

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

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## **Year Two Skill Specific Education**

Evaluation Report

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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.
AHCPE	Advance Hospice Palliative Care Education
CAPCE	Comprehensive Advanced Palliative Care Education
CCAC	Community Care Access Centre
COPD	Chronic Obstructive Pulmonary Disease
DNR	Do Not Resuscitate
ED/ ER	Emergency Department / Emergency Room
EOL/ EOLC	End of Life / End-of-Life Care
EOLCN	End-of-Life Care Network
ESC	Erie St. Clair
ESAS	Edmonton System Assessment Scale
HPC	Hospice Palliative Care
IT	Information Technology
LHIN	Local Health Integration Network
LTC	Long-Term Care
NP	Nurse Practitioner
OPQRSTU	Assessment acronym standing for onset, precipitating and alleviating factors, quality, region and radiation, severity, timing, affect of symptoms
OT	Occupational Therapy
OTN	Ontario Telemedicine Network
PCR	Palliative Care Resource
PON	Palliative Oncology Nurse
PPS	Palliative Performance Scale
PPSMC	Palliative Pain and Symptom Management Consultant
RT	Respiratory Therapist

SBAR	Communication tool acronym standing for: Situation, background, assessment, recommendation
SRK	Symptom Response Kit
SWO PPSMCP	Southwestern Ontario Palliative Pain and Symptom Management Consultation Program
PSW/HSW	Personal Support Worker/ Home Support Worker
PPI	Palliative Prognostic Indicator
RN/ RPN	Registered Nurse/ Registered Practical Nurse
VON	Victoria Order of Nurses – home care and community support provider agency
WHO	World Health Organization
WIFN	Walpole Island First Nation
WRCC	Windsor Regional Cancer Centre

# Education Blueprint Year 2 Evaluation Executive Summary

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

### INTRODUCTION

The Erie St. Clair End-of-Life Care Network (ESC EOLCN) has received funding from the Erie St. Clair Local Health Integration Network (LHIN)<sup>1</sup> to develop a LHIN-wide integrated and cross-sector hospice palliative care education program. An evaluation of the Year One initiatives of the Blueprint demonstrated that the stated objectives were largely met;<sup>2</sup> Year Two of the Blueprint builds on the initiatives of Year One and was informed by the evaluation. The following education initiatives make up the Year Two ESC HPC Education Blueprint:

- 1. Skill Specific Education for Care Providers:** An education session (*Right Patient, Right Place, Right Time*) designed to enhance the knowledge, confidence, and skill of nurses with novice through to expert capability in hospice palliative and end-of-life care. Four identical sessions were conducted, two in Kent County and two in Lambton County. As part of this session, information was provided on available community resources to support HPC service recipients to receive care at home for as long as possible or as they wish and to reduce unnecessary use of acute care.
- 2. Implementation of Nursing Guidelines for End-of-Life Care in Long-Term Care Settings:** Assessment of the implementation status of these guidelines and the identification of factors that facilitate and challenge implementation, which will inform the development for further supports to facilitate successful implementation and the development of a communications strategy to share and promote this initiative.
- 3. Expansion of Video-Conferencing Capacity:** Ongoing support and education to video-conferencing (Ontario Telemedicine Network, OTN) at two sites (Windsor and Sarnia).
- 4. Volunteer Education:** Building on Year One experiences, Year Two focused on: i) an environmental scan to describe the supply and demand for HPC volunteers in ESC, ii) continued promotion and support for the 'Share the Care™' model, and iii) standardization of volunteer education with the development/ sharing of one to two education sessions for HPC volunteers across Erie St. Clair.
- 5. Cultural Education:** Year Two focused on continued engagement of this community to increase their awareness of available HPC support and services in ESC and provision of the Advanced Hospice Palliative Care Education (AHPCE) Program<sup>3</sup> (as developed by and

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<sup>1</sup> The ESC LHIN consists of three counties: Windsor-Essex, Sarnia-Lambton, and Chatham-Kent.

<sup>2</sup> Hillier, L.M. (April 30, 2009). Erie St. Clair End-of-Life Care Network Hospice Palliative Care Education Blueprint. London, ON: Author.

<sup>3</sup> The AHPCE Program, along with the Fundamentals of Hospice Palliative Education Program and the Comprehensive Advanced Palliative Care Education Program (CAPCE), are palliative care education programs developed by the Southwestern Ontario Palliative Pain and Symptom Management Consultation Program that are widely delivered across the province. More information on these programs is available at: [www.palliativecareswo.ca](http://www.palliativecareswo.ca).

delivered through the Southwestern Ontario Palliative Pain and Symptom Management Consultation Program) and expanding First Nation Community relationships in ESC by introducing the Share the Care™ model to four First Nation communities in Southwestern Ontario.

- 6. System Mapping and Integration:** This component of the Blueprint aimed at continued planning for this initiative, namely the development of: a planned approach to HPC education across ESC to ensure that the HPC system is fully supported by a sustainable education structure, a strategic approach to the use of OTN within the ESC EOLCN, and a communication strategy to promote the work of the Education Blueprint.

A comprehensive evaluation of this Education Blueprint was undertaken, examining both outcomes (summative evaluation) and development and implementation (formative evaluation). The evaluation report describes the methods and results of this evaluation.

## EVALUATION METHODS

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

- i) Providing feedback on education 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 (Skill Specific Sessions, Share the Care™ information sessions); responses rates ranged from 80-90%.
- **Follow-up surveys** to assess impacts of the education delivered in Year One (Physical Skills, Hands on Care, Fundamentals Program); response rates ranged from 41 -100%.
- **Environmental scan:** Surveys and interviews with volunteer coordinators/ managers to assess the current state of volunteerism in ESC.
- **Individual and group interviews** with key stakeholders to gather in-depth information on impacts and to describe development and implementation of various initiatives (Skill Specific education, Share the Care™ with various First Nations communities, Nursing Guidelines for EOL Care in LTC, Story Telling Project); in total 30 individuals participated in the evaluation interviews.

## KEY FINDINGS AND CONCLUSIONS

### Skill Specific Education

- A total of 88% (N = 192) session participants completed reaction surveys. Across all sectors, participants viewed the program positively and perceived the session as very useful/ relevant to their work. Increases to knowledge, comfort and confidence were reported; it was anticipated that practice change was likely as a result of the session.
- Working group members (N = 11) participated individual interviews; factors that assisted with and that challenged the development and delivery of the education sessions were identified (none insurmountable), as well as suggestions for improvements/ sustainability.

These factors and strategies can inform the development and delivery of future sessions as well as provide a focus for improvements. Sessions offered in Year One and Year Two were noted to have an impact at an individual (increased access to information, increased trust in care), health provider (enhanced knowledge and skills, practice improvement), organizational (improved communication, development of policies and procedures to support palliative care), and health system levels (improved quality of care, potential for ED/ acute care diversion).

- Seventy individuals (41%) who participated in last year's Physical Skills sessions completed a follow-up survey. Changes to practice were identified as a result of last year's session, with associated client-related benefits including increased access to resources and supports, better pain and symptom management, and enhanced quality of care/ support. Some respondents identified increases in the amount of and access to palliative care services provided in the community and in the number of clients served at home and dying at home. Challenges exist associated with use of learned knowledge and skills including lack of support/ recognition, limited resources, and lack of integration and continuity of care across sectors. There was much support for ongoing education opportunities.

**Conclusions:** The Skill Specific education sessions were well received and described as a significant learning opportunity, relevant to practice, and likely to facilitate practice change. The significance of this learning opportunity is reflected in requests more palliative care related education and interest in formal palliative care programs. There is anecdotal evidence that this education program has had positive impacts on the system of care for individuals requiring palliative care. Most significantly, the sessions provided nurses with knowledge, skills, and resources to enhance palliative care within the community, thereby reducing the use of acute system resources and enhancing utilization of existing community resources. Challenges/ barriers to knowledge transfer were identified (e.g., limited physician and organizational support) - efforts aimed at reducing these will further enhance palliative care within the community; ongoing education is an important step toward addressing these challenges. Working group attention to evaluation feedback gathered at the Year One sessions served to resolve issues identified and to further develop education that is relevant and immediately applicable to practice. The structures created for this education initiative have the potential to ensure sustainability.

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

- Five individuals, representing 5 LTC homes (2 that fully implemented the guidelines, and 3 that had limited implementation) were interviewed.
- A number of factors were identified as facilitating both full and limited implementation of the guidelines: Management support ('buy in' prior to the education session, selection of appropriate staff to attend training, support for in-house staff education); peer support (willingness to learn, willingness to discuss and review their EOL practice), support from CAPCE trained nurses and effective education and resources.
- Challenges to implementation focused primarily on competing priorities, namely the implementation of the MDS-RAI, upcoming changes to corporate palliative care policies and procedures, limited staff time and support because of the overwhelming changes currently occurring in LTC and limited management support. Although representatives from homes that were limited in their implementation of the guidelines expressed an interest in perhaps revisiting the guidelines, it was noted that current challenges would continue to hinder

implementation. Interest was expressed in perhaps considering the use of the guidelines to assist in care planning and to increase the use of the PPS.

- There was identified interest in opportunities for on-going education related to palliative and end-of-life care and refresher sessions to sustain implementation of the guidelines. Homes with limited implementation identified the need for more time and dedicated staff to facilitate implementation.
- Impacts associated with the nursing guidelines for EOL care were related primarily to improved resident care, increased staff capacity to manage EOL care and reduced need to transfer patients to hospital as family members are confident in the care that their loved one is receiving.

**Conclusions:** Although the uptake of the nursing guidelines for EOL care in LTC settings has been limited, there continues to be interest and support for this initiative. Representatives from homes in which there has been limited implementation have been challenged by competing priorities, but continue to hope that they will have an opportunity to implement the guidelines fully in the near future; there is perceived value in implementation of the guidelines for residents and family members as well as care providers. Ongoing management and staff support are most likely the critical factors that maintained implementation of the guidelines as a priority despite other competing initiatives. Securing this type of support in other homes is an important factor needed to facilitate implementation. Strategies that focus on ‘baby steps’ towards implementation including opportunities for capacity building (ongoing education/ training opportunities) may maintain interest and momentum towards full implementation and would most likely be welcome by front-line staff. The implementation of an education session targeted to nurses with CAPCE training, along with ongoing support from the PPSMC, represents a significant move towards addressing the support needs of homes interested in implementing the guidelines, particularly in terms of supporting in-house champions for this initiative.

### **Volunteer Education**

- Surveys were completed by 13 individuals representing various organizations across sectors and counties; 7 individuals completed more in-depth interviews regarding HPC volunteerism. Although the response rate for the environmental scan survey and interviews was low, there was representation across sectors and some consistent themes. There are currently unmet needs for hospice palliative care volunteers. The environmental scan generated ideas for improving the recruitment, training and education, and retention of volunteers. Many of the issues raised regarding volunteerism were consistent across sectors; partnerships within and across sectors were identified as opportunities for resolving challenges related to volunteer training and education.
- Six individuals that participated in last year’s Hand on Care Training completed a follow-up survey. Over half of those surveyed had delivered the training (19 sessions) or had sessions scheduled. At least 35 individuals have been trained to date; sessions have been well received. The initial train-the-trainer session and available resources prepared trainers to deliver this training, though they were challenged by the long length of the program, limited volunteer interest in extended training and limited organizational support; suggestions for overcoming these challenges were identified.
- Two individuals participated in interviews regarding the Story Telling Project. It was noted that the tool kit binders, provided through funding from the Education Blueprint, were essential to the delivery of this project and to increase accessibility, as many clients were not able to pay for the binders independently. Benefits associated with this project included

the opportunity to leave a “legacy” for their family, to refocus their attention away from their health challenges to something positive and of interest to them, and to provide social interaction with others.

- Eighty percent (N = 38) participants of the Share the Care™ session completed a session reaction survey. The information session was well received. Respondents valued the case presentations (“stories”) illustrating use of and success with the model, resource materials, and the opportunity to share ideas with others. Great value was seen in this informal model of caregiving as an opportunity to reduce stress for primary caregivers/ family members, provide greater options for care, enhance ability to provide care at home/ remain at home, and improve quality of life for all involved.

**Conclusions:** Generally there is a need for more HPC volunteers, necessitating optimization of recruitment, training, and retention efforts. Strategies and opportunities for enhancing these efforts have been identified; there is much interest in cross-organization partnerships. Train-the-trainer models (e.g., Hands on Care) and promotion of initiatives that expand the volunteer pool (e.g., Share the Care™) provide significant opportunities for capacity building in hospice palliative care within the community.

### **Cultural (First Nation) Education**

- All of the participants of the Fundamentals Program delivered in Year One of the Education Blueprint on Walpole Island completed a follow-up survey. The program was well received by respondents and rated as very useful to their work. The majority of respondents indicated that as a result of the Fundamentals Program they now engage more often in various practice activities (consistent with the performance objectives for this program), and are more knowledgeable and more confident and comfortable in providing palliative care. Generally, it was reported that practice improvements had occurred as a result of the program and there is a strong desire for ongoing opportunities for education and performance improvement.
- A session feedback survey was completed by 90% (N = 17) of participants who attended a Share the Care™ information session, and interviews were conducted with 2 session organizers and representatives from 3 of the 4 First Nation communities in attendance. The Share the Care™ information session was well received and there is much interest in implementing the model within First Nation communities. Implementation of the session was facilitated by leadership support from the First Nation communities, support from the Share the Care™ Coordinator from the South West End-of-Life Care Network, the previous relationship between the Walpole Island First Nation communities and the ESC EOLCN and consistency of the model with the First Nation culture. Key lessons learned in the implementation of the session highlighted important things to consider when introducing the model to First Nation communities. Potential impacts associated with the use of this model within First Nation communities included: capacity building and increased resources for EOL care, improved palliative and EOL care, increased support for home deaths and strengthened relationships within the community. Dedicated leadership support and advocacy, resource support, strategies for caregiver self-care (to prevent burnout) and ongoing opportunities for palliative and EOL education and bereavement and grief support were identified as important for moving the model forward.

**Conclusions:** Over the past year, this initiative has gone a long way toward building the relationships with the Walpole Island First Nation community needed to introduce palliative and

EOL care supports and resources for both formal and informal caregivers. The success of the Share the Care™ information session with participants from four First Nation communities suggests the potential for future events in a similar format. Education provided to date has had a positive impact with participants reporting practice improvements and wanting more opportunities for capacity building (more education, more supportive resources). The lessons learned from the development and implementation of the Share the Care™ session, as well as other education programs with the Walpole Island First Nation community, can be used to inform the implementation of other education initiatives, particularly initiatives with other First Nation communities within the province.

### **System Mapping and Integration**

- The evaluation objectives for this component of the Education Blueprint were to: i) to develop a plan to describe the current state of HPC related education for care providers in ESC (across sectors and disciplines), ii) to assess key stakeholders' perceptions of the potential success of communication methods outlined within a communication strategy, developed in Year Two, for HPC education in this region, and iii) describe the progress in implementing the ESC EOLCN Education Blueprint and the number of individuals participating in the various initiatives.
- A survey has been developed with input from key stakeholders in the field to assess the current state of HPC related education for care providers in ESC. This survey will be administered in Year Three of the Education Blueprint. Similarly, a survey has been developed with input from key stakeholders in the field to explore opportunities for enhancing communications about HPC education. This survey will be administered in Year Three of the Education Blueprint.
- **Conclusions:** Across all of the components of the Education Blueprint, 396 individuals participated in education or information sessions. Year Two objectives were mostly completed or in-progress towards completion.). Year Three plans for further supports to HPC education and communication will be informed, in part, by a consultation process (survey-based) with key stakeholders. Video-conferencing technology is fully operational in two sites; there is much support for the use of the technology and leveraging learnings to date. Opportunities/ strategies to maximize use of the technology for education and meetings will further support the efforts to increase access to palliative care education in this region.

### **FINAL CONCLUSIONS**

Based on the results of the evaluation of the Year Two initiatives of the Erie St. Clair End-of-Life Care Network Education Blueprint the following conclusions can be made:

- The Year Two objectives of the Education Blueprint were mostly all achieved; some are still in progress. Education initiatives delivered in Year Two were well received and support overall efforts to enhance hospice palliative care across sectors in this region.
- Challenges to initiatives as identified in the Year One evaluation were attended to in Year Two and mostly resolved, demonstrating the interest of initiative organizers to reflect on feedback and resolve identified issues. Continued attention to key stakeholder feedback will serve to inform and maximize planning and education efforts for Year Three. Similarly,

identified factors facilitating and hindering implementation of Blueprint initiatives and key lessons learned can serve to inform not only other initiative developed by the Blueprint, but also the application of this Blueprint to other regions of the province.

- Evaluation efforts focused on the identification of impacts associated with education, resources and supports provided to date by the Education Blueprint. Although mostly self-report and anecdotal there are consistent benefits identified across sectors, counties, and key stakeholders. These benefits are namely related to enhanced client and caregiver access to quality of palliative and EOL care within the community, capacity building among care providers (enhanced knowledge, assessment and management skills, confidence), volunteers (increased access to training and supports), organizations (improved communication, development of policies and procedures to support hospice palliative care), with the potential for health system enhancements (improved quality of care, emergency department/ acute care diversion, improved/ more appropriate use of existing system resources). Although it would be difficult to attribute specific outcomes to specific Education Blueprint efforts, it is most likely that combined efforts to provide a coordinated and integrated approach to hospice palliative ad EOL care interact with other palliative care system enhancements (e.g., Hospice programs, expert consultation teams) to affect improvements to care. Plans to develop a more structured and standardized approach to volunteer and care provider education as well as efforts to develop a communication strategy to promote the hospice palliative care education will further support capacity building in this region.
- Many of the relationships (e.g., across sectors, with the Walpole Island First Nation community) and structures (e.g., working groups, committees) developed as result of the Education Blueprint have the potential to ensure sustainability. There is much support for more education regarding palliative and end-of-life care. The Blueprint has stimulated interest in and raised the “bar” for practice improvements; this can be sustained through exploration of strategies and opportunities to support ongoing HPC education.

***Evaluation Limitations:*** Response rates for some of the evaluation components (environmental scan on volunteerism, interviews on the implementation of the EOL nursing guidelines in LTC) were very low. Identified reasons for the poor response rates and potential solutions can inform the implementation of the Year Three evaluation in order maximize key stakeholder involvement, as for example in the survey of key stakeholders to inform the development of a sustainable education structure and communication strategy for education. Identified impacts associated with the initiatives that make up the Education Blueprint were largely self-reported and anecdotal. Although difficult to develop, objective measures of impacts (e.g., increase in inquiries/ registration in formal palliative care education programs, ED diversions/ reduction in crisis visits to ED, increase in deaths in preferred location) would provide further support for the work of the Education Blueprint.

# Skill Specific Education for Care Providers

## Executive Summary: Skill Specific Education of Care Providers

**Introduction:** The Skill Specific sessions (Year One and Two) were an opportunity for nurses from across sectors to enhance their knowledge and skills in palliative and EOL care.

**Evaluation Methods:** The objectives of this evaluation were to: i) describe learner's perceptions of the education sessions (Right Person, Right Place, Right Time; Community Resource Fair), ii) identify the longer-term impacts associated with the Year One education sessions, and iii) to describe the development and implementation of Year Two education. Session participants completed a **reaction survey**. Participants of last year's session completed a **follow-up survey** to assess longer-term impacts and **interviews with session working groups members** were conducted to provide detailed information on the development and implementation of this initiative.

### Key Findings

**Session Feedback:** Across all sectors, participants viewed the program positively and perceived the session as very useful/ relevant to their work. Increases to knowledge, comfort and confidence were reported; it was anticipated that practice change was likely as a result of the session.

**Longer-term impacts:** Changes to practice were identified as a result of last year's session, with associated client-related benefits including increased access to resources and supports, better pain and symptom management, and enhanced quality of care/ support. Some respondents identified increases in the amount of and access to palliative care services provided in the community and in the number of clients served at home and dying at home. Challenges exist associated with use of learned knowledge and skills including lack of support/ recognition, limited resources, and lack of integration and continuity of care across sectors. There was much support for ongoing education opportunities.

**Development and Implementation:** Factors that assisted with and that challenged the development and delivery of the education sessions were identified (none insurmountable), as well as suggestions for improvements/ sustainability. These factors and strategies can inform the development and delivery of future sessions as well as provide a focus for improvements. Sessions offered in Year One and Year Two were noted to have an impact at an individual (increased access to information, increased trust in care), health provider (enhanced knowledge and skills, practice improvement), organizational (improved communication, development of policies and procedures to support palliative care), and health system levels (improved quality of care, potential for ED/ acute care diversion).

**Conclusions:** The Skill Specific education sessions were well received and described as a significant learning opportunity, relevant to practice, and likely to facilitate practice change. The significance of this learning opportunity is reflected in requests for more palliative care related education and interest in formal palliative care programs. There is anecdotal evidence that this education program has had positive impacts on the system of care for individuals requiring palliative care. Most significantly, the sessions provided nurses with knowledge, skills, and resources to enhance palliative care within the community, thereby reducing the use of acute system resources and enhancing utilization of existing community resources. Challenges/ barriers to knowledge transfer were identified (e.g., limited physician and organizational support) - efforts aimed at reducing these will further enhance palliative care within the community; ongoing education is an important step toward addressing these challenges. Working group attention to evaluation feedback gathered at the Year One sessions served to resolve issues identified and to further develop education that is relevant and immediately applicable to practice. The structures created for this education initiative have the potential to ensure sustainability.

## 1.0 Introduction

1. **Skill Specific Education for Care Providers:** Working groups within each county developed a four-hour hospice palliative care (HPC) education session consisting of the following topics:

- i) **Right Patient, Right Place, Right Time:** HPC/EOL pain and symptom management for community-based Nurse Practitioners (NP), Registered Nurses (RN) and Registered Practical Nurses (RPN), Community Care Access Centre (CCAC) Case Managers, Hospice RNs/ RPNs, and selected hospital RNs/RPNs. The objective of this education was to enhance participants' knowledge and understanding of the needs of the person and family at end-of-life, weaving communication skills throughout, so that patients are cared for in the most appropriate setting. Breakout sessions allowed for information to be targeted specifically to novice and advanced knowledge participants. Case study presentations were used to illustrate key themes. Presentations and handouts included:
- A description of hospice palliative care settings
  - Typical hospice palliative care interventions/ procedures/ services provided on site and eligibility criteria per patient location
  - Location of death decision-making algorithm
  - Pain and symptom (e.g., dyspnea, delirium, restlessness, constipation) assessment and management
  - Guidelines for analgesic drug orders
  - Tools (WHO analgesic ladder, laminated pocket PPS, ESAS, PPI, equianalgesic dosing chart, guidelines for calculating breakthrough doses)
  - Communicating at end-of-life (SBAR tool).<sup>4</sup>
- ii) **Community Resources Fair:** Information was provided on available community resources to support HPC clients to receive care at home for as long as possible or as they wish and to reduce unnecessary use of acute care services. Various community services providers had displays and were available to present their services, distribute informational materials and answer questions.

Four identical sessions were held, two in Kent County (February 9, 11, 2010) and two in Lambton County (February 23, 25, 2010).<sup>5</sup> Staff time to attend the session was paid for by the Blueprint<sup>6</sup> as a strategy to ensure that all staff participated in the training. Mandatory attendance was necessary to ensure payment, though the sessions were not labelled 'mandatory'; each community agency strongly encouraged staff to attend. Two-hundred and seventy-seven individuals registered to participate in these sessions; 219 attended (79% attendance rate). The reduced attendance was attributed to inclement weather and competing priorities (primarily patient caseload).

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<sup>4</sup> SBAR: a framework for enhanced communication among health professionals; Acronym standing for: Situation, background, assessment, recommendation.

<sup>5</sup> Somewhat similar sessions were held in Windsor-Essex as a component of Year One of the Blueprint Education Blueprint.

<sup>6</sup> Coverage was provided through Blueprint funding for community-based RNs and RPNs only; coverage for hospital RNs and CCAC Case Managers was not provided.

## 2.0 Evaluation Objectives and Methods

The identified objectives of the evaluation of the Skill Specific Education component of the Blueprint were:

- i) to describe learner's perceptions of the education sessions (Right Person, Right Place, Right Time; Community Resource Fair):
  - What were the learners' reactions to program content?
  - What were the learners' reactions to the session facilitators and learning strategies used in this program (presentations, CSS displays/ stations)?
  - To what extent were learners satisfied with this session?
  - What were the learner perceptions of change in their knowledge, skill, and comfort/confidence in EOL care as a result of this session?
  - What were learners' intentions to change their practice based on this education session (reflection on learning and practice)?
  - What issues/ challenges did they anticipate may act as barriers to their ability to apply what they learned in this session?
  - What resources/ supports are needed to facilitate knowledge transfer to clinical practice?
  - What suggestions for improvement, including unmet education needs, did they have?
  
- ii) to identify the longer-term impacts associated with participation in the Year One Education Blueprint Skill Specific Education activities:
  - In what ways did clinical practice change (consistent with performance objectives for the Year One sessions) as a result of participating in this education initiative?
  - What were the impacts to patient care and use of health system resources?
  - What issues/ challenges did they experience as they applied new knowledge to their practice?
  
- iii) to describe the development and implementation of the Skill Specific education program:
  - To what extent were the topics selected for these education sessions the most relevant/ appropriate at this time?
  - To what extent did the working groups facilitate the process of developing and implementing this initiative?
  - To what extent were issues/ challenges experienced in Year One of this initiative (e.g., scheduling, lack of new knowledge for those experienced in palliative care) resolved?
  - What factors facilitated the development and implementation of this initiative?
  - What were the challenges associated with implementation and what are the potential strategies to overcome these?
  - What were the lessons learned in the development and implementation of this initiative?
  - What were suggestions for improvement? For sustainability?
  - What were the potential impacts associated with this initiative?
  - What were potential next steps for the EOL education in this region (year 3 plans for each initiative, overall)?

## Sources of Information

To meet the above evaluation objectives the following methods were employed:

### Reaction Survey for the Skill Specific Education Session

Learners at each of the sessions were invited to complete a survey to gather their perceptions of the session (as described above for evaluation objective i). To maximize the response rate time was allotted within the session agenda for survey completion. Survey completion was anonymous; participants were not required to identify themselves on the survey. This survey is presented in Appendix A.

The survey was distributed to 219 individuals participating in the four sessions; 192 surveys were completed, representing an 88% response rate.

A little over half of the survey respondents (54%) were registered nurses (See Table 1). Approximately half of the respondents (53%) had completed the Fundamentals of Palliative Care Education Program and fewer had completed the CAPCE (18%) or LEAP programs (11%). The majority of respondents (64%) worked in community (56%) and hospice settings (8%) and were employed full-time (54%). There was much variability in the amount of time that respondents have been employed in their current profession (6 months to 41 years), with the average being 15 years. The majority of respondents (59%) reported that they provide palliative care “often” (34%) or “all the time” (25%), few (11%) respondents never or rarely provide palliative care.

**Table 1: Description of the Skill Specific session reaction survey respondents (N = 192)**

<b>Demographic Variable</b>	<b>Percentage (#)</b>
<b>Discipline:</b>	Registered Nurse 54.2% (104)
	Registered Practical Nurse 39.1% (75)
	Other* 3.6% (7)
<b>Completion of Palliative Care Education:</b>	Fundamentals of Hospice Palliative Care 53.1% (102)
	Comprehensive Advanced Palliative Care Education 18.2% (35)
	Learning Essential Approaches to Palliative and EOL Care 10.9% (21)
<b>Practice Location:</b>	Community 56.3% (108)
	Residential Hospice 7.8% (15)
	Hospital 34.9% (67)
	Retirement Home 5.2% (10)
<b>Employment Status:</b>	Full-time 53.6% (103)
	Part-time 40.6% (78)

Demographic Variable	Percentage (#)
<b>Number of Years Working in their Field (N = 181)</b>	
Average (+/-)	14.69 years (11.0)
Range	.5 – 41 years
<b>Work Time Spent Providing Palliative Care</b>	
Never	2.1% (4)
Hardly ever/ rarely	8.9% (17)
Sometimes	27.6% (53)
Often/ all the time	34.4% (66)
All the time	24.5% (47)

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

\*Other disciplines: Case Manager, Occupational Therapist, Pharmacist, student

### Follow-up Survey for the Participants of the Year One Skill Specific Education Sessions

Learners who attended the Year One Education Blueprint Skill Specific education session were invited to complete a follow-up survey (posted on-line: [www.surveymonkey.com](http://www.surveymonkey.com)) to assess longer-term (one year post program) impacts associated with participation in this initiative (as described above for evaluation objective ii). Paper-based surveys were available for those who received the Year One evaluation surveys via postal service. Consistent with the method of survey distribution described by Dillman,<sup>7</sup> learners were invited to complete the survey via e-mail and received follow-up reminders via e-mail to complete the survey. Those who received a paper-based survey received a post-card reminder to complete the survey. Survey completion was anonymous; participants were not required to identify themselves on the survey. This survey is presented in Appendix B.

In total 202 invitations to complete the survey were be distributed, 156 via e-mail and 46 via postal service (paper-based survey); 27 of e-mail invitations and three postal surveys were returned undeliverable so in total 172 invitations were distributed. Invitations to complete on-line surveys were distributed on February 22, 2010, with a two-week deadline date (March 8, 2010); postal surveys were also distributed on February 22 (deadline date March 12). In total, 70 surveys were completed (41% response rate). Although this response rate is low, is not unusual to expect response rates of 20 - 30% for e-mail and mail-out surveys,<sup>8</sup> particularly for follow-up surveys.

The majority of survey respondents were registered nurses and relatively few (<22%) had completed the Fundamentals, CAPCE or LEAP Programs (see Table 2). The majority of respondents were employed part-time, and although 43% of respondents reported that they provide palliative care “often” or “all the time”, 46% of respondents “never”, “rarely” or “sometimes” provide palliative care. There was much variability in the amount of time that

<sup>7</sup> Dillman, D.A. (2000) *Mail and internet surveys. The Tailored Design Method 2<sup>nd</sup> Ed.* New York: John Wiley and Sons.

<sup>8</sup> Kaplowitz, M.D., Hadlock, T.D., & Levine, R. (2004). A comparison of web and mail survey response rates. *Public Opinion Quarterly*, 68(1), 94-101.

respondents have been employed in their current profession (2 – 47 years), with the average being 14 years.

**Table 2: Description of the Year One Education Blueprint Skill specific session reaction survey respondents (N = 70)**

<b>Demographic Variable</b>	<b>Percentage (#)</b>
<b>Discipline:</b>	
Registered Nurse	51.4% (36)
Registered Practical Nurse	31.4% (22)
<b>Completion of Palliative Care Education</b>	
Fundamentals of Hospice Palliative Care	34.3% (24)
Advanced Hospice Palliative Care Education (AHPCE)	2.9% (2)
Comprehensive Advanced Palliative Care	22.9% (16)
<b>Employment Status:</b>	
Full-time	34.3% (24)
Part-time	54.3% (38)
<b>Number of Years Working in their Field (N = 62)</b>	
Average (+/-)	13.7 years (9.7)
Range	2 – 47 years
<b>Work Time Spent Providing Palliative Care</b>	
Never	5.7% (8)
Hardly ever/rarely	14.3% (10)
Sometimes	25.7% (18)
Often	37.1% (26)
All the time	5.7% (4)

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

### **Individual interviews with Working Group Members**

In-depth individual interviews were conducted with members of the Skill Specific education working groups to provide detailed information on the development and implementation of this initiative (as described above for evaluation objective iii). The guide for this interview is presented in Appendix C; it was distributed to participants prior to the interview for review.

These interviews were conducted via telephone with 11 individuals (of 13 working group members), 4 from the Kent County working group, 4 from the Sarnia-Lambton working group and 3 individuals involved in the development and delivery of the sessions in both counties. Interviews ranged in length from 15 to 39 minutes, with an average of 25 minutes. The interviews were conducted between March 5 and 31, 2010.

## Data Collection and Analysis

Surveys completed by education session participants were distributed and collected by session leaders and returned to the evaluation consultant for data entry and analysis. Invitations to complete on-line surveys and surveys delivered by postal service were distributed by the evaluation consultant. All survey data were analyzed using SPSS15.0.<sup>9</sup> Descriptive statistics (frequencies, means, standard deviations) were generated for numeric variables. Content analyses were conducted on open-ended responses using an inductive analysis approach, in which common themes were identified and categorized.<sup>10</sup> All interviews were conducted by the evaluation consultant. Interviews were digitally recorded and transcribed. Interview data analysis was consistent with recommended practices for qualitative data.<sup>11</sup>

### 3.0 Results

The following is a summary of the highlights and main themes emerged from the evaluation of the Skill Specific Education for care providers component of the Blueprint. Detailed presentation of the results of the session reaction survey and follow-up survey with Year One initiative participants are located in Appendices F and G, respectively.

#### 3.1 Objective I: To describe learner perceptions of the Skill Specific education sessions (Right Person, Right Place, Right Time; Community Resource Fair)

As there were no statistically significant differences in survey ratings across the individual sessions, results are reported for all sessions combined. Similarly, there were no significant differences in survey ratings based on discipline, practice setting (sector), or by previous completion of palliative care courses (Fundamentals, CAPCE, LEAP).

#### Perceptions of the Session

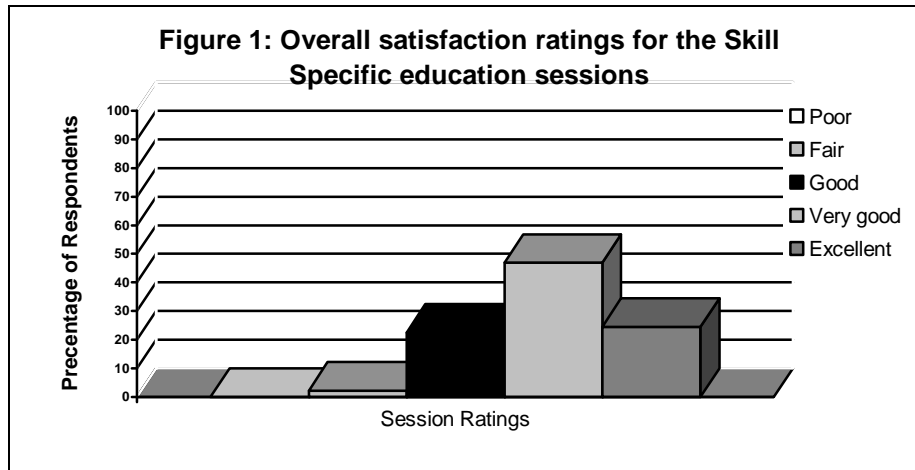
Overall, the majority of survey respondents viewed the program positively, with the majority of respondents (71%) providing ratings of “very good” (47%) to “excellent” (25%; See Figure 1); very few respondents (2%) held less favourable perceptions of the program (provided ratings of “fair”).

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<sup>9</sup> SPSS 15.0. Chicago, IL: SPSS Inc., 2007.

<sup>10</sup> Cavanagh, S. (1997). Content analysis: Concepts, methods, and applications. *Nurse Researcher*, 4, 5-16.

<sup>11</sup> Patton, M.Q. (2002). *Qualitative Evaluation and Research*. Thousand Oaks, CA: Sage.



Survey respondents were asked to rate the extent to which the various learning strategies used in the session were helpful, or valuable to their understanding and learning of the material covered in the workshop. Average ratings are presented in Table 3. Although average ratings for the learning strategies reflected that they were equally valued, ratings were the highest for the community support service fair (for which the majority of the respondents provided ratings of ‘very good’ or ‘excellent’).

**Table 3: Ratings\* of the learning strategies used in the session**

Average (+/-)	Learning Strategy
4.05 (80)	Community Support Service (Fair) displays/ stations
3.88 (.81)	Case study presentations
3.88 (.77)	Lecture presentations
3.81 (.88)	Small group discussions

\* 1-5 scale; 1 = poor, 2 = fair, 3 = good, 4 = very good, 5 = excellent

**Session Leaders:** Similarly, respondents were asked to use a 5-point rating scale (1 = poor; 5 = excellent) to rate the presentations by the session leaders. The majority of respondents (78%) provided ratings of “very good” (47%) and “excellent” (24%).

**Relevance:** Using a 5-point rating scale (1 = not at all relevant; 5 = extremely relevant), survey respondents were asked to rate how useful or relevant the information presented in the session was to their practice/ work. The average rating (4.26 +/- .74) reflected that respondents perceived the information presented to be very useful or relevant to their work.

In terms of the amount of new information relevant to their practice/ work, the majority of respondents (58%) thought it was “about right”; 28% thought it was between “about right” and “too much”; few (13%) thought there was too little new information.

Generally additional comments made about the education session were positive with some respondents commenting favorably to the presenters, content, and the usefulness of the

resource information provided. Comments were also made reiterating suggestions for improvements, such as lengthening the session (“*more time*”), more detail, and case studies.

## Impact of the Session

**New Learnings:** Survey respondents were asked to identify at least one new thing that they learned in the session that they were not aware of prior to the session. Most frequently survey respondents identified the SBAR communication tool, assessment tools, and community-based services. The following new learnings were identified:

- SBAR communication tool
- Assessment tools, PPI, ESAS, OPSQRST<sup>12</sup>
- Community services/ programs:
  - Hospice (services offered)
  - Palliative Pain and Symptom Management Consultation Program
  - Palliative Care Consultation Team (Lambton County)
  - Red Cross Homeward Bound Program
  - Share the Care™
  - CCAC services
  - VON children’s programs
- Information about physical symptoms:
  - Delusions
  - Delirium
  - Shortness of breath
  - Superior vena cava obstruction (SVCO)
- Hospital-related services:
  - GEM Nurse
  - End-of-life beds in complex continuing care
- Pain medication-related information:
  - Equianalgesic dosing/ medication conversions (morphine to fentanyl)
  - WHO ladder
- End-of-life management issues:
  - Role of walking/ standing for restlessness
  - Detrimental effects of suctioning for noisy breathing (‘death rattle’)
  - Ineffectiveness of anti-anxiety (e.g., Ativan®) for restlessness
  - Decision making regarding location of care (e.g., hospice, hospital, home)
- Available palliative care education programs (Fundamentals, CAPCE)
- Oncological emergencies.

**Knowledge:** The majority of survey respondents indicated that as a result of the Skill Specific session they are now more knowledgeable of various topic areas related to palliative or end-of-life care (See Table 4); most frequently respondents reported that they were more knowledgeable about available palliative care services and community support services and resources.

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<sup>12</sup> OPSQRST: a framework for assessing and reporting symptoms. Acronym standing for: Onset, provokes, quality, radiates, severity, time.

**Table 4: Ratings\* of the impact of the Skill Specific session on their knowledge of palliative and end-of-life care.**

<i>Knowledge of...</i>	<b>Less now**</b>	<b>The same</b>	<b>More now**</b>
Assessment & management of pain and other symptoms in clients	0	26.6% (51)	70.8% (136)
Communicating with the person/ family/ physician/ case manager	0	35.4% (68)	62.5% (120)
Palliative care services available across the continuum of care	0	17.2% (33)	80.7% (155)
Available community support services and resources	.5% (1)	19.3% (37)	78.1% (150)

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

\*5 point rating scale: 1 = Less knowledgeable now; 2; 3 = about the same; 4; 5 = More knowledgeable now

\*\* Less now = sum of 1 and 2 ratings; more now = sum of 4 and 5 ratings

**Comfort Level:** The majority of survey respondents indicated that as a result of the Skill Specific session they are now more comfortable in engaging in various palliative or end-of-life care activities (See Table 5). Consistent with reports of increased knowledge of community services, most frequently respondents reported that they were more comfortable with referring clients to appropriate community services and resources.

**Table 5: Ratings\* of the impact of the Skill Specific session on their comfort level with palliative and end-of-life care**

<i>Comfort Level with...</i>	<b>Less now**</b>	<b>The same</b>	<b>More now**</b>
Assessment & management of pain and other symptoms in clients	0	26.6% (51)	71.4% (137)
Communicating with person/ family/ physician / case manager	0	29.7% (57)	68.2% (131)
Referring clients to appropriate community services and resources	0	24.5% (47)	73.4% (141)

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

\*5 point rating scale: 1 = Less comfortable now; 2; 3 = about the same; 4; 5 = More comfortable now

\*\* Less now = sum of 1 and 2 ratings; more now = sum of 4 and 5 ratings

**Likelihood of Practice Change:** Using a 5-point rating scale (1 = not at all likely; 5 = extremely likely), survey respondents were asked to rate the likelihood that they would make a change in their practice as a result of the Skill Specific session; average ratings are presented in Table 6. Overall, average ratings reflected that respondents thought it likely that they would change their practice; ratings were highest for practice change related to pain and symptom assessment and management.

**Table 6: Ratings\* of the likelihood of changing practice as a result of the Skill Specific session (N = 182)**

Average (+/-)	Practice area
3.87 (.95)	Assessment & management of pain and other symptoms in clients using the tools presented today
3.86 (.95)	Communicating with person/ family physician/ case manager regarding end-of-life issues
3.83 (1.1)	Referring clients to appropriate community services and resources presented today

\* 5-point scale: 1 = not at all likely; 5 = extremely likely.

**Reflections on Improving Practice:** Survey respondents were asked to reflect on intentions to improve their practice by completing the following sentence: *“To improve my practice related to hospice palliative and end-of-life care, I plan to....”* Most frequently respondents commented on their intentions to improve their communication skills and access continuing education opportunities related to palliative and end-of-life care (See Table 7).

**Table 7: Survey respondents’ reflections on improving practice**

***“To improve my practice related to hospice palliative and end-of-life care, I plan to.....”***

- **Improve communication skills**  
*“try to listen more”*  
*“Communicate better - multidimensional and or explain better and clarify, therapeutic encounter, acknowledge with patient and family”*  
*“I plan to make a point of engaging patient in an open manner so that they may feel free to speak and ask questions.”*
- **Continue education related to palliative care (e.g., Fundamentals, CAPCE)**  
*“Continue attending education sessions. Ensure the palliative team is able to access education needed to continue their practice with current knowledge.”*  
*“Continue to enhance my education”*  
*“Register for the new phase I hospice palliative care course (have old version); practice better communication strategies”*
- **Increase use of assessment tools**  
*“Use the PPI tool”*  
*“Use the ESAS scores to better manage client’s service plan and care needs”*  
*“Regularly use the tools that were presented to me today/ help other staff gain knowledge so they can apply new skills to practice.”*

- 
- **Review resource material provided**
    - “Review medication calculation”*
    - “Review, review, review, continue learning”*
    - “Finish reading all material and keep as a resource.”*
  
  - **Increase communication/ collaboration with other team members and health professionals (e.g., PPSMC)**
    - “Communicate more with [Palliative Pain and Symptom Management Consultant]”*
    - “Collaborate with team members inside and outside my organization more quickly”*
    - “Engage more disciplines”*
  
  - **Increase knowledge of and access to community resources**
    - “Access all resources available.”*
    - “Become more knowledgeable in utilizing community resources and incorporating EOL care into my daily practice.”*
    - “Do further reading on local resources.”*
- 

**Challenges:** Nineteen (10%) respondents identified a number of issues or challenges that they anticipated would limit their ability to apply what they learned in the Skill Specific session to their clinical practice, these included: limited physician support (lack of willingness to use nursing expertise), limited opportunities for engaging in palliative care, access to available resources limited by organizational issues, and limited leadership/ management support.

**Needed Resources and Supports:** Fifty-nine (31%) survey respondents identified resources or supports needed to enhance the care they provide to clients requiring palliative or end-of-life care (See Table 8). The most frequently identified resource/ support was continuing education with many identifying the need for their completion of the Fundamentals and CAPCE Programs; some respondents identified specific topic areas for which they would like more information/ education including pain medications, conversions, grieving, and assessment (PPI).

**Table 8: Resources and supports needed to enhance palliative and end-of-life care**

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**Continuing education**

- “Continue my education”*
- “Take the Fundamentals course” “CAPCE”*
- “More education, education is important”*
- “Staff and physician education”*

**Education on specific topics**

- “More information on drug conversions; more case studies”*
  - “Pain and symptoms – detailed information other than what was taught today.”*
  - “Dealing with grieving / difficult families”*
  - “More on PPI and calculations of pain management”*
-

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**Consultation support**

*“Oncology support from experts”  
“Palliative care floor nurse”*

**Miscellaneous**

*“Pronouncing death, need more information who to call in long-term care facility  
some doctors won’t”  
“Medication delivery in home.”*

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**Suggestions for Improvements**

Survey respondents identified a number of suggestions for improvements to the session (See Appendix D for a list of the specific suggestions). Generally, suggestions for improvements were related to having more time; requests to lengthen the amount of time in the session were suggested to overcome concerns that the session felt “rushed” and the time constraints that precluded more detailed discussion of important issues. Similarly, many respondents suggested the increased use of case studies and small group discussions and increased time for the palliative physician presentation, as reflected in the following comments:

*“Wonderful afternoon! Should have started at 9:30 instead of 11:30 to appreciate such a vast amount of great information.”*

*“Have more discussions and presentations with challenging cases we have experiences in our day to day nursing practice.”*

*“A little more time for case studies.”*

*“Little rushed; very little time for questions.”*

*“Focus more about nurses providing palliative care at the bedside; each topic or presentation was only “scratched”.”*

**Additional Comments:** Additional comments made by survey respondents reflected their appreciation of the session and desire for more palliative care related education.

*“Thank you for providing the opportunity to expand my knowledge.”*

*“Great introductory to all aspect of team environment to clients/pt with palliative care case study - not enough time in general should rethink time allotment or strategy for discussing or presenting - very rushed”.*

*“Great job giving us all a better picture of the palliative care services available were can put faces on the services now as well.”*

*“Very much enjoyed networking. Good refresher day.”*

*“Have received Level I and Level II many years ago, I think that today's education was a good refresher and am considering perhaps upgrading my Palliative Education.”*

### 3.2 Objective II: To identify the longer-term impacts associated with participation in the Year One Skill Specific education activities

There were no significant differences in survey ratings based on discipline, employment status (full or part-time) or previous completion of palliative care courses (Fundamentals, AHPCE, CAPCE).

#### Practice Change

Survey respondents were asked to rate their current ability to assess pain and other physical symptoms, their ability to manage physical symptoms, and use of assessment tools in comparison to a year ago. The majority of respondents reported that they were now better able to assess (77%) and manage pain and physical symptoms (63%), and over half (51%) of the respondents reported that they are now using assessment tools more (See Table 9).

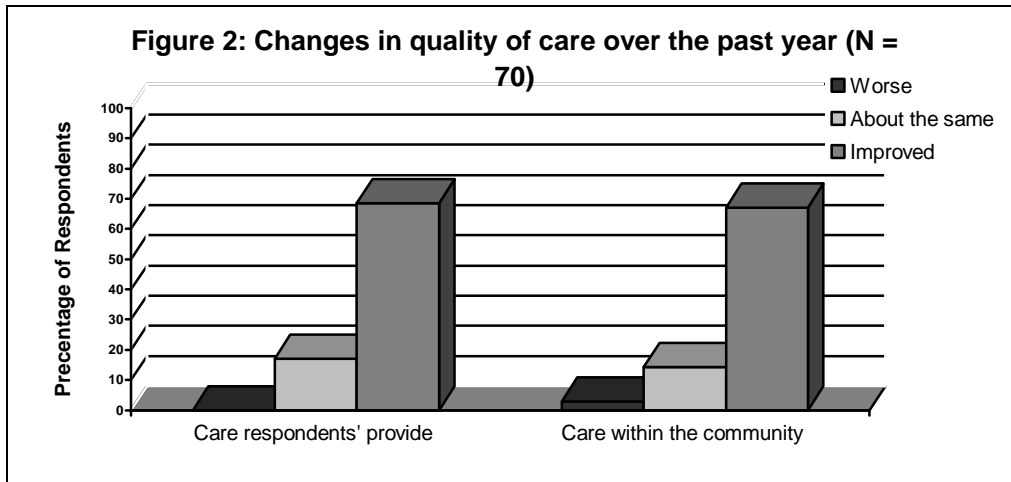
**Table 9: Ratings\* of ability to assess and manage pain and other physical symptoms and use of assessment tools in comparison to a year ago**

<b>Outcomes</b>	<b>Less now</b>	<b>About the same</b>	<b>More now</b>
Ability to assess pain and other physical symptoms	0	11.4% (8)	77.1% (54)
Ability to manage physical symptoms	0	22.9% (16)	62.9% (44)
Use of assessment tools (e.g., PPS, ESAS)	0	34.5% (24)	51.4% (36)

\*5 point rating scale: 1 = less now (capable/ use of tools); 2; 3 = about the same; 4; 5 = more now (capable/ use of tools)

\*\* Less now = sum of 1 and 2 ratings: more now = sum of 4 and 5 ratings

Related to changes in the quality of palliative and end-of-life care that they provide and that is generally provided within the community over the past year, the majority of respondents indicated that quality of care has improved (69% and 67%, respectively) (See Figure 2).



Survey respondents were asked to identify at least two things (best practices/ skills) that they learned in the 2009 physical skills sessions that they now use regularly. The following changes to practice were identified by respondents:

- Increased use of assessment tools
- Referrals to other expert resources (e.g., Palliative Oncology Nurse)
- More assertive advocacy for clients
- Improved pain management (increased confidence)
- Improved communication with families (increased confidence)
- Increased understanding of client and family needs
- Increased awareness of available resources
- Increased awareness of holistic care

## Impacts

**Client-related impacts:** Survey respondents were asked to identify the ways in which their clients and families benefited from changes in their palliative and end-of-life practice. Identified impacts included:

- Increased access to resources and supports
- Better pain and symptom management
- Enhanced quality of care/ support
- Development of more realistic goals
- Greater family involvement in decision-making
- More comprehensive assessment.

These changes are reflected in the following comments:

*“I am more knowledgeable about the resources available to support patients and families as they are moving thru this phase. I am also more confident in my pain assessment skills and speaking with patients and families about the realities of the situation.”*

*“The ways that this educational opportunity impacted my practice as an RN was very insightful giving me more tools and knowledge about palliative and it is informative*

*allowing me to have more confidence with palliative care the way the course was taught in the setting of a group with many group activity was very impacting and I am able to recall the things I've learned because they were hands on which I learn best from."*

*"Use assessment tools more, not only with palliative clients but all clients. More sensitive to the needs of the families and spend more time talking to them about palliative issues."*

**Workplace-related impacts:** Thirty-four percent of survey respondents reported that in the past year there have been changes within their workplace related to the assessment of palliative pain and symptoms and 31% reported changes within their workplace related to the management of palliative pain and symptoms. Similarly, 31% of respondents reported that in the past year there have been changes within their workplace to the management of last hours. These changes are summarized in Table 10 and are reflected in the following comments:

*"Lots of change - people appreciate the value of assessment, they talk more about it, they come to expect it. I think the "bar" has been raised - there is no excuse for not ensuring that pain/ symptoms are assessed and properly managed. People talk more about taking the palliative courses - there's almost a "buzz" about it - they see value in being able to learn more, though some of the older nurses do seem to think they know it already but this is debatable."*

*"Because of this educational opportunity all staff are more knowledgeable. Our flow sheets for pain management are from this educational opportunity."*

*"Since this opportunity our agency has changed some of its policy regarding management of palliative pain."*

*"New tools to use to assist with tracking pain and symptoms."*

*"Increased use of PPS [last hours] - this helps us figure out what we need to do. Everyone talks the same language regarding this so it's easy to deal with things among team members."*

*"Better collaboration with community partners"*

**Table 10: Workplace changes in palliative care over the past year**

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**Assessment of palliative pain and symptoms**

- Greater emphasis on use of assessment tools
  - Development of resources/ supports for assessment
  - Enhanced assessment
  - Improved documentation
  - More education that focuses on assessment
  - Greater interest in enhancing knowledge and skills related to assessment
-

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### **Management of palliative pain and symptoms**

- Improved communication
- Changes to reporting requirements
- More collaborative approaches to supporting clients
- Shorter waiting times to access in-home consultation
- Policy changes to palliative pain management

### **Management of last hours**

- Increased use of PPS and ESAS tools
  - Improved communication between care providers
  - Introduction of bereavement visits following death of a loved one to assess needs for further support
  - Increased service (shifts, extra time)
- 

**Health system related impacts:** Survey respondents were asked to rate the extent to which they have witnessed health system-related impacts over the past year. A relatively moderate proportion of respondents (40 - 49%) reported increases in the amount of and access to palliative care services provided in the community and in the number of clients served at home and dying at home (See Table 11). An equal proportion of respondents (37%) reported that visits to the ED for palliative care have decreased or remained the same. Changes to utilization of health system resources are reflected in the following comment:

*“I learned so much about what's available in the community at the session - I've used a lot of that information not only with palliative clients, but all clients. I think there is an increasing confidence in the community and we're better able to manage home deaths, so families don't feel the need to go to hospital out of fear that their loved one will have a painful or uncomfortable death at home. If we want more people to die at home - if they want to die at home then we need to support nurses to do this.”*

It was noted by several respondents that the elimination of the Community Liaison Nurse in their organization has resulted in delayed access to care/ services

*“Our [organization] has become less responsive (time delay) to our phoned reports and requests. As a nurse I feel as if I am alone out there. I need more support so I can do my job better.”*

*“Have found that referrals have increased as well as wait times for the palliative pain and symptom management team from hospice to be incorporated into client care, increasing wait times for relief, or increasing anxiety and frustration when needing to go to ER for assessment as often either [hospital] or family MD have declined to intervene.”*

**Table 11: Ratings\* of health system changes in the last year**

<b>Health system impacts</b>	<b>Decreased</b>	<b>About the Same</b>	<b>Increased</b>
Amount of palliative and end-of-life care services provided in the community	5.7% (4)	34.4% (24)	40.0% (28)
Access to palliative and end-of-life health care services	8.6% (6)	28.6% (20)	45.7% (32)
Number of end-of-life clients served at home	8.6% (6)	31.4% (3)	42.9% (30)
Number of deaths in hospital	34.3% (24)	42.9% (30)	5.7% (4)
Number of clients dying at home (expected deaths) consistent with their wishes	5.7% (4)	28.6% (20)	48.6% (34)
Visits to the Emergency Department related to palliative or end-of-life care issues	37.1% (26)	37.1% (26)	8.6% (6)
Communication among care providers across health sectors (community, hospital, long-term care)	8.6% (6)	40.0% (28)	34.3% (24)

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

\*5 point rating scale: 1 = much decreased; 2 = somewhat decreased; 3 = about the same; 4 = somewhat increased; 5 = much increased. Decreased is the sum of ratings of 1 and 2; Increased is the sum of ratings of 4 and 5.

**Challenges:** Survey respondents were asked whether they experienced any challenges as they applied what they learned in the 2009 physical skill sessions. Thirty-seven percent of respondents identified challenges; these included:

- Lack of integration and continuity of care across sectors
- Limited recognition of care provided in the community
- Managing pain and symptoms
- Lack of physician support
- Limited resources (palliative physicians, oxygen coverage)
- Limited support for RPNs as palliative care providers.

Challenges experienced are reflected in the following comments:

*“The system doesn't always support the work we do in the community - the physicians often challenge or don't respond to our assessments/ recommendations. Sometimes when clients go back to hospital, all that we did in the community to stabilize them gets messed up so that when they return we're back at square one. There needs to be more continuity of care - not only from hospital to community, but from community to hospital.”*

*“My greatest challenge is when the cancer physicians are not honest with the patient and do not make a referral to the Hospice physicians as early as I think that they should. The person is palliative and they continue to treat them.”*

**Needed Resources and Supports:** Thirty-four percent of respondents identified a number of resources or supports needed to enhance the care they provide to clients requiring palliative or end-of-life care. These included:

- Quicker response to requests for consultation/ supports
- More comprehensive palliative care education
- Supports for families to reduce burnout
- Increased physician and peer support
- Improved referral process for Hospice
- Improved communication for accessing resources/ supports
- Palliative care physicians

Resources and supports needed to minimize challenges associated with providing palliative care are reflected in the following comments:

*“Always challenges. Palliative Care is a work in progress. Each patient/family is unique and individual. The more education we as professionals have the more we are able to individualize care and help to contribute to a more positive outcome.”*

*“Physician support, team member support (there are still some community nurses that do things the 'old way' and haven't moved with the times), more time to spend with palliative clients - they need time to talk/ discuss things -these visits can't just be a quick in-out thing.”*

*“We need to have quick response to our reports, requests. We cannot wait 48 hours for response. Many times I have made a visit early AM only to call a report/request and wait for 36-48 hours for orders or a response. There is no time to fax reports. Faxing written reports means that I must wait until I go home in the evening to fax, which means that it will be the next AM before someone reads the fax, gets it to the correct practitioner, gets orders, then faxes back, then I finally receive orders and have already made my visit for that day because it is now 1700 the following day. We need portable fax machines or to be able to talk to a person now! Stop the faxed reports!”*

**Desired Education:** As a follow-up to the 2009 physical skills sessions, few respondents identified specific topics of interest, with most indicating they would like ongoing opportunities to be updated on latest best practices, to network and review cases studies and challenging issues.

### **3.3 Objective III: to describe the development and implementation of the Skill Specific education sessions**

#### **Facilitating Factors**

Working group members identified a number of factors that assisted with the development and delivery of the education sessions; these are summarized in Table 12 and focused primarily on

supports provided (project coordinator, leadership from PPSMCs, CCAC, funding for staff coverage, working group structures, and evaluation feedback from Year One).

**Table 12: Factors facilitating the development and delivery of the Skill Specific education sessions**

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**Facilitating Factors**

- Project coordinator role
  - Leadership support from the PPSMCs
  - Working groups
    - Cross sector membership
    - Face-to-face meetings
    - Secondary experts
  - Evaluation results from the Year 1 session
  - Support from CCAC
  - Cost sharing for attendance
- 

- **Project Coordinator role:** Having someone (Project Coordinator, Maura Purdon) to organize meetings, keep meetings focused and on track, follow-up on meeting action items and tasks, and to ensure that all of the session logistics (e.g., space/meals, equipment, PowerPoint presentations, handouts, invitation distribution, registration, communications) were taken care of was identified as critical to the delivery of the sessions as working group members did not feel that they had the time or skills to assume these tasks.

*“Having a coordinator was essential. We needed someone consistent to take care of the logistics, to take care of the IT piece and make sure that the meetings are well organized.”*

- **Leadership support from the Palliative Pain and Symptom Management Consultants (PPSMC):** It was noted that the PPSMCs were key to developing the content of the sessions so that it was consistent with that delivered in other education programs in terms of messaging, terminology used, and perspective. The consultants were also aware of what education/ content had already been delivered and so could avoid duplication. In addition, the consultants were knowledgeable of the key players in the various sectors so that the most appropriate individuals were invited to participate in the working groups.

*“And having the connection with the Palliative Pain and Symptom Management Consultation Program was critical. I think to have consistent messages to begin with. I think from an optic standpoint it’s important that the education piece be connected with that program, even though its not their formalized presentation, it’s still very important that this be seen as part of a whole, continuing, integration, that’s really critical.”*

- **Working groups:** Development of the session content, design, and identification of presenters was facilitated by the working groups within each county. Cross sector membership within the working groups ensured that the content was relevant to each sector. Having a diverse membership and the opportunity for face-to-face meetings facilitated dialogue/ discussion on topics that was essential to ensuring the quality of the content. It was noted also that cross sector representation increased the investment of each of the sectors and ensured “buy in” for attendance at the sessions. The use of secondary experts in palliative care to deliver the sessions served as an opportunity to build capacity among these individuals for education.

*“There was value in having the working groups, because there was buy in. When you help plan something then you’re going to make sure that its successful, because of that they promoted it to their constituents, to the people that were going to be attending.”*

*“I think there needs to be that dialogue and that communication between the parties [sectors] because you may hear something in someone’s discussion that triggers something, for example, a need that was identified.”*

- **Evaluation results from last year:** Results of the evaluation of the Physical Skills sessions held last year in Windsor-Essex helped the working groups to develop sessions to meet the identified needs of participants and to avoid the issues that were identified as challenges.

*“Well the development I think was having the evaluation from Windsor, which drove us to what to avoid and what to highlight, what the needs of people were, and so that was very important as we began our planning.”*

- **Support from CCAC:** It was noted that management support from the CCAC was important for organizing multi-site, multi-sector sessions and to securing “buy in” from the community agencies.
- **Cost sharing for attendance:** Covering the cost of nurses’ attendance at the sessions was viewed as vital to ensuring the majority of nurses would attend. It was suggested that without this in place, attendance would be greatly reduced.

## Challenges

Generally working group members noted that challenges experienced were not critical and that potential challenges were likely minimized by the efforts of the project coordinator. Identified challenges are summarized in Table 13 and were related to time constraints, which impacted their ability to get desired guest speakers and to schedule meetings in a timely fashion, addressing the varying needs of a diverse audience and some decision making (e.g., of session topics) that occurred outside of the working group meetings).

**Table 13: Challenges to the development and delivery of the Skill Specific Education Sessions**

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**Challenges**

- Time constraints
    - Preparation/ planning
    - Length of sessions
  - Addressing the varying needs of a diverse audience
  - Inconsistent preparation of presenters
  - Decision making outside of the working groups meetings
- 

- **Time constraints:** Although planning for the sessions started in October 2009, there was a lot of work that needed to be done in a relatively short period of time. Initially the topic of self-care was included in the agenda, however the desired guest speaker was not available, so the working groups had to find an alternative topic/ presenter. Time constraints further compounded the logistics of scheduling/ attending meetings (given competing priorities), particularly with members working in different sectors with different work hours (shifts) and keeping everyone informed of progress to date (communications). To overcome these challenges, it was suggested that topics and guest speakers be selected in greater advance of the session, all working group meetings be scheduled in advance, or alternatively, reduce the total number of working group meetings. Specific to communications, it was noted that e-mails regarding the sessions were numerous and quite lengthy; as this was due to time constraints it was suggested that planning start earlier so that some of information could be shared within meetings rather than electronically.

In addition, it was noted that the length of sessions and amount of time allotted for each topic/ presentation limited the information that could be covered so that in some cases it was not possible to go into great detail (*“scratching the surface”* only). To overcome this challenge it was suggested that the content of the sessions be focused on one or two key themes or that the length of the session be extended.

*“The time constraints and the amount of information that we were trying to get across, at the end of the day, it was just that you couldn’t deliver all that you wanted to and I think I felt the participants were cheated. It was just like giving them a little piece of candy and telling them they can’t have the rest.”*

- **Addressing the varying needs of a diverse audience:** Although the inclusion of care providers across sectors and with varying levels of expertise and work experience was viewed generally as positive, it posed a challenge to developing a session that met the diverse needs of the audience and that kept their attention and interest. Consistent with this, it was noted that having participants from different counties present was difficult because some policies and procedures/practice vary across counties and sectors so there were some instances where information was not applicable or relevant to participants of different counties. It was suggested that to overcome these challenges, sessions be focused on participants from specific catchment areas (counties) and to

specific levels of palliative care expertise (novice vs. advanced levels). Related to level of expertise. However, it was noted that some information was not new and repetitive from other sessions; it was also noted that some repetition of information should be tolerated to underscore its importance/ priority and to validate current practice.

*“So even though it might be repetitive for some, at least it validates that they’re doing the right thing. We feel empowered because this is very, very hard work, this palliative care nursing, and you need a lot of support, or at least an absence of negativity around it.”*

Consistent with this, it was noted that it was difficult to create breakout sessions based on level of expertise where participants self-select which group they are in; it was noted that in some cases, individuals who had registered for the advanced group should have been in the novice group, and some in the novice group were more appropriate for the advanced group.

*“There were some challenges with that in terms of people feeling they were in the wrong place, and there were people who felt they should have been in advanced, who when [presenter] was running the program felt they shouldn’t have been any way near there, because of the depth. And vice versa, there were people in the fundamental group who probably should have been over in advanced.”*

- **Inconsistent preparation of presenters:** Although most of the presenters were provided with their content and presentation materials in advance of the sessions, some did not get this information until the day of the session so that they were not as well prepared as those that had time to review/ practice their presentation material. This could be resolved by ensuring that all presenters receive their presentation materials well in advance of the session.
- **Decision-making outside of the working groups:** It was noted that although the working groups were involved in developing the content of the session and contributed to discussions about what topics would be important to include, some decisions about the specific topics included were made outside of the working groups; it was suggested that all working group members should participate in this decision-making.

**Resolution of challenges experienced last year:** Generally working group members believed that the actions they took to remediate the issues that arose with the Physical Skills sessions last year (scheduling issues, lack of new knowledge for those experienced in palliative care, mandatory nature of the sessions) were successful; participants expressed less negativity and appeared more positive and responsive to the sessions this year. Participation in the sessions this year was not called “mandatory”, though there were expectations that everyone attended.

*“We made it clear to the service providers that it was mandatory and so it was their role to, we used the word ‘opportunity’ in the flyers and notices, but they were to make sure that their people came... and I guess the service providers because they didn’t have CCAC saying it was mandatory didn’t require that staff follow through and I came across that with nurses that I’ve met and asked: ‘Are you coming?’ ‘Oh no, my work load is too heavy, I decided not to.’ Well it wasn’t their decision to make... We need to find middle ground between mandatory and opportunity and next time we might just hit it right on.”*

Breakout sessions were created specific to those at a “novice” and more “advanced” level. However it was noted that this may not be enough as there was some feedback that the panel discussion (that all participants attended) did not include new information for those with more advanced palliative care expertise. It was suggested that consideration be given to having entirely different sessions according to level of expertise/ experience. This year’s sessions included the hospital sector and retirement home staff and it was noted that increased cross-sector inclusion is important.

### **Relevance of the session topics**

Generally working group members were satisfied that the topics selected for this year’s sessions were the most relevant and appropriate at this time, particularly as related to the development of the Palliative Consultation Team in Chatham Kent, the communication component (SBAR tool), equianalgesic case studies and information aimed at assisting nurses to care for clients within the community. Discussion of available hospice palliative care services was particularly relevant for the Sarnia-Lambton session as it provided an opportunity to describe the services provided by the recently opened hospice centre in Sarnia. “Right patient, right place, right time” was viewed as timely from a systems perspective as much emphasis is placed on appropriate utilization of system resources. It was noted that selection of topics for these sessions should be based on input from nurses as well as working group members. Generally feedback on the topics selected was positive, as reflected in the following comments:

*“What I liked about the day was that there was something for everybody there, it didn’t matter whether you were relatively new to palliative care or you were experienced, there was something there for you.”*

*“I think that there will always be people who complain that they learned nothing new. Those who have been nurses a long time and say: ‘Nothing is new, I’m not going to change my practice.’ You just can’t satisfy everyone, but if you take those people out, I think you’ll find that we were right on with the content.”*

Working group members provided some feedback regarding the implementation/ delivery of the session in order to maximize attention/time on relevant components, including shortening the introductory component and allowing more time for the case studies and in break-out sessions. (More information on this is provided later under Suggestions for Improvement).

*“I would probably hope that there’d be additional time spent on case studies and working through some of that because that’s, I think that was sort of the meat and potatoes of what they are looking for.”*

### **Suggestions for future topics**

A number of topics for future sessions were identified; these are summarized in Table 14 and included: self-care, communication with families about end-of-life care and DNR orders, delirium, and psychosocial and spiritual care. In addition it was noted that nurses need and want more comprehensive information on pain assessment and management, with more opportunities to practice equianalgesic dosing and more information focused on cancer symptom management.

It was noted that the Education Blueprints' survey of education coordinators regarding educational needs, gaps, and opportunities (to be administered in Year Three of the Education Blueprint) will be a good opportunity to obtain the input of key stakeholders and will provide valuable information to develop an effective palliative care education sustainability strategy that builds on existing education opportunities and that avoids duplication.

**Table 14: Suggestions for future topics**

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**Suggestions for future topics:**

- Self-care/ compassion fatigue for nurses
  - Comprehensive pain assessment and management
  - Equianalgesic dosing – more opportunities to practice
  - Symptom management for cancer
  - Communication with families:
    - how to discuss end-of-life care
    - decision making regarding “Do Not Resuscitate” orders
  - Delirium – assessment, management to keep clients at home, case studies
  - Psychosocial/ spiritual care
- 

**Suggestions for Improvements and Sustainability**

Table 15 summarizes suggestions from improvements and sustainability as identified by working group members.

**Table 15: Suggestions for improvements and sustainability**

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***Suggestions for improvement:***

- Reduce introductory component
  - Allow more time for break-out sessions and case studies particularly equianalgesic dosing case studies
  - Increase use of case studies
  - Have clear criteria for assignment to novice vs. advanced break out sessions
  - Have a guest speaker while participants are eating (Maximizing available time)
  - Focus on “hands on” skills
  - Provide less significant information in handouts
  - Force table groupings so that participants have an opportunity to meet new people
  - Increase participation of retirement home sector
  - Separate sessions per county
  - Act on feedback to be provided in the survey distributed to education coordinators (Year Three Blueprint activity)
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- Act on participant evaluation feedback
  - Related to planning:
    - clarify purpose, target audience, intended outcomes
    - schedule all planning meetings in advance

**Suggestions for sustainability:**

- Develop strategy to build palliative care capacity among new nurses (e.g., mentoring from established nurses)
  - Develop a region-wide, cross sector education coordinator role
  - Use of provincial initiatives (e.g., RNAO) and technology (e.g., teleconferencing) for education
  - Share resources across sectors
- 

**Suggestions for improvements:** Generally it was suggested that more time be allotted to the break-out sessions and case studies as this is what participants are more interested in and currently, too much information is being covered in a short period of time.

*“In the advanced one [breakout session] there we touched on delirium and that was good, but none of the things we touched on there had enough time really... I just felt everything moved so quick that there wasn’t time to really ask more about it and digest it and, ask about things that you’ve seen or done or hear. It seemed too compacted.”*

It was noted that there needs to be clear criteria for assignment to novice vs. advanced break-out sessions as there were some nurses who indicated that they would not participate unless they could be included in the advanced group, however they did not have a basic understanding of palliative care to qualify for that group. It was suggested that years in practice should not be criteria for inclusion in the breakout session as there are many nurses to have been in practice many years who lack basic palliative care knowledge and similarly, there are nurses that have been in practice a short period of time who have advanced levels of palliative care expertise. It was also noted that generally there is a need for more education for nurses at advanced levels of palliative care knowledge whose work is focused on palliative care (e.g., those who work in hospice or hospital palliative care units).

*“Specifically, we might want to do a little bit more education for the advanced nurses who already have the education and its true, I mean, just speaking from myself, you do this for 20 some years and you’re always looking for a little bit different, it does become repetitive if you’re at the advanced level so if we could do something more advanced.”*

It was specifically noted that cross-sector participation continue as this provides an opportunity for networking that would not otherwise occur and allows each sector to learn how the others practice and what their challenges are. It was suggested that there be strategies in place (e.g., forced table groupings) to ensure cross-sector interactions.

*“The fact that here we have all this cross sector representation. How can we leverage that? I mean if you sat at the table of people you came in with and you knew them all before,*

*you'd go to the fair and you might or might not meet too many people at the fair.... So that I would probably try to build in more [opportunities for cross sector interaction].*

**Suggestions for sustainability:** It was noted that it is critical that a sustainability strategy be developed so that gains made from this initiative are not lost and so that this does not become a “one off” education program but a coordinated, integrated and ongoing education plan. It was suggested that there be a region-wide and cross sector education coordinator role to ensure a consistent and coordinated education plan and to avoid duplication and to reinforce transfer to practice. It was also suggested that strategies be developed to build capacity for palliative care among new nurses, perhaps by having experienced nurses mentor new nurses.

*“I think if we're going to develop education we need to make sure that there's the transfer to practice... because every education I've ever gone to has been 'oh, its amazing' and then you go away and you put it on the shelf, and sometimes its changes your thinking and your approach, but it might not change your practice. So yes education is important, but when we look at education it just can't be a one day or a half day, there needs to be an opportunity for application. So that would be a part of the sustainability, having somebody who could set up where there was follow up. And the other thing is, is having an opportunity for people to actually have a practical, to shadow somebody who's doing it.”*

It was also noted that there may be provincial initiatives (e.g., education fellowships and bursaries) and technologies (e.g., internet, Ontario Telemedicine Network - teleconferencing) that could be used for palliative care education; these opportunities need to be explored further.

*“How can we use resources that are available to us in Ontario and implement it here in Sarnia, for instance nursing fellowships? How can we do better palliative care here in our community by utilizing things that are out there and available to us? A lot of people don't use, like the RNAO reimbursement, things like that for education. How do we tackle all those and the internet and the electronic world?”*

To maximize existing resources, it was suggested that the provider agencies should collaborate to support and share existing resources, as illustrated in the following comment:

*“The providers themselves if you can get all them on board you know, share resources to buy in to that every year we need to get together, and let's see what we got out here so we can pull it together... So, getting everybody together and sort of brainstorming how to make the most of what resources we have.”*

## **Key Lessons Learned**

Working group members were asked to identify lessons learned in the planning and delivery of the Skill Specific sessions (If you had to provide advice to someone who was interested in implementing a similar initiative, what would it be?); these are summarized in Table 16.

## Table 16 Summary of the Key Lessons Learned

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### **Lessons Learned**

- Project coordinator role is essential/ critical
  - Ensure all relevant key players are at the planning table
  - Start planning early – at least 4 months in advance
  - Create an environment conducive to learning
  - Get commitment early from presenters
  - Conduct a needs assessment/ gap analysis to identify education needs
  - Make it easy for participants to attend (good timing, reimbursement)
  - Conduct ongoing evaluation to obtain participant feedback and act on that feedback
  - Make education a priority as a nursing retention strategy.
- 
- **Project coordinator role is essential/ critical:** It was noted by almost all of the working group members that a project coordinator role is essential to facilitate planning meetings, prepare supportive materials (PowerPoint presentations, handouts, communications), and to manage logistics. This role is critical to ensuring that the work gets done and that the product is of high quality, particularly when there are differences between sessions in terms of presenters, handouts, invitation distribution, and other logistics. Consistent with this, it was suggested that sessions have a moderator to keep presenters on time.

*“Our design had a lot of moving parts to it, and because you’re doing two sessions in Sarnia and two sessions in Chatham Kent, it was all arranged a little different, the content was a little different, your presenters were a little different. So you really need to be paying attention to all of the moving parts. Even the handouts were different, we had two different, somewhat different sets of handouts, so it was more work. The more complex you get with the design, it can make a session richer but it also makes it more work.”*
  - **Ensure all relevant key players are at the planning table:** Representation from all key stakeholders group in the working groups will ensure “buy in” for the sessions and will ensure that the education needs of participant groups are met.
  - **Start planning early:** Planning, at least 4 months in advance of the session, will ensure that desired speakers are available and will allow sufficient time for decision-making and completion of tasks to deliver the sessions.
  - **Create an environment conducive to learning:** It was noted that room set up is important to creating an environment that is comfortable and conducive to learning. For example, not setting up tables so that participants have their backs to the stage.
  - **Get commitment early from presenters:** Early planning and commitment from presenters will ensure that desired speakers are available.

- **Conduct a needs assessment/ gap analysis to identify education needs:** In order to meet the education needs of a diverse group of care providers a needs assessment and/ or gap analysis should be conducted to identify areas in which more/ enhanced knowledge/ skills are needed.
- **Make it easy for participants to attend:** As participants are busy professionals, the sessions should be set up in a way that makes it easy for participants to attend. Specifically, the timing of the sessions should be good in terms of time of year (not mid-winter when weather and travel are issues) and time of day, encouragement from management, and reimbursement for staff coverage.
- **Conduct ongoing evaluation to obtain participant feedback and act on that feedback:** Participant feedback was identified as important to the planning process so that their needs for education are met and methods of education (learning strategies) maximize learning and knowledge transfer.
- **Make education a priority as a nursing retention strategy:** It was noted that opportunities for education/ professional development is important to retaining nurses in the field and should be established as a priority.

*“I am in the evening of my career as a nurse.... If it weren’t for these kinds of learning opportunities I’d have retired by now.... They are so important to keeping you fresh and motivated, inspired.”*

## Potential Impacts

Working group members identified a number of impacts that have been associated with the education sessions that been delivered to date (Year 1 and Year 2) as part of this initiative; these are summarized in Table 17

**Table 17: Impacts associated with the palliative care education sessions delivered to date (Year 1 & 2)**

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***Client/ caregiver related impacts:***

- Increased access to quality/ optimal palliative care
- Increased access to information to inform decision making
- Increased trust in care provided within the home

***Health care provider related impacts:***

- Increased awareness of services, supports, and resources available in the community
  - Reduced sense of isolation
  - Increased access to new information and tools
  - Reinforcement/ support for existing knowledge
  - Increased access to practice tools and resources
  - Increased use of assessment tools
  - Greater understanding of the what palliative education is available
-

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- Increased awareness/ knowledge of pain assessment and management
  - Increased desire for performance improvement
  - Increased understanding of the domains of care
    - Heightened awareness of issues clients and caregivers face at end-of-life

***Health system related impacts:***

- Greater awareness/ better recognition of the key players in palliative care in the region
  - Increased access to community supports and resources thereby reducing reliance on acute care resources
  - Consistent language and messaging related to palliative care across sectors (fosters integration and continuity of care)
  - Improved communication/ interaction between health providers/ across sectors
  - Improved patient transition between sectors
  - Improved quality of care within the community (potential for ED/ acute care diversion)
  - Potential for increased nurse retention
- 

**Client/ caregiver related impacts:**

- **Increased access to quality/ optimal palliative care:** With more nurses educated on palliative care, clients and caregivers have increased access to nurses that are better prepared to provide palliative care.

*“Well any palliative education is definitely going to make the nurse feel a little more comfortable because it is such a tense, intense emotional challenge. Really, anything you can do to make the nurse feel more educated and more aware of the things that they’re going to deal with is going to help, and then of course in turn, they’re going to have the ability to offer more and do more with the client’s family, so everyone definitely benefits from palliative education.”*

- **Reduced sense of isolation:** Greater awareness of available resources and familiarity with services provided across sectors serves to reduce the isolation that nurses feel when managing complex palliative care issues.

*“They’re not feeling so alone; they’re part of a much larger picture.”*

- **Increased access to information to inform decision making:** As nurses are better informed about the resources and supports that are available in the community, clients and caregivers have greater access to information that can assist them in planning for end-of-life and to do so in a way that meets their needs and wishes.

*“I think first and foremost it’s about patient choices, about once they have this diagnosis they know already intuitively where they are in their projectory. Some want to spend their time at home when it comes to the end of their life, and others want to*

*be in another setting. Everything depends on so many factors as to why the choice, whether it be cultural, religious, the age that they are at and all of those things. I think it's just that with community and hospital nurses getting together and knowing what work that we do, and the ability to have that information ready for patients so they can have a choice, and also that we all get the same message; the nurses get the message that you know, we are well informed and that we are still care givers and it is a specialty that we do."*

- **Increased trust in care provided within the home:** The enhanced knowledge and skills of community nurses has increased patient and caregiver trust and confidence in the care that is provided within the home.

*"A level of confidence in the nurse because that's what they're looking to. The families I would say they're the team, we're the coach, and so the more knowledgeable you are when you walk in that door, the faster you gain their trust, that the suggestions you're making are evidence based."*

#### **Health care provider related impacts:**

- **Increased awareness of services, supports, and resources available in the community:** The community fairs have greatly increased nurses' awareness of what resources are available in the community to support clients and caregivers within the home. Working group members noted that they have received feedback from nurses that were unaware of some important/ significant resources available to clients.

*"Well you're going to have nurses who aren't doing palliative care all of the time, will have knowledge around resources because we had the community fair and just about everybody commented about how helpful that was around the resources that are out there. So nurses will be able to steer people to those community resources."*

*"I think that it will increase the quality of nursing care out there as well as giving them more options when they need it because the nurse will have more resources available to her and hopefully it will affect their patient care."*

- **Increased access to new information and tools:** The education sessions have provided nurses an opportunity to learn new information related to palliative care and about new tools (e.g., SBAR communication tool). It was noted that without these types of opportunities, nurses may not have access to this information.
- **Reinforcement/ support for existing knowledge:** In addition to providing nurses new information, the education sessions support nurses' efforts to use knowledge that they already have, as for example, in supporting/ reinforcing their ability to convert opioid doses (equianalgesic dosing), to use known assessment tools and develop management plans based on assessment results.
- **Increased comfort/ confidence:** The education sessions were credited with increasing nurses' comfort level and confidence in their ability to provide palliative care.

- **Increased physician trust in care provided in community:** It was noted that the focus on consistent language and enhanced communication has increased physician trust in the care provided by nurses within the community, as illustrated in the following comment:

*“I had a patient come on December 23<sup>rd</sup>. It said assess for hydration. This lady was vomiting every 90 minutes and of course the family doctor’s not available, and you’re calling doctors on call. Because I could use the language I had learned in these education sessions, I could say, this is what I need, otherwise she’s going to end up in your emergency department tonight and we don’t want that. And I would get the help I needed. Okay, we’ll order the hydration, we’ll order the medication you need, even though we haven’t seen that patient we trust you because you are the eyes and ears there.”*

- **Increased access to practice tools and resources:** The education sessions have increased nurses access to tools and resources that they can use in their practice, such as laminated PPI and ESAS tools and handouts on palliative care resources in the community.
- **Increased use of assessment tools:** It was noted that one of the most significant impacts of the education sessions to date has been in increased use of pain assessment tools and the PPS and ESAS tools among nurses across sectors. As an example it was noted that several years ago if a nurse mentioned a PPS score, most care providers would not be aware of what this meant, however as a result of the education sessions, most care providers are now aware of the PPS and the implications of the scores for end-of-life management.
- **Increased awareness/ knowledge of pain assessment and management:** Consistent with the increased use of assessment tools is the increased knowledge of how to effectively assess and manage pain.
- **Greater understanding of what palliative education is available:** Through the education sessions that have been delivered to date, nurses have been informed of the various palliative care education programs that are available to them (e.g., Fundamentals of Hospice Palliative Care, AHPCE, CAPCE). There has been an increase in interest in these programs.
- **Increased desire for performance improvement:** The education sessions delivered to date have been credited with motivating nurses to improve their practice, as evidenced in the interest in palliative care education programs.

*“From the feedback that I got, I really heard nurses saying that they wanted more, that they were interested in taking some of the palliative courses. I think it empowers them and motivates them to want to learn more. To do better.”*

- **Increased understanding of the domains of care:** Although there has been much emphasis on pain and symptom assessment and management, the education sessions have also focused on increasing nurses’ awareness of other domains of care such as

psychological, spiritual, social, and practical. As a result nurses have a heightened awareness of issues clients and caregivers face at end-of-life

#### Health system related impacts:

- **Greater awareness/ better recognition of the key players in palliative care in the region:** It was noted that education sessions have increased nurses awareness of the key palliative care programs and services offered in the region such as the PPSMP, Hospice programs (Windsor, Sarnia) and Palliative Consultation Teams (Sarnia-Lambton, Chatham-Kent). This has served to increase the profile and recognition of these services.
- **Increased use of community supports and resources thereby reducing reliance on acute care resources:** It was suggested that as nurses, both those in the community and those in acute care settings, increase their use of available community supports and resources for their clients, this may reduce the reliance on acute care resources – there is increased support for caring for clients within their homes.

*“I think hopefully because they [nurses] know that there are different options that it will keep people out of the ER, especially because the palliative care consultation team was part of the presentation in ‘Right person, Right place, Right time’, that they know that there’s a resource person to call and that unless the family insists or the person insists themselves, to go to the ER, then there are resources for the nurse in the home, so that should impact hopefully that. And with the community fair I mean they got so much information about what was out there.”*

*“There were a lot of questions about when a person is appropriate to go to hospice, and those were from hospital people. So for them to have their eyes opened up to what is out there for their patients rather than just their little world is going to benefit the system providing that continuity of care and transition to right care at the right time.”*

*“The amount of patients that are palliative that make emerge visits or have to come in to emerg, I would say has decreased significantly because the community nurses are doing a better job at identifying what the problem is and trying to treat at home. Or, trying to do a direct admission to the palliative unit to avoid the emerg. So yes, it has, I do see a big change.”*

- **Improved quality of care within the community (potential for ED/ acute care diversion):** As nurses build their capacity for palliative care and use available resources to support clients at home, the potential for ED and acute care diversion exists.

*“The goal has been to keep them [clients] out of hospital, and ER avoidance. So I think if we educate our nurses, give them all the critical thinking skills, we’ll save everybody. It’ll be better for the patient if they can stay at home where they want to be. It’s better for the nurse if she has the knowledge to make the decision, with the physician support, we can keep them out of the hospital, and can honour their end-of-life wishes at home.”*

- **Consistent language and messaging related to palliative care across sectors (fosters integration and continuity of care):** The education sessions have been credited with embedding a common language and messaging related to palliative care across sectors. One example of this is the use of the PPS and ESAS as a method of communicating a client's status and need for intervention. This serves to foster integration of care and continuity of care across sectors.

*“I think because we used the same language all the time that people are hearing the same information, and it becomes embedded. I think that's important that we continue to use the language of the model into program development and education and palliative care.”*

- **Improved communication/ interaction between health providers/ across sectors:** Use of a common language related to palliative care has served to improve communication and interaction between health care providers and across sectors. As an example, with greater awareness of the PPS and ESAS, it is easier for health providers to communicate about a clients status and need for intervention. The education sessions have been credited with improving the way in which health providers across sectors work together and serve to reduce isolation and territoriality.

*“I think that people are not feeling so alone; that they are part of a bigger picture. I think it really brought a sense of collegiality and harmony amongst the different sectors, even though we know each other seeing what they do, what we do and how we work together was kind of neat. It put a sense of meaning and purpose to the different sectors.”*

- **Improved patient transition between sectors:** It was noted that as community nurses build their capacity for palliative care, clients' transition from acute care following hospitalization has improved.
- **Potential for increased nurse retention:** It was suggested that ongoing education for community nurses could serve as a retention strategy as it reduces their sense of isolation and fosters their competence.

*“There is high turnover of nurses in the community and I think part of it is because they feel isolated and not very supported, especially when some of the palliative cases are so complex. I think that these kinds of education programs are going to be important to retaining our nurses.”*

#### 4.0 Conclusions

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

- The Skill Specific education sessions were well received. The sessions were described as a significant learning opportunity (new knowledge), relevant to practice, and likely to facilitate a change in practice.

- The significance of this learning opportunity is reflected in requests for longer and more palliative care related education sessions. The sessions increased participant motivation for more education with many participants expressing an interest in registering for formal palliative care programs (Fundamentals, AHPCE, CAPCE).
- Based on all sources of information, there are definite perceptions that the sessions offered in Year 1 and Year 2 have had an impact at an individual (increased access to information, increased trust in care), health provider (enhanced knowledge and skills, practice improvement), organizational (improved communication, development of policies and procedures to support palliative care), and health system (improved quality of care, potential for ED/ acute care diversion) level. Most significantly, the sessions provided nurses with knowledge, skills, and resources to enhance palliative care within the community, thereby reducing the use of acute system resources and enhancing utilization of existing resources. Given the nursing shortage opportunities for ongoing education and capacity building may be important to retaining nurses.
- It is clear that there is commitment across sectors, across the region to ensure access to quality palliative care education. Working group attention to evaluation feedback gathered at the Year One sessions served to resolve issues identified and to further develop education that is relevant and immediately applicable to practice. The structures created for this education initiative have the potential to ensure sustainability.
- Challenges/ barriers to knowledge transfer were identified (e.g., limited physician and organizational support) - efforts aimed at reducing these will further enhance palliative care within the community; ongoing education is an important step toward addressing these challenges.

**Limitations:** The changes in practice and system level impacts identified in this evaluation are based on self-report and anecdotal evidence. It may be possible to identify more objective outcome indicators (e.g., number of palliative care related ED visits, number of deaths in hospital and at home) to provide evidence of system enhancements over time. It is likely that the palliative care education provided by the Education Blueprint interacts significantly with other palliative care system enhancements (e.g., Hospice programs, expert consultation teams) to affect improvements to care.

## Acknowledgements

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The feedback and advice of the ESC Education Committee is gratefully acknowledged. The consultant is especially grateful to Julie Johnston, Maura Purdon, Carole Gill and Ann Brignell 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 quality palliative / end-of-life care across this region.

## List of Appendices

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As a result of today's education, how would you rate your knowledge now of the following topic areas related to palliative or end-of-life care? Please check the most appropriate response.

	Less knowledgeable now	Somewhat less now	About the same	Somewhat more now	More knowledgeable now
Assessment & management of pain and other symptoms in clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicating with the person/ family/ physician/ case manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palliative Care services available across the continuum of care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Available community support services and resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

As a result of today's education, how would you rate your comfort level now in engaging in the following activities related to palliative or end-of-life care? Please circle the most appropriate response.

	Less comfortable now	Somewhat less now	About the same	Somewhat more now	More comfortable now
Assessment & management of pain and other symptoms in clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicating with person/ family /physician / case manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referring clients to appropriate community services and resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

As a result of today's session, how likely is it that you will make a change in the following areas of your practice related to hospice palliative or end-of-life care?

	Not at all likely 1	2	3	4	Extremely likely 5
Assessment & management of pain and other symptoms in clients using the tools presented today	1	2	3	4	5
Communicating with person/ family physician/ case manager regarding end-of-life issues	1	2	3	4	5
Referring clients to appropriate community services and resources presented today	1	2	3	4	5

Do you anticipate any issues or challenges that would limit your ability to apply what you learned today?

- No  Yes, please specify:

Are there any resources or supports including additional education that you need to enhance the care you provide to clients requiring palliative or end-of-life care?

- No  Yes, please specify:

Please complete this sentence: *"To improve my practice related to hospice palliative and end-of-life care, I plan to....."*

Do you have any suggestions for improving this session?

Do you have any additional comments that you would like to make about this education initiative?

**Tell us about yourself!**

Are you a:

- Registered Nurse     Registered Practical Nurse     Other, please specify: \_\_\_\_\_

Have you completed The Fundamentals of Hospice Palliative Care Program?

- Yes             Currently in progress             No

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

- Yes             Currently in progress             No

Have you completed the Learning Essential Approaches to Palliative and End-of-life Care (LEAP) Program?

- Yes             Currently in progress             No

What is your practice location?

- Community     Residential Hospice             Hospital             Retirement Home

What is your current employment status (check one)?

- Full-time     Part-time or Casual

How many years have you been working in your field? \_\_\_\_\_years

How much of your work time do you currently spend providing palliative care (caring for dying clients)?

- never     hardly ever/rarely     sometimes     often     all the time

**You have come to the end of this survey. Thank you for completing this survey.**

## Appendix B

### Follow-up Survey for the Participants of the Year One Skill Specific Education Session

#### Impact on Clinical Practice

1. In what ways has your clinical practice related to palliative and end-of-life care changed as a result of your participation in these education sessions? Please identify at least two things (best practices/ skills) that you learned in these sessions that you now use regularly.  
 My practice did not change as a result of this education.
2. In what ways have your clients and their families benefited from the changes in your palliative and end-of-life care practice?  
 Not applicable - my practice did not change as a result of this education.
3. Did you experience any challenges as you applied what you learned in these sessions about palliative pain and symptom assessment and management, and about available community support services and resources, or related to these things in general?  
 No    Yes, please explain

We are interested in learning about how your practice related to the assessment and management of palliative pain and symptom management may have changed over the past year.

4. In comparison to a year ago, how would you rate your current **ability to assess** pain and other physical symptoms in clients requiring palliative or end-of-life care?

1                      2                      3                      4                      5  
Less capable                      About the                      More capable  
now                      same                      now

5. In comparison to a year ago, how would you rate your current **ability to manage physical symptoms** in clients requiring palliative or end-of-life care?

1                      2                      3                      4                      5  
Less capable                      About the                      More capable  
now                      same                      now

6. In comparison to a year ago, how would you rate your current **use of assessment tools** such as the Palliative Performance Scale (PPS), Edmonton Symptom Assessment System (ESAS), and the comprehensive pain assessment tool, with clients requiring palliative or end-of-life care?

1                      2                      3                      4                      5  
Use tools less                      About the                      Use tools more  
often now                      same                      often now

7. In comparison to a year ago, how would you rate the quality of palliative and end-of-life care that you provide?

1                      2                      3                      4                      5  
Much worse                      Somewhat                      About the                      Somewhat                      Much improved  
now                      worse                      same                      improved                      now

8. In comparison to a year ago, how would you rate the quality of palliative and end-of-life care that is, in general, provided within the community?

1                      2                      3                      4                      5  
Much worse                      Somewhat                      About the                      Somewhat                      Much improved  
now                      worse                      same                      improved                      now

### Workplace changes

9. Over the past year have there been any changes within your workplace related to the assessment of palliative pain and symptoms?

No     Yes, please explain:

10. Over the past year have there been any changes within your workplace related to the management of palliative pain and symptoms?

No     Yes, please explain:

11. Over the past year have there been any changes within your workplace related to the management of last hours?

No     Yes, please explain:

## Health System Changes

12. Based on what you have witnessed, to what extent do you think that the following have changed over the past year?

	Much decreased 1	Somewhat decreased 2	About the same 3	Somewhat increased 4	Much increased 5
Amount of palliative and end-of-life care services provided in the community (e.g., nursing visits, shift nursing hours, PSW hours for palliative/ end-of-life care)	1	2	3	4	5
Access to palliative and end-of-life health care services	1	2	3	4	5
Number of end-of-life clients served at home	1	2	3	4	5
Number of deaths in hospital	1	2	3	4	5
Number of clients dying at home (expected deaths) consistent with their wishes	1	2	3	4	5
Visits to the Emergency Department related to palliative or end-of-life care issues	1	2	3	4	5
Communication among care providers across health sectors (community, hospital, long-term care)	1	2	3	4	5

Do you have any comments you would like to make about this?

## Supports and Resources

13. 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:

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

- No  Yes, please specify:

15. Do you have any additional comments that you would like to make about this education initiative or about palliative and end-of-life care education in this region?

### **Tell us about yourself!**

The following information will be used to analyze the results of the survey and will be reported as group information only. This information will not be used to identify you. If you do not want to complete some of these questions, please leave them unanswered but still submit the survey.

Are you a:

- Registered Nurse
- Registered Practical Nurse
- Other, please specify: \_\_\_\_\_

Since you the physical skills session you participated in last year, have you participated in any of the following hospice palliative care education programs? Please check all that apply.

- Fundamentals of Hospice Palliative Care
- Advanced Hospice Palliative Care Education (AHPCE)
- Comprehensive Advanced Palliative Care Education (CAPCE)
- Other, please specify: \_\_\_\_\_

What is your current employment status (check one)?

- Full-time
- Part-time or Casual

How many years have you been working in your field? \_\_\_\_\_years

How much of your work time do you currently spend providing palliative care (caring for dying clients)?

- never
- hardly ever/rarely
- sometimes
- often
- all the time

**You have come to the end of the survey. Thank you for completing this survey.**

### Guide for the Interviews with Volunteer Education Working Group Members

#### Development and Implementation of the Year Two Skill Specific education program

1. What worked well, or facilitated the development and delivery of the Year Two Skill Specific education sessions?
  - 1.1 To what extent did the working groups facilitate the process of developing and implementation of initiative?
2. What challenges were experienced with the development and delivery of these sessions?
  - 2.2 What are the potential strategies to overcome these?
  - 2.3 To what extent were issues/ challenges experienced in Year One of this initiative (e.g., scheduling, lack of new knowledge for those experienced in palliative care) resolved?
3. To what extent were the topics selected for these education sessions the most relevant/ appropriate at this time?
  - i) In hindsight, what changes would you have made to these topics, or to the agenda?
4. Do you have any suggestions for topics for future skill specific sessions?
5. What are some of the key lessons learned in the development and implementation of this initiative? If you had to give advice to someone implementing this type of initiative in another region, what advice would you give them?
5. What are the potential impacts associated with this initiative? For example, what are the benefits to clients and their families? To care providers and their organizations? To the health system? Are there any potential sources of information/ evidence of these impacts?
6. What are suggestions for improvement to this initiative? For sustainability?
7. Do you have any final or additional comments you would like to make?

## Appendix D

### Results of the Reaction Survey for the Skill Specific Education Session

**N = 192**

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

There were no statistically significant differences in the ratings by session, so results are presented across all sessions.

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

Poor	Fair	Good	Very Good	Excellent
0	2.1% (4)	22.4% (43)	46.9% (90)	24.5% (47)

**How valuable were the following to your understanding and learning of the material covered in this session?**

	Poor	Fair	Good	Very Good	Excellent	Average (+/-)
Lecture presentations	0	4.7% (9)	21.9% (42)	53.1% (102)	19.8% (38)	3.88 (.77)
Case study presentations	0	5.2% (10)	24.0% (46)	48.4% (93)	22.4% (43)	3.88 (.81)
Small group discussions	0	8.3% (16)	24.0% (46)	44.3% (85)	21.9% (42)	3.81 (.88)
Community Support Service (Fair) displays/ stations	.5% (1)	2.6% (5)	18.2% (35)	48.4% (93)	30.2% (58)	4.05 (80)

**Overall, how would you rate the presentations by the session leaders today?**

Poor	Fair	Good	Very Good	Excellent
0	3.1% (6)	18.2% (35)	53.6% (103)	24.0% (46)

**How useful or relevant was the information presented today to your practice/ work? 5-point rating scale: 1 = not at all relevant; 5 = extremely relevant**

4.26 (.74)	Average (+/-)
2 – 5	Range
189	N

**How would you rate the amount of new information that you learned today?**

1 Too little	2	3 About right	4	5 Too much
3.1% (6)	9.9% (19)	57.8% (111)	27.6% (53)	.5% (1)

Please identify at least one new thing that you learned today that you were not aware of before today's session.

- SBAR
- Treatment for delirium in liver CA is lactulose
- The changes in the PC program Fundamentals - CAPCE
- Hospice in Windsor and London
- The names of important people in healthcare in our community
- SBAR communication tool
- PPSMCP
- More about PCCTs
- Made aware of the equianalgesic dosing
- The PCCT
- Affirmation of how fortunate we are to have a good palliative program.
- Complex continuing care has end-of-life beds in hospital
- Delusion learning
- Services in Chatham/ Sarnia area
- SBAR SSI
- Improved communication ideas
- The PPI
- Oncological emergencies
- PPI
- SBAR communication tool
- The many resources available
- Shower cap available for clients
- 15%!!!
- SBAR
- SBAR communication tool
- The new Palliative Care Consultation Team
- Medication changes - from oral - SC
- Aging at home information; GEM nurse, delirium
- St. Joe's hospice services
- I enjoyed the communication lecture
- GEM Nurse
- Wait - why am I talking
- Able to admit to PCU directly
- Red Cross program - Homeward bound program
- All was basically a review - some a review of more distant concepts (PPI)
- Signs and symptoms of delirium and management of it.
- The difference between palliative care and hospice
- The different services each organization provides
- DNR requirement for hospice
- Some of the different medications used in palliative patients in the palliative care unit.  
Example: increase pain/agitation etc.
- PPI
- PPI

- *The number of agencies in Sarnia devoted to help and care of clients in need.*
- *ESAS/PPS*
- *SBAR*
- *When the client is restless they like to walk a lot or stand up even if the PPS is 30%.*
- *Death rattle not hurtful to patient. Suctioning is worse.*
- *PPI Tool*
- *The different scales PPS and ESAS*
- *The PPS - very informative*
- *Great to review opioid equivalencies (I don't see this very often)*
- *PPI*
- *PPI*
- *Learned more about community supports*
- *PPS*
- *Morphine-fentanyl conversion (local) and SBAR*
- *equivalencies of meds*
- *ESAS and PPS*
- *Morphine 50mg po= 37.5 Fentanyl (local); always morphine 50po before a patch.*
- *PPI*
- *PPS*
- *More reasons about what causes delirium and how to manage and SBAR*
- *Pain medication/ conversions*
- *SBAR communication tool*
- *increase awareness of possible ways to manage admission to HPC units/beds in another area (i.e. Chatham Kent); existence and role of Dr. Maddison.*
- *PPI; Share the Care - was not aware.*
- *PPI*
- *SBAR form*
- *Versa usage*
- *Amount of delirium at EOL and how manageable PPI and SBAR tools*
- *Importance of pain management and good communication*
- *Conversion of pain meds<sup>3</sup>*
- *Ativan - not to take for restlessness at end of life.*
- *Ativan is not too great for end-of-life restlessness.*
- *Medication management of delirium*
- *SBAR*
- *Lyrica drug - client should be on at least 50mg morphine before changing to Fentanyl patch.*
- *PPS scale; WHO ladder*
- *Edmonton Symptom Assessment Scale*
- *WHO; PPS*
- *WHO ladder*
- *Palliative Care Consultation team*
- *PPI*
- *PPI*
- *PPI; SBAR tool*
- *Learned how to use PPI*

- *PPI*
- *SBAR; assessment sheets; OPSQRST*
- *PPI - plus exceptions; SBAR tools, OPQR*
- *Delirium and dementia are different*
- *Found the communication tool especially helpful*
- *PPS*
- *Med conversions*
- *CCAC*
- *How to use PPI*
- *Canada the first country to have model for care - standard principle; communication, national model*
- *VON children's programs*
- *PPS scoring/percent*
- *Increase communication for EOL discussions*
- *Lambton has such a large number of providers interested in improving provision of Palliative Care in our community.*
- *Community criteria for admission*
- *How to decide where a patient will go (I.e., hospice, hospital, stay home).*
- *More ways of communicating with patients and families.*
- *The medication dosing*
- *PPI*
- *Steps in pain management; critical question to consider SOB*
- *PPSMCP stands for palliative pain and symptom management consultation services; Fentanyl patch information*
- *PPI*
- *PPI*
- *The domains of issues associated with illness and bereavement.*
- *Better management of delirium*
- *Criteria for admission for palliative care and hospice*
- *Good review of conversions.*
- *The hospice about how its run and its assets*
- *Hospice is free*
- *Education available; Himalayan salt crystal lamp*
- *How closely all the different resources worked together; W.A.I.T. and ESAS*
- *SBAR communication tool, more knowledge of community care*
- *Palliative Care services across Lambton*
- *PPI scale*
- *SVCO*
- *Information on use of opioids to sue same brand for long-acting and BT.*
- *Med transfers*
- *Equianalgesic dosing chart*
- *PPI*
- *PPI*
- *medication conversion*
- *Criteria for each section*
- *PPI*

- Sedation for end-of-life delirium
- Reviewing calculations and updating are always important
- Palliative at hospital not just for the end of life person as I thought.

**As a result of today's education, how would you rate your knowledge now of the following topic areas related to palliative or end-of-life care? Please check the most appropriate response.**

	Less knowledgeable now	Somewhat less now	About the same	Somewhat more now	More knowledgeable now
Assessment & management of pain and other symptoms in clients	0	0	26.6% (51)	37.5% (72)	33.3% (64)
Communicating with the person/ family/ physician/ case manager	0	0	35.4% (68)	31.8% (61)	30.7% (59)
Palliative care services available across the continuum of care	0	0	17.2% (33)	40.1% (77)	40.6% (78)
Available community support services and resources	0	.5% (1)	19.3% (37)	42.2% (81)	35.9% (69)

**As a result of today's education, how would you rate your comfort level now in engaging in the following activities related to palliative or end-of-life care? Please circle the most appropriate response.**

	Less comfortable now	Somewhat less now	About the same	Somewhat more now	More comfortable Now
Assessment & management of pain and other symptoms in clients	0	0	26.6% (51)	43.2% (83)	28.1% (54)
Communicating with person/ family /physician / case manager	0	0	29.7% (57)	43.8% (84)	24.5% (47)
Referring clients to appropriate community services and resources	0	0	24.5% (47)	45.3% (87)	28.1% (54)

**As a result of today's session, how likely is it that you will make a change in the following areas of your practice related to hospice palliative or end-of-life care? 5-point scale: 1 = not at all likely; extremely likely.**

	Average (+/-)	Range
Assessment & management of pain and other symptoms in clients using the tools presented today (N = 182)	3.87 (.95)	1 – 5
Communicating with person/ family physician/ case manager regarding end-of-life issues (N = 182)	3.86 (.95)	1 – 5
Referring clients to appropriate community services and resources presented today (N = 182)	3.83 (1.1)	1 – 5

**Do you anticipate any issues or challenges that would limit your ability to apply what you learned today?**

80.7% (155)	No
9.9% (19)	<p>Yes, please specify:</p> <ul style="list-style-type: none"> <li>• <i>Political hoops of hospital bureaucracy</i></li> <li>• <i>More experiences required</i></li> <li>• <i>Patients' compliance</i></li> <li>• <i>Not having full knowledge of the material supplied</i></li> <li>• <i>Human resources</i></li> <li>• <i>This was a lot of information and my concern is how to access the resources mentioned today. "Ladder/ chain of command"</i></li> <li>• <i>Sometimes knowledge and beliefs of some family doctors. This is improving.</i></li> <li>• <i>I work in pharmacy and do not have a big role in this aspect of health care.</i></li> <li>• <i>Other staff not having tools to apply this care</i></li> <li>• <i>I don't regularly do palliative care</i></li> <li>• <i>Need more time on equianalgesic dosing chart, PPS</i></li> <li>• <i>Management</i></li> <li>• <i>Lack of expertise amongst co-workers some of whom feel they are "experts" but aren't even familiar with CHPCA model.</i></li> <li>• <i>Physicians do not like to prescribe pain medication or adequate meds.</i></li> <li>• <i>Not used at HDGH</i></li> <li>• <i>Physicians willingness to draw on my knowledge</i></li> <li>• <i>Getting family doctors to feel comfortable with new trends and meds</i></li> <li>• <i>Difficulty getting assistance from "charge" nurse in action to take.</i></li> <li>• <i>Theory different than reality in the community, the supports needed are not always there</i></li> </ul>

**Are there any resources or supports including additional education that you need to enhance the care you provide to clients requiring palliative or end-of-life care?**

46.9% (90)	No
30.7% (59)	<p>Yes, please specify:</p> <ul style="list-style-type: none"> <li>• <i>Community services - how accessible, specific services per agency</i></li> <li>• <i>More education - education is important</i></li> <li>• <i>Oncology support from experts</i></li> <li>• <i>Fundamentals, CAPCE</i></li> <li>• <i>Completion of level 1 &amp; 2 of palliative</i></li> <li>• <i>It would be beneficial to take CAPCE</i></li> <li>• <i>More information on drug conversion; more case studies</i></li> <li>• <i>Just knowledge of how to reach resources to supply this information to families.</i></li> <li>• <i>Always appreciate doing the changing of meds</i></li> <li>• <i>Symptom management at end of life can enhance delivery by enhancing knowledge.</i></li> <li>• <i>Further education</i></li> <li>• <i>Continue with my education</i></li> <li>• <i>Medications review</i></li> <li>• <i>Advanced palliative care</i></li> <li>• <i>Palliative care floor nurse</i></li> <li>• <i>CAPCE</i></li> <li>• <i>have Fundamentals, one step further</i></li> <li>• <i>Pain and symptom - detailed information other than what was taught today, CAPCE</i></li> <li>• <i>Keep on learning all that I can</i></li> <li>• <i>CAPCE course, more on PPI</i></li> <li>• <i>Dealing with grieving/difficult families</i></li> <li>• <i>More information re: WEC resources and supports</i></li> <li>• <i>CAPCE</i></li> <li>• <i>Review of med equivalency calculations</i></li> <li>• <i>look into CAPCE</i></li> <li>• <i>I need to attend Fundamentals - an am hoping to do so soon.</i></li> <li>• <i>More on the PPI and calculations of pain management</i></li> <li>• <i>Learn more</i></li> <li>• <i>Continued education</i></li> <li>• <i>Palliative education, communication</i></li> <li>• <i>Fundamentals of Palliative care course - going to take it soon.</i></li> <li>• <i>Book - "I didn't know what to say"</i></li> <li>• <i>More reading about case studies and discussions with other Palliative Care Resources Nurses</i></li> <li>• <i>Medication delivery in home</i></li> <li>• <i>Fundamentals, CAPCE</i></li> <li>• <i>Finish my palliative care courses</i></li> <li>• <i>Staff and physician education</i></li> </ul>

	<ul style="list-style-type: none"> <li>• <i>Conversions for medication</i></li> <li>• <i>Pronouncing death, need more info who to call in long-term care facility some doctors won't</i></li> <li>• <i>Fundamentals</i></li> <li>• <i>CAPCE Program</i></li> <li>• <i>Fundamentals</i></li> <li>• <i>Palliative care course</i></li> <li>• <i>Any extra education is always beneficial no matter what it is as long as it relates to our practice.</i></li> <li>• <i>Med's for pain control</i></li> <li>• <i>Fundamentals of Hospice Palliative Care</i></li> <li>• <i>Fundamentals course</i></li> <li>• <i>Fundamentals Program</i></li> <li>• <i>Any update/ education re: EOL care</i></li> <li>• <i>Continuous learning</i></li> <li>• <i>Need Fundamentals , medication end-of-life</i></li> <li>• <i>Fundamentals course, fewer palliative courses and programs</i></li> <li>• <i>ongoing consultation and support from palliative team</i></li> <li>• <i>More education on EOL meds</i></li> <li>• <i>review medication doses</i></li> <li>• <i>more education on medication</i></li> </ul>
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**Please complete this sentence: “To improve my practice related to hospice palliative and end-of-life care, I plan to.....”**

- *Try to listen more*
- *Continue education*
- *Continue educating myself in this area on an ongoing basis*
- *Review, review, review, continue learning*
- *Be more pro-active and encouraged by today's session*
- *Register for the new phase I hospice palliative care course (have old version); practice better communication strategies*
- *Communicate more with [Palliative Pain and Symptom Management Consultant]*
- *Collaborate with team members inside and outside my organization more quickly*
- *Take Fundamentals, CAPCE*
- *Continue education*
- *Use all tools provided*
- *Further my education in the palliative area to better care for my palliative clients*
- *Continue to expand my knowledge with palliative care to continue to keep me up to date so I can be an ongoing advanced palliative care nurse.*
- *Really listen*
- *Continue attending education sessions. Ensure the palliative team is able to access education needed to continue their practice with current knowledge.*
- *Review and absorb further all materials provided.*
- *Complete palliative 1 & 2; use my resources*
- *Finish reading all material and keep as a resource.*

- *Access all resources available.*
- *Communicate more within my disciplines*
- *Reflect on what I have learned today and apply in current and future situations with clients.*
- *Continuing education*
- *Listen more, observe more*
- *Use the ESAS scores to better manage client's service plan and care needs*
- *Follow up with more palliative care measures/teaching*
- *Continue to practice med conversions*
- *Continue reading and taking courses*
- *Think why is this client feeling this and how can I make it better*
- *Improve my communication skills with clients and family members*
- *Participate in in-services - read more books.*
- *Continue to increase knowledge in palliative care; "wait" - shine 90% of light on patient*
- *Consider the role of oxygen in delirium in palliative / hospice care.*
- *Continue to enhance my education*
- *Continuing care*
- *Research more into this topic.*
- *Educate myself more; take every education opportunity*
- *Review and continue to improve my communication skill very important with end-of-life care.*
- *Keep attending in-services to help keep my knowledge and practice up to date so I may better provide care to residents and their family members.*
- *An extremely well organized seminar! I feel fortunate to have come. Learned a lot!*
- *Take advantage of the education programs available.*
- *Communicate better - multidimensional and or explain better and clarify, therapeutic encounter, acknowledge with patient and family*
- *Attend more session like this one.*
- *Review these notes and take this in as much as I can.*
- *Review medication rotation*
- *Use the scales PPS & ESAS and the medication formulas*
- *Keep informed about the changes*
- *Regularly use the tools that were presented to me today/ help other staff gain knowledge so they can apply new skills to practice.*
- *Read about communication skills and go over medications that are given*
- *Keep trying- this area is huge and learning is a process.*
- *Refer to new handouts*
- *Read more of the palliative care info available to me and review what I already know but don't use very often.*
- *Continue ongoing education*
- *Complete the Fundamentals course*
- *Educate myself and become more accepting to this type of care (confidence).*
- *use this each and every time*
- *CAPCE*
- *Communicate better with family members.*

- *Use the information I have learned today in my work setting (PPS) I also plan to teach other co-workers what information I have.*
- *Use my pain management skills, knowledge I have learned today.*
- *Continue to attend conferences*
- *Engage more disciplines*
- *Provide an environment with compassion and utmost care to patient and family and support team players.*
- *Continue to explore and research best practices and complete Hospice Palliative Care Cert. Via Grant MacEwen University (Edmonton)*
- *Start using PPI*
- *I plan to make a point of engaging pt in an open manner so that they may feel free to speak and ask questions.*
- *attend CAPCE*  
*search more*
- *Improve my communication and insight of my clients needs*
- *Attend more education*
- *Apply the knowledge I learned today to enhance of hospice palliative and end-of-life care.*
- *Implement all that I have learned today.*
- *Further my education in form of BSCH then pursue more palliative education.*
- *improve and enhance my learning*
- *Continue to attend workshops around end-of-life care and use the information learned today with my work.*
- *Take Fundamentals Program*
- *Continue to obtain education*
- *Do CAPCE*
- *Do further reading on local resources*
- *Take more education*
- *Use the PPI tool*
- *Continue to learn and grow and improve my knowledge of EOL meds/ treatment etc.*
- *attend CAPCE*
- *Continue to attend these types of conferences*  
*Take further education*
- *Continue my education in palliative care and continue to work on communication skills*
- *Take the Fundamentals of Palliative Care course*
- *Work on EOL, listening skills and increase communication*
- *Focus more on the moment; improve communication*
- *Become more knowledgeable in utilizing community resources and incorporating EOL care into my daily practice.*
- *Take the Fundamentals & CAPCE course*
- *Improve my communication and to initiate conversations around the subject.*
- *Take the Fundamentals course and then do CAPCE*
- *Take more education/training*
- *Finish my Fundamentals course then go on to CAPCE*
- *Complete CAPCE certification*
- *Pain management*

- *Be more pro-active with delirium.*
- *Read and share information, share information at work*
- *Continue educating myself on advanced and changing standards of care.*
- *take more classes*
- *Continue educating myself on advanced standards of care*
- *Attend more education services*
- *Continue to always educate myself*
- *ease myself to working with palliative care patients, it's been something pulling at my heart for a long time*
- *Be more aware and competent of dosing calculations when a doctor orders a new opioid. It was informative, interactive, a good refresher.*
- *Continue to read new information as it becomes available and share knowledge and learn from co-workers.*
- *Honor the patient and do what I can to help them*
- *Get the above education ASAP*
- *become more efficient in equianalgesic conversions*
- *Practice drug calculations routinely*
- *discuss further education with my manager*
- *Keep updated and interest to all changes.*
- *learn new information as much as possible*
- *Continue to be an agent to my client and co-workers by continuous learning and good communication*
- *Review medication calculation*
- *Take the Fundamentals course. I wish there was more teaching on chemo-type side effects etc.*
- *Take the Fundamentals course*  
*keep updated and current with ongoing in-services and education opportunities*
- *Use PPI more on my assessment and communication to other health care professionals*
- *Complete CAPCE*
- *Continue to work in the field and keep following the journey of EOL and continue with my education*
- *request help, assessment, adjuvant therapies as I feel are necessary to improve quality of life of clients*

### **Do you have any suggestions for improving this session?**

- *Wonderful afternoon! Should have started at 9:30 instead of 11:30 to appreciate such a vast amount of great information. Thank you.*
- *Allowing more time for group session/ case studies. Table rushed, unable to work together effectively. Instead of group/case study do case study as an entire group and discuss as a group.*
- *We'd like more time with EOL physician, Dr. Maddison*
- *Find I am discouraged - our clients/ family require holistic - emotional, physical, spiritual care. Increasing financial and human resources limitations - diff; much volunteers needed. Increasing cost to agency; increasing personal cost.*
- *More case studies*

- *More emphasis on community resources*
- *Very well put together*
- *Increase heat, lengthen day maybe, 10-4:30 or to reduce of information.*
- *Earlier start time so nothing is lost in the program*
- *Focus more about nurses providing palliative care at the bedside; each topic or presentation was only "scratched".*
- *More time*
- *Always ongoing*
- *Not in Chatham. LOL!*
- *More intense, less basic*
- *PowerPoint's are great, with Fundamental slides, provide more information on slide so when I look back I can re-read info,, not "re-call" info*
- *Wonderful session*
- *More case studies, more small group interaction.*
- *Content pretty basic; probably better to have lecture earlier in day rather than end of day and have case studies at end - losing audience at end.*
- *I would have enjoyed more talk about palliative sedation.*
- *Well done*
- *It was a great session*
- *Number your handouts*
- *It's sad to have a 5 hr day and only 2 hours pay for this and fit the clients in for the day.*
- *Education wonderful - ideal, reality from it.*
- *Start the session at 9am - more time for case study and medication questions. It felt rushed!*
- *More time.*
- *More time*
- *Explain how to assess resources for patients.*
- *Unfortunate that emphasis on Chatham-Kent wasn't made clear in flyer. First speaker (introduction) rather long-winded. Carole was great but long.*
- *Other palliative speakers, e.g. Ottawa Dr. Brown Intern  
Not reading all the sheets*
- *Too fast- paced... many mentions of time constraints*
- *I would have like to learn the information from both sessions instead of going off into the separate groups (I.e., advanced fundamentals)*
- *Needs to be longer*
- *More advanced information; Dr. Maddison ++ and this session great also "I don't know what to say" presentation -cool*
- *More time devoted to Dr. Maddison; back and forth/teaching examples of actual patients/situations*
- *I wish we would have listened to the doctor re: experiences, meds etc for a longer period rather than introductions - would have learned lots more I believe. I enjoyed the last session - communication - good review with Carole.*
- *Maybe use something else besides PowerPoint's such as marker board*
- *Do more of these type get togethers to build partners in care in our community*
- *No, it was great*
- *Very very good. Easy to get through. Informative. Great speakers.*

- *Number sheets for breakout session. Carol was a good closing speaker; the sex to table and great statement.*
- *I had a wonderful time; thanks.*
- *No, good job guys!*
- *A little more time for case studies.*
- *excellent - well set up*
- *I want to take Fundamentals and CAPCE*
- *Have more discussions and presentations with challenging cases we have experiences in our day to day nursing practice.*  
*breakout sessions too short*
- *increase info on community resources*
- *Little rushed; very little time for questions, speakers more interesting when not reading from handouts; last speaker on communication was the best.*
- *Community nurses - no one with the table to talk about our role. Plus need good discharge planning to home care- clients are just discharged bang on a Friday, no supplies, no communication, Nurses in community are not communicated with regarding discharge from hospital.*
- *more case studies*
- *First hour was - "when can we start the education?"*
- *More dynamic speakers like Ann B and Carole.*

**Do you have any additional comments that you would like to make about this education initiative?**

- *The communication component was too basic! Dr. Madison was fantastic!*
- *Implement improved communication skills*
- *Thank you for providing the opportunity to expand my knowledge.*
- *Well put together efforts noted*
- *The communication in-service was well delivered however dry and basic. Really enjoyed Dr. Madison and his knowledge.*
- *Great introductory to all aspect of team environment to clients/pt with palliative care case study - not enough time in general should rethink time allotment or strategy for discussing or presenting - very rushed.*
- *Have felt this was a very worthwhile session. Delirium topic very relevant - never know enough about this.*
- *Consider breakout sessions per sector - visiting nursing issues different than 'in-patient' care issues in some cases.*
- *Well done!*
- *Enjoyed the day, thank you!*
- *It was a very informative session.*
- *Great workshop*
- *Thank you for the color-coded PPS scale and ESAS scale. The med-equivalency chart will also be handy! Lecture: very fast - good to have handouts. Please keep in mind that even though you deal with these topics daily, some of this is very new to us! Give us more time!*
- *Carole Gill was awesome*

- *More opportunities to network e.g., more encouragement to discuss with unfamiliar people.*
- *Excellent*
- *Well done, case studies were good and helped keep things interactive!*
- *Excellent especially advanced workshop*
- *Have received Level I and Level II many years ago, I think that today's education was a good refresher and am considering perhaps upgrading my Palliative Education*
- *Much needed education in Sarnia/ Lambton*
- *Great job giving us all a better picture of the palliative care services available were can put faces on the services now as well.*
- *Very much enjoyed networking. Good refresher day.*
- *Very informative*
- *Ann's flip chart info could be better if on PowerPoint, therefore we could see it better please.*
- *Thank you for the paid education session for us all today. I appreciate it. It was a good day that went by fast.*
- *Reduce introduction time - more case studies. Look at having this in the spring so travelling is better. No worry about ice, snow covered roads.*
- *I believe Fundamentals should be mandatory to each community nurse - opioid*
- *Well done considering the diversity of the audience*

**Tell us about yourself!**

**Are you a:**

54.2% (104)	Registered Nurse
39.1% (75)	Registered Practical Nurse
3.6% (7)	Other, please specify: <ul style="list-style-type: none"> <li>• Case manager (1)</li> <li>• Occupational therapist (1)</li> <li>• Pharmacist (1)</li> <li>• Student (3)</li> </ul>

**Have you completed The Fundamentals of Hospice Palliative Care Program?**

53.1% (102)	Yes
4.7% (9)	Currently in progress
37.5% (72)	No

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

18.2% (35)	Yes
4.7% (9)	Currently in progress
72.4% (139)	No

**Have you completed the Learning Essential Approaches to Palliative and End-of-life Care (LEAP) Program?**

10.9% (21)	Yes
1.0% (2)	Currently in progress
80.7% (155)	No

**What is your practice location?**

56.3% (108)	Community
7.8% (15)	Residential Hospice
34.9% (67)	Hospital
5.2% (10)	Retirement Home
	Other: <ul style="list-style-type: none"> <li>• LTC (2)</li> <li>• Hospice (1)</li> <li>• Community Health Centre (2)</li> </ul>

Note: Percentages exceed 100% because some respondents selected more than one practice location.

**What is your current employment status (check one)?**

53.6% (103)	Full time
40.6% (78)	Part time or Casual

**How many years have you been working in your field?**

14.69 (11.0)	Mean (SD)
.5 – 41	Range
181	N

**How much of your work time do you currently spend providing palliative care (caring for dying clients)?**

2.1% (4)	never
8.9% (17)	hardly ever/rarely
27.6% (53)	sometimes
34.4% (66)	often
24.5% (47)	all the time

### Results of the Follow-up Survey for the Participants of the Year One Skill Specific Education Session

N = 70

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

#### Impact on Clinical Practice

**In what ways has your clinical practice related to palliative and end-of-life care changed as a result of your participation in these education sessions? Please identify at least two things (best practices/ skills) that you learned in these sessions that you now use regularly.**

45.7% (32) My practice did not change as a result of this education.

- *Be very aggressive with doctor to advocate for client. Referral to PON - always*
- *Use assessment tools more, not only with palliative clients but all clients. More sensitive to the needs of the families and spend more time talking to them about palliative issues.*
- *My practice has not changed because I hardly care for palliative clients*
  - *1) more complete pain assessment 2) more information to the caregivers about signs of end of life*
- *It has been a year since I took this course. I don't remember much of it except to look in my book. This survey should have been conducted immediately or shortly after the class.*
- *I had had The Fundamentals and CAPCE prior to this session, however, Carole Gill has found a way to incorporate advanced and new students together to strengthen the learning of all levels. Much sharing and review made these sessions valuable to me.*
- *The skills identified within the education have already been implemented within my practice as this is standard orientation education that is reinforced by my employer.*
- *Pain Management, Communicating with family*
- *Better availability to doctors, standard medication guidelines*
- *I am more knowledgeable about the resources available to support patients and families as they are moving thru this phase. I am also more confident in my pain assessment skills and speaking with patients and families about the realities of the situation.*
- *EOL care management symptom management*
- *I wasn't aware that a nurse could request an RT assessment of their client to see if palliative O2 would be beneficial.*
- *Seeking out resources within the community and within the workplace pain management*
- *the ways that this educational opportunity impacted my practice as an RN was very insightful giving me more tools and knowledge about palliative and it is informative allowing me to have more confidence with palliative care the way the course was taught in the setting of a group with many group activity was very impacting and I am able to recall the things I've learned because they were hands on which I learn best from*

- *My primary work in the community involves the school program. I have not cared for any palliative clients in the last year therefore it is very difficult for me to participate in this survey. I do as always feel that any education is an asset to our practice even if it is something we do not currently deal with.*
- *ESAS, Domains*
- *The session simply reinforced ESAS and Pain assessment tools that I was previously utilizing.*
- *pain and skin condition*
- *It helped me to be more organized. I am able to see the whole picture of palliative care.*
- *what i have learned is how to better identify the level of pain the individual may be experiencing as well as understanding that pain is not normal behaviour and it may be controlled with meds*
- *I have been laid off since March and now on maternity leave so I have been unable to put my education into practice.*

**In what ways have your clients and their families benefited from the changes in your palliative and end-of-life care practice?**

40.0% (28) Not applicable - my practice did not change as a result of this education.

- *More access to resources/ PON*
- *I am an advanced foot care nurse. But I offer therapeutic touch treatment. I am a registered TT teacher and Reg TT practitioner.*
- *I think I am better able to manage their pain and symptoms and to address some of their concerns and distress - even before they bring it up.*
- *Families are very grateful for the support given to their loved one and support given to the caregivers and they express this after the person has passed away in the home*
- *More comfortable dealing with palliative clients and that shows. I am an ET nurse and so do not care for many clients in the end stages of life only if I am going into deal with a wound and usually the regular nurse goes too so I am not used to providing much care for palliative clients which makes it hard to put the new knowledge into practice often*
- *Their needs are met more now*
- *More realistic goals are established with greater family involvement. Families have been appreciative of the skill, confidence and knowledge I have given them in helping their loved one be at home throughout this time.*
- *In better collaboration with community partners-*
- *I am better able to understand the dynamics of the family during their crisis of dealing with a loved on dying. The family unit as a whole and all of the stages of grieving as well as understanding the process of death and dying this has helped the families out tremendously I am able to address their needs and advocate on their behalf. Being better informed and educating the family helps the family while they are grieving*
- *More in depth evaluation*
- *They are more supportive and able to provided better comfort for love ones repositioning to prevent discomfort from extra saliva and easier breathing*
- *Taught me patience.*
- *Some of my patients are fully aware of pain mgmt and whom to contact when it returns*
- *Same as #1 [on leave, not practicing]*

**Did you experience any challenges as you applied what you learned in these sessions about palliative pain and symptom assessment and management, and about available community support services and resources, or related to these things in general?**

48.6% (34)	No
37.1% (26)	<p>Yes, please explain:</p> <ul style="list-style-type: none"> <li>• <i>Area family doctors are not always receptive to any pain medication increase.</i></li> <li>• <i>Reducing pain, reducing nausea, increasing relaxation response.</i></li> <li>• <i>The system doesn't always support the work we do in the community - the physicians often challenge or don't respond to our assessments/ recommendations. Sometimes when clients go back to hospital, all that we did in the community to stabilize them gets messed up so that when they return we're back at square one. There needs to be more continuity of care - not only from hospital to community, but from community to hospital.</i></li> <li>• <i>It makes it easier to assess clients for pain and symptoms</i></li> <li>• <i>My greatest challenge is when the cancer physicians are not honest with the patient and do not make a referral to the Hospice physicians as early as I think that they should. The person is palliative and they continue to treat them.</i></li> <li>• <i>Always challenges. Palliative Care is a work in progress. Each patient/family is unique and individual. The more education we as professionals have the more we are able to individualize care and help to contribute to a more positive outcome.</i></li> <li>• <i>Because I see palliative clients infrequently</i></li> <li>• <i>There are always challenges and each client and family are unique it's what I've learned that has helped move through these challenges the resources and services are in place and it is great because we are never alone and can reach out to the services for their expertise and assistance</i></li> <li>• <i>Oxygen - covered for only 3 months Increase need for Pall Physician</i></li> <li>• <i>To be part of collaborative team</i></li> <li>• <i>The CCAC still has issues with RPN's providing palliative care. RPN's do not get enough opportunity to practice.</i></li> <li>• <i>Both myself and the family member were able to be in touch with proper personnel for further assistance.</i></li> </ul>

**In comparison to a year ago, how would you rate your current ability to assess pain and other physical symptoms in clients requiring palliative or end-of-life care?**

1 Less capable now	2	3 About the same	4	5 More capable now
0	0	11.4% (8)	37.1% (26)	40.0% (28)

In comparison to a year ago, how would you rate your current ability to manage physical symptoms in clients requiring palliative or end-of-life care?

1 Less capable now	2	3 About the same	4	5 More capable Now
0	0	22.9% (16)	28.6% (20)	34.5% (24)

In comparison to a year ago, how would you rate your current use of assessment tools such as the Palliative Performance Scale (PPS), Edmonton Symptom Assessment System (ESAS), and the comprehensive pain assessment tool, with clients requiring palliative or end-of-life care?

1 Use tools less often now	2	3 About the same	4	5 Use tools more often now
0	0	34.5% (24)	22.9% (16)	28.6% (20)

In comparison to a year ago, how would you rate the quality of palliative and end-of-life care that you provide?

Much worse now	Somewhat worse	About the same	Somewhat improved	Much improved now
0	0	17.1% (12)	37.1% (26)	31.4% (22)

In comparison to a year ago, how would you rate the quality of palliative and end-of-life care that is, in general, provided within the community?

Much worse now	Somewhat worse	About the same	Somewhat improved	Much improved now
0	2.9% (2)	14.3% (10)	34.4% (24)	34.4% (23)

## Workplace changes

Over the past year have there been any changes within your workplace related to the assessment of palliative pain and symptoms?

51.4% (36)	No
34.4% (24)	Yes, please explain: <ul style="list-style-type: none"> <li>• Our PON nurses are always willing to assist us and create "tools" for our use.</li> <li>• The nurses on staff out in the field share and discuss the format tools with the team</li> </ul>

	<ul style="list-style-type: none"> <li>• <i>Lots of change - people appreciate the value of assessment, they talk more about it, they come to expect it. I think the "bar" has been raised - there is no excuse for not ensuring that pain/ symptoms are assessed and properly managed. People talk more about taking the palliative courses - there's almost a "buzz" about it - they see value in being able to learn more, though some of the older nurses do seem to think they know it already but this is debatable.</i></li> <li>• <i>I find that our resources are less responsive in our area due to changes in reporting practice and response to caregiver (and professional) reporting and requests.</i></li> <li>• <i>Better pain assessment documentation</i></li> <li>• <i>More focus on palliative education.</i></li> <li>• <i>Yes there are in-services and there are updates and we are informed the supervisors are very helpful and they take the time to explain</i></li> <li>• <i>New forms for HPP</i></li> <li>• <i>We as an organization have always been very strong in palliative care.</i></li> <li>• <i>Because of this educational opportunity all staff are more knowledgeable. Our flow sheets for pain mgmt are from this educational opportunity</i></li> <li>• <i>Not currently working</i></li> </ul>
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**Over the past year have there been any changes within your workplace related to the management of palliative pain and symptoms?**

54.3% (38)	No
31.4% (22)	<p><b>Yes, please explain:</b></p> <ul style="list-style-type: none"> <li>• <i>New tools to use to assist with tracking pain and symptoms.</i></li> <li>• <i>Improved communication</i></li> <li>• <i>Management is better - no excuse for it not to be.</i></li> <li>• <i>You have to send in ESAS report every week. Our [hospital] has fired the liaison and started relying on faxed, written reports. Our Hospice has become less responsive (time delay) to our phoned reports and requests. As a nurse I feel as if I am alone out there. I need more support so I can do my job better.</i></li> <li>• <i>Education focus- supporting patients in community- collaborative approach.</i></li> <li>• <i>Yes my employer is very focused and they believe in the management of palliative care they are very good at educating us ongoing with this important area of health</i></li> <li>• <i>Shorter waiting time to get PMP to visit client at home when is problem - palliative pain</i></li> <li>• <i>Since this opportunity our agency has changed some of its policy regarding mgmt of palliative pain.</i></li> <li>• <i>Not currently working</i></li> </ul>

**Over the past year have there been any changes within your workplace related to the management of last hours?**

45.7% (32)	No
31.4% (22)	<p>Yes, please explain:</p> <ul style="list-style-type: none"> <li>• <i>Increased use of PPS - this helps us figure out what we need to do. Everyone talks the same language regarding this so it's easy to deal with things among team members.</i></li> <li>• <i>Because they are using ESAS tools and also PPS</i></li> <li>• <i>Delayed response to requests and reports.</i></li> <li>• <i>Don't know as I do not see regular clients</i></li> <li>• <i>CCAC give less time to care properly for the last hours</i></li> <li>• <i>We are able to make a Bereavement Visit following the death of our client, which is very helpful in supporting the family and determining if more assistance is needed.</i></li> <li>• <i>Better supports</i></li> <li>• <i>New care plan for EOL</i></li> <li>• <i>Shift work and extra visits are available</i></li> <li>• <i>Not sure as I haven't had this experience</i></li> </ul>

### Health System Changes

Based on what you have witnessed, to what extent do you think that the following have changed over the past year?

	Much decreased 1	Somewhat decreased 2	About the same 3	Somewhat increased 4	Much increased 5
Amount of palliative and end-of-life care services provided in the community (e.g., nursing visits, shift nursing hours, PSW hours for palliative/ end-of-life care)	0	5.7% (4)	34.4% (24)	25.7% (18)	14.3% (10)
Access to palliative and end-of-life health care services	0	8.6% (6)	28.6% (20)	20.0% (14)	5.7% (18)
Number of end-of-life clients served at home	0	8.6% (6)	31.4% (3)	34.3% (24)	8.6% (6)
Number of deaths in hospital	0	34.3% (24)	42.9% (30)	5.7% (4)	0
Number of clients dying at home (expected deaths) consistent with their wishes	0	5.7% (4)	28.6% (20)	37.1% (26)	11.4% (8)
Visits to the Emergency Department related to palliative or end-of-life care issues	5.7% (4)	31.4% (22)	37.1% (26)	8.6% (6)	0

Communication among care providers across health sectors (community, hospital, LTC)	5.7% (4)	2.9% (2)	40.0% (28)	25.7% (18)	8.6% (6)
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**Do you have any comments you would like to make about this?**

- *How many ways can you rehash the same facts we learned years ago.*
- *I learned so much about what's available in the community at the session - I've used a lot of that information not only with palliative clients, but all clients. I think there is an increasing confidence in the community and we're better able to manage home deaths, so families don't feel the need to go to hospital out of fear that their loved one will have a painful or uncomfortable death at home. If we want more people to die at home - if they want to die at home then we need to support nurses to do this.*
- *I really cannot answer these questions because I rarely care for palliative patients.*
- *Palliative EOL Care Practitioners of all levels can do there job well "if " they have support.*
- *Have found that referrals have increased as well as wait times for the palliative pain and symptom management team from hospice to be incorporated into client care, increasing wait times for relief, or increasing anxiety and frustration when needing to go to ER for assessment as often either [hospital] or family MD have declined to intervene.*
- *I am sorry but I have answered the same just because I do not care for clients at end of life and so I do not know the answer to these questions*
- *While I tried to partake in this survey as well as I could. I am a little concerned because I have done very few palliative shifts approx. 10 in the past year so this may not be a very fair assessment of changes and or improvements that have occurred in my particular agency.*
- *Communication with [hospital] has been greatly affected by eliminating the position of Community Liaison Nurse. Communication with Hospice for home care patients has also changed; delayed communication from Hospice has been observed.*
- *No*
- *There have been changes with the physicians and the other healthcare professionals and it is understandable and for the better it would be nice to see this sector of the palliative care professionals to see an increase in the department so that the clients have a more dynamic team over them*
- *Again, my caseload does not include any palliative client and therefore I am unable to answer many of these questions.*
- *Communication is still an issue-between community nurses, Hospice and the Cancer Center*
- *None*
- *No*

## Supports and Resources

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?

48.6% (34)	No
34.3% (24)	<p>Yes, please explain:</p> <ul style="list-style-type: none"> <li>• <i>Further more detailed palliative education and not so vague</i></li> <li>• <i>Windsor has fabulous Hospice care.</i></li> <li>• <i>Sooner nursing care for family relief. Families are at the burn out stage before they get relief and many clients don't live long enough to benefit.</i></li> <li>• <i>Physician support, team member support (there are still some community nurses that do things the 'old way' and haven't moved with the times, more time to spend with palliative clients - they need time to talk/ discuss things -these visits can't just be a quick in-out thing.</i></li> <li>• <i>I will be taking Level III therapeutic touch workshop this year.</i></li> <li>• <i>We need to have quick response to our reports, requests. We cannot wait 48 hours for response. Many times I have made a visit early AM only to call a report/request and wait for 36-48 hours for orders or a response. There is no time to fax reports. Faxing written reports means that I must wait until I go home in the evening to fax, which means that it will be the next AM before someone reads the fax, gets it to the correct practitioner, gets orders, then faxes back, then I finally receive orders and have already made my visit for that day because it is now 1700 the following day. We need portable fax machines or to be able to talk to a person now! Stop the faxed reports!</i></li> <li>• <i>Improved referral process for Hospice i.e., wait times for referral to take place, limitations of hospice MD's</i></li> <li>• <i>Clearer guidelines on the lines of communication etc clearer guidelines on how to meet home supply needs</i></li> <li>• <i>Palliative MD with passion and leadership skill.</i></li> <li>• <i>Better communication with cancer clinic.</i></li> <li>• <i>The WRH cancer center and the palliative care physicians could use an expansion</i></li> <li>• <i>Increase availability of PMP</i></li> <li>• <i>Hospice is great support</i></li> <li>• <i>RPN's need to be allowed to get involved</i></li> <li>• <i>Any new research, may improve the quality of care.</i></li> </ul>

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

40.0% (28)	No
42.9% (30)	<p>Yes, please explain:</p> <ul style="list-style-type: none"> <li>• <i>I would like to further the palliative programs with more detailed in-depth content.</i></li> <li>• <i>Ongoing opportunities to review cases, challenging issues, review case</i></li> </ul>

	<p><i>studies. I'd like to have a support group of a kind that meets regularly with expert input to these things.</i></p> <ul style="list-style-type: none"> <li>• <i>Any new methods that could help us to give better care to our dying clients</i></li> <li>• <i>Review, review, and share.</i></li> <li>• <i>I would like in-services on the medications used in palliative care.</i></li> <li>• <i>Yearly-- education</i></li> <li>• <i>CAPCE</i></li> <li>• <i>I am not sure about further education at this point, as palliative medical management has become rather conservative; so why educate regarding advanced symptoms management if none of that will be ordered through our Hospice</i></li> <li>• <i>There is an ongoing need between healthcare professional to continuously be updated and educated due to the need for better care for our clients and new ways of treatments are always changing so we need to be informed on an ongoing basis if we are to practice best practice</i></li> <li>• <i>In the process to attending International symposium of music therapy in supportive cancer care, from March 26-28, 2010 in Windsor</i></li> <li>• <i>For the case managers to trust and understand the scope of practice for the RPN</i></li> <li>• <i>Deep understanding of palliative care.</i></li> <li>• <i>I would like to have more educational opportunities such as this one.</i></li> <li>• <i>Yearly palliative update classes for CAPCE graduates to stay on top of things</i></li> </ul>
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**Do you have any additional comments that you would like to make about this education initiative or about palliative and end-of-life care education in this region?**

- *I found this course very vague and generally common sense.*
- *This should always be an on-going process.*
- *Add more alternative, holistic care*
- *Time held did not help since as a night shifter this was not a good learning time. I fell asleep. This was boring.*
- *I think that the session last year and the one this year were wonderful. Sure there were some things that I would have changed but overall I learned something new that I could use right away. We really need more of this. Please continue - it will be great loss if we don't have ongoing education like this. To improve care we need to be updated on the latest information and this is really the only way for us to do this.*
- *I wish attending physicians would be more sensitive to the caring families.*
- *Keep up the education. Teach resources that quick responses are absolutely necessary for the end caregivers and positive outcomes.*
- *It was very interesting education and I have gained knowledge from it but my access to end-of-life clients is very limited and so I am not able to utilize it frequently*
- *Overall I think my agency prepares us very well to provide palliative care in the community I think though that a formal meeting with the nurses in the community to*

discuss the experiences of the nurses and any common insufficiencies could be done on say a twice a year meeting.

- It was an excellent program & my clients have received the benefits of my attendance in this course.
- In Windsor /Essex, we have been instrumental in palliative care. I have really enjoyed serving the clients in community.
- Ongoing basic education is need for any new nurses involved in palliative care.
- No
- I wish for the program to continue so that we can better service our community
- I just started with a new company and therefore am unaware of the changes that may have happened within the company.
- The initiative is great but the delivery of the education needs to be more streamlined in that each service providers nurses have a varying level of palliative education and to make it education across the board is not a good thing-some nurses needed the info, others already knew the info and were already using it.
- None
- Public awareness/education.
- Just to continue with these in-services. The seminar should be shortened. Instead of having all nurses crammed into a tiny darkened room, perhaps you could have more resources to educate nurses within their own agency. Give family members (if interested) an opportunity to speak about their experiences.

**Tell us about yourself!**

**Are you a:**

51.4% (36)	Registered Nurse
31.4% (22)	Registered Practical Nurse
0	Other, please specify:

**Since you the physical skills session you participated in last year, have you participated in any of the following hospice palliative care education programs? Please check all that apply.**

34.3% (24)	Fundamentals of Hospice Palliative Care
2.9% (2)	Advanced Hospice Palliative Care Education (AHPCE)
22.9% (16)	Comprehensive Advanced Palliative Care Education (CAPCE)

**What is your current employment status (check one)?**

34.3% (24)	Full time
54.3% (38)	Part time or Casual

**How many years have you been working in your field?**

13.74 (9.7)	Average (years)
2 – 47	Range
62	Number

**How much of your work time do you currently spend providing palliative care (caring for dying clients)?**

5.7% (8)	Never
14.3% (10)	hardly ever/rarely
25.7% (18)	Sometimes
37.1% (26)	Often
5.7% (4)	all the time