

# Practicalities of promoting practice-based learning in end of life care for care home staff: Lessons from “online” supportive conversations and reflection sessions

Jo Hockley RN PhD<sup>1</sup>  | Julie Watson RN PhD<sup>2</sup> | Lucy Johnston MSc<sup>3</sup>  | Susan D. Shenkin MD<sup>1</sup>

<sup>1</sup>Usher Institute, University of Edinburgh, Edinburgh, Scotland

<sup>2</sup>School of Health in Social Sciences, University of Edinburgh, Edinburgh, Scotland

<sup>3</sup>School of Health & Social Care, Edinburgh Napier University, Edinburgh, Scotland

## Correspondence

Susan Shenkin MD, Usher Institute, University of Edinburgh, Edinburgh, Scotland.  
Email: [susan.shenkin@ed.ac.uk](mailto:susan.shenkin@ed.ac.uk)

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## Abstract

**Introduction:** Deaths in care homes and “at home” are anticipated to account for a third of UK deaths by 2040. Currently, palliative and end of life care are not part of statutory training in care homes. Reflective practice is a tool that can facilitate practice-based learning and support. Following a feasibility study to test “online” supportive conversations and reflection sessions (OSCaRS) to support care home staff in relation to death/dying during the first months of the COVID pandemic, a one-year practice development follow-up project was undertaken with the aim to create a team of NHS/specialist palliative care (SPC)-based facilitators to lead and support OSCaRS provision in up to 50 care homes in one region in Scotland—the focus of this paper.

**Methods:** Forty care home managers attended an on-line session explaining the project, with a similar session held for 19 NHS/SPC-based nurses external to care homes. Those interested in facilitating OSCaRS then attended three education sessions. Data collected: records of all activities; reflective notes on OSCaRS organised/delivered; a summary of each OSCaRS reflection/learning points; final interviews with NHS/SPC trainee facilitators.

**Results:** A total of 19 NHS/SPC facilitators delivered one or more OSCaRS in 22 participating care homes. However, as of January 2022 only six trained facilitators remained active. Out of the 158 OSCaRS arranged, 96 took place with a total of 262 staff attending. There were three important aspects that emerged: the role, remit, and resources of NHS/SPC supporting OSCaRS; requirements within care homes for establishing OSCaRS; and, the practice-based learning topics discussed at each OSCaRS.

**Conclusion:** Attempts to establish a team of NHS/SPC facilitators to lead OSCaRS highlights that end of life care education in care homes does not clearly fall within the contractual remit of either group or risks being missed due to more pressing priorities.

## KEYWORDS

care home education, end of life care, learning, online group reflection, support

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## 1 | BACKGROUND

Older people living in care homes (CHS) have a complex array of needs relating to the combination of age (85+ years), cognitive impairment, limited mobility, multi-morbidity, and polypharmacy (Gordon et al., 2014). Therefore, the majority of care delivered in UK CHs is within the remit of palliative and ultimately end of life care with the mean length of stay being 15 months (ISD Scotland, 2018). Palliative care affirms life and regards dying as a normal process—it intends neither to hasten nor postpone death (WHO, 2009).

CHs are now seen as “de facto” hospices (Connolly et al., 2014) with over a fifth of UK deaths occurring in CHs. The COVID-19 pandemic caused a surge in CH deaths, with a 220% increase in deaths in the first 10 weeks of the pandemic (Bone et al., 2020); this was against a background of massive operational challenges including a shortage of staff and changes in support from visiting healthcare professionals (Gordon et al., 2020).

Despite all of the above, palliative care is still not part of the statutory education laid down by the UK care registration organisations. Nonetheless, across the UK, CH managers, and staff have taken part in various palliative care courses/projects predominantly initiated by specialists in palliative care; for example: Gold Standards Framework in CHs (Badger et al., 2012; Kinley & Hockley, 2016); PACE (Hockley et al., 2019; Oosterveld-Vlug et al., 2019); ECHO (Diffin et al., 2021); and, Route to Success (NHS, 2010). However, ongoing sustainability is reliant on good leadership within CHs, stable staffing following such programmes, and commitment from professionals with end of life care expertise external to CHs.

Reflection has long been a practice to help increase self-awareness and confidence with the ability to turn experience into learning in both health care and education (Gibbs, 1988; Johns, 1998; Mezirow, 1991); however, group reflection is less common. Pearson and Smith (1985) first highlighted the importance of group reflection for reducing stress. Following the development of a tool for CH staff to reflect on their care of residents who had died (Hockley, 2014), undertaking group reflection has been shown to be of value enabling staff to come together to gain new learning in palliative and end of life care and to feel supported (Malloy & Phelan, 2021). The tool (see Figure 1) enables experienced facilitators from specialist palliative care (SPC), who have not known the resident/family, to lead the reflection. These sessions had been done “face to face” with CH staff in Lothian, Scotland by the author (JH), a nurse academic with time-limited funding from Macmillan, to develop palliative care in CHs in the locality.

### 1.1 | Development of the OSCaRS tool

As a result of the first wave of the COVID pandemic and when visiting restrictions meant that external facilitators were not allowed into CHs, these reflective debriefing sessions went “online” in the form of “Online Supportive Conversation and Reflection Sessions” (OSCaRS) (Johnston & Hockley, 2022). An adapted reflective debriefing outline

#### What does this research add to existing knowledge in Gerontology

- Practice-based group reflection in end of life care enables individual support and learning for care home staff, who have little knowledge of the process of death and dying, and is different from planned educational initiatives.
- “Online” supportive conversations and reflection sessions [OSCaRS] using a specific tool capture the complexity and situatedness of death/dying in care homes especially sudden death.
- Specialist palliative care facilitators and care home practitioner educators are well placed to facilitate OSCaRS but delivery and sustainability is challenging

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

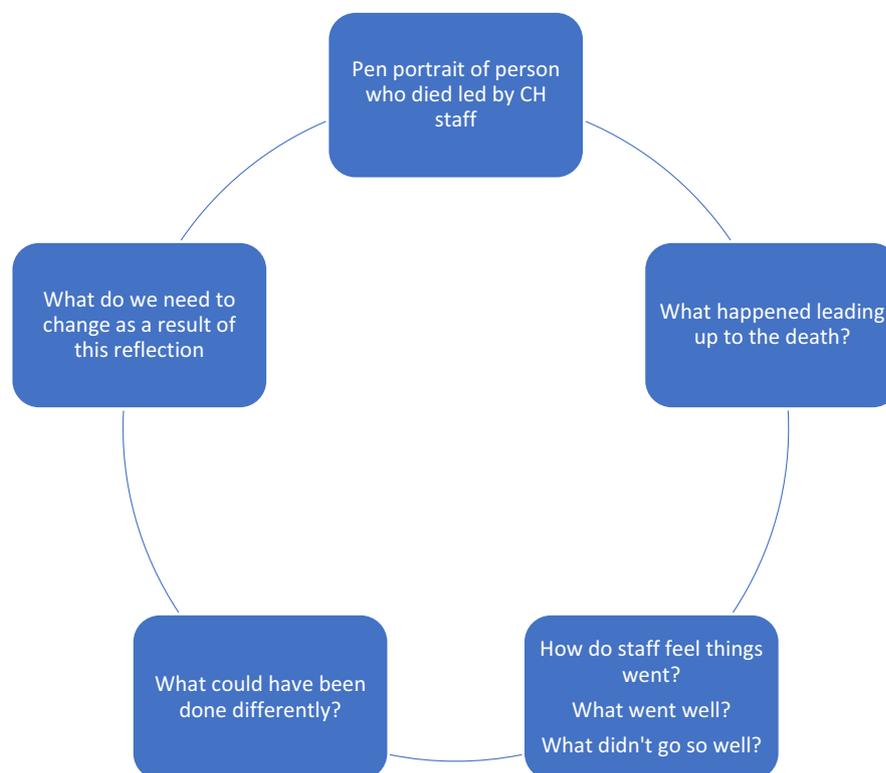
- Staff shortages often led to OSCaRS being cancelled therefore opportunities for learning and support is missed.
- Competing priorities and differences between the culture and context of the NHS/SPC and care homes means that establishing and maintaining a team of NHS/SPC OSCaR facilitators is challenging.
- Education on palliative and end of life care for care home staff risks being missed due to more pressing priorities.

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

- Care home staff want and need learning and support in relation to death/dying; but, staff shortages and workload mean it is difficult to prioritise.
- With 21% UK population now dying in care homes there are no clear lines of responsibility within the health and care system for who should support and deliver education on death/dying to care home staff.

was developed in order to accommodate the raw emotions many staff were experiencing as a result of multiple deaths within the care home. The online sessions began with everyone being asked to introduce themselves (their name, role/background, and, how long they had worked at the CH) after which one of the facilitators led a breathing exercise enabling participants to relax. Following the breathing exercise, the other facilitator asked the first of two questions: “Thinking about residents who have died or are dying and their relatives, what for you has been the hardest thing over the last few weeks?” All staff present were encouraged to respond. The second question, asked about 10 min before the end of the session helped to close the session

**FIGURE 1** Reflective cycle used within OSCaRS (Hockley, 2014).



on a positive note: “What one thing has gone well for you over the past few weeks?” Session were delivered by JH and JW, were found to be feasible and acceptable within CHs (Johnston & Hockley, 2022).

## 1.2 | Aim of current study

To *embed* OSCaRS in practice and sustain delivery through establishing a team of OSCaRS facilitators to replace JH and JW once their time-limited funding finished (January 2022). Further funding from Edinburgh Lothian Health Foundation was secured.

This paper describes the use of OSCaRS as a novel practice development initiative during the latter part of the pandemic (February 2021–January 2022) to support CHs through practice-based learning to improve end of life care, and, the process of working with NHS and SPC teams to enable the OSCaRS infrastructure to become embedded within the local NHS/SPC Care Home Support Programme.

## 2 | METHODOLOGY

We used a reflexive methodology (Alvesson & Skoldberg, 2000) to our implementation of a tool that had been previously derived inductively with care home staff undertaking an action research study (Hockley, 2006, 2014). Within the qualitative tradition, reflexivity is about acknowledging ones own role as researcher/s in a project where one is actively helping to bring about change; allowing one's prior experience, assumption and beliefs to transparently influence the process of the research.

Both JW and JH as part of the Delivery Team came with a background in SPC nursing and CHs. There were three parts to the implementation process: developing a community of OSCaRS practitioners within the NHS and SPC; engaging with staff in CHs; and, OSCaRS delivery (see Box 1).

Data collected during the implementation included:

- Delivery team action log
  - A weekly record, kept by the Delivery Team, of project activity and decisions taken in relation to CHs, facilitators, OSCaRS planned/delivered alongside reflections on what had worked well and key learning and new actions to progress the roll out.
- Session notes using the reflective tool
  - The co-facilitator of each session completed the OSCaRS tool and record of learning/teaching content covered during the session, uploaded onto sharepoint and sent it to the care home manager ( $n=81$ )
- Individual OSCaRS records
  - A written note of observations by facilitator after each session reflecting on what had worked well and not well, to capture learning for the roll out going forward ( $n=75$ )
- Interviews
  - Six OSCaRS trainee facilitators were audio recorded, transcribed and anonymised with codes
- Feedback from CH managers in receipt of OSCaRS.

The Action Log was analysed to provide descriptive statistics and plot progress of the project over time. These quantitative findings were triangulated with the qualitative data collected in

## BOX 1 Three aspects of the implementation

### 1. Developing a Community of OSCaRS practitioners within the NHS:

The academic Delivery Team (JH, JW) focussed upon recruiting and training a 'community of practitioners' from the NHS locality to deliver and facilitate OSCaRS. Information sessions were held for NHS staff employed to support care homes which included a newly established care home support teams (CHSTs) set up in response to challenges due to the pandemic, and practice education facilitators (PEFs); specialist palliative care (SPC) from Marie Curie and a local hospice; and, quality improvement nurses (QI). Nineteen were interested in facilitating OSCaRS.

Potential facilitators/co-facilitators attended three specific education sessions on end of life care of frail older people (all of which were recorded for further use), namely:

Process of dying:

Recognising dying (week/s)—sleeping more during the day than awake + reduced savoury appetite.

Peripheral shutdown (day/s), hearing is the last thing to go.

Central shutdown (hour/s)—recognising 'thin & thready' pulse in last hour/s.

Communication:

Not 'what' we say but 'how we say things'.

Speaking with family/friends of the resident who is dying.

Not being afraid if resident brings up 'dying'.

Using the word 'dying' versus 'deteriorating' – team communication.

Symptom Control and Dying:

Anxiety—the most common symptom in the last days of life in frail older people.

Pain control maintained before the dying process.

Rattly chest—dangers of hyoscine and other ways of controlling this symptom.

Bi-monthly 'community of practice' meetings for potential facilitators were planned and backfill costs were available.

An NHS project manager was appointed to support co-ordination and education/training associated with the implementation and to work with the local Health and Social Care Partnerships to prioritise input, aiming to include care homes in the region from across the different sectors. The initial appointee to the post of OSCaRS Co-ordinator left after 4 months and a new project officer was appointed for the remaining 8 months.

### 2. Engaging Care Homes:

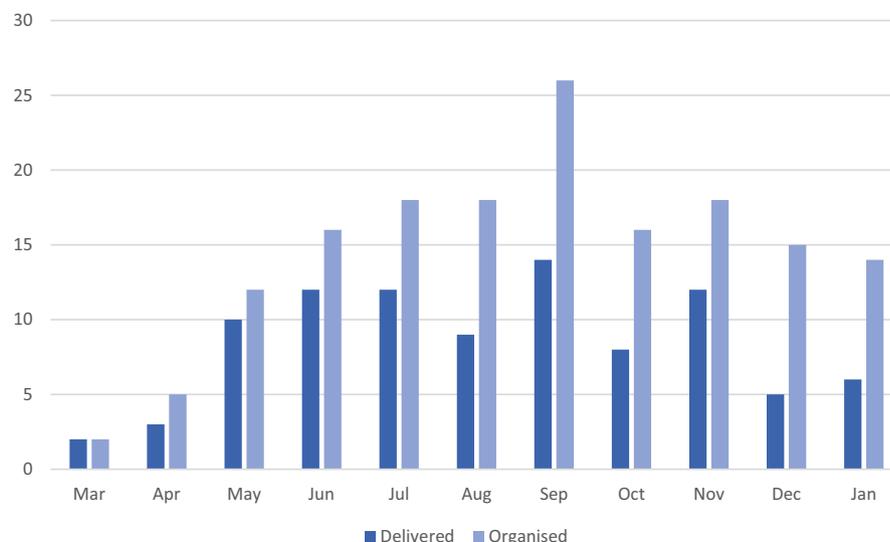
A purposive and proactive approach was taken to raise awareness of the OSCaRS roll out amongst care homes. Publicity flyers about the project were sent to all care home managers by email and also posted on the NHS Lothian Care Home website. Care homes were also referred by the local NHS Assurance Team and some care homes were introduced to OSCaRS via their contact with Quality Improvement. JH also re-contacted care homes known from previous projects. An Information Session for care home managers was held monthly from February to May 2021 and then a further one at the request of a couple of care homes. The sessions lasted up to an hour; a full explanation about how OSCaRS were to be introduced, and the tool being used, was given including time for questions.

### 3. OSCaRS delivery:

An NHS project manager was appointed to help support co-ordination and education/training associated with the implementation and to work with the local Health and Social Care Partnerships aiming to include care homes in the region from across the different sectors.

All OSCaRS were kept to 45-min and followed the prompts of the tool (see [Figure 2](#)). Trainee NHS/SPC facilitators shadowed JH & JW as co-facilitators until they felt confident to lead OSCaRS with another new facilitator. Co-facilitators wrote up a summary of each OSCaRS using the tool and included aspects of any training points discussed; these were sent to the care home manager as evidence of practice-based learning. The lead facilitator wrote a brief anonymised reflection on how the OSCaRS had gone after each session that is, the roles of those who attended, what had gone well with the session and what might need to change. Reasons for cancellation of planned sessions were also recorded. If there was no death in the previous month, then a 'learning' session was held relating to a palliative care issue/s raised by those present at the OSCaRS. This process not only enabled relevant new learning in relation to people they were caring for or had known, making it more poignant and applicable, but also provided support for care home staff who naturally build strong relationships with residents and their families.

**FIGURE 2** Roll Out month by month (number of sessions).



session notes, individual OSCaR records, interviews with facilitators and feedback from managers. The team reflected together on the process of undertaking OSCaRS with considerable discussion and debate highlighting the challenges and benefits evident from the sessions themselves and with the interview data.

The project was granted ethical approval from Edinburgh Napier University School of Health and Social Care Ethics Committee for the roll out of OSCaRS and further evaluation (SHSC 2729864).

### 3 | KEY FINDINGS

Out of the forty CHs invited to attend an on-line information session re the project, 22 CHs held one or more monthly OSCaRS, five engaged with the delivery team but never managed to arrange a session, seven CHs withdrew after initially expressing interest, and six CHs did not want to take part.

Of the 158 OSCaRS that were arranged, 96 took place. A total of 262 staff attended one or more OSCaRS across the 22 CHs (17 with on-site nurses; five without) across a mixture of private, charity and local authority care sector CHs with a mixture of roles of those attending (see Table 1).

Sixteen NHS-based and three SPC based trainee facilitators delivered one or more OSCaRS; however, by January 2022 only five NHS-based trainee facilitators and one SPC (who moved to the NHS during the project) remained active. Eighty percent of all OSCaRS sessions were facilitated by JH or JW with or without a co-facilitator.

We report the triangulated data from the different data sets under three important aspects/themes that emerged: the role, remit, and resources of NHS/SPC staff supporting CHs; the requirements in CHs delivering OSCaRS; and, finally, the record of OSCaRS learning in CHs.

#### 3.1 | The role, remit, and resources of NHS/SPC supporting OSCaRS

Critically, NHS leaders responsible for care home were committed to the roll-out of OSCaRS and provided funding for an NHS-based project co-ordinator whose role was to act as a bridge between the NHS, CHs, and the universities.

##### 3.1.1 | Skills to facilitate OSCaRS

The trainee facilitators who were most able to lead OSCaRS were nurses whose current role included a practice development or SPC background (Band 6 or 7) and senior nurses working more autonomously than the Band 5 nurses in the CHST. Those facilitators who also came with a strong interest in education became competent in facilitating OSCaRS independently. It was a passion either for the mode of delivery (i.e. reflective practice) or palliative care that helped motivate them. For one it was an opportunity to develop their own practice around facilitating reflective learning.

*I was keen to learn to use reflective discussion more in an education perspective and [the OSCaRS] gave me a good forum to do that. [F2 interview]*

For another it was drawing on expertise she already had around reflective learning.

*It appealed to me I think because I really liked having, kind of, sort of, reflective conversations with people. I've done a bit of work around that in my background in the past, so it was something that I felt quite confident, and it was an enjoyable piece of work for me, yes. [F4 interview]*

TABLE 1 Type of CH taking part in OSCaRS and number of attendees.

Type of CH + month OSCaRS started	OSCaRS delivered	Total number of attendees + roles of those attending OSCaRS
CH01a/b: with on-site nurses. <i>Charity</i> [March '21]	11/13	28 (manager +8 nurses +12 senior carers/carers +8 student nurses)
CH02: no on-site nurses. <i>Council</i> [May '21]	3 /6	9 (all senior carers/carers)
CH03: with on-site nurses *(sudden death of manager so OSCaRS ceased) <i>Private</i> [May '21]	7/9	15 (8 nurses +7 senior carers/carers)
CH04: with on-site nurses. <i>Not for Profit</i> [June '21]	8/8	30 (10 nurses +20 senior carers/carers)
CH05: with on-site nurses. <i>Private</i> [May '21]	9/9	21 (2 nurses +13 senior carers/carers +4 students +2 ancillary)
CH06: with on-site nurses. <i>Private</i> [May '21]	1/9	5 (1 nurse +3 carers +1 activities)
CH07: with on-site nurses. <i>Private</i> [May '21]	4/9	17 (15 senior carers/carers +2 ancillary staff)
CH10: with on-site nurses. <i>Private</i> [July '21]	3/7	7 (1 nurse +6 senior carers/carers)
CH11: with on-site nurses. <i>Not for Profit</i> [June '21]	6/8	9 (7 nurses +2 senior carers/carers)
CH12: no nurses on-site. <i>Private</i> [June '21]	4/8	11 (all senior carers/carers)
CH15: with on-site nurses. <i>Private</i> [August '21]	3/6	4 (3 senior carers/carers + night nurse)
CH16: no on-site nurses. <i>Not for Profit</i> . [May '21]	5/9	14 (8 nurses +6 senior carers/carers)
CH17: no on-site nurses. <i>Council</i> . [May '21]	8/9	18 (3 team leader +14 senior carers /carers +1 ancillary)
CH20: with on-site nurses. <i>Private</i> [June '21]	5/8	13 (1 manager +10 carers +2 nurses)
CH21: with on-site nurses. <i>Private</i> [June '21]	1/8	4 (senior carers/carers)
CH23: with on-site nurses. <i>Private</i> [Sept '21]	2/5	6 (1 manager +5 carers)
CH24: with on-site nurses. <i>Private</i> [Sept '21]	1/5	2 (manager + carer)
CH28: with on-site nurses. <i>Private</i> [August '21]	5/6	23 (manager + deputy, +13 nurses +7 carers +1 ancillary)
CH30: with on-site nurses. <i>Private</i> [Sept '21]	3/5	7 (manager +2 ancillary +2 carers, +2 activity team)
CH31: with on-site nurses. <i>Private</i> [Sept '21]	3/5	7 (4 nurses +3 senior carer/carer)
CH34: with on-site nurses.	2/3	10

TABLE 1 (Continued)

Type of CH + month OSCaRS started	OSCaRS delivered	Total number of attendees + roles of those attending OSCaRS
Private [Nov '21]		(3 nurses +7 carers)
CH37: no on-site nurses.	2/3	2
Council [Nov '21]		(manager + H@H doctor)

All of the final six newly trained facilitators committed to undertaking monthly OSCaRS saw the need within the CH and felt there was “definitely a thirst for palliative care” [F3 interview]. However, out of the three SPC practitioners who started off facilitating OSCaRS, only one remained at the end and had moved to the NHS; all three had changed jobs during the project. There were also role changes amongst those within the NHS teams including at senior levels.

The delivery team, who had put together three training days for new facilitators, were under the impression from senior NHS managers that those NHS nurses who attended all three training sessions were committing themselves to be facilitators. Subsequently this was found not to be the case as OSCaRS were not formally included in their role and remit but were an optional extra. Some NHS nurses, including those with experience of working in CHs, were extremely interested in co-facilitating OSCaRS but, not being given protected time (one afternoon/month) to co-facilitate two OSCaRS, meant that they couldn't fulfil the commitment.

*I think seeing it as a priority in the workload is important and identifying that, but I think the reality is that there are other priorities at the moment. [F4 interview]*

### 3.1.2 | Supporting the roll-out of OSCaRS

Within the remit to support the role out of OSCaRS, difficulties arose as a result of wider limited NHS resource and pressures within the service with priorities being given to administer the third COVID vaccination to CH residents rather than the monthly afternoon commitment to OSCaRS. Bi-monthly meetings to discuss things with the local NHS CHST management, who were from an acute setting background as opposed to a CH sector background, were arranged but the majority were cancelled due to unforeseen circumstances. Newly trained PEFs (Practice Educator Facilitators) who were very capable of facilitating OSCaRS often ended up leading a session on their own without a facilitator from the CHST.

*I don't think I've actually even managed to get anybody from the (NHS) care home team to come and help co-facilitate and that's not a criticism, it's a reality, of the pressures. Maybe they're not best placed to do this, I don't know, maybe there's just too much else going on. [F4 interview]*

Some facilitators felt that CH staff became confused with the deluge of NHS staff going into CHs and all the different roles:

*I know who the education team are, I know who the care home support team are, I know who the district nurse team is, I know who the quality improvement team corporately is. The [CHs] don't; for them we are just NHS ... they don't recognise the difference. At the minute it is just all these people being sent to help us, what is it they want to do? A lot of them don't want to say 'no' to anything ... But they are not quite clear who you are, what you are about, what it is you are actually ... a lot of them are just saying, 'oh yes, we will take anything'. [F6 interview]*

The answer appeared to be a more committed coordinated approach:

*It feels to me like the pandemic hit the CHs and everybody panicked and everything was chucked at them. There's not a lot of coordination going on, and I'm just sitting at the side lines watching it .... I think there could be real value in having a more coordinated approach... [F3 interview]*

### 3.1.3 | Necessary resources

Specific resource issues included a lack of space for some of the NHS CHST to have a quiet room in which to facilitate/co-facilitate an OSCaRS. Some wanted to be able to undertake the OSCaRS at home but this was not possible due to IT restrictions. And finally there were not enough laptops to go around. The delivery team found a lack of timely responses to emails difficult.

Towards the end of the study CHs were opening up to visitors and other health care professionals, (although at times suddenly a CH would get closed because of a COVID outbreak). At this point, there was a sense that doing the OSCaRS face to face might have a role. The 'O' instead of being “online” becomes “on-going” sessions.

*So I think sometimes it might be more successful if we actually did it face to face. But then I understand for people going all over the place that's not so easy either. It's easier for the facilitators I suppose to do it on Teams or on Zoom or whatever. (F5 Interview)*

Nonetheless travelling to a CH to do a session in an afternoon would certainly be more time-consuming; doing them 'online' was more resource efficient with most facilitators achieving two OSCaRS in an afternoon. The idea of a 'hybrid' model where 1 month an OSCaRS could be done online and then the next month face-to-face was certainly discussed openly at facilitators meetings towards the end of the project.

While there was a will to sustain the OSCaRS beyond the year of the project, the acute and ongoing pressures in the health and social care system were seen as a barrier:

*I have no idea how the various parties that are involved will be able to fully resource and commit, and that's the issue that I've got .... be it either financially resourced [or] personnel resourced; but keeping the word out there that [this project] is still kind of on-going and explaining what it is. [F1 interview]*

### 3.2 | Requirements within CHs for establishing OSCaRS

There were certain requirements needed in CHs to enable OSCaRS to happen. These included the realisation of the importance of palliative care for frail older people, good leadership and delegated responsibility for ensuring they happened.

#### 3.2.1 | Leadership within the care home

Working with good leaders within the CH and having the manager already aware of the importance of good palliative and end of life care were qualities that facilitated the 'monthly' OSCaRS. Dates each month were put down in the diary for the whole year—importantly by both CH managers diaries and the facilitators.

*I think what also works well is identifying a lead in each care home. Somebody who will get things up and running from their end, ... the two CHs I have, one of the care home managers is very, very, good at setting everything up and making sure her staff can attend. [F4 interview]*

Also, if there was an understanding about the importance of reflecting on practice and/or imparting knowledge about palliative care in both the CH manager and the facilitator, it made a huge difference to the commitment of monthly OSCaRS.

*We had the manager come along to the first session, just so she could see what [an OSCaRS] was and I think once she'd seen it she was like, 'yeah, this looks great, I'm really happy the staff are attending'. ... so it's, kind of, finding that key person who will be your, kind of, advocate at the care home end. [F2 interview]*

Generally, we encouraged managers not to attend more than one OSCaRS so as not to inhibit staff. The fact that all the OSCaRS were written up immediately after a session and sent to the CH manager meant that these managers knew what had been discussed – but with no attributed names in the write-up.

Some facilitators remarked there was sometimes a lack of organisation by those given responsibility for organising OSCaRS within the CH. On a few occasions CH staff attended a session probably because they had been told to but they had not really known the person who had died. Whilst this was likely because the CH manager wanted to support the concept of OSCaRS, it did result in the session losing some of its meaning

*Getting to the right people because [some say] "I didn't really know that person that well" or "I wasn't there at the end of their life" or "I was on leave for two weeks". [F6 interview]*

The advocacy between the facilitator and the care home galvanised a relationship and an important ingredient if OSCaRS were to continue.

#### 3.2.2 | Shortage of staffing affecting opportunities to learn

At the beginning of the project, we saw a regular number of monthly OSCaRS being organised from May through to November (see Figure 2). However, many OSCaRS (62–39%) were cancelled by the CHs and therefore not delivered. There were a number of reasons for OSCaRS being cancelled.

Staff shortages and sickness as a result of the continuing COVID-19 pandemic (mostly amongst staff—not residents) really stretched CHs at a time when staff were already struggling to maintain safe staffing numbers; this becomes even more critical with holiday periods and Christmas and, as a result, educational initiatives are difficult to fulfil.

*I think the clinical need and the demand on staff time is immense at the moment. I think a lot of the cancellation is due to staff pressures. If they're feeling pressured, again I don't know that it's right to push it ... and it's maybe something that they can't quite fit in that day. And I get that ... It's not been because it's not valued or they've not been interested. ... [F2 interview]*

It is evident from the level of short notice cancellations that there was (and still is) a capacity issue within the CHs. Whilst their commitment to OSCaRS was strong, staff shortages and service demands created a situation of competing priorities on a day-to-day basis resulting in all forms of training being poorly attended. One facilitator commented:

"Yes I wouldn't think it's an OSCaRS specific thing. I think it's any education thing. The first priority is patient care and the numbers on the floor. If there's anything to be cancelled, education's always the first thing" (F5 Interview)

There was even a concern that if something wasn't done to support staff in CHs the situation would deteriorate.

*I think a lot of the homes they are just not even taking the time to think about how they are feeling or what is happening with people at end of life because they are on a bit of a hamster wheel, for want of a better word. I think eventually it is going to come crashing down.* [F6 Interview]

### 3.2.3 | Technology

Technology was a factor causing a barrier to smooth flowing OSCaRS mentioned by the majority of facilitators although when it worked, it worked well. If there was someone in the CH who took responsibility, organising help with the laptop and getting connected then all would be well. However, on occasions the WiFi in the CH was weak and so issues with connectivity occurred.

*It's, kind of, difficult over MS teams or ZOOM, but generally we're all getting a bit more used to that I think. It's not as difficult as it was. I think as the nine months has gone on we've got better at things like that. We've all had to, haven't we, but one session I did was there was no video.* [F4 interview]

### 3.3 | OSCaRS as an opportunity for learning and support

There was no doubt that NHS/SPC OSCaRS facilitators role helped care home staff feel valued and supported in their relative lack of experience with death/dying and appreciated someone "from outside" facilitating the OSCaRS in the safe place of their own care home. Unlike other healthcare settings, staff working in CHs build strong emotional attachments with their residents over the months/years, many of whom have few visitors; such a relationship is what gives both satisfaction to the resident and staff alike. They want to do their best for residents they see as "family" and OSCaRS gave them reassurance in this:

*I think [OSCaRS] makes them feel valued .... we can reassure them that they are getting it right. You can hear by the way they speak about the residents that they're really fond of them and they want to do a good job. ... I*

*mean they definitely speak about the residents like it's their family.* [F5 interview]

There was evidence that some staff had felt totally unprepared to have to face death prior to coming to work in a CHs. OSCaRS had a role to play in normalising natural dying at the end of life but also recognising the importance of addressing the emotions it raises. The ease created by facilitators within the structure of the OSCaRS tool (see [Figure 1](#)) gave them opportunity to ask any question they liked.

*"... you wouldn't always get [that] in a formal teaching environment ... they're more open to saying things like, "oh, but why did they turn blue", and "what was that about?" ... and just these, kind of, questions* [F4 interview]

OSCaRS were attended by staff from across the care home team and were reaching many staff who would not normally be invited to teaching sessions (let alone sessions on death/dying) such as: ancillary staff, student nurses and activity team members alongside nurses and carers (see [Table 1](#)). Facilitators created a safe environment to talk about challenges together as a whole team which then was helping to develop a positive culture towards death/dying in the CH.

*"... the staff leave with a smile on their face. They start sometimes quite heavy hearted I would say. They're very open and they say things 'as they are' and as they happen. They don't hide anything ... They're not shy about sharing things that happen or didn't happen ...* [F5 interview]

OSCaRS were not seen as "criticism"—every session started with the facilitator saying that these are a 'no blame' session.

*... the one or two things that were picked up on, through no fault of their own, they were absolutely open ... "oh I didn't think about that" "Oh, well maybe we will think about that the next time". They didn't feel that they were being criticised or anything. They seemed quite open to suggestions.* [F5 interview].

All the residents who died were over the age of 80 years old except for five—one of whom was young at 50 years and who had motor neurone disease (see [Table 1](#)). Deaths were seen as 'typical' to the care home population and were not due to COVID.

Many aspects of learning, in relation to death and dying, were discussed during OSCaRS. Whilst each death was unique, there was general learning that facilitators drew on from the three session educational training (see [Box 1](#)) thus giving a consistent input on the overarching factors common in expected deaths. [Table 2](#) highlights the different topics raised during the OSCaRS across all CHs. Understanding the three different stages of dying was the topic that was most often discussed. This was discussed in 17/22 care home OSCaRS during the project.

TABLE 2 Topics discussed at OSCaRS.

- Types of dying
  - dwindling frailty trajectory;
  - sudden death – <1% older people in care homes survive CPR
  - death following an acute episode
- Concept of gerotranscendence – older people being more ready 'to go'
- Reduction of thirst receptors in older people
- Pain needs to be controlled prior to dying process – then dying is not painful
  - Oral pain intensity scale
- Spiritual care
  - Wild animals know they are dying so go to forest to die – so do human beings.
- Diagnosing dying
  - Using the surprise question
  - Pneumonia very common at the end of life in frail older people and is sometimes inappropriate to treat – 'being given permission to go'
  - Premonition of dying
  - Anticipatory end of life care medications
- Communication
  - Amongst staff
    - using the word 'dying' (not deteriorating) amongst staff members and with families
  - With a resident
    - anticipatory care planning
    - symbolic use of language by resident around 'dying'
    - resident asking if he is dying – keep conversation open by using the question: "what makes you think you might be dying"
    - giving permission to die
    - believing the resident
  - With family
    - encouraging family to be present
    - when asked "how long" – answer in terms of hours, days, weeks, months (no figure)
  - Relationship-based care
- Dying
  - three stages of the dying process
  - importance of regular turning (4hrly during the night and more often during the day to prevent stiffness)
  - dying itself is not painful if pain properly controlled months prior to dying process
  - anxiety/terminal restlessness
  - secretions and older people often due to pneumonia – the dangers of hyoscine; lying the resident flatter
- Dementia and dying
  - dementia cachexia
  - hallucinations
  - music

TABLE 2 (Continued)

- Motor Neurone Disease
- Last offices
- Usefulness of Kathryn Mannix book: "The End in Mind"
- Importance of team sharing – team support
- CHs as the new hospice – average length of stay of residents in CHs now 15 months
- Staff and GP collaboration - staff know the resident better than GP
- Palliative care – affirming life but allowing death

### BOX 2a Record of OSCaRS teaching points at one sessions [CH2]

Use of the 'surprise question': "Would you be surprised if he was to die within 6 months?"—a good tool to use to give a subjective view of deterioration/death [at the same time looking back over deterioration over last month/s or week/s].

Often people sleep more during the day and eat less in the weeks before death.

Older people have a biological feeling they are going to die [gerotranscendence].

Thirst receptors naturally diminish in older people in preparation of death/dying. Staff need to inform relatives of this so that they understand that reduced drinking in someone who is dying does not mean they feel thirsty.

Pneumonia very common at the end of life in frail older people and is sometimes inappropriate to treat with—"Naturalness of Dying" (McCue, 1995).

[OSCaRS Facilitator's Notes CH2 27/7/2021].

Teaching points were recorded by the facilitator during an OSCaRS and then sent to the care home manager who then knew the topics discussed and the aspects of care staff were learning about. An example of this (see Box 2a) relates to 'recognising dying' and the use of the surprise question.

Another common topic raised in teaching sessions was using the word 'dying' instead of talking about "deteriorating". This was seen in CH23 (a care home with on-site nurses):

*Too often staff prefer to use the word deteriorating rather than saying the word "dying". Encourage staff to use the word dying more—not just in the last two days of life. For the majority of dwindling deaths we know that they are dying "weeks" before they die. Staff need to use the word amongst themselves more in order to use the word with relatives as and when appropriate. [OSCaRS facilitator's log CH23 15/9/2021].*

### BOX 2b Record of OSCaRS teaching points [CH23].

Residents are usually aware they are dying

- Try not to be too fearful if someone wants to talk about dying.
- A good way to answer a resident who may ask if they are dying is: 'what makes you think you are dying?' This enables to keep the conversation 'open' rather than closing it down

[OSCaRS facilitator's notes CH23 15/9/2021].

In this OSCaRS, staff were being gently encouraged to use the word 'dying', initially amongst themselves, in the week/s leading up to the death of a resident in order to build confidence to talk about 'dying' as appropriate with the resident or family. Being present with someone who asks if they are dying can be very unsettling even for the most experienced nurse/doctor. Learning ways to keep the conversation open if a resident wants to speak about dying is an important aspect in respecting human rights (see [Box 2b](#)).

OSCaRS, as well as giving opportunities to discuss expected deaths and the normal process of end of life care which was the majority of cases, they also gave opportunities to discuss more unusual events where there was a learning need, for example, sudden deaths. In four out of the 22 OSCaRS, staff wanted to speak about a 'sudden' death that had occurred—one that felt was untimely and took staff by surprise, often making staff feel that they had done something wrong:

*The day of his death, the resident was his usual self. He was up and about and eating well. At 8 in the evening he collapsed suddenly in a communal area of the home. The staff knew he was dead but phoned 999. They said the resident was dead and he had a DNACPR form yet the staff nurse was told by the call handler to attempt resuscitation until paramedics arrived. When the paramedics arrived they pronounced him dead. The OOH doctor didn't come which meant the police had to be called as it was a sudden death. All the staff (4 in the session) had to give the police statements. The staff were traumatised by the indignity of it all and felt they hadn't done their job right. [OSCaRS Facilitators Notes CH 4 18/11/2022].*

Sudden deaths are uncommon in CHs but if one does occur it is often very upsetting for the whole care home team. Experiences of sudden death shared at OSCaRS revealed a need for greater multidisciplinary education on the policies and procedures around sudden death in CHs. As a result, a seminar was arranged with a panel discussion involving CH managers, a police officer, a paramedic, a GP,

representatives from Scottish Care, Borders Council, and the Royal College of Nursing.

OSCaRS provided opportunities to identify other ongoing learning needs such as pain assessment where a stand-alone seminar would have been beneficial had time permitted.

## 4 | DISCUSSION

This paper provides a detailed account of the practicalities of both promoting online practice-based learning (OSCaRS) in death/dying to care home staff using a team of NHS/SPC facilitators in one locality in SE Scotland, alongside a record of the educational topics discussed at the sessions.

OSCaRS gave a freedom and flexibility to learning that arose out of the practice situation compared to education that is planned in advance or takes a didactic approach. CH staff have learning and support needs which are distinct from those in hospitals because the delivery of end of life care in CHs is influenced by a number of factors which make it different to hospital-based end of life care. These factors include: the skill mix of staff; absence of on-site medical personnel; a homely setting as opposed to a clinical setting; and the relationship-based approach to care attributed to an average length of stay of 15 months (Care Home Census, 2018).

There isn't a one size fits all policy for end of life care education across all sectors. The reflective process embedded in OSCaRS as described above allowed us to capture the situatedness and complexity of death and dying in CHs and tailor learning to the context (Atkinson et al., 2008; Johansson et al., 2022). This enabled specific issues such as the lack of clarity around policies and procedures in relation to sudden death, which makes up about 10% of care home deaths (Hockley et al., 2010), to be highlighted and further in-depth multidisciplinary education sessions to build on the learning in OSCaRS. There is a need for more in-depth learning of this type in CHs which warrants ongoing opportunities for practice-based learning, online and/or face to face.

Malloy and Phelan (2021) found that while many residents die in long term care units (which includes CHs), death does not dominate the thoughts of the staff. Rather their main focus is on "potentialising human flourishing", a focus severely disrupted by the first wave of the pandemic by ongoing visiting restrictions in CHs. This is why monthly OSCaRS are important for keeping death and dying at the forefront of people's minds so that dying is noticed and recognised and good end of life care enabled (Borgstrom, 2020). This is in keeping with the Principles of Palliative Care which affirm life (and flourishing) but recognise dying as a natural process (WHO, 2009).

In response to the pandemic, greater collaboration in relation to health is being developed between the NHS and CHs; in England this is through the "Enhanced Universal Support Offer to CHs" (NHS England, 2020), and in Scotland through the "Enhanced Professional Clinical and Care Oversight of CHs" (Scottish Government, 2020). However, Fowler-Davies et al. (2021) found that the success of this in England has been mixed, with an overly reactive response

combined with "command and control" limiting the benefits that were achieved. Our findings suggest that NHS input in CHs was often driven by the need to respond to short-term goals. It is perhaps understandable that in the midst of a pandemic with the emergence of new COVID variants occurring during the time of the project that CHSTs will be reactive to the needs of the moment, with workforce development, learning and support being seen as less of a priority. In future, the roles and skills required by CHSTs requires further consideration. On a positive note, at the end of the project there was a commitment from the NHS to continue with OSCaRS with the ongoing employment of the project manager.

SPC also underwent profound changes during the pandemic with a significant shift towards people dying at home and more remote working (Keeble et al., 2022). SPC has a track record of supporting end of life care learning in CHs (Hockley et al., 2019; Kinley & Hockley, 2016; Oosterveld-Vlug et al., 2019). However, the challenges of sustainability are not new and are confirmed in our study.

The key finding of the process of rolling out OSCaRS highlighted the need for education and support in relation to death/dying for staff in CHs but at the same time alerted us to the challenges/barriers of promoting such learning when there is no clear line of contractual responsibility and capacity of educators, at a time when CHs are one of the main places where people die in the UK (Bone et al., 2018; Finucane et al., 2019). New models of advanced nurse practitioners for CHs are emerging. A way forward is perhaps to develop the specialism of CH nursing ensuring that palliative and end of life care is a core competency. This requires better understanding and valuing of the competencies required for CH nursing (Stanyon et al., 2017) and inclusion of CH nursing in undergraduate and postgraduate nursing curricula (Watson et al., 2020).

#### 4.1 | Strengths and limitations of the study

The strength of this practice development project is that it gives new insights into the role of group reflection in relation to learning and support around death/dying in CHs and the challenges faced in supporting practice-based learning in CHs in one locality. Data collected throughout the process by the academic facilitators strengthens understanding of the processes involved. We recognise that the previous experience of JH and JW in palliative care and the care home context was a unique part of the process. The one-year funding was ambitious while the pandemic was still at its height and a significant barrier to any sustainable implementation. The availability of NHS and SPC trainee facilitators and care home managers for interview, due to the emergence of the Omicron variant in late 2021, limits understandings of their perspectives.

## 5 | CONCLUSION

This article describes some of the practicalities in trying to develop a team of NHS/SPC nurses to support the promotion of

practice-based learning in relation to end of life care in CHs. Whilst care home staff were eager for monthly OSCaRS, staff shortages during the on-going pandemic often led to cancellations with opportunities for learning and support missed. Education on palliative and end of life care for care home staff risks being missed due to more pressing priorities within the NHS.

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For the purpose of open access, the author has applied a CC-BY public copyright licence to any Author Accepted Manuscript version arising from this submission.

#### DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

#### ORCID

Jo Hockley  <https://orcid.org/0000-0001-5445-0515>

Lucy Johnston  <https://orcid.org/0000-0002-9724-9253>

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