Is Palliative Care Work Stressful for Healthcare Assistants and Can Mindfulness be Used as a Tool to Alleviate that Stress?

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Education, is entirely my own work and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any copyright law, and has not been taken from the work of others save to the extent that such work has been cited and acknowledged within the text of my work.

Signed: (Mikey Monaghan) ID No.:14212496 Date: 9th of September 2022

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Finally, I would like to thank my family for their support over the years.

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Abbreviations

BTEI- Back to Education and Initiative

CETA- Connacht Education and Training Alliance

CSO- Central Statistics Office

FÁS- Foras Áiseanna Saothair

FET- Further Education and Training

FETAC- Further Education and Training Awards Council

GRETB- Galway Roscommon Education and Training Board

HCA- Healthcare Assistants

HIQA- Health Information and Quality Authority

HSE- Health Service Executive

MBSR- Mindfulness-Based Stress Reduction

NFQ- (Irish) National Framework Qualification

NHS- National Health Service (UK)

PCA-Palliative care assistant

PLC- Post-Leaving Certificate

QQI- Quality and Qualifications Ireland

RSG- Roscommon Disability Support Group (the D is not used in their logo)

SOLAS- Seirbhísí Oideachais Leanunaigh Agus Scileanna

UK- The United Kingdom

USA- United States of America

VTOS- Vocational Training and Opportunities Scheme

WHO- World Health Organisation

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Abstract

Is Palliative Care Work Stressful for Healthcare Assistants and Can Mindfulness be Used as a Tool to Alleviate that Stress by Mikey Monaghan

The basis of this study is to explore healthcare assistants' work-related stress while working in palliative care. The study examines palliative care tutors' and healthcare assistants' attitudes who work in palliative care in County Roscommon, Ireland. The desired outcome is to explore the possibility of using specific stress reduction techniques to reduce work-related stress for healthcare assistants in the Roscommon area. Therefore, the research focuses on palliative care tutors and healthcare assistants based in Roscommon who have worked, taught, or studied palliative care.

This research takes the form of a regional case study based in County Roscommon. Therefore, those participating in the interviews and surveys are all involved in the provision of palliative care education or care staff working directly in palliative care in the Roscommon area. The literature used in this study explores whether stress exists within the palliative care area from the care-worker/healthcare assistant point of view. Also, it examines stress-reduction techniques and their benefits/drawbacks. This is a qualitative study divided into two phases. Phase one focuses on whether stress exists in the career of palliative care assistants. Phase two focuses on whether mindfulness can help deal with palliative care stress. The findings of this study suggest that palliative care is a stressful area for palliative care assistants to work in, and the causes of that stress are multifaceted. Phase two of the study also confirms that for most participant's palliative care is a stressful area to work in, and for a minority, mindfulness is an effective tool in dealing with that stress.

Chapter 1: Introduction

1.1 Introduction

Can mindfulness reduce palliative care stress for PCAs? How can we identify ways for healthcare assistants to deal with the pressures of working in palliative care? The inability to cope with stressful situations can lead to many problems for healthcare assistants and those they provide care. Healthcare assistants provide care for some of the most vulnerable people in Ireland today, including people with disabilities, both intellectual and physical, to older people who may have lost their independence due to ill health such as a stroke or dementia. The diversity of the people healthcare assistants work with is broad and can be of any age profile or gender, including palliative and hospice care recipients. As educators, is there anything we can do to prepare future healthcare assistants in palliative care[1] to deal with the demands of working in the area? Coping with stress is a significant challenge facing the healthcare sector (Lee *et al.*, 2018). In the early part of 2020, palliative care has come under particular pressure due to the outbreak of COVID-19, which has seen PCAs and the rest of the multidisciplinary healthcare team put their lives on the line to protect the most vulnerable in our society. The author has trained PCAs for the past eleven years and, in doing so, has witnessed the enormous positive impact they have on Irish society, where PCAs have provided care for people who may be in their last year of life and ensured that the care provided meant they could spend their final months in a comfortable and dignified manner. The research population and topic were chosen to show PCAs in County Roscommon that their voice can be heard through this research; therefore, the author used this study to demonstrate a form of educational leadership for PCAs in Roscommon. The study also attempts to show a broader audience the impact stress can have on PCAs in Roscommon. There is little research conducted on healthcare assistants in the West of Ireland (Drennan *et al.*, 2018).[2] This dissertation attempts to contribute to the broader research on healthcare assistants in Ireland by focusing on healthcare assistants who work in palliative care.

Consequently, the author saw a niche in creating new knowledge on the topic of PCAs and work-related stress in palliative care in County Roscommon as an opportunity to highlight

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[1] Instead of identifying healthcare assistants who work in palliative care henceforth the author will identify them as PCAs (palliative care assistants).

[2] Drennan et al study was on healthcare assistants across Ireland but not specific to the West of Ireland.

areas in healthcare assistant training that can be supported by local education providers. Another facet of the dissertation was mindfulness and its use to reduce palliative care stress amongst PCAs. Many see stress as a fact of modern life; however, PCAs who provide physical and emotional care to people who may not have long to live have additional stress due to the personal nature of palliative care. The author has sought a technique that may help PCAs through difficult times at work, such as the COVID-19 pandemic that has hit the healthcare sector extremely hard, often contributing to the death of clients.

The purpose of the research is to assess the extent to which palliative care assistants (PCAs[3]) are stressed in their workplace and explore the usefulness/adequacy/efficacy of mindfulness in reducing stress levels. Throughout the current research, the author examines the lived experiences of people who either teach or work in palliative care and explore how palliative care staff understand their stress levels. In phase two, the author tests whether mindfulness can be used to help reduce that stress.

Figure 1 presents the stages of the dissertation, beginning with phase one, where the author conducted a focus group, interviews, and a survey that explored PCAs' and their teacher's attitudes towards palliative care stress. Using the same participants,[4] phase two is centred around an action research intervention where the author tested if mindfulness could be used to alleviate palliative care stress in PCAs and palliative care teachers in the region of County Roscommon.

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[3] PCAs—palliative care assistants—The author used this term to distinguish healthcare assistants who work in palliative care from those who worked in other areas of care.

[4] The participant group took part in both phases although less took part in phase two.

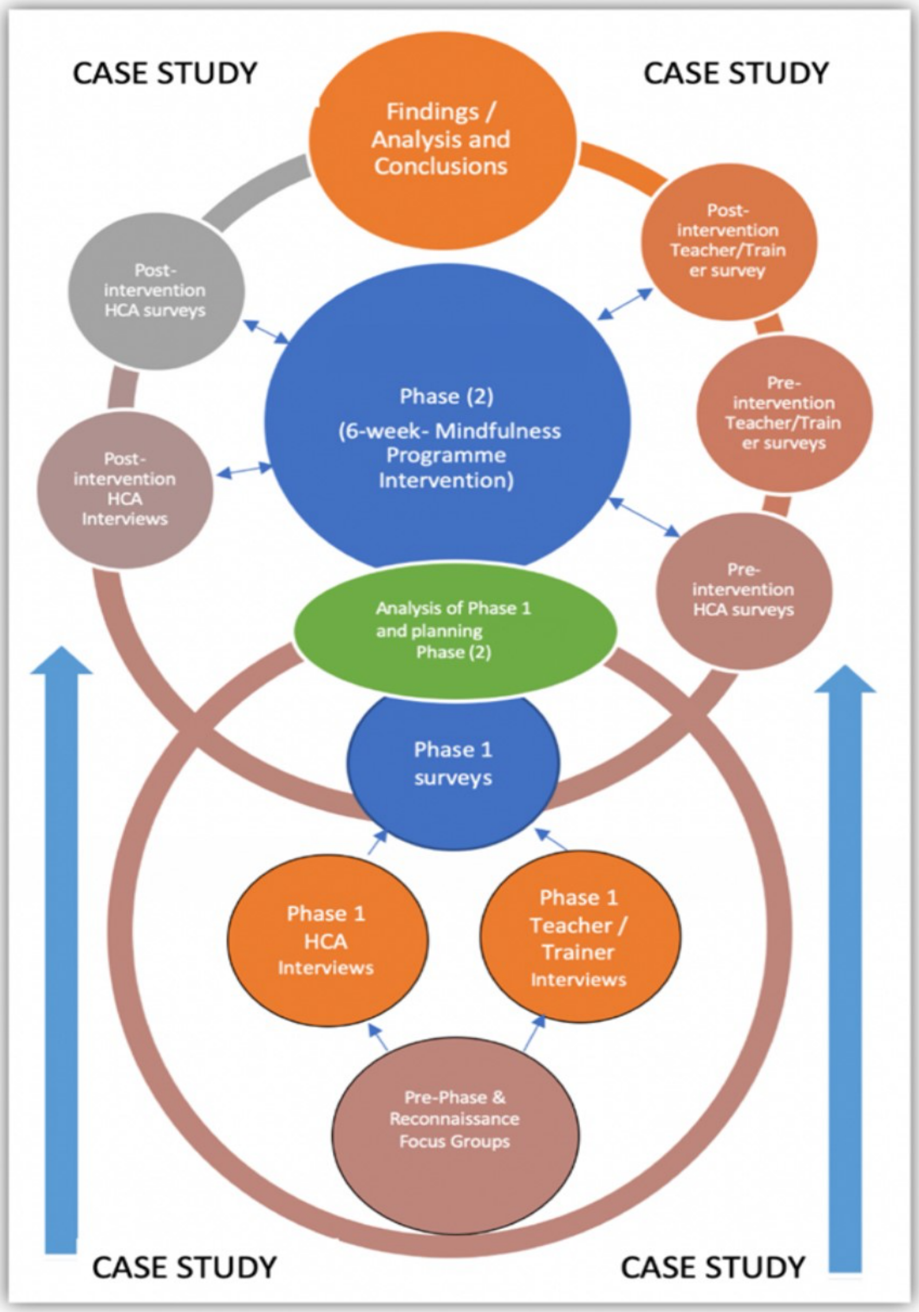

Figure 1. Case study outlines a summary of the research used in this study using a bottom-up inductive perspective.

The author explored the module QQI[5] level five, “palliative care support,” and asked teachers and graduate learners (who now work in palliative care) how they cope with palliative care stresses. The palliative care support module outlines the general details of a PCA role within the palliative care team. It examines how the PCA supports palliative care clients with

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[5] QQI-quality and qualifications Ireland.

particular emphasis on comfort rather than cure.[6] The author separated the first survey and interviews into phase one and the action research and post-action research interviews into phase two, as follows.

Phase one—Do workers in the palliative care sector experience stress?

The author investigated whether PCAs experience stress—and if so, what the most significant causes of that palliative care stress were. The author then used phase one to inform phase two, where he explored whether mindfulness could reduce the palliative care stress highlighted by the participants in phase one.

Phase two—Mindfulness intervention (exploring stress reduction on PCAs)

Having brought to light that most participants agreed that palliative care was a stressful area to work in phase one, the author invited the participants to partake in mindfulness sessions led by Dr Ray Sawyer (a mindfulness expert based in County Roscommon) and participate in a survey before each of the sessions took place with another three months after the mindfulness intervention had concluded. The author used a questionnaire to explore the participants' attitudes towards mindfulness before, during, and after its use over three months between January and April 2020.

1.2 The Objectives of the Study

- To identify if stress exists within the occupational field of PCAs who work in palliative care in County Roscommon
- To test if mindfulness could be used to reduce stress for PCAs currently employed within the region's palliative care sector.

The formal recognition of QQI level five healthcare (formally FETAC[7] level five) became mandatory only in 2013. Research in Ireland in this area is still in its infancy. Palliative care support (module) and training (in Roscommon) were introduced by the GRETB. However, healthcare assistants have worked in palliative care in the county for much longer. The dissertation is structured in six chapters, as follows.

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[6] Many palliative care clients will not get better and the emphasis within the module is comfort so that the client's final months/years are of good quality.

[7] FETAC—Further Education and Training Awards Council (Ireland).

Chapter 1: Introduction to this dissertation sets out what palliative care support QQI level five in healthcare support is. It discusses the general background of the dissertation set within a regional context. It also presents a visual illustration of how the author conducted the study based on an inductive (bottom-up) case study methodology outlining each stage of the dissertation.

Chapter 2 is the literature review, where the author introduces the reader to palliative care, what it is, and the family's role during the palliative process. The chapter explores the role of the healthcare assistant and their function in providing palliative care and how they are trained to work in the area with particular reference to the Irish further education sector. One of the current study's central themes is stress, and the chapter explores relevant literature regarding what stress is. It explores stress sources within the palliative care area, such as rumination, grief, palliative care clients' family, compassion fatigue, burnout, and anticipatory grief.

Having reviewed the literature on palliative care stress sources, the chapter then discusses coping mechanisms to address that stress, such as empathy, positive psychology.

Chapter 3 explains the methodology employed in the study, beginning with the research paradigm. It discusses qualitative research, its benefits, and why the author chose to use it for this study. The chapter continues by explaining the theoretical perspective and research rationale, and design. The research design explains the methods used to conduct surveys, questionnaires, and mindfulness intervention. Ethical considerations were made to ensure rigour throughout the study and are discussed in the methodology, including considerations to ensure privacy for participants with particular reference to GDPR[8] regulations. As this is a case study, the author describes two specific colleges in the County Roscommon region[9] and their role in providing a palliative care curriculum through QQI level five.

Chapter 4: Findings The findings emerged from two phases, as displayed below.

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[8] GDPR—general data protection regulation.

[9] They are the only two permanently based colleges that provide QQI level five Healthcare in Roscommon.

Phase one concerns the study of stress, including its causes, its impact on PCAs, and possible tools to reduce it. The research questions that oriented the investigation are as follows:

1. Is palliative care stressful?
2. Are the participants open to using stress-reduction techniques such as mindfulness to reduce palliative care stress?

The following methods were used in phase one.

1. Focus group with four PCAs
2. Interviews with palliative care teachers
3. Interviews with PCAs
4. Survey with fifty-six PCAs

Phase two—Having assessed that palliative care is stressful, most participants in phase one stated that they were open to learning more about mindfulness as a stress-reduction technique. Phase two presents the findings from a six-week mindfulness program conducted with twenty PCAs from phase one. The following data gathering techniques were used in phase two.

1. A pre-survey of PCAs before beginning mindfulness sessions
2. A survey using a variation of the Freiburg mindfulness inventory (FMI) of participating palliative care teachers
3. A survey using a variation of the FMI twenty PCAs[10]
4. A post-survey of PCAs
5. Interviews of 4 PCAs who took part in the mindfulness sessions

Chapter 5: Discussion Overall discussion of the dissertation, the findings, and the significance of those findings for palliative care in County Roscommon.

Chapter 6: Recommendations Based on the findings of the study, the author discusses various recommendations and implications that the research can have on the teaching of PCAs in Ireland.

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[10] It was based on the Freiburg mindfulness inventory but was altered as discussed in methodology

Chapter 7: Conclusion Discussion presented by the author reminding the reader of the primary aspects of the study and explaining where it lies in the larger picture of palliative care education and its importance to PCAs.

Appendices Documents relating to the dissertation, such as ethics application and consent letters for the surveys and interviews.

Chapter 2: Literature Review

2.1 Introduction

A good literature review tells a story and helps us understand what we already know (Jesson and Lacey, 2006). The purpose of this chapter is to show a familiarity with and understanding of current research in the palliative care field with particular reference to PCAs and stress while working in the area. This chapter focuses on palliative care's themes: the PCA's role (including how they are taught), stress levels within the profession, and the PCA's strategies to deal with that stress. The chapter is divided into four themes, as follows: palliative care, PCAs, stress, and mindfulness.

Figure 2. Themes of literature review

The chapter reviews the literature relevant to coping with stress for those who work in palliative care by discussing empathy, positive psychology, and mindfulness. The examination of stress and its impact on healthcare assistants is pivotal. The author reviews the definitions of mindfulness and its strengths and weaknesses when used as a stress reducer, discussing the contributions made by critical theorists in the field, such as Kabat-Zinn and Williams (2011).

Subsequently, the link between positive psychology and mindfulness is critically examined to investigate whether including these elements in an educational program is beneficial. As the central theme of this dissertation permeates stress, its (palliative care stress) impact on PCAs, and possible solutions for healthcare assistants who work in Roscommon, the author explores recent relevant studies about healthcare assistants (PCAs) in Ireland and their training, with particular reference to the palliative care module. The author then reviews studies based on palliative care workers and the effects of stress within their profession. The work of several researchers, theorists, and practitioners outside of Ireland is also explored. These include healthcare assistants, though not exclusively professionals who work specifically in the palliative care sector.

The literature review then expands on stress by exploring the effects of 'burnout' on palliative care workers and its impact on the people working with them. Furthermore, the author explores compassion and fatigue, and their effects on those working in palliative care. The literature review's final section scrutinizes solutions and coping mechanisms that may help alleviate stress for those working as PCAs in palliative care in the region. The author discusses positive psychology and the possible use of mindfulness as a technique that could be used to reduce stress for PCAs in Ireland.

2.2 Theme One Palliative Care

Theme one of the literature review is illustrated in **Figure 3**, where the author explains what palliative care is and then focuses on Saunders' theory of total pain and the practical application of that theory to working in palliative care (Saunders, 1964). The third section of the diagram highlights how the author discusses the role of PCAs, followed by the role of the client's family and how the family relates to the PCA.

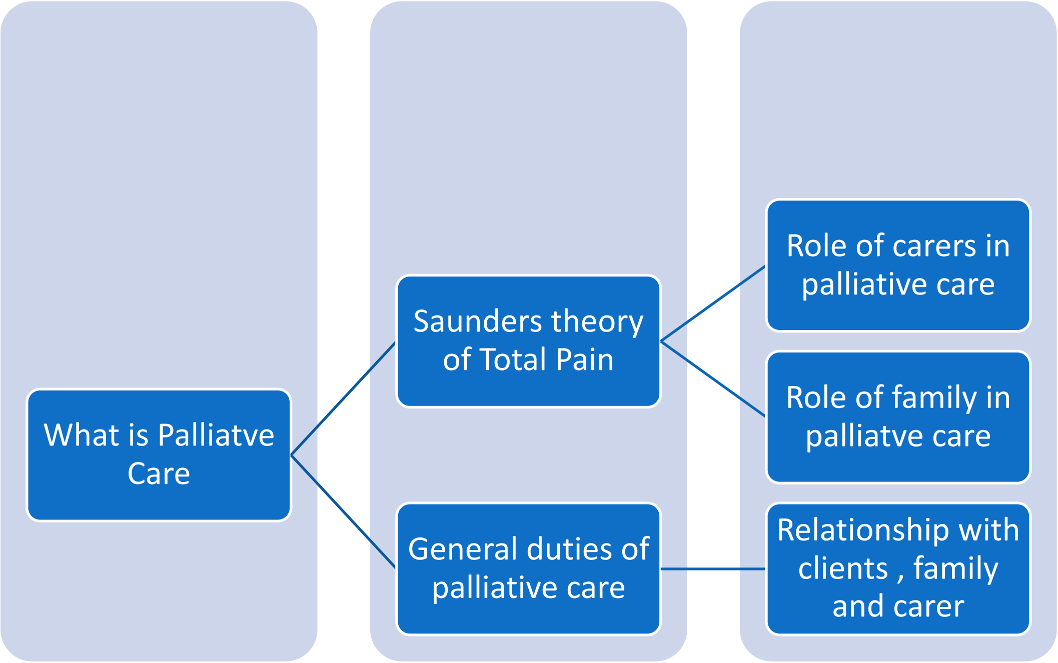

Figure 3. Theme one of literature review

Palliative care is a type of care associated with symptom management of a chronic illness that may be life-threatening. It is an approach that improves patients' quality of life (adults and children) and their families (WHO, 1990). According to Gomas (1993, p.841), 'Palliative care at home embraces what is most noble in medicine; sometimes it is curing, always relieving, supporting the right to the end,' which shows a very positive outlook towards the ideals of working in palliative care.

Modern palliative care originated in St Christopher's Hospice in London in 1967 by Dame Cicely Saunders (Oliver *et al.*, 2010). Saunders' theory is significant to this study, as the modern concept of providing palliative care has a starting point. Before the 1970s, pain control was a misunderstood aspect of cancer; pain is regarded as an inevitable consequence of the disease (Seymour *et al.*, 2005). The modern concept of palliative care began to evolve, whereby comfort and pain management became central to palliative care provision. From the late 1960s onwards, the idea of accepting a client not necessarily recovering began to emerge, with developments such as round-the-clock management of pain. There have been significant strides forward in palliative care's growth over the past few decades (Clark *et al.*, 2005). The philosophy of accepting that a client may not get better coincided with person-centred care through personal outcomes. The implementation of patients' outcomes depends on understanding a client's needs (Oandason and Darmour, 2009). PCAs use a crucial component of palliative care that is the belief in the promotion of comfort. The care worker then uses a client-based system called personal outcomes.

Today, comprehensive definitions of palliative care address the multidimensional aspects of patients and their families, including the physical, social, and spiritual (Mehta and Chan., 2008). The influence of Cicely Saunders in palliative care's development over the past forty years has been significant. Her ground-breaking change in providing total pain management allowed followers of her philosophy to view comfort-care as a central focus in looking after a person in palliative care. The significant difference[11] was that those providing palliative care (after Saunders) put comfort at the forefront by proactively managing palliative care clients' pain rather than reacting after the pain returned. They did this by using morphine pumps whereby the client could attain pain-reducing drugs before the pain resurfaced. Therefore, comfort is now a central aspect of palliative care rather than the cure-based philosophy previously dominant. Total pain is defined as 'the suffering that encompasses all of a person's physical, psychological, social, spiritual, and practical struggles' (Richmond, 2005, p.238). The concept of total pain addressed the physical pain of a palliative care client, but it also addressed its holistic needs. This brings attention to the PCA's role, which must manage the client's total pain. For example, the PCA communicates with the palliative care nurse in reporting a client's needs based on what they said regarding their level of pain.

Figure 4 illustrates Cecily Saunders theory of total pain, where each type of pain must be addressed by the care worker, and each type of pain is related to the other (Saunders, 1964). This means that the care team cannot address one type of pain without focussing on the other types of pain as well. An example of this is if a person is on a morphine pump and the physical pain is being addressed, the palliative care client may still be in social pain where they can no longer interact with the people they did before they were sick. The PCA may organise that the client can partake in bingo in the nursing home where he is resident, he may not be able to attend a public bingo, but the PCA tries to address the client's social pain. Therefore, the care team must address all aspects of the total pain to make the client comfortable.

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[11] In comparison to palliative care before Saunders where total pain concept did not exist.

Figure 4. Saunders theory of total pain

Using Saunders’ (1964) model, many PCAs provide practical nursing duties that reduce palliative care nurses’ workload. As nurses’ and doctors’ workloads increase, their time spent with patients/clients is diminished, and most direct care is provided by PCAs (Spilsbury and Meyer, 2005). Their duties include addressing the following needs of a client.[12]

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[12] This is not an exhaustive list but examples of common duties conducted by healthcare assistants who work in palliative care (PCAs). The duties outlined are areas of support the client needs and are generally called activities of daily living—ADLs.

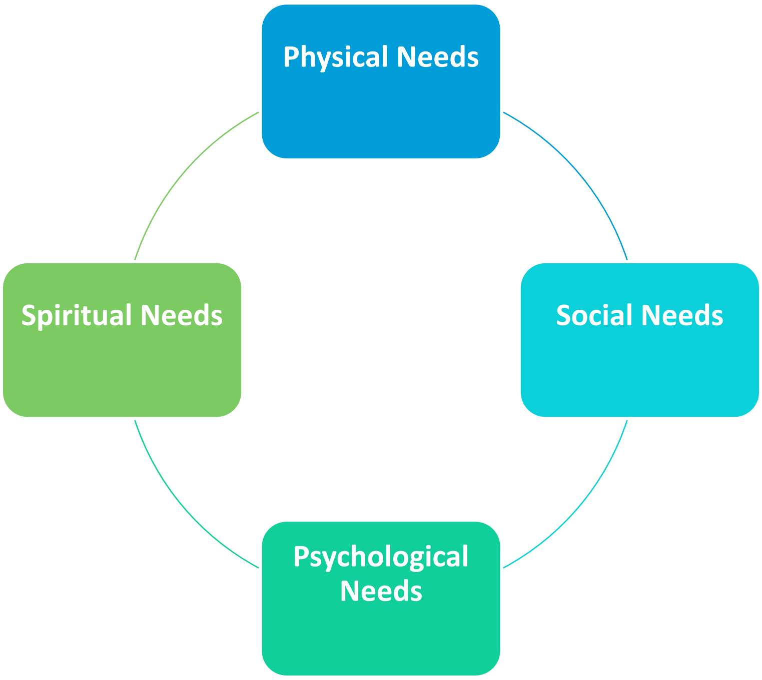

Figure 5. Duties of a PCA (Drennan et al., 2018)

Physical needs—Bringing the palliative care client to the toilet, showering them, feeding the person if needed, and dressing them. The physical duties of healthcare assistants are very diverse (Wilson *et al.*, 2009).

Psychological needs—The PCA sits with the client while the latter reflects on their illness, expressing their feelings for the future. The PCA addresses the palliative care client's psychological/emotional needs by interacting with them and showing empathy.

Social needs—If in a nursing home, the PCA may liaise with the client's family and communicate with them regarding their mood and mental awareness (this communication would only occur in the nursing home).[13]

Spiritual needs—For example, the PCA may turn on the radio for a Catholic client during the Angelus[14] or bring the client to mass to receive communion if the client requests it.

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[13] In homecare, the interaction with family could be on a greater scale, particularly if family members live with the palliative care client.

[14] Angelus—The Angelus is a common Catholic practice particularly amongst older people where they pray at a certain time each day usually 12pm and 6pm.

Research on the roles of PCAs suggests that using PCAs as part of the healthcare team reduces waiting times, enables easier access to appointments, and frees up more qualified staff to focus on more complex medical issues (Bosley *et al.*, 2010). The duties implemented by PCAs highlighted in **figure 5** are examples of how valuable they are in addressing a client's needs. Saunders' (1964) model ties in with another aspect of palliative care that is vastly important to the relationship between care staff and client/patient: the care staff working with the client's family. The Saunders model focuses on the client's comfort using principles such as clean bed linen and acceptable hygiene practices to provide a high standard of care for each client. An example of applying the Saunders model by a PCA was to change bed linen daily and the correct use of PPE[15] while assisting the client with personal care, such as toileting and liaising with the client's family members.

2.3 The Role of Family in Palliative Care

Families and their role within the palliative care process are central to ensuring high standards of care within the palliative care profession (Bezold, 2005). Families often act as advocates for palliative care clients and can also be their primary caregivers; as such, palliative care staff must collaborate with the family to achieve best practices (Hall and Ritchie, 2013). Care staff must understand the patient is immersed in the family, an interactive system (Mehta *et al.*, 2009). Therefore, the PCA must realise that to work with the palliative care client, they must also work with their families. The relationship between the PCA, the clients, and their families is central to the palliative care provision illustrated in **figure 6**.

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[15] PPE—personal protective equipment such as disposable gloves and aprons.

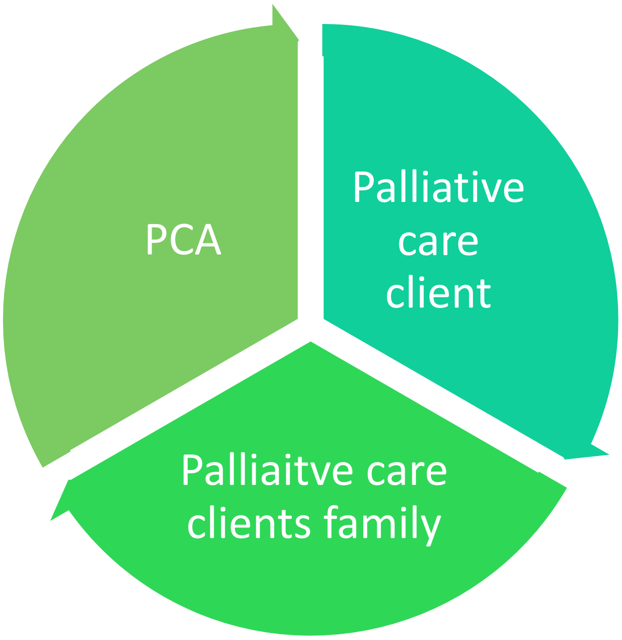

Figure 6. Three-way relationship

Figure 6 illustrates the PCA's proximity when working with the palliative care client and its family members. Healthcare assistants (PCA) spend more time with palliative care patients than any other healthcare professional (Stacey, 2005). One of the main principles of the provision of palliative care in Ireland is to allow patients to receive care at a location of their choice, including the patient's own home (Department of Health, 2012). In palliative care, the client may not recover. Therefore, the focus is not on rehabilitation but on maximizing the client's quality of life (if they wish), involving their family as much as possible. Palliative care is a unique area to research (Cassarett *et al.*, 2003). Unlike other aspects of care such as rehabilitation, a client receives care for a specific time and then recovers their independence. A fundamental part of palliative care is support for the client's family (Rome *et al.*, 2011). The PCA does not work in isolation with the patient/client; as the client's condition worsens, the PCA communicates more and sometimes works more directly with the client's/patient's family daily. Palliative care has changed over the years with a greater understanding of the client's point of view (Campion-Smith *et al.*, 2011). Therefore, a fundamental shift takes place in the provision of care for the client: that palliative care provision's whole philosophy is that of comfort management.

Moreover, a gradual acceptance that the client's condition will not improve and provide comfort is now the emphasis instead of finding curative methods, such as rehabilitation. The focus of palliative care is on functional capacity. That is, the palliative care team focuses on the client's ability to maximize their final months/years without particular attention on overcoming the illness and disease. This acceptance of a client's inevitable death is different from other healthcare types where cure or adjustment to disability is a priority. However, this transition from the belief in curative measures to accepting a client's inevitable death can create stress/strain for the caregiver, client, and client's family. The transition (from curative to palliative) can be complicated (Webber, 1998). As palliative care progresses, the relief of symptoms will increase emphasis; the family members get more attention; the family care becomes more intensive. Therefore, a system approach is essential (Visser *et al.*, 2005), where all aspects of the client's care can be addressed, including the total pain needs of the client. Providing this systematic approach may be very difficult, not least for the palliative care worker—particularly for PCAs in rural areas with limited contact with other palliative care professionals. Palliative care is a person-centred profession where the client-carer relationship is built on trust, respect, and acceptance of the reality of what the client/patient is experiencing.

Under the supervision and direction of qualified nursing staff, PCAs carry out a wide range of duties; to care for, support, and provide information to patients and their families (NHS, 2017).[16] As they work so closely together in supporting clients (including palliative care patients), the stresses of palliative care for nurses and PCAs are similar. Satisfactory palliative care provision requires staff to learn beyond academic guidance or school instruction (Abbey *et al.*, 2006). Palliative care is a people-oriented occupation. The PCA attend the client through both good and bad days. The patient may need to deal with the body deteriorating and with the psychological pressures of accepting death as a realistic inevitability. Therefore, as Abbey *et al.* (2006) highlight, the staff involved in palliative care will need to learn beyond their academic education and learn from the people they work with during this challenging time.

PCAs will need to learn to deal with these challenges at the coalface of working with clients who are faced with their mortality; this cannot be taught in the classroom. Kristjansen (2004) suggests that the impact of palliative care on the client's family is vitally important to acknowledge. Family members of clients receiving palliative care suffer from deteriorating

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[16] NHS—National Health Service (United Kingdom).

health during that time (ibid). A longitudinal study showed that highly stressed family caregivers providing palliative care have a higher mortality rate than non-caregivers (Schultz *et al.*, 1995). Wiley (1998) posits that these family members are viewed as hidden patients. This means that the family members may also be suffering due to the potential loss of a loved one.

2.4 Theme Two—the Healthcare Assistant (PCA)

Theme two, as illustrated in **figure 7**, shows how the author presents the following sections of the chapter by first discussing what a healthcare assistant/ PCA is, followed by how PCAs qualify through further education, and finally discussing the process of that training.

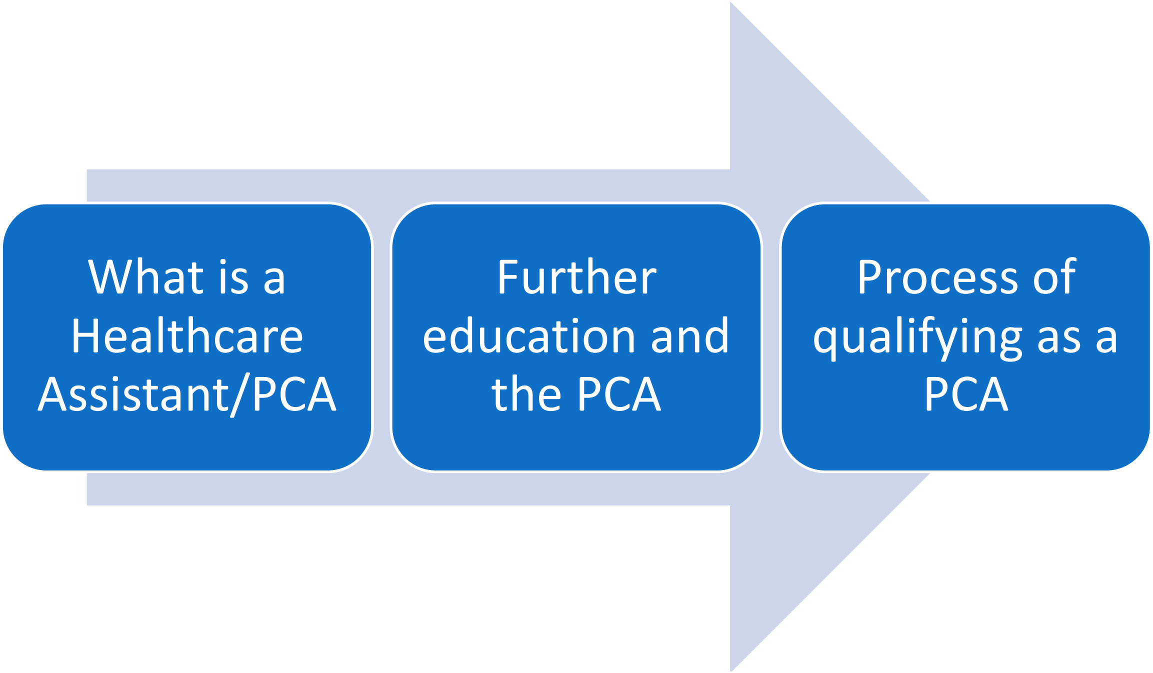

Figure 7. The PCA

Healthcare assistants who work in palliative care (PCAs) see themselves as a unique profession separated from other healthcare team members (Kontos *et al.*, 2010), suggesting that a distinct sense of identity different from other multidisciplinary team members is beginning to evolve. In Ireland and beyond, the healthcare assistant working in the palliative care domain is now a fully recognized and trained profession. The significance of this is that healthcare assistants can currently be researched in their own right to contribute to the caring profession, rather than just as a support for the nursing profession.

PCAs work in a wide variety of care facilities across the spectrum (Kelly, 2008). This is confirmed by the author's experience, who has taught PCAs for the past eleven years. PCAs may perform in the following workplaces.[17]

- Nursing homes
- Hospitals
- Residential care units
- Clients' own homes
- Hospices
- Day-care centres
- Respite centres
- Rehabilitation units/centres
- Community care

The healthcare assistant's role emerged to help support nursing staff with non-nursing duties (McKenna *et al.*, 2004). A PCA provides support for staff nurses, such as getting a client/patient up in the morning, which allows the nurse to provide more technical/medical duties to clients. The contribution of PCAs to the healthcare area is invaluable (Burns, 2006). In allowing nurses to complete procedures such as administering medications, a PCA can take up different duties, such as taking vital signs and personal care. Quality of care is dependent primarily on PCAs, as they provide a great deal of day-to-day non-clinical care (James *et al.*, 2010). An example of everyday care that may not be considered clinical would be the area of homecare[18] (and in nursing homes), as the ratio of PCAs to nurses is much higher. Under the direction of nurses, PCAs carry out most client-oriented personal care duties and provide end-of-life care to older people (Shanagher, 2013). Those employees are the Irish Health Service's most valuable asset (Byrne, 2006). In County Roscommon, 4.5% of the population identified themselves as carers (CSO, 2016 a); this includes family carers, who are sometimes regarded as informal carers and provide palliative care. This dissertation is primarily focused on formal or professional PCAs who work in the role of PCAs in palliative care.[19]

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[17] This is not an exhaustive list, wherever a person receives care can be the location of a PCAs work.

[18] *Homecare* is a term used where a client lives in their own home and the PCA goes into that person's home and provides care at that location.

[19] PCAs who are recognized having completed QQI level five health service skills or QQI level five healthcare support and are paid professionals which is distinct from family carers, who may not be qualified, are unpaid, and are known as informal carers.

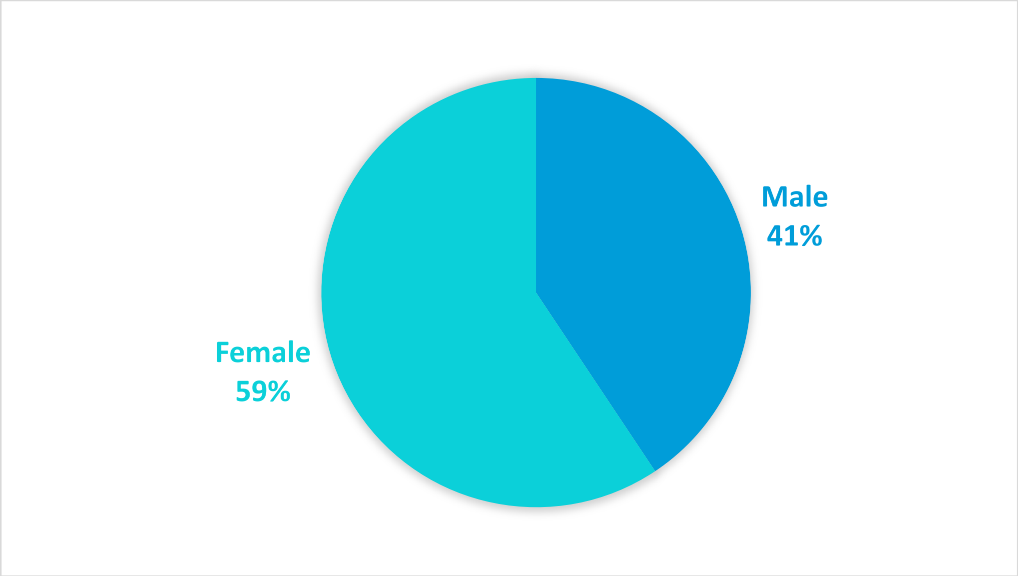

Figure 8. Roscommon carers by gender (CSO, 2016 a).

Figure 8 illustrates the total number of people in County Roscommon who identify themselves as carers. However, the image also represents family carers who may not be qualified as healthcare assistants. The gender breakdown is 59% female (1735) and 41% (1188) male; therefore, the majority of people who identify themselves as carers in Roscommon are female (ibid). To be recognized as a healthcare assistant/PCA, they must qualify through the further education sector.

2.5 Further Education and the PCA

To be qualified as a healthcare assistant (PCA) in Ireland, a person should graduate from QQI level five in healthcare support or health service skills, navigating their way through the further education route. QQI level five is regulated through the different education sectors of adult learning. The further education and training (FET) sector in Ireland provides training through levels one to six. It prepares learners to return to the labour market and prepares them for higher education (SOLAS, 2013). The FET Act 2013 was enacted to oversee the dissolution of FÁS.[20] The Act establishes SOLAS, which is required to propose a five-year plan for further education throughout Ireland (ibid).

Further education[21] refers to education and training that occurs after second-level schooling but is not part of the third-level system (Education, 1995). In Ireland, SOLAS is responsible

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[20] FÁS- Foras Áiseanna Saothair is now dissolved but was a state agency for adult training in Ireland.

[21] Further education—FE.

for planning, coordinating, and funding further education training (SOLAS, 2013). Adult education in Ireland is defined as 'systematic learning undertaken by adults who return to learning having concluded initial education or training' (Education, 2000, p.27). The Department of Further and Higher Education, Research, Innovation, and Science[22] identifies different types of programs and providers to deliver FET[23] programs: the Back to Education and Training Initiative (BTEI), post-leaving certificate programs (PLCs),[24] the Vocational Training Opportunities Scheme, Youthreach, and Adult Literacy and Community Education (Grummel and Murray, 2015). FET provides a wide range of courses not available elsewhere for people over the age of sixteen, acting as the leading provider of upskilling and retraining people in Ireland (Education, 2014). An action plan has been agreed upon between the transitions-reform FET/HE[25] working group to standardize third-level access for FET graduates (Education, 2020). The action plan outlined in 2020 sees a more joined-up approach between the FET sector and the HE sectors, which can help streamline the process of FET graduates gaining access to the third level. An example of this approach would be a graduate of health service skills at QQI level five, then transitioning to higher education to study nursing.

Many FET-funded programs such as VTOS[26] and BTEI[27] (where the author teaches) teach health service skills programmes. A wide diversity of employers have skills needs which FET can supply (Sweeney, 2013). As Roscommon has the fourth oldest population in the country (CSO, 2016 b), FET centres, as previously mentioned, must provide skilled workers for this ageing population. In this study, most PCAs are graduates of the major award of either healthcare support (5M4339) or health service skills QQI level five (5M3782). As part of either major award, the module palliative care support level five (5N3769) is provided by the Roscommon region of GRETB.

In the context of palliative care, a teacher who has practical experience can relate to the learner. Subject matter knowledge is where the teacher understands the subject they teach

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[22] Formerly known as the Department of Education.

[23] FET—further education and training.

[24] PLCs—post leaving certificate.

[25] HE-higher education.

[26] VTOS—vocational training opportunities scheme.

[27] BTEI—Back to Education Initiative.

(Gudsmundsdottir, 1987). The factors influencing teaching (FIT)[28] scale (Watt et al., 2012) was used to understand what motivates people to move into teaching. This is relevant to the current study because many palliative care teachers, including the author, have previous personal experience working in the palliative care area. Therefore, the teachers combine their teaching experience with their practical palliative care experience and apply both in the classroom to better inform their learners. Pedagogical knowledge is about those broad classroom management principles and organizations that appear to transcend subject matter (Shulman, 1987).

Staff must be provided with training and guidance in end-of-life care as appropriate to their role (HIQA, 2008).[29] However, this may mean in-house training for palliative care practices in a residential setting and not necessarily the specific QQI qualifications now required for healthcare assistants. These are discussed in the following pages. QQI level five palliative care support is an elective module, indicating that a qualified healthcare assistant can work in palliative care without completing QQI level five palliative care support. The person who completes the four mandatory modules—communications, infection prevention and control, work experience, and either care skills or care support—can choose any modules from a large group of electives. Upon completion, they are recognized as a healthcare assistant.

Many different titles are used for healthcare assistant roles, such as support worker, clinical support worker, ward assistant, care worker, and palliative care assistant (Thornley, 2000). In Ireland, the term now used is healthcare assistant. However, in previous years—like in the UK, as Thornley (2000) highlighted—there were many variations and definitions of a healthcare assistant.

Candidates for healthcare assistant positions must have personal competence and capacity to properly discharge the role's duties (HSE, 2012).[30] The 2012 National Carers Strategy (Ireland) (DOH, 2012)[31] espoused that healthcare assistants (PCAs) who work in palliative care should be recognized for the significant contribution they make. Galway Roscommon

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[28] FIT—factors influencing teaching.

[29] Health Information and Quality Authority is commonly known as HIQA.

[30] HSE—Health Service Executive.

[31] DOH—Department of Health (Ireland).

Education and Training Board (GRETB)[32] provides the following opportunities to provide training and accreditation linked to different healthcare sections.

Palliative care support (QQI Code 5N3769)—This module is provided to healthcare assistants for the learner to understand the palliative care process and its impact on the client and to differentiate palliative care from other areas of healthcare (Connaught Education & Training Alliance, 2012) (A).

Communications (QQI Code 5N0690)—Seen as immensely important, so that each healthcare assistant is aware of their duties regarding the maintenance of record keeping and can recognize verbal and non-verbal cues regarding the clients they work with (Connacht Education and Training Alliance, 2012) (B).

Person-centred focus on disability (QQI Code 5N1728)—This module is taught to future healthcare assistants to enable them to work with people with disabilities and apply theory to practice regarding disability awareness (Connacht Education and Training Alliance, 2012) (C).

Infection prevention and control (QQI Code 5N3734)—Taught learners to show the impact infection can have on a client and to encourage a greater awareness of how to prevent the spread of infection (Connacht Education and Training Alliance, 2012) (D).

Work experience (QQI Code 5N1356)—It is a class-based module linked directly to the learner's workplace placement. With GRETB, the learner is expected to complete 150 hours in a healthcare-based placement (Connacht Education and Training Alliance, 2012) (E).

Care support (QQI Code 5N0758)—This module is used to equip the learner with the knowledge to work in a healthcare environment (Connacht Education and Training Alliance, 2012). (F)

Care skills (QQI Code 5N2770)—this module teaches a learner to understand the knowledge, skill, and competence required to work with vulnerable people who need care (Connacht Education and Training Alliance, 2012) (G).

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[32] GRETB—Galway Roscommon Education and Training Board.

Care of the older person (QQI Code 5N2706)—the learner is encouraged to learn about the needs of older people and how a PCA should provide for those specific needs (Connacht Education & Training Alliance, 2012) (H).

The HSE description exposes what is needed to become a recognized healthcare assistant/PCA for Ireland's HSE. However, it does not stipulate a timeline for existing non-qualified healthcare assistants/PCAs to become qualified. People working in a PCA role do not have formal training at QQI level five. The qualification would also include healthcare assistants who worked in palliative care. However, it is a starting point for the recognition of the healthcare assistant/PCA. The PCA must meet the specific needs of each palliative care client/patient. However, these may vary considerably: not just their physical but also their social, psychological, spiritual, and emotional needs. The demands of the PCA may be stressful, depending on the circumstances of each palliative care client.

2.7 Stress Theme Three—Stress

Figure 9 outlines the different sections discussed under theme three of the literature review, starting with an explanation of what stress is in the context of the current study. Theme three continues by exploring rumination and its effects on the PCA. The section then focuses on causes of stress for a PCA by reviewing literature relating to death and dying, COVID-19, family members of a client, and anticipatory grief. The final section in theme three discusses burnout as a possible effect of stress for PCAs.

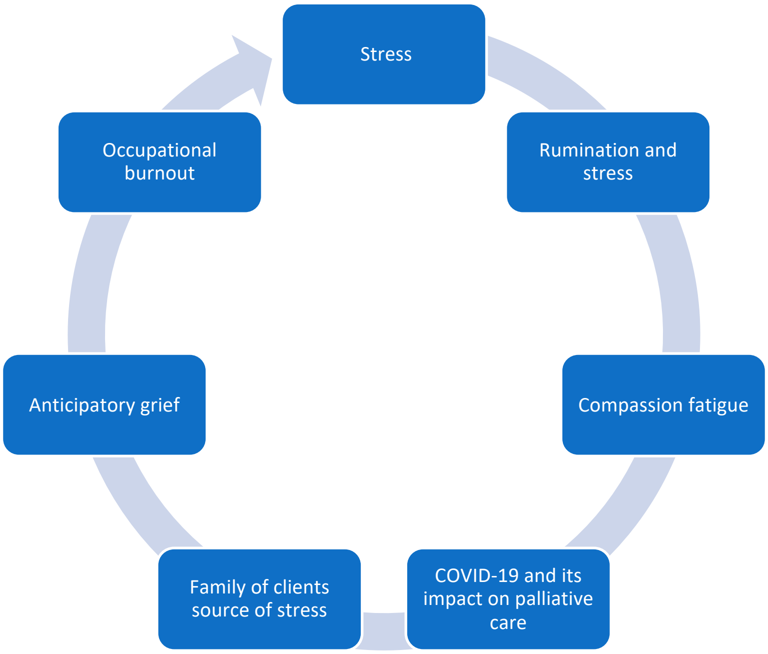

Figure 9. Breakdown of theme three

Occupational stress can be defined as an alteration in a person's physical or mental state as a reaction to a challenge or issue within their workplace (Colligan and Higgins, 2008). Stress is regarded as a physical and emotional threat that prepares the person to act (Selye, 1976) or a person's psychological and physical response to a perceived challenge (Topper, 2007). Stress is divided into two categories eustress (good stress) and distress (bad stress) (Selye, 1974). Eustress is a positive type of stress that can motivate people to complete a particularly taxing task (Selye, 1976). In other words, it allows us to react quickly to a situation to finish the job. Alternatively, distress is when our demands outweigh our resources or more is asked of us than we can deliver. Caring for those who are stressed is in itself stressful (Shapiro *et al.*, 2007). For example, a healthcare assistant may find it difficult, therefore stressful, to provide care for someone in distress due to their physical or mental condition, such as an elderly client who has dementia and cannot articulate what they want to say.

Stress (distress) has been shown to significantly reduce healthcare professionals' attention and concentration, detracting them from decision-making skills. Furthermore, it diminishes one's ability to communicate effectively, convey empathy, and establish meaningful relationships with a patient (Irving *et al.*, 2009).

Throughout this research body, the author will discuss techniques that can alleviate stress for healthcare assistants who work in palliative care and whether those techniques could be integrated as part of the palliative care support module at QQI level five. The following quote highlights the effect of stress on medical personal, 'Stress may affect not only medical student's well-being but may also have negative consequences on their effectiveness by diminishing the humanistic qualities fundamental to optimal patient care' (Shapiro *et al.*, 1998, p.582). Although this quote refers to medical students in palliative care, the quote is relevant to PCAs as they too strive to provide optimal care as part of the multidisciplinary team. The PCA may have to deal with a client coping with their impending death; the PCA may have to work with the client for a much more considerable length of time. In some cases, the PCA may have worked for years[33] with the same client daily. The psychological impact of losing a client who the PCA may have worked with for years is one source of stress that is important to this study. Most palliative care workers feel emotional and physical strain while working in the area (Newton *et al.*, 2002). A PCA may feel loss before and after the death of a client with whom they have worked for, in many cases, many years. A client's loss may be stressful for the PCA, leading to stress-related problems such as ruminating thoughts.

2.6.1 Rumination and stress

Rumination relates to a person focusing on thoughts that are symptoms of their distress (Nolen-Hoeksema, 1991). Occupational stress has become a recurring problem in healthcare workers over the past number of years. Considering the trend, various tools have been used to identify the different causes of stress (Golubic *et al.*, 2019). Determining what the cause of that stress is can then allow the person to address it. A PCA may over-focus on their symptoms, which can lead to depression. For example, if a healthcare assistant overly focuses on the negative aspects of working with a client with a chronic illness, this may lead to further psychological problems. People who think in a ruminative style repeatedly think about their negative emotions, focusing heavily on their distress symptoms (Lyubomirsky *et al.*, 1998). Caregivers in palliative care report unmet needs, where they sacrifice aspects of their own lives to care for the palliative care client and may not be addressing some of their own emotional needs. An example of this could be a PCA working long hours and neglecting

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[33] Interviewee three spoke about a client who lived in a nursing home in West Roscommon for over 30 years.

their own needs, such as not getting enough sleep, not getting regular exercise, or not taking time off.

People view death from their unique perspective based on their family networks (Waldrup, 2006). The nursing staff deal with death regularly (Gerow *et al.*, 2010). A client's death is a harsh reality of working in palliative care, unlike other care areas such as respite or rehabilitation. This shows that palliative care is separate from mainstream care. The prospect of recovery may not be possible in most cases as palliative care progresses to hospice care. The recipient of care is most likely to die; the caregiver must recognize their pain to deal with it (Stamm, 2002). The PCA must acknowledge and understand that the palliative care patient/client must come to terms with their mortality and possible reduction in independence. It may be a traumatic time for the client and the client's family, and the PCA must work with both to maximize the standard of care to be provided to the client. This time may also cause stress to the PCA as they would be working with the client, the client's family, and the reality that the client may not get better and may pass away. The PCA must deal with their grief as well as work with a grieving family.

2.6.2 Compassion fatigue

The person receiving care, the care worker, or the client's family may all go through the five stages of grief as defined by Kubler-Ross (1969).

1. Denial/isolation,
2. Anger,
3. Bargaining,
4. Depression, and
5. Acceptance.

Theoretical models of bereavement should serve when understanding grief and grieving during palliative care (Shear, 2015). Kubler-Ross's five stages of grief are examples of a process that a person/client goes through during the palliative care period. How that person deals with those stages of grief can impact directly on the palliative care assistant. For example, if a PCA works in a nursing home and the person who was receiving care from that PCA dies, the deceased person's bed may be occupied the following day by another client, and the PCA will need to provide the same level of care for that new client as for the one who just died. As highlighted above, palliative care staff members occasionally work with dying clients who may be going through the various stages of grief. If the client is going through the anger stage and is receiving twenty-four-hour care, it may be the PCA whom the client sees the most who receives this aggression. As previously stated, working in palliative care is emotionally demanding, and examples, such as the one highlighted above, can significantly impact the care worker's mental health, leading to compassion fatigue (Adams *et al.*, 2006).

Compassion fatigue is a well-recognized concept within palliative and hospice care sectors (Slocum-Gori *et al.*, 2011), occurring when palliative care staff empathize with the loss of the dying client and may, in some instances, feel a sense of failure when they cannot help the client feel better (Joinson, 1992). Compassion fatigue can also be seen as caregivers' fatigue from dispensing compassion and empathy to their clients over a long time (Figley, 2017). For example, it may materialize when a PCA is working in the palliative care client's home. For example, over, two years, the PCA sees the client's condition deteriorate from being reasonably healthy to being unable to care for themselves physically. The PCA must provide a high standard of care and work with the client who has to deal with the psychological impact of not recovering. This time can be highly demanding on the PCA, which in some cases may lead to compassion fatigue. Compassion fatigue is the emotional cost of caring and stress response that occurs suddenly, leading to helplessness, isolation, and confusion, whereby emotionally weary or traumatized healthcare workers have either considered leaving or even left the profession (Abendroth and Flannery, 2014). As palliative care clients' physical, emotional, and psychological conditions deteriorate, the client becomes more dependent on the PCA, leading to additional problems if the PCA suffers from compassion fatigue. Compassion fatigue is essential to understand as it reduces the caregiver's capacity to assist their clients (Cacciatore *et al.*, 2014). Compassion fatigue is thought to result from overexposure to others' suffering over time (Berzoff and Kita, 2010). It is similar to burnout; however, unlike burnout, the person can genuinely care for the client (Vachon, 2006). This association is significant, as burnout and stress can affect the emotional state of the PCA. To examine solutions to stress, the author explores stress in palliative care and possible causes, such as COVID-19.

2.6.3 COVID-19 and its impact on palliative care

The COVID-19 virus originated in Wuhan, China, and spread rapidly across the world in 2020. It was initially called "severe acute respiratory syndrome two" (SARS-2). It was later called COVID-19 [34] (Xu *et al.*, 2020). The incubation period of COVID-19 is just over five days (Li *et al.*, 2020). Symptoms generally start in the lungs as a form of viral pneumonia (Shereen *et al.*, 2020). Although the virus's mortality rates are low, with a hospitalization rate of 3%, of those hospitalizations, there is a mortality rate of 26% (WHO, 2020), what this means of those who are hospitalised with COVID-19 as of 2020, the mortality rate was one in four. Nursing home residents account for somewhere between 42-57% of all deaths related to COVID-19 (Shahid *et al.*, 2020). This shows that older people (nursing home residents) are disproportionately affected by COVID-19.[35] Healthcare workers are likely to encounter repeated exposures to COVID-19 as they work with more vulnerable people[36] (Rowan and Laffey, 2020). The significance of the high risk of exposure by healthcare workers to COVID-19 is that PCAs are in the high-risk group. Healthcare workers face unprecedented amounts of COVID-19 stress, both professionally and personally (Shanafelt *et al.*, 2020). A cross-sectional study in China found that healthcare workers reported a 50% increase in depression and a significant rise in distress reports during the COVID-19 pandemic (Lai *et al.*, 2020). Frontline workers are particularly vulnerable to mental health problems (Chen et al., 2020). There is an urgent need to assist frontline workers in utilising adaptive measures to help them cope with the stresses of working in care during the pandemic (Gavin *et al.*, 2020).

2.6.4 Family members of palliative care clients: A source of stress

One of palliative care's philosophical principles is working with the client's family (Davies, 1994). Fundamental to good end-of-life care is the support the care worker gives to the patient's family (Park *et al.*, 2015). Although the PCA is assigned to the client, they will almost certainly work in some capacity with the client's family, either directly (e.g., putting the client to bed with the client's son or daughter) or indirectly: by informing family members of the mood/health of the client.

In a national study of palliative caregivers in Germany, they were asked to assess their burdening factors. Of the participants, 51% stated that they felt firmly or strongly burdened when they could not meet all the objectives while working in palliative care (Olsen, 2004). 47.2% related to negative issues in building relationships with palliative

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[34] As it is believed to have originated in 2019, hence "19" and COVID stands for coronavirus identification.

[35] However not all palliative care clients are elderly but depending on their condition may also be seriously affected by COVID-19.

[36] People receiving palliative care.

care clients and their families (Back and Arnold, 2005). Of the caregivers, 40% had a severe conflict with a client's family when providing palliative care (Scharlach *et al.*, 2006). This suggests that a significant proportion of PCAs identify palliative care clients' family members as sources of stress while working in the area. Families of clients receiving palliative care suffer from increased stress levels (Zaider and Kissane, 2009). These are viewed as hidden patients (Wiley, 1998): the family member is also suffering, but they are not the focus from a treatment point of view. Therefore, they may not get the support they need as the attention/support is centred on the palliative care client. As Wiley (1998) puts it, this leaves the 'hidden patient' particularly vulnerable. PCAs may work in the client's home, where the family member has to comply with the rigours of providing palliative care and deal with the stress of a loved one going through a potentially terminal illness. A longitudinal study showed that highly stressed family caregivers providing palliative care have a higher mortality rate than non-caregivers (Williamson and Schultz, 1990). Family members of palliative clients also need the added stress of the anticipation of the death of a loved one.

2.6.5 Anticipatory grief

Anticipatory grief can be defined as any grief occurring before a loss, as distinguished from the grief at or after a loss (Aldrich, 1963). If a person is grieving for losing a family member before they have died, this is called anticipatory grief (Jane, 2001). The PCA may be mourning the client/patient's death before dying, leading to psychological difficulties in the working relationship. If the PCA is preparing mentally for their client's death while that person is still in their care, they may not be able to maximize the time they have with that person. Studies have shown that, if not dealt with, anticipatory grief can negatively impact the carer (Walker and Pomeroy, 1997). The combination of the demands of working with a terminally ill client and the possible guilt associated with anticipatory grief may, in some cases, lead to compassion fatigue—a resulting outcome may be that the PCA can be impacted subsequently from 'burnout'. This is significant, as a PCA may be less able to provide the same standard of care as previously, leading to reduced capacity. Therefore, the carer still has empathy for their client but struggles because the client is suffering from the illness, leading to compassion fatigue and possible burnout.

2.6.6 Occupational burnout from palliative care stress

This section examines occupational burnout for people who work in palliative care. According to Lobell (2001), 'If you keep pouring from a jug, you cannot pour and pour without ever refilling it; eventually, it will run dry' (p.7). Lobell's quote is relevant to those who provide palliative care in that the PCA gives a great deal of time both physically and emotionally to the client's care. If that person (PCA) does not look after themselves, they will run the risk of suffering from burnout.

Burnout occurs where a person who works with people suffers from emotional exhaustion (Maslach, 1979). Besides, burnout is a symptom of depersonalization and reduced personal accomplishment that can occur among individuals who work with people in some capacity (Maslach and Leiter, 2016). Lazarus and Folkman (1984) see burnout as an inability to cope. Burnout can lead to a high turnover of staff who work in nursing homes (Ghandi *et al.*, 2021); the significance is that with a high staff turnover, the experience of the PCAs may be reduced, which may affect their ability to deliver effective care.

Healthcare staff are at high risk of burnout (Cushway and Tyler, 1994) due to the increased interaction rate between PCAs and dying clients during the palliative care process. Healthcare workers are ill-equipped for the emotional suffering of palliative care patients/clients (Chapman and Gavrin, 1993) due to the possibility of a client dying. This suggests a gap in the palliative care staff's ability to deal with the area's stresses. Care workers are more likely to suffer burnout due to the additional stresses in the profession, such as a sense of failure or frustration as a client's condition worsens (Hayes *et al.*, 2017). In palliative care, priority is not curative; this sets this aspect of care on a different trajectory. In this context, 'priority' means that the care provided may not necessarily focus on the possibility of the client recovering from the illness.

Beyond Ireland, a study (Perreira, Fonseca & Carvalho, 2011) reported on palliative care workers in Portugal (which included doctors and nurses and was not exclusively with healthcare assistants) highlighted that some of the significant risk factors for burnout were:

- Lack of confidence in one's communication skills
- Time pressures
- Dealing with the pain and suffering of clients.

Research findings on burnout among healthcare workers have varied dramatically between low instances and higher rates (Payne, 2001); however, as highlighted in the previous pages, burnout is higher among care workers who work in palliative care. What Payne (2001) means is that burnout was higher in specific care areas, including palliative. Burnout has been associated with decreased patient satisfaction (Vahey *et al.*, 2004). This means that burnout in care staff can affect those receiving such care (e.g., palliative care clients in nursing homes). If the PCA shows burnout symptoms, this can affect how they engage with the client, which involves personal caring skills, such as empathy.

2.7 Theme Four: Dealing with Stress

Having explored causes of palliative care stress in PCAs in theme three, theme four focuses on solutions to work-related stress. Theme four begins with positive psychology: the methods a person can use to focus on personal qualities to help them deal with stress. **Figure 10** highlights the six topics discussed within theme four, beginning with positive psychology and ending with a section on measuring how people feel while practising mindfulness.

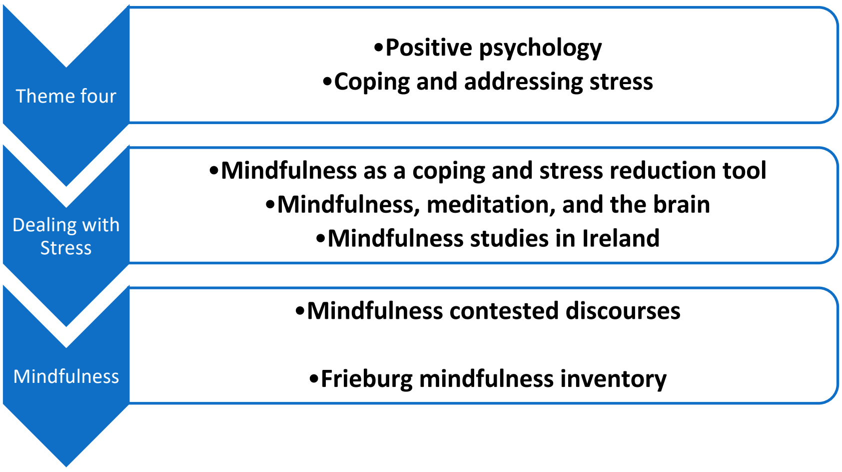

Figure 10. Addressing and coping with stress

2.7.1 Positive psychology

Positive psychology is the study of the most positive qualities of a person that focuses on the best aspects of that person's life (Seligman, 1998). This means that positive psychology is a school of thought that focuses on why a person is happy rather than the more traditional forms of psychology that concentrate more on the negative aspects of life. Positive psychology looks for a focus on the positive to counterbalance the broader focus of the negative (Pawelski, 2016). The purpose of positive psychology is to move psychology away from focusing on the worst aspects of life to concentrate on positive personal qualities to see why people are happy (Seligman and Csikszentmihalyi, 2000). According to Seligman and Csikszentmihalyi (2000), 'The field of positive psychology is a subjective experience, positive individual traits and positive institutions' (p.5). The subjective experience in the above quote explains that it is up to each individual to interpret and understand what positive psychology means to them. Positive psychology studies the conditions that contribute to the maximisation of a person's well-being (Gable and Haidt, 2005), exploring what aspects of life enhance a person's outlook.

A study that explored the characteristics of happy people found that the happiest of the group had strong social relationships (Diener *et al.*, 2018). The study focused on why people were happy rather than focusing on negative aspects of how people saw themselves, which was interesting in its focus at that time.

The practice of mindfulness is very much grounded in positive psychology (Vago and Silbersweig, 2012), which influenced the author greatly as positive psychology focuses on favourable emotions such as optimism and happiness which are non-invasive for the practitioner. One of this study's focuses is to look for techniques to help the PCAs address palliative care stress. The author attempts to identify a method that can be practical and enjoyable for the PCA. By exploring approaches within positive psychology, the author has found a relevant area that can be beneficial to PCAs that focuses on self-improvement in an achievable way. Positive psychology encourages feelings of optimism and enhances one's personal outlook on their own personality.

2.8 Addressing and Coping with Stress

Theme three explored stress in palliative care and what it may cause for PCAs. Theme four examines methods of coping with those stresses. Coping strategies are vital in assisting caregivers in managing burdens, as they form a preventative measure against affective disorders commonly associated with caring (Parks and Novielli, 2000).

Some staff may lack the proper skills to deal with death and dying in palliative care (Oakley, 1999). Therefore, as part of this study, this literature review investigates if there may be a gap between a PCA's skill set and their ability to cope with the stresses of working in palliative care. According to Lazarus and Folkman (1984), 'Coping is described as constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised or taxing or exceeding the person's resources' (p.141). Positive social relationships can significantly reduce stress within workplace teams (Mickan and Rodger, 2000). Working where a client/patient must deal with their mortality and decreasing health can also impact the PCA. Therefore, the PCA must find coping skills that can help them deal with the client, such as empathy. Empathy is a conscious mental effort by the caregiver to interpret what the other person is going through (Dohrenwend, 2018). This means the ability of a PCA to put themselves in the shoes of the person they are providing palliative care to, such as a PCA understanding that their client may be in physical and psychological pain. If the client is aggressive or frustrated, it is because of their condition rather than the PCA taking the frustration personally. Empathy can be seen as one individual's reactions to practical experiences (Davis, 1983). In this sense, the PCA must understand how to react to what is happening around them based on previous experiences. An experienced PCA may know that a client's expressed frustrations may not be directed at the PCA but due to the former's limitations that their condition has brought. In the current research context, the PCA observes and reacts to the palliative care client's feelings to determine the success or failure of this relationship. Empathy is 'the experience of foreign consciousness in general' (Stein, 1917/1989, p.11). According to Stein, empathy is the ability to feel for someone else: in other words, to understand another person's feelings. An example of this would be a PCA who feels sorrow or pain for a cancer patient. Although they cannot physically feel what the client is feeling, the PCA can empathize with the client when sad or happy.

The following studies have shown that meditation can improve empathy, a critical skill in care whereby the PCA attempts to put themselves in their client's shoes (Andersen, 2005; Martin, 1997; Morgan and Morgan, 2005; Shapiro and Izett, 2008). Although a PCA cannot exactly see the client's point of view, they are better equipped than most to empathize with the client as they see them quite a lot throughout the person's illness. Empathy should be a fundamental communication skill for healthcare workers to achieve positive healing results (Pembroke, 2007). Therefore, empathy can be viewed as a coping tool to deal with palliative stress.

2.9 Mindfulness as a Coping and Stress-reduction Tool

Mindfulness can be explained as waking up from a life lived without self-awareness (Siegel *et al.*, 2009). It can be viewed as a technique used to improve self-awareness. Mindfulness is used as a means of reducing stress, not just in healthcare but across many professions. Mindfulness is an elusive yet central aspect of the 2500-year-old Buddhist psychology tradition (Siegel *et al.*, 2009). Mindfulness began somewhere in the Indian sub-continent. Sati (which originated in the Pali language from India) is memory but means mindful and thoughtful and is believed to be the origin of the term *mindfulness*. The mind's activity and the constant presence are frequently inculcated in the good Buddhist (Rhys Davids, 1881). The Buddhist term (for mindfulness) was first translated by T.W Rhys David in 1881 into 'mindfulness' (Gethin, 2011). Mindfulness is at the core of the teachings of Buddhist psychology (Kabat-Zinn, J., 2003). The latter focuses on liberation from suffering, which ties in with mindfulness, which focuses on a person's thoughts. Mindfulness allows us to develop street smarts for the mind (Bhikku, 2007); the more we manage our positive and negative thoughts, the more mindful we become. However, definitions for mindfulness vary, leading to contention about what description is most accurate (Chiesa, 2012). Mindfulness is an umbrella term for many practices (Van Dam *et al.*, 2018). Therefore, it is challenging to define mindfulness as one specific stress-reduction technique.

MBSR (Mindfulness based stress reduction) began in 1979 in Massachusetts and can be seen as the beginning of the modern mindfulness movement in Western society (Kabat-Zinn and Williams, 2011). Mindfulness is a process of gaining insight into the nature of one's mind and through a decentred perspective (Bishop *et al.*, 2004). What this means is to see mindfulness not as a specific technique but as a broader mindset. There are many ways to explain mindfulness, such as keeping one's consciousness alive in the present reality (Hahn,1976). Hahn points out that a person using mindfulness thinks about remaining grounded in their current reality. Mindfulness has been defined as moment-by-moment awareness that the person using mindfulness is self-aware in the now (Germer, 2005). They use mindfulness as a mindset to avoid imposing judgments, memories, or other self-relevant cognitive manipulations on themselves (Glomb *et al.*, 2011). The person is grounded in the here and now: the person is thinking in the present moment without diverting their thoughts at that time to somewhere else (ibid).

Figure 11 highlights the different definitions from (Kabat-Zinn and Williams, 2011; Germer, 2015; Hahn, 1976), who all see mindfulness from slightly different points of view. At the top of the diagram is the word systematic (Kabat-Zinn and Williams, 2011). They emphasise that a mindfulness user must have a transparent system to attain the benefits of using mindfulness regularly. The bottom right circle highlights an explanation of mindfulness grounded in reality (Hahn, 1976). The mindfulness user focuses on the here and now and accepts the present reality; hence, the user is grounded in reality. An example of this is a PCA accepting that their client may not get better. The bottom left circle illustrates (Germer 2015), who sees mindfulness as a mindset, where the mindfulness user focuses on how the person thinks about themselves in the present moment.

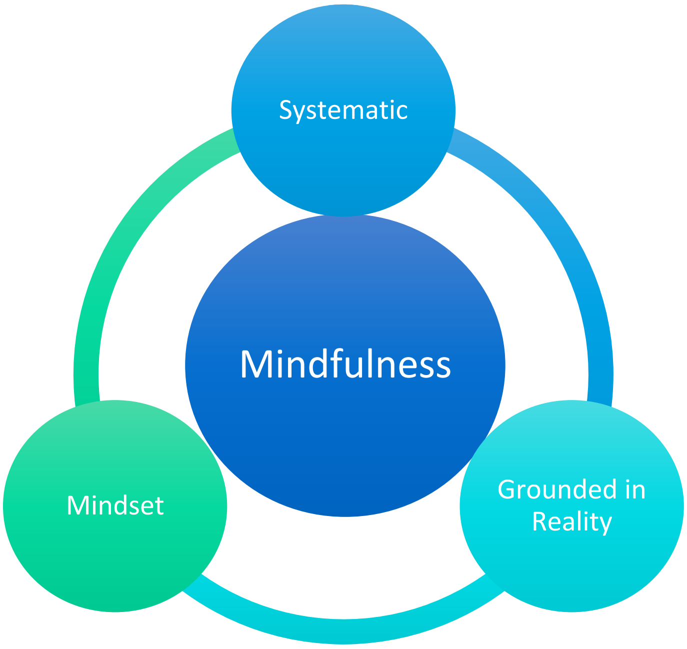

Figure 11. Understanding mindfulness

One's life's journey is one step at a time, moment by moment (Tolle, 2010). Therefore, mindfulness can allow a PCA to focus on positive emotions and avoid negative thoughts, such as rumination (as discussed earlier in this chapter). Supposing the PCA is having a difficult moment with a family member of a client, they can use mindfulness to focus on the positive aspects of the relationship, assisting the PCA in dealing with a difficult moment.

Mindfulness is a family of self-regulation practices that focus on training attention and awareness to bring mental processes under greater voluntary control and foster general mental well-being (Walsh and Shapiro, 2006). The purpose of mindfulness is for the user to voluntarily control their thoughts to think clearly and create a form of self-control that can be beneficial (Brown and Ryan, 2003). Mindfulness as a skill can be enhanced through training; the user must practice regularly to reap the benefits from mindfulness-based approaches. Continued training can lead to a state of wakefulness throughout a person's life (Walsh and Shapiro, 2006). This wakefulness can suggest a type of self-realization: that the person is grounded at the moment and may better focus on the task at hand. According to Shapiro *et al.* (2005), we see mindfulness as 'a process of gaining insight into the nature of one's mind and the adoption of a decentred perspective' (p.234). This means that a person can, in a particular moment, decentre or focus on more than one point of view (Bishop *et al.*, 2004), such as the PCA empathizing with, or seeing, the client's point of view, acknowledging/understanding the difficult moment.

Research has shown that carers of multiple sclerosis patients can benefit from using mindfulness in increasing coping capacity (Pakenham and Samios, 2013). This suggests a positive benefit to a carer who uses mindfulness to cope with a demanding aspect of care. As well as its impact on specific problems, mindfulness is capable of having effects on practical underlying emotional and social skills, such as the ability to feel in control, to make meaningful relationships, to accept experience without denying the facts, to manage ambiguous meanings, and to be calm, resilient, compassionate and empathetic (Baer, 2003). People who use mindfulness have shown higher patience and gratitude, which can assist with a person's resilience and well-being (Rothaup, 2007). That resilience is needed in all walks of life, but working in a palliative care environment can be particularly stressful: stress can occur where employees' demands outweigh their resources (Cox, Griffiths, & Rial-Gonzalez, 2000). Research has shown that nursing students who used mindfulness-based approaches have reported improved general well-being (Bruce *et al.*, 2010). Mindfulness in Buddhist traditions occupies a central role in a system developed as a path leading to personal suffering cessation (Thera, 1962). This highlights how people can stop or prevent negative rumination by altering their mindset using mindfulness.

2.10 Mindfulness, Meditation, and the Brain

The central nervous system is made up of two types of tissue: grey matter and white matter. Grey matter functions by processing information in the brain (Robertson, 2018), while white matter connects (white matter plasticity) various grey matter areas to each other, allowing electrical signals to jump from one area to another (Douglas Fields, 2010). A study examining long-term meditators using mindfulness deep breathing exercises via the control group. Over eight weeks, the authors found that the long-term meditators had increased grey matter in the insula, sensory regions, auditory and sensory cortex, and the brain's frontal cortex, parts associated with memory and decision-making (Lazar *et al.*, 2005). The changes were measured using magnetic resonance imaging (MRI), which showed a measurable difference. Lazar's study showed that regular meditation practice increases cortical regions' thickness, improving auditory, visual, and receptive processing (Ibid). In addition to increases in those areas, the study also found a decrease in the amygdala size (that controls our fight, flight, or freeze response), which was correlated to reducing stress levels. Similar results were found where larger grey matter volumes were found in meditators' brains and the right *hippocampus* (Luder *et al.*, 2009). As shown by MRI scans, mindfulness can enhance present moment awareness and physical and mental well-being (Ives-Deliperi *et al.*, 2010).

One of the strengths of using mindfulness consistently is that it can assist a person through regular meditation, reducing respiration during formal practice (Barnes *et al.*, 2008). Meditation used over a consistent period allows the brain to adapt and improve, similar to muscles that adapt and strengthen regularly. Like regular exercise, mindfulness (routinely used) allows the results to be achieved automatically, not by mind, manipulation, or control (Sharma, 2015). The adult nervous system can use plasticity, allowing the brain to alter its structure through mindfulness training (Gage, 2002). Results have shown increased grey matter in the right anterior insula in people who regularly use deep breathing mindfulness (Holzel *et al.*, 2008), indicating that mindfulness can positively change the brain's structure.

Plasticity refers to the brain's ability to change the structure to adapt to new functions (Kolb and Whiteshaw, 1998). The first person to be regarded as having coined the phrase plasticity was Ernesto Lugaro in 1906 when he claimed that the brain changed its *anatomo-functional* relations between neurons and areas of the brain (Berlucchi, 2002). *Neuroplasticity* is a term used to explain brain changes that occur in responses to experiences (Davidson and Lutz, 2008). A six-week study showed improved cognitive control and executive neural processing (taking in and dealing with information) (Allen *et al.*, 2012). The above study many similarities to the mindfulness intervention in phase two of this study and influenced the author to use a six-week program with the participants Allen *et al.* demonstrated that meditation practices could increase plasticity amongst mindfulness users' brains. Allen *et al.* used EEG[37] and structural neuroimaging to show a lower age-related decline in specific cortical areas (Xiong and Doraiswamy, 2009). Emerging research suggests that mindfulness might assist in neuroplastic changes in the structure and function of particular brain regions involved in attention, emotion, and self-awareness (Tang and Leve, 2016). Long-term meditation may decelerate cellular degeneration and help reduce stress by decreasing oxidative stress (Epel *et al.*, 2009). Meditation results in changes to the brain and improves mood, consciousness, and awareness; it helps activate different brain regions (Lee *et al.*, 2018). Meditation does not create a reorganization of the whole network (Lardone *et al.*, 2018), suggesting that it might slightly alter a person's brain but not significantly suggesting caution in overestimating the impact that mindfulness has on altering the brain. However, that significant change does not occur which may be interpreted that mindfulness use may be beneficial, but caution should be observed to prevent an over-optimistic view of its use.

2.11 Mindfulness Studies in Ireland

In Kent and McGuire's (2017) study, participants (i.e., all staff who worked at the hospital from a multidisciplinary team) were asked to complete MBSR[38] training over eight weeks at Sligo University Hospital. After that period, they partook in a focus group where they provided feedback about their experiences. The results suggested that MBSR training successfully improved stress management and mindfulness amongst staff at the hospital (ibid). Another Irish study used a ten-minute mindfulness intervention followed by a forty-minute decision-making task. The results suggest a positive effect on group performance, with participants using mindfulness scoring higher on group tasks (Cleirigh and Greaney, 2015).

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[37] EEG—electroencephalogram it records brain activity where electrodes are placed on the scalp to pick up electrical signals

[38] MBSR—Mindfulness-based stress reduction.

Mindfulness-based cognitive therapy significantly affected residual depressive symptoms (Kingston *et al.*, 2007). The study (Ibid) demonstrated that most mindfulness users who began practising (mindfulness) showed a significant reduction in depressive symptoms at the end of the sessions with a further reduction one month later. This suggests that regular mindfulness sessions in a structured environment can benefit those practising it.

In another Irish study (based in Dublin) (Colgan *et al.*, 2019), nineteen patients were introduced to mindfulness-based cognitive therapy using deep breathing exercises (each patient displayed depressive symptoms). The results showed a reduction in depressive symptoms after a month follow-up. Ruminative and depressive symptoms were assessed before and after one month. Mindfulness participants showed high levels of endorsement and acceptability while partaking in a study based on wellness and resilience intervention in healthcare workers, which were beneficial to the overall healthcare team.

2.12 Mindfulness: Contested Discourses

There is disagreement on how mindfulness should be defined, which leads to some uncertainty about defining exactly what it is. The criticisms of mindfulness reflect the instability of its meaning (Harrington and Dunne, 2015), demonstrating that the concept and practice of mindfulness might mean different things to different people. Individuals vary in their *dispositional* or *trait*[39] mindfulness (Baer *et al.*, 2006). Therefore, the effectiveness of mindfulness may depend on the "*trait*" or individual and, consequently, may be challenging to measure as each person is unique.

Literature suggests that it is essential not to be overly optimistic about the efficacy of mindfulness practice. High expectations of optimising human functioning through mindfulness mediation may be naïve and dangerous (Farias and Wikholm, 2016). Mindfulness practitioners have been disappointed with their results (Van Dam *et al.*, 2018), what this means is that studies such as (Van Dam *et al.*, 2018) found that mindfulness use did not significantly impact practitioners in improving mental health. The literature above warns that researchers not to be overly optimistic about mindfulness's influence on its practitioners.

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[39] Dispositional trait mindfulness—a self-awareness where our thoughts and feelings are in the present moment.

Therefore, users should dampen expectations. People are very diverse in their beliefs and values on mindfulness, and its application may differ significantly.

Yet, research on mindfulness has shown that it may increase self-awareness of complicated feelings and even exacerbate negative feelings (Lomas *et al.*, 2014). With palliative care, dealing with death is inevitable. Therefore, exploring perceptions of people who deal with death aspects may lead the mindfulness practitioner to have negative feelings towards the subject matter. Mindfulness was never intended to improve the functioning of anxious or depressed people (Sharf, 2014). However, mindfulness may have limitations for those who practice it. According to Ellis (1984), 'I recommend meditation, just as I recommend Jacobsen's relaxation method [40] or other focusing and relaxing techniques as a palliative distraction method, and advise most of my clients to use it with discretion and not take it too seriously or view it a serious therapeutic method' (p.673). Ellis shows a cautious approach to mindfulness, whereby his belief of its use is limited and not to be taken as a legitimate therapeutic technique. Measuring happiness is complex, and by using mindfulness, it (mindfulness) is too simplistic (Miller, 2008). Happiness is multifaceted; it is created through a variety of conditions (Smith, 2008). Therefore, using mindfulness is not a good indicator or instrument to measure happiness. Miller and Smith suggest that using mindfulness as a particular method for creating an individual's happier state is too limited and that happiness is made through multiple means. The literature indicates that reliable tools to measure the impact of mindfulness interventions can be used, such as the FMI.

2.13 Freiburg Mindfulness Inventory

The FMI has evolved qualitatively from Buddhist concepts based on non-judgemental self-reflection (Bucheld et al., 2001) and is used to measure the usefulness of mindfulness. The FMI is a self-reported questionnaire that allows the mindfulness user to reflect on their feelings while practising mindfulness (Walach et al., 2006). The FMI is user-friendly and can be used by people who had not previously practised mindfulness (Bergomi et al., 2013). FMI is a valuable tool in measuring mindfulness as it is measurable and reliable (Leigh et al., 2005). However, in a divergent view of FMI, it is challenging to apply to people who have little or no understanding of mindfulness (Trousselard et al., 2010). Their idea of mindfulness was to regulate one's attention in a non-judgemental self-awareness that fit into their

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[40] A physical therapy based on tightening and relaxing muscles.

Buddhist understanding of mindfulness (Walach et al., 2006). In other words, the mindfulness user becomes self-aware through practicing mindfulness. The FMI variations are prominent globally, such as the Chinese version, a valuable tool to measure mindfulness as reliable, consistent, and more accurate than other measurement scales (Zhang et al., 2014). This suggests that variations of the FMI have been widely used around the world. Similarly, a Turkish version is a valuable research tool as a self-report questionnaire (Karatepe and Yavuz, 2019). The Dutch translation of the FMI is an excellent and helpful tool for measuring mindfulness use (Bruggeman-Everts et al., 2017). This shows that FMI is used around the world as a valuable tool to measure mindfulness. In a Finnish study of FMI, it was found that there was a high correlation between perceived stress and psychological health amongst mindfulness users when measured using the FMI scale (Lehto et al., 2015).

2.14 Conclusion

This literature review explores four themes as illustrated in **Figure 12**: palliative care, PCAs, stress, and mindfulness. Theme one concerns palliative care and explains why Cecily Saunders' theory of total pain influenced the study. Theme two examined what a PCA is and how they are trained through the further education system in Ireland. Theme three explores stress and its causes for people who work in the provision of palliative care, emphasising occupational stress in the context of PCAs. Last, theme four explores mindfulness and its uses in reducing stress and techniques, such as the FMI, as a suitable tool for measuring how a person felt while practising mindfulness.

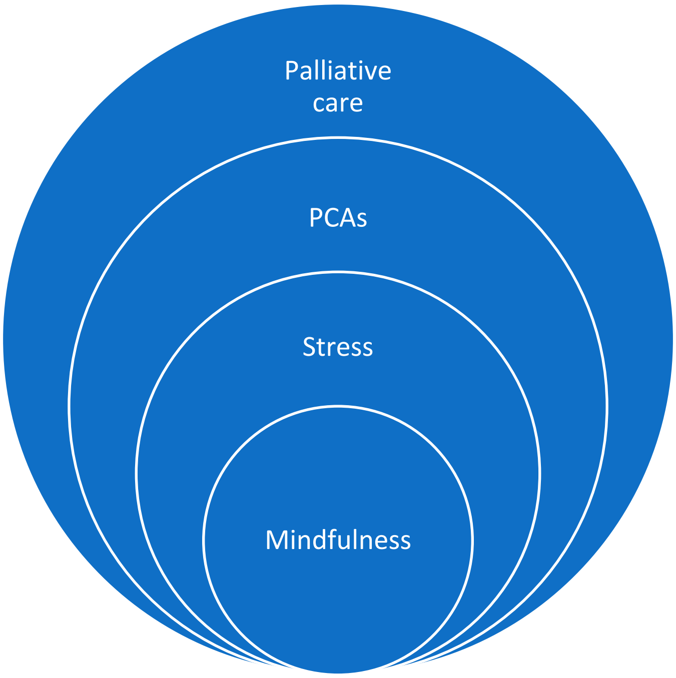

Figure 12. Summary of Literature Review

Since Dame Cicely Saunders's total pain concept evolution, the profession (palliative care) has developed rapidly over the past forty years. The significance of this change is for PCAs to consider the dying person's holistic needs and a greater emphasis on including and working with the client's family. Palliative care staff's importance in supporting the client's family members is discussed throughout this literature review. This chapter then continued (theme two) to explore the role of a PCA by first understanding what it means to be a PCA/healthcare assistant and then examining how a person is recognised as one in the Republic of Ireland.[41] Further on, the author described the modules that GRETB provide to people who wish to become healthcare assistants.

The literature review presents the relevant literature surrounding stress (theme three) and its impact on care workers who work in palliative care, including the enormous impact COVID-19 has unleashed nationally and globally. However, many studies cited (Perreira *et al.*, 2011) were based on palliative care workers but did not deal exclusively with healthcare assistants/PCAs. Research regarding stress and PCAs in Ireland is minimal. The chapter then reviewed relevant literature regarding stress, burnout, rumination, and palliative care staff's impact. The literature review's final section looks at mindfulness, what it is, its benefits, and

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[41] See section 2.4.

contested discourses, exploring an effective technique for measuring how a mindfulness practitioner feels. Interest in mindfulness has increased not just in healthcare but across the professional plain over the past few years. Studies have shown that using mindfulness is beneficial to the user in improving coping mechanisms in dealing with occupational stress. This literature review has highlighted that palliative care is a stressful area to work in. The literature suggests that mindfulness could help reduce occupational stress for PCAs who work in the area. Having reviewed the literature that shows that mindfulness can be beneficial in reducing occupational stress, the author will use the literature in this chapter as a platform to confirm whether mindfulness can be used as a tool to reduce work-related stress for PCAs in County Roscommon in phase two.

Chapter 3: Methodology

3.1 Introduction

A methodology is a set of complementary methods that suit the researcher's purpose and a theoretical framework that helps structure the research and anchors it in the literature (Henning *et al.*, 2004). Having a transparent methodology allows the researcher to choose a suitable technique that complements their research style. Research is a systematic method that describes, explains, predicts, and controls observed data (Babbie, 1998). This chapter outlines the most appropriate approach to investigate the proposed question of whether PCAs are stressed and to explores the usefulness/adequacy/efficacy of mindfulness in aiding the reduction in PCA stress levels.

The methodology chapter starts by examining what research is, identifying multiple paradigms with a specific focus on the post-positive approach, and exploring the study's ontological and epistemological dimensions. The author continues by exploring the conceptual and practical considerations for the research design to investigate the research questions. The research design focuses on the two phases of this case study. A brief review is being conducted on the instrument development, data collection, and phased analysis undertaken. The final section examines the ethical considerations, potential areas of concern, and the precautions taken to ensure rigour. The author outlined how the surveys were conducted and analysed using a Likert scale (phase one) and a variation of the FMI (phase two) to explain both methods (Likert,1932). It is also important to note that the data from phase one was compiled before the outbreak of COVID-19.

3.1.1 What is research

Research is based on investigating data, 'Life without inquiry is not worth living for a human being' (Socrates, 399 BC). Socrates's well-known quote highlights how he viewed research: it is not what we know now but what we can learn on our journey through the act of inquiry that allows us to create new knowledge. Research is a systematic search for further and relevant information. The research process must meet specific standards (Heinrich, 1993). For research to be valid, it must meet a respectable level of criteria. Research is an iterative process where data is connected and understood by the researcher (Becker, 2017).

Phase one of the study took place from 2016 until 2019, where the first survey took place and the eight interviews with palliative care teachers and PCAs. The data gathered was based on the Miles and Huberman model of data collection-data display-data condensation-conclusions/drawing/verifying (Miles and Huberman, 1994). The author gathers the data through the survey and interviews, reads the data, removes data that is not relevant, verifies the data, and continues the process.

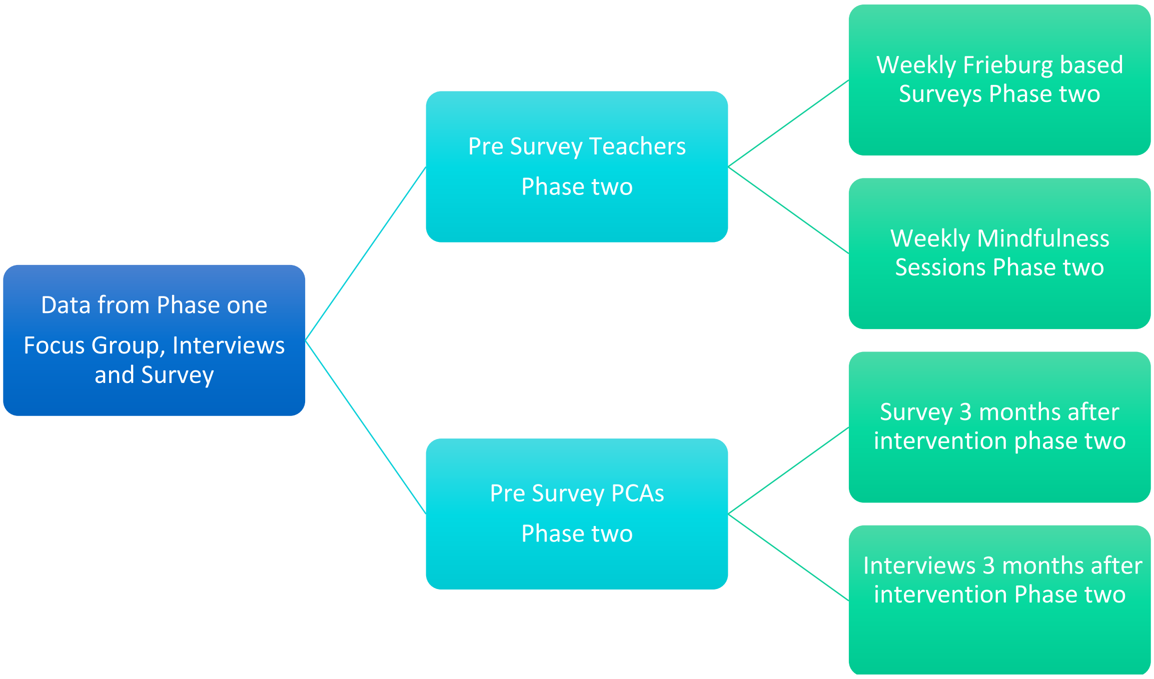

Figure 13. Phase two mindfulness intervention data gathering

Figure 13 illustrates how the data from phase one informed the construction of the pre-surveys, which in turn informed the FMI surveys, post-survey, and post-survey interviews. Three months after the conclusion of the six-week mindfulness program, the author conducted another survey and four interviews with participants who took part in the intervention. The data from phase one, which included a focus group, interviews, and survey (phase one dark blue box on the left), informed phase two, as presented. The author constructed pre-survey questions (beginning of phase two) for the participating teachers and PCAs based on what was learned in phase one (e.g., the data from the interviews [phase one] suggested that participants' knowledge of mindfulness varied considerably). Therefore, in the pre-survey (beginning of phase two), a question was asked to ascertain how much each participant knew about mindfulness.

3.2 Inductive Research–Interpretivism in the Post-Positivist Domain

Figure 14 illustrates a bottom-up approach (inductive) where the author observes the data, looks for patterns in it, and tests whether mindfulness can reduce stress amongst PCAs using action research in phase two. Based on the findings of both phases, it concludes the study.

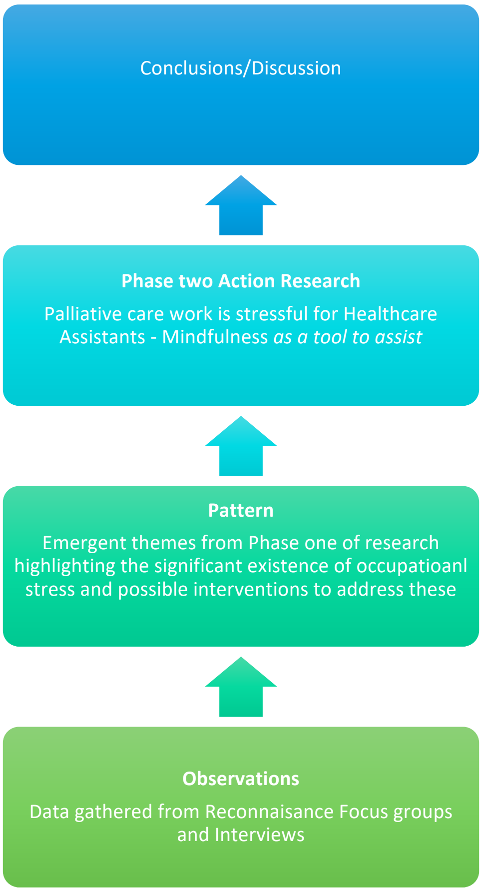

Figure 14. Inductive approach

3.3 Theoretical Perspective—Qualitative Research

The author chose a qualitative research approach as it allows more freedom to interpret data. According to Guba and Lincoln (1994), ‘Qualitative research involves the studied use and collection of various empirical materials that describe routine and problematic moments and meanings in individual lives’ (p.2). The difficult moments relevant to this research are the difficulties in dealing with clients’ stress, their families, the death of a client, and so forth. The author explored how each PCA sees their stress levels and the possibility of finding techniques to alleviate work-related stress. What we see depends on our angle of repose (Richardson, 1994). What Richardson means is that the person's point of view is essential when interpreting the data; therefore, the author had a clear philosophical perspective (inductive approach). The author has a background in palliative care and used a great deal of data from the interviews of people who work in the same profession. The author interpreted the interviewees' point of view as critical data to the study, as they (interviewees) demonstrated their experiences of practising mindfulness and working in palliative care. Using an inductive approach and conducting the interviews (phase one) before the first survey, the author could build the data from the bottom up and therefore had a clear philosophical position.

3.4 Post-positivist approach

While conducting research, the researcher must examine various factors, such as the participants' emotional responses. Responses are not necessarily made to the stimulation but rather upon interpretation (Blumer, 1969). Blumer's explanation suggests that people react differently depending on the circumstances of a conversation. Therefore, a researcher must consider how a person reacts in those circumstances.

Positivism is a set of scientific research practices focusing on logical, objective modes of analysis (Steinmitz, 2005). However, post-positivism's introduction sought deeper meaning on human emotion, which could not be easily quantified. Deductive research is an approach to a theory whereby the researcher tests whether it applies under certain circumstances (top-down approach) (Creswell and Plano-Clarke, 2007). In contrast, an inductive approach operates from the bottom up (Ivankova *et al.*, 2006). Using a bottom-up approach, the author can build on each section of the dissertation using the previous method as a platform for the next. Such as the data from phase one (palliative care stress) and then testing if mindfulness can be used to address that stress in phase two.

Post-positivist research focuses on objectivity by recognizing the possible effects of bias amongst the researcher and the research population (Robson, 2002). Post-positivists believe that there can be more than one reality: As presented in the findings section, participants in the interviews spoke about the death of clients and, in three interviews, the death of family members. As these topics are very personal and emotional, the author used a post-positivist approach in analysing the data as each participant's reality is different. Therefore, a post-positivist approach could explore deeper meaning. Researchers who use positivism prefer an analytical interpretation of measurable data (Sobh and Perry, 2006)*,* whereby quantifiable data is the information gathered by the author and then analysed and tested to assess the measurability of the content. Some of the author's collection is not measurable, such as an interviewee talking about a person's death. Therefore, the author used a more interpretive approach to this data by following post-positivism to interpret the interviewee's experiences and expressions. The author concluded that a positivist approach was too restrictive in that subjective feelings cannot be measured using merely quantitative techniques. Therefore, the author uses a post-positivist inductive approach in this study.

3.5 Inductive Approach

An inductive approach operates from the bottom up (Ivankova *et al.*, 2006) which aligns with the author's view that he should gather data, seek patterns, and then compile a discussion that leads to a theory. Interpretivism wrestles with maintaining a balance between subjectivity and objectivity based on the individual's uniqueness (Denzin, 1992). This dissertation's interpretive approach attempts to understand the participants' distinct experiences and individual traits (particularly in the interviews). All the participants are from a palliative care background. The author explores their experiences within palliative care, which may differ from people from other backgrounds. Therefore, the author used an interpretive approach as part of this study based on its uniqueness and chosen profession.

3.6 Ontology and Epistemology

3.6.1 Ontology

Ontology deals with the nature of reality (Hudson and Ozanne, 1988). An ontological investigation asks whether events are created externally by people or are created from an individual's consciousness. Ontology can be divided into two belief systems: *realism* and *nominalism*. In realism, reality, knowledge, and values exist independently of the human mind (Philips & Barbules, 2000). Therefore, material things can exist whether or not there are humans there to witness them. Alternatively, in nominalism, there are no universals (Goodman and Quine, 1947). The truth exists as a social construct created in our minds. The author's ontological approach in this study is nominalism, as the participants express the nature of stress in this study through their socially constructed experiences.

3.6.2 Epistemology

Epistemology examines the nature of knowledge (Blanshard, 1932) as the researcher explores the participants' knowledge; it leads one to ask: How can one know? There are many ways of interpreting epistemological beliefs, but seeking the truth is foundational for all researchers. Research should be evaluated and objectively tested to validate its usefulness (Giorgi, 2002). Therefore, the author sought to explore the research question by critically evaluating and analysing the knowledge gained using inductive reasoning through a post-positivist methodology in applying the research design.

3.6.3 Limitations of the study

The current research is a small-scale study. Generalizations can only be made based on PCAs in County Roscommon, as the investigation is limited to this geographical area. Roscommon is a rural county: its largest town has a population of just under 6,000 (CSO, 2016 b). Therefore, the participants represent a sparsely populated area, so comparisons with larger urban centres would be difficult. If the author had more time and resources, he would have conducted the study on a larger scale (e.g., he would have performed over a larger geographical area such as all five Connacht counties) which would have given the author a larger sample size. However, this may be considered in the future.

3.7 Research Design and Process

Figure 15 begins with the research idea and continues to the focus group to explore stress amongst PCAs.

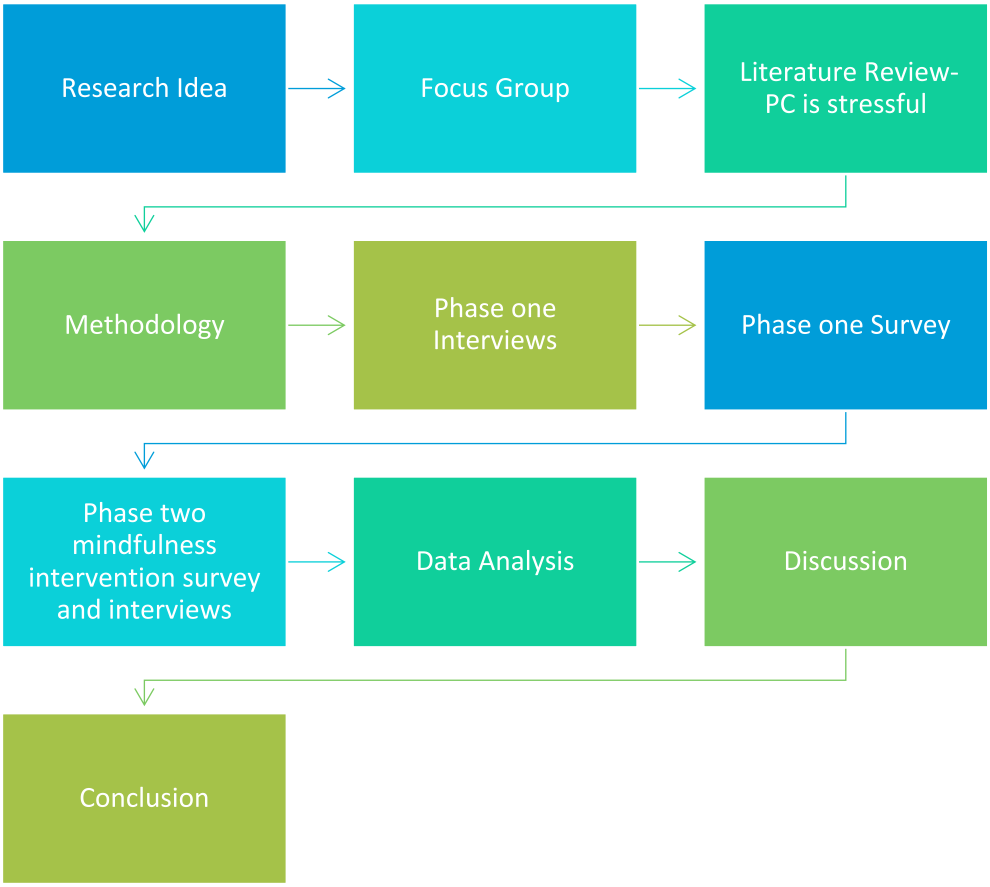

Figure 15. Research and dissertation process

The focus group was the first official step of the research journey, where the author explored the perceptions of four PCAs and their attitudes towards stress while working in palliative care and techniques they use to reduce that stress. The author then focused on the literature on the topic, which is presented in the literature review. The literature review helped inform the methodology by establishing a reliable literature platform linking palliative care and stress. The author then began phase one of the data gathering, which focused on whether it was stressful for PCAs to work in palliative care by using a focus group, a survey, and interviews. Having established that for most participants in phase one (and the literature review) that palliative care is stressful, the author moved the data gathering to phase two, which used surveys and interviews in this case study. The research design is about 'procedures for collecting, analysing, interpreting and reporting data in research studies' (Creswell and Plano-Clark, 2007, p.53). Having established the idea of researching palliative care partly because the author teaches PCAs, the author then conducted a focus group with four PCAs. The focus group helped the author develop the research topic, then explored through the literature review. The author constructed the methodology using two primary research tools: case study and action research—completed using a bottom-up inductive research method. Phase one showed that most participants agreed that palliative care was a stressful area to work in. The author used the data from phase one and the literature review to explore if mindfulness could reduce palliative care stress in phase two of the case study.

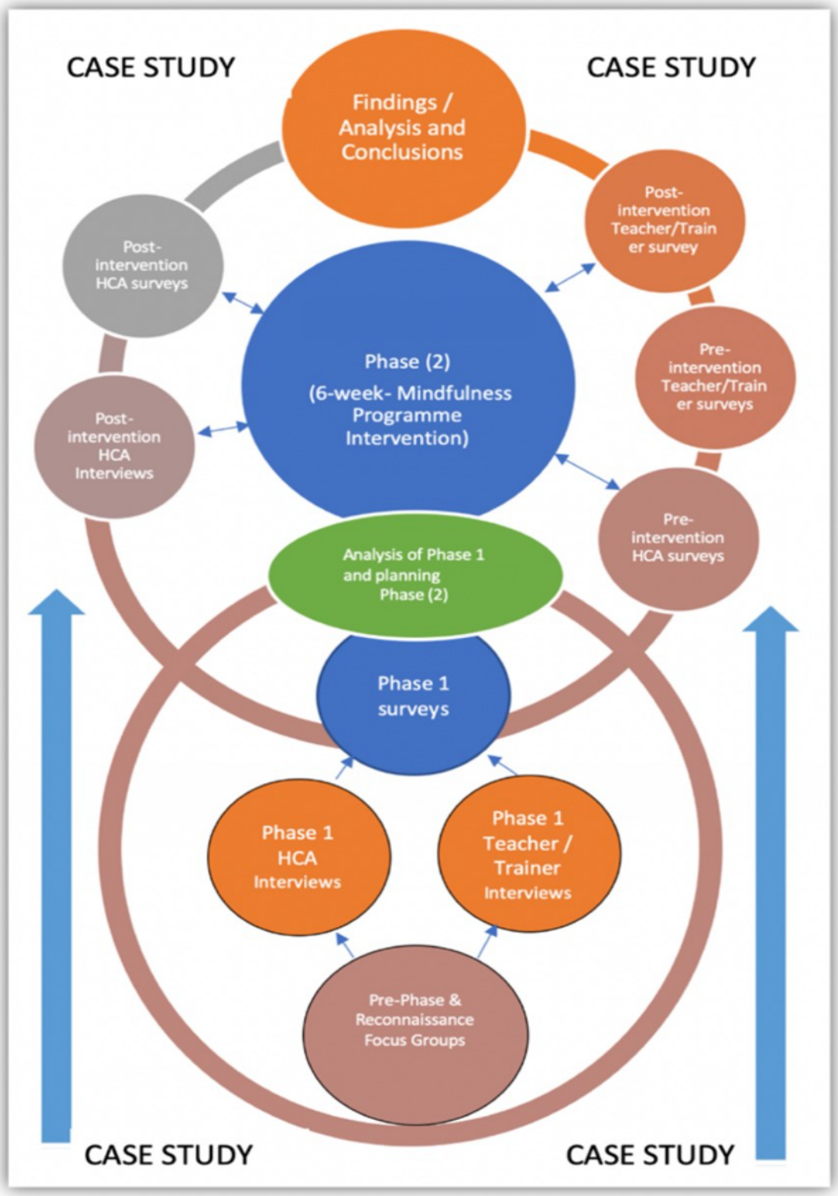

Figure 16. Case study approach

Figure 16 illustrates the author's research process, beginning with the focus group, phase one interview, and phase one survey. The green section shows how the author analysed the data from phase one and used it to help construct the interviews and surveys questions as part of the action research in phase two. After conducting the six-week action research in phase two, the author conducted a post-survey intervention and four post-survey interviews with participants three months after the mindfulness sessions, leading to the study's findings/conclusions.

Therefore, the author used the findings from phase one to justify conducting the mindfulness sessions to explore whether mindfulness could be used as a tool to reduce stress in PCAs who work in palliative care. The phase one process used three methods, focus group, survey, and interviews. Phase two began with a pre-survey (just before the participants took part in the mindfulness sessions), action research phase using a weekly survey, post-survey, and interviews, which were all methods within this case study dissertation.

3.7.1 Interview process

Each interviewee received a request by email, and if they agreed to the interview, they were presented with a consent form (see Appendix B). Each interviewee was offered a list of questions before the interview (none accepted the list of questions), and they participated without prior knowledge of the questions. The respondents were asked to discuss their opinions and experiences on stress and palliative care issues in the interviews. A Dictaphone was used to record each interview; the author also used a smartphone as a backup, which was put on flight mode to prevent incoming calls from cutting recording off during the interview.[42] The author emailed a copy of each interview's full transcript to the interviewees, ensuring that the participant could confirm the data and its interpretation (member checking). After interview two (phase one), the participant contacted the author to clarify her responses to questions. She stated that there were details she wanted to add and sent the author a detailed email. The author then decided to email a transcript to each participant. Sending the transcripts to the participants allowed each person to check that what was said was what they

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[42] The interview recorded on the phone was deleted after the Dictaphone was stored in a metal container.

meant, which increased the validity of the data.[43] As palliative care is very personal and emotional, the author felt it was important that his record of what the participants said was reliable and comfortable with its use as part of the research. All the interviews in phase one were conducted one on one and in person.[44] However, the interviews in phase two were performed using the Microsoft Teams application dues to the outbreak of COVID-19, which meant the author did not physically meet the participants but recorded each session using that application and were transcribed by the author. **Figure 17** illustrates how the author conducted interviews in chronological order, beginning with phase one.

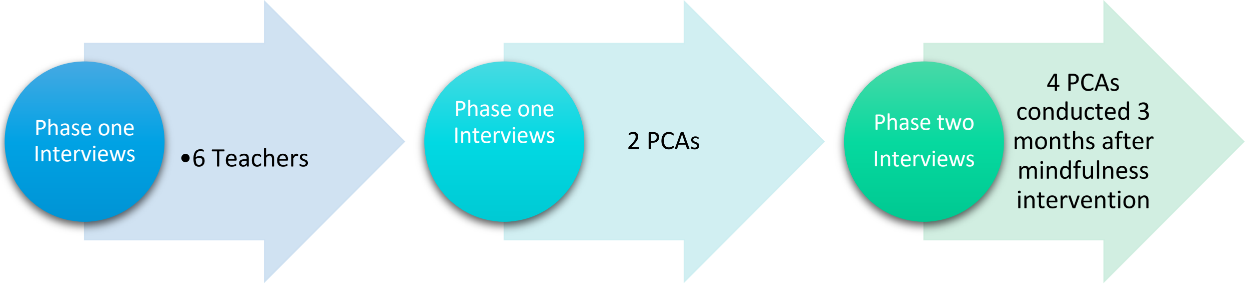

Figure 17. Interview Process Phase one and two

In phase one (highlighted above the first section of **figure 17**), the author primarily focused on the interviewees' experiences of stress while working or teaching in palliative care and ascertaining if the interviewees in phase one would be open to using mindfulness as a tool to reduce palliative care stress. The phase two interviews were conducted after the six-week mindfulness program, and the green arrow represents PCAs interviewed three months after the program ended. After three months, the author interviewed the PCAs (four in total)[45] to understand if the mindfulness sessions had a longer-term impact on each PCA. The third

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[43] See next section 3.13 on member checking.

[44] In phase two due to Covid-19 restrictions interviews were conducted using Microsoft Teams©.

[45] Not to be confused with phase one, phase two interviews totaled four PCAs and the person who conducted the mindfulness sessions.

arrow (also part of phase two) represents the last interview of the study conducted by the author with the mindfulness expert who delivered the six-week mindfulness sessions to the PCAs and the palliative care teachers. The author used member checking to confirm the interviews' validity.

3.8 Case Study

3.8.1 Why case study?

There are several advantages to using a case study, such as the possibility of richer data gathered than in other experimental designs due to the targeting of participants (PCAs). It allows the researcher to adapt throughout the study and explore complex topics (such as coping with the client's death) and target a specific group. Case studies enable participants to reflect on real-life situations and add value to their input through their reflection during the interviews. A case study allows the researcher to gain new insight from the participants' phenomena and is a practical data gathering technique (Baxter and Jack, 2008). A case study, like research of all kinds, has a conceptual structure. However, case studies explain, describe, and explore to accurately understand data (Yin, 2009). Case studies can target a specific area (as in the current research). The qualitative techniques used were semi-structured one-to-one interviews and in-depth surveys with palliative care tutors and PCAs who had taught or graduated from the QQI level five palliative care program. It is a regional case study; all of the participants work in County Roscommon.

3.9 Pre-Phase–Focus Group

Before conducting the survey and interviews, the author conducted a focus group with four PCAs who were graduates of the QQI level five palliative care support module. Three worked in nursing homes and the other in-home care, all in the Roscommon area. The purpose of this was that the focus group[46] was a precursor to the research and was conducted as a reconnaissance exercise to help the author design the dissertation question and the methods used for this study. At the beginning of the focus group, the participants explained their backgrounds. The author decided to continue with this practice in the survey and the interviews—at the beginning of each interview, the author asked each participant their

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[46] The focus group was conducted by the author.

background in palliative care and their educational experience. When the participants were asked to talk about stress, the focus group's feedback was varied; however, all members mentioned working with the family as a significant stressor. Therefore, the author's third question in the survey (phase one) asked participants the most stressful palliative care aspect. The question was repeated in each interview and asked in the survey (phase one).

3.10 Surveys

A survey is any procedure in which data is collected from a population or a sample through a format such as face-to-face interviews, telephone interviews, or mail questionnaires (Fredericks and McColskey, 2012). The author used surveys to explore the perceptions of palliative care teachers and PCAs; each survey allowed the author to access a larger group of PCAs across County Roscommon. If the author had only employed interviews in this study, the participant population would have been far smaller. It would have been impractical for the author to interview fifty-six PCAs across County Roscommon. Data can be collected using intelligent devices (Schobel *et al.*, 2015). Nineteen of twenty adults in Ireland have smartphones (Deloitte, 2020). Therefore, the author chose to distribute survey questions through the internet to use smartphones to complete each survey. The author collected the survey responses using a laptop and monitored the reactions on SurveyMonkey by using his code-protected smartphone. This was an online survey comprising eleven questions. All identifying data was removed to protect the anonymity of the participants. The author chose SurveyMonkey as it is a well-known and user-friendly medium that personal computers, laptops, tablets, or smartphones can access. The author conducted a pilot before sending out each survey. This was done to identify any weaknesses in the wording of each question. An example of the pilot surveys' benefit was when the author constructed a question with too much detail and therefore reduced the wording when sending it out as part of the study. The phase two survey conducted with the palliative care teachers had a small participant population. The author included a rating scale as an option for each participant; this was done to enrich the data from the teachers interviewed in phase one.[47]

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[47] As presented in the results section the totals add up to over 100% as the teachers used a rating scale.

3.10.1 Post-intervention survey phase two

Three months after the six-week action research intervention, the author used two methods to determine how the participating PCAs felt through interviews and a post-survey (non-Freiburg). The author chose to conduct a post-survey and interviews three months after the action research to allow the participants time to reflect on the impact of mindfulness sessions. The author designed the post-survey after the Freiburg data results had returned. He used an inductive process (bottom up) and developed the questions to explore the participants' data/responses in greater detail to benefit from three months' hindsight. The chronological order of how the author structured the dissertation was (phase one) focus group- interviews and surveys. Phase two (again in chronological order) began with a pre-mindfulness intervention survey, an FMI-based survey for six- week post-intervention survey (three months after intervention) and four interviews.

3.11 Interviews

The author explored each participant's understanding of stress and their coping skills by asking probing questions based on the interaction between him and the participant. This interview process explores the interviewees lived world's descriptions (based on a nominalist point of view)[48] and attempts to interpret the described meaning of phenomena. It comes close to an everyday conversation, but as a professional interview, it has a purpose, and it involves a specific technique: it is semi-structured (Kvale and Brinkmann, 2009). The author approached each interview similarly but, as it evolved, he adjusted his questions according to the reactions and points made by the interviewee. Semi-structured interviews are helpful when probing open-ended queries and wanting to know the independent thoughts of the interviewee (Adams, 2015). The semi-structured interviews allow the author to explore the experiences of PCAs whose specific knowledge of palliative care is invaluable to this study (e.g., the author asked the participating PCAs and teachers how they deal with the client's family; therefore, the interviewees can reflect on those experiences).

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[48] See 3.6.1.

3.12 Member checking

Returning data to a participant is known as member checking (Birt *et al.*, 2016). Member checking is used to verify and establish the trustworthiness of the data (Doyle, 2007). It is an effective technique to accurately portray what the participants have said (Creswell and Miller, 2000).

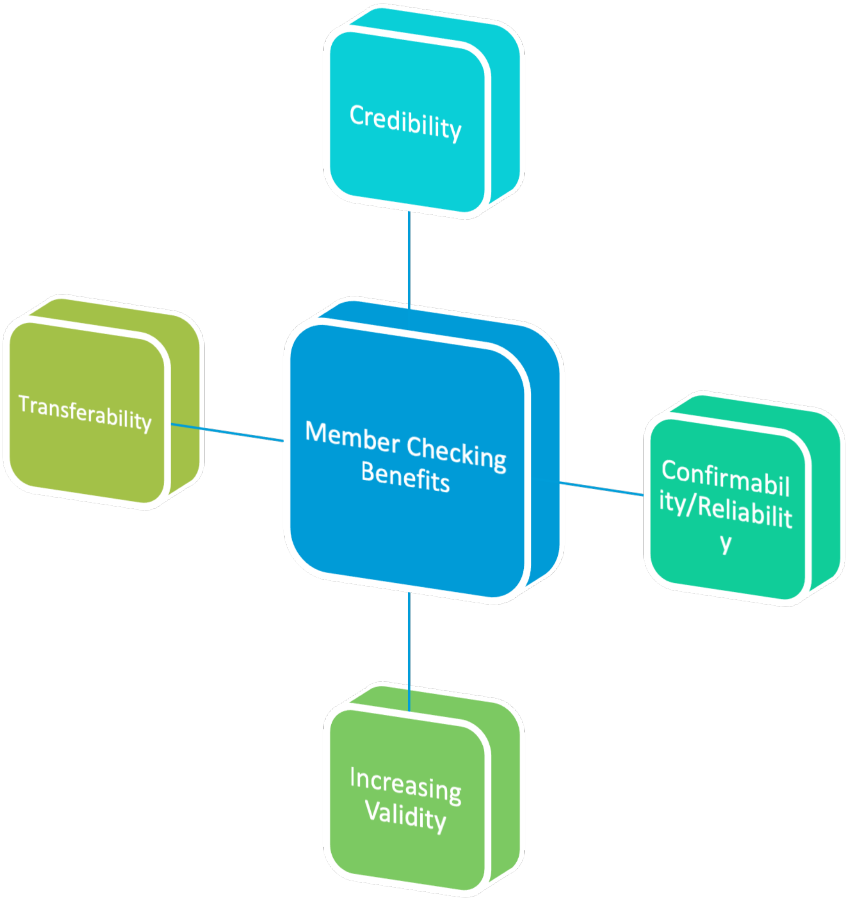

Figure 18. Member checking/validity

Figure 18 outlines how member checking can improve the validity and credibility of the data. As this is a qualitative study, the author depends on the authenticity of the participants' data transcribed.

Credibility—To ensure the data's legitimacy in the research, the author used member checking by showing each interviewee a transcript of their interviews. Allowing the participants to see transcripts of their interviews increases the credibility of the data.

Confirmability/reliability—Sending verbatim transcripts to the interview participants assists the author in eliminating possible mistakes.

Increasing validity—Transactional validity is where interactions between the researcher, the researched, and the data collection intend to achieve higher accuracy and consensus using the facts, feelings, experiences, and values or beliefs collected and interpreted (Cho and Trent, 2006). The researcher's argument is strengthened if the data has been checked and accepted as a fact by the participant.

Transferability—Validity focuses on the possibility of the findings of one study to be transferred to other situations (Merriam, 1998).

3.13 Sampling

3.13.1 Target population of interviewees

The author chose the participating teachers who had taught or were currently teaching QQI level five palliative care in County Roscommon. Each teacher taught in Flexible College or GRETB (or both). These are the only permanently based QQI level five colleges in County Roscommon. In the past five years, each interviewed teacher has taught the QQI level five or FETAC five palliative care approach in County Roscommon. The author of this research is the only permanently based QQI level five tutor in Roscommon who is not a participant. The author interviewed every other current QQI level five palliative care support tutor who works with each college.[49] A small number of respondents had not completed QQI level five palliative care support. Still, the author included their input as they have worked in palliative care and are qualified healthcare assistants.

Table 1 profiles each interviewee in phase one, distinguishing each by their occupation and professional background.

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[49] Permanently-based teacher between 2017-2020.

Table 1. Participant profiles—phase one interviews

Interviewee one—Palliative care assistant—a graduate of QQI level five palliative care support who currently works in palliative care in the client's own home.
Interviewee two—Palliative care tutor who works for GRETB in both North and South Roscommon and teaches palliative care support QQI level five.
Interviewee three—Palliative care nurse and tutor—previously trained healthcare assistants at QQI level five palliative care support.
Interviewee four—Palliative care tutor, formerly a tutor in the UK, now based in County Roscommon.
Interviewee five—Palliative care nurse and tutor—previously trained healthcare assistants at QQI level five Palliative care support. The purpose of interviewing a nurse who works in palliative care was to have the unique experience of working directly with healthcare assistants and delivering palliative care support.
Interviewee six—Palliative care assistant—currently works in a nursing home in County Roscommon, a graduate of palliative care support QQI level five.
Interviewee seven—Palliative care tutor works with GRETB in South Roscommon and currently teaches QQI level five palliative care support. At the interview, she taught (all female) HSE home care workers studying palliative care support level five.
Interviewee eight—Palliative care tutor who currently teaches palliative care support for GRETB in North County Roscommon.

Table 2. Presents the phase two interviewees

Interviewee one (C) Post-survey- PCA- twenty-five years' experience, works in a nursing home in County Roscommon
Interviewee two (AM) Post-survey- PCA- one-year experience works in a nursing home in County Roscommon
Interviewee three (C2) Post-survey- PCA five years working in palliative care in a nursing home in North Roscommon
Interviewee four (O) PCA- ten years working in palliative care in a nursing home in North Roscommon

However, some PCAs may not have completed the above module. Therefore, asking whether they had completed palliative care support level five was included in the survey. The target population could not be randomly selected, which would have significantly reduced the number of participants.

The researcher has taught QQI level five palliative care in the Roscommon area since 2009. Therefore, he had many former learners' email addresses, whom he added to the email invitation list. GRETB allowed the author access to email lists of graduates of its healthcare assistant programs. Similarly, RSG College gave access to its email list of graduates and current healthcare assistants. The author used these lists to send invitations to participate in the study.

3.13.2 Target population has pedagogical experience of palliative care

Sampling applies to identifying cases and choosing data sources that best help to understand the selected point (Stake, 2005). The researcher must choose the data source that can best yield the relevant data for the dissertation question from the target population.

Every person who took part in the study had some experience of working in palliative care. The author used purposeful sampling to attain the targeted population. Purposeful sampling is used in qualitative research to identify information-rich data (Palinkas *et al.*, 2015). The author chose purposeful sampling as a more accurate representation of a population than a convenient sample. It reduces participants to an expert grouping (PCAs and palliative care teachers). Using purposeful sampling allows the author to explore the rich experiences based on the participant's career in palliative care without including less relevant information from people who may not have worked formally in palliative care which may happen if he used random sampling.

However, there are disadvantages to using purposeful samplings, such as vulnerability to errors by the researcher and an inability to generalize data (Benoot, Hannes, and Bilsen, 2016). However, the author attempts to address those weaknesses using a three-stage coding process, which is discussed below.

3.14 Data Analysis

Coding or categorizing data means examining the information with similarities and interpreting the data (Glasser and Strauss, 1967). Manual coding is an effective method where the researcher prints out the text on hard copy[50] printouts rather than a computer screen (Bazeley, 2007). The author used manual coding of the interviews through constant comparison analysis using interpretive acts in line with the inductive post-positivist

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[50] The author transcribed each interview.

approach. Manual coding is beneficial. It gives the author the ability to identify emergent codes and prioritize relevant key-codes/words over others in the selective coding process, which helped identify critical themes, such as conflict with family and bureaucratic issues.

3.14.1 Inductive approach using a hybrid of open, axial, and selective coding

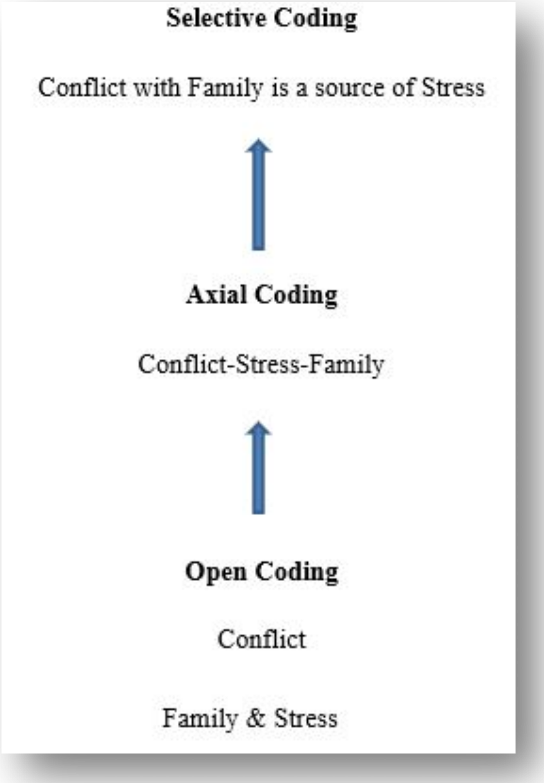

Figure 19. Coding Process

Figure 19 illustrates the author's coding process after each interview; the method is inductive (bottom up) and begins with open coding compiled to look for common themes. The second process is axial coding. The author looks for relationships between the open approach's themes and the third and final stage in the process. The author intends to create a narrative in the data that has been coded.

The above illustration highlights that the author found themes in the open coding stage, such as 'conflict, family, and stress'. In the second axial stage, the author looks for relationships between 'conflict, stress, and family', and in the final stage, the author uses selective coding to identify key concepts using the previously identified themes identify a narrative in this case, ‘conflict with family is a source of stress’.

3.14.2 Coding of open-ended questions in survey

The author designed a method of coding based on two factors, as follows: relevance to the topic question and similarities were found from the interviews, such as emergent themes.

The author used an open coding method with different-coloured highlighters to identify trends in the participants’ responses. As the method used is inductive, the codes used by the author were derived from the data from the interviews from both phases: open coding, axial coding, and selective coding.

3.15 Phase Two Mindfulness Intervention

Action research is a participative, educational research method based on the researcher’s role in the study (McNiff, 2002). It is also described as practice-changing practice (Kemmis, 2009): the researcher observes and reflects on their actions to learn from their (practitioners) experiences. It is also defined as a self-reflective, systematic, and critical approach to an inquiry by participants who have experience in the area (Cornwell, 1999). Action research can help empower researchers to address practical problems by researching to generate solutions (Meyer, 2000). The author used a participatory mindfulness intervention similar to action research with one variation: instead of the author conducting the mindfulness sessions, he asked a mindfulness expert to do so. However, in all other aspects, the intervention used the same techniques as an action research method, and therefore, the author would define the mindfulness intervention as one based on action research that includes an expert to ensure the participants took part in an authentic program conducted by an expert.

Action research involves educating the provider to identify questions they want to explore in their classrooms (Elliot, 2007). The author used a mindfulness intervention similar to action research within this case study to determine the feelings and reactions (to the interview questions) of an expert group, PCAs, and their teachers in County Roscommon. Action research is considered learning by doing (Freire, 1970), on which the six-week program planned by the author and taught by Dr Sawyer was based. The author used a hybrid of the Freiburg mindfulness survey to observe the participants’ feelings while learning through the mindfulness sessions. Freire's learning by doing model is relevant to the current study. It focuses on the participants' experiences of mindfulness and then reflects on its impact.

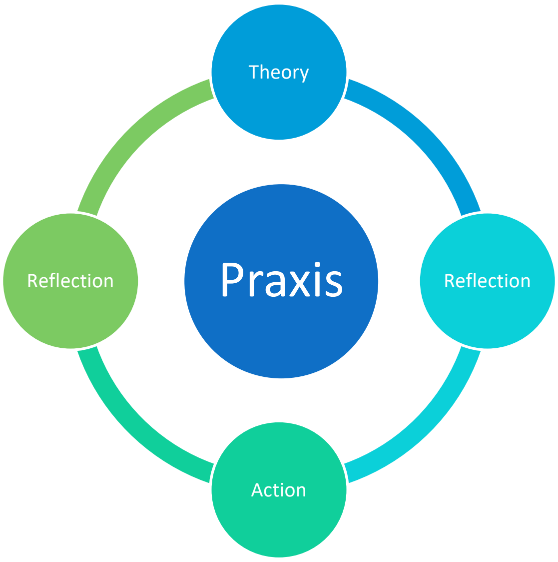

Figure 20. Action research

Figure 20 is an illustration of Freire's learning by doing. For the participant to understand and learn, they must see the theory, practice it, and continue reflecting upon those actions. Freire's model was influential in phase two of this study, where the author used a form of action research to explore whether PCAs saw mindfulness as a potential tool to reduce stress in their work life. One of the strengths of action research is that it is completed in a cycle: no action without research and no research without action (Lewin, 1946). **Figure 21** illustrates how the mindfulness expert delivered the mindfulness intervention once per week (the action). Then, the participants expressed how they felt through a weekly survey (the research). The cycle was repeated over a six-week period.

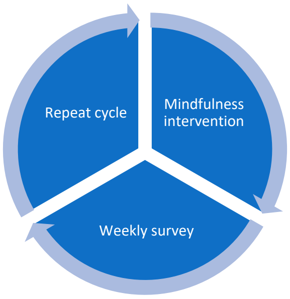

Figure 21. Mindfulness intervention

Therefore, this study's section on phase two is a partnership between the author who organized the mindfulness sessions and the participants who took part in them. However, the author used a hybrid of the action research model rather than the action research itself. In action research, the researcher takes an active role in the intervention. For the purpose of this dissertation, the author believed that the data would be better delivered if a mindfulness expert was brought in to conduct the sessions and would be more accurate in presenting the mindfulness sessions to each participative group.

3.15.1 Benefits of using a participative intervention

The following are the benefits of using participative intervention:

- Enables a systematic inquiring approach towards your practice (Frabutt *et al.*, 2008).
- A long range of people can contribute to action research and be individualistic (Cohen *et al.*, 2000).
- Action research enables the researcher to identify practical solutions through collaboration, whereby the author works with the participant (Reason and Bradbury, 2001).
- The action researcher can be profoundly changed by what they learn (Brydon-Miller *et al.*, 2003).
- Researchers and participants can achieve the most by collaborating with others through action research (Kasl and Yorks, 2002).
- Improves practice through understanding by practitioners and their experiences (Carr and Kemmis, 1986).

The above benefits show that action research is an effective and valuable tool in researching a specific technique (mindfulness) by users (PCAs and their teachers) to learn new information. The author thought that including a mindfulness expert was the most suitable methodology for phase two of this study as it allowed the author to test whether mindfulness could be used to reduce palliative care stress in PCAs. This is achieved by enabling the participants to experience mindfulness through a six-week program where the author surveyed each participant every week after a mindfulness session. This collaborative approach allows the participants to reflect on mindfulness delivered by an expert and how they feel after each weekly session. Therefore, the author would define the mindfulness intervention as one based on action research with a distinct caveat of including an expert that replaces the author in the delivery of each session.

3.16 Intervention—Conducting a 6-weeks Programme of Mindfulness Sessions

Dr Ray Sawyer (OPAL, 2020),[51] a psychotherapist and a mindfulness expert, agreed to conduct a six-week mindfulness session with the participants once per week. Dr Sawyer delivered each mindfulness session once per week. The author did not participate in these sessions but was in attendance. Dr Ray Sawyer, who conducted the OPAL institute's mindfulness sessions, describes his teaching method as non-spiritual in its delivery. After each mindfulness session, the author emailed each participant with a survey based on the Freiburg model. They completed and sent it back to the author before the next mindfulness session, which took place the following week. To adhere to GDPR,[52] the author had to adjust how he contacted participants after May 25th, 2018 which was when GDPR came into force—after the phase one interviews and survey (EU, 2021). To comply with the new regulations, the author contacted the manager of two nursing homes and the CEO of Roscommon Disability Support Group and sent them the survey after receiving a consent form from each manager. Prior to the 25th of May 2018, the author sought and received emails from graduates of GRETB (PCAs). However, the author ceased this practice to comply with GDPR. Upon receipt of each survey, each manager distributed the survey to

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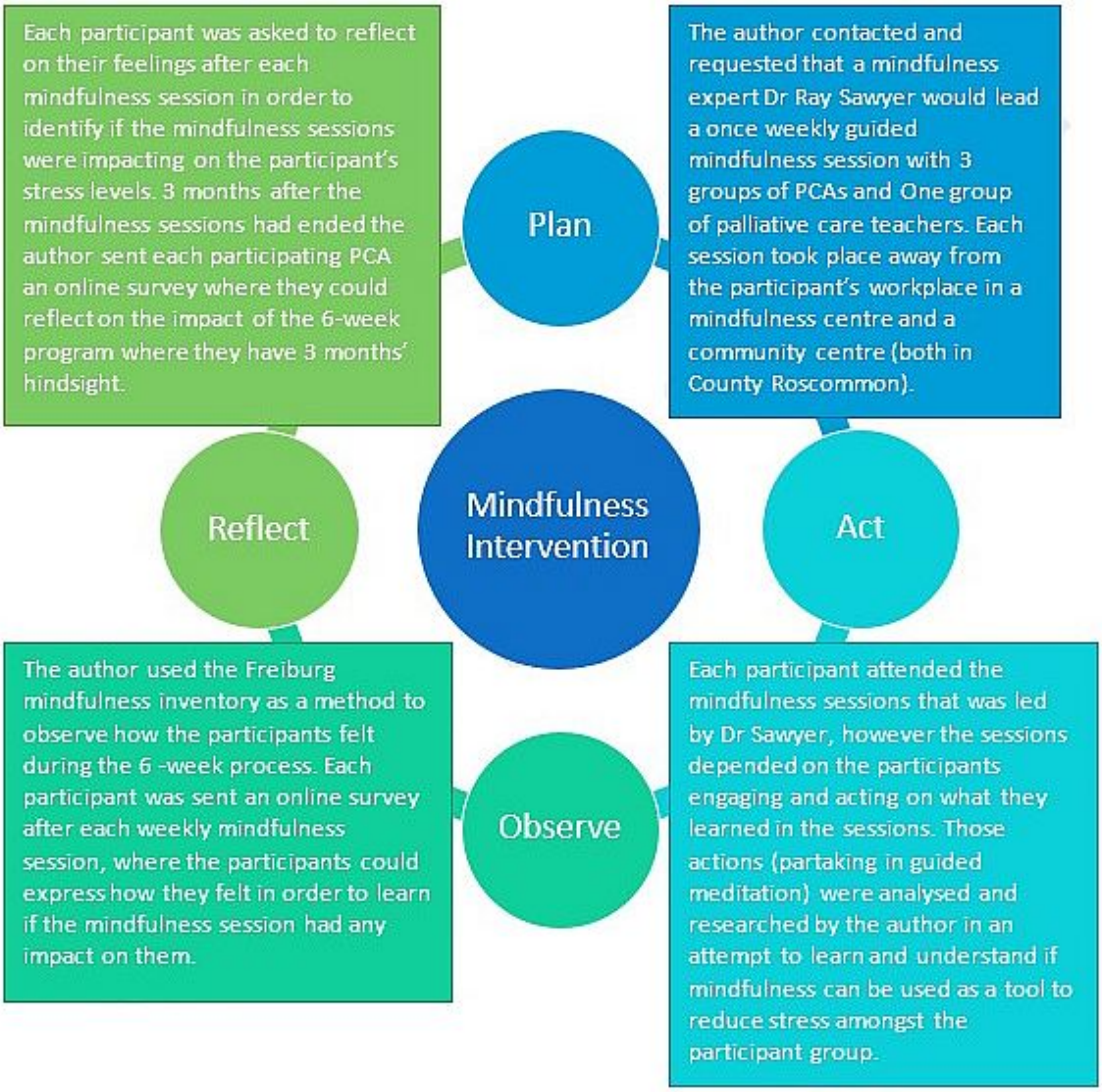
[51] OPAL (Opportunities of Personal Advancement in Life) is based in Donamon County Roscommon.

[52] GDPR—general data protection regulation.

each participant. The author had deleted the pre-25th of May 2018 email list and, after GDPR had come into force, no longer had personal data (participants' email addresses).[53]

3.16.1 Applying mindfulness intervention

Figure 22 illustrates how the author organised the action research for the PCAs and palliative care teachers.



Each participant was asked to reflect on their feelings after each mindfulness session in order to identify if the mindfulness sessions were impacting on the participant's stress levels. 3 months after the mindfulness sessions had ended the author sent each participating PCA an online survey where they could reflect on the impact of the 6-week program where they have 3 months' hindsight.

The author contacted and requested that a mindfulness expert Dr Ray Sawyer would lead a once weekly guided mindfulness session with 3 groups of PCAs and One group of palliative care teachers. Each session took place away from the participant's workplace in a mindfulness centre and a community centre (both in County Roscommon).

The author used the Freiburg mindfulness inventory as a method to observe how the participants felt during the 6 -week process. Each participant was sent an online survey after each weekly mindfulness session, where the participants could express how they felt in order to learn if the mindfulness session had any impact on them.

Each participant attended the mindfulness sessions that was led by Dr Sawyer, however the sessions depended on the participants engaging and acting on what they learned in the sessions. Those actions (partaking in guided meditation) were analysed and researched by the author in an attempt to learn and understand if mindfulness can be used as a tool to reduce stress amongst the participant group.

Figure 22. Mindfulness intervention (inductive approach)

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[53] The author did not use identifiers in any of the surveys; therefore, the surveys were confidential throughout.

Figure 22 shows how the author planned each mindfulness session, allowing each participant to act and participate in the weekly mindfulness session. The author observed the participants during the sessions and allowed them to reflect on how they felt after each session through the FMI weekly surveys.

3.16.2 Freiburg mindfulness inventory and its use in action research

Choosing a reliable tool to measure the participants' attitudes on mindfulness was an essential step in developing the current study. There is a clear need for reliable and valid techniques to measure the usage of mindfulness (Baer, 2003). The FMI[54] is a widely used tool to assess trait mindfulness. It has been validated in several studies (Sauer *et al.*, 2011). This validity of the instrument was one reason the author chose to use FMI. The FMI is a self-reported and reflected questionnaire used to measure a person's use of mindfulness (Belzer *et al.*, 2013). FMI is a reliable and valid tool for measuring a person's self-awareness while using mindfulness (Leigh *et al.*, 2005).

The author adapted this (FMI) technique as it is user-friendly and allowed the author to change the questions to suit this particular research. The author used a questionnaire based on FMI. The author used ten questions rather than the traditional fourteen and slightly modified some of the questions based on the number of weeks the participant has been involved, such as question one. The author used ten questions to ensure that the weekly survey was as user-friendly as possible and did not use four questions as they were similar to those already employed.

The two primary fundamental facets of the FMI[55] are: to self-measure a person's ability to focus on the present moment and become non-reactive by becoming more accepting (Baer *et al.*, 2006). The mindfulness user would self-assess their feelings using a questionnaire based on the FMI.

The FMI works by allowing each active participant to reflect once per week on how they feel answering a questionnaire. The questionnaire is user-friendly as the participant is presented

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[54] FMI—Freiburg Mindfulness Inventory.

with ten statements in this study. The participant reflects on that statement by expressing how they feel using a one to four scale similar to a Likert scale. **Table 3** highlights the questions and format presented to the participants.

Table 2. Questionnaire based on mindfulness-based intervention

	1 Rarely	**2 Occasionally**	**3 Fairly often**	**4 Almost always**
1. Having practised mindfulness for two weeks, I am open to the experience of the present moment.				
2. I sense my body, whether eating, cooking, cleaning, or talking.				
3. Mindfulness allows me to appreciate myself more.				
4. I pay attention to what is behind my actions.				
5. I see my mistakes and difficulties without judging them.				
6. After practising mindfulness for two weeks, I feel connected to my experience in the here and now.				
7. Having practised mindfulness for two weeks, I accept unpleasant experiences.				
8. Mindfulness helps me to be friendly to myself when things go wrong.				
9. In difficult situations, I can pause without immediately reacting.				
10. I can smile when I notice how I sometimes make life difficult.				

3.17 Triangulation

Triangulation refers to using multiple methods or data sources in qualitative research (Patton, 1999). The author collected data and used the following framework for the dissertation: phase one using focus groups, interviews, and surveys, and phase two using pre-survey, survey, post-survey, and interviews. Triangulation can help confirm findings and can help explore different perspectives (Denzin, 1978). The author used multiple sources in the two research phases to help increase validity and analyse the participants' different perspectives through interviews, surveys, and action research.

The author used interviews to explore the participants' point of view and used a quantitative survey, comparing the interview responses to those in the survey and literature review. Therefore, the author triangulated data from different sources. According to Denzin (1970), 'Triangulation is the combination of methodologies in the study of the same phenomena' (p.291). Triangulation increases the depth of understanding within research (Olsen, 2004). By using only one method, a researcher may run the risk of bias. Using multiple methods helps to compensate for the weaknesses of each process (Dillman, 2000). Triangulation allows the use of a quantitative method within this qualitative study and assists the researcher in capturing different dimensions of the same phenomenon.

3.18 Ethics

To promote and support the current research values, the author approached the research from an ethical point of view, with the fundamental principle of not harming the participants. From the beginning of the study, the author decided that it would not be ethically sound to involve palliative care clients (recipients of palliative care). The author did not include palliative care clients, as they may be coping with a potentially fatal illness. It may have been deemed inappropriate to ask them to partake in a study at such a difficult time.

A researcher can have ethical concerns at any part of the process (Bickman and Rog, 2009). Research ethics is the common denominator between the researcher and their participants (Resnik, 1998). The participants' privacy and confidentiality must be given due consideration during the research process (Jensen, 2002).

At the design stage of this study, the author sought permission from the GRETB and Roscommon Disability Support Group (RDSG) to research their organizations. After permission was granted, the author applied for approval to the Dublin City University ethics committee,[56] and the research project was deemed low-risk. Ethical principles that the author must consider include absolute respect for each participant's confidentiality.

Ethical procedures followed:

- Informed consent forms were used for surveys and interviews.
- Wording clear as possible.
- Each participant who took part in the study had excellent English language skills.[57]
- The consent forms inform participants that the use of this study was in line with DCU guidelines.
- Participants were selected from groups of people whom the research may benefit from.
- Each interviewee was coded into a number to ensure privacy.

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[56] See Appendix D.

[57] As graduates of QQI level five each participant would have a very good standard of English or were qualified teachers.

- A person's anonymity was guaranteed whereby the author does not use a person's details in the research (i.e., name, address, and where they work outside of the geographical area of County Roscommon).
- In the survey, the informed consent was online on the SurveyMonkey website and was code protected.
- No personal data was submitted or asked for, except the participant's name, age, and gender. The purpose of this was to identify the responses of each participant.

3.18.1 Ethical considerations and data collection

The primary ethical consideration regarding data collection involved enlisting participants. The author first wrote to the chief executive officers of GRETB and RSG,[58] who consented to allow the author to contact palliative care teachers from each organisation (and PCAs who work for RSG).

Having received permission to contact individual tutors and graduates of palliative care support level five, the author emailed each prospective interviewee who received an informed consent letter (see Appendix D): a form that outlines the research and any potential risks. The author informed each participant that the results of the interview were for this assignment only. This was done to make sure that the participant understood their rights and willingly participated in the research. The author's contact details were placed on each informed consent form. Before each interview, the informed consent form and a list of questions were discussed with the interviewee.

3.18.2 Ethical considerations during data analysis

The two participating organizations, GRETB and RSG,[59] were named county-wide organizations, but the names of participants are not stated anywhere in the research. The author followed the following principles throughout.

- The audio recordings and transcripts were available to the author only. Other than the name of the organization they worked in, no personal details were highlighted in the research for palliative care tutors.

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[58] Roscommon Disability Support Group is a small college that teach QQI level five palliative care support.

[59] Roscommon Disability Support Group—RSG (The D is not used in their logo).

- For the PCAs interviewed, the terms of the organizations they worked for were not included in the study.
- Each interviewee was assigned a number with a brief description of their background to be coded without divulging their identity.

3.18.3 Data storage

A locked metal filing cabinet at a secure location to which only the author has access contained the following:

- Original verbatim transcripts of interviews
- Coded transcripts of interviews
- Analysed data, including hand-written notes
- Dictaphone recording of interviews
- Printed copies of the survey that the author analysed
- Copies of coding by the author of the surveys
- Copies of survey results
- Copies of a consent form, survey, and interviews

The survey data is password-protected, and the password is available only to the author and his supervisor.

3.19 Bias

Bias is any change in the direction of truth in data collation, data analysis, interpretation, or publication and can be intentional or unintentional on the researcher's part (Gardenier and Resnik, 2002). The author chose a specific geographical area where he works and teaches to conduct this study, and therefore would personally know some of the participants. To avoid the possibility of bias, the author used member checking to clarify that each interviewee was clear about what was said.

The author used cloud-based electronic software to send, collate, and analyse the responses in the survey.[60] The author used plain language to ensure each participant understood the questions and could give informed answers without prompting from the author.

3.20 Presentation of Findings Using Themes

The author presents the survey findings and the interviews in one chapter to synthesize the overall findings into significant themes based on the findings. The themes included word clouds in the results to show the participants' keywords in the survey's open-ended questions. The purpose of this was to illustrate key themes that emerged during the research.

3.20.1 Emergent themes

The three extracts from phase one interviews highlighted in **Table 4** give insight into the participants' knowledge regarding stress reduction in a palliative care context. These influenced the author to adjust the survey questions, primarily to discover whether they knew what mindfulness was.

Table 3. Example of identifying emergent themes

Interviewee one	"They [the palliative care students] had not a clue, they never heard of it, no really, one person said "I heard"; it was a that was the answer."
Interviewee two	"It is just basically vacating life for a short period, or it is a calming of biorhythms, or well there are lots of different ways of understanding it. It is just like taking a holiday inside you."
Interviewee five	"Somebody mentioned it in the course today, and I do not know much about it."

The above quotes show a diverse understanding of mindfulness; therefore, the author included a question in the first survey (phase one) asking the participant to describe mindfulness. The above interviews took place before survey one phase one was conducted. The extract above helped inform the author of using an action research method to understand mindfulness significantly among participants. Therefore, the author decided to introduce mindfulness (through a mindfulness expert) to each participant from a beginner's perspective through action research.

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[60] SurveyMonkey.

3.21 Data Gathering Process

Using an inductive (bottom-up approach), the diagram in **Figure 23** illustrates how the author gathered the data for this study, starting at the bottom with a focus group as part of phase one and then progressing through phase two towards the findings at the top of the diagram.

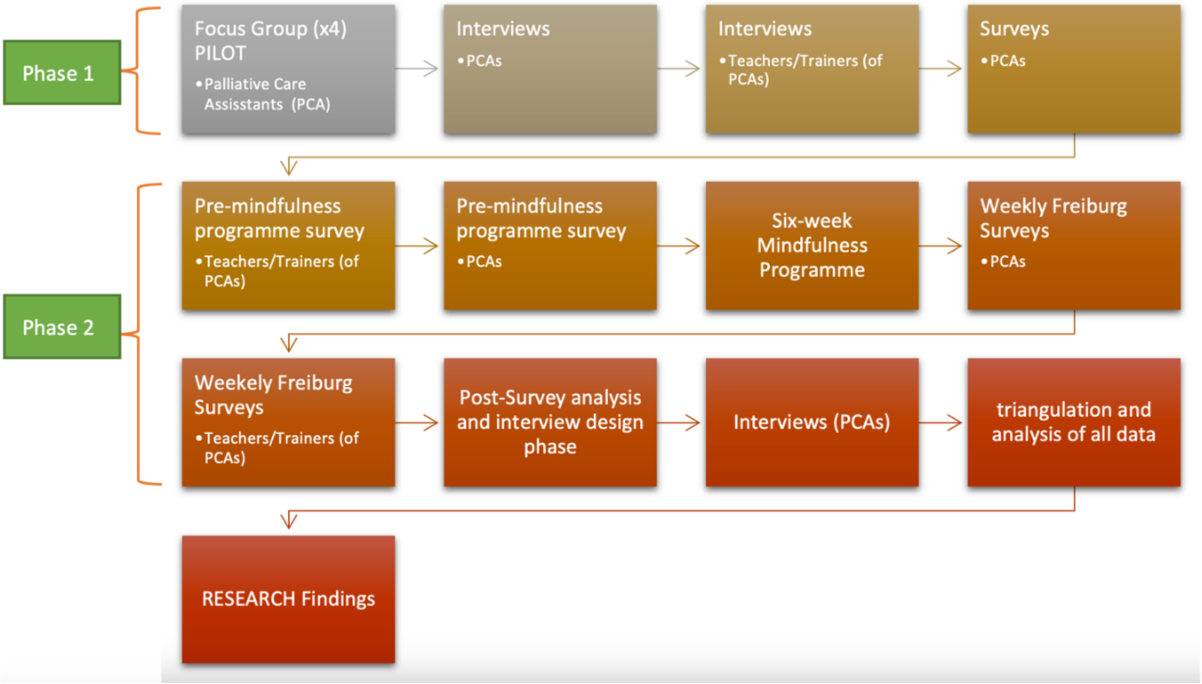

Figure 23. Data gathering process

3.22 Summary

This chapter discussed the post-positivist approach used in this qualitative research study. The methodology continued by describing the research methodology and how the author chose the subject matter, and the methods used to gather the data. The author discusses his philosophical position and continues by making a case for qualitative techniques using an inductive approach. The chapter continues by exploring the benefits of triangulation and member checking to improve the study's credibility. The chapter then presents the ethical considerations of the author's dissertation and techniques to ensure the study's safety.

The author explains the target population and describes each interviewee and survey population's background. The chapter explained how the author chose the topic questions for the surveys, interviews, and the focus group conducted at the beginning of the study. Towards the end of the chapter, the author used a visual illustration based on his philosophical perspective of an inductive approach, showing how the study was built from the bottom, beginning with the focus group and culminating with this study's conclusions.

Chapter 4: Findings

4.1 Introduction

The data presented in this chapter is structured into two phases: phase one, which focuses on investigating whether palliative care is stressful for PCAs and is divided into themes. Phase two focuses on mindfulness and whether it can be used as a tool to reduce palliative care stress.

4.1.1 The three themes of phase one

Phase one began with the focus group, continued to the interviews, and then finished with the survey of fifty-two participating PCAs. Survey one and the interviews in phase one focus on the PCA's role and explore if palliative care is a stressful area to work in and looks at whether the participants would use mindfulness as a tool to reduce work-related stress.

Theme one: Role of PCAs
Theme two: Understanding palliative care stress
Theme three: Mindfulness as a method to deal with palliative care stress
Conclusion of phase one results

4.1.2 Phase two is based on testing whether mindfulness can be used as a tool to reduce palliative care stress

The findings in phase two are presented in chronological order beginning with the pre-survey.[61] The pre-survey was undertaken to explore the participants' expectations before taking part in the action research. The second section of the findings presented is the results of the action research intervention. Both PCAs and palliative care teachers took part in a six-week mindfulness program showing the questionnaire based on FMI results. The third section of this chapter presented the results of the post-survey of PCAs and teachers. The final section of new data presented in phase two consists of the results of the post-survey interviews which took place three months after the action research.

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[61] The pre-survey was conducted as the first section of phase two, it was conducted before the mindfulness intervention and therefore was called a pre-survey being before the intervention.

4.1.3 Phase one: Background of participating PCAs who took part in survey one

The author began the survey by asking the participants about the length of time they had worked in palliative care.

Figure 24. Duration of working in palliative care

The majority of the seventy-one respondents, 59% (*N*=42), stated that they had worked in palliative care for less than one year. As discussed in the literature review in the section on burnout (2.66), there is a high turnover rate of staff in nursing homes, suggesting that a significant number of PCA staff do not remain in the same area of palliative care[62] for a sustained amount of time. Therefore, the author is justified in conducting short-term mindfulness interventions that the PCAs can use to benefit them in more than one working location.

21% (*N*=15) said one to five years, and 21% (*N*=15) had worked in the area for more than five years. Just over 21% stated that they had worked between one and five years in palliative care, with the same proportion saying they had worked in the area for over five years, meaning the majority of participants had worked in the area for less than five years. GRETB first introduced palliative care support level five in 2013, and the RDSG first taught the same module in 2014. Therefore, the participants who had worked in palliative care for more than

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[62] Not all palliative care.

one year either completed QQI level five with an educational provider outside County Roscommon or worked in the area without studying/graduating from the program.

75% (*N*=42) of respondents stated that they had completed the QQI level five palliative care support module, while the other 25% (N=14) had yet to complete the module. The author included healthcare assistants who work in the area but may not yet have completed the palliative care module. All respondents have some experience of palliative care, either academically or professionally.

4.2 Theme One–Role of PCAs

Interviewee three differentiates between working in palliative care and other areas of care. ‘But with palliative care, you know [the clients’] time is coming to an end, or it has ended. They’re no longer here, and that is a different ball game’ (interviewee three). Palliative care is unique and very personal.

Interviewee one expressed how working in palliative care is different from working in other professions as they have to work with people who are dying. ‘With palliative care, it is more about the person. So, that is big stress; you know when you lose somebody, or you know they are dying, it is about the person, not the system. That is the difference’ (interviewee one). The ‘system’ that the interviewee (1) highlights—the regular duties of the PCA—is very important; she emphasises the interpersonal nature of losing a client. Simply providing care to the client is not enough—the relationship between the carer and client is significant. It is in line with studies from the literature review, such as Golubic *et al.*, (2019), Stamm (2002), and Waldrup (2006). The PCA may have worked directly with the client for a long time; therefore, the relationship is more in-depth, and the death of the person impacts more on the PCA than it would on the staff in a hospice/hospital.[63] ‘If they lose a patient, I am sure they feel it, but it is not the same because they have not had a relationship with that person over time. It is an insufficient amount of time; whereas with us, it is you that build up that relationship over time’ (interviewee one). Interviewee one talks about the importance of a PCAs one-on-one experience with the client, which is unique and in-depth due to the length of time she spent with her client, who may not cope with the fact they may die.

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[63] As of October 2020, there is no hospice in County Roscommon.

Interviewee eight stressed that PCAs are undervalued in providing care at a critical time in a person’s life. Their part is not just providing care for the client but also supporting the client’s family, and she emphasises the importance of the responsibility they carry. ‘I do not think people understand the value a PCA brings into a client’s home at that period. Families will depend on them and seek advice and understanding and ask questions. It is difficult for PCA to explain; all you can do is show compassion, which takes more out of you and try and appreciate where they are coming from’ (interviewee eight). The above examples give context to a PCA’s role and explain some of the unique complexities of palliative care, such as their support for the dying clients’ families. This study primarily focuses on stress and PCAs that are highlighted through the experiences of the participants.

Palliative care can be an emotional time for all the people involved. The word cloud in **figure 25** presents critical themes that emerged throughout the open-ended questions in survey one phase one.

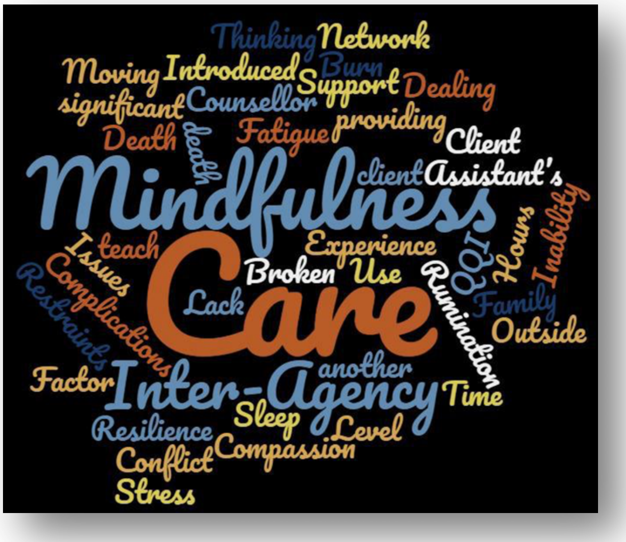

Figure 25. Critical themes interrogated through interviews

The word cloud in **Figure 25** shows critical themes used by participants in the survey when reflecting on their stress levels while working in palliative care. Prominent words that appear include death, stress, inability, rumination, conflict, and time which are all explored in the literature review and are significant because they are the causes of stress while working in palliative care.

4.3 Theme Two: Understanding Palliative Care Stress

In this section, the author focuses on data based on palliative care stress which is central to the overall research question on exploring work-related stress of PCAs.

Interviewee one highlights stress based on the client's circumstances and that there is a level of guilt because the client has died. Moreover, interviewee one becomes less anxious due to the client no longer being in pain. 'If you see somebody suffering you would be much stressed and slightly guilty, you feel relieved that they are out of that suffering, that guilt there is that you are relieved for them (the client) rather than if you see somebody suffer over a long time' (interviewee one).

Interviewee one combines her nursing experience with her teaching to illustrate the palliative care assistant's conflict when dealing with the client's wishes and those of the client's family. Interviewee one and interviewee two highlight the close relationship the palliative care assistant has with the client, suggesting that the client may have a closer relationship with the palliative care assistant in certain circumstances than family.

> They would have a huge relationship built up with the client, and trust is there, and the client would often talk to the carer, more so than the family, because the family is going through their own emotions. Their stages of grief and the client or the patient is trying to protect the family from that. So, they will tell the carer what they want. Ask me: what (do) I want? (interviewee two).

The PCAs that the interviewee speaks of may work directly with family members of the palliative care client in showering that person, for example. Therefore, the palliative care assistant works directly with a person dealing with a loved one's potential death and the practicalities they must confront.

Interviewee two discusses the proximity the palliative care assistant has with the client and their family during a potentially stressful period, where she (a tutor) uses examples from her students of the difficulties that exist at that time, as follows: 'I would say, yeah, number one [conflict with family]. If they care for somebody and have the relationship, and their emotional side, they can see. If they can help the client to die with dignity and respect and know their wishes, you know, that is fine, but it is the family, the conflict with the family when the family will not let it happen the way the client wants it to be' (interviewee two).

Interviewees one and two (both previous page) describe the various factors that can affect PCAs' stress levels while working in the area.

Interviewee two gives an example of the first time she had to work with a client who died:

> I did get that experience (coping with a dying client) … in the early days, in the student days—badly. Very emotional, you'll always remember the first one, and then after that … the coping mechanism, whatever that is, the human factor comes into it, and you deal with it. You cope with it. I think that's just the way the body reacts to survive. (interviewee two).

Interviewee two expresses how difficult it was, mainly in the early days of working in palliative care to cope with a dying client and explains how stress can affect her.

Figure 26. Pre-survey-mindfulness for PCAs

Figure 26 illustrates the PCAs' understanding of palliative care stress before participating in the mindfulness intervention in phase two. Just over half of the participants strongly agreed that working in the area was stressful, with just under one-quarter agreeing, while just under 5% disagreed. Like interviews one and two, the majority of participants stated that palliative care is a stressful area to work in. This confirmation is significant for the rest of the dissertation as it is in line with the literature review[64] and allows the author to explore palliative care stress as expressed by the majority of the participants.

4.4. How Work Stress Affects Work

Figure 27. How work stress affected the PCAs

The word cloud in **Figure 27** illustrates how stress affects a palliative care assistant. Words such as stress, family, home, and tiredness are prominent above. Thirteen participants highlighted that they had difficulty sleeping while suffering from palliative care work-related stress. Three interviewees also mentioned broken sleep as a factor while working in the area. Respondents (*N*=13) said that family life was affected by work-related stress in palliative care. Six participants stated that they do not suffer from stress. Four participants mentioned that they were affected physically by working in the area, while the same number of

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[64] See section 2.6.

respondents said they were less productive. Three respondents cited social withdrawal as a factor while working in palliative care. Five respondents stated that due to the stress of working in palliative care, they did not have enough time to function as they did before they worked in the area. Five stated that they suffered from or were affected by anxiety due to working in palliative care. Interviewee two describes how members of a palliative care client family can be a source of stress. This suggests a similarity between the survey and interview two (both phase one), where both indicate stress while working in palliative care.

A common theme with the responses was the lack of sleep when working in palliative care. One of the respondents (interviewee three) discussed how she could not switch off after finishing a shift and suffered from a lack of sleep because she was still thinking about a client. Another effect of stress in palliative care highlighted by the participants is that their family life could be affected. This is in line with the interviews: some interviewees discussed the difficulty of leaving their professional lives behind and immediately adjusting to their personal lives. As discussed in the literature review, mindfulness is a technique used to reduce stress by readjusting a person's thinking or just helping them switch off (Glomb *et al.*, 2011; Hahn, 1976).[65] Thirteen respondents highlighted that they had difficulty sleeping while suffering from palliative care work-related stress. Interviewees two, four, and six of phase one also expressed that a lack of sleep was an issue due to palliative care stress. The findings above suggest that palliative care stress can have physical effects for PCAs; therefore, the author is justified in exploring a therapeutic model that could address the issues highlighted by the participants.

4.4.1 Family of the client as a source of stress

Interviewee two outlines how listening to other palliative care staff helps her cope with the rigours of working in the area.

> Sometimes, it can be very emotional, and listen to carers; I get much learning from listening to carers. I was a nurse, and even the other night carers were saying: 'the day of the family respecting nurses and doctors are gone' (interviewee two).

In the first part of the quote, the interviewee reflects on the feedback she gets from palliative care students currently working in the field. She highlights how emotional their experiences

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[65] Switching off—to be able to refocus temporarily away from work.

can be: palliative care work's nature and the difficulties of working in the area. She then gives an example of the conflict between the family and a nurse/doctor; this has been an emergent theme in the other interviews. Conflict with family is a common theme throughout the eight interviews. The significance of the conflict theme for this research is that a source of the stress involved in palliative care has been identified; therefore, the author can look at stress as a real problem, and coping skills can be explored.

32.14% (*N*=18) of respondents in the survey stated that dealing with palliative care clients' families was the most significant source of stress for them. This shows a similarity between the findings in the interviews and the survey: just under 33% of survey participants and interviewees one and two see family members of palliative care clients as sources of stress. However, this also means that two thirds of the participants did not see family members as a source of stress while working in palliative care. This may suggest that the majority of participants do not have negative relationships with their client's families based on the data above.

Interviewee five gives a practical example of a challenging time she had while working in palliative care. 'I had an incident that I found very upsetting. I was distraught by this. A lady moved to the nursing home I was working in. Then the lady's daughter came in and started to scream at me at the nurses' station with a hectic time and in front of an awful lot of people and told me she would ring HIQA.[66] I found it incredibly upsetting and incredibly humiliating' (interviewee five). Interviewee five gives an in-depth example of the difficulty she experienced with a client's family member working within a nursing home. This example's significance is that it reflects the emergent theme that arose in phase one, that family members of clients can be a source of stress.

Interviewee seven emphasizes the difficulties that can arise for the family of a palliative care client. 'First of all, to deal with their issues and own grief and to realize families, it can be a very high and emotional time for them' (interviewee seven). Interviewee seven explains that as the palliative care client may be dying, the client's family must also deal with the emotional problems. 'Families can be very volatile at this stage; there's much diversity within families; they are not all the same' (interviewee seven). Interviewee seven highlights that volatility may also affect the PCA as they work directly with the dying client.

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[66] HIQA—Health Information and Quality Authority.

Interviewee eight gives an example of how she found it challenging to contact family members while clients were in the terminal stage of their care. 'Yes, if the palliative care goes on for an extended period but also the terminal stage. I mean, you know yourself; people can go through the motions. I mean, my father did it five times.'

Moreover, the stress levels go up, and do we call the family members this time? Alternatively, will we wait?' (interviewee eight). The example given by interviewee eight speaks of the moral dilemma of whether to tell family members when the client is in decline, and the possibility of death is near. 'You get many family members with differing, different ideas. You get long-distant relatives turning up at the door, taking over. You can get the primary family carer in the home being made entirely invisible because somebody comes in and says, "Right, we will deal with this now. Mum, you can sit there"; she has been caring for the last X number of years, and suddenly she is invisible' (interviewee eight).

The examples given above are in line with the literature review of this dissertation where studies such as those by Back and Arnold (2005), Davies (1994, and (Scharlach *et al.* (2006) highlight the difficulties palliative care staff has dealt with the family members of a palliative care client. Interviewee two gives an example of how palliative care staff can have a problem in providing care where the family view that type of care differently

> The emotional side of it is immense. A big part of stress is a conflict with families. Where the carer would try to make the palliative care approach, but the family might have a different perception of it altogether (interviewee two).

Interviewee three highlights how the palliative care assistant has a relationship built up with the client and that the client may feel more at ease in sharing their wishes with the carer than the family. 'And they would have a huge relationship built up with the client and trust is there and the client would often talk to the carer, more so than the family because the family is going through their own emotions, their stages of grief and the client or the patient is trying to protect the family from that. So, they will tell the carer what they want' (interviewee three).

Interviewee one expressed her frustration with the fact that a family member was grieving and angry.[67] 'If only I knew that was the stage, that's what was happening. She was

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[67] Anger stage of five stages of grief—see 2.6.2 of the literature review.

depressed; she was angry; she took it out on me. I didn’t cry for two years because I was depressed and that we were going through different stages of grief, and that’s why it wasn’t working with, say, family members’ (interviewee one). The five stages of grief interviewee one speaks of are also discussed in the literature review (Kubler-Ross, 1969). Interviewee two also outlines the difficulty of working with the family of a palliative care client. ‘That’s fine, but it’s the family, the conflict with the family when the family won’t let it happen … the way the client wants it to be’ (interviewee two). The interviewee explains that the client’s family may not want the client leaving the PCA in a position where they cannot implement the client’s wishes, and the client’s family wishes at the same time. Interviewee eight gives another practical example of how a PCA was brought into conflict with the client’s family. ‘There’s all that. If that goes on too long and the PCA[68] is there as the buffer because of the PCA … no one can say when a person will pass anyway. However, the PCA is on the receiving end of all that. You know, always—“Will we ring? Will we …?” and you cannot say “no ring” because you do not know whether they will recover or not either’ (interviewee eight).

Individual family members may confide in the PCA and ask for advice on delicate family issues that can have implications before, during, or after the client’s death. The above example shows the dilemma that a PCA has on whether to call the family if the person is potentially dying. Interviewees one, two, five, seven, and eight suggest that dealing with a palliative care client’s family is a source of stress while working in the area. Therefore, as this is a regional case study, this suggests that a significant number of respondents in this study indicate that families of palliative care clients in Roscommon can be a source of stress for those who work in the area. Interviewee eight highlights that the family sees the palliative care assistant as the first port of call: they will first go to a query. She sees this as a huge responsibility that can increase the stress levels of the palliative care assistant. ‘You would be more open with the health care assistant; you want them to understand what’s going on, you want to know is that something they should be worried about or reporting or is this, okay, you know’ (interviewee eight).

The relationship between the PCA and the family is a trusting one, ‘Moreover, the healthcare assistant is in this position where they have to normalize everything, “Oh, that is fine. That is

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[68] HCA- Health care assistant—though the author uses the term PCA throughout.

okay. That is expected", and that is huge accountability and responsibility, and it would increase your stress levels' (interviewee eight). In the above quote, the interviewee points out that the PCA has to reassure family members that the process is taking its natural path. This example gives a pragmatic view of how a PCA must shoulder a great deal of responsibility.

4.4.2 Area of palliative care causing the greatest stress

Figure 28 shows a description of the greatest areas of stress that the participants expressed.

Figure 28. Areas of Greatest Stress

Figure 28 shows that just under 46.5% (*N*=26) of respondents stated that time limitations were the most significant cause of stress while working in palliative care. 32.14% (*N*=18) said that dealing with clients' families was the most significant cause. Just over 10.5% (*N*=6 identified dealing with clients' challenging behaviour, while 3.57% (*N*=2) said dealing with their clients was the most prominent cause of stress while working in palliative care.

Palliative care clients with a chronic or terminal illness and potentially experiencing the five stages of loss (Kubler-Ross, 1969) is not the most stressful element of the work, as only two of the respondents cited this as the most stressful aspect of care. The fact that just under one-third of respondents stated that dealing with clients' families was the most stressful aspect was in line with the interviews' responses: Three interviewees expressed the same view in great detail. The author found it surprising that only 10.5% (*N*=4) identified dealing with clients' challenging behaviour as the most stressful aspect of working in palliative care, considering the pressure the client is under due to the stresses of dealing with the possibility of their death. However, this is in line with the interviews, in that six interviewees stated that dealing with the clients' families was more stressful than working with the clients. This section of this study shows that one of the causes of stress is working with the clients' families rather than the client themselves.

Interviewee seven gives an in-depth explanation of why she believes there is a link between stress and palliative care. She points out that staff may have unresolved grief issues that can be exacerbated by dealing with a receiving palliative care client. 'Yes, having taught it,[69] now this is my third time teaching it, and I would see a link between stress and palliative care work cause first of all girls and men, whoever is working in it, have unresolved grief themselves that can be very stressful' (interviewee seven). Studies highlighted that there had been instances of emotional burnout due to the pressure of working in palliative care (Aycock and Boyle, 2009; Blum, 2014; Hayes *et al.*, 2017; Cushway and Tyler, 1994). Interviewee two highlights the difficulty of not expressing how she feels due to confidentiality while working in palliative care. 'All the symptoms of stress, so, all the emotional, absenteeism, not dealing with the stress, not being able to talk. There's a huge thing with confidentiality. So not being able to talk about what's going on' (interviewee two). Interviewees one, two, five, six, and seven highlight ways in which a person can be affected by palliative care stress. Interviewee two specifically highlights burnout as an effect of not dealing with those stresses. Interviewee seven speaks in detail about the risks of not looking after oneself while working in palliative care. The literature review's burnout section also looks at the dangers of possible burnout while working in the area. Burnout is a serious issue in the palliative care field which can lead to significant complications within the PCA/client relationship. Question ten of survey one highlighted that all but one participant is at some stage stressed though the severity of which differs significantly. The majority of those surveyed and those interviewed are aware of palliative care stress effects. The findings in this section suggest that palliative care stress is a significant issue for PCAs and their teachers and, therefore, justifies the author's intent to explore mindfulness as a method to deal with palliative care stress.

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[69] Palliative care support QQI level five.

4.5 Theme Three: Mindfulness as a Method to Deal with Palliative Care Stress

The interviewees explain their understanding of mindfulness as a method that could be used to deal with palliative care stress. The following quotes are from phase one; the author sought to see what their perceptions of mindfulness were before any intervention had taken place. ‘I think it is looking after your mental state, the whole thing, the whole of your system. It is not just looking after yourself, eating right, and exercising. It’s minding your mental health and making sure you are not becoming depressed or too bogged down with everything’ (interviewee one).

Interviewee six explains that mindfulness is based on trying to get the client to focus on the here and now and enjoy the present. ‘Out of the scenario altogether and be able to you know to keep them focused on the day, every day, get the most out of every day that they are alive, you know, make sure that they have everything they want in the room’ (interviewee six). Keeping the client focused on a day-to-day basis can help them cope with their medical situation. ‘Yeah, and being aware of, actually I am lifting the pen now, I am aware of I am lifting this pen; I am not thinking of what time will this interview be over at’ (interviewee seven). Interviewees six, seven, and eight give similar explanations for what mindfulness is to the definitions provided in the literature review (Brown and Ryan, 2003; Shapiro *et al.*, 2005; Walsh and Shapiro, 2006). The interviewee also gives a clear definition of what mindfulness is; ‘It is just basically vacating life for a short period, or it is a calming of biorhythms, or well there are lots of different ways of understanding it. It is just like taking a holiday inside you, from all your worries, anxieties. However, it is also a period of reflection as well’ (interviewee eight). Interviewees one, six, seven, and eight had obvious ideas on what mindfulness was; however, this was not the case with interviewee two. Interviewee two (a palliative care tutor in Roscommon) did not know what mindfulness was, although she had an excellent experience of working and then teaching in palliative care. ‘Somebody mentioned it in the course today, and I do not know much about it … That is all I know about it. I do not know anything about it’ (interviewee two). Therefore, if the author wanted to explore if they wanted to use it, a practical intervention would have to be included in the study.[70]

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[70] Interviewee two from Phase one influenced the author to conduct the mindfulness intervention that took place in phase two. By doing so, every participant would have experienced mindfulness unlike interviewee two who had not in phase one.

As highlighted in the methodology chapter, mindfulness is not part of the curriculum with GRETB/RSG.[71] This finding (interviewee two, who did not know what mindfulness was) influenced the author to use an intervention with a teacher to ensure they all experienced and understood what mindfulness was in phase two.

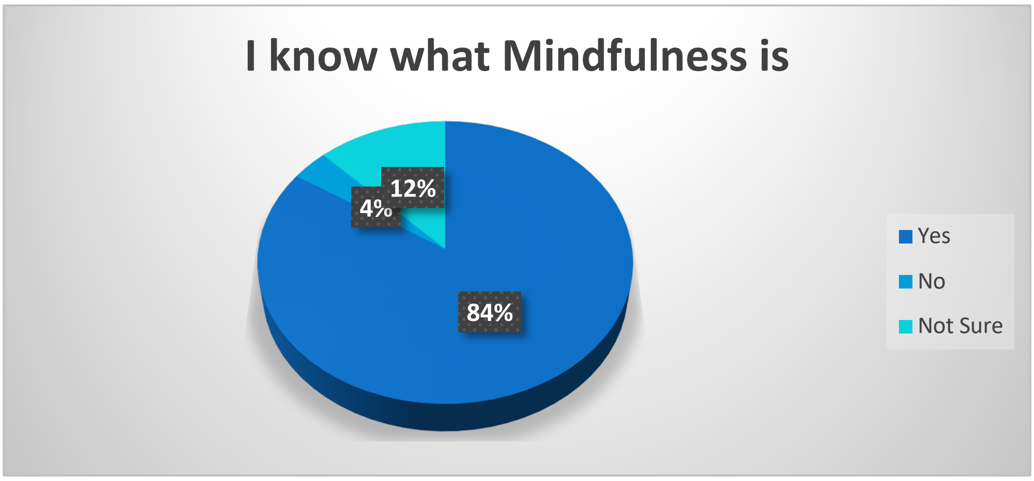

Figure 29. Understanding the term mindfulness

Figure 29 shows that 84.21% (*N*=48) of the respondents had heard of or were familiar with mindfulness, while 3.51% (*N*=2) said they had not heard of it. 12.28% (*N*=7) stated that they were not sure what mindfulness is. **Figure 30** shows very similar awareness to that of the participants in the interviews of phase one. This suggests that the interviewees and the PCAs had similar awareness of what mindfulness is.

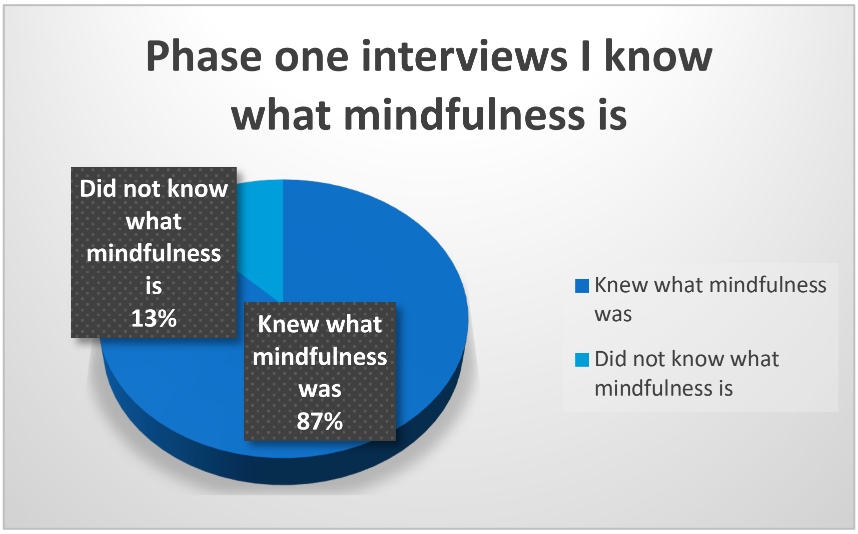

Figure 30. Interviewees understanding the term mindfulness

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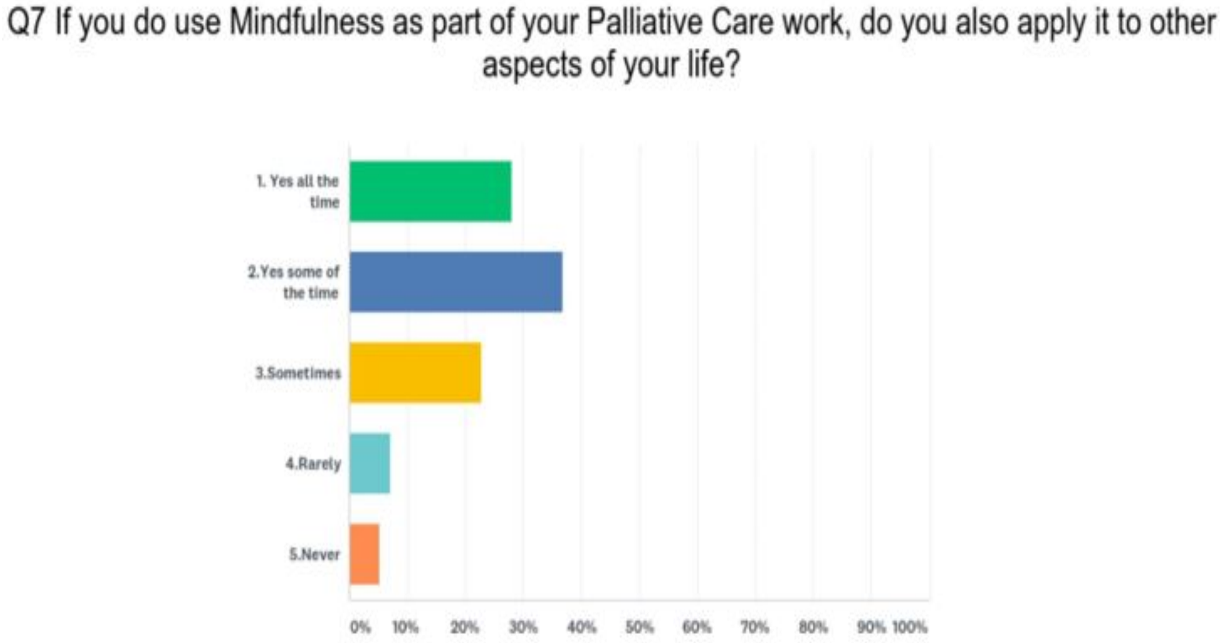
[71] Colleges that provide health service skills including palliative care in County Roscommon.

4.5.1 Mindfulness as a tool to deal with the stresses of palliative care

Interviewee four highlights the emotional difficulties of working in palliative care and the importance of the teacher’s role in encouraging students recognising those difficulties. ‘What we should be doing is working with students to give them skills on how not only how to cope with those emotive issues but also to help them to recognize those emotive issues’ (interviewee four). Interviewee five agreed in that when she worked in palliative care, she had to face up to the emotional pain of the profession, stating; ‘I do (facing emotional pain) because in my experience much pain can be fear-based and once that is identified and just observed and accepted, mindfulness is very much about acceptance that it can’ (interviewee five). In isolation, this does not justify the use of mindfulness to address palliative care stress, but it gives an insight into the teachers (interviewees four and five reflect on the emotional difficulties of working in palliative care). Interviewee five suggests that using mindfulness to accept the reality of the current situation is beneficial and similar to the definitions of mindfulness discussed in the literature review.


Q7 If you do use Mindfulness as part of your Palliative Care work, do you also apply it to other aspects of your life?

(Total respondents 56)

Figure 31. Applying Mindfulness

28.07% (*N*=16) stated that they use mindfulness all the time in other aspects of their lives. 38.84% (*N*=21) said they use it some of the time. 22.81% (*N*=13) said they sometimes use mindfulness in other aspects of their lives. Just over 7% (*N*=4) of respondents stated they rarely use mindfulness and 5.26% (*N*=3) said they never use mindfulness in other aspects of their lives.

Although the frequency varied, the vast majority of respondents used mindfulness; this suggests a clear awareness of what mindfulness is. Over 90% (*N*=54) saw some use in mindfulness as part of their palliative care work. The high percentage is significant to the overall dissertation question (Should mindfulness be introduced into QQI level five palliative care support?) because it shows:

- The majority of the participants had a good understanding of what mindfulness is
- The vast majority of the target population had used mindfulness while working in palliative care.

4.5.2 What mindfulness means

The PCAs in phase one were asked what mindfulness meant to them. The word cloud in **figure 32** illustrates the participants' answers.

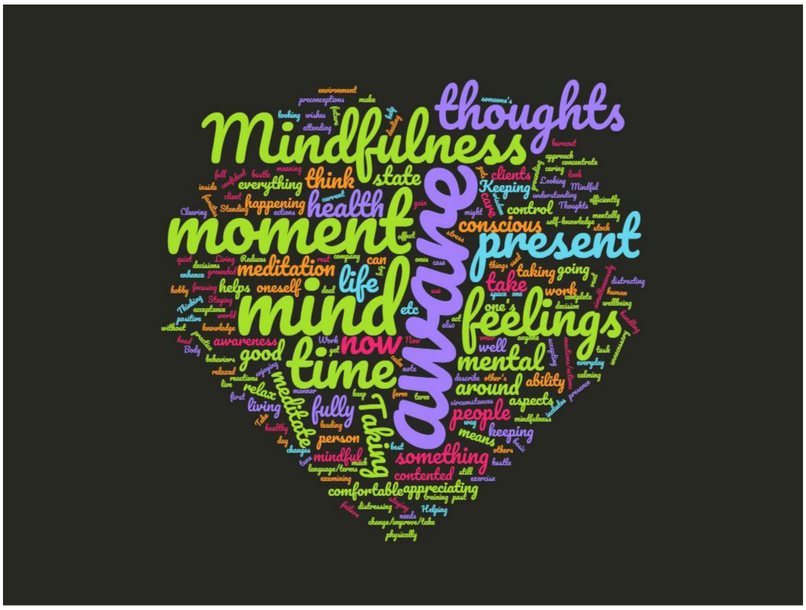


Figure 32. Word cloud What Mindfulness Means to each PCA

The reactions to the question of what mindfulness means to each PCA were diverse; however, the vast majority of one-word responses were positive. Words such as mindful, appreciating, aware, present, meditation, etc., were either positive or neutral words signifying that the participants saw mindfulness positively or neutrally with little or no negative connotations. This would suggest that the participants do not see mindfulness as a negative factor in understanding what it is.

4.5.3 Using mindfulness

Interviewee four expressed his belief that mindfulness could help PCAs recognize how they were feeling at the present point in time, which is in line with the definition of mindfulness outlined in the literature review such as Bishop *et al.* (2004) and Germer (2005). ‘That it helped them to recognize how they were feeling but also to recognize why they were doing what they were doing, and we did see quite a big transition in acceptance’ (interviewee four). As previously discussed, palliative care is an emotive and sometimes stressful area to work in. Interviewee four discussed the importance of the learner focusing on themselves. Interviewee five sees a benefit to using mindfulness in the teaching of palliative care:

> Beneficial, I think it would reduce stress levels, reduce sickness and probably absenteeism and that, you know, and accidents, be good for time management and staff morale and conflict (interviewee five).

Interviewee seven is very clear that she does not wish to see mindfulness introduced into QQI level five palliative care without consideration of possible drawbacks:

> I would be very wary of bringing it into any module because I think mindfulness is something that you have to be in a good place for, and I do not know anybody in the class that I teach is in a good place…. So, something that, it should be initiated, but it would have to be introduced by someone that is a professional and knows exactly what they are doing because I think tampering with stuff like that could be dangerous (interviewee seven).

Interviewee seven differs from the other seven interviewees in highlighting the risks she believes are associated with self-reflection while working in a stressful area. However, she states that if such an initiative were introduced, it should be delivered by someone qualified to do so:

> I think you could teach it as a self-care regulator, but people need to be taught how to be mindful. You need to have to create, say, an environment or give specific exercises in the classroom to give you an idea (interviewee seven).

Interviewee eight calls mindfulness a self-care regulator which can be beneficial to those who use it.

4.6 Conclusion–Phase One Results

Phase one was conducted first to ascertain if palliative care was stressful for the participants and determine if the participants were willing to learn more about mindfulness. The results of phase one show that both objectives were met. Interviewees one, three, four, five, seven, and eight all showed an appetite for mindfulness as a coping mechanism to reduce stress while working in palliative care. Therefore, the vast majority of those interviewed favoured mindfulness as a technique taught to palliative care students in County Roscommon. The interviews also highlighted causes of stress for the participants, such as clients' families being a significant one. The data from the phase one interviews were backed up by survey one. Having established that palliative care is stressful for participating PCAs and for most participating palliative care teachers, the data presented in phase one gives this dissertation a firm foundation for building phase two. The data in phase two emerges from the mindfulness intervention conducted to establish if the participants' use of mindfulness can be used as a tool to reduce or alleviate the palliative care stress highlighted throughout the findings of phase one.

4.7 Phase Two: Results of Pre-Survey

Part one of the presentation of phase two outlines the survey results conducted before the mindfulness course intervention took place. The purpose of this was to ascertain the expectations of the participants before the six-week intervention. It is presented in four sections:

1. Background of participants
2. Expectations of participants before the action research intervention
3. What each participant believes mindfulness is
4. Palliative care stress and how they can cope with it.

4.7.1 PCA participants

Just over 20% of participants had not completed all eight modules of health service skills QQI level five; however, all participants work in the area.[72] Having ascertained the participants' background, the author looked at their expectations before the mindfulness course interventions.

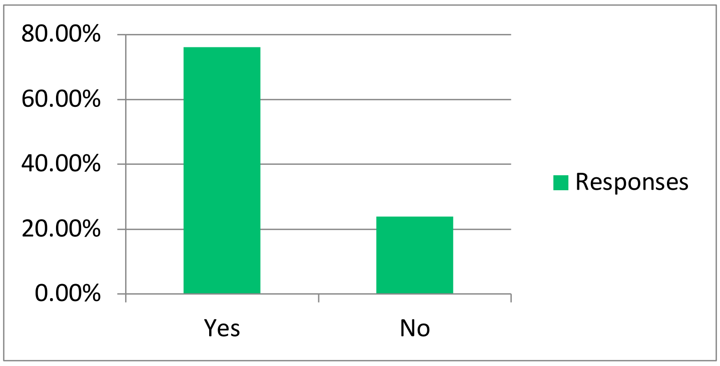


Figure 33. Percentage of qualified health care professionals

4.7.2 Expectations from the mindfulness sessions

The vast majority of participants below were open to looking at stress-reduction techniques to reduce work-related stress. **Figure 34** shows a willingness by the vast majority of participants to try stress-reduction techniques.

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[72] In the private sector, particularly in home care, care organizations will allow a person to work in care (including palliative) if they have completed QQI level five care skills and care of the older person on the agreement that they continue to complete the remaining modules.

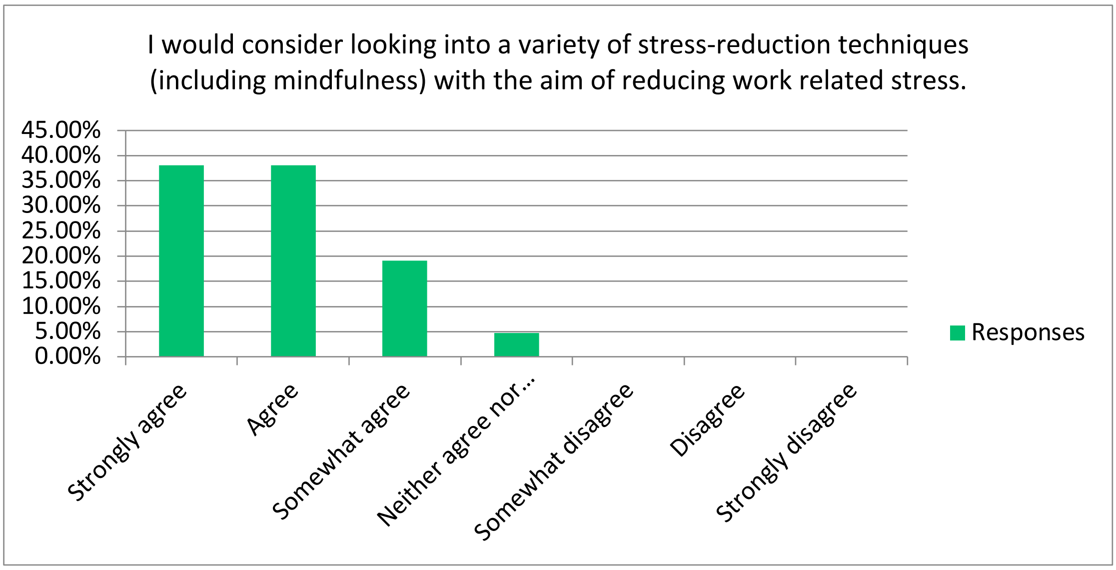

Figure 34. Participant's expectations of Mindfulness intervention

Table 4[73] shows the participants' expectations before participating in the action research mindfulness sessions. The table gives an insight into what the participants thought they would experience before beginning the mindfulness sessions.

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[73] Table 5 also looks at participants' expectations prior to the six-week mindfulness program.

Table 5. Participants expectations before mindfulness sessions began

Code	Participants Response
Reduce stress	Relieve stress, keep a clear mind
	Be less stressed
	To reduce life stress and calm the mind
	To help minimize stressful situations and use the techniques learned into practice when needed
	To calm my mind and reduce anxiety
To relax	Relax
	Relax
	To relax more
	I'd like to be better able to relax and clear my mind
	To be able to switch off when I get home from work
	To help relax and share thoughts
To learn more about stress reduction	To learn more about it
	Learn more about mindfulness
	To learn coping skills and to be more open-minded
	To learn more about mindfulness
	To view life in a different way
	I think they will help me find useful techniques to practice Mindfulness and get me into a routine of doing it regularly.
	To know precisely why mindfulness benefits our day today.
	To learn how to live in the present moment. To help alleviate stress.
Clear mind	I would expect to help declutter the mind to prevent mind racing when working in a fast-paced environment
	To refocus
Not sure	Not sure

In **Table 6**, the participants stated their expectations when asked how they expected to feel after the mindfulness sessions. The most frequent responses were calmer, more relaxed, less stressed, better, and informed, shown in column one, and the direct quotes are listed in column two.

Table 5. How they expect to feel after Mindfulness sessions

Code	Participants’ Expectation
Calmer	Calmer Be calm, more mindful Calmer Calm improved attention, reduced stress, better memory Calmer Calmer
More relaxed	More relaxed to deal with different issues in everyday life More relaxed So, chill out. I’ll forget to go to work
Less stressed	Stress-free Stress-free Hopefully more at peace with myself and less stressed I will feel more confident in practising Mindfulness and benefit from giving myself a little “me” time, helping me de-stress.
Better	Better Great Much better Better Better I will feel happier and confident in myself when being aware of my own emotions. Great
Informed	Informed

4.7.3 Participants’ expectations

The majority of responses in **Table 7** were positive in their expectations of how they might feel after four weeks of practicing mindfulness. Both illustrations suggest that the participants’ expectations were generally positive before taking part in the six-week programme.

Table 6. How they might feel after four weeks of practicing mindfulness

Code	Description
Self-awareness in the current time	Taking time for yourself, release all stress from your mind, clear your mind. It is being present in your own life and thoughts. It is taking time for self. Relaxing, living in the present. It is taking the time out to consider the stress that impacts daily. Living in the here and now, purposely without any judgment. It is at the moment. Mindfulness is being in the present situation. To be fully present in the moment and task in hand. I am living at the moment. It is aware of your thoughts, feelings, and surroundings at present. Being aware of a person's feelings', wants, and needs. Paying attention to our thoughts and feelings without judging them.
Clearing your mind	Chill out Clearing the mind and relaxing Mindfulness is being able to clear your mind of all distractions.
Relax and de-stress	Help you deal with stress. To me, it is relaxing the mind over the body. Help you deal with stress at work.
Don't know	Don't know

The majority of participants gave descriptions in the self-awareness code similar to the definitions in the literature review, such as Bhikku (2007), Bishop et al. (2011), Chiesa (2012), and Van Dam et al. (2018). This suggests a good understanding of what mindfulness is amongst PCAs before they took part in the mindfulness intervention.

Table 7. Pre-mindfulness program PCA stress relief techniques

Code	Description
Exercise	Exercise
	Cycling
	Do what I like: football and exercise
	Go for a walk.
	Taking regular exercise
	Managing my time, talking to someone, exercising, eat right, and sleeping well.
	Walking, reading, and talking to colleagues about things.
	Practicing self-care, enjoying my time, doing self-soothing exercises, listening to music
	Relax
	Exercise
Minding own thoughts/using mindfulness	Try to relax. Clear your mind
	Having a gratitude list
	Do what you like. Attend mindfulness classes.
	Meditation
	Trying to be as positive as I can
	Having an open opinion and respecting choices even if I disagree
Keeping time for myself	Try and relax, clear your head
	Taking time out for myself
Alcohol	Having a glass of wine
	By having wine
Drinking tea	Relax with a cuppa (tea/coffee)
Hobby	Gardening

The most popular response from the PCAs to dealing with stress is exercise. However, it is notable that six of the twenty-one answers mentioned ‘managing own thoughts/mindfulness’ to reduce stress, which is not surprising, considering a significant number of participants who showed a good awareness/understanding of what mindfulness is.

4.7.4 Palliative care stress and how they (PCAs) can cope with it

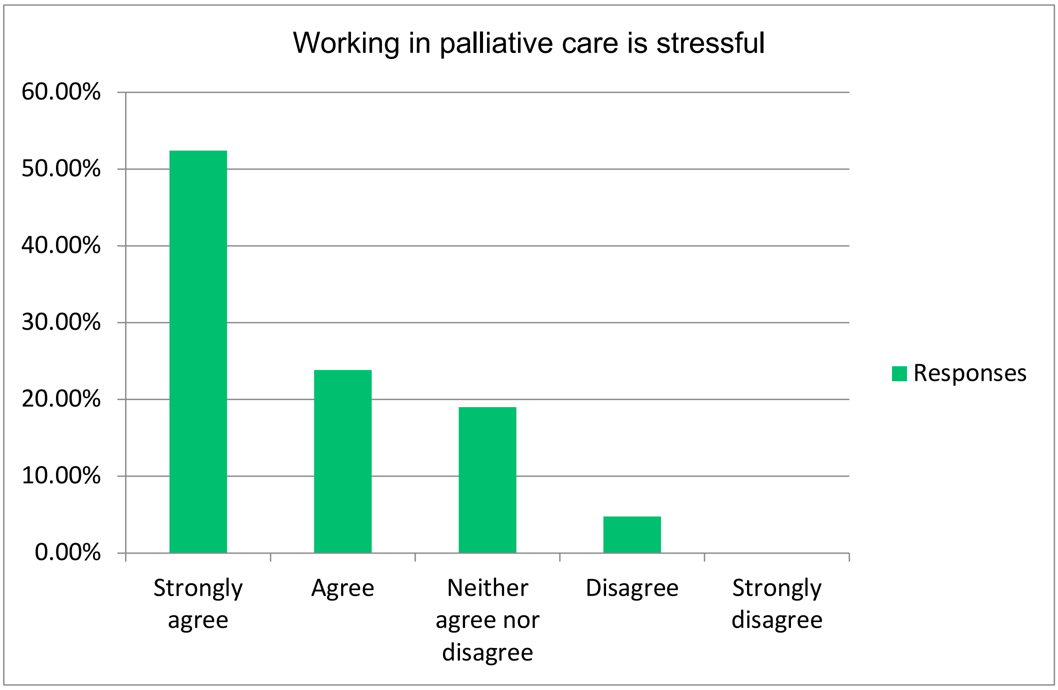

Figure 35. Working in Palliative care is stressful

Over 70% of participants either strongly agreed or agreed that palliative care was stressful, whereas only 5% disagreed that it was stressful. This was in line with phase one, where most respondents also felt palliative care was a stressful area to work in.

Table 8. How I deal with Stress

Code	Description
Talk to colleagues	Talk to colleagues. Speaking to people I trust and remembering it's just a job. Have a drink, talk to other staff. Have a drink. Talk to other staff members Deep breathing at times helps, Talking to someone. I track my stressors by getting enough sleep and eating well. Talk to a colleague and figure out how to minimize the problem.
Exercise	Walk Exercise / listen to music / have coffee. Exercise Go for a walk Give out at home and then go for a walk Yoga
Take time for me	Sleep Take some me-time if possible. Naturally not that good at dealing with stress as tending to take on too much and have an inability to say 'no'. I listen to music, watch a movie, or bake/cook. I am taking time out for myself.
Negatively	Poorly Alcohol
Socializing	Socializing
Don't bring work home	Calmly, get on with jobs and help out where needed and turn off when leaning the building. I don't take work home with me I try and control it as best I can and not bring work home

'Talking to colleagues' was the most common technique in dealing with work-related stress, followed by exercise. 'Taking time to oneself' was also prominent.

Table 9. How do you relax after a shift in palliative care?

Code	Description
Exercise	Walk Go for a walk I usually meditate and often go to the gym If I have had a rough day, I find going for a walk helps me relax and sleep better, clears the head. Exercise A hot bath and listening to music. Walk my dog, or I work out. I find talking to someone close help. Watch a funny film or something to take my mind off work completely, and shopping Walk the dog
Watch TV or listen to music	Music Television Watch television
Talk to family	Go home, talk to my partner Home to my family, ask and take interests in their day's activities and just relax, home is where I'm most relaxed and unwind I try and not bring work home and just chill when I get home Talk to my husband
Sleep	Sleep
Self-help	I would try to unwind and engage my senses with self-soothing techniques
Alcohol	Have a glass of wine Alcohol

Table 9 and **Table 10** highlight how the participants deal with palliative care stress (before the mindfulness session took part). The two most popular primary stress-reduction techniques were 'talking to colleagues' and using 'exercise'. Both are in line with the data from the interviews in phase one. Interviewees one and eight mentioned going for a walk, and five (also phase one interviews) expressed that 'talking to colleagues' was an effective technique to reduce palliative care stress.

Table 11 shows the participants stating their expectations when asked (prior to participating in mindfulness/action research): Can mindfulness be used as a tool for PCAs? The most frequent responses were 'yes' or 'depends on the person/circumstances'.

Table 10 Can mindfulness be used as a tool for PCAs

Affirmative	Yes, use to relax, keep calm Yes, and also self-care Yes Yes Yes Yes Yes Yes, because it can be transferred to clients, reducing anxiety and fear Yes Yes, a lot of people don't understand how to practice mindfulness. It would greatly benefit healthcare assistants and give us an extra tool to help us de-stress after a stressful shift. Yes Yes, to learn to respect everyone choices without having an opinion on everything, whether it be agreeing to disagree to something, learn to accept for what it is Absolutely Yes Absolutely! As health care assistants, we work ourselves to the limit. We need to engage in self-care to enable us to care for others. I believe it can be used as a tool and can help with stress As a healthcare assistant will be caring for many different people who have different wants, needs, and hopes. Being aware that not everyone may feel the same way or want the same thing is an essential aspect to know while working in palliative care
Depends on the person/circumstances	It's a difficult question as being fully present with someone in their last stages in life can be an honour, depending on your interpretation of death. It could be harmful if death is something to be feared. However, if you view death as a natural process being mindful in a moment could be an enlightening spiritual experience. Depends on the person
Negative	Nothing can relieve the strain of palliative care

The vast majority of participants believed that mindfulness could be used as a tool for PCAs. The participants' responses influenced the author to test whether mindfulness could be used in the six-week program conducted in early 2020. The pre-survey data showed that the expectations of the participants were broadly positive about the upcoming mindfulness sessions. This section presented the findings of the pre-action research survey. It was condensed into four areas where the participants explained their background expectations of the upcoming action research, their perceptions of mindfulness, and their attitude towards using mindfulness to reduce palliative care stress. The findings suggested that overall, most participants had a good understanding of what mindfulness is and believed that using mindfulness could reduce palliative care stress. The findings in this section were also similar to the literature review and phase one of the study. The majority of participants were open to using mindfulness through the action research intervention.

4.8 Mindfulness-based Intervention PCAs Weeks Two to Six[74]

Having practiced mindfulness, I am open to the experience of the present moment

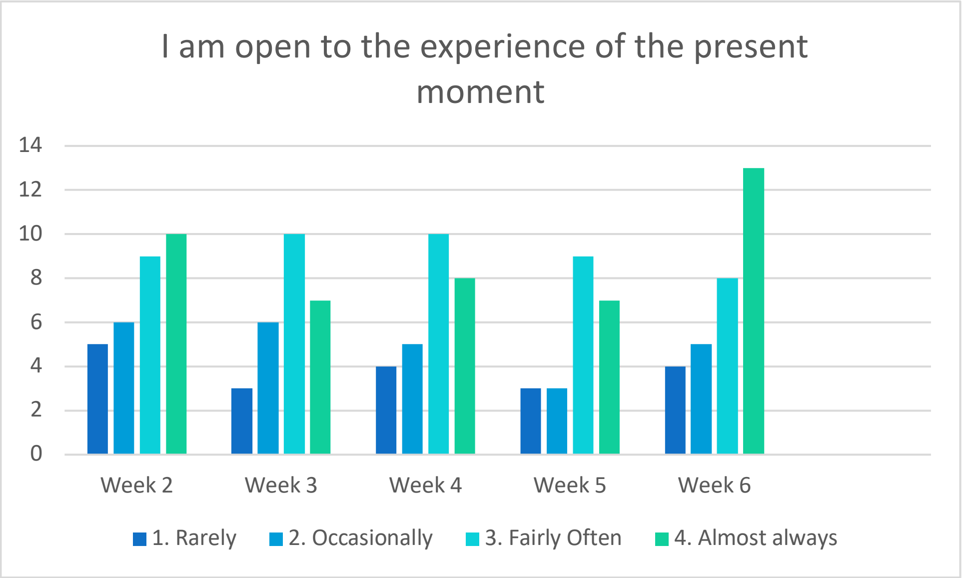

Figure 36. *PCAs*–experiencing the present moment[75]

From week two to week six, there is a reduction in those who stated ‘rarely’ or ‘occasionally’. In contrast, the majority said ‘fairly often’ or ‘almost always’ that they are open to the experience of the present moment.

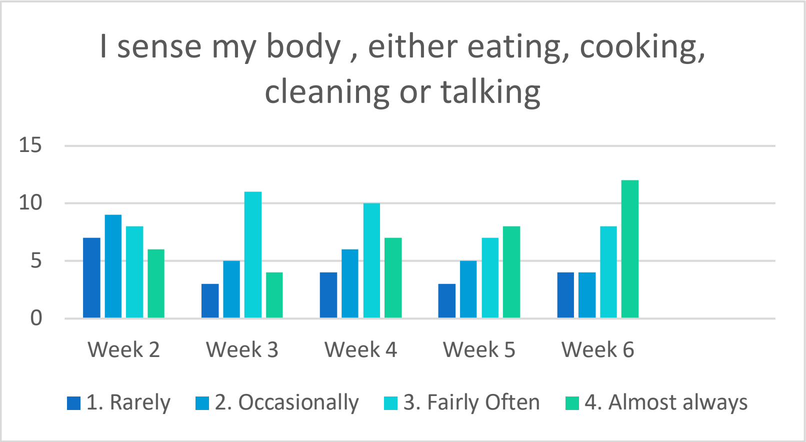

Figure 37. Sensing the body

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[74] Week 1 survey was not conducted using the FMI and can be seen in Appendix E section 6.7

[75] Please note that there is a variance in the totals as not every participant completed survey each week.

From week two to week six, there is a consistent decline in the number of participants stating 'rarely' with an increase almost always as the six weeks continued. This suggests a favourable trend from week two to week six, where most participants by the end of the six-week program were expressed 'fairly often' or 'almost always'.

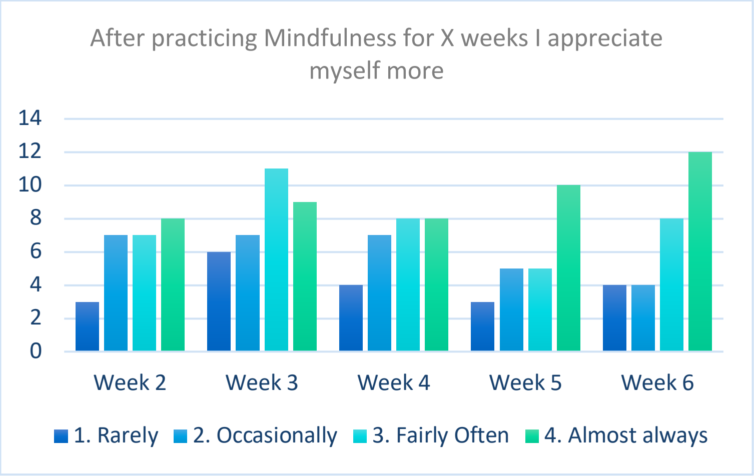

Figure 38. I appreciate myself more

By the end of the six-week program, most participants expressed favourable responses when asked if the PCAs who practiced mindfulness appreciated themselves more. Week six demonstrates an increase in those who stated 'almost always', whereas those who stated 'rarely' stayed consistently low through week two to week six.

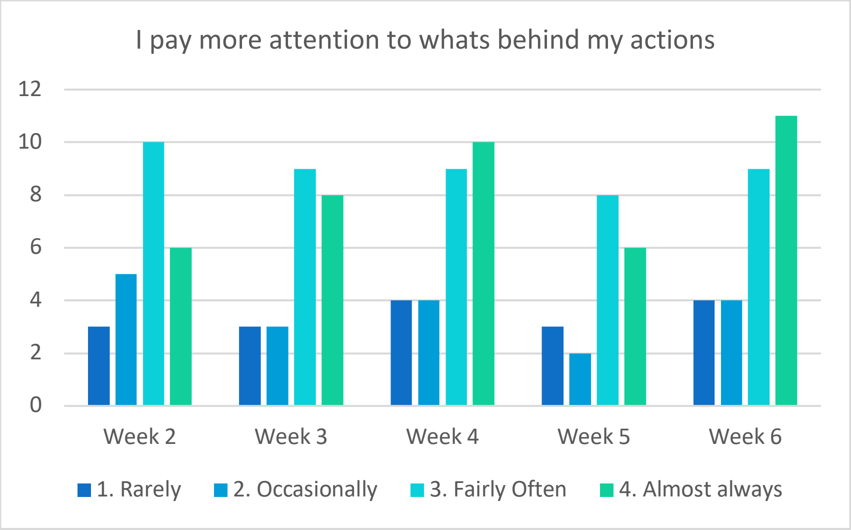

Figure 39. I pay more attention to what's behind my actions

The participants were consistent over week two through to week six in their responses to whether they pay more attention to what is behind their actions (**figure 39**). By the end of the six weeks, the majority reacted positively to the question suggesting that the majority paid more attention to their thoughts at the end of the sixth week.

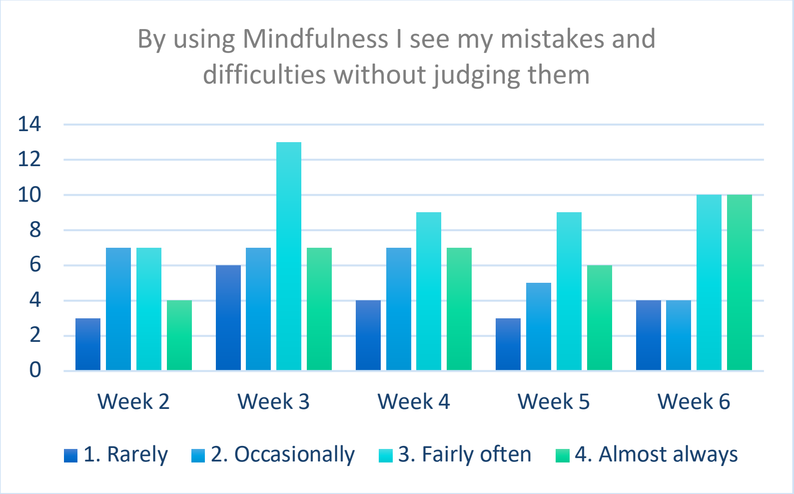

Figure 40. By using mindfulness I see my mistakes and difficulties without judging them

The question did not see a dramatic change in perceptions between weeks two and six. However, the majority stated ‘either fairly often’ or ‘almost always’ by week six of mindfulness to see their mistakes and difficulties without judging them. This data suggests that the mindfulness sessions by week six had a positive impact on the majority of participants.

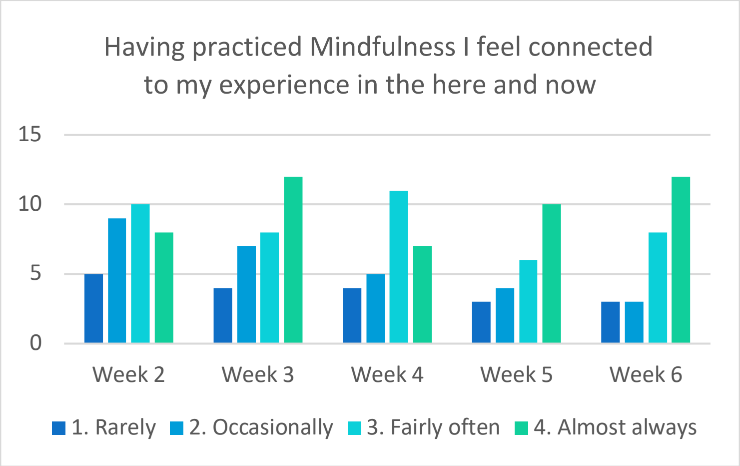

Figure 41. I feel connected to my experience

There was a slight but consistent reduction from week two to week six in the number of participants stating ‘rarely’ as to practicing mindfulness and how it made them feel connected in the here and now. By week six, there was a vast majority saying ‘fairly often’ or ‘almost always’, which shows a positive outlook on the participant’s attitudes to using mindfulness during the six-week program.

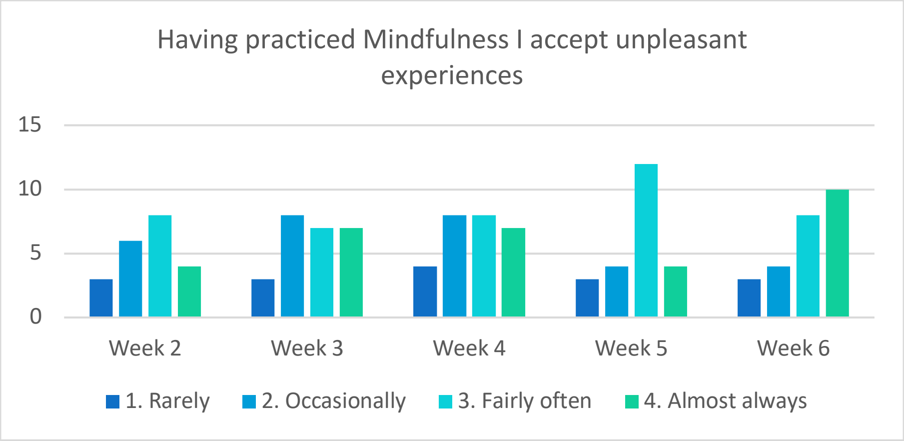

Figure 42. I accept unpleasant experiences

By week six, in comparison to week two, a larger majority ‘accepts unpleasant experiences’, suggesting that after six weeks of practicing mindfulness, the majority benefited from the sessions. Those that stated ‘rarely’ were reasonably consistent throughout weeks two to six.

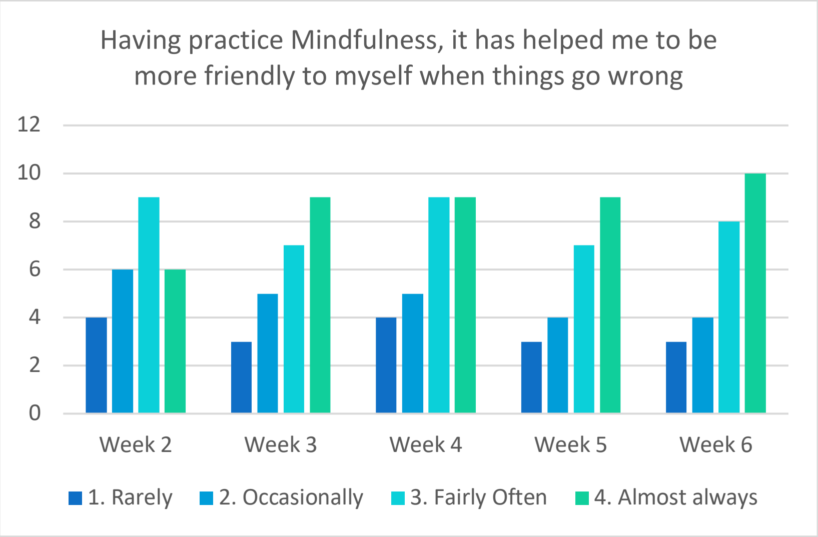

Figure 43. Mindfulness helped me to be more friendly to myself when things go wrong

From week three, the data suggests an upward trend in the number of participants stating ‘almost always’ and a slight reduction in those who ‘rarely’ said to be more friendly to oneself when things go wrong.

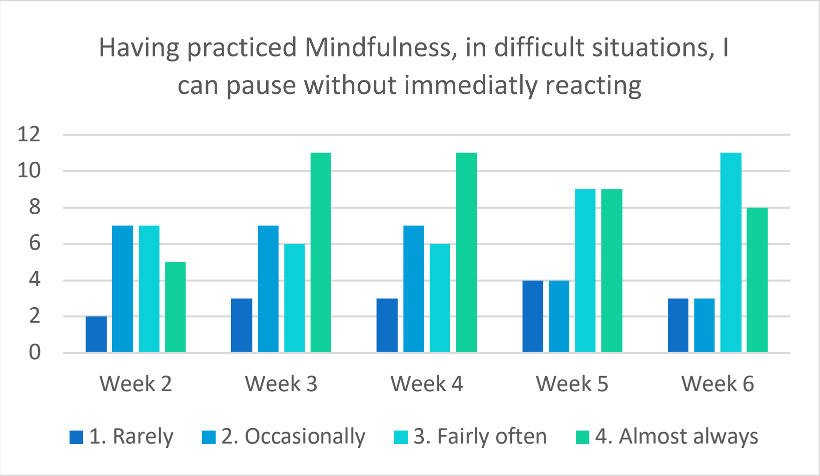

Figure 44. I can pause without immediately reacting

Figure 44 shows a reduction in those who stated ‘almost always’ from week four to week six, a different trend from the previous questions. However, the majority said ‘fairly often’ or ‘almost always’ by week six, describing a favourable impact when asked if they could pause without immediately reacting.

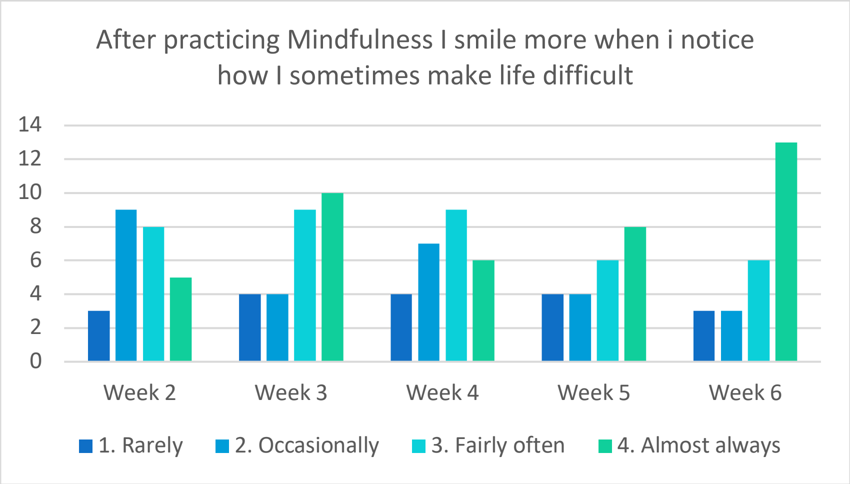

Figure 45. I smile more when I notice how I sometimes make life difficult

By week six, most participants stated either ‘fairly often’ or ‘almost always’ suggesting that the six-week program had a favourable view of using mindfulness.

4.8.1 Conclusion of PCA Freiburg responses of PCAs

Over the six weeks of the mindfulness sessions, the data shows (from week two to week six that most participating PCAs were positive about their mindfulness use). As the mindfulness sessions continued, the findings showed an upward trend in those who stated fairly often or almost always through each question. The significance of this is that as the mindfulness sessions continued, the data became more favourable to mindfulness use, which shows an encouraging trend that suggests most participants found mindfulness to be a useful tool that made them feel better. The findings from this section are in line with the literature review (Brown and Ryan, 2003; Kabat-Zinn and Williams, 2011; Walsh and Shapiro, 2006) and the results from phase one, which also showed that mindfulness is a useful tool to reduce palliative care stress in PCAs as expressed by the majority of participating PCAs. The literature suggests that the action research intervention was in line with the data from phase one which suggests that the majority of PCAs who took part in the six-week program found the sessions beneficial.

4.9 Teachers Freiburg Responses

Figure 46. I am open to the experience of the present moment

Figure 46 illustrates the participants' responses throughout weeks three to six which remained reasonably consistent throughout. By week six, a slight majority stated fairly often or almost always to 'being open to the experience of the present moment'. However, a significant minority stated 'rarely or occasionally', suggesting a mixed response to be open to the present moment.

Figure 47. I sense my body, either eating, cooking, cleaning, or talking

Week three (**figure 47**) shows that the responses by the palliative care teachers to 'sensing my body, either eating, cooking, cleaning or talking' was mixed, with only one participant stating 'almost always'. However, over the following weeks up to week six, that total goes up to three, along with another three stating 'fairly often', showing a gradual positive response to the same question from week three to week six.

Figure 48. After practicing mindfulness I appreciate myself more

In weeks three and four, a clear majority state either 'rarely' or 'occasionally' to the above question. By week six, there was a small majority that stated either 'fairly often' or 'almost always', suggesting that over the weeks from three to six, there was a change in how the participants saw themselves indicating that the mindfulness sessions were having a positive impact on how they saw themselves.

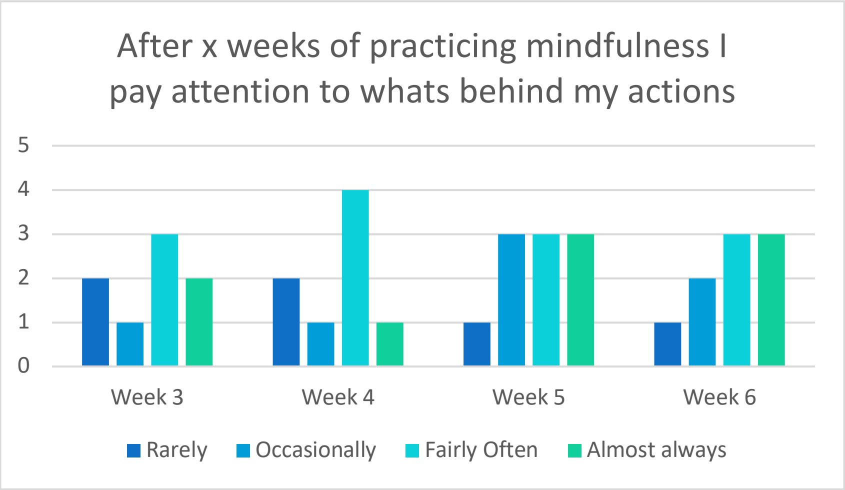

Figure 49. I pay attention to what is behind my actions

Week five and six shows that the majority of participating teachers stated 'fairly often' or 'almost always' reacting positively to the mindfulness intervention when asked about paying attention to what's behind my actions.

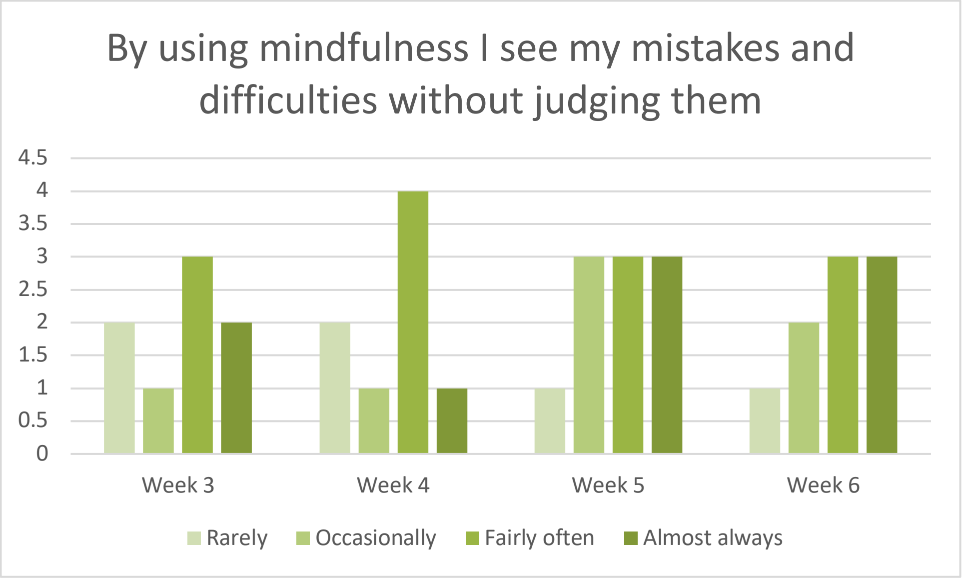

Figure 50. By using mindfulness, I see my mistakes and difficulties without judging them

Three participants in week three stated 'rarely or occasionally', and in the final week (six), three participants stated the same. The majority of the participants by week six 'stated fairly often or almost always', suggesting that through weeks three to six, the majority of palliative care teachers reflected positively on the above question.

Figure 51. I feel connected to my experience in the here and now

There was a significant spike in those who said 'occasionally' in week five. Week three showed an even split between the responses to the above questions which was similar in week four. The final week showed a majority stating 'fairly often' or 'almost always'. However, the responses suggest that the participants changed their minds from week to week which suggests an uncertainty by the participants.

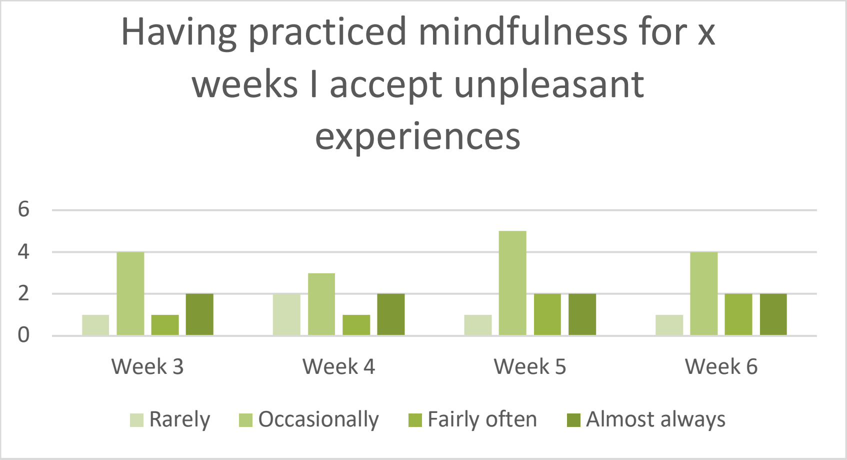

Figure 52. I accept unpleasant experiences

From week three to week six, a significant minority of teachers expressed 'occasionally' when asked if they accept unpleasant experiences consistent throughout week three to six. This suggests that the impact of the mindfulness sessions on the teachers who accepted unpleasant experiences was limited; therefore, the sessions did not address their needs, as highlighted above.

Figure 53. Mindfulness helps me to be friendly to myself when things go wrong

As discussed in the literature review, mindfulness is a personal skill based on self-regulation which allows the mindfulness user to control how they feel at a certain time (Hahn, 1976). Through weeks three to six (see above), the palliative care teachers expressed that ‘mindfulness helps them to be friendly to themselves when things go wrong’. The results were mixed, showing at least half of the participants stating either ‘rarely’ or ‘occasionally’, suggesting a contrast with the literature discussed above.

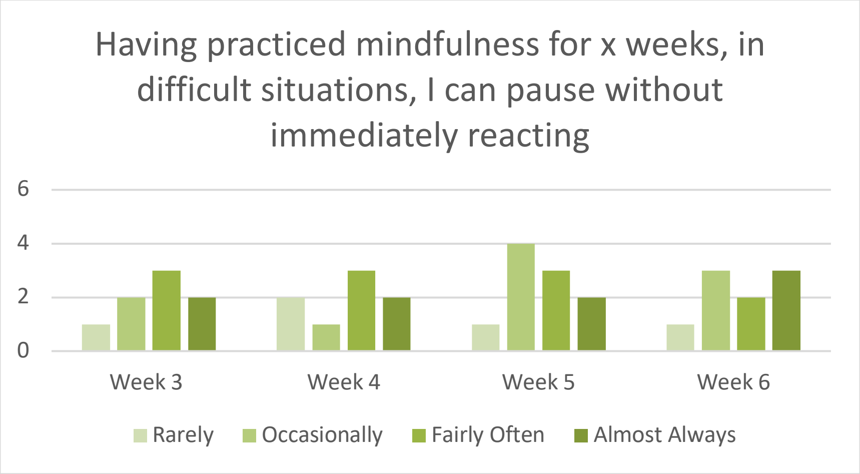

Figure 54. In difficult situations, I can pause without immediately reacting

A slight majority stated ‘fairly often’ or ‘almost always’ when expressing whether they can pause without immediately reacting. This suggests that just over half of the participants expressed a favourable reaction to the mindfulness sessions. However, just under half of the participants stated ‘rarely’ or ‘occasionally’, suggesting mixed results in the participant’s reactions.

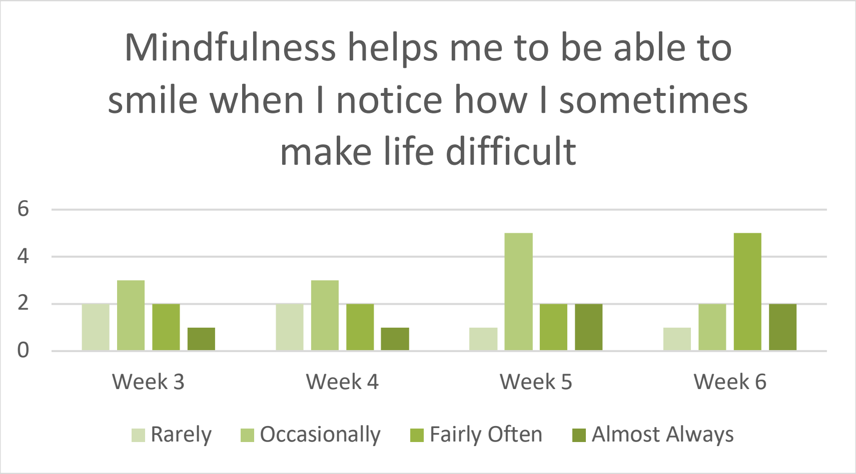

Figure 55. Mindfulness helps me to be able to smile when I notice how I sometimes make life difficult

Weeks three, four, and five in **figure 55** show that the majority of the teachers stated ‘rarely’ or ‘occasionally’, suggesting that the mindfulness intervention had a limited impact on the teachers. In contrast, week six shows that the majority of mindfulness practitioners reacted positively to the sessions. However, as displayed in **figure 55**, three of the four weeks illustrated that the majority of teachers reflected that ‘mindfulness helps them smile when life is difficult’. The following pages present how the PCAs felt three months after the end of the interventions, exploring whether there was a long-term impact on the mindfulness intervention.

4.10 Post-Mindfulness Survey PCAs (Three Months After Mindfulness Sessions)

Table 11 Why did you choose to work as a healthcare assistant?

Why a PCA	Description
Working with people	Love people
	Like working with people
	Love working with people
	I love caring for people
	I like helping vulnerable adults
Rewarding work	It is a gratifying job
	I thought it would be a lovely thing to do and a rewarding job to help others.
	I felt I would have a lot to give as a healthcare assistant.
	Money initially but stayed because of a sense of doing, something rewarding and worthwhile
	Interested in helping others
Family/previous experience	I minded grandparents and like this type of work
	Family experience
	Did it as work experience (as a school placement) when I was fifteen and loved it
Always wanted to work in the area	Something I always wanted to do
	Vocation
	Love the caring side of life

Figure 12 gives an insight into the motivations of why the participating PCAs work in palliative care. The table is important as it allows the author to understand why they stay in palliative care and what positive aspects of the profession are most rewarding for them. The table also explains to the reader what aspects of working in palliative care are positive and have meaning for the PCAs, such as working with people and the rewarding nature of the profession. This is an important insight for palliative care educators as they can relay what is presented above to future PCAs so that they can see the positive aspects of working as a PCA. In **Table 13**, the participants express the most satisfying aspects of working as a PCA and give unique insight from the point of view of the PCAs.

Table 12. The most satisfying aspects of working as a PCA

Satisfying Aspects	Description
Enjoy working with people	Caring for vulnerable people The clients The people you meet Knowing that you are making life a bit easier for people knowing you are giving comfort to people in need A happy patient
Rewarding work	It is a privilege working with people in the last year of life Rewarding work Be there for people in their time of need Caring for someone who cannot care for themselves. Cheering someone up
Make a difference	Hopefully that I can make a difference to the person and family Knowing what you can do can make a difference The most satisfying thing is to feel appreciated and to be able to help not only our clients but their families and give our clients the respect and dignity they deserve coming towards the end of life To offer the best care you can when a person needs it the most.

The responses were coded into three categories: ‘people they work with’, ‘rewarding work’, and ‘make a difference’. The positive responses given by the PCAs show a diverse list of positive aspects highlighted by the PCAs, as **Figure 56** shows.

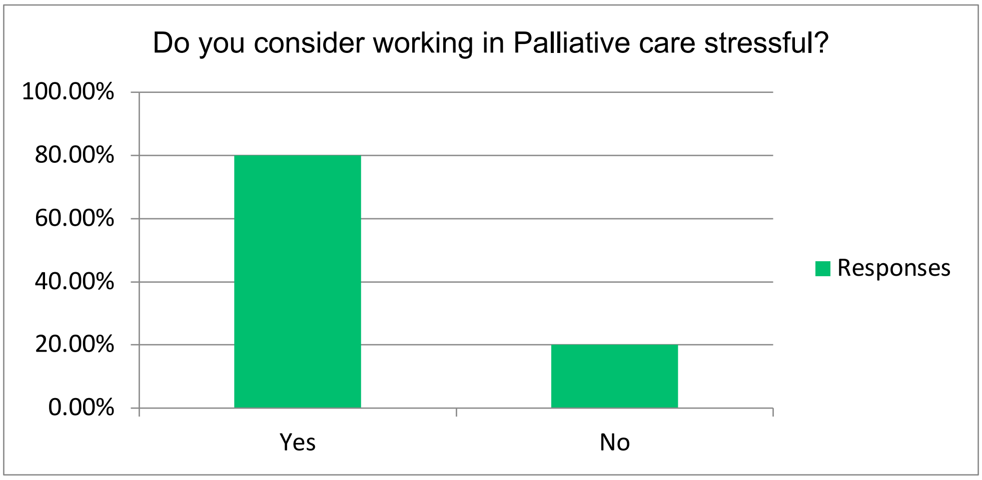

Figure 56. Do you consider working in Palliative care stressful

Three months after the mindfulness program, the PCAs were again asked if palliative care is a stressful area to work in. ‘80% of the PCAs believed that palliative care is stressful’, which is in line with the data from phase one of the study which also showed that most participants felt that working in palliative care is stressful.

Table 14 gives an insight into what the PCAs felt was the most stressful aspect of working in palliative care, as follows.

Table 13. What is the most stressful aspect of working in palliative care

Stressful Aspect	Description
Family	Working with clients' families
	Working with clients' families
	Son/ daughters of the family
	Family of residents
	Family of clients
	Probably losing clients who you have grown fond of over time. And dealing with families can be sometimes stressful
Time Constraints	Having too many clients needing support at the same time
	Meeting deadline
Coming to terms with condition/death	Seeing people pass
	When people are suffering
	Trying to help other people understand
Workload	The workload
	High needs of residents and few staff
	Sense of not doing enough for clients in most need
Not Stressful	Do not have any

Like the interviews in phase one, palliative care clients' family was a stressful aspect of working in the area. Coming to terms of palliative care/death, time restraints, and workload were also stressful aspects of working in the area.

Table 15 illustrates how the PCAs expressed how stress affects them.

Table 14. How work-related stress affects you

Effect of Stress	Description
Not Sleeping	Cannot sleep
	Cannot sleep
	If I were stressed from work, I would sometimes have trouble sleeping and be generally out of sorts. My head would be all over the place.
Ruminating/thinking about work after shift	Cannot switch off and think about work when at home
	When leaving work feeling like you should have done more
	Bringing worries home with you
	It is hard to switch off when you come home
	Just makes you mad that more staff cannot be employed.
Headaches	Headache
Workload	Sometimes feel the pressure of workloads
Home-Life affected	Home-life
Not affected	It does not
	No
	No, it does not

The PCAs expressed various ways stress can affect their sleep and cause rumination, two of the primary effects of work-related stress are described above. This is in line with the literature review (Lyubomirsky *et al.*, 1998; Nolen-Hoeksema, 1991), where it describes rumination as an effect of palliative care stress.

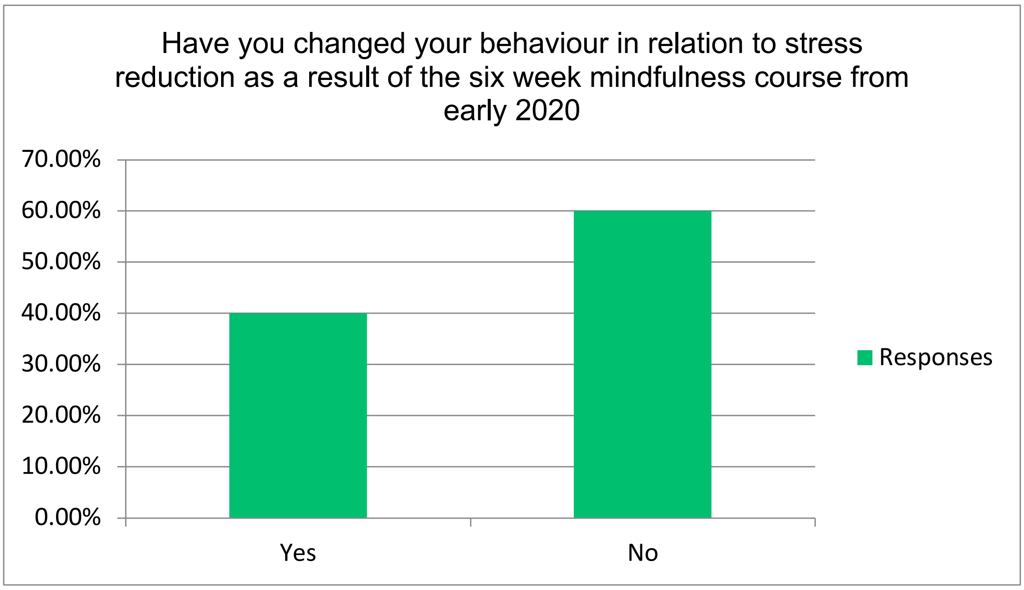

Figure 57. Changing Behaviour

40% of participants of respondents stated ‘they had changed their behaviour’ since the six-week mindfulness course. Like **figure 59** (next page), where the majority of PCAs showed that there was little impact on the mindfulness users, 60% in **figure 58** stated ‘their behaviour did not change’, suggesting that for the majority, the mindfulness intervention had limited impact on the participants.

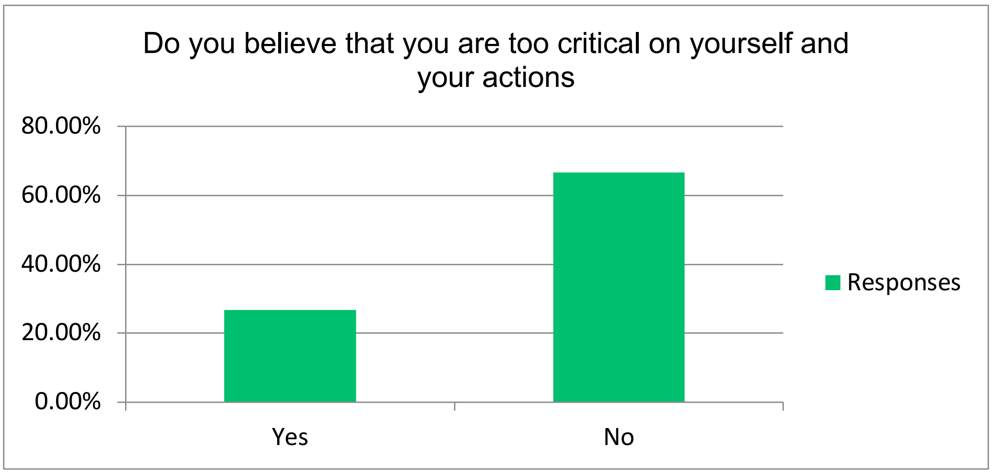

Figure 58. Do you believe that you are too critical on yourself and your actions

The post-survey responses showed that 66% of the respondents stated ‘that they were not too critical of themselves and their actions’. This suggests that the majority of participants do not ruminate or over-criticise themselves, which was a source of stress discussed in the literature review.[76]

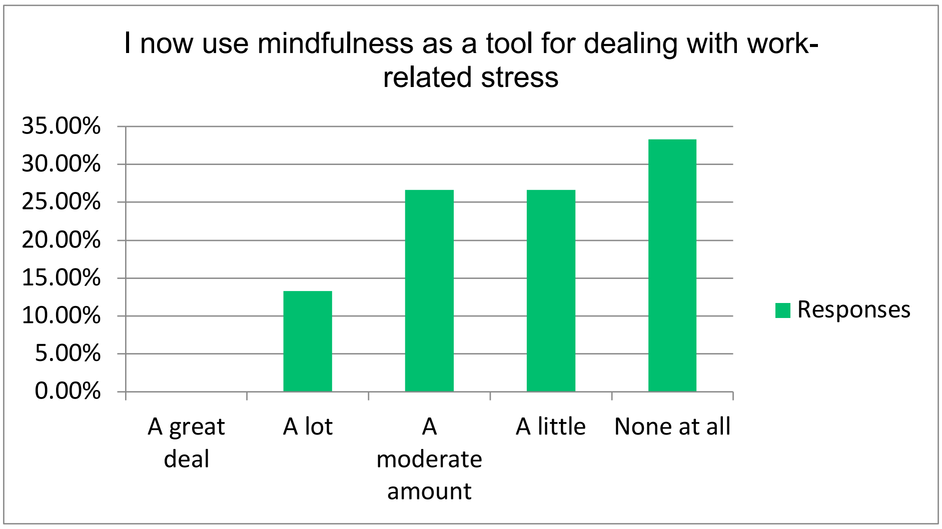

Figure 59. I now use Mindfulness as a tool for dealing with work-related stress

Three months after completing the six-week program, the majority of participants stated that they use mindfulness either ‘a little’ or ‘none at all’, suggesting that the mindfulness program had a limited impact on them. This suggests a contrast from the earlier demonstrated enthusiasm during the program. It also addresses the dissertation question: ‘Can mindfulness address work-related stress for those who work in palliative care?’ **Figure 59** shows that, after three months, the mindfulness sessions did not have a lasting impact on addressing stress for the majority of participants.

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[76] See section 2.6.1 on rumination and stress.

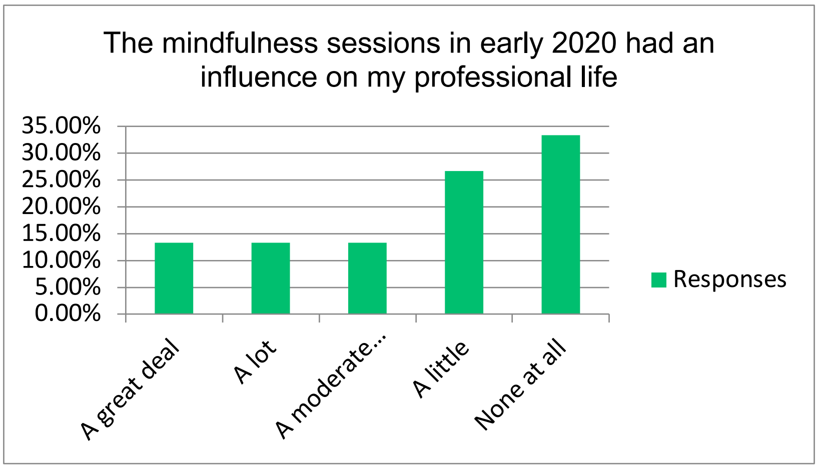

Figure 60. Influence of mindfulness sessions on PCAs professional life

33% of the respondents stated ‘none at all’ when asked if the mindfulness sessions influenced their professional life. Like the previous figure, three months after the intervention ended, the majority of participants stated ‘little or not at all’, suggesting that the impact the mindfulness sessions had on them was limited. This is in line with section 2.12 of the literature review which discusses the need for caution in not overestimating the impact of mindfulness practice (Ellis, 1984; Miller, 2008). However, it also shows that one-quarter of the participants also stated either a ‘great deal or a lot’ which shows that a minority (25%) were influenced positively by the mindfulness sessions.

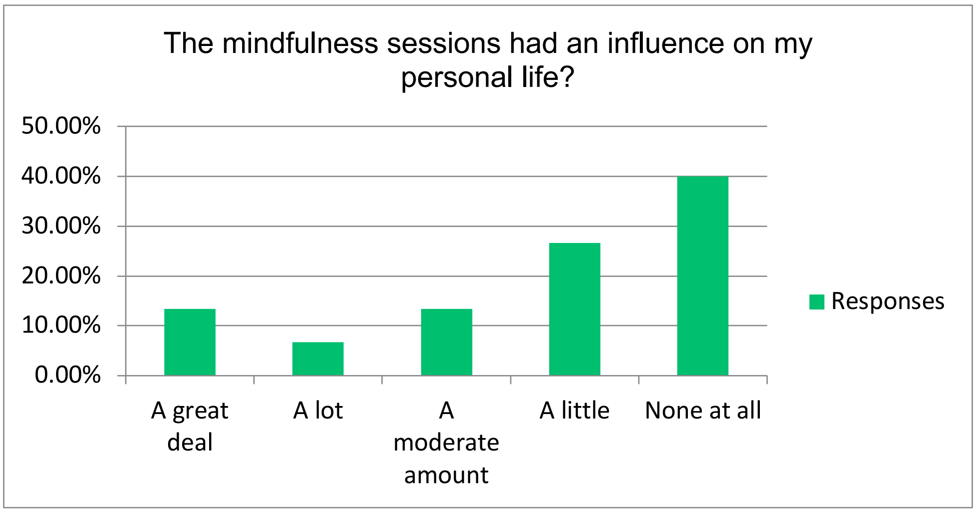

Figure 61. The Mindfulness sessions had an influence on my personal life

Figure 61 gives a clear illustration that the majority of participants had stated ‘little or none at all’ when reflecting if mindfulness influenced their personal life. This suggests that for the majority of those who took part in the mindfulness intervention three months previous that the long-term impact of the sessions was limited.

Table 16 illustrates how the PCAs could see barriers to using mindfulness.

Table 15. Post-Survey Barriers to Mindfulness

The Barrier(s) to Using Mindfulness	Description
Time	Time
	Time
	Too time-consuming
	Time
	Time
	Too difficult to switch off, and it is hard to find time with family life
	Rushing around
Mindfulness did not work for me	It did not work
	It does not work for me
	It did not help me
No barrier to using mindfulness	None
	None
	Nothing would stop me. There are no barriers or excuses not to practice it
	None

Table 16 showed seven respondents believing that time was a barrier to using mindfulness as a tool to reduce palliative care stress. This was backed up by the post-survey interviews, where three of the interviewees stated that having not enough time to practice mindfulness was a barrier.

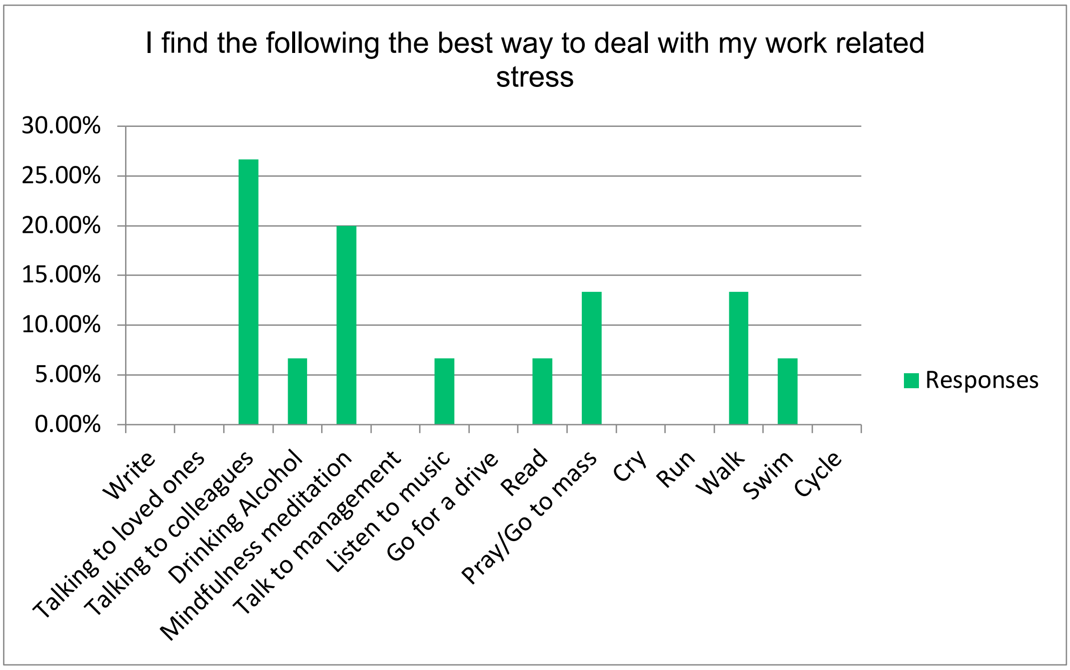

Figure 62. I find the following the best way to deal with my work-related stress

Just under 27% of respondents stated ‘that talking to colleagues was the best way to deal with palliative care stress’. This is in line with interviews in phase one and three of the interviews conducted after the post-survey. ‘Talking to colleagues’ was more popular than practising mindfulness three months after completing the intervention. In reflecting on how they deal with the death of a client, six of eight interviews in phase one stated that ‘talking to colleagues was a useful technique’, significantly the mindfulness intervention did not alter this perception as mindfulness meditation (20%) was statistically less than talking to colleagues.

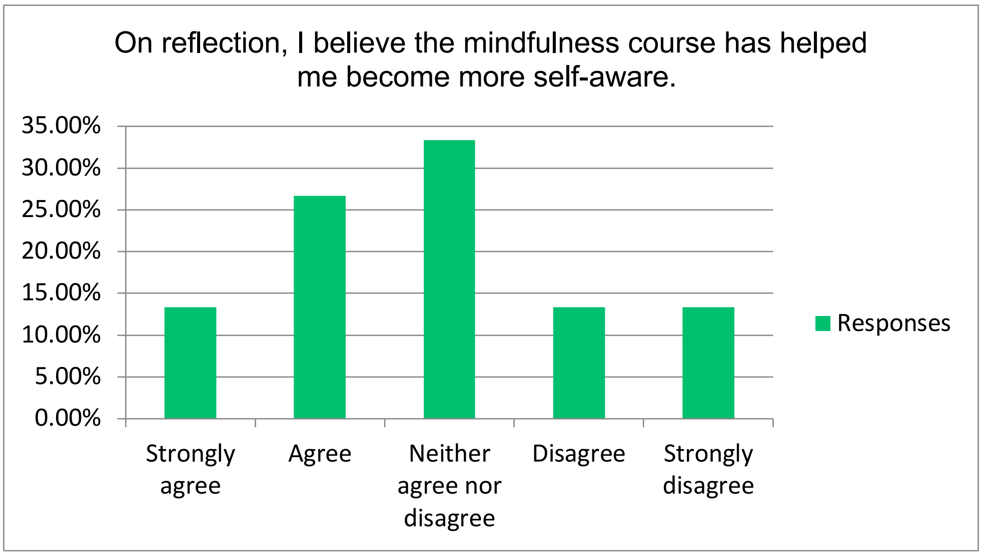

Figure 63. Reflecting on self- awareness

Just under 40% of respondents stated that the mindfulness course helped them become self-aware, whereas under 27% either ‘disagreed or strongly disagreed’ (**figure 63**). Therefore, the majority (just over 60%) ‘neither agreed nor strongly agreed’. Over 30% neither agreed nor disagreed, with over 20% disagreed or strongly disagreed.

Table 17 gives an insight into how the PCAs relax after working in palliative care.

Table 16. Post-survey how you relax after work

How I relax	Description
Exercise	Swimming
	Run
	Walk
	Go for a walk
	I usually walk for thirty-five minutes, have a long relaxing bath after that bed
	I walk a lot and then just relax at home
	I go for a walk, chatty with my loved ones, and end the day with my Mindfulness meditation before bed.
	Walking and praying
	I like to do something different or exercise, and I am now doing a foreign language course
	I sleep, read, go for a walk, spend time with my family and drink wine on a Friday
Watch TV / listen to music	Television
	Watching TV or a glass of wine if I am off the next day
	Put music on and switch off
Time for myself	Take time out for me and just chill
	Sit down, take a few deep breaths, preferably in the open air

Different forms of exercise were the most popular stress-reduction techniques highlighted by the participants, such as swimming, walking, and running as the most prominent. The PCAs expressed a wide variety of relaxation techniques such as praying, walking, and having a bath for them while working in the palliative care sector.

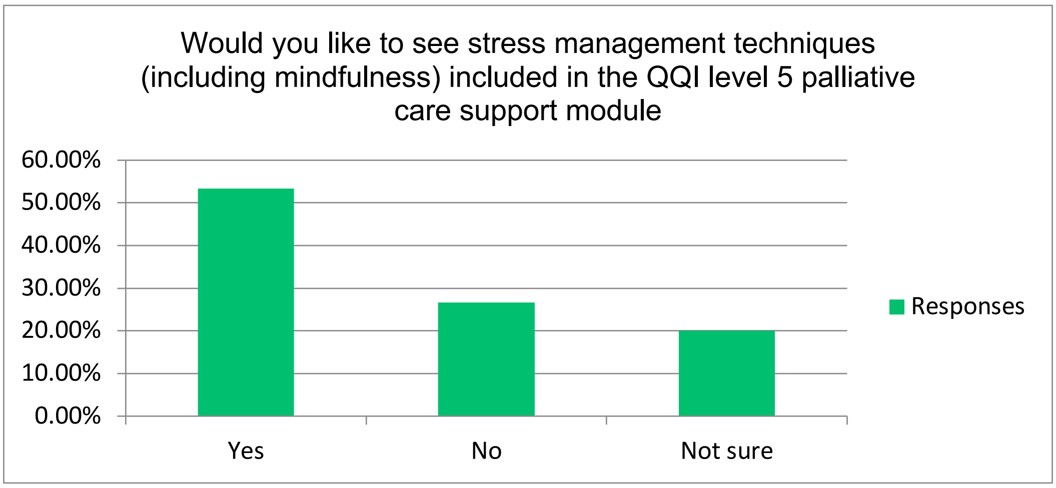

Figure 64. I would like to see stress management included in Palliative care

53.33% of respondents wanted mindfulness in the palliative care module, whereas 26.67% stated ‘no’. This contrasts with the long-term effects of the mindfulness sessions as presented on the three previous pages. **Figure 64** illustrates that the majority believe that stress management should be introduced to palliative care but does not state mindfulness; therefore, the participants may be open to other stress management techniques.

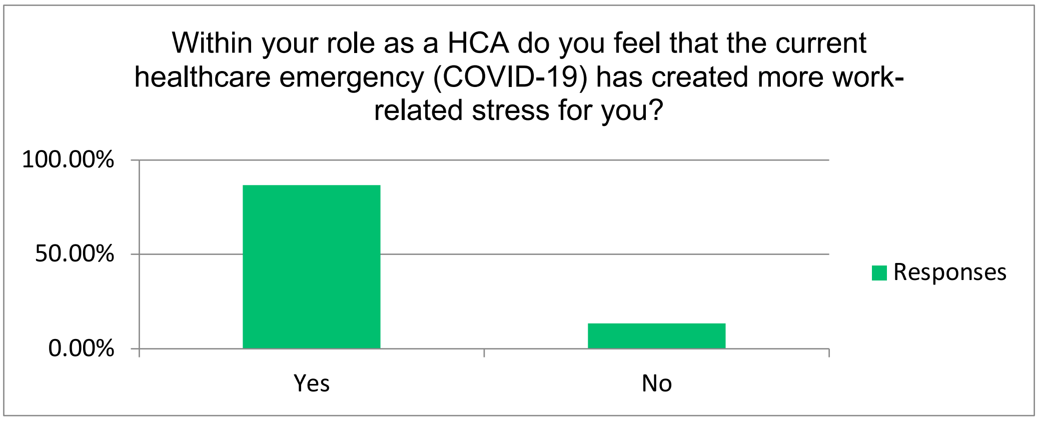

Figure 65. Post-survey has COVID 19 created more work-related stress

86.67% of respondents stated ‘that the COVID-19 pandemic had caused more work-related stress’, whereas 13.33% said it did not. This suggests that a large majority felt COVID-19 created more stress.

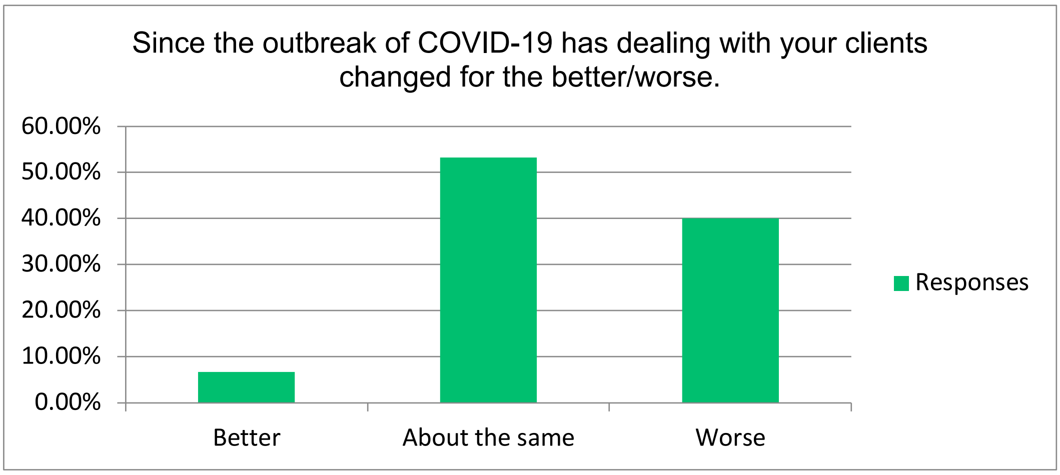

Figure 66. Post-survey has dealing with clients since the outbreak of COVID changed?

6.67% said ‘the COVID-19 crisis made dealing with their clients changed for the better’, whereas 40% stated ‘that it was worse’. Just over 50% said ‘about the same’.

Table 18 highlights how COVID-19 affected each PCA and how it affected them.

Table 17. Since the outbreak of COVID-19, has dealt with your clients changed for the better/worse?

Impact of COVID-19	Description
A virus infected me	I was infected, and so was my family, which was very difficult. I had to cocoon for 3 weeks. I contracted COVID 19 and was in isolation for three weeks. 98% of my nursing home caught it, including myself. It has been a very worrying and emotional time for families.
Increased workload	More rules, less time. More time spent on preparation and less time for patients. More reading, overflow of paper confusing by times. More aware of infection prevention and control measures. I am paranoid about cleaning. Stress
The effect it has had on residents/service users	Much harder, lost residents. I have less contact with service users. There is an increased focus on meeting the resident's psychologist as the interaction with the residents is reduced. It has made the job more challenging by having to wear PPE all the time. And we have to be a lot more aware of the symptoms in our clients and staff. It is also harder to deal with our residents, as some cannot understand why they cannot see their families.
COVID-19 no impact	It has not just made sure to stay safe.

Four of the fifteen respondents in the post-survey (phase two) stated that they were infected with COVID-19, with only one person saying that COVID-19 made little difference to their palliative care work. **Table 18** illustrates that two of the PCAs had to cocoon for a number of weeks showing how the virus can have impacted not just them but also their families. Phase one of this study highlighted that palliative care was a stressful area to work in PCAs. **Figures 66, 67,** and **Table 18** confirm this. As the outbreak of COVID-19 has, for the majority, increased the PCAs workload and their stress levels, thus, confirming that palliative care is a stressful area for PCAs to work in both phase one and two.

4.11 Post-survey Interviews (Phase Two) One, Two, Three, Four

This study's final data was collected in five interviews conducted after the post-survey. The primary findings from those interviews are presented over the next three pages. Interviewees C, A, C2, and O[77] are PCAs who took part in each section of the study. In the first two interviews of this section (C and A), both PCAs explained why mindfulness did not work for them. The section presents the findings of two more PCAs who found that mindfulness worked for them.

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[77] Both phase one and two

4.11.1 Why mindfulness session did not work for them

Two of the PCAs (C and A) whom the author interviewed after the six-week programme had finished explained why the mindfulness sessions did not significantly impact them.

> **C:** ‘It was hard to get the time to do it for a start because I’m doing nights and then go home to sleep. I also have to get up, do the kids, and then go back to work. It’s hard to get the time’.
>
> **A:** ‘Even doing days is hard because you’re only home in the evening and you’re getting ready to go back the next day. You don’t have time to sit down and push the family away so you can try and be mindful’.

Both participants (C and A) took part in each section of the research, including the first survey and focus group. The interview was conducted two weeks after the post-survey. C has worked in the area since she was fifteen (now forty), and A has worked in the area for one year. Therefore, C has twenty-five years’ experience, and A, one year. They both work in the same nursing home in County Roscommon. Despite the large difference in experience, their opinions of mindfulness and its effectiveness in dealing with palliative care were very similar. They expressed a clear understanding of mindfulness (with clear similarities to the definitions in the literature review) and had partaken in each section of the mindfulness sessions. Both participants were clear that mindfulness did not work for them in reducing palliative care stress which was in line with the results of a significant minority who stated ‘rarely’ in the mindfulness survey and the post-survey. Both stated that time restraint was an issue that correlates with **Table 16**, where seven participants also stated that a barrier to practicing mindfulness was time restraints.

The author also interviewed two PCAs who worked in a nursing home in Northern Roscommon where COVID-19 (as of June 2020) had not infected any of the staff. They were in favour of the mindfulness sessions, and both said they would continue to practice mindfulness in the future.

4.11.2 Is mindfulness useful in dealing with palliative care?

Interviewees C2 and O both found the six-week mindfulness program beneficial in addressing palliative care stress where it helped them to switch off and to help with stress.

> ‘Yes, it helped me to switch off, particularly after the loss of a client’ (C2).

> ‘Yes, it was time for myself. It also helped me sleep. I find it difficult to not think about work when I’m not there, and just switching off helped me when I went to bed’ (O).

Both interviewees stated that the mindfulness sessions significantly impacted their ability to manage difficult situations while working in palliative care. C2 spoke about using mindfulness to ‘switch off’ after a client’s death, while her colleague (from the same nursing home) said it helped her sleep better.

4.14 Findings from Research—Figure 67 Key Findings

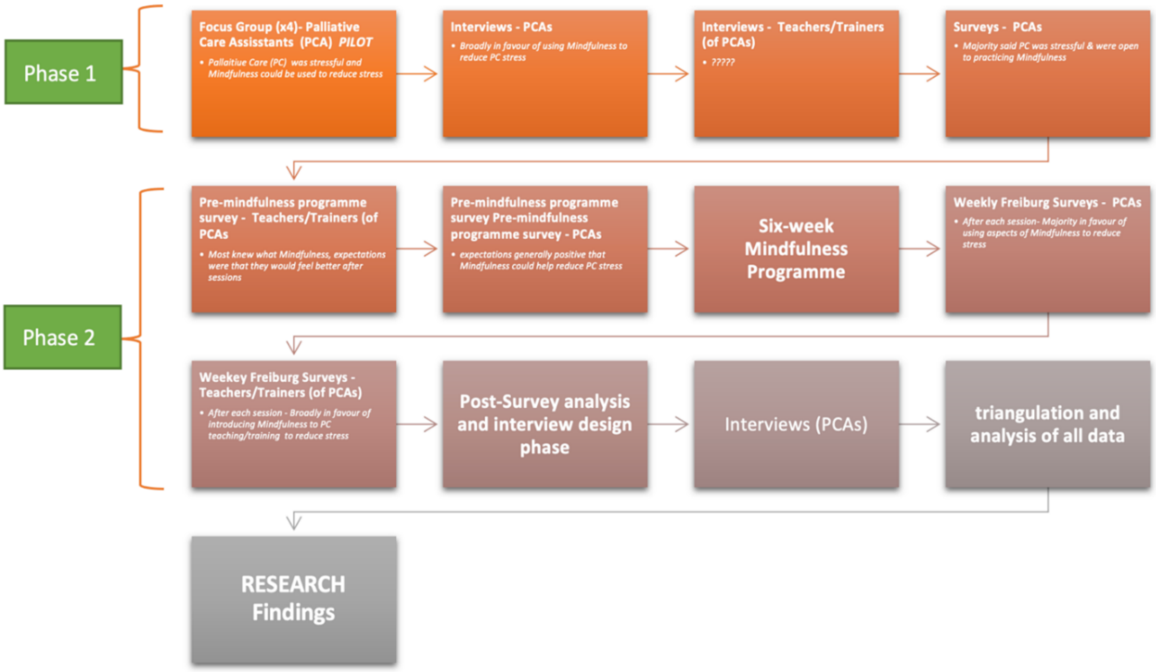

Figure 67

The illustration in **figure 67** outlines the study’s findings in chronological order beginning with the focus groups in phase one, where the author conducted the focus group with four PCAs who all stated that working in palliative care is stressful and that mindfulness could be used to reduce stress. Following up on the focus group, the author interviewed six palliative care teachers and two PCAs who were broadly in favour of using mindfulness to reduce palliative care stress. The author then conducted a survey where fifty-two PCAs took part, and the results reflected the previous methods in that the majority expressed that palliative care is stressful and were open to practicing mindfulness. Survey one concluded phase one of the study.

Phase two of the study began with a pilot pre-mindfulness survey of palliative care teachers and PCAs, where most expressed that they knew what mindfulness was. The majority stated as part of their expectations prior to practicing mindfulness that they would feel better after practicing it. After the pre-mindfulness survey, the participants took part in a six-week mindfulness-based intervention (weekly sessions) where each participant received and completed a survey based on the FMI.[78] The majority of teachers and PCAs continued to express that they were in favour of using mindfulness to reduce stress. Three months after the action research, the author conducted a post-survey with the PCAs and teachers who took part in the study. Like the other sections, the majority were in favour of using mindfulness as a tool to reduce palliative care stress. The author also interviewed four PCAs who took part in all parts of the study. Two were strongly in favour of mindfulness as a tool to reduce palliative care stress, while two were against it.

4.13 Conclusion of Findings

The findings of this study suggest that palliative care is a stressful area to work in. This is consistent throughout each section of phase one. The majority of participants in the focus group, survey one, and the interviews agreed that palliative care is a stressful area to work in. Phase two was also consistent with those findings. The majority of participants (PCAs and palliative care teachers) backed up the findings from phase one.

The data presented, particularly on pages 118-122, showed that the impact of the mindfulness intervention was limited in addressing the question 'could mindfulness be used as a stress-reduction technique'? The majority stated that the intervention had not changed their behaviour three months after the intervention had ended. However, the majority also stated in the post-survey that they would like to see mindfulness introduced to the teaching of the palliative care module as a stress reducer. At the time of the mindfulness interventions, roughly half of the participants spoke favourably about the effectiveness of the intervention while answering the Freiburg based questions which means roughly half were not in favour which is in contrast with the majority who stated they would like to see mindfulness introduced into the teaching of palliative care. The author concludes that the contrast is due

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[78] Week one was conducted using questions that were not modelled on the Freiberg mindfulness survey and therefore in the results section of the PCAs it begins at week two through to week six. This needs to be explained in the methodology chapter.

to the participants' reactions during the intervention being that of willing participants, while three months later, upon reflection, they saw less impact (after practicing mindfulness) on the stress in their lives, suggesting an enjoyable activity that had little long-term impact upon their perceptions of long-term work-related stress.

The teachers who participated in the study primarily came from nursing backgrounds, one of which was a healthcare assistant before going into the teaching profession. The PCAs have given throughout the interviews detailed examples of stressful situations that they deal with daily. In contrast, one deals with the academic aspects of palliative care (teachers), and the other is dealing with palliative care on a hands-on, day-to-day basis (PCAs). First, the data suggested that most of both groups agreed with the first survey that palliative care is a stressful area to work in.

The results from the first survey and the interviews (phase one) show that there are many different causes of palliative care stress for those who work in the area. The data showed causes of the stress, which included:

- Family of palliative care clients
- Time restraints
- Challenging clients
- Lack of support

The above causes of palliative care stress that emerged from survey one and the interviews also highlighted that burnout was a significant issue that emerged from the data when palliative care stress was left unchecked. This was backed up by the data presented in the literature review (Davies, 1994; Phase one showed that palliative care is a stressful area for PCAs to work in—in County Roscommon. The author then used the results from phase one, eight interviews, and the first survey as a platform to test whether mindfulness could be used as a tool to reduce palliative care stress which was highlighted by the participants in phase one.

The research was conducted over four years, between 2016 and 2020. The data suggests that the people who work in palliative care, dealing with stress daily, are self-aware and well informed about the rigours of working in their profession. This was highlighted in the interviews and consistently through the surveys where survey one (2017) and the post-survey

(2020) showed that the palliative care clients' family members were a source of stress. There were similarities between the two surveys from phase one and phase two, the results were similar, and the theme that family members are a source of stress appeared for several participating PCAs. The author attempted to address a complicated emotional state that a person may be in while working in a very challenging area. Stress is complicated but multifaceted, and the causes of that stress are many, as previously highlighted. Using mindfulness as a singular tool to reduce stress was tested by the author, and the findings show that for the majority the mindfulness did not reduce their palliative care stress. This study's significance showed an expert group[79] who was able to express themselves over six weeks. Their contribution to palliative care research should be highlighted for future researchers who can use this dissertation as a guide to explore other methods that can be used to address palliative care stress for PCAs.

In phase two, the author also asked respondents several questions about the outbreak of COVID-19 which is still ongoing as the author writes. The vast majority of PCAs expressed that their profession has been more stressful since the virus outbreak than before the outbreak and lockdown began. As the outbreak is ongoing, the author felt compelled to explore the impact of COVID-19 on palliative care in County Roscommon, and the findings suggest that COVID-19 and its implications are stressful, and the causes are summarised, as follows.

- Staff infected by a virus
- Increase in workload
- The effect it has had on residents and service users

The data in the findings section on COVID-19 were gathered in early to mid-2020. They showed the lived experiences of PCAs who had to deal with being infected by the virus, their increased workload, and their perceptions of the impact the virus has had on the clients they work with (some of whom have died from COVID-19).

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[79] PCAs and palliative care teachers.

Table 19 highlights the domains of contribution the dissertation has contributed to (Farndale, 2004).

Table 18. Domains of contribution of dissertation

Domains of Contribution	What Has Been Supported	What Has Been Developed	What Has Been Found Which is New
Theoretical Knowledge	Palliative care is stressful for PCAs	A greater understanding of the point of view of the PCAs and the sources of their occupational stress	By using a regional case study, the dissertation found sources of stress from PCAs and teachers and that mindfulness could be used as a tool to reduce palliative care stress for a minority but not a majority of those surveyed.
Context	Palliative care is a stressful area to work in for PCAs and teachers	A better understanding of the sources of palliative care Stress and a technique that can help address that stress (mindfulness) was tested	There are multiple sources of stress for PCAs, such as family members of clients and dealing with death
Empirical Evidence	Mindfulness is a useful technique in reducing palliative care Stress	Six-week mindfulness program for PCAs and palliative care teachers	Mindfulness was tested as a stress reducer using a mindfulness intervention that was delivered by an expert over six weeks. Three months afterwards, the majority of PCAs stated that it had little long-term effect on the participants.
Methodological Approaches	A variation of the FMI was used to allow participants to express how they feel while working in palliative care	Condensed variation FMI set of questions (10) used as a tool during a six-week period	A variation of the FMI is an effective tool to learn how PCAs feel after mindfulness sessions
Knowledge of Practice	Through mindfulness six-week program, PCAs in Roscommon expressed how they felt during the intervention	Local care organisation now delivers mindfulness classes for service users and staff.	Families are a source of stress, as expressed by participants

Chapter 5: Discussion

5.1 Introduction

This chapter outlines whether this research's objectives were met and discusses the study's significant findings, particularly palliative care stress, its sources, and whether mindfulness could be used to reduce palliative care stress. The study's focus was the work-related stress of PCAs and exploring the possibility of addressing that stress through a mindfulness intervention. The study was divided into two objectives.

5.2 Objectives of Current Research

1. To identify if stress exists within the occupational field of healthcare assistants (PCAs) who work in palliative care in County Roscommon

Objective one of the dissertation was met, where the vast majority of participants agreed that palliative care is a stressful area to work in. The data gathered in phase one and two backed up the literature that palliative care is a stressful area to work in,[80] which was in line with the literature discussed in Chapter 2.

2. To test if mindfulness could be used to reduce stress for healthcare assistants PCAs who work in palliative care.

Building on the data from survey one and the interviews (phase one), the author then tested whether mindfulness could be used as a tool to reduce palliative care stress. Through the construction of surveys and interviews, the author observed that the participants were in favour of learning more about mindfulness to see if it could be used to reduce work-related stress for PCAs. The author then conducted a pre-survey that also backed up the data from phase one showing a clear willingness to learn more about mindfulness. When the mindfulness sessions began after each intervention, the participants reflected on how they felt by answering the same ten questions each week. The data showed that the majority of participants' palliative care stress levels were not significantly changed based on the mindfulness intervention. The author conducted another survey three months later, and the

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[80] See Section 2.7.

data again showed that the majority of PCAs still relied on more traditional stress-reduction techniques such as exercise and talking to colleagues.

It would be remiss if the author did not explore the enormous impact the COVID-19 crisis has had on palliative care as it was within the dissertation subject matter (stress). The post-survey was conducted at the pandemic height (spring 2020) when palliative care in Roscommon was under unprecedented pressure. Therefore, the author included questions about COVID-19 in the post-survey.

The study suggests that the target group (PCAs and their teachers) have in-depth palliative care knowledge. They demonstrated this through the examples given in the surveys and interviews. The participants' experiences show that the very nature of palliative care stress is complicated: an individual's perception of that stress is unique to them. That uniqueness was highlighted many times throughout the results. The causes of the stress were diverse but with commonalities when participants reflected on their own experiences of working in palliative care. Those commonalities included the repeated description that family members of clients are a cause of palliative care stress.

The interviews in phase one presented practical examples of how the participants dealt with the death of the clients, with the interviews being particularly descriptive in presenting PCAs as having limited supports at that time.[81] Similarly, the ongoing COVID-19 pandemic that struck in the latter half of the study highlighted another source of stress that the participating PCAs have to deal with. The majority of PCAs surveyed stated that the virus has caused more work-related stress. Coping mechanisms varied from person to person, where the phase two post-survey[82] showed that the most popular coping mechanism was talking to fellow PCAs as a technique for dealing with palliative care stress. The exercise was also a popular technique for dealing with the stresses of working in palliative care, and like talking to fellow PCAs, they were both more popular coping mechanisms than practicing mindfulness after the six-week mindfulness intervention. This finding is significant in that although mindfulness was deemed enjoyable by the majority of participants, it did not overtake talking to

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[81] When a client dies.

[82] Survey conducted three months after the mindfulness intervention concluded.

colleagues or exercise. Therefore, its impact did not significantly alter the coping mechanisms of the majority of PCAs.

5.3 Palliative Care Is Stressful

The significance of this finding is that a problem must first be identified to be solved. That palliative care is a stressful area to work in was the most important finding from phase one. Having demonstrated that palliative care is a stressful area to work in for the participants, the author then focused on a solution to addressing that stress. The author asked the participants in phase one if they were willing to partake in a stress-reduction program. The majority of the participants were open to trying ways such as mindfulness to help reduce that stress. The findings and the literature confirm that working in palliative care is stressful and that correlation justifies the author's phase two mindfulness intervention, where the author explores whether mindfulness can reduce palliative care stress.

The interviews in this study showed that PCAs also experience some level of stress in the workplace. Many PCAs had difficulties 'switching off' at the end of a shift and found themselves still thinking about the client. This was in line with the section on rumination in the literature review, where it was highlighted that care staff find it very difficult to 'switch off' and stop thinking about their clients even when they are not at work. Both phase one and two explored several causes of palliative care stress highlighted by an expert group[83] who had over (PCAs in the post-survey) 150 years of practical experience working as PCAs.

5.3.1 Family of the client as a source of palliative care stress

This was an emergent theme that the interviewees throughout the research repeatedly highlighted. A number of the interviewees were quite expressive in stating that dealing with the palliative care clients' families was a primary cause of stress. This theme was consistent throughout every interview with a palliative care tutor. Many of the PCAs surveyed would have worked in palliative care and the client's own home. It starts as palliative, and as the condition worsens, moves on to hospice care; the burden on the palliative care team expands. However, the stress of family members who see their loved one's condition deteriorates and how they deal with this was also highlighted throughout the findings. Family/carer conflict

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[83] The PCAs who participated are considered an expert group as they have among them over 150 years' experience of working in their profession.

can occur not only in in-home care but also in nursing homes. The impact of a family member venting their frustrations on a member of the palliative care team can cause distress which may significantly affect the staff. The literature review supports this claim. It highlighted Elizabeth Kubler-Ross's (1969) five stages of grief (particularly the anger stage), where many of the participants highlighted practical examples of family members venting their frustration on the PCA. It underlines one of the central themes of this study: Palliative care in Roscommon is stressful. Therefore, techniques to eliminate or reduce stress levels are needed to maintain reasonable standards of palliative care. However, due to the nature of palliative care work, PCAs cannot avoid contact with clients' families. Acknowledging that this conflict exists can be the first step in addressing it. The significance of knowing this source of stress can allow the author to explore what the effects of that stress may be and to ask the participants what coping mechanisms they have to deal with that stress. This new knowledge can also be presented to palliative care teachers in the county and further afield and can be used as a teaching example to future PCAs.

5.3.2 The effects of palliative care stress and its sources

Many participants in this study articulated that they struggle to cope with the demands of palliative care. In Roscommon, palliative care tutors recognize that PCAs are under pressure and that stress is a significant difficulty in the area. The majority of survey respondents also emphasized stress as an issue.

During interview seven, the palliative care tutor discussed that the PCA might have unresolved personal grief to deal with. Interviewee two (phase one) discussed the psychological trauma of losing a client that she worked with over an extended period and then trying to reset and provide care immediately for someone else, pushing the PCA nearer to burnout. The significance of acknowledging that palliative care stress is an issue for those who work in the area allowed the author to explore methods to reduce the risk of burnout in those who work in palliative care in County Roscommon.

5.4 Mindfulness as a Tool to Reduce Palliative Care Stress

The literature review highlighted that individuals would vary in their dispositional or trait mindfulness (Baer *et al.*, 2006). In other words, mindfulness will differ from person to person based on the individual mindfulness user. The results of this study showed divergent opinions on the usefulness of mindfulness. However, the variation of Freiburg responses showed apparent trends from the participating PCAs, despite varying pedagogical experience from one year up to twenty-five. The majority of participating PCAs stated they still use mindfulness either occasionally, reasonably often, or almost always, suggesting that the six-week program had some positive effect on most participating PCAs. However, it must also be noted that a significant and consistent minority stated 'rarely' to the questions. This consistent minority has shown that they rarely use mindfulness, suggesting that for those participants, the mindfulness intervention had little impact; therefore, it would be assumed that mindfulness (as presented in the sessions) would not reduce their palliative care levels. In follow-up interviews, two of the participating PCAs said that mindfulness was not helpful for them, as it was too time-consuming. That type of guided meditation conducted once a week was not a realistic option to reduce their palliative care stress in the long term. Therefore, it must be concluded that the mindfulness sessions used in this study would not be a realistic option for PCAs to use as a long-term technique to address palliative care stress. Thus, the findings in the second phase of the study do not show that mindfulness can be used as a stress-reduction tool for PCAs. The literature review also reviewed the weakness of using mindfulness: measuring happiness through mindfulness is too simplistic (Miller, 2008). The findings showed that the causes of palliative care stress have more than one source, such as lack of time and families of clients. Therefore, as Miller points out, mindfulness is not a silver bullet as it cannot treat all sources of stress. The criticisms of mindfulness reflect the instability of its meaning (Harrington and Dunne, 2015). The results also showed various reflections on what mindfulness is. In phase one, where the author sought to understand what the participants knew about mindfulness, one palliative care teacher did not know what it was at the time (she partook in the six-week program afterwards). It is also important to note that some of the participants stated that they rarely used mindfulness after the intervention (phase two), and therefore, did not benefit from the intervention in a significant way.

5.5 COVID-19 and Its Impact on Palliative Care in Roscommon

The findings showed that the virus outbreak increased stress levels for most participating PCAs, which was significant. As we are still dealing with the virus outbreak at a national level, it may take years before we know the full extent of the impact it will have had on PCAs. Only one person in the post-survey (phase two) stated that they were unaffected by the virus. The majority expressed the issues that they had in three broad categories, as follows:

- A virus infected me (COVID-19)
- Increased workload
- The effect it has had on residents /service users

All of the nursing homes where the participants worked were directly affected by the virus, with one nursing home in particular having a very difficult time. Several residents died, and the participating PCAs who worked there contracted the virus and had to cocoon for three weeks. Two of the participating PCAs interviewed (electronically in phase two) after the post-survey spoke about the enormous psychological impact contracting the virus had on them and their family. They both contracted the virus directly from the nursing home where they provided palliative care. Therefore, it can be assumed that COVID-19 was an occupational hazard they had to overcome within their profession. They both stated that COVID-19 was a source of stress while working in palliative care. The respondents backed this up in the post-survey, who brought similar responses when they expressed that the virus's outbreak increased their stress levels while working in their profession. With issues such as contract tracing and more stringent measures to prevent the spread of COVID-19, many participants in the post-survey expressed that their workload had increased, putting more pressure on the PCA to deliver the same standard of care to their clients. Issues, such as staffing with colleagues unable to work due to contracting the virus, increased bureaucracy, and a higher death rate amongst clients, have increased demands on the PCA. In phase one, the data gathered showed that palliative care is a stressful area to work in, and with the addition of the implications of COVID-19, those stress levels have increased, as shown in phase two.

5.6. Contribution to Knowledge

One of the primary findings from this research was an observation of clients' family members as a source of stress for PCAs. The examples given in the findings section were unique to each individual who showed in-depth knowledge of the subject matter and justified the author's choice of purposeful sampling as an effective method for exploring individual experiences of PCAs and their teachers. In the future, the author may consider expanding on the family's findings as a source of palliative care stress in another qualitative study where perspectives of the family members and the PCAs, would be explored. Throughout this dissertation, the author explored professionals' perceptions of delivering palliative care or training for PCAs in County Roscommon. To the author's knowledge, no other research project has sought to explore palliative care professionals' stress levels in County Roscommon. Therefore, the author has asked for and received information that was not previously known: Families of palliative care clients may be a source of stress for PCAs.

5.6.2 Who are the findings relevant to?

The two colleges, GRETB, and RDSG, are permanently based in County Roscommon and offer QQI palliative care support level five courses. They are the primary sources for training healthcare assistants in County Roscommon. The author has taught palliative care for both organizations and intends to share his findings through a presentation with the tutors and module descriptor writers involved in course development. The Galway section of GRETB uses common briefs[84] and marking schemes with the Roscommon tutors within the same organisation, including QQI palliative care support level five. Therefore, the author has the opportunity to directly influence the course development of QQI level five palliative care support across the largest educator of healthcare assistants across two counties. If tutors can find a way to teach palliative care staff to reduce stress symptoms, the author would argue that this is a positive development.

This dissertation has highlighted the dangers of burnout and ruminating thoughts while a PCA works in the area. The findings suggest that the respondents acknowledge that stress is a factor while working in the area and are open to learning techniques to reduce that stress. The author argues that lowering stress levels in PCAs in a very challenging environment would be beneficial not just for the PCAs but also for the recipient of care and those involved with that person. As discussed in the literature review, reducing stress can help prevent burnout in PCAs and maintain good continuity for the palliative care client/patient. The findings of this study are relevant to all palliative care providers in the county as it can be viewed as an advisory to identifying sources of palliative care stress and a potential method for addressing it.[85]

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[84] Common briefs meaning palliative care teachers from both counties use the same assignment briefs.

[85] Since the mindfulness sessions took place, RSG now implement weekly sessions (currently online) with staff and service users, this was set up with the help of the author.

5.7. What is the Meaning of the Research?

The author chose PCAs as the primary participant population as they work in various areas within palliative care. Very little research was conducted on healthcare assistants' (PCAs) stress levels in the West of Ireland who works in palliative care. Therefore, the author identified a gap in knowledge of the chosen research object. The dissertation showed that palliative care is a stressful area to work in, and the causes of that stress are multifaceted.

The majority of PCAs during the six-week intervention reacted positively to the mindfulness sessions. When followed up via survey three months later, the long-term impact of the sessions showed that the majority of PCAs did not feel that the mindfulness sessions addressed their stress levels while working in the area. The author concludes that although the majority of the participants may have enjoyed the mindfulness sessions, the long-term impact on their stress levels was limited, and therefore, in answering whether mindfulness can be used as a tool to reduce palliative care stress, the data in this study shows that for the majority the sessions did not significantly reduce the stress levels of the majority of participants. However, the author argues that the study and intervention were a worthwhile endeavour in that an expert group in the West of Ireland were able to test whether mindfulness could be an effective tool in addressing palliative care stress. Using a case study methodology, the author could target a group of people with years of experience working in a challenging area who could reflect on how they feel before, during, and after the mindfulness intervention. The examples given throughout the study showed that the participants have in-depth knowledge of their careers, and therefore, their contribution to knowledge in the field of palliative care education for PCAs should be acknowledged and respected.

5.7.1 Significance of the study

As a palliative care educator, the author can inform potential PCAs about the possible conflict/difficulties that may occur as the client's family comes to terms with the potential loss of a loved one. PCAs, by their nature, are people-friendly: if they realise that clients' families are also having a difficult time, this could contribute to greater empathy. This study contributes to the understanding of the perceptions of PCAs and adds to the discourse of palliative education in the field by showing the causes of the stressors that affect their work. The mindfulness sessions' participants could provide a unique perspective on stress management in palliative care through the examples given by them. The participants contributed to new knowledge through a specific lens that is distinct from other professions. From their perspective, they could open up a world of experiences that has not been explored in any great detail. The richness of the participants' data was significant in that they described how they felt while delivering care to people whose lives were coming to an end and were able to express how they felt over a six-week period while taking part in the mindfulness intervention. This unique case study analysed a professional group in a county with an older than average population and demonstrates an understanding of a group of people who may not have been studied before.

6.0 Recommendations

6.1 Include PCAs in the Teaching Process

The author recommends that palliative care teachers introduce lectures /talks of experienced PCAs during the palliative care support QQI level five module. The data from the findings show that PCAs are well informed and experienced about their profession. This practical engagement between those on the coalface of palliative care and learners can help inform future PCAs about the stresses and experiences of working in a demanding area. Direct engagement between the palliative care learners and experienced PCAs may help bridge the gap in perceptions highlighted in the findings between the palliative care teachers and the PCAs. Asking PCAs about their sources of stress while working in palliative care can be informative to future PCAs and may help them cope with those stressors. For example, experienced PCAs can inform learners of the difficulties of working with palliative care clients' families. The author recommends that future PCAs would be better positioned to deal with palliative care clients' families if they are informed that this can be a source of stress while working in the area, as highlighted in the results section. In this study, experienced PCAs have shown that they are a rich source for identifying stress sources within their profession. Using experienced PCAs in the teaching/learning process can help future PCAs understand the nuances of working in this demanding area.

The majority of participants would like to see mindfulness introduced through the palliative care module. However, the post-survey also showed that mindfulness had little impact on the participants three months after the intervention. The data in this study showed that the majority of participants did not change their lifestyle significantly after the intervention and, for the most part, relied on traditional stress-reduction techniques, such as talking to colleagues and doing exercise. Therefore, the author recommends that mindfulness should not be introduced into QQI level five palliative care support. Roughly half of the teachers in the variation of the Freiburg responses expressed enthusiasm for using mindfulness as a stress reducer. This left approximately half less enthusiastic. Along with the data from the PCAs, the data is not conclusive enough to recommend that mindfulness could be used as an effective tool in reducing palliative car stress. Therefore, based on the data in this study, mindfulness should not be introduced to QQI level five palliative care support.

6.2 A Variation of the Freiburg Mindfulness Inventory Is a Useful Tool in Measuring PCAs' Perceptions

The author used a variation of the FMI, and therefore, used an untested/new technique to measure the participants' responses. The author recommends that the FMI variation used by the author should be developed further by implementing a follow-up to the current study and delivered using the same method with another group of PCAs to help understand the efficacy of the measurement tool.

The author recommends that the hybrid/variation of the FMI (used in this study) would be a useful tool to measure the feelings of PCAs while they practise mindfulness. Based on these conclusions, mindfulness researchers should consider using a variation of the FMI as it allows the researcher to ask the same questions over a prolonged period. Using a set of questions based on the FMI can help the researcher address the implications of using a stress-reduction method for people who work in palliative care. Based on the mindfulness intervention survey findings, it is recommended that a variation of the FMI be used in future research. The author found that using a variation of the FMI was a practical and valuable tool to explore mindfulness practitioners' perceptions. The findings presented from the FMI-based questions were direct and, as stated by the interviewees, were easy to use and reflect questions that are worded in a manner that is self-reflective in tone. What that means is the wording of the questions is based around how a person feels, and as each question was asked every week to a person after they had practiced mindfulness, the questions were relevant and consistent, giving the author data that was vital to the thesis question.

7.0 Conclusion

PCAs endeavour to ensure that all palliative care clients can receive dignified and respectful care in the latter stages of life. This dissertation explored two aspects of working in palliative care: whether the area is stressful and, if so, is there a technique that can be used to reduce that stress. The author did this by asking PCAs and their teachers about their experiences working in palliative care in a region in the West of Ireland. By using an inductive approach, the author gathered data through two phases, the first phase focused on stress in PCAs and the second focused on a mindfulness intervention to address the stress highlighted by the participants in phase one. The data in phase one showed that the participants expressed many examples of the difficulties of working in palliative care. The responses showed that palliative care is a unique profession where PCAs have to deal with acute emotions of people who are coming to terms with the mortality of themselves (the client) or family members in a highly stressful environment. The dissertation presents palliative care stress as a highly complex aspect of the delivery of palliative care with multiple causes that each PCA may have to deal with on a daily basis. By identifying the various sources of stress that affect PCAs, this study highlights difficulties that new and existing PCAs may have and, therefore, can inform palliative care students of possible sources of stress before they enter the profession. Armed with this new knowledge, the palliative care student can at least understand the difficulties the palliative care client and their families are going through and will have prior knowledge of the demands of palliative care stress before they enter the environment.

The literature review discussed empathy as a skill needed to work in palliative care. The findings (particularly the interviews) showed the point of view of the PCA in working with the clients and demonstrated how the PCAs think about the client during work and afterwards. The participants showed how they try to put themselves in the shoes of their clients and their families, suggesting that they are empathetic when providing palliative care. Based on the findings and the literature, empathy is a skill needed to work in palliative care, and if we as palliative care educators can inform future PCAs of the importance of understanding the point of view of the client, then a stronger relationship can be fostered that is beneficial to the client as well as the PCA.

The author tested if mindfulness could be used to help reduce the palliative care stress highlighted by the participants in phase one. The findings showed that the group of PCAs and their teachers who took part in the study presented diverse opinions on the efficacy of mindfulness. The majority of PCAs stating at the end of phase two that the mindfulness intervention did not significantly reduce their stress levels. This significant finding shows that mindfulness is not a perfect fit to reduce all aspects of palliative care stress. However, the majority also stated they would like to see it introduced in the palliative care module which suggests that although mindfulness may not have significantly reduced their work-related stress, the majority saw some benefit to using mindfulness and as a tool in teaching future PCAs. These findings will be presented in an online meeting, where all palliative care teachers who work for Galway Roscommon Education and Training Board and also Roscommon Disability Support Group will be invited and will be presented by the author. Therefore, the findings will be discussed and may in time influence policy in the training of PCAs in the two Counties.

PCAs provide an important service for people who may be in the last year of life, they ensure the dignity and wellbeing of their clients and do so interacting with the client's family at a very turbulent time. However, although this dissertation highlights many difficulties that PCAs have to work through it also shows how PCAs use personal skills such as empathy to provide adequate support for the people involved. The PCAs spoke of how they build relationships with their clients and the clients families and that speaking to other PCAs about aspects of their profession is therapeutic particularly during the final stages of palliative care. The author concludes that by informing local care organisations that PCAs can support each other by encouraging PCAs to speak to each other about the rigours of their profession is mutually beneficial. As presented in the phase one interviews PCAs understand their own profession from a unique perspective that can be only fully understood by others who also work in the area. Therefore, the author concludes that a form of networking amongst PCAs within each organisation be set up as a support, based on the findings of this dissertation. The author intends to make this recommendation to the participating care organisations after the conclusion of the study. Following on, a network support based on the findings merit exploring and can be of benefit to PCAs in County Roscommon and further afield.

Palliative care is a part of life most of us will face at some time, it may not be something people consider when their loved ones are healthy, however death is unavoidable. This dissertation explores how those who work in palliative care see their profession, it looks at the more difficult aspects of working in the area and explored a technique that could be used as a support for PCAs. The participants showed that they address palliative care stress in different ways from using exercise, listening to music, phase two of this study took place in early 2020 just as the pandemic was beginning, the participants gave the author information about how they dealt with the pandemic, with the vast majority stating that it increased their stress levels. The participants expressed their feelings when the pandemic was new and vaccinations had not yet begun, expressing the difficulties of working with clients who had died from the virus. Examples such as the PCAs speaking about having contracted the virus in the nursing home that they worked in and its impact on their family showed that palliative care stress is fluid and new challenges can emerge at any time. The data shown by the PCAs during the early stages of the pandemic can used as examples of the difficulties they were confronted with while still attempting to maintain the highest standards of palliative care.

The dissertation also highlighted the positive aspects of working in palliative care (see tables 12 and 13 in 4.10) noting the great satisfaction and honour the PCAs had in working with people who are in the last year or so of their life. The PCAs expressed through the data how rewarding it is to be in such a unique profession and the pride they take in providing care to vulnerable people. This dissertation did not just focus on negative aspects of palliative such as stress but also received insights into the experiences of the PCAs who see their profession as a vocation that has benefits such as been able to take pride in their job due to the relationships that they have built over the years. In the recommendation section, the author explained the benefits of listening to PCAs, the study shows that by asking experienced PCAs to express why they work in the area, it too can inform future PCAs of the benefits of working in palliative care. By using the findings of this dissertation the author intends to present the data to other palliative care teachers and recommend that they use experienced PCAs to explain the personal benefits of working in the area to palliative care learners as highlighted in the data. The experiences expressed by the PCAs in this study can directly benefit palliative care learners by informing them of the challenges faced by the PCAs and the methods they have used to overcome those difficulties while working in the area. Thus making this study a worthwhile endeavour that can help advise future PCAs about the profession that they will enter in to.

The purpose of this study was to investigate if palliative care was a stressful profession for PCAs and to see if mindfulness could be used to reduce that stress. The first objective was clearly proved and the second to a lesser extent suggested for some PCAs (though not the majority) that it could. Future researchers who have an interest in this topic, may use this research as an example into the field of health care assistants in the West of Ireland. The literature stated that mindfulness is a difficult term to define and that the specific method used in this study showed that for the majority it did not have significant impact on their lives. However, this can inform future researchers of the same topic to try other methods using mindfulness. One of the limitations of this research is that the participant population was small and based in a specific County in the West of Ireland. A similar study in a larger populated area such as Dublin may or may not have the same findings, but a future researcher could use this research as a template for an attempt to better understand palliative care stress in PCAs and explore a method to address that stress.

By using the current research as an example of how mindfulness impacted on a group first over six weeks and then three months after, future researchers in this area have an additional study that they can compare their own research to. The future areas of research that that can branch off from this study are many, with three possibilities based on the main findings being interesting topics that deserve further study. The first is the area of stress in the profession of PCAs which could include identifying the biggest sources as highlighted in this study.

One area of which the author found surprising and influential was that families are a major source of stress for the PCAs. This finding opened up the possibility for this author to explore in greater detail, with interesting angles of greater exploration such as the point of view of the family member which was not explored in this study. By using the current study as a starting point, the author could compare the points of view of the family member and the PCA through interviews (a significant time after the client had passed in order to meet ethical guidelines), which could complement the inductive process that took place in the current study. By attempting to understand both points of view may be informative for those who both teach palliative care and also for those who work in its provision.

The author began teaching PCAs in 2009 and has done so consistently since, this study has enabled the author to significantly improve his research skills which he now feels honour bound to contribute to the larger research field of PCAs. The PCAs in this study along with the palliative care teachers expressed their personal feelings surrounding deeply emotional subjects such as the deaths of clients and loved ones. PCAs work in a demanding area of care, working with people who may have to come to terms with their own mortality. The PCA must address the physical, emotional, social, and psychological needs of a person who is terminally ill. It is the duty of the author to present the findings as professionally as possible and also to develop their ideas and contribution into the future. This bottom up approach has brought the author on a journey that has contributed to the knowledge of palliative care in further education and a follow up study based on the major findings can build on this dissertation.

As stated in the discussion the current study has already had a long term effect on teaching with Roscommon Disability Support Group (RSG). After the conclusion of the six- week mindfulness sessions, the RSG requested that the author along with the mindfulness expert (Dr Ray Sawyer) set up weekly sessions for their carers (including PCAs). It is now run by another mindfulness expert and has been expanded to include sessions for their service users. The mindfulness session continues at time of writing (December 2021) despite the initial intervention concluding in early 2020.

The training of PCAs is fluid and changes over time, the purpose of training PCAs is to ensure that their clients receive the best standard of palliative care possible. By understanding the perspectives and attitudes of PCAs, we as palliative care educators can broaden our understanding of PCAs in the workplace. This study focused on the point of view of PCAs, and explored how they feel about their profession, the clients they work with and other stakeholders in order to contribute to the wider research of palliative care in Ireland.

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Appendices

Appendix A—Consent form—Interviewing with Audiotaping

My name is Mikey Monaghan. As part of my professional doctorate in education, I am interviewing people who have or are currently working in palliative care. The interview topic is stress while working in palliative care and ways to deal with that stress.

With your permission, I will audiotape the conversation. If you agree to be audiotaped but feel uncomfortable at any stage during the interview, I can turn off the recorder at your request. Or, if you want to end the interview, you can stop it at any time.

Confidentiality

All data used in the interview will be used upholding confidentially. The information will be used for my coursework/assessment only and not in any other way.

Rights

You are free to decline to answer any questions or to stop taking part at any time

Consent

You will be given a copy of this consent form to keep for your own records.
If you wish to participate in this study, please sign and date below.

Name (Please Print): ________________________________

Signature: ________________________________

Date: ____________________________________

Appendix B—Questions for Survey One

1. How Long have you Worked in palliative care?
2. Have you completed the QQI/FETAC level five palliative care support module/course?
3. In your experience, what aspect of palliative care causes the greatest stress?
4. Extreme stress can cause burnout. Have you ever experienced burnout due to your work in palliative care?
5. Are you familiar with the term mindfulness?
6. In your own words, could you explain what mindfulness means to you (1 sentence)?
7. If you use Mindfulness as part of your palliative care work, do you also apply it to other aspects of your life?
8. How would you like to see mindfulness taught?
9. How do you manage your stress after working a shift (or a series of shifts) in palliative care?
10. How would you rate your stress levels while working in palliative care (On a scale of one being not at all and five being very stressful)?
11. Please describe how work stress affected you, your life, and your work.

Appendix C—Informed Consent Form

Dublin City University Consent Form

Research Title

Work-Related Stress of Healthcare Assistants who work in Palliative care.

Investigator- Mikey Monaghan
Supervisor -Dr Justin Rami

The desired outcome of this study is to explore work-related stress of healthcare assistants while dealing with the stresses of working in palliative care.

I have read the plain language statement or had it read to me. Yes/No

I understand the information provided. Yes/No

I have had a chance to understand the research. Yes/No

I have had a chance to ask questions about the study. Yes/No

I have received satisfactory answers to my questions. Yes/No

I am aware that I have been recorded. Yes/No

I am aware that I can withdraw from this study at any point. Yes/No

I understand that total anonymity is not guaranteed. Yes/No

All data used in the research will be considered confidential and will not be used for any other purpose other than this research.

I have read and understood all the information in this form. The researcher has answered my questions; I have retained a copy of this consent form. I consent to participate in this study.

Signature_________________________

Block Capitals__________________________

Date__________________

Appendix D—Ethical Approval

Dublin City University
RESEARCH ETHICS COMMITTEE

NOTIFICATION FORM FOR
LOW-RISK PROJECTS

Application No. *(office use only)* DCUREC/2016/____

Section A: Applicant Details

PROJECT TITLE:	Should Mindfulness be introduced in QQI Level 5 Palliative care Module
APPLICANT NAME:	Mikey Monaghan
SCHOOL/UNIT:	Education
APPLICANT EMAIL:	mikey.monaghan9@dcu.ie
If a student applicant, please provide the following additional information:	
Programme of Study:	PDPE1
Supervisor Name:	Dr Justin Rami
Supervisor Email:	Justin.rami@dcu.ie

Section B: Questions

1. Notification Review is reserved for low-risk social studies that fall under the following classifications. Please indicate your project type below:

Please mark as appropriate:	
I	Anonymous Survey (the topic will not elicit significant difficulties for participants)
	Observation (without audio or visual recording) of a public setting
I	Questioning participants regarding their opinions on products or services
	Questioning students about standard educational practices
	The study will monitor the impact of participants' daily activities
I	Questioning public figures/professionals in their professional capacity regarding their professional activities

I	Analysis of existing anonymized data which has been provided to the researcher by a third party
	Collection of biological samples which are anonymized and do not require invasive techniques (e.g., hair, nails).
	Other ***Please explain:*** Questionnaires' Focus groups with Palliative care Tutors Interviews with graduates of Palliative care programmes and programme designers.

2**. Please justify why your study is low-risk?**

The respondents will be asked to reflect on their coping mechanisms while working in Palliative care. That is, each respondent will be a professional working within the Palliative care area, and it is their professional experiences that the researcher will explore.

The research undertaken will include health care assistants, teachers and policy managers that are all over the age of 18. Although the central topic is the use of Mindfulness in Palliative care, the researcher will not be including Palliative care patients or their families as participants in any capacity.

The participant's anonymity and privacy will be respected at all times.

3. Please describe how your participants will be recruited?

The researcher will write to each potential participant who is participating in the research, seeing if they will agree to be interviewed.

The participants who are participating via the survey will be recruited by email from the researcher outlining their rights as part of the research.

If they agree to take part, they will be presented with a consent form (paper for the interviewees) and electronic for those participating through a survey. The consent forms (see appendix) will outline all the relevant ethical considerations and related oversight mechanisms before, during, and after the interviews/surveys.

Surveys- The researcher will send surveys online to a population of Health Care Assistants who graduated in palliative care QQI Level 5 (5 N3769) in Health Service Skills with Galway Roscommon Education and Training Board through emails. The surveys used will be constructed using Survey Monkey.

4. Informing your participants—Plain Language Statement

Plain Language Statement

Title of Project
Should Mindfulness be introduced into QQI Level 5 palliative care?

Introduction
My name is Mikey Monaghan. I am a teacher with Galway Roscommon Education and Training Board. I teach QQI level 5 Palliative care. As part of my Professional Doctorate in Education, I am undertaking a piece of research based on the possibility of using Mindfulness as part of Palliative care training.

Background
Mindfulness is a stress-reduction technique; it is used across many professions; for this research, the author intends to explore whether Mindfulness should be used by healthcare assistants while learning Palliative care. As a teacher of the QQI level 5 healthcare, I have found that healthcare assistants are willing to explore the possibility of including Mindfulness techniques as part of the learning experience within Palliative care.

Why is this research being conducted?
The reason the author has chosen the above research is that he teaches Palliative care support, and he intends to continue to explore the possibility of introducing Mindfulness into Palliative care as he previously did in his pilot. The author found that there is a lack of research around taught Palliative care programmes for Healthcare Assistants in Ireland and wishes to contribute to this body of knowledge.

What will happen if this person participates in this study?
I will contact each participant before the interview taking place and explain to them any queries that they may have. By using the consent form, I will explain what each section means to the participant. When I believe, the participant is aware of their rights; I will then present consent to the participant (before the interview starting). At the end of each interview, the participant will be given with another consent form; this is done to ensure that the participant is willing to allow his/her shared information to be part of the overall study.

What are the Risks of taking part in the research?
Each participant is entitled to withdraw participation from the research at any time, which reduces the risk to the participant.

How will privacy be protected?

The identity of the participants will always be protected, and no person will be informed about their participation in the study. Data that could lead to the identification of a participant will not be used in presentations or be published. All data relating to the study will be locked away in a metal filing cabinet that is locked in a room where the researcher only will have access to it. The data held will be destroyed one year after the completion of the research.

Objectives

Explore the consequences of introducing Mindfulness into the Palliative care Program.

Identify existing attitudes towards Mindfulness from Healthcare Assistants and Healthcare educators' point of view.

Determine whether Palliative care tutors are willing to introduce Mindfulness to their taught programmes.

To look at the benefits and limitations of using Mindfulness-based cognitive therapy approaches within the Palliative care program specifically for Health Care Assistants.

To explore Mindfulness-Based Approaches in the context of Palliative care Work

Structure of Research

The author will interview Palliative care tutors to explore their perspective/opinions as relevant to the topic question. The interviews will be approximately 1-hour long. Each participant will be emailed or posted consent forms before the interview outlining their rights before, during and after the interview (please see appendix).

Aims

This study aims to explore whether Mindfulness should be introduced into Quality Qualifications Ireland (QQI) level five Palliative care Module for Healthcare Assistants. The objectives are
To explore existing attitudes towards Mindfulness from Healthcare Assistants and Healthcare educators point of view.
Determine whether Palliative care tutors are willing to introduce Mindfulness to their taught programmes.
To look at the benefits and limitations of using Mindfulness-based therapies within the Palliative care programme.
To explore Mindfulness-based approaches in the context of Palliative care work.

onfirm whether the following issues have been addressed in your plain language statement for participants:

	YES **or** **NO**
Introductory Statement (PI and researcher names, school, the title of the research)	**Yes**
What is this research about?	**Yes**
Why is this research being conducted?	**Yes**
What will happen if the person decides to participate in the research study?	**Yes**
How will their privacy be protected?	**Yes**
How will the data be used and subsequently disposed of?	**Yes**
What are the legal limitations to data confidentiality?	**No**
What are the benefits of taking part in the research study (if any)?	**Yes**
What are the risks of taking part in the research study?	**Yes**
Confirmation that participants can change their mind at any stage and withdraw from the study	**Yes**
How will participants find out what happens with the project?	**No**
Contact details for further information (including REC contact details)	**Yes**

Appendix E—Survey Results

Q4 Extreme stress can lead to burnout. Have you ever experienced burnout due to your work in the palliative care sector?[86]

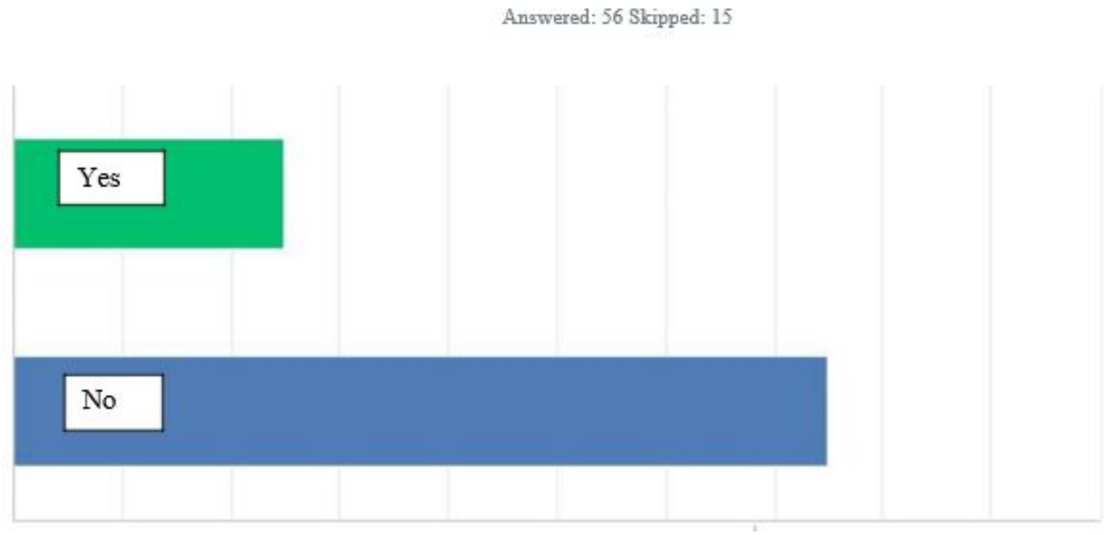

Figure 68. Question four of the survey

A quarter of the total respondents (*N*=14) stated that they have suffered from burnout while working in palliative care; 75% (*N*=42) said that they have not suffered from burnout while working in the sector. As burnout can have a hugely negative impact on a care worker (as highlighted in the literature review), the author found it surprising that so many participants in the study stated that they have suffered from burnout.

As discussed under question two, the majority of the participants (just under 80%) had worked in the area for less than five years. The author cannot distinguish which group those who have suffered from burnout come from regarding experience. In any case, the above statistics suggest that burnout is a real occurrence within the target population that can have a significant impact on the client/healthcare assistant relationship. As this is a small-scale regional case study, a study with a more substantial population may be needed to build on these findings.

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[86] The above question was removed from findings as the wording could be construed as leading.

6.7 Pre-Survey Teachers Week 1

Question 1

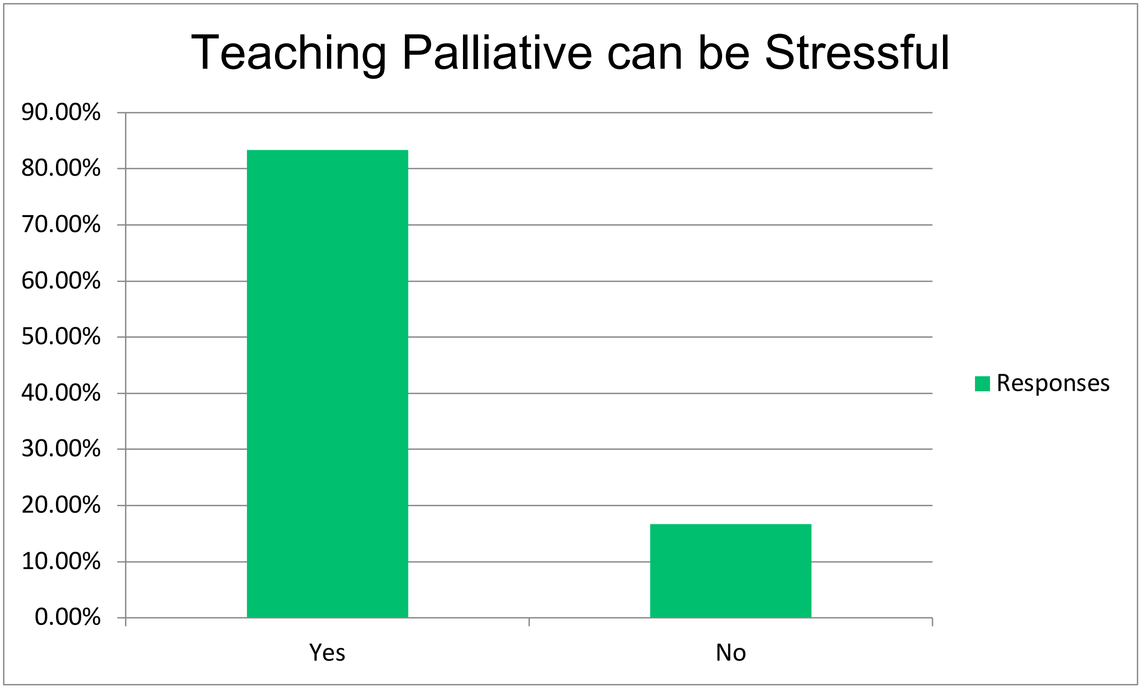

Figure 69. Non-Freiburg Responses Teachers Question 1

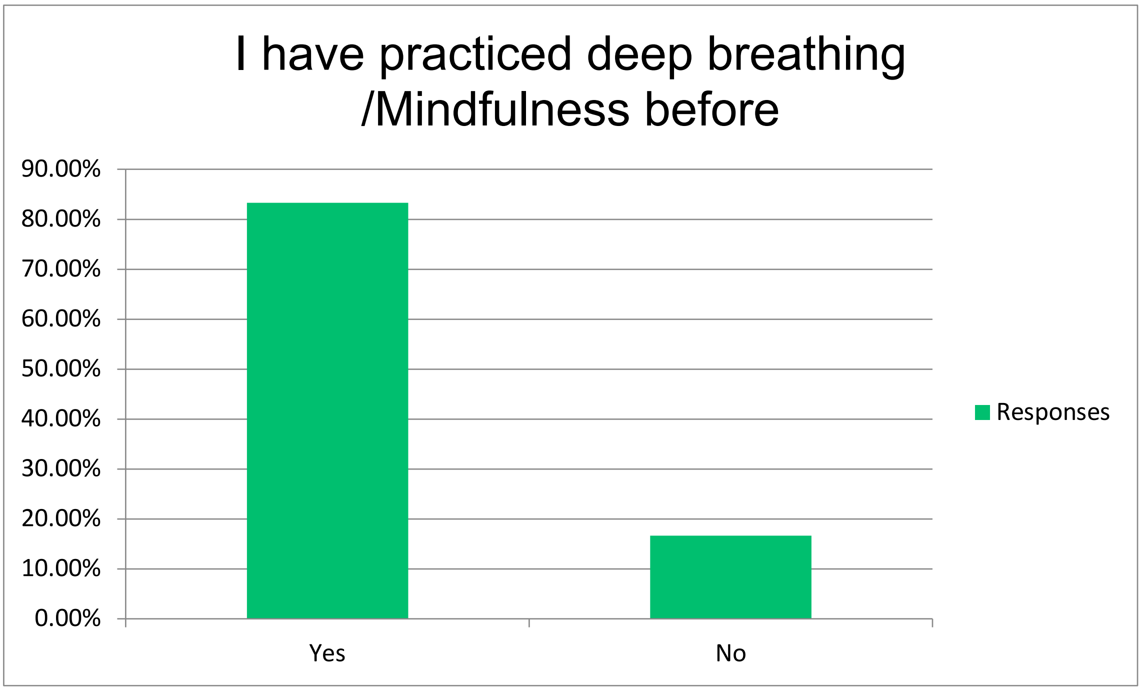

Figure 70. I have practiced deep breathing/Mindfulness before

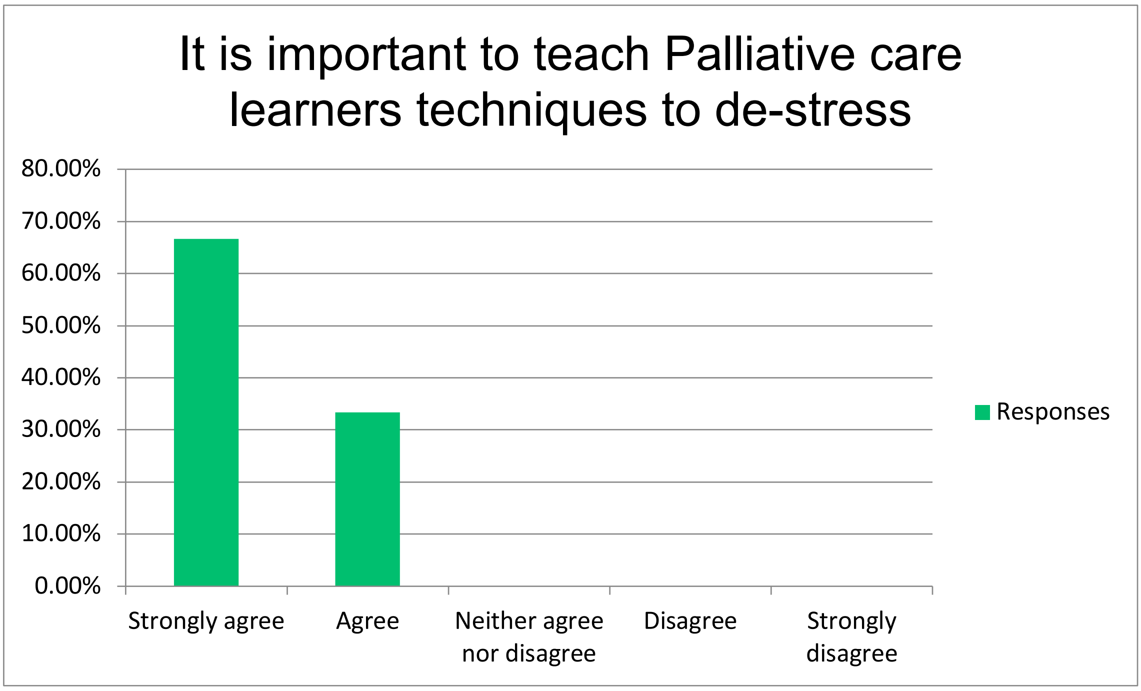

Figure 71. It is important to teach palliative care learners techniques to de-stress

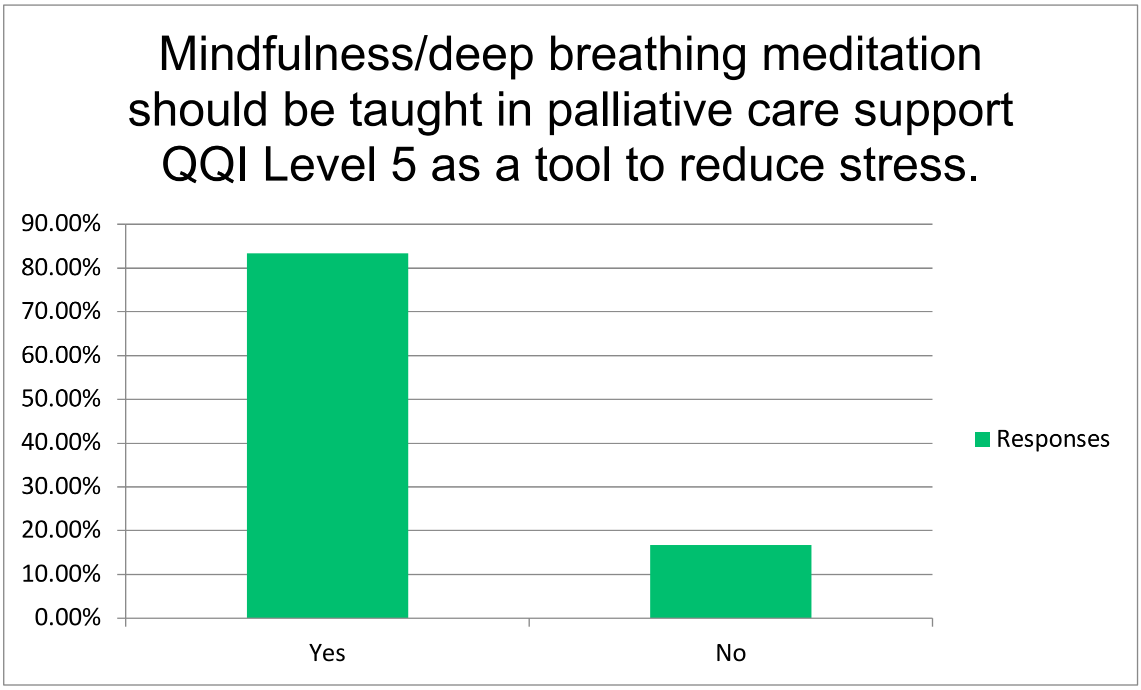

Figure 72. Mindfulness/deep breathing should be taught in palliative care support QQI level five

6.8 Week 2 Teachers (Non-Freiburg Responses)

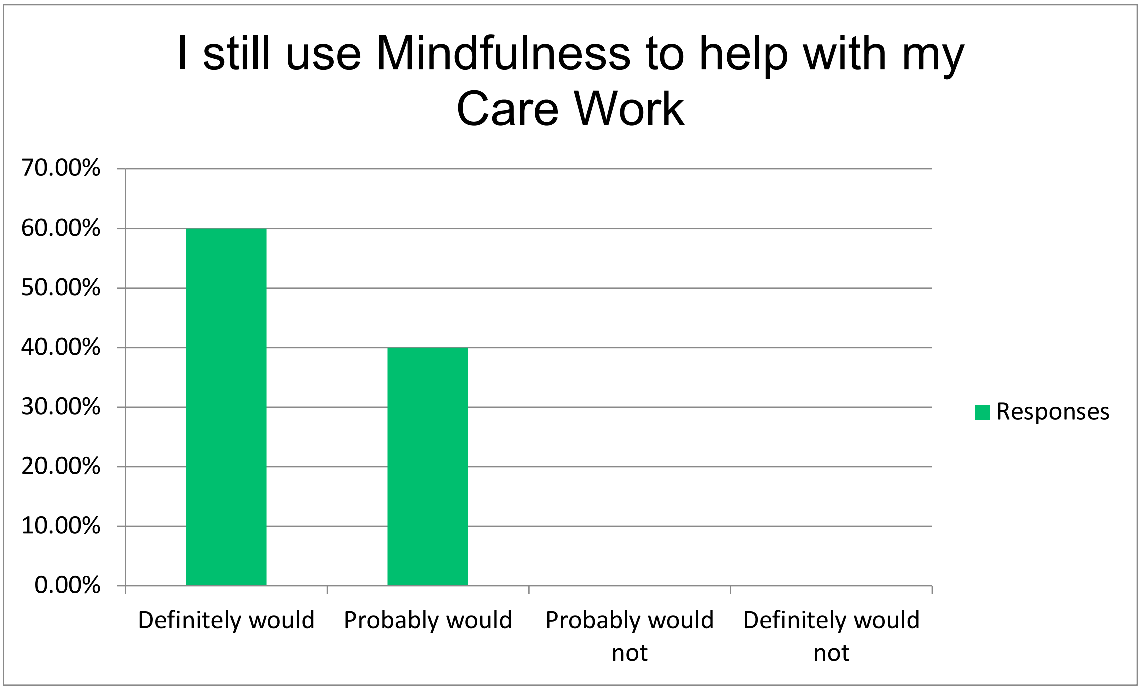

Figure 73. I still use mindfulness to help with my care work

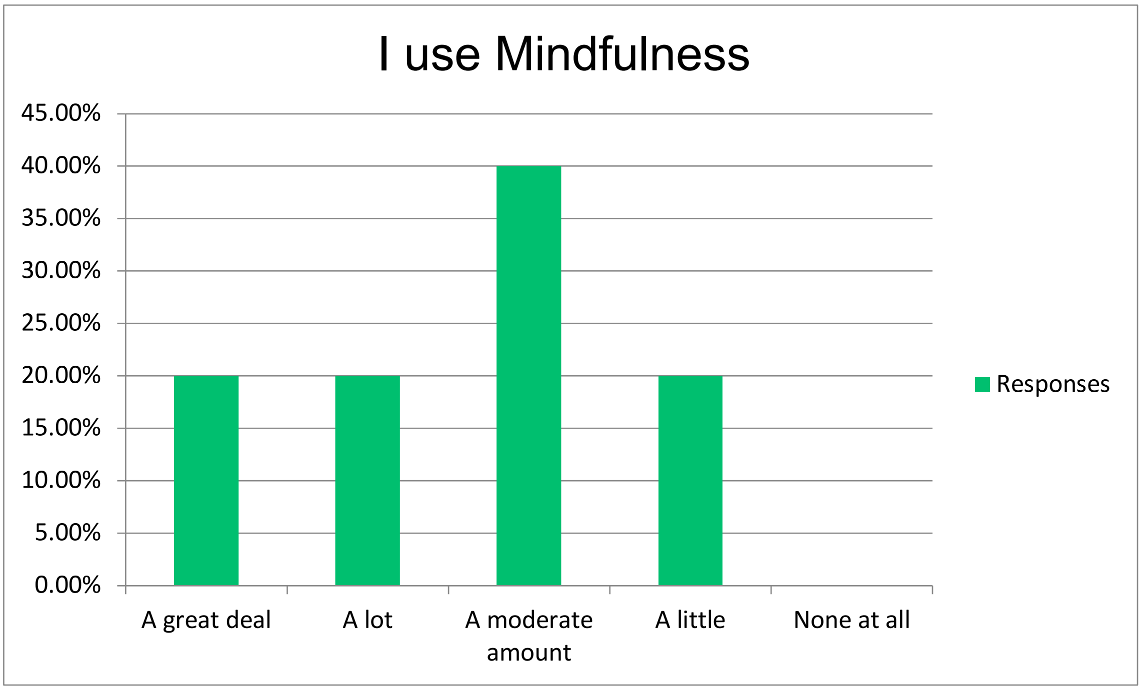

Figure 74. I use mindfulness

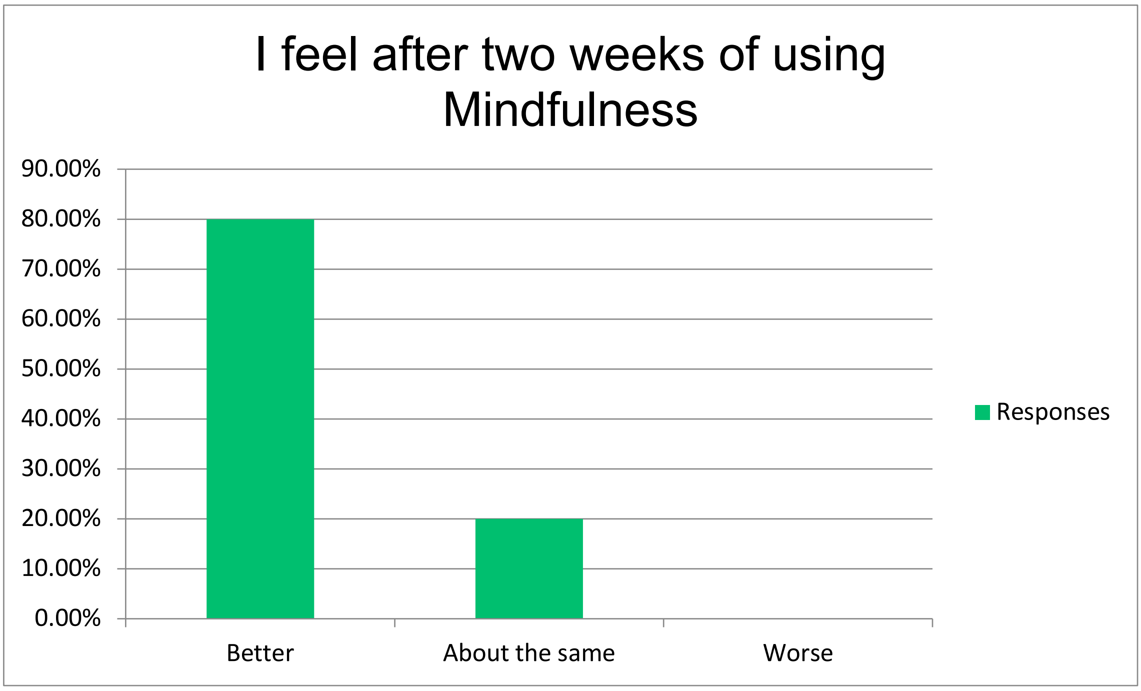

Figure 75. I feel after 2 weeks of using mindfulness

Figure 76. I am more aware after practicing mindfulness for 2 weeks

Figure 77. I am confident I will continue to use mindfulness

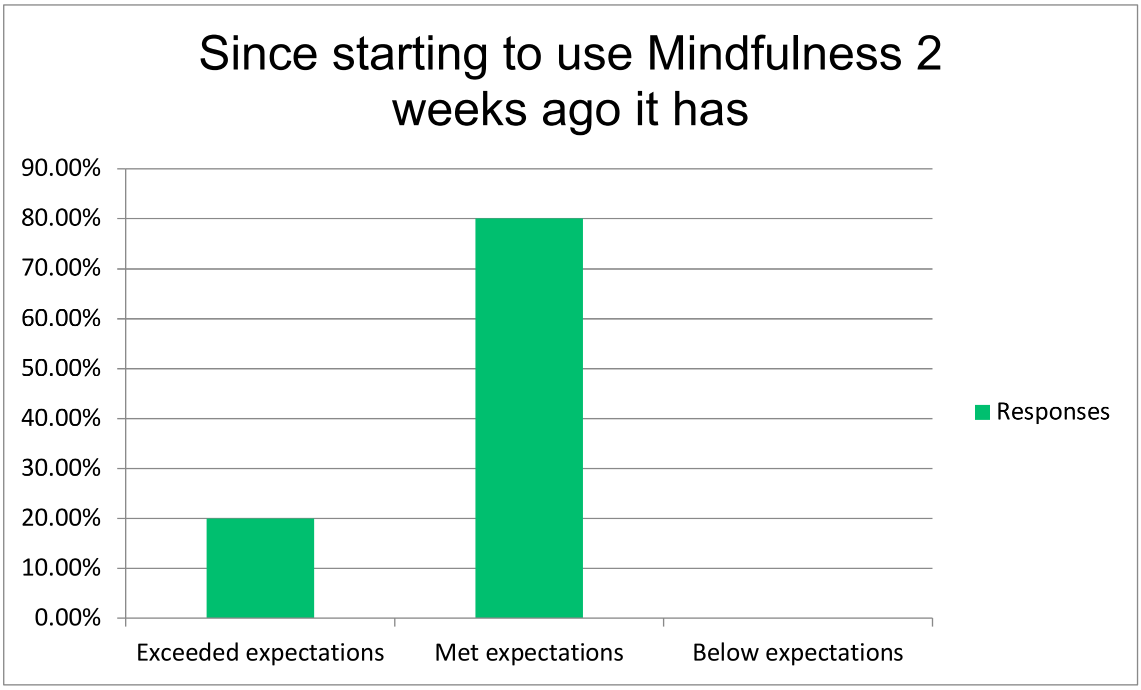

Figure 78 Since starting to use mindfulness 2 weeks ago

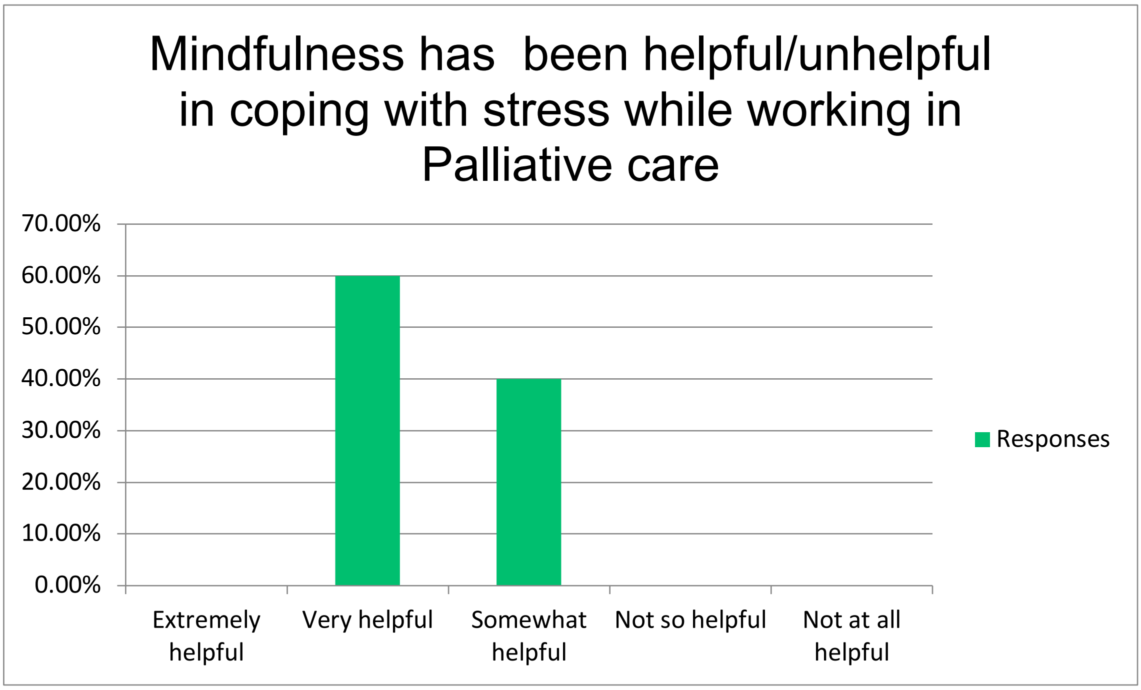

Figure 79. Mindfulness has been helpful/unhelpful in coping with stress while working in palliative care

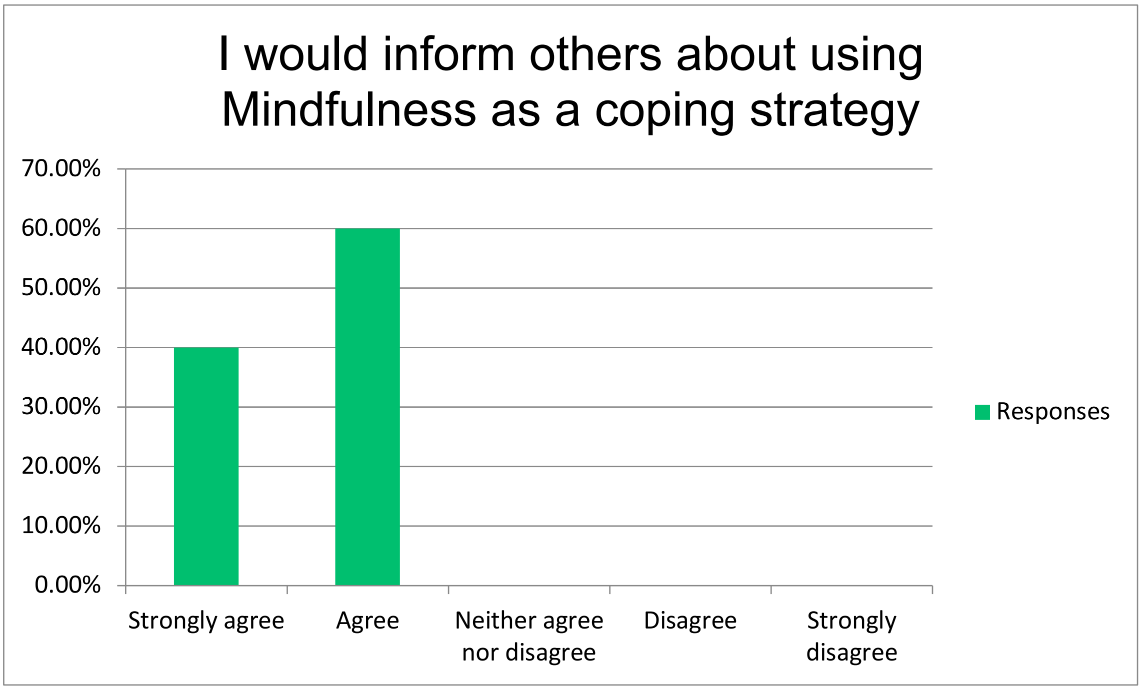

Figure 80. I would inform others about using mindfulness as a coping strategy

6.9 Non-Freiburg Results PCAs

Question 1

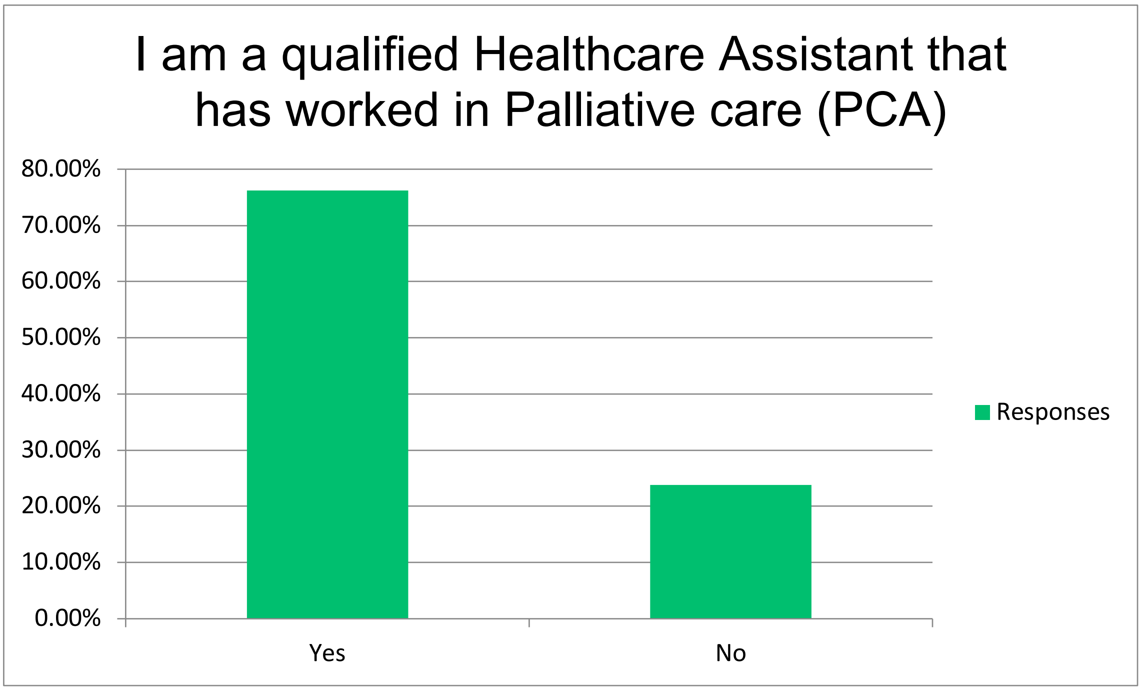

Figure 81. I am a qualified PCA

Twenty-one answered sixteen qualified HCAs, three of which were completed QQI level five healthcare, and two were nursing students who were working as healthcare assistants in a nursing home in North Roscommon. All twenty-one were working as healthcare assistants at the time of the pre-survey.

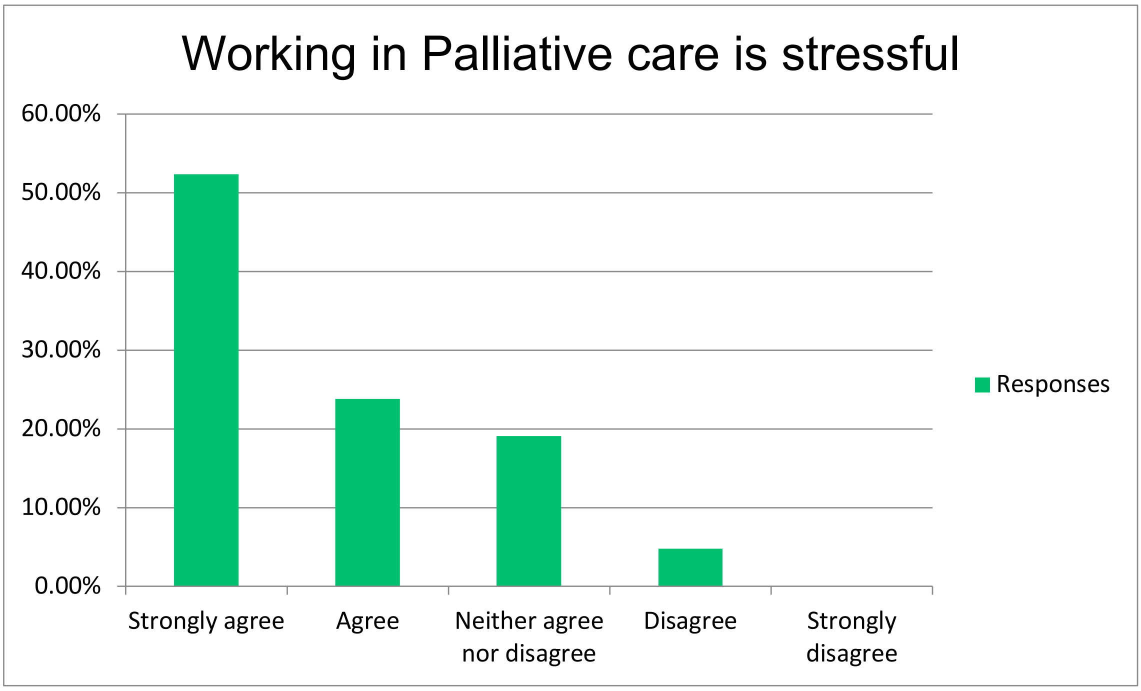

Figure 82. Working in palliative care is stressful

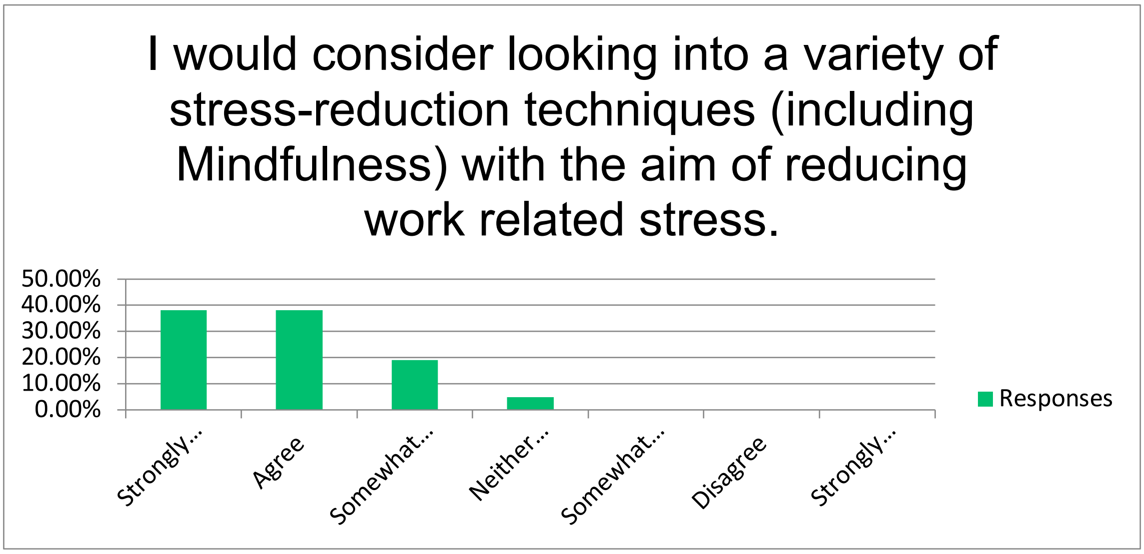

Figure 83. I would consider looking into a variety of stress-reduction techniques

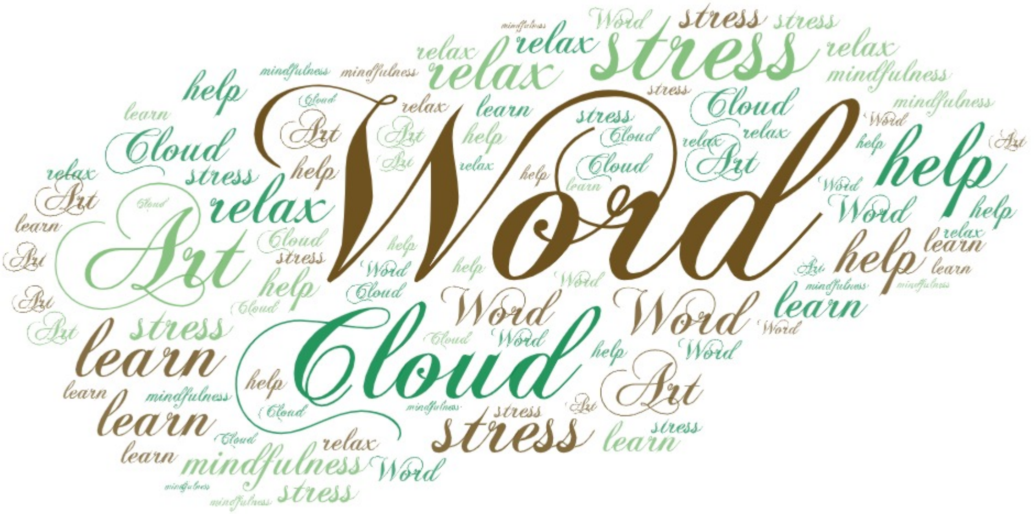

Figure 84. What are your expectations from these Mindfulness sessions?

Figure 85. How do you think you will feel after four weeks of applying Mindfulness to yourself?

6.10 Week One Survey

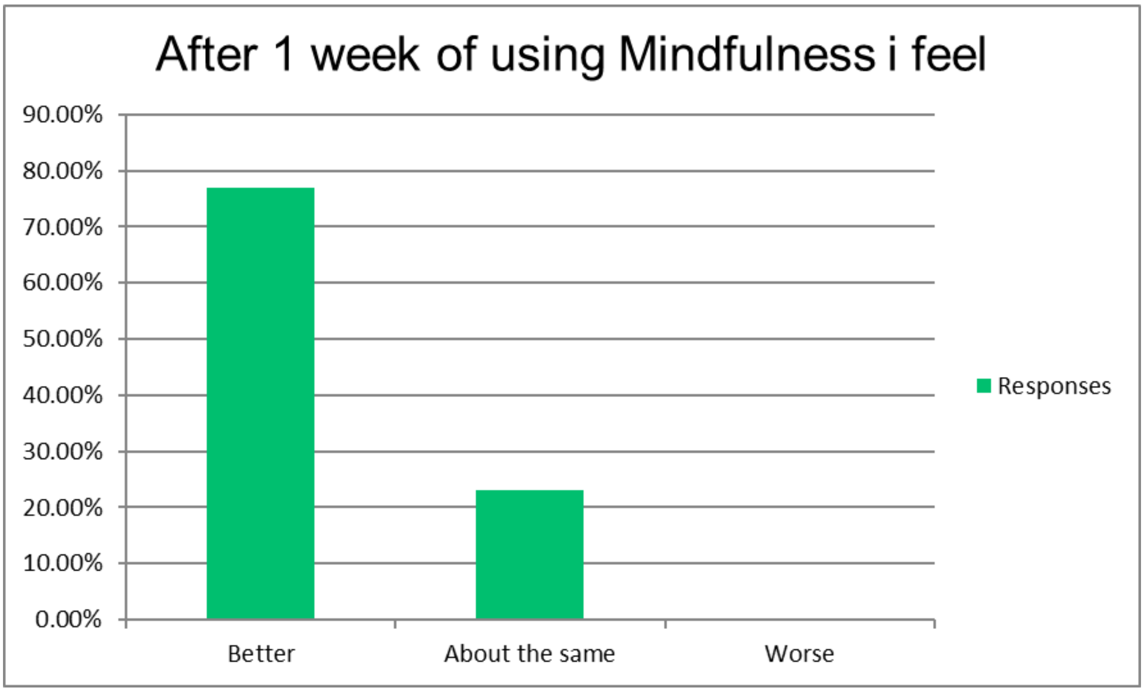

Figure 86 After 1 week of using mindfulness I feel

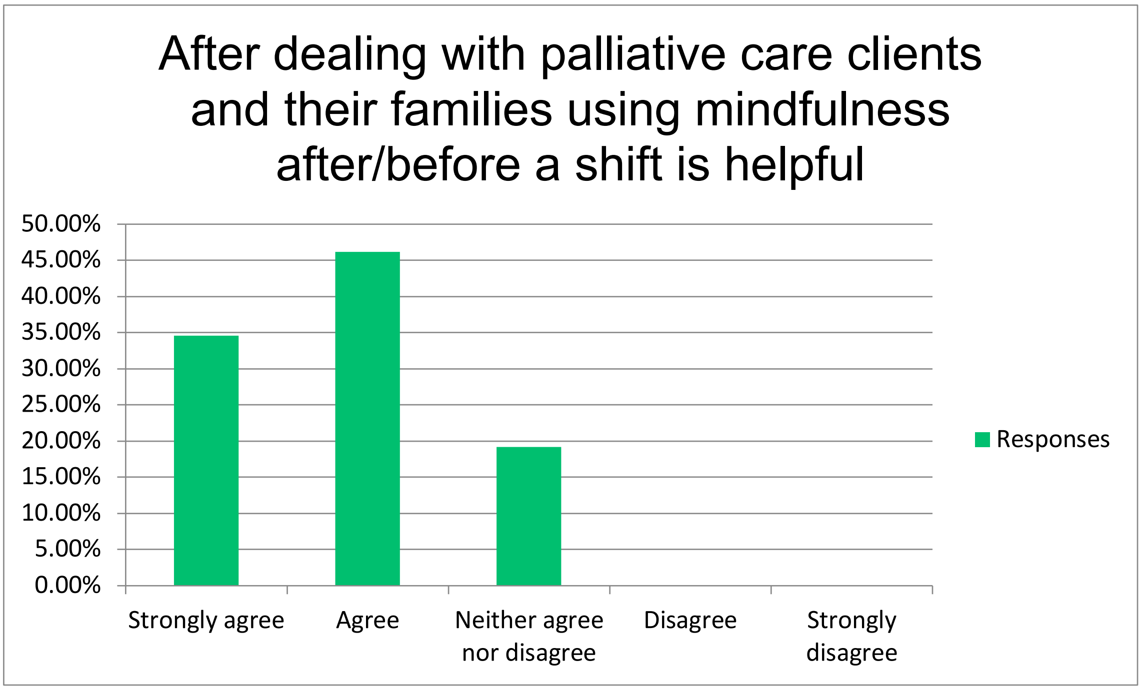

Figure 87. After dealing with Palliative care clients and their families, using mindfulness after/before a shift is helpful

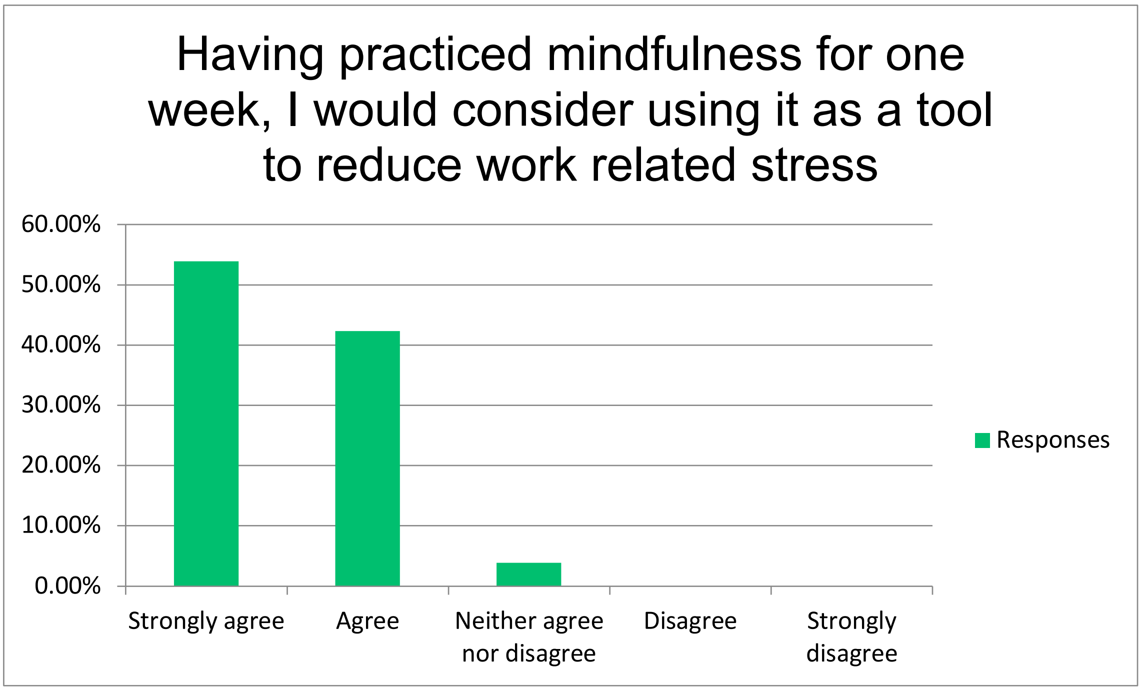

Figure 88. Having practiced mindfulness for 1 week, I would consider using it as a tool to reduce work-related stress

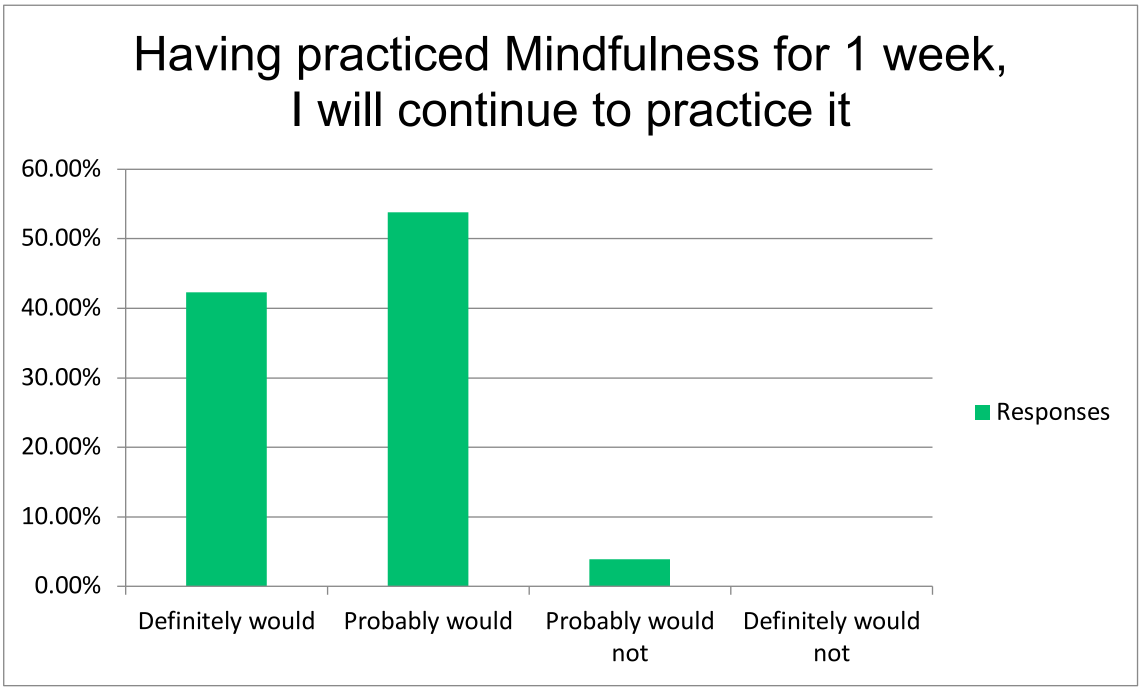

Figure 89. Having practiced mindfulness for 1 week, I will continue to practice it

Figure 90. Having practiced mindfulness for one week, it has met my expectations

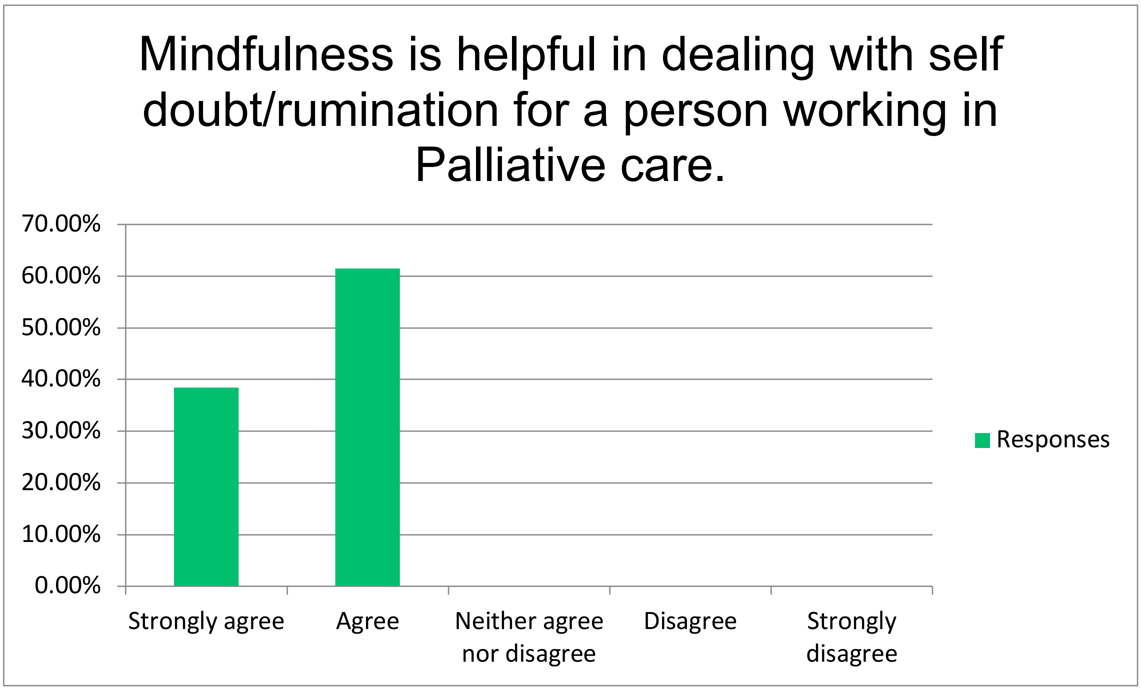

Figure 91. Mindfulness is helpful in dealing with self-doubt/rumination for a person working in palliative care

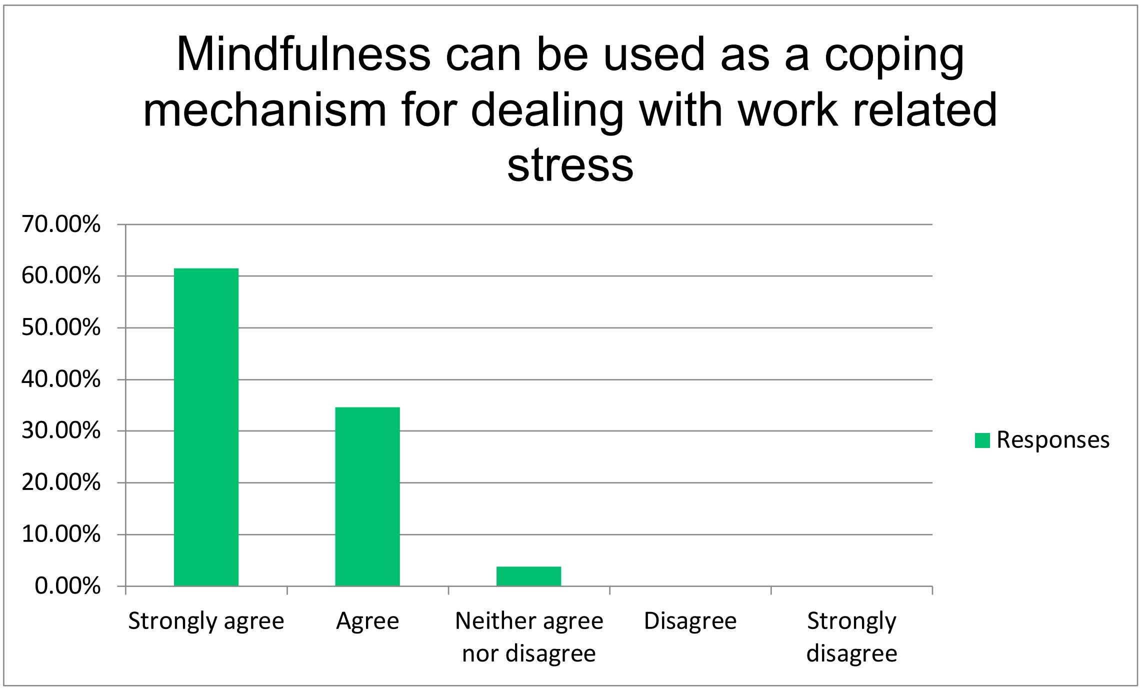

Figure 92. Mindfulness can be used as a coping mechanism for dealing with work-related stress

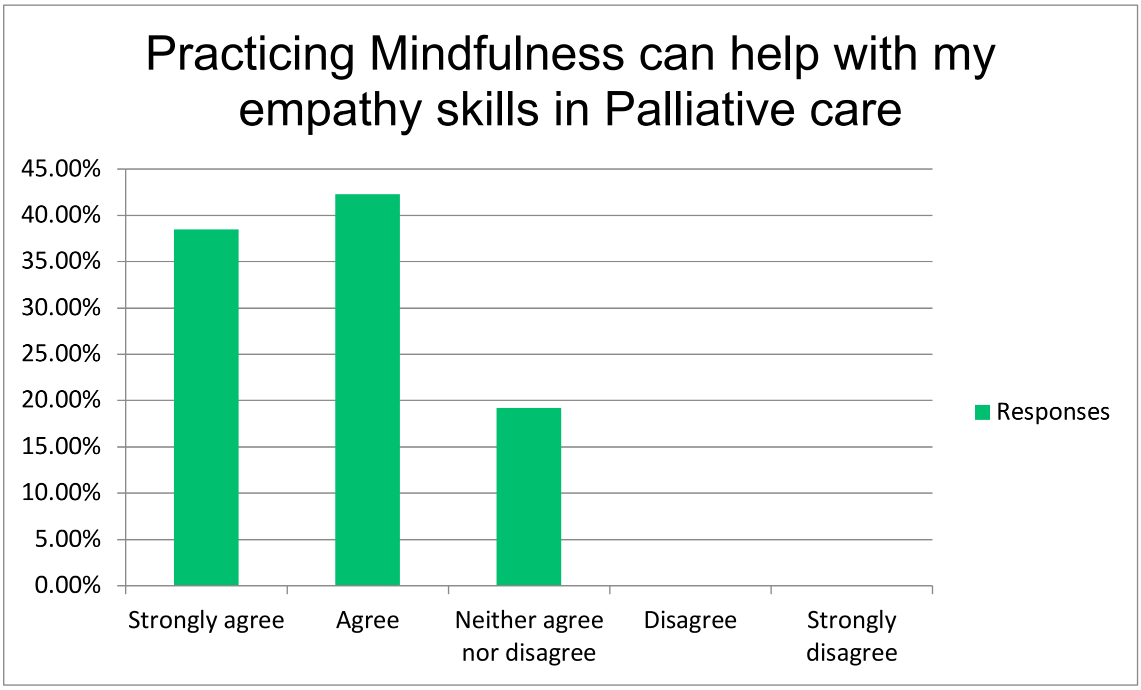

Figure 93 Practicing mindfulness can help with my empathy skills in palliative care

Figure 93. What mindfulness means to me (word cloud)

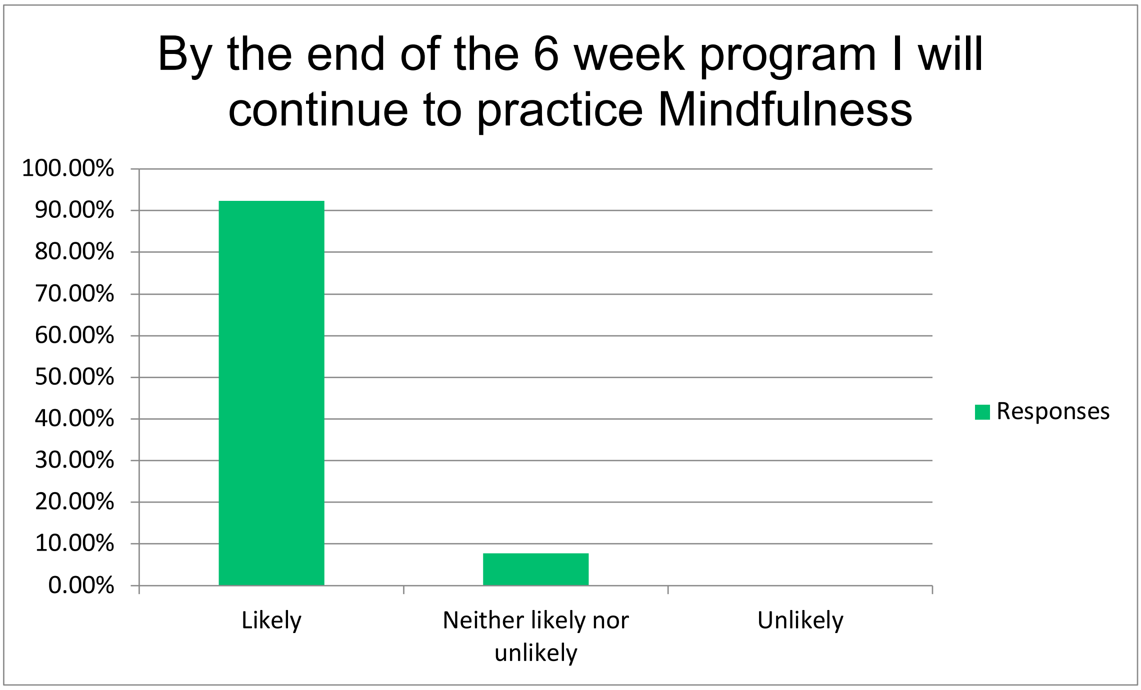

Figure 94. By the end of the six-week program, I will continue to practice mindfulness

6.11 Post-survey Results from Fifteen Respondents Explaining Their Backgrounds

Question 7

15 gave their names and are coded as follows- E1, C 1, C 2, O, N, B, A, I, H, E2, M1, C3, A M, T, and M2

Question 8

Age of each respondent

29,61, 35, 39,49, 43, 42,50,43, 58,60,40,36,46,57, the average age of the participants was 45.86 years old.

Question 9

Gender
All fifteen Female

Question 10

Years Working in palliative care

19,4,5,10,20,11,16,5,3,27,16,25,1,4,15 = 181 years' palliative care experience between fifteen participants. The average amount of years that the participants have worked in palliative care is 12.06 years, and the median is 11, with a range of 1-26 years.