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DR MARGARET O'CONNOR AM FACN AND TIM MOORE

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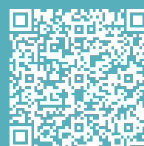

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HOW TELEHEALTH ENHANCED COMMUNITY PALLIATIVE CARE SERVICE RESPONSES DURING COVID-19

Contributing to sustainable health care

BACKGROUND

Telehealth, while available in Australia for many years, has come into its own during the COVID-19 pandemic over 2020-2022, with calls by various medical groups to make it a permanent feature of Medicare (Dykgraaf et al., 2021). Telehealth enables connections between those who require care from health and support services, and eases the difficulties of distance, access and travel time, among others (Burbury et al 2021, Johnston et al., 2011). Telehealth consultations may reduce episodes of hospitalisation and will ultimately contribute to a sustained change in health care delivery by normalising this method among other modes of care (Dykgraaf et al., 2021).

While the benefits of telehealth are demonstrable when distance is an issue, there is increasing demand from urban dwellers for more remote access to their health carer, to promote their independence and control; for example, for 24-hour access to information and support and to computerised resources like assessment tools, to assist in self-monitoring (www.csiro.au).

COVID-19

The catastrophic impact of the pandemic on all health care services has been well documented (Dykgraaf et al., 2021), including reports of those requiring acute health care being fearful of attending appointments and reluctant to present for procedures (Bloom et al., 2021).

The impact of COVID-19 on community-based palliative care has remained somewhat hidden. Anecdotal evidence points to an exponential increase in workload, mainly precipitated by visitor restrictions in institutional health settings. Forced separation between a dying person and their family, arising from such policies, caused much grief and anger (O'Connor & Wilson 2021). As a result, many family members chose to care for their loved one at home, wanting to be by their bedside until death. Thus, community palliative care services have experienced many more referrals from families wanting to provide this care; and consequently, the rate of deaths at home significantly increased.

Staff required an essential service permit to travel beyond the geographic limits imposed on the community and often needed to traverse checkpoints. At the height of the pandemic, community palliative care staff were challenged by situations such as needing to assess the dying person in a home where family members, or the dying person, were COVID-positive. Staff worked in full personal protective equipment, often donning and doffing on the veranda of a home. The risk of contracting COVID-19 in such home environments was high.

COMMUNITY PALLIATIVE CARE

Well before the COVID-19 pandemic, a Victorian Auditor-General's Report (2015) recommended that palliative care services needed to be more responsive to unmet demand, especially for those who may experience barriers to care; and to ease access to such services. Perhaps, like other health care services, telehealth only became a realistic option in palliative care when faced with the challenging pandemic environment, as a substitute between face-to-face visits, or to replace visits altogether for a time where possible (Dykgraaf et al., 2021). One home-based palliative care service uses a program called 'PalCareGO', a model that has incorporated telehealth video consultations into the organisation's existing data platform. Integration with the existing data system was important, so that telehealth would be regarded as an equal choice among other methods of contact (Tieman et al., 2016).

Besides being able to accommodate an increased daily workload, the efficiency provided by telehealth consultations has also enabled more time for planning care with the person in need. While telehealth did not replace all physical home visits, being able to substitute visits for telehealth when needs could be met using this mode, meant the service could respond to more people requiring palliative care support. Additionally, specialist medical staff were

“ The impact of COVID-19 on community-based palliative care has remained somewhat hidden. ”

encouraged to connect using the program to work more effectively and collaboratively with other relevant health care providers.

Including telehealth as a component of the support provided to those in need of care has resulted in benefits such as more efficient discussions about care options and reducing unnecessary tests and treatments. It has also enabled the inclusion of family members where it may otherwise have been difficult to gather for a face-to-face family meeting. Some users spoke of the additional involvement in their own care to, for example, managing and reporting their symptoms. Telehealth provided the necessary close clinical support, enabling a more efficient use of time. Hospital admissions have also been alleviated in some instances, where issues could be flagged at onset and appropriate advice given by clinicians. Reduced need to travel to the home has meant that staff are able to support more individuals in their daily workload.

While telehealth is reported as promoting a sense of control for the person receiving care, there have been inevitable difficulties in assisting some to take on new technology, as well as limitations in relation to availability of equipment and broadband. Johnson et al., (2011), caution about discrimination based on ability to engage with technology, be it in skills, physical ability, or affordability. Anecdotally, staff reported telehealth can be more effective than a phone call due to the increased rapport, and visual and body-language cues which can be missed with only a phone call.

Implementation of the telehealth technology has also been difficult for some staff, with varying degrees of readiness evident; differing professional confidence in assessing a person via this technology; and reports of technical quality challenges.

CONCLUSION

While not suitable for all in need of palliative care, telehealth is now a routine offering for some. It seems hopeful that this ongoing provision and surveillance can contribute to higher levels of engagement and self-determination for those requiring care.

Ultimately telehealth needs to be perceived as trusted and valuable for both those needing care as well as the staff involved in providing this care. While anecdotal reports were positive from staff and clients in regular use of this technology, further work is required to demonstrate the outcomes in relation to both organisational efficiency and clinical effectiveness.

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DR MARGARET O’CONNOR AM FACN

TIM MOORE

CREATING RESPECTFUL WORKPLACE BEHAVIOURS

Making a difference for everyone

Negative workplace behaviours in the nursing profession are a common occurrence and have been found to have damaging impacts upon individual nurses' emotional and physical health as well as on the quality of care provided and patient outcomes (Hartin et al., 2018, Hawking et al., 2019a). On a daily basis around the world, nurses are subject to these behaviours and often describe their workplaces as 'battlefields' (Hartin et al., 2018 p2). Negative workplace behaviours can be classified into three categories: work-related bullying (e.g. unmanageable workloads or withholding information); person-related bullying (e.g. being humiliated or ignored); and physically intimidating bullying (e.g. being shouted at or even threats of violence) (Einarsen et al., 2009). There are many organisational factors, such as culture, area of employment (e.g. high intensity areas), workload, and management leadership styles that have been identified as contributing to the prevalence of these behaviours in the workplace (Karatuna et al., 2020; Wolf et al., 2021).

In my role as a clinical nurse educator and an academic in a regional setting, I have witnessed the distress that new graduate nurses experience when they are exposed to negative workplace behaviour, such as bullying, harassment or incivility. I genuinely wanted to make a difference to the work lives of my colleagues, which led me to further study through the University of Newcastle, where I am now completing my PhD. To begin, I completed an in-depth literature review where I discovered that despite previous extensive research being undertaken, negative workplace behaviour amongst nurses continued to be problematic (Hawkins et al, 2019a; Hawkins et al., 2019b). I also discovered that while there were a plethora of explorative and descriptive studies calling for action to mitigate bullying and harassment due to the negative impact on nurses and patients, there was a lack of implementation research with feasible interventions and actions in acute care settings, particularly in rural areas. There had also been very few studies undertaken that included comparison or control groups (Olsen et al., 2020), and this helped me recognise the gaps in the literature and design my study.

> **“ Increased stress on nurses creates the perfect environment for negative behaviour to thrive. ”**

In response to the need for higher quality evidence, my study aimed to investigate self-reported exposure and experiences of negative workplace behaviour and ways of coping for nursing staff before and after educational workshops. The detailed study protocol is published elsewhere (Hawkins et al., 2021). Data was collected at two points in time (before and after the workshops) using a structured questionnaire. Nurse unit managers, registered nurses, and new graduate nurses (N=230) from 12 medical/surgical units in four regional acute care hospitals were invited to participate in the study. Two hospitals were assigned as intervention sites, where the educational intervention would occur, and two hospitals were assigned as control sites (no education). After the first data collection period was complete, face-to-face educational workshops were implemented by the organisation at the two hospitals that were assigned as intervention sites.

The intervention was in the form of educational workshops titled, *The Respectful Workplace Workshops*. These comprised three copyrighted face-to-face training modules that were developed and delivered at the two intervention sites by the Respectful Workplace Team at the Local Health District (LHD). The aim of the modules was to promote respectful workplace behaviour by improving communication between staff members for the purpose of recognising, managing and mitigating negative workplace behaviour (LHD, 2016). The modules used a combination of training methods, including role-play, brainstorming, didactic teaching with PowerPoint presentations and workbooks. The second stage of data collection occurred three months after these workshops were completed.

The response rate was 32% (n=74) in the baseline survey and 24% (n=56) in the follow up survey. A total of 28.5% (n=16) of participants completed both questionnaires. Overall, 111 participants attended the educational intervention, 20% (n=22) completed the follow up survey. This study found that participants were exposed to both bullying (31%, n=40) and uncivil behaviour (46%, n=59) at rates similar to those reported in previous studies (Simons, 2008; Johnson & Rea, 2009). In this study, participants indicated they were more likely to be exposed to work-related negative acts, such as excessive workloads, compared to person-related and physically

intimidating negative acts (Hawkins et al., 2022). Participants used a variety of ways of coping, with the majority utilising problem focused coping strategies and seeking social support when exposed to negative behaviours. Although in the bottom five reported ways of coping, there were still 23% of participants who indicated they took it out on other people which is concerning given the endemic nature of the problem.

Overall, there was a small decrease in levels of bullying and incivility experienced by participants across the total sample in the follow up surveys (Hawkins et al, 2022). However, participants at the intervention sites reported a rise in incivility levels. This was surprising, given the workshops were delivered to these sites and aimed to improve the culture. However, similar findings have been reported in other studies, which can be attributed to a heightened level of recognition of previously covert negative behaviour (Chipps & McRrury, 2012). The detailed findings are published elsewhere (Hawkins et al., 2022).

While findings from this study have strengthened evidence related to organisational interventions to mitigate negative workplace behaviour amongst nurses, there was insufficient evidence to indicate the workshops were the source of changes in the levels of negative behaviours experienced by participants. The most common type of bullying experienced overall by participants in this study were work-related acts such as exposure to unmanageable workloads and being given tasks with unreasonable or impossible deadlines. It needs to be noted that educational interventions aimed at improving interactions at a staff level have little to no influence upon the workloads or deadlines that staff have placed upon them. There remains scant evidence supporting the use of individually focused educational interventions aimed at improving knowledge, recognition and response to negative behaviour as a standalone measure to mitigate the behaviour (Johnson & Rea, 2009).

Consistent with previous studies (Hutchinson et al., 2009; Hartin et al., 2019), this study highlights that the ongoing deprivation of resources within some organisations, including lack of staffing, and excessive workloads, places increasing stress upon nurses and creates the perfect environment for negative behaviour to thrive and become the cultural norm. Therefore, hospital administrators must consider the effect of work-related bullying acts, such as unfair or unreasonable workloads and lack of resources, upon individuals when aiming to develop a respectful workplace culture. Creating respectful workplaces is not easy but it is possible if we all work together to eliminate negative workplace behaviours.

ACKNOWLEDGEMENT

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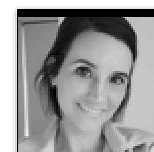


AUTHOR

TASH HAWKINS MACN

Fremantle Hospital Museum

A visit to a hidden gem

“As nurses, we should all be proud of the contribution we each make towards the nursing profession.”

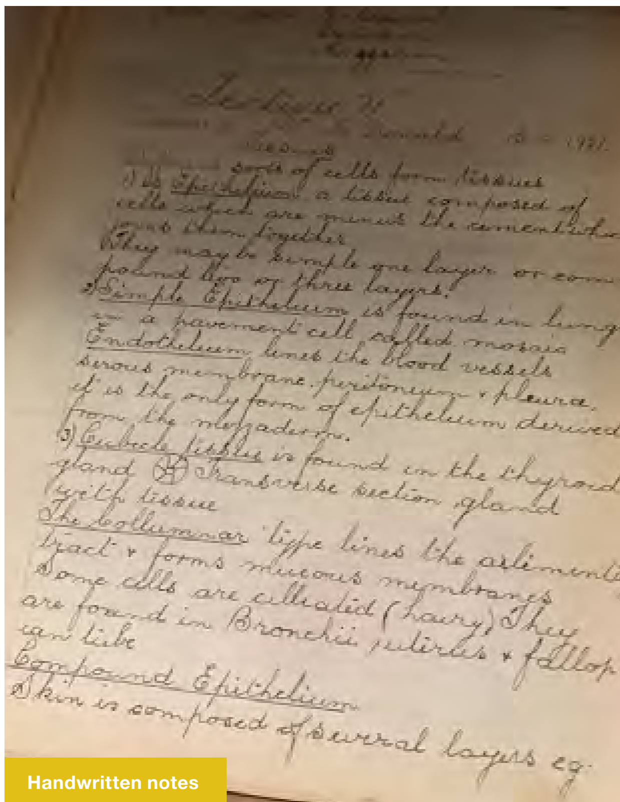
Early equipment and nurses’ uniforms

Much like many of the restaurants and dining places in Fremantle, the Fremantle Hospital Museum is a hidden gem. The key to sightseeing in Fremantle is for a local resident to tell you the secrets to all the right places to go! Interestingly, the Hospital is placed next to the infamous Fremantle Prison, a prison no longer in service, but a great tourist attraction in Fremantle and one of the largest surviving convict prisons in the world. The hospital itself was originally housed in a residence called the Knowles before becoming Fremantle Public Hospital in 1897. Walking through Fremantle Hospital, one stumbles onto this local treasure within the hospital walls.

The founder of the museum, Ruth Letts AM, offered a friendly greeting at the door. She is an enthusiast for the history of nursing in Fremantle. What Ruth, as the last Matron of Fremantle Hospital, omits to tell you is how greatly she has contributed to the history of Fremantle Hospital – after all she began her nursing training here in 1973 and spent almost her entire career at the Fremantle Hospital. The hospital’s storyincludes the history of the nurses who trained in Fremantle from the 1960s when training was still hospital-based. The museum volunteers have worked tirelessly to ensure that the stories of the nurses who trained at Fremantle Hospital are told. Ruth has a wealth of knowledge and has worked towards bringing the history of these nurses to life – hearing their stories makes you feel that you know them personally.

An extremely fascinating part of the Museum tour was the reports and stories of the nurses who studied and worked at Fremantle Hospital. This makes it possible to find personal records of any friends or family who may have studied and worked at Fremantle Hospital, adding to the sense of closeness. Former trainees can also look back at their own training records and reminisce about their time at the hospital. The photos of the nurses are accompanied by descriptions of how each nurse contributed and brought to life the culture of Fremantle Hospital.

Walking through the museum, one is overwhelmed by the amount of history that can be packed into five small rooms. It is packed with artefacts and documents that have been found in the hospital or donated. Walking back through time, you start with the paediatric room with medical devices once used from neonates to adolescents. Going through to reception you are reminded of the technology once used to collect data including typewriters and the first desktop computer acquired in 1984, while in the next room you are presented with medication ampoules, some still unopened! These ampoules are believed to have been


Lecture II
Tissues
sorts of cells form tissues
1) Epithelium a tissue composed of
cells which are
them together
They may be simple one layer or com-
pound two or three layers.
2) Simple Epithelium is found in lung
a pavement cell called mosaic
Endothelium lines the blood vessels
serous membrane, peritoneum & pleura
it is the only form of epithelium derived
from the mesoderm.
The collumnar type lines the alimenta
tract & forms mucous membranes
Some cells are ciliated (hairy) They
are found in Bronchii, tubules & fallop-
ian tube
Compound Epithelium
Skin is composed of several layers eg.

Handwritten notes

The medicine tray

Electroconvulsive therapy machine

Hyperbaric chamber

buried between 1925 and 1939. Each of the rooms offers up evidence of past medical technology in its displays. These include the hyperbaric chambers once in use and different surgical instruments, some still in use. There are also mannequins displaying nursing uniforms throughout the years.

We moved onto the old medical records and the beautiful handwritten archives. Our fellow medical officers could take some lessons from these matrons on how to write legibly! While the uniforms and instruments are fascinating, the written records and photographs really bring to life the rich history of Fremantle Hospital and nursing and how people lived and worked here. They are also a reminder of other epidemics and disease outbreaks from diphtheria to measles and typhoid to Spanish flu – COVID-19, as we know, is not the first outbreak we have experienced.

This helps to better understand the journey of nursing and the advances that have been made from once being considered a trade to now being a profession – one of the most trusted in Australia!

As nurses, we should all be proud of the contribution we each make towards the nursing profession. Museums such as the Fremantle Hospital Museum allow us to reflect on each person's contribution to the nursing profession as it is today and appreciate the milestones and achievements that have been made throughout the decades. If you find yourself in the region, the Fremantle Museum is well worth a visit to relive the history of nursing in Western Australia.

The Fremantle Hospital Museum has a series of books which can be purchased and which outline the contributions from Fremantle Hospital nurses. These books took over a year to compile, ensuring all information included was accurate. The proceeds of the books go back into developing the Museum to allow continued learning about our rich nursing history.

The museum is currently open on Mondays and Wednesdays.

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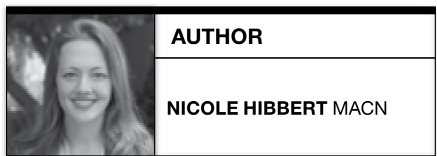

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