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A joint hospital initiative to strengthen general palliative care in the hospital: an action research study on challenges and facilitators

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Abstract

Background Providing general palliative care in hospital settings challenges hospitals' multifaceted role in both saving lives and managing end-of-life care. The challenges in delivering general palliative care are compounded by organizational and cultural factors, underscoring the importance of establishing coordinated care frameworks for patients in their final stages of life. However, little is known about how to organize the enhancement of general palliative care in the hospital setting. The aim of this study is to examine the barriers and facilitators on the organizational level during the process of strengthening general palliative care within a joint hospital initiative.

Methods This study is qualitative action research that follows four cyclical phases: 1. Problem identification: Qualitative interviews were performed with 24 departments and hospital management, totaling $n=64$ participants. 2–3. Planning and taking action: Workshops were developed and performed in 14 departments. 4. Evaluation: Qualitative evaluation interviews on the process were performed with 16 departments and hospital management, totaling $n=27$.

Results The data analysis identified three central themes: 1: Delivering general palliative care – from lack of systematic approach to increased awareness; 2:. Strengthening interdisciplinary communication and collaboration and 3: Paraclinical involvement in palliative care - balancing treatment protocols with patient well-being. The results highlight barriers such as a lack of standardized structures and fragmented care approaches, alongside facilitators like employing dedicated palliative resource persons, increasing awareness of general palliative care, and involvement of paraclinical specialties who face ethical dilemmas balancing treatment protocols with patient well-being.

Conclusion This study highlights the complexity of the process of strengthening a joint initiative in a hospital setting, with identified barriers centered around interdisciplinary collaboration and paraclinical care integration. Enhancing collaboration faces challenges in knowledge dissemination and decision-making discrepancies. Overcoming these barriers is crucial to enhancing general palliative care delivery, emphasizing sustained initiatives in promoting collaboration, improving communication, and integrating healthcare sectors involved in palliative care. Continued education, training, and knowledge-sharing initiatives are essential for the ongoing general palliative care services and alignment with evolving patient needs and healthcare practices.

Keywords General palliative care, Hospital, Action research, Organization

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Background

The provision of general palliative care (GPC) within a hospital setting presents significant challenges due to the dual function of hospitals in both saving lives and facilitating end-of-life care [1–3]. This inherent tension, as highlighted by Cicely Saunders, the pioneer of the modern hospice movement, has been a cornerstone challenge in healthcare delivery [4].

GPC refers to the care provided by healthcare professionals in healthcare settings that do not specialize in palliative care (PC) but rather integrate the task into their broader care and treatment approach [5, 6]. This differs from specialized palliative care, provided by dedicated hospices, PC units, and teams [5, 7]. Delivering GPC in hospital settings is still complex due to factors such as inconsistent access to specialist support, poor communication among healthcare providers, and delayed identification of PC needs, which can lead to delayed care [3, 8, 9]. Also, the organization of acute care, the interdisciplinary collaboration, clinician attitudes, communication structures, and insufficient education and training in palliative care principles can delay the provision of adequate PC for patients in hospital settings [8].

The challenges can also be attributed to organizational and cultural factors [10, 11]. In particular, a lack of coordination between different layers of the hospital's organizational structure has resulted in fragmented care and disjointed efforts for individual patients [11]. This reliance on chance in determining the care and treatment received by patients in their final stages of life highlights the need for hospitals to establish a cohesive framework that prioritizes continuity of care for each patient. These challenges and knowledge gaps are not unique to the Danish healthcare system [12], as international studies also highlight the need to further explore and improve the organization and implementation of PC [13]. Most recommendations on standards and norms for PC in European countries have remained unchanged since 2009 [14], which could indicate that there is a need to review whether the guidelines are still relevant or if the work in PC requires new approaches and organizational structures, but also how we do we translate these guidelines into clinical practice.

Furthermore, studies have shown a lack of understanding regarding why and how PC interventions and programs lose their effectiveness over time and how these initiatives can inadvertently have unintended consequences during implementation [13]. Therefore, there is a need to identify effective implementation strategies to enhance PC service organization [15]. It is recommended that managers and decision-makers should drive efforts to promote PC initiatives at all levels of the healthcare organization [16]. Similar efforts to improve PC treatment and care and the implementation processes involved are being sought in other countries by developing national strategies [17]. Finally, it is essential to acknowledge that PC interventions within healthcare settings are underreported, and further research is required to fully understand the complexities of these processes, particularly within the context of chronic diseases such as COPD, liver disease, and heart disease [18–20]. Nonetheless, national registries [21] have indicated that a considerable proportion of patients end their lives in hospitals, and a Danish study shows that 22% of all hospitalized patients die within one year after hospitalization [22]. This underscores the vital role of hospitals in providing GPC.

Based on this current knowledge and challenges, a hospital management in a large University Hospital in Denmark decided to develop a joint hospital initiative for GPC to improve end-of-life care for all patients with life-threatening diseases and their families admitted to the hospital irrespective of their diagnosis or location of admission.

Aim

This study aims to examine the barriers and facilitators on the organizational level during the process of optimizing general palliative care within a joint hospital initiative.

Methods

Setting

The study took place at a large University Hospital in Denmark. The hospital contains all specialties, except thoracic and neurosurgery, and is distributed across four geographical units. It has 1020 beds overall and 6000 employees. The clinical departments treat all kinds of patients, including patients with and without cancer. The hospital covered 1301 in-house deaths in 2023.

Design and methods

The study follows a qualitative research design. Its methodological approach is the four cyclical phases of action research by Coghlan [23], which will be described below. Action research inherently operates cyclically, involving iterative phases of problem construction, action and evaluation, and analysis. This paper presents the results of this cyclical work.

This method was chosen as action research addresses practical concerns in real-world settings and, through collaboration with leaders, practitioners, and researchers, to identify problems and co-create solutions to the identified issues. Action research is not used for purely theoretical inquiries, as it focuses on finding solutions to concrete challenges faced by practitioners [23]. The study

was a collaborative partnership between researchers, hospital- and department management, and PC resource persons.

Following years of grassroots advocacy by healthcare professionals for enhanced GPC, the hospital management issued a directive mandating GPC improvement initiatives across all departments. To facilitate this, two consultants (the first and last authors) were hired to assess the current situation and examine future perspectives with the department managers and stakeholders. The consultants were affiliated with the hospital's research department and, as such, were external to the departments under investigation. The last author was a physician with decades of experience in end-of-life decision-making, and first author was a nurse and associate professor whose area of research expertise was in the field of GPC. In addition, the second author was employed as a research assistant to participate in the analysis and conduct some of the evaluative interviews. This assistant was a nurse with a master's degree and had clinical experience with GPC in a medical departments.

Phase 1. Problem construction

The barriers and facilitators for working with GPC in the various departments were explored in the period March–May 2023 through qualitative interviews [24] performed by the first and last author. The participating departments were both clinical, paraclinical, and service departments as it is a foundation for the study to view the hospital as a whole organization, and the notion was that almost all professionals working in a hospital setting come across patients with life-threatening diseases, e.g. from an oncology specialist to the radiographer providing a bed x-ray on a terminal patient.

The initial interviews explored, through a semi-structured interview guide [25], how GPC was organized in the departments. This with the overall question: How is GPC currently organized within the department? Who are the PC patients in the department? How are the patients' needs identified (and what tools are used)? How is the conversation about the end of life ensured (including taking a position on the level of treatment)? What are the biggest challenges, and what is needed to overcome them?

The results from this phase were incorporated into phase two as the basis for the steps moving forward.

Phase 2 and 3. Planning and taking action

Based on the results from phase 1, a working group consisting of hospital management, researchers, and experienced clinicians developed a work package (the action) consisting of workshops/teaching based on the needs described by the department management in phase 1 as well as both national recommendations and knowledge in the field provided by the experienced researchers (Table 1) [26–28]. The workshops took place between May 2023 and March 2024 and lasted 1- 3 h, depending on the time provided by the departments, and were facilitated by the two consultants (first and last author).

It is important to note that the action taken (workshops) was not the evaluating point in this study. This study focused on the joint hospital initiative that strengthened GPC, and the barriers and facilitators encountered in this process. However, the iterative approach enabled continuous refinement of workshop experiences, fostering a culture of learning and improvement.

It was up to each department to develop an action plan to tailor it to their problem areas. The two consultants were available to advise on this process.

Phase 4. Evaluation

The evaluation of the process took place from December 2023 to August 2024 and was done by conducting qualitative interviews. These were performed by the first and second authors. Through a semi-structured interview guide, the evaluation interviews explored how the departments had been working with GPC within the last year. This is with the overall question: "What has happened since the initial meeting to strengthen GPC in the department?" "What needs further work?" and "What is the biggest challenge? What needs to be done to make it a success?" The focus was on the development of enhancing GPC on both the barriers and facilitators experienced from phase three to deduce which factors match the organization and what needs further development to achieve successful GPC integration.

Data material

The data collection for this study included interviews and workshops. The initial interviews in phase one were performed with 24 (out of 26 departments), and the participants were the department management (head doctor and head nurse) as well as their PC resource persons (if available). Furthermore, an interview was performed with a representative from the hospital management. The interviews were performed as online meetings, each lasting 45 min. In all, $n = 64$ participated in the initial interviews. Moreover, an interview with the head of the hospital ($n = 1$) was performed.

In phases 2–3 (workshops), $n = 14$ departments participated, including doctors, nursing staff, and department leaders. The workshops were facilitated by an experienced clinician (doctor) and a researcher (nurse) (last and first author) from the GPC field. Five departments developed an action plan.

Table 1 Content in workshops (action)

First, a general introduction to general palliative care was given, including knowledge of existing national guidelines. The package was adjusted to fit the need of each department as not all paraclinical departments needed point 2,3 & 5
This was followed by:
1. ***Reflections on one's own practice***
This section involved reflecting on the departments experiences in providing palliative care including:
- What are your strengths and weaknesses in providing palliative care?
- What are your personal beliefs and values about death and dying?
- How do you cope with the emotional challenges of providing palliative care?
2***. Identification of the palliative patient and assessment of the patient's needs***
This section would cover how to identify patients who need palliative care and how to assess their needs. By using validated tools such as Surprise question, SPICT and EORTC-QLQ-C15-PAL
- The different criteria that can be used to identify palliative patients
- The different tools that can be used to assess palliative patients' needs
- The importance of involving the patient and their family in the assessment process
3. ***The conversation with the patient about the end of life and the palliative care***
This section would focus on how to have a conversation with a patient about the end of life
- The importance of starting the conversation early
- How to create a safe and supportive environment for the conversation
- How to listen to the patient's wishes and preferences
- How to address the patient's fears and concerns
4***. Legal issues regarding the right to refuse treatment for nurses and doctors and documentation of the agreed level of treatment***
This section would cover the legal aspects of providing palliative care. This including:
- The patient's legal right to refuse treatment
- The nurse's and doctor's legal duty to respect the patient's wishes
- The doctor's obligation to decide level of treatment for critically ill patients
- The importance of documenting the patient's wishes
5. ***Collaboration with specialized palliative care***
This section would discuss how to collaborate with specialized palliative care teams. This including:
- The different roles of the generalist and specialist palliative care teams
- How to make a referral to a specialist palliative care team
- How to communicate and collaborate with the specialist palliative care team
6. ***Preparation of an action plan for the department's palliative care efforts—'what needs to happen in the short term and what next year'***
This section was a preparation of an action plan for the departments in order to achieve at strengthened general palliative care. This including:
- The goals of the action plan
- The specific steps that need to be taken to achieve the goals
- The timeline for implementing the action plan
- The resources that will be needed to implement the action plan
The plans were developed by the departments. Following the workshops it was planned that that the department management shared a post summarizing the key points of the action plan

In phase 4, evaluation interviews on the process were performed with 16 out of 26 departments. The participants were the management (head doctor and head nurse) and their PC resource persons. The interviews ranged in duration from 20 to 60 min and were performed either in person or online, depending on the participant's preference. In all, $n = 27$ participated in the evaluation interviews. A follow-up interview with the hospital management representative was performed ($n = 1$).

The discrepancies in N between phases one and four arose because departments that indicated in the initial interviews to have minimal contact with GPC (fx service departments, ophthalmology, and nuclear medicine) did not participate in phases two and three and, therefore, were not in the evaluative interviews.

Data analysis

In phases 1 and 4 of the study, the interviews were transcribed and summarized by the first author, and the department managements approved the summary. Braun

and Clarke's thematic analysis method was employed to analyze the interviews. This method was chosen due to its widespread use in qualitative data analysis and flexible approach [29]. The analysis consisted of six phases: familiarization, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and finally presenting the results in this paper. In phases 1–4, the codes and search for themes were applied to all the data material to provide a comprehensive understanding of the barriers and facilitators encountered in optimizing GPC within a joint hospital initiative. The second author performed the initial analysis and coding, followed by a joint analysis between the first and second authors. The preliminary themes were discussed with the last author, and through a collaborative process, the final themes emerged. The process was inductive within the framework of eliciting meaning about the organization of GPC in the departments.

The data in phases 2–3 came from the workshops and the action plans. The action plans included working towards more systematic screening, better interdisciplinary collaboration, and communication. Still, only five departments completed these, as it was not mandatory, making the evaluating interviews essential for gaining knowledge on the actions taken during the project period. In the evaluating interviews, participants were questioned regarding the follow-up on items within their action plans and their experiences of the workshops. These responses were incorporated into the thematic analysis presented above. The action plans and workshops themselves were not analyzed as separate entities.

Ethical considerations

The study has been notified and approved by Region Zealand's Research Register with no. REG- 002–2022. Ethical approval was not required, according to the Regional Ethics Committee for Medical Research (nr. EMN- 2022–015750157).

Furthermore, the ethical principles in the Declaration of Helsinki [30] were followed so that all participants were informed about the project and were guaranteed anonymity. The participants received oral and written information about the project and gave written consent before the project started.

Conducting action research demands a high degree of researcher reflexivity [23], given the direct involvement of researchers in the action under study. This rigorous approach was crucial in addressing the diverse motivations, interests, and objectives of the multiple stakeholders involved in the study. The researchers' personal beliefs, values, and preconceptions also played a role, presenting ethical challenges that were carefully navigated. As previously noted, the consultants involved in data collection for this study possessed familiarity with the GPC field. The establishment of a larger steering committee served to mitigate the potential influence of the consultants' prior experiences and preconceptions. This was facilitated through monthly discussions within the full author group, where the consultants shared their ongoing observations and experiences gathered during the data collection process. Importantly, all voices, including those critical of the study, were acknowledged, ensuring a comprehensive and balanced approach.

Results

The data analysis identified three themes, and the results are presented below:

Theme 1: Delivering GPC – from lack of systematic approach to increased awareness

The initial interviews revealed several challenges (barriers) with a systematic approach to GPC. A key challenge identified by the respondents was the lack of a standardized structure (who does what, when?), revealing the complexity of integrating GPC care into a fast-paced clinical environment to guide who initiates end-of-life discussions at the appropriate time.

> *The biggest challenge is that palliative care competes with all the other things that need to be done. (Cardiology)*

This was further compounded by the demands of daily clinical routines, making it challenging to identify patient needs effectively. Despite the knowledge of existing tools for use in GPC, a systematic approach to identifying and registering patient needs was lacking, and the PC tools were used primarily for terminally ill patients.

> *There is no systematic identification and registration of needs. We know EORTC, but it is not used systematically and primarily for terminal patients. (Oncology)*

This was also supported by the hospital management, who viewed the lack of a systematic approach as the catalyst for the joint project:

> *GPC in the hospital is currently provided by dedicated individuals within each department, often in an ad-hoc and sporadic manner. (Hospital Management)*

However, what seemed to strengthen (facilitate) the systematic approach was employing PC resource persons in the departments, which was described as making a significant difference in the work by strengthening GPC.

The employment of a resource person has had a great impact on the department's efforts. We are doing well. (Medical Department)

However, it was also described that the PC resource persons were challenged regarding knowledge sharing and ensuring that every healthcare professional involved in patient care had the same understanding. The departments with employed resources expressed that GPC was allocated to only the PC resource persons, making it a vulnerable organizational solution.

One of the challenges in the department is that the palliative patients are only Maria's patients. (anonymized PC resource person in Surgical Department)

Throughout the project, what seemed to change from the initial to the evaluating interviews was the increased awareness of GPC in the departments.

… there has been a greater awareness of the palliative patients in the ward, especially after the workshop. (Surgical Department)

We consider palliative care in many contexts to a greater extent than before and are good at getting a decision on the treatment level. (Medical Department)

In the evaluating interviews, several respondents expressed that the departments were implementing various strategies to identify patients with PC needs early. These include utilizing validated tools like SPICT [31] and Surprise Question [27] and systematically evaluating patient symptoms with ESAS [32] scores in the outpatient clinic.

Efforts are being made to define and identify early those patients who need palliative care. (Cardiology)

During the study, several departments reported starting local projects to strengthen GPC. Some established dedicated PC groups in the departments, and another local department project focused on facilitating conversations about Advance Care Planning (ACP). Furthermore, two projects delved deeper into the specific needs of nephrology patients requiring palliative care, and two departments are piloting projects on Shared Decision Making.

However, several barriers were expressed in the evaluating interviews regarding what hampered these initiatives and the lack of development of action plans in phases two and three. This was mainly due to hospital savings and day-to-day operations, as the hospital went through a sizeable economic saving round during the study period, meaning the departments had to find ways to reduce their spending significantly.

The biggest challenge is that the day-to-day operation swallows a lot, and it is difficult to find time and space to meet. (Cardiology)

At the moment, it is the art of the possible due to savings (Surgical department)

In sum, the respondents from the departments went from sparse knowledge and systematic approach in the initial interviews to reporting about many initiatives in place to strengthen GPC when evaluating their efforts during the project year. Still, the daily operation and hospital savings also impacted the initiatives as prioritizing had to be made.

Theme 2: Strengthening interdisciplinary communication and collaboration

This theme refers to the department's call for better cooperation in the individual departments and across departments and specialties at the hospital. While the initial interviews revealed that the respondents assessed that dedicated healthcare professionals staffed their departments, they also emphasized a need for a more structured and interdisciplinary approach to enhancing the GPC effort, which suggests a desire to move beyond individual efforts and establish a more systematic departmental framework.

There are many good forces in the department, but there is a lack of a structured and interdisciplinary approach, and we would very much like to become better at talking to patients about death. (Medical Department)

Interdisciplinary consensus, meaning agreements between different health care professionals involved in a patient's care, also emerged as a significant challenge as the respondents mention discrepancies in decision-making between nurses and doctors:

The biggest challenge we see in the department is to achieve more interdisciplinary consensus, as we experience that nurses and doctors do not always agree on decisions. (Cardiology)

This was further highlighted by the apparent lack of doctor involvement in GPC as it was often the nursing staff who were most enthusiastic about the involvement in participating in the workshops:

Engaging medical doctors in GPC is a significant challenge. I believe doctors should consistently con-

sider palliative care as an underlying factor in patient management. It is important that we not only focus on what we see with the eye but also what we see with the heart. (Hospital Management)

This created a key barrier to disseminating knowledge to ensure everyone had enough knowledge on GPC. Ideally, the department management aimed to ensure that all healthcare professionals had sufficient knowledge and felt comfortable collaborating on GPC matters. However, the interviews also revealed that late initiation and documentation of GPC were a part of the current situation.

The challenge is knowledge dissemination - that everyone has enough knowledge and are focused on working with palliative care. (Medical Department)

The department management viewed this as a difficult task. Although they were very clear in their communicated direction for GPC in the department, they struggled to change the culture and have not *"cracked the code to create the change that is needed" (Surgical Department).*

The hospital management emphasized the leadership perspective and recognized that the initiative also requires strong leadership.

I want to contribute to sowing the seed of palliative care - and management has a responsibility, and decisions should be made collectively. (Hospital Management)

The evaluation interviews stated that there had been an increased focus on collaboration between the departments during the project period, which is an advantage as some departments treat the same patients. Furthermore, some departments reported enhanced cooperation with general practitioners as well as the primary sector:

We have established good cooperation with the gynecology department in recent months and think this works much better now. There have also been major improvements in cross-sectoral collaboration, as collaboration with general practitioners and home care has improved much over the past year. (Urology)

However, this was not an unequivocal finding as some departments, both in the initial and evaluation interviews, reported that a significant barrier in GPC work was collaboration with the primary sector and hospice:

Lack of increased cooperation between hospital, municipality and hospice. It feels that the hospice does not take the referrals made, and there is no transparency about how searches are carried out. (Medical Department)

A challenge described in the initial and final interviews was who took responsibility for decision-making. For example, the emergency department was very dependent on other departments deciding on the treatment level, as the patient's condition in the emergency department was often so bad that it was difficult to assess:

The department is entirely dependent on good decisions being made before they enter the emergency department. (Emergency)

There was an explicit desire for the departments at the hospital to share knowledge to a greater extent, both about the patients and about knowledge about GPC in general, so that the departments could learn from each other. However, this organizational set-up was experienced as lacking.

(There is a need)....To strengthen collaboration across departments, where knowledge is shared, and experiences are exchanged about the palliative patients. (Otorhinolaryngology)

From the initial to the evaluative interviews, an increased collaboration could be seen to some extent. However, there were still wishes for more robust interdisciplinary communication and cooperation, demanding an organization where knowledge can be collected and shared between departments and extended to the primary sector and the level of specialized palliative care.

Theme 3: Paraclincial involvement in palliative care—balancing treatment protocols with patient well-being

The analysis showed that the paraclinical departments played a significant role in GPC at the hospital and highlighted the ethical challenges faced by healthcare professionals working in these departments. The central concern was the potential tension between adhering to standard treatment protocols and prioritizing patient comfort and quality of life during the final stages.

In the initial interviews, the healthcare professionals from paraclinical departments expressed feelings of meaninglessness when subjecting terminally ill patients to seemingly unnecessary tests and procedures. They viewed these interventions as disrupting crucial moments of connection and reflection for patients and their grieving families. Furthermore, following prescribed protocols despite ethical discomfort created moral stress for health care professionals as, for example, extracting blood samples from dying patients can elicit feelings of intrusion and violation.

I feel I am violating by standing and taking blood samples from patients who are dying. (Clinical biochemistry department)

Furthermore, a need was expressed for a more nuanced approach to patient care in the context of terminal illness. Balancing the potential for marginal medical benefit with the emotional well-being of patients and families is crucial for ensuring ethical and compassionate care.

> *Can it be right that terminally ill (palliative) patients have to undergo an examination that may not have a major impact on treatment and which is associated with discomfort for the patient? (Radiology)*

> *Why do they (the patients) need to have/be subjected to this test? (Clinical biochemistry department)*

It was expressed that healthcare professionals from paraclinical departments feel they lack a voice in deciding whether PC patients should undergo various treatments. The interviews raised an essential question about balancing providing medical treatment and respecting the patient's wishes.

> *We feel like we are subjecting patients to unnecessary tests and disturbing important last moments with families in grief/crisis. (Clinical biochemistry department)*

This also led to healthcare professionals questioning many recent tests, whether a blood test or an X-ray was essential before they felt comfortable "releasing" them, and it almost got to the point where people were joking that doctors needed a final test before they could let patients die.

> *Sometimes we call it Saint PETer because you need a PET scan before you can be admitted through the gate (of death). (Radiology)*

The analysis showed that, throughout the project, the paraclinical departments placed a much greater focus on being part of the effort.

> *Something new has happened since the last time, other than great enthusiasm in the department, which has been expressed for being involved in the project and happy with the teaching (workshop). (Radiology)*

The most significant barrier remained that tests are ordered in the departments, making the paraclinical departments highly dependent on the organization and staffing handled there.

> *There is a lack of tools to be able to improve workflows as this often lies in the departments. (Radiology)*

Initiatives during the study were also observed in some departments that made it easier for the paraclinical departments to access the rooms of terminal patients. For instance, one department was seen as having positive signage on the patient's door, which was experienced as an invitation to greater collaboration with health care professionals in the departments.

> *Some departments have put up signs that indicate that you must turn to a nurse when you enter the ward, and this is a help for the bio analysts also in the palliative courses - you stop straight away. A small step with a big meaning. (Clinical biochemistry department)*

In sum, this study found that paraclinical departments play an essential role in hospital GPC. However, the healthcare professionals in these departments face ethical dilemmas and feel a lack of voice in decision-making.

Discussion

This study focused on the challenges of coordinating work across an entire hospital and aimed to understand the barriers and facilitators of this joint approach, which will be discussed below.

Barriers to strengthening a joint GPC initiative

The challenges in providing GPC in hospital settings have been well described [1]. The hospital as an institution has exhibited a complex and challenging nature, often prioritizing acute curative care, leaving little room for PC efforts [3, 11].

Lack of standardized structure and procedures

The initial phase of our study revealed several *barriers* to strengthening the joint GPC initiative, such as the lack of a standardized structure for the distribution of responsibility for patients and the complexity of integrating GPC care into a fast-paced clinical environment. Daily clinical routines and limited time complicated the situation, making it challenging to identify patient needs and prioritize GPC effectively. Additionally, existing tools for identifying patients requiring GPC were often underutilized and restricted to terminally ill patients, even though national and international guidelines recommend early identification and planning [5, 7, 9, 33]. Also, a lack of established channels for sharing knowledge and experiences between departments about GPC and patient care limited the collaboration and this lack of structured, interdisciplinary collaboration across departments seemed to hinder the enhancement of GPC in the hospital.

Another barrier was a lack of standardized procedures for initiating and conducting GPC discussions. This resulted in confusion among healthcare professionals

regarding who should initiate these conversations and the appropriate timing in line with other studies [34], which describe unclear roles, inadequate competencies, and an unsupportive physical and organizational environment, hindering effective communication about patients' wishes and long-term care planning. This confusion regarding the responsibility of GPC decision-making was expressed particularly in the emergency department as they expressed dependency on other departments deciding on the treatment level. Discrepancies in treatment-level decisions were described between nurses and doctors, which some of the departments addressed by taking a collaborative approach between physicians, nurses, and other healthcare professionals in GPC. This constitutes a significant barrier to effective care as this confusion may cause ambiguity surrounding responsibility for GPC decision-making. This interdepartmental dependency underscores the need for clearly defined protocols that delineate responsibilities and facilitate seamless care transitions. Furthermore, observed discrepancies in treatment-level decisions between nurses and doctors within the same department highlight the lack of a unified approach to GPC. The fact that collaborative discussions are implemented on a departmental level, rather than as a system-wide standard, suggests a recognition of the problem without a comprehensive solution. This inconsistency in practice perpetuates confusion and potentially compromises the quality and consistency of patient care. However, such system-wide standards also require targeted education and training for all relevant healthcare professionals to develop GPC competencies alongside clarifying roles and responsibilities. However, it has been highlighted that the specific competencies required at the GPC level for physicians and nurses remain unclear; there is a consensus that conversations are considered a necessary task [35, 36].

Our study furthermore revealed that the hospital faced significant pressures from mergers and budget cuts during the project period, necessitating departmental adaptability. We see this as a condition in the work with hospital GPC, and future initiatives should acknowledge the dynamic and ever-evolving context in which such changes must occur. Considering these dynamic factors, we see it is essential for hospital leadership to adopt a flexible and adaptive approach to GPC initiatives. This includes an ongoing assessment of the effectiveness of existing protocols, fostering a culture of continuous improvement, and focusing on GPC.

Lack of paraclinical involvement

Another finding in our study was related to the paraclinical involvement in GPC, which, to our knowledge, was unique new knowledge in the field of GPC. As the paraclinical staff expressed in the initial interviews that they were not conceived as part of the GPC, it created ethical concerns among the staff. They often had a conflict between adhering to standard treatment protocols and prioritizing patient comfort and quality of life during their final stages. They expressed concerns about subjecting terminally ill patients to seemingly unnecessary and potentially disruptive tests and procedures creating moral stress for paraclinical staff. They also felt they lacked a voice in determining if PC patients should undergo specific treatments. From this there is a potential in the involvement of these departments. By including paraclinical departments in PC discussions, we argue that it may contribute to the early detection of potential complications, allowing for timely intervention and prevention of unnecessary suffering, ultimately reducing the need for multiple referrals and improving efficiency and resource utilization. The theory of Relational Coordination by Gittell [34] posits that successful collaboration in highly interconnected work environments depends on strong relationships characterized by shared goals, knowledge, and mutual respect. Effective, timely, accurate, and focused problem-solving communication is key to maintaining these relationships. From our study, we see that paraclinical and clinical departments should cooperate to establish clear, shared goals that align with the overall objectives of patient care. This includes ensuring that both groups understand the specific needs and challenges of patients with PC needs, which may lead to more informed decision-making and better care coordination.

Facilitators to strengthening a joint GPC initiative

The study also identified several *facilitators* that fostered a more proactive approach to GPC. This was in both what the departments already had GPC initiatives working for them in the initial interviews and the actions taken throughout the project period.

Palliative care resource persons

In our study, employing dedicated PC resource persons within departments improved GPC and provided dedicated expertise and support. Resource nurses have been shown to contribute to high-quality PC by role modeling, knowledge sharing, and fostering collaboration, but knowledge and support are required to fulfill this role [37, 38]. Our findings indicate that knowledge sharing is challenging and heavily reliant on individual PC resource persons, creating a vulnerable GPC foundation. This vulnerability is further compounded by the ambiguity surrounding the competencies required of these resource persons. As previously noted, a lack of clarity exists regarding the requisite GPC competencies in general,

leaving individual departments and resource persons to define the scope and content of their roles and the specific skills required. This decentralized approach risks creating a fragmented and inconsistent GPC landscape, making it up to the individual resource person to execute the tasks. Future strategies should distribute knowledge management responsibilities to build a robust, sustainable framework to withstand staff turnover.

Increased awareness

What also seemed to facilitate GPC awareness was the increased focus on GPC, which was established throughout the study period. Here, it is essential to note that the hospital management established the project, which was also reflected in the interviews, as the hospital manager had a great interest in enhancing GPC. It was communicated to the department managements that the project was important (top-down decision) based on years of grassroots movements in the departments (bottom-up) led by passionate individuals who were committed to GPC. This may have led to the departments dedicating themselves to a greater degree as it was a wish from a higher organizational level. It has been described by Chisholm et al. [32] that there is a relationship between administrators' awareness of the relationship between resources and PC programs, and there is a great task for the hospital management in determining the resources spent on strengthening PC programs. Managerial support is crucial [35] in integrating PC into healthcare as it can create a conducive environment, align resources, and inspire employees to achieve common goals. We see this as a primary facilitator for the process and progress of this study. A recent study in Australia [39] emphasizes that optimizing GPC within hospitals requires changes in policies, practices, education, and research aligned with patient and family needs and suggests that achieving this transformation demands a collaborative, nationwide effort with strong leadership at both national and regional levels.

The awareness from our study seemed to facilitate several local departmental initiatives, from the establishment of dedicated GPC teams to projects on shared decision-making. However, these were local initiatives that grew out of the department's wishes and needs but were not planned with the rest of the hospital's departments, making them unconnected. This calls for an overall strategy for the hospital GPC to systemize the steps taken with the possibility of adapting the initiatives to the single department's context.

It is important to note that the hospital cannot work alone to find GPC solutions. The primary care sector is an important player. Forbat et al. [38] have shown that a specialist PC intervention in residential care homes can reduce time spent in acute hospitals and also inpatient PC consultations can have a positive impact on patient outcomes and transitions to the community, which can relieve overburdened acute care systems [38]. Therefore, cross-sectoral collaboration is essential in the patient's trajectory with PC needs to ensure continuity for the individual patient and their relatives. The healthcare system is a single unit on some parameters, but organizationally, it is fragmented, which creates the challenge for good cooperation, and with new reforms in the healthcare system [40], new collaborative models may also need to be developed that think of GPC as a coherent process across hospitals, primary care, specialized PC, and general practitioners.

In our study, the next cycle in the action research process is under development, in close collaboration with relevant stakeholders, and will include the results from this study. What is already planned is an upgrade of PC resource persons in all departments as well as the establishment of a center for GPC working with the development of a minimum standard for GPC, as also suggested by Hentcsh et al. [41]. Based on this study, we recommend researching paraclinical interventions and implementation processes to ensure systematic and coherent PC trajectories.

Strengths and limitations

This study focuses on the challenges and facilitators on the organizational level, and we see this as both a strength and a limitation. A strength as this is not much highlighted in the GPC literature, but also a weakness as many other factors influence how GPC can be carried out, such as external factors such as education, cross-sectoral agreements, and individual factors in the individual healthcare professional.

The limitation of an action research study relates to generalizability and subjectivity as a bias [23].

Firstly, as this study was conducted in a specific Danish hospital context, the findings may not apply to other situations. The unique circumstances of the study limit the ability to draw broad conclusions or generalize beyond the scope of this study. Secondly, the study involved active participation from the researchers (authors), which may introduce subjectivity and bias as the researchers' personal beliefs, experiences, and perspectives may influence all stages of the study. To address this issue, the working group held regular meetings to discuss it and any other challenges during the study. Furthermore, an experienced action researcher was consulted during the study.

Another limitation is that the evaluation relied on self-reported data, and we lacked concrete evidence of the effectiveness of the implemented initiatives.

The strength of this study lies within the novelty as, to our knowledge, no other research studies have undertaken a joint hospital initiative. Additionally, all departments within the hospital were involved, to varying degrees, which we see as a strength of the action research as it emphasizes collaboration and active participation of various stakeholders, which fosters a sense of empowerment among participants, as they are actively involved in identifying problems, strengthening initiatives, and evaluating outcomes. We saw that this involvement led to increased motivation, ownership, and engagement in the study.

Conclusion and future perspectives

This study underscored the complexities of strengthening a joint GPC initiative across an entire hospital.

Despite the emergence of specific facilitators, like increased awareness and departmental initiatives on GPC, notable barriers remained, particularly concerning interdisciplinary collaboration and the incorporation of paraclinical care. Although interdisciplinary collaboration is recognized as crucial, it faces obstacles such as knowledge dissemination and decision-making discrepancies. Paraclinical departments play a vital role in GPC but encounter ethical dilemmas related to balancing treatment protocols with patient well-being.

Moving forward, it is essential to address these barriers to further enhance GPC delivery and develop a more cohesive and efficient approach within hospital settings. This will require sustained efforts to promote collaboration across disciplines, improve communication channels, and prioritize the integration of all healthcare sectors involved in PC. Focusing on ongoing education, training, and knowledge-sharing initiatives will also be crucial to overcome these obstacles and ensure the continuous improvement of GPC services. Future perspectives include continued research and development efforts to refine the GPC implementation process, alongside close collaboration with stakeholders to adapt strategies and interventions. By leveraging current insights and building on existing facilitators, hospitals can work towards creating a more seamless and patient-centered GPC program that meets the needs of patients and healthcare providers.

Abbreviations

GPC General Palliative Care
PC Palliative Care

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Authors' contributions

All authors (HB, CK, MZ, BBH, OG) conceived and contributed to the design and were involved in conducting the study. HB, OG, and CK collected the data and participated in the analysis. All authors were involved in the writing of the manuscript and read and approved the final manuscript.

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Data availability

All data generated or analyzed during this study are included in this published article.

Declarations

Ethics approval and consent to participate

The study has been notified and approved by Region Zealand's Research Register with no. REG- 002–2022. Ethical approval was not required, according to the Regional Ethics Committee for Medical Research (nr. EMN- 2022–015750157).

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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