

**DYING TO KNOW:  
ADVANCING PALLIATIVE CARE NURSING  
COMPETENCE WITH EDUCATION IN ELDERLY  
HEALTH SETTINGS**

by

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## **ABSTRACT**

This paper explores the benefits of using education as one means to advance palliative care competence for nurses. Key groups and the influences they generate in relation to this topic will be identified.

A literature search using key words was conducted revealing numerous educational initiatives and approaches have been developed to improve palliative care. Benefits include improved nursing knowledge, confidence and competence which directly correlate with improved patient outcomes.

Palliative care is no longer the sole domain of specialised providers such as Hospices. Accompanying the shift of palliative care from Hospices to varied health care providers globally, are disparities in care provision. The literature suggests that reasons for such disparities include insufficient specialised palliative care knowledge and skills of nurses to effectively deliver this care within generalist health settings and lack of information for caregivers. In response, approaches aimed at improving palliative care include reviewing, redefining and implementing nursing roles, education courses, and theoretical frameworks to inform practice and improve outcomes. This paper focuses on the benefits of offering tailored palliative care education in work settings to improve patient care.

One entrepreneurial education initiative aimed at advancing palliative nursing and which is currently being implemented in aged care contexts will be shared.

Careful strategic planning and working more collaboratively between all stakeholders, is strongly recommended in order to manage current and future challenges. Advancing palliative nursing care using appropriate education is achievable and beneficial but is fraught with complexities.

**Keywords:** Nursing, Education, Palliative Care, Benefits, Challenges

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## **DEDICATION**

This research paper is dedicated in honour of the work pioneered by Dame Cecily Saunders and to current nursing pioneers and visionaries of tomorrow, who are committed to growing and improving palliative care globally.

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## **SECTION ONE: Friend or Foe**

### INTRODUCTION

Despite all nurses being involved in the delivery of care to dying people albeit to a greater or lesser degree, there remains marked variability of knowledge and skill surrounding both the care provided and outcomes achieved. I maintain that one way of addressing disparities is through the provision of relevant and readily available palliative care education. I have an abiding interest in the advancement of professional development with education and observe that some colleagues either embrace this as a friend or view it as a foe.

With this in mind and as organisations are in the process of addressing both systems and staff training needs about palliative care in response to relevant government policies, I wanted to offer an educational opportunity for nurses within my local region. Reviewing national palliative care education initiatives and associated challenges led to the development of my topic for exploration and subsequent aims.

### Topic and aims for exploration

Advancing generalist palliative care competence for nurses and caregivers using education with the aim of: exploring the benefits of providing palliative care education for all nurses, exploring the influences that impact on advancing palliative nursing care competence with education, identifying and exploring some educational theories and sharing one entrepreneurial education initiative that aims to advance palliative care competence within aged care contexts.

### Exploratory approach

A combined approach of literature review and biographical statement alongside my area of practice statement were used to explore and support the topic. A literature review is one means of gaining an understanding of the topic being explored. It involves a methodical process of pursuing one or more lines of enquiry in order to become better informed about a chosen topic (Hart, 1998). 1



The ability to identify who we are and what we do is an essential part of palliative care practice. Professional nursing credibility comes under scrutiny by consumers of our care. In relation to the consumers of the palliative care education I offer, I need to be able to validate and demonstrate that I am not only competent to educate on this topic but can also demonstrate this practically. An autobiography paved the way to introduce how the topic and aims were developed and explored.

My area of practice as a registered nurse includes palliative care, elderly health, health care education and management. While working within a Hospice inpatient unit I observed that we (the Hospice) were fielding many calls from public and community health care providers consistently seeking basic palliative care symptom management guidance. We were also experiencing admissions to the inpatient unit, of people whose symptoms I believe, could have been comfortably and effectively managed within the respective health care environments from where they came. While applauding collegial enquiry aimed at improving client outcomes, I simultaneously questioned the level of palliative care education colleagues within these settings had undertaken or had access too.

In the absence of any formal palliative care educator within the region I recognized this need as being one opportunity to use my knowledge and skills for the common good. I was engaged in studying towards my MA (Applied) in Nursing, which included a Postgraduate Certificate in Palliative Care as well as a Diploma in Adult Education and Learning. I had previous experience as a nurse educator. I had a passion for palliative care and elderly health and had previous experience managing residential care facilities for the elderly all of which provided me with unique insights into care provision and staff training requirements for this specific client population group. This observation led to the development of my chosen topic for exploration.

This paper has as its central focus the advancement of palliative care competence through education. Section two explores palliative care and nursing education as separate entities, providing background information that situates the context of the work to follow. From this position I have focused attention on three areas. The influences that impact on advancing palliative care nursing competence and is presented in section three. The second identifies the benefits of advancing all nurses knowledge of palliative care and explores some theories of learning as well as information relating to knowledge acquisition, transfer and utilization. This is located in section four. The third a case study, shares one educational initiative developed by myself which is aimed at advancing palliative care, currently being implemented within Residential aged care settings in Invercargill, New Zealand. This is located in section five. Section six, a conclusion, completes the work.





## **SECTION TWO: Parallel Pathways: The advancement of palliative care and palliative nursing education**

This section presents background information about palliative care and related nursing education. An overview of each as separate entities will be provided to reveal their development as they progress along parallel pathways of advancement.

### Palliative Care

Palliative care as a practice has existed since the beginning of time when dying was viewed in its most basic application as end of life care. Nursing care of the dying was primarily the responsibility of family members with symptoms being managed using the knowledge and practice of remedies being passed down to chosen people throughout the generations. Accessibility and affordability of shared care with a medical doctor was largely available then to those who could afford to pay.

In family and community, life, death and dying are recognised as normal events of the life cycle. Palliative care and symptom management are relatively recent medical terms recognised in New Zealand communities and have become popularised since the work of Elizabeth Kubler- Ross (1969) and Dame Cecily Saunders (Smith, 2005).

### Early days: The inception of the modern Hospice movement

The identification of the specific needs of individuals who are dying can be largely attributed to the work of the late Dame Cecily Saunders (1918-2005). A former nurse, medical social worker and latterly doctor, her pioneering work and passion for improving care for dying people, has and continues to help shape and influence palliative care today.

Saunders identified that symptomatic relief of physical pain was only one aspect in providing effective end of life care, and she expanded on the pain concept to include physical, spiritual, psychological and social dimensions (Smith, 2005).

I draw interesting conclusions from her observations when comparing the often perceived crude care of earlier years and what she describes as the current components of effective palliative care. Despite clearly impoverished physical symptom control synonymous with medical knowledge of the time, previous generations amply provided for the spiritual and psychosocial dimensions so necessary in such care. Interestingly symptom control remains one issue in palliative care that is often mismanaged and misunderstood, despite our medical, nursing and health technology advancements today.

Saunders opened her first Hospice or designated place of dying, St Christophers, in London in 1967 and commenced the first home based care provision of palliative care in 1969. In 1974 she sent a team of Doctors to the United States of America and from there the Hospice movement has gradually spread throughout the world.

The advent of Hospices saw the shift in care provision from earlier years when individuals were cared for in their own homes to an alternative care provider. The provider was perceived as being more equipped and better able to effectively provide care for the dying.

Saunders' work has provided a solid and fertile foundation on which to further build and develop our ongoing understandings and approaches to palliative care.

### Palliative Care Defined

Palliative care is defined by the World Health Organisation (2005) as being:

“An approach that improves the quality of life of patients and their families facing the problem 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” ([www.who.int/cancer](http://www.who.int/cancer)).

This definition evolved after much discussion and input from many contributors who shared collective knowledge and understandings gained from their varied experiences caring for dying people. Note that palliative care here is described as an approach and that assessment requires the highest order of care.

This is quite a pivotal concept for me in that it denotes that palliative care is a way of caring and can be viewed as a philosophy underpinning care, rather than simply being an end in itself. Given that palliative care can be viewed as a philosophical approach to care for dying people, it can theoretically, be implemented in any clinical setting. It cannot be simply administered however, without the sharing of knowledge fundamental to the components it comprises. Impeccable assessment requires reflection on the practice of palliative care. It is a learned art based on a huge body of knowledge. This is where I believe, education plays a vital role in advancing palliative care provision. This will be demonstrated in the case study in section five.

### The changing face of palliative care

People of all ages are being assisted to live longer as a result of advancing health knowledge, technology and management approaches. Increased longevity is not without its' challenges and while individuals may indeed be living longer, they have an increased risk of developing a number of age related health issues and co-morbidities that may require admission to a public hospital or residential care facility for management. Regardless of whether our population is ageing or not however, death remains a given component of any lifespan.

In the last 20 years there has been a tremendous growth in Residential Care facilities providing total care for older people, to include end of life care. The New Zealand Palliative Care Strategy (2001) recognises that dying people's preferred place of death is at home but what of those individuals residing in residential care settings that have become their homes? This has heralded yet another significant shift in end of life care provision. Palliative care then is no longer the sole domain of specialised providers such as Hospices. It would seem a reasonable assumption then, that all health care providers are able to adequately and effectively provide end of life care as one aspect of their service. But is this the case? Such care as Curow and Hegarty (2006) identified, requires a generalist as well as specialist set of medical and nursing skills underpinned by a comprehensive knowledge base.

### Impacts of shifting palliative care provision

The subsequent shift in palliative care from Hospice providers to generalist or residential care settings, has not been without its' causalities, among which are disparities in care provision for consumers (Thompson & McClement, 2002); McDonnell, Johnston, Gallagher & McGlade, 2002; Dowell, 2002; Fisher, 2005; Hanson, Reynolds, Henderson & Pickard, 2005). New Zealand reflects global findings in this regard.



The healthcare providers in such instances are not only challenged but also mandated by government policy and funding initiatives, to be able to meet varied health care needs and illness processes, to include palliative care.

Mandates and initiatives include: The New Zealand Health Strategy (2000); The New Zealand Palliative Care Strategy (2001); The Positive Ageing Strategy (2001); The New Zealand Cancer Control Strategy (2003); and The New Zealand Cancer Control Strategy Action Plan 2005-2010 (2005). Local policies include: The Southland District Health Board Strategic Business Plan 2005-2010 (2005). All these documents acknowledge in some way that people should have access to appropriate health services to include palliative care and that this should be administered by a suitably trained workforce.

Research aimed at identifying nurses perceptions of the efficacy of their palliative care provision in hospital and residential care settings, has identified various perceived inadequacies and challenges associated with implementing such care (Fisher, 2005; Goodridge, Bond, Cameron & McKean, 2005). Nurses within these settings have identified that inadequate palliative care knowledge and skills, hinders their ability to provide effective care (McDowell, Johnston, & McGlade, 2002). Experiential or on the job learning alone is not deemed by nurses, sufficient to rectify these deficits. One way the literature has identified to address these issues, is the provision of appropriate education relevant to palliative care that incorporates relevant empirical knowledge that will inform and enhance practice (McClement and Degner, 2005).

#### Nursing Education and Palliative Care

Education is defined by the Collins English Dictionary (1991) as the act or process of acquiring knowledge (p 496). Nursing knowledge acquisition springs from many different sources and includes theoretical, clinical or experiential learning components and intuitive knowledge (Benner, 1984). Nursing education as with other evolutionary processes has and continues to be reshaped, redefined and repackaged.

A shift in preparing nurses for their role in managing end of life care has occurred also. Prior to the transfer of nursing education to the tertiary sector palliative nursing education was largely focused on the physical aspects of how to 'lay out' the dead person. Current undergraduate nursing curricula offer a much expanded learning component around many aspects of death and dying, largely informed by the work of pioneers such as Saunders and Kubler-Ross. This reflects the New Zealand Palliative Care Strategy's staff training vision, which recognises the need to make available relevant training at both undergraduate and post-graduate levels (New Zealand Palliative Care Strategy, 2001, p19).

Kuebler and Moore (2002) suggest that palliative care nursing education is limited, inconsistent and sometimes neglected. When contemplating the implications of this belief, I recognize that advancement has occurred and would cite current undergraduate nursing curricula in New Zealand as an example of this shift. I do however concur with their findings in relation to the education and training gaps for postgraduate and other care provider groups.

#### Post-graduate Palliative Care Education In New Zealand

Of the available post-graduate palliative care courses currently offered, most are administered by tertiary providers including universities, polytechnics and Hospice New Zealand who work in collaboration with Whitireia Polytechnic. Courses are mostly available to registered nurses only with the exception of Hospice New Zealand whose modular course in palliative care makes the learning of modules one and two available to enrolled nurses also. Enrolled nurse participants do not receive a formal academic qualification but rather receive a certificate of attendance in recognition of their participation. Most tertiary programs of study require the completion of two academic papers or their equivalent which results in the achievement of a post-graduate certificate in a given practice specialty.

One limitation I recognise with current palliative care education is that it is not adequately inclusive of all area of practice levels for nursing care providers. Another perceived limitation is that not all generalist nurses wish to engage in lengthy tertiary academic pathways as a means to enhance their professional knowledge and practice in this regard.

I question the suitability of a tertiary approach as being the only option for generalist nurses who simply wish to avail themselves of specific palliative care knowledge and skills relevant and applicable to their varied practice contexts. This is not to say that there is no place for such programmes of study but rather I question the privileging of postgraduate education in palliative care as being the predominant option available for nurses to access. I am mindful also that care provision in some clinical settings for example aged care, is administered largely by care givers under the direction of a registered nurse. Caregivers also have specific educational needs in this regard.

I am aware that nationally there are others who have been proactive in attempting to address these educational needs in their community settings and are documenting outcomes. Nurses, Meldrum and Gellately have been funded specifically by their Hospices and health boards to provide academic leadership and palliative mentoring to their colleagues in local residential elderly care settings (Personal Communication, 2006). The literature has identified many complexities inherent in developing and implementing suitable palliative care and other nursing education programs in ways that satisfactorily meet varied consumer needs (Froggat, 2000; Davey, Neale & Matthews, 2003; Dickson, Gray & Hayllar, 2005).

## CONCLUSION

This section has briefly explored palliative nursing care and related education. The information shared, provided necessary background information to lead into discussion of those influences that have an impact when combining the two to advance palliative care nursing competence. The influences will be explored in section three to follow.



**SECTION THREE: The Melting Pot: The varying influences on palliative care practice.**

**INTRODUCTION**

There are many influences that impact on attempting to advance palliative care competence with education. These can best be understood when viewed separately and in context of the key groups identified as being central to this discussion. I have categorised the key groups and influences to be addressed in this section in Table 1. While the influences originating from each group will be presented as separate entities, the interdependent nature of their relationships and how they collectively contribute to the topic being explored will become apparent. The key group influences form the main topic headings in this section and where appropriate, subheadings for related information to support each main topic have been used.

Table 1: Key groups and their influences in advancing palliative care competence with education

<b><u>Key Groups</u></b>		<b><u>Influences</u></b>
Society	→	Socio-cultural
Political Government	→	Political
Nursing Council	→	Regulatory
Health Care Organisations	→	Organisational
Education Providers	→	Educational
Nurses and Professional Organisations	→	Professional

Why is it important to understand the nature of what influences palliative care? I regard my role as a manager and educator in health to be one of interpreting and analysing national documents and trends and being able to impart this understanding appropriately to colleagues who work at the bedside. These colleagues may not have had an opportunity to access documents or be involved in the debates or discussions that have informed the policies that so directly impact, almost invisibly, on their practice world.

I consider that education empowers nurses to understand how these invisible influences can be engaged with and in turn shaped for the common good. I have been witness to how education enables nurses to take ownership of their practice environments and as a result become more able to determine the need to advocate for change. In this section I have taken the opportunity to provide a few examples of how political speak is transferred and located by nurses, using colloquial language to pin down what these expressions mean to them at the bedside.

#### Socio-cultural Influences

Attitudes, values, beliefs and expectations surrounding end of life care are largely influenced by the societies in which we are raised and live. The advent of more accessible and affordable international travel amongst other things, has contributed to the reshuffling of societal make up. In some instances once largely mono-cultural societies have altered and now comprise multi-cultural components. Each cultural group within these societies, bring with them their unique set of values, beliefs and practices about end of life care.

One of the biggest challenges facing health professionals has been to try and establish a universally safe and acceptable approach to managing end of life care in ways that honour amongst other things social and cultural differences.

Palliative care is one approach that when delivered effectively, honours these differences and attempts to incorporate such considerations into care provided. As with other nursing models of care, consumers are placed central to care assessment, planning, implementation and evaluation.

Consumers of palliative and health care in general have and continue to become more informed about their rights in relation to service provision. Consumer confidence is growing in relation to advocating for care that is more responsive to meet their needs. Consumer expectation and demand then is central to shaping and evaluating the efficacy of health care provision to include end of life services.

An example of honouring socio-cultural differences might include recognition that family members are fearful of the impending death of a loved one and are physically, spiritually and emotionally worn out from maintaining a bedside vigil. The provision of well intentioned and appropriately informed loving support transcends all cultures. The nurse might arrange to speak with the family members in order to ascertain how they are all coping. During facilitated discussions she might be the mirror that reflects back to the family that she recognises they are looking “tired and afraid”. Giving voice to this reality can promote conversations around need identification at this time and allow for some gentle guidance and permission to press the ‘pause’ button. Fears may or may not be able to be discussed at that time, however once skillfully identified by the nurse outcomes can be respected and accommodated.

It might be that the physical need for sleep is of paramount importance and so the nurse in discussion with family members could explore how this might be best achieved. Several priority needs may be competing for attention simultaneously, for example physical tiredness and intense emotional sorrow.



The nurse can assess the need to give stoical family members permission to simply have a good cry in a place that is safe for them to express their grief, offering a supportive presence if needed. Public displays of grief are not always appropriate for everyone. Verbal and nonverbal cues given by clients or family members provide the 'in tune' nurse with valuable information so that appropriate assistance can be offered.

Palliative care does not simply involve or focus on the individual but recognises and includes the family and greater social structure and context to which they belong and identify. Every journey is unique and while there may be similarities in palliative care scenarios, effective care is that which honours both the similarities and the differences.

To meet growing demand and consumer expectation from an ever increasing informed public, nurses and providers of palliative care must avail themselves of opportunities to obtain the necessary knowledge and skills required to meet these varied needs. If needs are not met consumers will justifiably complain (Bill of Rights Act, 1990; Human Rights Act, 1993; Human Rights Act Amendment, 2001).

#### Political Influences:

Political influences are powerful in directing and funding palliative care outcomes. Governments are charged with the responsibility for deciding what the priority issues are in this regard and how these will be addressed and funded. In New Zealand the Palliative Care Strategy was developed in 2001. This document broadly outlines the vision for the development and provision of palliative care services in New Zealand. The document comprises 9 strategies each aimed at supporting the overall vision. Strategy 9 relates to the development of the palliative care workforce and training. In relation to workforce training requirements, the Strategy recognises the difficulties inherent in attempting to estimate these as palliative care services evolve (p 41).

The development and release of The New Zealand Cancer Control Strategy, (2003), and The New Zealand Cancer Control Strategy Action Plan (2005), followed closely after the Palliative Care Strategy. These documents compliment each other and aim to support the seamless transition of health care provision to clients along a continuum of care, encompassing acute to chronic and end of life stages.

An example of complimentary alignment between these policy documents is Goal 4 and associated objectives of the Cancer Control Strategy (2003), which relates to the improvement of quality of life for those with cancer and their family, through appropriate support, rehabilitation and palliative care (pp 39 - 46). While the overall focus of this strategy is to minimise and reduce the incidence of cancer in New Zealand this particular goal recognises and acknowledges the role of palliative care as being one component of overall cancer care provision.

As well as developing and implementing health policies and strategies, governments need to consider the funding required to meet achievability of these as they relate to the development and advancement of the workforce responsible for providing the care.

#### Funding and The Clinical Training Agency (CTA)

The clinical training agency is one funding arm of the government.

“The role of the CTA is to facilitate the development of the health and disability workforce through funding of Post Entry Clinical Training (PECT). The strategy takes into account government direction, service requirements and workforce trends, and has been developed in consultation with many stakeholders to help forecast the required numbers of trainees for the next 10 years” ([www.moh.govt/moh](http://www.moh.govt/moh) 2006).

The CTA has made available funding for post-graduate palliative care courses for registered nurses. An initial period of five years was decided upon by the government to be sufficient in meeting this particular educational need. Despite programs of study being well supported by registered nurses nationally, the future beyond the five year period was not considered.

A significant change in funding administration has recently occurred. Initially the CTA directly allocated funding to tertiary providers for administering these programs of training. Now the responsibility for funding palliative care and other government courses of priority has been devolved to the District Health Boards of each region to administer. The implications associated with devolving funding responsibility and allocation will have a huge impact on the ongoing professional development of nurses wanting to up-skill in this area.

District Health Boards have to decide where the limited CTA funding will best be spent to include staff from all specialties in need of professional development. Initially nurses who could be guaranteed funding assistance to complete their tertiary studies in palliative care now have to compete with colleagues who seek funding to advance their practice in alternative specialties. I believe the motivation to self fund expensive tertiary studies may be a deterrent for many nurses.

#### Tertiary Education Commission (TEC)

“The Tertiary Education Commission is a crown entity responsible for funding the Government’s contribution to tertiary education and training offered by universities, polytechnics, colleges of education, wananga, private training establishments, foundation education agencies, industry training organizations and adult and community education providers” ([www.tec.govt.nz](http://www.tec.govt.nz) 2006).

One aim of the TEC is to work collaboratively with the tertiary education sector to support the development of New Zealand's knowledge society. It seeks to achieve this by improving the strategic use of resources, enhance strategic capability building and to implement the Government's Tertiary Education Strategy 2002-2007 ([www.tec.govt.nz](http://www.tec.govt.nz) 2006).

Funding here is designed and allocated exclusively for tertiary providers. Courses with a duration totaling less than 6 months do not receive any governmental funding assistance at all. This can result in making the development of alternative palliative care courses less viable and attractive to develop for other education providers. Watson, (2006) believes that changing educational directions and funding reforms may also create tensions between education providers. Healthy tensions are I believe an important role in ensuring provider accountability and responsiveness to changing consumer needs.

If the tensions created are too competitive however, this can result in destroying the potentially collaborative opportunities between providers. Rather than enhancing palliative care education choice and availability government policies and funding initiatives in this instance, serve to further narrow and restrict professional development opportunities. Hennessy and Spurgeon (2000) believe that nurses can influence health policy and funding initiatives by advocating their needs in this debate. Nurses interested in pursuing palliative care education courses would benefit from encouragement to articulate their needs in ways that effect appropriate change at both political and ultimately clinical nursing levels.

### Regulatory Influences

The regulatory body for nurses within this country is the Nursing Council of New Zealand. One aspect of its' role is to ensure that nurses are competent to practice within their identified scopes. Competence is defined by the Nursing Council as the combination of skills, knowledge, attitudes and values that underpin effective performance as a nurse (2003, p1). The Council monitors and guides nurses in the achievement of competence using the Guidelines for Competence-based Practising Certificates for Registered and Enrolled Nurses (2000), Continuing Competence Framework (Nursing Council of New Zealand, (2003), Health Practitioners Competence Assurance Act (2003), and Competencies for the Registered Nurse scope of practice (2005).

These documents outline the Council's requirements and expectations for New Zealand nurses to adopt in order to demonstrate their competency and maintain practice certification. One such expectation is that nurses will take greater responsibility for maintaining their ongoing professional development and can demonstrate the relevance of any training undertaken as it relates to advancing care within their given practice contexts.

Competence to practice can be assessed by the submission of a mandatory portfolio. All nurses must undertake no less than 60 hours of professional development training and complete 450 hours of clinical practice every three years. The portfolio is one means to compile and record this information. Provision is made for nurses to share with Council, practice advancement as it relates to their scoped competencies (Endacott, Gray, Jasper, McMullan, Miller, Scholes & Webb, 2004). New Zealand Nursing Council requirements and directions reflect global trends in this regard. Unlike the Royal College of Nursing in England however, the New Zealand Nursing Council has not as yet assisted with the development of a specific competence framework for nurses working within palliative care settings (Royal College of Nursing, 2002). 19

The competency based focus of the Council is I believe very appropriate, however assessment processes used to determine competence have not yet been rigorously analysed for their efficacy. Nurses can feel confident in their palliative care provision but lack competence and conversely nurses can demonstrate competent palliative care practice yet lack confidence. Competence and confidence do not necessarily occur simultaneously.

The written means to demonstrate or support competence as currently required by Nursing Council is I believe, not without limitations. Guarding against professional complacency and encouraging nurses to be more accountable for their current and ongoing practice advancement, is however beneficial. Palliative nursing knowledge and related health care trends are dynamic and therefore I believe nurses have a professional and moral responsibility to remain abreast of such changes in order to provide adequate palliative care. I am uncertain if the Nursing Council assessment processes adequately ascertain the palliative care competence of generalist nurses who work within aged care contexts for example.

The competency framework does allow nurses to engage more consciously in the process of critical reflection and analysis of their practice performance. This process as Price (2004) suggests, safely supports identification of nursing care limitations and advocates training to rectify deficits while at the same time acknowledges nursing care strengths.

#### Organisational Influences:

Health care organisations have the unenviable task of juggling and managing many competing demands in the planning and delivery of health services to include palliative care. Demands include: socio-political, professional, service industry and regulatory, consumer demands and expectations (Bensemen, Findsen & Scott, (1996); Ministry of Health (2003; 2001); Ministry of Education (2003); Goodridge, Bond, Cameron & McKean, (2005); Chiarella, (2006).

Health care organisations are challenged to uphold their responsibilities towards progressing the palliative care strategy and the competing demands of other governmental initiatives and strategies simultaneously vying for precious health funding. Health care organisations have responsibilities and vested interests in supporting ongoing professional development of their staff if they are to demonstrate how they are meeting these government directed and industry specific strategies (Clifford, & Robatham, 1997).

In relation to the palliative care strategy, funding is apportioned to service providers within local communities for whom they are responsible and not only includes services but also ongoing professional development. In times of fiscal constraints health care providers are facing even more challenges in having to decide where and how to appropriately spend their valuable funds. Audits are also conducted to ensure compliance and accountability (The New Zealand Cancer Control Strategy Action Plan 2005-2010, 2005).

Some challenges facing organisations deciding how to spend allocated palliative care funding include: cost of supporting generalist versus specialist training simultaneously; implementing competing program types and or changing educational roles or approaches (Ellershaw, Foster, Shea & Overill, 1997).

Coupled with this is the challenge of providing services using a transient workforce and fluctuating staffing levels (Pelletier, 2005; North, Hughes, Findlayson, Rasmussen, Ashton, Campbell & Tomkins, 2006). In times of staff retention and recruitment difficulties, organisations need to rationalise the benefits of spending money for staff on specific professional development, with the uncertainty of staff remaining in their respective areas and sharing knowledge and skills learned.

Organisations are also challenged to look at alternative ways to support professional development and this may include release time from ward and rostered duties in order to undertake programs of study. Cultures of learning and organisational attitudes towards this need to be nurtured and supported in order for staff to feel that their new knowledge and skills will be accepted, valued and shared (Froggatt, 2000; Lugton & McIntyre, 2005). If palliative care could be recognised as a generalised approach underpinning all end of life care delivered by health care providers, then this could make it easier to promote widespread training in this regard. This would also honor the palliative care strategy vision and staff needs simultaneously.

Clifford and Robotham (1997) when reviewing the impacts of changing health care management on nursing care, identified that changing philosophies in both domains have simultaneously developed alongside each other (p 55). Collaboration then between these two groups especially is vital in managing current and future palliative care provision and outcomes. Effective collaboration I believe is that which recognises the collective potential and seeks active commitment of all involved to work together in ways that maximise synergistic outcomes.

#### Educational Influences:

Education providers are yet another group who are constantly being challenged to meet varied needs and demands to include: socio-political directions and expectations, (Palliative Care Strategy, 2001; Chiarella, 2006; Tertiary Education Strategy 2002-2007); funding reductions and allocation amendments (Ministry of Education, 2003; Clinical Training Agency Strategic Intentions, 2004- 2013); increasing and variable consumer numbers, age and demands (Ehrlich, 1995; Ehlers, 2000; Kenny, 2003); changing knowledge, trends, technologies and approaches (Wood, 1990; Payne, Seymour & Singleton, 2004; Dickson, Grey & Hayllar, 2005; McAllister, 2005); and provider competition.



Given that the majority of palliative care programs are administered by or in collaboration with tertiary providers, course development is complex and must reflect robust and rigorous academic content and processes. Much time, energy and resourcing accompanies course development and implementation. In the fickle world of changing consumer need, government direction and funding, the lifespan of specialised courses such as palliative care, are unpredictable and not without risk. For education providers to remain competitive and responsive they need to ascertain where their funding and other resources are best directed.

This might in part explain the limited availability of course provision specific to palliative care. Nurse Educators in both tertiary and health organisations themselves also have powerful roles to play in establishing and nurturing professional growth, confidence and competence and achieve this by giving careful consideration to both education content and the way knowledge is shared. This concept will be explored in more depth in the next section.

The availability, accessibility and flexibility of different types of palliative care focused educational programs, the education providers, use of and access to technologies (Burchell, 2001; Payne, Seymour & Singleton, 2004); libraries, academic support, learning styles and educational experiences (Spence & Fielding, 2004; Dickson, Gray & Hayllar, 2005) and nursing decision making styles (Wood, 1990) also impact on nurses choosing to advance their knowledge and skills with education (Davey, Neale & Matthews, 2003; Ellis & Nolan, 2004; Dickson et al, 2005). The perceived relevance of the learning to the student's own purposes is yet another consideration (McGee & Fraser, 2001; French, 2006). All these factors reveal something of the complexities education providers attempt to consider and accommodate when developing palliative care courses for nurses.

### Professional Influences

The issues that influence nurses deciding to advance their palliative care competence with education are plentiful and varied. These influences can be generated by professional organisations such as The Palliative Care Competence Advisory Committee, The New Zealand Nurses Organisation and the New Zealand College of Nurses, or by nurses themselves. I will now focus on those influences generated by nurses themselves which can include: cost, availability and accessibility to appropriate palliative care education, knowledge utilization, cultures of learning to name but a few. Each of these influences will now be addressed independently.

### Costs of Palliative Care Education

The costs of advancing palliative care competence for nurses with tertiary education can be classified into different categories and are comparable to those costs broadly identified by the literature as being common to many tertiary students. Financial costs can comprise tertiary fees, travel to education centres, when specific programs are not locally available to nurses; accommodation; food and loss of income while engaging in study. Costs other than financial can include: time away from family while studying, disruption to usual family life in terms of roles and routines to accommodate study requirements and aiming to juggle work life study balance (Gower & Findlayson, 2002; Mellor, Foley, Connolly, Mercer & Spanswick, 2004; Kariv & Helman, 2005).

### Physical and Compassion Fatigue

Physical fatigue can be problematic for nurses who at the end of a working day can be required to juggle the competing demands of personal and family needs as well as find regular uninterrupted time to study. Many nurses lack the motivation to undertake lengthy programs of study because the costs outweigh the perceived benefits.

New Zealand has an ageing nursing workforce who may be less enthusiastic to embark upon lengthy tertiary palliative care studies in order to up-grade knowledge and skills (Nursing Management, 2006). Some nurses currently struggle with professional requirements to undertake 20 hours of development annually without the added stress of lengthy training courses that also require learning tertiary academic skills.

Compassion fatigue is a term used to describe health care workers feelings of emotional overextension and exhaustion that can result from interactions with patients and families (Cox, 2005). It is closely aligned with secondary traumatic stress as the signs and symptoms closely resemble those of post-traumatic stress disorder. Palliative care nursing can involve heavy emotional investment and it is essential for nurses to be appropriately supported to incorporate effective strategies for professional self care.

The stressors identified as being inherent with palliative care provision and associated professional self care strategies usually form a component of palliative care education, however, if nurses are unaware of such stressors and associated practice impacts then they have reduced opportunities to recognise let alone implement varied stress management techniques. Paradoxically the stressors inherent in palliative care provision and associated professional self care strategies often identified within palliative care education programmes, can be further compounded I believe, by stressors of the tertiary education process itself.

### Nursing Culture

The prevailing nursing culture also has a role in influencing the advancement of professional development and competence (Cobden-Grainge & Walker, 2002). As with any culture there are varied opinions and degrees of support available to those staff choosing to enhance their professional development educationally. There are those for whom ongoing development is encouraged and applauded while yet others, whatever the motivation, may belittle the efforts of their colleagues in this regard, especially if they pursue academic pathways (Carrier, 2002; Richardson, 2005).

Nursing culture is that which is absolutely borne out of individual beliefs that are embodied in practice. Given that nursing does not occur in professional isolation but rather within a team framework, if negative attitudes towards ongoing professional development prevail then this can adversely impact on nursing desire to engage in educational pursuits or implement new skills learned, in the work place. An example might include a caregiver who has learned about the importance of simply 'being with' someone as they are dying. They recognise the importance of providing a supportive presence to the dying person and have a desire to fulfil this, yet still have other clients for whom they must provide care. The ability to negotiate workload support with colleagues is vital in allowing this to happen in ways that appropriately meet the needs of all involved.

### Professional Obligation and recognition of limitations

Morgan (2006) suggests that nurses who choose to avail themselves of educational courses aimed at improving their palliative care practice do so because they recognise the need to improve knowledge and skills.

She goes on to reveal that accompanying this is a widespread lack of nursing recognition about palliative care deficits despite it being administered in varied clinical settings. I agree however I also think that prevailing palliative care perceptions, limited training opportunities and previous training or educational experiences might in part be contributing to this. The ability to critically reflect on practice is a vital skill in assisting recognition of strengths and limitations (Williams & Lowes, 2001)

### Conclusion

This section has broadly identified the influences generated by six key groups involved in shaping the advancement of palliative care with education. Despite each set of influences being presented as separate entities there is clearly inter-relatedness between all groups which I believe highlight some of the complexities surrounding the topic. A nursing awareness of those influences that impact on the advancement of their palliative care practice is vital if nurses are to more consciously engage with systems and processes in advocating for change.

In the next section I will present some of the benefits associated with advancing palliative care nursing competence with education. I will also explore some theories of learning and discuss aspects of knowledge acquisition, transfer and utilization as these related to advancing nursing practice.

## **SECTION FOUR: The benefits of knowledge on practice outcomes**

### **INTRODUCTION**

In this section I present some of the benefits of advancing palliative care competence for nurses using a selected sample of various palliative care educational approaches and roles. I have reviewed them to report on benefits. These annotated references are available to share in teaching discussions but they more importantly enable me to explore and reflexively develop my practice model in mentoring situations. The role of reflection in mentoring sessions has been particularly significant and as a manager I have explored the more fundamental issues surrounding the acquisition, transfer and utilization of nursing knowledge as these apply to advancing palliative care competence.

Given the many reported benefits of advancing palliative care competence with education initiatives (refer Table 2 next page) and that nurses themselves have identified issues that prohibit delivery of effective care (McDonnell, Johnston, Gallagher & McGlade, 2002), one wonders why there are not more colleagues keen to seek opportunities to rectify knowledge and skill deficits? The casualties of these actual or perceived inadequacies are after all, nurses themselves and the clients and families for whom they provide the care.

Table 2: Sampling of reported benefits of educational initiatives on Palliative Care outcomes

<b>Education Approach or Role</b>	<b>Reported Benefits regarding Palliative Care</b>	<b>Reference</b>
Palliative Care Educator	<ul style="list-style-type: none"> <li>*Improved Pain assessment</li> <li>*Improved pain management</li> <li>*Increased Hospice Referrals</li> <li>Appropriate 'shared care'</li> <li>*Improved care planning</li> </ul>	Hanson, Kimberly, Reynolds, Henderson & Pickard (2005)
Network Nurse	<ul style="list-style-type: none"> <li>*Increased Knowledge</li> <li>*Improved care provision</li> <li>*Increased empowerment to discuss issues with Multi-Disciplinary Team Members</li> </ul>	Gambles, Saltmarsh, Murphy, Hutchinson & Ellershaw (2004)
Palliative Care Modular Programme of Education	<ul style="list-style-type: none"> <li>*Improved Knowledge</li> <li>*Improved Confidence and competence</li> <li>*Increased skills to manage all care aspects</li> </ul>	Kenny (2001)
Care Networks	<ul style="list-style-type: none"> <li>*Provide much needed collegial, medical and nursing support for those administering care</li> </ul>	Travis & Hunt (2001)
Liverpool Care Pathway	<ul style="list-style-type: none"> <li>*Improved symptom control and management</li> <li>*Discontinuation inappropriate care and nursing practices</li> <li>*Reduced paperwork</li> <li>*Increased confidence and competence with care provision</li> </ul>	Jack, Gambles, Murphy & Ellershaw (2003)

Keubler and Moore (2002) suggest there is a paucity of available palliative care education. In the intervening years since this article was written there have been advances made with palliative care education and the availability of educational opportunities are increasing. I would suggest however that there are still gaps in the educational opportunities available to some individuals as not all levels of care provider needs are being effectively accommodated in this regard. Core palliative care concepts remain the same despite the varied clinical contexts in where they can be applied. I believe greater educational success can be achieved when these core concepts are delivered in ways that meet all levels of care provider understanding.

Thompson, Estabrook & Degner (2006) identify a prevailing assumption that increasing knowledge availability will automatically lead to behaviour change. This is not the case. Many variables impact on initiating and sustaining practice change and this extends well beyond the simple provision of information. For knowledge to be of any benefit it must be relevant, evidence-based, shared in a way that promotes understanding and then be translated into practice (McClement & Degner, 2005). I see the role of the educator in this instance as being the bridge for nurses to cross and which allows them to receive and process information and then carry it back to their practice environments for implementation. The process of gathering, interpreting and using the knowledge will now be explored.

### The Acquisition of Knowledge

The pioneering work of Pat Benner in the 1980's has and continues to influence the way nursing knowledge is understood and classified. In her book from novice to expert, Benner (1984) uncovered and identified those nursing behaviours that she believed denoted the varied skills and knowledge demonstrated by different levels of nurses along a professional development continuum. These levels include: novice, advanced beginner, competent, proficient and expert.



As confidence and competence grow nursing behaviours at each level undergo sequential change. For example knowledge requirement at the novice level is more directed by others and must be more 'concrete' while at the expert level, it is more self-directed and comprises the ability to think abstractly as well. Benner's initial and subsequent works in this regard have contributed hugely to our ongoing understandings of the complimentary links between theoretical and experiential learning in building nursing knowledge and skills (Benner, Tanner & Chelsea, 1996).

Once concepts and skills are learned and mastered, they become embodied in everyday practice. In my work with adults both qualified and unqualified, an interesting paradox prevailed. Adult students while considered novice in some aspects of their care provision, drew on their expert knowledge grounded in real life experiences in order to further build their knowledge and understandings. As an educator using Benner's work to inform my practice, I needed to further my own understanding about how people learn in order to be a more responsive education provider.

Biddulph and Carr (1999) when exploring theories of learning discovered that despite being classified as separate entities there is often divergence among each of the theoretical learning groups. The five learning theories include: behaviourist, developmental, humanistic, social constructivist and enactivist. Table 3 presents an overview of each theory and associated features.

Table 3: An outline of five influential theories of learning (Biddulf & Carr 1999)	
<i>Building- block idea:</i>	<p><b>BEHAVIOURIST</b></p> <ul style="list-style-type: none"> <li>• Concepts are broken down into manageable parts</li> <li>• Prerequisite blocks are needed to build on</li> <li>• Learning occurs by accretion, that is, the learning of discrete parts is thought to lead to the development of whole ideas</li> <li>• External rewards are often used to promote learning.</li> </ul>
<i>Staircase idea:</i>	<p><b>DEVELOPMENTAL</b></p> <ul style="list-style-type: none"> <li>• Learning passes through an identifiable sequence</li> <li>• Learning is partly dependent on maturation</li> <li>• It is necessary to reach one level of understanding before progressing to the next</li> <li>• Abstract reasoning is possible only from adolescence</li> </ul>
<i>Affective idea:</i>	<p><b>HUMANISTIC</b></p> <ul style="list-style-type: none"> <li>• Significant learning depends on the perceived relevance to the learner's own purposes</li> <li>• Much significant learning is acquired through doing and experiencing</li> <li>• Self-initiated learning involving intellect, feelings and a sense of self-control is the most lasting</li> <li>• Independence, creativity and self-reliance are facilitated by self evaluation (not evaluation by others)</li> </ul>
<i>Network idea:</i>	<p><b>SOCIAL CONSTRUCTIVIST</b></p> <ul style="list-style-type: none"> <li>• Learning is a personal linking of ideas and experiences</li> <li>• Learning often involves extending, restructuring or changing present ideas</li> <li>• Learning can be greatly facilitated through interaction with others</li> <li>• Learning is influenced by prior ideas and feelings</li> </ul>
<i>Ecological idea:</i>	<p><b>ENACTIVIST</b></p> <ul style="list-style-type: none"> <li>• Learning is experiential, requiring people to act on their world</li> <li>• Learning is evolutionary, having a biological, social and historical basis and involves a continual process of reinterpretation</li> <li>• Learning stems from dynamic interdependence of individual and environment, self and others and hence is not an individual action but a reciprocal process.</li> <li>• Learning is complex (not linear), co-emergent, occasioned (not caused by teaching) and situated</li> </ul>

When I reflect on these learning theories and apply Benner's knowledge and skill acquisition behaviours, I see as an educator the value of adapting and using an eclectic teaching approach that maximises learning outcomes for palliative care training and development initiatives. An example of this might be exploring spiritual issues in end of life care. Facilitating discussions amongst a group of nurses that draws on their actual experiences may be classified as a humanistic or developmental approach, allowing the powerful sharing of expert wisdom to inform collective understandings. The learning that results from such interaction with others could be considered social constructivist. Each has relevance in building the bigger picture of knowledge acquisition. In this instance the provision of knowledge promotes understanding of that which was perhaps previously intuitively known or developed, to a concept that takes on a different significance once stated. This is sometimes described as one of those 'aha' moments when something that was thought to be true assumes a deeper meaning once it has been given a name or been identified concretely?

If nurses can be encouraged to recognise the many benefits of having palliative care knowledge and skill training relevant to their practice context and learning style, then subsequent training can be modified to meet their needs. Some expert nurses will draw on their existing expertise to adapt a palliative approach to their care while other nurses who have little formal experience or training can be assisted to improve care delivery given appropriate education commensurate with their need. Years of nursing experience are not necessarily an indicator of advanced skills as Rich (2005) discovered when assessing the correlation of relationships between prior Registered Nurse experience and advanced clinical skill competence. Factors that influence nurses' decisions to undertake ongoing training and impacts on learning were outlined in the previous section.

In light of these insights the provision of training alone is insufficient to rectify practice deficits.

### Knowledge Transfer

Olsson (1999) suggests that to progress knowledge and skill acquisition throughout all levels of nursing, a triangulated approach that blends education, professional practice and research is vital, given the inter-dependent nature of these facets. How this is achieved is what Thompson, Estabrook and Degner (2006) suggest is crucial to outcomes.

They suggest that initially there must be clarity around what is trying to be achieved and that decisions about the best approach to take in order to transfer knowledge effectively in ways to suit different contexts should then be made. Table 2 identified the nursing benefits that have resulted from various initiatives or approaches trialed as these relate to the transfer of palliative care knowledge.

The literature has also identified that educational approaches influence how knowledge can be transferred, for example: Traditional teaching methods, (Ehrlich, 1995), flexible learning approaches to include on-line, formal, modular and self-directed (Bye, 2006). Approaches to transferring knowledge must constantly meet changing consumer demand and other influences as outlined in section three. Another important consideration is that clinical expertise is not necessarily synonymous with an ability to impart knowledge or vice versa.

### Knowledge Utilisation

Perry (1997) suggests that a nurse's ability to act autonomously and accountably assumes a sound knowledge base for practice. One way of achieving this is through the development of a critical consciousness which as McAllister (2005), explains supports linking theory to practice in ways that challenge nursing assumptions and theories, thereby enhancing praxis.

McAllister believes that nursing is fraught with practices for which there no supportable theories and nurses' sometimes feel uncomfortable reviewing practice that cannot be supported with adequate rationale. Richardson (2005) makes links between utilisation of research to provide the basis of articulating nursing actions.

Critical reflection has become an expected norm for professional nursing training, development and advancement today (Williams & Lowes, 2001; Papps, 2002). Previous nursing curricula did not formally recognise this as a necessary skill even if it was being informally demonstrated by some experienced colleagues. During the last 25 years however its' value has and continues to be recognised by many nurses, governing and regulatory bodies and educationalists.

Nursing ability to critically reflect on end of life care practice has several advantages. I believe it serves to honour and respect that which is already achieved and can provide new insights into how such care can be further improved. Nurses themselves are best suited to critically analyse those issues within their practice environments that enhance or constrain the achievability of optimum palliative care outcomes. If nurses lack palliative care knowledge and skills however the ability to effectively analyse practice outcomes is of little benefit. Adequate training and expert mentorship can assist in this process.

#### Practice Environment

Kenny (2003) believes that unless nurses are able to action what they have learned, education alone is of little benefit. Issues of poor staffing, limited resources, poor collegial support and the prevailing practice milieu (Ellis & Nolan, 2004), all detract from nursing ability to provide optimum palliative care. How these issues might be addressed remains the challenge for all involved to confront and resolve.

If health policies, organisations, governing and regulatory bodies and consumers expect nurses to deliver the best possible palliative care, then effective collaboration is needed to allow this to happen. Nurses themselves have a professional and moral obligation to make known those issues that detract from optimal palliative care outcomes and advocate for change. This requires nursing recognition of abilities to influence change and to be more conversant with health and social policies and impacts (Antrobus & Kitson, 1999).

When external expectations are mal-aligned with actual or perceived achievable nursing practice reality then there is a strong potential for conflict to occur. Consultation and collaboration as well as a willingness to embrace changing ideals and realities are suggested by the literature as being may well be one way forward (Antrobus & Kitson, 1999; Burchell, 2001; Kenny, 2001; Traivs & Hunt, 2001; Dowell, 2002; Dickson, Gray & Hayllar, 2005; Bye, 2006).

### Conclusion

This section has outlined some benefits for nurses seeking to advance their palliative care competence with education. A review of the literature provided useful insights into those varied approaches and educational initiatives that have been useful in supporting positive practice change in varying degrees.

There is no conclusive evidence however to suggest that any one specific initiative or approach would be suitable for adaptation and or implementation within different clinical settings. A review of some theories of learning provided a useful backdrop for exploring and introducing the possibility of blending different theories and educational approaches when tailor making palliative care initiatives to meet differing nursing practice contexts and learning needs.

Nursing knowledge was explored in relation to its' acquisition, transfer and utilisation.

In the next section I weave together elements of the previous work and link the logical progression incorporating influences, benefits, learning theories and knowledge to the development of an education initiative aimed at advancing palliative care competence with education.

## **SECTION FIVE: Case Study: The jigsaw puzzle**

### INTRODUCTION

Reviewing the previous sections can be likened to completing a jigsaw puzzle. As with any jigsaw the pieces fit together in a specific way enabling the puzzle to be completed. Puzzle pieces on their own generate interest but the real beauty and sense of accomplishment comes when the pieces fit together to create a beautiful whole. I believe this to be an appropriate analogy to view palliative care and interestingly my own practice.

The puzzle pieces in this text are the previous sections of work and as I review them I create a positioning statement about the nature and form of my area of practice.

Section two explored palliative care and nursing education as separate entities and then linked their roles in ways that highlighted their interdependence.

Section three explored the influences generated by key groups in attempting to advance palliative care competence for nurses using education as the change agent. Section four presented some theories of learning and discussion around the acquisition, transfer and utilisation of knowledge.

This section of work will demonstrate how I incorporated the knowledge gained from the previous sections to develop an entrepreneurial education initiative aimed at advancing palliative care competence for nurses in elderly health residential care settings. A case study is the chosen format to share information. I discuss how I would present a staff training palliative care educational initiative for consideration to a Manager of a residential care setting for the elderly. I will also demonstrate how the initiative would be presented to staff. Each aspect of information shared will be supported by the rationale for the actions thereby positioning the case study as an example of an educational process in the wider context.



I wish to state at the outset, that I have much respect for my colleagues who work within the aged care sector. The decision to develop a case study as an example of a practice initiative reveals their openness to seek and participate in learning opportunities and appeals to the current context of developing best practice through accreditation.

In the future, anticipated national changes in funding will better support elderly residents and community or hospital transferred patients receiving palliative care in the full range of elder care settings. As is accepted practice in order to receive the funding, performance criteria will require an accreditation process that shows educational opportunities have been put in place for the staff to support best practice (The New Zealand Cancer Control Strategy Action Plan 2005-2010, 2005).

To guide implementation of palliative care best practice standards Hospice New Zealand and Palliative Care New Zealand are lobbying the Ministry of Health to develop a standards framework based on established international guidelines. These standards will assist Hospices to provide expert guidance to colleagues administering palliative care across the sector. Two individual specialist palliative care nurse colleagues working specifically within the aged care sector in New Zealand, have identified staff educational needs in eldercare settings for the systematic development of palliative care practices. Both colleagues Gellatly in Lower Hutt and Meldrum in Auckland have been funded by their district health boards to implement educational initiatives for staff in elder care settings. These colleagues are reporting and documenting outcomes. Gellatly and Meldrum have indicated that the knowledge and understanding caregivers have of the dying process is the key to the success of best practice being achieved for elderly residents and their families (Personal communication, 2004).

This point underpins my own awareness of what is required and provides the incentive and rationale for offering a fictionalized case study of discussion with an aged care manager to develop an educational opportunity for care givers in the setting. The aim of which would hopefully enable confident longer term practice development goals of best practice in palliative care to be achieved.

While reporting on the problems and individual site initiatives is important, it is the community wide initiatives that engage large groups of elder care residential sites in a regional development that will reflect the value of best practice standards of care. Other performance indicators such as reductions in hospital admissions of dying elderly are also important considerations.

It is this latter group that I am most interested in as caregivers offer the day to day care of the dying elderly in residential settings, assisted and guided by registered nurses and general practitioners. It is this group to whom I have directed the following fictional case study as an example of one palliative care initiative for care givers. The contextual setting and the preamble are representative of how I position myself to engage with an elder care facility manager as together we develop a palliative care educational package for staff in that residence.

### The Context

Understanding the context is crucial to the success of initiatives as it defines and positions the organisation of care beyond the individual sites of care.

Invercargill is the southern most city of New Zealand. It has a population of 50,328 (Statistics New Zealand Census Data, 2006). It has one 350 bed base hospital, 12 residential care settings of which 4 provide hospital level care and one six bed Hospice. There is one tertiary institution which offers nursing education at both undergraduate and postgraduate levels.

There is currently no specific palliative care education offered by any nursing care provider in the region. However, individuals can choose to travel from the region to participate in educational opportunities in other regions or national education programmes. This provider offers educational opportunities for caregivers and specializes in aged care education.

One educational programme provider Aged Care Education (ACE) offers accredited training for eldercare staff and they have recently developed one palliative care module in conjunction with Hospice New Zealand. The majority of staff in the Invercargill region have undertaken the introductory training programme modules offered by this provider. Comments are often heard about the value of learning surrounding dementia care modules however less have participated in the palliative care module. These training packages have required staff to travel and hence come at a cost and the knowledge gained is then held by an individual who has to develop their practice and integrate it into the structure of their workplace.

The vision of onsite collaborative staff development in each of the eldercare settings to develop palliative care best practice seems like a realistic goal for Invercargill city. In time this initiative could flow to the wider region where there are small outlying hospitals and other care provider organisations.

#### Area of Practice Introduction: Nurse Educator

As a registered nurse of 23 years with previous managerial, educator experience and undertaking studies in both a Masters (Applied) in Nursing and a Diploma in Adult Learning and Education, I identified a local need for the provision of palliative care education using my credentials and peer esteem. My clinical passions and expertise include but are not restricted to health management, education, palliative care and elderly health. My professional credibility locates the credentials I have to develop and implement such an initiative.

When introducing myself and my small business to organisational managers and colleagues I find the ability to articulate my area of practice is useful in initiating and maintaining ongoing dialogue.

#### Establishing The Need For The Educational Initiative

Facilitated discussions with consumers of any education or training is vital, in order to identify their specific needs. Following facilitated discussions with organisational leaders and staff within the region I developed two introductory palliative care courses for all levels of nursing staff entitled: Dying, Death and Grief (Refer Table 4) and Palliative Care (Refer Table 5).

*Rationale:* These discussions enabled me to be context wise and therefore a more responsive provider. It also supports collaboration which (Dowell, 2002; Ellis & Nolan, 2004) have identified as being one way to improve the advancement of palliative nursing care with education. In discussion I identified the need to develop two courses. Lesson Plan One was developed in response to organisational requests for a one hour staff training initiative that minimised costs and would be conducted in the organisation's premises. Lesson Plan Two provided individual nurses with the opportunity to spend more time exploring the topic independently, at a separate venue hired specifically for this purpose. Examples of both documents follow and provide an overview of course content that formed the basis of discussions with elder care managers.

Table 4: Lesson Plan One: Dying, Death & Grief

<b>LESSON PLAN ONE</b>		
<u>Topic:</u> Introduction to Dying, Death & Grief		<u>Date:</u>
<u>Venue:</u>		<u>Duration:</u> One Hour
<u>Participants:</u> Mixed skill, (RN, EN, CA)		
Resources: Handouts x20 each of the following: Dying, Death, Grief; Critical reflection exercise, Te Whare Tapa Wha A, B, Course evaluation sheets; box of tissues, selection of sympathy cards, thinking of you cards; cross, photos, rosary beads, book of poetry, teddy bear; vase of flowers, whiteboard and selection of coloured pens; pinwheel, sweets selection.		
<u>Introduction:</u> Self and Objectives	( 2 Mins)	Whiteboard/Dicsussion
<u>Body of Lesson:</u>		
Exploration of individual and collective Values and beliefs that impact on nursing care delivery and outcomes in death and dying.	( 5 mins)	Group discussion Handout Dying, Death,
<u>Dying and Death</u>		
Overview of Physiological changes	( 5 mins)	Whiteboard/discussion
Common symptoms: control + management	( 5 mins)	Whiteboard
Role of needs assessment in managing care	( 5 mins)	Discussion
<u>Grief</u>		
What is Grief?		Brainstorm
Types of grief: Normal, Complicated, Anticipatory, Disenfranchised		
What influences grief processes and response?		Brainstorm
Exploring (2) Models of Grief		Discussion/Whiteboard
Kubler Ross; Pinwheel	(10 mins)	
Critical reflection on practice scenario	( 5mins)	Handout
<u>Professional Self Care</u>		
Identification of stressors		Discussion/whiteboard
Strategies for self care		
Te Whare Tapa Wha	(15 mins)	Handout
Assessment: No formal assessment		
Evaluations	(5 mins)	Handout

Table 5: Lesson Plan Two: Palliative Care

<b>LESSON PLAN TWO</b>		
<u>Topic:</u> Palliative Care		<u>Date:</u>
<u>Venue:</u>		<u>Duration:</u> Three Hours
<u>Participants:</u> Scope specific: (RN, EN, CG)		
<p><u>Resources:</u> Handouts x20 each of the following: Dying, death, grief; Critical reflection exercise, Te Whare Tapa Wha A, B, Course evaluation sheets; The NZ Palliative Care Strategy, The Cancer Control Strategy, Nursing Council of NZ Competencies (2005) for all scopes of practice, box of tissues, selection of sympathy cards, thinking of you cards; cross, photos, rosary beads, book of poetry, teddy bear; vase of flowers, whiteboard and selection of coloured pens; sweets selection. Selection of relevant journal articles.</p>		
<u>Objectives:</u>		
To facilitate safe + sensitive discussion on palliative care components		
To introduce relevant gov't documents + relate relevance to nursing practice		
To encourage reflection on practice and promote a greater understanding + awareness		
To explore challenges involved in administering this type of care in aged care context		
To identify stressors and strategies for professional self care in this context		
<u>Introduction:</u> Self and topic	( 5 mins)	Discussion/whiteboard
<u>Body of Lesson:</u>		
Facilitate exploration of values + beliefs about dying, death and grief	(20 mins)	Handout, discussion Whiteboard
<u>Palliative Care</u>		
Palliative Care defined		
Palliative care as a philosophy or approach to end of life care		
Introduction to the NZ Palliative Care Strategy (2001) and The NZ Cancer Control Strategy (2003)		
Discussion of relevance of strategies to aged care practice context	(30 mins)	Discussion
<u>Death and Dying</u>		
Overview of physiological changes in dying process		
Identification of common symptoms, control + management		
Role of needs assessment in managing care		
Role of Hospice in palliative care provision and education	(30 mins)	Discussion, whiteboard

(Lesson Plan cont'd from previous page)

Grief

Grief defined

Discussions on grief manifestations

Types of grief and strategies to deal with these

Review of grief and identification of cultural context differences

Identification of two models of grief: Kubler-Ross, Pinwheel model

(30 mins) Discussion

Professional Self Care

Identification of carer stress/ors in palliative care provision

Strategies aimed at promoting effective professional self care

Professional self care exercise using Te Whare Tapa Wha

(30 mins) Handouts, discussion

Assessment: Quiz (crossword)

(15 mins)

Evaluation:

( 5 mins)

Lesson Plan Review

When managers have considered the lesson plans they are able to comment on the timeframe allocated for each concept and associated discussion and thereby guide the educator in a way that shapes my insight into their training goals. Discussions with nurse managers and leaders of organisations are often focused around the cost of staff training. Presenting lesson plans for review allows managers the opportunity to analyse the cost benefit and visualize the meaningful sharing of knowledge that can be translated into practice outcomes.

*Rationale:* When managers can see how focused educational packages frame learning opportunity and positively shape the quality and amount of information shared, they can then be encouraged to consider implementing three one hour sessions. This breakdown of a training process lesson plan has been successful in inviting their involvement and enabling them to commit to sequential one hour staff training sessions that can be built on and integrated into practice while still being cost effective.

To emphasise the reality of the national and regional strategic plans for palliative care, cancer care and elder care that will impact on service delivery, hard copies of the relevant documents that inform the initiative and the education sessions are brought to these discussions. I explain and encourage managers to avail themselves of these documents and suggest making them available for all staff and particularly registered nurses. I highlight the relevance of these documents in assisting organisations to implement the national palliative care vision at a local level in relation to service provision and workforce development. I discuss palliative care funding and associated service audits that are undertaken to ensure provider accountability.

*Rationale:* Discussions of this nature assist managers to recognise the relevance of these documents in their practice environments. Being able to discuss their relevance not only reinforces the need to provide palliative care training to their staff who are expected to implement the care, which in turn drives the revenue generated by these organisations, but also further establishes my own credibility on the topic and ability to demonstrate vital links.

Working sequentially through the lesson plan allows managers the opportunity to conceptualise the depth of the topic being introduced and explored. Providing a context for the role of specific training and impacts of palliative care provision on staff and consumers of care is a vital consideration for managers. There is a changing focus of palliative care provision with it being only located in principle in specialist Hospices for the most complex patients. Most people are cared for at home or transferred to residential care settings either for respite or to die, when dying at home is not an option. This discussion enhances recognition that palliative care involves all who are dying in any setting and thereby locates all care providers within the District Health Board's span of attention for palliative care funding. This simultaneously changes the workforce training requirement which challenges perceptions of palliative care as being a 'nice to know' topic to one of becoming a 'required to know' topic.



The benefits of implementing the education are then shared and further reiterated. Benefits include: providing a safe forum for sensitive practice related discussions to occur; facilitation of new knowledge and the sharing of experiences that shape and impact on palliative care outcomes; creating a forum to celebrate that care which is already being successfully implemented and ways this might be further enhanced; linking in vital political and industry specific documents and their relevance to palliative care nursing provision; the opportunity to raise collegial respect within a team framework; enhanced team commitment and networking opportunities; re-iteration of the importance of professional self care especially as it relates to the provision of palliative care; fostering greater learning opportunities for those who wish to extend their knowledge.

*Rationale:* Opportunities to highlight the many benefits of providing such education and the resulting impacts on the consumers of care, the staff and organisation promotes managers abilities to see beyond the financial cost of implementing such training.

#### Implementing the Initiative with Staff: Setting the Environment

I give careful consideration to the environment I create when facilitating palliative care discussions. I prepare a table displaying some symbols of what I describe as being commonly associated with grief as expressed by Western European cultures.

This can include: a box of tissues, a selection of music CD's, a cuddly teddy bear, sympathy cards, flowers in a vase, photographs of loved ones, selection of candles, aromatherapy oils and burner, a Bible and a book of poetry. These objects might usefully generate a discussion around what participants use in their cultures and what they in turn might consider would generate a discussion with residents and families as to their preferences.

*Rationale:* This provides visible cues as to how attitudes and behaviour about death and dying can be socially and culturally constructed.

I aim to make the learning environment free from distractions such as phones and will close windows if there are unnecessarily loud and potentially unwelcome or disruptive noises. This attention to environmental detail when shared with participants enables me to discuss the special nature of creating the environment of care and preparing oneself to participate in the process of another person's death. Environmental considerations will vary from person to person however most favour a quiet, gentle and peaceful atmosphere. This can promote discussions around how we create this space within our often busy work environments and the subsequent alteration in care provider pace required in such care provision. There is something unique and special about the 'therapeutic stillness' which involves simply 'being with' rather than 'doing for' our clients that is more commonly associated with care. In some settings a caregiver is allocated to sit with the person who is dying and this role is rotated around staff who would like to be involved in this way. While the person is sitting with the resident who is dying, colleagues recognise the special nature of the work that they are doing and fully support them (Gellatly, 2007, Personal Communication).

*Rationale:* The culture of care has to be developed as a framework for practice and staff who work in Hospices are aware of the culture they develop and uphold in their work environment and as they visit families at home. Disruptions can distract the person's journey and equally interrupt participant involvement in the design of the learning process.

### Commencing the Education

I formally commence the session with a short introduction of who I am and describe my area of practice. This means that I can position my professional background and personal story.

*Rationale:* This introduction validates my professional credibility and authority to talk on the topic. This most importantly allows me to invite the participants to share their identity as professional care givers. It is very empowering and honouring.

I thank everyone present for the opportunity to be with them and to share something of our professional insights and journeys. I usually state that I consider it a privilege to be able to share something of the insights and knowledge I have been assisted to learn throughout my professional journey and consider this yet another opportunity to add to my knowledge through the contributions of others.

*Rationale:* The content of this 'formalised speech' creates a platform of honouring and respect upon which I suggest to those present they can in turn role model when they engage in professionally offering care for the dying elderly resident and their families. It acknowledges that learning is an ongoing journey for every family and organisation which is constantly evolving. Sharing experiences through story telling is a powerful learning opportunity recognised and promoted by Benner, Hooper-Kyriakidis, & Stannard, (1999) and McDrury & Alterio (2002).

I like to acknowledge the sensitivity of discussions and state that there may be aspects of the discussions that expose current or suppressed feelings of vulnerability. I express my desire to all present and indicate that participants should feel free to express and respond to these feelings as they need to and that

we as colleagues on this journey respect and support our peers appropriately as we are moved to do so. I also make a statement honouring all discussions shared and unshared and ask that the disclosure of content of a personal nature remain confidential to those present.

*Rationale:* Participant safety is an important consideration in any educational setting. As participants process new learning they will often do this on both professional and personal levels and this can expose vulnerabilities and unreconciled issues. Issues that may have been buried for whatever reason can readily resurface as unconscious memories are brought into the conscious realm. Reactions to this resurfacing of issues can result in unexpected emotional responses and by stating this at the outset, it recognises a known reality and allows participants to respect this occurrence should it arise. It also allows me to introduce the opportunity for further sessions on professional self care.

Sharing of information is encouraged on a voluntary basis and I ask that all contributions be respected. I explain that no question should be considered inappropriate and that I will attempt to answer queries as best I can and will honestly identify if I don't have an answer. In such instances I will endeavour to locate someone who does know and will provide feedback accordingly.

*Rationale:* Once again this promotes a respectful environment and clarifies boundaries around topic discussions. It establishes humility by reinforcing that no-one has all the knowledge and there may be questions to which there are no answers at that time. Despite this, participants can be assured that their queries will be answered.

I provide an overview of how the shape of our time together will be spent and then identify the topics to be explored. I like to seek feedback from participants to confirm if this aligns with what they expected to achieve and or if there is anything else the group would like to include.

*Rationale:* This discussion provides clarity about the education content and direction and empowers colleagues to seek alternative information that may be related to the education and which they would like included. It allows for challenging my assumptions that what is planned is going to meet the needs of all present and promotes flexibility to make adjustments accordingly.

#### Reflective Exercise

The first part of the session involves a reflective exercise encouraging participants to choose words that they associate with each of the three key words on a handout entitled: Dying, Death and Grief. (Refer Appendix One). After a short time lapse the group engages and brainstorms words about dying that are common to their environment.

*Rationale:* This exercise provides a wonderful opportunity for sharing our collective insights as well as providing a springboard from which to launch into deeper discussions. Opportunities to celebrate individual and collective knowledge about the topic being explored are also facilitated and can be empowering for those who are uncertain or think they have little to offer. It also establishes a positive forum for collegial sharing. Sheehan & Ferrell, (2001), suggest the importance of not only imparting palliative care knowledge and skills but also giving attention to the care provider's values, beliefs, experiences and culture which ultimately help shape their practice (p 692).

I conclude this exercise by thanking participants for sharing in the activity and acknowledge their responses as coming from a position of 'knowing'.

I then introduce the hard copies of relevant political documents and policies and give a brief overview of these. I like to circulate them for all to see.

*Rationale:* Many staff have never seen these documents and have not understood how or where the framework for their practice is shaped. Vital links are forged for many on new levels as information relayed assists participants to a greater level of understanding around the relevance of these policies on their practice worlds.

#### Dying and Death

We then explore the physiological changes associated with the dying process and I find a useful format to achieve this is to move systematically over the physical body from the head to the feet. We share some of the changes we see in the physical body and I aim explain why these occur, in sufficient detail so as not to confound but rather enlighten participants. I also include some of the medical and nursing terminology used to describe these changes. As we proceed through this part of the session, I incorporate some of the symptoms associated with these changes and briefly outline some of the medications that can be used to treat these using current evidence based practice (Macleod, Vella-Brincat, & Macleod, 2004; [www.palliativedrugs.com](http://www.palliativedrugs.com)).

I simultaneously outline the importance of impeccable assessment highlighting that this guides the implementation of interventions that are relevant and appropriate for the dying person and their families. I emphasise collective roles in contributing to assessment processes which are integral to the interdisciplinary process recognised internationally in palliative care.

This enables participants to better understand the role of the general practitioner and others involved in care provision. I like to use this opportunity to celebrate the knowledge shared and appropriately praise questions that seek to gain a better understanding. I also like to encourage sharing of our experiences both personal and professional as they relate to dying.

*Rationale:* The educational session provides some basic building blocks of information for participants. Components of impeccable assessment when addressed reveal something of the complexity involved in implementing truly holistic and effective palliative care for clients and their families (Glass, Cluxton, & Rancour, 2001). Concepts are clarified and can add to existing knowledge. Sharing experiences grounded in everyday practice reinforces the reality of some of the challenges inherent in providing effective palliative care and this supports Errington's (2003) recognition that scenario-based learning opportunities are effective learning opportunities.

Once we have covered the physical changes I ask the group to consider how spiritual pain might manifest and how it might be treated. This usually causes some uncomfortable shuffling and pregnant pauses and provides an appropriate lead in to discussions around this sensitive and often ill managed aspect of palliative care as Cobb, (2001) rightfully identified. Together we then explore what it is to care for someone holistically and I ask participants to think about how well they as a group manage palliative care and what if anything they could improve.

*Rationale:* Engaging participants promotes the exploration of how to care for someone in a truly holistic way. It reveals something of ongoing challenges associated with caring for dying people and helps facilitate discussion on these new concepts. Approaching discussions in this way removes the threat that I as an outsider am criticising their care and allows the group to conduct their own analysis of their collective palliative care provision efficacy.

I then link in the role of Hospice and try to actively encourage participants to contact them for advice; phone to make an appointment to visit this special place (which many of them financially support in fund raising endeavors) and see what is available in their own region. I also encourage them to arrange staff education using the skills and expertise of those Hospice staff available for this purpose. I suggest that any information received can be used to develop a palliative care resource folder for their work environment.

*Rationale:* Many colleagues have not visited their local Hospice and this is a unique and enjoyable experience. It raises awareness as to the role and functions of the Hospice and promotes new opportunities for networking and liaising among colleagues.

#### Critical Reflection Exercise

The next activity provides participants with the opportunity to critically reflect on their practice in a non-threatening way. I explain that this exercise can be incorporated into their professional development portfolios. (Refer Appendix Two).

*Rationale:* For many colleagues this is their first introduction to guided reflection. If time does not prevail I encourage staff to take this home for completion.



## Grief

The next part of the session deals with grief. I like to compare two models of grief, Kubler-Ross's stages of grief (Kubler Ross, 1969) and the Pinwheel Model of bereavement (Moules, Simonson, Prins, Angus & Bell, 2004). I like to acknowledge Kubler-Ross's pioneering and subsequent numerous works on grief as I find this model and her work with dying people is often more widely known about. This provides me with an opportunity to identify that much work has and continues to be developed to assist our understanding of grief, its manifestations and management. I introduce the Pinwheel model as an alternative perspective and provide a brief comparison and contrast of the two models.

Ross's model is linear and identifies a series of grief stages that may be experienced in any sequence at any time by those who are grieving. These include: shock, anger, denial, bargaining, acceptance. The pinwheel model is circular and core themes central to this model include: being stopped, hurting, missing, holding, seeking and valuing as these attitudes and behaviour relate to the loss of someone significant (Moules et al, 2004, p. 323). Both models recognise that grief is a normal response to loss and is a unique and individually determined experience. Grief can be an ongoing experience and the way it manifests with time may change. At times the grief can make its presence felt like a gentle breeze while at other times it can be turbulent and chaotic like a force ten gale.

*Rationale:* This exercise opens the group to the possibility that grief can and does take many forms. There is no fixed or prescribed method for grieving. It allows permission for grief to take its own journey and shares how grief can so easily be disenfranchised by societal or personal attitudes and expectations.

We then review what complicated grief might look like and explore some interventions that may be useful for staff to use when working with clients and family members who are grieving. This can involve cues for pursuing conversational openings, a decision to simply be with someone and sit companionably in silence; it may involve being a mirror that reflects back to individuals that they are looking sad, unhappy, distracted; or it may be the offer of other alternatives to verbal communication such as the use of creative arts therapy or a simple sincere and heartfelt hug where appropriate.

The importance of assessment processes in this regard are reinforced and will guide or determine the interventions for the care we go on to implement. Discussions can then be focused on how we incorporate caring for significant others at this often difficult time. We discuss some management strategies for dealing with complex situations and difficult family dynamics. Questions from participants are usually freely flowing at this time and only require the occasional prompt by myself. We share how grief and its responses can be both learned and or influenced by the societies and cultures to which we belong or identify with.

*Rationale:* This section is key as it provides further opportunities to unpack that huge topic which is palliative care and thereby broaden understandings.

#### Professional Self Care

The next part of the session explores professional self care. Palliative care can be fraught with stressors and as Vachon (1997, 2001) and Cox (2005) share, effective professional self care strategies are vital for nurses to maintain their own health and wellbeing if they are to practice effectively. Nurses are often very good at caring for others but can neglect to care adequately for themselves.

I use a guided reflection exercise to assist nurses to reflect on the ways they care for themselves. I choose the Te Whare Tapa Wha Model of Maori Health and Well-Being (Durie, 1998) as the tool to achieve this. This holistic model encompasses physical, mental/emotional, spiritual and social assessment components. (Refer Appendix Three).

After explaining about the model and what it symbolizes I ask participants to write on the diagram how they care for themselves using this model as a guide. In this context the assessment model is used for staff and not clients, but it is a versatile model suitable for both. This exercise can be approached from two different yet inter-linked levels to include personal and professional self care.

*Rationale:* Participants are exposed to new models. An emphasis on the importance of professional self care in general is explored but also as it relates to the special stressors inherent in palliative care. It also provides an important opportunity to touch on cultural differences to dying, death and grief as expressed by cultures different to our own. It provides a forum to safely raise issues of bias or conflict which can be dealt with and given voice at this time. Spence (2003), recognises that such tensions and conflicts as being essential for ongoing development of nursing practice. Discussions relating to the application of the Treaty Of Waitangi in the provision of culturally sensitive palliative care are also addressed at this time. This provides an opportunity to honour the valuable contributions offered by Maori academics and colleagues in ways that further inform and guide our practice (Durie, 1998; Whaia Te Whanaungatanga, 1998; Ramsden 2002; He Korowai Oranga, 2002; Whahatataka, 2002).

I also use this opportunity to celebrate those practices that may already be in place for clients, families and staff as they relate to this topic and will sensitively suggest areas that might be reviewed or included within the organisation to further improve outcomes.

Together we brainstorm and discuss professional self care strategies that are used to care for ourselves and each other. These can include but are not restricted too: informal peer support, formal team debriefing and or clinical supervision. Others find writing their reflections useful in assisting them to understand more intimately what has happened within a given practice scenario and attempt to make sense of outcomes on all levels. Ethical issues that can arise frequently in palliative care as identified by Stanley & Zoloth-Dorfman (2001), and also aged care respond well to facilitated exploration using written reflection.

*Rationale:* Various strategies are identified as tools available for participants to be made aware of and utilise.

Conclusion to the session:

A question and answer session concludes the session followed by formal written participant evaluation of our time together (Refer Appendix Four). To assess the efficacy of some of the learning content I make available a short quiz for participants to take away with them and an answer sheet is given to the organisational manager or leader to provide the answers. (Refer Appendix Five).

I usually conclude the session by thanking everyone present for their participation and wish them well on their quest to improve their palliative care knowledge and skills. All participants receive a Certificate of Attendance. (Refer Appendix Six).

### Section Conclusion

This section has reviewed and discussed the sequential development and implementation of one palliative care educational initiative for all levels of nursing staff currently being implemented within aged care settings in Invercargill. Rationale was used to support discussions at each stage of the development and implementation of the initiative. The rationale and indeed the education initiative itself were informed by and incorporated findings from the previous four sections of work. I liken this process to that of completing a jigsaw puzzle and will now talk to this by way of reflection.

As with any jigsaw the puzzle once completed produces an image that remains for a while and then the puzzle is pulled apart again and potentially reconstructed at another point in time. The context is different, the season is different and the person completing the puzzle perhaps comes to understand that they know something of the way in which the puzzle is put together. Each time the puzzle is attempted a different experience can be created or approach utilised but none the less the effort of putting the pieces together must still be made if the ultimate goal of puzzle completion is to be achieved. One might choose to commence construction by laying down the outer edges of the puzzle first and then place them methodically or systematically to create the framework or they may sort the pieces into colours or shapes. Whatever methodology is decided upon each time the puzzle is completed enjoyment and achievement are experienced anew. This is further maximised if puzzle completion is shared by the contributions of others or if the puzzle is handed on to others to complete in their own time and way.

While I have used the puzzle metaphor I have gained a sense of standing in a different place from which I have created a new appreciation of all the aspects of my own practice and a greater ability to share the passion I have for knowledge and particularly care for the dying. The next section will complete and conclude the topic exploration.

## **SECTION SIX: Conclusion**

This paper has introduced and explored some of the vital components necessary to consider when seeking the advancement of palliative care nursing competence with education.

To reduce inequitable and unsatisfactory palliative care outcomes for consumers and providers alike, that have occurred subsequent to: changing palliative care providers and practice environments, altered palliative care funding administration and workforce training requirements, professional regulations; socio-political demands and expectations, education that is relevant, accessible affordable and appropriate for all levels of nurses needs to be made available.

Education plays a significant role in advancing palliative care outcomes as the many documented benefits testify. It is however not an end or even the means to an end in itself. Many variables impact on the efficacy of education provided to improve practice outcomes. How and by whom the knowledge will be transferred to practice as well as consideration of learning styles and behaviours, determines the most effective approach to guide the type of knowledge required and how this can be most effectively imparted to all levels of care providers. Attempting to achieve the right 'mix' between knowledge acquisition, transfer and utilisation, is one of a number of challenges presenting themselves to key players in this particular debate.

One consistent recommendation emerging from the literature and central to advancing palliative care provision with education, is the need for greater collaboration between all the key players involved and identified in section three.

As a sole provider of education collaborative relationships that have been developed in conjunction with colleagues from within and external to my local region have been hugely beneficial in assisting me to progress this area of practice development. I aim to use the Teaching Model I have developed and which was further informed by exploring this topic (refer Figure One), as well as the rich experience gained, to further build upon this and other health education initiatives I plan to implement.

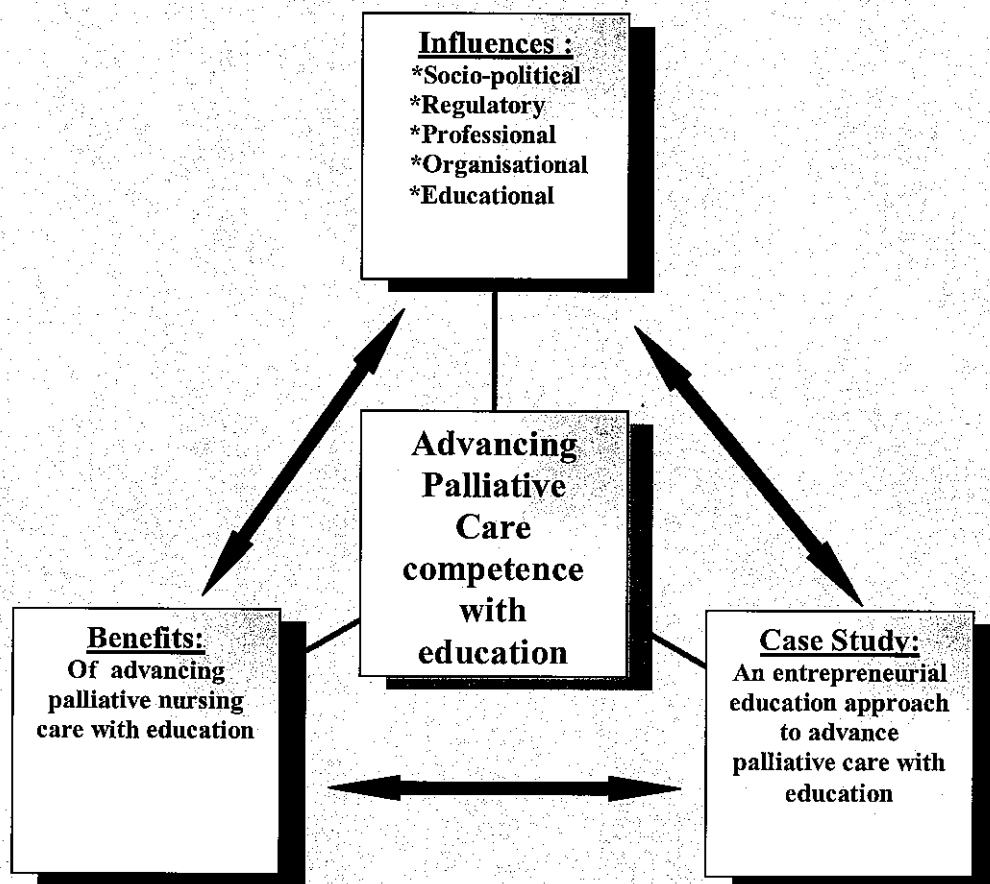


Figure One: Teaching Model used to guide and advance palliative nursing care competence.

The challenges I have encountered as a sole provider of education not affiliated to any established organisation have largely centered around, the initial establishment of professional credibility and identity, funding resources, mixed consumer reaction and support.

Establishing and growing my professional credibility has been achieved directly at the consumer provider interface. Involving consumers in course development to meet organisational and individual professional needs has been pivotal to ensuring the successful outcomes thus far achieved. My ability to deliver education that is cost effective, affordable, accessible, relevant, evidenced based and enjoyable has been well evaluated by consumers using formal evaluation processes. The greatest consumers of the education I offer have been residential care settings within the immediate local and latterly rural southland region. I have received overwhelming support from these colleagues which has been very encouraging for me. The more my education service is accessed the greater my professional credibility and identity grows.

I have self funded the short course development of my education service and have drawn on many credible and robust resources to ensure course content is relevant, evidence based and appropriate. I carefully researched the relevant professional, regulatory and health industry specific requirements for staff training prior to implementing the short courses. I am mindful of the need to remain abreast of current and changing knowledge on the topics I offer and maintain professional memberships of relevant organisations to assist in achieving this. I maintain regular liason with colleagues in various palliative care network groups and attend relevant professional conferences as I can afford. I am forever mindful however that despite due diligence in attempting to provide and maintain an effective educational service that there are limitations with what I can offer as a sole provider.



One limitation of the education service I provide is that I am unable at this time to evaluate the efficacy of knowledge shared in terms of its' translation to practice with improved outcomes. It is my belief that sharing knowledge about palliative care involves a considerable amount of time and that the provision of one or two short courses on the topic will be insufficient to adequately sustain meaningful practice change. A series of short courses however may be beneficial if the information provided is presented in meaningful blocks allowing adequate time for nurses to process and then implement information received. Suitably trained palliative care clinical mentors are invaluable in this regard. A pleasing outcome of the short courses I offer has been the interest generated by some registered and enrolled nursing colleagues seeking to undertake further postgraduate studies in palliative care. These colleagues would be well situated to provide the clinical mentorship I speak of within their respective clinical settings.

Another limitation is that of remaining viable in a highly competitive educational arena. Larger and better established education providers have access to more funding and a greater staff skill base to assist them in developing and implementing new educational initiatives aimed at meeting the varied needs of their consumers. These providers for example those within the tertiary sector, also offer accredited courses that on successful completion usually result in a formal qualification. The courses I offer do not and this may be less attractive to consumers.

Despite the challenges and limitations, I remain encouraged and inspired to contribute to sharing the national vision of palliative care service provision locally in my own small way. I draw inspiration and motivation from my predecessors whose hard work and much documented evidence provides a solid foundation on which I can continue to progress their work in shaping future directions of palliative care as both philosophy and practice in Invercargill and New Zealand.

## **APPENDIX ONE**

### **Contents**

1. Exploratory exercise: Dying, Death and Grief

Exploring my Thoughts, Values and Beliefs

DYING

DEATH

GRIEF

## APPENDIX TWO

### Contents

1. Critical Reflection Exercise

### Critical Reflection Exercise

Recall a professional practice scenario where you were involved in caring for an individual who was dying? If writing is not your preferred method of reflection, try an alternative option, such as discussion with a peer or drawing to illustrate the scenario.

Introduction: Provide some background information to set the scene. Who was involved? Remember confidentiality, use fictitious names.

What was most memorable for you about this occasion?

What went really well?

What if anything, could have been done differently or improved?

What new learning occurred for you from this scenario that has changed and improved your practice?

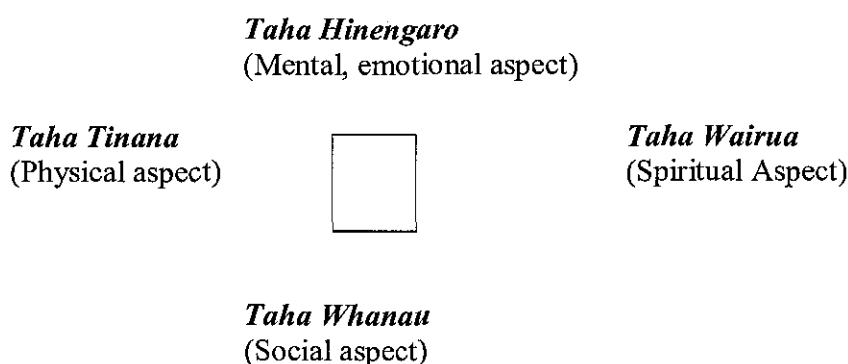
## **APPENDIX THREE**

### Contents

1. Te Whare Tapa Wha A)
2. Te Whare Tapa Wha B)

## Te Whare Tapa Wha A)

The house of four walls. Introduced by Mason Durie in 1998, this model compares health to the four walls of a house. Each wall represents a different aspect of wellness and are necessary for strength and symmetry. Each of the four aspects of *hauora* (health), influence and supports the others.



Each of the four aspects of hauora influence and supports the others.

**Taha Hinengaro:** *Mental and Emotional well-being*

: The mental and emotional wellbeing of the whanau as well as each individual within it.

**Taha Tinana:** *Physical Well-being*

: The physical body  
: Physical aspects of health  
: Physical symptoms of health

**Taha Wairua:** *Spiritual Well-being*

: The spiritual health of the whanau  
: Includes the practice of tikanga Maori  
: Personal identity and self-awareness

**Taha Whanau:** *Social Well-being*

: The whanau environment in which individuals live  
: The cohesiveness of the whanau unit  
: The health of the environment created within the whanau  
: The relationship of the whanau to the community

Durie, M. (1998). Whaiora: Maori health development. Auckland: Oxford University Press <http://www.nhf.org.nz/index.asp>

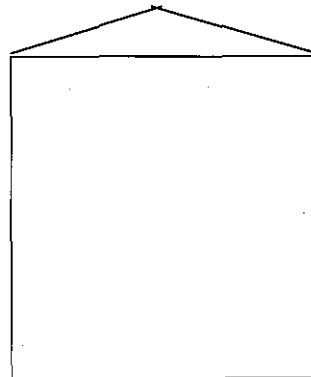
Te Whare Tapa Wha B)  
Maori Health Model Durie, M. (1998).

Te Whare Tapa Wha as an assessment model. In the context to follow this model will be applied and used as a framework for assessing professional self care. Under each of the main headings below, think about and identify the ways you care for yourself professionally.

Taha Hinengaro  
Mental, Emotional Wellbeing

Taha Tinana  
Physical Wellbeing

Taha Wairua  
Spiritual Wellbeing



Taha Whanau  
Social Wellbeing

Guided Reflection:

As you progress through this exercise you might ask yourself:

Are all aspects of my professional life in balance?

What areas of my professional life are receiving more attention than others? Why?

Are there areas of my professional life that might benefit from more attention? Which ones?

What strategies might I use to further enhance my professional well-being?



## APPENDIX FOUR

### Contents

1. Evaluation Form

*Health Professional Services*  
Evaluation Form

Professional Development Topic:

Date: \_\_\_\_\_

Job Title: \_\_\_\_\_

Organisation: \_\_\_\_\_

1. Was the content of this education seminar relevant to your work?
2. Can you identify three things you found useful from today's seminar that will improve your nursing practice?
  - i)
  - ii)
  - iii)
3. What did you enjoy most about the seminar?
4. Was there anything you didn't like about today's seminar?
5. Was the allocated time-frame adequate?
6. Did you like the presentation style of the seminar?
7. Was there anything else you would have liked to have included in the seminar?
8. General Comments:

**Many thanks for taking the time to provide me with your valuable feedback, it is much appreciated.**

Health Professional Services  
Noreen McLoughlin

MA (Applied) Nursing, (Student), RCpN, Dip. Massage; Dip. Adult Education & Learning (Student), Cert. Professional Supervision

## **APPENDIX FIVE**

### Contents

1. Palliative Care Assessment Quiz
2. Palliative Care Quiz Answers

## Dying, Death and Grief Quizz

1	2		4				6		3, 8										
						10								12					
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							21												
						23													

**Across**

1. Drug useful in reducing anxiety and terminal restlessness (9)
3. Grief is a \_\_\_\_\_ (7) that varies between people and cultures
5. One common cause of Grief (4)
7. The name given to this model of grief is also the name of a scone and child's toy (8)
9. Dying, death and grief can create and result in much \_\_\_\_\_ (6) for patients, significant others and staff
11. One coping strategy that staff can use to work through practice difficulties (7)
13. A \_\_\_\_\_ (7) driver is a piece of equipment often used to administer medications subcutaneously
15. \_\_\_\_\_ (10) is an ongoing and vital tool for gathering information on changing patient and significant others needs
17. \_\_\_\_\_ (4) is said to heal many things
19. \_\_\_\_\_ (5) These must be met to ensure quality outcomes
21. The final stage or phase of the dying process (8)
23. The name given to irregular and intermittent breathing often associated with dying (12)

**Down**

2. Another name for Karakia or prayer (11)
4. Group of drugs administered to control pain (10)
6. Common analgesic also useful in reducing breathlessness (8)
8. One of the most common symptoms that can and does cause much fear and distress (4)
10. One way to clarify needs is to \_\_\_\_\_ (3) relevant questions
12. Another name for those who have experienced or suffered loss of a loved one (11)
14. One Maori name for spirit
16. A term used to describe the change in skin appearances associated with shutdown (8)
18. \_\_\_\_\_ (4) of the unknown can markedly increase stress
20. Elizabeth Kubler \_\_\_\_\_ (4) was one of the early pioneers of proposing a model of grief that she believed and classified as occurring in stages
22. By empowering patients and significant others we increase their \_\_\_\_\_ (7)
24. The best assistance we can give to those who are dying and or grieving is appropriate \_\_\_\_\_ (7)
26. One hallmark of safe practice and care is to be \_\_\_\_\_ (9) to individuals' varying needs
28. Values and \_\_\_\_\_ (7) are often what shape our expectations, assumptions and perceptions in life and death

### Dying, Death & Grief Quizz

M	I	D	A	Z	O	L	A	M		P	R	O	C	E	S	S				
	N		N					O		A										
	C		A			A		R		I				B						
	A		L	O	S	S		P	I	N	W	H	E	E	L		M			
	N		G			K		H			A			R			O			
S	T	R	E	S	S			I			I			E			T			
	A		S					N			R			A			T			
	T		I					E			U			V			L			
	I		C								A			D	E	B	R	I	E	F
	O		S	Y	R	I	N	G	E			C		M			N		E	
	N				O							O		E			G		A	
					S							N		N					R	
			A	S	S	E	S	S	M	E	N	T		T	I	M	E			
				U			E					R								
				P			N					O				B				
				P			S					L			N	E	E	D	S	
				O			I									L				
				R			T	E	R	M	I	N	A	L		I				
				T			I									E				
							V									F				
						C	H	E	Y	N	E	S	T	O	K	E	S			

**Across**

1. Drug useful in reducing anxiety and terminal restlessness (9)
3. Grief is a \_\_\_\_\_ (7) that varies between people and cultures
5. One common cause of Grief (4)
7. The name given to this model of grief is also the name of a scone and childs' toy(8)
9. Dying, death and grief can create and result in much \_\_\_\_\_(6) for patients, significant others and staff
11. One coping strategy that staff can use to work through practice difficulties (7)
13. A \_\_\_\_\_(7) driver is a piece of equipment often used to administer medications subcutaneously
15. \_\_\_\_\_(10) is an ongoing and vital tool for gathering information on changing patient and significant others needs
17. \_\_\_\_\_(4) is said to heal many things
19. \_\_\_\_\_(5) These must be met to ensure quality outcomes
21. The final stage or phase of the dying process (8)
23. The name given to irregular and intermittent breathing often associated with dying (12)

**Down**

2. Another name for Karakia or prayer (11)
4. Group of drugs administered to control pain (10)
6. Common analgesic also useful in reducing breathlessness (8)
8. One of the most common symptoms that can and does cause much fear and distress (4)
10. One way to clarify needs is to \_\_\_\_ (3) relevant questions
12. Another name for those who have experienced or suffered loss of a loved one(11)
14. One Maori name for spirit
16. A term used to describe the change in skin appearances associated with shutdown (8)
18. \_\_\_\_\_(4) of the unknown can markedly increase stress
20. Elizabeth Kubler \_\_\_\_\_(4) was one of the early pioneers of proposing a model of grief that she believed and classified as occurring in stages
22. By empowering patients and significant others we increase their \_\_\_\_\_(7)
24. The best assistance we can give to those who are dying and or grieving is appropriate \_\_\_\_\_(7)
26. One hallmark of safe practice and care is to be \_\_\_\_\_(9) to individuals' varying needs
28. Values and \_\_\_\_\_(7) are often what shape our expectations, assumptions and perceptions in life and death

## **APPENDIX FIVE**

### Contents

1. Palliative Care Assessment Quiz
2. Palliative Care Quiz Answers

## Dying, Death and Grief Quizz

1	2		4				6		3, 8										
						10								12					
			5				7			14							16		
9																			
														11					18
			13		20								22						
			15	24			26								17				
																		28	
																	19		
							21												
							23												

**Across**

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M	I	D	A	Z	O	L	A	M		P	R	O	C	E	S	S			
	N		N					O		A									
	C		A			A		R		I				B					
	A		L	O	S	S		P	I	N	W	H	E	E	L		M		
	N		G			K		H		A				R		O			
S	T	R	E	S	S			I		I				E		T			
	A		S					N		R				A		T			
	T		I					E		U				V		L			
	I		C							A			D	E	B	R	I	E	F
	O		S	Y	R	I	N	G	E			C		M		N		E	
	N				O							O		E		G		A	
					S							N		N					R
			A	S	S	E	S	S	M	E	N	T		T	I	M	E		
				U			E					R							
				P			N					O				B			
				P			S					L			N	E	E	D	S
				O			I									L			
				R			T	E	R	M	I	N	A	L		I			
				T			I									E			
							V									F			
						C	H	E	Y	N	E	S	T	O	K	E	S		

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## **APPENDIX SIX**

### Contents

1. Sample Certificate of Attendance

*Health Professional Services*  
(Education, Supervision, Massage)

Certificate of Attendance

This is to confirm that *Mae West* attended a three hour professional development seminar on the topic: Palliative Care.

Information included:

- \*Exploration of individual and collective values and beliefs about dying, death and grief
  - \*Defining Palliative Care as an Approach and or Philosophy for end of life care
  - \*Introduction to the NZ Palliative Care Strategy (2001) and related documents e.g. NZ Cancer Control Strategy (2003)
  - \*Discussion of relevance of Strategies to aged care practice context
  - \*Overview of physiological changes in the dying process
  - \*Identification of common symptoms, control and management
  - \*Role of needs assessment in managing care
  - \*Role of Hospice in Palliative Care provision and education
  - \*Critical reflection exercise
- 
- \*Review of Grief and identification of cultural context differences
  - \*Discussion on grief manifestations
  - \*Identification of two models of grief: Kubler-Ross; Pinwheel Model
  - \*Abnormal grief responses and management strategies
- 
- \*Staff stressor identification and management strategies as these relate to caring for individuals who are dying within specific practice contexts
  - \*Professional Self Care exercise using Te Whare Tapa Wha

Date: 30<sup>th</sup> March 2006

Certified By: \_\_\_\_\_

Noreen Mcloughlin MA (Applied) Nursing (Student)  
RCpN  
Dip. Adult Learning & Education (Student)  
Dip. Massage  
Cert. Supervision

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