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Moderating the work distress experience among inpatient hospice staff: a qualitative study

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## **Abstract**

*Background:* Palliative and hospice care health professionals may be at risk of poorer psychological outcomes. It is unclear what specific stressors are experienced by staff and the impact on their psychological wellbeing.

*Aims:* To identify stressors experienced when working in an adult hospice inpatient unit environment and how these are managed.

*Methods:* Individual interviews were conducted with healthcare professionals working in a hospice adult inpatient unit.

*Findings:* Nineteen staff were interviewed. Six themes were constructed. Four related to stressors experienced: ‘unrealistic workload’, ‘patient care’, ‘managing relationships’, and ‘work culture’. Two themes concerned strategies for managing stressors: ‘peer support’ and ‘time out’.

*Conclusion:* Changes within hospice care provision are placing demands on staff and limited resources. This may be alleviated by a move towards more compassionate workplaces. There is a need for further research to identify how distress can best be managed and how hospice organisations can best support healthcare staff.

## **Conflicts of interest**

The authors declare that there is no conflict of interest.

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Conclusion: Changes within hospice care provision are placing demands on staff and limited resources. This may be alleviated by a move towards more compassionate workplaces. There is a need for further research to identify how distress can best be managed and how hospice organisations can best support healthcare staff.

Keywords:

Burnout, psychological; hospices; health personnel; qualitative research

## **INTRODUCTION**

Hospice and palliative care healthcare professionals (HCPs) aim to improve the quality of life of terminally ill patients through preventing and managing pain, as well as addressing patients’ physical, psychological and spiritual needs (WHO 2015). Palliative care can begin at diagnosis and is delivered in hospital and community settings. Hospice care begins after treatment of the disease is stopped, when the person is not going to survive the illness. Again, it can be delivered in a range of settings including, but not limited to, hospices.

HCPs in hospices are regularly exposed to death and patient suffering as well as working in areas of clinical uncertainty; all of which can result in unique emotional demands (Rokach 2005). Although work-related distress has been widely studied among physicians and nurses working in non-hospice care settings (Delgado et al. 2017; Fox et al. 2017), palliative and hospice care research has primarily focused on the psychological well-being of patients and families and limited research has been conducted with HCPs (Jaiswal et al. 2014). This is despite the estimation that around 50% of palliative care HCPs are at risk of poor psychological outcomes (Kamau et al. 2014). The research that has been conducted with hospice and palliative care HCPs has primarily focused on outcome variables and estimating prevalence (e.g. Martins Pereira et al. 2011) and there is less research on the antecedent and causal factors of the distress experienced and how these are managed (Ablett and Jones 2007).

Two reviews (Peters et al. 2012; Powell et al. 2019) summarised the research exploring antecedents of work distress among nurses working in different hospice and palliative care environments, and suggested that the main stressors in the workplace are: high workloads, the work environment (specifically “living with sadness” because of the frequent loss and close interactions with patients), inadequate resources, team communication difficulties and conflict, and situations that staff personally identify with. Kavalieratos and colleagues examined burnout among a broader range of hospice and palliative care professions through focus groups, and identified the main stressors as: workload, tensions between staff, and regulatory issues (Kavalieratos et al. 2017).

Given that elements of the work environment (including staff tensions) are suggested as key antecedents of work distress, it is important to consider the different contextual influences of HCPs working in different palliative care environments, such as a hospice inpatient unit, as the pressures experienced there may differ from other palliative care

settings, such as in the community or an advisory service in a hospital. In addition, an existing gap in the research is a good understanding of the factors that might moderate the relationship between potential stressors and distress. Moderators of distress could be included in any intervention designed to help hospice care staff to manage potential stressors and thereby reduce distress. Previous research has highlighted that there is a need for interventions of this nature to be rigorously developed based on good evidence (Hill et al. 2016). Consequently, the present study aims to identify: the potential stressors experienced by healthcare staff working in a hospice inpatient unit environment; and how these staff manage these stressors.

## **METHODS**

The methods are reported according to the COREQ guideline (Tong et al. 2007).

This qualitative study adopted a phenomenological approach using a semi-structured interview schedule. The interview schedule was informed by previous research and pilot tested and structured according to the Job Demand-Control-Support (JDCS) Model (Karasek 1979; Johnson and Hall 1988), which has been influential in exploring occupational stress, how it is managed, and its relationship to employee health and psychological well-being (Van der Doef and Maes 1999), and has been used previously to explain work distress among physicians and nurses (Fischer et al. 2016; Negussie and Kaur 2016). Participants were asked about the aspects of their job that are challenging and rewarding; their perceptions of workload; their experiences of working with colleagues and other professions; flexibility and control within their role; support available for managing stress in the workplace; strategies they would recommend for managing stress; and any barriers they experience to managing stress effectively.

Purposive sampling was used, whereby an invitation to participate was circulated to all nurses and doctors who had been working in the hospice adult inpatient unit for at least three months. This time frame was chosen to ensure that the participant would have enough experience in their role working in this environment to address the interview topics. The invitation was issued by the clinical leads in the hospice and highlighted at team meetings. Anyone interested in participating made this known to one of the administrative staff, who passed this information to the researchers. Participants were made aware of the overall aim of the research study. The participating hospice has an 18 bed adult inpatient unit in a UK region with approximately 300 admissions a year, over 100 discharges and almost 200 deaths. Occupancy levels are consistently high at over 85%. The hospice is typical of those seen in the UK, providing palliative care and managed by a charitable organisation.

Face to face individual interviews were conducted for those expressing willingness to participate during work hours in a room separate from the participants' working environment, by a male and female researcher independent to the hospice (JS & MMcK), both with training in qualitative research methods and who were postgraduate students at the time of the interviews. The researcher was unknown to participants prior to data collection. Anonymity was assured. Interviews (which lasted a median time of 31 minutes) took place in a private room in the hospice (January to May 2019), were audio recorded and subsequently transcribed. The data was analysed using thematic analysis as described by Braun and Clark (Braun and Clarke 2006). Themes were identified inductively and at an explicit level to ensure the themes were strongly allied to the data and that the interest was solely in what the participant said (Patton 1990).

Firstly, the interview data was transcribed and read to gain familiarity, with initial ideas being noted. Next, initial codes were generated inductively to gain knowledge in regard to the participant's actual experience of stressors in the hospice and how these are managed.

Third, themes were generated from collating the codes identified previously. Next, themes were reviewed to ensure they were accurate in relation to both the codes identified and the overall data set. Fifth, the themes were defined and named before, finally, the analysis was written up and related back to the research questions and literature.

This process was undertaken by a primary analyst. As a credibility check on the process of analysis and final themes identified, all transcripts were read by a second analyst and the primary analyst explained the process of coding and determination of final themes to the second analyst. Themes were agreed by both analysts. It was also agreed that data saturation had been achieved prior to the interviews ending.

Ethics approval was obtained from the University Ethics Committee (Ref: EPS 18\_194).

## **RESULTS**

A total of 19 individual interviews (10 nurses, 9 doctors) were completed. They included a range of full time and part time staff and a range of years' experience (less than 3 years to more than 5 years). Four themes were generated which related to stressors ('unrealistic workload', 'patient care', 'managing relationships', and 'work culture') and two related to managing stressors ('peer support' and 'time out'). All of the themes were found across both staff groups. Example quotes from nurses and doctors are labelled with 'N' or 'D' respectively.

### **Stressors**

#### Unrealistic Workload



Participants consistently indicated that there is insufficient time to complete all their tasks in the working day:

*“totally overwhelmingly unrealistic...we could work 24 hours a day, 7 days a week and still not get everything done that needs done” (N1).*

As a result, work was not delimited:

*“It will be left undone until we get the time, sometimes we have to do it over lunch or breaks or, you know, when we are meant to be home” (N2)*

*“a challenge for everybody working is just trying to balance the many demands... to try to fit everything you need to do into your day and try not let it spill over into becoming the rest of your life as well” (D1).*

The effect of workload was compounded when there were staff absences, which was not an unusual occurrence:

*“Things become more stressful...one of the biggest things that influence that is the level of staff but you can't predict from one day to the next who's going to be here, who's going to be unwell” (N3).*

Furthermore, there was a perception that staffing levels were not acknowledged by senior management:

*“no matter how many times you say it, no-one listens to us above. They'll have had some computer programme, it tells you how many staff you need, but it's not real life... it doesn't take into consideration that one of your staff is off sick” (N1).*

*“and maybe the people who are a little bit higher up listening to the people who are on the ground saying – there aren't enough of us around today to do this” (D2).*

## Patient Care

Nurses and doctors explained how they perceived a change in that they were caring for younger patients at the hospice and reported the impact this had:

*“we’ve a lot more patients under 65 now, a lot more younger patients...so they bring their own complexities as well” (N5).*

*“We deal with a lot of patients that have a lot of needs and young patients as I said before. That can be really, really emotionally draining for everybody” (D2).*

However, the remainder of this theme was constructed for nurses and doctors in a different way and related to their perceived roles in patient care. Nurses highlighted the increasing complexity of hospice care in responding to the needs of a greater variation of patients, particularly symptom control and pain management:

*“their symptom managements are much more challenging...we’re ending up nearly like a high dependency unit sometimes whereas before it would have been just, you know, comfort care” (N5).*

This in turn influences the amount of time spent with medications, instead of time with the patient:

*“I have very little contact with the patients... I’m in the drug room doing IV [intravenous] antibiotics, doing syringe drivers ... there’s a lot more demands... all those kinds of things are time consuming...years ago we wouldn’t have had that which gave you more time with the patient” (N7).*

Indeed, nurses emphasised the positive impact of patient contact on their psychological wellbeing and the perception that this contact was being prevented or reduced by increased medicalisation was, therefore, a threat:

*“I particularly like the one on one care because I think that’s what palliative care is about and sometimes I think it gets lost in the dynamics of the day... that’s what I find most rewarding but very difficult to get,” (N3)*

The doctors in the study spoke about how the patient care part of their job compares with the work of other physicians in non-palliative care settings and the challenges that this raises in relation to curing patients. Some doctors had resolved this conflict in a positive manner:

*“in terms of its ethos [palliative care] is different, we’re not in the narrative of curing ... I think it’s by far the most rewarding job I have ever done” (D4).*

However, other doctors indicated that they were missing an important element of the work of physicians:

*“We have the same strains [as general practitioners] ... but we don’t have the same ups... I cure nobody. There’s no up for me” (D3)*

### Managing Relationships

There was some tension around what was considered to be misperceptions of the role of different staff members. For example, some doctors indicated that decisions are made in the best interests of patients and they could not comprehend why others would question these decisions:

*“Quite often the decision has to be made by the doctor and sometimes other members of the team can be critical of that decision or second-guess that decision without understanding the weight of that decision on the doctor” (D2).*

However, a different perspective was provided by other nurses and doctors who said that they were excluded from the decision-making process, either because they did not have the time to attend multidisciplinary team meetings or because the reasons for the decision were not cascaded to them, yet they were in a position of communicating the decision to family members:

*“we’ll question why things are happening because we’re dealing with those patients day in and day out... maybe a drug is stopped or an intervention is done... the challenge is*

*trying to understand why those things have happened because we're the first port of call for the families as to why something's happened or not happened"* (N3)

This misperception of the role of others could result in additional work being requested from staff, which could lead to a feeling of not being valued or being overwhelmed:

*"I sometimes don't think they appreciate the pressure on us because it all comes back to the nurses. So the [other health professional] might say...could you fill out the paperwork for them... inevitably it all comes back to us ... I don't know if people appreciate that they're the fifth person to ask me to do something in the last twenty minutes and I can't do everything"* (N1).

The perceived tension in relationships obviously impacted on interpersonal relationships:

*"The biggest stressor is the interpersonal relationships within the teams...the clinical challenges are less than the staff and internal politics which are at play ... it's all just personality and history between different folk."* (D4).

### Work Culture

The above stressors were readily identified by participants as issues which impacted on their well-being at work. However, the theme of 'work culture' had a more insidious nature. When participants were discussing workload issues (in particular), they highlighted how this is problematic, but then often made an attempt to present this as the norm and accepted the situation. This cognitive dissonance is a potential source of stress:

*"All jobs are busy ... We think we're very busy – and we are very busy, it's not saying we're not, it is a very busy job – but I kind of think, you know most jobs are very busy and pressured. I think that's life"*. (D5).

*“support isn’t the problem, the problem is you’ve 20 jobs to do but only 2 hands, so inevitably you’ve to just keep going,”* (N1).

This suggests a workplace culture where working additional hours is common practice and where staff experience guilt when not following suit:

*“Generally folk work above and beyond with their hours, I know that. I’m guilty of that as well. It’s a mixture of causes ... there’s a kind of almost guilt”.* (D4)

## **Managing Stressors**

### Peer Support

In addition to the stressors identified in the themes above, participants also reflected on their experiences of what helped them to manage distress in the workplace. They identified ‘peer support’ and ‘time out’ as two effective approaches.

Having informal contact with colleagues was identified as a source of support across the interviews:

*“we all had a cup of tea and just talked about all the stuff that was good and bad and those are really good, really good for the team morale”* (N1)

This peer support was described as a useful informal debrief:

*“it’s having friendships, you can talk to each other...you know not formally or in the debrief...just informally debriefing with each other and getting that reassurance that you done the best you could do...just getting reassurance”* (N9).

Participants expressed the benefits of having peer support and how this mediated stress experienced:

*“I would get a lot of benefit talking to [others] because they’ve been there and done it and know exactly what I’m talking about and they can relate to what I’m saying. It’s not*

*judgmental and I think peer groups are really good because you're allowed to vent and allowed to talk about it in a protected environment.” (D2).*

### Time Out

Participants also highlighted the importance of being allowed to take a short break from the busy workplace to address difficult situations in their own way. In some cases this was explicit:

*“it's good sometimes just to take time out and reflect and to look at how we respond to things” (D5)*

*“years ago, somebody would have said take a cup of tea into the linen cupboard... nobody disturbed you, then you were able to come out and face it again. You just needed that time out...it would be nearly impossible to do that now...allow that time that's protected just for you” (N2).*

This example evokes a warm, protective, compassionate image that has been lost from the past.

The notion of 'time out' was also expressed in subtler ways. Often participants talked about the comfort they felt from spending time with patients but the common feature in their descriptions was that they were isolating themselves from the busyness of the rest of the workplace:

*“you're always on the clock but when you're in there with them and the door's closed and you've the sign on the door...they're having their personal hygiene and that's kind of the best time” (N4).*

## **DISCUSSION**

Four stressors were identified in the study. These will be considered from the perspective of the JDCS model.

### **Demands**

Hospice staff highlighted the demands of workload and of adapting to the changing nature of palliative care work. These findings are similar to the job demands found in other studies conducted with hospice and palliative care staff (Kavalieratos et al. 2017; Peters et al. 2012; Powell et al. 2019). This stressor (which comprises time pressures and staff shortages) has also been found in studies with doctors and nurses outside palliative care (Johnston et al. 2016; Martins Pereira et al. 2011) and is a common work demand found across a range of professions (Gillespie et al. 2001).

Powell et al. (2019) showed that another important stressor is when palliative care nurses identify with the patient they are caring for – they called this theme ‘too close to home’. This is similar to part of our theme of ‘patient care’. Within this theme, staff indicated that hospice care patients are becoming younger and, therefore, more similar to the age of the staff who are treating them.

### **Control**

Although perceived work demands are potential stressors, perceiving control over your work can “buffer” these negative effects in the workplace (Van der Moef and Maes 1999). However, in the current study, some staff indicated that they had little control over their work and this perceived lack of control amplified the problem of high demands. For example, staff pointed out that due to unpredictable staff sickness, the hospice could be an unpredictable environment to work in. Also, staff talked about the increasing complexity of hospice care (part of the ‘patient care’ theme) and how this forced them to spend increasing amounts of time away from patients. This finding seems to be specific to healthcare staff working in a hospice inpatient unit. The increasing medicalisation of their role creates a

situation where nurses suggested that their role is being modified and the parts of their job that they enjoy (patient contact) and that moderate work distress are being eroded. Therefore, a protective factor is being removed and the nurses report feeling powerless to prevent this.

Some doctors in the study also pointed to lack of control in the theme 'patient care'. Although having chosen to work in an inpatient hospice care setting in the full knowledge of the type of patients they would be working with, the relentless lack of curing patients seemed to be wearing down many of the doctors in the hospice. This could be a result of an idealised comparison with their peers in a non-hospice care environment or it could be a way of expressing the effect of the constant exposure to death and dying. 'Living with sadness', because of the frequent loss of patients with whom you have had close interactions, has been identified as a stressor in previous research (Powell et al. 2019).

## **Support**

As with control, support in the workplace is a moderator between stressors and distress. When it is present, it can help to alleviate or prevent distress but when absent it can add to the distress experienced. In the current study, staff indicated where a perceived lack of support existed but were also able to identify sources of support that could be helpful.

Interpersonal conflict is the opposite of peer support in the workplace and this conflict was alluded to by staff. Tensions between staff and team communication difficulties have been identified as stressors in previous research among hospice and palliative care staff (Kavalieratos et al. 2017; Powell et al. 2019). In the current study, staff also identified informal peer support as a useful coping mechanism, which matches with the findings of Powell et al. (2019) who reported that the most widely identified coping strategy from palliative care nurses was 'offloading' and gaining support from colleagues. Indeed, interpersonal relationships and support from colleagues are identified resilience strategies used by GP's, consultants and physicians from different disciplines (O'Dowd et al. 2018).



There is some acknowledgement of the importance of peer support in strategies employed by organisations to manage potential distress, for example, debriefs and Schwartz Rounds. Schwartz Rounds typically occur in structured, multidisciplinary group settings and involve exploring difficult situations or patients, often requiring staff to share their thoughts and feelings about their work (Taylor et al. 2018). Such organisational strategies require staff to have a certain degree of self-reflection, openness and awareness of their emotions, along with problem-solving skills. In contrast, participants in the current study emphasised the value of a more informal and less cognitively challenging support system.

In the current study, participants identified that, at times, they perceived a work culture that encouraged acceptance of heavy workloads. This could potentially feel like an unsupportive environment as it creates an expectation of working beyond normal hours, which forms a barrier to discussing how this might be resolved and causes distress via guilt when the person is trying to adequately manage the boundary between work and home life. When staff do not feel empowered (either actual or perceived) to discuss their job pressures and seek solutions with management, and their time in work is relentless to the point that there is no space to accommodate 'time out' in the working day, then staff might conclude that their only recourse is to take time off work. This situation then can create a 'vicious cycle': staff are ill (possibly as a result of burnout) and are absent from work; this then places further demand on the remaining staff, potentially resulting in them requiring leave and continuing the cycle. The original response gives rise to effects which essentially feedback to the original problem, either maintaining or worsening it (Kennerley et al. 2011). This hypothesised maintenance pattern has organisational consequences and consequences for staff well-being.

Although employers might reasonably argue that there is a limit to the staffing resources that can be provided and that they do not encourage a culture of working longer

hours, a proactive approach to this issue could be for employers to show compassion to the current difficulties experienced within the organisation. A model of compassion in the workplace has evolved around noticing and having an openness to what's going on in the environment, feeling or showing empathy for the person, and responding appropriately (Kanov et al. 2004). This model has many similarities with the Institute for Healthcare Improvement's Framework for Improving Joy in Work (Perlo et al. 2017). Compassionate communication to staff, which includes non-verbal communication, can be effective in relieving distress (Miller 2007) and a compassionate workplace can protect staff from burnout (Kahn 1993). In fact, minimising compassion fatigue among hospice and palliative care staff can also impact positively on the quality of care experienced by patients (Powell et al. 2019).

A low-cost compassionate workplace could be fostered by implementing 'well-being breaks' for staff during work hours, where staff can avail of informal peer support or simply have time alone to process their thoughts in a designated space. Perhaps regular staff coffee mornings could also be useful. These would be multi-purpose in that they would give staff time out from their busy day; encourage staff to communicate with colleagues to develop an understanding of their work; and create a sense of being valued among staff. The dividends for the organisations and patients could be large for a small amount of physical and psychological nourishment. Such initiatives ought to be rigorously evaluated before being recommended on a large scale.

### **Study Limitations**

Collecting the data in the hospice setting is a useful way to facilitate staff participation. However, this meant that participants needed to take time out of their busy working day to participate in the research and this might have negatively influenced responses to the interview questions. Ideally, this type of research would be conducted in a

neutral venue with no time pressure on the participants, but this in turn could result in a low participation rate.

## **Conclusions**

The current study has sought to extend knowledge of and provide clarity about the stressors experienced and how these are managed by hospice staff. The themes which were constructed demonstrate the complexity of personal, interpersonal and system-level factors which all interplay in the work experience. With an ageing population and inevitable increase in demand for hospice care, it is essential for services to ensure the well-being and retention of their staff. The compassion (for patients and families) that is central to the hospice ethos (Peters et al. 2012) should be extended to staff. Compassion creates compassion – those who experience it are then more likely to demonstrate it towards others (Goetz et al. 2010).

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### **Reflective questions**

1. What are the 3 components that contribute to work stress according to Karasek's model?
2. According to this research, what are the 4 main stressors faced by doctors and nurses in a hospice environment?
3. What are the 2 moderators of stress identified by participants in this research?