

CAPCE

Evaluation of the Comprehensive Advanced Palliative Care Education Program – Southwest Region

Final Evaluation Report: Learner Reactions to the 2004 – 2005 CAPCE
Program

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Executive Summary

1.0 Background and Introduction

The Comprehensive Advanced Palliative Care Education Program (CAPCE) completed its inaugural year in March 2004. The evaluation of the 2003-2004 CAPCE program indicated that it was well-received and positively evaluated by learners. Learners reported increased palliative care knowledge and skills and experienced increased confidence with their clinical practice. They provided evidence of their ability to act as Palliative Care Resource (PCR) professionals within their workplace; they were able to increase the capacity of their peers to provide optimal palliative care, to develop palliative care resources and guidelines for their workplace, to prioritize palliative care within their workplace, and were able to transfer knowledge to their practice, with positive impacts on client care.

Feedback from the 2003-04 CAPCE learners was used to make revisions to the 2004-2005 program, however, the basic format and structure of the program (i.e., regional and local sessions, the mentorship component) remained the same. This report describes the methods and results of evaluation of the 2004 – 2005 CAPCE program.

2.0 Evaluation Methods

The objectives of this evaluation are:

- i) to provide feedback on the learner's reactions to the program, including the learning strategies used and their suggestions for improvement, and,
- ii) to describe the potential ways in which the education is being transferred to clinical practice.

Sources of Information

A survey methodology was used to obtain both quantitative and qualitative information. Although surveys were used primarily to gain evaluation information, they were also intended to be part of the learning process. Questions were designed to be reflective and to assist learners to reflect on their clinical practice and to identify areas in which additional support and resources are necessary in order from them to be successful. All surveys were completed on-line at the CAPCE website.

A **Registration Form** was developed to collect the demographic information on the learners and information about their organizations. (This form is presented in the Description of CAPCE Learners report, October 4, 2004). This form was completed on-line at the time that learners registered for the program (spring and summer 2004; response rate = 100%).

The **Learner Assessment** form was used to gather information about the learner, their organization, and the frequency with which they engaged in various palliative care practices (with none/very few of my dying clients; with some of my dying clients; with all or most of my

dying clients). The learner assessment was completed on-line, prior to the start of CAPCE (August - September 2004). A similar assessment was completed by learners as a follow-up three months after the end of the program (June 2005) to assess the extent to which learners were engaged in the Palliative Care Resource role, and the impact of the role in their workplace. Questions were asked about the factors that enabled and hindered the transfer of knowledge to clinical practice. (Response rate = 100%).

Reaction surveys were developed for each of the five program sessions. Questions were asked related to perceptions of the sessions, workplace support, knowledge transfer and reflections on how they planned to improve their palliative care practice. Reaction surveys were completed on-line and were made available the day following each session. (Response rates for each of the surveys ranged from 75 to 100%).

Learning Strategies Survey was developed to focus specifically on learner perceptions of the learning strategies used in the CAPCE program. Questions were related to the usefulness of learning strategies, valuable resources and supports, internet use and, suggestions for changes or improvements to the CAPCE program. This survey was available for on-line completion approximately two weeks after the last CAPCE session (response rate = 95%)

3.0 **Results**

Feedback on learner reactions to CAPCE:

- Overall, the sessions were well received by learners. The majority of learners rated the pace, volume of material, complexity and opportunities to participate in each session as “just right”. These ratings were consistent across the sessions. The majority of learners provided overall ratings of the sessions of “very good” or “excellent”.
- Learners perceived the CAPCE content material to be extremely relevant to their setting and practice.
- All learners (100%) reported that CAPCE met their needs for new information, skills, and resources, and almost all learners indicated that they would recommend the CAPCE program to others interested in improving their palliative care practice.
- Learners perceived the format of the sessions (regional and local sessions, formal and informal) as helpful, or valuable, to their learning and application of the CAPCE curriculum; the majority of learners giving these formats a range of ratings from ‘good’ to ‘excellent’. Their ratings indicated that they perceived the local sessions to be more useful than the regional sessions.
- Learners responded positively to the learning strategies used in the program, particularly the CAPCE resource material and homework assignment. Learners were less enthusiastic about role play activities, and internet based activities. Throughout the program learners

responded positively to the steps of the therapeutic encounter and at follow-up the majority of learners continued to use them on a regular basis.

- There was a significant increase in learners' usage of the internet and their comfort level with the internet from pre- to post-CAPCE. Comfort level with the internet increased with increased usage. Overall, the CAPCE website was considered to be user-friendly and the majority of learners rarely or never required assistance, either from the Webmaster or from peers, to access or use the on-line material. The majority of learners intended to continue to use the internet to access palliative care resources.
- Overall, learners responded positively to CAPCE educators and mentors, were satisfied with the level of support they received from their mentor and accessibility to their mentor, and perceived the mentoring process to be valuable to their ability to transfer knowledge to their clinical practice. Mentors were identified as a significant learning resource.

Knowledge Transfer: The Palliative Care Resource Role

- Throughout the program, the majority of learners described their opportunities to apply new knowledge and skills to their clinical practice. More learners were able apply new knowledge after the session on communication and conflict resolution, and fewer did so after the session on grief and bereavement.
- Early in the program and maintained throughout learners provided anecdotal evidence of their ability to improve their palliative care practice and demonstrated their ability to act as palliative care resources in their workplace to affect a change in palliative care practice.
- Learner's confidence in their ability to assume the PCR role was moderate, however, overall, they were more confident in their ability to provide palliative care than prior to CAPCE.
- At follow-up the majority of learners (78%) continued to serve as a PCR in their workplace. Many of those who did not act in the role did not do so because there was already a PCR in their workplace. The majority of learners (60%) acted as a PCR in "some palliative care cases"; 36% in most or all cases. Many are sought out by peers for advice or suggestions related to palliative care.
- At follow-up, 52% of learners rated themselves as "quite" to "extremely" successful as a PCR. (The main rating across learners reflected their perception that they were "fairly" successful). The majority of learners (88%) indicated that the quality of palliative care in their workplace had improved in the past year.
- Key activities of the PCRs included:
 - education
 - staff: registered and non-regulated – all aspects of palliative care

- family members – end-of-life, last hours, decision making
 - clients
 - pain and symptom management;
 - assessment (pain, symptoms, physical);
 - care planning, goal setting;
 - end-of-life planning; decision-making with families;
 - conflict resolution with family members;
 - medication reviews;
 - development of policies, guidelines, procedures;
 - development of palliative care committees/working groups; and
 - case conferencing (interdisciplinary and family)
- Knowledge transfer was enabled by the CAPCE curriculum (relevance to clinical practice and learning integration), peer support (belief in palliative care as a priority, willingness to try new things), and management support (interest in learners' goals and objectives for palliative care).
 - Generally, the majority of learners reported they were providing palliative care according to the CAPCE performance objectives, prior to and following the CAPCE program. Although, there were only a few statistically significant differences in the performance objectives from pre CAPCE to follow-up, these were opposite to what would have been expected; at follow-up significantly fewer learners engaged in some of the palliative activities. This may be because they overestimated their palliative care practice prior to the program. Quality of care, not frequency of care, may have been the most significant practice change.
 - Work and time pressures and lack of resources (staff, funding, space) were identified as key barriers to knowledge transfer.
 - Lack of peer support/knowledge, lack of physician and administrative support, organizational issues (slow to change, changes, structured work routine, and lack of funding), and learner characteristics (e.g., poor communication skills, interpersonal skills) were identified by mentors as barriers to learning transfer. Within the mentorship sessions, mentors were able to resolve or to start a process for resolving these barriers for many of the learners.

Comparison with 2003-2004 CAPCE Program Evaluation

In general, the findings of the evaluation of the 2004-05 CAPCE program were quite consistent with those of the 2003-04 program. Some key differences in the findings of the 2004-05 evaluation included:

- There were fewer negative comments about the use of the internet for evaluation and program activities and fewer learners required assistance from the webmaster or peers to access information.

- The number of learners who continued to serve as PCR was reduced, but this may be because its role already exists in their workplace.
- At follow-up the percentage of organizations that were in the process of revising their palliative care policies increased from 36% in 2004 to 56% in 2005.
- Management willingness to try new things was more significant as a facilitating factor in 2005 (ranked at #5) than in 2004 (ranked at #10), reflecting an increase in organizational support for changes to palliative care. Consistent with this, fewer learners (9%) identified lack of management interest in learner goals and objectives for palliative care as a significant barrier in 2005, in comparison to 2004 when it was the top ranked barrier identified by 73% of learners.

4.0 Conclusion

The 2004-05 CAPCE program was well-received and positively evaluated by learners. The curriculum, resource manual, and mentorship component contributed to knowledge transfer and were valued by learners. Early in the program learners provided evidence of their ability to act as Palliative Care Resource professionals in their workplace and for the majority of learners this role was sustained at follow-up. Learners were able to transfer new knowledge to their clinical practice, with positive impacts on client care and were able to increase the capacity of their peers and colleagues to provide optimal palliative care by providing formal and informal education opportunities and by developing workplace resources, guidelines, and policies for palliative care. Management and peer support for enhanced palliative care had a significant impact on learners' ability to optimize the resource role.

1.0 Background and Introduction

The Comprehensive Advanced Palliative Care Education Program (CAPCE) completed its inaugural year in March 2004. The evaluation of the 2003-2004 CAPCE program indicated that it was well-received and positively evaluated by learners^{1,2}. Learners reported increased palliative care knowledge and skills and experienced increased confidence with their clinical practice. They provided evidence of their ability to act as Palliative Care Resource (PCR) professionals within their workplace; they were able to increase the capacity of their peers to provide optimal palliative care, to develop palliative care resources and guidelines for their workplace, to prioritize palliative care within their workplace, and were able to transfer knowledge to their practice, with positive impacts on client care.

Feedback from the 2003-04 CAPCE learners was used to make revisions to the 2004-2005 program, however, the basic format and structure of the program (i.e., regional and local sessions, the mentorship component) remained the same. Descriptions of the program are provided in detail elsewhere.^{1,3} An overview of the 2004-2005 CAPCE program is presented in Appendix A.

This report describes the methods and results of evaluation of the 2004 – 2005 CAPCE program.

2.0 Evaluation Methods

The evaluation objectives and methods were developed in collaboration with program organizers, an educational consultant, and other key stakeholders (See Appendix B).

2.1 Evaluation Objectives

The objectives of this evaluation are:

- iii) to provide feedback on the learner's reactions to the program, including the learning strategies used and their suggestions for improvement, and,
- iv) to describe the potential ways in which the education is being transferred to clinical practice.

2.2 Evaluation Methods

A survey methodology was used to obtain both quantitative and qualitative information. Learners completed a registration survey, learner assessment (prior to and following the

¹ Loretta M. Hillier (May, 2004). Comprehensive Advanced Palliative Care Education. Interim Evaluation Interim Evaluation Report: Learner Reactions to the 2003 – 2004 CAPCE Program.

² Loretta M. Hillier (July, 2005). Comprehensive Advanced Palliative Care Education. Interim Evaluation Interim Evaluation Report: Final Evaluation Report of the 2003 – 2004 CAPCE Program. Author.

³ CAPCE website: www.palliativecareswo.ca

program), reaction surveys for each of the program sessions, and a learning strategies reaction survey. Although these surveys were used primarily to gain evaluation information, they were also intended to be part of the learning process. Questions were designed to be reflective and to assist learners to reflect on their clinical practice and to identify areas in which additional support and resources are necessary in order for them to be successful. All surveys were completed on-line at the CAPCE website.³

2.2.1 Sources of Information

Registration Form

A registration form was developed to collect the demographic information on the learners and information about their organizations. (This form is presented in the Description of CAPCE Learners report, October 4, 2004). This form was completed on-line at the time that learners registered for the program (spring and summer 2004).

Learner Assessment (Pre-CAPCE and Follow-up)

Pre-CAPCE: The Learner Assessment form was used to gather information about the learner, their organization, and the frequency with which they engaged in various palliative care practices (with none/very few of my dying clients; with some of my dying clients; with all or most of my dying clients). The learner assessment was completed on-line, prior to the start of CAPCE (August - September 2004).

Post-CAPCE: A similar assessment was completed by learners as a follow-up three months after the end of the program (June 2005) to assess the extent to which learners were engaged in the Palliative Care Resource role, and the impact of the role in their workplace. Questions were asked about the factors that enabled and hindered the transfer of knowledge to clinical practice (See Appendix C).

Reaction Surveys

Reaction surveys were developed for each of the five program sessions. (The surveys are presented in the evaluation reports for each individual session). Questions were asked related to perceptions of the sessions, workplace support, knowledge transfer and reflections on how they planned to improve their palliative care practice. Reaction surveys were completed on-line and were made available the day following each session.

Learning Strategies Survey

This survey was developed to focus specifically on learner perceptions of the learning strategies used in the CAPCE program (See Appendix D). Questions were related to the usefulness of learning strategies, valuable resources and supports, internet use and, suggestions for changes or improvements to the CAPCE program. This survey was available for on-line completion approximately two weeks after the last CAPCE session.

2.2.2 Response Rates

The following table summarizes the main sources of evaluation information and the number of responses received (Surveys are listed in the order in which they were completed):

Source of Information	Response Rate*
Registration Form	98 (100%)
Learner Assessment – Pre-CAPCE	98 (100%)
Reaction Surveys:	
Norms of practice, assessment, pain management (Sept 15)	98 (100%)
Pain assessment and management (Oct 13)	95 (98%)
Symptom assessment and management (Nov 10)	92 (97%)
Communication and conflict resolution (Dec 8)	93 (98%)
End-of-life decision making, last hours (Feb 2)	88 (93%)
Grief, bereavement, resource role (Mar 2)*	90 (75%)
Learning Strategies Survey	90 (95%)
Learner Assessment – Follow-up	86 (91%)

* Response rate is calculated based on the number of learners that were registered in the program at the time of data collection.

**Although the majority of learners attended this session in London, due to inclement weather some learners received this session at a later date in their local areas.

Data analysis

Data were analyzed using SPSS11.5⁴. Descriptive statistics (frequencies, means, standard deviations) were generated for numeric variables. Chi-square, t-tests, and analysis of variance (as appropriate) were conducted to determine whether there were differences in learner ratings based on:

- Discipline (RN, RPN)
- Workplace setting (hospital, long-term care, community)
- Practice area (geriatrics, other)
- Years of experience in palliative care (1-5 yrs; 6-10yrs; 11-15yrs; >16yrs)
- Percentage of time spent providing palliative care (< 50%, 51%>)
- Whether or not learners were asked (invited) to participate in CAPCE.

Evaluation of pairwise comparisons among means was conducted with Tukey's Honestly Significant Difference (HSD), a widely used posteriori procedure for testing differences among means.⁵ Content analyses were conducted on open-ended responses using an inductive analysis approach, in which common themes are identified and categorized⁶.

⁴ SPSS 11.5. Chicago, IL: SPSS Inc., 2003.

⁵ Kirk, R.E. (1982). *Experimental Design: Procedures for the Behavioral Sciences* 2nd Ed. Monterey, CA: Brooks/Cole.

⁶ Patton, M.Q. (1990). *Qualitative Evaluation and Research Methods* (2nd Ed.). Newbury Park, CA: Sage.

3.0 Evaluation Results

3.1 DESCRIPTION OF CAPCE LEARNERS

A total of 103 people were registered to participate in CAPCE. Five of these registrants audited the program and were not required to participate in the evaluation. Three learners dropped out; 95 learners completed the program.

The mean number of learners per mentor (N = 7) was 13 (SD = 4), with a range of 6 to 18 learners per mentor.

Demographic Information

Table 1 presents a description of the CAPCE learners. The majority of CAPCE learners were Registered Nurses and worked in geriatrics. The highest proportion of learners worked in long-term care settings, with smaller proportions of learners working in acute care hospitals and within the community. CAPCE learners were evenly distributed across the Elgin/Middlesex/Oxford and Kent/Lambton/Essex District Health Council (DHC) Areas, with a lower percentage of learners from the Grey Bruce/Huron/Perth DHC areas. There was great variability in the amount of time that learners spent providing palliative care (range from 2% to 100% of their time), on average learners spent about 49% of their work time providing palliative care. There was also great variability in the amount of end-of-life/palliative care experience learners had, ranging from less than one year to 35 years, though on average they had 14 years of palliative care experience.

Involvement in education: While the majority of CAPCE learners (60%) had previously participated in palliative care related continuing education initiatives (in-services, education and refresher days, and college courses), other than the Level I Palliative Care Course or the Mentorship Program in Long -Term Care), for 40% of the learners CAPCE was one of their first palliative care learning opportunities.

Involvement with committee work: A high proportion of the learners (81%) have participated in a least one health care related committee in the past three years, though many of these were not specifically related to palliative care. Many were members of their workplace palliative care team, and many listed professional practice committees (accreditation, advisory, policy and procedures) and other workplace committees (handle with care, wound control, health and safety, infection control). Six learners listed their involvement with P.I.E.C.E.S. and most likely served as the Psychogeriatric Resource Person in their workplace.

Table 1: Description of the CAPCE participants

	Number (%)
Discipline (N = 97):	
Registered Nurse	75 (77.3%)
Registered Practical Nurse	22 (22.7%)
Location by District Health Council Areas (N = 98):	
Grey Bruce/Huron/Perth	30 (30.6%)
Elgin/Middlesex/Oxford	31 (31.6%)
Kent/Lambton/Essex	37 (37.8%)
Workplace setting (N = 98):	
Teaching hospital	10 (10.2%)
Non-teaching hospital	11 (11.2%)
Chronic/long-term care/nursing home	44 (44.9%)
Community	27 (27.6%)
Hospice and/or palliative care program	2 (2.0%)
Other settings	4 (4.1%)
Practice area (N = 98):	
Geriatrics	50 (51.0%)
Complex continuing care	13 (13.3%)
Oncology	5 (5.1%)
Primary Care	4 (4.1%)
Community nursing	10 (10.2%)
Hospice/palliative care	5 (5.1%)
Multiple areas	5 (5.1%)
Other (Critical Care, Medical Unit)	6 (6.1%)
Years of palliative care/end-of-life experience (N = 98) :	
Mean	13.62 years
(SD)	(8.6yrs)
Range	1 - 35 years
Percentage of current work time providing palliative care/end-of-life care (N = 98)	
50% or less of time	63 (64.3%)
51% or more of time	35 (35.7%)
Mean (SD)	48.5% (24.9%)
Range	2 - 100%

Involvement in special projects: Many learners (72%) reported that they had participated in special health care related (workplace) projects in the past three years, though most of these were not palliative care related. Projects listed included research, training and education, and development of best practices, policies, and procedures.

Information about CAPCE: Most CAPCE learners were informed about CAPCE by their department head, manager, or supervisor (48%), or from their Pain and Symptom Management Consultant (25%). The majority of learners (58%) were asked (invited) to participate in CAPCE, mostly by their workplace superior. Many learners thought they were asked to participate because of their interest in ('passion') and experience with palliative care.

Workplace description

The majority of learners (64%) worked in settings that do not have a designated Palliative Care unit. Although a large proportion of learners (82%) reported that their organization has specific workgroups or committees related to palliative care in place, only 40% indicated that they were involved in these activities. Eighteen (18%) learners reported that their workplace did not have any palliative care committees in place, but reported that their workplace would be very receptive to doing so (mean receptively score = 9.0; SD = .94; 1 – 10 scale, 10 = extremely receptive). Similarly, learners described their management and peers as being very receptive to changing palliative care policies or treatment guidelines in their workplace (mean receptively score = 8.6; SD = 1.5; 1 – 10 scale, 10 = extremely receptive).

Table 2: Description of the CAPCE learner's workplace settings

	Number (%)
Presence of a designated palliative care unit (N = 98)	35 (35.7%)
Presence of workgroups or committees related to palliative care (N = 95)	80 (84.2%) (1% of learners are not involved in these workgroups or committees)
Receptivity to forming palliative care workgroups or committees (for those who do not currently have these) N = 14	
Mean (SD)	9.1 (.83)
Range	8 – 10
Management and peer receptivity to changing palliative care policies or treatment guidelines (1 – 10 scale; not at all – extremely; N = 98)	
Mean (SD)	8.6 (1.5)
Range	5 – 10

3.2 LEARNER REACTIONS TO THE CAPCE PROGRAM

3.2.1 Learner Reactions to the Sessions

Session Ratings: Figures 1 to 5 present learner ratings of the pace of activity, volume of information, complexity of material, opportunities to participate, and new information applicable to clinical practice across all of the sessions (as rated on 1 to 5 scales; 1 = minimum extreme, 2, 3 = just right, 4, 5 = maximum extreme, respectively). The majority of learners rated pace, volume of material, complexity, opportunities to participate, and new information applicable to clinical practice as “just right”. In regards to the overall complexity of the material covered in CAPCE (as measured at the end of the program), although the majority of learners (57%) indicated that the material was just right for this program level (See Table 3), 39% indicated that the material was more complex (somewhat complex and very complex ratings) for this program level.

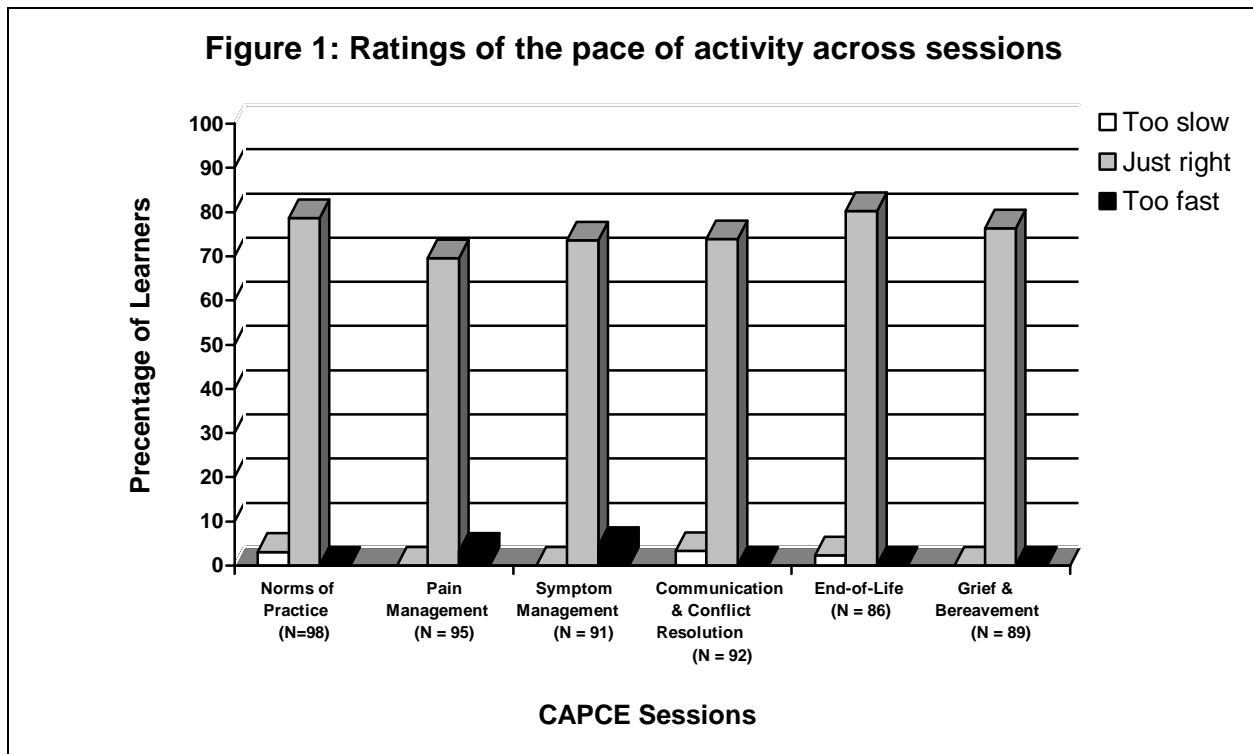


Figure 2: Ratings of the volume of material across sessions

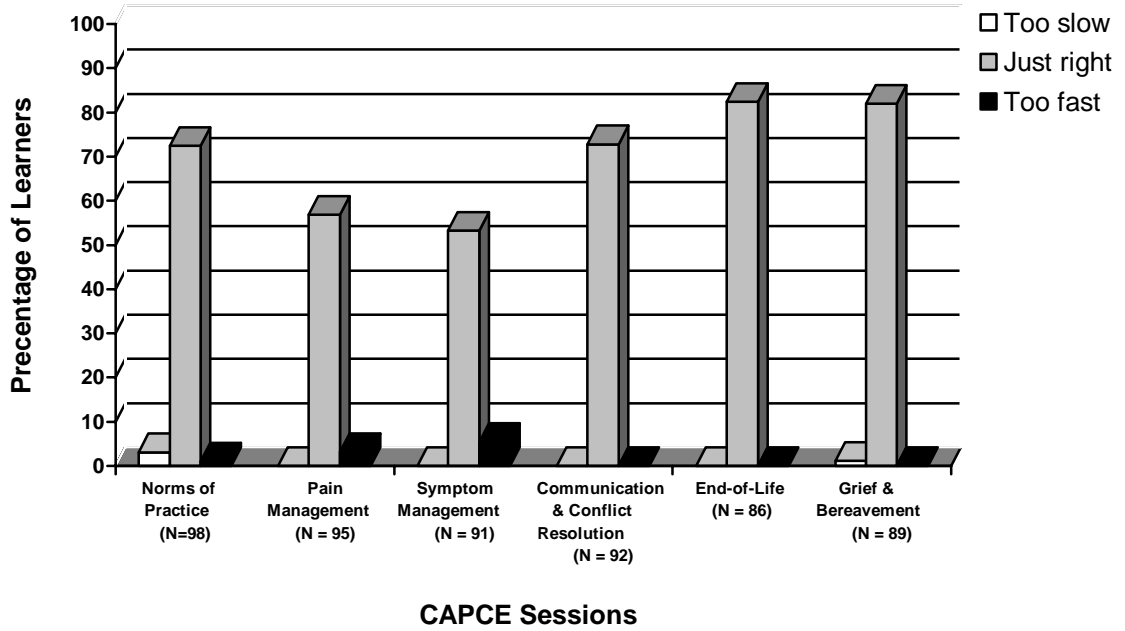


Figure 3: Ratings of the complexity of material across sessions

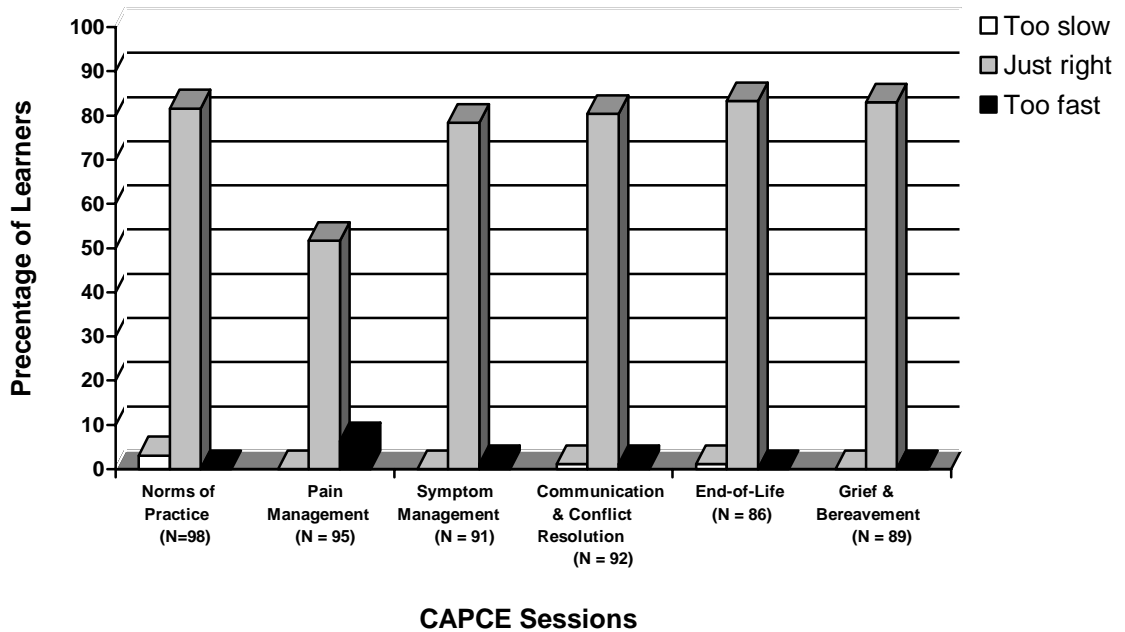


Figure 4: Ratings of the opportunities to participate across sessions

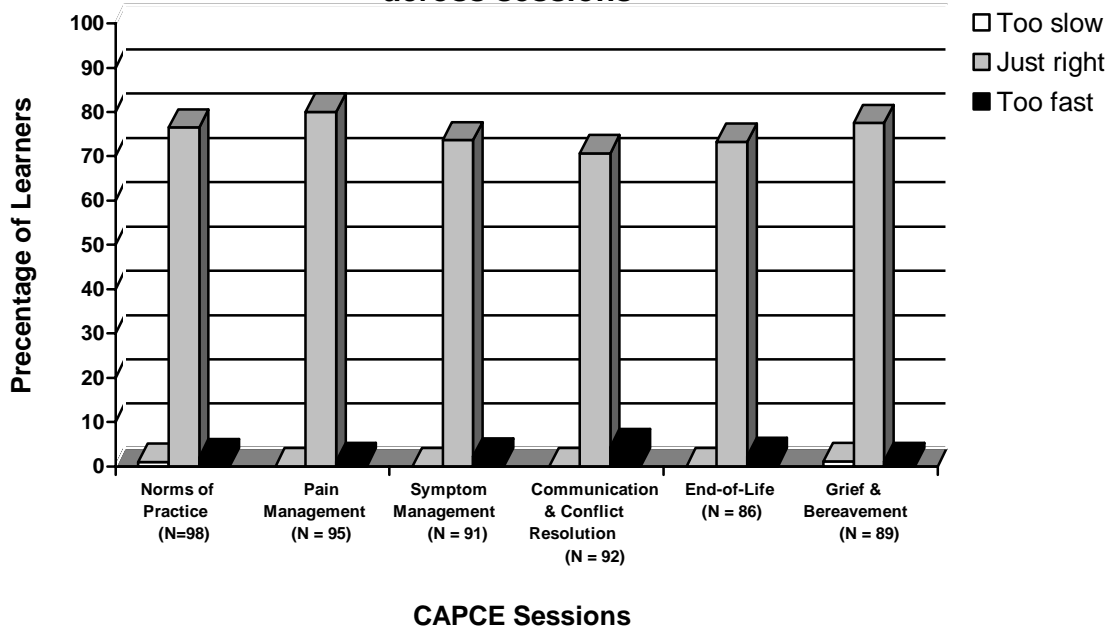


Figure 5: Ratings of new information applicable to clinical practice

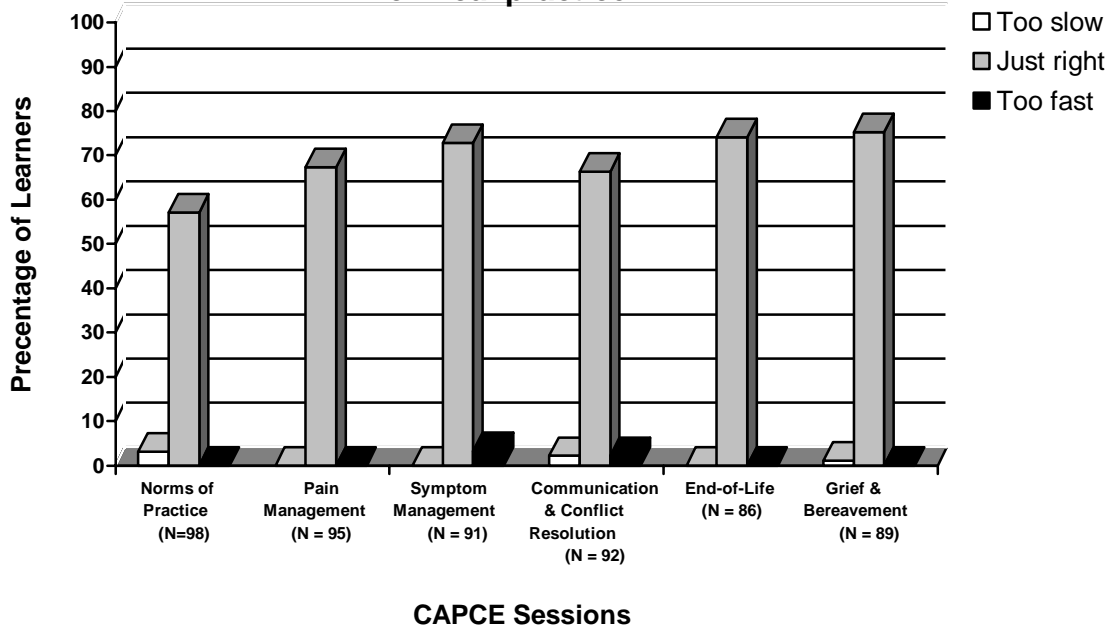
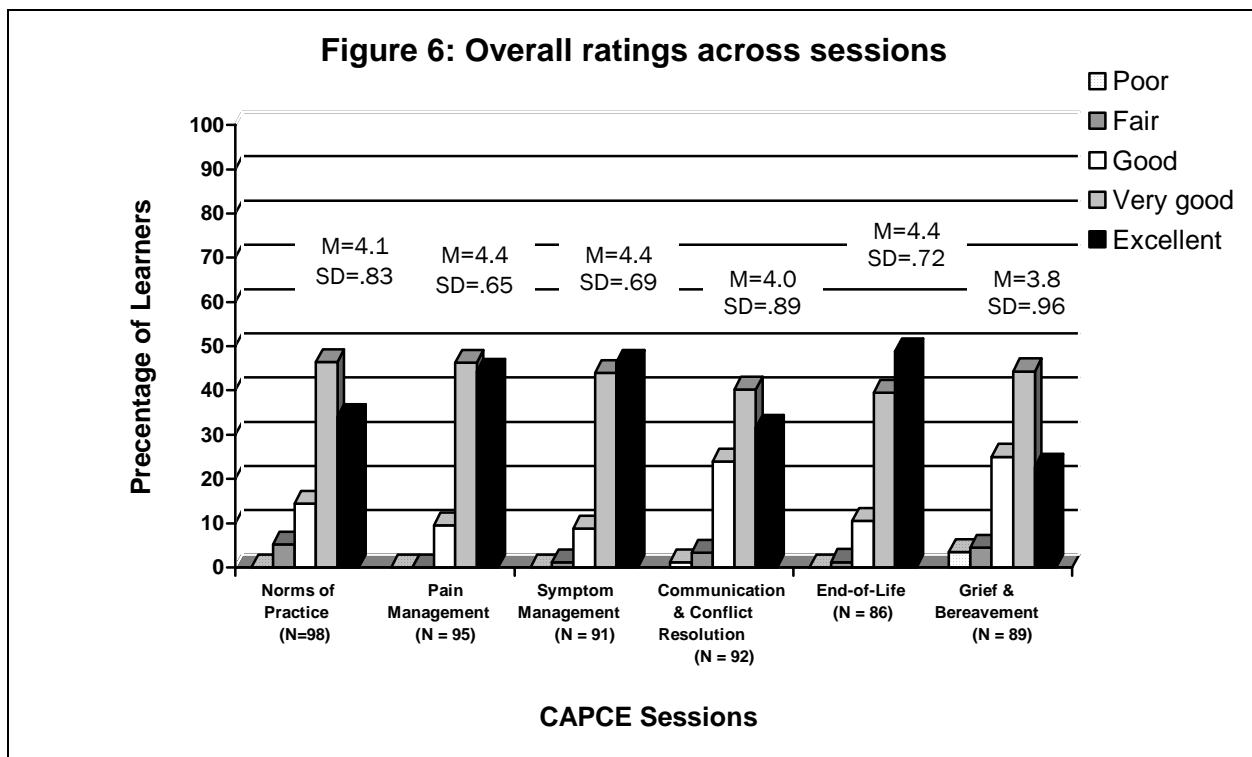


Table 3: Learner ratings* of the level of complexity of the CAPCE program material (N=90)

Level of Complexity	Number (%)
Very basic level	0
Somewhat basic level	4 (4.4%)
Just right for this program level	51 (56.7%)
Somewhat complex	34 (37.8%)
Very complex	1 (1.1%)

* Mean rating = 3.4 (SD = .59)

Overall session ratings: Overall, the majority of learners rated each of the sessions very positively, with most learners providing the sessions with a “very good” or “excellent” rating (See Figure 6). There were no statistically significant differences in the mean ratings across sessions.



Relevance of the CAPCE content: At the end of the program learners were asked to rate the relevance of the information and material covered in CAPCE to their work setting and clinical practice (1 – 5 scale; 5 = extremely relevant). Learners' ratings ranged from 3 to 5, with a mean rating of 4.6 (SD = .56; N = 90), indicating that the learners perceived the material to be extremely relevant to their setting and practice (the majority of learners, 97%, provided ratings of 4 or 5).

Meeting learner needs: All (100%) of the learners reported that CAPCE met their needs for new information, skills, and resources (15% indicated that CAPCE 'definitely' met their needs, 85% indicated that CAPCE 'somewhat' met their needs). Almost all of the learners (N = 87; 97%) indicated that they would recommend the CAPCE program to others interested in improving their palliative care practice.

Throughout the program, learners provided positive comments about the sessions that reflected: their enthusiasm and excitement about the program, their satisfaction with the sessions (content and speakers) and their mentors, the high level of information learned, and the usefulness of the information for improving their practice. ⁷

Learner Reactions to CAPCE – The influence of various demographic variables

Analyses were conducted to determine whether learners' reactions to the sessions (pace, volume, complexity of material, opportunities to participate, amount of new material, and overall ratings) varied by discipline, practice area, work setting, years of palliative care experience, and percentage of work time providing palliative care.

There were no statistically significant differences in learners' reactions to the sessions based on their discipline (RN vs. RPN), work setting, years of palliative care experience, or percentage of work time spent providing palliative care, however, there were differences based on:

- **Practice Area:** Learners working in geriatrics had higher ratings of the volume of material covered in the sessions on pain management (October 2) and communication (December 8) than those working in other areas (See Table 4).
 - For the October 2nd session: Learners working in geriatrics had lower overall ratings of the session on pain management than those working in other areas, though their mean ratings are still quite positive (ratings of "very good").
 - For the December 8th session: Learners working in geriatrics had higher ratings of the amount of new information applicable to their clinical practice (indicating that there was too much new information) than those working in other settings.

⁷ Learners' comments about the sessions are presented in the evaluation reports for each of the sessions.

Table 4: Significant differences in learner ratings of the sessions based on practice area (N=89).*

	Geriatrics (N = 46)	Other (N = 43)	F (df) p
Pain Management (October 2)			
Volume of material	3.59 (.62)	3.28 (.50)	6.6 (1,87), p<.01
Overall session rating	4.22 (.59)	4.51 (.67)	4.8 (1,87), p<.05
Communication, Conflict Resolution (December 8)			
Volume of material	3.24 (.48)	3.00 (.49)	5.4 (1,87), p<.05
Amount of new information	3.33 (.56)	3.00 (.72)	5.7 (1,87), p<.05

* Rated on a 1 to 5 scale; volume and amount of new information: 5 = too much; overall rating: 5 = excellent.

3.2.2 Learner Reactions to the Format of CAPCE

Using 5-point ratings scales, learners were asked to rate the extent to which the format of the sessions, that is regional and local sessions, formal (lectures) and informal (small group discussions and problem-solving) formats were helpful, or valuable, to their learning and application of the CAPCE curriculum. Table 5 presents learners' mean ratings of the usefulness of the formats used in CAPCE. Overall, the ratings reflect that learners perceived these formats to be valuable to their learning, with the majority of learners giving these formats a range of ratings from 'good' to 'excellent'; very few learners provided 'poor' or 'fair' ratings (See Appendix D). Learners' ratings indicated that they perceived the local sessions to be more useful than the regional sessions.

Table 5: Ratings* of the formats of the CAPCE sessions (N = 103)

Mean (Sd)	Format
4.47 (.62)	Learning at the local sessions (N=89)
4.19 (.65)	Learning through lectures (formal presentations) (N=90)
3.97 (.84)	Learning from each other (small group sharing, problem solving) (N=90)
3.80 (.86)	Learning at the regional sessions (N=90)

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

3.2.3 Learner Reactions to the Learning Strategies Used in CAPCE

Learners were asked to rate the extent to which the various learning strategies used in CAPCE were helpful, or valuable to their learning and application of the CAPCE curriculum. These ratings are presented in Table 6. Overall, mean ratings were the highest for the

CAPCE resource manual and the homework assignments (for which the majority of learners provided ratings of ‘very good’ and ‘excellent’), and lowest, but still moderate, for role play activities and internet based activities (for which the majority of ratings were ‘good’ and ‘very good’). Despite the high ratings for the homework assignments, some learners reported that there was too much homework (See section on learner suggestions for improving CAPCE and Appendix D.)

Table 6: Ratings* of the learning strategies used in the CAPCE program

Mean (Sd)	Format
4.50 (.62)	The CAPCE resource manual (N=90)
4.11 (.66)	Homework assignments (pre-read material, practical assignments) (N=90)
3.98 (.78)	Multi-media (video) (N=90)
3.93 (.96)	Case studies (N=90)
3.61 (.98)	Internet-based activities (CAPCE website) (N=90)
3.31 (1.04)	Role play activities (N=89)

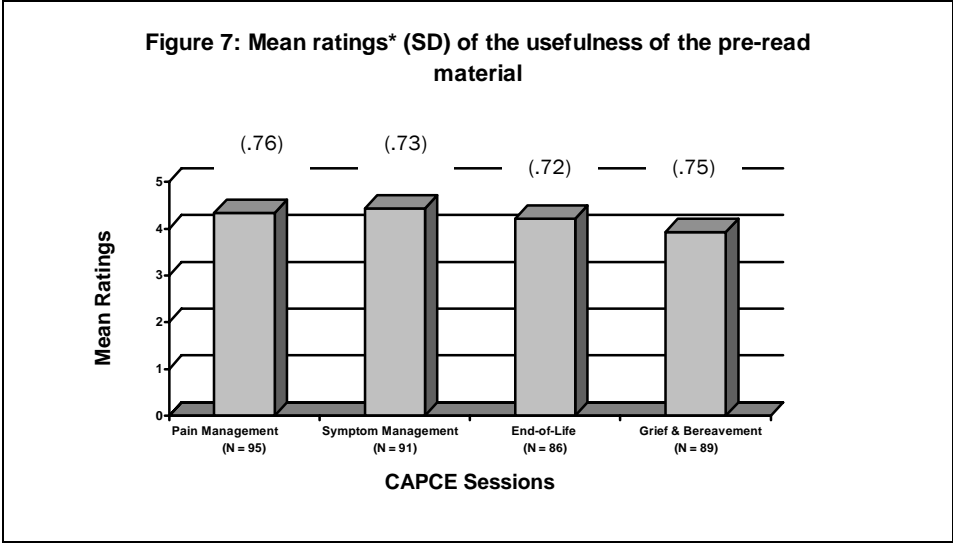
* 1-5 scale; 1 = poor, 2 = fair, 3 = good, 4 = very good, 5 = excellent

Reactions to the video presentation on pain: Following the presentation of the video on pain (featuring Dr. D. Moulin), learners provided reactions to the video. Overall, most of the learners thought that:

- the volume of material was about right (N = 50; 55%); some (N = 36; 40%) thought it was between right and too much;
- the material was complex; (N = 41; 45%) thought it was between about right and too complex; some (N = 36; 40%) thought it was just right; and
- the amount of new material applicable to clinical practice was about right (N = 64; 70%).

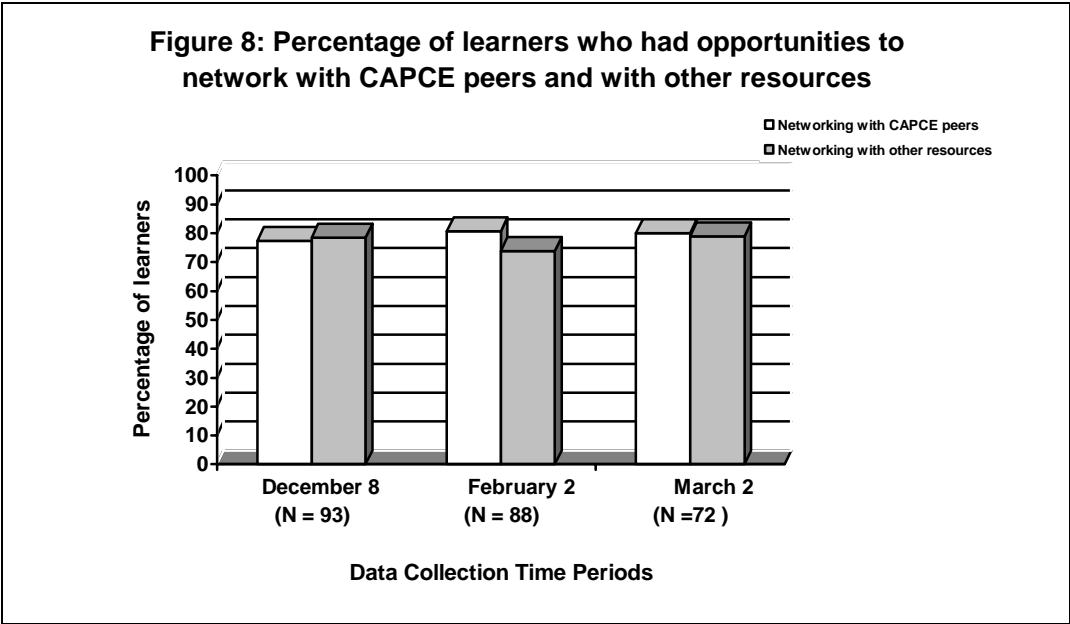
Usefulness of the pre-read material

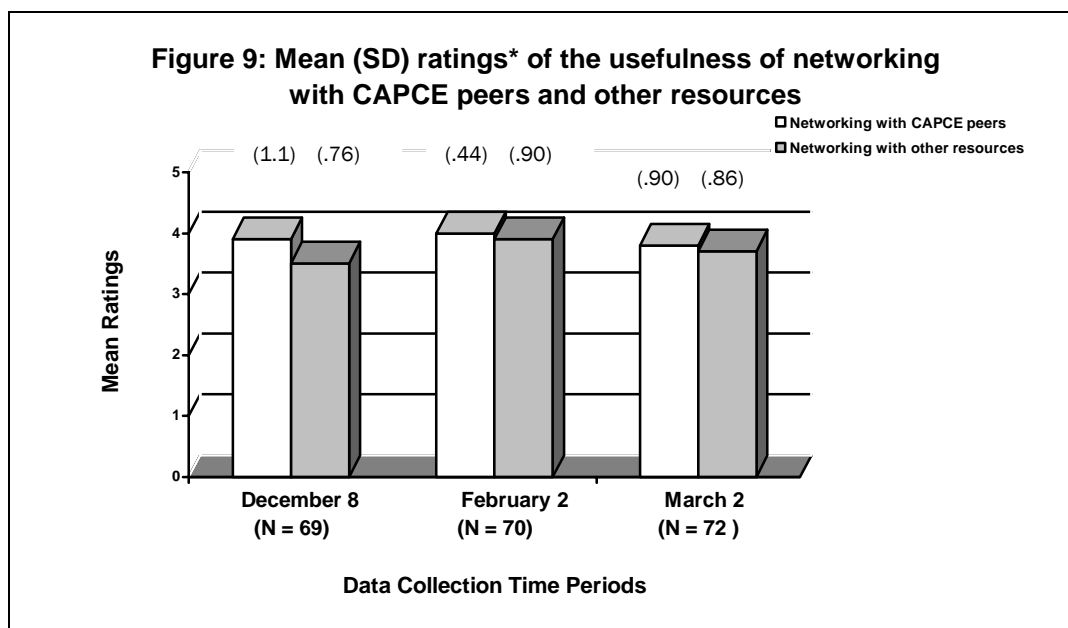
Figure 7 presents learners ratings of the usefulness of the pre-read material across the sessions. In general, learner ratings (1 to 5 scale; 5 = extremely useful) indicated that they perceived the readings to be useful in helping them to prepare for the sessions. The ratings were consistent across the sessions; there were no statistically significant differences in the ratings across the sessions (means ranged from 3.9 to 4.4). Learner ratings of the usefulness of the pre-read material did not vary according to any of the demographic variables.



Networking

Across the data collection time periods, the majority of learners indicated that they had the opportunity to network with their CAPCE peers (over 77% of learners) and with other resources (over 74% of learners; See Figure 8). This networking was rated (1 to 5 scale; 5 = extremely useful) as moderately useful (means ranged from 3.5 to 4.0; See Figure 9).





* 1 to 5 scale; 1 = not at all useful; 5 = extremely useful

Post-CAPCE (learning strategies survey), learners rated how helpful, or valuable informal networking with other learners (at lunch time, via e-mail) was to their learning (See Table 7). The majority of learners (73%) provided 'good' or 'very good' ratings. Learner perceptions of their opportunities to network with CAPCE peers and other resources and their ratings of the usefulness of this networking did not vary according to any of the demographic variables.

Table 7: Ratings of the usefulness of informal networking (N = 90)

	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
Learning from each other informally (e.g., networking at lunch, e-mail; M = 3.46; SD = .94)	2 (2.2%)	12 (13.3%)	29 (32.2%)	37 (41.1%)	10 (11.1%)

Consultation Support

As part of the learning process and their role as PCRs, many learners have consulted with other resource professionals regarding palliative care cases (See Table 8). Most frequently learners consulted with other health professionals in their workplace and with palliative care team members or palliative care specialists.

Table 8: Number (%) of learners who have consulted with resource professionals regarding palliative care cases (N = 86)

Resource Professional	Number (%)
Palliative Pain and Symptom Management Consultant	40 (46.5%)
CAPCE graduates	37 (43.0%)
Palliative Care Team members or palliative care specialists	52 (60.5%)
Other disciplines (physician, dietician, pharmacist)	61 (70.9%)

The Steps of the Therapeutic Encounter

Figure 10 presents learners’ ratings of the extent to which the steps of the therapeutic encounter were helpful when addressing particular issues that had been identified for their clients. Across the data collection time periods, learner perceptions of the helpfulness of the steps remained positive (means = 4.0 and 4.11, respectively). Learners’ ratings of the usefulness of the steps of the therapeutic encounter did not vary according to any of the demographic variables. At follow-up, the majority of learners (76%) continued to apply the steps most or all of the time (See Table 9).

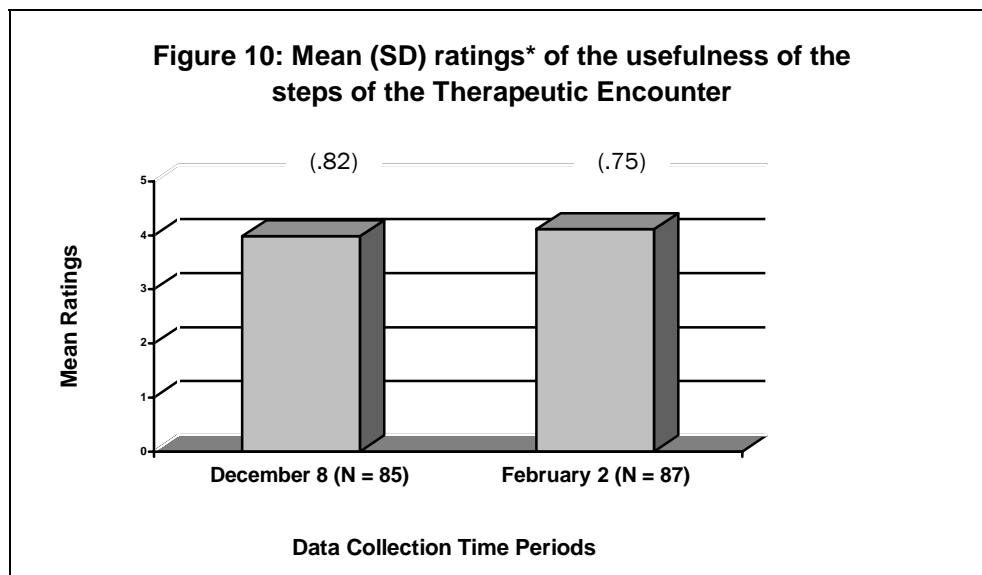


Table 9: The number (%) of learners who continued at follow-up to use the process of providing care to assist them to apply the essential steps during a therapeutic encounter (N = 67).

Frequency	Number (%)
Never/hardly ever	3 (4.5%)
Sometimes	13 (19.4%)
Most of the time	37 (55.2%)
All the time	14 (20.9%)

Throughout the program learners identified the use of the square of care as new information that they planned to share with peers and as a method of improving their palliative care practice. Some comments related to the square of care:

“Through my work I carry out the square of care with each new admission. This has given me a wider range of questions and allows me to dig deeper into a client's history.”

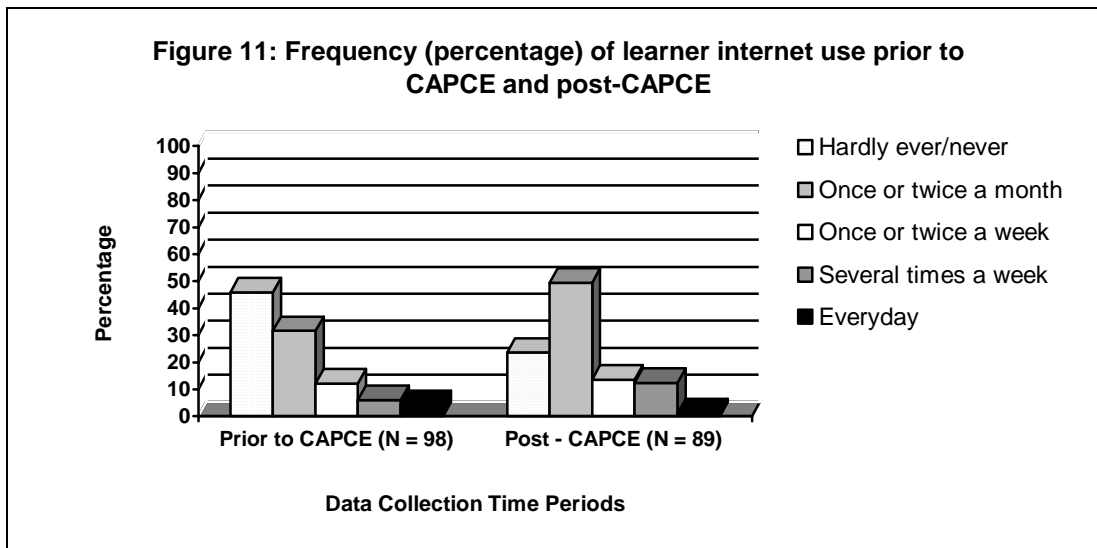
“I have been using the square of care as a guideline when assessing my residents so I remember to treat the whole person.”

Goal: “be knowledgeable of my client's square of care so that I can have effective and efficient dialogue with service providers when discussing the services required for my patient's care. With this knowledge-I am better able to authorize the services required at the right place in the right time”

Internet use

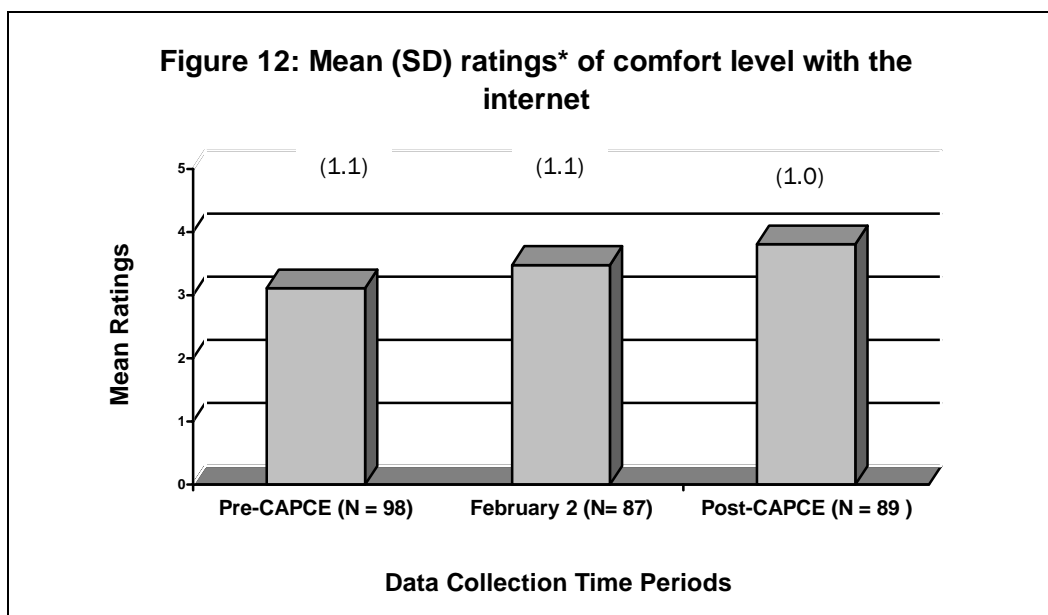
Frequency of use: Figure 11 presents the frequency of learners’ internet use in the six months prior to the start of CAPCE and post-CAPCE. Prior to the start of CAPCE the majority of learners (N = 76, 78%) had used the internet less than twice a month, to access information (best-practice guidelines, research, evidence-based care). Of these learners, 46% hardly ever or rarely used the internet. Less than 6% (N = 6) used the internet more than 3 - 5 times per week.

There was a significant increase in learner usage of the internet from pre-to post-CAPCE, $\chi^2(16) = 64.4, p < .001$. At follow-up the percentage of learners who never used the internet decreased (from 46% pre-CAPCE to 24% post CAPCE) and the number of learners who use the internet once or twice a month increased (from 32% pre-CAPCE to 49% post-CAPCE).



Comfort level: Learners' ratings (1 to 5 scale; 5 = extremely comfortable) of their comfort level with the internet increased during CAPCE. There was a statistically significant difference in mean comfort level with the internet from pre-CAPCE (M = 3.10; SD = 1.1, N = 89) to post-CAPCE (M = 3.81; SD = 1.2, N = 89), $t(88) = 7.69, p < .001$ (See Figure 12).

Comfort level was positively correlated with use of the internet, both pre ($r = .60, p < .01$) and post ($r = .41, p < .01$) CAPCE, indicating that comfort level with the internet increased with usage.



Learners' use of the internet did not vary by any of the demographic variables. Learners' comfort level with the internet varied only by discipline: pre-CAPCE RNs had higher comfort ratings ($M = 3.67$; $SD = 1.08$; $N=67$) than RPNs ($M = 2.71$; $SD = 1.38$; $N=14$), $F(1,79) = 8.25$, $p<.01$. Similarly, post-CAPCE RNs had higher comfort ratings ($M = 3.96$; $SD = 1.04$; $N=70$) than RPNs ($M = 3.22$; $SD = 1.06$; $N=18$), $F(1,86) = 7.08$, $p<.01$.

As a result of their participation in CAPCE, many learners indicated that they were now more likely to use email and the internet as a resource (See Table 10).

Table 10: Use of the e-mail and the internet as a result of participation in CAPCE (N = 89)

As a result of your participation in CAPCE are you now more likely to....	Yes	No	Not Sure
...use email on a regular basis for work-related purposes?	42 (47%)	31 (34%)	16 (18%)
... use the internet as a resource in your professional practice?	61 (69%)	19 (21%)	9 (10%)

Website user-friendliness: Learners overall mean rating of the user-friendliness of the CAPCE website (i.e., how easy it was to access and use the on-line material) was 4.16 ($SD = .84$, $N = 88$; 1 to 5 scale: 5 = extremely easy) indicating that it was very easy to access. The majority of learners (59%) rarely or never required assistance, either from the Webmaster or from peers, to access or use the on-line material (See Table 11). Learner ratings of the user-friendliness of the CAPCE website and the frequency with which they required assistance to access and use on-line material did not vary according to any of the demographic variables.

Table 11: Frequency with which learners required assistance to access or use on-line material from the CAPCE website (N = 89)

	Never	Rarely	Sometimes	Frequently	Always
Assistance required to access and use on-line material	36 (40%)	33 (37%)	16 (18%)	3 (3%)	1 (1%)

CAPCE Educators and Mentors

Overall, learners responded positively to CAPCE educators and mentors, as reflected in their ratings (1 to 5 scale, 1 = poor, 5 = excellent; See Figure 13). As a learning strategy, learner ratings reflected their perceptions that the mentoring process was valuable to their learning, with the majority of learners (78%) providing ratings of ‘very good’ or ‘excellent’ (See Table 12).

Consistent with this, 94% (N = 85) of learners were satisfied with the level of support they received from their mentor. As rated on a 5-point scale (1 = not at all accessible, 5 = extremely accessible), learners reported that their mentors were quite accessible (M = 4.6, SD = .70).

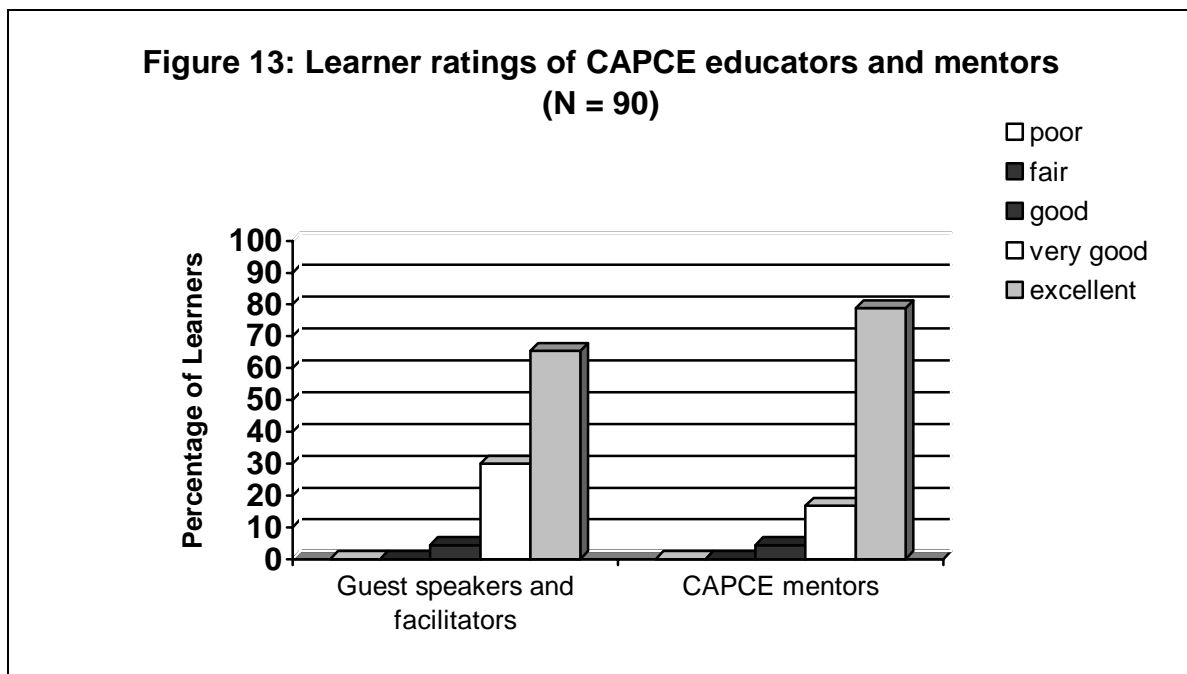


Table 12: Ratings of mentoring process (N = 87)

	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
Learning through the mentoring process (M = 4.06 SD = .87)	1 (1%)	3 (3%)	15 (17%)	39 (45%)	29 (33%)

Throughout the program learners provided positive comments and feedback about their experience with their mentors (See evaluation reports for the individual sessions and Appendix D), as illustrated by these examples:

“The mentors and co-facilitators were excellent throughout the CAPCE learning process – very approachable, helpful, supportive, and knowledgeable. They challenged me to improve my own practice as well as to inspire improvements for my colleagues and my organization.”

“I continue to learn so much from this course. The speaker was extremely interesting. [Mentor and educator] are so calm and caring and have a great sense of humor. They make learning enjoyable.”

“[Mentor] really has a gift for sharing and getting any information or point across effectively and accurately.”

“My mentor is a wonderful teacher and she has given us tremendous support and guidance. [She] is a fantastic advocate for palliative care.”

Valued resources: At follow-up, learners were asked to identify the two most valuable resources to them as they learned the CAPCE curriculum and applied what they had learned to their clinical practice. Table 13 presents the proportion of learners selecting each of the resources, presented in rank order – the majority of learners identified the CAPCE sessions as being their most valuable resource; CAPCE mentors and resource manual were ranked as the top 2nd and 3rd valued resources.

Table 13: Learners identification of the most valuable learning resources, listed in rank order (N = 90)

Resources	Number (%)
CAPCE sessions (regional and local)	46 (51.1%)
CAPCE mentor	39 (43.3%)
CAPCE resource manual	34 (37.8%)
CAPCE homework assignments (pre-read material, practical assignments)	21 (23.3%)
Support from peers/co-workers/colleagues	10 (11.1%)

Resources	Number (%)
Fellow CAPCE participants	9 (10%)
Work place resources (e.g., time and opportunities to practice)	6 (6.7%)
Support from management (supervisor, administration, senior leaders)	5 (5.6%)
Physician support	4 (4.4%)
CAPCE case studies	4 (4.4%)
CAPCE role play activities	0
Internet-based activities (CAPCE website)	0

Learner suggestions for improvements to CAPCE

Learners' verbatim suggestions for improving CAPCE are presented in Appendix D. The following is a summary of some of the key suggestions made by one or more learners.

- Reduce the amount of time between sessions, particularly between the December and February sessions.
 - Hold monthly sessions
 - Hold bi-monthly half-day sessions
- Make the last session a local rather than regional session (to reduce impact of inclement weather and to celebrate accomplishments with a smaller group of co-learners).
- Given the volume of pain assessment and management material to cover, expand this topic to cover two full sessions.
- Use different case studies throughout the program.
- Balance the amount of information tailored to specific settings (community vs. long-term care).
- Reduce the amount of group work (discussions) in favor of more discussions with experts.

- Number pages in the resource manual sequentially (continuous) throughout rather than new numbering for each module.
- Modify homework component.
 - Provide more immediate feedback on homework so that it can be used to complete the next assignment
 - Reduce the amount of homework
- Sustain learning opportunities for learners.
 - Annual “refresher days”
 - Learner reunions
 - CAPCE website as a resource for updated information about palliative care

3.3 THE PALLIATIVE CARE RESOURCE ROLE

At three months following the last CAPCE session, the majority of learners (N = 67; 78%) continued to serve as a PCR in their workplace. Those who were not serving in the role reported that there was already a PCR in place (N = 8), they were not recognized as a PCR (N = 3), or they had changed workplace (N=2).

Table 14 presents the frequency with which learners acted as a PCR. The majority of learners acted as a PCR “in some palliative care cases” in their workplace (60%); few learners were involved in all palliative care cases (8%). Thirty-seven percent of learners reported that staff sought them out for advice and suggestions more than once or twice a week.

Table 14: Frequency with which learners acted as a Palliative Care Resource.

Frequency of serving as a Palliative Care Resource (N = 67)	Number (%)
Never	3 (4.5%)
In some palliative care cases	40 (59.7%)
In most cases	19 (28.4%)
In all cases	5 (7.5%)
Frequency of staff members seeking advice or suggestions regarding palliative care issues (N = 67)	
Never/hardly ever	5 (7.5%)
About once or twice a month	37 (55.2%)
About once or twice a week	14 (20.9%)
Several times a week (3-5 times)	6 (9.0%)
Everyday	5 (7.5%)

Ratings of Success: Table 15 presents learners’ ratings of their success as a PCR in their workplace. The mean rating reflected their perception that they were “fairly” successful. The majority of learners (52%) provided ratings of “quite” to “extremely” successful. Fourteen (21%) learners provided ratings of “not at all” to “somewhat” successful.

Table 15: Learners’ ratings of their success as a Palliative Care Resource in their workplace.

N = 68	1 Not at all Successful	2 Minimally	3 Somewhat	4 Fairly	5 Quite	6 Very	7 Extremely Successful
Mean = 4.43 SD = 1.16	0	5 (7.4%)	9 (13.2%)	18 (26.8%)	25 (36.8%)	10 (14.7%)	1 (1.5%)

Confidence in Assuming the PCR Role

Close to the end of the program (after the February 2nd session), learners were asked to rate their level of confidence in their ability to assume the PCR role in their workplace (1-5 scale; 5 = extremely confident) and how this compared with their level of confidence prior to starting CAPCE (1-5 scale; 1 = less confident; 5 = more confident).

Learner’s confidence in their ability to assume the PCR role was moderate (M = 3.6, SD = .83, N = 87). However, they were more confident than when first starting CAPCE (M = 4.2, SD = .76, N = 87).

Throughout the program, learners commented on an increasing confidence in their skills:

“Already after two sessions I feel more knowledgeable and confident in my assessment and treatment of pain.” (October 13)

“The information enhanced my knowledge and helped me to be more comfortable with assessment of pain, in particular the type of pain and the reason for the pain.” (October 13)

“I feel more confident in speaking with a patient or family member about what they want and what is acceptable for a pain goal.” (November 10)

“...to better participate and give input to our palliative care committee by looking at more of the total person in our assessment of resident. I was more comfortable to speak up and to give my suggestions.” (November 10)

“I have been able to screen patients for depression. I am now more comfortable asking questions about depression.” (December 8)

“I learned to feel more comfortable with my own spirituality and therefore more comfortable in my ability to talk with residents about their spirituality when they are ready to.” (December 8)

“I find that I am actually comfortable talking to people when they are dying. Asking them if there is anything they still want to do. Before I would never talk so openly to them.” (February 2)

“I have been able to have better control of some of the symptoms in the last few days. I am able to communicate better with the family, sooner than I was before. I am also a lot more comfortable doing this.” (March 3)

“I have felt more confident and clear, precise about my role in obtaining DNR from a patient. I am more clear.” (March 3)

“I felt more comfortable supporting a family at end-of-life situation. Did not feel judgmental, nor pressure that the interaction did not go as I had perceived it to happen.” (March 3)

Workplace Changes

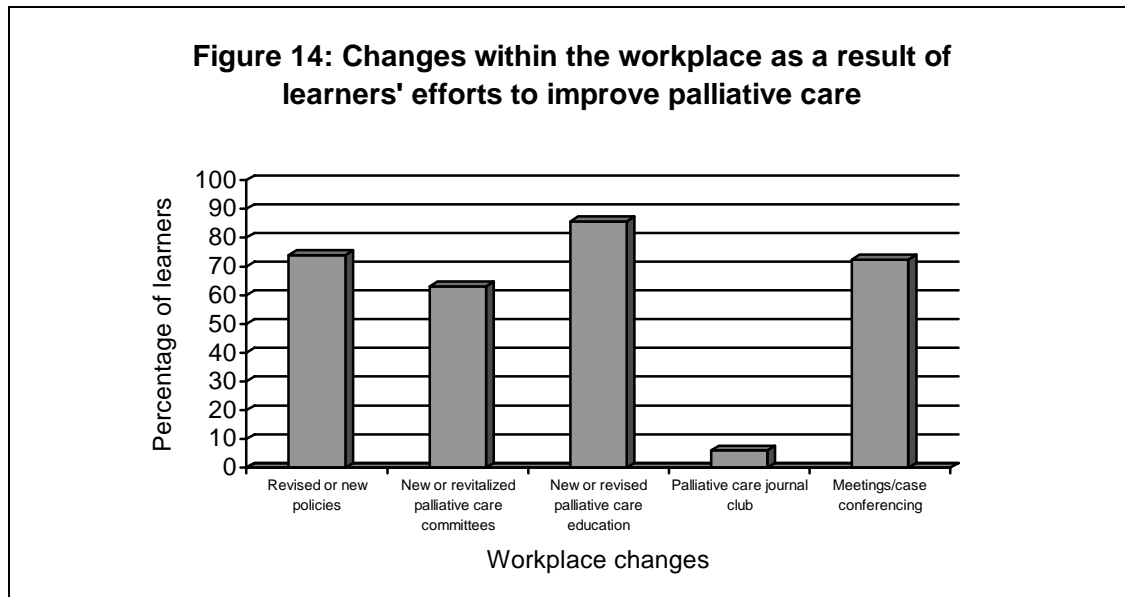
At follow-up, the majority of learners (88%) indicated that the quality of palliative care in their workplace had improved in the previous year (See Table 16).

Table 16: PCR reports of changes to the quality of palliative care in their workplace in the previous year (N = 85)

Quality of Palliative Care	Number (%)
Deteriorated	1 (1.2%)
Stayed the same	9 (10.6%)
Improved	75 (88.2%)

Figure 14 presents the some of the changes that have occurred (or are in the process of changing) in the workplace as a result of learners’ efforts to improve palliative care. Many learners had either revised or created, or were in the process of revising or creating, new palliative care policies or standards (74%), palliative care work groups or committees (72%),

palliative care education (86%). In contrast, very few learners created palliative care journal clubs (6%).



Activities of the Palliative Care Resource

At follow-up, learners identified a variety of activities that they were engaged in as PCRs (detailed descriptions are presented in Appendix C). Key activities were pain and symptom management, assessment, and care planning. The following is a summary of the resource activities described by learners.

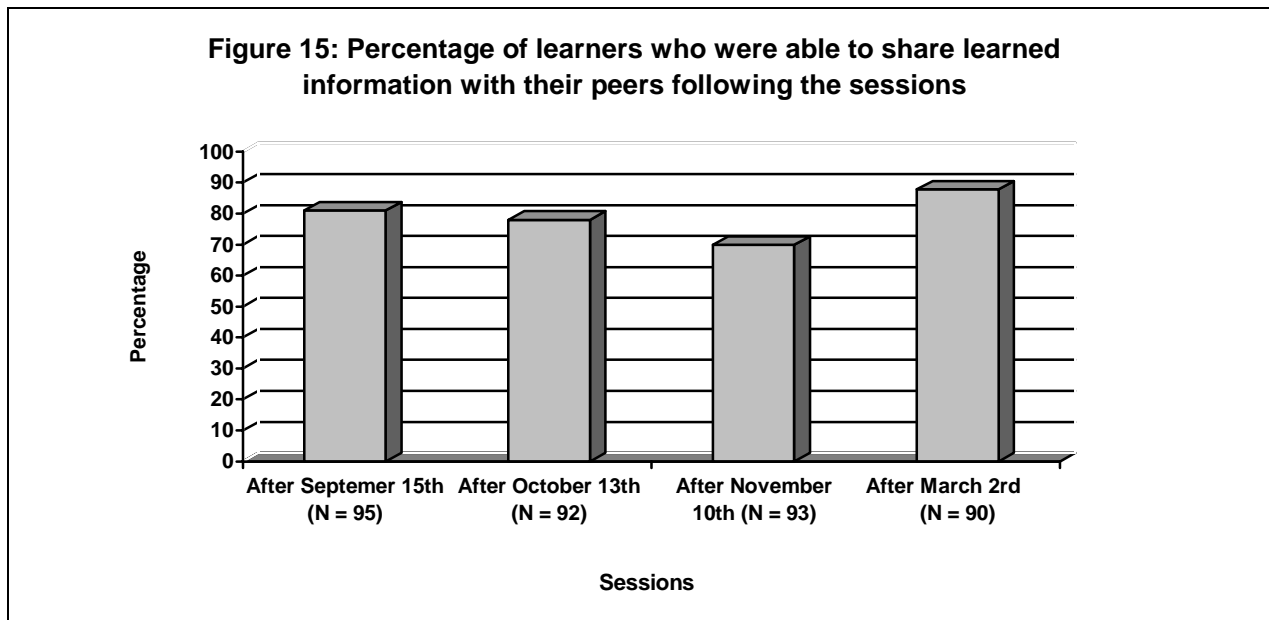
- education
 - staff: registered and non-registered – all aspects of palliative care
 - family members – end-of-life, last hours, decision making
 - clients
- pain and symptom management;
- assessment (pain, symptoms, physical);
- care planning, goal setting;
- end-of-life planning; decision-making with families;
- conflict resolution with family members;
- medication reviews;
- development of policies, guidelines, procedures;
- development of palliative care committees/working groups; and
- case conferencing (interdisciplinary and family)

Learners identified various goals that they had for improving palliative care in their workplace in the subsequent six months. These included:

- formal education (e.g., in-services) for staff on various palliative care topics;
- development of palliative care policies and best practice guidelines;
- development of resources (e.g., reference material, equipment, space such as serenity rooms);
- development of volunteer program;
- development of palliative care teams; and
- encouraging other staff members to take CAPCE.

CAPCE learners as teachers

Across sessions, the majority of learners (ranging from 70 – 89%) indicated that they had shared learned information with their peers (See Figure 15). Overall, there was good consistency between the information learners intended to share and the information actually shared with peers. Shared information reflects areas of clinical relevance and new information of importance to learners. This sharing of information also highlights the CAPCE learners’ new role as Palliative Care Resource Professionals within their work setting. (The types of information shared across each session are presented in the evaluation reports for the individual sessions).



3.3.1 CAPCE Performance Objectives: Palliative Care Practice

Prior to and following their participation in CAPCE, learners were asked to rate the frequency with which they engaged in various palliative care activities that form the performance

objectives for CAPCE. To determine frequency of engaging in the performance objectives, learners were given the following response choices: “with none”, “with some”, “with almost all or all of my dying clients”. The following is a summary of the key findings that emerged from these data. A more detailed presentation of the results is located in Appendix C.

Use of Screening Tools

Learners’ frequency of use of the various screening tools prior to and following CAPCE is presented in Figures 16 to 23.

- Prior to and following CAPCE the majority of learners (at least 78%) were using screening tools with some, almost all, or all of their dying clients. The most frequently used screening tools were for:
 - pain and symptom management
 - end-of-life care/death management.
- There were no statistically significant differences in use of tools from pre-CAPCE to follow-up and use of screening tools did not vary by any of the demographic variables.

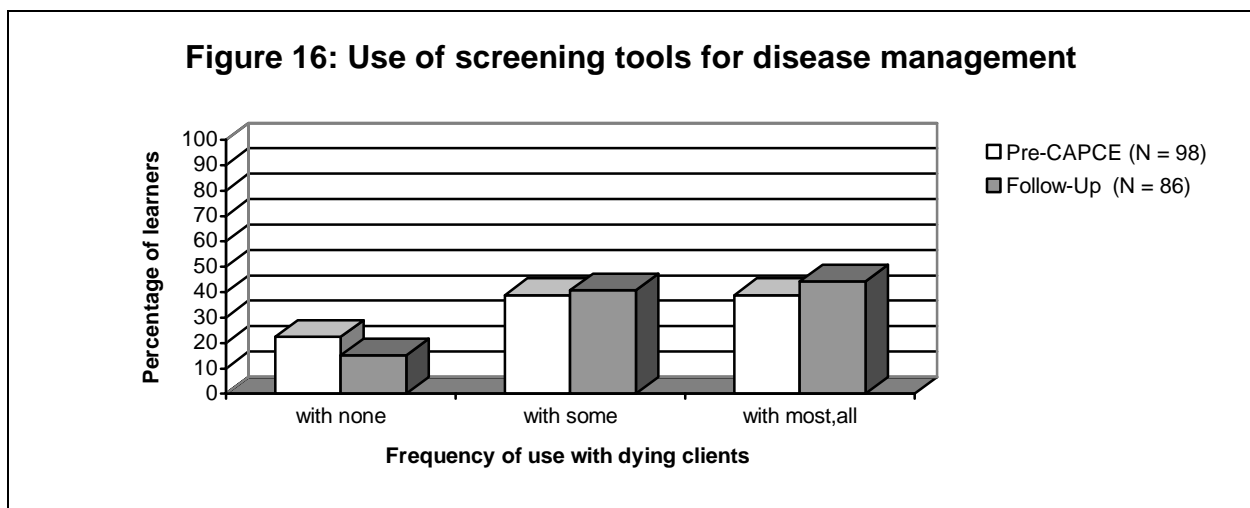


Figure 17: Use of screening tools for pain and symptom management

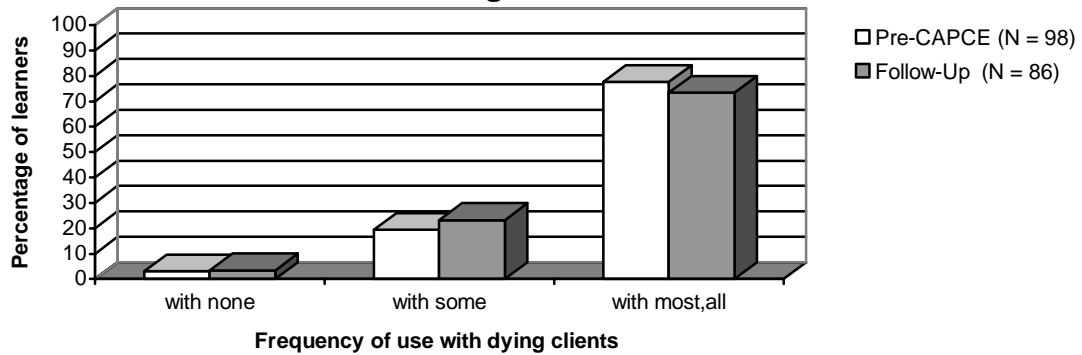


Figure 18: Use of screening tools for psychological symptoms

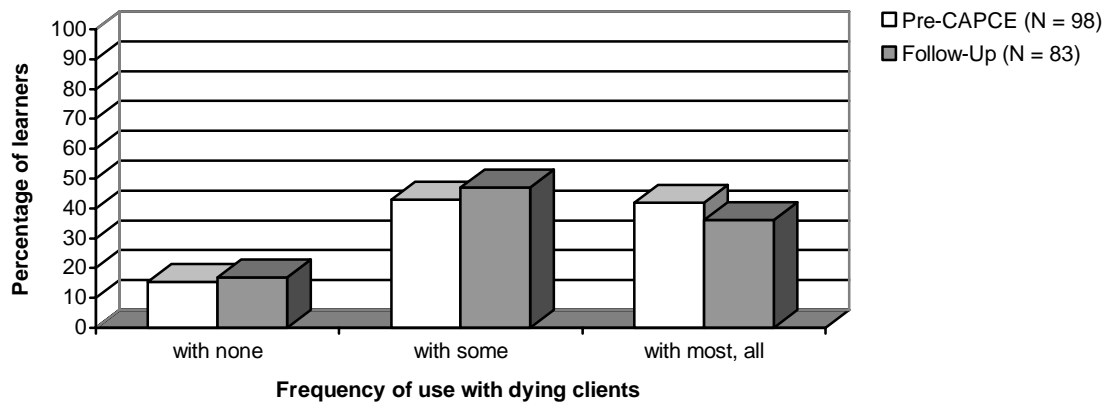


Figure 19: Use of screening tools for social issues

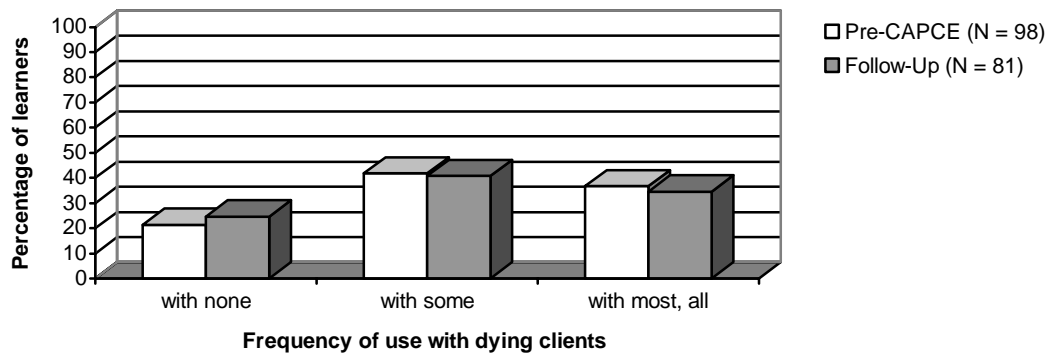


Figure 20: Use of screening tools for spiritual issues

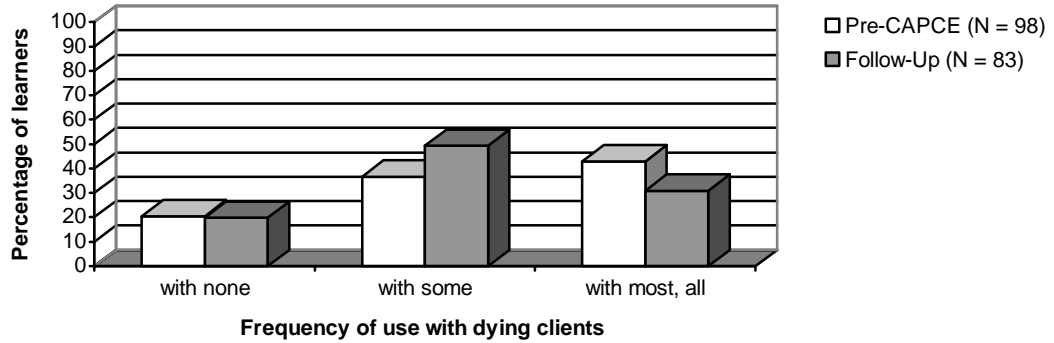


Figure 21: Use of screening tools for practical issues



Figure 22: Use of screening tools for end of life/death management

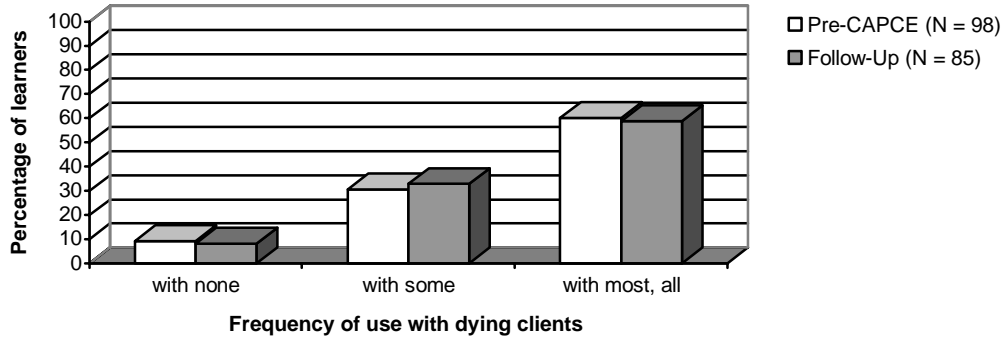
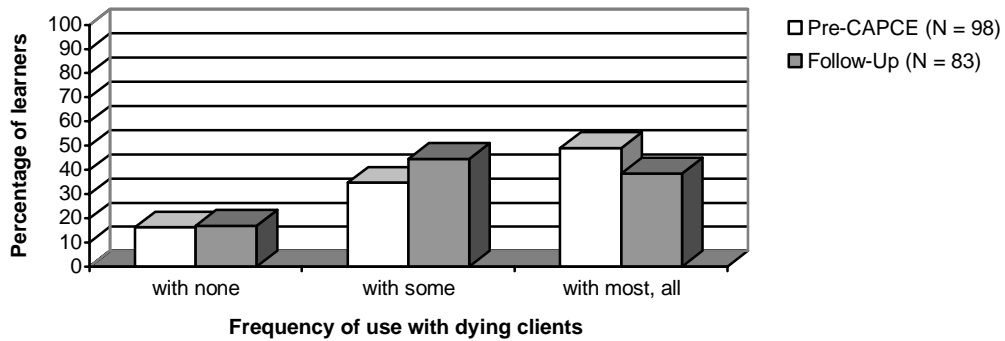


Figure 23: Use of screening tools for loss and grief



Completion of Assessments

Learners' frequency of completing assessments (according to the CAPCE performance objectives) prior to and following CAPCE is presented in Figures 24 to 26.

- Prior to and following CAPCE the majority of learners (at least 78%) completed assessments according to the CAPCE performance objectives with some, almost all, or all of their dying clients.
- There were several statistically significant differences in the completion of assessments from pre CAPCE to follow-up: learners were gathering detailed information about each identified issue and including information from physical history and test results with more of their clients prior to CAPCE than they did following CAPCE.
- The completion of assessments did not vary with any of the demographic variables.

Figure 24: Frequency of gathering detailed information

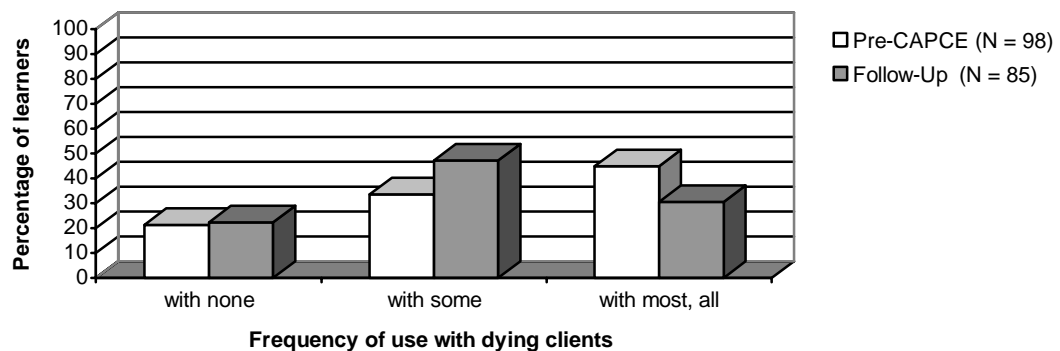


Figure 25: Use of appropriate assessment tools and scales

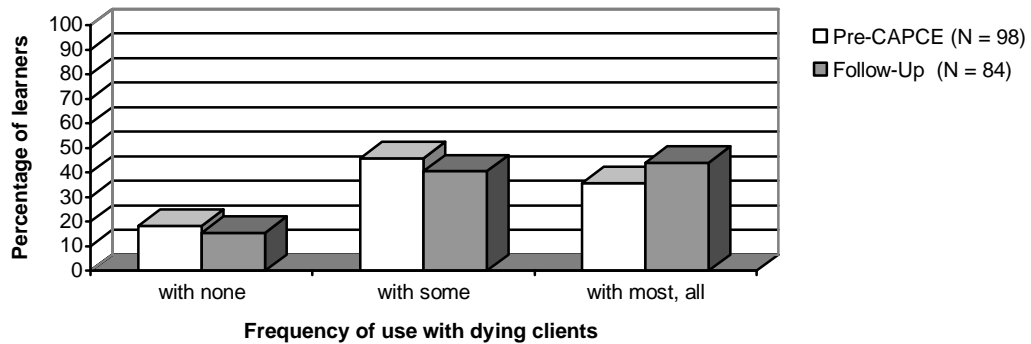
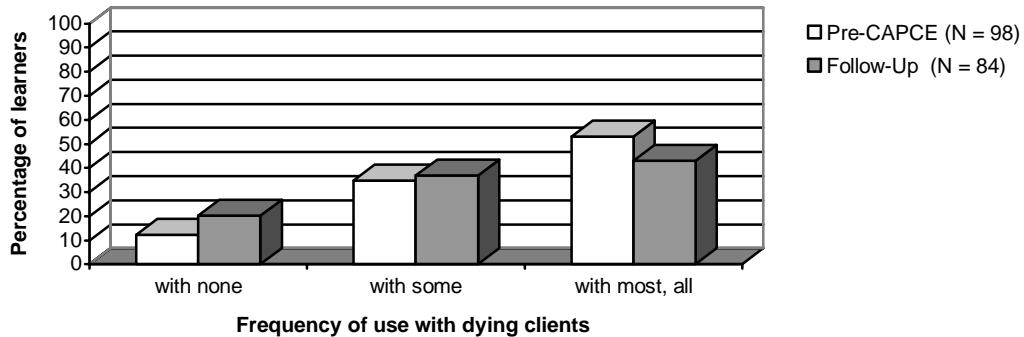


Figure 26: Use of information from history, examination, and diagnostic testing



Sharing Information

The frequency with which learners shared information to the extent that they followed the guidelines outlined in the CAPCE performance objectives is presented in Figures 27 to 34.

- Prior to and following CAPCE, the majority of learners (at least 84%) were sharing information according to the CAPCE objectives with some, almost all, or all of their dying clients.
- While the percentage of learners sharing information according to the CAPCE objectives was lower following CAPCE, the only statistically significant differences from pre to follow-up was for:
 - determining and documenting confidentiality limits;
 - determining and documenting the need for translation;

- observing and documenting physical and emotional reaction to information provided; and,
- determining and documenting the desire for additional information.
- Sharing information did not vary according to any of the demographic variables.

Figure 27: Determine, document, and respect confidentiality limits set by client

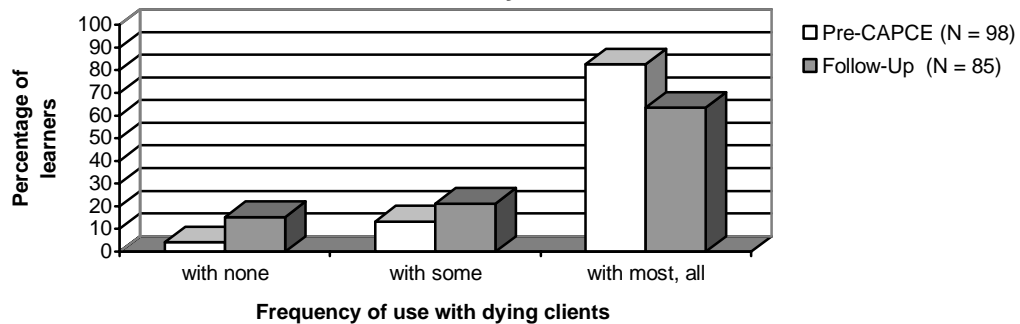


Figure 28: Determine what clients/family already know

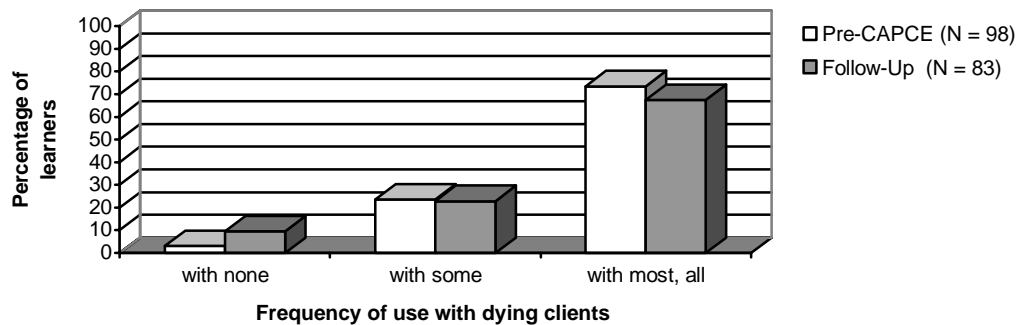


Figure 29: Assess and document client's desire and readiness for information

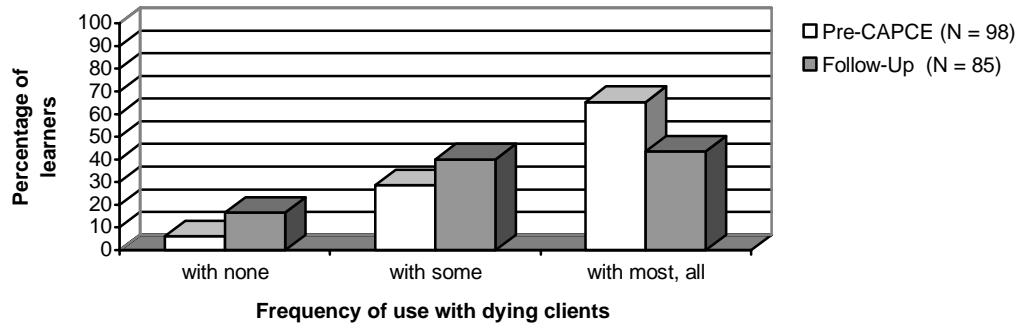


Figure 30: Develop and document plan for sharing information

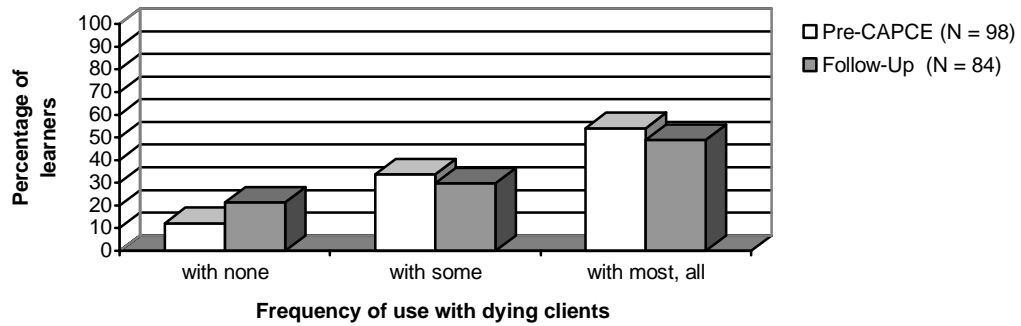


Figure 31: Determine and document need for translation

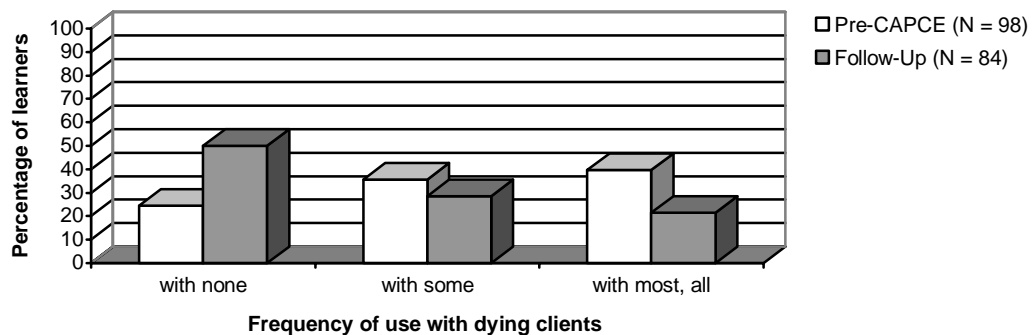


Figure 32: Observe and document physical and emotional reaction to information provided

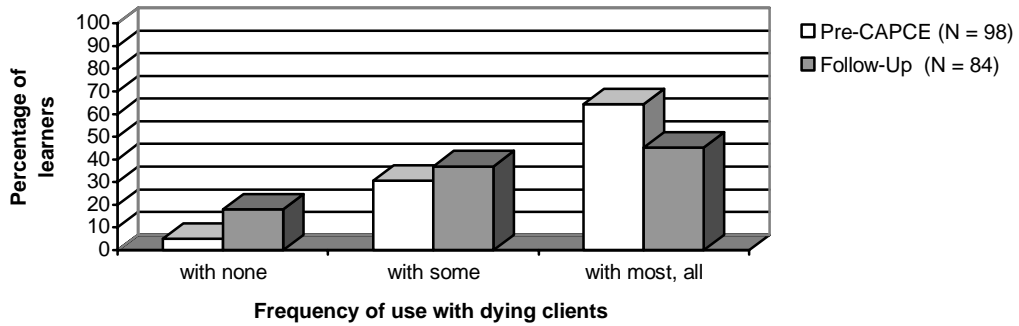


Figure 33: Assess understanding of information by requesting feedback

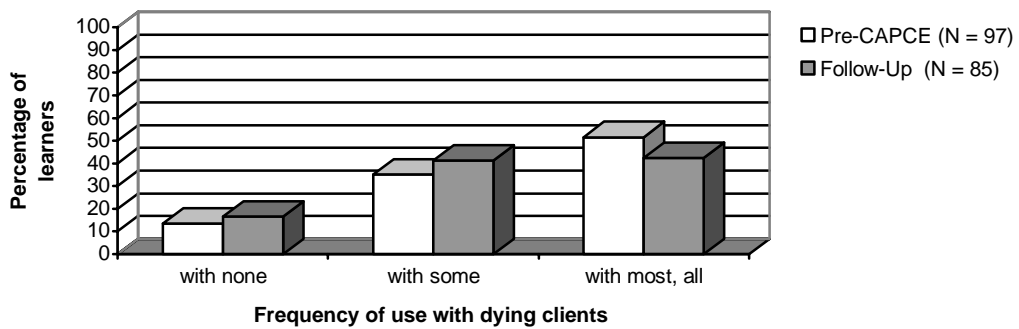
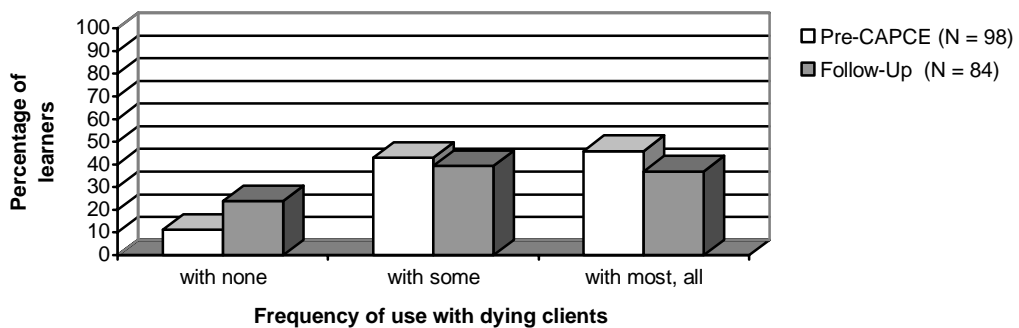


Figure 34: Determine and document desire for additional information



Decision-Making Process

The frequency with which learners assisted in the decision making process according to the guidelines outlined in the CAPCE performance objectives is presented in Figures 35 to 41.

- Prior to and following CAPCE the majority of learners (at least 60%) were assisting in the decision making process according to the CAPCE performance objectives with some, most, or all of their most of their dying clients.
- Generally, the frequency of assisting in the decision-making process according to CAPCE objectives was higher prior to CAPCE than following CAPCE. These differences were statistically significant for the following performance objectives:
 - Documenting that they client had given consent for treatment without coercion and with full understanding;
 - Assessing and documenting decision-making capacity;
 - Determining and documenting the substitute decision maker;
 - Discussing and documenting requests for withholding therapy or hastened death; and,
 - Developing a plan for conflict resolution.
- Assisting in the decision making process varied by percentage of time providing palliative care: Those who provided palliative care for more than 50% of their work time determined and documented the legal decision makers with more of their clients than those who provided palliative care for less than 50% of their work time.

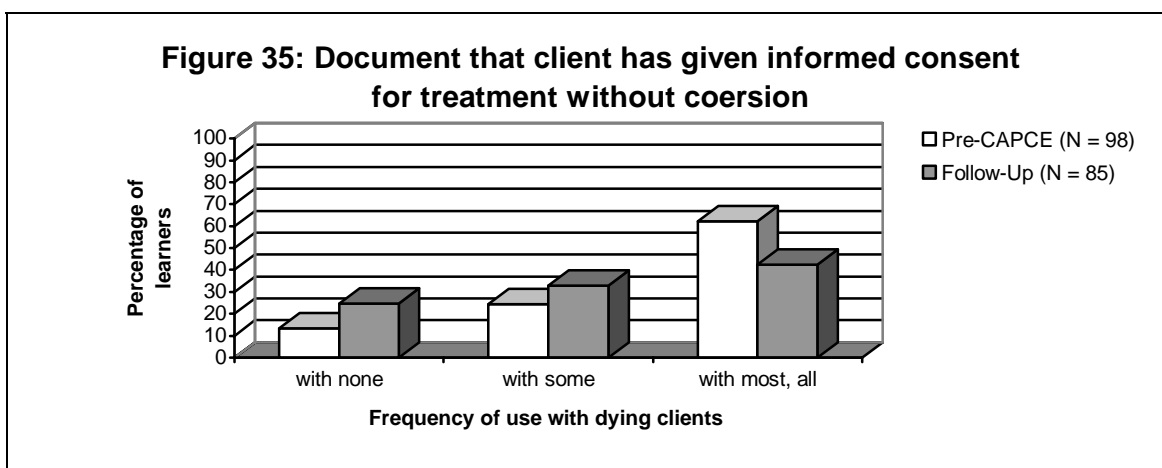


Figure 36: Assess and document decision-making capacity

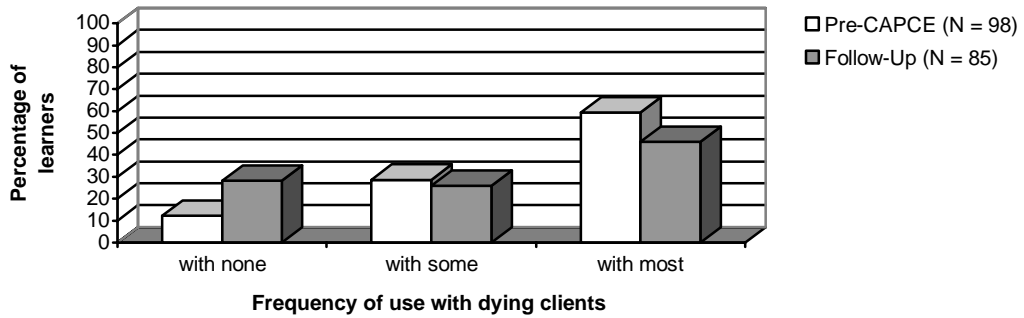


Figure 37: Determine and document the legal substitute decision-maker

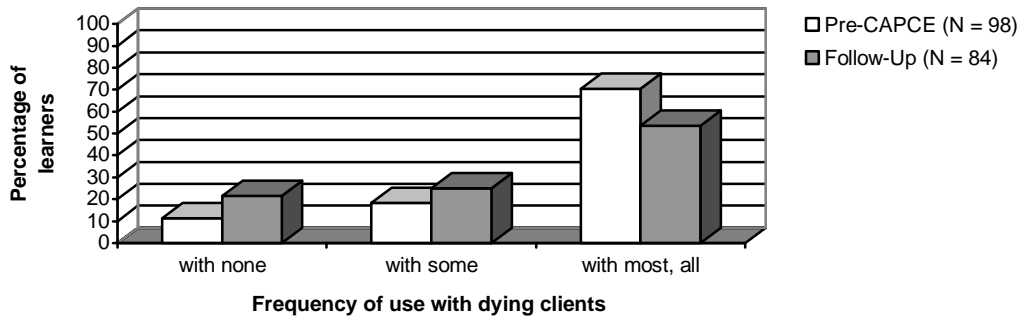


Figure 38: Determine who client wants to include in decision-making

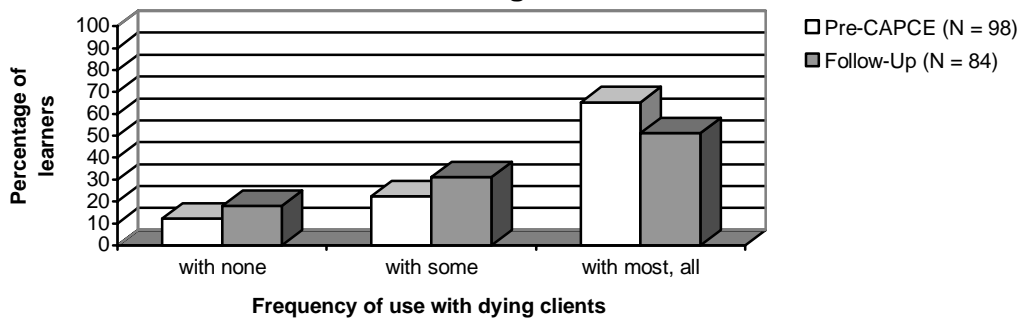


Figure 39: Discuss client's wishes and clarify/prioritize goals regularly

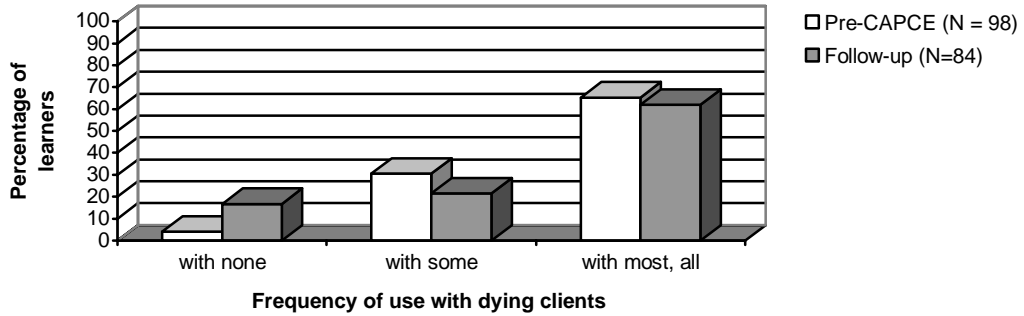


Figure 40: Discuss and document requests for withdrawing therapy or hastened death

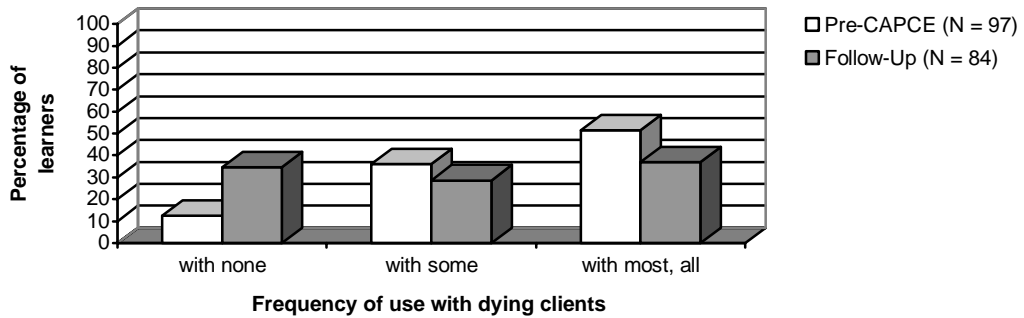
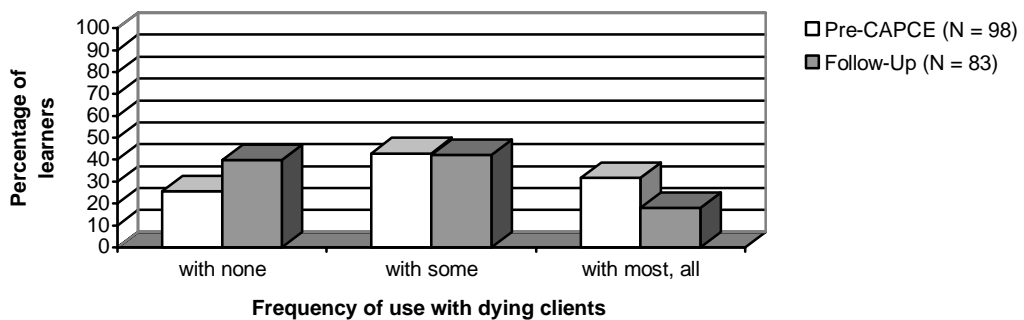


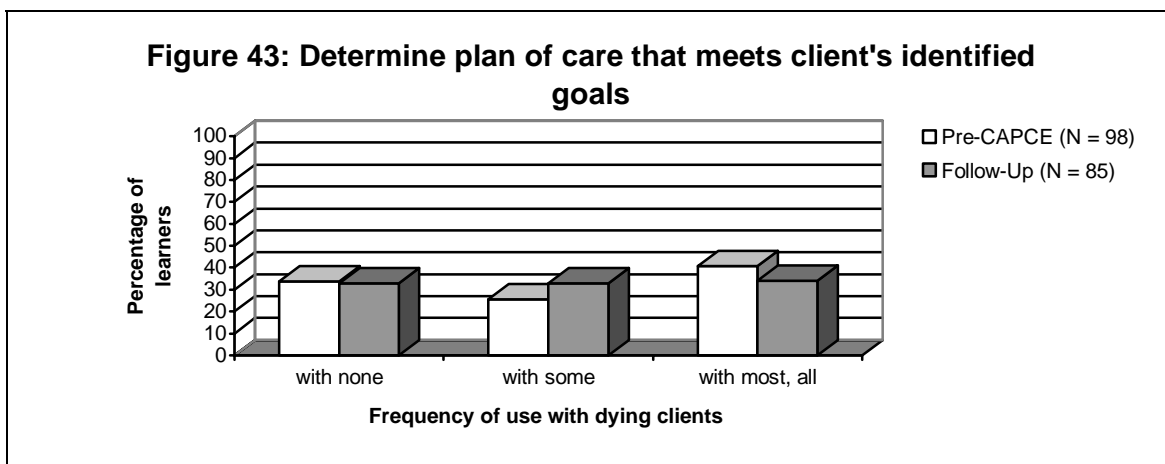
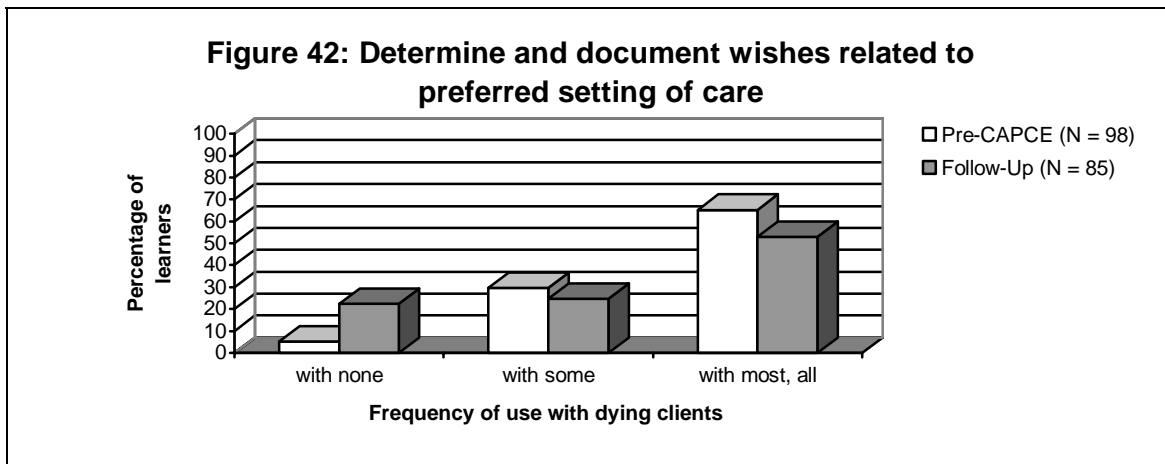
Figure 41: Develop a plan for conflict resolution when indicated

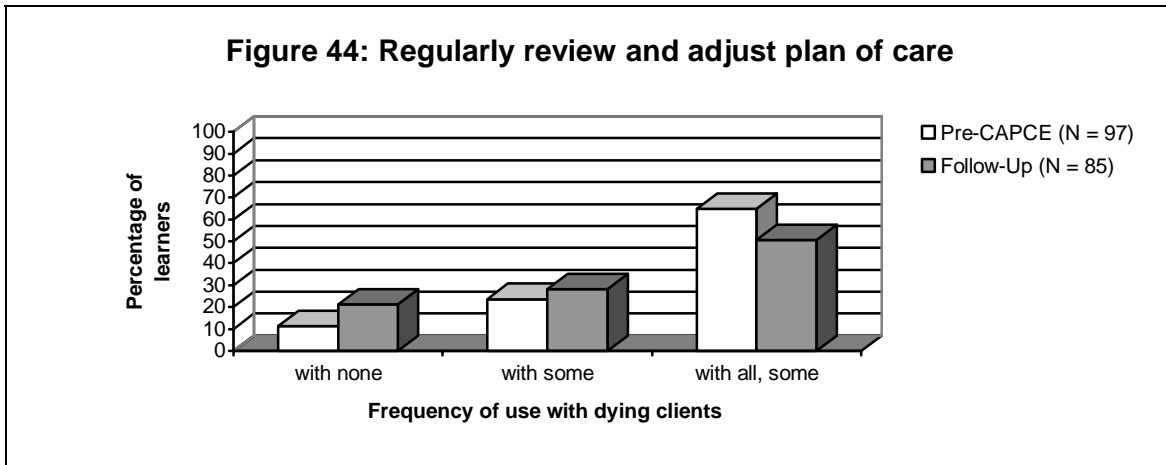


Care Planning

The frequency with which learners engaged in care planning to the extent that they followed the guidelines outlined in the CAPCE performance objectives is presented in Figures 42 to 44.

- Prior to and following CAPCE, the majority of learners (at least 66%) engaged in care planning according to CAPCE objectives with some to all of their dying clients.
- Generally, care planning according to CAPCE objectives was higher prior to CAPCE than following CAPCE. These differences were statistically significant for the following performance objectives:
 - Determining and documenting wishes related to preferred setting of care; and
 - Regularly reviewing and adjusting the plan of care to compensate for any changes.
- Care planning varied by workplace setting: those who worked in LTC regularly reviewed and adjusted the plan of care to compensate for any changes with more of their clients than those who worked in hospital or community settings.

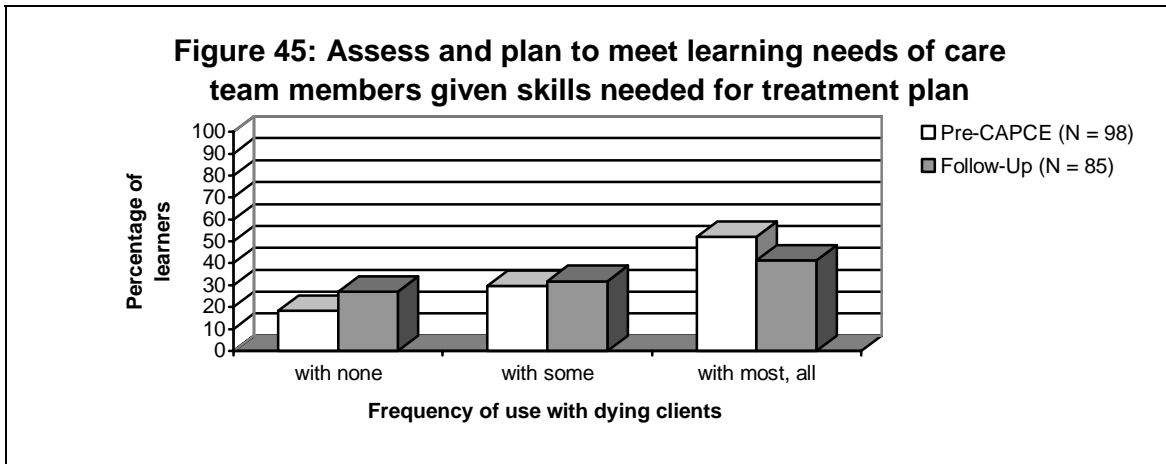


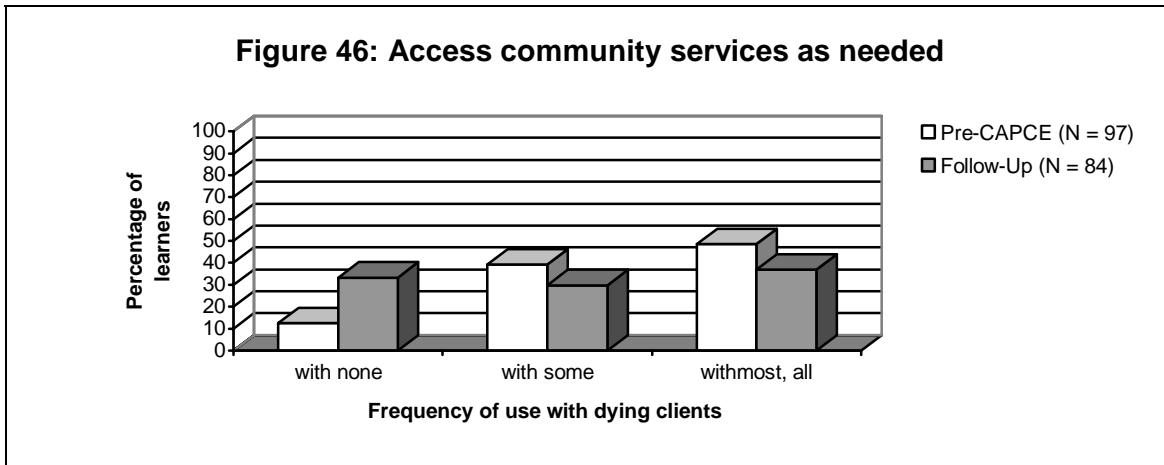


Care Delivery

The frequency with which learners engaged in care delivery to the extent that they followed the guidelines outlined in the CAPCE performance objectives is presented in Figures 45 to 46.

- Prior to and following CAPCE, the majority of learners (at least 67%) were engaged in care delivery according to the CAPCE objectives with some to all of their dying clients.
- The only statistically significant difference from pre CAPCE to follow-up was for accessing community services as needed: significantly fewer learners were doing this following CAPCE than before CAPCE.
- Care delivery did not vary with any of the demographic variables.





Confirming Understanding and Satisfaction with Treatment Plan

The frequency with which learners confirmed understanding and satisfaction with treatment plans to the extent that they followed the guidelines outlined in the CAPCE performance objectives is presented in Figures 47 to 49.

- Prior to and following CAPCE, the majority of learners (at least 81%) confirmed understanding and satisfaction in treatment plans and documented the effects of therapeutic intervention according to CAPCE objectives with some to all of their dying clients.
- Care planning according to CAPCE objectives was higher prior to CAPCE than following CAPCE.
- One of the performance objectives: documenting level of satisfaction with the plan of care and delivery of care, varied by discipline: RNs did this with more of their clients than RPNs.

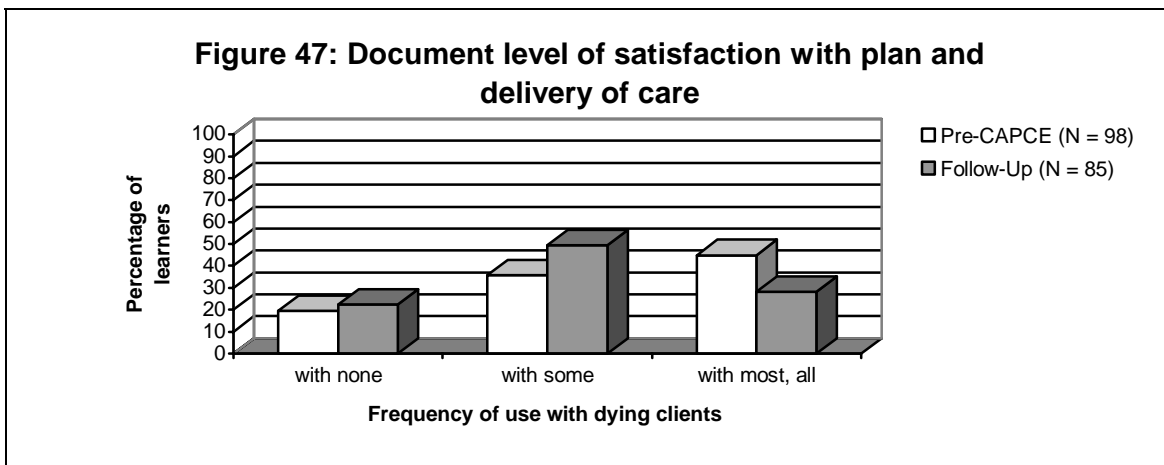


Figure 48: Determine and document concerns, questions, and issues raised about treatment

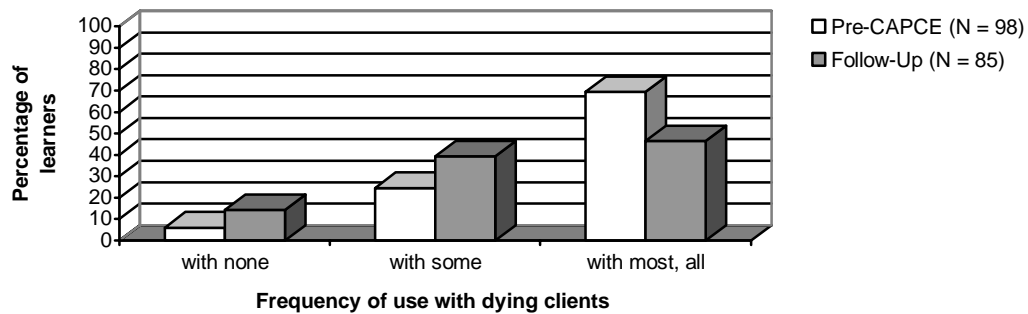
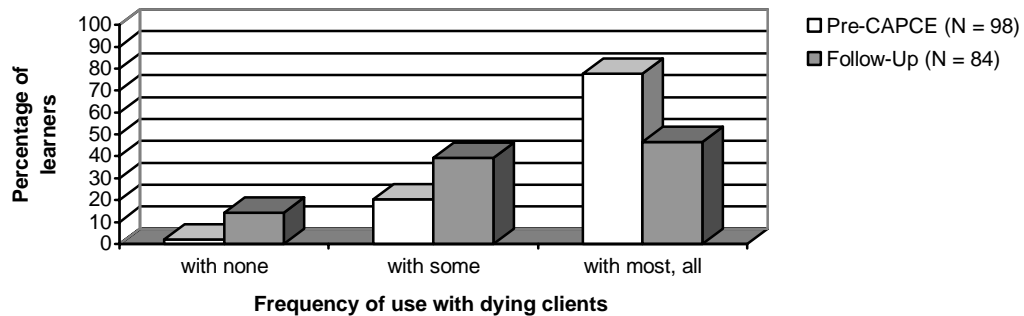


Figure 49: Document effects of therapeutic interventions and advocate for further interventions as necessary

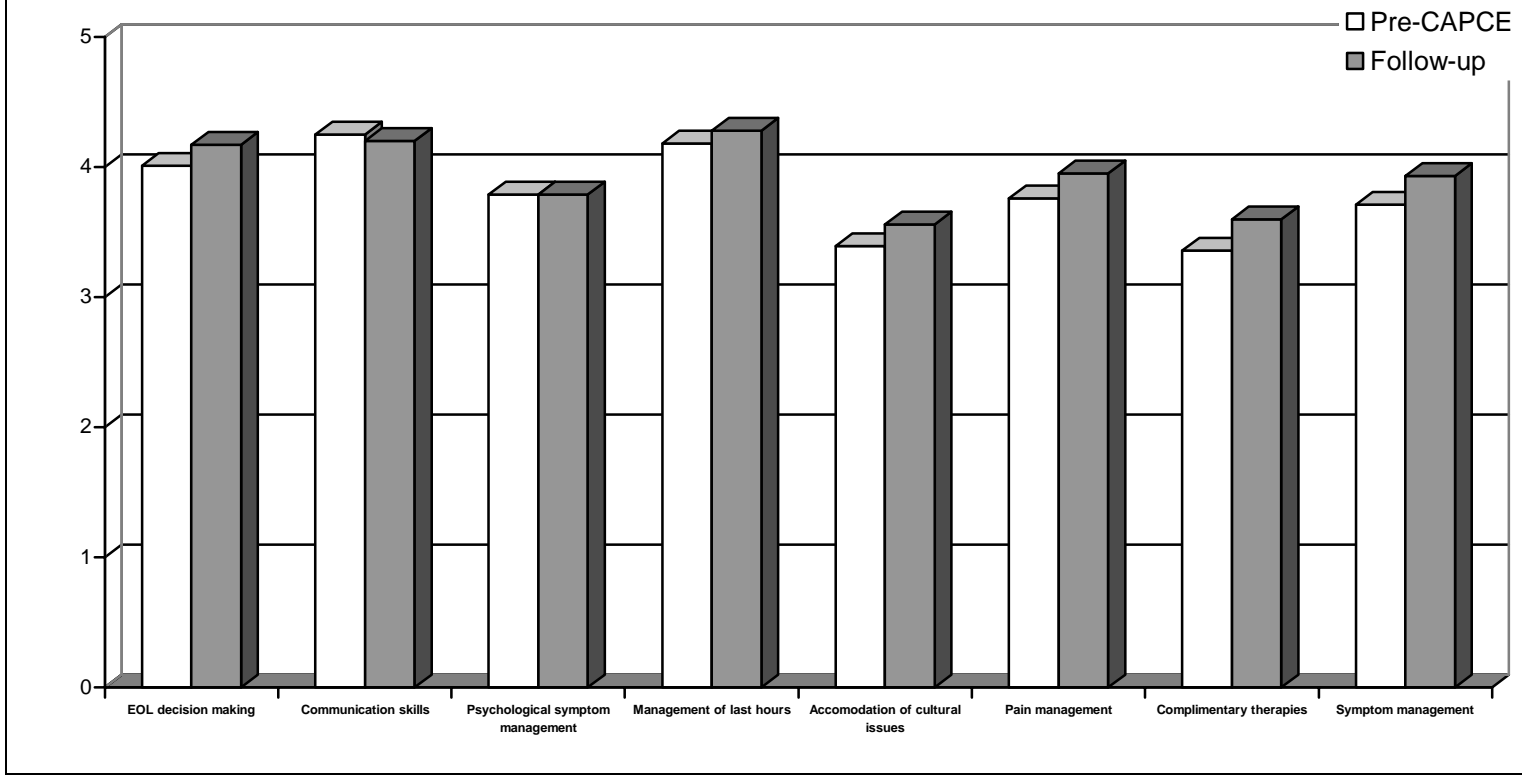


Self-Efficacy: Belief in their palliative care skills

Prior to CAPCE and at follow-up, learners were asked to rate their ability to implement or engage in a variety of palliative activities (1-5 scale; 1 = not at all capable; 5 = extremely capable (see Figure 50; Appendix C). Generally, prior to CAPCE and at follow-up, learners perceived themselves to be fairly capable of engaging in various palliative care activities, with most of the average ratings falling between 3.4 and 4.3. The lowest ratings were for ability to identify and accommodate cultural issues at end-of-life (pre mean = 3.39, sd = .96; follow-up mean = 3.56, sd = .78). The highest ratings were for management of last hours (pre mean = 4.18, sd = .86; follow-up mean = 4.28, sd = .68) and for communicating with dying clients (pre mean = 4.25, sd = .20; follow-up mean = 4.20, sd = .63). There was a significant increase in ratings of self-efficacy from pre-CAPCE to follow-up for the following activities:

- Pain management
- Use of complimentary therapies
- Symptom management

Figure 50: Learners' mean ratings of their ability to implement various palliative care activities prior to CAPCE and at follow-up.



3.4 KNOWLEDGE TRANSFER: IMPROVING PALLIATIVE CARE PRACTICE

After each session, learners were asked to reflect on what they had actually applied into their clinical practice from the previous session. Across the sessions, the majority of learners were able to apply new information following the session; knowledge transfer was highest after the December 8th session (communication; 88%) and lowest after the March 2nd session (grief and bereavement; 62%; See Figure 51).

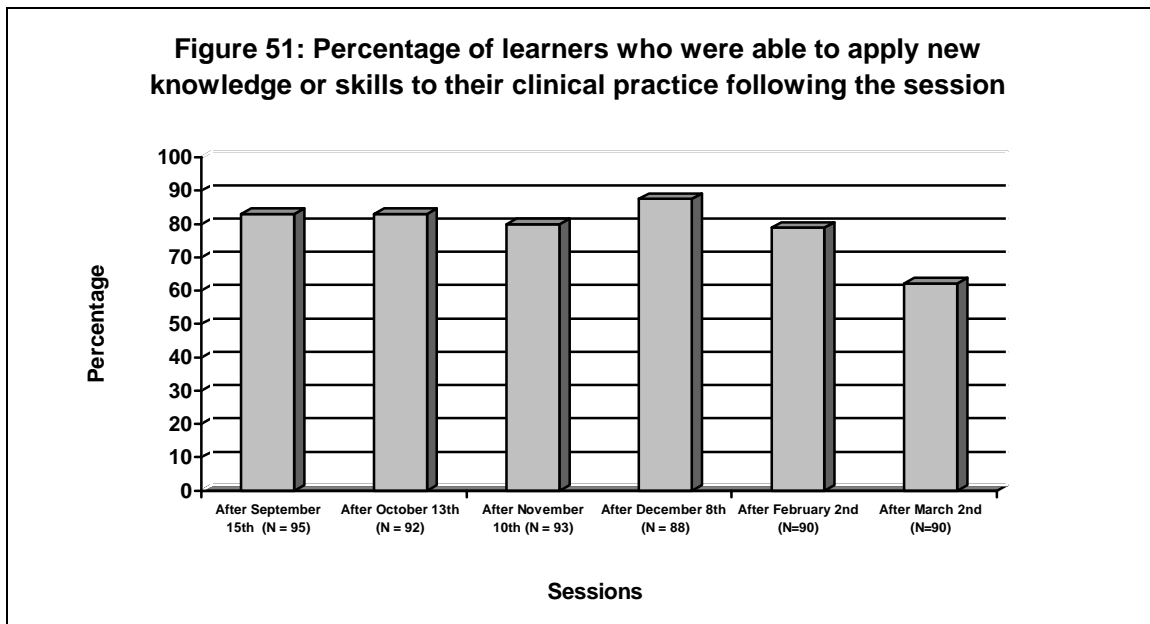


Table 17 shows the types of new information and skills learners applied from the sessions. Verbatim examples of applied knowledge and skills are presented in the evaluation reports for each of the individual sessions.

Table 17: Types of new information and skills learners applied from the sessions.

September 15 Norms of Practice & Pain Management	October 13 Pain Management	November 10 Symptom Management	December 8 Communication and Conflict Resolution	February 2 End-of-life	March 2 Grief and Bereavement
<p>Pain assessment (tools, 'total pain', thorough pain assessments, RNAO guidelines); Use pain assessment data to inform discussions with physicians; Encouraging positive work environments (avoiding downward spirals, positive support and reinforcement for staff); Use of the square of care in a therapeutic encounter; and, Use of medications for pain control.</p>	<p>Comprehensive pain assessment; Use of specific medications; Medication conversions; and, Use of new information to impact a change in the care of a client.</p>	<p>Pain assessment (tools, listening skills); Use pain assessment data to inform physicians; Use of the square of care in a therapeutic encounter; Pain and symptom management (drug therapies); Spiritual symptom assessment and management; and Psychological assessment: depression.</p>	<p>Effective listening ; Effective and timely conflict resolution; Communication with physicians; Role of non-verbal communication; and, Cultural differences.</p>	<p>Communicating with clients and families about: End-of-life care planning End-of-life decision making DNR wishes Development of resource material (e.g., EOL care package); and, Management of last hours, symptoms, pain.</p>	<p>Communication with clients and families: death and dying spiritual beliefs enhanced listening skills; Pain assessment and management; Education: staff, community agency; Development of a Pain and Symptom Management team; Development of end-of-life care resources; Creation of a comfortable environment for final hours; Grief counseling with families; reassurance and support; Identification of grief and tasks of mourning; Symptom management at end-of-life (e.g., secretions; and Utilizing the square of care.</p>

Early in the program and maintained throughout, there was evidence that learners were able to improve their palliative care practice:

“I did a Pain Assessment on an elderly lady who I mistakenly thought did not have pain, then she classified her pain as an 8. Management of her medications changed drastically for the better.” (October 13)

“I have been able to apply the PQRST U when assessing residents complaining about pain. It helps me direct the focus on the issue of pain but I recognize that more questions needed to be asked to get a complete picture of the pain” (October 13)

“When asking a client about pain, he answered no to pain, and discomfort, but yes to ache. In broadening my question, we were able to address what he was experiencing.” (October 13)

“A patient that I've had has been very hard to assess for pain for a number of different reasons, i.e.; cerebral palsy, language barrier, cultural barrier. His mother was a big help in sharing her knowledge with her pain assessment skills because she could read the subtle differences in his character. He would often tell us that he had "no pain, no hurt, no discomfort", etc. In utilizing her information and relating this back to his diagnoses I was able to make a suggestion to get him started on a long acting opioid and to possibly increase his decadron also to provide better pain control.” (November 10)

“I have been using the square of care as a guideline when assessing my residents so I remember to treat the whole person.” (November 10)

“I am now gathering more information and clarifying the patient's goals of care. Particularly I am doing with the community nurses when they call into Hospice with a report for the Palliative Physician.” (November 10)

“Taking the time to listen to a resident that had just been told he is dying. A family conference had recently been held, and he needed to talk about it. I sat with him, allowing him to verbalize and cry. He hadn't been able to talk with his family about it, and he really needed the opportunity to talk.” (December 8)

“A 68 year old lady dying of lung cancer had all her needs effectively met at the time of her death. She had optimal pain control and all personal matters in place. The therapeutic encounter helped meet all goals for the client in all aspects of her care.” (December 8)

“Physical assessment: I used the nausea scale which is new for me...I was able to assess symptoms and make recommendations for a client who suffered from nausea and vomiting. He also had a complete bowel obstruction which I was able to make recommendations for abdominal discomfort.” (December 8)

“Through different conversations with both family and patients I have found many aspects of the communication module valuable. As a wife was watching her husband die I was able to listen to her stories of their life together, about their combined families, and of different plans they had together. I was able to provide her comfort through listening, reflection and touch.” (February 2)

“I was given the opportunity to sit with a palliative patient who asked how Do I Say Goodbye to My Family and Grandchildren. By having just completed the communication module I was able to respond in a therapeutic way. It was beneficial to the patient and to myself.” (February 2)

“I have been able to listen better to a resident of French background and appreciate her culture and her values regarding her faith and her family. With this knowledge I was able to help the resident and the family make decisions for her care as she is now palliative. We were able to problem solve some issues and now the resident is at peace with the knowledge that her level of care during her last weeks/months will be just how she would like it to be: preserving her dignity and surrounded by her family and priest.” (February 2)

“I have been able to better educate clients and their families regarding decision making and care planning at end of life. Discussing advanced directives and answering questions is such an important part of what we do.” (March 2)

“I was able to talk to a teenager about the end of life with her mother. She seemed opened and knew what to expect with her. I gave her support and reinsurance and shared what info I had.” (March 3)

Throughout the program, some learners provided examples demonstrating their ability to act as palliative care resources in their work place and to affect a change in palliative care practice:

“Due to some of the information within the Sept. module and the homework done in preparation for the Oct. class, my colleagues at [long-term care facility] and I have looked at our pain assessment tool very seriously, used it several times recently and are looking at ways to improve it.” (October 13)

“I have familiarized myself with the Best Practice Guidelines on Pain Assessment; and have looked at the tools we are using in the 2 different counties in which I work.” (October 13)

“My colleagues who are taking the course and I have developed a pain assessment tool which will be developed into being part of our hospital's admitting assessment document.” (October 13).

“Have been able to sit with a patient to discuss pain and the management of pain. Also initiated a pain assessment and teaching my fellow co-workers about why it is necessary to do these assessments.” (November 10)

“I made a reference sheet for opioid calculations and conversions for my and the Doctors' use. I photocopied the Opioid Conversion Chart, Calculating BTD, and Simple Calculations from Equi-Analgesic-Dosing onto one sheet. The Calculations included the Technique and also work area at the bottom of the page” (November 10)

“Informal talks with co-workers regarding use of adjuvant medications and the fact that many of our patients are already on these drugs for other reasons.” (November 10)

“I had a resident that I suspected had a spinal cord compression. I taught my peers what the symptoms were for this oncological emergency.” (December 8)

“I am looking at the total patient care. When a nurse calls with a report I look at all elements of the patient care. In particular if I see a change in the patient e.g. PPS decreasing I will be enquiring about psychosocial issues, family issues and changes needed in symptom management. Also in team meeting as Team Leader I am challenging the other team members to look at other issues within the Therapeutic Encounter. In my orientation of a new staff nurse I am also challenging her to look beyond the surface.” (December 8)

“I had a resident who was dying this past weekend when I was working. I was able to use knowledge learned to educate HCAs and PSWs in understanding the final stages of dying. I felt more comfortable with the family as well.” (February 2)

“I have been able to provide front line nurses with resources with regards to Culture and Diversity, purchasing the manual Cultures and Religions for the S.D.C.'s.” (February 2)

“I often forget how as nurses we have to take care of each other. When I went back to work on Thursday talked about a long term resident who had died the night before. This de-briefing proved invaluable as several of the staff started to cry as they will miss this resident and how he touched our lives. In the future we will make a point of discussing our own reactions to a resident's death and what we learned from the experience.” (March 3)

“We have worked together to look at creating an End of Life care package” (March 3)

Factors facilitating learners' efforts to transfer new learning to their clinical practice

At follow-up, learners were provided with a list of 21 factors that have been identified in the literature as contributing to knowledge transfer and were asked to identify the factors that assisted them to apply what they had learned in CAPCE to their clinical practice. Table 18 presents the top 10 factors identified by learners. The factor endorsed most frequently was

the relevance of the CAPCE curriculum to learners' clinical practice. Also important to learning related to CAPCE was the fact that the learning was integrated into clinical practice. The importance of peer and management support was emphasized in the top ten list. Support was in form of consistent beliefs that palliative care is a clinical priority, their willingness to try new things, and management's display of interest in learners' goals and objectives for palliative care. Support from physicians, clients, and family members were also important to transfer of learning.

Table 18: The top ten factors identified by learners as assisting them to apply what they had learned in CAPCE to their clinical practice. (N = 86).

Rank Order	Factor	Number (%) of learners
1	CAPCE content was relevant to my practice	73 (84.9%)
2	Access to resource material (best practices, guidelines, assessment tools)	61 (70.9%)
3	My peers' belief in palliative care as a priority	58 (67.4%)
4	CAPCE learning was integrated into practice	57 (66.3%)
5	The willingness of my peers to try new things	55 (64.0%)
6	Management interest in my goals and objectives for palliative care	54 (62.8%)
7	Management belief in palliative care as a priority	52 (60.5%)
8	Support from clients and family members	47 (54.7%)
9	Palliative care policies and standards in place	44 (51.2%)
10	Physician support	43 (50.0%)

Factors (barriers) limiting learners' efforts to transfer new learning to their clinical practice

Similar to the list of facilitating factors, learners were provided with a list of 21 factors that could potentially limit their transfer of knowledge and were asked to identify the factors limited their knowledge transfer. Table 19 presents the top 10 barriers to knowledge transfer. Work and time pressures were identified as a barrier by 80% of the learners. Frequently appearing on the list is lack of organizational support from management and peers and physicians – in terms of unwillingness to provide the time needed for enhancing palliative care, lack of workplace goals for palliative care, lack of resources, unwillingness of peers to take on additional work tasks and their resistance to change, and lack of physician support. It is important to note that with the exception of the top two barriers identified, most of the identified barriers were endorsed by fewer than 35% of the learners.

Table 19: The top ten barriers to knowledge transfer (N = 86).

Rank Order	Factor	Number (%) of learners
1	Work and time pressures	69 (80.2%)
2	Lack of resources (staff, funding, space) to devote to palliative care	45 (52.3%)
3	Unwillingness of my peers to take on additional work tasks	30 (34.9%)
4	Insufficient authority to make changes	28 (32.6%)
5	Lack of physician support	27 (31.4%)
6	Unwillingness of management to give me the time needed to enhance palliative care	21 (24.4%)
7	Lack of clear organizational goals for palliative care	19 (22.1%)
8	Limited opportunities (i.e., cases) to practice palliative care	16 (18.6%)
9	Peer resistance to try new things or to change	15 (17.4%)
10	Lack of management support of my efforts clearly communicated with others in my workplace (e.g., praise, encouragement)	14 (16.3%)

3.5 WORKPLACE SUPPORT

Prior to registration, almost all (94%) of the learners discussed their participation in CAPCE with their administrative support. Most of these discussions centered on logistics (time, travel, staff coverage, cost; 76%); fewer learners discussed the organizations expectations for learner performance, support, and evaluation of learning (54%), and learner goals and expectations for CAPCE (59%).

At the time of the first session, most participants (67%) had reviewed the CAPCE performance objectives with their administrative support. Time constraints were listed most often as the reason why they did not review performance objectives with their administrative support. However, some learners indicated that it was not clear to them the extent to which their administrative support wanted to be involved. Similarly, some learners indicated that because their workplace has a CAPCE graduate, and presumably the administrative support is familiar with the objectives, it was not necessary for them to do this themselves.

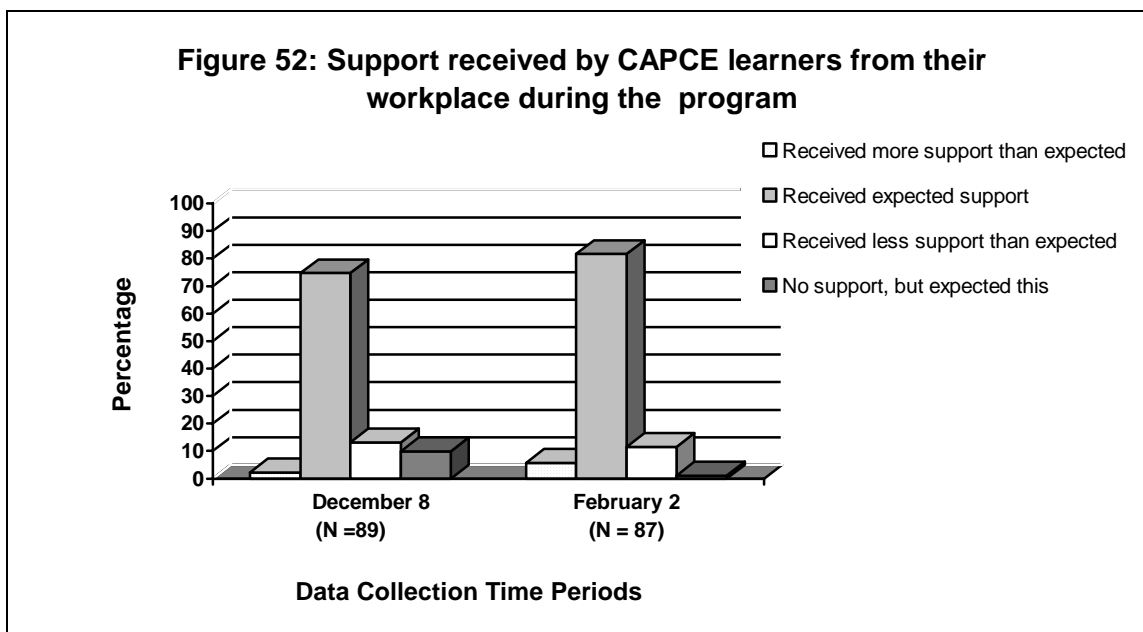
Table 20 presents the number (percentage) of learners who received various workplace resources to attend CAPCE. The majority of learners had organizations that were providing full support for staff coverage while learners attended sessions and access to computer resources. Fewer received financial support. Although most learners (86%) reported that they were limited to the resources listed in Table 20, some (15%) indicated that their organizations specified that they would provide other supports such as encouragement, study time, library resources, and support from CAPCE graduate.

Table 20: The number (%) of learners receiving full support to attend CAPCE (N=98)

Resources	Number (%)
Paid time away from work	42 (43.0%)
Staff coverage while attending sessions	77 (78.5%)
Financial support (e.g., registration fee, travel expenses)	52 (53.0%)
Access to computer resources	69 (70.4%)

Workplace support during CAPCE

Figures 52 and 53 present learner ratings of the amount of support they received from their workplace. Across the data collection time periods, the majority of learners reported that they had received the support that they had expected (See Figure 54); fewer learners received less support than expected. The amount of support they received throughout the program was rated as moderate (mean scores ranging from 3.1 - 3.5 on a 1 to 5 scale; See Figure 55), and was much less than the support they received for taking CAPCE (rated prior to starting the program).



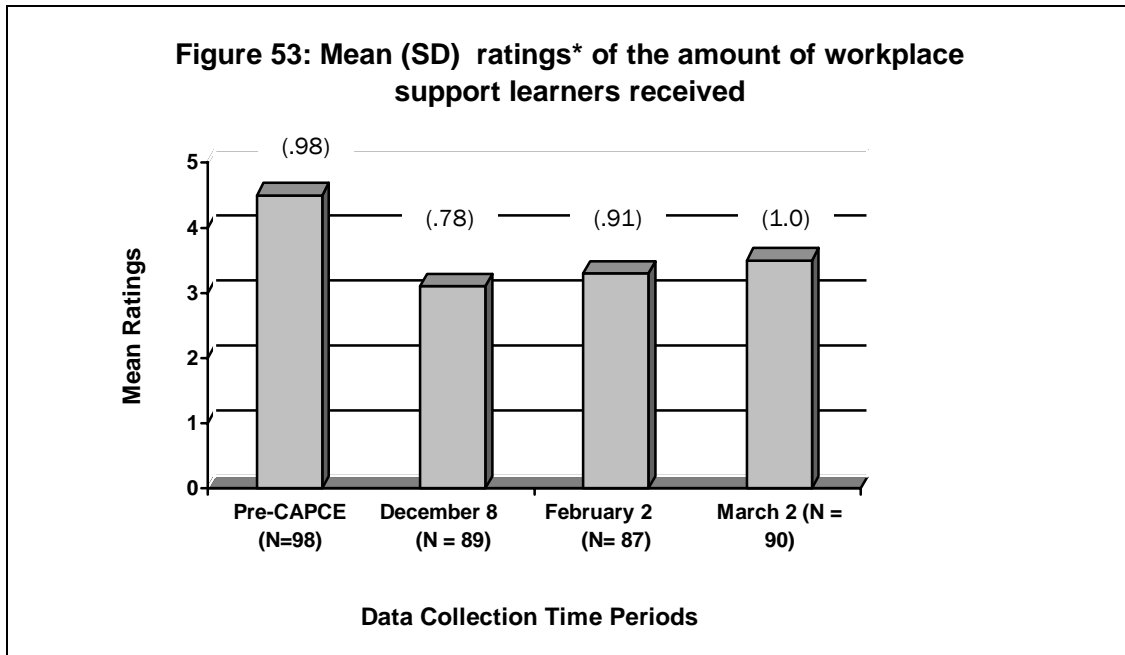


Table 21 presents learners ratings of the overall support they received from their workplace for their efforts to improve palliative care, as collected at follow-up. The mean rating reflected that overall support was “good –very good”. Fifty-two percent of learners provided ratings of “very good” or “excellent”.

Table 21: Learners’ ratings of the workplace support they have received to improve palliative care (N = 81).

	Poor	Fair	Good	Very Good	Excellent
Mean = 3.5 SD = .98	3 (3.7%)	9 (11.1%)	27 (33.3%)	32 (39.5%)	10 (12.3%)

One measure of organizational support for the PCR role is the incorporation of the role into the workplace job description. Table 22 presents the number of learners who have had the role incorporated into their job description. Forty-six percent of learners have the role incorporated into their job description (32%) or plan to do so within 6 months (14%).

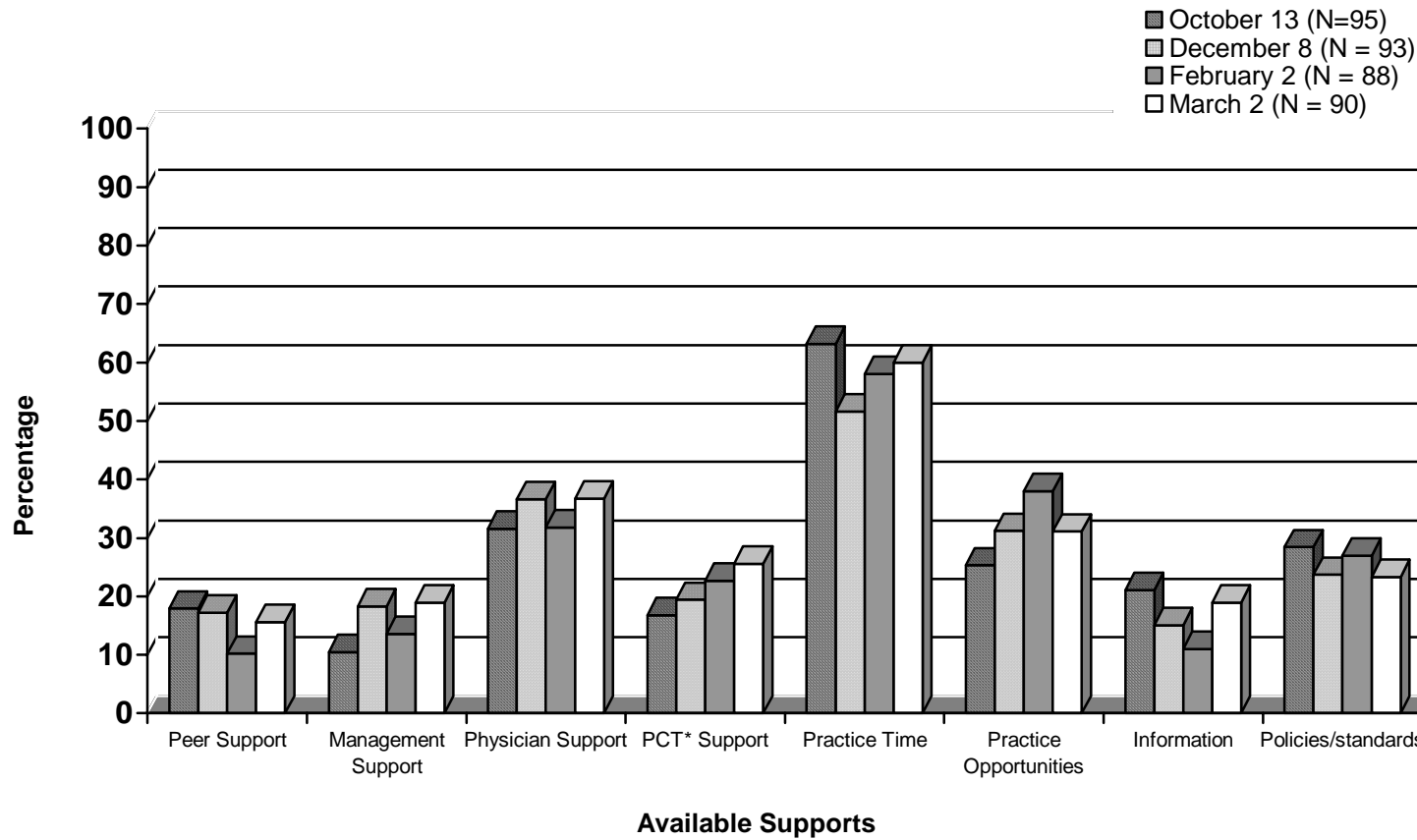
Table 22: Number (%) of learners who have had the Palliative Care Resource role incorporated into their job description. (N = 44).

	Number (%)
Yes	37 (31.8%)
No	46 (54.1%)
No, but plan to within 6 months	12 (14.1%)

Needed supports

Figure 54 presents learners reports of the supports they needed to improve their palliative care practice, but were not available to them as they progressed through the program. The majority of learners reported the need for more time to practice and implement new knowledge and skills (52%, 58%, and 60%, respectively, across the time periods). Physician support and practice opportunities were also needed supports identified by at least 25% of learners.

Figure 54: Percentage of learners identified the need for various supports to improve their palliative care practice as identified throughout the program.



* PCT = Palliative Care Team

4.0 Summary and Conclusions

4.1 KEY FINDINGS

The following are key findings related to the evaluation objectives.

1. Feedback on learner reactions to CAPCE:

- Overall, the sessions were well received by learners. The majority of learners rated the pace, volume of material, complexity and opportunities to participate in each session as “just right”. These ratings were consistent across the sessions. The majority of learners provided overall ratings of the sessions of “very good” or “excellent”.
- Learners perceived the CAPCE content material to be extremely relevant to their setting and practice.
- All learners (100%) reported that CAPCE met their needs for new information, skills, and resources, and almost all learners indicated that they would recommend the CAPCE program to others interested in improving their palliative care practice.
- Learners perceived the format of the sessions (regional and local sessions, formal and informal) as helpful, or valuable, to their learning and application of the CAPCE curriculum; the majority of learners giving these formats a range of ratings from ‘good’ to ‘excellent’. Their ratings indicated that they perceived the local sessions to be more useful than the regional sessions.
- Learners responded positively to the learning strategies used in the program, particularly the CAPCE resource material and homework assignment. Learners were less enthusiastic about role play activities, and internet based activities. Throughout the program learners responded positively to the steps of the therapeutic encounter and at follow-up the majority of learners continued to use them on a regular basis.
- There was a significant increase in learners’ usage of the internet and their comfort level with the internet from pre- to post-CAPCE. Comfort level with the internet increased with increased usage. Overall, the CAPCE website was considered to be user-friendly and the majority of learners rarely or never required assistance, either from the Webmaster or from peers, to access or use the on-line material. The majority of learners intended to continue to use the internet to access palliative care resources.
- Overall, learners responded positively to CAPCE educators and mentors, were satisfied with the level of support they received from their mentor and accessibility to their mentor, and perceived the mentoring process to be valuable to their ability to transfer knowledge to their clinical practice. Mentors were identified as a significant learning resource.

2. Knowledge Transfer: The Palliative Care Resource Role

- Throughout the program, the majority of learners described their opportunities to apply new knowledge and skills to their clinical practice. More learners were able apply new knowledge after the session on communication and conflict resolution, and fewer did so after the session on grief and bereavement.
- Early in the program and maintained throughout learners provided anecdotal evidence of their ability to improve their palliative care practice and demonstrated their ability to act as palliative care resources in their workplace to affect a change in palliative care practice.
- Learner's confidence in their ability to assume the PCR role was moderate, however, overall, they were more confident in their ability to provide palliative care than prior to CAPCE.
- At follow-up the majority of learners (78%) continued to serve as a PCR in their workplace. Many of those who did not act in the role, did not do so because there was already a PCR in their workplace. The majority of learners (60%) acted as a PCR in "some palliative care cases"; 36% in most or all cases. Many are sought out by peers for advice or suggestions related to palliative care.
- At follow-up, 52% of learners rated themselves as "quite" to "extremely" successful as a PCR. (The main rating across learners reflected their perception that they were "fairly" successful). The majority of learners (88%) indicated that the quality of palliative care in their workplace had improved in the past year.
- Key activities of the PCRs included:
 - education
 - staff: registered and non-regulated – all aspects of palliative care
 - family members – end-of-life, last hours, decision making
 - clients
 - pain and symptom management;
 - assessment (pain, symptoms, physical);
 - care planning, goal setting;
 - end-of-life planning; decision-making with families;
 - conflict resolution with family members;
 - medication reviews;
 - development of policies, guidelines, procedures;
 - development of palliative care committees/working groups; and
 - case conferencing (interdisciplinary and family)

- Knowledge transfer was enabled by the CAPCE curriculum (relevance to clinical practice and learning integration), peer support (belief in palliative care as a priority, willingness to try new things), and management support (interest in learners' goals and objectives for palliative care).
- Generally, the majority of learners reported they were providing palliative care according to the CAPCE performance objectives, prior to and following the CAPCE program. Although, there were only a few statistically significant differences in the performance objectives from pre CAPCE to follow-up, these were opposite to what would have been expected; at follow-up significantly fewer learners engaged in some of the palliative activities. This may be because they overestimated their palliative care practice prior to the program. Quality of care, not frequency of care, may have been the most significant practice change.
- Work and time pressures and lack of resources (staff, funding, space) were identified as key barriers to knowledge transfer.
- Lack of peer support/knowledge, lack of physician and administrative support, organizational issues (slow to change, changes, structured work routine, and lack of funding), and learner characteristics (e.g., poor communication skills, interpersonal skills) were identified by mentors as barriers to learning transfer. Within the mentorship sessions, mentors were able to resolve or to start a process for resolving these barriers for many of the learners.

4.2 COMPARISON WITH 2003-2004 CAPCE PROGRAM EVALUATION

In general, the findings of the evaluation of the 2004-05 CAPCE program were quite consistent with those of the 2003-04 program. Some key differences in the findings of the 2004-05 evaluation included:

- There were fewer negative comments about the use of the internet for evaluation and program activities and fewer learners required assistance from the webmaster or peers to access information.
- The number of learners who continued to serve as PCR was reduced, but this may be because its role already exists in their workplace.
- At follow-up the percentage of organizations that were in the process of revising their palliative care policies increased from 36% in 2004 to 56% in 2005.
- Management willingness to try new things was more significant as a facilitating factor in 2005 (ranked at #5) than in 2004 (ranked at #10), reflecting an increase in organizational support for changes to palliative care. Consistent with this, fewer learners (9%) identified lack of management interest in learner goals and objectives for palliative care as a significant barrier in 2005, in comparison to 2004 when it was the top ranked barrier identified by 73% of learners.

4.3 CONCLUSION

The 2004-05 CAPCE program was well-received and positively evaluated by learners. The curriculum, resource manual, and mentorship component contributed to knowledge transfer and were valued by learners. Early in the program learners provided evidence of their ability to act as Palliative Care Resource professionals in their workplace and for the majority of learners this role was sustained at follow-up. Learners were able to transfer new knowledge to their clinical practice, with positive impacts on client care and were able to increase the capacity of their peers and colleagues to provide optimal palliative care by providing formal and informal education opportunities and by developing workplace resources, guidelines, and policies for palliative care. Management and peer support for enhanced palliative care had a significant impact on learners' ability to optimize the resource role.

Acknowledgements

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The involvement of the CAPCE learners in this evaluation is especially appreciated. Their contribution of time and insight reflects their commitment improving palliative care in Southwestern Ontario.

Appendices

Appendix A 2004-2005 CAPCE Program

Appendix B CAPCE Advisory Committee Members – CAPCE Program Developers

Appendix C Follow-up Learner Assessment (Results)

Appendix D Learning Strategies Survey (Results)

Appendix A

Overview of the 2004-2005 CAPCE Program

Module	Date	Content	Location
1	September 15	Program overview and expectations The CAPCE Vision Leadership and the Resource Professional Introduction to the National Model: The Square of Care Domains of Issues and the Therapeutic Encounter Pain Assessment and Management Part A: Components of a Comprehensive Pain Assessment in the context of the Therapeutic Encounter	London
2	October 13	Pain Assessment and Management Part B: Pain Management in the context of the Therapeutic Encounter	In your local area
3	November 10	Physical, Psychological and Spiritual Symptom Assessment and Management in the context of the Therapeutic Encounter	In your local area
4	December 8	Communication and Culture	In your local area
	January 2005 And ongoing	Project Planning in Your Work Setting	
5	February 2	End of Life Decision Making and Conflict Management	In your local area
6	March 2	Grief, Bereavement and the Last Hours The Finale	London

Appendix B

CAPCE Advisory Committee Members – CAPCE Program Developers

Ann Brignell, Palliative Pain and Symptom Management Consultant/Educator, Sarnia-Lambton County

Debbie Burke, Palliative Pain and Symptom Management Consultant/Educator, Chatham-Kent County

Janice Cosgrove, Director, Complex Care Program, St. Joseph's Health Care - Parkwood Hospital, London

Denise Eppel, WebMaster Cabhru Solutions

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Carole Gill, Palliative Pain and Symptom Management Consultant/Educator, Windsor-Essex County

Diane Harris, Learning and Performance Consultant, Tillsonburg, Ontario

Nancy Keat, Palliative Pain and Symptom Management Consultant/Educator, London and Middlesex County

Marie Palmer, Palliative Pain and Symptom Management Consultant/Educator, Grey-Bruce County

Pat Shanahan, Program Consultant, SW Region Health Care Programs, Ministry of Health and Long-Term Care, London, Ontario

Ida Tigchelaar, Palliative Pain and Symptom Management Consultant/Educator, Oxford-Elgin County

Judy White, Palliative Pain and Symptom Management Consultant/Educator, Huron-Perth County

Appendix C

Follow-up Learner Assessment (Results)

PART I: Your Role as a Palliative Care Resource

1. In the past 3 months, how many clients in your clinical practice required palliative care? (N = 86)

None	3 (3.5%)
Less than 25% of the client population	46 (53.5%)
26% - 50% of the client population	20 (23.3%)
76%-99% of the client population	8 (9.3%)
All of the clients require palliative care (100%)	9 (10.5%)

2. Are you currently serving as a Palliative Care Resource in your workplace? (N = 86)

Yes: 67 (77.9%)

No: 19 (22.1%)

If no, why not?

I have changed workplace = 2

I have changed positions within my workplace = 1

My workplace is unable to support the Palliative Care Resource role = 1

My workplace does not recognize me as a Palliative Care Resource = 3

Other: 8 - many were because a previous CAPCE graduate was acting in the role.

If you answered No, you are now finished Part I. Please proceed to Part II: Palliative Care in Your Workplace.

3. How often are you involved in serving as a Palliative Care Resource within your workplace? (Please check one) (N = 67)

Never	3 (4.5%)
In some palliative care cases	40 (59.7%)
In most cases	19 (28.4%)
In all cases	5 (7.5%)

4. In the past 3 months, how many times did staff members ask for your advice or suggestions regarding palliative care issues? (Please check one) (N = 67)

Never/hardly ever	5 (7.5%)
About once or twice a month	37 (55.2%)
About once or twice a week	14 (20.9%)
Several times a week (3-5 times)	6 (9.0%)
Everyday	5 (7.5%)

5. When asked to function in your role as a Palliative Care Resource, what clinical activities are you involved in (e.g., assessment, care planning, pain and symptom management, conflict resolution, education to clients and family, etc)? Please list the most common palliative care (clinical) activities that you are involved with.

- education to clients and their families; providing them with information re management of symptoms near end of life, how to listen and observe body language.
- education of family members re. norms of dying process and what is actually happening care planning i.e. special mattress, mouth care turning reeducation of PSW's, holding meds and treatment at end stage and discussing this with family Doc.
- Education to clients' family and to non-regulated health care workers. Most common care is the education and some conflict resolution with family
- I am involved in all of the above but mostly it is the assessment and care planning. Conflict resolution is usually left to the DORC who is also a CAPCE person and likes to have first hand one to one with the families. Pain and symptom management is usually a combination of all the registered staff who deal with the resident. We confer and decide on what we think might work for the resident. We offer suggestions to the Doctor and he/she discusses options with us if able (time) and adjusts meds accordingly. Meds are further adjusted as needed and there is no problem with Doctors working with us.
- I do a lot of assessing and referrals for Hospice and PCCT. I also am involved with conflict resolutions amongst family dynamics and educate, educate, educate. I also help resolve problems with Dr's inadequate knowledge. I answer questions for staff and/or refer to other contacts.
- Education to families and support to co-workers and families
- As a palliative care resource person I am involved with all clinical activities. The most common assessment pain and symptom management with families.
- consulted re: pain and symptom management
- assessment
pain and symptom management
education
- Mostly education to clients and family, also pain and symptom management, assessments.
- As the temporary charge nurse I am involved in all of these aspects of care. I assess patients daily as to their needs and coordinate care with all disciplines. I conduct care conferences with patients and families on a formal and informal basis and am a primary resource for pt. /family education needs. I deal with the complexity of the patient/family dynamics as part of my role and act to resolve conflict.
- education to clients and families
- assessment, opioid suggestions, care planning, educate resident and family (always), and pain and symptom management. I've only had one end of life conflict, good outcome since acting as a palliative care resource person.
- Assessment, care planning, pain and symptom management, conflict resolution
- I was sent to our Ottawa Branch for 7 weeks and they have a Palliative Nursing contract. I assisted novice nurses on care planning, did conflict resolution with clients and case managers. Mentored nurses in the field about post chemo care. Evaluated technical skills and identified areas of training needed. It was very intense but the knowledge I acquired during this course was very helpful and valuable.
- I am involved with Pain assessments, some symptom management and education to staff and families

- pain and symptom management, conflict resolution education to families
- assessment, pain and symptom management, education to client and family
- As Palliative Care Coordinator for the Hospice Palliative Team as well as a liaison between the Palliative Physician and other community partners, I am involved in assessment by phone, or in person, care planning assisting service providers and my clinical team, pain and symptom management, conflict resolution between my agency and others as well as at time between staff, patient other and families. I provide education internally within my organization, service providers, patient and families as well as in a formal setting to PSW and volunteer trainees.
- Active participation with the pain and symptom management team within the hospital. This is a new team, so I have the privilege of getting it going in our hospital. There is much to do but we have a start! Will be doing a "lunch & learn" in the fall to educate staff of the team and its purpose and function in the hospital.
- assessment, care planning symptom management conflict resolution education. As I am the nurse manager I am involved in all aspects of palliative care.
- revising the End of Life Care Plan
- Most common would be assessment, care planning and symptom management, education to family.
- pain and symptom management
assessment
education
pain and symptom management
- *Assisting in setting up Palliative Education Rounds.*
Conflict Resolution.
Patient and family education.
Pain and symptom management.
- *assessment and care planning pain management education to staff patients and family*
- assessment and pain and symptom management
- Palliative Care Team
- Family education and symptom management
- assessment pain and symptom management
- Pain management issues with emphasis on related symptom management. Educating and supporting clients and their families. Medication review and monitoring compliance as prescribed.
- I will be more involved once this team is organized I have been asked to bring all info in to start a information center
- I am involved with every aspect of palliative care. the only thing I don't do is pick lines due to cno guidelines
- family education, offering suggestions to the family doctors i.e. meds
- -palliative care committee
-assessment, planning, education to staff
- care planning and conflict resolution
- assessment, care planning, pain and symptom management, education to family more than Res. but some encouragement to the Res.
- assessing residents-pain, suggesting things to DR, teaching staff to use assessment tools to monitor pain till it is controlled well.
- never asked just do it

- symptom management and explaining EDITH
- assessment
 - pain and symptom management
 - education to clients and family
- I would say that I am involved in pain and symptom management, conflict resolution, and education for pt and families.
- I do some assessments, initiate pain scale to see if medication that the person has been placed on is being effective and completing pain assessment tools. I also do some education with the families and participate in the palliative care meeting that is done monthly.
- pain and symptom management
- assessment and care planning and symptom management
- care planning, education mostly
- Mostly involved with pain & symptom mgmt. assessments, including developing recommendations for the physician for pain mgmt. interventions. I have also been working on developing new reference tools and education materials for my peers to assist them with assessment and care planning for our palliative residents.
- When I am involved as a palliative care resource I am involved in all of the above, but more often in the pain & symptom management aspect.
- I deal with conflict resolution and educate family and clients about palliative care. Completing the palliative care forms is key for information sharing. It is important to update the care plans to reflect the change in a persons health status.
- assessment, care planning , symptom management, education to families and clients, hands on care
- pain and symptom management seems to be the most involved area.
- -compose end of guidelines
 - palliative care task force member
 - palliative representative for community liaison/meetings
- education to clients and family.
- I am most involved with assessment, care planning and pain and symptom management. Almost in every case I spend time with the family members educating them on the s/s of death and dying and involving them in decisions and interactions with the resident.
- At present assessment and care planning and pain and symptom management.
- I am now the EOL case manager for [county] so am dealing with most of the EOL clients. The other case managers come to me to ask questions about their clients who may not be end stage – questions are about treatments, resources
- *I would think that most of the questions, both from staff and family, deal with comfort measures and specifically pain and symptom management. The binder is a good resource book for all to use.*
- *pain management*
- *implementing policies and procedures for registered staff to follow*
- *I have been involved in the assessment, care planning, and mostly pain and symptom management.*
- I'm involved in all the mentioned above. As the Charge Nurse on the unit I am involved in the interdisciplinary conferences family conferences and deal with staff and family concerns. *Assessment (what is the underlying cause and what is needed for this resident to make him/her more comfortable) and care planning (incl. calling the physician)*

Pain and symptom management (including consulting with physician and agreeing to best treatment)

Education of client (especially at first) and family (more time spend doing that often, as there are more people involved)

6. Have you been involved in teaching or mentoring other staff to enhance their palliative care skills? (Please check all that apply) (N = 86)

No	38 (44.2%)
Yes, I have developed educational/resource material	31 (36.0%)
Yes, I have conducted in-service or teaching sessions	19 (22.1%)
Yes, I have informally taught staff through teachable moments	31 (36.0%)

7. In the past six months, have you consulted with the following resource people regarding palliative care cases? (N = 86)

	<u>Yes</u>	<u>No</u>
Palliative Pain and Symptom Management Consultant?	40 (46.5%)	46 (53.5%)
CAPCE graduates?	37 (43.0%)	49 (57.8%)
Palliative Care Team members or palliative care specialists?	52 (60.5%)	34 (39.5%)
People in other disciplines (physician, dietician, pharmacist)	61 (70.9%)	25 (29.1%)
Other (please specify)	7 (8.1%)	
<i>“Also accessed the physiotherapist and social worker.”</i>		
<i>“CCAC Palliative Care Case Manager”</i>		
<i>“HCA and PSW for their input re: hands on care.”</i>		
<i>“Outreach team”</i>		
<i>“Physician and dietician”</i>		

8. Have you continued to use the process of providing care to help you to apply the essential steps during a therapeutic encounter? (N = 67)

Never/hardly ever	3 (4.5%)
Sometimes	13 (19.4%)
Most of the time	37 (55.2%)
All the time	14 (20.9%)

9. Please list two goals or visions that you have for palliative care in your workplace in the next six months.

Work Goals #1

- educate families about palliative care
- I will be changing my place of employment within the next month. I am in the process of seeking employment at the present time. My goal is to work solely in Palliative care within the community or on a palliative unit in a hospital.
- To be more proactive and keeping teams aware of palliative care and resources
- To have all staff nurses and physicians educated about palliative care what it means and how to care for these patients by meeting their needs etc and caring for their love ones.
- For all Registered staff to know who to consult and where to find CAPCE information.
- our doctors get more familiar with the drugs available for palliative.
- to have all staff in all departments in serviced about changes and expectations in palliative care.
- To be able to use a tool that we can use for pain assessment
- Continue to develop and support the role of the CAPCE trained nurse to provide a "CAPCE nursing visit" to all palliative care clients within 7 days of admission to our visiting program, as per CCAC EOL model.
- Family conference before resident dies.
- to have a standard care plan for just palliative care residents.
- This is hard. Our palliative care is quite well run. Most Staff (all domains) are interested in taking part in implementing and carrying out PC. I do plan to implement Palliative Care Conferencing although I foresee difficulties in including all disciplines.
- I would really like to increase my resource hours so I can be more helpful to my team members.
- Implement a pain assessment tool
- continue to provide excellent palliative care to the dying
- more education
- improved pain management
- Increased knowledge (regarding Pain Management) in non-registered staff (HCA's, dietary, housekeeping, adjuvants etc.) and therefore increased ability to recognize and report pain in residents to Registered Staff.
- To ensure all staff are better educated in palliative care, as we are moving into our new building soon, and all residents will have their own private rooms, therefore during the time they will require palliative care they will stay in their own room. At this time I take all palliative persons in my area, as my area has the only room that is deemed palliative room.
- To implement the nausea/vomiting assessment tool that we are devising as our improvement initiative
- to have a nausea and vomiting tool in place to be used on unit to better care for patients experiencing these problems which is based on best practice.
- To implement a nausea and vomiting assessment tool and care plan
- Start up a palliative care team in the fall.
- Start educating staff through in-services, Q&A, pay stub attachments, access to information, ETC>>

- To establish a palliative care team, with all members of the team receiving required palliative care training.
- To go out in the field with nurses who are caring for Palliative Care clients so I can review documentation /pain management.
- To ensure that our residents are comfortable and have adequate pain control
- With the assistance of other staff restart our Palliative Care Team
- KEPT enhancing info
- To provide on-going information for P.S.W.'s in an informal manner via a bulletin board. An in-service is scheduled for the early fall. (Inappropriate timing now due to other in-services, S.A.L.T training, and vacations).
- My first goal and expectation is the clinical team (Hospice SW and Nurses) provide Palliative and End of Life care based on the Square of Care. They are comfortable helping families with planning end of life care plans. At present Nursing does a great job at symptom management, but I am hoping they gain more skills at Care Planning for end of life with patients and families.
- Continue to work with the pain and symptom management team in providing better palliative care to clients and family. example (nurse's being able to pronounce expected death's, provide reading material for family and client's in regards to palliative care, educate staff on better pain management etc.)
- To implement soft sets for our palliative residents.
- Have clients be transferred to the palliative care team earlier
- Goal one is to address all pain issues involved with my palliative residents
- Palliative care protocol information book to be in full swing. Changes and updates to the Palliative Care Book to be continuously made until policies and procedures can be written
- to have VON staff take the CAPCE course. Three have agreed to apply
- Education/resource info board for residents/families/staff
- Staff education re symptom management
- team effort
- To participate in an interagency challenging case and to be able to advocate for the family/client utilizing my knowledge and experiences in palliative care.
- make each step of the palliative care process easier
- I would like our unit to make better use of the pps scoring
- I would like to see the palliative care that we provide our clients improve with regards to pain assessments and recommendations of medications, etc. With the new pain assessment tool that I developed, there should be a more consistent, comprehensive picture of every client's pain.
- New pain assessments for non-cognizant; New monitoring form; New pain policy
- I am currently in the process of developing a palliative care room for clients and their families. My goal is to provide the best care possible to decrease the anxieties of both family and the client.
- implement a new package for palliative and pain management for all of the nurses to use as a new tool
- Fundraising to be able to purchase different items to facilitate family and resident needs.
- -retrospective chart audit with Dr. to support budget submission for pediatric palliative care- looking at pain assessment, pain history, bereavement follow-up, services involved i.e.; social work, psych, dietitian, chaplain etc

- to establish palliative rounds.
- My first goal would be to ensure that all registered co-workers work closely to ensure that the palliative resident has care that has a smoother delivery where all staff follow the same basic steps and procedures in their care.
- Having another member of staff as CAPCE trained colleague
- that I have another case manager doing EOL case management along with me on a regular basis for back-up, coverage, emotional and physical support
- Education and Updates on Pain and Symptom management
- to have all CM's possess basic knowledge regarding pain and symptom management
- To have ALL staff to be more aware of all aspects of pain management.
- to review policies and procedures of palliative care and revise. Make a resource manual for all units for easy access for staff.
- That we work as a team the senior staff members help educate others
- Prepare a reference binder for community resources available to help us provide care. i.e. wigs, support groups, etc.
- update policies.
- Make the pain and symptom team more accessible
- all residents to have pain assessments done along with their quarterly profiles
- I am trying to get them to use a pain assessment tool.
- Improved/comprehensive pain assessments by registered nursing staff of all residents, including regular monitoring of the effectiveness of interventions.
- Ensure all staff are aware of the importance of symptom management and that they are implementing all interventions that promote relief from the pt's symptoms
- To teach nursing staff about the different aspects of pain and pain control.
- Continue to keep working towards providing good pain management.

Work Goals #2

- to improve communication with physicians
- utilize CAPCE resource binder to access information and share with peers.
- My long term goal is to set up a residential hospice in [my area]. I have connected with 3 other women with the same interests and we have started our plans within the community.
- To have more of my peers take CAPCE.
- To educate every family about end of life issues. The more information families have the less stressed they are.
- all staff are on the same page as far as what they do and don't do when caring for palliative patients.
- help establish new family rooms on each unit at work to have some place comfortable and private for families to spend time with their loved ones or each other.
- To educate and mentor staff in regards to pain and symptom management.
- encourage one nurse per team to train in the CAPCE program in the future
- Assist in our agencies program development as we revamp our Palliative Care program
- Doctors on board with stopping unnecessary med's and treatments.
- to have education awareness for family and non-regulated health care workers by either an information library at our facility or through in-services.
- The only other thing I can think of is to obtain a video that would explain to staff the process of dying, how the resident and family feel and how the caregiver responds.

- *I hope to plan further education and mentoring for staff especially for new staff members.*
- *Provide written information to families with palliative care services offered.*
- *continue with pain assessments/worksheets and continually reassess need for pain control changes*
- *more comfort among colleagues with palliative care, the dying, and their efforts to help*
- *active palliative care team*
 - to provide education and support to other staff*
 - to provide debriefing when a resident dies*
- *Sharing between registered staff regarding palliative residents and ways they (reg.staff) have been able to alleviate pain, anxiety and other symptoms.*
- *To ensure ALL families and residents better understand the palliative process, and grieving process.*
- *To encourage other staff to take part in advanced education and to develop a pain and symptom manual for our unit sharing some of the information that we have learned*
- *education for staff with a guideline review for pain and symptom management that staff can use to review.*
- *Pain management education and appropriate use of analgesia*
- *Be used as a Resource for palliative care when people have questions.*
- *pain free facility with symptom management and a solid, consistent, individualized action plan.*
- *To have nursing staff do a complete pain assessment and formulate a nursing diagnosis, and to follow up with physician's etc, to ensure that the appropriate med are being used. To have staff use our new documentation tools pain care plan, data and symptom flow assessment sheet, E.S.A.S and the P.P.S and use this info as team member.*
- *To evaluate nurses skill level in order to recommend training or provide internal training and mentoring to enhance their understanding of Palliative Care.*
- *I want to see that my coworkers are comfortable making decisions for symptom management in Palliative care*
- *That Pain Assessment tool be used to a greater extent.*
- *get a unit*
- *To work with a regular palliative care volunteer team. The team has not been visible or has fallen apart. I would like to contact these volunteers to see if our facility could re-establish a working relationship. In the past, the palliative care volunteers had a much more active role than now. I would like to discover what has happen and hopefully, invite these volunteers to join our team again.*
- *My next goals are that my Hospice Social workers gain knowledge and confidence in End of Life care with patient and caregivers. They anticipate problems and assist families. I am also hoping that they become more proficient and comfortable working with the Palliative Physician and clinical team, becoming models for others in Palliative care.*
- *To improve my own assessment skills by hopefully being able to work more directly with palliative client's and family.*
- *To teach all registered staff about soft sets*
- *Educate all staff on the End of Life Care Plan*
- *To assist my peers and co-workers in enhancing their involvement with palliative.*
- *Palliative Care monthly meetings with continue and more staff will get involved.*
- *to always use square of care and educate staff and physicians to use and understand the tools. This is ongoing as a member of the palliative care committee,*

- Update Palliative Care Policy
- Family education re grieving process
- maintenance
- To continue with ongoing interagency in-services that address pain and symptom management.
- implement new paperwork to allow staff a guideline to follow, give each staff member the chance to learn new skill strategies around palliative care
- Improving and increasing our knowledge in pain management
- I also hope that communication can improve between not only the nurses on the team, but the physicians, pharmacists, CAPCE nurses, and other disciplines. I would like to see more team meetings held with the clients and their families to review goals and evaluate outcomes.
- Establish serenity rooms on each unit
- One goal I hope to reach is to have a good, strong palliative care team!!!
- assist my fellow colleagues to use the new package and to collaborate the use so it is always being used
- Having regular scheduled meetings monthly to keep staff informed
- -complete end of life guidelines for [my hospital] and implement with the necessary/appropriate education
- -offer a second palliative care level 1 course at [my hospital]
- to use the resources available to us and learn others to use them.
- I want to continue to make the dying process less clinical as it can seem in an institution. I want to be able to ensure that there is time spent with the resident to deal with spiritual interests, I want to deal with more than just the physical and focus on being more in tune with interests and concern that the palliative person may wish to discuss or practice.
- Implementation of a County wide Interdisciplinary Palliative Care Team
- That I become more relaxed in my role as EOL case manager.
- Initiation of New Care plans from the previous CAPCE Grads.
- standardized use of pain/symptom management assessment tool
- To be more consistent with giving a Pain Level ac and pc analgesic intervention.
- Palliative team to have regular meetings and educate more staff re-pain control. All these goals will improve pain control and palliative care in the workplace.
- One of my visions is that we have more time to have the art of nursing back into our different settings once again. Instead of being so detached from life and death, the people we are to care for in their last days.
- Support the nurses presently providing palliative care, and assist others in feeling comfortable with palliative care, either through shared care visits, etc.
- Ensure staff perform complete pain assessments frequently on patient's
- to finish booklet on assessment with palliative care.
- Continue to educate peers.
- a greater involvement of staff with the palliative care team
- Assess constipation.
- Continued support for ongoing palliative care education of all staff to support better assessments, care planning and care delivery that will address the multidimensional needs of the dying person: physical, psychosocial and spiritual symptoms.

- To become more involved with primary care nurses from [local] regional cancer centre and London regional cancer program to better enhance the care of the patients that are admitted to this hospital that they have been also caring for.
- Educate the staff with the signs of pain in the confused residents and proper body positioning when lying in bed.

9a. As a Palliative Care Resource, what is your role in completing these goals and how do you plan to do this?

- to keep the info board updated and interesting using the web networking with palliative specialists researching upcoming conferences and speakers to keep our team aware of pain and symptom management
- ongoing liaison with families and have brought in CAPCE resource binder to have on my unit
- We have opened up the project to the community and are receiving much interest as a result. People are stepping forward with their skills and talents to assist in a various number of ways.
I plan to be the R.N. working at the hospice and will utilize my time with the next job I am seeking to net-work, and make connections with doctors, other nursing staff, reiki therapists, art therapists, etc.
- I am promoting the CAPCE program along with a fellow CAPCE graduate. I am taking the time to sit with Doctors and discuss the needs of these patients and making my self available for my peers to seek me for help by educating, teaching and showing them how to use the tools in palliative care and how to be effective in palliative care nursing. I am trying to be their mentor.
- Registered staff are made aware of the CAPCE program at registered staff meetings and on each unit. Educational material is made available to all staff. Teaching opportunities arise with each client (we usually have 3 - 4 deaths a month on our unit) we have put a brochure together to be given to family members as a teaching tool.
- for our project myself and one coworker are presenting end of life, so that all the staff can start to think the same way.
- I will be helping organize the in-service and what information needs to be presented.
- I have already given my ideas for paint and furniture to the administrator and talked with the auxiliary who are willing to donate money to get this project started.
- Have a deadline to give in-service regarding palliative care focusing on pain management.
- I will continue to actively participate in the EOL Model project and by attending all meetings and providing input to the feasibility of what our agency is able to offer.
I will continue to provide support to all my nurses by using teachable moments in team meetings, reviewing the tools that the nurses will see in their practice that are relatively new to them i.e.: PPS.
I will share information from the resources provided by CAPCE. For example, recently a nurse required information regarding spiritual needs/customs for someone from the B'nai faith. I was able to share information that was given to us at the local sessions.
- Discuss with team members and DOC and present at Medical rounds
- I can assist and offer my knowledge for the in-services as well assist in getting the library material from various sources.

- Palliative Care Conferencing will be outlined in a Policy my Facility will be adopting. It will be useful in identifying and dealing with conflict issues, end of life fears, and pain issues. The video may be obtained by asking Judy White if she has knowledge of any such material or anyone who might be able to procure same.
- I have already talked with my employer to increase my hours of resource but due to the almighty dollar it isn't feasible at this time.
- I will take the lead role in the two goals with most support rec'd from the physician and manager of the unit.
- talk to dr.; I put pain sheets in binder with tick sheets for HCA and teach them as needed how to do them
- In-services, lunch & learn, making myself available to them, informal discussions R/T clients, nurses' feelings, etc.
- -have created a pain screening tool
-working on up-dating policies and procedures related to pain management
-plan to revive palliative care team
- Follow-up on in-services (done on all 4 the floors) to find out if recognition and reporting of pain by non registered staff has improved.
Continue with Palliative Care meetings every other month with registered staff and encourage sharing experiences and success stories.
- My CAPCE partner at work and I have been working on an information bulletin for staff to go along with their pay stubs, informing staff of new ideas and trying to get all staff on the same page. Also, we have been working on a booklet for families and residents on the palliative process, an in-depth look at how the body works and what signs to look for at end of life, also the grieving process.
- Formal production of a N and V assessment tool and care plan.
- My role is to implement the team and inspire a vision for good care for all our co-workers. I am going to put my name on the bulletin board as the palliative care resource person for anyone who has any concerns or questions so that old and new staff will be made aware of who to contact.
- I plan to achieve these goals with the palliative care team, supporting disciplines, physicians, other staff and family. I feel my role would be the education.
- I am working with our management and the resource people we currently have in place to ensure that staff have opportunities to participate in Palliative Level 1 and C.A.P.C.E and A.P.C.E as able.
- Clients and staff are seen in the field on a regular basis. Managers are required to shadow nurses during their shift and visits. This allows the manager the opportunity to observe communication assessment and documentation. Based on my findings we will develop strategies to enhance the nurses palliative care skills.
- My role is to develop a teaching manual, in simple terms, so that my co-workers can refer to it when I am not around. I also will be providing in-services on pain and symptom management
- Share with other registered staff the background of the pain assessment tool and explain how to assess the resident with questions and observations. Until staff aware then maybe I could do the assessments on my shift
- keep pushing for it
- Continue to learn myself and pass on information to others. At our R.N. meetings, we can plan and strategize how to care plan for acute palliative cases and when to bring in other

disciplines for deteriorating conditions. This is a good venue to discuss the demise of the palliative care volunteer team and try to develop a liaison with the volunteers again.

- I see myself as a leader, guide, teacher and mentor. I also identify needs, provide or assist in providing education and mentorship.
- I see my role as developing, because the team is new, we are all learning together how we will make the team "work" probably will be better able answer in about 4 months.
- Have the policies and procedures passed at our PAC meeting.
Personally educate staff in the use of the soft sets.
- Work with the other staff involved and schedule education time
- Pain - I have introduced pain evaluation forms received at the CAPCE course and have reviewed with the DOC and fellow registered staff members.
We are currently researching the nausea/vomiting assessment tool and plan to trial it in the next few months. With that complete we will implement it along with an education component as to the different causes and treatments of nausea. I have encouraged 2 other staff to apply to CAPSE to increase the resource to our unit. We will also be working with [physician] to increase the staff knowledge re pain and symptom management through a written manual including some of the material we have learned.
- I plan to continue to write our home's Palliative Care book, present it to my co-workers and work with my DOC to write/rewrite policies and procedures as necessary.
- we have a palliative care committee to assist and follow through with goals. We are planning an education session in the fall.
- I have contacted many Societies and have already received pamphlets for info board.
Awaiting approval to buy supplies and build board.
Currently working on P.C. Policy
- My partner and I already finished two projects in this regard .Staff will receive palliative information attached to paycheck as a newsletter.
Families will have the opportunity to read booklet re grieving and symptom management in the "Tranquility room" where we are taking care of residents in their last hours.
- encourage by example
- This role would emphasize teaching of valid and reliable information as pertaining to palliative care and referencing to the CAPCE material as appropriate.
- offer guidance/ support to staff
ask for support
finish developing my CAPCE project
- pain and symptom management I am putting a teaching package together and placing on our hosp internet ed. site.
The use of the pps needs work; no plan yet.
- -use CAPCE knowledge and resources available
from CAPCE manual and website
- I have spoke to my co-workers about my pain assessment tool, and all that is involved with a comprehensive pain assessment. I also encouraged them to attend the RNAO best practice guidelines that Judy taught. I am glad that all of them have (or will), and three other nurses have applied to take the CAPCE course next year. So we can all support each other in these changes and obtaining these goals. Encouraging more team meetings will require some persistence when talking to other disciplines, and with some organization, time management, and close communication with the case managers, they should be carried out smoothly.

- Goal A: already done
Goal B: working on it
- I plan to seek out all the resources I have and put them into use. Our administrator is a very strong supporter of palliative care and is willing to provide us with time and monies needed to complete our palliative care room.
- we plan on having in-services and group sessions with my fellow colleagues
- Being a chairperson on the palliative care committee and encouraging all staff to become involved in this great and rewarding challenge.
- -EOL guidelines will go through palliative care task force and be presented by director to pediatric program committee for final approval then formatted as per hospital requirements-this is likely to involve several drafts and significant time
- On an ongoing basis.
- With my fellow CAPCE grads we have developed a checklist/careplan to deal primarily with Palliative Care Residents so that we all have the same approach and so that important aspects for care are addressed in a timely way.
- Advocating for CAPCE attendance as I'm able!
Participate in the planning process as to my level of responsibility.
- advocate for support in my role as EOL case manager as the position is re-evaluated
- Update fellow colleagues by voicemail with new information obtained by reading and experience with clients and physicians. Continuing to support and edit care plans as required.
- Somewhat like a cheer leader encouraging all staff to be more aware of reporting pain to Charge Nurse and making sure something is done about Res. individual pain.
- I plan to help chair meetings and encourage the team to meet regularly and reach our goals to improve the team and residents pain control.
- It's not going to happen as I do not believe that the older members of the staff even care anymore.
- Once the Palliative government guidelines are completed, assist my company in implementing them within our workplace
- Give an in-service to all staff on my unit in regards to pain and symptom management
- I plan to teach classes on the units for pain and symptom management and will try to access the staff at the regional cancer centers as much as I can and hopefully meet with them at meetings planned by our department.
- I plan on completing this by talking with staff individually and keep trying to get them on board.
- meet with administration once draft copy is made.
to provide a Palliative care guideline book for staff members to follow.
- Attempt to stay on top of new developments in palliative care. Use my manual when I need to refresh.
- the pain assessments have been implemented and in-service to educate staff re the importance of being part of a team
- to make people more aware, going to discuss these issues at ward meeting. Already got together with the clinician regarding these issues.
- My role will be to provide leadership and facilitate networking among colleagues. I have also been actively involved in providing informal & formal education sessions to my peers. A lot of my role at the PC resource nurse has been done informally through changes in my own practice which acts as an example to my colleagues.

- *I plan on working with my fellow CAPCE co-worker along with the support of my manager and manager of Clinical Practice and Physician on the unit .My co-worker and myself will develop the tools and have the above mentioned review them and provide us feedback. We will then put a program together to educate the staff.*

10. **Considering all that you learned from CAPCE about palliative care, what have you found most helpful, or useful, to your clinical practice? What did you learn that is working well for you and your clients?**

- *Using the Therapeutic Encounter keeps things more focused and in order. It helps with care planning when communicating with family and the team*
- *most helpful has been doing the pain assessments and assessing the type of pain the resident is experiencing*
- *Planning ahead. Having an understanding of what the patient/family want and developing goals around those wishes.*
- *The tools that we use in palliative care, assessment skills, drug calculations and what drugs are appropriate in pain and symptom management health teaching to patients and family. Oddly enough I have been more receptive to other disciplines assisting with palliative care, as it is no longer just a nursing issue. Our physician has been very receptive to any recommendations.*
- *understanding the meds better.*
- *that suctioning is not always appropriate for noisy secretions. To position residents on their sides & let gravity take over.*
- *I find the pain and symptom management very useful because I can work collaboratively with the physician. I am able to relate and suggest ideas regarding this issue.*
- *I feel better equipped to be a resource to the nursing working in our agency. I found every session with CAPCE useful. I feel I have improved my skills in conflict resolution. The CAPCE binder is a useful resource.*
- *Pathways of pain and how some things work well and others do not have the desired effect so it's ok to try something else*
- *Most helpful: To involve nok in process
Working well: To ensure that my client is understanding and aware of what is happening.*
- *The most profound was the last session with Judy White and grieving. There is no cut and dried response for what I learned apart from the fact that everybody must grieve in some way over every loss they experience. Being able to empathize with another person by feeling some degree of loss is vital to helping that person come to terms with his/her feelings. The entire session was very personal clinical reactions to death/grieving that I process. How I relate to another person in grief is directly related to my own feelings and Judy made that clear in her class. I hope to relay to other Staff that it is OK to show families and residents that you grieve with them. I also hope to demonstrate how we can support families and residents during their time of grief.*
- *I learned how important it is to take a little time to assess pain issues and to get them under control. Also I have learned that many doctors need increase knowledge on how to handle end of life issues.*
- *Conflict resolution skills are the most beneficial.*
- *pain assessments/worksheets working well in our facility; Dr. even looks at them and signs them.*

- *Pain management; Symptom management; last hours of care; advanced planning*
- *the material on pain & symptom management -particularly adjunctive therapies "palliative performance score" doing the pain management problems very helpful -I think I've got it now*
- *To have knowledge of different pain medications for different situations (am better able to discuss treatments with doctor) and to be able to recognize different symptoms in a palliative person and to be able to treat (or request permission to treat) this particular problem. This way I can alleviate suffering and increase resident's ability to communicate with loved ones and increase their quality of life.*
- *I would have to say , information sharing with the family, I feel more equipped and educated to explain the different processes, I have found families are stressed when they do not understand what is happening and why, as soon as they are well informed, they relax and feel better about the whole process and in turn the experience is much easier on the resident.*
- *The increased knowledge re pain and symptom management. I have more confidence that I can provide the care that my patients need and that if I don't have an answer I have a resource to guide me in providing that care.*
- *I found being able to access network resources I wasn't aware of extremely helpful. Also having Carole as a resource and not knowing I could utilize before.*
- *The reassurance of my abilities and the influence we can make in the workplace.*
- *I believe that it has been most helpful to understand the signs of end of life. I know we can't be completely accurate, but these seem to be the questions people always want answered, how long and what will it be like?*
- *Everything I learned has been extremely helpful but I think the most helpful is educating the families and feeling confident with ever word I speak.*
- *Info on the "Therapeutic Encounter" and the "Square of Care"- The info on the "Therapeutic Encounter" and the "Square of Care".*
- *To listen to communicate and teach effectively, to involve the family and be empathetic. To use the domains of issues and the therapeutic encounter.*
- *I definitely found the pain and symptom management sections very helpful as I work long-term care. I also found the square of care helpful as a tool to follow*
- *To observe and assess the resident to improve all care I must look at the "total" resident and all aspects of him or her.*
- *how to apply the knowledge*
- *Pain and symptom management. This clinical knowledge has helped me to use different assessment tools to identify and obtain medical intervention for patients. The knowledge base has provided the ability to approach doctors for discussion or requests for medication changes. Before, this was an intimidating task.*
- *All aspects of CAPCE have been helpful, the group sessions, the practice but the sharing at sessions were exceptionally helpful.*
- *To have an organized data sheet that can be presented to the physician in order to increase pain medication.*
- *Using the PPS with all staff and service providers*
- *I have learned that I must include the whole team to be most effective in my palliative approach. I make myself available to staff and family as required to assist them in better caring for our palliative residents. Doctors have been quite receptive to this approach.*

- *-increased knowledge about analgesics has been more helpful.*
- *-Palliative Care Meetings are working well.*
- *I am not sure how to put this in words but it is the concept and understanding the needs of the palliative client without being there first, to help and actually see that I have.*
- *End of Life meds; Proper use of narcotics for pain control; Resources available.*
- *The therapeutic encounter gives a comprehensive structure. Symptom management made me more knowledgeable. Families look up to the knowledge.*
- *square of care and to know there is support.*
- *Identifying the underlying cause of a symptom that was determined following a thorough assessment. As well as CAPCE material has proved to be an excellent reference.*
- *new communication skills*
knowing that you can not deal with the client until you deal with the pain
- *Pain and symptom management*
- *I definitely think the information regarding pain control, as well as symptom management is very beneficial. These things can be applied not only to palliative clients, but other clients as well. My pain assessment tool, created around the RNAO best practice guidelines seems to be working well. The clients are being asked the same questions by every nurse, and the format is easy to follow.*
- *use of resources helpful*
- *One of the best things I have learned from the CAPCE is the importance of communication. Only through good communication can health care providers convey their caring and empathy for the dying person and provide good quality end-of-life care.*
- *assessment, networking with the other members of the multidisciplinary team, increased knowledge*
- *I found that the therapeutic encounter is one of the greatest assets. This allows you to look at all domains of issue associated with illness and bereavement.*
- *-therapeutic counter-communication and listening skills-don't be afraid to ask-listening to what they're saying so you can hear what they're not saying.*
- *To use the resources available to you.*
- *I find that CAPCE has taught me more in-depth education in pain management that I have found most helpful. I also found that approaching doctors with requests for a change in meds very successful when I follow the steps I learned in the course.*
- *Always being open to the therapeutic encounter. Having the binder to go back to for reference for the WHO scale and other specific info.*
- *resources - where to go for information/ support*
assessment tools
advocating on behalf of my clients
- *The square of care is most helpful in my visiting nurse position.*
- *Knowing the medications that are most effective with the different types of pain and symptom related problems. This has been especially helpful with reviews of medication that my clients are on. In addition, I feel more skilled to make recommendations to hospital staff regarding symptom management. I also feel that I can communicate on an improved clinical level with the community nurses and have been able to problem solve with them for improved care.*
- *To be more open to all staff with their concerns re all aspects of Res. care. Also not to take myself too seriously, to be approachable to all staff to make them feel what they have to say*

is important (which it is). To make them part of the decision of what possible pain control might be used.

- Assessment of pain and to continue to assess till optimal pain control is met or resident's goals are met. I find using assessment tools and communicating to DR more effective.
- I have found how to ask the doctors for what I believe needs to be done for the residents and have had some success with it. I also have been able to advocate for comfort measures for the resident in their last hours, even going against my nursing manager.
- A lot more comfortable with symptom management
- The information given to us in regards to pain and symptom management have been most helpful. I learned that there is treatment for most symptoms that a pt is experiencing and most times they are successful.
- I found the pain and symptom management section of CAPCE the most interesting and I find that I can speak with the patients and families more confidently about this and also the physicians.
- Being able to complete a proper pain assessment and to complete pain scale with changes of the resident or medications.
- Palliative care meetings held last Tuesday of every month. It allows us to review any changes with a resident, and to assess his or her needs at this time e.g. pain medication, diet, or any other comfort measures. Always a follow up.
- All the different types of pain. One drug does not provide pain control for different pain causes.
- 1.pain assessments 2.the assessment process
- increased my listening skills, more open and comfortable talking about death, can handle conflict better without taking it personal
- I learned a lot about pain & symptom management – a very broad knowledge base and realized that my/our current practice could be greatly improved in terms of assessment and collaborative care planning using the "Therapeutic Encounter" process. The most helpful part of the CAPCE program has been the ongoing support, encouragement and inspiration received from my CAPCE mentor. I have greatly enhanced my knowledge of palliative & EOL care which has increased my confidence and competence in clinical nursing practice.
- The thing I found most helpful was the assessment tools we were given, I found I lacked a lot when it came to actually assessing a client and now I feel much more comfortable with the assessment because I have tools to guide me.

11. Overall, how successful do you think that you've been as a Palliative Care Resource in your workplace?

	1	2	3	4	5	6	7
	Not at all Successful	Minimally	Somewhat	Fairly	Quite	Very	Extremely Successful
N = 68							
Mean = 4.43	0	5 (7.4%)	9 (13.2%)	18 (26.8%)	25 (36.8%)	10 (14.7%)	1 (1.5%)
SD = 1.16							

12. Overall, how would you rate the CAPCE program in terms of how it prepared you for your role as a Palliative Care Resource?

N = 68	Poor	Fair	Good	Very Good	Excellent
Mean = 4.04 SD = .74	0	2 (2.9%)	18 (26.5%)	30 (44.1%)	18 (26.5%)

PART II: Palliative Care in Your Workplace

1. Has your role as a Palliative Care Resource been incorporated into your job description? (Please check one) (N=85)

Yes	27 (31.8%)
No	46 (54.1%)
Not yet, but there are plans to do this within the next 6 months	12 (14.1%)

2. What changes have occurred in your organization as a result of your efforts to improve palliative care? Please check all that apply.

	Yes	No	In progress
Revised or new policies or standards in place (N=77)	14 (18.2%)	20 (26.0%)	43 (55.8%)
New or revitalized palliative care work groups or committees (N=73)	22 (30.1%)	27 (37.0%)	24 (32.9%)
New or revised palliative care education (N=77)	21 (27.3%)	11 (14.3%)	45 (58.4%)
Palliative care related journal club (N=67)	1 (1.5%)	63 (94.0%)	3 (4.5%)
Palliative care related meetings or case conferencing (N=76)	32 (42.1%)	21 (27.6%)	23 (30.3%)

4. Overall, in the past year, do you think that the quality of palliative care in your workplace has: (Please check one) (N=85)

Deteriorated	1 (1.2%)
Stayed the same	9 (10.6%)
Improved	75 (88.2%)

5. We are interested in learning more about the things that help to facilitate the transfer of continuing education learning to clinical practice so that we can develop strategies to assist learners and their organizations to adopt new information, skills, and care approaches. In your

workplace, what are the main factors that have assisted you to apply what you learned in CAPCE to your clinical practice? Please check all that apply. (N=86)

Number (%)	Facilitating Factors
73 (84.9%)	CAPCE content was relevant to my practice
61 (70.9%)	Access to resource material (best practices, guidelines, assessment tools)
58 (67.4%)	My peers' belief in palliative care as a priority
57 (66.3%)	CAPCE learning was integrated into practice
55 (64.0%)	The willingness of my peers to try new things
54 (62.8%)	Management interest in my goals and objectives for palliative care
52 (60.5%)	Management belief in palliative care as a priority
47 (54.7%)	Support from clients and family members
44 (51.2%)	Palliative care policies and standards in place
43 (50.0%)	Physician support
41 (47.7%)	Management willingness to allow me to do new things
41 (47.7%)	Sufficient opportunities (i.e., cases) to apply learned information and skills
38 (44.2%)	My peers' acceptance of my use of time to enhance palliative care
35 (40.7%)	Management support of my efforts clearly communicated with others in my workplace (e.g., praise, encouragement)
26 (30.2%)	Clear organizational goals for palliative care
25 (29.1%)	Sufficient resources (staff, funding, space) to devote to palliative care
24 (27.9%)	Sufficient time to apply learned information and skills
22 (25.6%)	Management willingness to give me the time needed to enhance palliative care
21 (24.4%)	The willingness of my peers to take on additional work tasks
21 (24.4%)	Sufficient authority to make changes
17 (19.8%)	Management support of my efforts when things don't work out as planned
	Other, please specify:
	<ul style="list-style-type: none"> • <i>My enthusiasm and support from our Palliative Care Manager.</i> • <i>Director of Nursing recognizes that staff members have completed CAPCE course and acknowledges that we will be making suggestions as situations arise.</i> • <i>While several of the staff of CAPCE trained, our facility is severely short staffed. The knowledge base has helped in pain and symptom management and comfort at end of life. I have also learned how to better approach physicians and family at this time of</i> • <i>other staff members taking the CAPCE program at the same time</i> • <i>palliative care is on the education agenda for our annual education days.</i> • <i>My biggest support has been the fact that 3 other RN's have the same course and know what I am talking about and support me when a change is needed.</i> • <i>Our DOC is in the process of implementing new pain assessment tools. She is very open to suggestions of any information I have learned from the CAPCE course. My fellow staff have also begun to listen and ask for my opinions. I have my huge binder of info</i> •

7. In your workplace, what are the main factors that have limited your ability to apply what you learned in CAPCE to your clinical practice? Please check all that apply. (N = 86)

Number (%)	Limiting Factors
69 (80.2%)	Work and time pressures
45 (52.3%)	Lack of resources (staff, funding, space) to devote to palliative care
30 (34.9%)	Unwillingness of my peers to take on additional work tasks
28 (32.6%)	Insufficient authority to make changes
27 (31.4%)	Lack of physician support
21 (24.4%)	Unwillingness of management to give me the time needed to enhance palliative care
19 (22.1%)	Lack of clear organizational goals for palliative care
16 (18.6%)	Limited opportunities (i.e., cases) to practice palliative care
15 (17.4%)	Peer resistance to try new things or to change
14 (16.3%)	Lack of management support of my efforts clearly communicated with others in my workplace (e.g., praise, encouragement)
13 (15.1%)	Lack of palliative care policies and standards in place
12 (14.0%)	Lack of management support for palliative care as a priority
11 (12.8%)	Lack of management support to do new things
9 (10.5%)	Negative attitude of my peers towards my use of time to enhance palliative care
9 (10.5%)	Lack of peer support for palliative care as a priority
8 (9.3%)	Lack of management interest in my goals and objectives for palliative care
8 (9.3%)	Lack of management support of my efforts when things don't work out as planned
8 (9.3%)	Limited access to resource material (best practices, guidelines, assessment tools)
2 (2.3%)	Limited support from clients and family members
2 (2.3%)	CAPCE learning was not integrated into practice
1 (1.2%)	CAPCE content was not relevant to my practice
	Other, please specify:
	<ul style="list-style-type: none"> • <i>there is a palliative care policy but it is out-of- date</i> • <i>The main obstacle to improvement is the time it takes to implement change. The past few months particularly have been very challenging. I am hoping that the next few months will give me more flexibility for the time needed to accomplish some of the goal</i> • <i>no area or unit</i> • <i>Anew PCM has just been hired in my workplace and is very interested in this CAPCE program. Prior to this I had no support from my workplace but she is presently working on improving our palliative care team and I will be very much involved.</i> • <i>change of jobs, but I would like to see my new employers start a palliative care team</i> • <i>I work on a palliative unit lack of nursing hrs is the most difficult deterrent</i> • <i>We are able to use our knowledge in the workplace to give good palliative care to all clients. The only problem at this point is that we are extremely busy and do not have enough staff so our days are long and</i>

Number (%)	Limiting Factors
	<p><i>sometimes it seems that we don't have the time</i></p> <ul style="list-style-type: none"> <i>I have a mixed caseload so there isn't enough time to focus on the CAPCE related assessment</i> <i>I have found the PSW's are skeptical of some of the things I have spent time on related to palliative work. My co-worker RN's are supportive but I don't work directly with them. Management does not really recognize CAPCE as a benefit that needs money an</i> <i>Because at present, the future of palliative care and how it will best be administered is going to be changing, it is hard now to do a lot, as I may be "wasting my time " by implementing something now that gets changed in a month or so</i> <i>There are palliative care nurses on staff, so when any assistance is needed for palliative pt., they are called first. Staff tend to look to them first for questions and answers.</i> <i>not enough time to be able to do a proper assessment</i> <i>The house doctor is a retired from practice doctor who has never been comfortable with nurses using their knowledge to the best of their abilities. Staff know this but with the education of CAPCE we are better able to give details of symptoms of our residents</i>

8. How would you rate the amount of support that you have received from your workplace for your efforts to improve palliative care?

N = 81	Poor	Fair	Good	Very Good	Excellent
Mean = 3.46 SD = .98	3 (3.7%)	9 (11.1%)	27 (33.3%)	32 (39.5%)	10 (12.3%)

CAPCE Performance Objectives
Pre-CAPCE (Learner Assessment Part II)
and Post CAPCE (Follow-up Assessment Part III)

How often do you use **screening questions or tools** to identify active (unresolved or new) and potential issues in the following domains associated with illness and bereavement? Please select the ONE number that best represents your response.

	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
1.1 disease management			
Pre-CAPCE (N=98)	22 (22.4%)	38 (38.8%)	38 (38.8%)
Follow-up (N=86)	13 (15.1%)	35 (40.7%)	38 (44.2%)
1.2 pain and symptom management			
Pre-CAPCE (N=98)	3 (3.1%)	19 (19.4%)	76 (77.6%)
Follow-up (N = 86)	3 (3.5%)	20 (23.3%)	63 (73.3%)
1.3 psychological symptoms			
Pre-CAPCE (N=98)	15 (15.3%)	42 (42.9%)	41 (41.8%)
Follow-up (N = 83)	14 (16.9%)	39 (47.0%)	30 (36.1%)
1.4 social issues			
Pre-CAPCE (N=98)	21 (21.4%)	41 (41.8%)	36 (36.7%)
Follow-up (N=81)	20 (24.7%)	33 (40.7%)	28 (34.6%)

1.5 spiritual issues	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	20 (20.4%)	36 (36.7%)	42 (42.9%)
Follow-up (N=81)	16 (19.8%)	40 (49.4%)	25 (30.9%)
1.6 practical issues	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	11 (11.5%)	37 (38.5%)	48 (50.0%)
Follow-up (N=83)	14 (16.9%)	28 (33.7%)	41 (49.4%)
1.7 end of life care/death management	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	9 (9.2%)	30 (30.6%)	59 (60.2%)
Follow-up (N=85)	7 (8.2%)	28 (32.9%)	50 (58.8%)
1.8 loss and grief	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	16 (16.3%)	34 (34.7%)	48 (49.0%)
Follow-up (N=83)	14 (16.9%)	37 (44.6%)	32 (38.6%)

Use of Screening tools – Comparison of Pre and Follow-up Responses (Paired t-tests)

	Pre CAPCE Mean (SD)	Follow-Up Mean (SD)	t	p
1.1 disease management (N=86)	2.20 (.76)	2.29 (.72)	.92	n.s. ⁸
1.2 pain and symptom management (N=86)	2.77 (.48)	2.70 (.53)	1.0	n.s.
1.3 psychological symptoms (N=83)	2.27 (.72)	2.19 (.71)	.72	n.s.
1.4 social issues (N=81)	2.17 (.75)	2.10 (.77)	.75	n.s.
1.5 spiritual issues (N=81)	2.23 (.76)	2.11 (.71)	1.3	n.s.
1.6 practical issues (N=81)	2.42 (.67)	2.36 (.73)	.69	n.s.
1.7 end of life care/death management (N=85)	2.52 (.67)	2.51 (.65)	.13	n.s.
1.8 loss and grief (N=83)	2.35 (.74)	2.22 (.72)	1.4	n.s.

How often do you **complete an assessment** to the extent that you...

2.1 ...gather detailed information about each identified issue including status, potential cause, associated expectations, needs, hopes and fears?	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	21 (21.4%)	33 (33.7%)	44 (44.9%)
Follow-up (N=85)	19 (22.4%)	40(47.1%)	26(30.6%)

2.2 ...use appropriate assessment tools and scales in data collection related to the issues identified?	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	18 (18.4%)	45 (45.9%)	35 (35.7%)
Follow-up (N=84)	13(15.5%)	34(40.5%)	37(44.0%)

⁸ n.s. = not statistically significant

	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
2.3 ... include information from physical history and examination and results from lab and radiology.			
Pre-CAPCE (N=98)	12 (12.2%)	34 (34.7%)	52 (53.1%)
Follow-up (N=84)	17(20.2%)	31(36.9%)	36(42.9%)

Complete Assessments – Comparison of Pre and Follow-up Responses (Paired t-tests)

	Pre CAPCE Mean (SD)	Follow-Up Mean (SD)	t	p
2.1 ...gather detailed information about each identified issue including status, potential cause, associated expectations, needs, hopes and fears? (N=85)	2.31 (.76)	2.08 (.73)	2.5	.05
2.2 ...use appropriate assessment tools and scales in data collection related to the issues identified? (N=84)	2.21 (.70)	2.29 (.72)	.79	n.s
2.3 ... include information from physical history and examination and results from lab and radiology. (N=84)	2.42 (.71)	2.23 (.77)	2.0	.05

How often do you **share information** to the extent that you...

	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
3.1 ...determine, document and respect confidentiality limits defined by your clients?			
Pre-CAPCE (N=98)	4 (4.1%)	13 (13.3%)	81 (82.7%)
Follow-up (N=85)	13(15.3%)	18(21.2%)	54(63.5%)

	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
3.2 ...determine what your clients and their informal caregivers already know?			
Pre-CAPCE (N=98)	3 (3.1%)	23 (23.5%)	72 (73.5%)
Follow-up (N=83)	8(9.6%)	19(22.9%)	56(67.5%)

3.3 ...assess and document your clients' desire and readiness for information?	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	6 (6.1%)	28 (28.6%)	64 (65.3%)
Follow-up (N=85)	14(16.5%)	34(40.0%)	37(43.5%)
3.4 ...develop a process and document a plan for sharing information in a manner acceptable to your clients and their families?	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	12(12.2%)	33 (33.7%)	53 (54.1%)
Follow-up (N=84)	18(21.4%)	25(29.8%)	41(48.8%)
3.5 ...determine and document the need for translation?	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	24 (24.5%)	35 (35.7%)	39 (39.8%)
Follow-up (N=84)	42(50.0%)	24(28.6%)	18(21.4%)
3.6 ...observe and document the physical and emotional reaction to information provided?	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	5(5.1%)	30 (30.6%)	63(64.3%)
Follow-up (N=84)	15(17.9%)	31(36.9%)	38(45.2%)
3.7 ...assess understanding of information shared and its implications by requesting feedback?	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=97)	13(13.4%)	34(35.1%)	50(51.5%)
Follow-up (N=85)	14(16.5%)	35(41.2%)	36(42.4%)

3.8 ...determine and document the desire for additional information?	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	11 (11.2%)	42(42.9%	45(45.9%)
Follow-up (N=84)	20(23.8%)	33(39.3%)	31(36.9%)

Sharing Information – Comparison of Pre and Follow-up Responses (Paired t-tests)

	Pre CAPCE Mean (SD)	Follow-Up Mean (SD)	t	p
3.1 ...determine, document and respect confidentiality limits defined by your clients? (N=85)	2.80 (.48)	2.48 (.75)	3.6	.001
3.2 ...determine what your clients and their informal caregivers already know? (N=83)	2.71 (.51)	2.58 (.66)	1.7	n.s
3.3 ...assess and document your clients' desire and readiness for information? (N=85)	2.60 (.60)	2.27 (.73)	4.0	.001
3.4 ...develop a process and document a plan for sharing information in a manner acceptable to your clients and their families? (N=84)	2.40 (.70)	2.27 (.80)	.1.2	n.s
3.5 ...determine and document the need for translation? (N=84)	2.13 (.79)	1.71 (.80)	3.6	.001
3.6 ...observe and document the physical and emotional reaction to information provided? (N=84)	2.61 (.56)	2.27 (.75)	3.6	.001
3.7 ...assess understanding of information shared and its implications by requesting feedback? (N=84)	2.36 (.72)	2.27 (.72)	.88	n.s
3.8 ...determine and document the desire for additional information? (N=84)	2.36 (.67)	2.13 (.77)	2.3	.05

How often do you assist in the **decision-making** process to the extent that you...?

4.1 ... document that the client has given consent for treatment without coercion and with full understanding.	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	13(13.3%)	24 (24.5%)	61(62.2%)
Follow-up (N=85)	21(24.7%)	28(32.9%)	36(42.4%)
4.2 ...assess and document decision-making capacity.	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	12(12.2%)	28 (28.6%)	58 (59.2%)
Follow-up (N=85)	24(28.2%)	22(25.9%)	39(45.9%)
4.3 ...determine and document the legal substitute decision-maker?	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	11(11.2%)	18 (18.4%)	69 (70.4%)
Follow-up (N=84)	18(21.4%)	21(25.0%)	45(53.6%)
4.4 ...determine who your client wants to include in the decision making process?	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	12(12.2%)	22 (22.4%)	64(65.3%)
Follow-up (N=84)	15(17.9%)	26(31.0%)	43(51.2%)
4.5 ...discuss your client's current wishes and clarify and prioritize their goals on a regular basis?	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	4 (4.1%)	30 (30.6%)	64 (65.3%)
Follow-up (N=84)	14(16.7%)	18(21.4%)	52(61.9%)
4.6 ...discuss and document requests for: withholding or withdrawing therapy,	1	2	3

<i>therapy with no potential for benefit, or hastened death (euthanasia or assisted suicide)?</i>	With none/very few of my dying clients	With some of my dying clients	With all or most of my dying clients
Pre-CAPCE (N=97)	12 (12.4%)	35 (36.1%)	50 (51.5%)
Follow-up (N=84)	29(34.5%)	24(28.6%)	31(36.9%)

<i>4.7 ...develop a plan for conflict resolution when indicated?</i>	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	25(25.5%)	42(42.9%)	31(31.6%)
Follow-up (N=83)	33(39.8%)	35(42.2%)	15(18.1%)

Decision Making – Comparison of Pre and Follow-up Responses (Paired t-tests)

	Pre CAPCE Mean (SD)	Follow-Up Mean (SD)	t	p
4.1 ... document that the client has given consent for treatment without coercion and with full understanding. (N=85)	2.47 (.73)	2.18 (.80)	3.0	.01
4.2 ...assess and document decision-making capacity. (N=85)	2.46 (.72)	2.18 (.85)	2.8	.01
4.3 ...determine and document the legal substitute decision-maker? (N=84)	2.60 (.68)	2.32 (.81)	3.1	.01
4.4 ...determine who your client wants to include in the decision making process? (N=84)	2.50 (.72)	2.33 (.77)	1.8	n.s
4.5 ...discuss your client's current wishes and clarify and prioritize their goals on a regular basis? (N=84)	2.62 (.58)	2.45 (.77)	1.8	n.s
4.6 ...discuss and document requests for: withholding or withdrawing therapy, therapy with no potential for benefit, or hastened death (euthanasia or assisted suicide)? (N=83)	2.42 (.68)	2.01 (.85)	3.8	.001
4.7 ...develop a plan for conflict resolution when indicated? (N=83)	2.10 (.76)	1.78 (.73)	3.0	.01

How often do you engage in **care planning** to the extent that you...?

5.1 ... determine and document wishes related to preferred setting of care?	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	5(5.1%)	29(29.6%)	64(65.3%)
Follow-up (N=85)	19(22.4%)	21(24.7%)	45(52.9%)
5.2 ... determine a plan of care that meets clients' identified goals including: care of dependents, backup coverage, respite care, emergencies, discharge planning, and bereavement care	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	33(33.7%)	25(25.5%)	40(40.8%)
Follow-up (N=85)	28(32.9%)	28(32.9%)	29(34.1%)
5.3 ... regularly review and adjust the plan of care to compensate for any changes.	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=97)	11 (11.2%)	23(23.7%)	63(64.9%)
Follow-up (N=85)	18(21.2%)	24(28.2%)	43(50.6%)

Care Planning – Comparison of Pre and Follow-up Responses (Paired t-tests)

	Pre CAPCE Mean (SD)	Follow-Up Mean (SD)	t	p
5.1 ... determine and document wishes related to preferred setting of care? (N=85)	2.61 (.60)	2.31 (.82)	3.7	.001
5.2 ... determine a plan of care that meets clients' identified goals including: care of dependents, backup coverage, respite care, emergencies, discharge planning, and bereavement care? (N=85)	2.08 (.85)	2.01 (.82)	.67	n.s
5.3 ... regularly review and adjust the plan of care to compensate for any changes? (N=84)	2.55 (.68)	2.29 (.80)	3.2	.01

How often do you engage in **care delivery** to the extent that you....

6.1...assess the learning needs of care team members given the skills needed to deliver the treatment plan and develop a plan to meet these needs?	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	18(18.4%)	29 (29.6%)	51(52.0%)
Follow-up (N=85)	23(27.1%)	27(31.8%)	35(41.2%)

6.2 ...access community services as needed?	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=97)	12(12.4%)	38(39.2%)	47(48.5%)
Follow-up (N=84)	28(33.3%)	25(29.8%)	31(36.9%)

Care Delivery – Comparison of Pre and Follow-up Responses (Paired t-tests)

	Pre CAPCE Mean (SD)	Follow-Up Mean (SD)	t	p
6.1...assess the learning needs of care team members given the skills needed to deliver the treatment plan and develop a plan to meet these needs? (n=85)	2.14 (.82)	2.34 (.80)	1.9	n.s
6.2 ...access community services as needed? (N=83)	2.02 (.84)	2.34 (.70)	3.3	.01

How often do you **confirm** understanding and satisfaction of the treatment plan to the extent that you...?

7.1 ...document the level of satisfaction with the plan of care and the delivery of care?	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	19(19.4%)	35 (35.7%)	44 (44.9%)
Follow-up (N=85)	19(22.4%)	42(49.4%)	24(28.2%)

<i>7.2...determine and document concerns, questions and issues raised about the treatment?</i>	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	6(6.1%)	24(24.5%)	68(69.4%)
Follow-up (N=84)	12(14.3%)	33(39.3%)	39(46.4%)

<i>7.3...document the effects of therapeutic interventions and advocate for further intervention when goals and expectations are not met?</i>	1 With none/very few of my dying clients	2 With some of my dying clients	3 With all or most of my dying clients
Pre-CAPCE (N=98)	2 (2.0%)	20(20.4%)	76(77.6%)
Follow-up (N=84)	12(14.3%)	33(39.3%)	39(46.4%)

Question 7– Comparison of Pre and Follow-up Responses (Paired t-tests)

	Pre CAPCE Mean (SD)	Follow-Up Mean (SD)	t	p
7.1 ...document the level of satisfaction with the plan of care and the delivery of care? (N=85)	2.26 (.77)	2.06 (.71)	2.2	.05
7.2...determine and document concerns, questions and issues raised about the treatment? (N=84)	2.68 (.54)	2.32 (.71)	4.2	.001
7.3...document the effects of therapeutic interventions and advocate for further intervention when goals and expectations are not met? (N=84)	2.76 (.48)	2.32 (.71)	4.9	.001

DEMOGRAPHIC VARIABLES:

Performance objectives related to use of tools, completing assessments, sharing information, and care planning did not vary by any of the demographic variables.

Assisting in the decision making process varied by:

Percentage of time providing palliative care:

Those who provide palliative care for more than 50% of their work time determined and documented the legal decision maker with more of their patients than those who provide palliative care for less than 50% of their work time, $\chi^2 (2) = 6.27, p = .05$.

Confirmation of treatment plan varied by:

Workplace Setting:

Those who work in LTC regularly reviewed and adjusted the plan of care to compensate for any changes with more of their patients than those who work in hospital or community settings, $\chi^2 (4) = 9.9, p = .05$.

Care delivery varied by:

Discipline:

RNs documented the level of satisfaction with the plan of care and the delivery of care with more of their patients than RPNs, $\chi^2 (2) = 9.5, p = .01$.

Overall, how would you rate **your ability to implement or engage** in the following palliative care activities? (Rated on 1 – 5 scales; 1 = not at all capable, 5 = extremely capable)

	<u>Pre-CAPCE</u> Mean (SD)	<u>Follow-up</u> Mean (SD)	<u>t</u>	<u>p</u>
8.1 End-of-life decision making (including advance care planning, determining capacity, discussing DNR orders) (N=86)	4.01 (.73)	4.17 (.72)	1.9	n.s.
8.2 Communicating with dying clients and their families about palliative care (including discussing bad news, using appropriate language, listening to concerns, demonstrating empathy).(N=85)	4.25 (.72)	4.20 (.63)	.60	n.s.
8.3 Assessment and management of psychological symptoms (depression, anxiety, delirium and grief)?(N=84)	3.79 (.81)	3.79 (.62)	.0	n.s.
8.4 Management of the last hours of life (including identification and management of the signs and symptoms of impending death, education and support of family caregivers, planning for management of pain and other symptoms, planning for pronouncement and certification of death)?(N=85)	4.18 (.86)	4.28 (.68)	1.2	n.s.
8.5 Identification and accommodation of cultural issues at end-of-life?(N=85)	3.39 (.96)	3.56 (.78)	1.5	n.s.
8.6 Pain management (including comprehensive assessment, use of opioids, use of adjuvant medications, and management of side effects)?(N=85)	3.76 (.92)	3.95 (.69)	2.1	.05

	<u>Pre-CAPCE</u> <u>Mean (SD)</u>	<u>Follow-up</u> <u>Mean (SD)</u>	<u>t</u>	<u>p</u>
8.7 Use of complimentary therapies (including heat, massage, music therapy, meditation, therapeutic touch)? (N=85)	3.36 (.86)	3.60 (.82)	2.0	.05
8.8 Symptom management (including the assessment and management of asthenia, anorexia, nausea, vomiting, constipation, and oncologic emergencies).(N=83)	3.71 (.85)	3.93 (.68)	2.2	.05

Self-efficacy ratings did not vary by any of the demographic variables.

Appendix D

Learning Strategies Survey

Please rate the extent to which the following learning strategies were helpful, or valuable, to your learning and application of the CAPCE curriculum. Please select the ONE number that best represents your response.

	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (sd)
Learning through the lectures (formal presentations). (N=90)	0	0	12 (13.3%)	49 (54.4%)	29 (32.2%)	4.19 (.65)
Learning at the regional sessions. (N=90)	1 (1.1%)	3 (3.3%)	29 (32.2%)	37 (41.1%)	20 (22.2%)	3.80 (.86)
Learning at the local sessions. (N=89)	0	0	6 (6.7%)	35 (39.3%)	48 (53.9%)	4.47 (.62)
Learning from each other (e.g. small group sharing and problem solving). (N=90)	1 (1.1%)	4 (4.4%)	15 (16.7%)	47 (52.2%)	23 (25.6%)	3.97 (.84)
Learning from each other informally (e.g., networking at lunch, e-mail). (N=90)	2 (2.2%)	12 (13.3%)	29 (32.2%)	37 (41.1%)	10 (11.1%)	3.46 (.94)
Learning through the mentoring process. (N=87)	1 (1.1%)	3 (3.4%)	15 (17.2%)	39 (44.8%)	29 (33.3%)	4.06 (.87)
Learning through the use of:						
case studies (N=90)	2 (2.2%)	5 (5.6%)	17 (18.9%)	39 (43.3%)	27 (30.0%)	3.93 (.96)
role play activities (N=89)	5 (5.6%)	10 (11.2%)	39 (43.8%)	22 (24.7%)	13 (14.6%)	3.31 (1.04)
homework assignments (pre-read material, practical assignments) (N=90)	0	1 (1.1%)	12 (13.3%)	53 (58.9%)	24 (26.7%)	4.11 (.66)
multi-media (video) (N=90)	1 (1.1%)	0	22 (24.4%)	44 (48.9%)	23 (25.6%)	3.98 (.78)

	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (sd)
internet-based activities (CAPCE website) (N=90)	2 (2.2%)	8 (8.9%)	31 (34.4%)	31 (34.4%)	18 (20.0%)	3.61 (.98)
the CAPCE resource manual (N=90)	0	0	6 (6.7%)	33 (36.7%)	51 (56.7%)	4.5 (.62)

Overall, how would you rate the CAPCE educators (guest speakers, facilitators) and mentors?

	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (sd)
Educators (guest speakers, facilitators). (N=90)	0	0	4 (4.4%)	27 (30.0%)	59 (65.6%)	4.61 (.57)
Mentors (N=90)	0	0	4 (4.4%)	15 (16.7%)	71 (78.9%)	4.74 (.53)

From the list below, please select the two most valuable resources to you as you learned the CAPCE curriculum and applied what you learned to your clinical practice? (N=90)

46 (51.1%)	CAPCE sessions (regional and local)
39 (43.3%)	CAPCE mentor
34 (37.8%)	CAPCE resource manual
21 (23.3%)	CAPCE homework assignments (pre-read material, practical assignments)
10 (11.1%)	Support from peers/co-workers/colleagues
9 (10%)	Fellow CAPCE participants
6 (6.7%)	Work place resources (e.g., time and opportunities to practice)
5 (5.6%)	Support from management (supervisor, administration, senior leaders)
4 (4.4%)	Physician support
4 (4.4%)	CAPCE case studies
0	CAPCE role play activities
0	Internet-based activities (CAPCE website)

Are there any resources that you did not have that you think could have helped you to learn and apply the CAPCE curriculum?

77 (85.6%) No, I had everything I needed.

13 (14.4%) Yes

Verbatim responses:

- I don't believe I've yet learned everything I need to learn but I believe this curriculum has a strong base, lots of resources, and plenty of information for a great start on a long journey.
- I think the county resources should be common knowledge as it's nice to be proactive and if you are aware of resources ahead of time, it's very helpful.
- More support from management/workplace
- More support from the work place
- More specific ethnic/religious considerations particularly at end of life
- More time at work to apply what I learned.
- I think that Ira Byock's book *Dying Well* should be a required read. I would like to see more videos, required books to read, journal articles. There also should be a choice of final project. Not everyone has easy access to doing a project at work. There should have been an individual option to do a paper, book review, etc.
- I would have benefited from more time to clinically practice what I have learned. Being in mostly a management position it did not allow me to practice as much as I would have liked, in particular my conversational skills. I feel confident with my physical assessments but still need more practice with psychosocial assessment and support.
- Our region leaders always handed out extra learning material...so hats off to them!!
- I am still looking for more management support in my facility.
- Doctors need more knowledge re CAPCE
- A completed Square of Care with Lillian, Carl or Hannah. To use as an example of what was expected from us. I was never sure if my homework assignments were too lengthy, or just right.
- Work Place Resources, Physician Support
- I would have liked to have medication conversion problems available on line that I would be able to do independently and then check if the answer and rationale for answer is available on line.
- Internet based activities
- But additional support from my workplace management and physicians to incorporate and share my new knowledge would have better facilitated the learning process, particularly in terms of developing improved palliative care practices/policies for our LTC.

Since September, how often have you used the internet to access information (best-practice guidelines, research, evidence-based care) for work-related purposes? (N=89)

21 (23.6%)	Hardly ever/never
44 (49.4%)	Once or twice a month
12 (13.5%)	Once or twice a week
11 (12.4%)	Several times a week (3-5 times)
1 (1.1%)	Everyday

Overall, at this point in time, how would you rate your comfort level with using the internet? (1-5 rating scale: 1 = not at all comfortable, 5 = extremely comfortable) (N=89)

Mean (sd):	3.81 (1.08)
Range:	1-5
	67% provided ratings of 4-5 on 1-5 point scale

As a result of your participation in CAPCE are you now more likely to...

.... use email on a regular basis for work-related purposes? (N=89)

Yes:	42 (47.2%)
No:	31 (34.4%)
Not sure:	16 (18.0%)

....use the internet as a resource in your professional practice? (N=89)

Yes:	61 (68.5%)
No:	19 (21.3%)
Not sure:	9 (10.1%)

How would you rate the user-friendliness of the CAPCE website (i.e., how easy was it to access and use the on-line material)? 1-5 rating scale: 1 = not at all easy, 5 = extremely easy) (N=88)

Mean (sd):	4.16 (.84)
Range:	2-5
	81% provided ratings of 4-5 on 1-5 point scale

How frequently did you require assistance (e.g., Webmaster support, problem-solving or instructions from peers) to use the CAPCE website or email for CAPCE purposes? (N=89)

Never	36 (40.4%)
Rarely	33 (37.1%)
Sometimes	16 (18.0%)
Frequently	3 (3.4%)
Always	1 (1.1%)

Overall, how accessible was support from your mentor when you needed it? (1-5 rating scale: 1 = not at all accessible, 5 = extremely accessible) (N=89)

Mean (sd):	4.6 (.70)
Range:	2-5
	92% provided ratings of 4-5 on 1-5 point scale

Are you satisfied with the level of support you received from your mentor?

Yes: 85 (94.4%)

No: 5 (5.6%)

Overall, how relevant was the information and material covered in CAPCE to your work setting and clinical practice? (1-5 rating scale: 1 = not at all relevant, 5 = extremely relevant) (N=90)

Mean (sd):	4.6 (.56)
Range:	3-5
	97% provided ratings of 4-5 on 1-5 point scale

Thinking about the material that was covered throughout the program, how would you rate the level of complexity of the material? (N=90)

very basic level	0
somewhat basic	4 (4.4%)
just right for this program level	51 (56.7%)
somewhat complex	34 (37.8%)
very complex	1 (1.1%)

Did CAPCE meet your needs for new information, skills, and resources?

Yes, definitely:	13 (14.6%)
Yes, somewhat:	76 (85.4%)
No:	0

Would you recommend the CAPCE program to others interested in improving their palliative care practice?

Yes:	87 (96.7%)
No:	3 (3.3%)

Do you have suggestions for changes or improvements to the CAPCE program?

Verbatim Responses:

- Long pause between Dec and Feb session-tend to lose some focus on CAPCE during this time. I realize that winter driving conditions are a consideration at this time. Trinity Place in London is a great facility. Nancy and Faye are AWESOME
- Pain and symptom management is such a large volume of material to cover and all very relevant. An extra day, by extending the course into April would be of great benefit I believe. Thanks for the loving and the learning.
- No. I think everyone involved did a great job and we all benefited. Thank you
- By the 3rd month I was so tired of the three case studies, could have been a bit more creative with them. I felt the days were drawn out to accommodate the right number of hours.

- I noticed that most of the time, the information given to us are relevant to community set-up. Maybe it would be better if there would be a balance between community and long term care or geriatrics because that is where our focus is in our work.
- I would want to ensure that the CAPCE graduates have access to current resources and would ask that we have an annual refresher day... An educational refresher day that reviews pain physiology, medication update, conversion practice, etc.
- The session we had on communication would it have been better to combine it with another session I personally found that day very long and drawn out
- It would be nice to see the homework assignments returned by the next class with some comments as to how we are doing instead of leaving us guessing if we did it correctly or not or at least on the right tract.
- I abhor little groups as I find them a waste of time although others learn well from them. My suggestion would be to drastically reduce the frequency of them as discussion was limited to what the self appointed recorders/leaders consistently felt was appropriate. All viewpoints were not addressed within discussion and eventually I saw that participation plummeted within the group(s) I was involved in.
Perhaps a microphone for soft spoken speakers might enhance the presentation.
I enjoyed Judy's teaching and found her very approachable.
- I would really find it helpful especially as a Resource to more information on process for county and even some in the city. I would then be feeling better to help my peers.
- Course is stretched out over too long of a period. Difficult for a shift worker who works two jobs. On-line deadlines were difficult to meet at times. Grief session (I feel) would be better and more effective held at a local session as this can be a very difficult/emotional topic for some people and a bond was built with in the smaller local groups.
- None at this time.
- I would like to have had two sessions for pain and symptom management. I personally thought meeting only once a month didn't help me keep up the momentum of the course and enthusiasm as I had wanted.
- The resource binder is very thorough.
I think it would only be fair to hold some of the local sessions for Lambton-Kent in the Chatham area -it was nice for those of us from Lambton but the folks from Kent had to do all the driving
- I really enjoyed the format with regional and local sessions. The mentor program is excellent. The only thing to improve would be the weather we had on March 2, but since we had no control over that, we just worked/drove through that! It was just great!
- Some homework assignments were pretty demanding -more than I expected but were still useful.
- I would have liked to have about 1 more week between the Feb 2 and March 2 session. I felt a bit rushed.
- -More clinical/disease process information sessions.
- Less case studies. If you don't learn by that style it is a disadvantage.
-More information on the health and well-being of nurses.
- I think more advanced clinical knowledge would help those taking CAPCE; however, this comes from an RN. Another designation could find the increased complexity overwhelming and often not useful in day to day practice.
- The page numbers and section in the binder were difficult to follow. Warm up the rooms.
- I would like to see more application to different case scenarios.....with all of the content from the various modules.
- I feel that one regional session may be valuable to kick off the program but would have preferred the last session to be local for many reasons. It is a time to celebrate with our class mates a time

to be happy at our accomplishment not to mention that the weather was bad. I feel that it would be more meaningful and intimate if we could celebrate the last class as a group that studied and supported each other for so many months. It would promote team spirit and continue our net working.

- I would like to see more time spent on Emergencies in Palliative Care and how to deal with them. I felt that this session was very rushed. It would be helpful to add one more day to the CAPCE program so that this important session wouldn't be so rushed. I would also like to see (perhaps during the extra session) a review of pain assessment and medications. Overall, it was an excellent program that really made my brain cells work again!
- No suggestions
- Too much info at times some speakers were hard to hear
- Having the last regional session in April to decrease probability of bad weather.
- Should be a shorter time frame. It was too drawn out. But also understand the complexities of getting days off work. This is a difficult topic on how to make the course shorter!
 2. Required reading of chosen books, articles, etc.
 3. Change the case studies. Would have liked different case studies instead of adding on to the same ones.
 4. Change workplace project to a choice of several projects.
 5. Since we were in London, it would have been nice to have a field trip to a palliative care unit. I am from a small rural area, so it always nice to see how another palliative care unit is operated.
- I would have liked to have had the opportunity to work on a small project with a group. Although I realize that time and distance may not have made this easy but the group project would have given me an opportunity to share and learn from other nurses and their experiences. Certainly the sharing in our sessions were very beneficial especially from the nurses who work in LTC facilities.
- Of all the learning opportunities I feel the regional meeting was least informative.
- The resource manual would have been easier to follow if the pages did not get renumbered at each module. It was confusing to find the page you wanted when each module is numbered starting at page 1. Also each time a page is referenced the exact title on that page should be used not a similar title.
- I would like to see the program completed in a more timely fashion. I am finding it more difficult to set aside time with other demands on me. I found some of the on line assessments repetitive (questions)
- Split it up a bit so that you add one more course day
- Wonderful course, I just loved it, I hope I get the opportunity to use my new knowledge!
- I think more time should be spent on the medication used for pain management and the physiology of pain.
- More examples in booklet.
Different speaker for last session, anticipating grief, or 2 different speakers. He was very knowledgeable, but had a monotonous speaking style.
- As much as we all dislike homework, I realize and appreciate the importance of the homework assignments. It really was helpful in transforming our approach to palliative care to include all facets of a person through the use of the Square of Care. My concern centers around the feedback we received about our assignments. I really felt at a loss as to whether or not I had successfully gotten a grasp of the assignment (and hence the Square of Care) before having to do the second homework assignment. Perhaps giving some more general feedback sooner would help raise the confidence level of the next group of learners.

- This program will be an excellent reference for material that can be applied now and in the future. Perhaps if there are any new suggestions to care, this can be identified on the web site under an identifiable heading.
- The best speaker was on March 2 I learn better from actual video or movie situations I enjoyed level 1 much better
- I would suggest that less time in a session was devoted to group work...I would prefer to here from the experts and obtain more information as opposed to chit chatting with others.
- Out of the program the reading material was informative but the written home work assignments I didn't find a value as a learning tool. I do not have any suggestions on how to improve the program.
- -not skip the month of January for local session-too long between
-try not to have regional session in March-less likely to have inclement weather April on, very stressful trying to attend last session-not focused due to difficult drive and fear of trip
- I feel that the CAPCE programme should not occur the month of December. There are too many other preparations and activities in that month.
- The CAPCE program was excellent for me and I feel it covered everything necessary for palliative care. Our mentor was excellent and my resource guide will be with me for quick reference.
- Shorter times between classes
- Decrease the amount of homework
- No
- I would suggest not having the last information in LONDON in MARCH. This caused much stress with driving.
- I think that the CAPCE program was quite good and I really learned a lot that I know I will continue to use in my daily practice.
- Well done!
- As a case manager I found the course quite relevant and helpful and would suggest that other case managers be allowed to take the course as a "learner", not just to audit.
- Maybe if the course was shorter. It was really long and the space between meetings made it easier to forget things. Could be condensed.
- I would really have likes to spend a day on symptom management as these change frequently and I would be very beneficial in my line of work to have new techniques or medications being used, and also to discuss difficult client and solutions that have been used.
- I would like to have a refresher day once or twice yearly.
- People need to be aware of the commitment they are making when they are thinking of taking the course. It was a lot more homework than I thought it would be and I found myself very stressed with it. There was a lot of homework and sometimes I felt overwhelmed with it particularly at Christmas. On the other hand it is great to take a course where I actually get to go back to work and use it. The homework helps you apply what you have learned and therefore remember it better.
- Some future meetings of CAPCE people to see how they are getting on in their place of work - email or otherwise.
- No it was an excellent course that I can use in my day to day work life to improve resident care-pain control, holistic care.
- I thought the program was wonderful. It really gave me the information I was looking for in dealing with the palliative patients and their families. I feel that I am a better nurse and resource person from this program.

- Month longer sections could have been absorbed better if split up. Make local sessions really local travel was not great especially in the winter.
- Use more time on pain assessments and conversions, expand the course time.
- I found it difficult to do assignments each month. Most times I didn't have a resident to write about. Most assignments I tried to remember what happened in the situations that happened months or years ago.

I have been in Nursing for 30 years and have many residents die whom I have cared for. I have tried to remember past cases for assignments.

I thought that perhaps if we had clinical classes then for the next few months we could do assignments. I realize this would be difficult for many especially since this would go into summer holiday times.

- I was disappointed that we didn't get our certificate at the last class. Since I paid for it and won't be getting my money back until I get my certificate which will be almost a year. Last year they got their certificate at the last session.
- An RPN should learn the medications separate from the RN
- I'm not sure this would be feasible, but I think there may be better continuity of learning if the sessions were held as half-day bi-monthly. Sometimes it seemed like a long time in between the class sessions and perhaps having more regular meeting with mentors and CAPCE peers would better facilitate and motivate learning. I think sometimes the volume of information covered in one session (pain and symptom mgmt, for example) is overwhelming to some participants who may not be able to absorb/process this much new information at one time.

The mentors and co-facilitators were excellent throughout the CAPCE learning process – very approachable, helpful, supportive, and knowledgeable. They challenged me to improve my own practice as well as to inspire improvements for my colleagues and my organization. I think though there is some discrepancy in the "support" that various CAPCE participants receive from their employers/management. To truly benefit the organization through improved palliative care, the management must be willing/able to accept and support changes to practice.

Thank you for a wonderful experience ... I think I am both a better nurse and a better person because of the CAPCE program.

- I really feel that the entire format was done in a very 'user friendly' way. Websites were easy to access, the mentors were eager to help in any way. I have nothing but praise and an incredible respect for my 'teachers'. It's a difficult subject matter and I thought it was presented in a very caring manner. I was glad it was only once a month...it gave me that time to get the reading in and the assignments done. (As well as work).