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Understanding Quality of Care in a Hospice Setting

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College of Health Sciences

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Walden University

2018

Abstract

Understanding Quality of Care in a Hospice Setting

by

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MSN, Walden University, 2014

BSN, Western Governors University, 2012

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

May 2018

Abstract

Assuring quality of care for patients who face the end of life has been a major concern for those in hospice settings. Limited research is available that has a focus on understanding what quality of care in a hospice setting looks like. This research is important to provide insight into hospice health care providers' perceptions of the quality of care in the hospice setting and on the indicators that influence care quality. A qualitative phenomenological approach was used to answer the research questions on the perspectives of the health care providers in the hospice care setting regarding the quality of care and the factors that health care providers perceive as important to the quality of care in the hospice setting. Kolcaba's comfort theory served as the theoretical framework that guided the preparation of the questions used for the interviews and for interpreting the findings. Data collection was conducted through structured interviews with a sample of 15 hospice health care providers. Interviews were held in a private office of the hospice setting. After Walden Institutional Review Board approval, participants consented and interviews commenced. Data were transcribed and Nvivo software was used to assist with identifying major themes. Recommendations from the study reflect Kolcaba's comfort theory providing patient-centered care and enhanced quality of care for patients in a hospice setting. The research findings and recommendations will help promote a positive social change by raising awareness for effective provider communication, staffing, education and adequacy of resources in the hospice setting.

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Chapter 1: Introduction to the Study

Hospice care is a specialized medical care program designed to offer emotional, psychological, and medical support to the chronically ill. Although the essence of having hospice care facilities is to ensure patient safety and provide quality care with an aim of alleviating pain, many staff in hospice settings are still unaware of the indicators that may improve quality of care (Nicol & Nyatanga, 2014). Health care providers play an important role in determining the quality of care in a hospice setting (Hughes, 2008). One of the major problems facing hospice settings is associated with the dramatic increase in hospice patients and the limited number of health care providers. Even though qualified providers are limited in supply, health care professionals, paraprofessionals, and family members have always worked toward ensuring that the quality of health care is maintained (De Chesney, 2014).

The Institute of Medicine defined *quality care* as the provision of effective and timely patient care that is safe and patient-oriented (Hughes, 2008). The Institute of Medicine uses six aspects to define quality care: effectiveness in care, equity in care, patient-oriented care, safe care, timeliness in care, and efficiency in care (Nelson & Watson, 2013). Although each health care provider has a different understanding of quality care, there are fundamental practices that act as indicators of quality care. These practices range from process indicators, which include descriptions of how things are done in a health care facility, to outcome indicators (Hughes, 2008). To ensure quality care, it is pertinent to understand health care providers' perceptions on quality care (Wolf

& Wolf, 2013). Further, it is important to understand what the health care providers' thoughts are on ways to improve quality care in a hospice setting (De Chesnay, 2014).

The main goal of a hospice program is to ensure comfort and enhance the quality of life for the patients (Casarett, 2015). Regardless of the type of hospice setting, quality services are paramount in end-of-life care for a smooth and comfortable transition (Nelson & Watson, 2013). Factors such as an inadequate number of care givers and resources have been attributed to low quality care (Wolf & Wolf, 2013). Quality care can be divided into two dimensions, namely, functional and technical quality (Miller & Mor, 2014). The technical quality in a hospice setting is primarily the basis of accuracy in technique-related activities, especially during diagnosis and procedures. The functional quality of health care services refers to the way in which the services are offered to the patient.

The identification and description of the environment or context of a study is essential in understanding the applicability of the results of a research (Dresch, Lacerda, & Cauchick, 2015). This study was conducted in a hospice care setting, located in the southwestern area of Houston, Texas. The hospice setting is a profit-based organization aimed at providing quality care to individuals who are terminally ill. The setting provides the option for in-home care and inpatient hospice care. In general, the setting provides services to 250 home-based hospice patients as well as 120 facility-based patients each month. The hospice operates with the help of 500 employees. Three hundred of the employees are hospice aide's nurses and physicians.

Patient care should be of optimal quality for hospice to achieve its goal toward attracting more people to trust the services offered (Forman, 2013). The quality of care in hospice settings is one of the areas that has not been routinely researched and studied by researchers and scholars (Mohammad, 2014). As such, more research and analysis is needed to identify what the health care providers' thoughts are regarding quality of care and how care can be improved in the hospice setting. A review of current literature suggested that several hospices still face challenges in providing quality care (Miller & Mor, 2014). The main goal of this research was to understand what health care providers thought about resources, staffing, communication, education, and coordination of care. These indicators are the backbone of quality care in a hospice setting. By creating an awareness of the quality of services provided to patients and closing some of the gaps in the existing literature, this study can educate health care workers in many ways in which they could implement care.

Background

A sudden rise in the number of patients admitted with severe health conditions has been seen in many hospice settings. This increase is consistent with the escalation of general health care problems in the United States (Forman, 2013). Hospice settings have often been the center of attention due to the standards of care provided, an aspect that is influenced by a variety of factors. According to De Chesnay (2014), different indicators account for the reduced standards of care in a hospice setting such as staffing ratio, lack of resources, unqualified staff, poor communication among the health care providers, and poor coordination of care. According to Kolcaba (2013), hospice care providers are the

pillars of quality care in a hospice setting; therefore, to understand the perspectives regarding service provision, it is important to select a specific hospice setting and determine how care is perceived by its providers while they are taking care of the physical and social needs of the patients admitted to the setting (Iliffe et al., 2016). The main goal of this research was to understand what health care providers thought about resources, staffing, communication, education, and coordination of care. These indicators are the backbone of quality care in a hospice setting. The responses obtained from the health care providers were expected to deepen understanding and enhance the quality of care offered in the hospice setting.

Problem Statement

Since the year 2000, the number of hospice providers has increased by 53%, growing to more than 3,500 providers who care for more than 1.3 million hospice patients (Barello, 2015). Even with the increase in the number of hospice providers, quality care in hospice settings remains a problem for many patients and families (Horne, 2013). Various factors have been attributed to the lack of quality care in hospice settings including a lack of appropriate training, failure to use recent medical advancements, regulatory barriers of hospices, as well as the hospices' vision and practices (Casarett, Karlawish, & Crowley, 2013). Lack of training for the hospice staff, limited resources for the provision of quality care, a limited number of hospice providers in the health care industry (i.e., patient–staff ratio), and poor communication among staff affect the quality of care in the hospice setting (Barello, 2015). The need to understand these indicators from the perspective of the hospice health care providers prompted this research in a

hospice setting. This study may provide insight into ways that may lead to program intervention to improve the quality of care for patients who are the consumers of hospice care (see Marrelli, 2015).

Purpose

The purpose of this study was to explore health providers' perceptions of care quality in a hospice setting. Providing quality care for patients who are facing the end of life in hospice care is an essential requirement for all levels of providers in the hospice setting (Marrelli, 2015). This is critical for the nurses and physicians who are positioned to serve the clients with continuous care. End-of-life care encompasses support for patient needs on many levels (Barello, 2015). It involves care that addresses the patient's feelings of satisfaction with the care they receive and it adds value to the quality of the patient's life, in addition to meeting the physical, mental, and emotional needs of the patient (Chesney, 2015). According to Goldman, Hain, and Liben (2014), quality care that addresses the patient's needs leads to satisfaction and adds value to the quality of the patient's life (Casarett et al., 2013). Quality care also includes patient safety and the care provider's coordination and communication. With this study, I sought to gain a better understanding of the providers' perceptions of the meaning of quality of care, what factors impact the provision of quality of care in the hospice setting, and how quality might be improved.

Research Questions

1. What are the perspectives of health care providers in the hospice care setting regarding quality of care delivered in hospice?

2. What are factors that health care providers perceive as important to the provision of quality of care in the hospice setting?

Theoretical Framework

Comfort care theory (CT) was originally developed by Kolcaba, in 1990 and published in 1994. According to Kolcaba (2013), nursing approaches that apply the CT enhances the chances of addressing patient problems in a hospice setting. The CT ensures that the level of care provided is based on patient-centered care and enhances the quality of care provided to the patients in a hospice setting. Interventions provided in patient care should address the contexts of the theory on how relief, transcendence, and ease is important to promote effective patient care and comfort (Kolcaba, 2013). The specific application of the theory forms the basis of providing patient-centered care in a hospice setting and leads to improved outcomes such as a better quality of care.

There are four different contexts in which the comfort of the patient takes place: (a) physical, (b) environmental, (c) sociocultural, and (d) psychospiritual (Kolcaba, 2013). According to Kolcaba (2013), nurses assess the holistic comfort needs of patients in all settings and apply a number of interventions to meet the needs of the patient's comfort levels before and after those interventions. Kolcaba described comfort as anything that makes life easier by lessening grief and inspiring hope. The cognitive view on the need for quality of nursing care can be demonstrated by the theory. It gives an outline of the sensitivity a nurse should maintain while ensuring that a patient receives enough comfort in her or his care. The theory recommends care services to be provided based on a patient-centered approach. CT is based on holistic care, which makes it

appropriate to be applied in this study. According to the CT, providing quality care to patients seeking assistance in a hospice setting should be the primary objective of health care providers (Kolcaba, 2013).

The basic principles involved in hospice care delivery are clinical excellence and safety, workforce competence, accessibility, ethical behavior, family-centered services, and organizational excellence (Barello, 2015). These are congruent with comfort theory principles. The application of the theory's principles guided this study of care practices and recommendations for intervention to ensure the provision of quality care to enhance comfort to patients in the hospice setting. Therefore, I chose Kolcaba's (2013) CT as the theoretical framework guiding this research.

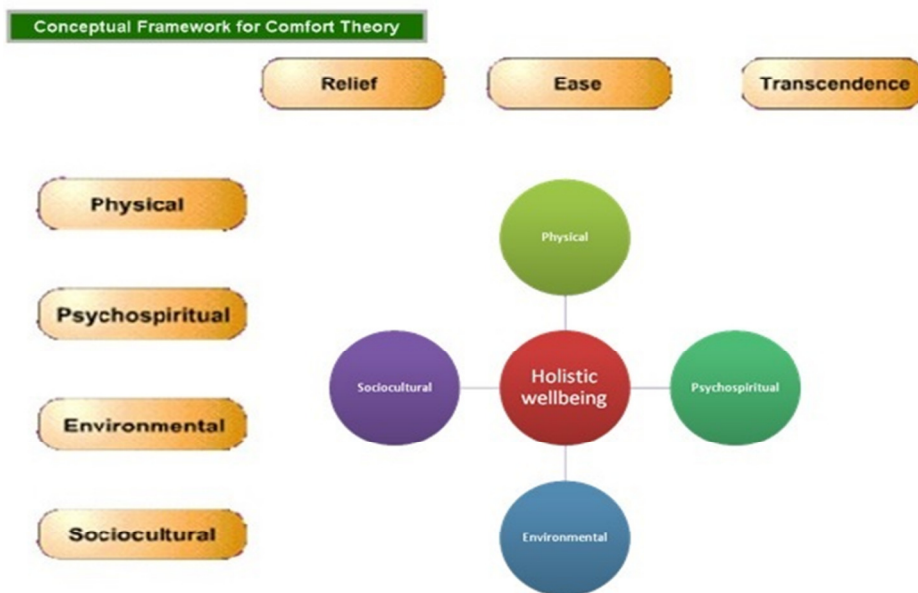


Figure 1. Conceptual framework of comfort care.

Nature of the Study

I selected a qualitative phenomenological research approach, which is well-suited to gaining a deeper understanding of a given problem within a population (Creswell, 2014). Adding interviews to the data collection provided rich data. Information obtained through interviews revealed unpredicted information (see Goldman et al., 2014). Using a phenomenological approach illuminated the specific views of the participants and provided answers to the research questions without bias (Creswell, 2014). I used this method to determine how quality care is perceived by the health care providers who participated in the study. Information gathered through this method yielded quality data through qualitative methods. As such, interviews were an effective method to understand the perspectives of the research participants. The data represents the subjective perspectives of the health care providers.

Definition of Terms

Indicators of health care: Aspects connected to the welfare and health care of the patients who are affected directly or indirectly by the activities of the caregivers. These indicators show how well, or how poorly, the service is offered (Shiu, Jiang, & Tu, 2013).

Quality of care: The provision of effective, safe, equitable, and timely care to the patients. The care given must be patient-oriented (Forman, 2013).

Supportive care: A program designed to meet the physical, emotional, informational, psychological, spiritual, social, and practical needs of the patient during the provision of care (Nicol & Nyatanga, 2014).

Hospice care: An interdisciplinary care that focuses on enhancing the patients' life quality by meeting their physical, spiritual, emotional, and social needs (Nicol & Nyatanga, 2014). Hospice care refers to a philosophy of medical care that places preeminence on the alleviation of illness symptoms and pain experienced by terminally ill patients while, at the same time, offering them emotional and spiritual support (Kao & Chiang, 2015). Because hospice care is focused on caring for patients and making them as comfortable as possible rather than curing them, most patients prefer to receive this care in the comfort of their homes.

End-of-life care: The care that is offered to patients with advanced and incurable medical conditions so that their lives can be as comfortable as possible until they die (Noe & Forgione, 2014).

Quality of life: The subjective experience of life.

Assumptions

One of the primary assumptions in this study was that participants would respond truthfully and candidly to the questions. The participants were assumed to have a sincere interest in participating in this study and not have other motives such as getting a reward. I assumed that participants would provide truthful information about their academic qualifications, which helped in the recruitment process because the sample consisted of registered nurses (RNs), licensed practical nurses, medical doctors, and certified nurse's aides. Therefore, it was pertinent to obtain this information during the recruitment process (see Shiu et al., 2013). I sought to explore the perceptions of health care providers who worked in hospice settings to gain a better understanding of the indicators

that may impact the quality of care. Understanding these indicators is critical to realizing the objective of the study (Shiu et al., 2013).

Before data collection, I thought participants who had experienced negative situations at work or in personal life might not participate in the study or that these experiences might influence their perception of quality care. I was also worried that limitations could potentially arise from miscommunication due to the respondent's failure to understand some of the questions asked or missing information. I was also concerned that providers in the study may be absent during the data collection period, or some providers may have been too tired to attend the scheduled interview, or providers may have misplaced the interview schedule.

Scope and Delimitations

The scope of the research comprised the indicators of quality care in a hospice setting. I sought to determine the health care providers' perceptions of quality care to patients and to their family members. The study was intended to provide a basis for proposing solutions to mitigate potential challenges to quality-of-care indicators that could affect the quality of care in a hospice setting. The perspectives of health care providers on communication, training, staffing levels, and resources were an important issue because understanding what they thought can shed light on areas of concern and provide information on whether these indicators are helpful in promoting quality care in a hospice setting (see Van, 2015).

Limitations

During the study, I had only one hospice setting to use for data collection. A potential limitation is that the results of the study may not be applicable to similar settings. Another potential limitation involved the possibility that providers who have had negative experiences in the hospice work setting may not have provided honest feedback. The respondents may not have understood the questions asked and therefore not have provided an answer. Providers may not have been working during the time of the study and therefore their input may have been missed.

Significance of the Study

This research is important in that it provides insight into the perceptions of health care providers who work in hospice settings, and it sheds light on indicators that may impact the quality of care. An understanding of health care providers' perceptions of factors impacting the quality of care they provide in the hospice setting can help to facilitate a better understanding of the care provided in hospice settings (Mannay, 2015). The interview questions were designed to obtain information on coordination and staffing levels, resources, and training. The answers provided the basis for understanding how these indicators can impact quality care. Goldman et al. (2014) stated that proper education of health care providers in the field of hospice care is pertinent to improving the quality of care in a hospice setting. Additionally, to support the indicators explored in this study, I considered Marrelli's (2015) suggestion that the provision of care should be coordinated so that the burden on the patient is minimized, and the staff-to-patient ratio should be favorable so that maximum attention can be given to the patients.

The achievement of quality services in hospice settings is important to overall patient care. This information will serve as the foundations of programs and interventions that will increase the quality of care provided to patients receiving hospice care. Improvement in quality of care for this population will increase patient satisfaction with care and facilitate positive social change through improved patient outcomes.

Summary

A number of challenges requiring attention have been highlighted as key indicators of quality care in hospice settings. It is necessary for the health care sector to consider the key contributors of these problems and mitigate their effects (Marrelli, 2015). Due to the increased number of patients with terminal illnesses, it has become necessary to ensure that patients are well taken care of and receive the best care in hospice facilities. Hospice care is essential and fundamental for the chronically ill population. This research is important for those involved in hospice settings and for those who plan to become involved. Quality care has been a major challenge in hospice care settings. Additionally, there is limited research available with a focus on improving quality care in a hospice setting (Wilson, Steers, Steele, Turner, & Tinker, 2015). This research is important, as it provides insight into the perceptions of health care providers who work in hospice settings and thus sheds light on indicators that may impact the quality of care.

The interview questions explored coordination and the ratio of staff to patients as well as resources and training. These indicators provided the basis for determining the type of care provided in a hospice setting. Without the information provided by this

study, it is difficult to make useful recommendations on how better to implement these quality indicators and improve the quality of care in a hospice setting.

Chapter 2: Literature Review

Introduction

The provision of quality hospice care is one of America's objectives to health care reform. Such care should be synchronized in different care settings, be patient-centered, offered by a multidisciplinary group of professionals, and successfully enhance the clinical outcomes of patients at the end of their lives (Kirolos et al., 2014). In addition to enhancing the quality of end of life for patients, hospice care in America is also intended to assist patients and their families to gain access to health care that is in tandem with their preferences. There is an increased number of evidence-based parameters aimed at enhancing care at the end of a patient's life. These parameters guide the processes of controlling symptoms, offering patients psychological support, and giving the patients' families bereavement care (Research Triangle Institute International [RTI], 2016). Despite this, health care professionals are still facing many challenges with regard to offering quality care in hospice settings.

Several studies have raised questions concerning the quality of hospice services and their reception by the patients. To improve these services it is important to understand how hospice services are provided, how health care providers perceive care, and how care can be improved. Prior research that I found on hospice settings provided little recommendation on how care can be improved. In my search, prior research has also not established proper interventions that could enhance the quality of care provided in the hospice settings to ensure positive outcomes (Wilson et al., 2015). There is also insufficient literature describing or discussing different factors affecting quality care in

hospice settings. Factors that obstruct the delivery of quality care by health staff in such settings may be categorized into either organizational or personal factors. Herndon et al. (2016) asserted that organizational factors that may impact quality care include communication systems, access to relevant information, resources, regulatory barriers and hospice vision and practices, whereas the personal factor includes training/education. The objective of this study was to understand what quality care is to health care providers in a hospice setting in order to develop an effective intervention and promote quality care.

Literature Search Strategy

The literature review was an iterative procedure based on the process population, intervention/treatment, comparator or study design. In this case not all the terms based on process population, intervention/treatment, and comparator or study design were used. The development of keywords and key search terms was an iterative process. Initially, I searched databases and websites using the following keywords: *hospice care* and *end-of-life care quality* combined with *best practices*, *challenges*, *practice*, *quality*, *statistics*, and *theory*. The terms defined in the Definition section were directly translated into the search concept in the identified databases. All the identified studies resulting from the search were then reviewed to determine which studies were most relevant.

The following online databases of peer-reviewed scholarly journal articles were searched: Academic Search Premier, CINAHL, EBSCOhost, ERIC, Google Scholar, JSTOR, Medical Library Gateway, National Hospice and Palliative Care Organization (NHPCO) Hospice database, Nursing and Allied Health Care Database, and PubMed, and

the Welch Medical Library. In addition, the following public and private hospice care-related websites were searched: Dr. Steevens's Library, Health and Wellness Resource Center, National Hospice Organization, National Institute of Health, Irish Hospice Foundation, Our Lady's Hospice and Care Services, and Share Zedek Palliative Medicine Reference Database. The Google search engine was employed for all searches except when individual sites or databases required the use of an internal search engine.

The literature review included peer-reviewed journal articles, medical procedures, books, published and unpublished dissertations, state and federal statutes, state and federal policies and regulations governing hospice care. The literature review period included 2000 to 2017, but I relied on earlier works for history, and theory. A total of 87 works are part of the literature, with approximately 67 % covering qualitative research or theory and 33% mixed studies. Articles were chosen based on their relevance to the research questions, purpose, and research design.

Research Approach & Methodology

The research methodology and approach was qualitative with a phenomenological research approach. Data were collected through interviews. Although the phenomenological research approach ensured that the issue of interest is understood and explored thoroughly, the techniques of interview provided the descriptive data that is required in the thorough exploration of the research.

Theoretical Foundation

CT served as the theoretical framework for this study. CT suggests that comfort is a sensitive outcome that should emerge from good nursing practices. Comfort is the most

important preferable outcome of nursing care. CT is a humanistic theory that is based on highly prioritizing the needs of patients and advocates for caregivers in hospices to ensure that patients receive comfort as an outcome of their nursing care (Wilson et al., 2015). The theory has been applied to improve quality care in hospice settings and is appropriate for improving quality care in hospices because it encourages nurses to be considerate of patients' emotional, psychological, and physical well-being. In this theory, Kolcaba (2013) argued that the main interest of different stakeholders in the health care system is to access quality health care from the facility. The theory is most suited for the current study on factors affecting quality care in hospice care because it is founded on the premises of holistic care. By applying the tenets of the CT to the study, it was easier to examine organizational excellence, the competence of health care staff, and the effects that such parameters have on quality of care in a hospice setting (see Kolcaba, 2013).

Literature Review on Theory and Methodology

CT is a nursing theory that was first developed by Katharine Kolcaba in the 1990s (Kolcaba, 2013). The principle tenet of this theory is that comfort is one of the most immediate desirable effects of nursing care. In creating this theory, Kolcaba established a taxonomic system whose main purpose is to direct and inform the processes of evaluating, measuring, and assessing the comfort of patients. This taxonomic structure is founded in three types of comfort and four contexts in which human life occurrences take place in a holistic manner; the three forms of comfort are ease, relief, and transcendence, and the four contexts are physical, sociocultural, environmental, and psychospiritual (Kolcaba, 2013). This theory is thus applicable in the current study. According to RTI

(2016), hospice care in America was established permanently by the Medicare hospice benefit in 1986. According to the requirements of this benefit, patients and their families have the right to access hospice and supportive services to help address physical, psychosocial, and other symptoms at the end of life (RTI, 2016).

Studies guided by CT have shown that quality of care affects patient satisfaction. For example, Casarett, Karlawish, and Crowley (2013) performed a qualitative study using the CT. The authors employed a phenomenological approach to determine the impact of quality care on the overall patient satisfaction in the hospice environment in Canada. The instruments used during the study included structured interviews. The study was regarded successful by using 56 interviews coupled with nine interviews of the homes visited as well as reviewing of documents. The study revealed that patient satisfaction in hospice settings decreased due to low quality of care.

Other studies have been conducted using the CT that have also shown how the quality of care affects patients in hospice settings. Dresch et al. (2015) conducted a qualitative study to determine factors that affect quality of care in hospice settings using the CT. Through interviews with 40 health care professionals, Dresch et al. concluded that the major factors that influence the quality of care include personal facets and organizational elements. Additionally, Moumtzoglou and Kastania (2014) used CT to conduct an epistemological study to examine why most of the hospice settings are not accessed. The findings from the study showed that anxiety, attitude, knowledge, and belief had an influence on the access and use of hospice care. However, Nelson and Watson (2013) used CT and carried out an ethnographical study on hospice health care

professionals in Canada to explore gender relationships and how they modeled the client and health care provider relationships as well as experiences in hospice settings. Nelson and Watson used 34 interviews in the homes visited as well as reviewing of documents, revealing revealed that most people in the hospice environment believe the gender stereotype that considers women as the dominant care providers.

Fawcett (2015) also conducted a phenomenological approach using the CT that explored the beliefs regarding hospice care among health care providers as well as the correlation among religion and spirituality, job satisfaction, and compassion fatigue. The study was carried out in hospice health care agencies in San Bernardino and Riverside counties in Southern California. The instruments used for data collection in this case involved the use of interviews with 13 health care professionals and structured interviews within the setting. The results of the study indicated that compassion fatigue was influenced by increased contacts with patients that are terminally ill. In addition, all the participants demonstrated they had 100% job satisfaction in their interaction with patient care.

Another important aspect of CT is the three indicators of comfort: relief, ease and transcendence (Kolcaba, 2013). In order for patient comfort needs to be satisfactorily met, it is vital that patients achieve relief from any form of pain and discomfort that they may be experiencing. In the next section, I will present research that shows the importance of these indicators of comfort.

Indicators of Comfort in Hospice Care

Relief

According to Schenck, Rokoske, Durham, Cagle, and Hanson (2014), relief is the ability of nurses to alleviate the discomfort experienced by a patient. In order to ensure the patient achieves relief, a professional nurse needs to administer relevant medical care such as analgesia for pain management. Hill, Dempster, Donnelly, and McCorry (2016) asserted that maximum staffing to patient ratio of 1:2 should be employed to ensure the patient gets an enhanced level of medical attention. A nurse with an additional training in hospice care is instrumental in promoting relief among patients because he or she understands the holistic approach of treatment (Hill et al., 2016). According to Kolcaba (2013), nurses require medical knowledge and good communication skills to meet the comfort needs of the patients. A nurse who has undergone proper training on how to communicate with staff and patients can better manage the patients care while facilitating communication with the other health care providers. Research on how to improve hospice care has led to conclusions that constant communication between health care staff and patients is essential for productive results (de Graaf, Zweers, Valkenburg, Uyttewaal, & Teunissen, 2016). Patient relief cannot be addressed unless adequate resources are available to meet their needs (de Graaf et al., 2016).

De Chesnay (2014) used a qualitative study to assess the aspect of relief as applied in hospice care among African Americans between the ages of 18 and 64 who were terminally ill. De Chesnay used CT because it suited the indicators of quality care in a health care institution. The major methods for data collection involved the use of in-

depth interviews of individuals with terminal illnesses (see also Grabusts, 2014). The result of the study indicated that attitudes, beliefs, knowledge related to hospice care, as well as lack of trust in the health care framework influenced the use of hospice among African Americans.

Hatfield and Lovas (2014) conducted a phenomenological approach in Florida, using 12 interview questions to determine how addressing the concept of relief could improve the quality of care in hospice settings. The findings of the study yielded improvements in communication, coordination, and the increment of patient–staff ratio (Morton et al., 2016). Meanwhile, the Department for Veterans in Venezuela released a report titled Transformed End-of-Life Care for Veterans which was based on analyzing the concept of relief in a phenomenological approach (Marrelli, 2015). The report gave guidelines on the importance of quality care to the terminally ill. The main purpose of the report was to investigate the cause of poor provision of health services in a hospice setting as long as the estimation of the underlying problem is a determining factor for the solutions searching process. The final purpose of the research was to offer an option on how to improve the comfort of patients in hospice settings (Comfort Care Hospice, 2015).

Ease

The term *ease* implies the absence of discomfort and the presence of calmness and contentment on the part of the patient (Schenck et al., 2014). It is essential for the hospice staff to listen to the patients suffering from terminal illnesses (Kolcaba, 2013). A favorable staff-to-patient ratio often implies the patient has someone readily available to

meet their needs. This helps the patients find a confidant, and friend, to trust. Winning patient trust is an important aspect in the treatment plan. Similarly, an open communication channel between the nurses and patients is instrumental in the patients expressing themselves genuinely without the fear of reprimand (de Graaf et al., 2016). This often helps the nurses design the best treatment program to make the patient feel at ease. Another way that nurses can make patients feel at ease is by earning a certification in hospice care education (Hill et al., 2016). An educated staff is needed to give professional service to the patients, and appropriate resources allocated to make this happen. The underlying idea is to make the patients feel cared for and strengthened despite their worsened state of health (Hill et al., 2016).

Other studies have shown different challenges to comforting patients and offering quality care in hospice setting. De Chesnay (2014) gave insight into the emotional condition of patients in hospices, emphasizing providing compassionate care to the terminally ill patients and implementation various techniques for physicians and nurses to help instill quality performance and empathy (see also Teno, Freedman, Kasper, Gozalo, & Mor, 2015). Additionally, the U.S. Health Care Department wrote an article on the need for special hospice care to reduce costs and give hope to the patients. Hospice care is expected to provide appropriate care to enhance patients comfort; therefore, the setting should have a qualified staff knowledgeable enough in providing compassionate care (Grabusts, 2014). Marrelli (2015) asserted that hospice settings should provide patients with qualified care; however, the settings are often challenged due the provision of care by unqualified staff. The report released by Operation Restore Trust indicted that hospice

settings served their intended purpose but quality of care remained a problem (Leung, 2015).

Transcendence

Transcendence refers to the ability of a patient to rise above their pain and problems. According to Kolcaba (2013), patients suffering from terminal illnesses are often depressed. As such, the nurses should be educated on how to strengthen and inspire the patients through motivational talks (Schenck et al., 2014). Wilson et al. (2015) explained that self-transcendence among ill patients is often characterized by increased awareness, emotional well-being, and increased appreciation for the present. Venable and Baskerville (2012) defined transcendence as the ability of a person to reach out to others, experience a greater self-acceptance, and express more appreciation of the present, past, and future. Compassion fatigue is also prevalent among the hospice nurses who have to demonstrate self-sacrifice in order to offer comfort to the patients (Venable & Baskerville, 2012). The aim is to make the patients look at life from an optimistic perspective (Hill et al., 2016). However, nurses are exposed daily to sensitive traumatic experiences as they build close relationships with the terminally ill patients. In a comparative study on the concept of transcendence in relation to fatigue, Teno et al. (2015) found that a significant correlation existed between fatigue and self-transcendence. A good communication channel is required to enable the nurses to pass on messages to the patients. Similarly, staff-to-patient ratio should be favorable to ensure patients have other people who can help keep them revitalized (Kolcaba, 2013). At the same time, in addressing the concept of transcendence, Herndon et al. (2016) performed a

qualitative research study to examine the experiences and interactions of hospice volunteers at a general level. The study was carried out in a mid-west hospice in California. The study used structured interviews to collect more information from volunteers working at this hospice. In addition, structural interviews were used in garnering data in which hospice volunteers were closely observed during their day to day operations. The research concluded that volunteers have numerous experiences which greatly influence the provision of care, and ability to exhibit, transcendence (De Chesnay, 2014).

National Hospice and Palliative Care Organization

The main organization that regulates hospice care standards in the United States is the NHPCO, which was founded in 1978 with the objective of developing educational programs regarding hospice and palliative care, offering technical information to its members, and conducting research on how to promote hospice care within the United States (Friebert & Williams, 2009). According to the NHPCO and explained by Friebert and Williams (2009), quality care in a hospice setting encompasses effective staff training, a well-coordinated care system, sufficient resources and adequate staff to manage the patients.

The first standard under NHPCO is that hospice settings should offer patient care that is value-based in nature. Value-based care requires nurses to offer patients services in a manner that is not only competent but also compassionate (Forman, 2013). The provision of care should be coordinated so that the burden on the patient is minimized and the staff to patient ratio should be favorable so that maximum attention is given to the

patients (Friebert & Williams, 2009). The second national standard is to improve communication among the patients and health care providers to create a comfortable environment for the patients (Wool, 2015). In addition, the provision of hospice care should be in line with a patient's physical, emotional, and cultural needs. According to Friebert and Williams (2009), proper education for the health care providers in the field of hospice care is pertinent to improving the quality of care in a hospice setting. It is important that RNs, physicians, and other health care providers working in a hospice setting be certified in hospice care. This additional certification will ensure that health care providers in a hospice setting are educated enough to provide competent care. This also implies that the staff should be properly educated about the drugs that a patient may require, as well as the different techniques that can help them overcome discomfort. Most importantly, hospices require sufficient resources in the form of educational materials, drugs and equipment (Bell, Hunt, & Varvel, 2013). As such, meticulous plans should be made by administrators, together with other staff members, to ensure the comfort of a patient is not compromised. In order to meet this requirement successfully, health care providers must ensure that their communication skills are superior and the patients are accorded sufficient time to offer their opinions and concerns. The implication of this standard is to recognize the needs of the patients and their families and to assure consideration in the process of assessment, and planning of care (National Institute for Health and Care Excellence, 2011).

Quality Indicators of the National Hospice and Palliative Care Organization

Table 1

Summary of NHPCO Indicators of Quality Health

NHPCO Indicators	Explanation
Value-based hospice care	Involves nurses offering patients quality care services in both a competent and friendly manner.
Improved communication among stakeholders	Deals with the ability of health care providers to listen to the patients and provide encouragement to make the patients feel at ease.
Coordinated hospice care	Entails organization of the hospice care program in which the responsibilities of staff are clearly outlined and there is no redundancy in treatment procedures.
Flexible hospice care	Entails the ability to adjust the treatment program according to changing patient needs (e.g., respecting patients' cultural background or faith when taking care of them).
Equitable hospice care	Entails the ability of every patient to get a minimum expected level of hospice care; it mainly involves adequate staff–patient ratio.

Value Based Hospice Care

A close analysis of value based hospice care reveals that it is founded mainly on sufficient staff-to-patient ratio. Staff that is properly trained is an excellent information dissemination network, and a well-coordinated care system. Without adequate staff to manage the patients the quality of care reduces, and hence, the need for a favorable staff-to-patient ratio in hospice care. Bell, Hunt, and Varvel (2013) asserted that in America health staff lacks sufficient access to the information which may be used in the promotion of effective utilization of out-of-hours medical services. In order to ensure the wellbeing of patients in hospice care settings, professionals who offer primary care must have access to the information they need to fulfill their responsibility of informing patients and

their families how to access out-of-hours medical services if the need arises (Chochinov et al., 2015). When the communication system is open and the access to information readily available, nurses find it easy to not only monitor their patients' progress, but also detect any scenario that may need urgent attention (Wilson et al., 2015). Meanwhile, de Graaf, Zweers, Valkenburg, Uyttewaal, and Teunissen (2016) explained that value based hospice care should be characterized by the presence of adequate resources such as beds designed for maximum comfort, as well as mobile chairs that can allow the patient to move around with ease.

It is important to coordinate the different treatment and support programs in order to minimize redundancy and ensure the quality care is maintained (Wolf & Wolf, 2013). The mission, vision, and practices in some hospice care facilities also contribute to poor quality of care particularly when they cause poor connection between services. Wilson et al. (2015) posited that it is not uncommon to request physicians to offer care in a complicated and time-consuming end of life cases while they have limited or no information regarding previous services offered to the patient or the patient's past medical history (Chochinov et al., 2015). As such, care coordination is very crucial in ensuring the value of service offered to patients is optimized.

Most hospice providers cannot offer incentives to staff which might ensure that the staff 'give their all' in providing quality care (Watson Campbell, 2015). Studies have revealed that some staff in hospices are not qualified to work due to questionable or improper training (Noble & Smith, 2016; Noe & Forgione, 2014). According to Fleming and Haney (2014), policy change, continuous educational programs for staff of hospice

providers, timely care of patients, and provision of incentives plays a vital role in quality patient care. Schulz et al. (2015) stated that staff members who work in hospices should be rigorously trained. Training should be continuous to make sure that they keep abreast of advancements in the field of hospice care.

Improved Communication among Health Care Providers

Proper communication among the health care providers, and administration involved in hospice care is very fundamental to creating a conducive atmosphere that promotes warmth and revitalization of the patients. According to RTI (2016), poor communication among the health staff can create disorganization, skipped treatment, and increased tension among the patients. Uneven staff-to-patient ratio is a key cause of poor communication as nurses are overburdened and do not have sufficient time to harmonize their various activities. Similarly, recruitment of unqualified health staff may create disconnects among the workers and result in poor communication (Chochinov et al., 2015). As such, it is crucial to not only employ adequate staff, but also ensure they are well trained and qualified to work in a hospice setting. Marrelli (2015) posited that nursing staff can play an instrumental role in resolving the challenge of poor communication in hospice settings by making available information about the clinical status of the patients, and clarifying any issues resulting from wrong or inadequate prescriptions.

In order to overcome the challenges of poor communication it is often required that the health care provider submit patients information to the Centers for Medicare & Medicaid Services via a quality Improvement and Evaluation System (QIES),

Assessment Submission and Processing (ASAP) system within 30 days after the admission or discharge of a patient (Centers for Medicare & Medicaid Services, 2016). This is often aimed at coordinating care services and ensuring that an external monitor steps in when something goes wrong (Centers for Medicare & Medicaid Services, 2016). Most importantly, patient drug and treatment information should be stored in a central data base so all health care workers have access. This calls for a massive investment in electronic medical records to bridge the communication gap (Teno et al., 2015).

Nursing staff have greater contact with patients in hospice care settings and as a result, are instrumental resource and an essential link between the patient and other medical staff (Miyashita, Morita, Sato, Tsuneto, & Shima, 2015). Nursing staff can play an instrumental role in resolving the challenge of poor communication in hospice settings by providing information about the clinical status of patients and clarifying any issues resulting from wrong or inadequate prescriptions and overall care (Gwyther, 2014). Proper communication among health care providers leads to provision of quality care for patients (Alavi & Habek, 2016).

Good communication will ensure clarity of a care plan as well as prompt follow-up care. Hospice staff must ensure that patients are safe from physical, emotional and psychological harm. A hospice setting where patients are physically, emotionally and psychologically safe implies that there is quality care provision in the setting (Morton et al., 2016).

Coordinated Hospice Care

Coordinated hospice care involves the creation of a smooth treatment program in which each nurse understands their duties. At the heart of standards of NHPCO is the concept of connecting the different programs outlined for a patient in an organized manner (Teno et al., 2015). The third national standard of approved hospice settings is that they must offer patients nursing care that is coordinated in nature. The main reason for this is that coordinated hospice care tends to reduce the burden that is borne by the patients, care givers and patients' families in hospice settings (Chochinov et al., 2015). In order to achieve coordinated hospice care, the staff-to-patient ratio should be favorable to allow nurses to coordinate treatment schedules and monitoring of drug inventory, food, and other essential resources needed by patients (Casarett et al., 2013). Health staff should be properly educated on management skills so they understand the importance of keeping records and sharing crucial information about patients with other nurses (Teno et al., 2015).

An analysis of the hospice care system in the U. S., carried out by Teno et al. (2015), revealed that from 2000 to 2013 the American health care system underwent tremendous transformations, including growth of hospice care settings. This shed new light on how important the coordination of services is to hospice care. Both verbal and written communication is very crucial in promoting the coordination of hospice care (Dahlke, Hall, & Phinney, 2015). On a different note, Chochinov et al. (2015) concluded that dignity therapy forms a crucial therapeutic intervention when properly done through

a coordinated system, negating distress to the patient which could lead to feelings of neglect.

Failure to use recent medical advancements in health care, particularly in hospice settings also jeopardizes the quality of care delivered to patients by health care staff (Gwyther, 2014). A considerable number of staff assigned to hospice settings failed to use recent medical technology either because they do not have the knowledge and training to do so, or because such technology is not available to them (Kirolos et al., 2014).

Equitable Hospice Care Access

Equitable hospice care access requires every patient to get a minimum expected level of hospice care. The main factors that hinder provision of balanced hospice care include improper planning, insufficient staff, unqualified staff, and meager resources (Hill et al., 2016). At the same time, different factors which obstruct the delivery of quality care by health staff in such settings may be categorized into either organizational or personal factors (Schenck et al., 2014). Wilson et al. (2015) asserted that organizational factors in the lack of quality hospice care include poor communication systems, a lack of access to relevant information, limited resources, regulatory barriers and unsupportive hospice vision and practices. Personal factors include incompetence of health care staff due to insufficient training and limited education (Fawcett, 2015).

Enhancement of equitable hospice care can be achieved through open communication channels that allow the health care staff to voice their opinions and improve their output (Kirolos et al., 2014). The communication among the nurses can be

promoted by teambuilding activities in order to create a team spirit and cohesion in the health facility. An efficient communication system implies that the staff pull in one direction so quality of care is magnified as efforts are focused toward a designated patient (Bell et al., 2013). It is important to organize training workshops for the health care staff in order to make them aware of emerging trends in the sector and how to embrace technology to improve service delivery (Kao & Chiang, 2015). Such educational workshops should be supported by availability of resources, such as acquisition of tablets and laptops, to allow the nurses put their knowledge into practice (Wilson et al, 2015). According to de Graaf et al. (2016), adoption of modern technology by health professionals mainly helps in the coordination of different activities ensuring equitable health care access by all patients.

Limited resources make it increasingly difficult for health care providers in the hospice settings to deliver quality care to patients. In order to offer patients high quality hospice care, it is vital for health care providers to access adequate amounts of necessary resources, in a timely manner (Gwyther, 2014). The most important resources include medicines such as opiates which are used in the management of pain. Syringes, gloves and technological devices such as computers are all vital in maintaining accurate patient records (Shin et al., 2016). At times, lack of resources and budgetary constraints mean there is an inadequate number of health care staff, and limited resources available, to offer adequate hospice services to patients.

Flexible Hospice Care

Flexible hospice care is the ability to adjust a treatment program according to changing patient needs. In order to achieve this there should be a sufficient staff-to-patient ratio (Shin et al., 2016). As such, the nurses must be well educated on data analysis and flexible treatment modules to adjust appropriately according to a patient's needs. Schenck et al. (2014) asserted that hospice care at different levels in the American facilities are typified by models that allow patients and their families to access care that is either increasingly or decreasingly complex based on their degree of need. Certainly, the achievement of flexible hospice care is mainly dependent on the smooth coordination of care services at both the personal and institutional level (Gwyther, 2014). Meanwhile, Harrison & Connor (2016) suggested that this standard implies that all the needs of patients be planned, and the resources acquired, to anticipate the changes in treatment method (Hansen, Martin, Jones, Pomeroy, 2015).

Nevertheless, flexible hospice care should align itself with existing regulations. Regulatory barriers also play an instrumental role in obstructing health care providers (Kirolos et al., 2014). It is noted that in many places there are stringent laws and regulations which make it harder for health care staff to prescribe or access strong opiates which are vital in pain management for the hospice patients (de Graaf et al., 2016). In cases where such drugs are accessible, limitations are placed on the recommended dosages (Kao & Chiang, 2015). The mission, vision and practices in some hospice care facilities also contribute to poor quality of hospice care particularly when they result in poor connection between services. Harrison and Connor (2016) stated it is not uncommon

to ask physicians to offer care in complicated and time-consuming end of life cases with little or no information regarding the previous treatments received or past medical history (Marrelli, 2015). The management and leadership of contemporary hospice facilities are thus tasked with the duty of ensuring that their vision and mission statements and the practices encouraged in their facilities are supportive of integration in the services offered to patients.

Summary

The studies examined in this literature review observed the national standards of hospice care in America and highlighted several factors and issues that can affect quality care. The factors discussed range from organizational to personal challenges such as poor communication systems, a lack of access to relevant information, limited resources, regulatory barriers and unsupportive hospice vision and practices, incompetence of health care staff due to insufficient training and education in technology which can obstruct the delivery of quality hospice care. These challenges have been identified in past literature yet limited research has been done to investigate the results of these factors, it is therefore important that research be conducted in a hospice setting to understand the relationship of the challenges in quality care indicators in promoting quality care.

Chapter 3: Research Method

In this chapter, I explain the research methods used in the study. The purpose of this study was to provide an insight into the perceptions of health care providers who work in hospice settings about the indicators of quality care and to show how these indicators may impact the quality of care. In this chapter, I also explain the methods to attain the objectives and goal of the study, which includes the research design and rationale, role of the researcher, selection of participants, instrumentation, data analysis and processing, and issues of trustworthiness.

Research Questions

Research questions posed for this study were as follows:

1. What are the perspectives of health care providers in the hospice care setting regarding quality of care delivered in hospice?
2. What are factors that health care providers perceive as important to the provision of quality of care in the hospice setting?

Research Design and Rationale

According to Dresch et al. (2015), *research design* is defined as the tool for carrying out a study with optimum control over the various facets that may affect the results. In this study, I employed a qualitative phenomenological research approach to answer the research questions. A phenomenological research approach is useful in a qualitative study because it facilitates an in-depth understanding of the research process and the perspective of the participants on the phenomenon being studied (Alavi & Habek, 2016). Because the purpose of this study was to deepen the understanding regarding the

perceptions of health care providers who work in hospice settings and to shed light on the indicators that may impact the quality of care, using a phenomenological approach helped to illuminate the specific views of the participants and led to answers for the research questions. Furthermore, this approach was applied in the current study because it provided an accurate account of the opinions and knowledge of the participants (see Casarett et al., 2013). The phenomenological approach involves the use of interviews to collect data (Alavi & Habek, 2016), and the information I collected from interviews was useful in answering the research questions.

Role of the Researcher

My role as the researcher in this study was to collect and analyze the data. I fulfilled this function by interviewing health care providers in the hospice setting. I also ensured that the interview questions were formulated so that the research questions posed for the study could be answered with the data obtained. While striving for a bias-free interview process, I showed respect for the participants and treated them equally. I also made sure not to use the actual names of the participants to safeguard confidentiality and the participants' privacy. I used identifiers such as Participant 1, Participant 2, and so on, throughout the study. During data collection and data analysis, I took care to provide quality, unbiased data.

Methodology

Using appropriate methods in any given research is important for obtaining high-quality, detailed data (Chandra & Liang, 2016). In this regard, the appropriate method for this study was a qualitative design using a phenomenological approach. The selection of

participants has an impact on the results, or outcome, of a given study (Chiang-Hanisko, Newman, Dyess, Piyakong, and Liehr, 2016). To achieve high-quality results, it is important to define the population under study and clearly establish the appropriate sampling criteria. Primary data were collected from the staff in the hospice settings chosen as the research sites through interviews. This method provided the opportunity to gather subjective opinions from the health care providers (Marrelli, 2015).

Sampling

A sample of 15 participants was interviewed. A sample is a group of elements that are selected with the aim of assessing and making findings concerning the population from which the elements are taken (White & Hind, 2015). The sample of 15 participants consisted of 10 health care providers and five administrators.

Having a universal method to reach data saturation in qualitative research is not possible because study designs are not universal (Fleming & Haney, 2014). Although researchers agree that the levels of saturation vary according to the form of data collection, White and Hind (2015) pointed out that data saturation can be reached by conducting as few as six interviews, based on the sample size, and the data can be classified as either thick or rich data. Mueller, Hamilton, Rodden, and DeHeer (2014) stated that among items that cannot be quantified easily are interview data, and these types of data can easily reach the saturation level. In structured interviews, multiple participants are asked the same questions, and in this study, data saturation was achieved with the 15th participant. Data saturation is attained when the addition of more participants does not yield additional information (Henly, 2015).

As participants were recruited for this study, they signed the informed consent form (see Appendix A). Once that was accomplished, data collection commenced. Henly (2015) stated that the sample size chosen for a qualitative study has a remarkable impact on qualitative saturation. He further stated that saturation is attained when the addition of more participants would not yield additional information. Saturation was reached with the 15th volunteer-participant, and no further informants were included in the sample.

Instrumentation

The use of structured interviews using open-ended questions was appropriate for this study because it provided room for the expansion of thoughts and trends (Casarett et al., 2013). The use of open ended questions during the face to face interview made the study a success. Face to face interviews using open ended questions provided room for the interviewer to use the same questions with each interviewee. The use of open ended questions in this study was important for the collection of comprehensive responses, as it gave participants the opportunity explicitly to express themselves.

I prepared a series of open-ended questions that followed a distinct protocol. In designing the questions prior to the interviews, I endeavored to cover all aspects under study with great care, because any alterations to the questions, once the interviews had begun, would have affected the quality of data collected. The format of the questions was also simplified such that the problem under research was closely followed. The questions that were designed were distributed to the participants during the interview. Markedly, each participant answered the questions independently in order to enhance the provision of detailed responses.

Procedures for Recruitment, Participation, and Data Collection

Before signing the consent form, participants were made aware that participation is voluntary. Face-to-face interviews were carried out using open-ended questions (Appendix A). This protocol helped to ensure the integrity and consistency of the process. Upon completion of the interviews, recorded data were entered into the NVivo software for analysis.

Data Analysis Plan

The collected data were entered into Excel worksheets. Any connection that existed between an item of data and a specific research questions was clearly defined by the NVivo software. The method of data analysis used in this study was constant comparative analysis (Udtha, Nomie, Yu, & Sanner, 2014). This method entails the use of open coding to organize the data so that it can be easily understood. This initial organization was later accompanied by axial coding, which was essential in categorizing individual items of data that had various relationships and associations. Last, selective coding was used to reveal any relationships that existed between the categories obtained with the first two coding processes.

Issues of Trustworthiness

Issues of trustworthiness are essential during the process of data collection and data analysis (Meier, 2011). Essentially, ensuring credibility, transferability, dependability, and conformability are integral to the results obtained in a study. These issues are further discussed in the following sections.

Credibility

According to Noble and Smith (2016), credibility entails the value of the findings of a study. In order to ensure that the results obtained are credible, it was important to ensure that persistent interviews, coupled with prolonged engagement, were enhanced. Even though the period for conducting interviews is set to be 2 weeks, it was important to continue with the interview until no new information was obtained.

Transferability

The transferability of data will be enhanced by employing detailed descriptions of the research context (Leung, 2015). Appropriate and detailed descriptions are, therefore, provided in the data analysis section, to help readers make the best decisions concerning the application of the results of this study. Details such as the accounts of study and forms of raw data are included so that various interpretations can be made. In this regard, direct quotes from the participants are provided in Chapter 4.

Dependability

The dependability of the data was enhanced by generating queries using NVivo software for data analysis. Coded data were integrated with location and contexts that matched a particular query. This helped to ensure that the described issues in the section on findings are not just the perceptions of an individual but rather constitute a collection of similar opinions expressed by the participants (Henly, 2015).

Conformability

The conformability of data was enhanced through audit trails. Open coding, axial coding, and selective coding was carried out at different stages to aid in decision making

(Leung, 2015). The NVivo software was help in this as well as in identifying contexts that matched a particular query. The determination of the contexts that matched a given query was important for ensuring that the issues described in the findings are not just the perception of an individual but rather the expressions of similar opinions held by various participants.

Ethical Procedures

The participants were clearly informed that their participation was entirely voluntary and that they could withdraw from the study at any time and for any reason without negative repercussions. Volunteers who met the inclusion criteria were selected as full participants of the study. Before the participants engaged in the study, detailed information about the study was provided to them. This information included a description of the purpose of the study, what the participants were expected to do, and the ability to choose to withdraw from participation at any time. Making the decision to withdraw at any time during the study would not affect the participants' position at work in any way. In order to promote honesty among the respondents, I provided informed consent forms that assured respondents that the information given will be used for academic purposes only. In addition, the respondents were not required to write their names, because I only used code names such as Respondent 1, Respondent 2, and so on. Using this method helped to assure the respondents' privacy and the confidentiality of the study. I also made sure that participants understood that all information provided is confidential and that the responses provided will be reported in aggregate form with no names attached to the information.

Summary

In an effort to attain the objective and goal of this study, the research methods in this chapter, namely, research design and rationale, role of the researcher, population and sample selection, instrumentation, data analysis and processing, and issues of trustworthiness and ethics in research. It is also evident that data were analyzed through the constant comparison approach using the NVivo software that helped in the generation of queries. The next chapter contains a discussion of the data analysis and the research findings.

Chapter 4: Results

This chapter covers the results of the interviews with the health care providers in a hospice setting in the southeastern United States. The study findings provide important insight into the perceptions of health care providers who work in a hospice setting and the results further shed light on the indicators that may impact quality of care in the setting. The interview questions were directed toward coordination and staff–patient ratios, resources, and training. These indicators provided the basis for determining the type of care provided in a hospice setting (Bell et al., 2013). The main goal of this research was to understand what health care providers thought about resources, staffing, communication, education, and coordination of care. These indicators are the backbone of quality care in a hospice setting. The responses obtained from the health care providers were expected to deepen understanding and enhance the quality of care offered in the hospice setting. In the following sections, I will describe the setting, report the findings, talk about participants’ demographics, data collection and data analysis procedures, evidence of trustworthiness, and the results of the study.

Restatement of the Research Questions

1. What are the perspectives of health care providers in the hospice care setting regarding quality of care delivered in hospice?
2. What are factors that health care providers perceive as important to the provision of quality of care in the hospice setting?

Setting

The identification and description of the environment or context of a study is essential in understanding the background of the results (Aline, Pacheco, & Augusto, 2015). The current study was conducted in a hospice setting located in a large metropolitan city in the southern United States. The setting is a profit-based organization aimed at providing quality care to individuals who are terminally ill. Although most of the patients in the setting were provided home-based care, the setting included a provision for in-patient care services at five local facilities. The setting provided services to 250 home-based care patients and 120 facility-based patients each month. The hospice operated with the help of 50 employees. Eighteen of the employees were hospice aides, 25 were nurses, and seven were physicians.

Participant Demographics

A sample consisting of 15 participants was interviewed for this study. RNs accounted for 40% of the sample. Licensed vocational nurses (LVNs) constituted 33.3% of the sample, whereas physicians accounted for 26.7%. The age range of the nurses was between 45 and 55 years, and the age of the physicians was between 45 and 68 years. The average and median ages of these participants were 45 and 47 years, respectively. The educational level of each participant was also obtained from the information they provided on the consent form. The educational backgrounds of the RNs consisted of having a bachelor's degree, whereas the physicians had a doctorate degree. The length of time each participant had been working in the hospice setting was also recorded. Most of the participants (33.3%) had been working in this setting for a period of 7 years. The

longest serving participant had spent 15 years in the hospice setting. The average number of years served was 8 years, and the median was 4.1 years. The descriptive information of each of the participants is presented in Table 2.

Table 2

Summary of Participant Demographics

	Frequency	Frequency	Percentage
GENDER			
Male		5	33.33%
Female		15	66.67%
AGE			
25–35		6	40%
36–44		3	20%
45–54		3	20%
55–64		2	13%
64 +		1	7%
EDUCATION			
RN (bachelor’s degree)		6	40%
LVN (associate degree)		5	33.33%
MD (Doctorate degree)		4	26.67%
YEARS OF WORK EXPERIENCE			
0–3		5	33.33%
4–7		3	20%
6–11		2	13%
12–15		1	7%

Data Collection

The location, frequency, and duration of data collection are influential on the quality and quantity of information obtained (Gubrium & Holstein, 2013). Data were collected via individual face-to-face interviews conducted with all 15 participants. Data collection by interview is appropriate for gathering comprehensive and detailed data (Chandra & Liang, 2016). Interviews can provide deep insights into the aspect being studied (Chandra & Liang, 2016). On the other hand, the structure of the interview plays an important role in collecting detailed information (Hamed, 2016). Therefore, interviews were carried out with 15 participants in a hospice setting to collect detailed and

comprehensive understanding of their perspectives of quality of care in the hospice setting and to understand the factors that influence care quality.

Location and Frequency and Duration of Data Collection

Casarett et al. (2013) suggested that it is important, when collecting data through interviews, that both the duration and frequency of the interviews are considered because they can influence the quality of information gathered. A consistent schedule was important in this phase of the current study. Interviews were conducted in a quiet room most often used for meetings. During the first phase of the data collection, the participants were introduced to the study; this was the time that I explained the study to the participants. I gave them enough time to ask questions. After all their concerns and questions had been dealt with, I gave them the informed consent forms to read and sign. With the informed consent forms signed and returned, the data collection phase was scheduled. During this period, I interviewed the participants daily over a period of 1 week. Due to the consistent approach to data collection, I was able to complete the interviews within 1 week as planned. By the end of Week 1, the interview phase had been completed.

Data Recording

The data obtained through interviews were recorded using a digital recorder. I turned on the recorder, asked the questions, and allowed the participant to respond. Each participant was provided time to answer a total of five interview questions from the interview sheet (see Appendix A). Each participant was interviewed individually and face-to-face in a private room in the hospice facility. The interview was not timed;

participants were given time to elaborate on their answers as much as they wanted; however, I noticed that each interview lasted about 20 to 25 minutes. When the participants had responded to all five questions, the recording was saved, and the recorder was ready for the next participant. This sequence was followed for each of the 15 participants.

Variations in Data Collection from Previous Plan

The data collection plan that I had developed earlier provided that the interview period would take place over a period of 2 weeks. However, I was granted access to the facility for 1 week; therefore, I came in every day for 1 week to complete the scheduled interviews instead of once a week as was discussed in Chapter 3. Each participant who was available and ready was invited to the private meeting room in the facility for the interview. Participants were interviewed one at a time. During research, adjustments can be made to the original data collection plan based on the quantity and quality of data that is needed to be obtained (Chiang-Hanisko et al., 2016).

Unusual Circumstances Encountered in Data Collection

Because the period of the interview was reduced from 2 weeks to 1 week, five participants who experienced unplanned circumstances were not able to attend the first scheduled meeting. However, they were all present in the next scheduled meeting and made up for the missed appointment. According to Hatfield and Lovas (2014), a small sample size tends to result in reduced bias and increased accuracy in the results obtained. Given the small sample size of 15 participants, I was able to complete data collection in a timely manner with all 15 participants as was originally planned.

Data Analysis

Data were collected using face-to-face interviews. This approach of data collection was significant because it facilitated the collection of comprehensive and detailed information. During the interview, participants were allowed to ask questions and seek clarification in the areas that were not clear. NVivo software was used in transcribing, coding, and analyzing the data. The primary objective of this study was to understand the perceptions of the health care providers about care quality in a hospice setting, and how care quality can be improved.

Data were transcribed using NVivo software and the Dragon Naturally Speaking dictation software. NVivo allowed me to enter the audio recordings using the feature called the “do it yourself NVivo transcribe features.” Data transcription began as I touched the play key. NVivo also provided me with the following features: volume, play forward, stop, skip forward, and skip back. Within a couple of hours, all data were successfully transcribed. I then used the Dragon Naturally Speaking dictation software to check for accuracy in the transcribed data. I listened to the recorded interview with a headphone and dictated what I heard into Dragon Naturally Speaking. As I listened to the audio, I paused the audio tape and dictated into the software what I heard.

Dictated data were transcribed to a Word document. The transcript was used to compare with the previously transcribed data. After this step was completed and transcription accuracy was confirmed, data analysis began. During data analysis, the NVivo software features allowed me to use firsthand level coding, which is valuable in data analysis. Key expressions were identified, including recurring themes words and

concepts and codes categories and themes. After the identification of the common codes categories, and themes, the content units were grouped in order of similarities and differences (see Richards, 2013) and the excerpts were categorized into groups with similar meanings. Some excerpts could not be linked to one code; these selections were refined and interpreted into the coded data. Upon completion of the first-level coding, the second level of coding that involved interpreting the codes, categories, and themes and grouping them into excerpts began. The excerpts were then examined and compared against different responses; this helped in identifying themes that were related to the research problem. The themes were then compared for differences, similarities, relationships, and trends (see Richards, 2013).

Results Presented by Research Questions

Research Question 1 (RQ1)

RQ1: What are the perspectives of health providers in the hospice care setting regarding the quality of care?

Communication and Advocacy Across Disciplines. To address RQ1, participants provided insights into their perspectives of quality of care in a hospice setting. Respondent 1, a nurse, stated that you had to “Look out for your patients. Protect them. Watch out for them, call and question physicians when necessary. Support their decisions and be bold in communication. Failure to encourage them [patients] to talk is a disadvantage.”

Another participant concurred that communication was important and added that speaking up for the patient when they could not speak for themselves was a part of

advocacy. For example, “Since some patients and family members are afraid to speak up I take the initiative to speak up on their behalf . . . I have to be very bold in communicating . . . not being afraid to. I have to be an advocate for the patient while ensuring that they receive person-centered care” (Respondent 3).

One more participant added that

I think that most often there is a lack of effective communication not only with the patients but also with the entire inter-disciplinary team. There is a need for effective communication with the members of the interdisciplinary team, and subsequently one should not be afraid of being an advocate of the patient. I guess that is another aspect of quality care. (Respondent 15).

Communication to Prevent Errors. One participant stated that

Poor communication among us [health care providers] may negatively affect patients in different ways as it may lead to overlooked changes in the status of the patient or lack of critical information. Also, misinterpretation of information may occur if communication among us is ineffective, increasing medical errors. Medical errors arising from poor communication are a pervasive problem today in a hospice setting. (Respondent 7)

Education for the health care providers. One of the participants stated that Throughout our [nurses] career, we should be offered training and education to enable us to deliver excellent patient care with the appropriate skills, behavior, and values. Continuous training and education ensures that we are equipped with the necessary knowledge and skills to provide quality care . . . This [education]

also increases our confidence while dealing with issues that affect patient's recovery. (Respondent 10)

Another participant conceded that

It is important for us [nurses] and other health care professionals to keep up to date with new research and medical advancements . . . actually; nursing practice should be based on evidences, and thus, nurses' decisions on the best care practices should be supported by sufficient evidences. Evidence-based training incorporating a general computer application program should be offered in hospice settings. (Respondent 11)

One more participant indicated that "I think of several nurses on the floor who are excellent. Many years of experience and training on that floor have made them perfect advocates of the patients . . . I want to mimic what they do . . . but there is a lack of such qualified nurses on the floor, and lack of technology-aided education in the facility"(Respondent1).

More to that a participant stated that "Experience is part of education. The more experience a nurse possesses, the more quality care treatment a patient will have. Experienced nurses play an active part in educating less experienced nurses on various issues" (Respondent 4).

Another participant indicated that "I think that improved knowledge is a vital tool for preventing errors and providing high quality care Lack of sufficient knowledge or poor education can lead to detrimental consequences including poor patient outcomes, low quality care, and increased patient dissatisfaction" (Respondent 13).

Finally, a participant agreed that “I felt ill-prepared for the reality of nursing . . . high technology is imminent. I don’t have even the basic knowledge on how to use a computer, leave alone surfing the internet looking for evidence. I will leave nursing soon if something does not change” (Respondent 5).

Resources for the health care providers. One of the participants stated that “Sometimes it is not possible for us [health care professionals] to provide the best care for patients even if we work as hard as we can when we lack the necessary resources such as medical equipment to offer high quality care” (Respondent 15).

Another participant agreed that “Although we are expected to provide evidence-based care, we lack access to adequate resources such as computers and access of resources in certain areas of the facility. It becomes difficult for us to offer care based on current evidence when we cannot find the current evidence” (Respondent 2).

Staffing for the health care providers. One participant indicated that “The staffing levels in the hospice care setting are inadequate to deliver high quality care. I say this because there is low nurse staffing levels. Some situations force us [nurses] to significantly limit the time we spend on each patient leaving some care aspects unattended so as to care for more patients” (Respondent 6).

Another participant stated that “Since I have to provide care for very many patients each day, sometimes I feel so tired. Although I like my work, I sometimes feel like my monthly pay is not worth all the work. Sometimes I feel dissatisfied with my job and my career as a nurse. I feel like quitting sometimes” (Respondent 7).

One more participant mentioned that “Sometimes my shift ends before I provide care to all my patients. Although I know it may have detrimental consequences to the patients, I am left without an alternative since by the end of the day I am exhausted and the list of patients is still quite long” (Respondent 13).

Research Question 2 (RQ2)

RQ 2: What are factors that health care providers perceive as important to the provision of quality of care in the hospice setting?

Communication across family members. To address research question 2, one of the participants stated that “Communication should be encouraged between health care providers, patients, family members and friends because it encourages the patients/family to open up and share their feelings, goals and hope with the health care providers. Consequently, they can provide direction of hope and peace. Lack of communication is a cause of poor patient care quality.” (Respondent 7).

Another participant suggested that “I think that there is a lot of satisfaction in going a step beyond to do something right and to monitor whatever is done for the patient. It helps in not missing things that the patient requires. It is easy to miss things like a medication order . . . but it really depends on the nurse who is at the bedside and in charge of medications” (Respondent 6).

Education for the health care providers. One of the participants mentioned that “Education opportunities should be increased in all hospice facilities. The more the nurses know, the better they will be able to attend to patients. Majority of the nurses I

work with told me they fully disagree with the number of limitations they are experiencing in the hospice setting.” (Respondent 12).

Resources for the health care providers. One of the participants indicated that “Material resources are essential in providing high quality care to terminally sick patients. Therefore, a hospice facility should have enough resources to cater the medical, social, psychological and spiritual needs of the patients and families. Intellectual resources should be encouraged as they enhance the quality of patient care.” (Respondent 1).

Staffing for the Health Care Providers. In responding to the interview questions, a participant mentioned that “Hospice facilities should look into staffing issues. Enough staff should be employed including volunteer caregivers to improve quality of care offered. Also, there should be an increase in motivation and in job satisfaction among all the health care providers in the hospice setting.” (Respondent 2).

Results Presented by Codes, Categories and Themes

Results of the study revealed that personal factors and organizational factors markedly influence the quality of care in a hospice setting. This is evidenced by the codes, categories and themes encountered during data analysis. The responses from the interview questions are presented in direct quotations followed by an explanation for a better understanding. Analysis of the responses revealed the following codes, categories and themes.

Codes, Categories, and Themes

Various codes, categories, and themes emerged from the data collected during the study. The major themes that unfolded during the assessment of factors that influence the quality of care in the setting included the personal facets and the organizational elements. The categories that developed from these themes included communication, education/training, resources, stress, exhaustion, availability of information, regulations, vision and mission, and availability of resources. In determining how qualified the staff are in providing care, expertise and academic qualifications are the primary themes that emerged. The categories that unfolded from these themes included communication skills, certification as well as accreditation, and decision making.

Defining the Factors Affecting the Quality of Care in the Setting

The study sought to understand the factors that affect the quality of care in a hospice setting. The data collected from the study revealed that organizational factors and personal factors have a great impact on the quality of care in hospice settings. Grabusts, (2014), in his study observed that the organizational factors that can affect the quality of care include access to information, availability of resources, the level of communication and patient–staff ratio. This conformed to the results of the data collected in this study. On the other hand, personal factor encompasses the attitudes that the health care providers had towards work. The major themes that developed from this study included

1. Personal factors influence the quality of care settings.
2. Organizational factors influence the quality of care settings.

The categories that accompany each of the themes are discussed and illustrated through meaning units and explained by literature.

Theme 1: Personal Factors

White and Hind (2015) explained that personal factors have a great influence on the quality of care that patients receive in hospice settings. In this case, the interactions of the health care providers and the patient have a significant influence on the quality of care. One of the personal factors that appeared to affect the quality of care was communication. Mueller et al. (2014) provided that poor communication protocols, lack of co-ordination, lack of good communication skills, and the failure to involve patients result to poor quality of care. Henly (2015) also observed that the level of training is an element that affects the quality of care in hospice settings. In this study, the level of training was found to influence the quality of care that patients receive. Wool (2015), further asserted that the lack of competency in deploying medical technology in the delivery of services greatly influences the quality of care in a hospice setting. Finally, exhaustion and stress caused by heavy workloads is associated with high-patient to staff ratio. The result here is that quality of care can be greatly compromised with poor communication, limited resources, limited education/training, and a high patient- staff ratio. The categories emerging from this theme are presented in Table 3.

Table 3

Summary of Theme 1 Personal Factors

Theme	Category	Subcategory
Personal Factors	Communication	Poor communication protocols Failure to involve patient during communication Lack of good communication skills Lack of coordination
	Training	Failure to deploy medical technology in the delivery of services
	Stress and Exhaustion	High patient:staff ratio

Theme 2: Organizational Factors

Hughes (2015) stated that the structure of the organization providing hospice care services has an influence on the quality of care. In this case, the availability of information, the vision and mission of the hospice setting, and regulations have impacts on overall care. The availability of information in this scenario relates to how frequently the health care provider can access patient data. Goldman et al. (2014) also explained that the lack of accessibility to patient information results to poor care quality since important components in patients care such as the medical histories as well as diagnosis are not traced so that the appropriate medication or treatment can be presented. Aline, Pacheco, and Augusto (2015) observed that a mismatch between the goals of the health care providers and the hospice are also an implication of low standards of quality care. The availability of resources such as medical equipment and labor also influence the standard of care. Dahlke, Hall, and Phinney (2015) asserted that the lack of appropriate medical apparatus coupled with insufficient staff translates to poor quality care. The categories and subcategories for this theme are described in Table 4.

Table 4

Summary of Theme 2: Organizational Factors

Category	Subcategory
Availability of information	Lack of access to patient information
Vision and mission	Mismatch between goals of health care providers and the hospice
Regulations	Stringent measures and laws
Availability of resources	Lack of medical equipment
	Lack of sufficient staff

Theme 3: Education and Training

Tracy (2013) stated that the qualifications of the staff have an influence on the quality of care in a hospice setting. Therefore, in addition to determining the factors that affect the quality of care in hospice settings, the qualifications of the staff in delivering health care services was determined. This involved examining the skills they possessed, the years they worked in the hospice, and their professional as well as academic qualifications. Poor decision making, lack of interpersonal skills, and the lack of competency in the area of specialization results to poor care quality. Baernholdt, Campbell, Hinton, Yan, and Lewis (2015) stated that the qualifications of the staff in providing care can also be defined by academic achievement. Limited education in the area of hospice care and not having an additional certification in hospice care implies that the health care provider may not have sufficient knowledge in the area of specialization. Ponciano (2013) asserted that lack of knowledge impacts the quality of care that individuals receive in a hospice setting. The categories and sub-categories that emerged from the two themes are illustrated in Table 5.

Table 5

Summary of Theme 3: Education and Training

Theme	Category	Subcategories
Expertise and Skills	Decision making. Communication skills. Knowledge in area of specialization.	Poor decision making. Lack of interpersonal skills. Lack of competency in area of specialization.
Academic qualifications	Received additional certification in hospice care. Licensed Practical Nurse.	Has not been certified in hospice care. Not an RN.

Evidence of Trustworthiness**Credibility**

In order to enhance the credibility of this study, interview questions were directed to include the indicators that may impact care quality in a hospice setting. I did not divert from the interview questions or try to lead the responses of the participants in any way. The participants were provided with enough time to reflect on each question being asked before responding. The participants were all asked the same amount of questions. The questions asked were structured and every participant received the same set of questions.

Furthermore, each participant was given an opportunity to make corrections if any, before the recorder is turned off. According to White and Hind (2015), credibility involves what makes results believable. Credibility involves data quality not quantity. In other words, the richness of collected data is what is important not the amount of data gathered. As such, the participants will be the ones to reevaluate the data that they provide for credible results. That is why I ensured that participants are provided enough time to reflect on the answers they provide, and also provide an opportunity for them to make corrections before ending the interview.

Transferability

In a bid to ensure transferability, thick descriptive language which deployed the use of a voice recorder was instituted. In addition to the use of voice recordings, the details of the information collected were further enhanced by the use of narrations. Details based on the various forms of raw data of the study were included in the study to create room for interpretations. According to Aline et al. (2015), transferability will enable the reader to compare situation in a research to that of a similar research work. If the contexts of the research align with the methods and other similar situation that the researcher is familiar with, then the research is deemed more credible. That is why it is import that I supply a detailed description of the data collection process.

Dependability

Chiang-Hanisko et al. (2016) provided that the dependability of data can be augmented by carrying out a series of audits. Based on this idea, the study ensured dependability through auditing. In this case, a documentation of the methods, data, and any decisions made based on the results of the study were analyzed. A detailed elaboration of data and methods of the research were used to enhance auditing. Furthermore, dependability was maintained by allowing the interviewees to make their own corrections instead of assuming. By providing to them a copy of the translated audio transcript for them to review, they were able to make additional comments and provide clarifications.

Confirmability

The confirmability of data was enhanced through audit trails. During auditing, it was important to provide a detailed and succinct account of how the study or research was carried out. Open coding, axial coding, and selective coding were carried out at various stages to aid in quick decision-making. In a bid to enhance the process of coding, NVivo was used for the open code and the saturate code. The software were considered important in the determination of the contexts that matched with a given query so that the issues presented in the findings were not a view of an individual but rather they constituted of different participants who had the same opinion.

Summary of Results

Notably, 15 participants were interviewed on communication as an indicator of quality care. It was noted that the participants demonstrated the importance of excellent communication skills during the delivery of patient care. This concluded that effective communication is an important indicator in providing quality of care in a hospice setting. In the study, it was also noted that participants stated that limited resources especially during the interaction with the patients and colleagues can result to poor quality of care. Therefore, this concluded that limited resources can negatively impact care quality in a hospice setting.

It was further noted the participants responded that an extra training/certification in hospice care coupled with excellent knowledge on the use of medical equipment can positively impact care quality in a hospice setting. The result concluded that education/training has a positive influence on quality of care.

More to that, the health care providers interviewed on the effect of staffing ratio and the impact it has on quality of care in a hospice setting stated that quality of care can be negatively impacted with a higher ratio of patients and a lesser ratio of staff to meet the patients' needs.

The perspectives of health care providers that participated in this study call for an improvement in communication, staffing levels and education/training. An understanding of these matters will improve care quality in a hospice setting. From the data analysis, it is clear that nurses believe that communication, education/training, adequate resources, and proper staffing levels are important factors that determine the quality of care in hospice setting. More precisely, health care providers should perceive open, clear, and effective communication amongst all the staff members and patients so as to improve the quality of care provided. An adequate, sufficient, and continuous training and education for the health care providers should be employed as a tool to ensure improved care quality. Also, sufficient resources for the health care providers are important factors for the provision of quality care in a hospice setting.

Summary

In the light of the above discussion, it is evident that the factors that influence the quality of care in a hospice setting include personal and organizational aspects. Udtha, Nomie, Yu, and Sanner (2014) stated that personal factors and organizational factors had an influence on care quality. The personal factors that were identified to impact the quality of care in this research include communication, education/training, while the organizational factors include resources, and staffing levels. The next chapter contains an

interpretation of the findings. I explain the limitations of the study, provide recommendations, discuss implications of the study, and end with a final summary of the study.

Chapter 5: Discussion, Conclusions, and Recommendations

Hospice services are provided for terminally ill patients to promote quality of life and to ensure that patients transition in a comfortable manner as they approach the final phase of their lives. Care in hospice entails a variety of services; this includes spiritual services, nursing care, and medical care (Kirolos et al., 2014). The quality of hospice services in the United States has become important with the rise in the demand of hospice care services (Forman, 2013).

The aim of this research was to understand health care providers' perspectives and lived experiences on the indicators of care quality in a hospice setting and its impact to the overall care provided in the setting. These indicators include resources, staffing level, communication, and education and training. This study was qualitative with a phenomenological research approach. In Chapter 5, I will cover the interpretation of the findings, limitations of the study, recommendations, implications, and conclusions.

Summary of Key Findings

The findings indicated that effective communication in a hospice setting is vital in the provision of quality care. This is taken into consideration because a considerable number of respondents reported that effective communication skills were critical in the provision of quality hospice care services. A large percentage of the participants also affirmed that high patient–staff ratio affected the quality of health care services provided in a hospice setting. Most respondents asserted that patients were satisfied when they were served by a greater number of hospice care providers who were available at all times. Moreover, a majority of the participants explained that working in a hospice

setting is stressful. A ratio of 1:10 of nurses to patients is too high for a shift and negatively impacts the care provided to the patients. Therefore, staffing ratio in a hospice setting is fundamental in providing comfort care to the patient in a timely manner.

Furthermore, staff qualification was presented as a key factor that affected care quality in a hospice setting. A majority of respondents mentioned that it is more complicated when the facility employs LVNs to work in the hospice facility. It was also stated that the functions of the LVNs are limited, so the RNs cover a majority of the work on every shift because the LVNs cannot cover admissions and make independent decisions on patient care without consulting with the RNs. The nurses found this arrangement as a delay to timely care provided to the patients.

Interpretation of the Findings

Setting

Data were collected in a hospice setting, a facility that is committed to offering quality services to terminally ill patients. The hospice provides services to more than 250 home-base care patients and 120 facility-based patients each month. The establishment has a total number of 50 employees who operate in different areas. Organizational factors that may impact quality care include communication systems, access to relevant information, resources, regulatory barriers and hospice vision and practices; care can also be affected by the personal factor of training/education (Herndon et al., 2016). Although there are similarities in the findings of this research to others in literature, limited research that I found provided details on how these indicators may impact care quality.

Comparison of Findings with the Existing Literature

Coordination of care is important in ascertaining that quality services are offered in a hospice care facility. The administration in the hospice setting has to ensure that all patients are cared for in the appropriate manner. In addition, the chain of command has to be respected to ascertain that the right types of services are offered to the patients (Van, 2015). Moreover, management at the hospice settings has an important role in ensuring that all resources are aligned according to patients' needs (Van, 2015). The hospice care setting has to facilitate the transition and ascertain that patients get quality treatment until the end of life. The research findings indicated that ineffective coordination of care in the area of communication, staffing level, resources, and education/training can affect care quality in a hospice setting.

Staffing Levels

The findings further confirmed that the health care providers in the hospice setting commented on challenges that include the staff-to-patient ratio. The majority of the responses were directed toward the negative impact of a high patient-to-staff ratio in a hospice setting. A similar point was raised by de Graaf et al. (2016), who asserted that health care professionals in the hospice setting encounter difficulties in offering efficient services due to work overload. In order to achieve coordinated hospice care, the staff-to-patient ratio should be favorable to allow nurses to coordinate care plan, treatment schedules of drug and food inventory, and other essential resources needed by patients (Casarett et al., 2013). A close analysis of responses revealed that staffing level can greatly impact care quality in a hospice setting.

A hospice setting that uses a staffing pattern based on a recommended standard will have a well-coordinated care system. In addition to that, a high patient–staff ratio hinders the provision of care quality in a hospice setting. According to Matzo and Sherman (2015), one nurse per four patients is ideal in meeting the patients’ needs in a timely manner. Based on the results from the participants in the current study a high patient–staff ratio greatly reduced the quality of services provided in a hospice setting. Moreover, the respondents suggested that one nurse to four patients is ideally good in the provision of quality care in a hospice setting consistent with Matzo and Sherman’s findings.

Communication

The findings from the research also confirmed that personal factors like communication affected the quality of care provided in a hospice setting. It was reported that care is impacted when the staff have problems communicating effectively with each other. The professionals who work in a hospice care facility have to fulfill a variety of responsibilities that are mentally and emotionally demanding (White & Hind, 2015). As a result, the individuals who work in hospice care settings can be stressed and psychologically exhausted (Sandsdalen et al., 2016). At times, due to pressure from work, the staff members can become apprehensive, which can impair the ability to communicate effectively with other staff members. This could impair how decisions are made regarding patient care.

Studies have shown how good communication is connected to transcendence. For example, Teno et al. (2015) carried out a comparative study to analyze the concept of

transcendence in relation to fatigue among hospice nurses, finding a significant correlation between fatigue and self-transcendence. A good communication channel is required to enable the nurses to pass on messages to the patients and other care providers. Similarly, staff-to-patient ratio should be favorable to ensure patients have other people who can help to educate them and encourage them about the disease process (Kolcaba, 2013). Another study indicated through interviews with health care providers and hospice volunteers that health care providers have numerous experiences that influence the provision of care, and ability to exhibit, transcendence (Herndon et al., 2016). However, this would not be possible without a good communication network (De Chesnay, 2014).

Similar studies have shown the effect of poor communication on quality of care. For example, Mueller et al. (2014) asserted that a lack of cooperation and poor communication are two factors that may impact care quality in a hospice setting. Schenck et al. (2014) also indicated that the health care providers who are good communicators are able to focus on the individual needs of the patients in a timely manner. From the data analysis in Chapter 4, it is clear that the health care professionals at the hospice setting considered communication to be paramount in the provision of hospice services, as evidenced by the majority of the responses received from the respondents who asserted that communication could negatively affect the quality of hospice care services offered.

Education/Training

The findings during data analysis shows that the participants supported training in hospice care as being pertinent in improving care quality in a hospice setting. This means that an institution that does not provide employee education relative to care in a hospice

care setting may see care quality decreased. This phenomenon is supported by Hansen, Martin, Jones, and Pomeroy (2015), who asserted that health care providers require knowledge in the area of specialty, as well as knowledge in the use of computers and electronic health records in the provision of care in the setting. Therefore, the knowledge to access patients' information is important in monitoring the well-being of patients who are admitted in the setting, who are being transferred to other locations, and/or who are being discharged from the facility. Having knowledge in this area can facilitate timely care and limit the risk of unexpected coincidence. In various health care facilities, information is stored in electronic systems, which make it easier to disseminate. This is why majority of the employees indicated that limited knowledge in the use of electronic health systems is detrimental to care quality in a hospice setting.

The analysis further indicated that the LVNs that make up 30% of employees in the facility do not have the knowledge and effective skills in admitting patients in the setting. Moreover, 15% of employees indicated that they have not acquired an additional certification in hospice care. This occurrence is attributed to a limited training in hospice care that is vital in the hospice sector. With optimal care quality in a hospice setting, nurses would be able to cover all the aspects of patient care in the setting (Albrecht et al., 2013). Therefore, it is important to provide employees with the necessary knowledge to ensure that they can serve patients in an effective manner (Wool, 2015). Overall, the findings indicated that a lack of sufficient professional expertise has a poor impact of care quality in a hospice setting.

Resources

A lack of resources is another factor that limits the provision of quality hospice services by support staff (Dahlke et al., 2015). Reasonably, medical equipment that is important in this area includes oxygen, pain medications vital sign monitors, comfortable bed mattresses, comfortable adjustable beds for optimal comfort care, and wheelchairs. A majority of the respondents indicated that a lack of these resources might impact the quality of care in a hospice setting. According to Van (2015), resources such as beds, mattresses, oxygen, and vital sign monitors used for comfort care in a hospice setting are import for optimal comfort care and, consequently, improved care quality in the setting.

Limited resources make it increasingly difficult for health care providers in the hospice settings to deliver quality care to patients. In order to offer patients good quality hospice care, it is vital for health care providers to access adequate amounts of necessary resources, in a timely manner (Gwyther, 2014). The most important resources include medicines such as pain medications used in the management of pain and oxygen for comfort care. Syringes, gloves, and technological devices such as computers are all vital in providing optimal patient care (Shin et al., 2016). At times, lack of resources and budgetary constraints mean there is an inadequate number of health care staff, and limited resources available, to offer adequate hospice services to patients.

Interpreting the Findings in the Context of Comfort Theory

Organizational as well as personal factors can affect the quality of hospice services. Problems with care coordination including poor communication, limited resources, limited education/training, and poor staffing levels are factors that may impact

care quality in a hospice setting with outcomes that are unfavorable to both the workers and patients in the setting. According to Kolcaba (2013), CT is a humanistic theory that is based on highly prioritizing the needs of patients and advocates for caregivers in hospices to ensure that patients receive comfort care as a favorable outcome of nursing care (Wilson et al., 2015). The theory has been applied to improve quality care in hospice settings (Gwyther, 2014), and is appropriate for improving care quality in hospices because it encourages nurses to be considerate of patients' emotional, psychological and physical wellbeing.

The theory is suitable for this study because it serves as a gauge to measure care quality in a hospice setting (Dahlke et al., 2015). Based on the responses from the participants, there is a need for the local setting to be sure that it is congruent with the holistic care standards indicated in the comfort theory. The theory can be applied to examine organizational excellence as well as the nursing care provided in a hospice setting. According to Kolcaba (2013), the theory suggested three key concepts which include ease, relief, and transcendence.

Based on the results, a hospice care setting needs to provide quality care services to its patients to be congruent with the taxonomic structure instituted by Kolcaba (2013). This structure has three types of comfort and four contexts in which human life occurrences take place in a holistic manner; while the three forms of comfort are ease, relief, and transcendence, the four contexts are physical, sociocultural, environmental, and psychospiritual (Kolcaba, 2013). In order for patient comfort needs to be satisfactorily met, it is important that the setting use this guide in providing holistic care.

Limitations of the Study

Trustworthiness

One of the limitations encountered in the study is the use of one hospice setting only to collect the research data instead of drawing participants from different hospice settings to enhance understanding on how care quality is perceived by the health care providers in diverse hospices. This limitation could have greatly impacted the study however; this is not considered a problem anymore because results from this setting could easily be applied to like settings with similar characteristics. Dresch et al. (2015) suggested the identification and description of the environment or context of a study is essential in understanding the applicability of the results of the research to similar settings. Credibility was also a major issue given that the accuracy of the responses was difficult to gauge. It was not possible to assess the level of accuracy since the participants had the choice to respond according to their preferences. Majority of the nurses were worried about responding to questions that could implicate them negatively with their administration. In order to resolve this issue and boost the nurses' confidence, assurances were given that the project is not for academic purposes only but to improve care quality in a hospice setting and promote social change. As such their honest opinion will be very import to be able to understand the problems to make a meaningful change. It was further explained to the respondents that all the responses to the research questions will be confidential.

Recommendations

Findings from this research suggested that communication, resources, education/training, and staffing may impact care quality in a hospice setting. But this fact is not certain since this study was conducted in one hospice setting only instead of drawing participants from multiple hospice settings to enhance understanding on how care quality is perceived by the health care providers in diverse hospices. For that reason, recommendations were made to include a larger sample size for future research studies. These recommendations may be helpful in creating a better understanding on how staffing, education/ training, resources and communication may impact care quality in a hospice setting.

Recommendations to Include a Larger Sample Size

In a research work, having access to a larger sample size is critical for several reasons. It is important for a sample to be large enough to represent more representative of the population. A sufficiently large sample size produces results that are significantly different from a smaller sample size (Baernholdt et al., 2015). In qualitative studies like this one, where the objective is to lessen the chances of discovery failure, a large sample size broadens and forms a better picture for data analysis and results. Therefore, in order to ensure that care quality can be improved in a hospice setting by providing appropriate staffing, using effective communication, making resources available and providing proper education/training, this study and other future studies should emphasize on a larger sample size in order to provide a broader recommendations with certainty on how care quality can be improved in a hospice setting using the aforementioned indicators.

In other to provide future recommendations on how care quality could be improved in a hospice setting, it is important to recommend that succeeding researchers relate this findings to similar research studies with a larger sample size drawn from different hospices and expand further, to include the relationship that exist between quality care and staffing, quality care and education/training, quality care and communication, and quality care and resources. Results from the findings may help better identify how these indicators are related in the provision of care quality in a hospice setting, and may help guide further recommendations on ways of improving care quality in a hospice setting. Other researchers have investigated similar phenomenon and made valuable suggestions that were in some way related to this research.

Improving Quality Care Aiming at Staffing

Herndon et al. (2016) indicated that the consequence of low staffing levels may predispose some patients to risk as they are left unattended due to the high workloads for the providers. The participants in the current study described inadequate staffing levels as reducing the quality of care in the setting. Two participants (Respondent number 5 and 7) listed dissatisfaction with their jobs and considered leaving the profession. According to Friebert and Williams (2009) having such dissatisfied nurses, may make it very difficult for them to provide good care quality to the hospice patients. These two providers perceived staffing levels in the hospice setting as being inadequate. Per the two providers, high patient volume and insufficient staffing levels have been associated with poor patient outcomes and a poor care quality. Therefore it is recommended that future

research involving a larger sample size drawn from different hospices should investigate further on staffing as a relating factor on improving care quality in a hospice setting.

Improving Care Quality Aiming at Education/Training

Education and training are essential in ensuring that workers have the necessary skills in their area of specialization. Hill et al. (2016) stated that sufficient knowledge and skills is the key to improve patient outcomes, improve the quality of care, and increase patient satisfaction. Education/training is essential in ensuring that workers have the necessary skills in their area of specialization (Baernholdt et al., 2015). As noted by the answers from the participants, it is pertinent for nurses to continue with education even after becoming certified nurses. Continuous education and specialized training in hospice is a way of providing nurses with the necessary knowledge, skills, and values that will guarantee that the care they provide is the best (Grabusts, 2014). Recognizing the importance of evidence based practice, and the need for evidence based training to be offered to the hospice providers, will increase the evidence based skills and knowledge among health care professionals. Since the lack of evidence-based skills and knowledge is a barrier for the implementation of evidence-based practice, offering education in support of the required skills will increase the likelihood of caring for patients using practices supported by evidence (Hatfield & Lovas, 2014). Therefore an expanded research from more than just one hospice setting is needed in this area to ascertain that similar recommendations like this one could be applied in future research work with certainty, and used as recommendations for evidence based study.

Improving Care Quality Aiming at Communication

As evidenced by the answers from the participants, communication is a factor that affects patient outcomes. Poor communication may lead to lack of critical information or even overlooked changes in the patient's status. Communication is the key to solving many issues that create barriers to patients receiving quality care. Effective communication enhances understanding between all stakeholders in providing care for the patients (Hill et al., 2016). Additionally, poor communication may lead to misinterpretation of information, an aspect that may increase the likelihood of occurrence of medical errors. According to Schenck, Rokoske, Durham, Cagle, and Hanson (2014), medical errors have the potential to cause unexpected death or severe injury to the patients. Hill, Dempster, Donnelly, and McCorry (2016) stated that communication with patients is paramount to quality of care. Communication improves the relationship between care providers and patients as the two share beliefs and listens to each other. These are facts that are closely related to this research however, specific research work using multiple hospice facilities and targeting communication as an important factor in improving care quality in a hospice setting is recommended before concluding on the applicability of these facts.

Improving Care Quality Aiming at Resources

Resources are essential in ensuring that workers have the necessary equipment's needed for patient care (Baernholdt et al., 2015). As noted by the answers from the participants, it is pertinent for nurses to have resources available at all times. Today, technology is one resource that is important in nursing education (Marrelli, 2015). For nurses that graduated several decades ago, it becomes a challenge for them to keep up with the nursing technological advancement, as they lack the important skills which ultimately makes them feel like quitting the profession is the only option viable (Baernholdt et al., 2015). Making computers available at every nursing station in the hospice setting could facilitate learning. The nursing profession is viewed as a process of learning in order to improve the quality of patient's care. The availability of the necessary resources increases nurses' confidence in dealing with certain issues such as when making decisions on the type of care a patient might need (De Chesnay, 2014). Also, Wilson et al. (2015) suggested that hospice care settings should adopt the use of modern technology by health professionals to help in the coordination of activities that ensures equitable health care access by all patients. However, further research focusing on this area as a phenomenon of interest will unveil the relationship between care quality and resources.

Summary of Recommendations

Bell, Hunt, and Varvel (2013) asserted that Hospice care facilities that have too many employees, have problems improving communication among the healthcare providers, have limited resources, have problems instituting methods to improve

education and training amongst the healthcare providers, and face challenges in meeting patients' needs and demands. Consequently, it is recommended that future study with a larger sample size from multiple hospice facilities focus on the relationship on these indicators, in the provision of care quality care in a hospice setting.

Implications

Positive Societal Change

This research will promote positive social change. Students and health care professionals may use this study finding as evidence to support their practice in providing quality care in a hospice setting. Suggestions will be made on how to better implement these quality indicators to improve care quality. The facts will be published as evidence on factors that may affect care quality in a hospice setting. Other hospices, students as well as health care providers working in the hospice settings will be educated based on my recommendations. Clearly, improvement in the area of patient care will reduce the financial burden to various families as well as the government: Medicare, Medicaid and commercial insurances due to a reduction in the hospitalization rate.

Implications for Practice

This study will be resourceful to hospices and will serve as evidence on how care quality can improve in various hospice organizations. Health care providers and students interested in improving care quality in different hospice settings will use this as a resource to draw knowledge in understanding care quality in a hospice setting so that end-of-life care for the hospice patients can be improved in a global level, as patients transition comfortably to the end of life. This research will provide opportunities for

nurses and other health care providers to continue to advance the care for hospice patients and families so that patients and their loved ones could enjoy the quality services they seek for in a hospice setting.

Conclusion

A number of factors affect the quality of services provided in a hospice setting. Chiefly among them rank lack of knowledge about hospice care, inadequate resources and staffing levels, and ineffective communication. I successfully interviewed the selected respondents and analyzed the extensive data they provided with an identified tool. The findings of this research study should be helpful at the organizational, individual, and societal or policy-making levels. The recommendations, based on the findings of this study, are provided to improve quality hospice services. The limitations are discussed to ensure that future studies look up to this research as a guide for future studies. Finally, it is imperative for hospice care facilities to offer quality services to all patients and ensure that employees are empowered to execute their duties in a manner that empathizes with the difficult times the patients are facing and provide the necessary comfort that patients seek in a hospice setting.

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Appendix A: Interview Questions

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1. Tell me what you think about quality of care in a hospice setting.
2. Tell me your thoughts about obtaining additional training in hospice care.
3. Tell me what your thoughts are about resources in a hospice setting and their impact on quality of care.
4. Tell me what your thoughts are about communication and its impact on the provision of care in a hospice setting.
5. Tell me your understanding about staffing level and its impact on the provision of care in a hospice setting.