International Journal of Practice-based Learning in Health and Social Care

International Journal of Practice-based Learning in Health and Social Care
Vol. 10 No 1 June 2022, pages 48-58

Online Supportive Conversations and Reflection Sessions (OSCaRS): A Feasibility Pilot with Care Home Staff during the Pandemic

Lucy Johnston[a]; Jo Hockley[b]; Julie Watson[b;] Susan D Shenkin [b]
a: Edinburgh Napier University, UK b: University of Edinburgh, UK

Abstract

Care homes care for people with complex needs, supporting them to the end of life and are now being seen as the 'de facto' hospice. Reflective debriefing for care home staff has been found to help support staff and provide an educative and communicative function when a resident dies. Pre-COVID-19, one of the authors had been conducting reflective debriefings face-to-face with care home staff but when COVID-19 struck, face-to-face sessions were impossible. An online format was developed with the aim of providing emotional support and practice-based learning in relation to death and dying through reflection. This study assessed the acceptability and feasibility of delivering online supportive conversations and reflective sessions (OSCaRS) on palliative and end of life care to care home staff during the pandemic. A mixed methods study design was undertaken in April to September 2020. Qualitative data comprised of digital recordings of sessions and semi-structured interviews with OSCaRS participants, managers and session facilitators. An online survey was sent to all staff and had a response rate of 12%. Eleven OSCaRS were conducted over ten weeks. Thirty-four staff members attended one or more sessions. Three overarching themes were identified from the data: pressures of working in a pandemic, practicalities of delivering online support and, practice development opportunities. Engaging care home staff in online structured supportive conversations and reflections in relation to death and dying is acceptable, feasible and valuable for providing support with the pressures of working in a pandemic. There is value for OSCaRS to continue as online sessions as they provide care home staff access to practice-based learning and support from professionals and allows specialists based in a range of settings to in-reach into care homes in an efficient way. Future implementation must consider the availability of sufficient devices with cameras to aid participation, timing and frequency of sessions to accommodate staff workflows, the engagement and support of managers and post-session support.

Keywords: care homes; death/dying; online support; pandemic; practice-based learning

**Corresponding Author:* Lucy Johnston, School of Nursing, Midwifery & Social Care, Edinburgh Napier University, Sighthill Campus, Sighthill Court, Edinburgh, EH11 4BN Email: L.Johnston@napier.ac.uk

Journal URL: https://publications.coventry.ac.uk/index.php/pblh

Johnston, L. et al. (2022). Online supportive conversations and reflection sessions (OSCaRS): a feasibility with care home staff during the pandemic. *International Journal of Practice-based Learning in Health and Social Care*, *Care*, *10*(1), 48-58 DOI 10.18552/ijpblhsc.v10i1.743

Introduction

Older people living in care homes are increasingly frail with multiple co-morbidities. In the UK, care homes are now being seen as the 'de facto' hospice where staff care for people with advanced, progressive and incurable diseases and a mean length of stay of 15 months (Connolly et al., 2014; Information Services Division Scotland, 2018). By 2040, it is predicted that 40% of people will live and subsequently die in a care home in the UK (Bone et al., 2018). However, prior to the COVID-19 pandemic, the critical role care homes already had in palliative and end-of-life care was often overlooked at a strategic level within health and social care (McGilton et al., 2020). Internationally, frontline care home staff have borne witness to a pandemic that has disproportionality and devastatingly affected them (Gordon et al., 2020; Veronese et al., 2021; Deschacht et al., 2021).
Since the outbreak of COVID-19, all care homes have worked to ensure this vulnerable population continue to both live and die well. They have done this whilst facing unimaginable operational challenges. These included shortage of staff because of furlough or sickness; a lack of Personal Protective Equipment (PPE); changes in support from visiting healthcare professionals (Gordon et al., 2020), and the need to translate into practice large amounts of government and clinical guidance which was frequently changed or updated (Towers et al., 2020). The importance of high quality end-of-life care was reinforced (Cousins et al., 2020).

However, the most difficult challenge for care home staff has not just been about implementing new guidance and procedures, it has been very personal. Residents were dying more frequently and in greater numbers in some care homes. In the UK, during the first 10 weeks of the pandemic, care home deaths increased by 220% (Bone et al., 2020). Deaths were unexpected (before their time) and lockdown measures kept families apart and made it difficult for staff to have sufficient time and space to process these bereavements and their own grief (McGilton, K. et al., 2020).

In care homes for older people, the majority of direct personal and social care is provided to residents by staff who are not registered nurses. In the UK, palliative and end-of-life care is not part of statutory training for social care staff in care homes. Care home staff learn a significant amount by doing and learning on the job; they are not unskilled in care of the dying, and often draw on their own humanity and compassion, building relationships with residents and their families (Watson, 2019).

The concept of reflection is generally understood as a means of translating experience into learning, by examining one's responses, beliefs, and actions, to draw conclusions to enable better choices in the future (Ahlstrom et al., 2018). Braun and Zir (2005) suggest that reflective debriefing in care homes harnesses the oral tradition of care assistants. However, the concept of reflection is relatively new for many staff working in care homes and rarely done formally or regularly. Reflection integrated into practice-based professions as reflective practice can help practitioners increase self-awareness and confidence (Gibbs, 1988; Mezirow, 1991).

This article is about reflective and experience based-learning for developing skills in palliative and end-of-life care for care home staff. It presents our experiences of facilitating reflection and providing support for end-of-life and palliative care practice during the pandemic to staff working in care homes. We discuss the feasibility of moving an adapted version of a traditionally face-to-face, after-death reflective debriefing to an online platform; what we found out about whether this was acceptable and of benefit to care home staff. We present key learning and suggest future practice implications.

Background

The authors are members of the Care Home Innovation Partnership (CHIP) in South East Scotland (Hockley, 2019). Prior to the outbreak of the COVID-19 pandemic, one of the authors, Jo Hockley, (JH) was conducting monthly after-death reflective debriefings with staff in the partner care homes. The format for the reflective debriefing sessions, based on Gibbs (1988) reflective cycle, had been inductively derived as part of an action research study to support care home staff and had been found to have an educational and communicative function around death and dying (Hockley, 2014). Lockdown measures prevented JH from entering the care homes and conducting face-to-face after-death reflective debriefings. However, as the pandemic unfolded in March 2020, senior staff from a number of care homes contacted

JH to discuss ways of alleviating the high levels of distress that staff were experiencing as a result of numerous and frequent resident deaths. In response to these requests, a decision was taken to move online to deliver the after-death reflective debriefings. A small number of pre-feasibility study sessions were then delivered online. These acted as pilots to test the audio-visual technology and various meeting platforms (Zoom, Webex, MS Teams) and the adequacy of Wi-Fi connections within the care homes. The 'test runs' exposed the scale of resident deaths. These were occurring at an intense and anxious time while the UK was in lockdown and the number of people dying was considerably higher than when the debriefing tool had been developed. Moreover, National Health Service (NHS) and Social Care organisations were being made aware that at times of crisis and emergency response, it could be counter-productive to "debrief" as it could re-traumatise staff (Rose et al., 2002; McNally et al., 2003). COVID-19 Trauma Guidance recommended that it would be valuable for organisations to "offer opportunities for structured, time-limited discussions about current experiences" (Billings et al., 2020), rather than formal debriefing. In this context, the experienced session facilitators were able to respond and develop a tool and approach that was more fit for purpose during the pandemic.

The format of the sessions was changed to incorporate a broader conceptualisation of support and context/COVID-specific reflective practice learning. From this a new COVID-19 tool, and approach was developed: Online Supportive Conversations and Reflection Sessions (OSCaRS).

Funding was secured from the Chief Scientist Office as part of the COVID-19 Rapid Research Programme. with the aim of assessing the feasibility and acceptability of the OSCaRS in providing emotional support and practice-based learning on death and dying, with groups of care home staff caring for older people, during the first wave of the COVID-19 pandemic.

Research design and methods

This was a small mixed methods study (Doyle et al., 2009) undertaken over a six-month period (April to September 2020). Ethical approval for the methods was granted by Edinburgh Napier University School of Health and Social Care Ethics Committee (Reference No. SHSC20026). Care home managers gave gate-keeper consent and were asked to disseminate Participant Information Sheets (PIS) to all the staff. At the start of the session, permission was sought for it to be recorded and all participants agreed. The facilitator then reiterated the main points of the PIS with different aspects of informed consent being spoken by the facilitator and oral consent was recorded. The participating care homes were given a laptop funded from the research grant. They accessed the OSCaRS via this, and/or existing technology in the home/personal devices.
OSCaRS were offered up to twice monthly with care home staff joining a session from either a place in the care home or their own home. See Figure 1 for a description of an OSCaR session.

An online pre/post survey was distributed to all staff in the care homes. The validated Chesney Coping Self Efficacy Scale (Chesney et al., 2006) was included, as were open-ended text questions about role and length of employment in the home, experiences and confidence in end-of-life care. All sessions were digitally recorded and reflective fieldnotes were taken by the facilitators.

Following the OSCaRS, Lucy Johnston (LJ) conducted semi-structured interviews with four OSCaR participants, two care home managers and both session facilitators: JH & Julie Watson (JW). All interviews were recorded and transcribed verbatim. A reflexive thematic analysis was undertaken following Braun and Clark (2019). JH and JW undertook an initial reading and re-reading of the transcripts of the OSCaRS and interviews. Initial reflections were written which led to JH and JW each inductively deriving initial codes manually. Areas of agreement and disagreement between the two researchers were discussed leading to the development of themes. A further reading of the transcripts was undertaken by LJ and consensus was reached on the three overarching themes.

Figure 1

Description of OSCaRS

OSCaR sessions were held every two weeks at a time that suited each care home, usually early afternoon. The facilitators (JH or JW) sent a secure link to the online session to the care home manager who then advertised the session and assembled the staff on the day in a private office space within the care home where the conversation could not be overheard. On occasion the link was forwarded to a staff member who was not at work on the day of the session, so they could attend remotely.
Each session was led by either JH or JW, both experienced palliative care nurses with knowledge of care homes.
In order to create a safe emotional space everyone present was asked to keep the discussion within the session 'confidential'. Once everyone was settled, the session started with introductions with those present saying their name, their role/background and how long they had worked at the care home. These introductions helped individuals to start to talk and enabled them to start contributing. Once introductions were complete, one of the facilitators led a breathing exercise to facilitate participants to relax and be present in the session.

Following the breathing exercise, the facilitator for that session then asked the first of two open 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?"

The second question, asked about 10 minutes before the end of the session, acted as a closing question so that the OSCaR ended with positive discussion:

- "What one thing has gone well for you over the past few weeks?"

The OSCaRS were limited to 45-minutes duration.

Results

Three care homes were purposively sampled (referred to as CH1; CH2 and CH3). Their managers were known to the facilitators through previous practice development initiatives and research. The care homes were all medium sized (between 40 and 65 beds), each employing around 100 individual staff in a range of roles including nurses, care workers, activity coordinators and housekeeping/catering. One care home was not-for-profit and two were charitable funded. Two care homes had on-site nurses and all had been affected by increased deaths due to COVID-19.

In total, eleven OSCaRS were conducted over a 10-week period from May to August 2020 (See Table 1). Overall, thirty-four different staff members attended one or more OSCaRS. On average four staff attended each session with a minimum of two for one session and a maximum of six. In CH1 five staff attended more than one session. The attendees included care assistants, senior care assistants, registered nurses and activity providers. In CH1 and CH2 a separate OSCaRS for managers and senior staff was also provided. CH3 only undertook one OSCaRS as the manager left and during the transition period to a new manager, senior staff had limited time to accommodate both the evaluation and set up in the time available.

The response rate to the online survey was 12% and we could not score the Coping Scale, however all text responses were coded and analysed. From these and data collected from the digital recordings of the sessions and the interviews with staff, managers and facilitators, three overarching themes were identified: pressures of working in a pandemic; practicalities of delivering online support and, practice development opportunities. These are discussed below in relation to the research aim to test the acceptability and feasibility of delivering online supportive conversations and reflections on palliative and end of life care practice.

Table 1

Care Homes taking part in OSCaR Session

	Care Home 1	**Care Home 2**	**Care Home 3**
Size	40-bedded	60-bedded	63-bedded
Sector	Charity	Charity	Not for profit
On-Site Nurses	No	Yes	Yes
Number of OSCaRS	5	5	1
Dates of OSCaRS	18.6.2020 25.6.2020 9.7.2020 16.7.2020 (managers) 6.8.2020	23/6/2020 14/7/2020 29/7/2020 13/8/2020 26/8/2020 (managers)	1/7/2020
Total Number Staff Attending	8	21	5

Pressures of working in a pandemic

The staff who participated in the OSCaRS spoke openly about the pressures they were facing with the onset of the pandemic and found speaking about these pressures beneficial. Through OSCaRS, staff found that their feelings were given a 'voice' and could be acknowledged and understood better by their peers. Participants reported that this contributed to better team communication and cohesion – a feeling of all being in this together.

> "We spoke about lots of different things and I think it was helpful to speak about the deaths, so that my colleagues could see it's affecting us [nurses] as well… we're not immune to the sadness and the loss" (Interviewee CH2)

> "So, I think I enjoyed the fact that you were able to talk about your experience on a topic. It just kind of affirmed that I work in a good team. You know, it's nice to know that your colleagues feel like they can sit and trust you as well in that kind of environment and be open" (Interviewee CH1)

Interviewees also described benefitting from this mutual learning and support. Care workers in care homes without on-site nurses were less experienced and less knowledgeable about palliative care principles and end-of-life care practice. There were three main issues staff were dealing with which were raised in all the sessions: difficult deaths; disruption to normal care home life, and the depth of relationships with residents.

All three care homes were under considerable pressures in relation to learning how to accommodate PPE, shortage of staff, social distancing, and coping with deaths that had more challenging symptoms than would normally occur in a care home. The staff often spoke about residents being 'like family' and this depth of relationship contributed to the grief of staff when residents died, as well as bearing witness to the suffering of residents missing families not allowed to visit. In keeping with the ethical duty of care of researchers for participants in research on sensitive topics, we provided the care homes with posters displaying sources of wellbeing and support resources and managers and senior staff were made aware of who was participating in the event they needed post-session support. Moreover, the facilitators used the second OSCaRS question to work with the group to end the session on a positive note. This was in recognition of the emotional nature of discussing death and dying and draws on counselling and communications skills used in difficult conversations in palliative care practice (Fallowfield, 2004).

Some staff benefitted from a regular opportunity to reflect, while for others sharing their own 'COVID story' once was cathartic.

> "So, the first session I gave what I had to give, and then the other sessions, I sort of felt that I maybe I didn't have anything else to add but I was sat listening to other people. And their experiences were quite difficult". (Interviewee CH1)

Practicalities of delivering OSCaRS

Ease of accessing digital technology

The choice of which secure meeting platform to use was driven by what managers were familiar with and felt confident to use. It was simpler to use a platform that did not require participants to download software before logging into the meeting. It was necessary to support the administration and organisation of the online meetings with clear guidance.

> "it was all very clear what we had to do and it was easy enough. I think the only concern I would have is that if the Teams [MS Teams] didn't…the link didn't work, but, again, we've done a few trial runs and we are using Teams more and more now, so there wasn't an issue with that. But, certainly, the emails, the content and what we had to do, in order to allow staff to participate, everything was fine" (Interviewee CH2)

For the majority of sessions, participants were in the same room, using one device although on three occasions care staff joined the session from their own home. When staff were in one room together, using only one camera meant that time had to be spent positioning everyone so they could be 'seen' on screen by the facilitators. Depending on the room size and layout the staff were sometimes sitting in front of or behind their colleagues, which may have limited their engagement with each other.

> "With social distancing we all had to speak with our masks on…the breathing environment gets very hot and airless. Also with social distancing [it's] hard to position four people in front of laptop screen" (Survey Respondent CH1)

Overall, many of the delivery issues were less about the online meeting platform and technology, and more about the space/environment within the care home. Taking part online was acceptable – it was seen as the way it now was - given lockdown measures and part of their overall new ways of working. However for some sessions, the room was too small to accommodate all participants in comfort whilst adhering to social distancing measures. In addition, having to wear masks was difficult for the facilitators in identifying who was speaking, hearing clearly and reading emotional signals through facial expressions, but not insurmountable.

Engagement of managers

Providing OSCaRS during the pandemic is dependent on the engagement, support and capacity of managers. When CH3's manager left, they were unable to continue. Managers had to consider the administrative practicalities for those who wanted to attend and time the sessions to accommodate staff workflows. Staff who participated in OSCaRS were 'taken off the floor' for an hour to do so.

Pre–lockdown CH1 had not undertaken after death reflective debriefing and the concept of OSCaRS was new. The manager had to spend time explaining the aim and format of OSCaRS, and as a result, recruiting participants (particularly male carers) was reported as difficult. It appears that whilst time and work pressures may have meant some staff could not attend, apprehension about what would happen at the session and what was expected of them was also reported. We heard how staff talked to their colleagues about the sessions and word of mouth recommendations increased participation.

> "after the first session, the two staff, I think it was two staff that had taken part thought it was so good that I asked them to speak at the next team meeting. So they shared how helpful they'd found it and one of them actually said she felt like she'd had a weight taken off her back" (Interviewee CH1)

Expert external facilitation

Our feasibility study identified the added value of OSCaRS being facilitated by someone from out with the care home. Participants and managers reported that this created a 'safe space' in which to share. Staff valued the input of the facilitators as impartial and non-judgemental.

> "I really enjoyed the session because having gone through this experience of COVID in the care home and having had deaths, being able to talk about it to people who are genuinely interested and have an idea [of care in care homes] was a lot different from coming to work and just talking with your colleagues" (Interviewee CH1)

> "Yeah, very successful, and staff are coming back saying they have really benefited from taking part … I think it's possibly that it's been done with someone that staff don't know so well…I feel that they open-up a wee bit more" (Interviewee CH2)

In addition to being external to the care home, facilitation was enhanced by the facilitators having a working knowledge of care homes. Both JH and JW understand the context, working environment and pressures of working in a care home and importantly from this appreciate the deep bonds staff form with residents and relatives.

> "I could talk openly with people who could understand me about the situation we had at work during the first breakdown of COVID-19 and how I couldn't cope with so much loss" (Survey Respondent CH1)

Practice development opportunities

The provision of OSCaRS had the dual aim of providing emotional support and practice-based learning in relation to death/dying through reflection. We found that OSCaRS are best facilitated by experienced practitioners who can guide and support staff as they reflect on how they had used their skills in a challenging environment.

The facilitator's knowledge and experience of palliative and end-of-life care provided authentic affirmation to staff regarding their skills and provided much needed reassurance that they were doing a good job in difficult circumstances. Interviewees talked of feeling lifted by taking part in the sessions and how it had helped them feel more confident and to keep going.

> "I would say that coming away from the session I felt more confident in myself thinking that I had done a good job, even though I had been absolutely exhausted the last few months, been heavy going in here.. Because we're not always very good at giving ourselves good compliments, because we're so busy looking after other people" (Interviewee CH2)

Discussion

This study has demonstrated that engaging care home staff in online structured supportive conversations and reflections on practice around death and dying is acceptable, feasible and valuable. In a time when access to care homes for face-to-face support was stopped, it provided a safe space for staff to speak openly about the pressures they were facing due to the COVID-19 pandemic and provided an opportunity to deliver much needed practice-based context-sensitive learning opportunities for care home staff about delivering palliative and end-of-life care. OSCaRS also served to provide emotional support through supportive conversations embedded within the immediate context and challenges of the disruptions to normal care home life as a result of COVID-19 and lockdown.

The sessions offered affirmation and reassurance in addition to the opportunity to reflect on their practice and develop future skills and confidence in end-of-life care. External facilitation by people with knowledge and understanding of care home residents and work environments was combined to create a

safe space to reflect and learn. Providing this to mixed staff groups appeared to contribute to enhanced team communication and cohesion and provided practice-based opportunities for care staff to learn about delivering palliative and end-of-life care from different perspectives. It also provided opportunities for the facilitators to develop an understanding directly from care home staff regarding the pressures faced during the pandemic and the potential learning opportunities for the future. Across the sessions it was observed that there is a need to increase care home staff's understanding in relation to frailty, recognising dying and pain management.

During the COVID-19 pandemic, death and loss was recognised as a trigger for mental health problems among frontline care home staff (Nyashanu et al., 2021). Hanna et al., (2021) suggest that reflection, continuing into the recovery phase of the pandemic when there is now perhaps more space for reflection, is needed to support health and social care staff providing end of life care. Moving forward, even as care homes are opening up to external face-to-face support, online support may still have a significant role to play. However, a number of factors need to be considered for this intervention to be implemented and sustained. On a practical level, implementation must consider the availability of sufficient devices with cameras to aid participation and social distancing across the home, timing of sessions to accommodate staff workflows, the engagement and support of managers and post-session measures. There is also a need to consider the frequency of sessions and how often staff attend to ensure an appropriate balance is struck during the pandemic, between broader supportive conversations and practice based reflection on end-of-life care practices which would be recurring.

At a systems level, consideration needs to be given to who could deliver OSCaRS in a sustainable way. The pandemic has highlighted the interdependency of health and social care, the centrality of care homes to a functional and functioning health and social care system (Devi et al., 2020) and the need for integration between statutory health care providers and care homes (Gordon et al., 2020, Deschacht et al., 2021). With this in mind, we believe the OSCaRS facilitator role can be performed by experienced nurses from within specialist palliative care. It is important for such facilitators to recognise the differences between the frail older people population of care homes and the cancer-orientated focus of hospices (Hockley, 2017). However, the availability of specialists in palliative care nursing is variable and often limited (Lancaster et al., 2018). Specialists in palliative care do however have an important educational role (Caper & Macdonald, 2016) which can potentially be harnessed together with the online approach which has the added value of being time efficient. In the context of this study, the pandemic prompted the establishment of an NHS Care Home Support Team (CHST). The authors have secured funding to work alongside the CHST to establish a Community of OSCaRS Practitioners supported by local Specialists in Palliative Care. Alongside this, in recognition of the challenges of conducting research in care homes we will develop and pilot different evaluation approaches and determine how to best establish, embed, sustain and evaluate the impact of practice-based wellbeing support for staff, residents and relatives.

Conclusion

This study looked at the feasibility of changing face-to face reflective practice-based learning and support to an online format. OSCaRS are just one of many innovations developed to mitigate the impact and restrictions of COVID-19.

OSCaRS allow care home staff to access practice-based learning and support from professionals, at times when access may be restricted, for example, during infection outbreaks. In addition, the online format can facilitate specialists based in a range of settings to in-reach to care homes in an efficient way. Facilitation skills of empathy and active listening must be underpinned by expertise in palliative and end-of-life care skills and practice. The principles of online supportive conversation and reflections, if embedded within care homes, may have a place to continue to support the wellbeing and education of staff through COVID-19 and beyond.

Acknowledgements

We would like to thank the Care Homes who participated.

Sources of funding

Scotland's Chief Scientist Office funded the study and JW's role was part funded by an Economic and Social Research Council Impact Accelerator Grant.

Ethical approval

Edinburgh Napier University School of Health and Social Care Ethics Committee (Reference No. SHSC20026).

ORCID

Lucy Johnston	ORCID URL 0000-0002-9724-9253
Jo Hockley	ORCID URL 0000-0001-5445-0515
Julie Watson	ORCID URL 0000-0002-1936-1258
Susan D. Shenkin	ORCID URL 0000-0001-7375-4776

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