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RESEARCH ARTICLE

Perceptions of healthcare professional about the "PACE Steps to Success" palliative care program for long-term care: A qualitative study in Switzerland

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Abstract

Aim: This study aimed to examine the healthcare professionals' perceptions after implementing the "PACE Steps to Success" program in the French-speaking part of Switzerland.

Design: A qualitative descriptive study.

Methods: Thematic analysis of semi-structured face-to-face and group interviews with health professionals, PACE coordinators, and managers purposely invited in the four long-term home facilities that had previously participated in the PACE cluster randomized clinical trial intervention group.

Results: The PACE program implementation has improved communication with residents regarding end-of-life issues and helped identify patients' needs. The introduction of codified tools can complete internal tools and support decision-making. In addition, the training has promoted inter-professional collaboration, particularly in the case of care assistants, by defining each profession's specific responsibilities in providing care for older adults.

KEYWORDS
collaboration cross-professional, education, long-term facilities, nursing home, palliative care

1 | INTRODUCTION

Due to an aging population, European countries are experiencing an increased need for palliative care, especially in long-term care facilities (LCTF). In French-speaking Switzerland, about 40% of deaths occur in care facilities (Füglister-Dousse & Pellegrini, 2019), and by 2032 an estimated 13.000 people will require palliative care (Luta et al., 2016). Furthermore, the median survival of patients after institutionalization tends to decrease, with the consequence that most residents are in an end-of-life situation (Forder & Fernandez, 2011). Most residents are over 80 of age, and 86% of them have several morbidities, among which 43% have at least four chronic conditions (Füglister-Dousse & Pellegrini, 2019) and multiple symptoms. Residents with symptoms such as pain, depression, digestive disorders, and anxiety would benefit from early identification of palliative care needs and comprehensive support. However, care facilities often struggle to meet these needs (Piers et al., 2010). Although 69% to 82% of people near the end of life would benefit from early palliative care, the median time to initiation is only two weeks (Murtagh et al., 2014; Ten Koppel, Onwuteaka-Philipsen, Van den Block, et al., 2019). Furthermore, late initiation leads to inappropriate care and unnecessary hospital referrals (Reymond et al., 2011). Facilities professionals have a great deal of experience in providing end-of-life care. However, they often lack specific training in palliative care, knowledge of symptoms management and communication, and support from specialist teams (Brajtman et al., 2009; Brazil et al., 2006, 2012; Goddard et al., 2013; Miller et al., 2017; Miller-Lewis et al., 2019). For this reason, the "Six Steps to Success Programme" was developed in the United Kingdom (O'Brien et al., 2016): a one-year palliative care training intervention for nursing homes based on the "Gold Standards Framework" (Badger et al., 2012).

2 | BACKGROUND

The "Palliative Care for Older People (PACE) Step to Success" program was designed to adapt the English program to the cultures of different European countries, and the material was translated and provided in the relevant languages (Smets et al., 2018). The aim is to train facility staff to provide high-quality palliative care to residents, thus improving the quality of death. The PACE program is a standardized intervention to integrate primary or general palliative care into the daily routine of long-term care facilities (Smets et al., 2018). It is based on training, by national experts, of coordinators identified in each structure who will then train and transmit specific tools to all staff. The coordinators are followed and supported through monthly meetings with the national experts throughout the program implementation. The program comprises three phases introduced over twelve months: Getting ready, Introducing the program, and Keeping the program going. During the "Getting ready" phase, which lasts two months, the program's national experts train the coordinators within each facility and provide the tools for palliative care implementation. The coordinators then train all healthcare personnel during the six-month "Introducing the program" phase, each month corresponding to one of the six steps of the program: (1) discussion about current and future care, (2) assessment and review, (3) coordination of care, (4) delivery of high-quality palliative care: symptom management, (5) care in the last days of life, and (6) care after death (Figure 1) (Hockley et al., 2019). Finally, the training concludes with a four-month "Keeping the program going" phase to consolidate the program and mobilize the tools and knowledge acquired.

A cluster randomized clinical trial evaluated the implementation of the PACE program to determine its impact on resident outcomes, as reported by staff (Van den Block et al., 2020). This randomized clinical trial was conducted in 78 nursing homes throughout 7 countries. It compared the PACE program with standard care by evaluating data on 551 deceased residents at baseline and 984 after the intervention, as well as data on 2680 staff at baseline and 2437 after the intervention. The trial results showed that residents' comfort did not improve in the last week of life. Furthermore, the staff's understanding of palliative care improved only slightly after the intervention (Van den Block et al., 2020).

FIGURE 1 The 6 steps of the "PACE Steps to Success Program" (Hockley et al., 2019).

2.1 | Research question

In the frame of the PACE trial, we aimed to examine the overall perceptions of the healthcare professionals after the program implementation in the French-speaking part of Switzerland. Therefore, we addressed the following research questions to get better insight into the staff experiences:

- What are the overall perceptions of managers, PACE coordinators, and care staff after implementing the PACE program?
- To what extent did the PACE program affect the roles of staff working in LTCFs in Switzerland?

3 | METHODS

3.1 | Study design

This qualitative descriptive study explores the perceptions of the changes that have occurred since implementing the "PACE Steps to Success Program" in French-speaking Switzerland through thematic analysis of face-to-face interviews. The interviews started the month after the program implementation was completed in the Swiss facilities and were conducted between November 2016 and January 2017.

The study was developed following the guidelines and recommendations of the Standards for Reporting Qualitative Research (SRQR) (O'Brien et al., 2014).

3.2 | Setting

Interviews were conducted in the four long-term care facilities in the French part of Switzerland that had previously been included in the PACE randomized trial intervention group. The four residences comprised two public and two private, medium (50–99 beds) and small-sized (0–49 beds) not-for-profit long-term care facilities. The facilities provide on-site nursing care and personal assistance with activities of daily living, while the family physicians/GPs responsible for the resident's medical care are off-site. The characteristics are described in Table 1.

TABLE 1 Characteristics of long-term care facilities (*N* = 4).

	LTCF 1	LTCF 2	LTCF 3	LTCF4
Number of beds	36	78	60	66
Registered nurses (*n*)	10	18	15	17
Care assistants (*n*)	15	36	30	31
Number of deaths in last year	8	24	17	18
Mean attendance rate of HP during the PACE project (%)	77	81	55	72

3.3 | Participants

Participation in the study was purposely proposed to three professional groups: managers, PACE coordinators, and care teams. The researchers invited one facility manager per facility with a global view of the program's implementation and all the PACE coordinators (*n* = 10). The care teams were invited by the coordinators and asked to contact the research team if they wished to participate in the study. The inclusion criteria for the staff were members of the permanent care staff and active participation in at least 80% of the six training sessions. The care staff included nurses and care assistants with various levels of education, age groups, and professional roles. In two facilities, the chief nurses were very involved in the daily care of the residents and decided to be included in the care staff.

3.4 | Data collection

Participants' experiences and perceptions were collected in semi-structured face-to-face interviews. Focus groups or individual interviews were conducted considering the characteristics of the participants. Focus groups have the potential to generate new ideas through verbal interaction driven by group dynamics and are more time- and cost-efficient than a series of individual interviews (Krueger & Casey, 2009; Rabiee, 2004). Individual interviews were preferred for the managers since they had different work backgrounds and belonged to a smaller group (Ryan et al., 2009).

The research team developed guiding questions for the interviews (Table 2), which were conducted by a research psychologist not involved in patient care or the PACE program. The interviews began with an introduction to the study, then opening questions were asked. Finally, additional questions were added to elicit further details (e.g., "Could you tell me more…?"), ensuring that all topics were covered.

The focus group interviews were conducted with respect to the affiliation to the care team or PACE coordinators. The research psychologist was supported by a co-moderator, responsible for observing the group interactions, taking notes, and summarizing the group discussions at the end of the interviews, ensuring that all relevant topics had been covered. The co-moderator was a research psychologist not involved in patient care or the PACE educational program. The care team was asked to share their experiences applying the intervention steps in daily practice. The topics discussed were changes in practice (time investment, residents' reactions, communication with residents, physicians, and other staff members) and obstacles or reasons for applying the intervention steps. The PACE coordinators were asked to share their experiences regarding the program's implementation, barriers, facilitators, and time investment.

TABLE 2 Opening questions for the semi-structured interviews.

Opening questions for care staff focus group interview

- What are your experiences with performing each PACE step (1–6) in daily practice?
  - What are difficult parts/steps?
  - What are unnecessary parts/steps?
  - What are nice/good parts/steps?
  - What are your experiences with starting to talk about preferences and wishes? (step 1)
  - How did residents react when starting talking about preferences and wishes?
  - What are your experiences with using the condition charts? (step 2)
  - What are your experiences with the multidisciplinary meetings? (step 3)
  - What are your experiences with using tools for pain and depression (step 4)?
  - What are your experiences with using integrated care plan to 'manage last days'? (step 5)
  - What are your experiences with the monthly reflective de-briefings groups? (step 6)
- What are barriers to perform each PACE step in daily practice?
- What are facilitators to perform each PACE step in daily practice?
- Should steps be adapted to be better performed in daily practice?
  - How should they be adapted?
- What could/should change in the PACE steps for broader implementation (e.g. in all LTCFs in country)?
  - How should this be changed?
- Are there any unintended consequences in daily practice when performing the PACE steps?
- What are your experiences with following the PACE training?
  - What are difficult parts?
  - What are unnecessary parts?
  - What are nice/good parts?
  - What should be added to the training and what could be skipped?
  - What do you think of the length of each training session?
  - What do you think of the number of training sessions?
  - What do you think of the training material?

Opening questions for the PACE coordinators focus group interview

- What are your experiences with performing the PACE steps (1–6) in daily practice? For yourself, and for the nursing staff?
  - What are difficult parts/steps?
  - What are unnecessary parts/steps?
  - What are nice/good parts/steps?
- What are your experiences with being a role model?
  - Challenges/ difficulties?
  - Unintended consequences?
  - Time investment?
- What are barriers to implement PACE in daily practice?
- What are facilitators to implement PACE in daily practice?
- Should the PACE intervention be adapted to be more feasible to perform in daily practice?
  - How should it be adapted?
- What could/should change in the PACE intervention for broader implementation (e.g. in all LTCFs in country)?
  - How should this be changed?

Opening questions for manager individual interview

- What are your experiences with implementing PACE in your facility (organizational aspect)?
  - To what extent do you feel that the PACE intervention is adopted in your facility?
  - What were barriers for implementing PACE in your facility?
  - What were facilitators for implementing PACE in your facility?
  - Were there unintended consequences with implementing PACE in your facility?
- What do you think of the time investment of staff to learn how to use PACE in daily practice?
- What do you think of the time investment of staff to perform PACE in daily practice?
  - Feasible/too much?
- What do you think of countrywide implementation of PACE?
  - Why good idea/why not?
- What could/should change in the PACE intervention for country wide implementation?

The individual interviews with the facility managers covered their experiences and opinions regarding the implementation of the program, the feasibility, and practical consequences for the staff.

Saturation was reached when all topics were discussed, and no new topics were added during focus groups and individual interviews.

3.5 | Data analysis

All interviews were recorded, transcribed, and anonymized directly during transcription. The verbal transcripts of all interviews were analysed with Maxqda (qualitative data analysis software). The authors analysed the data using the six steps of Braun and Clarke's thematic analysis (Braun & Clarke, 2014). Thematic analysis was conducted independently by two research team members (PAC; SP), who then met regularly to discuss the coding structure. The first step was for the authors to familiarize themselves with the data: listening to the recorded interviews and reading and re-reading the transcripts to gain an overall impression and become familiar with the text. The second step was the designation of initial codes. In the third step, the codes were sorted into different preliminary themes. These three phases were conducted separately for the three interview groups. After, the analysis was continued by integrating all data without any interview group separation or role distinctions within the groups. All the preliminary themes were brought together and compared in the fourth step. Relationships were highlighted through thematic mapping to identify similarities and differences and to define themes and subthemes. The fifth step of the analysis involved discussing the subthemes and themes until a consensus was reached and each theme was clearly named. Finally, in the sixth and final step, narratives were extracted from the data to represent the themes and subthemes.

The analysis was subject to regular meetings of the co-authors to review and agree on the results before proceeding with the next step and approving the results.

4 | RESULTS

4.1 | Participant characteristics

Thirty-four people participated in the interviews, divided into six focus groups and four individual interviews (Table 3). Four focus groups involved twenty care staff members representing diverse caring roles in the four facilities; two focus groups involved the ten PACE coordinators, also corresponding to different positions in the facilities. In addition, the four managers had various roles in their respective facilities. The average duration of the focus groups was 62 ± 15 min, while the average duration of individual interviews was 33 ± 16 min.

4.2 | Themes

The interviews allowed the researchers to identify two main themes: Impact on practices actions and Impact on the professional role. The first theme was divided into three subthemes: (A) reflecting on end-of-life and existing palliative care practices, (B) improving existing practices, and (C) improving communication and teamwork. The second theme was organized into four subthemes: (a) valuing each professional role in caring for patients, (b) empowering the healthcare team, (c) questioning each role, and (d) changing the perception of the physician's role (Figure 2).

4.3 | Impact on practices actions

The program reflected on the existing practices and helped the communication between staff members and with residents, and families.

4.3.1 | Reflecting on end-of-life and existing palliative care practices

The participants noted that the training triggered a questioning about the end of life and created momentum for change around palliative care in their facility.

TABLE 3 Characteristics of interview participants ($N = 34$).

	Focus group interviews ($n = 4$)	Focus group interviews ($n = 2$)	Individual interviews ($n = 4$)
Target participants	Care staff members	PACE coordinators	Managers
Number of participants	20	10	4
Professions/rank (*n*)	Chief nurse (2) Registered nurse (3) Care assistant (14) Community care assistant (1)	Chief nurse (4) Registered nurse (4) Palliative care nurse (1) Care assistant (1)	Chief nurse (1) Assistant chief nurse (1) Director of care (1) Managing director (1)
Sex			
Female: male ratio	16:4	6:4	2:2
Age			
Mean (range)	42.8 (23–62)	43.4 (28–57)	50.5 (42–56)
Number of working months experience in this NH			
Mean (range)	93.8 (6–252)	81.5 (28–150)	96.5 (48–140)
Number of working hours per week in this NH			
Mean (range)	38.8 (30–42)	37.5 (22–42)	42 (42–42)
Attendance rate to the six training sessions			
Mean percentage	90	100	0

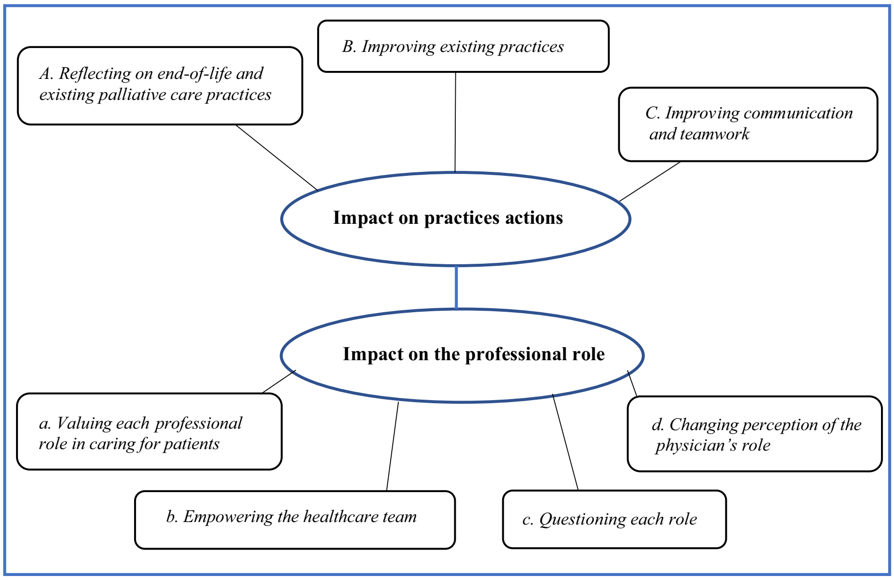

FIGURE 2 Results of the thematic analysis: Themes (impact on practices action–impact on the professional role) and subthemes.

> Talking about it in a team setting, taking a position, questioning yourself, (…) I would say that the most important element of the program is really that every co-worker is thinking about this on a personal basis, even in relation to death, and then how to handle the situation. About death and then how to imagine this end-of-life event.
>
> Director of care; managers

The program unblocked the difficulties in starting to talk about death and enabled team members to express their emotions after a death.

> This has led to discussion, making it possible to talk more about these deaths and to be able to really express what she was feeling. (…) And I think that it also helps to anticipate the death and the feelings we may have about the situation.
>
> Registered nurse 1; focus group 1

Taking a reflective stance has led to clearer positioning and better anticipating of needs.

> Nevertheless, there is much greater anticipation of an end-of-life scenario (…). Here, at some stage, the physician, caregivers, and facilitators are also taking a position (…), and this position-taking leads to support that is much more appropriate.
>
> Chief nurse 2; focus group 5

In those facilities where palliative care had already been established, the training helped strengthen caregivers' practices and skills.

> I think we're, we're already well ahead in terms of the program. I think that it has helped to make the staff aware that in terms of what we were doing we were already on the right track. Maybe that has been a comfort for the staff.
>
> Assistant Chief nurse 1; managers

In facilities where palliative care was not as extensive, the PACE training made it possible to take stock of how people are accommodated and explore new perspectives of care.

> This has allowed us to take stock of where we were in terms of our knowledge and skills as well, and where there were gaps, we have put things in place.
>
> Palliative care nurse 1; focus group 5

4.3.2 | Improving existing practices

The points that can improve care were incorporated into practice to strengthen existing instruments in the structure.

> And then, after the other "Thinking about looking to the future" documents that we combined with ours, because we already had a document (…) so in fact we added what was missing from ours.
>
> Registered nurse 2; focus group 2

The documents represented an excellent basis for informal discussions, even if sometimes challenging to complete, because they are not tailored to the residents' cognitive abilities.

> It is a document that really acts as a support for the resident's advocate. As a way of having a discussion to understand better who this person is, what are their priorities for their life, what is important to them, what they don't like … So, it really acts as a guideline (…) and in fact, it is a document that is constantly being added to (…) throughout the accompaniment process. (…) we draw on it when we meet as an interdisciplinary group in the critical phases…
>
> Palliative care nurse 1; focus group 5

Participants mentioned that the training helped to make some practices more systematic.

> For example, for a resident who was on pain medication, we did not carry out a systematic pain assessment every week… (…) Whereas now, gradually, (…) it is being systematically noted…
>
> Registered nurse 3; focus group 4

4.3.3 | Improving communication and teamwork

The program recommends monthly multidisciplinary meetings to discuss palliative care needs with physician participation. This has created the opportunity to speak directly with physicians.

> I found the sessions with the doctor very interesting. It created a link between the caregivers and the, I mean the care assistants … and it's very interesting to be able to talk directly with the doctor about our residents.
>
> Care assistant 4; focus group 2

Also, registered nurses and care assistants communicated more accurately and appropriately with physicians about symptoms.

> A: Speaking as a nurse, it also saves us (…) from "banging our heads against a brick wall" over problems we can't resolve because we can't find the right way of communicating with the physician (…). We can also start to triage the doctor's work …
>
> F: We are more up for taking vitals directly or asking about pain
>
> A: Rather than calling the physician and saying he's in pain. (…) we say he's six out of ten, he's eight out of ten and then maybe the doctor is able to be a little more responsive.
>
> Palliative care nurse 1 and registered nurse 6; focus group 5

Moreover, it allowed improved cohesion, teamwork, and broader staff integration.

> The entire staff of the care home is becoming more aware (…) it's about everything, everyone (…). I've noticed that they are more involved
>
> It has been an interdisciplinary task to listen to each other and accept other people's s skills (…) to work together, to incorporate them into your own skillset (…), I think that PACE has rocked some comfort zones.
>
> Registered nurse 7; focus group 6

4.4 | Impact on the professional role

The interviews revealed that the program enabled a better perception of professional roles and an improved knowledge of the functions of others.

4.4.1 | Valuing each professional role in caring for patients

The training highlighted each role specificity, mainly for the care assistants, in the day-to-day support of residents and physicians.

> I find that, I don't know if it's just me, but that they listen a lot more to the care assistants to ask for symptoms, or about treatment. I think we are much freer to speak. You feel more listened to as a care assistant. (…) Also, to suggest treatment (…) to say what needs to be done at the time, I find that they listen more there too.
>
> Care assistant 3; focus group 1

4.4.2 | Empowering the healthcare team

The proposed tools were sometimes used to support decision-making processes.

> "It is hard to get the on-call physician to understand that the resident does not want aggressive treatment. What they want is to be able to die in peace, and sometimes it's hard to get the message across. (…)" care assistant 12, focus group 3 "This person doesn't want to be admitted to hospital". (…) So, it's not always easy for a doctor to find him or herself facing a nurse who says, "No, I don't want to admit him or her". "Here's what's on the advance directives."
>
> Care assistant 2; focus group 1

4.4.3 | Questioning each role

The care assistants reported difficulties with boundaries in support. They mentioned a disconnection between their role and more active involvement in supporting families following a death.

> D: I am not allowed to overstep my boundaries talking to their families, because we can't. And I didn't know at what point I should stop. I don't know how far I can go. (…). This is what we learn in school … It often depends on the facility where we work too.
>
> Care assistant 11; focus group 3

> B: And when the family came, well, her daughter was crying, I just gave her a kiss, I expressed my condolences, would you like something to drink? That's it, I stopped there. (…). Sometimes I'd like to open the door and say, I'd like to make some kind of gesture, but I don't know if I am entitled to, if I don't have the right to, I just don't know.
>
> Care assistant 8; focus group 2

The care assistants found it difficult to clearly define their responsibility in using the tools and did not take the initiative to assume ownership of them.

> It's more for the nurse, I think. (…) I know some care assistants who wouldn't dare. There are some like (First name C) who will say: "Let's get started, yes, let's do it". But there are many others who are a bit like (First name T) and who wouldn't dare, if we don't say, come on, let's sit around the table and have a think about the case of Mrs Doe. Then they will say what they are thinking. But they are not going to pick up the sheet of paper by themselves and say: "I think it is time for us to talk about such and such a situation"
>
> Care assistant 12; focus group 3

4.4.4 | Changing perception of the physician's role

The training initiated the change in the perception of the physicians' role.

> Personally, what I appreciated was the doctor's external view, since, as we introduce the residents, he can also give us his opinion and tell us what to do. So that's very important, an outside point of view.
>
> Palliative care nurse 1; focus group 5

5 | DISCUSSION

The results of our study highlighted the positive perceptions of healthcare professionals in implementing the program, which is perceived as a suitable tool to enforce palliative care practice in long-term facilities. One of the principles of palliative care focuses on patient care to relieve pain and other distressing symptoms and to anticipate potential complications. Implementing the PACE program in long-term care facilities in French-speaking Switzerland led to a deepening of knowledge about palliative care. Moreover, the training helped health professionals review how palliative care is offered and develop better communication with residents on end-of-life issues with better anticipation of palliative care needs.

The authors remarked on an alignment in the themes and an overlapping in the three different interview sets after the third step of thematic analysis. So, the authors agreed to integrate all data to define and analyse themes and subthemes. This avoided losing information relevant to the research question if the data had been examined by separating the different professional roles or the interview sets and resulted in a better overall perception of the program implementation.

The participants, particularly the coordinators and managers, noted that the training created momentum for change around palliative care in their facility. The program drew up the questioning of the personal relationship between the end of life and death, an essential prerequisite for developing interpersonal skills. Indeed, care assistants are often not prepared to discuss death and dying with residents' families, preferring non-verbal communication, especially touch. In addition, several factors can limit discussions about death, for example, when relatively inexperienced young nurses develop an intense fear of death, when the taboo of death is culturally entrenched, or when caregivers have learned to act rather than communicate (Oosterveld-Vlug et al., 2019; Ten Koppel, Onwuteaka-Philipsen, van der Steen, et al., 2019). The 'reflective debriefing' tool proposed in step 6 encouraged a better understanding of one's fears, defence mechanisms, and perplexities. Health professionals were induced to explore existential issues with patients more deeply when death was imminent. This aspect might help prevent the risk of burnout or compassion fatigue (Miller-Lewis et al., 2019). Also, giving voice to patients' preferences makes it easier to implement early palliative care (Ten Koppel, Onwuteaka-Philipsen, van der Steen, et al., 2019). The anticipation of patients' needs results in greater treatment consistency, reduced unwanted hospital admissions, and respect for the choice to die in a long-term care facility (Martin et al., 2016). The 'thinking ahead' tool, proposed in step 1, was crucial to offer advanced palliative care planning. The document is intended to gather the views of residents and/or their families about end-of-life care. It encouraged teams to express patients' specific needs and wishes and facilitated the discussion of advance directives, better planning, and subsequent anticipation of palliative care. Moreover, authentic, compassionate, and empathic listening has built trust and helped patients express their end-of-life needs, even when in conflict with caregivers' values.

The program also positively impacted collaboration between different professional levels and fostered empowerment, interdisciplinary communication, and a more in-depth assessment of symptoms. Effective palliative care is based on interdisciplinary collaboration and valuing each role in caring for older adults. However, often there is a poor joint decision on patient management, and each stakeholder is concerned with his own area (D'Amour et al., 2008) and preserving his autonomy (O'Brien et al., 2016). Moreover, professionals tend to relate according to their educational background and professional perspective (Eloranta et al., 2010). D'Amour points out that 'active interdisciplinary collaboration' is governed by significant criteria. First, shared communication tools and discussion spaces for professionals help to establish patient-centered care goals, reconcile personal viewpoints, and reduce rivalries. Then, the quality of interaction is determined by the shared knowledge of values and competencies, which creates a sense of belonging and trust. Those criteria contribute to better governance and greater connectivity between health professionals, regardless of hierarchical levels (D'Amour et al., 2008). The PACE training encouraged the application of the various principles developed by D'Amour. Collaborative tools involving different professionals in a shared agenda and communication spaces enabled clinical judgement. Better communication encouraged a more in-depth analysis of situations and, ultimately, more active participation in treatment and new options for care. One example is the 'Looking and thinking Ahead' document proposed in step 1, which was used by care assistants to address aggressive overtreatment with physicians and to articulate better the residents' wishes for the end of life. Caregivers particularly appreciated directing attention to the patient's needs when exchanging with other staff members. This aspect is of great importance given the role played by care assistants in the facilities. Indeed, caregivers provide the most direct care to residents and play a crucial role in delivering high-quality care (Davila et al., 2016). Furthermore, the program helped to clarify everyone's responsibilities with the result of strengthening autonomy. A better understanding of each other's roles and proactive symptom assessment contribute to a sense of trust (O'Brien et al., 2016). Especially concerning the figure of the physicians as supervisors and advisers, the program evidenced the importance of getting their opinion when encountering difficult situations. Care assistants reported having a better perception of their professional role in the facility also when compared to other's functions. The definition of their role specificity in the day-to-day support of residents and physicians resulted in care assistants feeling more listened to and that their skills were more effectively considered. All the healthcare professionals appreciated the clarification of professionals' roles because it clarified the assignments, thus easing the request for others' intervention when needed. The improved interprofessional discussion and collaboration, supported by the more straightforward evaluation of decisions made by physicians, indirectly contributed to empowering the care teams.

The training period encouraged teams to use the proposed tools, adapt them to existing resources, and systematize certain practices. The adapted tools complemented the internal ones and helped the decision-making process. For example, the pain assessment and management chart in step 4 "Delivery of high-quality palliative care," helped formalize and integrate this diagnostic tool into the daily routine. Also, standardizing the tools has helped clarify responsibilities and has contributed to a more positive perception of the quality of the care given (D'Amour et al., 2008; Seymour et al., 2011). However, the proposed tools must remain a complementary element guiding users toward an ideal in terms of care. Awareness is necessary to avoid duplication or additional burdens on the team. Especially when similar tools have already been implemented, team members risk becoming reluctant to use them (Oosterveld-Vlug et al., 2019). Moreover, the tools cannot replace the unique contact that is the keystone of any approach and remain a complementary element of the relationship.

5.1 | Strengths and limitations of the study

The main strength of this study is the use of qualitative research methods to understand the lack of effect of the randomized trial palliative intervention. In addition, the qualitative approach allowed for an in-depth exploration of the issues using semi-structured interviews to achieve data saturation.

Focus groups were used to collect the data, and group discussions may have influenced participants' contributions to the topic. The sample of clinical nurses who attended all training sessions might limit the generalization of results. Interview results from other countries included in the PACE study are not available to our knowledge to measure the generalization of our results.

6 | CONCLUSIONS

The PACE program participates in changing perceptions, values, and professional practices specific to palliative care. These results are encouraging, but long-term 'maintenance' is essential to ensure the program's continued success. Co-creative densification' is about bringing together the specific expertise of each stakeholder to find shared solutions for the elderly and their families. This study suggests that long-term care facilities must engage in a culture of interprofessional collaboration during the palliative phase of their residents.

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CONFLIECT OF INTEREST

None.

DATA AVAILABILITY STATEMENT

Data are available on https://hugge-my.sharepoint.com/:x:/g/personal/sophie_pautex_hcuge_ch/EX7lese77q9Bir6CyTSwtKwBlXfS15R0ghHc4KPC62jsJA?e=7PW0gx.

RESEARCH ETHICS COMMITTEE APPROVAL

The different cantonal research committees approved the protocol (Main ethic commission: Commission cantonaled'éthique de la recherche scientifique de Genève (CCER), 6/8/2015; Amendement 28/09/2016). Written and verbal information was given, and we obtained each participant's signed consent form. The directorates provided their agreement to be part of the research project.

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