assisting with funeral arrangements.

When to Start EOLC

The interviews uncovered a range of different views on when end-of-life care should commence for residents. For some CHS across the different types of care homes, living in a care home was synonymous with being at the end of life, and as such an EOLC approach was relevant early on. It was felt by some that an EOLC approach should be implemented before the terminal phase, and these CHS stressed the importance of establishing EOLC preferences and encouraging advance care planning (ACP) discussions around the time of admission:

In terms of end of life care I think we should be planning toward it all the time, so when our residents come in, I think we should try and establish their needs, their wishes, their understanding of the care that could be provided. The planning is relevant early on (Manager, dual-registered home, CM15).
For some, ACP was seen as necessary to establish preferences before residents become too ill or cognitively impaired to communicate their wishes. However, some felt this might result in residents believing that they are entering the care home to die, or that they are about to die.

CHS described a variety of indicators of transition to the terminal phase. Increasing frailty or visible signs of deterioration were often described as cues to initiate terminal care across both types of care homes: “. . . Well as soon as you see the resident deteriorating, you need to put in more observation, give an intense care” (Care assistant, dual-registered home, CA18). Some nursing care homes also described the use of a prognostic indicator to help determine whether a resident is actively dying. Others felt that an important cue came directly from residents: “. . . If somebody themselves is telling you that they feel they are dying, because they often know better than the professional, then it might be appropriate to look at what their needs are” (Manager, dual-registered home, CM15). Recognizing when a resident was in the terminal phase was particularly difficult for care homes providing personal care only. Staff in these care homes described their dependency on outside agencies to help with this, often because some felt that they did not have the necessary clinical skills: “. . . I’m not a medical person, I would have to be told by a medical professional that, yeah, is the end. So you would have to get the professional to say “ok this is the end of life” (Manager, home with personal care only, CM14). CNs felt that initiation of EOLC was relevant for residents after considering the stage of illness, or when the resident is showing the signs of entering the terminal phase: “. . . It means caring for people who are very ill, terminally ill and perhaps likely to die perhaps, ooh, I don’t know, perhaps two weeks, three weeks, four weeks sort of time, quite short time” (CN1).

Dying in the Care Home

For many staff across the different care homes, the care home was seen as the preferred place of death for residents. They were reluctant to transfer dying residents to hospital as they felt that remaining in familiar surroundings would help provide residents with peace and comfort:

I think that just because we are familiar—they know us [the residents]—they feel more comfortable here and sometimes you’ve got to be a very intrusive carer when somebody gets toward the end of life. I’m sure for a lot of them it’s nicer to have a person they know and care about them, than somebody maybe they don’t know, because even in hospitals it can’t be the same nurse all the time, and I think it’s probably more personal because it is home. I’m not suggesting that hospitals don’t care, but it’s a completely different sort of environment isn’t it (Manager, home with personal care only, CM1).
Some CHS felt that residents often die shortly after being transferred to hospital and in these instances they often die alone:

It’s better than being admitted to hospital—may be hours on a trolley and maybe even a chance of passing away on that trolley. So our whole aim is to, obviously you have to take into account the persons wishes, but what we try to do, is actually the end of life actually takes place in familiar surroundings (Manager, nursing home, CM27).

**Stress of Providing EOLC**

CHS across the different care homes felt that providing EOLC was stressful, which affected their ability to cope with providing EOLC. Their concerns mainly focused on (a) dealing with families; and (b) the impact of the resident’s death on staff.

When dealing with the family, staff described the notion of “relative control,” referring to the influence family members may have on the care that residents receive at the end of life. Some described relatives as a barrier to a peaceful and comfortable death, and they reported their frustration with families repeatedly demanding a resident be transferred to hospital when death was imminent. They described how families intervene and often change their mind at the last minute regarding hospital transfers:

Sometimes we have relatives who, at the last minute they change their minds, and they think that the hospital will be the best place for their relative to go. So that’s a big barrier, and because the person may not be in a position to say yay or nay . . . and the relative has control, so we let them go. But then, we know that they’re gonna go and they’ll be on a trolley, and before sometime they even get into bed properly, we get a phone call that they have passed away, which is not nice, that’s a big barrier (Manager, dual-registered home, CM31).

As described earlier, some staff develop close relationships with residents, which can result in a sense of loss when the resident dies. The impact of this was described by some as similar to losing a family member:

In the NVQ, they say you mustn’t try get too close to residents. It’s very hard not to. Because like for me, I’m here 18 years, and there is residents here, next year she’s 100, she’s here 19 years, you going to tell me now after being with one residents like, she is like a mother, a grandmother, everything to me
and so am I to her. How can I not get close to her? They come like part of your family, and when it’s seeing them on their last, many times I break down and cry (Care assistant, home with personal care only, CA9).

**Views on How To Improve EOLC**

CHS across the different care homes acknowledged that improvements in EOLC were much needed. They described lacking the skills, experience, and confidence needed to deal with death and dying. Despite this, CHS appeared to hold a strong desire to improve their skills and EOLC provision. To provide EOLC that meets the needs of the residents, staff identified a range of opportunities for improvement, including the following: Clinical education; resource allocation; and access to additional staff. Differences between the care homes were noted. For nursing homes, the need for education around the management of pain was prominent, with staff reporting issues around identifying and dealing with pain, particularly for residents suffering from dementia. For care homes with personal care only, the lack of resources was a barrier to effective EOLC. Concerns focused on having no trained nurses employed by the care home, and care assistants being unskilled and lacking in confidence. The manager of one care home highlighted the need for more training around understanding the principles of EOLC: “... I’d like to train the staff to understand what end of life care is all about” (Manager, home with personal care only, CM19). Better access to equipment was viewed as fundamental to improving EOLC provision in care homes providing personal care only, as their current facilities were described by some as inadequate:

> I don’t think we have the facilities here, because as I said, we don’t have drips or anything, because it’s a residential home, we don’t use pumps and all these things. You know it’s a different sort of thing from hospital setting or a nursing home (Care assistant, home with personal care only, CA12).

For many CHS across the different care homes, the need to feel more comfortable in discussing death was frequently stated, with recognition that EOLC could be improved by normalizing death and dying. The interviews uncovered a certain degree of trepidation in CHS engaging in such conversations, often associated with the following: Culture; feelings of embarrassment; fear; and lack of confidence in discussing death and dying. Staff sometimes felt that the terminology used in EOLC, perpetuated this uneasiness: “... I think for many nurses and carers, to use that phrase ‘dying’ or ‘end of life’ is quite difficult for them” (Manager, nursing home, CM3).
For those who had received training in EOLC, this was often brief, and considered by some as insufficient:

Somehow you get one study day and you’re supposed to be an expert in what took other people months and months to learn and to do their palliative care course, but somebody sent on a study day is supposed to know everything (Manager, dual-registered home, CM15).

Although some CHS wanted more training in EOLC, there were perceived barriers to this, including, limited availability of educational seminars; the logistics of attending any externally run courses while still staffing the home; and simply not being offered training:

Unfortunately the manager cancelled it [training in EOLC]—no I’ve never had one. Yeah it was cancelled. Because it is our manager he says “Nah nah nurses should be the ones doing this.” Most of the time when they patient dies you know, we carers, we’re involved. So we need to go for this training. Everybody in the care home should go for the training (Care assistant, dual-registered home, CA21).

CNs felt that although some care homes are “doing a good job,” suboptimal care provision delivered by untrained care staff was still a concern. The quality-of-care assistants was discussed and improvements deemed necessary in their ability to meet the end-of-life needs of residents. In particular, some felt that, although the care assistants are able to conduct personal care adequately, more complex tasks such as symptom control were not conducted well, especially at the end of life. Improving the standard of this care was seen as essential:

Well, pain management, I mean they [care homes] will seek help. I feel that they’re more into personal care, making them comfortable, washing, dressing, clean sheets, rather than the whole holistic, what the patient there needs—they’ve got fears. I think there needs to be, you know, symptom control, whether it’s nausea, vomiting, dermatitis, symptom managing more effectively I think, and picking up on it a lot sooner rather than it becoming an issue, and then dealing with it. I think that’s what I tend to find as well. I think about symptom management and I think that’s an important thing because it’s hard to recognise symptom management, and how it’s managed is going to be different to how a non-palliative care patient will be managed (CN16).
The CNs felt problems were often overlooked by CHS:

Most of the carers are not trained at all, they are not trained to observe for any problem that will leave them to call an ambulance. They need to be well trained, they can’t just employ a carer in a care home for elderly people, they [the residents] need a lot of support and the support is not there. Sometimes they just leave them because they don’t know what to do. So I reckon that these carers need to be trained, so that they’ll be able to provide the necessary care when it does happen (CN17).

Some of the CNs felt that, as a direct result of lack of knowledge, more unnecessary hospital admissions are made as the care homes are less confident in managing the residents at the end of life:

In care homes they have a tendency to just admit them to hospital don’t they? I think the staff is a bit scared of handling palliative care, and I think they don’t realise that we’re at hand, and we’re available to help. I think that if someone gets really ill, they just ring 999 don’t they? Send them to hospital (CN22).

Although CNs acknowledged EOLC could be improved by more training, they felt that some care homes were reluctant to improve their skills, and were unmotivated to participate in training:

Some homes have not even a basic knowledge about the palliative care at all. I’ve also visited a home that’s as clear as day they don’t want to know, even though we have been there, we have advised them, we have tried to train them, give them teaching sessions, they were not interested. Some carers have not got a basic knowledge of anything at all. They are just there to work and earn their money (CN9).

Despite this, many recognized that managing the end of life is challenging and that the support they provide to the care homes should be increased.

Staffing levels were identified as an area that makes it difficult for the care homes to cope with care at the end of life. This was an issue for both types of care homes. There was a perception that EOLC is more demanding for staff, as caring for a dying resident requires more resources. CHS described how limited staff may mean less opportunity to spend quality time with residents. As one nurse from a dual-registered care home stated: “. . . This place is too big and too busy and it’s hard to give one-to-one quality care to everybody” (Nurse, dual-registered home, N15). More resources
were viewed as fundamental to improving this. End-of-life care was presented as both physically and mentally stressful for CHS. Some viewed the level of bereavement or emotional support available to staff as inadequate. In many care homes, no formal support systems were established to provide CHS with support either during the provision of care or after the resident’s death: “. . . I don’t think we’re very good at counselling staff who are having problems with losing a service user” (Manager, nursing home, CM27).

The Role of the Community Nurse

Although CNs saw their role in the care home as offering support and guidance in helping care homes to manage the care of the residents, there were some tensions reported. Some of the CNs interviewed felt that as CHS were not adequately trained to care for both general and end-of-life needs, they often overutilized the CNs to manage this care. They described their frustration at care homes continually relying on them to manage the basic clinical care of residents, as this was not a good use of their time (e.g. catheter care, collecting repeat prescription for residents): “. . . Sometimes care staff could do it themselves, but they don’t do anything and call the nurses out. Some care homes are good and only call if they really need something but some staff won’t do anything themselves” (CN10). Although CNs reported continually having to educate CHS, some felt that the care homes were reluctant to take advice from them when it was offered. This conflict was explained by one CN who felt that care staff sometimes feel undermined by the CNs: “. . . They do find us a bit of a threat, coming in and dictating, and I think it’s again about knowing your roles and your boundaries and what relationship you have with that care home” (CN16).

Discussion

This study reports the views of a range of CHS and community nurses providing end-of-life care in care homes for older people, and illustrates that CHS feel that they are committed to providing the best care to residents at the end of life. Despite this, care homes may not always be well equipped to deal with the complex needs of residents at the end of life. Limited staff knowledge and resources were identified as key areas of concern by CHS and CNs. We found that although there were many similarities between the care homes, some important differences exist. In particular, care homes providing personal care only feel less confident in recognizing when a resident is approaching the end of life and described their facilities as a barrier to EOLC provision. Differences in training needs were also identified between the care homes. Findings suggest that, despite
a care-focused attitude in care homes, a number of barriers and challenges exist which may limit the quality of EOLC.

When discussing what the CHS understood EOLC to encompass, we observed a focus on the terminal phase and on symptom control and comfort specifically in those final days. Similar findings were reported in a study conducted in Australia which noted that CHS associated EOLC with the final days (McInerney, Ford, & Simpson, 2009). Our study highlighted an increased awareness among the CHS that an EOLC approach is relevant early on, in particular, a number of the care homes described initiating ACP on admission.

We found that staff relied on a variety of triggers to initiate terminal care. This reliance on indicators to identify the dying has been reported previously in the literature (Porock & Oliver, 2007). Our findings are important, as they also highlight that specific challenges exist for the different types of care homes, particularly the difficulties for care homes providing personal care only, who do not employ trained nurses, in identifying dying residents. Staff in these care homes felt that they lacked the skills to recognize this transition, and that they were often reliant on other primary health care professionals visiting the care home for advice. Failure to identify this transition is one of the main factors contributing to family dissatisfaction with the care delivered to residents at the end of life in long-term care facilities (Thompson, Menec, Chochinov, & McClement, 2008).

In the United Kingdom, 61% of care home facilities provide personal care only (Office of Fair Trading, 2005). With the expected future demand for care homes, we can expect that residents admitted to these care homes will be frailer and have more complex needs. Moreover, a recent U.K. audit showed that hospice patients are often considered for transfer to care homes, and when transferred tend to die shortly after admission (Reith & Lucas, 2008), thereby increasing the need for effective EOLC. Interventions to improve EOLC in these settings are underway. For example, in the United Kingdom, The Gold Standards Framework for Care Homes (GSFCH), which focuses on organizing and improving the quality of end-of-life care for residents, advocates the use of prognostic indicators to help identify residents in the last months or year of life (Thomas, Meehan, & Maryon, 2005). The GSFCH is currently only implemented in care homes providing nursing care; our findings highlight the need to extend this initiative to care homes providing personal care only. However, an important element of the GSFCH concerns identifying prognostic indicators, our findings highlight that it may be difficult to implement without adequate staff education, and that these care homes may need more support compared to care homes providing nursing care.

An EOLC approach in care homes should, not only encompass a high quality care for residents, but must also consider the needs of the families,
with The World Health Organization outlining this as a fundamental principle of palliative care (World Health Organization, 1990). We found evidence that support for relatives was an important consideration for the care homes. Many staff described the instrumental and emotional support they provided to families, both during the terminal phase of the resident, and in their bereavement.

We found that many CHS felt strongly that residents should die in the care home rather than in hospital. Despite this, perceived confidence in managing EOLC in the care home varied. Not having the appropriate facilities was seen as a barrier to managing the end of life effectively in care homes providing personal care only. There has been a strong emphasis placed on decreasing the proportion of residents who are inappropriately admitted to hospital at the end of life, with the GSFCH placing death in the care home rather than in hospital, as the primary outcome for evaluations. Our findings suggest that this may not necessarily be the most appropriate outcome, as some care homes are not equipped to manage the needs of dying residents.

The need for education was identified as an important concern for the CHS, who described the extent of their EOLC training as limited. This is supported by a recent audit conducted in the United Kingdom on the educational needs of CHS. The study found only 7% of qualified nursing staff had completed a course in palliative care, and only 22% reported attending a study day in relation to palliative care during the last two years. For care assistants this was lower, with 11% reporting attending a course in palliative care in the last 2 years (Whittaker, George, Hasson, Howard, & McLaughlin, 2006; Whittaker, Kernohan, & Hasson, 2007). Our findings highlight some of the barriers to accessing training. In particular, some of the care assistants in our study felt that attending training was more difficult for care assistants, and offered less frequently. As they are often providing most of the care that residents receive, it is crucial to increase availability of education programs for all staff, particularly the care assistants.

This study helped to map out some of the potential differences in training needs among the care homes. In our study, a number of care staff from nursing care homes reported issues with the assessment and management of pain, especially for residents with dementia. This issue has been raised in a study conducted in the United States that found problems with pain control in cognitively impaired residents was a concern for nursing home staff (Moss, Braunschweig, & Rubinstein, 2002). It has been reported that 683,597 people are living with dementia in the United Kingdom, and that 66.9% of nursing home residents and 52.2% of residential home residents have a degree of dementia (Alzheimer’s Society, 2007). Given this, more training in the effective management of pain is presented as a top priority.
A number of stressors concerning the provision of EOLC in care homes were identified. Families demanding that a resident is sent to hospital when death was imminent was raised as a concern. This may be because families do not understand or believe that the resident is dying, or that they lack confidence in the ability of the care home to provide good EOLC. Previous research exploring the views of family members on EOLC in care homes has highlighted their concerns and dissatisfaction with care provision at the end of life in care homes (Hanson, Danis, & Garrett, 1997; Wetle, Shield, Teno, Miller, & Welch, 2005). Further research is warranted that explores the motivations behind family members’ requests for a resident to be transferred to hospital at the end of life.

A further stressor concerned the impact of death on CHS. In support of the findings of an earlier study, our findings indicate that following a resident’s death, the emotional impact often experienced by CHS can be substantial, and is often attributed to the close relationship that has developed between staff and residents (Ersek, Kraybill, & Hansberry, 2000; Munn, Dobbs, & Meier, 2008). It has been documented in the literature, that caring for dying residents is burdensome, and that workload and emotional strain may result in nurses engaging less with the dying (Jenull & Brunner, 2008). In view of the emotional demands placed on CHS providing EOLC, we feel that there is a need to improve support networks to help staff to deal with their grief, and that the care delivered to residents does not suffer as a consequence of carer burnout. Although staff from some care homes described informal support systems, these may not be sufficient to deal with the emotional demands placed on CHS. Given the fast-pace environment and staffing issues, the care home may not be conducive to providing adequate support, therefore alternative support networks may need to be explored.

Our findings highlighted a tension which appears to exist for some CNs when working with care homes. This is something that has not been widely reported in the literature. In particular, there was a degree of frustration reported around the expectations that came with their role in terms of care provision. The suboptimal care delivered in the care homes, both generally, and at the end of life, were identified as major concerns for the CNs in our study. They felt that as a direct result of these inadequacies (an unskilled workforce), there was an increased demand placed on the CNs. When considering the dependency of some homes providing personal care only on community based services, ensuring an amicable partnership between the care homes and CNs is essential to the delivery of high-quality care to residents. Our findings may reflect restrictions that are placed on care assistants. A U.K. study highlighted a tendency for care assistants working in nursing homes to always involve the nurse employed in the care home for any medical issue, usually related to the boundaries surrounding their role (Perry, Carpenter,
Challis, & Hope, 2003). Raising the status of care assistants and increasing their responsibility is considered important in ensuring that care homes providing personal care only are not excessively reliant on the input of CNs. If achieved, this may help to alleviate the burden experienced by CNs. However the role of the CN has not traditionally been expected to encompass support in care homes (Seymour & Froggatt, 2008). This may explain why some of the CNs in our study reported tensions over their role (e.g., they felt overutilized by the care homes). It may be that attitudes toward their role may need to change. As their support and skills are vital in helping the care homes to manage EOLC in care homes, it may be appropriate to consider commissioning their time to facilitate an increase in support. This is especially pertinent as more older people are expected to die in care homes and they are likely to have more complex EOLC needs.

**Strengths and Limitations of the Study**

Despite an increased research interest in this area, many of the qualitative studies looking at the views of health care workers working in care homes for older people have been small. The main strength of this study is that the sample captures the views of staff working in almost all care homes in two London boroughs and includes the views of managers, care assistants, nurses employed by the care home, and CNs. A limitation is that we were unable to represent the views of General Practitioners (GPs). Including their views may have provided a deeper understanding and a more complete picture. GPs provide an important part of care for residents in care homes, however a recent study conducted in Australia reported a degree of GP uncertainty around EOLC for care homes regarding what it encompasses (Phillips, Davidson, & Willcock, 2009). Future research should focus on what these challenges may be.

**Conclusions**

We suggest that one of the greatest challenges to providing good-quality EOLC, concerns the care home workforce being unskilled, underconfident, and unprepared to manage the increasingly complex needs of residents, despite a strong desire to provide good care at the end of life. Given the expected future demands for care home places, and U.K. policy advocating improvement in EOLC for all adults at the end of life (Department of Health, 2008), the need to overcome these barriers and prepare the care home workforce for the future is ever more prominent. Our findings suggest that while all care homes need ongoing support, those care homes providing personal care only are likely to need more support. Increasing availability of education for all staff is central to improving the situation.
On-site training delivered in the care homes may increase access for more care assistants. Given the emotional demands placed on CHS during the end of life, there is a need to improve support networks.

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