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A stakeholder evaluation of the impact of the palliative care clinical nurse specialist upon doctors and nurses, within an acute hospital setting

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Abstract: There has been an expansion in the number of palliative care teams based in the acute hospital setting. Although organization of these teams varies both in structure and approach, the clinical nurse specialist is one of the key members. The last decade has seen an escalation in the UK of clinical nurse specialists, and following the Calman-Hine Report and the more recent NHS Cancer Plan, it is anticipated that the number of clinical nurse specialists in palliative and cancer care is likely to grow.

This paper presents the qualitative findings of an evaluation study designed to investigate the impact of the clinical nurse specialist within a palliative care team based in an acute hospital setting. A stakeholder evaluation that encompassed 31 tape-recorded semi-structured interviews with senior nurses, consultants, junior doctors and nurses representing different grades were performed. The data was analysed for emerging themes utilising a case and cross case analysis methodology.

The results suggested the presence of the clinical nurse specialists is seen as beneficial to both medical and nursing staff. This paper will focus upon exploring these potential benefits, included providing support, advice and education. *Palliative Medicine* 2003; **17:** 283–288

Key words: acute hospital; clinical nurse specialists; palliative care

Introduction

Since the establishment of the hospice movement in the mid-1960s, developments have occurred both within the community and more recently in the acute hospital setting resulting in the emergence of hospital based palliative care teams.[1–8] Within the UK it is estimated that by 1999 there were approximately 340 acute hospital based palliative care teams.[9] Palliative care teams have assumed a variety of titles including symptom control teams, symptom assessment teams and palliative care teams.[10] Additionally the organisation of the hospital teams varies both in their structure and approach. This can range from teams that work across the primary–secondary care interface to those that are purely being hospital based. Furthermore the composition and leadership of the team can vary considerably.[10,11]

Regardless of the composition of the palliative care team, one of the key members is argued as being the clinical nurse specialist.[6] This is supported by the recommendations of the Calman-Hine report[12] and subsequent publication by the Cancer Collaboration of the Workforce and Training Implication for Cancer Care,[13] which stressed the need for more clinical nurse specialists. Additional recommendations have also been made by the recent publication of the Nurses Contribution To Cancer Care,[14] and the NHS Cancer Plan,[15] supporting the need for an increase in the number of cancer and palliative care clinical nurses. Additionally the reports support the development of tumour site-specific specialist cancer nurses to focus on the care of patients with a specific cancer. All these developments emhpasize the access to specialist services and the provision of a quality service. Although to date, there are no figures available to assess this expansion in number of posts in the UK, the last year has seen a plethora of vacancies advertised for cancer specialist nurses.

Clinical Nurse Specialists

The increase over the last decade in the number of clinical nurse specialists in palliative and cancer care is also seen in other clinical specialties.[16,17] This increase is argued as

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being due to a change in professional boundaries between doctors and nurses and the subsequent emergence of advanced nursing roles.[17] Castledine[18] identified 60 areas of specialist practice, whilst McGee *et al.*'s survey[17] demonstrated an increase to over 320 areas of specialist practice. This increase is associated with numerous attempts to establish a workable definition of the term clinical nurse specialist.[19] The original clinical nurse specialist definition stemmed from the American Nursing Association (ANA) whose definition was a registered nurse 'who, through study and supervised practice at the graduate level [master's or doctorate], has become expert in a defined area of knowledge and practice in a selected clinical area of nursing'.[20] The United Kingdom Central Council (UKCC) definition focused upon specialist practice, and did not state the need for graduate level status. This definition included demonstration of higher levels of clinical decision making as well as the monitoring and improvement of standards of care through the supervision of practice, clinical audit, development and local practice.[21]

Despite the ANA definition and the recommendations by the UKCC confusion persists regarding the role of the clinical nurse specialist, resulting in a multiplicity of meanings.[17–19] However there appears to be a consensus that the core components of the role include expert practice, education, consultation and research.[22,23]

Despite the increase in the number of clinical nurse specialists, there is a paucity of research studies to demonstrate their effectiveness, and no studies that specifically focus on hospital based palliative care. Existing studies have indicated benefits for the patients and financial benefits for the organisation; although these studies have in the main compared the clinical nurse specialist with traditional often medically led care.[24–28]

With the current emphasis on clinical and cost effectiveness, there is an urgent need to evaluate the contribution of the clinical nurse specialist. This is particularly important as clinical nurse specialists are at the top end of the grading scale and are viewed as costly.[29] Thus there is an issue for those purchasing health care that they need to see the value of the contribution that the clinical nurse specialist makes.[7,29]

This paper forms part of a Doctoral thesis that evaluated the impact of hospital based palliative care clinical nurse specialists.[30] The study included evaluating the impact that clinical nurse specialists had on patients' symptoms and insight scores. Additionally it explored doctors' and nurses' views on the impact that clinical nurse specialists made. This paper focuses on exploring the impact that the clinical nurse specialists had upon doctors and nurses within an acute hospital setting. Benefits have been demonstrated for nurses and medical staff that have included that of clinical development,[31,32] acting as advocate[33,34] and providing education and support of professional colleagues.[31–33] However, evidence to support this benefit is limited and further research is required.

Methodology

The study was located in a large urban (1300 beds) acute NHS hospital in the northwest of England. The palliative care team comprised four full-time clinical nurse specialists who were solely hospital based. The medical staff included a consultant and registrar who were available for advice, but did not routinely see all referrals to the palliative care team. Hospital inpatients were referred to palliative care by medical staff managing the patient's care. Following referral, patients requiring palliative care input were all seen by clinical nurse specialists. Additional involvement of palliative care medical staff for complex cases was made after the initial assessment. At the time of the study no protocols for referral were used.

In order to explore the impact that the clinical nurse specialist had upon the medical and nursing staff in the hospital, a stakeholder evaluation approach was selected. This approach was chosen as the term stakeholder evaluation is argued as applying to people who make decisions about a service, and also those who are affected by the service.[35,36] This part of the study aimed to explore the impact that the palliative care clinical nurse specialist had upon the doctors and nurses, therefore a qualitative stakeholder evaluation was selected for the study as it enables a plurality of perspectives to be obtained and increases the range and quantity of the information that is available.[37]

Sample

A nonprobability sample design was selected,[38] including various grades of qualified doctors and nurses working in differing clinical areas for the study. The palliative care clinical nurse specialists were also included in the study in order to explore their own perceptions of their impact. As the aim of this part of the study was to explore the impact on doctors and nurses, patients were not included as stakeholders as they would generally not be aware of the impact.

In order for the doctors and nurses to have had experience of the palliative care clinical nurse specialists, staff who had been employed in the hospital for less than six months were excluded from the study.[10] Additionally staff from the clinical areas of intensive therapy unit, accident and emergency and mental health that normally had little contact with the palliative care team were also excluded. Thirty-one stakeholders were included in the

Table 1 The sample selected for the study

Nurses	Number	Doctors	Number
Director of Nursing	1	Consultants:	
		Medicine	1
Assistant Director of Nursing	1	Surgery	1
Clinical Service Managers	2	Elderly	1
CNS-Palliative Care	4	Palliative care	1
G grade	4	Doctors:	
F grade	2	All specialities	4
E grade	5		
D grade	4		

study including 23 nurses and eight medical staff (Table 1). Research ethics committee approval was granted for the study and verbal consent was obtained from each subject.

Data Collection and Analysis

The data was collected using tape-recorded standardized open-ended interviews, which were all conducted by one researcher.[30] The approach adopted for the study was that proposed by Patton,[35,36] of a standardized open-ended interview. Taking respondents through the same questions, with the inclusion of probing questions, ensured that interview time was maximized. Had a more unstructured interview format been used, the interview would have taken longer and would have been less acceptable to key stakeholders with the concomitant loss of data both in terms of volume and quality. For this phase of the study the interview guide focused upon exploring the question: 'Thinking of your experience of the clinical nurse specialist within the palliative care team what do you see as their effect upon doctors and nurses?'. Respondents were prompted to give clinical examples where appropriate. Data was analyzed using what Patton[35,36] refers to as case and cross case analysis. Categories under each question were identified and subsequently numerically coded.[39] To increase the credibility of the data collection and analysis process, transcribed interviews were returned to respondents for checking and alteration if they so wished.[38,39]

Results

The data analysis suggests that stakeholders perceived palliative care clinical nurse specialists to have a positive impact upon doctors and nurses. This impact could be subdivided into that of support and advice and education.

Support and Advice

The advice that clinical nurse specialists were able to give was identified by all but two respondents. This advice predominantly referred to symptom control. One doctor further illustrated this advice stating:

> I'm a doctor but I still don't know as much about some of the pump regimes or the way to proceed with treatments for anti-nausea, they really are experts on that and I very much value their advice. (Clinical assistant)

Support was emphasized by all nursing staff who used terms such as 'support' and 'reassurance'. Two ward managers gave examples of this support:

> The palliative care nurse will come after a death if you have had a particularly difficult death so we can discuss the good points of that death or the bad points of the death and where we could have done more. (G Grade)

> As a clinical supervisor role . . . in that you can actually talk with them and say how you feel and discuss individual cases. (G Grade)

This supportive role was also acknowledged by the palliative care clinical nurse specialists. One postholder further elaborated on this role stating:

> Nurses will come for support themselves even if that is probably more supervision really, the fact that they need someone to off load to when they have got a particularly difficult patient. (Clinical nurse specialist)

Education

The educational input by palliative care clinical nurse specialists was in the main identified by the nurses and doctors who held more senior posts. This input included formal teaching sessions for nursing and medical staff. One G grade ward manager illustrated this point:

> Small teaching sessions from simple things on communication to the use of syringe drivers. (G Grade)

One doctor referred to interactions that she had with clinical nurse specialists and how this had influenced her care with palliative care patients:

> I've learned from my interactions with them a lot more about the situations that the dying patient experience and I don't just have to think that this is a case of raising up the diamorphine because that isn't always the case. (Clinical assistant)

The clinical nurse specialist postholders also identified the educational input of their role. Two clinical nurse specialists emphasized it was an important part of their role, stressing how they saw it as a means of empowering staff in caring for palliative care patients:

> With education we feel our job is to get them to enhance their skills further. It's not our job to come in and take over from staff. (Clinical nurse specialist palliative care)

> Letting those nurses out there realise that they are the ones that deliver it . . . we are here to tap into but they are the ones that deliver it. (Clinical nurse specialist palliative care)

This emphasis upon empowering staff through education was also acknowledged by the consultant in palliative care who stated:

> We have been very careful in the past to maintain that role as a specialist resource and enable the general nurse and indeed the junior doctors to deliver the care themselves.

Furthermore the palliative care consultant who identified positive effects of this educational input illustrated this effect of education on medical and nursing staff:

> We have noticed, that for instance, on a Monday we don't hear the horror stories of what has been going on at the weekend. People over the weekend have been using their own initiative and started using the drugs and it is a distinct measure and I realise that measure because of my phone calls at a weekend. (Consultant palliative care)

Discussion

The results from the stakeholder evaluation strongly suggested that palliative care clinical nurse specialists had a positive impact upon doctors and nurses. This impact centred upon the broad areas of support, advice and education. This is in keeping with other studies that have reported the benefits of clinical development, education and support.[31–34] All the stakeholders identified the provision of support and advice, in particular those doctors and nurses who were based upon the wards and thus had direct contact with cancer patients. The examples of the input that clinical nurse specialists made relating to symptom management was suggestive of the skills the clinical nurse specialists had on palliative care symptom control. The medical staff also reported this input, with one doctor illustrating this in terms of expertise on pump regimes and treatments for anti-nausea. This supports the findings by Wood and Ward,[40] where nonspecialist staff reported a lack of basic knowledge about cancer care and treatment.

The identification of support that was provided by the palliative care clinical nurse specialists, included examples of the input that the clinical nurse specialist gave on a ward following a difficult death. This was a recurring theme with the stakeholders. This reference to the provision of support for the staff is indicative of the findings by Wood and Ward[40] they found that nonspecialist staff identified difficulties in communicating with cancer patients, referring to how they had a fear of talking to patients with cancer and their families, and how they often felt daunted. Findings supported by earlier studies that have indicated the problems nurses have in communicating with cancer patients.[41,42]

The stakeholders, who held the more senior posts, identified the importance of the education of clinical staff as being an integral part of the clinical nurse specialists role. This may have been due to them having a clearer understanding as to the clinical nurse specialist's role. This education included communication skills to enable staff to deal more effectively with the dying patient and their families, as well as the practical skills for example drug administration. The palliative care consultant, who illustrated how medical and nursing staff appeared to be using their initiative over the weekends when the palliative care team was not available for normal consultation, further expanded upon the positive effect of this educational input.

Furthermore the clinical nurse specialist postholders emphasized their important educational role. They all identified the educational input as being part of giving the staff skills to empower them to care for palliative care patients and their families. Additionally they saw this input as helping to avoid potential deskilling, that is argued as being a result of clinical nurse specialists being in post.[17]

The inclusion of the palliative care team in the study enabled their perceptions of their impact to be explored. Of interest was their emphasis upon education, in order to empower the clinical staff caring for palliative care patients. Further research to explore the content and effect of this educational input is clearly required.

Limitations of the study

There are certain limitations of the study design that need to be taken in to consideration when interpreting the results. The study was only conducted in one acute hospital setting, and it is acknowledged there is a wide variation in composition of hospital palliative care teams.[10,11] Thus is it is important to consider the specific influence this design of team may have had upon the findings.

Additionally the data collection only focused upon a short interview with the stakeholders due to time constraints. This did not allow for the whole context of issues to be explored, nor for in-depth probing which an orthodox qualitative interview permits. Although this is recognised as a potential limitation of the study, nevertheless this approach enabled a wide selection of key stakeholders views to be obtained. Furthermore the

findings are in keeping with other studies that have reported positive benefits for clinical staff. Additional qualitative research that includes in-depth interviews, along with an observational study would enable the study to be taken further, and explore the actual input that the clinical nurse specialist makes.

Conclusion

Although criticisms are levelled against the study design and further research is undoubtedly required this study has suggested that palliative care clinical nurse specialists within an acute hospital appear to provide benefits for doctors and nurses. Benefits that include supporting and educating nonspecialist staff in the skills needed to provide optimal care for palliative care patients within the acute hospital setting.

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