
iPANEL Education Symposium Proceedings

May 2, 2012 – Coast Capri Hotel, Kelowna, BC



iPANEL

INITIATIVE FOR A
PALLIATIVE APPROACH IN NURSING:
EVIDENCE & LEADERSHIP

Through research, we create new knowledge about how nurses can further integrate palliative philosophies and services into non-specialized settings that provide end-of-life care (iPANEL).

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We are indebted to the participants who came together to give and receive knowledge and to envision better ways to educate nurses to provide nursing care to those living with life-limiting chronic illnesses and to several research assistants and iPANEL student affiliates who took extensive notes on the proceedings of the day (Sherin Jamal, Lori Rietze, Ibolya Agoston and Miranda Dalhuisen).

This report was prepared by Barbara Pesut on behalf of the iPANEL team.

Introduction to iPANEL– Initiative for a Palliative Approach in Nursing: Education and Leadership

The Initiative for a Palliative Approach in Nursing: Evidence and Leadership (iPANEL) is a practice-relevant nursing health services research initiative funded for 4 years by the Michael Smith Foundation for Health Research (BC Nursing Research Initiative). Members of iPANEL conduct research to inform how we can best integrate a palliative approach into the care of people with advancing chronic life-limiting conditions such as heart, lung and kidney disease, dementia and cancer. Our collective research is guided by the following tenants:

- ❖ **Three quarters of the British Columbians who die do so without being identified as people who could benefit from the services associated with palliative care.** Specialized palliative units and hospices are essential for end of life care but not appropriate for all persons facing life-limiting chronic conditions. By offering a palliative approach in multiple settings, we can better care for people and their families through the many transitions of chronic conditions like dementia, lung, kidney and heart diseases, and cancer.
- ❖ **Through research, we create new knowledge about how nurses can further integrate palliative philosophies and services into non-specialized settings that provide end of life care.** Throughout BC, people are dying in many settings including residential care facilities, on general hospital wards and at home. Our research seeks to understand how to apply and integrate the palliative approach to any care setting where people with life-limiting chronic conditions are cared for.
- ❖ **Our research is informed by and informs clinical practice.** By creating a cycle of nursing practice to nursing research and back again, we can ensure our research is informed by clinical practice. And that the evidence we gather is relevant, useful, and well-communicated to nurses. We accomplish this through our partnerships with both practicing and academic nurses throughout BC.
- ❖ **Our ultimate goal is to advance the further integration of the palliative approach into nursing practice in every care setting.** We know this takes the support and cooperation of many parties including health professionals, employers and health care consumers, but we believe that nurses can and will contribute to a better and more supported experience for British Columbians toward the end of their lives.

Introduction to iPANEL Educational Symposium

How can we best educate nurses and nursing care providers to provide a palliative approach to the care of individuals living with chronic life-limiting illness across contexts of care?

In May 2012, iPANEL held its first symposium focused on educating nursing care providers for a palliative approach. The goal of this one-day symposium was to bring knowledge producers and users together to share current research findings and to construct new knowledge around building the educational capacity of nurses in the province to provide a palliative approach to care.

Fifty-two educators, clinicians, family care-givers, regulators, researchers, administrators, and policy makers from around BC gathered to discuss the following questions related to a palliative approach through means of presentations, panel commentary and audience participation (see Appendix A for participant list):

1. How does the knowledge generated from the iPANEL program of research to date resonate with your knowledge and experience in this area? Can you help us to interpret and explain these findings?
2. Do the current generalist educational competencies for each of the nursing care providers reflect the palliative needs of the populations residing in residential care, acute care and home care? If not, what is missing? Are there particular competencies that should be considered specialist competencies, and if so, how might we address these specialist competencies within care delivery areas that are staffed primarily by generalists?
3. What innovative curricular and clinical educational models should we consider when educating nurses for a palliative approach?
4. Assuming that nurses have sufficient knowledge in a palliative approach, what barriers exist in residential, acute and home care to the enactment of that knowledge? How might these barriers be overcome?
5. How do the scopes of practice of nursing care providers intersect/differ on the palliative approach competencies and how well do these scopes of practices reflect the needs of the populations within residential care, acute care and home care, taking into account current care delivery models?
6. Who needs to receive the knowledge we have generated today and what steps are necessary in terms of programs or research to move this knowledge forward?

We engaged a number of strategies through the day to address these questions (see Appendix B).

Activities of the Day

Research Presentations

Four research projects were presented. Dr. Richard Sawatzky and Della Roberts presented preliminary results of a provincial wide survey of nurses' perceived confidence in a palliative approach. Lynnelle Erbacher presented the results of a scoping review of the best evidence from the literature on how to educate nurses in palliative care. Dr. Barbara Pesut presented a secondary analysis of two qualitative data sets asking the question of how generalist nurses in rural areas provide a palliative approach. Drs. Kelli Stajduhar and Gweneth Doane presented preliminary research findings from a study aimed at gaining a better understanding of point-of-care knowledge translation, using end of life care as the site of inquiry. After each presentation there was time for audience discussion and participants were asked to complete a short written response to questions generated by the researchers, which were designed to enable them to better explain and interpret their findings.

Panel Responses

Three panels were convened to respond to the research findings. The first panel focused on educational competencies and included Dr. Joyce Black, Education Consultant from the College of Registered Nurses of BC, Denice Evanishin, Nursing Practice Advisor from the College of Licensed Practical Nurses of BC, Darcee Bidgood, President of the Palliative Care Nurses Interest Group of the Canadian Nurses Association, who was involved in the development of palliative competencies from the Canadian Association Schools of Nursing, and Barbara McLean, Executive Director of the Family Caregivers' Network Society.

The second panel focused on innovative curricular and clinical educational models related to palliative care and a palliative approach and included Susan Ross, Faculty at Thompson Rivers University, Barbara McLeod, Clinical Nurse Specialist in End of Life Care, Fraser Health and Pat Porterfield, Regional Leader for Palliative Care, Vancouver Coastal Health.

The third panel focused on practice contexts in relation to a palliative approach and included Donna Mendel, Acting Chief of Professional Practice for Interior Health Authority, Teresa Nutini, nurse and rural family caregiver, Gail Potter, Faculty at Selkirk College and Tammy McLean, Nurse Practitioner student and Faculty at Selkirk College.

Consensus Building Exercise

The purpose of this exercise was to facilitate discussion and begin to build consensus around the competencies for a palliative approach. Participants were divided into groups by their nursing practice context (e.g., acute care, residential care, community care). Using the *Palliative Care Nursing Self-Competence Scale*^{1, 2} participants were asked to build consensus around three primary questions: Do these competencies adequately reflect a palliative approach in your care

¹ The Palliative Care Nursing Self-Competence Scale was developed by Jean-François Desbiens. The objective of this tool was to develop an instrument that could measure perceived palliative care nursing self-competence.

² Desbien JF, Fillion L. Development of the Palliative Care Nursing Self-Competence Scale. *J Hosp Palliat Nurs*. 2011;13(4):230-241.

context? Are there specialty aspects to these competencies for each of the nursing care providers? Are there barriers to the enactment of these competencies in your setting? If so, what are they?

Synthesis of the Day

This final exercise of the day asked participants to reflect on their most significant learning from the day and on how they will incorporate that learning back into their practice. Consensus was sought for priorities for next steps in terms of policy, research and practice.

Evening Presentation

Dr. Gweneth Doane, Professor and 3M Teaching fellow presented on how to prepare relational and reflective practitioners for a palliative approach to care.

The remainder of the report will provide a general overview of the research and the panel proceedings in the order that they were presented. For each research and panel presentation a summary of the audience discussion and written feedback will be provided.

Research Presentation 1 – Preliminary results of a provincial survey of nurses' knowledge in a palliative approach

- ❖ **Rick Sawatzky, PhD, RN, School of Nursing, Trinity Western University and Centre for Health Evaluation and Outcome Sciences**
 - ❖ **Della Roberts, Clinical Nurse Specialist, End of Life Care, Fraser Health**
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Study Overview

A mixed-methods province-wide survey was conducted to obtain baseline descriptive information relevant to the integration of a palliative approach from care providers in a variety of nursing care settings that do not specialize in palliative care. Registered Nurses, Licensed Practical Nurses and Health Care Workers from a variety of settings were surveyed using a questionnaire that included information about self-perceived competency; integration of a palliative approach in practice; adequacy and sources of knowledge and education; the nursing work environment; and demographic information.

Preliminary Findings

Nurses' ratings of the extent to which they apply a palliative approach do not necessarily correspond with the proportion of patients who have life-limiting illness. In other words, nurses often do not apply a palliative approach, but the number of patients they care for in need of a palliative approach is high.

Nurses feel least confident in the following: promoting communication between patients and their family members when a conflict occurs; assisting patients and their families in identifying personal resources in order to cope with problems related to illness; assisting persons with life-limiting conditions to make informed decisions regarding end of life care; and recognizing signs of spiritual distress in persons with life-limiting conditions and their families;

Nurses feel most confident in the following: identifying the signs and symptoms of imminent death in persons with life-limiting conditions; assessing pain in persons with life-limiting conditions; using non-pharmacological and complementary interventions to relieve pain in persons with life-limiting conditions; assessing the needs associated with activities of daily living in persons with life-limiting conditions; implementing appropriate interventions to help relieve burden on family members caring for persons with life-limiting conditions; providing proper mouth care to promote comfort in persons with life-limiting conditions; and providing effective care to relieve fatigue in persons with life-limiting conditions.

Overall, preliminary findings suggest that nurses in hospital settings feel relatively less confident regarding a palliative approach than nurses in residential or home care. Areas where nurses feel less confident include: social needs, spiritual needs, and ethical/legal issues.

Audience Discussion

Audience discussion ensued about the meaning of competence and how that understanding might differ between self-rated competence and observed clinical competence. In particular, participants noted that a lower self-rated competence could indeed indicate a higher level of self-awareness of the complexities inherent in a palliative approach. Audience members

suggested that we not assume that competencies that are rated lower necessarily indicate a lack of competence.

Audience Written Responses

Participants were asked to respond in writing to the following questions. Thirty participants provided written responses.

(1) *Preliminary survey results indicate that patient care providers do not consistently apply a palliative approach to people with chronic life-limiting illness, in particular in hospital-based medical units. To what extent is this of concern? What are some possible explanations for this finding?*

The majority of respondents felt it was a significant concern that nursing care providers surveyed do not consistently apply a palliative approach to people with chronic, life-limiting illness. The most common explanations given by participants were:

- ❖ The acute care focus on “healing”, “saving”, “rescuing”, and “fixing” patients to extend life (n=7).
- ❖ A lack of time to provide a palliative approach due to staffing shortages and busy workloads (n=6).
- ❖ Misunderstandings or incongruent understandings of a palliative approach, e.g. if nurses perceive a palliative approach to mean a patient is in their last weeks to days of life. More education may be needed to understand the philosophy of a palliative approach (n=6).

(2) *Patient care providers in all sectors feel least capable in dimensions of social needs, spiritual needs, and ethical/legal issues. What factors do you think are contributing to this finding?*

The following factors were suggested as contributing to nurses feeling less capable in meeting social needs, spiritual needs and ethical/legal issues:

- ❖ Contexts of care. “The sacred aspects of care are not highly valued in a medically dominated system.” Despite being given “lip service” social, spiritual and legal/ethical may not be viewed as “clinical care” within facilities (e.g. the lack of professional development activities related to spiritual care). Real-time practice to develop skill, knowledge and confidence in these dimensions of care may be inhibited by resource/workload issues: lack of funding; staffing shortages; and “Code Purples”, which lead to a fast pace of nursing. Thus, with a focus on meeting physical needs, it can be difficult to practice and implement this type of care. Other work environment factors included little support or encouragement to have these conversations, lack of debriefing opportunities and health care providers working in silo’s, without team coordination and family involvement. In contrast, in a private setting (e.g. patient’s home) it may be easier to know the patient and family beliefs and traditions and thus there may be more willingness to address family dynamics (e.g. conflict). There may also be a perception that “family issues do not belong in public place” such as health care facilities, with less discussions related to “private” issues, such as spirituality (n=22).
- ❖ Other explanations included lack of education (n=14), complexity of care (n=7), individual nurse characteristics (n=5), social norms (n=4), and lack of emotional energy (n=2).

Panel 1 – Curricular competencies and scopes of practice

The focus of panel 1 was to discuss curricular competencies and scopes of practice from the perspectives of various stakeholders in a nursing palliative approach. Panel participants were:

- ❖ **Dr. Joyce Black**, Education Consultant, College of Registered Nurses of British Columbia (CRNBC)
- ❖ **Darcee Bidgood**, iPANEL member, represented the Canadian Hospice Palliative Care Nurses Group on the Canadian Association of Schools of Nursing (CASN) Palliative End of Life (PEOL) Project Task Force 2010-2012
- ❖ **Denice Evanishin**, Nursing Practice Advisor, College of Licensed Practical Nurses of British Columbia (CLPNBC)
- ❖ **Barb McLean**, Executive Director, Family Caregivers' Network Society

Questions the panel was asked to respond to:

- ❖ *Do current generalist competencies for each nursing care provider reflect palliative needs in acute care, residential care and home care?*
- ❖ *Are there some that should be specialized and how would we address these in areas staffed by generalists?*
- ❖ *Scopes of nursing care differ across scopes of practice and do they reflect the needs of the populations within residential care, acute care and home care, taking into account current care delivery models?*

Dr. Joyce Black, Education Consultant, CRNBC

Dr. Black provided an overview of CRNBC and its role in regulation of Registered Nurses's (RNs) and Nurse Practitioners (NPs) through creation of entry-level competencies and governance over scopes of practice. CRNBC entry-level competencies regulate generalist practitioners, not specialists. CRNBC Entry-Level Competency # 80 states: "Provides registered nursing care to meet hospice, palliative, or end of life care needs (i.e. pain and symptom control; spiritual support; advocacy; and support for significant others)." However, it is difficult for nursing students to obtain practice experience in palliative and end of life care. There are also other competencies such as communication, critical inquiry, relational practice and cultural safety, engaging clients in decision-making, collaborative practice, ethics, leadership and advocacy, pain prevention and management that support a palliative approach. In the Regulations, the definition of nursing includes palliation of illness and injury and coordination of health services. The Health Professions Act uses a Restricted Activities model of scope of scopes of practice and looks at functions that are deemed to threaten public safety. Within this model there are overlapping scopes that support greater teamwork and inter-professional collaboration. Despite these competencies and scopes of practice that support a palliative approach, student surveys at the end of nursing programs suggest that students may not feel well prepared. However, it is important to ask whether this is because confidence or competence? These are different concepts.

Darcee Bidgood, iPANEL member, CASN PEOL Project Task Force

Surveys of 91 schools of nursing in Canada showed a lack of end of life content in curriculum and lack of faculty expertise. Nursing students find clinical experience with death and dying challenging. Entry-level nurses do not feel adequately prepared. There is a need for education related to death, dying, and associated factors. The goal of the project was to ensure that all nurses should be educated to provide palliative and end of life care; all nurses require a basic level of knowledge about death, dying and associated factors. The working group conducted an environmental scan, created drafts of the documents through working groups and evaluated those drafts through symposiums with key stakeholders and individuals in practice. The deliverables from the project included the following:

- ❖ Knowledge tools
 - A Story of Care (available on virtualhospice.ca)
 - Palliative and end of life care environmental scan (available on casn.ca)
 - Story based learning guide (available on casn.ca)
 - Toolkit (available on casn.ca)
- ❖ Curriculum models: Three methods of integration are possible: stand-alone courses, integration throughout entire program, or a combination of the two.
- ❖ Nine CASN PEOLC Competencies with indicators that have been incorporated into the accreditation process (available on casn.ca).

Denice Evanishin, Nursing Practice Advisory, CLPNBC

The changing landscape of nursing includes the increasing utilization of Licensed Practical Nurses (LPNs). Curricular models are moving to reflect these changes by emphasizing critical thinking, clinical decision-making, leadership, cultural safety, inter-professional education and practice. LPNs generally care for clients with less complexity and more predictable outcomes; however, whether specialist competencies will become part of the framework for LPNs remains to be seen. At this point there are educational programs to assist LPNs attain further education in palliative care. However, with LPNs now working across contexts, including home care, and with the high acuity of clients, more emphasis on a palliative approach would be helpful. Ms. Evanishin concluded by emphasizing that where two or more categories of nurses work together, safe and appropriate care can best be achieved through collaboration and cooperation among nurses, respecting the contributions of each professional.

Barb McLean, Executive Director, Family Caregivers' Network Society

Ms. McLean began by emphasizing the role of family caregivers within end of life care: family caregivers contribute \$25-29 billion dollars if replaced by the lowest home care cost and this will only increase with the aging demographic. There is more weight placed on caregivers than ever before; however, the responsibilities of caregiving are not always matched by the voice given to caregivers in the system. She shared several poignant stories illustrating how caregivers are not included as important partners in care. It is critical that nurses ask the right questions of patients and families: what is working and how can we help? Nurses are experts clinically; caregivers are experts emotionally. The tremendous burden and solution for the

future is collaboration. This collaboration should recognize that caregivers too have emotional needs and that they are partners in care. This concept needs to be embedded within nursing curriculum.

Audience Discussion

The initial comment was a passionate statement of our need to bring palliative care back to the generalist nurse, that we owe it to the public to do this so that they can be cared for in whatever context they are in. “Still nurses say, ‘I don’t do death.’ The public needs better than that.” Much of the consequent discussion focused on two distinct areas of nursing care, the physical/tangible which is easily taught, learned and measured and the social/intangible which can be difficult to articulate, difficult to grasp and difficult to measure. In general the physical nursing needs are those in which nurses feel more comfortable and competent. This has been exacerbated by the fact that as a culture, the social aspects of care have not been highly valued. We have exponential growth in knowledge around the more physical aspects of care (e.g. pain management) but we know less about the emotional aspects. Further, it is important to remember that curriculum and competencies are not about the “whole,” they are about the small measurable things we can grasp. Maybe we are looking at something different like cultural humility; educators can go beyond the technical aspects of care but the more intangible aspect of care are difficult to explain – these are the ‘inarticulate’ aspects.

Panel Summary

Based on the panel presentation and subsequent discussions, written competencies for palliative care nursing have been developed and distributed to schools of nursing across Canada. While these competencies provide guidance to nurse educators there has been little focus on delineating competencies around a palliative approach and differentiating expectations between nurses who specialize in palliative care and those who are generalist nursing care providers. In developing such competencies it is important to consider including patients (as able) and family caregivers in these discussions.

Research Presentation 2 – Scoping review of best evidence for preparing nurses in palliative care

- ❖ *Investigators: Pesut, B, McLeod, B, Sawatzky, R, Stajduhar, K and Erbacker, L.*
 - ❖ *Presenter: **Lynnelle Erbacker**, Research Coordinator, UBC Okanagan*
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Study Overview

To inform evidence for education in a palliative approach, a scoping review was conducted to determine the evidence available to guide curriculum and educational strategies for teaching palliative care to health care professionals. CINAHL, MEDLINE, EMBASE, ERIC, and AGELINE were searched using database specific terms related to palliative care and education. Articles were included if: they were empirical studies or program evaluations with clear outcome criteria; published between 2001 and 2011; written in English; and had palliative education as the primary focus of the study.

Findings

Educational foci included general principles of palliative care as well as more specific foci on legal and ethical considerations, spiritual care, cultural awareness, pronouncing death, and advance directives. Teaching strategies were diverse including traditional lectures, group discussions, case studies and less traditional strategies of email education, expert panels and self-reflection. Time frames of the educational initiatives represented in the studies ranged from 1.5 hours to 127 hours over one day to four years. Educational outcomes were measured through self-reports of learning and through a variety of instruments measuring health care provider knowledge, attitudes, ways of being, comfort, and self-efficacy. Research designs tended toward less rigorous approaches making it difficult to evaluate the overall efficacy of the different educational strategies. Although, there is a substantial body of literature evaluating various palliative care educational strategies for health care providers, it is difficult to draw conclusions in light of the tendency toward descriptive designs and the diversity of educational content and delivery strategies. The vast majority of studies indicated positive gains in the outcomes measured.

Audience Discussion

Discussion focused on the limitations of educational research and how difficult it is to get a sense of the learning that occurred in terms of change of care or behaviour. Measuring individual educational attainment without looking at the context within which that knowledge can be enacted fails to appreciate the more contextual aspects of knowledge development.

Audience Written Responses

Participants were asked to respond in writing to the following two questions. Thirty-one participants provided written responses.

(1) *Does it surprise you that all education seems to work? Why or why not?*

- ❖ Most participants were not surprised that the preliminary results showed such positive outcomes of the educational intervention. Reasons given included: education results in more knowledge which results in greater skills and confidence resulting in positive outcomes (n=9); the relatively low baseline knowledge that many nurse have means that any education can quickly lead to improvement (n=3); education is relatively intangible to measure which may cause the results to be skewed to the positive.
- (2)** *Why is it that we seem to have so much education but we still seem to have such large gaps in quality end of life care? Is it education or something else?*
- ❖ When asked why it is that we seem to have so much education but such continuing gaps in quality end of life care most participants spoke of the workplace environment (n=14). The social context of care delivery needs to include supports which encourage nurses to use their increased knowledge. Resources such as appropriate staffing were also noted by several participants to affect gaps in quality end of life care. The workload of caring for an increased number of persons with chronic diseases results in less time to spend with patients, particularly on acute medical floors where nurses may already feel overwhelmed. Good end of life care takes both commitment and energy. One participant stated, “At the system level, it takes time, money, leadership, political will, innovation, opportunity, a legal framework, etc. to pull it all together in a collaborative environment.”
- ❖ Other reasons provided to explain a disconnect between educational gains and gaps in care included: fear of death (n=6); the fact that knowing does not equal doing (n=6), and personal nurse characteristics (n=5).
- ❖ Some questioned the underlying assumption that there is so much education (n=4).

Panel 2 – Innovative curricular and clinical education models

The focus of this panel was to discuss innovative curricular and clinical education models for a palliative approach. Panel participants were:

- ❖ **Susan Ross**, Nursing Faculty, Thompson Rivers University
- ❖ **Barbara McLeod**, Clinical Nurse Specialist End of Life Care, Fraser Health
- ❖ **Pat Porterfield**, Palliative Care – Regional Leader, Vancouver Coastal Health

Susan Ross, Nursing Faculty, Thompson Rivers University

Ms. Ross described a unique interdisciplinary course she teaches entitled “Death and Dying, Life and Living” at Thompson Rivers University. The incentive for creating this course arose out of a survey she did that showed as little as 1.5% of nursing textbooks addressed end of life care. She also noted a lack of consistency in how this material was presented, and that it was often based on outdated theorists. Ms. Ross described a unique dramatic approach she takes to teaching the course that helps to reveal cultural stereotypes of death. The response from students has been overwhelmingly positive.

Barbara McLeod, Clinical Nurse Specialist, End of Life Care, Fraser Health

Ms. McLeod began by highlighting the importance of altering our understandings about who requires palliative care. Palliative approach is not common language for practicing nurses despite the fact that we are caring for patients with chronic life-limiting illness of whom 80% will not be labeled as palliative and yet will live and die with a heavy symptom burden. This means that we need to deal with palliative care along the trajectory of function and well-being from diagnosis, to de-compensation, to actively dying, and through bereavement. Further, we need to understand the differing clinical courses.

Pat Porterfield, Regional Leader for Palliative Care, Vancouver Coastal Health

Ms. Porterfield began by bringing to light the inherent differences between palliative care and a palliative approach. Whereas individuals who adopt the label “palliative” generally consider themselves to be dying, those with chronic life-limiting illness often do not see themselves the same way. And even though it is important to bring palliative care upstream to help those with chronic life-limiting illness, we do not yet know how to integrate it into education or practice. To do so we need to address both staff and families. Staff have generally had in-service training on how to improve care for those who are imminently dying – particularly in terms of pain management. Staff receive less education about the trajectories of care within illness. We have suffered from the “Lego approach” to palliative care. That is, we teach the illness experience and then we put the last block of care as end of life when the patient is dying but we do not educate along a continuum. We also need to learn more about how to partner with families and to educate the public more broadly about a palliative approach.

Ms. Porterfield then focused on the various conceptualizations of palliative care within residential care on a continuum of integration. Residential care is a good example because this integration of a palliative approach can also be used for other disease processes. We need to

look at excellence in disease management and at quality of life more broadly than simply symptom management.

Audience Discussion

The ensuing discussion revealed some of the difficulties around educating for a palliative approach. The primary point of discussion was around timing and trajectory and the risks of using the palliative language. For example, one participant discussed the risks of introducing advance care planning on admission to residential care. Others discussed the implications of the surprise question: “Would you be surprised if this person died within the next year?” Some found this question to be very helpful, others cautioned that if health care providers are asking this question they should be having similar conversations with the patient themselves - this should not be another “secret that nurses know.” And yet, those conversations are difficult if everyone is not in agreement. Several participants indicated that patients and families are the key to good integration of a palliative approach.

One participant question revealed the challenges inherent in using the palliative approach language. If palliative care referrals come within the last 6 months, how do referrals get made for palliative approach? This question highlighted the timing dilemmas between specialized palliative benefits and a palliative approach. Panel respondents clarified that the idea of palliative approach is not to increase specialized palliative referrals but to increase the capacity and competence within the generalist providers. This does not mean that specialized palliative care does not have a role, but specialized care cannot support every person within BC. A palliative approach is simply good care...the right care at the right time in the disease trajectory. Overall, this discussion points to the necessity of having an agreed upon understanding of both a palliative approach and palliative care as the foundation for curricula.

Panel Summary

What this panel highlighted are the challenges inherent in curricular innovations that seek to embed what has become specialist care back within generalist practice. The contextual factors that shape palliative care more generally have a profound impact on innovative education for a palliative approach. For example, in a climate where the designation of palliative is often determined in accordance with a formal set of procedures that identify a patient and family as eligible for benefits, it may be difficult to conceptualize timing as more fluid. Likewise, when skills and knowledge for nurses have been specialized under the label of palliative, how does one re-embed those within good generalist practice? Innovations suggested by this panel include helping nurses and others to come to terms with their cultural assumptions about death; teaching chronic illness management with a trajectory rather than a Lego approach; and using the momentum of person-centred care to teach it as the right care at the right time.

Research Presentation 3 – Qualitative secondary analysis: What do generalist nurses need to know to provide a palliative approach to care in rural areas?³

❖ *Investigators: Pesut, B, McLeod, B, Hole, R and Dalhuisen, M.*

❖ *Presenter: **Barbara Pesut**, PhD, RN, School of Nursing, University of British Columbia*

Study Overview

Despite the benefits of specialized palliative services at end of life, many people do not have access to such services, either because they are not identified as dying or because such services are not available. This is particularly true in rural areas where palliative services are often provided within the context of generalist nursing practice. An aging population has led to increasing interest in a palliative approach whereby individuals with life-limiting chronic illness are identified early in the end of life trajectory and provided with the supportive, humanistic principles of palliative care. But what do those principles look like in the absence of specialized services? The purpose of this study was to conduct a secondary analysis of qualitative data gathered from an ethnographic exploration of rural palliative care to better understand a nursing palliative approach within rural contexts. Interviews with 47 rural family care providers and 26 rural nurses were analyzed using the guiding question of: How is a palliative approach enacted in rural areas and what role does it play in meeting the needs of those with life-limiting illness? Data were analyzed using the principles of Interpretive Description.

Findings

Rural contexts had the effect of dialing up the intensity of palliative care. Nurses characterized the rural context as a “pocketland” of services, responsibilities, policies and procedures that required a high degree of specialized knowledge and skills to piece together. Nurses had to do this in the absence of a “dream team” focused on palliative care. Instead a core group of champions provided expertise, services and advocacy – often at high cost to themselves. The sense of ownership illustrated by these champions resulted in a dual role of “professional responsibility and personal accountability” that could lead to a high degree of satisfaction or burden depending upon how they perceived the quality of the care they were able to provide.

Families identified a number of ways that nurses could facilitate their comfort and connection. Nurses who were able to respond in a timely manner respecting the limited amount of time family members had left with their loved one, to facilitate privacy while giving an impression of availability and to provide anticipatory guidance and support were particularly therapeutic. However, in a rural context where nursing workloads may not be structured for a palliative approach, where dual relationships place an inordinate degree of accountability on the nurse, and where there is such a high degree of specialized knowledge the question remains of how to support and prepare nurses.

³ Pesut, B, McLeod, B, Hole, R, Dalhuisen, M. Rural nursing and quality end-of-life care: palliative care...palliative approach...or somewhere in-between? *ANS Adv Nurs Sci*. 2012;35(4):288-304. doi: 10.1097/ANS.0b013e31826b8687

Audience Discussion

Participants spoke of the essential differences between urban and rural nursing, such as the presence of dual-relationships, the necessity of being available off-hours, the distress of lacking resources, and the importance of knowing the contextual social relationships of the community. It was pointed out that palliative care was constructed within the urban model, and that there is much to be learned about the palliative approach from rural nurses' work. "We shouldn't assume models that work in urban areas will be exactly what rural communities need, as well."

Audience Written Responses

Participants were asked to respond in writing to the following questions. Eighteen participants provided written responses.

(1) *Can we teach nurses the types of relational skills necessary to the rural context, and if so, how should they be taught?*

- ❖ The majority of participants responded that relational skills such as these could indeed be taught through role playing, modeling, mentoring, case studies, and structured learning sessions. Hearing stories from patients and families may also help to facilitate these skills. Important factors must include an explicit valuing of this type of education and recognition of the complexity inherent in these skills. Facilitating the achievement of these skills requires administrative support, an environment where relationship is valued over skills, a desire to learn, and guidelines to facilitate the process. Not all participants felt that these skills could or should be learned through education but rather that they are learned over time and with experience in the system. Further, one participant cautioned that they must come out of nurses' core values otherwise they may be seen as insincere.

(2) *How can we better support community health workers in light of the important role and central role they play in supporting rural family caregivers?*

- ❖ Respondents suggested a number of ways to better support community health workers in their practice including further education, better collaboration and more supports. Education included establishing educational competencies in a palliative approach, teaching more theory on chronic disease management and providing ongoing education through a variety of approaches. Collaborative strategies included formally recognizing the importance of the role by including community health workers in staff meetings, providing them with more information about patients, soliciting their advice on care, helping them to better articulate the work they do, and facilitating their communication with family caregivers. Supports included time to provide proper palliative care; networks (online interactive tools, social media) to build communities of practice; mentored experiences; opportunities to debrief; and tools to communicate with the health care team and to assess, teach and support family caregivers.

Panel 3 – Nursing scopes of practice and barriers to care

This panel was invited to emphasize some of the unique aspects of a palliative approach within rural settings from a variety of perspectives. Panel members were:

- ❖ **Donna Mendel**, Acting Chief of Professional Practice and Nursing, Interior Health
- ❖ **Teresa Nutini**, Nurse and rural family caregiver
- ❖ **Gail Potter**, Nursing Faculty, Selkirk College, Palliative Educator
- ❖ **Tammy McLean**, Nursing Faculty, Selkirk College, Palliative Educator

Donna Mendel, Acting Chief of Professional Practice and Nursing, Interior Health

Ms. Mendel described two distinct barriers to enacting a palliative approach in practice: the health system and the mental models existing in practice and administration. A health system that is “task-focused” generates nurses who deal with increased workloads by focusing on tasks. Consequently these conversations around a palliative approach do not always occur. Also, acute care environments are not set up to have conversations like this because of the lack of privacy (e.g. hallway patients), the increasing paperwork, and the complicated palliative benefits programs that nurses must learn and navigate. In addition, the medical model adopted by so many nurses suggests that a palliative approach is not their role; they “don’t deal with the dying.” Nurses carry two fears about identifying individuals as dying. The first is that no further care will be provided. The second is that they will not have the knowledge to provide the appropriate care.

Scopes of practice among nursing care providers may also become barriers to a palliative approach if decision makers are focusing on tasks rather than the more complex aspects of care. The most important question around scopes of practice should always be, “What are the needs of this population?” An aging population indicates that a palliative approach is essential and so we need to think more carefully about the needs required of a palliative approach and which nursing care provider can best meet those needs.

Teresa Nutini, nurse and rural family caregiver

It was Ms. Nutini’s 30 years of nursing experience that helped guide her through being the primary caregiver for her father during his palliative course. She told a compelling story of her father’s illness and the skills and knowledge required of family caregivers in a rural context. Because of her nursing expertise she was able to draw upon a variety of supports. But one day her father asked, “What would I have done without you and what would other people do if they didn’t know the system?” This is the essence of the dilemma of rural family caregivers.

Furthermore, typically family crises arise in the evening and night when there are no supports to call on. There is a need for more supports for rural family caregivers so that they can do their job well.

Gail Potter, Faculty, Selkirk College, Palliative Educator

Tammy McLean, Faculty, Selkirk College, Palliative Educator

Ms. Potter and Ms. McLean provided an overview of barriers and solutions to a palliative approach in rural contexts:

- ❖ Poor communication between providers because of limited information during patient transfers, insufficient home nursing care hours, lack of traveling charts, and different language (e.g. Palliative Performance Scale vs. Edmonton Symptom Assessment Scale). Common nursing care provider tools need to be developed.
- ❖ A lack of clarity around roles between the RN and LPN within acute care contexts. Specific guidelines around responsibilities need to be developed.
- ❖ Nurses may be protective of their palliative patients and so may not be as willing to share information with others. There is a need for self-reflection and a team leader to enable a collaborative approach.
- ❖ Mentorship opportunities for younger nurses are not available, in part because of reluctance of senior nurses. There needs to be greater recognition of Standards of Practice and individual/institutional responsibilities to mentor.
- ❖ In rural areas there is no central intake for patients with life-limiting illness, no inter-professional rounds; no upstream identification. A palliative registry and coordinator of services and advanced care planning in all settings would help.
- ❖ Physicians may have less experience/knowledge than nurses and this may set up challenging encounters for nurses. Nurses need skills to enable them to navigate these situations better.
- ❖ Physicians may be reluctant to leave orders with “ranges” for nurses treating symptoms. Preprinted orders for physicians and education for nurses in using those orders would help.
- ❖ There may be little agreement among caregivers about who is living with a life-limiting illness because of poor prognostication and sharing of information. The use of standardized prognostication tools and team consultation would help.
- ❖ Rural nurses require specialized knowledge of how to treat the symptoms of life-limiting illness. For example, patients with congestive heart failure average 6.7 symptoms per patient (dyspnea, fatigue, pain, nausea, anxiety, depression, confusion). More specialized palliative care knowledge is required for rural nurses.

These presenters concluded with questions to consider:

- ❖ *Do nurses actually see and discuss the palliative competencies in Scopes of Practice during their training?*
- ❖ *Do nurses get any inter-professional training to be able to work with one another effectively?*
- ❖ *Do nurses really have the daily opportunity to share and contribute to care planning?*
- ❖ *What do nurses do with their moral distress if palliative care is not done well and patients suffer?*

Audience Discussion

Discussion surrounded the challenges of language and communication. Conversations between health care providers and patients surrounding goals of care are necessary but difficult. Health care providers are waiting to be asked by family, while family are waiting to be cued from health care providers. The word “palliative” is particularly problematic. The term is convenient for health care providers but we need to think about language that is useful to patients and families. We must start with thoughtful and compassionate phrasing. It is not about standardizing language but about having compassionate care. It is not just end of life care but a philosophical approach of how we deal with end of life.

Panel Summary

This panel highlighted the need to adapt a palliative approach to the context and to ensure that appropriate supports are in place for a palliative approach. Ms. Mendel spoke to the need to provide a supportive environment for nurses to have those difficult conversations around end of life. Ms. Nutini spoke to the importance of supporting and educating rural family caregivers so that they can do their job well. Ms. Potter and Ms. McLean spoke to the unique factors of rural nurses that bring an added layer of complexity to a palliative approach to care.

Research Presentation 4 – Translating a palliative approach at the bedside

❖ **Kelli Stajduhar**, PhD, RN, School of Nursing, Centre for Aging, University of Victoria

❖ **Gweneth Doane**, PhD, RN, School of Nursing, University of Victoria

Study Overview

Building upon previous work with family caregivers that indicated significant gaps in institutional care of the dying, the purpose of this participatory action study was to support nurses and other health professionals to provide a palliative approach to care in acute medicine and residential care. The study involved three phases. In Phase 1 interviews were conducted with nursing staff, allied health professionals, doctors, educators and clinical leaders in medicine and residential care. In Phase 2 interventions were developed collaboratively to enhance practice. These interventions were then evaluated in Phase 3.

Emerging Findings

Contextual factors that influence the provision of a palliative approach include: time pressures, bureaucracy, communication breakdowns, inappropriate orders, role conflict, and staff inexperience. Nurses have a tendency to view palliative care as a place where people go to die and are cared for by health care providers who specialize in palliative care. This belief tends to ignore the reality that people die everywhere in the health system and that nurses have a key role to play. In addition, there are often conflicting perspectives between health care providers of who should receive a palliative approach and what care is ideal within that approach. Some nurses carry the belief that where they work is the worst place to die resulting in a sense of moral distress.

The implications for learning are significant. Translating a palliative approach at the bedside is not simply a matter of more knowledge and requires learning for everyone involved. Both technical and adaptive knowledge is required. Adaptive knowledge is characterized by being willing to step into that gap between the real and the ideal and living with the complexity that exists in that space. It involves integrating different types of knowledge uniquely adapted to that situation. This means that the practitioners at the bedside are literally the ones brokering this knowledge and we must learn from them.

Audience Discussion

Two important points arose in the audience discussion. The first concerned hierarchies in knowledge and how often health care providers are characterized as the “knowers” while family caregivers are characterized as the “unknowers.” We need to find a way to incorporate family knowing into this paradigm. The second concerned how important it is to attach the idea of a palliative approach to other emerging developments in health care such as patient-centered care or relational practice so that the idea can gain better traction.

Audience Written Responses

Participants were asked to respond to the following questions. Fifteen participants provided written responses.

(1) *What are the adaptive learning challenges that need addressing?*

- ❖ Adaptive challenges included the following: learning to share our knowledge with one another in ways that provide important knowledge in a way that is both usable and understandable; having a common language (e.g. around advance care planning) and communication skills that supports a palliative approach; unlearning our ideas around specialized palliative care; appreciating rather than avoiding complexity; and becoming more reflective about our practice.

(2) *What are some potential first steps to address those learning challenges within acute and long term care settings?*

- ❖ Participant suggestions for how to respond to these adaptive challenges included:
 - **Communication:** Communication skills education should be available to health care providers and to patients and families. When communicating with families use a glossary of language at a Grade 6 level without the use of medical acronyms and pay attention to language barriers. Communication “cross-walks” can help communicate across different world views. On a macro-scale, language is critical when communicating a palliative approach to the public – participants note a palliative approach can learn from organ donation programs in raising awareness or can identify with the patient-centered care movement.
 - **Collaboration:** The relational aspect of communication includes participants’ feedback to break down barriers between doctors, nurses, patients and families, with increased communication between this team. Two participants noted the importance of valuing the wisdom of everyone involved (not just the Most Responsible Physician [MRP] or RN) and “sharing” knowledge rather than “owning” knowledge to best determine how each can best “use” the knowledge within their role. Ad hoc and regular meetings with nurses to address emerging issues and provide education are important. The focus needs to be on what is best for patients and families rather than what is best for staff. Often staff with their intimate knowledge of the context and relationship have the creativity to solve situations. We can draw upon their knowledge.

Consensus Building Exercise

The purpose of this consensus building exercise was to have participants discuss the practicalities of enacting palliative approach competencies within generalist nursing contexts. Participants were divided into groups according to their practice contexts of acute, community or residential care and were asked to comment on some of the barriers to the enactment of palliative approach competencies in their practice setting. The following is a compilation of their comments:

- ❖ Lacking confidence to give patient and family the correct information, and to identify patient needs.
- ❖ Practicality of applying palliative competencies in the acute setting where the focus is on medical intervention.
- ❖ Inability to meet family expectations.
- ❖ Family physician not fulfilling their role in communication with the family.
- ❖ Lack of knowledge of available resources.
- ❖ Not having a Social Worker (or other resources) to help with ethical, legal social needs in rural areas.
- ❖ Lack of time to spend with patients and families to support them.
- ❖ Life-limiting illness is not a term that is commonly used.
- ❖ Priority given to skills tends to de-emphasize relational practice and the development of communication skills.
- ❖ The approach of the nurse can be a barrier, if they are operating in palliative care mindset, instead of palliative approach. There is a need to embrace the “not knowing” and become competent in context.
- ❖ The changing system and responsibilities surrounding advance care planning can be a barrier and the need to understand your responsibility to stay on top of it.

Summary of Consensus Building Exercise

We cannot think about educating for a palliative approach without thinking about context. There are multiple barriers both within the system and within our own mental maps that require modification and re-learning. We can teach nurses to consider prognoses and to begin conversations around goals of care but that inevitably provides an entry point into the complex and specialized field of palliative care. Here is where a whole new set of expectations arise for nurses for which they have varying degrees of confidence. In addition, the degree to which they have access to specialized knowledge and care influences the degree of knowledge and confidence they must have themselves.

Synthesis of the Day

❖ **Deanna Hutchings**, *Clinical Nurse Specialist, End of Life Care, Vancouver Island Health*

This exercise encouraged participants to pull out some of the threads of what was synthesized and learned over the course of the day. Six questions below were posed to the group and placed on flip charts around the room for people to write their responses.

❖ *What was a significant learning?*

- The barrier of language, especially between palliative care and palliative approach. One remarked, “To be more cognizant of our language and assumptions that people in other professions and/or family cultures understand what we are attempting to communicate.” This barrier was felt between health care providers and family as well as between different health care providers.
- The importance of the surprise question and how helpful it was for triggering discussions with patients around goals of care.

❖ *Any ‘aha’ moments?*

- Many comments revolved around participants’ expanded view and understanding of a “palliative approach.” Some aspects were: “excellence in disease management, it begins at the time of diagnosis” and “medical directives are important to discuss early.” Others realized that there is a need to look at the two populations separately, those who need palliative care and those who would benefit from a palliative approach.
- Many commented on the need surrounding family support and the need to think about creative solutions and realistic expectations around end of life care. We need to be more mindful of family education and provide for good health literacy. We prepare families for birth and surgery – we need to do the same for death. There needs to be a “patient and family caregiver voice in everything we do.”

❖ *What have we not learned that we still need to know?*

- Most comments were focused on the logistics, “What are the costs of going ahead?”; “Is upper management on board?”; “How do we use this information in acute care?” and “How do we incorporate all care settings as well as family care providers in the project?”

❖ *What did you **not** learn today from an education/research/policy perspective?*

- Is there a one-size fits all approach for palliative approach – or do we need to tailor the palliative approach to be gender-sensitive? Do men and women experience palliative care similarly?
- What does undergraduate education need to look like for a palliative approach?
- How do we speak easily to clients and families about death and dying?

- If we are transposing the model of the dementia or chronic disease end-stage management onto the palliative care experience, what should that look like and what are the skills to navigate the uncertainties?
 - How do we explore/incorporate cultures/ethnic views and beliefs in a palliative approach?
 - How are advance care planning and palliative approach different?
- ❖ *In a perfect world, where do we need to go?*
- Dissemination of the findings from today to the government, to policy makers, to other researchers, to citizens, to differing levels of education, and to physicians.
- ❖ *How do we follow up – from what we have learned and gaps?*
- Continue the connections through webinars and teleconferences, yearly if possible.
 - Create opportunities for nurses to gain expert consultation on palliative care and a palliative approach.
 - Information dissemination to health care professionals and the general public is essential, also to nursing schools, public health, etc.
 - Get the public on side to create demand for health care that incorporates a palliative approach.

Symposium Summary and Conclusion

These notes were analyzed thematically to assist with summarizing the various activities of the day. The following five themes summarize the findings and conclusions of the symposium.

Competence and Confidence: Preparation for Care

Preliminary results from a provincial survey of nurses' self-perceived capability in a palliative approach indicate that nurses in practice perceive themselves as more capable in the physical aspects of care than some of the more intangible psychosocial, spiritual and ethical aspects of care. One of the areas where nurses feel least capable is communicating with families when a conflict occurs: an important finding as it relates to nurses engaging conversations around goals of care. When educating nurses for a palliative approach, it is important to incorporate considerations of both competence and confidence to ensure that nurses feel well prepared.

A substantial body of work has been done to ensure there are competency statements for entry-level practitioners in palliative care within a generalist context. However, typically entry-level practitioners do not feel confident until they have received clinical experience with this population. Palliative clinical experience is often equated with specialized palliative care units rather than with the many places in which nurses care for those who are dying; this presents a challenge for entry-level competency in a palliative approach.

Language and Labels: Concepts for Care

What is a palliative approach and how does it differ from palliative care? The challenge of conceptualizing these labels was a common theme throughout the day. Some of the most profound learning from the day was a deeper understanding of a palliative approach. How we define these concepts is important from an educational perspective. Education for a palliative approach and palliative care are not discrete bodies of knowledge. The common foundation is recognition of a dying trajectory and conversations around goals of care; the knowledge required to provide high-quality care from that point is fluid and context dependent.

If we teach nurses to recognize those who are on a dying trajectory and to engage conversations around goals of care, then we must also help them to feel confident in supportive care. Further, the knowledge required is shaped by context. The rural nurse who has limited access to palliative experts may require more in-depth knowledge than the urban nurse who has ready access to a multi-disciplinary palliative team.

Legos and Rivers: Metaphors for Care

The specialization of palliative care has left an enduring legacy for a palliative approach across nursing contexts. The Lego approach to care whereby an individual is at some juncture labeled palliative and then specialized palliative nursing comes to bear has allowed some nurses to abdicate their responsibilities for supportive care of the dying. This is not to be construed as intentional neglect, but rather as a socialized model of care that delegates care of the dying to those that are perceived to be best prepared, and hence most competent, to provide high quality-care. What is required is a reclaiming of care of the dying at the basic level of preparation for every nurse. The river metaphor directs us to go upstream to educate about

chronic disease management as a continuum of person-centered care, characterized by ongoing conversations about what is the best care for this person at this moment in time, right up until death.

Knowing and Knowings: Challenging Hierarchies of Knowledge for Care

Health care has all too often been shaped by hierarchies of knowledge; physicians know more than nurses who know more than nursing care providers who know more than families who know more than patients. This paradigm needs to shift if we want to achieve a palliative approach to care across sectors. Conversations around care must include all the "knowings" from partners in care for a knowledgeable plan. Some sectors do not receive adequate education. Nursing care assistants require more focused education, development and inclusion in the care team. Families require preparation for the vital role they are being asked to fulfill and they must be included as essential members of the team. The adaptive challenge of integrating a palliative approach will require fresh eyes, unlearning, action at all levels, and the courage to work in between the real and the ideal to build capacity for high-quality care.

Places and Spaces: Environments for Care

Palliative care is a place and outside of that context it is difficult to create space for a palliative approach. This understanding was the greatest barrier to enacting a palliative approach to care. Multiple barriers to enacting a palliative approach were cited: heavy workloads of nurses; curative cultures of care; task-focused care; lack of knowledge of resources; and confidence in knowledge and skills. Clearly, education without attention to the social contexts of care will be insufficient. The complexity of the social context means that we must not think of this challenge merely as more learning. It is those nurses at the bedside who are the ones to engage and broker this knowledge; they are our teachers.

Conclusion

Knowledge gained from this day will be used to inform a set of recommendations for enhancing a palliative approach to care that is part of the broader iPANEL initiative.

Once again, we would like to acknowledge the many individuals who participated in this day. The findings are an important contribution to further understanding how to support nurses in a palliative approach to care.

Appendix A: List of Participants

iPANEL Team

Ami Bitschy
Dr. Barb Pesut
Barbara McLeod
Darcee Bidgood
Deanna Hutchings
Della Roberts
Elisabeth Antifeau
Dr. Gweneth Doane
Judy Lett
Dr. Kelli Stajduhar
Michelle Funk
Pat Porterfield
Pauline James
Dr. Rick Sawatzky

iPANEL Advisory

Dr. Christine Penney
Colleen Butcher
Dr. Pat Coward
Dr. Sally Thorne

iPANEL Graduate Students

Ibolya Agoston
Sherin Jamal

Invited Graduate Students

Erin Donald
Lori Rietze

Presenters

Barb McLean
Denice Evanishin
Donna Mendel
Gail Potter
Dr. Joyce Black
Lynnelle Erbacker
Susan Ross
Tammy McLean
Teresa Nutini
Yvonne Moritz

Other Invited Guests

Baljit Lail
Brenda Hooper
Dr. Carole Robinson
Diana Barker
Dr. Joan Bottorff
Kath Murray
Katrina Plamondon
Ruth Edwards
Sharon Whitby
Sheila Epp
Miranda Dalhuisen

Nurses and Nursing Care Providers from Acute, Community and Residential Settings

Lorianne Topft
Shirley Logan
Terri-Lynn Ross
Treena Creebo
Wendy Remirsz
Carrie Kirkness
Laurie Barnhardt
Raelene Hansen
Karen Jaillet

Appendix B: May 2, 2012 Symposium Agenda

Time	Agenda Item	Persons
0830 - 0845	Welcome and Introductions	<ul style="list-style-type: none"> ❖ Dr. Barbara Pesut, Faculty UBC Okanagan ❖ Barbara McLeod, CNS, End of Life Care, Fraser Health
0845-0900	Introduction to iPANEL	<ul style="list-style-type: none"> ❖ Dr. Kelli Stajduhar, Faculty, UVIC
0900 - 0930	Research Presentation 1: Preliminary results of a provincial survey of nurses' knowledge in a palliative approach	<ul style="list-style-type: none"> ❖ Dr. Richard Sawatzky, Faculty, Trinity Western University ❖ Della Roberts, CNS, End of Life Care, Fraser Health
0930-1030	Panel 1: Curricular competencies and scopes of practice	<ul style="list-style-type: none"> ❖ Dr. Joyce Black, Education Consultant, CRNBC ❖ Denice Evanishin, Nursing Practice Advisor, CLPNBC ❖ Darcee Bidgood, iPANEL member, CASN competencies contributor ❖ Barb McLean: Executive Director, Family Caregivers' Network Society
1030-1050	Coffee Break	
1050-1115	Research presentation 2: Scoping review of best evidence for preparing nurses in a palliative approach	<ul style="list-style-type: none"> ❖ Lynnelle Erbacher, Research Coordinator, UBC Okanagan
1115 - 1200	Panel 2: Innovative curricular and clinical education models	<ul style="list-style-type: none"> ❖ Susan Ross, Faculty Thompson Rivers University ❖ Barbara McLeod, CNS, End of Life Care, Fraser Health ❖ Pat Porterfield, Palliative Care, Regional Leader Vancouver Coastal Health
1200-1300	Lunch	
1300 - 1330	Research presentation 3: Qualitative secondary analysis: What do generalist nurses need to know to provide a palliative approach to care in rural areas?	<ul style="list-style-type: none"> ❖ Dr. Barbara Pesut, Faculty UBC Okanagan
1330-1430	Panel 3: Nursing scopes of practice and barriers to care	<ul style="list-style-type: none"> ❖ Donna Mendel, Acting Chief of Professional Practice and Nursing, Interior Health ❖ Teresa Nutini, rural family caregiver ❖ Gail Potter, Faculty, Selkirk College, Palliative Educator ❖ Tammy McLean, Faculty, Selkirk College, Palliative Educator
1430- 1500	Research presentation: Translating a palliative approach at the bedside	<ul style="list-style-type: none"> ❖ Dr. Kelli Stajduhar, Faculty, UVIC ❖ Dr. Gweneth Doane, Faculty, UVIC
1500-1615	Consensus Building Exercise	<ul style="list-style-type: none"> ❖ Dr. Barbara Pesut, Faculty UBC Okanagan
1615-1645	Strategic Visioning Exercise	<ul style="list-style-type: none"> ❖ Deanna Hutchings, CNS, End of Life Care, Vancouver Island Health