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Empowering Leader Behaviours: Impact on Health Professionals' Empowerment and Commitment

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Background: The importance of leaders' behaviours in empowering staff in the workplace is advocated in healthcare management literature. However, there is a lack of empirical evidence linking empowering leadership behaviours with professionals' sense of workplace empowerment and commitment. Facilitative leadership styles are considered important to redesigning work in palliative care provided in primary care services.
Aims: To test a model linking leader-empowering behaviours to health professionals' perceptions of workplace empowerment and commitment in primary care.
Methods: As part of a larger multicenter survey study, a random sample of 209 professionals (nurses and physicians) providing palliative care in primary care settings in two Spanish regions was drawn. Three pre-validated scales were used to measure leader-empowering behaviours, empowerment and commitment. Multiple regression analyses were conducted to test the mediation model.
Results: Overall, perceptions of workplace empowerment were significantly related to all dimensions of leader-empowering behaviours. These dimensions were correlated with empowerment and commitment (rs= .31 to .63). Empowerment at least partially mediated the relationship between leader-empowering behaviours and commitment. Empowerment had a significant impact on commitment ($\beta = .64$, $p < .05$).
Conclusions: The results of this study highlight the importance of facilitative leaders in creating empowering work environments. Hence, recommendations can be made to ensure that healthcare managers leading primary care teams facilitate the implementation and delivery of palliative care in these settings by promoting professionals' empowerment and commitment. This study provides encouraging empirical support and guidance for healthcare leaders interested in creating highly-effective work environments that benefit both patients and professionals who care for them within current turbulent healthcare organisations.

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The Organizational Landscape of Generalist Palliative Care in Danish Hospital Departments

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Background: In Denmark, 48% of all deaths take place in hospitals. Many die from chronic progressive diseases, often preceded by frequent hospital stays. Obviously, the need for palliative care (PC) should be addressed in the patients' encounter with the hospital system, as a routine in the daily clinical work. If, and how, the departments have organised their provision of PC, is by large unknown.
Aims: To examine Danish hospital departments' organisation and focus on PC.
Methods: A survey was sent to managers of the 410 hospital departments in Denmark, who treat patients. The survey addressed whether PC was prioritised and implemented at the organisational level in the departments (depts).
Results: A total of 318 (78%) depts responded, 85% had palliative patients among their clientele, 73% could provide PC if indicated, and 64% had focus on PC. Among medical (N=80), surgical (N=95), psychiatric (N=40) and childrens' (N=14) depts, 93%, 77%, 43% and 71% could provide PC, respectively. Half of the depts would refer palliative patients to specialist PC to a greater or lesser extent (32% answered 'always or often'), 33% of the depts had a policy for PC, 17% had allocated resources to PC, and 11% had used the specialised PC teams to increase the staffs' palliative skills. Whether the depts had guidelines for PC, was only known by 35% of the respondents.
Conclusion / Discussion: The majority of managers of hospital depts confirmed they had a focus on PC. However, focus did not seem to equal a policy or organisation of PC in the depts as recommended by the health authorities and the hospitals' national accreditation procedure. This survey has pinpointed some areas to address in the depts' provision of PC; e.g. sparse allocation of resources, unawareness of guidelines and scant use of specialist PC teams to improve the staff's PC skills. It is imperative to know the depts' awareness towards PC and organisation of PC if general PC in the hospitals shall be promoted and improved.

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Is Emergency Department Attendance Associated with Factors Relating to Preferences for Place of Death? A Population-based Mortality Followback Survey

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Background: Emergency Department (ED) use is considered an indicator of poor quality end-of-life care and increases the risk of dying in hospital but it is unclear whether this reflects patient preference.
Aims: To examine the association between factors related to preferences for Place of Death (PoD) with ED attendance by cancer patients in the last 3 months of life.
Methods: Population-based mortality followback survey with 596 bereaved relatives of adults who died of cancer (QUALYCARE study, London 2009–10, response rate 39.3%). 582 responses and corresponding death registration data were analysed using bivariate analysis to compare patients who attended the ED to those that did not in terms of hospital stay and death, and factors relating to preferences for PoD.
Results: 56% of patients visited the ED once or more in the last 3 months of life (median 1, range 1 to 8 visits). ED attenders were more often admitted to hospital (93.8% vs. 52.7%, p< 0.001), were hospitalised for longer (median 14 vs. 0 days, p< 0.001) and more often experienced a hospital death (37.1% vs. 19.5%, p< 0.001). Moreover, ED attenders were less likely to have discussed their preference for PoD with family (54.8% vs. 66.5%, p=0.005) or health professionals (50.4% vs. 65.5%, p=0.002). Their preference for hospital death was no different from those who did not attend ED (5.7% vs. 3.9%, p=0.482). The most common preference was to die at home (69.2% ED attenders, 67.8% non-attenders).
Conclusions: We found that ED attendance by terminal cancer patients is common (more than 1 in 2 experience this) and associates with increased hospital stay and hospital death. This has cost implications as health systems struggle with funding and ED closures. Our results also suggest that ED attendance may reflect poorer planning and patient choice for PoD. This prompts policy and practice to improve community palliative care and facilitate discussion of preferences.
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National Perspectives on Dying and Bereavement – Ireland 2004 and 2014

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Background: Policy/service developments benefit from being planned relative to people's views – their current opinion & future concerns. Over the last decade international and Irish surveys have engaged with the public about end of life.
Aims: This study aims to examine the contemporary knowledge, attitudes and behaviour of Irish people with respect to death and bereavement. Comparisons with baseline data from 2004 & UK data will be made.
Method: A questionnaire was designed based on Irish and UK surveys. Research ethics approval for a survey process was obtained. Adults from the republic of Ireland were randomly sampled to participate in an omnibus telephone survey. A telephone survey was conducted with a representative sample (n=891) during May 2014.
Analysis: Frequencies & descriptive statistics were generated; comparison by region, gender, age and class was conducted.
Results: 57% felt there was not enough discussion about death & dying (up from 51%). Dying at home was the preference of 74% (up from 67%) & most do not believe their preference will be available for them (53% up from 45% in 2004).
More than half (53%) experienced the death of someone close in the previous two years & 26% of these deaths were at home. Wishes for end-of-life were consistent with 2004 & with international surveys – to be surrounded by people you love, and free from pain. Nevertheless, most (two thirds) have not given others direction on their preference or written advance plans. Organ donation and writing a will are the exceptions. Suicide and accidental death were thought to be in the top three causes of death by 47% and 35%. In fact these causes account for only 5% of deaths in Ireland annually.
Conclusion: There is appetite for discussion but still limited **action** around end of life plans though over half have been recently bereaved. Preferences are more strongly stated than in 2004. These trends will be discussed relative to changes in Ireland between 2004 & 14.

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The Orkdal Model: Establishment of an Integrated Oncology and Palliative Care Outpatient Clinic to Improve Collaboration and Care – Who Are the Patients?

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Background: Integration of palliative care into oncology may improve quality of life for patients and family members, increase patients' time spent at home, and reduce aggressive end-of-life treatment. An integrated outpatient cancer clinic was established at a local hospital (Orkdal) in Mid-Norway in 2012.
Aims: The Orkdal Model aims to develop, implement and evaluate an integrated model of palliative cancer care. It consists of a standardised care pathway coordinating care within specialist- and community care, and between the two levels; an educational programme for healthcare providers; and information on palliative care to patients, their family, and the general public. The present study aimed for describing the patient population.
Methods: All patients visiting the Orkdal outpatient cancer clinic from October 2013 to July 2014 were eligible. Data regarding socio-demographics, cancer disease and subjective symptoms were collected by the EAPC Basic Dataset. Numerical rating scales from 0 to 10 were used for symptom assessment.
Results: 119 patients participated. Mean age was 67. Fifty-one percent were females. Stage of disease was: metastatic 62%, locally advanced 14% and local 19%. The three most prevalent cancer diagnoses were prostate (21%), breast (19%) and colon (15%). Treatment intention was: curative 30% and palliative 66%. Mean Karnofsky performance status was 84%. 101 patients had more than one registration. 31 patients died in the study period; among these 33% died at home. Mean intensity scores were: pain 1.86, depression1.30 and well-being 2.46.
Conclusion: An integrated model to improve palliative cancer care is developed. Data from patients, family members and healthcare providers will be collected prospectively and compared with the present data and with a control population. The model may be applied in other regions and for other chronic diseases.
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