Perceptions of Hospital-Based Clinical Staff on the Role of Speech and Language Therapists in Palliative Care.

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Abstract

**Background:** Speech and language therapists (SLTs) are becoming increasingly involved in palliative care through the management of communication and swallowing difficulties. The role of SLTs in this area remains unclear. This research originated in response to a concern raised by SLTs regarding the withdrawal of referrals to SLTs for palliative care patients in an acute setting. Therefore, it is worth exploring how this role is perceived in order to ensure that appropriate service decisions for patients are made.

**Aims:** To explore the perceptions of SLTs and hospital-based clinical staff (doctors, nurses, medical social workers and dieticians; the main referrers), regarding the role of SLTs in palliative care and to present an integrated overview of these perceptions.

**Methods:** An exploratory qualitative research design was used. Access to staff was achieved via an SLT internal to the hospital who acted as gatekeeper. 7 SLTs participated in a focus group and 8 hospital-based clinical staff participated in semi-structured interviews. Data obtained were transcribed, anonymised and analysed using thematic analysis and organised according to thematic networks.

**Results:** Three global themes were identified: SLT Role in Palliative Care; Referral Matters; and Palliative Care Considerations. Findings reflect the complex nature of palliative care. Conflicting perceptions from participants as to what SLTs can offer, SLTs’ lack of confidence, and SLTs’ role in communication often being overlooked emerged as key issues.

**Conclusions:** A lack of certainty regarding the role of SLTs in palliative care prevents referrals to this service. Education of both SLTs and hospital-based clinical staff in the principles of this role are needed at an undergraduate level to increase confidence in this area. Intra-professional guidelines and clear referral pathways are warranted to improve service provision for patients.

**Keywords:** Palliative Care, Speech and Language Therapy, Role, Perceptions, Hospital-Based Clinical Staff.
1.0 Introduction

Palliative care aims to improve the quality of life of patients and families encountering life-threatening illness by focusing on the prevention and treatment of emotional, social, and spiritual suffering, as well as physical pain (World Health Organisation; WHO, 2002).

As medical care advances and the average lifespan increases, people are experiencing a gradual deterioration in health due to terminal illness more frequently than unexpected death from acute illness (Toner and Shadden, 2012). With this dramatically ageing population palliative care is becoming an increasingly important public health issue. It is estimated that by 2050, more than 25% of the European population will be aged 65 and older (OECD, 2009). It is crucial that palliative care services are developed in order to meet the multitude of needs of those facing life-threatening illnesses.

The role of the speech and language therapists (SLTs) in palliative care has only recently (and briefly) been recognised in official documents such as the National Institute for Clinical Excellence guidelines (NICE, 2004). Given the recency of SLT involvement in this area, it is worth investigating their role further.

1.1 Current Issues in Palliative Care

Traditionally, palliative care was associated with malignant conditions, typically cancer (National Council for Palliative Care, 2010), but since the 1980s, policy has promoted extension to all population groups (Department of Heath, 2008). Patients with non-malignant conditions (such as cardiovascular disease, dementia, motor neuron disease and Parkinson's disease) may have less access to palliative care services (Mitchell et al, 2010) than those with a diagnosis of cancer, as the course of palliative care is not as clear-cut and predictable and involves palliative rehabilitation throughout the entire disease progression.

Palliative rehabilitation can be defined as the process whereby patients are helped to reach their fullest physical, social, and psychological potential until they die (Santiago-
Palma & Payne, 2001). A misconception is that rehabilitation in palliative care attempts to restore the patient to their previous level of functioning when in reality it consists of compensatory strategies to reduce the impact of difficulties. Roe and Leslie (2010) state that this may be a barrier in palliative care as patients, families and medical staff may see rehabilitation as inappropriate or unrealistic. It is in this area of palliative rehabilitation that SLTs have a role.

1.2 The Role of SLTs in Palliative Care

The Royal College of Speech and Language Therapists (RCSLT; 2014) states that SLTs implement life-changing treatment for individuals presenting with speech, language, communication, and swallowing difficulties. The SLT’s role in the management of swallowing difficulties (dysphagia) was officially stated in the Irish Association of Speech and Language Therapists’ policy statement in 2007 (IASLT, 2007). In non-palliative settings, the benefits of SLT intervention for speech and language difficulties and dysphagia have been well documented (Brady et al, 2012; Enderby & Emerson, 1996; Law et al, 2010) and SLTs tend to be perceived to resolve or “fix” disorders.

On the other hand, the role of SLTs in palliative care is a relatively new contribution and as such, remains unclear. The need to provide adequate palliative care services in Ireland has been accepted since 2001, when the Report of the National Advisory Committee on Palliative Care (NACPC, 2001) was published but there was no mention of SLTs in this report. Since then, the Health Service Executive (HSE) developed a Palliative Care Competence Framework (Ryan et al, 2014) that lists the competences recommended for each health discipline and which did mention SLTs. However, the competences listed for SLT, occupational therapy and physiotherapy are identical and vague which may contribute to the lack of clarity on the SLT’s role.

1.3 Importance of the Role of SLTs in Palliative Care

Palliative care focuses on goal setting with active involvement of the patient. For this to occur good communication skills are crucial. Speech, language and communication encompass aspects of the personality and identity of a person. With the progressive loss of communication there is a corresponding loss of self-image, purpose, self-
esteem, as well as a loss of control of the environment (Oliver et al, 2014).

Despite the lack of official guidelines, Pollens (2004) has published recommendations on the four roles of SLTs in palliative care:

1) Provide consultation with the patient and the family regarding choices in terms of communication and dysphagia, for example, in the ethical decision-making process around tube feeding (Langmore et al, 2009).
2) Develop communication strategies to support the patient in their decision-making and to maintain their social interaction.
3) Optimize function with regards to dysphagia symptoms in order improve the patient's comfort and eating enjoyment.
4) Collaborate with team members to receive and provide information regarding the overall care of the patient.

Evidence (albeit in the form of case studies) has been conducted that backs up these recommendations and reports the positive patient experiences of palliative rehabilitation throughout disease progression (van Dam van Isselt et al, 2013).

1.4 Gaps in the Literature

A qualitative study by Waldron et al (2011) was conducted in the UK that explored the views of physiotherapists, occupational therapists, and SLTs on their role in palliative care. It was found that that timing and response rates to referrals impeded service delivery and that there was a lack of communication between professionals. While a useful contribution to the literature in this area, this study didn't investigate the perceptions of the hospital-based clinical staff (HCS) such as doctors and nurses who are the primary referral sources. One Irish study did shed some light on this question by exploring Irish nurses' perception of the role of physiotherapists in palliative rehabilitation (Nelson et al, 2012). Nurses stated that they tended to hold off or withdraw referrals to physical therapy due to a belief that the therapists may lack palliative care skills and give patients false hope, a lack of familiarity with what physical therapy entails, and an inadequate referral system. While specific to physiotherapy, it could be hypothesized that similar perceptions might exist about the role of the SLT in
palliative care, especially given the fact that communication impairments are more difficult to detect than physical impairments (Salt and Robertson, 1998).

It is clear from examples above (Nelson et al, 2012; Waldon et al, 2011) that the HSE's (2008) guidelines for joint team working in palliative care have yet to be met. Publications such as the role of the SLT outlined by Pollens (2004) and the NICE guidelines (NICE, 2004) have been very important in getting the role of SLTs in palliative care “on the map”. However, they give no recommendations as to how to organise this care in terms of referral pathways and it has yet to be determined whether these guidelines have been implemented in concrete practices. Given the relatively established conceptual base for SLTs in palliative rehabilitation, and the publications mentioned above, questions must be raised as to whether SLTs are involved in providing these services. If not, why, as Krival (2013) anecdotally reported, are SLTs not routinely involved in palliative care? The level of referral is dependent upon the knowledge and perception of HCS (Waldron et al, 2011) and a gap in the literature exists as to the perception of HCS on the role of the SLT.

1.5 Aims of the Current Study

This research project, based in Ireland, originated in response to a concern raised by SLTs in an acute hospital setting that referrals to SLTs are occasionally withdrawn when patients are imminently dying. Despite some acknowledgement that barriers may exist to impede SLT involvement in palliative care, there has been very little research conducted to explore this area further. To bridge this gap and contribute to literature on the subject, the current study aims to:

1) Develop an understanding of the perceptions of SLTs regarding their role in palliative care.
2) Develop an understanding of the perceptions of HCS (the primary referrers to SLT) regarding the role of SLTs in palliative care.
3) Explore the similarities and differences in the perceptions of both groups in order to present an integrated overview of understandings regarding the role of the SLT in palliative care with a view to facilitating service development.
2.0 Methods

2.1 Research Design

In order to achieve an integrated overview of the perceptions of the role of the SLT in palliative care, an exploratory approach using qualitative methodologies was used. A focus group was run with SLTs and semi-structured one-on-one interviews were carried out with HCS. The focus group questions (see Appendix A) and interview questions (see Appendix B) were developed based on the literature reviewed and the referral concern that spurred this study.

2.2 Participants

Convenience sampling was used to recruit participants. An SLT internal to the hospital acted as gatekeeper and disseminated information sheets (see Appendix C) to potential participants via email. Table 1 shows the inclusionary and exclusionary criteria for participants.

Table 1: Inclusion and exclusion criteria for participants

<table>
<thead>
<tr>
<th></th>
<th>Group 1: SLTs</th>
<th>Group 2: HCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusion Criteria</td>
<td>Hospital SLT staff who provide communication and dysphagia services throughout the hospital and to palliative care patients.</td>
<td>Hospital staff responsible for the management of patients receiving palliative care and who refer patients receiving palliative care for SLT management.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Staff who do not provide SLT services in the hospital in which the research took place.</td>
<td>Hospital staff that are not responsible for the management of patients receiving palliative care or of referrals to SLT services.</td>
</tr>
</tbody>
</table>

In the event that the target sample size of 7/8 participants for each group was exceeded, a protocol was in place whereby participants would be selected on a first-come, first-served basis. The size of the target samples reflects the number of participants typically required to support qualitative methodologies and the maximum
number suitable for focus groups in Group 1’s case (Silverman, 2013). 7 SLTs and 8 HCS volunteered to take part. Prior to the focus group and interviews written consent (see Appendix D) was obtained.

2.3 Data Collection

Data collection was carried out in the acute Irish hospital where the concern regarding withdrawal of referrals was raised. A focus group was chosen as the vehicle for gathering data from the SLTs in order to attain their range of opinions and collective view. All 3 researchers were present for the focus group with one acting as interviewer, one as scribe, and one as timekeeper. The HCS were interviewed separately, to ensure that the views of all four disciplines were expressed in order to gain data representative of the hospital. The semi-structured interviews were conducted one-to-one and the 3 researchers acted as interviewers on a rotating basis. Separate interviews for HCS adhered to ethical practice, taking into account the sensitive nature of the subject as the potentially differing opinions between disciplines may have led to discomfort sharing views in a focus group.

The focus group lasted 45 minutes and the semi-structured interviews lasted an average of 10 minutes, both were audio recorded using Dictaphones. The same question format was used throughout so there was limited variance in the main stimulus questions. After each interview data were downloaded, transcribed and anonymised.

2.4 Data Analysis

Data from the focus groups and semi-structured interviews were combined at the analysis stage to achieve an integrated overview, and in order to compare and contrast the differences that emerged thoroughly. Data were analysed using Attride-Stirling’s (2001) thematic analysis guidelines and organised according to thematic networks. Coding occurred in 6 phases (see Table 2), with an initial noding phase to immerse the researches in the data (see Appendix E for an example of the coding process).
Table 2: Data analysis phases

<table>
<thead>
<tr>
<th>Phase 1: Noding Phase</th>
<th>Transcripts assigned keywords and phrases.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 2: Codes identified</td>
<td>Data reduced by dissecting transcripts into meaningful texts segments with the use of a coding framework.</td>
</tr>
<tr>
<td>Phase 3: Codes Categorised into Themes</td>
<td>Salient, common, significant themes extracted from the coded segments.</td>
</tr>
<tr>
<td>Phase 4: Thematic networks constructed</td>
<td>(1) basic themes selected; (2) Basic themes rearranged into organising themes; (3) global themes deduced.</td>
</tr>
<tr>
<td>Phase 5: Thematic networks explored</td>
<td>Themes which emerged were explored and patterns underlying them were identified. In such a way the original text was returned to and interpreted with the aid of the networks.</td>
</tr>
<tr>
<td>Phase 6: Thematic networks verified and refined</td>
<td>Summary of main themes and patterns characterising them made explicit. Original research questions returned to and addressed with the patterns that emerged in the exploration of the data.</td>
</tr>
</tbody>
</table>

Saldana’s (2011) coding manual for qualitative research emphasizes that the phases listed above are a cyclical process as opposed to linear and as such phases were re-refined and verified using inter-rater agreement throughout the analysis stage.

2.5 Ethics

Ethical approval for the study was granted by the Clinical Research Ethics Committee of the University of Limerick and the hospital’s Ethics Committee. Convenience sampling meant that participants were known to the gatekeeper. For the purposes of this study however convenience sampling was required in order to recruit appropriate personnel. Participants were informed via information sheets and verbally prior to data collection that they could withdraw from the study at any point. Data was rendered anonymous during the transcription process.
2.6 Reliability and Validity of the Research

The following measures were taken to ensure that Lincoln and Guba’s (1985) recommendations for establishing that the credibility, transferability, dependability and confirmability of interpretive research were met:

- The focus group was member checked using a narrative summary to increase credibility of findings. Member checking gave participants an opportunity to confirm the accuracy of what was said (Denscombe, 2007).
- The data were transcribed and analysed by three researchers to enhance inter-rater reliability.
- Mind-maps and detailed records of data generation were utilised to track the development of coding. The researchers have provided descriptions that are rich enough to allow other researchers to judge the extent to which findings are transferable to other settings.
- The coding system was checked for its validity by an independent third party who was asked to assign codes to the basic themes they felt to be most appropriate. Agreement was achieved for 7 out of 10 codes.
3.0 Results

3.1 Sample

7 SLTs took part in the focus groups and 8 HCS took part in the semi-structured interviews. All participants were female. In Group 1, 6 senior grade SLTs and 1 basic grade SLT took part. In Group 2, 2 doctors, 2 nurses, 3 medical social workers, and 1 dietician took part. Table 3 shows the assigned pseudonyms of participants.

Table 3: Participant pseudonyms

<table>
<thead>
<tr>
<th>Group 1: SLTs</th>
<th>Group 2: HCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claire</td>
<td>Margaret</td>
</tr>
<tr>
<td>Aisling</td>
<td>Hannah</td>
</tr>
<tr>
<td>Aoife</td>
<td>Lina</td>
</tr>
<tr>
<td>Julie</td>
<td>Emily</td>
</tr>
<tr>
<td>Annie</td>
<td>Brenda</td>
</tr>
<tr>
<td>Laura</td>
<td>Melissa</td>
</tr>
<tr>
<td>Olivia</td>
<td>Emma</td>
</tr>
<tr>
<td></td>
<td>Joanne</td>
</tr>
</tbody>
</table>

3.2 Overview of Themes

Analysis of the data identified three global themes: 1) SLT role in palliative care; 2) Referral Matters and; 3) Palliative Care Considerations. The names of the 3 global themes reflect the seemingly straightforward nature of the original concern that spurred the project. However, the data obtained reflects the complexities of each theme and frequent anomalies, inconsistencies, and differences of opinion between and within the groups emerged.

The three global themes can be seen as interacting with, and influencing each other to shape perceptions of the role of SLT in palliative care. The global and organising themes will be now be outlined with supportive quotations from participants.
3.3.1 Theme 1: SLT Role in Palliative Care

SLT Role in Palliative Care encompasses the finding that although SLTs’ current role is facilitated by certain team working factors, the role is limited as it is not reflective of SLTs’ broad skills and is often not fully implemented due to certain challenges.

3.3.2 Current Role

SLTs and HCS unanimously felt that SLTs do have a role in palliative care and both groups highlighted that SLTs’ role in palliative care often revolves around consultation and indirect work with patients, families, and members of the team as direct work with patients “pulls back” (Joanne; HCS).

The SLTs listed the strategies they can offer in palliative care. For dysphagia management these included diet modification, postural adjustments, “weighing quality of life versus risk” (Aisling; SLT) and facilitating difficult decisions around non-oral feeding. For communication management SLTs stated that they “really allow them the time to communicate” (Julie; SLT) and listed the approaches they can offer in palliative care as finding other means to maintain communication and maximise
function, be it through the use of “AAC (augmentative and alternative communication) devices or gesture” (Julie; SLT), and facilitating the use of “visual aids and memory books” (Annie; SLT). When given the opportunity, SLTs stated that they can have a role in supporting families by facilitating their communication, planning for the future and reducing their anxiety levels by “facilitating family meetings about care needs and wants” (Aoife; SLT).

All HCS were aware that the role of the SLT in palliative care includes supporting patients’ communication and dysphagia symptoms. Despite the awareness of all HCS that SLTs have a role in communication, it emerged that, in practice, SLTs are “mainly called upon for swallow management towards the end-of-life” (Olivia; SLT). The SLT role was often seen in terms of physical needs; “the MDT (multidisciplinary team) feels it’s about the physical stuff around the swallow” (Brenda; HCS). Annie (SLT) voiced her concern that “they don’t realise how much we can offer from a communication point of view” and Aoife (SLT) remarked that she sometimes gets a sense of “they’re palliative why would you bother?”. Some support for this concern was found as Brenda (HCS) stated that SLTs “do kind of take a step back when the person is imminently dying because there’s no real need for communication”.

3.3.3 Team Working

A recurring consensus throughout the data was the strong feeling of mutual respect shared between HCS and SLTs. SLTs agreed that when HCS decided the role of SLT was not warranted they respected their opinion and moved on but that if SLTs felt they “really” had a role “it wouldn’t be hard to push for it” (Claire; SLT). The importance of an efficient multidisciplinary approach emerged as crucial in order to understand the role of the SLT and mutually benefit through learning from each other. SLTs remarked that multidisciplinary approach is often needed in order to “show them what we do” (Laura; SLT). Multidisciplinary team meetings were important for SLTs in order to have reassurance in how cases are being managed and that “they’re all on the same page” (Julie; SLT). Claire (SLT) summed up the importance of communication between team members; “decisions can’t be made without the team”.
3.3.4 Challenges to Role

The role of the SLT in palliative care was impeded by a number of challenges, including, for a number of the SLTs, a lack of confidence; “I very much lack confidence in my role in palliative care” (Olivia; SLT). There was a consensus that this lack of confidence was made up by a combination of the following factors among SLTs; fear of “being intrusive” (Olivia; SLT), fear of “not knowing how aware the family are about the patient's prognosis” (Olivia; SLT), fear of not being able to follow through on potential interventions that could benefit, and not having “a good in depth understanding of our role” (Aisling; SLT).

The challenge of confidence seemed to be pertinent only to SLTs, as HCS didn’t express a lack of confidence in the role of the SLT. However, a second challenge around a lack of training was felt by both SLTs and HCS. HCS unanimously stated that they had no formal education regarding the role of the SLT during their qualifications and all learned about it “on the job” (Melissa; HCS). Likewise, SLTs reflected on the gap in undergraduate training in relation to palliative care. In particular Aisling (SLT) highlighted the lack of training for end-of-life conversations and conversations about dying “and all the emotions that comes with that is something we end up talking about quite a lot” and questioned whether SLTs are the “best trained to deal with this”.

A third challenge to the role of the SLT in palliative care highlighted by participants were the organisational issues and service constraints associated with hospital working. Barriers to delivering palliative care in the hospital were associated with time pressure in relation to sourcing AAC devices in time, not having the time to determine whether SLTs had a role, and the burden of the number of patients to be seen. Aoife (SLT) stated that because of the fast-paced nature of the acute setting; “If they say no we move on, there’s another 5 people that need to be seen, there isn’t really time to think about it”. The lack of continuity between services such as the hospital and hospices was raised as a concern; “the problem with the hospices are that there aren’t SLTs employed” (Claire; SLT) as SLTs don’t know if the decisions they’re making will be continued there.
3.4.1 Theme 2: Referral Matters

As this study originated from the concern that referrals are withdrawn when patients are imminently dying, specific questions around the referral process were asked. While SLTs acknowledged that withdrawals happen, no consensus between SLTs or HCS as to whether or not this is always a significant problem was established. It emerged however, that SLTs were as concerned by low levels of referrals and late-stage referrals, as the withdrawal of referrals and conflicting perceptions emerged regarding this matter. This theme addresses the barriers that impede access to SLT services in the hospital and specific factors that influence referrals.

3.4.2 Barriers to Access

When the SLTs were asked if referrals are ever withdrawn some felt it “happens a lot” (Claire; SLT) and stated that they find themselves “in a strange position” (Julie; SLT) as they’re trying to “gauge” whether this is because HCS think SLTs don’t have anything to offer or because they aren’t aware of what they could offer. SLTs remarked that when patients become placed under palliative care it is often a case that SLTs are told they no longer need to go near them and “it’s just a blanket no” (Julie; SLT). However Olivia (SLT) stated “it’s better to give the referral than not” as “it’s hard to know when those referrals are withdrawn whether we would have had some expertise in that
area”. That being said, other SLTs felt that withdrawals were often appropriate so a consensus as to whether or not withdrawals are always an issue was not met.

HCS all reported that withdrawals only occur when appropriate at the very end-of-life as in the last few days “less is more” (Hannah; HCS). Lina (HCS) stated that referrals are withdrawn if the patient or family don’t want SLT input and that “the referral naturally closes” when the patient is imminently dying.

Taking a wider look, not just at withdrawals but referral rates in general, SLTs made it clear that they were surprised by certain teams’ “low levels of referrals to us” (Aoife; SLT), and indeed one HCS (Emma) stated that at end-of-life she “wouldn’t necessarily think of SLT first off”. A recurring finding underlying barriers to access that emerged were the conflicting perceptions between SLTs and HCS. Brenda (HCS) felt other team members may not perceive SLT input as a useful resource for patients at end-of-life to “enrich their life at that point”, whereas contrastively others saw a big role, especially in terms of supporting the family.

Not only did conflicting perceptions emerge as to whether or not SLT was a useful resource at end-of-life but conflicting perceptions about what SLTs can offer patients at the end-of-life also emerged. For example, Emily (HCS) reflected that she wouldn’t see SLT input as appropriate when the patient is imminently dying as she thought SLTs would be involved in teaching the patient; “if someone is imminently dying and as part of your rehab you’re asking them to learn something... I would rather not...”. This illustrates HCS’ uncertainty of what SLTs can offer in terms of improving quality of life through compensatory strategies, maintaining function, and indirect work with families. An uncertainty of what SLTs can offer specifically around dysphagia management was also apparent, SLTs weren’t sure whether HCS “have that knowledge that we do more maybe than just modify” (Laura; SLT).

3.4.3 Specific Factors

Prognosis and timing were noted as key factors influencing referrals. It was noted that for the head and neck cancer population, teams are good at early referral as it is
clearer “where the diagnosis is going” (Aoife; SLT). The benefits of early referral were brought up by SLTs time and time again for getting patient’s “wishes and directives documented” (Annie; SLT). Annie (SLT) highlighted that often they only receive referrals later, they may have less to offer as cognitive function declines; “often referred patients with dementia in the very late stages, and there wasn’t a huge amount I felt I could offer at those stages”. Due to the variability of SLT involvement with certain populations, it was noted that certain teams are more aware of what SLT can offer and are comfortable making referrals whereas other teams are less sure.

That being said, when patients are imminently dying, SLTs noted that they still have a lot to offer. Missed opportunities were brought up by SLTs as on the rare occasion that referrals are made late in the prognosis they felt they had a lot to offer in terms of facilitating communication but; “my feeling is that if the team knew how close (to dying) she was, they may not have referred her” (Claire; SLT).

A key finding was that the prognosis of a patient will place them under the care of a certain team and Olivia (SLT) wondered whether being under a certain team leads to some confusion as the palliative care team may arrive on a consultation basis and incorrectly “assume that if speech therapy were needed it would be done by the overall team”. Not only did SLTs note early referrals as important for patients, but Aisling (SLT) also noted how referring earlier can improve team working as SLTs can get to patients earlier and say to the multidisciplinary team; “look this is what we do so if there’s any referrals along this continuum you give me a ring”.

3.5.1 Theme 3: Palliative Care Considerations

This theme addresses the considerations specific to palliative care that differentiate it from working with non-palliative care populations that emerged. Not only is this an area of health care that has changed and evolved over time, but it is also differs greatly to other healthcare areas which often aim to “fix” problems.
3.5.2 Evolving Speciality

Participants collectively confirmed that palliative care is now getting more involved early with progressive neurological conditions and maintenance of function and that there is now more highlighting that a person is palliative. Despite this progress, Olivia (SLT) reflected; “I suppose it’s still emerging and we’re still discovering what it really means to be palliative”. Participants felt that palliative care management can be “tricky” as “people’s conditions change quickly” (Brenda; HCS), SLT input “might have been appropriate this morning but by the time someone gets there this afternoon it’s no longer appropriate” (Joanne; HCS), and “there’s no set time on end-of-life care” (Hannah; HCS). Olivia (SLT) summed this up by stating, “palliative care is not an exact science”.

The SLT role is being continuously adapted in line with the evolution and development of palliative care. The SLTs, on the whole, felt positive that there is an increased awareness of what SLTs can offer, and that they are more involved in palliative care “than we have been 5 years ago” (Aoife; SLT). Comments were made by SLTs however, that in the hospital the SLTs’ role will hopefully expand to include more
communication input and that in areas like dementia there is room for future developments.

An onus on SLTs to educate teams was highlighted around what they can offer. However before this can happen, Laura (SLT) noted “maybe we need to identify what that role is specifically as a group of therapists and as a professional standard first”.

3.5.3 Holistic Approach

All participants were emphatic that comfort, quality of life, and choice are the central components in palliative care. The balancing act of trying to prioritise what’s the most important thing for quality of life and pain management was suggested. Margaret (HCS) noted pain management as being key at this time and how families “now wish for comfort to be a priority”. Certain HCS recognised that SLTs can improve quality of life through ensuring patients can enjoy eating “in a safe way” (Melissa; HCS). In terms of communication, central to quality of life is the ability of patients to express their wishes for end-of-life care. Emily (HCS) remarked on how when she “could tell he (a patient) wanted to say more” she had witnessed the success of an SLT facilitating this patient to use an AAC device with his family. However, as mentioned, not all HCS were aware of what SLTs could offer for quality of life. Aisling (SLT) questioned whether HCS saw pain management as the most important consideration at end-of-life; “I don’t know whether dysphagia and communication difficulties are seen as symptoms. . .or are seen as having the same impact as pain”.

HCS were generally of the opinion that referrals should not be made to SLT “if people are at the very end of their life and it has been decided that we’re going to focus solely on their comfort” (Emma; HCS). However the uncertainty around what comfort at end-of-life really means was summed up by Brenda’s (HCS) remark that; “it’s very nebulous because you’ll say comfort measures or palliative care in general but what do we mean by that?”. 
Integral to palliative care is the patient’s choice and the fact that it’s “all about the family” (Joanne; HCS). This priority was recognised by all participants. The importance of really questioning what comfort is and “ultimately handing over the responsibility and decision making to the family” was raised (Brenda; HCS). This can change the management approach of this population as even though staff may feel they’re doing something beneficial to improve quality of life, some patients may prefer to just spend time uninterrupted and as Claire (SLT) remarked; “that’s a valid emotion”. Similar scenarios were brought up by Brenda (HCS) who said that “sometimes at the end of their journey what people need is just quiet and time to get used to it”. Different patients were noted to have different outlooks on this. Therefore, on the whole, in order to ensure patient-centered care it was noted that making “case by case” (Aoife; SLT), individualised decisions is the key.
4.0 Discussion

The themes outlined reflect the complexities of working in this area and the extent to which the perceptions of both groups can influence practice. Findings from this study support the premise that SLTs do have a role in palliative care, as outlined in research and policy (NICE, 2004). However, although it is recognised that SLTs do have a role, inconsistencies regarding what that role is emerged. As such, contrary to recent international findings (O’Reilly & Walsh, 2015) that the role of the SLT in palliative care is frequently unrecognised at regional levels, it appears in the acute hospital in which this study was based, that this role is under-recognised as opposed to unrecognised. The role appears to be limited in this setting and not reflective of SLTs broad skills. Specific personal, perceptual, educational, and organisational barriers emerged throughout the themes that were identified as hindering the perception of the role of the SLT in palliative care.

4.1 Perceptual Barriers

Evidence of the perceptual barriers that emerged in the current study can be summarised as follows; the role is perceived by HCS as mainly centering around dysphagia management and even in this area the perception of what SLTs can offer is restricted to diet modification. SLTs role in communication is often overlooked by HCS.

Previous research supports the finding that positive quality of life outcomes of palliative care patients have been found when SLTs re-establish mealtimes as a time for loving interaction using compensatory strategies such as chin tuck, postural modifications and diet modification, as long as eating remains enjoyable (Grogher & Grogher, 2012; Langmore et al, 2009). Eating for comfort as opposed to survival can be a difficult concept for HCS and families to adjust to (Regnard, 1995), which may be contributing to the findings of the current study. Moreover, in terms of SLTs role in communication being under-recognised, this finding supports the concern of Salt and Robertson (1998) that communication difficulties in the palliative care population are often hidden and may not be addressed. This is a professional concern as SLTs have been found to maximise patients’ ability to complete a life review and engage in other
psychosocial support activities by facilitating the use of compensatory strategies (Rahman, 2000) such as breath support, voice amplifiers, visual and gestural aids (Salt & Robertson, 1998).

It is clear from the above examples that SLT rehabilitation mainly consists of compensatory strategies to enable patients to live to their fullest possible potential until they die. However, as stated by Santiago-Palma & Payne (2001) the misleading term “rehabilitation” leads to a misperception that rehabilitation in palliative care attempts to restore patients to their previous level of functioning (Roe & Leslie, 2010). Roe & Leslie (2010) stated that the rapid evolution of SLTs into palliative care specialist and multidisciplinary teams may lead to a perception that their rehabilitative role is less appropriate at end-of-life. Cheville (2001) found that this often accounts for the limited number of referrals to SLTs. 14 years on and it appears from the current study that this perceptual barrier between HCS and SLTs remains.

These perceptual barriers contradict Pollens’ (2004) recommendations on the four roles of the SLT in palliative care. While it is clear that these four roles are not being met in practice, what is less clear is whether these roles are realistic or attainable in acute settings. Personal barriers and the role of the patient need to be addressed before this question can be answered.

4.2 Personal Barriers and the Patient Role

The lack of referrals to SLTs means that they do not get the opportunity to build up the experience and expertise in treating palliative care patients which impacts on their confidence in this area. This is a significant finding as it replicates recent international quantitative findings that SLTs are uncertain and unconfident about the their role in palliative care (O’Reilly & Walsh, 2015). Palliative care is a unique area where rehabilitation and comfort must be balanced and constantly re-evaluated which can lead to challenges in the referral process (Roe & Leslie, 2010). These considerations that come into play specific to palliative care around quality of life, rehabilitation, and comfort also impact on the confidence of SLTs, centered around the fear of being intrusive. The growing demand for palliative care means that generalist SLTs will
increasingly be expected to provide palliative care as part of their practice (Johnson et al, 2011), therefore this is a barrier that needs to be overcome.

The question raised as to whether communication difficulties and dysphagia have the same impact as pain is a question that ultimately cannot be answered by SLTs or HCS. The inconsistencies surrounding this question reflect personal barriers regarding the uncertainties of HCS and SLTs around the complex experience of dying. Neither SLTs nor HCS have the “right” answer as to how a patient should be construed at the end-of-life. That being said there is a growing concern that medical approaches to symptom management in palliative care offer a routinised and more certain response to the uncertainty of dying than psychological and social approaches which leads to medical being the go-to approach (Broom et al, 2013). While it was positive that all participants highlighted that holistic care means considering the patient’s choice for management, questions remain as to how this choice is facilitated in practice.

Pollens (2012) states the importance that this decision be made by the patient and their family. Research has found that patients and families are often unaware of what SLTs can offer (Cheville, 2001), but when the role of the SLT is explained to them in a contextually meaningful way they were more likely to prioritise SLT input (Schleinich et al, 2008). Tools for identifying the needs and priorities of palliative care patients are beginning to be developed and utilised (Waller et al, 2008) but in the current study no mention was made of a systematic method for responding to patient priorities. Further examination of patients’ perceptions and priorities regarding the role of the SLT is warranted to determine whether SLTs’ lack of confidence due to the fear of being intrusive is an accurate one.

4.3 Organisational Barriers

Timing is an organisational barrier in palliative care that has been replicated in other studies (Johnson et al, 2011). Participants in both groups highlighted the benefits of early referral to SLT for patients in terms of quality of life, reflecting the findings of Grogher and Grogher (2012) and Rahman (2000). Despite this awareness, this study found that the majority of referrals to SLT are made as a patient's swallow deteriorates
towards the very end-of-life. This occurs despite the awareness of SLTs that there is a national move towards advanced care directives (Law Reform Commission, 2009). No consensus was met as to the ideal timing of referral, however other studies have found that referral to SLT services should relate to the complexity of needs and the ability of SLTs to meet those needs, rather than the timing of functional decline or disease progression (Johnson et al, 2011).

Poor communication between teams has been found to inhibit the efficiency of palliative care in other settings (Johnson et al, 2011; O’Reilly & Walsh, 2015). This setting reported good team working and mutual respect between teams; despite this, misconceptions regarding the role and referral concerns still exist. Therefore, further developments towards formalisation of referral guidelines are warranted to ameliorate the time pressure issues raised. According to Roe and Leslie (2010) there is a culture of boundary blurring in palliative care, which, in theory, ensures that a team monitors for changes and refer to the SLT when their input is necessary. This is a professional concern, given that one team or professional in isolation may not always identify all patient needs or all patients who may benefit from accessing SLTs (Newell et al, 1998; Ouwens et al, 2005).

4.4 Educational Barriers

The lack of undergraduate training or specialist expertise in palliative care was alluded to as an obstacle by the SLTs. This comes back to the NICE (2004) guidelines, which require only an awareness of palliative care issues, rather than the acquisition of specialist skills and education. Likewise a lack of education on the role of SLTs in palliative care was confirmed by all HCS, which has been found as a barrier to care internationally by O’ Reilly and Walsh (2015).

In the current study the interaction of the perceptual, personal, organizational and educational barriers can be seen to lead to a “cycle” of negative reinforcement in the referral process (see Figure 4). Breaking down the educational barriers for both SLTs and HCS will be a key development that is likely to have positive knock-on effects on the perceptual, personal, and organisational barriers.
The concern raised by this study that needs outside of physical symptoms do not trigger as many referrals, is consistent with quantitative data (Johnson et al, 2008). The view that physical symptoms are more responsive to intervention than communication, social and emotional symptoms (Broom et al, 2013) is an educational barrier. As SLTs are the experts in communication and dysphagia, the onus is on them to advocate for what they can offer and educate teams. However, as revealed by the data, the ability to educate teams is likely to be impeded by SLTs lack of confidence and clarity on their role in this area. This leads to recommendations that the current study proposes.

4.5 Limitations of the Study

Qualitative approaches to data collection may influence results in term of: (1) the group dynamic associated with focus groups and (2) the potential “social acceptance bias” (Collins et al, 2005) associated with one-on-one interviews due to the fact that the interviews were led by SLT students asking questions about their discipline. However the benefit of using these methods outweighed the burden of these influences.
As this was a preliminary study intended to inform service development, broad questions were asked. The study design used an in-depth approach in one acute Irish setting, which somewhat limits the scope of the findings in terms of generalisability. That being said, very similar findings have been found in other Irish settings (Waldron et al, 2011) and internationally (O’Reilly & Walsh, 2015). As such, it is hoped that future research will hone in on more specific questions guided from the current findings and that research will be extended to the other settings such as hospices.
5.0 Conclusions

The aim of this study was to present an integrated overview of the understandings of SLTs and HCS surrounding the role of the SLT in palliative care. This integrated overview can be seen as a series of inconsistent and conflicting perceptions. Inconsistent perceptions may explain the anecdotal concern regarding withdrawal of referrals and the fact that a consensus as to whether or not these withdrawals are appropriate was not met. This study found that a more specific understanding of what the SLT can offer to palliative care patients is required. A range of barriers were identified which result in some palliative care patients not accessing SLT services or not accessing them at a time when they may receive maximum benefit.

Conflicting perceptions may be seen as inevitable in this area as palliative care may never be an “exact science”, but the development of effective guidelines to channel referrals should still be made available to professionals (Johnson et al, 2011). It is hoped that the recommendations arising from this study are actualised so that patients affected by acute, short-term, and long-term degenerative conditions can all receive whatever support is needed. Collaborative working, shared caseload management, and familiarization of all staff with each-others’ roles could bring more patients the benefits of best practice in palliative care. This crucial area of development is needed because, as noted by Parker-Oliver and colleagues (2005, p.279) “teamwork is critical to the service and management of the entire person and his or her environment, and is essential in providing a good death”.

5.1 Recommendations

From the current findings key areas where action is required to further the development of the perception of, and involvement of, the SLT in palliative care are recommended:

1) Education of SLTs at an undergraduate level on their role in palliative care.
2) Education of HCS at undergraduate level on the role of SLTs in palliative care.
3) Formalisation of referral guidelines to ensure efficient palliative care management;

4) SLTs provide referrers with feedback on the outcomes of SLT input to improve understandings about the benefits of accessing these services early.

5) Investigation of the perceptions and priorities of patients and families regarding the role of the SLT in palliative care in order to shape referral guidelines around patient-centered evidence-based-practice;

6) Regular assessment of patients’ and families’ level of needs and priorities in hospitals using validated assessment tools (Waller et al, 2008) to facilitate appropriate needs-based access to SLT services.
6.0 Acknowledgements

I would like to sincerely thank Dr Arlene McCurtin for her guidance and extensive insight throughout this project. Thank you to the participants who agreed to make time in their busy schedules to partake in the interviews and for the help from the gatekeeper who recruited them. Thank you for being so willing to openly discuss your perceptions, which laid the foundations for this project.

Thank you to my fellow speech and language therapy student researchers Jemma Colclough and Rebecca Burke; working with you during the data collection was a pleasure.

Thank you to my family and friends for supporting me over the last two years. In particular thank you to my parents Liv and David, and my brother Eoin, for the ample encouragement. To Lewis, thank you for believing in me and inspiring me always.
7.0 References


Irish Association of Speech and Language Therapists; IASLT. (2007). *Standards of Practice for Speech and Language Therapists on the Management of Feeding, Eating, Drinking and Swallowing Disorders (Dysphagia)* IASLT.


Royal College of Speech and Language Therapists; RCSLT. (2014). What is speech and language therapy? Available at [http://www.rcslt.org/speech_and_language_therapy/what_is_an_sl](http://www.rcslt.org/speech_and_language_therapy/what_is_an_sl) [Accessed 5 November 2014].


Appendices

Appendix A: Focus Group Questions

Q1. Roles
Let’s pretend, I don’t know anything about speech and language therapy, could you tell me about the general role of the SLT in the hospital?
   i. How does this general role differ when working with patients receiving palliative care?
   ii. How do you define palliative care?

Q2. Role development
Tell me about role development
   i. How has your role developed in the past decades?
      a) For SLTs in general?
      b) For SLTs in the hospital?
   ii. How do you see it changing in the future?
      a) For SLTs in general?
      b) For SLTs in the hospital?

Q3. Experiences and Caseload in Palliative Care
So let’s talk about the role of the SLT in palliative care
   i. Do you think there is a role?
   ii. What are your experiences of working in this role?
   iii. How much of your caseload involves working with patients receiving palliative care?

Q4. Service Provision and Withdrawal
Tell us about your experience receiving referrals for palliative care patients
   i. Have you ever had a palliative care referral withdrawn?
   ii. How did that make you feel?
   iii. What does referrals being withdrawn say about how other professionals view the role of the SLT in palliative care?
Appendix B: Semi-structured Interview Questions

1. Could you tell me, in your own words, what the SLT does?
   (Probe-What do you think the SLT’s role in hospitals is? What about communication/dysphagia?

2. How did you learn about the role of the SLT?
   (Probe-During your qualification or on the job? Do you have much contact with SLTs?)

3. In palliative care, when do you think it is appropriate to refer to SLT and for what reasons?
   (Probe-specific cases? Specific populations?)

4. Are there any cases/situations where you would not make a referral to SLT?
   (Probe- could you elaborate on that a little bit)

5. In a scenario where you have made a referral to SLT, why might you later withdraw the referral?
   (Probe- What's the process involved if you are withdrawing a referral?).
PARTICIPANT INFORMATION LEAFLET

Date: November 2014
Version No: 2

The purpose of this information sheet is to give you the information about our study so you can make an informed choice about whether to participate or not. Please read this carefully before deciding whether or not to participate.

<table>
<thead>
<tr>
<th>Research Study Title:</th>
<th>Perceptions of hospital-based clinical staff of the role on speech &amp; language therapists in palliative care.</th>
</tr>
</thead>
</table>

What is the purpose of the research study?
Speech and language intervention is a relatively new contribution to the area of palliative care (end of life care) and Speech and language therapists (SLTs) are receiving an increasing number of referrals to their services from their colleagues in other disciplines (specifically medical and nursing disciplines).
The aim of this study is to explore the perceptions of both SLTs and their hospital clinical colleagues regarding the role of the SLT in palliative care.
• This study is being carried out as part of an academic qualification to meet the requirements of the MSc in Speech and Language Therapy at the University of Limerick.
• The study findings may inform service development in this area.

Who can take part?
• Hospital doctors, nurses, medical social workers and dieticians who work with patients receiving palliative or end of life care.
• Hospital SLTs.
• The number of participants required is 8 clinical staff (in total across the 3 disciplines of doctors, nurses, medical social workers and dieticians), and 8 SLTs.

Why have I been chosen?
• You fit the above criteria.
• The SLT study organiser at the Hospital has identified you as a possible study participant and sent you this information, with the researchers’ contact details.
• If you are a doctor, nurse, medical social worker or dietician, and you agree to participate you will be contacted by one of the 3 Research Assistants (University of Limerick Students) to arrange an appointment for an individual interview. If you are a SLT, and you agree to participate, you will be contacted by one of the 3 Research Assistants (University of Limerick Students) to arrange a group appointment time for a focus group discussion. These will take place in the Hospital.

• For participants who are not SLTs, only the Research Assistant will know that you have participated in this study. Your name will not be released to any other person involved in the study, anyone else in the hospital or during the write up of the research.

• SLT participants will know other SLT participants in the focus group, but your name will not be released to any other person involved in the study, anyone else in the hospital or during the write up of the research.

• The name of the hospital will not be identified in the study during write up of the data, or for publication.

What will happen to me if I take part?

• Hospital doctors, nurses, medical social workers and dieticians who agree to contribute will be asked to participate in a once-off, one-to-one semi-structured interview of 20-25 minutes duration with a Research Assistant.

• Hospital SLTs will be asked to participate in a once-off focus group (of 8 Hospital SLTs) lasting 30-45 minutes which will be facilitated by the Research Assistants.

• Exact locations in the Hospital will be agreed and confirmed with participants nearer to the time.

• This study is specific to the Hospital and will not be carried out on any other sites.

• At the beginning of the interview and focus group, you will be asked to sign a consent form. The interview and focus group will then be audio recorded for later transcription. Once the interviews are over, recorded data from the interviews will be downloaded to a password protected computer and immediately deleted from the recorder. Audio recordings will only be available to the Research Assistants, and to Dr. Arlene McCurtin – University of Limerick Co-ordinator. The audio-recordings will be transcribed and then deleted from the computer. Data will then be anonymised before analysis takes place. There will be no audio or identifying information of your participation. This includes identification of your discipline, except if you are a speech and language therapist.

• On conclusion of the study, the data will be kept in the office of the Co-Investigator, Arlene McCurtin for a period of seven years as dictated by University of Limerick Research Ethics requirements. Data will be destroyed in May 2022.

• Participants can withdraw at any time up to the end of the semi-structured interviews/focus groups. Focus group participants may leave the room if they wish to withdraw once the groups have started. Their data will be removed from the recording on request.
Who is organising the research study?

- There are co-ordinators at both the Mater Hospital and the University of Limerick. Dr Arlene McCurtin, Course Director for the SLT programme is the University of Limerick co-ordinator. Ms Siobhan Manning, Clinical Specialist SLT/Practice Tutor and Ms Anne Claffey, Senior Speech & Language Therapist/Practice Tutor are the Mater Hospital co-ordinators.
- This study has been in development since the summer of 2014. Data collection (interviews and focus group) will take place in January/February 2015 and the data will be analysed and written up by May 2015.

What is the study design?

- This study uses a qualitative methodology and use interviews and focus groups to meet participants and ask their opinions. The materials from these interviews is analysed using thematic analysis - the opinion of participants will be organised into themes in order to help better understand the opinions of the participants.

Are there any disadvantages in taking part in this research study?

- There are no disadvantages to taking part or withdrawing.
- Any complaints or concerns should be directed to the Principal Investigator, Heather Coetzee, SLT Manager, Mater Hospital.

What are the possible benefits of taking part?

- The opinions you provide may help speech and language therapists in developing or refining their services to patients undergoing palliative care.

Who approved this study?

- Mater Hospital Research Ethics Committee approved this study.

What will happen to the results of the research study?

The study results will be used for the following purposes:

- Contribute to the professional qualification degree of the student researchers.
- Presentation/poster at IALP (Dublin) conference August 2016.
- Inform SLT service development with regard to palliative care services.
- Published article.

Interested in taking part in the study?

- If you are interested in taking part in the study, please email and we will contact you to arrange a time convenient to you.
- If you do not understand or would like more information please contact the Principal Investigator, Heather Coetzee, SLT Manager at Mater Hospital.
Appendix D: Participant Consent Form

CONSENT FORM

Title of Research Study: Perceptions of hospital-based clinical staff on the role of speech & language therapists in palliative care

Participant name:

1. I confirm that I have read and understood the information leaflet dated………. for the above research study and received an explanation of the nature, purpose, duration of the research study and what my involvement will be

2. I have had time to consider whether to take part in this research study. My questions have been answered satisfactorily and I have received a copy of the Information Leaflet

3. I understand that my participation is voluntary (my choice) and that I am free to withdraw at any time up to semi-structured interviews/focus group.

4. I understand that the semi-structured interviews/focus group will be audio recorded with a dictaphone and give my permission for this.

5. I understand my data will be anonymised and deleted after completion of the study.

6. I agree to take part in the above research study

........................................................................................................................................
Name of Participant (in block letters) Date Signature

........................................................................................................................................
Name of Person taking consent Date Signature (Researcher)
Appendix E: Example of Coding Process

<table>
<thead>
<tr>
<th>Nodes</th>
<th>Codes</th>
<th>Basic Theme</th>
<th>Organising Theme</th>
<th>Global Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>A question asked a lot: How palliative? It's a grey area It's not really clear to us What exactly do you mean here? Still discovering what it really means to be palliative Palliative care means different things to different people Palliative care—very nebulous It's not an exact science Hard on medical teams Hard on SLTs Months to live—pass away within a week It's tricky Happens more quickly than expected People's conditions change very quickly No set time on end-of-life care</td>
<td>Unclear terminology</td>
<td>Lack of clarity</td>
<td>Evolving Speciality</td>
<td>Palliative Considerations</td>
</tr>
<tr>
<td>Much bigger role Not just end stages SLTs feature more More of an appearance More involved than 5 years ago More involved in</td>
<td>Increased role</td>
<td>SLT role development</td>
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<td>counselling</td>
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<td>More awareness of role</td>
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<td>Starting to see role</td>
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<td>Increased awareness</td>
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<td>SLT role</td>
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<td>AHPs have bigger profile in hospitals</td>
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<td>Increased awareness</td>
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<td>Developing an awareness among the team</td>
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<td>Should educate teams about SLT role</td>
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<td>&quot;Look at what I can actually do&quot;</td>
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<td>Get in early and show them</td>
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<td>Onus to educate teams: especially in communication</td>
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<td>Need to identify SLT role</td>
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<td>Set professional standard</td>
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<td>Teaching Possible role for SLT</td>
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<td>Role will develop</td>
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<td>Role in advocacy</td>
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<td>Role will expand</td>
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<tr>
<td>SLT might be more involved in communication</td>
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<td>Expand role in dementia</td>
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<td>SLT role has developed with PC development</td>
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<td>Whole package given to PC patients</td>
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<td>Future developments</td>
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<td>Adapting role to PC development</td>
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</table>
Adapting role to PC development

Thoughts for PC changing PC highlighted more
More highlighting person is palliative
Role of PC has changed
Now getting in earlier
Broader continuum
Maintaining function
Now not just end-of-life care
Not just actively dying
PC changed over last 10 years
Evolved over time
Still emerging
Still discovering PC
What it really means to be palliative
Medicine evolving
Things are shifting
Things are moving
Palliative medicine huge now

<table>
<thead>
<tr>
<th>Nodes</th>
<th>Codes</th>
<th>Basic themes</th>
<th>Organising theme</th>
<th>Main theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not comfortable</td>
<td>Comfort</td>
<td>Quality of life</td>
<td>Holistic Approach</td>
<td>Palliative</td>
</tr>
<tr>
<td>Good quality, comfort-centred care</td>
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| Family wishes |
| Family time prioritised |
| Patient's choice |
| Individualised care |

| Family wishes |
| Choice |
| Patient-centred |
| Palliative considerations |