Erie St. Clair End-of-Life Care Network
Hospice Palliative Care Education Blueprint

Nursing Guidelines for End of Life Care in Long-Term Care

Evaluation Report

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For:
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Glossary of Terms

Average (+/-)	Average is calculated as the mean score ; +/- = standard deviation, which is the average distance between individual scores from the overall average score.
CAPCE	Comprehensive Advanced Palliative Care Education
CCAC	Community Care Access Centre
COPD	Chronic Obstructive Pulmonary Disease
DNR	Do Not Resuscitate
EOL/ EOLC	End of Life / End-of-Life Care
ESC EOLCN	Erie St. Clair End-of-Life Care Network
ESAS	Edmonton System Assessment Scale
LHIN	Local Health Integration Network
LTC	Long-Term Care
NP	Nurse Practitioner
OSCMC	Ontario Cancer Symptom Management Collaboration
OT	Occupational Therapy
OTN	Ontario Telehealth Network
PCR	Palliative Care Resource
PPS	Palliative Performance Scale
PPSMC	Palliative Pain and Symptom Management Consultant
RT	Respiratory Therapy
SRK	Symptom Response Kit
SWO PPSMCP	Southwestern Ontario Palliative Pain and Symptom Management Consultation Program
PSW/HSW	Personal Support Worker/ Home Support Workers
RN/ RPN	Registered Nurse/ Registered Practical Nurse
WIFN	Walpole Island First Nation
WRCC	Windsor Regional Cancer Centre

Education Blueprint Evaluation Executive Summary

Erie St. Clair End-of-Life Care Network
Hospice Palliative Care Education Blueprint

INTRODUCTION

The Erie St. Clair End-of-Life Care Network has secured funding for several initiatives aimed at creating and supporting an integrated hospice palliative care system in this region. One of these initiatives is a multi-year framework for palliative / end-of-life care education consisting of the following initiatives:

1. **Volunteer Education:** Implementation of strategic volunteer education planning sessions; training programs to enhance the scope of volunteer training (e.g., Hands on Care training, Story Telling Project,) and promotion of the 'Share the Care' model to support informal caregivers/ volunteers***.***
2. **Cultural Education:** Working with First Nation representatives to identify the palliative care needs of this community develop strategies to meet these needs and to assess the training needs of health care providers working within the Walpole Island First Nation community.
3. **Skill Specific Education for Care Providers:** Implementation of two education programs to build capacity for palliative care: Physical Skills Education (pain and symptom management for community-based nurses: Year 1) and ER Avoidance Education (chemotherapy/radiation therapy side effects management education; Year 2). In addition, in Year 1, Community Resource Education sessions were delivered to increase awareness of available community resources and services.
4. **Nursing Guidelines for End-of-Life Care in Long-Term Care Settings Homes:** Training to support the implementation of EOL Care Nursing guidelines across all ESC Long-Term Care Homes.
5. **Expansion of Video-Conferencing Capacity:** Development of video-conferencing sites to support education across the system, including training of in-house support for video-conferencing operation.

A comprehensive evaluation of the Education Blueprint was undertaken, examining both outcomes (summative evaluation) and development and implementation (formative evaluation). The evaluation report provides detailed information about the methods and results. This report focuses on the evaluation of the Nursing Guidelines for EOLC in LTC education program.

EVALUATION METHODS

Evaluation objectives across all of the components of the Blueprint were aimed at:

i) Providing feedback on planning/ training sessions
ii) Identifying impacts associated with education
iii) Describing the development and implementation of initiatives
iv) Describing progress to date

A mixed methods approach (quantitative and qualitative) was used to achieve the objectives of this evaluation. Sources of information included:

- ***Feedback surveys*** completed by education participants to obtain reactions to the sessions (Volunteer training sessions, physical skills sessions, nursing guidelines for end-of-life care sessions); responses rates ranged from 73 -89%.

- ***Follow-up surveys*** to assess impacts of the education (physical skills, nursing guidelines for end-of-life care education programs); response rates ranged from 30-41%.
- ***Individual and focus group interviews*** with participants and managers (physical skills), managers to gather in-depth information on impacts and with initiative organizers to assess impacts and describe development and implementation (volunteer education, cultural education, expansion of videoconferencing capacity and the overall Blueprint initiative); in total 36 individuals participated in the evaluation interviews.

KEY FINDINGS AND CONCLUSIONS

Volunteer Education

- A total of 46 individuals participated in volunteer planning sessions; 51 individuals participated in various sessions aimed at volunteers.
- Training and information sessions (Hands on Care, Share the Care) were viewed positively; participants held favourable reactions to various aspects of these sessions including supporting resource material. Suggestions were made regarding improvements to delivery and potential topic areas for inclusion.
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- A partnership was formed with the Victoria Order of Nurses (VON) to deliver the Story-Telling Project; VON provided a coordinator to deliver the training and the Education Blueprint provided funding for resource materials.
- Cross-Sector Volunteer Planning sessions were well received; they were described as a significant opportunity for bringing all the sectors together to identify common needs, challenges, sharing of ideas, and solutions.
- Key impacts associated with the volunteer initiative have included: enhanced volunteer training, improved recruitment and retention, improved credibility of volunteers, and standardization of training and care.
- A number of factors were identified as facilitating the development and implementation of the volunteer training events: funding support, dedicated leadership and project management, and effective session facilitation. Challenges have included; tight timelines, lack of clarity/ understanding of in-kind contributions, limited follow-up support available, particularly for Share the Care, and limited local human resources to plan and prepare training events.
- Strategies for further implementation were suggested, including the need for clarity regarding in-kind contributions and continued opportunities for networking and planning.

Conclusions: The potential for enhanced training and concomitant enhancements to volunteer confidence, comfort, and performance are great. One of the most significant outcomes of this initiative has been the involvement of a broad range of stakeholders across sectors in the strategic planning of volunteer training in this region. Excitement was generated regarding the potential for shared training and resources as it was believed that this will have a significant impact on improvements to volunteer training across sectors and across the region. Further evaluation efforts might consider direct impacts of the training sessions on objective changes to volunteers practice (i.e., an examination of the ways in which volunteer work changes).

Cultural Education

- Two meetings were held to develop relationships within the Walpole Island First Nation (WIFN) community and 15 members of this First Nation's community are currently participating in the Fundamentals of Hospice Palliative Care education program

(PPSMCP). Seven members of the WIFN community were individually interviewed to identify palliative care/ end-of-life care needs and gaps.

- A major accomplishment has been the development of relationships with Walpole Island First Nation leaders and health professionals. These relationships have facilitated the identification of the palliative care needs of the First Nation population, strategies to address these needs as part of the Education Blueprint and those that could be addressed through the PPSMCP.
- Introduction/ delivery of the Fundamentals of Hospice Palliative Care Education program on Walpole Island for PSWs represents a significant opportunity to fill an identified gap and is the first palliative care specific education program that has been delivered on Walpole Island. The availability of funding and support from Chief Joseph Gilbert were identified as facilitating the introduction of Blueprint organizers into this First Nation Community.
- Initiative specific and service delivery challenges were identified: time constraints, the slower pace of activity within the First Nation community, limited system capacity for palliative care and socioeconomic challenges that hinder optimal palliative care, and the cultural relevance of the Fundamentals program (content and delivery).
- Key to ongoing capacity building will be opportunities for exploring the relevance of the Fundamentals program for the WIFN community.
- Needs and gaps in palliative care within the WIFN community were identified specific to resources for institutional care (retirement home, LTC) and better supported home care.

Conclusions: Significant headway was made in establishing relationships with First Nation's leaders and health professionals on Walpole Island. This process of relationship building will take time and will be critical for continued support and sustainability. Resolution of the issues associated with the Fundamentals program will be important to developing the trust of the First Nation leaders and health care providers so that continued capacity building can occur.

Skill Specific Education

- A total of 242 community-based frontline workers participated in the Physical Skills education program; 207 attended the Community Resources Education sessions.
- The Physical Skills sessions were well received by survey respondents; very few participants provided negative ratings and at least half of the respondents were able to identify changes to their knowledge and assessment and management skills.
- Interview participants described the Physical Skills sessions as largely review, particularly for those with previous palliative care education, and did not significantly impact practice change.
- The Community Resource Education session was described as most useful and the one in which participants learned the most "new' information.
- Overall, the sessions were described as a good opportunity to network with nurses from other agencies and share common experiences, challenges, and potential solutions, however, there were suggestions that this education did not need to be mandatory; it would have been preferable to target the Physical Skills sessions to new learners or to have basic and advanced levels to reflect existing capacity.
- Additional suggestions were made for improving the content, additional topic areas, learning supports and resources and the learning environment. Education delivered in conjunction with team meetings was a preferred format for delivery of education.

Conclusions: A number of positive impacts were associated with these sessions, including improved pain and symptom assessment and management and increased awareness of

available community support services. However, these perceptions were in contradiction of those managers and nurses who were interviewed; these individuals perceived that there was limited new information, thus they believed the sessions should not have been mandatory. Generally, there was much support for more palliative / end-of-life care education, for standardization of education, and ensuring that all community nurses are familiar with key palliative care concepts; both survey respondents and interview participants suggested additional topic areas that would be beneficial. Greater collaboration with the provider agencies around topic areas, scheduling, formats, and eligibility criteria may ensure greater "buy in" and support for future education.

Nursing Guidelines for End-of-Life Care in Long-Term Care Settings

- The Nursing Guidelines for End-of-Life Care education program was delivered to 62 individuals representing 16 LTC homes in the region.
- The sessions were well received by survey respondents; ratings of various aspects of the sessions and the session leader were positive.
- The nursing guidelines were also well received; intuitively they make sense, create a common language and common goals for end-of-life care thus creating consistency in care (standardized care, provide direction for less experienced staff) and are easy to use.
- The guidelines are being used with most/ almost all residents or at least some residents who were at end-of-life. Some homes have not yet implemented the guidelines because of competing initiatives (e.g., the implementation of the MDS-RAI), but they have plans in place to do so in the near future.
- Key practice changes resulting from this initiative were related to use of the standardized tools (PPS, ESAS), use of the admission review check list, use of the EOL care pamphlet which has opened dialogue with family members, and increased knowledge regarding the signs and symptoms of impending death. Health system improvements include improved quality of care in long-term care, standardized end-of-life care, and improved communication among providers.

Conclusions: Overall, this education program was well received and positively evaluated by participants. The training assisted participants to change their practice/ use the nursing guidelines. Homes have been challenged to implement the guidelines and in-house training by time constraints and competing initiatives. However, the guidelines are viewed as a priority and many homes have plans in place to implement them in the near future. Many benefits (impacts) have been associated with the use of the guidelines; they have the potential to increase quality of life for residents and quality of end-of-life care in long-term care through the use of standardized assessment tools, provision of a common language with which to describe end of life, and development of consistent/ standardized care plans.

Expansion of Video-Conferencing Capacity

- The expansion of video-conferencing capacity is currently in progress in two sites, one in Windsor, the other in Sarnia.
- A number of factors facilitated the development and implementation of this initiative including: Windsor Hospice's history of providing education, existing network infrastructure (Windsor site), dedicated project management support, partnership and mentorship across sites and support at all levels (Blueprint and site-specific leadership, IT, OTN).
- Challenges to date have included delays created by technological issues, tight-time lines, and planning for installation in a building that is not yet built.
- Key lessons learned in the implementation of this initiative have included: the importance of utilizing existing experience and having basic IT support available, acknowledging that

installation takes time, the need to ensure equipment is compatible across the system, and planning for use.
- Strategies to sustain use were identified reflecting the importance of ongoing funding, champions, IT and administrative support, and promotion.

Conclusions: The major objective of this videoconferencing initiative was to have one site fully operational by the end of the first funding year. Technical delays external to and beyond the control of project organizers have prevented the achievement of this objective. Information and resource sharing between sites has facilitated implementation at the Sarnia site. This experience as well as additional lessons learned, particularly the importance of dedicated project management and technical support can be used to facilitate successful expansion across the region. Leveraging of existing infrastructures, particularly as related to technological supports will assist in the selection in additional sites. Although videoconferencing has yet to be utilized for education, there is much anticipation that it will greatly impact accessibility to education across sectors and across the region and that travel cost savings will be realized. Important strategies for ensuring sustained use of the equipment were identified in this evaluation. Strategies related to planning for marketing and promotion, identification of key champions for its use and availability of IT and administrative support will also be important to facilitating initial use and success. When operational, opportunities to gather feedback from users on technology performance (sound and picture quality), satisfaction, comfort, benefits, and suggestions for improvement can be used to inform further development and implementation of this initiative.

Evaluation of the Overall Education Blueprint

- Across all of the initiatives of the Education Blueprint, various information, education, and planning sessions were delivered with 581 individuals in attendance.
- Development and implementation of the blueprint were facilitated by: existing information on education needs and gaps; existing and new infrastructure; financial support; effective leadership, and good communication, support at all levels; project management support and forced deadlines.
- Challenges to implementation included: short timelines, lack of existing infrastructure, relationships and champions in some areas, technological and personnel issues impeding completion of the video-conferencing initiative, competing projects, nursing layoffs, and limited cross-sector involvement.
- Key lessons learned that will assist with continued implementation have highlighted the importance of champions, funding commitment, dedicated human resources, support at all levels, networking and partnerships, leveraging existing structures, effective communication strategies, and evaluation.
- Suggestions for improvements and further implementation of the blueprint included: better admin support and financial accounting system, continued leveraging of programs and the need for: increased cross county and sector collaboration, more skill specific education, strategies to ensure knowledge transfer, greater emphasis on a systems-level approach, continued leadership and promotion and the need to clarify responsibilities regarding in-kind contributions.
- Although the short time makes it difficult to demonstrate improved competency at a system level, early impacts were identified related improved quality of care, increased access to palliative care education and capacity building for health care providers and volunteers, enhanced relationships/ partnerships for education, improved coordination and integration of education; increased participation of the volunteer sector and increased awareness of palliative care issues across the system.

CONCLUSIONS: Based the results of this evaluation the following conclusions can be made:

- The ESC EOLCN Education Blueprint has accomplished a great deal in a short period of time. Overall objectives were largely achieved and those that were not were beyond the control of Blueprint organizers (e.g., technological delays with the videoconferencing installation). A number of important training/ education programs were held for volunteers and frontline workers in the community and long-term sectors. The sessions were generally well attended and well received. Although there were some challenges experienced in implementing these initiatives, some unique to the specific programs (e.g., the mandatory nature of the Skills Specific sessions) and others common across all program (e.g., tight lines, competing priorities), changes in practice and benefits to care recipients and their families, care providers and the health system were identified. Major achievements identified across the initiatives of the Blueprint highlight the support for more palliative / end-of-life education in this region and the importance of relationship and partnership building, opportunities for networking across sectors and across the region to share ideas and resources, and inclusion of all key stakeholders in planning and decision making in order to maximize education strategies, including leveraging existing infrastructure and resources for capacity building.

- The need for enhanced palliative care is well documented in the published literature and there is much support for education as a strategy to improve care. The initiatives of the Education Blueprint have the potential to have a significant impact on palliative care across the region. The Blueprint provides an opportunity to provide a coordinated, integrated, and standardized approach to education. This type of approach to palliative care education is unprecedented in southwestern Ontario, and most likely the entire province. This evaluation has identified a number of important and practical strategies for sustainability and further development, many of which will further enhance education efforts (e.g., planning for shared implementation of volunteer education, exploring how existing education programs meet the needs of the WIFN learners, building skill specific education on existing capacity, mentorship support for ensuring practice change and greater inclusion of the long-term care, complex continuing care, and acute care sectors). Increasing capacity for palliative care across the continuum of care by ensuring the consistent use of assessment tools, common language, and care models will serve to support and enhance other initiatives of the ESC EOLCN aimed at enhancing palliative care (e.g., the expansion of Palliative Consultation Teams across the region).

- This evaluation identified many factors that facilitated and challenged the development and implementation of education programs. Attention to these factors as well as identified lessons learned will serve to inform and maximize education efforts going into Year 2 of this initiative. Similarly, this evaluation identified factors that facilitated and challenged application of education to clinical practice. Attention to these factors as well as strategies identified by evaluation participants to support knowledge transfer (e.g., resource materials, mentorship and follow-up support) will also serve to support education efforts going into Year 2.

Evaluation Limitations: The identified impacts associated with the training provided as part of the Education Blueprint were largely self-reported by key stakeholders and anecdotal; objective measures of impacts (i.e., performance/ outcome indicators providing empirical evidence of practice changes and impacts) while difficult to develop would provide validation of the qualitative data generated by this evaluation

Executive Summary: Nursing Guidelines for End-of-Life Care Training

Introduction: Training was provided to RNs and RPNs to support the implementation of EOL Care Nursing guidelines across all ESC LTC homes. Three sessions were held (one per county). A total of 64 individuals participated in these sessions.

Evaluation Methods: The evaluation objectives for this program were to: i) Provide feedback on the training initiative; ii) Describe the implementation of the guidelines and identify potential impacts. Participants at each of the three sessions completed a **feedback survey** to gather their perceptions of the training session**.** At least two months following training, participants were invited to complete a **follow-up survey** to gather information on the implementation of the guidelines and potential outcomes for patients and the health care system.

Key Findings:
Session Feedback: Overall, feedback was very positive; the majority of respondents rated pace, volume of material, complexity, and opportunities to participate, as "just right" and rated the training as "very helpful" to their use of the nursing guidelines. Similarly, the leaders' ability to communicate, ability to clearly answer questions, and preparedness was rated as "very good" or "excellent". Overall ratings of the leader were "excellent".

Feedback on the guidelines: The nursing guidelines were well received. The majority of respondents rated the guidelines' ability to create a common language for describing end-of-life care, develop effective care plans, and improve end-of-life care as "very good" or "excellent". Respondents commented that the guidelines intuitively make sense, create a common language and common goals for end-of-life care thus creating consistency in care (standardized care, provide direction for less experienced staff) and are easy to use.

Use of the guidelines: The majority of respondents reported that they are using the guidelines with most/ almost all residents or at least some residents who were at end-of-life. Some homes have not yet implemented the guidelines because of competing initiatives (e.g., the implementation of the MDS-RAI), but they have plans in place to do so in the near future. Access to resource materials was identified as a key factor facilitating use of the guidelines. Insufficient time and opportunities to apply learned information and skills were as identified as challenging respondents' ability to apply the nursing guidelines.

Impacts: Key practice changes resulting from this initiative were related to use of the standardized tools (PPS, ESAS), use of the admission review check list, use of the EOL care pamphlet which has opened dialogue with family members, and increased knowledge regarding the signs and symptoms of impending death. It was noted that family understanding of end-of-life care, quality of care and life and continuity of care for residents has improved. Health system improvements include improved quality of care in long-term care, standardized end-of-life care, and improved communication among providers.

Conclusions: Overall, this education program was well received and positively evaluated by participants. The training assisted participants to change their practice/ use the nursing guidelines. Homes have been challenged to implement the guidelines and in-house training by time constraints and competing initiatives, However, the guidelines are viewed as a priority and many homes have plans in place to implement them in the near future. Many benefits (impacts) have been associated with the use of the guidelines; they have the potential to increase quality of life for residents and quality of end-of-life care in long-term care through the use of standardized assessment tools, provision of a common language with which to describe end-of-life, and development of consistent/ standardized care plans.

1.0 Introduction

Training was provided to RNs and RPNs to support the implementation of EOL Care Nursing guidelines across all ESC LTC homes. This three and a half hour training program emphasized a provision of a framework for Hospice Palliative Care, an introduction to palliative / end-of-life care pain assessment and management tools (Palliative Performance Scale, Edmonton Symptom Assessment System), and the implementation of nursing guidelines for end-of-life care. Based on the Palliative Performance Scale (PPS), these guidelines provide a cuing mechanism for nurses to initiate end-of-life care activities according to residents' functional levels. As part of this session participants viewed the video *Dying for Care.* This education was delivered by Carole Gill, Palliative Care Consultant, who along with Ann Brignell, PPSMC, provided mentorship support to LTC homes as they implement the guidelines. Each session was video-taped; each home received a copy of the video and education materials for in-house training.

Sessions were held in three counties:

- ***Kent County (Dover Centre):*** February 10, 2009; 10 participants (4 RNs, 5 RPNs, 1 discipline unknown), two representatives from each of 5 long-term care homes), plus one guest (PPSMC).
- ***Lambton County (Sarnia)***: January 26, 2009; 20 participants (11 RNs, 9 RPNs), two representatives from each of 10 long-term care homes, plus two guests (nurse practitioner, physician)
- ***Essex County (Windsor):*** February 12, 2009; 32 participants (15 RNs, 16 RPNs, 1 discipline unknown), representing 16 long-term care homes (two representatives from each of 14 long-term care home, one home had only one representative, another home had three representatives), plus 5 guests.

Across all three counties, 62 individuals participated in this education program.

2.0 Evaluation Objectives and Methods

Evaluation Objectives: The evaluation objectives for the Nursing EOLC guidelines training program were to:

i) Provide feedback on the training initiative:
    - What are the participants' overall ratings of satisfaction with this education/training session?
    - What are the participants' reactions to program content?
    - What are the participants' reactions to the leader's facilitation skills?
    - Suggestions for improvement and identification of unmet needs.
    - What are learners' intentions to change their practice based on this education program (reflection on learning and practice)?

ii) Describe the implementation of the guidelines and identify potential impacts (changes to EOLC practice):
    - What are some of the facilitators and barriers to optimal implementation of the guidelines?
    - How frequently are the guidelines being used?
    - What supports or resources are needed to improve and sustain use of the guidelines?
    - What do nurses think of the guidelines (usefulness, ease of use, practicality, ability to improve EOL care)?

- In what ways does clinical practice change as a result of using the EOLC guidelines?
- What have been the patient- and health system-related outcomes as result of the guidelines?

Source of Information: To meet the above evaluation objectives the following sources of information were employed:

Education/ training Feedback Survey: Participants at each of the three sessions completed a survey to gather their perceptions of the session (as described above). Reflective questions related to intentions to improve practice based on new knowledge/skills were also asked. This survey is presented in Appendix A. At two of the sessions (Kent and Essex counties) the paper based survey was completed towards the end of the session with time allotted within the agenda for survey completion. Participants from the Lambton county session received a survey by postal delivery to complete.

A total of 48 training feedback surveys were completed across the three sessions[1] (77% response rate).

Follow-up Survey: Participants were invited to complete a follow-up survey to gather information on the implementation of the guidelines and potential outcomes for patients and the health care system (as described above). This survey is presented in AppendixB.

At each of the training sessions participants were asked to provide their e-mail address so that they could be sent a link to complete the survey on-line (www.surveymonkey.com). Those who did not have internet access were asked to provide a postal address so that they could be mailed a survey. Consistent with the method of e-mail survey distribution recommended by Dillman,[2] learners were invited to complete the survey via e-mail and received follow-up reminders via e-mail to complete the survey. Survey completion was anonymous; learners were not required to identify themselves on the survey.

The on-line survey was available for completion for a 2-week period from March 9 to March 23, 2009; this deadline was extended to March 27 due to a low response rate. Invitations to complete the on-line survey were initially distributed to 33 individuals; 3 of which were undeliverable (incorrect/ inactive e-mail address), thus a total of 30 invitations were distributed. Paper-based surveys were distributed to 29 individuals via postal service. In total, 59 individuals were invited to complete a survey; 24 were completed (41% response rate).

Half of the survey respondents were registered nurses and less than 25% were CAPCE trained (See Table 1). There was much variability in the amount of time that respondents have been working in long-term care (.5 – 37 years), with the average being 10 -12 years across both surveys.

[1] Completed surveys by county: Kent: N = 9 (90% response rate); Lambton: N=7 (35% response rate); Essex: N=32 (100% response rate).
[2] Dillman, D.A. (2000) *Mail and internet surveys. The Tailored Design Method 2nd Ed.* New York: John Wiley and Sons.

Table 1: Description of Nursing Guidelines For EOL Care Sessions Feedback (N = 48) and Follow-Up Survey Respondents (N = 24)

Demographic Variable	Feedback Survey Percentage (#)	Follow-up Survey Percentage (#)
Discipline :		
Registered Nurse	50.0% (24)	50.0% (12)
Registered Practical Nurse	45.8% (22)	41.7% (10)
Personal Support Worker	2.1% (1)	0
Health Care Aide	0	0
Other*	2.1% (1)	0
Completion of the Comprehensive Advance Palliative Care Education (CAPCE)		
Yes	22.9% (11)	25.0% (6)
In Progress	12.5% (6)	4.2% (1)
No	64.6% (31)	54.2% (13)
Number of years working in Long-Term Care		
Average (+/-)	10.0 years (8.3)	11.9 years (10.0)
Range	.5 – 37 years	1 – 37 years

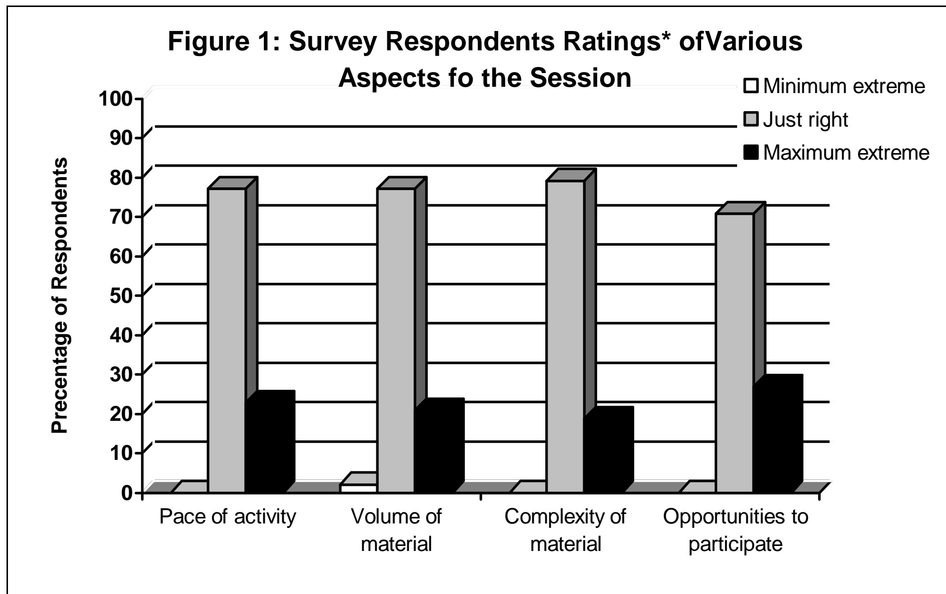
Note: Percentages may not sum to 100% due to missing responses.
* Other disciplines included: Director of Care

3.0 Results

The following is a summary of the highlights and main themes that have emerged from the evaluation of the Nursing Guidelines for End-of-Life Care in LTC training. Detailed presentation of the results of the training feedback survey and follow-up survey are located in Appendices C and D, respectively.

3.1 Objective I: Provide feedback on this training initiative

Figure 1 presents survey respondents ratings of various aspects of the training session: pace of activity, volume of information, complexity of material, and opportunities to participate (as rated on a 1 to 5 scale; 1 = minimum extreme, 2, 3 = just right, 4, 5 = maximum extreme). The majority of respondents rated pace, volume of material, complexity, and opportunities to participate, as “just right”.



Note: Percentages do not sum to 100% due to missing values. 5-point rating scale: 1 = minimum extreme, 2, 3 = just right, 4, 5 = maximum extreme; minimum extreme is the sum of ratings of 1 and 2; maximum extreme is the sum of ratings of 4 and 5.

Figure 2 presents follow-up survey respondents ratings of the helpfulness of the training in preparing them to use the nursing guidelines. The majority of respondents (63%) rated the training as “very helpful”; 25% rated it as “extremely helpful.”

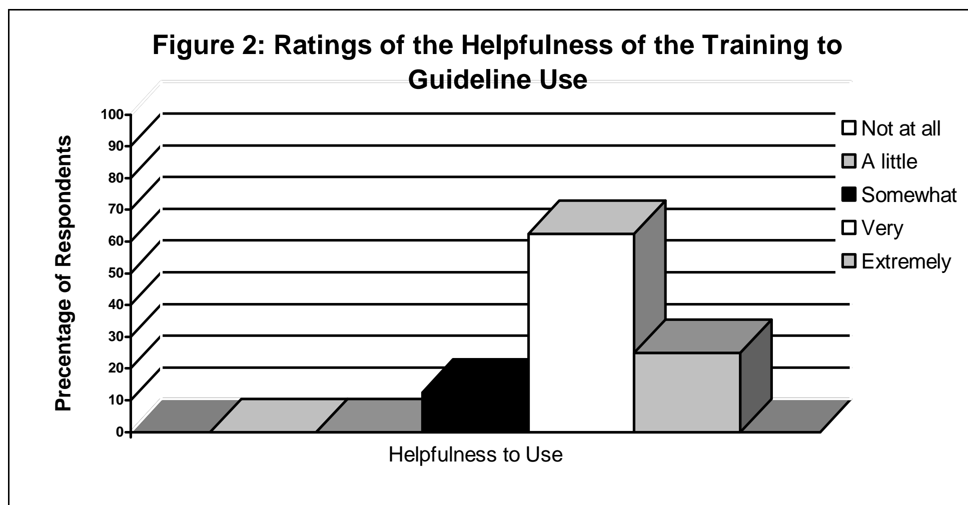


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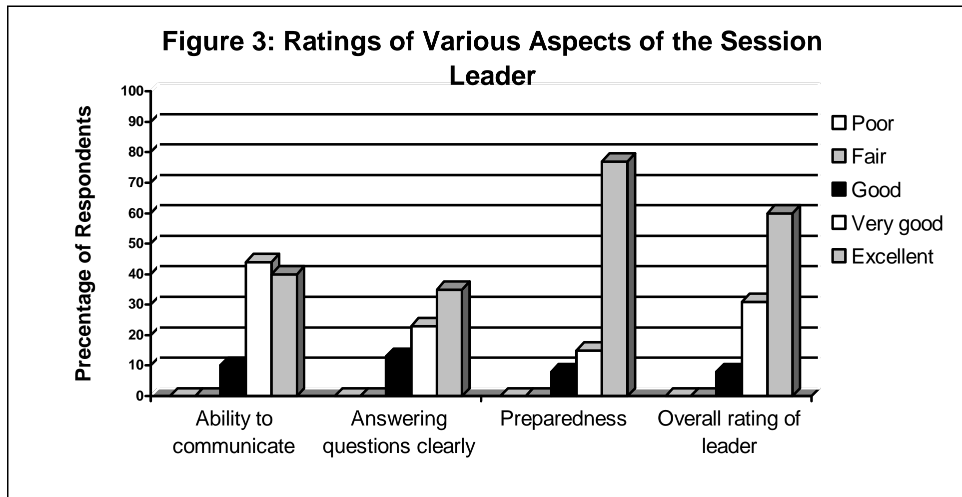
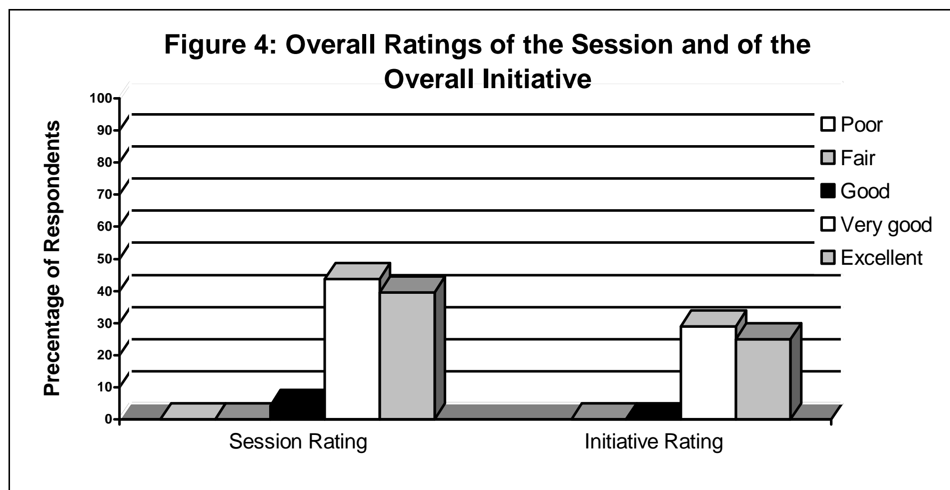
Figure 3 presents survey respondents ratings of various aspects of the session leader. The majority of respondents rated leaders’ ability to communicate, ability to clearly answer questions, and preparedness and “very good” or “excellent”. Similarly, the majority of respondents (92%) provide overall ratings of the leader as “very good” (31.3%) or “excellent” (60.4%).



Overall, feedback survey respondents viewed the session positively, with the majority of respondents (84%) providing ratings of "very good" (44%) or "excellent" (40%; See Figure 4). Respondents of the follow-up survey viewed the initiative, overall, positively, with the majority of respondents (71%) providing ratings of "very good" (25%) or "excellent" (46%).



Note: Percentages do not sum to 100% due to missing values.

To enhance their ability to apply what they learned in the training session, survey respondents reported that it would be useful to them to have pamphlets related to palliative care and end-of-life and materials to assist them in training others (e.g., PowerPoint presentation, videos) and a follow-up session.

Generally survey respondents were quite satisfied with the session and provided few suggestions for improvements. Identified suggestions included:

- Greater use of case studies
- Creation of videos presenting the use of the guidelines
- On-site training
- Improved ability to read the words on the video (e.g., slow it down).

Additional/ final comments about the education session reflected respondents satisfaction with the session as illustrated in the following comments:

"very interesting and informative."

"It's very useful in understanding the difference between palliative care and end of life care."

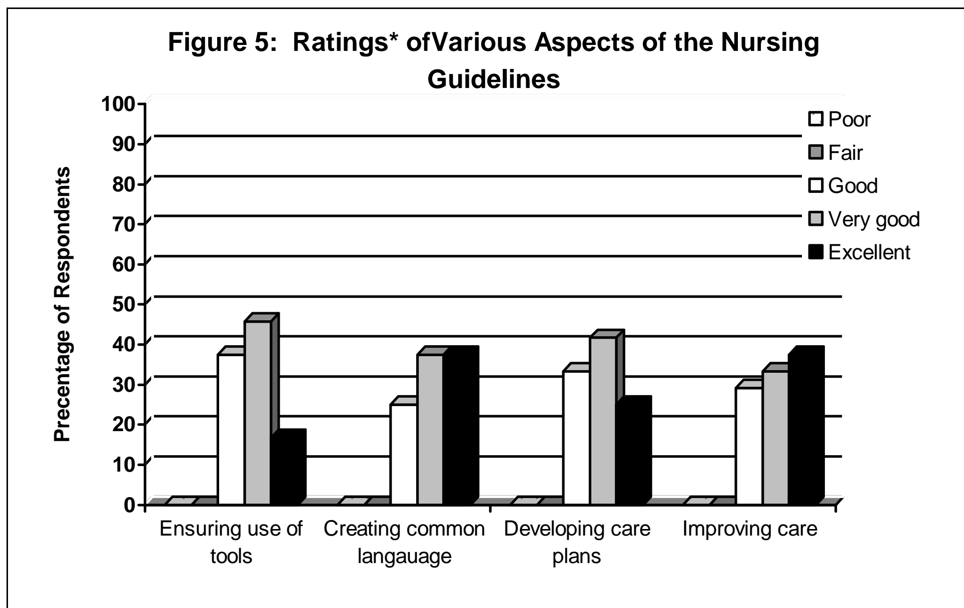
"Lots of beneficial information"

"Excellent coverage of the material. I feel it will be an easy transition in our home with the materials provided."

"It was wonderful. I am so glad I attended!"

Feedback on the Nursing Guidelines

At follow-up, survey respondents were asked to provide feedback on the nursing guidelines in terms of their ability to meet a number of goals (See Figure 5). The majority of respondents (83%) rated the guidelines' ability to ensure the use to standardized tools as "good" (38%) or "very good" (56%). The majority of respondents (over 67%) rated the guidelines' ability to create a common language for describing end-of-life care, develop effective care plans, and improve end-of-life care as "very good" (387%, 42%, 33%, respectively) or "excellent" (38% 25%, 38%, respectively).



When asked to identify what they liked about the guidelines, follow-up survey respondents commented that the guidelines intuitively make sense, create a common language and common goals for end-of-life care thus creating consistency in care (standardized care, provide direction for less experienced staff, and are easy to use. The following are some of the comments made by respondents about the guidelines:

"They make sense! It all works out nicely!"

"It includes staff at every level and is easy to understand."

"The use of the tools. I feel these tools will allow all staff to be using a common language and common guidelines to assess a Resident".

"Very" family friendly "information easy to understand especially the DNR booklet. Will save us a lot of time and families will feel empowered."

3.2 Objective II: Describe the implementation of the guidelines and identify potential impacts (changes to EOL care practice)

Feedback survey respondents were asked to identify one thing that they learned in the session that they planned to use or apply when they cared for someone at end-of-life. Respondents identified a number of key learnings that they intended to apply to their practice. The majority of respondents identified the use of the PPS and ESAS to plan for care. In addition respondents commented on strategies for educating staff regarding the guidelines and key palliative care/ end-of-life concepts such as:

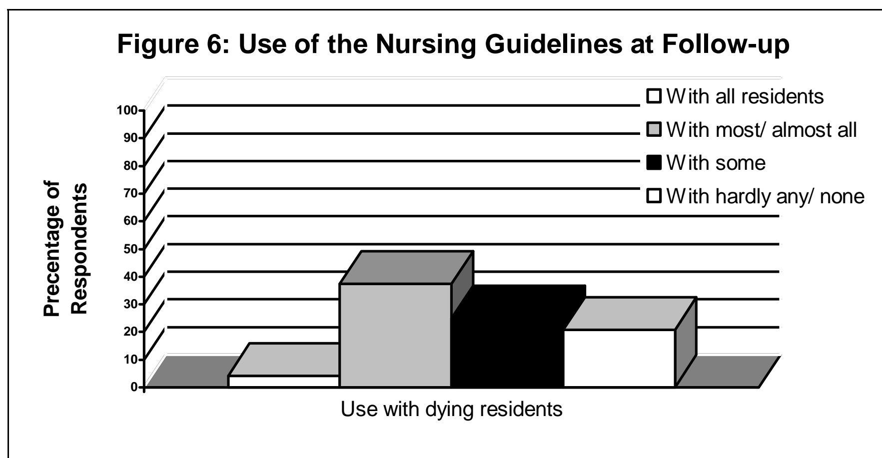
"Palliative care differs in definition from EOL care."

"Preparation does not prevent hope, it merely reframes it."

" To enhance someone's comfort is more important than what is protocol i.e., turning every 4 hours is not as important as pain control by not moving them too much."

"Asking the question "What is the goal here" will be very helpful in addressing many issues."

The majority of respondents (63%) reported that they are using the guidelines with most/ almost all residents (38%) or some residents (25%) who were at end of life (See Figure 6). Several respondents noted that their home has not yet implemented the guidelines because of competing initiatives (e.g., implementation of the MDS-RAI), but that plans are in place to do so in the near future.



Note: Percentages do not sum to 100% due to missing values.

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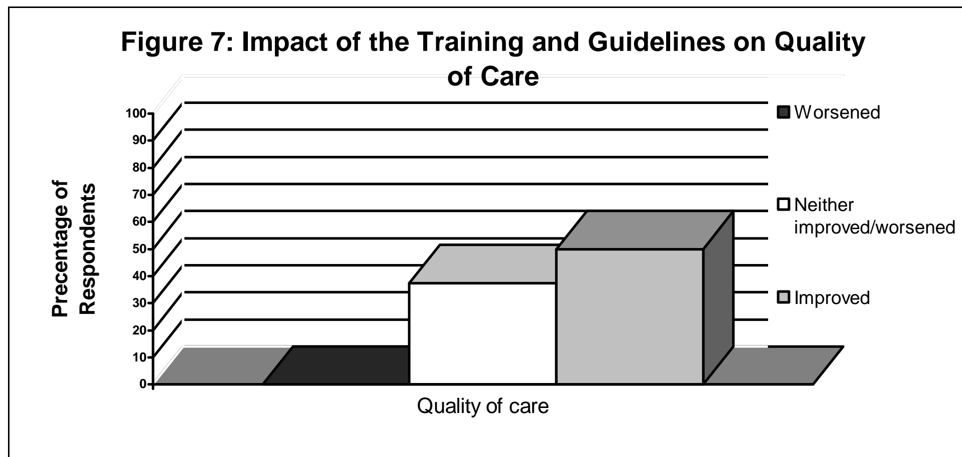
At follow-up half of the respondents reported that as result of the training and use of the end-of-life nursing guidelines quality of care has improved in their home (sum of much improved and improved ratings); the same proportion (38%) of respondents that perceived that care had improved, indicated that care had not changed (See Figure 7). This latter finding most likely reflects the limited implementation at the time of follow-up.



Impacts resulting from the guidelines

Changes to Practice: At follow-up, 63% (N = 15) of survey respondents identified at least one way in which their practice has changed as a result of this training program; some respondents indicated that practice has not changed either because they were already implementing the guidelines, or had not yet implemented them within their long-term care home. Key practice changes identified by survey respondents were related to use of the standardized tools (PPS, ESAS), use of the admission review check list, use of the EOL care pamphlet which has opened dialogue with family members, and increased knowledge regarding the signs and symptoms of impending death.

Benefits to Residents: Survey respondents noted that family understanding of end-of-life care, quality of care and life and continuity of care for residents has improved, as reflected in the following comments:

> *"Improved quality of life and care - the right care at the right time."*
>
> *"By talking to family member they are starting to understand why we do or don't do certain things and this allows us to provide care with a different understanding."*
>
> *"Better EOL care, they are able to give a voice to many more of their concerns."*
>
> *"The resident is seen as a whole and unique person with individual needs and desires in many different areas."*

Health System Benefits: Survey respondents reported health system improvements including improved quality of care in long-term care, standardized end-of-life care, and improved communication among care providers as reflected in the following comments:

> *"Including all staff on the unit of 32 residents in the delivery of care has been positive. I believe that anytime there is a universal language and understanding it allows for the same standard for everyone to receive and to comply with."*
>
> *"It is too early to know. Maybe dying in LTC will improve and people won't think that dying here is less or not as good as dying in hospital."*
>
> *"It's made EOL care better and more consistent."*
>
> *"Improved communication between care givers in different levels of care. Give LTC nurses more confidence in providing care in more difficult situations."*
>
> *"Getting information to the bedside where it belongs."*

Factors Facilitating Application of New Knowledge to Clinical Practice

Survey respondents were presented with a list of 9 factors that have been identified in the literature[3] as contributing to knowledge transfer and were asked to identify the factors that assisted them to apply what they had learned in the training session to their clinical practice (See Table 2). The factor endorsed most frequently (by 42% of respondents) was access to resource materials (best practices, guidelines, assessment tools). Also important to the application of learned information was sufficient resources (time, tools), management belief in palliative care as a priority, and support from physicians, residents, and families.

Table 2: Factors Endorsed By Survey Respondents as Assisting Them to Apply What They had Learned to Their Clinical Practice.

Facilitating Factors	Percentage (#)
Access to resource material	41.7% (10)
Sufficient resources (time, tools)	29.2% (7)
Management belief in palliative/ end-of-life care as a priority	29.2% (7)
Physician support	29.2% (7)

[3] Broad, M. L. & Newstrom, J. W. (1992). *Transfer of training. Action packed strategies to ensure high payoff from training investments.* Reading MA: Perseus Books.
Green, L. W. & Kreuter, M. W. (1991). *Health promotion planning. An educational and environmental approach.* (2nd ed.) Toronto: Mayfield Publishing Co.
Harris, D., Hillier, L.M., & Keat, N. (2007). Sustainable Practice Improvements: Impacts of the Comprehensive Advanced Palliative Care Education (CAPCE) Program. *Journal of Palliative Care, 23(4),* 262-272.
McAiney, C., Stolee P., Hillier, L. M., Harris, D., Hamilton, P., Kessler, L. et al. (2007). Evaluation of the sustained implementation of a mental health learning initiative in long-term care. *International Psychogeriatrics, 19,* 842-858.

Facilitating Factors	Percentage (#)
Support from residents and family members	29.2% (7)
Management support	25.0% (6)
Clear organizational goals/ policies for end-of-life care	20.8% (5)
Sufficient time to apply learned information and skills	20.8% (5)
Sufficient opportunities (i.e., cases) to apply learned information and skills	8.3% (2)

Challenges

Similarly, survey respondents identified insufficient time and opportunities to apply learned information and skills as challenging their ability to apply the nursing guidelines (See Table 3).

Table 3: Factors Endorsed by Survey Respondents as Challenging their Ability to Apply What they had Learned to their Clinical Practice.

Challenges/ Factors	Percentage (#)
Insufficient time to apply learned information and skills	70.8% (17)
Lack of resources (time, tools) to devote to palliative / end-of-life care	16.7% (4)
Limited management support	12.5% (3)
Lack of clear organizational goals/ policies for palliative / end-of-life care	12.5% (3)
Limited access to resource material (best practices, guidelines, assessment tools)	12.5% (3)
Insufficient opportunities (i.e., cases) to apply learned information and skills	12.5% (3)
Limited physician support	8.3% (2)
Limited management belief in palliative / end-of-life care as a priority	4.2% (1)
Limited support from residents and family members	4.2% (1)

4.0 Conclusions

Based on the results of this evaluation the following conclusions can be made about the education program on the nursing guidelines for end-of-care:

- Overall, this education program was well received and positively evaluated by participants. The training program assisted participants to change their practice/ use the nursing guidelines.

- Many homes have been challenged to implement the guidelines and in-house training by time constraints and competing initiatives, such as the implementation of the MDS-RAI. However, the guidelines are viewed as a priority and many homes have plans in place to implement them in the near future.

- Many benefits (impacts) have been associated with the use of the guidelines; they have the potential to increase quality of life for residents and quality of end-of-life care in long-term care through the use of standardized assessment tools, provision of a common language with which to describe end-of-life, and development of consistent/ standardized care plans.

Acknowledgements

The feedback and advice of the ESC Education Committee is gratefully acknowledged. The consultant is especially grateful to Julie Johnston, Maura Purdon, and Carole Gill for their assistance in facilitating the implementation of the evaluation across the many projects. The contribution of those who participated in this evaluation by completing a survey or participating in interviews is especially appreciated. Their contribution of time and insight reflects their commitment to building capacity for palliative / end-of-life care across this region.

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Appendix A

Nursing Guidelines for End-of-Life Care Training Feedback Survey

Feedback on the Training Session					
How would you rate the following aspects of this session (please circle your response):					
Pace of activity	Too slow 1	2	About Right 3	4	Too fast 5
Amount of information	Too little 1	2	About Right 3	4	Too much 5
Level of complexity	Too simple 1	2	About Right 3	4	Too hard 5
Opportunities to participate	Too many 1	2	About Right 3	4	Too few 5
New information to use in my practice	Too little 1	2	About right 3	4	Too much 5

Overall, how would you rate today's training session?

Poor   Fair   Good   Very Good   Excellent

How would you rate the following aspects of the **session leader**:	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
Ability to communicate	Poor	Fair	Good	Very Good	Excellent
Ability to clearly answer questions	Poor	Fair	Good	Very Good	Excellent
Preparedness	Poor	Fair	Good	Very Good	Excellent
Overall rating of the workshop leader:	Poor	Fair	Good	Very Good	Excellent

Is there any information or resources (support from people, information, skills, time, materials) that you do not currently have, that you think would be helpful to your ability to apply what you learned in this session?

☐ No ☐ Yes, please describe:

Do you have any suggestions for improving this session?

Please identify one thing that you learned today that you plan to use or apply when you care for someone at the end-of-life.

Do you have any comments you would like to make about today's session?

Tell us about yourself!

Are you a:

☐ Registered Nurse (RN) ☐ Registered Practical Nurse (RPN)
☐ Personal Support Worker (PSW) ☐ Health Care Aide
☐ Other, please specify: ________________________

Have you completed the Comprehensive Advance Palliative Care Education (CAPCE) program?
☐ Yes ☐ Currently in progress ☐No

How many years have you been working in long-term care: __________years

Appendix B

Nursing Guidelines for End-of-Life Care Training Follow-up Survey

Feedback on this Education Initiative

Overall, how would you rate this education initiative?

Poor	Fair	Good	Very Good	Excellent

How helpful it was the training you received in preparing you to use the Nursing Guidelines for End-of-Life care?

Not at all helpful	A little	Somewhat	Very	Extremely helpful

Do you have any suggestions for improving this initiative (training and support received)?

Feedback on the Nursing Guidelines

How would you rate the guidelines in meeting the following goals?

	Poor	Fair	Good	Very Good	Excellent
Ensuring the use of standardized tools	poor	fair	good	very good	excellent
Creating a common language for describing end-of-life care	poor	fair	good	very good	excellent
Developing of effective end-of-life care plans	poor	fair	good	very good	excellent
Improving end-of-life care	poor	fair	good	very good	excellent

Please identify at least one thing that you really like about the end-of-life care guidelines.
1.

2.

Application to Clinical Practice

Since introduced, how often were the nursing guidelines used in your long-term care home?

- ☐ With all residents who were at end-of-life
- ☐ With most/ almost all residents who were at end-of-life
- ☐ With some residents who were at end-of-life
- ☐ With hardly any/ no residents who were at end-of-life

As a result of the training you received and the use of the end-of-life nursing guidelines, do you think that the quality of care provided to residents in your long-term care home is:

- ☐ Much improved?
- ☐ Improved?
- ☐ Neither improved or worsened?
- ☐ Worsened?
- ☐ Much worsened?

Please identify at least one way in which your practice related to end-of-life care has changed as a result of the training your received and your use of the nursing guidelines.

1.

2.

In what ways have your residents benefited from the nursing guidelines?

In what ways has the health care system benefited from the nursing guidelines?

Facilitators and Barriers to Application

We are interested in learning more about the things that helped you to apply what you learned in the education sessions - that is, the things that have helped you to apply the nursing guidelines for end-of-care.

Which of the following **helped you to apply** the nursing guidelines?

- ☐ Sufficient resources (time, tools)
- ☐ Management support
- ☐ Management belief in palliative / end-of-life care as a priority
- ☐ Clear organizational goals/ policies for end-of-life care
- ☐ Physician support
- ☐ Access to resource material (best practices, guidelines, assessment tools)
- ☐ Support from residents and family members
- ☐ Sufficient time to apply learned information and skills
- ☐ Sufficient opportunities (i.e., cases) to apply learned information and skills
- ☐ Other, please specify:

Which of the following things posed as **challenges or barriers** to your ability to apply the guidelines?

- ☐ Lack of resources (time, tools) to devote to palliative / end-of-life care
- ☐ Limited management support
- ☐ Limited management belief in palliative / end-of-life care as a priority
- ☐ Lack of clear organizational goals/ policies for palliative / end-of-life care
- ☐ Limited physician support
- ☐ Limited access to resource material (best practices, guidelines, assessment tools)
- ☐ Limited support from residents and family members
- ☐ Insufficient time to apply learned information and skills
- ☐ Insufficient opportunities (i.e., cases) to apply learned information and skills
- ☐ Other, please specify:

Are there any resources or supports that you need to enhance the care you provide (or sustain improvements) to clients requiring palliative or end-of-life care?

- ☐ No
- ☐ Yes, please specify:

Is there any specific education or training that you would like as a follow-up to these sessions?

- ☐ No
- ☐ Yes, please specify:

Do you have any additional comments that you would like to make about this education initiative or the nursing guidelines for end-of-life care?

Demographic Information: Tell us about yourself!

Are you a:

- ☐ Registered Nurse?
- ☐ Registered Practical Nurse?
- ☐ Other, please specify: ____________________

Have you completed the Comprehensive Advance Palliative Care Education (CAPCE) program?

- ☐ Yes
- ☐ Currently in progress
- ☐ No

What is your current employment status (check one)?

☐ Full-time ☐ Part-time or Casual

How many years have you been working in long-term care? _______years

Appendix C

Results of the Nursing Guidelines for End-of-Life Care Training Feedback Survey

N = 48

Feedback on the Training Session

Session:

66.7% (32)	Essex
18.8% (9)	Kent
14.6% (7)	Lambton

How would you rate the following aspects of this session?

	1	2	About right 3	4	5
	Too slow				**Too fast**
Pace of activity:	0	0	77.1% (37)	22.9% (11)	0
	Too little				**Too much**
Volume of material:	0	2.1% (1)	77.1% (37)	18.8% (9)	2.1% (1)
	Too basic				**Too complex**
Complexity of material:	0	0	79.2% (38)	18.8% (9)	0
	Too few				**Too many**
Opportunities to participate:	0	4.2% (2)	79.2% (38)	16.7% (8)	0
	Too little				**Too much**
New information to use in my practice:	0	0	70.8% (34)	20.8% (10)	6.3% (3)

Note: Percentages may not add to 100% due to missing responses.

Overall, how would you rate today's training session?

Poor	Fair	Good	Very Good	Excellent
0	0	4.2% (2)	43.8% (21)	39.6% (19)

How would you rate the following aspects of the session leader?

	Poor	Fair	Good	Very Good	Excellent
Ability to communicate	0	0	10.4% (2)	43.8% (21)	39.6% (19)
Ability to clearly answer questions	0	0	12.5% (6)	22.9% (11)	64.6% (31)
Preparedness	0	0	8.3% (4)	14.6% (7)	77.1% (37)
Overall rating of the workshop leader:	0	0	8.3% (4)	31.3% (15)	60.4% (29)

Is there any information or resources (support from people, information, skills, time, materials) that you do not currently have, that you think would be helpful to your ability to apply what you learned in this session?

56.3% (27)	No
25.0% (12)	Yes, please describe: • *Different pamphlets related to palliative care and end of life PowerPoint, videos* • *Disc with slides for easier presentation to colleagues. The video of the training session but it is being mailed soon. It would have been better if it came sooner.* • *Follow-up session would be beneficial.*

Note: Percentages may not add to 100% due to missing responses.

Do you have any suggestions for improving this session?

- *There may have been more discussion if not being taped*
- *No, it was very good*
- *No, enjoyed this session as is*
- *No, it was well done*
- *Everything was great*
- *Everything was great, no improvements needed*
- *Not at this time, everything is provided*
- *No, great job*
- *On first video slow down words - difficult to read*
- *Difficult to read words on the video shown at the beginning*
- *Better lighting*
- *No, you were very good!*
- *No, but most certainly enjoy any regular update or follow-up sessions*
- *Video of homes that are actively involved in palliative care - feedback would be interesting to see*
- *More case studies, Maybe bring some from own home.*
- *Onsite training*
- *The staff in most LTC homes who have the opportunity to spend the most time with the resident and provide the care is the PSW. This project would benefit from a 3 person*

team - RN, RPN, & PSW. PSWs also offer a different view and approach to palliative care.
- *Could have been longer and included more on how to implement.*

Please identify one thing that you learned today that you plan to use or apply when you care for someone at the end-of-life.

- *A more successful use of the terms palliative / end of life*
- *PPS*
- *PPS*
- *The PPS, we have never used anything like it before.*
- *PPS ESAS*
- *PPS was a tool that looks helpful not only for Registered but for all those involved.*
- *Palliative care differs in definition from EOL care*
- *Provide communication*
- *measurements*
- *Preparation does not prevent hope, it merely reframes it*
- *Every person has individualized personal needs*
- *Respect families and patient's wishes, advocate for their pain management*
- *PPS guidelines will help us to identify death soon*
- *Educating staff on the goals of the resident not goals for staff*
- *End of life care manual*
- *PPS*
- *PPS tool*
- *Pain management*
- *Not turn every 2 hours*
- *PPS & ESAS*
- *Palliative starts when person is diagnosed live till you die*
- *apply PPS & ESAS*
- *Reviewing and updating PPS & ESAS*
- *to be m ore culturally sensitive with residents and families*
- *The need not to reposition a resident during end stage if it is appropriate*
- *PPS*
- *PPS*
- *PPS*
- *PPS ESAS Nursing guidelines*
- *PPS system*
- *Palliative - more on care*
- *To enhance someone's comfort is more important than what is protocol i.e., turning every 4 hours is not as important as pain control by not moving them too much.*
- *Asking the question "What is the goal here" will be very helpful in addressing many issues.*
- *Definitely PPS - also more information sharing with family at end of life.*
- *Implementing standards of care when PPS reaches 40% (30%) - great.*
- *The PPS various ratings correspond to interventions. Easier discussion with physicians and families.*

- *I was familiar with both the PPS and ESAS tools but currently not using them in the home I work. I feel they are excellent tools and look forward to being able to implement their use.*
- *How to educate the staff.*
- *Share the information by educating colleagues on PPS and ESAS - changing current policies and procedures.*

Do you have any comments you would like to make about today's session?

- *good job*
- *No, very useful*
- *very good!*
- *excellent*
- *No, everything is perfect*
- *Finally! I was waiting for this.*
- *excellent*
- *very interesting and informative*
- *It's very useful in understanding the difference between palliative care and end of life care*
- *Very educational*
- *A very good informative reaffirm what I have learned*
- *Very informative and exciting*
- *very informative*
- *no*
- *Lots of beneficial information*
- *Perfect*
- *very informative*
- *Please it is presented and documented for all to participate!*
- *It was very good.*
- *Excellent Concise - easy to understand!*
- *Really enjoyed.*
- *Excellent coverage of the material. I feel it will be an easy transition in our home with the materials provided.*
- *It was wonderful. I am so glad I attended!*
- *It was nice to have the information packages available to take back and get started.*

Demographic Information

There were no statistically significant differences in ratings based on any of demographic variables.

Are you a:

50.0% (24)	Registered Nurse (RN)
45.8% (22)	Registered Practical Nurse (RPN)
2.1% (1)	Personal Support Worker (PSW)
0	Health Care Aide
2.1% (1)	Other, please specify: • *DOC*

Have you completed the Comprehensive Advance Palliative Care Education (CAPCE) program?

22.9% (11)	Yes
12.5% (6)	Currently in progress
64.6% (31)	No

Note: Percentages do not sum to 100% due to missing responses.

How many years have you been working in long-term care? (N = 48)

10.0 (8.3)	Avg (+/-) Years
.5 - 37	Range

Appendix D

Results of the Nursing Guidelines for End-of-Life Care Training Follow-up Survey

N = 24

Feedback on this Education Initiative

Overall, how would you rate this education initiative?

Poor	Fair	Good	Very Good	Excellent
0	0	29.2% (7)	25.0% (6)	45.8% (11)

How helpful it was the training you received in preparing you to use the Nursing Guidelines for End-of-Life care?

Not at all helpful	A little	Somewhat	Very	Extremely helpful
0	0	12.5% (3)	62.5% (15)	25.0% (6)

Do you have any suggestions for improving this initiative (training and support received)?

- *The session could have been longer and included more information and tips on how to implement effectively*
- *In-service visits to each facility.*
- *No, all was done extremely well*

Feedback on the Nursing Guidelines

How would you rate the guidelines in meeting the following goals?

	Poor	Fair	Good	Very Good	Excellent
Ensuring the use of standardized tools	0	0	37.5% (9)	45.8% (11)	16.7% (4)
Creating a common language for describing end-of-life care	0	0	25.0% (6)	37.5% (9)	37.5% (9)
Developing of effective end-of-life care plans	0	0	33.3% (8)	41.7% (10)	25.0% (6)
Improving end-of-life care	0	0	29.2% (7)	33.3% (8)	37.5% (9)

Please identify at least one thing that you really like about the end-of-life care guidelines.

1.

- *They make sense! It all works out nicely!*
- *A decision making guide for patients, families - booklet is an excellent tool in assisting residents and families to understand what CPR is and how it works.*
- *Creating common language for describing end of life care*
- *These guide lines are universal for staff, client and family*
- *Everyone will be on the same level when discussing EOL*
- *It includes staff at every level and is easy to understand.*
- *to help identify the different ritual of the different religions and the importance to know them*
- *The use of the tools. I feel these tools will allow all staff to be using a common language and common guidelines for assess a Resident.*
- *care plans give direction for less experienced staff*
- *finally being able to use a common language*
- *user friendly not lengthy*
- *The one-one care time to talk with the residents*
- *medical directives for all palliative care*
- *Instructor was down to earth and used personal examples thus facilitating students to share common experiences.*
- *standardizing the care*
- *Consistency to ALL staff in my building.*
- *A common language used by health care providers to ensure quality care for everyone at end of life*
- *creates common language*
- *PPS*
- *common language and common goals for all palliative clients*
- *all residence will be evaluated*

2.

- *The resources are helpful*
- *Providing palliative care and improving the quality of life of residents at any time during illness*
- *Great tool when updating the physicians*
- *The care plans are good.*
- *improved communication by promoting common language*
- *having everyone on the same page providing the same EOL care*
- *everyone using the same language makes communicating with different team members easier*
- *Care plan specific*
- *Videos and music very excellent way of rendering a message.*
- *information for families*
- *Very" family friendly "information easy to understand especially the DNR booklet. Will save us a lot of time and families will feel empowered.*
- *Care plan*

Application to Clinical Practice

Since introduced, how often were the nursing guidelines used in your long-term care home?

4.2% (1)	With all residents who were at end-of-life
37.5% (9)	With most/ almost all residents who were at end-of-life
25.0% (6)	With some residents who were at end-of-life
20.8% (5)	With hardly any/ no residents who were at end-of-life

Note: Percentages do not sum to 100% due to missing responses.

As a result of the training you received and the use of the end-of-life nursing guidelines, do you think that the quality of care provided to residents in your long-term care home is:

12.5% (3)	Much improved?
37.5% (9)	Improved?
37.5% (9)	Neither improved nor worsened?
0	Worsened?
0	Much worsened?

Note: Percentages do not sum to 100% due to missing responses.

Please identify at least one way in which your practice related to end-of-life care has changed as a result of the training your received and your use of the nursing guidelines.

- *I focus on the things that are truly important at the time*
- *Admission review check list has been helpful*
- *Guidelines are not fully implemented but in talking to staff they agree this is how end of life care should be.*
- *My practice has not changed- we just now fill out the paperwork assessment.*
- *Palliative care is not about dying it is about living.*
- *Staff at every level feel more involved and provide more input.*
- *not much changed, already a CAPCE graduate, and familiar with these concepts*
- *We are now looking at all the domains of a person/family*
- *we are still preparing to implement by our March 31 deadline*
- *Resident care*
- *Use of domains and ESAS and PPS tools make it more easy to care for patients at end of life.*
- *Using the pamphlet has opened dialogue with families*
- *Unregulated care givers fell empowered re PPS as are included in the assessments and therefore quality of their work has increased ,they are more positive as have greater knowledge.*
- *More staff and family members and friends may understand better the importance of end-of-life care.*
- *have not implemented the program therefore cannot comment*
- *not implemented the program therefore unable to comment*
- *Resuscitation booklet - a wonderful tool for new admissions.*
- *We are more able to discuss issues with person/family and better meet their goals*
- *we have completed 2 education sessions where feedback was very positive*

- *Base knowledge on end-of-life care*
- *Staff (PSW) were enlightened as to signs and symptoms of impending death.*
- *Looking at the whole patient*
- *All levels of facility are becoming more aware of importance of palliative care as affects everyone.*

In what ways have your residents benefited from the nursing guidelines?

- *Improved quality of life and care - the right care at the right time*
- *We are still in a process of implementation*
- *By talking to family member they are starting to understand why we do or don't do certain things and this allows us to provide care with a different understanding.*
- *This will benefit the resident's families more so, as it can give them a clearer picture of the stages of EOL.*
- *More staff involvement at every level.*
- *The whole nursing teams is on board to assist the resident in his transition and to make it as easy as possible.*
- *Residents will benefit with continuity of care.*
- *Will hopefully receive more consistent care, again I'm focusing on less experienced nurses. I think our experienced nurses did a pretty good job before.*
- *Better EOL care, they are able to give a voice to many more of their concerns*
- *We have not yet initiated our pilot unit we are still working to reach our implementation date of March 31*
- *Residents have baseline knowledge of end of life care.*
- *Better care; more empathy; comfortable in their last days.*
- *Care with re-opened eyes*
- *Better quality of care from staff overall.*
- *The resident is seen as a whole and unique person with individual needs and desires in many different areas.*

In what ways has the health care system benefited from the nursing guidelines?

- *Not sure - it is too early to know. Maybe dying in LTC will improve and people won't think that dying here is less or not as good as dying in hospital.*
- *Including all staff on the unit of 32 residents in the delivery of care has been positive. I believe that anytime there is a universal language and understanding it allows for the same standard for everyone to receive and to comply with.*
- *It's made EOL care better and more consistent.*
- *It has identified specific needs related to palliative care in a long term care setting.*
- *Care should be universal. Residents in one LTC home should receive the same care as another. Staff moving from one home to another should be able to provide the same level of care regardless of where they work.*
- *Improve communication between care givers in different levels of care. Give LTC nurses more confidence in providing care in more difficult situations.*
- *A common language that everyone speaks*
- *So far staff are interested and positive about the new information we still have a few that need educating before our pilot begins*
- *1) Make staff aware of end of life care education.*

- *Clear instructions; common practices - ESAS and PPS so that everyone is on the same page.*
- *Getting information to the bedside where it belongs.*
- *A more consistent process, easier to access.*
- *That all health care providers provide the same and equal quality of care.*

Facilitators and Barriers to Application

We are interested in learning more about the things that helped you to apply what you learned in the education sessions - that is, the things that have helped you to apply the nursing guidelines for end-of-care.

Which of the following helped you to apply the nursing guidelines?

29.2% (7)	Sufficient resources (time, tools)
25.0% (6)	Management support
29.2% (7)	Management belief in pallaitive / end-of-life care as a priority
20.8% (5)	Clear organizational goals/ policies for end-of-life care
29.2% (7)	Physician support
41.7% (10)	Access to resource material (best practices, guidelines, assessment tools)
29.2% (7)	Support from residents and family members
20.8% (5)	Sufficient time to apply learned information and skills
8.3% (2)	Sufficient opportunities (i.e., cases) to apply learned information and skills
8.3% (2)	Other, please specify: No responses provided

Which of the following things posed as challenges or barriers to your ability to apply the guidelines?

16.7% (4)	Lack of resources (time, tools) to devote to pallaitive / end-of-life care
12.5% (3)	Limited management support
4.2% (1)	Limited management belief in pallaitive / end-of-life care as a priority
12.5% (3)	Lack of clear organizational goals/ policies for pallaitive / end-of-life care
8.3% (2)	Limited physician support
12.5% (3)	Limited access to resource material (best practices, guidelines, assessment tools)
4.2% (1)	Limited support from residents and family members
70.8% (17)	Insufficient time to apply learned information and skills
12.5% (3)	Insufficient opportunities (i.e., cases) to apply learned information and skills
12.5% (3)	Other, please specify: • *Time is a huge factor. Our EOL care has always been above the norm, and we take great pride in that.* • *There is some duplication in assessments when adding these assessments. I believe this will improve when we can include all of our assessments into one system. Our home plans to get "point click care" and I am told that all the assessments will be combined and will eliminate duplicate charting and different scales e.g. esas pain scale from 1-10, MDS RAI scale 0-3. The duplicate charting*

	has become an issue. • *Staff members not liking change*

Are there any resources or supports that you need to enhance the care you provide (or sustain improvements) to clients requiring palliative or end-of-life care?

54.2% (13)	No
16.7% (4)	Yes, please specify: • *In our home we plan to try and raise awareness of our palliative care needs and find ways to raise money to purchase items that will be designated for palliative patients and their families.* • *All education should be ongoing. Re-enforcing of information learned and any new updates or changes.* • *we are trying to develop a user friendly resource manual* • *We just need time to activate the program.*

Note: Percentages do not sum to 100% due to missing responses.

Is there any specific education or training that you would like as a follow-up to these sessions?

45.8% (11)	No
20.8% (5)	Yes, please specify: • *More sessions would be nice.* • *in the near future an educational session for staff and family members along with our Doctors* • *A video to present to staff on palliative care and end of life care* • *I would like to see physicians who provide care for LTC homes to be current on pain management.* • *A chance to meet with other members of the community in 3 months to see what there obstacles were what worked what didn't*

Note: Percentages do not sum to 100% due to missing responses.

Do you have any additional comments that you would like to make about this education initiative or the nursing guidelines for end-of-life care?

- *Great job - the leader was knowledgeable and very helpful*
- *In our facility we have a very good palliative care program, but I would like to see a similar program for new admissions as I find first 6 weeks can be very difficult for new residents and they need a lot of emotional support.*
- *Program to be initiated at a later time due to implementation of RAI MDS 2.0. Very positive approach needed and sufficient time and staff to form team for end of life care.*
- *These guidelines have been a part of community nursing and are now finally apart of long term care.*
- *We are just beginning to implement the guidelines in our home. I would like to see a follow-up in a years time, to study the impact and the long term effect these guidelines have on the palliative care being provided.*
- *It was a great learning experience and provided a lot of the materials necessary to implement this into my facility*

- *It was a great session It would have been nice to have more time or a schedule of how to begin implementation*
- *Great program. Great teacher.*
- *The end of life education session was very interesting and useful. Still implementing. We have not encountered any barriers/ challenges. Quality of care for our residents was great and any ideas/ improvements are very welcome!*
- *this just adds another assessment to our already heavy workload and I feel that these issues are addressed when we do RAI/RAP assessments*
- *this just adds another assessment to our already heavy work load, and I feel these issues are addressed in our RAI/RAP assessments.*

Demographic Information: Tell us about yourself!

Are you a:

50.0% (12)	Registered Nurse
41.7% (10)	Registered Practical Nurse
0	Other, please specify

Note: Percentages do not sum to 100% due to missing responses.

Have you completed the Comprehensive Advance Palliative Care Education (CAPCE) program?

25.0% (6)	Yes
4.2% (1)	Currently in progress
54.2% (13)	No

Note: Percentages do not sum to 100% due to missing responses.

What is your current employment status (check one)?

75.0% (18)	Full-time
16.7% (4)	Part-time or Casual

Note: Percentages do not sum to 100% due to missing responses.

How many years have you been working in long-term care? (N = 20)

11.9 (10.0) years	Avg (+/-)
1 – 37	Range