FINAL REPORT

Canadian Association of Schools of Nursing (CASN)
Competencies for Palliative and End-of-Life Care

Submitted by

The Canadian Association of Schools of Nursing (CASN)

To

Health Canada
Secretariat on Palliative and End of Life Care

March 31, 2008

Contract Reference Number: 4500171593

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3
BACKGROUND 3
Goals of the Task Force 3
DEVELOPMENT AND DISSEMINATION OF THE SURVEYS 4
Purposive Sample 4
Data Collection 4
Data analysis 5
Limitations 5
SUMMARY RESULTS FOR THE DEANS AND DIRECTORS SURVEY 5
SUMMARY RESULTS FOR THE CONTENT EXPERT SURVEY 11
Specific Competency 1 13
Specific Competency 2 13
Specific Competency 3 13
Specific Competency 4 14
Specific Competency 5 14
Specific Competency 6 14
Specific Competency 7 14
Specific Competency 8 15
Specific Competency 9 15
Specific Competency 10 15
Specific Competency 11 16
Specific Competency 12 16
Specific Competency 13 17
CONCLUSION 18
Next Steps 19
APPENDIX A: Competencies 20
APPENDIX B: Invitation to Deans/Directors 28
APPENDIX C: Invitation for Content Experts 29
APPENDIX D: Dean and Director Survey 31
APPENDIX E: Content Expert Survey 36
ACKNOWLEDGEMENTS 43
REFERENCES 44

EXECUTIVE SUMMARY

Research shows that nursing students have concerns and anxieties when dealing with death and dying and caring for patients during this time. Historically nurses have not been prepared for these situations (Mallory, 2003). To support closing this identified gap, the Canadian Association of Schools of Nursing (CASN) has been developing nursing competencies for Palliative and End-of-Life Care (PEOLC). Following a national symposium, which was held in March 2007, surveys were developed and disseminated to Deans and Directors of CASN's 91 member schools and content experts in the area of PEOLC. The purpose of the surveys was to gain additional input, stakeholder engagement and buy-in of these PEOLC competencies.

Analysis of these surveys showed support for these competencies and commended CASN for the work done to assist future nurses in being prepared to work in palliative and end-of-life situations. PEOLC is currently implemented into curriculum and survey data suggests that faculty would most likely be in favour of working with these competencies. In going forward, the surveys highlighted the potential for a variety issues which might arise during implementation of the PEOLC competencies. Therefore, there is further work that can and should be done to work in accomplishing the implementation of these competencies.

BACKGROUND

CASN represents 91 universities and colleges that offer or participate in offering undergraduate and graduate degrees in nursing and is the official accrediting agency for degree nursing programs in Canada. Governed by an executive committee and a board of directors, CASN's mission is to "lead nursing education and nursing scholarship in the interest of healthier Canadians."

The CASN Task Force on Palliative and End-Of-Life Care was established in 2004 to gather input for the development of recommendations and program guidelines for preparing health professionals to deliver palliative and end-of-life care.

Goals of the Task Force

- To create palliative care nursing competencies to support the future development of a palliative care curriculum for Canada's 91 nursing schools (CASN, 2004).
- To develop and conduct a survey to describe the current status of undergraduate nursing education in Canada in palliative and end-of-life care (CASN, 2004).
- To provide a forum to help build a national consensus on palliative and end-of-life care competencies (CASN, 2004).

The competencies were developed with the feedback from various experts and deans and directors. In March 2007 a national symposium was held to discuss the competencies at a national level. The final step was to survey content experts and deans and directors following the feedback from the national symposium. The purpose of this final step was to confirm that there was national consensus on these competencies following the symposium. See Appendix A for the competency document.

DEVELOPMENT AND DISSEMINATION OF THE SURVEYS

Two different surveys were developed for this final step – one for Deans and Directors and the second for Palliative/Hospice Care content experts. The purpose of the surveys was to further refine the content and to determine barriers and facilitators within educational institutions to the incorporation of the competencies into curriculum. Hence the need for two surveys - the content experts were asked to review the content of the specific competencies whereas, the Deans and Directors were asked to review the general competencies and whether and how the competencies could be incorporated into curriculum.

Survey questions were prepared by an expert panel familiar with survey development and content validity process. The 'expert panel' was comprised of members of the CASN Task Force on Palliative and End of Life Care. The survey questions were based on competencies and practice experience. The competencies and surveys were translated to French in December 2007.

Purposive Sample

All Deans and Directors that are CASN members were invited to participate in the survey.

The content experts were identified using the following criteria:

- faculty member either knowledgeable and informed on PEOLC, working in the area of PEOLC, or teaching course content in which some of the competencies would fit
- the Canadian Hospice Palliative Care list serve
- provincial professional associations
- networks of task force members

Data Collection

The Deans and Directors were informed of the survey during the opening remarks of the 2007 CASN Council meeting, which was held in November. Paper copies of the document and survey were available at the council meeting.

The Deans and Directors, and content experts were contacted via separate email messages on January 15, 2008 and reminder emails were sent out on January 31st and February 13th. The email messages contained a link to Survey Monkey.

In an attempt to improve the response rate, the option of requesting the survey in other formats as an alternative to completing it on-line was also offered. Respondents initially had until Friday, February 8th to respond. The deadline was extended until February 22nd, following a decision of the CASN Task Force on PEOLC to allow further time for respondents. Deans and Directors and content experts were informed of this change.

See Appendix B and C for the invitation and Appendix D and E for the survey questionnaire. Informed consent was obtained from all participants.

Data analysis
Quantitative analysis included basic statistics including frequencies, and measures of central tendency. Percentages were calculated when the number of responses was adequate. Qualitative data were comparatively analyzed, grouped into categories that were coded and then analyzed for themes.

Limitations
The survey is lengthy and may not have been a priority for Deans and Directors. Generalizations of survey findings in relation to the Dean/Director survey cannot be made due to the low response rate. In contrast the sample of 45 content experts were geographically representative of palliative and hospice Nursing care expertise in Canada. The findings/themes that were generated could be validated by either a face to face or email verification process with Deans/Directors who did not complete the survey. The Qualitative findings are rich and complex and provide thoughtful insight and pose important questions pertaining to integration and use of these competencies in curriculum.

SUMMARY RESULTS FOR THE DEANS AND DIRECTORS SURVEY

The findings are presented in summary format and are organized using the survey questions as a framework.

Demographics
A total of 16 of the 91 Deans/Directors of CASN member schools responded to the survey. Their institutions were located in British Columbia (4), Ontario (4), Alberta (3), New Brunswick (2), Newfoundland (1), Northwest Territories (1) and Quebec (1). Although participants provided information regarding their name and position these will not be shared to preserve/protect privacy and confidentiality.

Question 5: In terms of content, how would you describe the 'General Competencies' section of the document?
This question specifically asked respondents to highlight strengths, areas for development and rationale/relevant sources.

Strengths
When the respondents reviewed the document, feedback on strengths included: the clarity of the competencies, very clear and concise identification of the relevant knowledge, skills and practices, holistic, encompasses palliative care philosophy, concepts of interdisciplinary collaboration and advocacy. Reviewers commented positively on the document being evidence-based, providing definitions and a comprehensive reference list.

Areas for Development

Comments from the respondents included:

> *"I wonder if an over-arching statement about HPC couldn't be constructed that hits on the generalized statements around leadership and excellence in practice which is contained in the mission/value statements of our target audience."*
>
> *"Speaks about cultural relevance but not generational or social assumptions & does not include spirituality (not religiosity but spirituality in the most general sense)"*
>
> *"While I believe that the general competencies are relevant to the needs of persons requiring palliative care and their families, there needs to be clear delineation between knowledge and actual practice. While students in our curriculum receive content in all of these areas, the degree to which all have an opportunity to work extensively and continuously with palliative patients is more limited. Also, many of these skills take time and require the establishment of a longer term relationship with patients and families. Something that is more difficult to achieve in the student practice environment."*
>
> *"If palliative care is holistic, then competence in the physical aspects should be as prominent as the interpersonal"*

Rationale/Relevant Sources

Comments from the respondents included:

> *"25 years in the biz"*
>
> *"Palliative care has many similarities across the lifespan (i.e. goals for symptom relief and supporting a dignified death) but also there are generational/lifespan issues that should also be spoken of especially given the tremendous gerontology age wave in Canada; spirituality is vital in palliative and end of life care and can be what allows for hope during hopelessness, peace, and closure - it is very often neglected in health care and by nurses but an essential component of holistic care"*
>
> *"See Wilkes, L.M. Australia"*

Question 6: Does your school of nursing currently address PEOLC competencies in the curriculum? (n = 16)

Thirteen out of the sixteen schools who responded currently address the PEOLC competencies in their curriculum.

Question 7: On a scale of 0-4, what is your estimation of the potential of faculty to favourably view the introduction of new PEOLC in the curriculum? (n = 16)

The scale that was used is as follows: 0 = unknown 1= limited in favour 2=somewhat in favour 3=in favour 4=in great favour
MEAN 2.3
MEDIAN 3 "Somewhat in favour"

Question 8: Delineate four key issues that you anticipate facing if you were to suggest introducing new PEOLC competencies in the curriculum (n = 16)

Common themes derived from analysis of data from this question include:

1. **Competing content**: there is an already overfilled curriculum, so will need to evaluate what, if anything, can be removed from the curriculum before adding in content that is not already covered. Content will also have to be appropriately leveled throughout the years of the program. Many of the competencies are already being met by some curriculum.
2. **Curriculum structure**: some programs use problem based learning as a primary teaching method. For these programs, introducing more palliative care, there introduces two challenges: development of appropriate case studies, and the risk of superficial coverage of the topic.
3. **Time**: time required to develop new curriculum, time or "space" within the curriculum for additional content.
4. **Limited opportunities to apply knowledge in practice** There is always a challenge to find appropriate clinical placements, especially "practice environments which MEET CHPCA Standards of Practice supporting the "theory" being taught in the classroom".
5. **Approval processes for changes**: from the faculty, the school, and/or university/college**.**
6. **Faculty comfort and buy-in to the need to include these competencies**.
7. **Uniqueness of individual nursing programs**

   "Mainstreaming all "content" areas for all students is very challenging. We already assess our program as being too ambitious in the amount of learning we are expecting from our students."

   "The main constraint is to agree upon what content can be removed from the curriculum so as to have more space to cover additional content on palliative care."

   "Why is it necessary to separate out Palliative care competencies from the ones we already have that mirror these competencies? If we focus on incorporating specific competencies for palliative care, should we not also do the same for gerontology, public health, maternal-child, psychiatry and other more focused practices or is it expected that all students should be comfortable in providing palliative care and how does this competency differ from the compassionate, caring, holistic, professional care they should give any and every patient (even those not considered palliative)"

   "Several of the general and specific competencies addressing relational, family-centred, ethical practice are within the curriculum already, perhaps not specifically targeted to palliative care. A major barrier would be how to address the addition of curriculum and content in an already content packed curriculum. Nursing faculty are constantly besieged by specialties and special interest groups to add to the curriculum (Canadian Patient Safety Initiative, Amnesty International, Pandemic Planning, Public Health and the core competencies for Public Health; Quit smoking initiatives from Health Canada to name just a few.) Faculty experience burnout and overload with the numerous requests. We would need to take time to look at how we are already meeting the competencies and ways in which we could meet the unmet ones. This takes time."

Question 9: If your school or faculty were to introduce these new competencies, what is your estimate of how this would be achieved? (n=16)

Three approaches were identified in the 16 responses introducing these new competencies. These were:

- introduce the new competencies in a single course (1),
- integrate competencies throughout several courses (12),
- use other methods, including a combination of an integrated thread through many courses, and a separate course being available (3).

"Likely, both of these options....integrated within different courses but also having an in depth course for those students who are interested. We are in the process of curriculum development and are considering using choices/focuses in clinical practice areas for students with required related support courses to support depth of knowledge and competencies. An end of life theory course would likely be one of these courses to support the clinical focus."

"Both [formats would be used]; some core information and application of expected overall competencies for professional nursing care integrated throughout the program and an elective focusing more in depth for those interested in incorporating palliative care within their practice repertoire."

"I personally would like to have a credit course available to all students as well as the threading through of the competencies in other existing courses. My experience with "threading" content is that it may look good on paper but may not be adequately covered in practice."

Question 10: What three strategies would facilitate implementing these new competencies in your setting? (n=15)

Strategies that would facilitate the implementation of these new competencies include:

- faculty discussion
- curriculum committee discussion
- linkages with experts, institutions and community partners
- identifying faculty champions
- sharing ideas with other schools

Question 11: What are three key barriers to implementing these new competencies in your setting? (n=16)

The barriers to implementing these competencies that were highlighted by the respondents include:

- faculty (expertise, buy-in)
- clinical placements
- time (for faculty to design and implement new curriculum, room in the curriculum – need to take something away from an already overfilled curriculum)
- resources (money, learning resources).

Question 12: If your school/faculty were to move forward on introducing these new competencies, what three key faculty development strategies would you recommend? (n=12)

The needs that the Deans and Directors felt would be required to move forward on introducing these competencies include:

- Faculty education time in which to highlight the need, rationale for the palliative care competencies. They describe a need for workshops with faculty to evaluate the competencies to see how they are currently being met by individual program curriculum and what would need to be done to meet the new competencies.
- Collaboration between schools, sharing resources, perhaps through an online portal with access to resources and continuing education.
- Local champions in palliative care to act as an expert on the subject matter. If one was not currently available within a School of Nursing, one dean suggested CASN hold a week-long train-the-trainer for faculty taking on the role of a local champion.

Question 13: How would the competencies fit within other demands made on curriculum content (please describe)? (n=13)

Approximately half of those respondents who commented said that these competencies are already being met or are close to being met within their current curriculum.

Others stated the challenge of the competing demands on the nursing curriculum, including increasing general non nursing courses, increasing content and practice to facilitate interprofessional practice; content demands from specialties and special interest groups; less access to practice placements; nursing faculty shortage. Some schools are in the process of reviewing their curriculum and identifying priorities.

> *"The introduction of competencies is the way to go as this will accord palliative care the importance that it so deserves in theory, research, and practice."*
>
> *"[There is] definitely a demand for "content" but should we not be teaching about principles and concepts related to palliative care? Evidence-based research guides practice and*

'content' (what meds, procedures etc.) but the principles change less often and less dramatically so would it not be better to focus on the key concepts and principles that inform palliative care practice with examples of 'content' that is current in practice?"

Question 14: Any other comments?

Other comments received from the respondents include:

"There is a real opportunity for Schools of Nursing to provide NATIONAL and GLOBAL leadership in HPC nursing. The potential for disparate HPC programs being developed by faculty without expertise in HPC, nor any dedicated evaluative strategy is enormous. Intentional leadership in curriculum development and program evaluation strategies will be key in ensuring the work doesn't get stalled in its 5th year. CASN needs a big grant from the feds to ensure that this work gets off the ground with the same distinction and quality we are asking of our emerging practitioners."

"Specific competency #5: I'm not sure undergraduate nurses have a sufficient knowledge base to attend to meaning in suffering. It would help to clarify what this means."

"I would be interested in further discussions on this and working with others in curriculum development as it is a definite interest of mine"

"Thank you for the opportunity to supply feedback. I am totally sold on the value and need for this content in a nursing program and I congratulate you on the work done to date on this issue."

"Based on the model of problem based learning these competencies may be addressed by some groups of students. Not all students however would be exposed. Concepts e.g. being present, relational practice, critical reflection, are already embedded into the nursing curriculum."

"This needs to be experiential as well as theoretical learning thus it could be accommodated by a combination of on-line and group activities."

SUMMARY RESULTS FOR THE CONTENT EXPERT SURVEY

The findings are presented in summary format and are organized using the survey questions as a framework.

There were 45 participants in the Content Experts Survey. Approximately 95 content experts were contacted to participate in the survey. Personal participant information was collected but will not be shared due to privacy and confidentiality clauses. The largest portion of respondents were from Ontario (42.2%) followed by Nova Scotia (17.8%). There were no respondents from Nunavut, Prince Edward Island and Saskatchewan. See table 1 for complete information about institution locations.

Table 1: Province / Territory Institution Located

	Response Count	Response %
Alberta	4	8.9%
British Columbia	6	13.3%
Manitoba	2	4.4%
New Brunswick	1	2.2%
Newfoundland	2	4.4%
Northwest Territories	1	2.2%
Nova Scotia	8	17.8%
Ontario	19	42.2%
Quebec	1	2.2%
Yukon	1	2.2%
Total	45	100%
Missing data	**0**	

The respondents included Administrators, Coordinators, Leaders and Managers (10); Nursing consultants (8); Faculty members and clinical instructors (7); Clinical Nurse Specialist and Nurse Practitioners (7); Social Workers and Volunteers (3); Palliative Care physicians (2); Deans and Directors (2); Registered Nurses (2); Licensed Practical Nurses (1); Nursing Interest Groups (1). (n=43)

Question 5: In terms of content, how would you describe the 'Preamble' section of the document? (n=37)

Strengths

Content experts stated that strengths included: clear and concise, builds on the CHPCA Norms of Practice and other contemporary national palliative resources, describes the different dimensions of the role of the nurse in supportive/palliative care acknowledging the complexity of the role in alleviating suffering and supporting patient and family coping.

Areas for development

Content experts recommended:

- Explain the purpose of the document up front. Nowhere does it mention that this is to form the basis of curriculum for undergraduate nursing programs
- Expansion of discussion on symptom management other than pain
- Include some additional definitions (hospice palliative care, holistic, interpersonal, suffering)
- Strengthen the nurse's place within health systems, social determinants of health
- Re-examine the nurse's place within the interdisciplinary team (i.e. nurse as leader versus active participant, nurse as collaborator and coordinator.)

> *"The section on "Nurses' roles in PC" indicates that "Nurses' roles include leadership in . . ." Rather than emphasizing "leadership", it might be preferable to emphasize "active participation". Since we are talking about an inter-professional team, I would question whether nurses should be taught that they should assume leadership. I don't consider nurses to be greater than or less than other professionals and, given the quality and quantity of their interaction with patients and family members, they play a key role in decision-making. However, I'm not sure the hierarchy in health care is ready for nurses to be THE leaders."*
>
> *"Consultation, collaboration and co-ordination -nursing is the center of the team so we need to know they will consult and collaborate with IP team rather than centralize care in silos of medicine and nursing."*

Rationale or relevant sources

Comments from the respondents included:

> *"Palliative nursing has evolved considerably since CHPCA Norms and Palliative Nursing Standards developed related to federal initiatives, accreditation, patient safety, workforce constraints."*
>
> *"Management of psychological, emotional pain is as needed as symptom relief of physical pain."*
> *(www.chpca.net/interest_groups/nurses/Hospice_Palliative_Care_Nursing_Standards_of_Practice.pdf)*
>
> *"This section should be revised to reflect the Framework for Hospice Palliative Care Nursing - the Supportive Care Model (Davies & Oberle, 1990). This is the framework that underpins the Standards for Hospice Palliative Care Nursing and would serve to help students connect nursing theory into practice. Furthermore, I had a hard time following the logic presented in this section that a patient who experiences pain is unsafe and affects a nurse's work life. …the source referenced in making these statements and noted that the reference was the Canadian Nurses' Pain Issues Working Group, August 2005 document: "Pain management: A patient safety, quality work life and social justice issue for nursing?"…it is an editorial in a newsletter. This needs to be addressed in that it is difficult to consider this to be "evidence"."*
>
> *"CHPCA Norms of practice for pediatric palliative care; Oxford textbook of palliative care for children"*

"The content is clearly laid out and easy to follow. After reviewing the sources more thoroughly, it is apparent that the bulk of the content in this section is drawn from relatively few sources. I am not familiar with most of the sources, but would appreciate other supporting references being listed. This is especially the case in the section on "Nurses' Role in PC", in which Davis & Oberle clearly dominates."

Question 6: In terms of content, do you feel that the 'Specific Competencies' section of this document is appropriate?

Specific Competency 1

Possess self-awareness of personal attitudes, beliefs, and values about death and dying. It includes care of self, understanding one's own needs, developing one's own support and knowledge networks, being open to learning, and knowing how to be with suffering.

Most of the respondents 43/45 (95.6%) agreed with this competency. Most comments approved of the need for self-awareness and knowing how to be with suffering. If these are to be competencies for undergraduates, several experts raised questions about how this would be evaluated in the curriculum.

"I would like to see how this is measured and taught in schools: that will be the challenge. I am a bit leery in the belief that one can come out of school with this insight that generally takes years to develop with palliative-death experience. In an ideal world, students would possess this insight"

"I think this is extremely important to emphasize with students as many of them have not had an opportunity to examine their own beliefs and values around death and they need to do that especially prior to doing a placement in palliative care."

Specific Competency 2

Exhibit skill in conducting holistic individual and family assessments, including pain and symptom management.

Reviewers agreed (40/45) that the emphasis on holistic and family be included in descriptions of assessment. Some were concerned that the emphasis in this statement on pain and symptom management risks making palliative care being viewed only as pain and symptom management. As one reviewer put it "This needs to be more specific e.g. describe domains which may be included as part of holistic assessment (see CHPCA Square of Care)." One other reviewer suggested "Demonstrates skill in the holistic assessment of pain and other symptoms, including emotional, social, or spiritual distress experienced by the individual and/or family." A recommendation was made to include "total pain" in the concept of pain and symptom management to better reflect the current term being used in textbooks.

Specific Competency 3

Demonstrate knowledge and skill in managing pain and symptoms.

42/45 reviewers agreed with the competency. Many recommendations were made to enhance the competency including: ensuring that non-pharmacological and complementary therapy measures are also integrated into knowledge and skill development; including mention of pain management

in patients with cognitive impairments; using terms to describe the therapeutic encounter such as "assessment, information sharing, decision making, care planning, care delivery and confirmation" or rework to emphasis the holistic and interprofessional approach of palliative care. Some concern was raised about the ability of a newly graduated nurse to effectively manage complex pain and perhaps this might be best described as a leveled competency (new graduate be able to manage simple pain and symptoms while a more experienced nurse be competent at managing complex pain and symptom clusters).

Specific Competency 4

Possess requisite communication skills and an ability to engage in end-of-life decision making and planning, and artfully and gracefully negotiate modes of care on an ongoing basis.

Two respondents did not complete this question. 39/43 respondents agreed with this competency. All who commented agreed with the importance of communication skills, but many were concerned that the term "artfully and gracefully" was not appropriate for various reasons, and recommended removing the term from the competency.

Specific Competency 5

Possess knowledge of cultural and spiritual issues and the ability to recognize and attend to meaning in suffering.

Majority of the respondents 42/43 (97.7%) agreed with this competency. Two of the responses were blank. Several reviewers suggested the word "possess" be changed to "demonstrate". Reviewers agreed with the need for nurses to be culturally sensitive, but as one reviewer stated "Nurses may not have knowledge of the variety of cultures encountered in practice, but need to be sensitive to this variety. The ability to recognize and attend to meaning is the key." The challenge of how to address "suffering" in an academic setting was raised.

> *"Although I think the student would have had to have seen enough suffering patients to adequately possess this skill to support the theory of what has been taught in school. If the topic can be covered in class and in the clinical setting… that would assist in the learning process. Instructors would need to also be able to 'spot' suffering in choosing a client for a student to follow."*

Specific Competency 6

Demonstrate ability to assess and attend to individual/family psychosocial and practical issues such as discharge planning.

This competency had the lowest percentage of respondents in agreement. However, 38/44 (86.4%) still agreed with it. One response was blank. Majority of the comments made suggested some way to reword this competency.

Specific Competency 7

Shows evidence of an ability to collaborate effectively within an integrated inter-professional team.

The respondents agreed (41/44) with this competency. One response was blank. Several reviewers recommended changing "shows evidence of ability to…" to "demonstrate ability to…"

> *"..to be able to clearly articulate the nursing role within this team. Current palliative nurses very much struggle with the articulation of their incredibly significant role. We have to be*

able to do this particularly to our nursing and medical colleagues as well as to administration. Our clients and their families seem to be able to understand this."

"The opportunity to do so does not exist in all areas of the country."

"Interdisciplinary as opposed to inter-professional because your team is often made up of non-professionals such as volunteers, PCA's, and the family is also part of your team."

Specific Competency 8

Possess knowledge and skills in recognizing and attending to ethical issues.

Only 41 responses were received for this competency. 39 respondents did agree. There were several comments on potential rewording of this competency including:

And to demonstrate use of a practical framework or integration into care

add...and refer family and patient to necessary disciplines to assist in resolving conflict or reducing stress about end of life decisions/issues.

This should be strengthened to identify some of the relevant ethical principles such as autonomy etc.

I suggest using: Identify knowledge and apply appropriate skills/strategies to address ethical issues

Also ability to recognize and attend to one's own moral distress

The distinction between legal and ethical issues is particularly important to emphasize.

Like with many of the competencies, the question of how to prepare undergraduates to meet this was raised.

"Ethical issues are not often well-defined. They are also unique, in terms of each patient's circumstances. The skills in recognizing ethical issues develop with time and experience, I feel. I'm not certain that undergraduates would have acquired those skills at completion of their undergraduate program."

Specific Competency 9

Recognize and respond to the unique needs of special populations, i.e. elders, children, those with cognitive impairment, unique and marginalized populations.

Majority of the respondents (42/43) agreed with this competency. Two respondents did not complete this question. Other populations were defined by reviewers including: those in rural sector, homeless, and patients with chronic diseases, mental health, and addictions.

"[This is] another place where the subject of "empowering" needs special emphasis. Also "valuing" and finding creative/innovative ways of "connecting"."

Specific Competency 10

Demonstrate knowledge of grief and bereavement and the ability to support others.

41/42 of the respondents agreed with this competency. Several reviewers made comments on the language in this competency and suggest rewording "demonstrate knowledge".

"Should it be stated as, "demonstrate ability to recognize grief and bereavement"? Demonstrating "knowledge" would be expected of a new graduate, but more would be expected of a practising Palliative Care Nurse."

"While I would want this for all graduates, again this might be unrealistic to achieve in an undergraduate program - something better aimed at graduate studies..."

Specific Competency 11

Demonstrate caring for self while supporting others in their grief and bereavement. Real compassion is uplifting and contributes to personal growth; unresolved grief causes pain, which can contribute to fatigue. The nurse recognizes his or her limitations, and issues that could contribute to burnout.

Out of the respondents, 40/44 agreed with this competency. One reviewer commented on the challenge of teaching this competency in theory versus in practice.

"In the provision of palliative and end-of-life care nurses are often faced with many losses. It is critical that they care for themselves and that they develop strategies to deal with loss, say goodbye, have closure etc. If this is not learned then it becomes very difficult to work in this field of nursing."

"Suggest the inclusion of the importance of hardiness and social support in sustained coping in this role. The characteristics of hardiness defined by Vachon (2002) are: commitment, control & challenge."

"Could this be included in effective group function? What is meant by real compassion? I like Jean Vanier's definition that goes something like compassion is competence laced with tenderness."

Specific Competency 12

Possess awareness of the full range and continuum of palliative care/end-of-life services and the settings in which they are available (e.g. home care), and the ability to access (and advocate for access where not available) timely, comprehensive, high quality palliative/end-of-life care in any setting, particularly the home (CHPCA, 2006).

The majority of the respondents (42/43) agreed with this competency. Two responses were blank. Several reviewers reminded authors not to forget palliative services offered in long-term care facilities.

"Palliative care services should be available in all areas of residency and the transition between each area should be as smooth and easy for patients and families as possible."

"I would prefer to use another verb such as: Define the full range and continuum of palliative care/end-of-life services and the settings in which they are available (e.g. home care), and facilitate access (and advocate for access where not available) timely, comprehensive, high quality palliative/end-of-life care in any setting, particularly the home (CHPCA, 2006.)"

Specific Competency 13

Have the ability to: educate and train patients and family members on care needs, identify the need for respite for family members, and safely and appropriately delegate care to other caregivers (e.g. personal care workers) (CHPCA, 2006).

The majority of the respondents (43/44) agreed with this competency. Only one response was not completed. Some concern was raised over the word "train". Recommendations to replace this word included: "coach" or "mentor".

Question 7: Is there another specific competency that is missing?

There were 36 responses to this question. Out of those responses 25 (69.4%) felt no other competency was needed, compared to 11 (30.6%) who felt a specific competency was missing.

Question 8: On a scale of 0-4, how well does the document convey the broad scope of the nursing role?

The scale that was used to measure this is as follows:
1=minimally conveys the broad scope 2=somewhat conveys the broad scope 3=conveys the broad scope 4=strongly conveys the broad scope

The majority of the respondents (55.8%) felt that this document conveys the broad scope of the nursing role. Whereas 34.9% of respondents felt that it strongly conveys this scope for nurses. For complete information about the respondents' views on the conveying of the broad scope of the nursing role in this document please see Table 2.

Table 2: Conveying the Broad Scope of the Nursing role (n=45)

	Response Count	Response %
Minimally conveys the broad scope	0	0%
Somewhat conveys the broad scope	4	9.3%
Conveys the broad scope	24	55.8%
Strongly conveys the broad scope	15	34.9%
Total	43	100%
missing data	**2**	

Question 9: On a scale of 0-4, how well does the document reflect an interprofessional role for nurses in palliative and end-of-life care?

The scale that was used to measure this is as follows:
0=does reflect this role 1=minimally reflects this role 2=somewhat reflects this role 3=reflects this role 4=strongly reflects this role

There was some disparity in these responses. While 23.8% responded that the document somewhat reflects an interprofessional role for nurses, the majority (69.1%) stated that it reflects (45.3%) or strongly reflects (23.8%) this role. For complete information about how the respondents felt that this document reflects an interprofessional role for nurses in palliative care please see Table 3.

Table 3: Interprofessional role for nurses in Palliative and End-of-Life Care

	Response Count	Response %
Minimally reflects this role	3	7.1%
Somewhat reflects this role	10	23.8%
Reflects this role	19	45.3%
Strongly reflects this role	10	23.8%
Total	42	100%
Missing data	**3**	

Question 10: Any other comments?

Further comments from the respondents included:

"Need to clarify re competencies for all nurses vs. specialists in hospice palliative care."

"Please define - differentiate Palliative & End of Life Care Also nurses & others practice according to their professional standards"

"My concern is that the Standards and the Framework might suggest that the nurse can function in the role of SW/counselor - that s/he can "do it all". Maybe we do, but it can lead to role confusion and role conflict."

"Not sure how document reflects inter-professional role"

"I am pleased to see that the competencies for the undergraduate nurse have been developed and that they reflect core knowledge and skills required."

"There is no mention of negotiating skills or conflict resolution in the role of nurse. Both are necessary in effectively working with clients, families and the ID team"

"This role needs to be changed and we need to be validated. What you have suggested here is a great beginning…."

"The document strongly reflects nursing's role...but does it speak to what the team needs from nursing..."

CONCLUSION

The Deans and Directors surveys demonstrate that Palliative and End-of-life care is currently being addressed in curriculum and that faculty would most likely be in favour of new PEOLC curriculum. However, there are many issues that would possibly be faced in the implementation of new competencies including: competing content, curriculum structure, time, faculty buy-in, approval processes, opportunities to apply knowledge in practice and uniqueness of the individual programs. A more overarching concern gathered from these findings is the ever present tension to balance generalist and specific competencies in nursing education; much of the competencies are met in a generalist curriculum, while some critical competencies are palliative specific and would thus require a specific focus.

Overall, the content experts overall were in favour of these competencies and applauded CASN for taking a lead in preparing such a document that could assist future nurses in being prepared to work in palliative and end-of-life situations. There was also encouragement to continue and further examine the holistic and interdisciplinary approach that is vital to PEOLC. A few concerns included the wording and language used in the competencies and the feasibility of teaching and evaluating these competencies.

Findings from these surveys indicate there is further work for CASN in regard to exploring options for the incorporation of these competencies into curricula.

Next Steps

1. Verify the themes/constraints identified by the 16 respondents of the Deans and Directors survey regarding the integration of competencies into curriculum with the 75 Deans and Directors of CASN member schools that did not respond to the survey.
2. Examine the use of language in the competency document (eg. artful and graceful) that does not seem to be understood or perceived as meaningful from the perspective of the survey respondents.
3. Determine existing generalist competencies and identify the ones specific to palliative and end-of-life care (identified by both Deans and Directors, and content experts) and find ways to integrate into curricula. This is important given the constraints of time, space, financial and human resources.
4. Provide leadership in nursing with regard to reconceptualizing nursing curricula by:
    a. Developing a model for curriculum that explicitly addresses the relationship between 'content' and competencies. A model could demonstrate how a curriculum could foster development of specific competencies while raising consciousness about 'big' ideas in nursing (eg. impact of systems-level factors on nursing care, professionalism in nursing), addressing key curricular threads (eg. ethics, health promotion, and relational practice), relative to particular situations and contexts (eg. culture, gender, addictions, homelessness)
    b. Working with other health professionals groups that have developed and incorporated competencies into their curricula
5. Support initiatives to incorporate PEOLC competencies into nursing education (need for financial and human resources) including: faculty development (workshops, institutes) and curriculum development.
6. Examine issues surrounding curriculum accountability for the integration of competencies the role of accreditation of nursing education standards. We must also have discussions surrounding what should be integrated and how can CASN assist its members.

The Principles and Practice of Palliative Care Nursing and Palliative Care Competencies for Canadian Nurses (July 2007)

Preamble

Definition of Palliative Care

Palliative care (CHPCA, 2002):

- affirms life and regards dying as a normal process;
- neither hastens nor postpones death;
- provides relief from pain and other distressing symptoms;
- integrates the psychological and spiritual aspects of care;
- offers a support system to help persons live as actively as possible until death; and
- offers a support system to help families cope during the person's illness and in their own bereavement.

Palliative care is "the combination of active and compassionate therapies intended to comfort and support individuals and families who are living with, or dying from, a progressive life-threatening illness, or are bereaved" (CHPCA, 2002, p. 5). Palliative care guided by the principles of Primary Health Care is characterized by care that is: accessible, participatory, inter-professional, health promoting, and uses appropriate technology and skill (CNA, 2002).

According to the World Health Organization (retrieved May 31, 2007 from http://www.who.int/cancer/palliative/definition/en/), "palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care: …

- uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications."

Nurses' Roles in Palliative Care

Professional nursing practice is based on a philosophy that nursing is interpersonal and holistic in nature. This implies that the nurse uses the nurse-patient relationship as the foundation for care in order to address the patient and family's physiological, emotional, psycho-social, spiritual, and practical needs. The achievement of an effective nurse-patient relationship, involves certain crucial attitudes and behaviours on the part of the nurse. These attitudes and behaviours allow the nurse to empathize with the patient and to be sensitive to the patient's needs without becoming overly enmeshed in the patient's situation.

The nurses' roles in palliative care encompass many interconnected dimensions. These dimensions include: valuing; finding meaning; empowering; connecting; doing for; and preserving integrity of self and others. (Davies & Oberle, 1990, cited by CHPCA, 2002). While some of these dimensions are more task oriented, others are largely attitudinal and reflect the interpersonal and holistic nature of nursing. They imply that the nurse as a professional cannot be separated from the nurse as a person, if a therapeutic nurse-patient relationship is to be achieved. Central to this is the dimension of *valuing.* The following describe the dimensions of the nurses' role:

- *Valuing* means that the nurse has a basic belief in the inherent worth of all human beings, regardless of any particular characteristics of any one individual. Valuing allows the nurse to be able to continue to respect and provide care to the patient, even under adverse conditions (Davies & Oberle, 1990).
- *Finding meaning* means that the nurse is able to assist patients to find meaning in their situations. This includes helping patients to focus on living until they die, helping them to make the best of their situation, offering hope, encouraging reflection on their life, helping them to fulfill spiritual needs, and acknowledging death by talking openly about death when patients and families want them to do so (Davies & Oberle, 1990).
- *Empowering* involves facilitating, encouraging, defusing, mending, and giving information. Facilitating builds individual and family strengths. The nurse facilitates by involving the patient and family in planning strategies, offering suggestions, explaining options, and providing information. Through these actions the nurse respects the patient and family's right and ability to make decisions. The nurse also recognizes limitations and helps them to work toward a more positive outcome. Encouraging is when the nurse acknowledges patient and family abilities, gives approval, supports choices, and encourages patients and families to do what they want. Defusing is helping the patients or families to deal with their negative feelings and giving them permission to express them. By listening openly and not acting defensively, the nurse allows the person to ventilate their anger. Mending means the nurse helps to facilitate healing between family members by interpreting behaviours and enabling individuals to see each other's point of view. Giving information pertains to the nurse's teaching and explaining about medications, changes, and pain and other symptoms. This strengthens the patient and families ability to manage for themselves (Davies & Oberle, 1990).

- *Connecting* refers to the nurse making contact with the patient and establishing a therapeutic relationship. This involves introductions, establishing credentials,

explaining roles, collecting baseline information, and explaining how to contact the nurse (Davies & Oberle, 1990).

- *Doing for* is focused on the physical care of the patient. It involves controlling pain and symptoms, making arrangements such as discharge planning and helping families to access equipment, and helping with hands-on care. Team playing is also a component of doing for. Team playing involves negotiating the system on behalf of the patient and family, consulting with other team members, sharing information, serving as a liaison between various institutions and programs, mediating on behalf of the family and often explaining, encouraging and pleading for the benefit of the patient and family (Davies & Oberle, 1990).
- *Preserving own integrity* refers to the nurse's ability to maintain feelings of self-worth, self-esteem, and energy levels in the face of routine exposure to suffering, pain and loss. This involves reflecting on what the nurse regards as important and gives meaning to life and the work that the nurse is doing. It is also influenced by the nurse's evaluation of the care she/he has given to a patient and feeling that it has helped the patient. Self-awareness, being able to acknowledge his/her own feelings and reactions is also integral to preserving own integrity. This enables the nurse to assess whether he/she is doing the right thing for the right reason and helps him/her to maintain perspective, as well as an awareness of one's own limitations. The nurse needs to accept that he/she cannot do all and be all to everyone and know when to draw the line. Otherwise exhaustion and burnout will result (Davies & Oberle, 1990).

Nurses' roles include leadership in: clinical care, education, inter-professional collaboration, system capacity, competence in palliative care, research, and policy. Palliative Care guided by the Principles of Primary Health Care would extend the nurses' role to include that of advocate. Primary health care in this context extends beyond the health care system itself to include: accessibility, community care, and the social determinants of health. Nurses also play a coordination role in supporting the family and inter-professional team. Palliative care is central to expressing and reflecting the essence of nursing and nursing care because it encompasses spiritual, emotional, family, and other non-clinical dimensions.

Effective pain management is integral to patient safety, a quality work environment, and ethical nursing practice (Canadian Nurses' Pain Issues Working Group, August 2005). "Ineffective pain management casts a dark shadow over the health experience of patients and many of their families and places patients at increased risk for morbidity and mortality. Hence ineffective pain management is a patient safety issue. Since ineffective pain management disrupts the relationships between nurses and their patients, between nurses and physicians, and between nurses and other professionals, it is a factor that affects the quality of nurses' work life. Finally, as professionals are the gatekeepers of pain management in both hospitals and community settings, ineffective pain management is a social justice issue since citizens suffer as a result of the quality of professional decision-making." (Canadian Nurses' Pain Issues Working Group, August 2005)

These guiding principles underpin the following requisite general and specific/core competencies for nurses caring for individuals and families who are facing the end of life.

General competencies

1. Engages in relational practice, which is characterized by: skill with listening; the ability to engage in difficult conversations; the ability to *be present* with patients; responsiveness; respect for lived experience and meanings arising; appreciating patient and family choices and strengths; collaborative care and fostering dignity.
2. Demonstrate knowledge of and skill in utilizing the principles and standards of palliative and end of life care in a culturally relevant Canadian context.
3. Uses reflexivity in practice, reflexivity being defined as the ability to critically reflect on the values, beliefs, and assumptions underpinning culturally relevant practice and awareness of the system level influences and discourses that impact on the caring process.
4. Practices according to the CNA Code of Ethics and the Canadian Hospice and Palliative Care Association Standards of Practice.
5. Demonstrates intentionality in practice, intentionality defined as the congruence between espoused knowledge, values, and beliefs and those used in practice (Doanne and Varcoe, 2005).
6. Engages in family-centered care defined as a relational practice that focuses on family as defined by the patient (Doane & Varcoe, 2005).
7. Utilizes evidence-based practice defined as an approach to decision making in which the clinician uses the best evidence available, in consultation with the patient and family, to decide upon which course of action is most appropriate (Retrieved April 26, 2006 from www.nhstayside.scot.nhs.uk/FoISA/Glossary.htm.; Green, 2001).
8. Shows ability in inter-professional practice, defined as practice that integrates concepts and collaborations across health disciplines/professions, and includes anyone who works under a formally accredited organization. It includes volunteers who are under the supervision of the organization (thus differentiating them from family members who provide care).
9. Practices advocacy defined as: "the process wherein the nurse, knowledgeable of the socio-political context, acts on behalf of the patient or the nursing profession to assure the delivery of quality nursing care and to promote professional standards of practice. The skills of advocacy include mediating, coordinating, clarifying, resolving conflict, and assisting the patient to acquire, interpret, and utilize health care information." (Retrieved April 26, 2006 from http://web.uccs.edu/bethelstudenthandbook/definition_of_curriculum_terms.htm)

Specific competencies

1. Possess self-awareness of personal attitudes, beliefs, and values about death and dying. It includes care of self, understanding one's own needs, developing one's own support and knowledge networks, being open to learning, and knowing how to be with suffering.
2. Exhibit skill in conducting holistic individual and family assessments, including pain and symptom management.
3. Demonstrate knowledge and skill in managing pain and symptoms.
4. Possess requisite communication skills and an ability to engage in end-of-life decision making and planning, and artfully and gracefully negotiate modes of care on an ongoing basis.
5. Possess knowledge of cultural and spiritual issues and the ability to recognize and attend to meaning in suffering.
6. Demonstrate ability to assess and attend to individual/family psychosocial and practical issues such as discharge planning.
7. Shows evidence of an ability to collaborate effectively within an integrated inter-professional team.
8. Possess knowledge and skills in recognizing and attending to ethical issues.
9. Recognize and respond to the unique needs of special populations, i.e. elders, children, those with cognitive impairment, unique and marginalized populations.
10. Demonstrate knowledge of grief and bereavement and the ability to support others.
11. Demonstrate caring for self while supporting others in their grief and bereavement. Real compassion is uplifting and contributes to personal growth; unresolved grief causes pain, which can contribute to fatigue. The nurse recognizes his or her limitations, and issues that could contribute to burnout.
12. Possess awareness of the full range and continuum of palliative care/end-of-life services and the settings in which they are available (e.g. home care), and the ability to access (and advocate for access where not available) timely, comprehensive, high quality palliative/end-of-life care in any setting, particularly the home (CHPCA, 2006).
13. Have the ability to: educate and train patients and family members on care needs, identify the need for respite for family members, and safely and appropriately delegate care to other caregivers (e.g. personal care workers) (CHPCA, 2006).

Lexicon of Commonly Used Terms

Ability to "be present" (Melnechenko, 2003): Nursing presence is an "…elusive concept in actual nursing practice" (p. 19). The pressures and demands of the current health system have led nurses to "…the need to be with patients in meaningful ways …and find ways to make a difference in the lives of their patients" (p. 19). "Inherent within our present healthcare settings lies the belief that practice methods should be standardized, measurable, and focused on productivity. Advances in science and technology sustain this belief; the focus of nursing care thus becomes driven by visions of reaching the masses. …nurses turn to routines and task-focused approaches, continuing to foster impersonal relations" (p. 18). "The increasing demands to focus on paperwork, efficiency, and numbers have driven nurses away from the bedside, leaving them feeling disconnected with practice…" (p. 19). "Presence is commonly referred to as being with or being there" (p. 19). It relates to the concepts of caring, empathy, support (Gardner, 1985, cited in Melnechenko, 2003, p. 19), and the "…therapeutic use of self in which the nurse sustains the other" (Roach, 1997, cited in Melnechenko, 2003, p. 19).

Cultural competence (Hanson, 2007): "Cultural competence is a human relational capacity to seek and find compassionate understanding within, between, and among people with differing cultural backgrounds and perspectives".

Evidence-based practice (CNA, November 2002, p. 1): "Evidence-based decision-making is a continuous interactive process involving the explicit, conscientious and judicious consideration of the best available evidence to provide care. Although rating systems have been developed to rank order this evidence, it is imperative to acknowledge that the use of the higher levels of evidence does not eliminate the need for professional clinical judgment nor for the consideration of client preferences. Evidence is information acquired through scientific evaluation of practice. Types of evidence include experimental studies such as randomized controlled trials and meta-analysis, non-experimental research studies that include quasi experimental and observational studies, expert opinion in the form of consensus documents and commission reports and historical or experiential information. Evidence-based nursing refers to the incorporation of evidence from research, clinical expertise, client preferences and other available resources to make decisions about clients. Decision-making in nursing practice is influenced by evidence and also by individual values, client choice, theories, clinical judgment, ethics, legislation and practice environments."

References

Canadian Hospice Palliative Care Association (CHPCA) Nursing Standards Committee (2002). Hospice palliative care nursing standards of practice. Ottawa, ON: Author.

CHPCA (December 2006). The Pan-Canadian Gold Standard for Palliative Home Care. Ottawa, ON: Author.

Canadian Nurses Association (CNA) (2002). Primary healthy care: A new approach to health care reform. Retrieved April 25, 2006 from http://www.cna-nurses.ca/CNA/documents/pdf/publications/PHC_presentation_Kirby_6602_e.pdf

CNA (November 2002). Position Statement: Evidence-Based Decision-Making and Nursing Practice. Retrieved June 4, 2007 from http://www.cna-nurses.ca/CNA/documents/pdf/publications/PS63_Evidence_based_Decision_making_Nursing_Practice_e.pdf.

Canadian Nurses' Pain Issues Working Group (August, 2005). Pain management: A patient safety, quality work life, and social justice issue for nursing?

Davies, B. & Oberle, K. (1990) Dimensions of the Supportive Role of the Nurse in Palliative Care. *Oncology Nursing Forum, 17*(1), 87–94.

Doane, G. & Varcoe, C. (2005). Family as relational inquiry: Developing health promoting practice. New York, NY: Lippincott, Williams, and Wilkins.

Gardner, D. 1985. Presence. In G. Bulechek & J. McCloskey (Eds.), *Nursing Interventions: Treatments for nursing diagnosis* (pp. 316-324). Philadelphia: Saunders.

Green, L.W. (2001). From research to best practices in other settings and populations. *American Journal of Human Behavior, 25*, 165-178.

Hanson, G. (3 May 2007). Cultural sensitivity in your nursing practice. Presented to Saskatchewan Registered Nurses Association, Prince Albert, Saskatchewan.

Liehr, P. (1989). The core of true presence: A loving center. *Nursing Science Quarterly, 2*(1), 7-8.

Melnechenko, K.L. (April-June 2003). To Make a Difference: Nursing Presence. *Nursing Forum, 38*(2), 18-24.

Parse, R.R. (1991). Mysteries of health and healing: Two perspectives. *Nursing Science Quarterly, 4*, 93.

Parse, R.R. (1992). Human becoming: Parse's theory of nursing. *Nursing Science Quarterly, 5*, 35-42.

Parse, R.R. (1994). Quality of life: Sciencing and living the art of human becoming. *Nursing Science Quarterly, 7*(1), 16-21.

Pettigrew, J. (1990). International nursing care: The ministry of presence. *Critical Care Nursing Clinics of North America, 2*, 503-508.

Wilson, D., Northcott, H., Truman, C., Smith, S., Anderson, M., Fainsinger, R. & Stingl, M. (2001). Location of death in Canada: A comparison of 20th century hospital and non hospital locations of death and corresponding population trends. *Evaluation and the Health Professions, 24*(4), 385-403.

Roach, M.S. (1997). Reflections on the theme. In M. Roach (Ed.), *Caring from the heart: The convergence of caring and spirituality*(pp. 7-20). New York: Paulist Press.

Watson, J. (1985). *Nursing: Human science and human care.* Norwalk, CT: Appleton Century.

APPENDIX B: Invitation to Deans/Directors

*****Le message français suit*****

On behalf of the Canadian Association of Schools of Nursing (CASN) and the CASN Task Force on Palliative/End-of-Life Care (PEOLC), the goal of this survey is to gather information that will help the CASN Task Force on PEOLC understand issues related to adoption and implementation of new PEOLC competencies in baccalaureate nursing programs. Schools of nursing are inundated with requests to include content in their curriculum. Therefore, as part of a dissemination strategy, the task force is interested in your perspective regarding the relevance of the finalized competencies. Your responses will inform the development of a dissemination strategy to facilitate buy-in and adoption of the competencies.

DEADLINE: FEBRUARY 8, 2008

To access the survey please click on the following link:
https://www.surveymonkey.com/s.aspx?sm=UrG7ZUj2vp59YDbGIXlOsA_3d_3d

If you require more information or would prefer to complete and submit a paper copy of this survey, please contact Colleen Ferris at cferris@casn.ca or fax at 613-235-4476.

Réalisé au nom de l'Association canadienne des écoles de sciences infirmières (ACESI) et de son Groupe de travail sur les soins palliatifs et en fin de vie (SPFV), le présent sondage vise à recueillir de l'information afin d'aider les membres du groupe de travail à comprendre les questions associées à l'adoption et à la mise en application de nouvelles compétences à l'égard des SPFV dans les programmes de sciences infirmières de premier cycle. Les écoles de sciences infirmières sont inondées de demandes visant l'inclusion de ce volet de théorie dans leur programme d'enseignement, et c'est pourquoi le groupe de travail cherche à connaître votre point de vue sur la pertinence de la version définitive de ces compétences. Vos réponses contribueront à élaborer une stratégie de diffusion qui facilitera l'adhésion aux compétences et leur adoption. Nous avons BESOIN de vos commentaires!

DÉLAI: le 8 février 2008

SVP cliquer ici pour accéder le sondage:
https://www.surveymonkey.com/s.aspx?sm=lbnRoqtc_2fcfq_2fQ6iDtDWOg_3d_3d

Pour obtenir de plus amples renseignements à ce sujet ou si vous préférez remplir et soumettre une version papier du sondage, veuillez écrire à Colleen Ferris par courriel, à cferris@casn.ca, ou par télécopieur, au 613-235-4476.

APPENDIX C: Invitation for Content Experts

*****le message français suit*****

On behalf of the Canadian Association of Schools of Nursing (CASN), the CASN Task Force on Palliative/End-of-Life Care (PEOLC) is seeking national consensus on PEOLC competencies for baccalaureate nurses in Canada. The goal of this survey is to obtain feedback from PEOLC experts on the content of the draft competencies. This will help the CASN Task Force on PEOLC to finalize these new PEOLC competencies.

You were identified as a content expert in PEOLC through:

- your Dean/Director because you are a faculty member either knowledgeable and informed on PEOLC, working in the area of PEOLC, or teaching course content in which some of the competencies would fit
- the Canadian Hospice Palliative Care list serve
- provincial professional associations
- networks of task force

To access the survey please click on the following link:
https://www.surveymonkey.com/s.aspx?sm=TYiUjo3T0kYNcSNOSrLW6Q_3d_3d

If you require more information or would prefer to complete and submit a paper copy of this survey, please contact Colleen Ferris at cferris@casn.ca.

DEADLINE: FEBRUARY 8, 2008

Kindest regards,
Colleen

Réalisé au nom de l'Association canadienne des écoles de sciences infirmières (ACESI) et de son Groupe de travail sur les soins palliatifs et en fin de vie (SPFV), le présent sondage vise à recueillir de l'information afin d'aider les membres du groupe de travail à comprendre les questions associées à l'adoption et à la mise en application de nouvelles compétences à l'égard des SPFV dans les programmes de sciences infirmières de premier cycle. Les écoles de sciences infirmières sont inondées de demandes visant l'inclusion de ce volet de théorie dans leur programme d'enseignement, et c'est pourquoi le groupe de travail cherche à connaître votre point de vue sur la pertinence de la version définitive de ces compétences. Vos réponses contribueront à élaborer une stratégie de diffusion qui facilitera l'adhésion aux compétences et leur adoption. Nous avons BESOIN de vos commentaires!

Au nom de l'Association canadienne des écoles de sciences infirmières (ACESI), le Groupe de travail sur les soins palliatifs et en fin de vie (SPFV) de l'ACESI cherche à dégager un consensus à l'échelle du pays au sujet des compétences des infirmières

bachelières à l'égard des SPFV au Canada. Le sondage vise à obtenir la rétroaction des experts des SPFV au sujet des compétences proposées.

Votre candidature à ce titre émane :

- de votre doyenne ou directrice, selon qui vous êtes un membre du personnel enseignant bien informé et connaissant bien les SPFV, qui travaille dans le domaine des SPFV ou qui donne un cours dont le contenu peut être associé à certaines des compétences;
- de la liste de diffusion de l'Association canadienne de soins palliatifs;
- d'une association professionnelle provinciale;
- d'un réseau de groupes de travail.

SVP cliquer ici pour accéder le sondage:
https://www.surveymonkey.com/s.aspx?sm=WSssAGJgzFaiwQs_2bh_2bD3qw_3d_3d

Pour obtenir de plus amples renseignements à ce sujet ou si vous préférez remplir et soumettre une version papier du sondage, veuillez écrire à Colleen Ferris par courriel, à cferris@casn.ca, ou par télécopieur, au 613-235-4476.

DÉLAI: le 8 février 2008

Sincèrement,
Colleen

APPENDIX D: Dean and Director Survey

Canadian Association of Schools of Nursing – Task Force on Palliative/End-of-Life Care
Survey #1: Adoption and Implementation of Palliative/End-of-Life Care Competencies
(Deans and Directors of CASN member schools)

1. Introduction

On behalf of the Canadian Association of Schools of Nursing (CASN) and the CASN Task Force on Palliative/End-of-Life Care (PEOLC), the goal of this survey is to gather information that will help the CASN Task Force on PEOLC understand issues related to adoption and implementation of new PEOLC competencies in baccalaureate nursing programs. Schools of nursing are inundated with requests to include content in their curriculum. Therefore, as part of a dissemination strategy, the task force is interested in your perspective regarding the relevance of the finalized competencies. Your responses will inform the development of a dissemination strategy to facilitate buy-in and adoption of the competencies. We NEED your input!

The attached document 'The Principles and Practice of Palliative Care Nursing and Palliative Care Competencies for Canadian Nurses (July 2007)' contains these new competencies.

An additional survey separate to this one (Survey #2) will seek input from PEOLC experts on the content of the competencies. Deans/ Directors of CASN member schools will be asked to have this separate survey completed by a faculty member both knowledgeable and informed on PEOLC, working in the area of PEOLC, or teaching course content in which some of the competencies would fit.

2. Instructions

Your participation will involve completing 13 questions. It may take you **up to 30 minutes** to complete. You will need to first review the attached document 'The Principles and Practice of Palliative Care Nursing and Palliative Care Competencies for Canadian Nurses (July 2007)' before being able to answer the questions.

Your participation is voluntary. You and your school/institution's participation and responses will be treated as confidential and anonymous. Individuals, schools of nursing and institutions will not be identified in reports. Results will be pooled and reported as aggregate data only in reports and publications. Individual quotes may be used in reports and publications, but personal and institutional identifiers will be removed from any published quotes.

If you require more information or would prefer to complete and submit a paper copy of this survey, please contact Colleen Ferris at cferris@casn.ca or fax at 613-235-4476.

Your responses are important to us. By completing and submitting this survey, you are providing CASN with permission to use your responses for research and publication purposes.

For information on CASN's Privacy Policy please refer to: www.casn.ca/Casn/policy

Please complete the survey by **February 8, 2008**.

Please note there may be follow-up emails regarding this survey.

3. Consent
1. Consent

___ I have read and understand the above information and wish to continue with this survey

___ I do not consent to the above and do not wish to participate in this survey.

Canadian Association of Schools of Nursing – Task Force on Palliative/End-of-Life Care

Survey on Adoption and Implementation of Palliative/End-of-Life Care Competencies

4. Demographic Questions

1. Please identify your school of nursing/institution: _____
2. Province/Territory of your school of nursing/institution:

   BC__ AB__ SK__ MB__ NT __ ON__ QC__

   NB__ NS__ PEI__ NF__ NU__
3. Name of Individual Completing: _____
4. Position of Individual Completing: _____

5. Questions related to Adoption and Implementation of the new PEOLC Competencies

After reviewing the attached document 'The Principles and Practice of Palliative Care Nursing and Palliative Care Competencies for Canadian Nurses (July 2007)' please answer the following questions:

1. In terms of content, how would you describe the "General Competencies" section of the document?

Strengths: _____

Areas for development: _____

Rationale or relevant sources: _____

2. Does your school of nursing currently address PEOLC competencies in the curriculum?

   Yes__
   No __

3. On a scale of 0-4, what is your estimation of the potential of faculty to favourably view the introduction of new PEOLC in the curriculum?

0 = unknown 1= limited in favour 2=somewhat in favour 3=in favour 4=in great favour

Scale number: _____

4. Delineate four key issues that you anticipate facing if you were to suggest introducing new PEOLC competencies in the curriculum

_____

5. If your school or faculty were to introduce these new competencies, what is your estimate of how this would be achieved?

   a. As one course __
   b. Integrated within different courses __
   c. Other, please specify: _____

6. What three strategies would facilitate implementing these new competencies in your setting?

7. What are three key barriers to implementing these new competencies in your setting?

8. If your school/faculty were to move forward on introducing these new competencies, what three key faculty development strategies would you recommend?

9. How would the competencies fit within other demands made on curriculum content (please describe)?

10. Any other comments?

END OF SURVEY

Thank you for taking the time to participate in this survey.

Your responses will help the CASN Task Force on PEOLC develop a dissemination strategy that will facilitate buy-in and adoption of the competencies.

For more information on the additional survey seeking input from PEOLC experts on the content of the competencies, please contact Colleen Ferris at cferris@casn.ca.

APPENDIX E: Content Expert Survey

Canadian Association of Schools of Nursing – Task Force on Palliative/End-of-Life Care
Survey #2: Content Review of Palliative/End-of-Life Care Competencies
(for Palliative/End-of-Life Care Content Experts)

1. Introduction

On behalf of the Canadian Association of Schools of Nursing (CASN), the CASN Task Force on Palliative/End-of-Life Care (PEOLC) is seeking national consensus on PEOLC competencies for baccalaureate nurses in Canada. The goal of this survey is to obtain feedback from PEOLC experts on the content of the draft competencies. This will help the CASN Task Force on PEOLC to finalize these new PEOLC competencies.

You were identified as a content expert in PEOLC through:

- your Dean/Director because you are a faculty member either knowledgeable and informed on PEOLC, working in the area of PEOLC, or teaching course content in which some of the competencies would fit
- the Canadian Hospice Palliative Care list serve
- provincial professional associations
- networks of task force

The attached document 'The Principles and Practice of Palliative Care Nursing and Palliative Care Competencies for Canadian Nurses (July 2007)' contains these new competencies.

An additional survey separate to this one (Survey #1) will seek input from Deans and Directors of CASN member schools of nursing on issues related to adoption and implementation of these new PEOLC competencies. Deans/ Directors of CASN member schools have also been asked to have this survey completed by a faculty member either knowledgeable and informed on PEOLC, working in the area of PEOLC, or teaching course content in which some of the competencies would fit.

2. Instructions

Your participation will involve completing 10 questions. It may take you up to30 minutes to complete. You will need to first review the attached document 'The Principles and Practice of Palliative Care Nursing and Palliative Care Competencies for Canadian Nurses
(July 2007)' before being able to answer the questions.

Your participation is voluntary. You and your school/institution's participation and responses will be treated as confidential and anonymous. Individuals, schools of nursing and institutions will not be identified in reports. Results will be pooled and reported as aggregate data only in reports and publications. Individual quotes may be used in reports

and publications, but personal and institutional identifiers will be removed from any published quotes.

If you require more information or would prefer to complete and submit a paper copy of this survey, please contact Colleen Ferris at cferris@casn.ca.

Your responses are important to us. By completing and submitting this survey, you are providing CASN with permission to use your responses for research and publication purposes.

For information on CASN's Privacy Policy please refer to: www.casn.ca/Casn/policy

Please complete the survey by **February 8, 2008**.

Please note there may be follow-up emails regarding this survey.

3. Consent

___ I have read and understand the above information and wish to continue with this survey
___ I do not consent to the above and do not wish to participate in this survey.

Canadian Association of Schools of Nursing – Task Force on Palliative/End-of-Life Care

Survey #2: Content Review of Palliative/End-of-Life Care Competencies

Demographic Questions

5. Please identify your institution: _____

6. Province/Territory of your school of nursing/institution:

   BC__ AB__ SK__ MB__ NT __ ON__ QC__

   NB__ NS__ PEI__ NF__ NU__

7. Name of Individual Completing: _____

8. Position of Individual Completing: _____

After reviewing the attached document 'The Principles and Practice of Palliative Care Nursing and Palliative Care Competencies for Canadian Nurses (July 2007)' please answer the following questions:

Questions related to Content of the new PEOLC Competencies

9. In terms of content, how would you describe the 'Preamble' section of the document?
Strengths:

_____

_____

Areas for development: _____

_____

_____

Rationale or relevant sources: _____

_____

10. In terms of content, do you feel that the 'Specific Competencies' section of this document is appropriate?

SPECIFIC COMPETENCIES		COMMENTS
1. Possess self-awareness of personal attitudes, beliefs, and values about death and dying. It includes care of self, understanding	Agree __ Disagree __	

	one's own needs, developing one's own support and knowledge networks, being open to learning, and knowing how to be with suffering		
	2. Exhibit skill in conducting holistic individual and family assessments, including pain and symptom management.	Agree __ Disagree __	
	3. Demonstrate knowledge and skill in managing pain and symptoms.	Agree __ Disagree __	
	4. Possess requisite communication skills and an ability to engage in end-of-life decision making and planning, and artfully and gracefully negotiate modes of care on an ongoing basis.	Agree __ Disagree __	
	5. Possess knowledge of cultural and spiritual issues and the ability to recognize and attend to meaning in suffering.	Agree __ Disagree __	
	6. Demonstrate ability to assess and attend to individual/family psychosocial and practical issues such as discharge planning.	Agree __ Disagree __	
	7. Shows evidence of an ability to	Agree __	

collaborate effectively within an integrated inter-professional team.	Disagree __	
8. Possess knowledge and skills in recognizing and attending to ethical issues.	Agree __ Disagree __	
9. Recognize and respond to the unique needs of special populations, i.e. elders, children, those with cognitive impairment, unique and marginalized populations.	Agree __ Disagree __	
10. Demonstrate knowledge of grief and bereavement and the ability to support others.	Agree __ Disagree __	
11. Demonstrate caring for self while supporting others in their grief and bereavement. Real compassion is uplifting and contributes to personal growth; unresolved grief causes pain, which can contribute to fatigue. The nurse recognizes his or her limitations, and issues that could contribute to burnout.	Agree __ Disagree __	

12. Possess awareness of the full range and continuum of palliative care/end-of-life services and the settings in which they are available (e.g. home care), and the ability to access (and advocate for access where not available) timely, comprehensive, high quality palliative/end-of-life care in any setting, particularly the home (CHPCA, 2006).	Agree __ Disagree __	
13. Have the ability to: educate and train patients and family members on care needs, identify the need for respite for family members, and safely and appropriately delegate care to other caregivers (e.g. personal care workers) (CHPCA, 2006).	Agree __ Disagree __	

Is there another specific competency that is missing?

Yes __
No __
If yes, please specify: _____

_____

11. On a scale of 0-4, how well does the document convey the broad scope of the nursing role? 0=does not convey the broad scope 1=minimally conveys the broad scope 2=somewhat conveys the broad scope 3=conveys the broad scope 4=strongly conveys the broad scope
    Scale Number: _____

12. On a scale of 0-4, how well does the document reflect an interprofessional role for nurses in palliative and end-of-life care? 0=does reflect this role 1=minimally reflects this role 2=somewhat reflects this role 3=reflects this role 4=strongly reflects this role
    Scale Number: _____

13. Any other comments? _____
_____
_____

END OF SURVEY

Thank you for taking the time to participate in this survey.

Your responses will help the CASN Task Force on PEOLC develop a dissemination strategy that will facilitate buy-in and adoption of the competencies.

For more information on the additional survey seeking input from PEOLC experts on the content of the competencies, please contact Colleen Ferris at cferris@casn.ca.

ACKNOWLEDGEMENTS

This process and report have been accomplished thanks to the work and dedication of the following individuals:

CASN Task Force on Palliative and End-of-Life Care

Brenda Jacono - CHAIR
Cape Breton University

David Gregory – BOARD LIASION
University of Lethbridge

Sharon Baxter
Canadian Hospice Palliative Care Association

Beryl Cable-Williams
Trent University

Cathy Foster
Brandon Univerity

Dennie Hycha
Regional Palliative Care Program, Capital Health

Heather Jewes
St. Francis Xavier University

Mireille Lavoie
Université Laval

Mitzi Grace Mitchell
York University

Holly Richardson
Dalhousie University

Lynne Young
University of Victoria

CASN Executive Director

Ellen Rukholm

CASN Communications Officer

Colleen Ferris

CASN Information Officer

Alicia Ashton

REFERENCES

Mallory, J. (2003). The impact of a palliative care educational component on attitudes toward care of the dying in undergraduate nursing students. *Journal of Professional Nursing, 19* (5), pp.305-312