



South West End-of-Life
Care Network

Education Needs Assessment

Summary Report

**Prepared by Tazim Virani & Associates Consulting Firm
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SOUTH WEST END-OF-LIFE CARE NETWORK

EDUCATION NEEDS ASSESSMENT

EXECUTIVE SUMMARY

Although hospice palliative care (HPC) is a relatively young practice, there is now general consensus on the values, principles and norms in service delivery and care to patients/clients and their families. The implementation of these values, principles and model of care however, is not always uniform across communities or even between care settings.

The South West End-of-Life Care Network (SWEOLCN) took a bold step to systematically design and support the implementation of best practices in HPC across the care settings and to address key barriers that prevent optimal care. A key initiative was the design and implementation of an education strategy as a key pillar for an integrated HPC service delivery system. In order to support the development of the education strategy, the SWEOLCN commissioned a comprehensive education needs assessment.

The key objectives of the HPC education needs assessment were to gather information about the learning needs and preferred learning methods of regulated and unregulated health care providers and Volunteers as well as to understand their self care needs and response to suffering. It was also hoped that the needs assessment would help to identify priority education needs for different care providers and for different care settings.

Under the leadership of the Education Committee and a Core Working Group, a needs assessment work plan was refined, approved and supported. The plan included key informant interviews, teleconference focus groups and an online survey. Over 300 care providers participated in various ways to share their perspectives.

The SWEOLCN education needs assessment has revealed information that can inform the development of an education strategy for most HPC providers. The key take away messages were as follows:

- The education strategy must be developed in concert with the broader end of life strategy in order to address the many systemic issues that impact access to education and impact the required supports to implement best practices.
- The education strategy must focus on high priority target groups. High priority sub-target groups must include care providers working in the community (home care agencies, family practice and family health teams) to increase their knowledge and skills and to establish key supports to transfer HPC knowledge to practice.

- Key learning areas include psychological care needs of the patients; supporting decision making, care planning as well as loss and grief; meeting the physical needs of patients; and working collaboratively in teams in a coordinated manner.
- The strategy should address effective interprofessional team work from a structure, process and education perspectives.
- Existing HPC programs were generally well received but require modifications to address both content requirements by various sub-target groups as well as modifications to the manner in which they are delivered.
- The role of the PPSMCs was highly valued and more time and access to these resources was requested.
- The preferred learning methods are “on the job learning” (learning while working), case based learning and small group learning. These methods will likely require attention to creating greater capacity for local expertise to provide coaching, preceptorship, mentorship or “just in time” learning models.
- Leverage electronic resources and e-learning using a well balanced approach with other preferred learning methods.
- The education strategy needs to pay attention to raising awareness of education programs, finding creative mechanisms to address financial resources, staffing and time constraints, and implementing strategies to raise the priority of HPC at the organization and system level.
- Key considerations must include working with organization decision makers to create enabling conditions for knowledge transfer and supports to implement the best practices.
- Education strategy will require assessment of existing capacity in the region and to establish specific capacity development targets.
- In order to support care providers in their capacity to provide excellence in HPC, the self care needs of care providers must be addressed through approaches such as debriefing with colleagues in a safe environment, opportunities to engage in wellness programs and education on recognizing signs of compassion fatigue and prevention strategies.

SOUTH WEST END-OF-LIFE CARE NETWORK

EDUCATION NEEDS ASSESSMENT

INTRODUCTION

The South West End-of-Life Care Network (SWEOLCN) is an alliance of community agencies, hospitals, long-term care homes, and other stakeholders who are all working together to improve hospice palliative care (HPC) services in South West Ontario (the area defined by the boundaries of the South West Local Health Integration Network or LHIN). In total, there are 14 End-of-Life Care Networks (some called Hospice Palliative Care Networks) across the province. All align with LHIN boundaries.

The SWEOLCN is not an incorporated body; it has a representative steering committee rather than a board. It is accountable to its member agencies and their clients, the Ministry of Health & Long-Term Care (MOHLTC), and the South West LHIN. It works collaboratively with Cancer Care Ontario (through the London Regional Cancer Program) and the Palliative Pain and Symptom Management Consultation Program that serves the Erie – St. Clair and South West LHINs. It is also accountable to its host agency, the South West Community Care Access Centre (CCAC), which is a member of the Network.

WHAT IS HOSPICE PALLIATIVE CARE?

Hospice palliative care provides physical, psychological, social, spiritual and practical support to people living with progressive, life-threatening illness and their loved ones. Care teams include physicians, Volunteers, nurses, personal support workers (PSWs), social workers, spiritual care providers, friends and family. It can be provided at home, in hospitals, nursing homes or free-standing hospices. It is most effectively delivered by an interdisciplinary team of health care providers.

IMPETUS FOR THE EDUCATION NEEDS ASSESSMENT

The SWEOLCN has a mandate to work with its alliance members towards establishing an integrated service delivery system for HPC. Education has been considered one of the key pillars to establishing an integrated system. The South West has previously been a leader in the development of various innovative HPC educational programs; some of which have been adopted elsewhere in the province. However, in order to continue to maintain progress and to address new challenges that have stemmed from human resource shortages, increased care responsibilities, decreased mentorship and financial resources and growing recognition of compassion fatigue, there has been a call for a renewed and creative HPC education strategy.

This report provides the summary of an education needs assessment conducted in the South West with the view to informing the development of the SWEOLCN Education Strategy.

OBJECTIVES FOR THE EDUCATION NEEDS ASSESSMENT

The key objectives of the HPC education needs assessment were as follows:

- a) Gather information about the learning needs and preferred learning methods of regulated and unregulated health care providers and volunteers who work in a variety of settings; some of whom are considered generalists (working with diverse patient populations) while others are considered specialized (working primarily with patients with life threatening or limiting illness).
- b) Include in the needs assessment, care provider's own understanding of their self care, self-awareness, personal resilience and response to suffering.
- c) Leverage recently collected information on educational and professional development needs.
- d) Conduct an assessment of existing educational programs that were accessed for HPC; including extent of use, applicability to various health care settings and gaps in education.
- e) Identify priority needs for different health care disciplines as well as different health care settings.

GUIDING PRINCIPLES

The following provided some of the key guiding principles for designing the education needs assessment:

- An Education Committee was established by the SWEOLCN to develop the education strategy. The needs assessment process was guided by a Core Working group with membership from the Education Committee. The Core Working group provided input to the needs assessment plan, supported access to needs assessment participants; and together with the broader Education Committee, validated the findings and provided insights to the analysis.
- The alliances of the SWEOLCN provided access to data sources, leaders and care providers to support information gathering.

- Cross project synergy (between Project 1 and Project 2¹) in order to optimize successful outcomes, ensure strategic alignment and efficient and effective use of resources.
- Respectful engagement of key informants at all phases of the project including development of summary findings to share with all who participated in the needs assessment.

METHODOLOGY

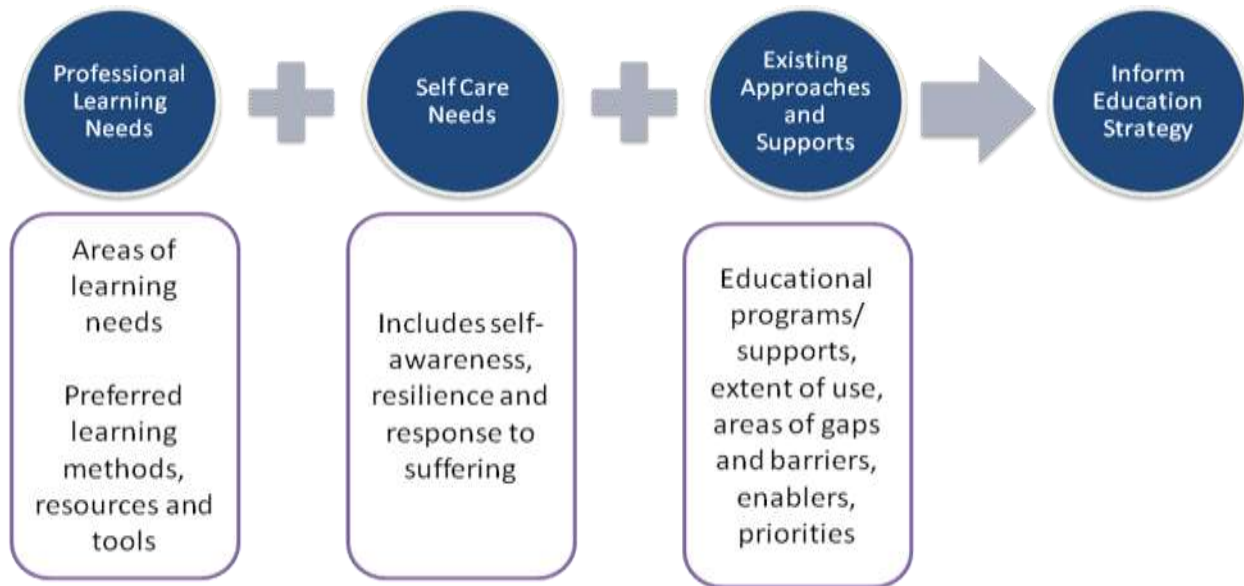
Under the leadership of the Education Committee and a Core Working group, a needs assessment work plan was refined, approved and supported. The plan included gathering information from a wide range of care providers, across the South West, using different data collection methods. An initial set of phone interviews were conducted with multi-disciplinary members in order to develop a beginning understanding of the learning needs, barriers, enablers and existing education programs. This early understanding was used to develop the context for the focus groups and an online survey. The focus groups provided a more detailed understanding while the online survey provided the opportunity to reach a greater number of care providers to participate in the needs assessment. The multi-faceted approach provided both qualitative and quantitative information to inform the understanding of the learning needs of various care providers.

FRAMEWORK

The framework below, derived from the needs assessment objectives, provided the content areas to explore with participants. Specific areas of questions were informed by a brief review of existing tools from previous needs assessments, literature sources, feedback from the Core Working group and initial interviews with key informants. A key area which has not been addressed in previous needs assessments was in the area of compassion fatigue and self care. Literature sources and a key Internet site (www.compassionfatigue.org) were particularly helpful for developing questions items. See reference list in Appendix A.

¹ Project 2 is the actual development of the education strategy while Project 1 has the focus on the education needs assessment.

Figure 1: Needs Assessment Framework



DATA COLLECTION TOOLS

Three data or information collection tools were developed:

- a) Key informant interview questions
- b) Teleconference focus group guide
- c) Online survey

See Appendices B, C, D for the data collection tools.

LIMITATIONS

There were several limitations to the needs assessment methodology that may mean that some findings may need to be taken with caution while further information gathering may need to be undertaken to fill the gaps. The limitations are:

- a) Use of purposeful sample means that the sample may not be generalized with strict confidence to all sub-target groups.
- b) Since the scope of the needs assessment included a vast number of care providers, there are some sub-target groups that have small numbers resulting in minimal information. Additionally, representation from all geographic areas in the South West was not always possible for each sub-target group. Analyses for some groups was conducted by pooling provider groups and therefore are not homogeneous.

PARTICIPANTS

Participants for all three data collection methods were identified as follows:

- a) Key informant list with 14 names was generated by the Education Committee and an email invitation was sent out to all members on the list followed by telephone or email follow up by the Needs Assessment Consultant. All those who responded within the required time frame were interviewed. Interview questions were sent to key informants prior to the telephone interview which lasted about an hour. The three individuals not interviewed were not available during the time period.
- b) Members for the teleconference focus groups were identified by the Palliative Pain & Symptom Management Consultants (PPSMC) through their local networks. For the RN, RPN, and PSWs, the PPSMC contacted the managers of facilities and requested time to be provided for staff to attend the teleconference focus groups. Some of these staff attended during their work day while others attended from home. The physicians and other health care discipline names were generated by the PPSMC and Core Working group members. These individuals were contacted by the Needs Assessment Consultant and invited to participate at designated date/time. In most instances, both phone and email contacts were made. Volunteer Coordinators in different parts of the South West were the prime source for identifying and confirming the participation of volunteers at the focus group.
- c) The participants for the online survey were contacted largely through the efforts of the Education Committee, the PPSMC, existing lists available with the Director for the SWEOLCN, Volunteer Coordinators and through requests to “fan” out a standard email script with electronic link to the online survey. A pdf version of the online survey was also made available to participants on a request basis. These participants were asked to print the survey, complete it and mail it directly to the Needs Assessment Consultant who later manually entered the information on the online survey database.

KEY INFORMANT INTERVIEWS

One hour telephone interviews with 11 key informants were conducted. Table 1 below provides characteristics of these key informants:

Table 1: Key Informant Participants – Telephone Interviews

Role	Number	Region
PPSMCs	4	All
Physicians	2	Elgin, Oxford, Grey, Bruce
Nurse Practitioner	1	London
Spiritual Care Provider	1	London
Social Worker	1	London
Managers (home care, volunteers)	2	Huron, Perth, London
TOTAL	11	

FOCUS GROUPS

Six teleconference focus groups (1.5 hour long) represented by individuals from across the South West were conducted. These included:

- i. 3 groups with RN/RPNs
- ii. 1 group with PSWs
- iii. 1 group with Volunteers
- iv. 1 group with Physicians and Other Health Disciplines²

Specific characteristics of the participants are provided in Table 2 below.

Table 2: Focus Group Participants

Focus Group	Role	#	Care Setting	Geography
1	RN	6	6 – community	3 – Elgin/Oxford 3 – Grey/Bruce 2 – Huron/Perth 1 – London/Middlesex
	RPN	3	3 – community	
2	RN	5	2 – community 1 – hospital 2 – LTC homes	4 – Elgin/Oxford 1 – Grey 2 – Huron/Perth 1 – London/Middlesex
	RPN	3	1 – Community 2 – LTC home	
3	RN	9	2 – community 4 – hospitals 3 – LTC homes	5 – Elgin/Oxford 4 – Grey/Bruce 1 – London
	RPN	1	1 – community	
4	PSW	15	8 – community 7 – LTC homes	7 – Grey/Bruce 7 – Huron/Perth 1 – Unknown
5	Volunteers	7	1 – residential hospice 6 – community	1 – Grey/Bruce 2 – Elgin/Oxford 3 – London Middlesex 1 – Unknown
6	MD	3	3 – Family practice	4 – Grey/Bruce 5 – Huron/Perth
	Other Health Disciplines	6	5 – community 1 – LTC home	

² Other health disciplines included Occupational Therapists, Physiotherapists, Registered Dieticians, Social Workers and Spiritual Care Providers.

ONLINE SURVEY

The online survey resulted in 270 responses. The majority of the responses were from Managers/Coordinators (21%), Registered Nurses (16%), Volunteers (15%) and Registered Practical Nurses (8%).

All geographic locations in the South West were represented with most sub-target groups. The most numbers of participants were from London (23%) and the lowest number from Grey (15%). See Table 3 for details.

Table 3: Online Survey Participant

Geographic Areas in the South West	SUB-TARGET GROUPS								
	RN/RPN	PSW	Volunteers	MD	APN, NP, CM, Educ	Other Health Providers	Managers	Other	Total
Bruce	12(24%)		12(24%)		4 (8%)	3 (6%)	13(26%)	6(12%)	50
Elgin	5(10.2%)	1(2%)	11(22.4%)	1(2%)	7(14.3%)	3(6.1%)	19(38.8%)	2(4.1%)	49
Grey	5(12.9%)		11(28.2%)		3(7.7%)	3(7.8%)	10(25.6%)	7(17.9%)	39
Huron	16(30.2%)	1(1.9%)	3(5.7%)		2(3.8%)	7(13.3%)	19(35.9%)	5(9.4%)	53
London	12(19.2%)		1(1.6%)	2(3.2%)	13(21%)	13(21%)	15(24.2%)	6(9.7%)	62
Middlesex	4(8%)	5(10%)		2(4%)	10(20%)	12(24%)	11(22%)	6(12%)	50
Oxford	7(16.6%)			1(2.4%)	5(11.9%)	6(14.3%)	18(42.9%)	5(11.9%)	42
Perth	10(17.6%)	11(19.3%)	8(14%)	4(7%)	3(5.3%)	5(8.8%)	12(21.1%)	4(7%)	57

Most of the participants worked in the following care settings: LTC homes (40%), community/home care (31%), hospitals (21%) and Visiting Hospice (13%). The high response from LTC homes was likely due to availability of a comprehensive list of LTC home Directors of Care.

Participants who had worked the longest time in their current role were the RN/RPN group (75% had over 10 years of experience in their current role) and the Other Health Disciplines (74% had over 10 years of experience) while the APN/NP/Educators/Case Managers had the shortest time in their current role (91% were in their current role for less than 10 years).

Half of the APN/NP/Educators/Case Managers self identified themselves as specialized (working primarily with HPC patients) while the groups least identified as specialized were the Other Health Disciplines (71%) and Physician group (70%). The group that worked with children the most were Physicians (50%).

FINDINGS

The following section provides summaries of the needs assessment findings. First, the care provider's previous educational experiences in HPC will be discussed as well as the barriers and enablers. Second, the identified areas of learning needs will be summarized along with identified priority areas and preferred methods of learning. Third, care providers' reports on signs of compassion fatigue in the workplace will be discussed as well as strategies that could be used to support self care. See Appendix E for Slide Deck with visual presentation of the findings.

PREVIOUS EDUCATION

Although there was a wide range of educational programs that were attended by participants, the most frequently accessed programs were the Fundamentals course (51.6% of all participants had taken the course), in-services provided by PPSMC (49.8%), CAPCE (26.9%) and Provincial Hospice Palliative Care Conference (17.4%). Different sub-target groups, however, had somewhat different use of available educational programs. For example, Volunteers used the Hospice Volunteer Training program most frequently while Physicians and Other Health Disciplines reported "Other" as one of their most frequent choices; indicating access to a wide range of possible education programs.

Almost half of all participants (49.8%) reported that they took 1-3 formal educational opportunities over the past year and 29.3% reported they had not taken any formal education opportunities. Majority of participants, however, indicated they had informal education with 42.2% having had 1-3 informal educational opportunities over the past year and another 42.2% having greater than 3 informal education opportunities.

On average, the participants had a moderate self-perceived level of competency in HPC (3.3 on a scale of 1 to 5 where 1 is novice and 5 is expert). The group that had the lowest self-competency were the Other Health Care Disciplines (3.1) while the Physicians had the highest self-perceived rating (4.0), followed by the APN/NP/Educators/Case Managers group (3.7).

When it came to having a formal education plan, the APN/NP/Educators/Case Managers group were most likely to have a plan (61% of this group had a plan) while the least likely were the Physicians (16% of this group had a plan) and the Volunteers (30% had a plan).

BARRIERS & ENABLERS

The most frequent barriers identified for the whole sample were lack of awareness of HPC education programs in their area (32.3%), cost of travel for education (32.3%), staff shortages (29.7%), not having funds to undertake education (29.2%), not getting paid time off to attend education program (25.5%), and, lack of priority for HPC in the organization (22.9%). There were some slight differences between health care providers in terms of the frequency to which

barriers were reported. For example, timing of education sessions was an important barrier for PSWs, RN/RPN and Physicians but it was the most frequently reported barriers for Volunteers (37.5%).

For those who worked in the community care settings, getting paid time to attend education session was mostly unavailable. PSWs and Other Health Disciplines spoke of having to reduce their assignment in order to take time to attend a session. This meant they had reduced income when pursuing educational opportunities.

Most of the barriers were similar when comparing responses across geographies in the South West. Tertiary and community hospital settings, however, reported having less support for HPC in terms of priority, resources, resource person, motivation and organizational/management support to remove barriers to implementing what is known as best practices.

The other barrier that was faced by most care providers was the time and capacity to implement what they had learned. This was most frequently reported at the focus groups. For example, PSWs in the community felt that they had little time to provide support to family members who were struggling with anticipatory loss and grief. Some CAPCE trained nurses spoke about not having an adequate case load of clients requiring HPC and felt they would lose their knowledge and skills.

The most frequently reported enablers for the whole sample for accessing education included personal motivation (53.2%), organizational/management support (47.8%), knowing who to go to for what information and support (46.2%), having access to programs in their area (43.8%) and using the Internet and other e-learning on their own (43.8%). Having access to coaches, mentors and supportive group of colleagues was important to most groups at varying degrees of importance. Managers also reported that having their organization linked to a network of other organizations provided them with greater access to educational programs.

LEARNING NEEDS

Psychological care as an area for learning was rated with the strongest agreement with all sub-target groups and five out of the seven sub-target groups also reported strong agreement with loss and grief as an area of learning. RN/RPN, Physicians, APN/NP/Educators/Case Managers and Manager sub-target groups rated physical care requirements in the top 3 areas of learning needs. PSWs, APN/NP/Educators/Case Managers and Manager groups rated very high the remaining areas of HPC dimensions based on the Square of Care model. These remaining areas included disease management, social care, spiritual care and end of life care. At the focus groups, some of specific areas reported included understanding different cancers, newer therapies,

approaches for children and their families as well as approaches in caring for those with dementia.

When asked about learning needs related to processes of HPC, confirmation³ was strongly rated by all sub-target groups while decision making and care planning were also strongly rated by four out of the seven sub-target groups. For decision making, these groups were RN/RPN, Other Health Disciplines, APN/NP/Educators/Case Managers and Managers. For care planning, these groups were PSWs, RN/RPN, APN/NP/Educators/Case Managers and Managers.

In exploring psychological care learning needs more specifically, the areas that were most strongly agreed related to managing emotional suffering, handling ethical issues and helping family members through the bereavement process. At the focus groups, participants elaborated on a number of specific themes including developing appropriate communication skills to support patients and families, addressing family dynamics (this was considered as most draining), teaching families and addressing their questions and concerns; and overall supporting patients in having a “good death”.

Participants were also asked about their learning needs related to team work and resources. The two most highly rated areas across all sub-target groups were in the areas of resource available in the health care system to support patients/residents and their families and resources available in the health care system to support health care providers and volunteers. Having standard processes, protocols and standing orders were identified as examples of supportive resources. Many participants commented that these resources need to be “simple to implement”. Overall, many of the providers spoke of the need to be aware of the resources that are available in their area. This was particularly evident for the community care settings.

Through the focus groups and open-ended questions, some of the other learning needs included having better communication systems between care providers including better system navigation and tools and systems for a smoother transition of care across care settings, consistency in better and more comprehensive assessment, pain management approaches, supporting/teaching families, public education about death and dying, helping people to stay in their homes at end of life, and overall having more educational opportunities.

Additionally, RN/RPNs spoke extensively of their struggles in working with some physicians particularly, those who did not work from the same palliative care philosophy as they did. Similarly, PSWs related examples of their difficulty in working with RN/RPNs, particularly in the LTC homes, where they felt that their assessment and opinions were being disregarded.

³ Examples of confirmation provided on the survey included “understanding, satisfaction, complexity, stress).

PSWs were also the only group that reported the lowest ratings for supports or reinforcements available in the work place to implement best practices. They relied mainly on their personal motivation and somewhat on their colleagues.

PRIORITY AREAS

When asked at the focus groups for participants' most important areas for focus, the majority pointed to areas of improvement in the system in order for care providers to better support the patients/residents and their families. The need for better coordination was most important when patients were cared for in their own homes. The need for greater communication, team work, knowledge of resources and understanding of the progression of diseases, discussing goals for care and supporting clients and families' emotional and psychological needs were most pronounced. The focus on supporting educational and system needs for those providing care in the community and for those who interface between care settings was discussed as a high priority.

In most instances, existing programs were well received with requests to add or modify content to suit specific sub-target group needs such as needs of children and youth; care for those working in rural settings where some of the resources and expertise were not available; and, addressing discussions for end of life goals early in the stay in LTC homes. However, access to existing programs was faced by significant barriers and lack of support as well as inadequate opportunities. Increasing the number of existing programs with the necessary modifications as well as matching the appropriate numbers of coaches and mentors was also in high demand. Overall, many of the providers spoke of not being able to implement what they had learned. Having knowledge transfer supports is, therefore, important to address and establish.

A key theme generated from the needs assessment was to ensure that all care providers had basic education and understanding of palliative care. This had to be the core foundation for all care settings and all roles. In addition, having adequate numbers of more advanced trained practitioners such as CAPCE nurses and Physicians/NPs who had a focus in palliative care was seen as important for providing the necessary coaching and mentoring to others.

PREFERRED METHODS OF LEARNING

The three most frequently identified methods of learning that all care providers preferred were learning on the job (60.6% of respondents), case based learning (48.6%) and using small groups for learning (43.6%). All of these three methods require a high degree of local level capacity for coaching, preceptorship, mentorship and facilitation; particularly for case based learning and small group learning. The role of the PPSMC's was strongly validated both in terms of their current role in providing in-services, coaching and mentoring but also in terms of the value they provided to addressing difficult client/patient situations. More time and access to PPSMC was

requested. Additionally, attendance at educational meetings was rated high (42.2%) by the APN/NP/Educators/Case Managers and Other Health Disciplines and highest by CAPCE nurses (67%).

The majority of the participants for the survey (65.9% of participants) reported that they would likely or very likely use electronic resources via the Internet for learning purposes and 59.9% of them would also access e-learning courses and webinars. A little over half (54.4%) would also likely or very likely use the Internet for networking purposes. Most, however, would unlikely use a Personal Digital Assistant (PDA) for learning purposes (47.4% would not use) or use chat rooms or other live Internet based interactions to learn (52.1% would not use). Those working in London, Middlesex and Oxford were more likely to report that they would use electronic resources for learning compared to other geographic areas. PSWs and Volunteers were least comfortable in using electronic resources for learning.

Addressing the length of the education sessions for all health care providers (minus Volunteers), over half (56.4%) preferred learning sessions that were an hour long and 38.1% would also find half day sessions acceptable. Some preferred shorter than an hour (29.8%) long session. Only 20% preferred day long sessions. The Volunteers overwhelmingly preferred half day sessions (70.6%) followed by one hour long sessions (50%) and one day long sessions (44.1%).

The best time of the day for education sessions for Volunteers was equally split between morning (44.4%) and the afternoon (44.4%). For the PSWs, half preferred the morning (50%), 42.9% preferred the afternoon and 28.6% preferred the evening. The majority of the RN/RPN group preferred the afternoon (58%) while 32% preferred the morning. The physicians preferred lunch time sessions (57.1%) while 42.9% preferred morning and 14.3% preferred evening. There was an almost equal split for Other Health Disciplines for the morning (42.9%) and the afternoon (45.7%). A third also preferred lunch time (31.4%). The majority of the APN/NP/Educators/Case Managers (65.2%) preferred the morning and 30.4% preferred the afternoon. The majority of the managers also preferred the afternoon (51.9%) while 37% preferred the morning. Lunch and learn sessions which have been increasing in frequency as an alternate way to provide education sessions for busy health care providers was not the preferred learning method for majority of care providers except for Physicians and Other Health Care Disciplines.

Participants at the focus groups spoke about the need for supports in implementing what they had learned and to have their colleagues and other team members on the “same page” or working out of the same philosophy. When there were differences in approaches, this caused problems in how goals of care were discussed with patients and families and how care was planned and delivered. There was also discussion about deferring to the physician for communicating changes in patient’s health, and leading the conversation around goals of care. The hierarchical structure of health care and the differences in care approaches created difficulties in care provision and lack

of satisfaction. Creating incentives for implementing known best practices was considered an important support that was required in most care settings.

COMPASSION FATIGUE AND SELF CARE

The two most frequently mentioned signs of compassion fatigue reported by all health care providers were being physically and mentally tired (average rating of 3.52 and 3.59 on a scale from 1 to 5). PSWs rated signs of compassion fatigue the highest. In the focus group, PSWs who worked in the community discussed how particularly vulnerable they felt because they worked in isolation with little peer and other team member support. All care providers used informal colleague support and attendance at funerals and bereavement visits as a way of coping and bringing closure. Most of these strategies were self initiated and during their own time. Those working in residential hospice received more supports than others. Some facility based care settings also provided opportunities for memorial services and formalized debriefing for particularly difficult cases. Although some of the home care agencies used to provide a bereavement visit for staff, these have either stopped or were not seen as particularly helpful for the purpose of self care.

The most frequently reported strategies that were reported as supports in addressing compassion fatigue included having formalized debriefing sessions in a safe environment; having wellness events and activities; and, education to better understand sign of compassion fatigue and how to prevent this from occurring. Some of the key barriers were lack of time, organizational and management attention and support, as well as lack of formalized supports. Most providers identified a range of signs of compassion fatigue in the care settings except for the volunteers who on average were not identifying signs of compassion fatigue.

DISCUSSION OF FINDINGS

INTERSECTION BETWEEN EDUCATION NEEDS AND SYSTEM LEVEL NEEDS

Health care providers and volunteers spoke of their educational or learning needs intermingled with patient care and systemic needs. In fact, the participants had a lot of difficulty discussing educational needs in isolation. This point to the need to address end of life care issues in a holistic manner. Educational needs are often a reflection of the challenges faced in the health care system and are part of the many strategies needed in developing an overall End-of-Life Care strategy. It is, therefore, important to *ensure that the education strategy is not developed in isolation from other end of life strategy activities*. In a previous provincial needs assessment of oncology nurses, a similar conclusion was drawn and the report concluded the need to establish advocacy channels for the identified issues at the right tables at the right time (Provincial Needs Assessment of Oncology Nurses, Unpublished, 2009).

PRIORITY LEARNING NEEDS

Learning needs of health care providers differed in terms of where they put emphasis. However, majority of health care providers noted learning needs in the areas of *psychological care needs of the patients; supporting loss and grief, decision making, care planning; meeting the physical needs of patients; and working collaboratively in teams in a coordinated manner*. It should be noted that other areas of the dimensions and processes of the “Square of Care”⁴ model as well as more specific areas of psychological, ethical and team work were also rated moderately high. *Overall, care providers identified many areas of HPC where additional education would be helpful to them.*

Other specific areas of education identified by sub-target groups included focus on HPC for paediatric population and their families, understanding and working within the constraints of resources available in rural settings, addressing end of life care needs of residents with Alzheimer’s or other dementias and their families, care requirements of patients transitioning across care settings, specialized services from other health professionals such as non-pharmacological pain management supports and cultural specific requirements of various populations

Previous needs assessments have also identified psychosocial care needs as key areas for further professional development amongst those who are serving people with life threatening illnesses (Provincial Needs Assessment of Oncology Nurses, Unpublished, 2009). Additionally, this needs assessment validated the hierarchical structure of the health care team and the often excluded voices of those who are considered at the bottom of the hierarchy. For example, the PSWs spoke extensively of their frustration in not being heard by registered nursing staff (particularly in the LTC homes). They indicated that their knowledge of residents, their assessment and their suggestions were not being acknowledged or respected. PSWs in the community also noted that they felt disconnected from the care team; and often not provided with much information about the client. Similarly, nurses spoke of the difficulty they had in working with some physicians; particularly, those who did not work within a framework of palliative care that was congruent with their own. Generally, there was the lack of effective team structures with systems that did not allow team members to know and respect each others’ roles as well as lack of forums and tools for communicating and coordinating their respective activities with the patient and family. *There is a need to address effective interprofessional team work from a structure, process and education perspectives.* Learning together in teams was highly recommended by most sub-target groups.

⁴ A conceptual framework that identifies the processes of care and domains/issues faced by patients and families (Ferris, 2002)

CONTEXT OF ROLE REQUIREMENTS

Most health care providers in the sample reported a moderate level of competency (3 to 3.7) except for the physician sample⁵ which reported high level of competency in HPC (4 on a scale of 1 to 5). Moreover, the level of competency did not necessarily correlate with the extent to which health care providers identified their learning needs. For example, although the Nurse Practitioner/APN/Educator/Case Manager group reported a moderately high level of competency (3.7), they also reported a high need for learning/educational resources. Similarly, nurses who had received CAPCE training also reported high need for additional education supports. It appears that a group's learning needs are not necessarily related to deficits or gaps in knowledge and skills. Perhaps, the learning needs identified are a reflection of the complexity of patient care issues they are addressing, the care providers' readiness to learn more, the desire to expand their knowledge and skills and their professional development ambitions. These sub-target groups that continue to require HPC education also require more advanced or higher order learning opportunities as they are likely in a position where they are consulted or required to manage some of the more difficult palliative care issues. *It is therefore important to understand the perceived learning needs of health care providers in the context of their role requirement as opposed to viewing the learning needs as deficits or gaps.* Furthermore, in planning educational strategies, the content will need to support the role requirements of the care providers. For example, although decision making and care planning were identified as common areas of learning needs, some care providers will require more advanced content to increase their knowledge and skills.

MOVING AWAY FROM TRADITIONAL EDUCATION APPROACHES

The needs assessment also clearly identified that care providers had very specific preferences for methods of learning. *These included learning on the job (learning while working); case based learning and small group learning.* These preferences were rated high for all care providers indicating a strong preference for learning that is relevant to their specific roles and the specific needs of patient populations that they were serving. These findings indicate a strong desire to move away from the traditional classroom or workshop based educational models to *learning strategies that are based on coaching, preceptorship, mentorship or "just in time" learning*

⁵ The physician sample was small (only 10 physicians responded to the survey and 3 in the focus group). Additionally, these physicians were likely those who were providing palliative care services for some time. From the comments provided, it appears that some were also involved in providing HPC training to other health care providers. In order to develop an education strategy for physicians, a broader sample of physicians will need to be accessed for additional information gathering. In particular, physicians from family practice and those working in smaller centres and rural areas need to be included in future information gathering.

models. Case based learning can also be strategies that can be integrated in the flow of work as part of care conferences, planned debriefing sessions or other continuous quality improvement strategies. Such strategies can also be conducted in a manner that meets the need for a more interprofessional or interdisciplinary work environment and processes that allow team members to learn from each other.

It should be noted that certain groups such as the Nurse Practitioners/APN/Educators/Case Managers, Other Health Care Disciplines and CAPCE nurses also *gave high scores for educational sessions at meetings or conferences.* This may be reflective of the need for these groups to network with other professionals in their region or province and to act as the “boundary spanners” or “knowledge brokers” for their work setting. As such, they have a high need to seek out new knowledge from experts outside their settings, identify how others are addressing complex care issues and learn about the latest research evidence as well as innovative interventions that are used by others.

LEVERAGING ELECTRONIC RESOURCES AND E-LEARNING

Majority of care providers, except for PSWs and Volunteers, reported comfort in accessing electronic resources and e-learning. In particular, those who had the most difficulty getting away from patient/client care felt that having access to learning materials, webcasts or other e-learning modules would allow them to learn at their own pace. Having such resources accessible from one location on the Internet would also be valuable. Some physicians reported on existing systems such as the Schulich School of Medicine as a possible forum through which to access HPC e-learning. They appreciated the short 15 minute presentations followed by an interactive question and answer session. Providing these sessions both synchronous and asynchronous would allow for a large number of care providers to access the education sessions. CAPCE trained nurses also reported the need to have brief but regular “boosters” such as electronic newsletters, emails with quick tips or quizzes, and other educational materials in order to maintain their level of knowledge and expertise. *It is, therefore, important to leverage electronic resources and e-learning using a well balanced approach with other preferred learning methods.*

ADDRESS SYSTEMIC BARRIERS TO INCREASE ACCESS TO HPC EDUCATION

The key barriers to accessing HPC education were very similar across all sub-target groups for the needs assessment. These included lack of awareness of HPC education programs in their area, staff shortages and inability to find replacements, cost for attending education programs that were far, funding to pursue education, inability to get paid time off to attend education sessions and convenient timing of the education sessions. Some sub-target groups (Nurse Practitioners/APN/Educators/Case Managers and Other Health Disciplines) reported that HPC did not get adequate priority in their organizations and this posed a barrier to accessing education. Almost a third of all survey participants indicated they did not receive any formal

HPC education in the past 12 months. Additionally, there was a great variation amongst the care providers in having a formal education plan. Majority of the physicians, PSWs and Volunteers did not have a formal education plan.

The key enablers to accessing education included personal motivation, organizational support, use of Internet and other e-learning resources and access to supportive colleagues, coaches and mentors. *The education strategy, therefore, needs to pay attention to raising awareness of education programs, finding creative mechanisms to addressing financial resources, staffing and timing constraints, and implementing strategies to raise the priority of HPC at the organization and system level.* Linking this finding with the earlier discussion of “on the job learning”, case based and small group learning preferences could result in more localized education endeavours for some of the sub-target groups such as PSWs, RN/RPNs, Volunteers and Other Health Disciplines. Such endeavours could leverage existing initiatives such as CAPCE and LEAP to *train local coaches, mentors, champions or trainers and to use the Internet and other e-learning mechanisms* to provide them with ongoing supports. *Key considerations must include working with organization decision makers to create enabling conditions for knowledge transfer and establish supports to implement the best practices and to support care providers in developing their own continuing education plans for HPC.*

ASSESS CURRENT CAPACITY AND ESTABLISH NEW TARGETS

Geographic differences were evident not only in the education needs of care providers but also the extent to which educational supports were available to them. In the sample identified for this needs assessment, there was a wide range of attendance at available education programs such as Fundamentals, CAPCE and LEAP. The care providers reported similar learning needs, particularly for psychological care and team work. Some regions, however, reported somewhat greater needs in the area of care dimensions and processes identified in the “Square of Care” model. Although there were no significant differences in preferred learning methods, participants from London, Middlesex and Oxford were more likely to access and use electronic methods for learning. Additionally, Perth and Bruce participants reported having the least supports for knowledge transfer and implementation of best practices while Middlesex participants reported the most supports. *The education strategy will need to assess and address existing capacity in the region (e.g. % of care providers who have accessed existing educational programs) as well as establish specific capacity development targets.*

The survey results found that there were minimal differences in learning needs between various care settings. However, tertiary care participants reported that HPC did not receive a lot of priority in their work setting and they also reported they did not have adequate resources in their workplace as well as other supports such as a resource person to turn to or motivation to change their practice when best practices were known. Tertiary care participants were also least likely to

have a formal education plan. Lastly LTC and tertiary care participants had the least awareness of HPC education programs in their area. These findings are somewhat surprising as overall there were more specialized care providers in tertiary settings. As well, information gathered through the focus groups indicated that community based care providers, particularly PSWs and RN/RPNs, had little access to educational resources and mentors as well as faced many challenges in providing HPC to their clients. These results need to be addressed in combination with other reports where high educational needs of community based care providers were also found. Taking all findings in consideration as well as the increasing number of people being served in the community at all stages of their care, it is important to ensure that *care providers in the community are provided higher priority in developing greater knowledge and skills and receive supports to transfer knowledge to practice*. Better understanding of the needs of care providers in tertiary care is, however, warranted with a larger sample.

Lastly, the needs assessment focused on the self care needs of care providers; that is, the extent to which they recognized signs of compassion fatigue in their work place and the strategies needed to address compassion fatigue. Care providers were very similar in their responses with majority of them reporting the *need for education on compassion fatigue, formal and informal debriefing sessions in a safe environment with their colleagues or team members and wellness programs and interventions for care providers*.

SUMMARY/KEY MESSAGES

In summary, the SWEOLCN education needs assessment revealed information that can inform the development of an education strategy for most HPC providers. The key take away messages are as follows:

- The education strategy must be developed in concert with the broader end of life strategy in order to address the many systemic issues that impact access to education and supports to implement best practices.
- Key sub-target groups must include care providers working in community based settings to increase their knowledge, skills and supports to transfer HPC knowledge to practice.
- Key learning areas include psychological care needs of the patients; supporting loss and grief, decision making, care planning; meeting the physical needs of patients; and working collaboratively in teams in a coordinated manner.
- The strategy should address effective interprofessional team work from a structure, process and education perspectives.
- Existing HPC programs were generally well received but require modifications to address both content requirements by various sub-target groups as well as modifications to the manner in which they are delivered.

- The role of the PPSMCs was highly valued and more time and access to these resources was requested.
- The preferred learning methods are “on the job learning” (learning while working), case based learning and small group learning. These methods will likely require attention to creating greater capacity for local expertise to provide coaching, preceptorship, mentorship or “just in time” learning models.
- Leverage electronic resources and e-learning using a well balanced approach with other preferred learning methods.
- The education strategy needs to pay attention to raising awareness of education programs, finding creative mechanisms to address financial resources, staffing and time constraints, and implementing strategies to raise the priority of HPC at the organization and system level.
- Key considerations must include working with organization decision makers to create enabling conditions for knowledge transfer and supports to implement the best practices.
- Education strategy will need to assess and address existing capacity in the region as well as establish specific capacity development targets.
- In order to support care providers in their capacity to provide excellence in HPC, the self care needs of care providers must be addressed through approaches such as debriefing with colleagues in a safe environment, opportunities to engage in wellness programs and education on recognizing signs of compassion fatigue and prevention strategies.

APPENDICES

- A. References
- B. Key Informant Interview Questions
- C. Focus Group Discussion Guide
- D. Online Survey
- E. Presentation slide deck

APPENDIX A: REFERENCES

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APPENDIX B: KEY INFORMANT INTERVIEWS

LEARNING NEEDS:

1. What are the knowledge, skills, attitudes and behaviours that you would like to foster in care providers (professionals and volunteers) who care for people who have life threatening illness? (think re square of care)
2. What would assist in enhancing care providers' capacity to provide very good hospice palliative care? Specifically, what educational, mentorship or other capacity development approaches, and supports are needed?

EXISTING PROGRAMS:

3. What approaches, programs or educational offerings have worked well?
4. What has *not* worked well in building capacity?
5. Are there any opportunities for linkages, partnerships to improve capacity development in the South West?

PREFERRED LEARNING METHODS:

6. What education/capacity development methods have resulted in effective or high impact on care provider knowledge, skills, behaviours and care improvements?
7. How frequently do care providers get offered various education/capacity development approaches that you have identified as the preferred methods?
8. What are the enablers and barriers to providing the preferred learning methods?

SELF CARE NEEDS:

9. How do care providers cope with the stresses related to their work with patients who have life threatening illness and their families?
10. To what extent do you recognize signs of compassion fatigue/burnout in your place of work? (*probes: individual signs – excessive blaming/complaints, isolation, poor self-hygiene, denials, apathy, physical and mentally tired; organizational signs – high absenteeism, high turnover of staff/volunteers, inability of team to work together, lack of flexibility, reluctance to accept change, negativity, lack of vision for the future*)

11. Are there approaches/supports to address these stresses? What supports are available to care providers through the organization or the community? How well are these accessed or used? (*probes: education to raise awareness about compassion fatigue, coaching around maintaining personal boundaries, wellness initiatives, support groups/reflection sessions, etc*)
12. What additional type of approaches/supports would be helpful to care providers to address these stresses?

GAPS:

13. What are the barriers or challenges in creating strong capacity for hospice palliative care in this region? (probe: resource availability)
14. If you already have good capacity, what would make it even better?

OVERALL CONCLUDING QUESTIONS:

15. If you had 3 wishes to improve hospice palliative care capacity, what would those be? (probe: think of high impact, highly feasible)
16. What key readiness factors would need to be considered to implement these wishes?

LEARNING NEEDS:

17. What are the knowledge, skills, attitudes and behaviours that you would like to foster in care providers (professionals and volunteers) who care for people who have life threatening illness? (think re square of care)
18. What would assist in enhancing care providers' capacity to provide very good hospice palliative care? Specifically, what educational, mentorship or other capacity development approaches, and supports are needed?

EXISTING PROGRAMS:

19. What approaches, programs or educational offerings have worked well?
20. What has *not* worked well in building capacity?
21. Are there any opportunities for linkages, partnerships to improve capacity development in the South West?

PREFERRED LEARNING METHODS:

- 22. What education/capacity development methods have resulted in effective or high impact on care provider knowledge, skills, behaviours and care improvements?
- 23. How frequently do care providers get offered various education/capacity development approaches that you have identified as the preferred methods?
- 24. What are the enablers and barriers to providing the preferred learning methods?

SELF CARE NEEDS:

- 25. How do care providers cope with the stresses related to their work with patients who have life threatening illness and their families?
- 26. To what extent do you recognize signs of compassion fatigue/burnout in your place of work? (*probes: individual signs – excessive blaming/complaints, isolation, poor self-hygiene, denials, apathy, physical and mentally tired; organizational signs – high absenteeism, high turnover of staff/volunteers, inability of team to work together, lack of flexibility, reluctance to accept change, negativity, lack of vision for the future*)
- 27. Are there approaches/supports to address these stresses? What supports are available to care providers through the organization or the community? How well are these accessed or used? (*probes: education to raise awareness about compassion fatigue, coaching around maintaining personal boundaries, wellness initiatives, support groups/reflection sessions, etc*)
- 28. What additional type of approaches/supports would be helpful to care providers to address these stresses?

GAPS:

- 29. What are the barriers or challenges in creating strong capacity for hospice palliative care in this region? (probe: resource availability)
- 30. If you already have good capacity, what would make it even better?

OVERALL CONCLUDING QUESTIONS:

- 31. If you had 3 wishes to improve hospice palliative care capacity, what would those be? (probe: think of high impact, highly feasible)
- 32. What key readiness factors would need to be considered to implement these wishes?

APPENDIX C: FOCUS GROUP DISCUSSION GUIDE

LEARNING NEEDS:

1. Have each of you had an experience with a resident with a terminal illness that you didn't feel prepared to deal with? Think back to one experience in particular. What was it about that situation that made you feel uncomfortable or unprepared?
2. If you were to encounter that situation again, are there any particular skills or kinds of knowledge that you would like to have that you don't have now?
3. What would assist in enhancing care providers' capacity to provide very good hospice palliative care?
4. Specifically, what educational, mentorship or other capacity development approaches, and supports are needed?
5. The results of this focus group will be used to help develop palliative care educational tools, materials, approaches and other supports. Are there any particular topics that you want to learn more about?

EXISTING PROGRAMS:

6. What approaches, programs or educational offerings have worked well?
7. What has not worked well in building capacity?
8. What are ways that organizations or care settings assist in supporting you to use or implement what you have learned to your patient care? That is, supports for knowledge transfer to practice. (probe: practice time, job shadow, group problem solving, peer coaching, reminder systems/cheat sheets, etc)

PREFERRED LEARNING METHODS:

9. What learning methods have you found you prefer or enjoy?
10. What are the enablers and barriers to providing the preferred learning methods?

SELF CARE NEEDS:

11. How do you and/or your colleagues cope with the stresses related to your work with patients who are terminally ill and their families?

12. To what extent do you recognize signs of compassion fatigue/burnout in your place of work? (*probes: individual signs – excessive blaming/complaints, isolation, poor self-hygiene, denials, apathy, physical and mentally tired; organizational signs – high absenteeism, high turnover of staff/volunteers, inability of team to work together, lack of flexibility, reluctance to accept change, negativity, lack of vision for the future*)
13. Are there approaches/supports to address these stresses? What supports are available to you through the organization or the community? How well are these accessed or used? (*probes: education to raise awareness about compassion fatigue, coaching around maintaining personal boundaries, wellness initiatives, support groups/reflection sessions, etc*)
14. What additional type of approaches/supports would be helpful to care providers to address these stresses?

GAPS:

15. What are the barriers or challenges in creating strong capacity for hospice palliative care in this region?
16. If you already have good capacity, what would make it even better?

OVERALL CONCLUDING QUESTIONS:

17. If you had 3 wishes to improve hospice palliative care capacity, what would those be? (*probe: think of high impact, highly feasible*)
18. What key readiness factors would need to be considered to implement these wishes?

APPENDIX D: ONLINE SURVEY

See Attachment (pdf file)

APPENDIX E: DATA ANALYSIS SLIDE DECK

See Attachment (pdf file)