# Evidence Brief: End of Life Care

## Contents

*HEE Knowledge Management Team, April 2019*

Produced by the HEE Knowledge Management team Evidence Briefs offer a quick overview of the published reports, research and evidence on a workforce-related topic. A starter for 10 on the evidence if you will.

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## Key publications – the big picture

### *The NHS Long Term Plan* NHS, January 2019

The NHS Long Term Plan was developed in partnership with those who know the NHS best – frontline health and care staff, patients and their families and other experts. See section 1.3 “people will get more control over their own health and more personalised care when they need it”.

### *Learning from deaths* Care Quality Commission, 2019

This report outlines the findings from the first year of assessing how well trusts are implementing national guidance introduced to support improved investigations and better family engagement when patients die.

### *End of life care: strengthening choice* Together for Shorter Lives, October 2018

See point 81 for “Workforce”
The All-Party Parliamentary Group (APPG) for Children Who Need Palliative Care has published the results of its inquiry, which examined the extent to which the government is meeting its end of life care choice commitment for the growing number of babies, children and young people in England with life-limiting and life-limiting conditions.

### *Cancer workforce in England: a census of cancer, palliative and chemotherapy speciality nurses and support workers in England 2017* Macmillan Cancer Support, April 2018

Findings of its census of specialist cancer nurses and support workers[i], the first in depth investigation into the cancer nursing and support workforce in England since 2014.

### Thinking differently: Macmillan’s vision for the future cancer workforce in England February 2017, Macmillan Cancer Support

In setting out our vision, this report examines the current challenges facing the cancer workforce. These include gaps in key roles such as Clinical Nurse Specialists (CNSs), inefficient use of specialist skills, and poor coordination and communication leading to lack of support both for recovery and at end of life.

*Cancer Workforce Plan Phase 1: Delivering the cancer strategy to 2021* 2017, NHS

The prevalence of cancer is forecast to increase, and scientific and technological innovations offer the potential to transform our ability to prevent, diagnose, treat and care for people affected. We know that some key parts of the workforce are under pressure now and unless we take action then we may not have enough staff with the right skills to deliver the Cancer Taskforce Strategy. This is a pragmatic plan to increase the net supply of numbers and skills in the short term whilst we develop a longer-term approach alongside our wider workforce strategy to be published in summer 2018.

*Dying to care: a report into social care at the end of life* December 2016, Marie Curie

Good social care is fundamental to people achieving the outcomes they want as they approach the end of their life. This report looks at the barriers in Scotland to people receiving social care and how they can be overcome. See Chapter 5 “Who cares?” which looks at the professional social care workforce.

*Staff prepared to care? Capacity and competence in the end of life care workforce* May 2016, National Council for Palliative Care

A lack of data about palliative care staff could lead staff shortages in the next few years. The National Council for Palliative Care's Workforce report found a lack of data about staff working in palliative and end of life care, making it hard to know if there will be enough staff to meet the rising need for end of life care.

*NHS England specialist level palliative care: information for commissioners* April 2016, NHS England

The document is for people who provide, deliver and commission specialist palliative care services and palliative care education and training.

*Better endings: right care, right place, right time (themed review)* December 2015, NIHR Dissemination Centre

This review brings together recent evidence which might help those delivering, planning or using end of life services. The review focuses on studies funded by the National Institute for Health Research (NIHR), which was set up in 2006 as the research arm of the NHS to provide a health research system focused on the needs of patients and the public. The NIHR has funded a number of programmes, projects, work streams and researchers working in palliative and end of life care over recent years. These different studies from different programmes have not been brought together in this way before. It is not a comprehensive review of all evidence in this field, but offers insights from a range of NIHR funded work published since 2010 in the context of recent evidence on the organisation and quality of end of life care services. Details of the eighteen completed and twelve ongoing NIHR funded studies are given in the appendices.

*One chance to get it right: improving people's experience of care in the last few days and hours of life* June 2014, Leadership Alliance for the Care of Dying People

This document sets out the approach to caring for dying people that health and care organisations and staff caring for dying people in England should adopt in future. The approach should be applied irrespective of the place in which someone is dying: hospital, hospice, own or other home and during transfers between different settings.

*NCPC Specialist Palliative Care (SPC) Workforce Survey 2013 SPC Longitudinal Survey of England Strategic Clinical Networks* September 2014 Public Health England, The National Council for Palliative Care, Mouchel

This report identifies some of the key findings from the 2013 collection results and then highlights some of the trends over the years the survey has been running (2005-13). The report has been produced by Mouchel plc and has been supported by the National End of Life Care Intelligence Network (NEoLCIN) and Public Health England (PHE).

*Ambitions for palliative and end of life care: a national framework for local action 2015-2020* n.d., National Palliative and End of Life Care Partnership

This national framework for local action looks at a movement towards better end-of-life care through six ambitions: each person is seen as an individual, each person gets fair access to care, maximising comfort and wellbeing, care is coordinated, all staff are prepared to care, and each community is prepared to help. These compliment the priorities of care for the dying person.

*Improving end of life care: professional development for physicians – report of a working party* March 2012, Royal College of Physicians

This report informs and recommends how physicians can continue with professional development and who within the healthcare sector can support with the implementation. Taking into account data from 2000 physicians, this document includes recommendations for trust boards, commissioners, physicians and palliative care teams.

## Case Studies

*Tailored end-of-life care training* August 2018, NHS Employers

Discover how Leeds Teaching Hospitals provided a tailored approach to training, in the final of a suite of case studies focused on enhancing end-of-life care. In addition to trust-wide training opportunities, the palliative care and end-of-life care specialists offered bespoke departmental teaching and focused interventions to improve care within specific clinical areas.

*Supporting bereaved relatives training for porters* June 2017, eWIN

Improving end of life care is a priority at national and local level and this includes how relatives of those who have died are supported. A 2015 NIHR report “Better Endings”, raised concerns about the way certain bereavement services are provided including “skills and training gaps for general staff caring for the dying.” Some porters had stated that when they were collecting the deceased to take them to the mortuary they wanted to “get in and out of there as quickly as possible” and that they often felt uncomfortable and ill equipped to talk with the bereaved “in case they made things worse.”

*Making staff experts in end-of-life care* July 2016, NHS Employers

Discover the benefits of empowering staff to deliver end-of-life care in this new case study from Salford Royal NHS Foundation Trust. By providing access to training such as coaching, role modelling and workshops, the trust has enabled staff to build on their knowledge, skills and confidence in caring for patients and their families.

*Flexible ways to deliver end-of-life care training*
July 2016, NHS Employers

Discover the benefits of working flexibly to deliver end-of-life care training in this new case study from Kent Community Health NHS Trust. By providing training workshops in locations across the county, the trust achieved the following outcomes:

- improvements in the end-of-life care being delivered to patients
- increased staff confidence in having end-of-life care conversations
- more than 850 training sessions attended by staff
- more evidence of good practice.

*Raising awareness of end-of-life care* July 2016, NHS Employers

NHS Employers Discover the benefits of raising awareness of the end-of-life care agenda in this new case study from Shrewsbury and Telford Hospital NHS trust. The trust has done this through implementing a robust end-of-life plan and hosting an annual conference, which have had significant impact including:

- increasing skills, knowledge and understanding of the plan and providing individualised end-of-life care for patients
- raising awareness of the importance of talking about end-of-life care
- allowing staff of all levels to have open conversations in an informal setting.

*Making mandatory end-of-life care training*
May 2016, NHS Employers

This case study shows how Worcestershire Acute Hospitals NHS Trust:

- ensured that end-of-life care was part of its mandatory training programme
- significantly reduced hospital readmissions
- worked across organisations to provide additional training for staff
- built staff confidence in starting conversations with patients about the end of life.

*Hospice redesigns its support workforce structure to help more people to access end of life care in their own homes and communities* n.d., Skills for Health

Background: St Nicholas Hospice Care in Bury St Edmunds worked with Help the Hospices (the umbrella organisation for hospices) and Skills for Health to create a new structure for its support workforce. Why redesign the support structure? Demand for hospice care is increasing as more people are living longer and living with complex conditions. Our strategic goal is to meet the needs of this growing and changing demand by adapting how we work. We believe the support workforce are a critically important resource; with leadership from registered professionals and following contemporary development opportunities they are able to help more people facing progressive ill-health, death, dying and bereavement.

## HEE Star

More resources and tools are available in the **"Up-Skilling"** section of the HEE Star if you search for **"End of Life Care"**: https://www.hee.nhs.uk/our-work/hee-star

## Statistics

You can find relevant statistics on the Health and Care Statistics Landscape under **"End of Life Care"** https://gss.civilservice.gov.uk/hc-statistics-landscape/

## Webinar

*End of life care* July 2016, NHS Employers

In this end-of-life care webinar we hear from guest speakers who share their knowledge and experience in this important area of healthcare, including:

- information around the roles of NHS Employers and Health Education England in supporting the end-of-life care agenda
- good practice from Hampshire Hospitals NHS Foundation Trust about how it is improving end-of-life care for patients through the education and training of staff
- guidance on starting conversations with patients at the end of life.

# Published Peer Reviewed Research

## New, expanded or specialist roles

*Systematic review of general practice end-of-life symptom control* BMJ Supportive & Palliative Care, December 2018

BACKGROUNDEnd of life care (EoLC) is a fundamental role of general practice, which will become more important as the population ages. It is essential that general practice's role and performance of at the end of life is understood in order to maximise the skills of the entire workforce.OBJECTIVETo provide a comprehensive description of the role and performance of general practitioners (GPs) and general practice nurses (GPNs) in EoLC symptom control.METHODSystematic literature review of papers from 2000 to 2017 were sought from Medline, PsycINFO, Embase, Joanna Briggs Institute and Cochrane databases.RESULTSFrom 6209 journal articles, 46 papers reported GP performance in symptom management. There was no reference to the performance of GPNs in any paper identified. Most GPs expressed confidence in identifying EoLC symptoms. However, they reported lack of confidence in providing EoLC at the beginning of their careers, and improvements with time in practice. They perceived emotional support as being the most important aspect of EoLC that they provide, but there were barriers to its provision. GPs felt most comfortable treating pain, and least confident with dyspnoea and depression. Observed pain management was sometimes not optimal. More formal training, particularly in the use of opioids was considered important to improve management of both pain and dyspnoea.CONCLUSIONSIt is essential that GPs receive regular education and training, and exposure to EoLC from an early stage in their careers to ensure skill and confidence. Research into the role of GPNs in symptom control needs to occur.

*Assistant practitioners in palliative care: doing things differently* British Journal of Healthcare Assistants, December 2018

The acute hospital palliative care team at London North West University Healthcare NHS Trust provides specialist palliative care advice and supports end-of-life care across the trust. We have experienced a year-on-year increase in demand for our services and have previously managed this by recruiting more clinical nurse specialists. The appointment of two assistant practitioners to support end-of-life care has allowed us to look at a different model of care and new ways of working to meet increasing demands on our service.

*What role do Death Doulas play in end-of-life care? A systematic review* Health and Social Care in the Community, September 2018

Current health and social care systems do not always meet the needs of the dying in our communities. As a result, patients and families are choosing to place their trust in those who can advocate for them or fill the gaps in care. Birth Doulas have been working with women during pregnancy and after birth for many years, and we are now seeing a new role, that of a Death Doula emerging in the end-of-life care space. How Death Doulas work within health and social care systems is not understood and we conducted a systematic review to explore the published literature to explore the role and potential implications for models of care delivery. Following the PRISMA recommendations, we searched the literature in January 2018 via bibliographic databases and the grey literature without search date parameters to capture all published literature. We looked for articles that describe the role/work of a death doula or a death midwife in the context of end-of-life care, or death and dying. Our search retrieved 162 unique records of which five papers were included. We analysed the papers in relation to relationship to health service, funding source, number and demand for services, training, licensing and ongoing support, and tasks undertaken. Death Doulas are working with people at the end of life in varied roles that are still little understood, and can be described as similar to that of "an eldest daughter" or to a role that has similarities to specialist palliative care nurses. Death doulas may represent a new direction for personalised care directly controlled by the dying person, an adjunct to existing services, or an unregulated form of care provision without governing oversight.

*Can specially trained community care workers effectively support patients and their families in the home setting at the end of life?* Health & social care in the community, March 2018

Surveys indicate that many Australians would prefer to die at home, but relatively few do. Recognising that patients and their families may not have the support they need to enable end-of-life care at home, a consortium of care providers developed, and received funding to trial, the Palliative Care Home Support Program (PCHSP) across seven health districts in New South Wales, Australia. The programme aimed to supplement end-of-life care in the home provided by existing multidisciplinary community palliative care teams, with specialist supportive community care workers (CCWs). An evaluation of the service was undertaken, focussing on the self-reported impact of the service on family carers (FCs), with triangulation of findings from community palliative care teams and CCWs. Service evaluation data were obtained through postal surveys and/or qualitative interviews with FCs, community palliative care teams and CCWs. FCs also reported the experience of their loved one based on 10 items drawn from the Quality of Death and Dying Questionnaire (QODD). Thematic analysis of surveys and interviews found that the support provided by CCWs was valued by FCs for: enabling choice (i.e. to realise end-of-life care in the home); providing practical assistance ("hands-on"); and for emotional support and reassurance. This was corroborated by community palliative care teams and CCWs. Responses by FCs on the QODD items indicated that in the last week of life, effective control of symptoms was occurring and quality of life was being maintained. This study suggests that satisfactory outcomes for patients and their families who wish to have end-of-life care in the home can be enabled with the additional support of specially trained CCWs. A notable benefit of the PCHSP model, which provided specific palliative care vocational training to an existing community care workforce, was a relatively rapid increase in the palliative care workforce across the state.

*Primary palliative Care in General Practice - study protocol of a three-stage mixed-methods organizational health services research study* BMC Palliative Care, January 2018

BACKGROUNDThe focus of this project is on improving the provision of primary palliative care (PC) by general practitioners (GPs). While approximately 10-15% of the incurable, seriously ill or dying people will be in need of specialist PC, the vast majority can be adequately treated within generalist care. The strengthening of the GP's role in PC, as well as ensuring close collaboration between specialist PC services and GPs have been identified as top priorities for the improvement of PC in Germany. Despite healthcare policy actions, diverse obstacles still exist to successful implementation of primary PC on a structural, process, and economic level. Therefore, this project aims at addressing barriers and facilitators to primary PC delivery in general practice in Germany.METHODSThe study follows a three-step approach; first, it aims at systematically analyzing barriers and facilitators to primary PC provision by GPs. Second, based on these outcomes, a tailored intervention package will be developed to enhance the provision of primary PC by GPs. Third, the intervention package will be implemented and evaluated in practice. The expected outcome will be an evidence-based model for successful implementation of primary PC delivery tailored to the German healthcare system, followed by a strategic action plan on how to improve current practice both on a local level and nationally.DISCUSSIONThe first step of the project has been partly completed at the time of writing. The chosen methodologies of four sub-projects within this first step have opened up different advantages and disadvantages for the data collection. In sum of all sub-projects, the different methodologies and target groups contributed valuable information to the systematic analysis of barriers and facilitators to primary PC provision by GPs.TRIAL REGISTRATIONThe study (BMBF-FK 01 GY 1610) was retrospectively registered at the German Clinical Trials Register (Deutsches Register Klinischer Studien) (Registration N° DRKS00011821 ; date of registration: December 04th 2017) and at the German Register of health care research (Versorgungsforschung Deutschland - Datenbank) (Registration N° VfD_ALLPRAX_16_003817 ; date of registration: March 30th 2017).

*The Family Meeting in Palliative Care: Role of the Oncology Nurse* Seminars in Oncology Nursing, December 2017

OBJECTIVESTo describe the family meeting in palliative and end-of-life care, highlighting the role of the oncology nurse. Specific strategies will be provided for pre-meeting preparation, communication, and follow-up activities.DATA SOURCESA conceptual framework drawn from family and communication theory, and best practices from the clinical, research, nursing, and palliative care literature.CONCLUSIONWorking with patients and families is complex, but the family meeting is a promising tool and a potential quality indicator in palliative care.IMPLICATIONS FOR NURSING PRACTICEThe nurse is well positioned to participate fully in every aspect of the family meeting.

*Independent non-medical prescribing in children's hospices in the UK: a practice snapshot* International Journal of Palliative Nursing, August 2017

BACKGROUNDNon-medical prescribing is well established within the British health service, with increasing numbers of nurses practicing within children's hospices.AIMTo identify the context of non-medical prescribing in children's hospices in the UK, focusing on the perceived benefits and challenges.METHODInternet-based questionnaires were sent to 55 UK children's hospices, exploring the practice and context of prescribing.RESULTSOf the 55 invited, 20 children's hospices responded to the questionnaire, 14 of which employed a total of 39 non-medical prescribers (NMPs). Sixteen individual NMPs responded, of which half (50%) prescribed to enable the continuation of existing medicines, 37.5% prescribed independently surrounding symptom management and control and 31.3% in end-of-life care. Perceived benefits of prescribing included timely access to medicines, increased efficiency and accuracy in the admissions process and medicine reconciliation and the increased ability to offer choice in the place of palliative and hospice care. Perceived barriers to prescribing surrounded opportunities to develop confidence, defining the scope of practice and the time required to assess, diagnose and treat.CONCLUSIONNMPs are making a significant contribution to the prescribing workforce within hospices; however, a number of challenges need to be addressed to enable hospices to realise the benefits.

*Social workers' involvement in advance care planning: a systematic narrative review* BMC Palliative Care, July 2017

BACKGROUNDAdvance care planning is a process of discussion that enables competent adults to express their wishes about end-of-life care through periods of decisional incapacity. Although a number of studies have documented social workers' attitudes toward, knowledge about, and involvement in advance care planning, the information is fragmented. The purpose of this review was to provide a narrative synthesis of evidence on social workers' perspectives and experiences regarding implementation of advance care planning.METHODSSix databases were searched for peer-reviewed research papers from their respective inception through December 2016. All of the resulting studies relevant to both advance care planning and social worker were examined. The findings of relevant studies were synthesized thematically.RESULTSThirty-one articles met the eligibility criteria. Six research themes were identified: social workers' attitudes toward advance care planning; social workers' knowledge, education and training regarding advance care planning; social workers' involvement in advance care planning; social workers' perceptions of their roles; ethical issues relevant to advance care planning; and the effect of social work intervention on advance care planning engagement. The findings suggest that there is a consensus among social workers that advance care planning is their duty and responsibility and that social workers play an important role in promoting and implementing advance care planning through an array of activities.CONCLUSIONSThis study provides useful knowledge for implementing advance care planning through illustrating social workers' perspectives and experiences. Further studies are warranted to understand the complexity inherent in social workers' involvement in advance care planning for different life-limiting illnesses or within different socio-cultural contexts.

*Specialist palliative care nursing and the philosophy of palliative care: a critical discussion* International Journal of Palliative Nursing, July 2017

Nursing is the largest regulated health professional workforce providing palliative care across a range of clinical settings. Historically, palliative care nursing has been informed by a strong philosophy of care which is soundly articulated in palliative care policy, research and practice. Indeed, palliative care is now considered to be an integral component of nursing practice regardless of the specialty or clinical setting. However, there has been a change in the way palliative care is provided. Upstreaming and mainstreaming of palliative care and the dominance of a biomedical model with increasing medicalisation and specialisation are key factors in the evolution of contemporary palliative care and are likely to impact on nursing practice. Using a critical reflection of the authors own experiences and supported by literature and theory from seminal texts and contemporary academic, policy and clinical literature, this discussion paper will explore the influence of philosophy on nursing knowledge and theory in the context of an evolving model of palliative care.

*The Role of Advanced Practice Registered Nurses in the Completion of Physician Orders for Life-Sustaining Treatment* Journal of Palliative Medicine, April 2017

BACKGROUNDThe Physician Orders for Life-Sustaining Treatment (POLST) Paradigm records advance care planning for patients with advanced illness or frailty as actionable medical records. The National POLST Paradigm Task Force recommends that physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs) be permitted to execute POLST forms.OBJECTIVETo investigate the percentage of Oregon POLST forms signed by APRNs, and examine the obstacles faced by states attempting to allow APRNs to sign POLST forms.DESIGNCross-sectional.SETTING/SUBJECTS226,101 Oregon POLST Registry forms from 2010 to 2015.MEASUREMENTSPOLST forms in the Oregon Registry were matched with signer type (MD, DO, APRN, PA).RESULTS226,101 POLST forms have been added to the Oregon POLST Registry from 2010 to 2015: 85.3% of forms were signed by a physician, 10.9% of forms were signed by an APRN, and 3.8% of forms were signed by a PA. From 2010 to 2015, the overall percentage of POLST forms signed by an APRN has increased from 9.0% in 2010 to 11.9% in 2015. Physicians are authorized signers in all 19 states with endorsed POLST Paradigm programs; 16 of these states also authorize APRN signature, and 3 states (LA, NY, and GA) allow only physicians to sign.CONCLUSIONSMore than 10% of Oregon POLST forms are signed by APRNs. Given the need for timely POLST form completion, ideally by a member of the interdisciplinary team who knows the patient's preferences best, these data support authorizing APRNs to complete POLST forms.

*The Role of Physical Therapists Within Hospice and Palliative Care in the United States and Canada* The American Journal of Hospice & Palliative Care, February 2017

PURPOSELittle is known regarding the extent to which physical therapy is integrated into Hospice and Palliative Care (HPC). The purpose of this study was to describe perceptions of physical therapists (PTs) regarding their role within HPC or working with patients having life-threatening illnesses and to develop a conceptual framework depicting a PTs role within HPC and factors affecting it.PARTICIPANTSTen PTs, 5 from the United States and 5 from Canada, with at least 5 years of physical therapy experience and 5 years working experience with patients having life-threatening illnesses or in HPC.METHODSDemographic data were collected by electronic questionnaire. A semistructured interview was conducted with each participant to investigate their perceptions about the role of PTs in HPC.DATA ANALYSISInterview results were analyzed for trends between participants, practice settings, regions, and other sociocultural aspects. The constant comparative method of qualitative data analysis was used to identify similarities and differences and to develop themes and concepts relative to the role of PT in HPC.RESULTSParticipants identified their 3 primary roles in HPC: providing patient/family care, serving as an interdisciplinary team member, and fulfilling professional responsibilities outside of direct patient care. They described factors within and outside direct patient care which influenced their roles. Concepts included shifting priorities, care across the continuum, and changing perceptions of PTs within HPC.CLINICAL RELEVANCEThis study described perceptions of the role of PTs within HPC that may be utilized when coordinating future strategies to appropriately promote and expand the role.

*Provision of Palliative Care Services by Family Physicians Is Common* Journal of the American Board of Family Medicine, 2017

OBJECTIVEProvision of palliative care services by primary care physicians is increasingly important with an aging population, but it is unknown whether US primary care physicians see themselves as palliative practitioners.METHODSThis study used cross-sectional analysis of data from the 2013 American Board of Family Medicine Maintenance of Certification Demographic Survey.RESULTSOf 10,894 family physicians, 33.1% (n = 3609) report providing palliative care. Those providing palliative care are significantly more likely to provide non-clinic-based services such as care in nursing homes, home visits, and hospice. Controlling for other characteristics, physicians reporting palliative care provision are significantly ($P < .05$) more likely to be older, white, male, rural, and practicing in a patient-centered medical home.CONCLUSIONOne third of family physicians recertifying in 2013 reported providing palliative care, with physician and practice characteristics driving reporting palliative care provision.

*A dedicated palliative care nurse improves access to palliative care and hospice services in an urban ED* The American Journal of Emergency Medicine, December 2016

*Athens log in required*

Patients with advanced and end-stage disease in need of symptom management, pain relief, and care coordination often present to the Emergency Department (ED). Moreover, a large proportion of patients with chronically progressive and terminal illnesses lack coordination of care, especially among the elderly and underserved [1]. Thus, their healthcare needs are often episodic and unplanned, with the ED being a primary source of medical care. However, for many of these patients traditional life-prolonging treatments offered by ED providers may not be concordant with their goals, and may not address the symptoms for which they sought care.

## Recruitment, Retention and Supply

*The Growing Demand for Hospice and Palliative Medicine Physicians: Will the Supply Keep Up?* Journal of Pain and Symptom Management, April 2018

CONTEXTThe need for hospice and palliative care is growing rapidly as the population increases and ages and as both hospice and palliative care become more accepted. Hospice and palliative medicine (HPM) is a relatively new physician specialty, currently training 325 new fellows annually. Given the time needed to increase the supply of specialty-trained physicians, it is important to assess future needs to guide planning for future training capacity.OBJECTIVESWe modeled the need for and supply of specialist HPM physicians through the year 2040 to determine whether training capacity should continue growing.METHODSTo create a benchmark for need, we used a population-based approach to look at the current geographic distribution of the HPM physician supply. To model future supply, we calculated the annual change in current supply by adding newly trained physicians and subtracting physicians leaving the labor force.RESULTSThe current U.S. supply of HPM specialists is 13.35 per 100,000 adults 65 and older. This ratio varies greatly across the country. Using alternate assumptions for future supply and demand, we project that need in 2040 will range from 10,640 to almost 24,000 HPM specialist physicians. Supply will range from 8100 to 19,000.CONCLUSIONCurrent training capacity is insufficient to keep up with population growth and demand for services. HPM fellowships would need to grow from the current 325 graduates annually to between 500 and 600 per year by 2030 to assure sufficient physician workforce for hospice and palliative care services given current service provision patterns.

*Sidewalk Chalk Art: A Creative Way To Engage Millennials in Palliative Care* Journal of Palliative Medicine, April 2017
The article focuses on employing ways for engage millennial in palliative care focusing on sidewalk chalk art. It mentions that psychology students were formally trained as hospice volunteers and spent a semester personally caring for patients and families, wherein at the end of the course, the students took part in a reflection celebration, where they identified at least one quote from their patients that evoked fond memories of their volunteer experience.

*Canada needs twice as many palliative specialists* CMAJ: Canadian Medical Association Journal, January 2017
The article reports on the increase demand of palliative care doctors in Canada. It highlights the role of the palliative specialists

in giving the suffering patients an alternative to assisted death particularly in remote communities. It also notes that the palliative care doctors must undergo a national course for palliative care training and workforce planning.

*Using Agency Nurses to Fill RN Vacancies Within Specialized Hospice and Palliative Care* Policy, Politics and Nursing Practice, August 2016
The use of agency nurses offers flexibility in filling registered nurse (RN) openings during times of shortage, yet little is known about their use in specialized palliative care. In an effort to fill this knowledge gap, this study determined whether significant relationships existed between full-time and part-time RN vacancies and the use of agency RNs within specialized hospices that deliver perinatal end-of-life care to women and their families in the event of miscarriage, ectopic pregnancy, or other neonatal complications resulting in death. This study used data from the 2007 National Home and Hospice Care Survey and multivariate regression methods to estimate the association between RN vacancies and agency RNs use. Approximately 13% of perinatal hospices in 2007 used agency nurses. Increases in full-time RN vacancies are associated with a significant increase in the use of agency RNs, while part-time RN vacancies are associated with a significant decrease in agency RNs. These results suggest that full-time agency RNs were used as a supplemental workforce to fill vacancies until the full-time position is recruited. However, for part-time vacancies, the responsibilities of those positions shifted onto existing staff and the position was not filled.

*Collecting evidence of nursing vacancies in voluntary children's palliative care organisations* Palliative Medicine, April 2016
Health systems around the world report a global shortage of nurses.1 In the United Kingdom 55% of registered nurses are not practising in the NHS2. How many nurses delivering complex care to children with life-limiting conditions are employed in voluntary organisations? Is this number enough to provide safe, sustainable care whenever and wherever they need it, now and into the future? To explore this we gathered direct feedback from voluntary children's hospice and palliative care organisations. We carried out data collection via online survey for an agreed date and in-depth analysis Two thirds of the children's hospice and community services completed the survey allowing us to extrapolate and predict there are over 1500 nurses employed in the sector. The average vacancy rate we found was 10% which reflects the national rate for NHS Services across the United Kingdom. Over 60% of vacancies were defined as "hard to fill" (post vacant for over three months) Almost half of services had to reduce the service offered to families due to vacancies; reducing the short break offered or reducing the out of hour's part of the service. Despite the vacancy rate in the sector matching the NHS, the responses suggest differences in terms and conditions compared to NHS which may be a barrier to attracting and retaining nurses in children's hospice organisations. Responses also suggested a barrier when attracting nurses to a sector sometimes perceived as "sad". We asked sector leaders to relate these findings to the global picture and suggest local solutions to recruitment practice. The survey highlighted the urgent need to increase the profile of working in this sector, ensure roles are made attractive to prospective nurses and find creative solutions to skill mix in future workforce planning. 1. The Global Nursing Shortage: Priority Areas for Intervention. International Council of Nurses 2006 2. Growing Nurse Numbers, Health Education England 2014.

## Staff Perceptions

*Nurses' perspectives on the personal and professional impact of providing nurse-led primary palliative care in outpatient oncology settings International* Journal of Palliative Nursing, January 2019

BACKGROUND:Palliative care (PC) workforce shortages have led to a need for primary PC provided by non-specialists. The Care Management by Oncology Nurses (CONNECT) intervention provides infusion room oncology nurses with training and support to provide primary PC.AIMS:To describe nurses' perspectives on the personal and professional impact of training and provision of primary PC as part of CONNECT.METHODS:This qualitative study consisted of in-depth telephone interviews with 11 nurses at oncology practices in Pennsylvania. Data was analysed using qualitative content analysis.FINDINGS:Nurses reported a sense of personal and professional fulfillment from providing primary PC, while noting the risk of increased emotional attachment to patients. Participation improved nursing communication skills. A supportive workplace helped to minimise stress related to incorporating primary PC into busy treatment schedules.CONCLUSION:Providing primary PC challenges the task-oriented paradigm of nursing practice and will potentially alter the professional roles and workloads of infusion room nurses.

*Meeting patients' spiritual needs during end-of-life care: A qualitative study of nurses' and healthcare professionals' perceptions of spiritual care training* Journal of Clinical Nursing, January 2019

Aims and objectives: To explore nurses' and healthcare professionals' perceptions of spiritual care and the impact of spiritual care training on their clinical roles. Background: Many nurses and healthcare professionals feel unprepared and lack confidence, competence and skills, to recognise, assess and address patients' spiritual issues. Patients with unmet spiritual needs are at increased risk of poorer psychological outcomes, diminished quality of life and reduced sense of spiritual peace. There are implications for patient care if nurses and healthcare professionals cannot attend to patients' spiritual needs. Design: A qualitative methodology was adopted. Methods: Recruitment was purposive. A total of 21 generalist and specialist nursing and healthcare professionals from North West and South West England, who undertook spiritual care training between 2015–2017, were recruited. Participants were required to be a minimum of 3 months posttraining. Digitally audio-recorded semistructured interviews lasting 11–40 min were undertaken in 2016–2017. Data were subjected to thematic analysis. Ethical committee approval was obtained. COREQ reporting guidelines were utilised. Results: Two main themes were identified, recognising spirituality, with subthemes of what spirituality means and what matters, and supporting spiritual needs, with subthemes of recognition of spiritual distress, communication skills, not having the answers and going beyond the physical. Conclusions: Supporting patients as they approach the end of life needs a skilled workforce; acknowledging the importance of spiritual care and having skills to address it are central to delivery of best holistic care. Relevance to clinical practice: Spiritual care is as important as physical care and supporting patients spiritually as they approach the end of life is vital. Appropriately trained, nurses and healthcare professionals are better able to assess, explore and meet patients' spiritual needs.

*Constituents of effective support for homecare workers providing care to people with dementia at end of life*
International Journal of Geriatric Psychiatry, November 2018

Objective: The aim of this study was to enhance understanding about homecare workers providing care to people with dementia at end of life by exploring homecare workers' perceptions of challenges and the support they needed and sometimes received. Conclusions: Peer and manager support are essential and effective in coping with work pressures. There is a need to develop models of effective support to alleviate staff's practical, emotional, and interpersonal pressures. However, due to the isolating nature of homecare work, managers may not recognise early signs of their staff finding stress unmanageable and miss the opportunity to mitigate these negative effects.

*Am I really any good at this? Exploring and managing the imposter phenomenon in palliative care* Journal of Pain and Symptom Management, February 2018

Objectives * Define the imposter phenomenon and describe how it manifests in medical practice. * Describe how early career palliative care providers may be vulnerable to the imposter phenomenon. * Identify concrete strategies to manage feelings of imposterism. The imposter phenomenon (IP) describes the experience of questioning one's abilities and fearing exposure as an intellectual fraud, despite objective evidence of success. This phenomenon has been associated with high-achieving individuals and is common among medical providers early in their career. Despite being common, feelings of imposterism are likely under-acknowledged in the medical community. Such feelings may signal a normal part of professional development, and may even be productive, by promoting self-reflection in one's practice. For some providers, however, the IP can be associated with significant anxiety and psychological distress. Early career palliative care providers may be vulnerable to feelings of imposterism as they transition to independent practice, take on new roles as educators and investigators, and strive to emulate respected mentors. In this session, a panel of early career palliatricians and a psychologist will use case examples to explore the IP, highlight its relevance to palliative care practice, and provide targeted strategies to manage such feelings. By normalizing the IP and offering tools to navigate it, this session aims to help providers build confidence and enhance professional satisfaction.

*'Working to the end': Experiences of the home care workforce providing end-of-life care* Alzheimer’s and Dementia, July 2017

Background: The experiences and beliefs of the home care workforce supporting people with dementia to live in their own homes up to the end of life have been relatively ignored in research. Methods:This qualitative empirical study conducted in 2016, interviewed 28 home care workers and 12 managers from a range of home care agencies in South-East England and London. Framework analysis was conducted to identify themes or consistencies in the data. Results:Preliminary findings suggest that blurred boundaries, the need for communication, the constant flux of a home care worker's role and their perceptions of a client's death were important factors in their work. This paper elaborates on the theme of "perceptions of a client's death". This encompasses participants' experiences of a client's death; the relevance of 'emotional labour' to explain the impact of their actions and reactions; and support in place to contextualise their experiences. Participants described close relationships with clients, at times resulting in strong attachments that made the process of grieving harder. A blurring of boundaries was reported regarding their role when the client's death occurred, with some families wanting to be left alone, whilst current employment practices require the worker to stay in the home until professionals arrived. Moreover, home care workers were generally instructed not to touch the body, while some family requested assistance with cleaning, laying out, preparing or moving the body. Participants reported a range of sources of support, mainly from personal family and friends, and other colleagues. However, only a small proportion of staff reported being offered individual telephone support or group supervision to discuss work experiences. Many worked in isolation and felt there were few avenues for support from their employers. Conclusions: Home care workers provide care to people with dementia at the end of life in isolation, with many experiencing lack of clarity in their caring role and limited support as their client nears the end of their life. Preliminary findings from this study may be helpful in developing support resources for home care practice and human resources management.

*Palliative care knowledge and attitudes of multidisciplinary health profession trainees* Journal of Pain and Symptom Management, February 2017

Objectives * Describe the reported KNOWLEDGE of palliative care and end-of-life care of a multidisciplinary health professions sample. * Describe the reported ATTITUDES towards palliative care and end-of-life care of a multidisciplinary health professions sample. Original Research Background. A strong interprofessional palliative care workforce is needed to care for the growing older American population, in particular. The Institute of Medicine (2014) critically noted the inadequately staffed palliative care workforce and recommended increasing training and exposure in primary palliative care for all health professionals. Research Objectives. We wanted to examine multiple health professions' knowledge, attitudes, and intentions towards palliative care. Methods. During May-April 2016, we conducted an IRB-approved online survey of 360 students in their final years of training in pharmacy, medicine, nursing, physician assistant, occupational therapy, physical therapy, and public health programs at five universities. We queried their knowledge and attitudes regarding palliative care and care delivered near the end of life. Results. Sufficient knowledge of palliative care was reported by 25% of the sample while sufficient knowledge of advance care planning was reported by 17%. Respondents (96%) thought it was important to discuss end-of-life issues in their training curricula; 92% believed their profession could play an important role in patients' end-of-life care. Managing pain was reported as the best example of palliative care by 93.6% over removing life sustaining equipment (2.5%) and performing surgery to cure illness (2.5%). Designating a health care proxy was reported as the best example of advance care planning by 55.8%. We will discuss these and other findings related to each professional subsets' perceptions of their didactic preparation in palliative care, knowledge of palliative care access/function, attitudes about death/dying, and intentions to care for seriously ill patients in their future practice. Conclusion. There is interest in palliative care, including end-of-life care, and knowledge of its function among students from multiple health professions. Implications for Research, Policy, or Practice. These findings can provide guidance for how we train health professionals from multiple disciplines to care for the people they will serve in their future professional practice.

## Leadership

*Palliative nursing leadership intensive* Journal of Pain and Symptom Management, February 2017

Objectives * Differentiate essential nursing leadership qualities. * Apply 5 areas of palliative nursing leadership throughout workforce venues. * Develop an individualized leadership competency plan to maximize knowledge, transfer and application. Leadership within palliative nursing is not defined or grounded by level of nursing practice nor education but rather on qualities. Leadership in hospice and palliative nurses is present throughout the spectrum of nursing roles such as nursing assistant, licensed vocational/ practical nurse, registered nurse, and advanced practice registered nurse. Many organizations have focused time and resources to enhance leadership skills in their staff. These initiatives usually focus on dedicated nurse leadership positions, such as administrators, managers, directors, or executives. However, leadership extends beyond these roles. Nurses with higher levels of motivation lead in many areas besides a designated leadership position. Leadership in palliative care is characterized by leading others with a clear vision of palliative care initiatives, motivating and inspiring others to achieve excellence in care, positively relating to others to create healthy work environments, and changing the behavior of others to work collaboratively in palliative care (Speck 2006). These leadership qualities may be attained by any nurse at any level from the bedside nurse, the nurse group leader or organizer, to the nurse in a designated leadership position. The skills of these nurse leaders focus on a broad view of nursing and the ability to respond to change proactively, rather than reactively, in anticipating the future landscape (Wolf 2012). More specifically, the nurse leader must first assess their personal leadership capabilities prior to moving towards team development and competence. Through didactic, role play, and interactive media, this session will articulate the value of palliative nursing leadership, describe the characteristics of leaders, explore leadership of nurses at all levels of nursing practice, across the spectrum of nursing including clinical, management, education, research, and policy, and delineate necessary skills of the palliative nurse leader.

## Workforce Planning and Demographics

*Using simulation modelling to test the impact of future demand for end-of-life care* Healthcare Management Forum, July 2018

Health systems globally are exploring new models of care to address the increasing demand for palliative, hospice, and end-of-life care. Yet few tools exist at the population level to explore "what if" scenarios and test, in a "cost avoidance environment," the impact of these new care models on policy, workforce, technology, and funding. This article introduces the application of scenario-based "what if" thinking and discrete event simulation in strategic planning for a not-for-profit hospice organization. It will describe how a set of conceptual models was designed to frame discussions between strategic partners about the implications and alternatives in implementing a new, integrated service model for palliative and end-of-life care.Copyright © 2018, 2018 The Canadian College of Health Leaders.

*Future of the palliative care workforce: preview to an impending crisis* The American Journal of Medicine, February 2017

Objective: We sought to characterize the self-described future plans of the palliative care workforce and match those plans to predicted future populations eligible for palliative care. Results: We received surveys from 1357 of 3773 invited clinicians (36% response rate). Respondents were 65% female, with 55% between ages 51 and 70 years. Two-thirds had worked in clinical palliative care for 10 years or less; 62% of respondents reported burnout. Participants described their future plans, with 19% expressing a 50% or higher chance of leaving the field in 5 years, 47% intending to leave in 10 years, and 66% leaving in 15 years. The most common reason selected for leaving was “Retirement” (49%), followed by “Burnout” (24%), “Dissatisfaction with organization/practice” (20%), and “Lack of fair compensation” (16%). The multivariable logistic regression analysis demonstrated that physicians younger than age 50 years, those with burnout, and those with >75% clinical effort were at the greatest risk to leave the field early. The Figure plots the available palliative care physician workforce based on the year when respondents anticipated leaving the field. After adjusting for the annual influx of new fellowship graduates (N = 250), which is currently the only mechanism to achieve board certification, this net workforce is then plotted against population estimates of patients with one or more chronic illnesses who would be considered eligible.

*Characterizing the Hospice and Palliative Care Workforce in the U.S.: Clinician Demographics and Professional Responsibilities* Journal of Pain and Symptom management, March 2016

CONTEXTPalliative care services are growing at an unprecedented pace. Yet, the characteristics of the clinician population who deliver these services are not known. Information on the roles, motivations, and future plans of the clinician workforce would allow for planning to sustain and grow the field.OBJECTIVESTo better understand the characteristics of clinicians within the field of hospice and palliative care.METHODSFrom June through December 2013, we conducted an electronic survey of American Academy of Hospice and Palliative Medicine members. We queried information on demographics, professional roles and responsibilities, motivations for entering the field, and future plans. We compared palliative care and hospice populations alongside clinician roles using chi-square analyses. Multivariable logistic regression was used to identify predictors of leaving the field early.RESULTSA total of 1365 persons, representing a 30% response rate, participated. Our survey findings revealed a current palliative care clinician workforce that is older, predominantly female, and generally with less than 10 years clinical experience in the field. Most clinicians have both clinical hospice and palliative care responsibilities. Many cite personal or professional growth or influential experiences during training or practice as motivations to enter the field.CONCLUSIONPalliative care clinicians are a heterogeneous group. We identified motivations for entering the field that can be leveraged to sustain and grow the workforce.

## Staff Health and Wellbeing

*Burnout syndrome in nurses working in palliative care units: An analysis of associated factors* Journal of Nursing Management, January 2018

AIMSTo analyse the association between psychological, labour and demographic factors and burnout in palliative care nursing.BACKGROUNDThere is a lack of published research evaluating burnout in palliative care nursing.METHODSThis observational cross-sectional study involved 185 palliative care nurses in Mexico. The primary variables were burnout defined by its three dimensions (emotional exhaustion, depersonalization and personal accomplishment). As secondary variables, psychological, labour and demographic factors were considered. A binary logistic regression model was constructed to determine factors associated with burnout.RESULTSA total of 69 nurses experienced high emotional exhaustion (37.3%), 65 had high depersonalization (35.1%) and 70 had low personal performance (37.8%). A higher proportion of burnout was found in the participants who were single parents, working >8 hr per day, with a medium/high workload, a lack of a high professional quality of life and a self-care deficit.CONCLUSIONOur multivariate models were very accurate in explaining burnout in palliative care nurses. These models must be externally validated to predict burnout and prevent future complications of the syndrome accurately.IMPLICATIONS FOR NURSING MANAGEMENTNurses who present the factors found should be the focus of interventions to reduce work stress.

*Examining self-care, self-compassion and compassion for others: a cross-sectional survey of palliative care nurses and doctors* International Journal of Palliative Nursing, January 2018

This study examined levels of, and relationships between, self-care ability, self-compassion, and compassion among palliative care nurses and doctors. Methods: A total of 369 participants across Australia completed a cross-sectional survey comprising a demographic questionnaire and outcome measures for each variable. Descriptive and inferential statistics were analysed, controlling for potential social-desirability bias. Results: Levels of compassion, self-compassion and self-care ability varied, with some individuals scoring high or low in each. Self-compassion and self-care ability were positively correlated (r = .412, p<.001), whereas a negative correlation was observed between compassion and self-compassion (r = -.122, p<.05). Linear regression further indicated that: increased compassion was associated with a decrease in self-compassion, and increased self-care ability was associated with an increase in self-compassion. Conclusion: These results suggest important implications for self-care in the palliative care workforce. Moreover, this study contributes an empirical basis to inform future research and education to promote balanced compassion and compassion literacy in palliative care practice.

*Burnout and job satisfaction of intensive care personnel and the relationship with personality and religious traits: An observational, multicenter, cross-sectional study* Intensive & Critical Care Nursing, August 2017

OBJECTIVESTo investigate if burnout in the Intensive Care Unit (ICU) is influenced by aspects of personality, religiosity and job satisfaction.RESEARCH METHODOLOGYCross-sectional study, designed to assess burnout in the ICU and to investigate possible determinants. Three different questionnaires were used: the Malach Burnout Inventory, the Eysenck Personality Questionnaire and the Spiritual/Religious Attitudes Questionnaire. Predicting factors for high burnout were identified by multivariate logistic regression analysis.SETTING/PARTICIPANTSThis national study was addressed to physicians and nurses working full-time in 18 Greek ICU departments from June to December 2015.RESULTSThe participation rate was 67.9% (n=149) and 65% (n=320) for ICU physicians and nurses, respectively). High job satisfaction was recorded in both doctors (80.8%) and nurses (63.4%). Burnout was observed in 32.8% of the study participants, higher in nurses compared to doctors (p<0.001). Multivariate analysis revealed that neuroticism was a positive and extraversion a negative predictor of exhaustion (OR 5.1, 95%CI 2.7-9.7, p<0.001 and OR 0.49, 95%CI 0.28-0.87, p=0.014, respectively). Moreover, three other factors were identified: Job satisfaction (OR 0.26, 95%CI 0.14-0.48, p<0.001), satisfaction with current End-of-Life care (OR 0.41, 95%CI 0.23-0.76, p=0.005) and isolation feelings after decisions to forego life sustaining treatments (OR 3.48, 95%CI 1.25-9.65, p=0.017).CONCLUSIONSPersonality traits, job satisfaction and the way End-of-Life care is practiced influence burnout in the ICU.

*Addressing Palliative Care Clinician Burnout in Organizations: A Workforce Necessity, an Ethical Imperative* Journal of Pain and Symptom Management, June 2017

Clinician burnout reduces the capacity for providers and health systems to deliver timely, high quality, patient-centered care and increases the risk that clinicians will leave practice. This is especially problematic in hospice and palliative care: patients are often frail, elderly, vulnerable, and complex; access to care is often outstripped by need; and demand for clinical experts will increase as palliative care further integrates into usual care. Efforts to mitigate and prevent burnout currently focus on individual clinicians. However, analysis of the problem of burnout should be expanded to include both individual- and systems-level factors as well as solutions; comprehensive interventions must address both. As a society, we hold organizations responsible for acting ethically, especially when it relates to deployment and protection of valuable and constrained resources. We should similarly hold organizations responsible for being ethical stewards of the resource of highly trained and talented clinicians through comprehensive programs to address burnout.

*Self-Care in Palliative Care Nursing and Medical Professionals: A Cross-Sectional Survey* Journal of Palliative Medicine, June 2017

Background: Self-care is an important consideration for palliative care professionals. To date, few details have been recorded about the nature or uptake of self-care practices in the palliative care workforce. As part of a broader mixed methods study, this article reports findings from a national survey of nurses and doctors. Objective: The objective of this study was to examine perceptions, education, and practices relating to self-care among palliative care nursing and medical professionals. Design: A cross-sectional survey using REDCap software was conducted between April and May 2015. Perceived importance of self-care, self-care education and planning, and self-care strategies most utilized were explored. Descriptive statistics were calculated and content analysis used to identify domains of self-care. Setting/Subjects: Three hundred seventy-two palliative care nursing and medical professionals practicing in Australia. Results: Most respondents regarded self-care as very important (86%). Some rarely practised self-care and less than half (39%) had received training in self-care. Physical self-care strategies were most commonly reported, followed closely by social self-care and inner self-care. Self-care plans had been used by a small proportion of respondents (6%) and over two-thirds (70%) would consider using self-care plans if training could be provided. Conclusions: Self-care is practised across multiple health related domains, with physical self-care strategies used most frequently. Australian palliative care nurses and doctors recognize the importance of self-care practice, but further education and training are needed to increase their understanding of, and consistency in, using effective self-care strategies. These findings carry implications for professional practice and future research.

*"It Is Like Heart Failure. It Is Chronic ... and It Will Kill You": A Qualitative Analysis of Burnout Among Hospice and Palliative Care Clinicians* Journal of Pain and Symptom Management, May 2017

Context Although prior surveys have identified rates of self-reported burnout among palliative care clinicians as high as 62%, limited data exist to elucidate the causes, ameliorators, and effects of this phenomenon. Objectives We explored burnout among palliative care clinicians, specifically their experiences with burnout, their perceived sources of burnout, and potential individual, interpersonal, organizational, and policy-level solutions to address burnout. Methods During the 2014 American Academy of Hospice and Palliative Medicine/Hospice and Palliative Nurses Association Annual Assembly, we conducted three focus groups to examine personal narratives of burnout, how burnout differs within hospice and palliative care, and strategies to mitigate burnout. Two investigators independently analyzed data using template analysis, an inductive/deductive qualitative analytic technique. Results We interviewed 20 palliative care clinicians (14 physicians, four advanced practice providers, and two social workers). Common sources of burnout included increasing workload, tensions between nonspecialists and palliative care specialists, and regulatory issues. We heard grave concerns about the stability of the palliative care workforce and concerns about providing high-quality palliative care in light of a distressed and overburdened discipline. Participants proposed antiburnout solutions, including promoting the provision of generalist palliative care, frequent rotations on-and-off service, and organizational support for self-care. We observed variability in sources of burnout between clinician type and by practice setting, such as role monotony among full-time clinicians. Conclusion Our results reinforce and expand on the severity and potential ramifications of burnout on the palliative care workforce. Future research is needed to confirm our findings and investigate interventions to address or prevent burnout.

### *The professional working groupdhow to create and use a process group to build community, prevent burnout, and make work-life sustainable* Journal of Pain and Symptom Management, February 2017

Objectives * Recognize the domains of burnout and describe a model that predicts burnout using the gold standard Maslach Burnout Inventory scale. * Understand how a Balint group could be adapted to the palliative care fellowship training setting to promote sustainability and prevent burnout. Discuss models for group support and peer mentoring that can be used beyond fellowship training to (1) help participants identify work-related issues leading to burnout, (2) provide a support base to strategize ways to prevent burnout and increase engagement and sustainability. Burnout is a psychological syndrome occurring in response to chronic interpersonal stressors affecting up to 50% of the clinician workforce, and 62% of the palliative care workforce. Left unattended, burnout leads to job dissatisfaction, workplace turnover, and increased clinician error. In order to prevent burnout, palliative care fellowship must include training related to self-care and resilience. Based on our fellowship experience, we present a resiliency-buildingmodel for fellowship training and beyond that aims to prevent burnout, foster community, and make work-life sustainable. In this session, we will discuss the domains of burnout and describe a model that predicts risk of burnout using the Maslach Burnout Inventory scale. We will then outline palliative care fellowship core competencies related to burnout and resilience and explore how these competencies can be translated into a yearlong curriculum that promotes resilience through self-reflection and community building. In particular, we will discuss the use of a Balint group and explore how this model for physician support can be modified for palliative care clinicians in training. Finally, we will explore the use of group process and peer-mentoring after fellowship across geographic settings to help faculty prevent burnout and increase engagement and sustainability. In our case, an interdisciplinary group of four engage in an online professional group, meetingmonthly to maintain our supportive relationships, discuss complex clinical issues we are struggling with, and celebrate our professional and personal successes. We are tracking our own burnout scores to see if there is a correlation between participation in such a group and degree of stress and burnout.

### *How to survive as a new palliative care advanced practice registered nurse* Journal of Pain and Symptom Management, February 2017

Objectives * Describe strategies used to manage expectations for the new graduate palliative care APRN. * Summarize resources available to guide the new APRN in cultivating a sustainable professional practice. * Give examples highlighting the importance of mentorship for the new palliative care APRN. Advanced practice registered nurses (APRNs) have been a key to the expansion of palliative care programs throughout the country. Unfortunately, a standardized pipeline for the support and development of new palliative care APRNs does not yet exist. This can leave new palliative care APRNs feeling unsupported and lost in their new role, and may predispose them to the burnout and caregiver fatigue that already plague our clinical community. New graduate palliative care APRNs and the teams that look to hire this desired group of clinicians as part of an interdisciplinary palliative care team need to have in place a framework for professional practice. This session will use case studies and current literature to describe strategies used to manage expectations for the new graduate palliative care APRN, map out resources for the new APRN to support sustainability and longevity in the field, and highlight the importance of mentorship for the new palliative care APRN. We will provide framework to assist the APRN in identifying and defining their professional role within the context of the palliative care team and larger health system. This concurrent session will provide structure for negotiating an employment contract and navigating the collaborative physician relationship. Lastly, we will identify both clinical resources and career tools for the new APN to help make their way through uncharted territory as a palliative care clinician.

*Prevalence and Predictors of Burnout Among Hospice and Palliative Care Clinicians in the U.S.* Journal of Pain and Symptom Management, April 2016

CONTEXTMany clinical disciplines report high rates of burnout, which lead to low quality of care. Palliative care clinicians routinely manage patients with significant suffering, aiming to improve quality of life. As a major role of palliative care clinicians involves educating patients and caregivers regarding identifying priorities and balancing stress, we wondered how clinician self-management of burnout matches against the emotionally exhaustive nature of the work.OBJECTIVESWe sought to understand the prevalence and predictors of burnout using a discipline-wide survey.METHODSWe asked American Academy of Hospice and Palliative Medicine clinician members to complete an electronic survey querying demographic factors, job responsibilities, and the Maslach Burnout Inventory. We performed univariate and multivariate regression analyses to identify predictors of high rates of burnout.RESULTSWe received 1357 responses (response rate 30%). Overall, we observed a burnout rate of 62%, with higher rates reported by nonphysician clinicians. Most burnout stemmed from emotional exhaustion, with depersonalization comprising a minor portion. Factors associated with higher rates of burnout include working in smaller organizations, working longer hours, being younger than 50 years, and working weekends. We did not observe different rates between palliative care clinicians and hospice clinicians. Higher rated self-management activities to mitigate burnout include participating in interpersonal relationships and taking vacations.CONCLUSIONSBurnout is a major issue facing the palliative care clinician workforce. Strategies at the discipline-wide and individual levels are needed to sustain the delivery of responsive, available, high-quality palliative care for all patients with serious illness.

## Workforce

*Mind the gap: is the Canadian long-term care workforce ready for a palliative care mandate?* Age and Ageing, January 2019

The average expected lifespan in Canadian long-term care (LTC) homes is now less than two years post-admission, making LTC a palliative care setting. As little is known about the readiness of LTC staff in Canada to embrace a palliative care mandate, the main objective of this study was to assess qualities relevant to palliative care, including personal emotional wellbeing, palliative care self-efficacy and person-centred practices (e.g. knowing the person, comfort care). A convenience sample of 228 professional and non-professional staff (e.g. nurses and nursing assistants) across four Canadian LTC homes participated in a survey. Burnout, secondary traumatic stress and poor job satisfaction were well below accepted thresholds, e.g. burnout: mean = 20.49 (standard deviation (SD) = 5.39) for professionals; mean = 22.09 (SD = 4.98) for non-professionals; cut score = 42. Furthermore, only 0–1 per cent of each group showed a score above cut-off for any of these variables. Reported self-efficacy was moderate, e.g. efficacy in delivery: mean = 18.63 (SD = 6.29) for professionals; mean = 15.33 (SD = 7.52) for non-professionals; maximum = 32. The same was true of self-reported person-centred care, e.g. knowing the person; mean = 22.05 (SD = 6.55) for professionals; mean = 22.91 (SD = 6.16) for non-professionals; maximum = 35. t-Tests showed that non-professional staff reported relatively higher levels of burnout, while professional staff reported greater job satisfaction and self-efficacy ($p < 0.05$). There was no difference in secondary traumatic stress or person-centred care ($p > 0.05$). Overall, these results suggest that the emotional wellbeing of the Canadian LTC workforce is unlikely to impede effective palliative care. However, palliative care self-efficacy and person-centred care can be further cultivated in this context.

### *The Hospice and Palliative Care Advanced Practice Registered Nurse Workforce: Results of a National Survey* Journal of Hospital and Palliative Nursing: JHPN: the official journal of the Hospice and Palliative Nurses Association, August 2018

One barrier to continued growth of palliative care is the shortage of qualified hospice and palliative care clinicians. Advanced practice registered nurses are an important part of the interdisciplinary palliative care team, and strengthening this workforce can help alleviate the shortage of clinicians and improve access to quality palliative care. However, there is a dearth of information about this workforce. The purpose of this study was to describe the current hospice and palliative care advanced practice registered nurse workforce, their educational needs, and barriers to practice. The investigators distributed an online survey between October 2016 and January 2017 and received 556 responses. Sixty-three percent had more than 20 years of experience as a registered nurse yet were newer to practice as a hospice and palliative care advanced practice nurse, with 53.8% having 0 to 5 years of experience in this role. Forty-one percent indicated that their traditional graduate educational preparation was insufficient in preparing them for their specialty role. Most indicated that they did not experience barriers to practice in their current position, but 7.3% identified significant issues. These results can inform future professional, educational, and regulatory efforts to support and develop the palliative care advanced practice registered nurse workforce.

### *Integration and expansion of palliative care work force* Journal of Clinical Oncology, November 2017

Background: The specialty of Hospice and Palliative Medicine has grown out of the need for care of patients who are living longer with cancer and other serious illness and struggle with symptoms, decisions and care. Cancer patients and others often do not have access to Palliative Care services due to availability or accessibility of PC services. Since 2012, fellowship training is required for board eligibility but available programs do not meet the workforce need. As described by Weissman and Meier, viewing Palliative care services in the context of a primary, secondary or tertiary focus, allows for the expansion of these services outside of the traditional fellowship training. With additional intensive training, it is possible that experienced physicians can fill workforce gaps by providing primary palliative care in the providers practice area such as a clinic. Method(s): The faculty member who will participate in a yearlong training program based in the Palliative Care Clinic is the Director of the Outpatient Clinic. This clinic is the center of the Duke resident ambulatory experience for the duration of their training. The complexity of these patients is high and often the DOC is the only place that these patients receive care. The Palliative Care training program will provide the faculty member the opportunity to see patients in the cancer center with board certified palliative care physicians. There will be 3 areas of focus for the trainee: clinical experience, didactic information and mentorship from a board certified palliative care provider around faculty identified cases from her own practice. Result(s): We have developed a yearlong intensive training program for experienced faculty to gain skills in Palliative Care. Conclusion(s): 1. It is hoped that this will allow for integration of primary palliative care into patient care areas where there is no formal palliative care program. 2. Integration of Palliative Care principles in the clinic to address symptoms of chronic severe illness as well as difficult conversations with more confidence and skill. 3. Earlier palliative care management-develop a systematic approach to assessing needs in high risk populations ie. Hospital Discharge reviews, now commonly done at the clinic.

*Workforce characteristics and interventions associated with high-quality care and support to older people with cancer: a systematic review* BMJ Open, July 2017

OBJECTIVESTo provide an overview of the evidence base on the effectiveness of workforce interventions for improving the outcomes for older people with cancer, as well as analysing key features of the workforce associated with those improvements.DESIGNSystematic review.METHODSRelevant databases were searched for primary research, published in English, reporting on older people and cancer and the outcomes of interventions to improve workforce knowledge, attitudes or skills; involving a change in workforce composition and/or skill mix; and/or requiring significant workforce reconfiguration or new roles. Studies were also sought on associations between the composition and characteristics of the cancer care workforce and older people's outcomes. A narrative synthesis was conducted and supported by tabulation of key study data.RESULTSStudies (n=24) included 4555 patients aged 60+ from targeted cancer screening to end of life care. Interventions were diverse and two-thirds of the studies were assessed as low quality. Only two studies directly targeted workforce knowledge and skills and only two studies addressed the nature of workforce features related to improved outcomes. Interventions focused on discrete groups of older people with specific needs offering guidance or psychological support were more effective than those broadly targeting survival outcomes. Advanced Practice Nursing roles, voluntary support roles and the involvement of geriatric teams provided some evidence of effectiveness.CONCLUSIONSAn array of workforce interventions focus on improving outcomes for older people with cancer but these are diverse and thinly spread across the cancer journey. Higher quality and larger scale research that focuses on workforce features is now needed to guide developments in this field, and review findings indicate that interventions targeted at specific subgroups of older people with complex needs, and that involve input from advanced practice nurses, geriatric teams and trained volunteers appear most promising.

*Productivity in Pediatric Palliative Care: Measuring and Monitoring an Elusive Metric* Journal of Pain and Symptom Management, May 2017

CONTEXTWorkforce productivity is poorly defined in health care. Particularly in the field of pediatric palliative care (PPC), the absence of consensus metrics impedes aggregation and analysis of data to track workforce efficiency and effectiveness. Lack of uniformly measured data also compromises the development of innovative strategies to improve productivity and hinders investigation of the link between productivity and quality of care, which are interrelated but not interchangeable.OBJECTIVESTo review the literature regarding the definition and measurement of productivity in PPC; to identify barriers to productivity within traditional PPC models; and to recommend novel metrics to study productivity as a component of quality care in PPC.METHODSPubMed® and Cochrane Database of Systematic Reviews searches for scholarly literature were performed using key words (pediatric palliative care, palliative care, team, workforce, workflow, productivity, algorithm, quality care, quality improvement, quality metric, inpatient, hospital, consultation, model) for articles published between 2000 and 2016. Organizational searches of Center to Advance Palliative Care, National Hospice and Palliative Care Organization, National Association for Home Care & Hospice, American Academy of Hospice and Palliative Medicine, Hospice and Palliative Nurses Association, National Quality Forum, and National Consensus Project for Quality Palliative Care were also performed. Additional semistructured interviews were conducted with directors from seven prominent PPC programs across the U.S. to review standard operating procedures for PPC team workflow and productivity.RESULTSLittle consensus exists in the PPC field regarding optimal ways to define, measure, and analyze provider and program productivity. Barriers to accurate monitoring of productivity include difficulties with identification, measurement, and interpretation of metrics applicable to an interdisciplinary care paradigm. In the context of inefficiencies inherent to traditional consultation models, novel productivity metrics are proposed.CONCLUSIONSFurther research is needed to determine optimal metrics for monitoring productivity within PPC teams. Innovative approaches should be studied with the goal of improving efficiency of care without compromising value.

*Workforce profile of Australian occupational therapists working with people who are terminally ill* Australian Occupational Therapy Journal, February 2017

BACKGROUND/AIMThe role played by Australian occupational therapists with clients living with terminal illness has recently been highlighted in the Occupational Therapy Australia () position paper on palliative care. To date, little evidence exists about the work profile of these therapists, the type of clients seen, their practice settings and how long therapists are planning to remain in this clinical role. This paper presents results from a national survey of Australian occupational therapists working with people who are terminally ill.METHODSThe largest ever sample (n = 171) of Australian occupational therapists working with clients who are terminally ill were purposively surveyed in this national mixed-method study, which was analysed using descriptive statistics and grounded theory.RESULTSResults revealed a predominantly full-time, publicly employed (81%), female (93%) workforce, with an average six years of experience in this setting. Most therapists treated clients in the community (49%), with slightly fewer working in inpatient settings (40%). Many had dual caseloads, employed in palliative care clinical roles, aged care or oncology settings. Neoplasms of varying kinds represented the dominant clinical diagnostic category. The majority of respondents planned to remain in their current role on average seven more years, citing job satisfaction as the main reason for doing so. CONCLUSIONS Results from this study reveal important data for future workforce planning in this clinical area. The information gathered about client diagnoses and practice contexts will enable more targeted preparation of students for graduation.

*Opportunities and Challenges Facing the Integrated Physician Workforce of Emergency Medicine and Hospice and Palliative Medicine* The Journal of Emergency Medicine, December 2016

BACKGROUNDThe American Board of Emergency Medicine joined nine other American Board of Medical Specialties member boards to sponsor the subspecialty of Hospice and Palliative Medicine; the first subspecialty examination was administered in 2008. Since then an increasing number of emergency physicians has sought this certification and entered the workforce. There has been limited discussion regarding the experiences and challenges facing this new workforce.DISCUSSIONWe use excerpts from conversations with emergency physicians to highlight the challenges in hospice and palliative medicine training and practice that are commonly being identified by these physicians, at varying phases of their careers. The lessons learned from this initial dual-certified physician cohort in real practice fills a current literature gap. Practical guidance is offered for the increasing number of trainees and mid-career emergency physicians who may have an interest in the subspecialty pathway but are seeking answers to what a future integrated practice will look like in order to make informed career decisions.CONCLUSIONThe Emergency and Hospice and Palliative Medicine integrated workforce is facing novel challenges, opportunities, and growth. The first few years have seen a growing interest in the field among emergency medicine resident trainees. As the dual certified workforce matures, it is expected to impact the clinical practice, research, and education related to emergency palliative care.

*What Makes a Good Palliative Care Physician? A Qualitative Study about the Patient's Expectations and Needs when Being Admitted to a Palliative Care Unit* PloS One, 2016

OBJECTIVEThe aims of the study were to examine a) patients' knowledge of palliative care, b) patients' expectations and needs when being admitted to a palliative care unit, and c) patient's concept of a good palliative care physician.METHODSThe study was based on a qualitative methodology, comprising 32 semistructured interviews with advanced cancer patients admitted to the palliative care unit of the Medical University of Vienna. Interviews were conducted with 20 patients during the first three days after admission to the unit and after one week, recorded digitally, and transcribed verbatim. Data were analyzed using NVivo 10 software, based on thematic analysis enhanced with grounded theory techniques.RESULTSThe results revealed four themes: (1) information about palliative care, (2) supportive care needs, (3) being treated in a palliative care unit, and (4) qualities required of palliative care physicians. The data showed that patients lack information about palliative care, that help in social concerns plays a central role in palliative care, and attentiveness as well as symptom management are important to patients. Patients desire a personal patient-physician relationship. The qualities of a good palliative care physician were honesty, the ability to listen, taking time, being experienced in their field, speaking the patient's language, being human, and being gentle. Patients experienced relief when being treated in a palliative care unit, perceived their care as an interdisciplinary activity, and felt that their burdensome symptoms were being attended to with emotional care. Negative perceptions included the overtly intense treatment.CONCLUSIONSThe results of the present study offer an insight into what patients expect from palliative care teams. Being aware of patient's needs will enable medical teams to improve professional and individualized care.

*A quantitative framework classifying the palliative care workforce into specialist and generalist components* Journal of Palliative Medicine, December 2015

Objective: To undertake a retrospective examination of clinical data obtained from a PC benchmarking project to develop a quantitative framework guiding classification of PC services into specialist and generalist components. Results: More than 50% of patients had symptom, overall psychological or social distress scores of nil or mild severity at episode start and end. Approximately 20% of all 2726 patients accounted for approximately half of all visits made by the team regardless of the reasons for review. This patient percentage minority had more PC episodes starting with moderate or severe pain. These findings suggest a Pareto-like distribution in the occurrence of moderate/severe PC problems and the intensity of PC input. Conclusions: Large-scale clinical data supports the use of a Pareto-based quantitative framework for a workforce comprising of mainly generalist PC staff supported by smaller numbers of PC specialists.

## Training, education and upskilling

*Using Simulation to Teach Interprofessional Communication in Palliative Care (FR482A)* Journal of Pain and Symptom Management, February 2019

Objectives: *Compare and contrast different types of palliative care simulation described in the literature.*Identify opportunities within one's own institution to develop similar coursework.*Create learning outcomes for the use of simulation in palliative care education. Background(s): Simulation has become a common education modality across most health professions but is not widely adopted in palliative care education. In a recent review, Smith et al. (2018) found several examples in the literature of end-of-life communication training for nurses and nursing students. However, less than 25% of the thirty articles reviewed included team-based simulation encompassing nursing, social work, and medical students. Simulation provides students a tangible experience in interprofessional palliative care prior to workforce entry. Audience: The Foundation for Interprofessional Collaborative Practice course incorporates learners from the UT Austin Schools of Pharmacy, Medicine, Nursing, and Social Work and would be appropriate for additional disciplines including psychology and chaplaincy. Approach: This two-semester experience places students in small interprofessional teams which meet monthly. In the first part of the palliative care module, learners participate in a three-hour large group session with small group breakouts based on materials adapted from the iCOPE curriculum (Head, et al. 2014). In the second part of the module, the focus of our Interactive Educational Exchange, students participate in a twenty-minute goals-of-care conversation in a standardized patient lab utilizing trained patient actors. The group facilitator observes the interaction remotely and then provides direct feedback. This portion of the module is based on original content created by our steering committee. Result(s): Over 500 learners have participated and report increased comfort with palliative care communication and interprofessional teamwork. Impact: Introduction to palliative care is an important opportunity for interprofessional learners. Many students have little previous knowledge of palliative care and end-of-life issues. This course allows students to explore these concepts in a safe environment while being positively exposed to the field. Critique/Next Steps: We plan to evaluate whether interprofessional communication training influences learner comfort with difficult conversations in future clinical practice.

*Training Nonpalliative Care Clinicians in Serious Illness Communication: Results of a Train-the-Trainer Model in Three Health Systems (SA511D)* Journal of Pain and Symptom Management, February 2019

Objectives: *List the steps of a structured approach to training clinicians in serious illness communication using the Serious Illness Conversation Guide.*Evaluate clinician-reported outcomes of serious illness communication training, including self-assessment of change in skills.*Categorize and reflect on clinician takeaways from training that they will apply in practice as well as trainer perceptions of common barriers. Background(s): Failure to initiate discussions about values and goals in serious illness ('serious illness communication') remains a common problem. Insufficient training leaves clinicians unsure of what to say or how/when to approach these conversations. Given the shortage of palliative care clinicians, evidence is needed to guide the development and implementation of consistent high-quality communication training for all clinicians. Aim Statement: Evaluate the impact of clinician training as part of an organization-wide initiative and train-the-trainer program in three health systems. Method(s): In partnership with the Serious Illness Care Program at Ariadne Labs (AL), 3 health systems identified champions to complete a novel train-the-trainer program. Subsequently, these trainers delivered skills-based trainings on the

Serious Illness Conversation Guide (SICG) to nonpalliative-care clinicians in their own systems. After each training, clinician participants completed a survey, including self-assessment of change in skills and self-reported learnings. Result(s): From 2016-2018, AL trained 22 trainers (18/22 were palliative care MDs) in three systems, who then trained 331 clinicians (48% MD; 32% APP; 20% RN, SW) in 53 sessions spanning subspecialties (67%); primary care (25%); other (8%). Upon completion, participants reported improvement in each of the communication tasks (e.g. assessing illness understanding, sharing prognosis, exploring goals/values); improvements between self-rating scores pre- and posttraining were all significant ($p<0.0001$). Participants rated the quality of the training highly (98% mostly/extremely effective) and shared a diverse array of personalized takeaways to apply in practice, including core skills learned (e.g. reflective listening) and the usefulness of a structure. Conclusions and Implications: Serious Illness Conversation Guide training, delivered through a train-the-trainer model and system-level program, was highly acceptable and resulted in significant measurable improvements in clinician self-reported skills. This is a viable and scalable method for health systems seeking to train their own workforce in serious illness communication.

*Teaching nurses to teach: A qualitative study of nurses' perceptions of the impact of education and skills training to prepare them to teach end-of-life care* Journal of Clinical Nursing, January 2019

AIMS AND OBJECTIVESTo explore nurses' perceptions of the impact of a programme designed to train them to teach end-of-life care.BACKGROUNDCentral to national and international policies is the need for generalist healthcare staff to have education in end-of-life care. Much end-of-life care education is provided by specialist nurses who often have no specific education development to prepare them to teach. To address this gap an Education Development Programme (EDP) was developed and delivered to specialist nurses. We report on the evaluation of the programme.DESIGNA qualitative programme evaluation methodology was adopted.METHODSData were collected through focus groups, at three hospice education centres in North West England, with a total of 20 participants. Nurses who had completed the EDP were purposively sampled. Data were digitally audio-recorded and subjected to thematic analysis to organise, reduce and refine the data. Ethical approval was obtained. COREQ guidelines have been adhered to in the reporting of this study.RESULTSTwo main themes were identified; learning to teach and building skills to change teaching practice. Participants felt more confident and better prepared to teach.CONCLUSIONSIt cannot be assumed that specialist staff, with teaching in their role, have the skills to facilitate learning. This programme offers a potential method of improving facilitation skills for nurses who have an education element to their role.RELEVANCE TO CLINICAL PRACTICEQuality end-of-life care is only possible with a skilled workforce, confident and able to apply the principles of compassionate end-of-life care to everyday practice. Appropriately trained, specialist staff are better able to teach others how to deliver good quality end-of-life care. Specialist staff with teaching responsibilities should be provided with, or engage in, Continuous Professional Development to develop their skills and improve their efficacy when teaching.

*Interprofessional training: Geriatrics and palliative care principles for primary care teams in an ACO* Gerontology & Geriatrics Education, 2019

There is a well-described need to increase the competence of the primary care workforce in the principles of geriatrics and palliative care, and as value-based payment models proliferate, there is increased incentive for the acquisition of these skills. Through a Geriatric Workforce Enhancement Program grant, we developed an adaptable curriculum around commonly encountered topics in palliative care and geriatrics that can be delivered to multidisciplinary clinicians in primary care settings. All participants in this training were part of an Accountable Care Organization (ACO) and were motivated to improve to care for complex older adults. A needs assessment was performed on each practice or group of learners and the curriculum was adapted accordingly. With the use of patient education and screening tools with strong validity evidence, the participants were trained in the principals of geriatrics and palliative care with a focus on advance care planning and assessing for frailty and functional decline. Comparison of pre- and post-test scores demonstrated increased confidence and knowledge in goals of care and basic geriatric assessment. Participants described feeling more able to address needs, have conversations around goals of care, and more able to recognize patients who would benefit from collaboration with geriatrics and palliative care.

*Upskilling the primary care workforce in cancer survivorship*
Asia Pacific Journal of Clinical Oncology, November 2018

Aim: There is a rapidly increasing population of people living with and beyond cancer due to ageing and improvements in detection and treatment. This has impacted on the complexity of the primary care practitioners' role in managing cancer survivorship. The Cancer Survivorship for Primary Care Practitioners program aims to enhance the knowledge and skills in the transition of survivors from oncology treatment into shared care. Method(s):Aimed at primary healthcare practitioners including General Practitioners, nurses and allied health professionals; the program was developed to adhere to best practice survivorship care in the areas of: Survivorship Fundamentals; Communication and Coordination of Care; Surveillance, Late and Long-Term Effects; Palliative Care and New Cancer Therapies. The program is contextualised in the narrative of a patient story and includes a series of real patient stories, interactive presentations, interviews, readings, online discussions, quizzes and peer reviewed assessments. An online survey was distributed to all participants before and after their completion of the program. Paired tests will be conducted and compared for the participant craft groups that attend the program measuring the effect of participation in the online and / or workshop on confidence, knowledge and intention to change practice. Result(s): The program launched in July 2018 to a registration of over 500 participants for the online component from around the globe and a local representation of over 50 attended the workshops. The online course received a high calibre of engagement throughout. The workshops evaluated positively with participants feeling confident to implement keymessages into their workplace. Conclusion(s): Best practice survivorship care promotes the formation and consolidation of a collaborative, interdisciplinary care team who are sensitive and responsive to each individual and their needs. The program delivers an innovative, interactive, flexible and free professional development opportunity for PCPs in response to the evolving population health landscape.

*Assessing nursing assistants' competency in palliative care: An evaluation tool* Nurse Education in Practice, November 2018

Nursing assistants are the largest aged care workforce providing direct care to older people in residential aged care facilities (RACF) in Australia and internationally. A palliative approach is a large component of this direct care that necessitates nursing assistants possess requisite knowledge, skills and attitudes. While training needs have been identified to enhance their practices, preservice education is variable, educational interventions have been adhoc and professional development found to be inadequate to the demands of the workplace. In addition, evaluation of nursing assistants' knowledge, skills and attitudes has lacked an instrument specifically tailored to nursing assistants' level of education and role responsibilities when providing a palliative approach. This paper reports on Phase 3 of a research study to develop such an instrument capable of assessing nursing assistants' knowledge of, skills in, and attitudes within a palliative approach. This phase assesses the usability and performance capabilities of the new instrument on a purposive sample of nursing assistants in two RACFs using the survey method. Results showed that the instrument was able to discriminate between groups of nursing assistants based on experience in role. Usability results indicated that the instrument is user friendly and time efficient.

*Care for Dying Children and Their Families in the PICU: Promoting Clinician Education, Support, and Resilience* Paediatric Critical Care Medicine: a journal of the Society of Critical Care Medicine and the World Federation of Paediatric Intensive and Critical Care Societies, August 2018

OBJECTIVESTo describe the consequences of workplace stressors on healthcare clinicians in PICU, and strategies for personal well-being, and professional effectiveness in providing high-quality end-of-life care.DATA SOURCESLiterature review, clinical experience, and expert opinion.STUDY SELECTIONA sampling of foundational and current evidence was accessed.DATA SYNTHESISNarrative review and experiential reflection.CONCLUSIONSThe well-being of healthcare clinicians in the PICU influences the day-to-day quality and effectiveness of patient care, team functioning, and the retention of skilled individuals in the PICU workforce. End-of-life care, including decision making, can be complicated. Both are major stressors for PICU staff that can lead to adverse personal and professional consequences. Overresponsiveness to routine stressors may be seen in those with moral distress, and underresponsiveness may be seen in those with compassion fatigue or burnout. Ideally, all healthcare professionals in PICU can rise to the day-to-day workplace challenges-responding in an adaptive, effective manner. Strategies to proactively increase resilience and well-being include self-awareness, self-care, situational awareness, and education to increase confidence and skills for providing end-of-life care. Reactive strategies include case conferences, prebriefings in ongoing preidentified situations, debriefings, and other postevent meetings. Nurturing a culture of practice that acknowledges the emotional impacts of pediatric critical care work and celebrates the shared experiences of families and clinicians to build resilient, effective, and professionally fulfilled healthcare professionals thus enabling the provision of high-quality end-of-life care for children and their families.

*Development, Implementation, and Evaluation of a Curriculum to Prepare Volunteer Navigators to Support Older Persons Living With Serious Illness* The American Journal of Hospice and Palliative Care, May 2018

The purpose of this article is to report the development, implementation, and evaluation of a curriculum designed to prepare volunteer navigators to support community-dwelling older persons with serious chronic illness. The role of the volunteer navigator was to facilitate independence and quality of life through building social connections, improving access to resources, and fostering engagement. A curriculum was constructed from evidence-based competencies, piloted and revised, and then implemented in 7 subsequent workshops. Workshop participants were 51 volunteers and health-care providers recruited through local hospice societies and health regions. Curriculum was evaluated through satisfaction and self-efficacy questionnaires completed at workshop conclusion.

Postworkshop evaluation indicated a high degree of satisfaction with the training. One workshop cohort of 7 participants was followed for 1 year to provide longitudinal evaluation data. Participants followed longitudinally reported improved self-efficacy over 12 months and some challenges with role transition. Future improvements will include further structured learning opportunities offered by telephone postworkshop, focusing on advocacy, communication, and conflict management. Overall, volunteers were satisfied with the curriculum and reported good self-perceived efficacy in their new role as navigators.

*Palliative and end-of-life care in the masters of social work curriculum* Palliative and Supportive Care, April 2018

*Athens log in required*

ABSTRACTObjective:There is a shortage of social workers who have palliative care expertise. The aging U.S. population and advances in extending life for seriously ill persons require social workers in a wide range of health care and other settings with specialized palliative care expertise, as well as those with basic competence in palliative care. The objective of the present study was to document course content on palliative care in MSW programs in the United States and Canada.METHODA cross-sectional design with an online questionnaire was used. All 248 accredited MSW programs in the United States and 32 programs in Canada were invited to participate. The measures included the characteristics of the courses on palliative care.RESULTSOf the 105 participating programs, only 10 had courses dedicated to palliative care, 9 of which were part of a specialization/certificate program. Few programs had plans to develop a dedicated course. There were 106 courses in 63 MSW programs with some content on palliative care. The majority of these had <25%, and few had at least 50%, of palliative care content.SIGNIFICANCE OF RESULTSCurricula are needed for preparing MSW graduates for specialty hospice and palliative care practice and non-specialty practice. While there are practice competencies for specialty practitioners, consensus on a core curriculum for all MSW students would be beneficial. Consensus on basic palliative care knowledge and skills for non-specialty social workers in health care and other settings and subsequent curriculum development are also needed. Innovative ways in which to introduce basic and more specialized content on palliative care into the already-crowded MSW curricula will be needed.

*Building A High Quality Oncology Nursing Workforce Through Lifelong Learning: The De Souza Model* International Journal of Nursing Education Scholarship, January 2018

AbstractCancer is one of the leading causes of death in the world. Along with increased new cases, cancer care has become increasingly complex due to advances in diagnostics and treatments, greater survival, and new models of palliative care. Nurses are a critical resource for cancer patients and their families. Their roles and responsibilities are expanding across the cancer care continuum, calling for specialized training and support. Formal education prepares nurses for entry level of practice, however, it does not provide the specialized competencies required for quality care of cancer patients. There is urgent need to align the educational system to the demands of the health care system, ease transition from formal academic systems to care settings, and to instill a philosophy of lifelong learning. We describe a model of education developed by de Souza Institute in Canada, based on the Novice to Expert specialty training framework, and its success in offering structured oncology continuing education training to nurses, from undergraduate levels to continued career development in the clinical setting. This model may have global relevance, given the challenge in managing the demand for high quality care in all disease areas and in keeping pace with the emerging advances in technologies.

### *Innovative training for consultant practitioners in frailty* Age and Ageing, May 2017

Background: Health Education Wessex (HEW) and Thames Valley (HETV) for Postgraduate Education have run a programme for Consultant Practitioner Trainees (CPTs) since 1991. Senior clinicians are competitively selected to the programme. Training was in Emergency Care, Midwifery, Mental Health, Learning Disability, and Cardiovascular/Neurology. Innovation: In 2015 the programme extended to the field of frailty, following workforce development planning. Four CPTs were appointed, three nurses and a physiotherapist. Academic study is funded in higher education centres at Masters or Doctorate level, alongside clinical placements. The four pillars of Consultant Practice form the backbone for development, namely expert clinical practice, leadership, education and training, and service development through research and evaluation. The aspiration is to develop highly skilled clinical leaders who take innovative roles within the workforce, with passion and expertise to enhance service delivery. Evaluation: The trainees have undertaken placements in Community Geriatric Medicine, Community Older Person's Mental Health, Palliative Care, General Practice and Hospital based Medicine for Older People to date. They influenced changes in practice using Quality Improvement methodology. These included medication management within Care Homes, reducing the risk of inappropriate medication administration, managing end of life care from the Emergency Department (ED), ensuring older people achieve their preferred place of care, remodelling older persons services within General Practice, delivering a plateau in ED attendances and undertaking Gold Standard Comprehensive Geriatric Assessments in Primary Care. Patients report that they appreciate the breadth of experience of the CPTs, and their flexibility in working outside traditional boundaries. Conclusion: Observations indicate the inclusion of Consultant Practitioners as part of a reshaped workforce enhances independence in older people; is well received, and cost effective. Health Education England should encourage other local education and training boards to innovate in this way. Health Trusts need to be encouraged to recognise the value of such posts.

### *A new geriatrics and palliative care immersion course for inter-professional teams* Journal of the American Geriatrics Society, May 2017

Introduction Older adults with multiple progressing illnesses and geriatric syndromes need interprofessional teams to optimize care. There are insufficient numbers of trained geriatrics experts; it is critical to devise practical ways to train frontline clinicians in geriatrics and palliative care principles. To meet this need, with support from a HRSA grant, the authors devised a new Immersion Course modeled on the successful CRIT program (Chief Resident Immersion Training in the Care of Older Adults). Basic changes to the CRIT structure included: Broadening the learners to include a wide range of trainees and professionals, shifting to the outpatient setting, substituting quality improvement training for chief resident skills training, emphasizing dementia, palliative care and the importance of interprofessional teams. Participants Roughly 70 people attended including students and clinicians, senior executives, doctors, MAs, RNs, social workers, chaplains, PAs, NPs, PT, administrators, pharmacists, etc. Course The course was held at a mountain resort over a day and a half. It interspersed mini-lectures with 3 case modules depicting a patient with progressing dementia. The lectures were given by interprofessional faculty pairs and the discussion groups and communication skills training were structured to maximize interprofessional learning. Didactic sessions included introductions to the "3 Ds", caregiver stress, falls, frailty, hospice, etc. Quality improvement exercises and coaching focused on several projects launched as part of Baystate Health's Geriatric Work Force Enhancement Program. Additional activities included a senior leadership panel, a "Geri-Pal" Jeopardy game and a "pill drill" testing the ability to comply with a candy drug regimen. Results Average pre-test scores = 59%; the post-test average rose to 80%. This improvement is consistently across all professions and experience levels. All participants were enthusiastic in their evaluations and they reported that the content was at the right level. Conclusion This new immersion course for interprofessional team was well accepted and successfully imparted core geriatrics, palliative care and quality improvement content while fostering interprofessional teamwork. This conference could serve as a model for how to train the existing workforce to better care for vulnerable elderly. This is the first report of such a course in the literature.

*Interprofessional master of science in palliative care: Bridging the gap between primary and tertiary palliative care* Journal of General Internal Medicine, April 2017

NEEDS AND OBJECTIVES: 1. Summarize need for more interprofessional Palliative Care healthcare providers and our programmatic response. 2. Demonstrate case-based woven curriculum designed for interprofessional adult PC learners. 3. Review initial student-self-assessment evaluations and learning outcomes of the curriculum with programmatic response. SETTING AND PARTICIPANTS: Current workforce pipeline for PC providers is dramatically inadequate to meet the national need - many potential providers develop their interest later in their careers when it is difficult to relocate for the limited available opportunities for training. In response to this need, we developed an interprofessional Master of Science in Palliative Care (MSPC) at the University of Colorado AnschutzMedical Campus. TheMSPC is a hybrid program offered primarily online with on-campus weekend intensives. Faculty and course content are sourced from nursing, medicine, pharmacy, bioethics, social work, spiritual care, psychology, and communication disciplines. The inaugural cohort (2016-17) consists of nurses, pharmacists, physician assistants, and physicians (16 students) and will be expanded to include social workers, chaplains, psychologists, and counselors. DESCRIPTION: MSPC longitudinal curriculum spans 6 semesters of two three credit hour course; total of 36 credits. The online curriculum begins with 5-10 min patient/family/provider dialogue representing scenarios on the illness trajectory to demonstrate communication skills and illustrate learning points. Followed by two learning modules: biomedically-focused topic and related psycho-social-spiritual-ethics topic developed/presented by content experts from the interprofessional faculty. Content presented by pedagogical methods including readings, videos, Quizlets, knowledge checks, and narrated lectures. Student assignments vary from reflection/discussion to interprofessional case-based integration of topic materials. On-campus intensive focus on communication skills training and acquisition. Communication skills learned online are reinforced with videostaped standardized patients interaction with immediate feedback. Other topics include: working as an interprofessional team using simulated tasks common in PC clinical care, and self-care strategies. Demonstration of the curricular elements provided during presentation. EVALUATION: Program evaluation is accomplished through a mixed method process including: learner self-assessments on 39 PC skills/tasks before, during, and after the program's formal training; self-reports on type/amount of PC in their practice; and standard course evaluations and scored communication skills exercises with standardized patients, semi-structured interviews and other methods. DISCUSSION/REFLECTION/LESSONS LEARNED: Interprofessional master's program in PC, designed/delivered by nterprofessional faculty, fills a gap in the national PC workforce pipeline. Programs of this nature are scalable and meet the needs for PC training of mid-career providers who wish to transition into PC practice.

### *High-fidelity simulation: Teaching end-of-life care* Nurse Education Today, February 2017

The American Nurses Association, American Association of Colleges of Nursing, and the Institute of Medicine of the National Academies are unified in the position that nursing education must prepare students to coordinate and perform end-of-life (EOL) care. Yet, according to literature, undergraduate nursing education in EOL care remains inadequate. Following a review of literature indicating a need for more EOL instruction, a high-fidelity simulation activity is introduced and described. Included are guidelines for preparation, role assignment, integration of other professionals and family, and student reflection after the activity. Student evaluations indicate that the simulation is valuable and improves self-efficacy in caring for the dying. By providing students with the opportunity to experience EOL in a low-risk, learning environment, a high-fidelity EOL simulation activity can help educators bridge the knowledge gap in nursing education.

### *Caring to Learn and Learning to Care* Journal of Correctional Health Care: the official journal of the National Commission on Correctional Health Care, January 2017

The increasing numbers of aging and chronically ill prisoners incarcerated in Western nations is well-documented, as is the growing need for prison-based palliative and end-of-life care. Less often discussed is specifically how end-of-life care can and should be provided, by whom, and with what resources. One strategy incorporates prisoner volunteers into end-of-life services within a peer-care program. This article reports on one such program based on focused ethnographic study including in-depth interviews with inmate hospice volunteers, nursing staff, and corrections officers working in the hospice program. We describe how inmate volunteers learn hospice care through formal education and training, supervised practice, guidance from more experienced inmates, and support from correctional staff. We discuss how emergent values of mentorship and stewardship are seen by volunteers and staff as integral to prison hospice sustainability and discuss implications of this volunteer-centric model for response-ability for the end-of-life care of prisoners.

### *On the ground floor looking up-Managing trainees' uncertainty at the end of life* Healthcare, December 2017

Recent US healthcare policy changes set the stage for integrating palliative and end-of-life care into routine medicine. However, these changes may not affect the daily practice of medical trainees-fellows, residents, and medical students-who as front-line care providers are not always equipped with the skills needed to treat terminally ill patients. We review evidence on trainees' discomfort with end-of-life care and highlight limitations of recent policy changes. Key barriers to proficiency include inadequate conversational training, prognostic uncertainty, and unfamiliarity with hospice and palliative care. Educator-, accreditor-, and policy-level interventions may improve trainees' experience caring for seriously ill patients.

### *Effectiveness of Pediatric Palliative Care Education on Pediatric Clinicians* Western Journal of Nursing Research, December 2017

A lack of knowledge and skills in pediatric palliative care may create hesitation in caring for children with serious life-threatening conditions and their families. Our research examined the effectiveness of pediatric palliative care training for pediatric clinicians. A pretest-posttest study provided educational training in pediatric palliative care to pediatric clinicians and used a pretest and a posttest to assess outcomes. Fifty pediatric clinicians attended this research with 83.3% response rate. After training, participants reported significantly increased confidence in a variety of areas, including providing emotional support to clinicians, personal knowledge, skills, and communication; ethical and legal concerns; and providing emotional support to dying children and their families. Results showed a significant main effect of training on confidence levels ( p < .000). This suggests that education can effectively boost pediatric clinicians' confidence regarding providing pediatric palliative care and therefore should regularly be provided to clinicians.

*Master of science in palliative care: On becoming a palliative care community specialist* Journal of Pain and Symptom Management, February 2017

Objectives * Develop a case-based on-line interprofessional PC educational program for mid-career working professionals who wish to provide high quality PC in their community. * Use patient/family/provider dialogues to ground on-line education in the clinical experience. * Provide an educational experience with a woven curriculum of bio-medical content and psycho-social-spiritual-ethical and communications lessons to replicate in-person preceptorship. * Define a PCCS as a provider of high-quality consultative PC outside an academic setting. Background. Workforce issues related to an inadequate supply of physicians and other providers educated in Palliative and Hospice Care are well documented. The recent IOM report called for alternative and expanded training opportunities for providers to expand the workforce and supplement primary palliative care (PC) across all settings. There is significant untapped demand for rigorous PC education options for mid-career providers who need to stay in their community and practice. Our newly developed Master of Science in Palliative Care (MSPC) will prepare healthcare providers (nurses, pharmacists, physicians, and physician assistants) to become Palliative Care Community Specialists (PCCS). Methods. A 36-credit hour MSPC program has been designed to be completed over 24 months of continuous study. Students may choose flexible completion options; courses are currently offered once per academic year. Education will include: * Case-based learning and problem-solving methodologies within a caring framework of PC approaches encompassing the whole person; * Intensive education and practice in communication skills; * Pain and non-pain symptom assessment and management; * Interdisciplinary team support for psycho-socialspiritual distress; * Ethical principles and decision-making methodologies Results. Seventeen students representing all disciplines have enrolled; classes begin August 2016. Extensive evaluation has been integrated. We will report on student learning and reaction to learning of the first two courses: Palliative Care Concepts and Communication Skills (on-line with on-campus intensive) and Basic Pain Management with IDT Care (online). Discussion. PCCSs will receive education and skill development enabling them to provide high quality PC to patients/families in the community whose needs are greater than can be provided by Primary Care Providers, and neither need nor desire care in an academic tertiary medical center. The PCCS will be linked to tertiary PC experts, creating a network of PC services that may better support the needs of patients/ families throughout the care continuum across settings. Conclusion. We have found there is a need and demand for educational options to expand PC services. The PCCS may be an important part of the solution to the workforce deficit issue.

*[Doctors' learning experiences in end-of-life care - a focus group study from nursing homes](#)* BMC Medical Education, January 2017

BACKGROUNDDoctors often find dialogues about death difficult. In Norway, 45% of deaths take place in nursing homes. Newly qualified medical doctors serve as house officers in nursing homes during internship. Little is known about how nursing homes can become useful sites for learning about end-of-life care. The aim of this study was to explore newly qualified doctors' learning experiences with end-of-life care in nursing homes, especially focusing on dialogues about death.METHODSHouse officers in nursing homes (n = 16) participated in three focus group interviews. Interviews were audiotaped and transcribed verbatim. Data were analysed with systematic text condensation. Lave & Wenger's theory about situated learning was used to support interpretations, focusing on how the newly qualified doctors gained knowledge of end-of-life care through participation in the nursing home's community of practice.RESULTSNewly qualified doctors explained how nursing home staff's attitudes taught them how calmness and acceptance could be more appropriate than heroic action when death was imminent. Shifting focus from disease treatment to symptom relief was demanding, yet participants comprehended situations where death could even be welcomed. Through challenging dialogues dealing with family members' hope and trust, they learnt how to adjust words and decisions according to family and patient's life story. Interdisciplinary role models helped them balance uncertainty and competence in the intermediate position of being in charge while also needing surveillance.CONCLUSIONSThere is a considerable potential for training doctors in EOL care in nursing homes, which can be developed and integrated in medical education. This practice based learning arena offers newly qualified doctors close interaction with patients, relatives and nurses, teaching them to perform difficult dialogues, individualize medical decisions and balance their professional role in an interdisciplinary setting.

*P232 Tailored Education Required Across the Long Term Care Workforce to Ensure Quality Palliative Care* Journal of Pain and Symptom Management, December 2016

Objective: The purpose of this study was to compare the differences across discipline groups related to their comfort level with engaging in palliative care activities in long-term care (LTC) homes. Methods: A cross-sectional survey (End of Life Professional Caregiver Survey, ELPS; and Intensity of Interprofessional Collaboration Scale, IIPCS) was administered at four LTC homes in Ontario, Canada using a modified Dilman's approach. The ELPCS included three domains: patients and family-centered communication, cultural and ethical values, effective care delivery. The IIPCS included two subscales: care sharing activities, and interprofessional coordination. In total, 697 LTC staff were given surveys, including personal support workers (PSWs or care aides), support staff (housekeeping, kitchen, activities and recreation, laundry, dietician aids, office staff), and registered staff (licensed nurses, physiotherapists, social workers, pharmacists, physicians). Results: Overall, 317 participants completed the survey (126 PSWs, 109 support staff, 82 registered staff) with a total response rate of 45%. ANOVAs revealed significant differences among discipline groups across all scales and subscales. The most significant differences were between the registered staff and support staff on all subscales. Significant differences were also found, but to a lesser extent, between the nurses and PSWs on the three subscales of the ELPS but not the IIPCS. Conclusions: These study findings suggest there are differing needs of LTC staff, specific to discipline group. Both the PSW and support staff groups appeared to have higher needs for education; support staff also reported higher needs related to integration on the interdisciplinary team. Efforts to build capacity within support staff related to working with dying residents and their families are needed. Optimal palliative care may require resources to increase the availability of support for all LTC staff involved.

*Education, implementation, and policy barriers to greater integration of palliative care: A literature review* Palliative Medicine, March 2016

BACKGROUNDEarly integration of palliative care into the management of patients with serious disease has the potential to both improve quality of life of patients and families and reduce healthcare costs. Despite these benefits, significant barriers exist in the United States to the early integration of palliative care in the disease trajectory of individuals with serious illness.AIMTo provide an overview of the barriers to more widespread palliative care integration in the United States.DESIGN AND DATA SOURCESA literature review using PubMed from 2005 to March 2015 augmented by primary data collected from 405 hospitals included in the Center to Advance Palliative Care's National Palliative Care Registry for years 2012 and 2013. We use the World Health Organization's Public Health Strategy for Palliative Care as a framework for analyzing barriers to palliative care integration.RESULTSWe identified key barriers to palliative care integration across three World Health Organization domains: (1) education domain: lack of adequate education/training and perception of palliative care as end-of-life care; (2) implementation domain: inadequate size of palliative medicine-trained workforce, challenge of identifying patients appropriate for palliative care referral, and need for culture change across settings; (3) policy domain: fragmented healthcare system, need for greater funding for research, lack of adequate reimbursement for palliative care, and regulatory barriers.CONCLUSIONWe describe the key policy and educational opportunities in the United States to address and potentially overcome the barriers to greater integration of palliative care into the healthcare of Americans with serious illness.

*Nurse Practitioners: Knowledge, Skills, and Leadership for the End-of-Life Conversation in Intensive Care* Nursing Science Quarterly, January 2016

An impending policy change in Medicare will provide reimbursement for the end-of-life conversation. The rise in numbers of older adults who face serious illness coupled with advances in healthcare technology are increasing the need for providers to address end of life issues in the acute care setting. Doctoral-level nurse practitioners who specialize in acute care of older adults are poised to be leaders and facilitators of this conversation in a particularly challenging context-the intensive care unit. The focus of this article is the new end-of-life policy in relation to the particular contributions that adult gerontology acute care nurse practitioners offer in the acute care setting.

*Vision of Professional Development of Oncology Nursing in the World* Asia-Pacific Journal of Oncology Nursing, January 2016

The author reflects on the worldwide nursing workforce that is prepared cancer care across continuum from prevention to palliative care. The author states that the better-educated nursing workforce results to better patient outcomes. The author mentions that nurses should lead the discussions about addressing cancer care.

*Why every health care worker should have palliative and end of life care education* Inside Palliative Care, 2015

Professor Sheila Payne, of the International Observatory on End of Life Care, University of Lancaster, and President of the European Association for Palliative Care, reflects on the importance of training.

*Enhancing Care of Aged and Dying Prisoners: Is e-Learning a Feasible Approach?* Journal of Forensic Nursing, n.d.

BACKGROUNDPrisons and jails are facing sharply increased demands in caring for aged and dying inmates. Our Toolkit for Enhancing End-of-life Care in Prisons effectively addressed end-of-life (EOL) care; however, geriatric content was limited, and the product was not formatted for broad dissemination. Prior research adapted best practices in EOL care and aging; but, delivery methods lacked emerging technology-focused learning and interactivity.PURPOSESOur purposes were to uncover current training approaches and preferences and to ascertain the technological capacity of correctional settings to deliver computer-based and other e-learning training.METHODSAn environmental scan was conducted with 11 participants from U.S. prisons and jails to ensure proper fit, in terms of content and technology capacity, between an envisioned computer-based training product and correctional settings.RESULTSEnvironmental scan findings focused on content of training, desirable qualities of training, prominence of "homegrown" products, and feasibility of commercial e-learning.CONCLUSIONS/IMPLICATIONSThis study identified qualities of training programs to adopt and pitfalls to avoid and revealed technology-related issues to be mindful of when designing computer-based training for correctional settings, and participants spontaneously expressed an interest in geriatrics and EOL training using this learning modality as long as training allowed for tailoring of materials.

## New ways of working

*Turning Water into Wine: A New Community Pharmacy Workforce Delivering Paediatric Palliative Care Services Across Scotland* Journal of Pain and Symptom Management, December 2018

Background: A ground breaking paediatric palliative care study in Scotland in 2015 identified that 15,400 babies, children and young people (BCYP) with life-limiting conditions required input from palliative care services, significantly higher than previously thought. Innovative and transformational approaches to palliative care need to be investigated if services are to meet demand. To this end, a Paediatric Palliative Care Community Pharmacy Network was conceptualised to deliver medicines optimisation to BCYP and improve access to specialist palliative care medication thereby improving patient outcomes. This pioneering new model of care unlocks the clinical capacity of community pharmacists and capitalises on their unique reach across Scotland to deliver palliative care services deep into the heart of all communities. Furthermore, this shift from the traditional medical and nursing models of palliative care will provide sustainable and affordable services and reduce the burden on the already stretched hospital and hospice services. Method(s): Through stakeholder engagement, a service delivery framework was designed. The framework is set out under 3 key domains: (1) Core Services from Community Pharmacies (2) Required Training and Resources for Community Pharmacies, (3) Service Evaluation and Patient Outcomes. The core services from community pharmacies will be delivered free of charge at the point of care. Result(s): The framework was presented to national commissioning bodies, and full funding to test the model has been successfully secured. The model is currently being tested in a pilot site in Scotland before full service evaluation and national roll-out. Conclusion(s): A pioneering new model of care, maximising community pharmacy capacity and reach, to deliver palliative care services deep into communities and improve patient outcomes has been conceptualised. Funding has been successfully secured and testing of the model is currently underway, with the first results due to be formally analysed in the summer of 2018.

*Innovations in community pharmacy: Implications for cancer care* Asia-Pacific Journal of Clinical Oncology, November 2017

The utilization of all health professionals through collaborative multidisciplinary models of care is essential to the success of health care reform. With medication often the main or only treatment option for many illnesses, including cancer, pharmacists as the "medicines experts, " are integral members of the health care team. The safe and efficacious use of medicines is the professional domain of pharmacists, no matter which part of the health system they work within. This includes the traditional role in dispensing and supplying medicines along with providing advice to patients, carers, prescribers, nurses and other health professionals, to support the quality use of medicines. Recent and current reforms, particularly in primary health care have seen the role of pharmacists extend beyond the supply of medicines and associated advice, to the provision of professional services which complement those of other health professionals. Examples of innovation include health screening, blood pressure monitoring, minor ailments, blood glucose and cholesterol testing and monitoring, dose administration aids, staged supply services, palliative care and pain management. In this presentation you will learn about recent innovations in community pharmacy and the implications for cancer care. Patient-centred and team-based care are fundamental principles as we move forward as a profession. Pharmacists are realising the opportunity they have to assist individuals and the community to improve health literacy, better understand their illnesses, manage side-effects, implement disease prevention and self-care strategies. The profession is stepping into this space and filling in the gaps at local levels by responding to individuals' health care needs on a daily basis. Governments are recognizing the value in better utilising this highly skilled workforce, and the wellstructured and accessible "health hubs" of community pharmacies distributed across the community. You will also discover how pharmacists are working in settings such as general practises, hospices, aged care facilities and as medication review consultants within the home. Reforms are being supported through more formalised referral systems enabling team-based care, which is truly patient centred.

*New ways of working in palliative and end of life care: crossing traditional acute hospital occupational therapy boundaries...RCOT (Royal College of Occupational Therapist) Annual Conference 2017* British Journal of Occupational Therapy, August 2017

In 2013, a successful funding bid to Macmillan enabled a new specialist palliative occupational therapy (OT) service to be created. In 2016, the team were recognised for innovative practice by winning an Abbvie Healthcare Award and through inclusion in a new occupational therapy report (College of Occupational Therapists 2016). We are sharing our experience of this new service to encourage other clinicians to innovate. All palliative patients should have access to client-centred care coordinated between acute and community settings (NHS England 2015). With increased accident and emergency (A&E) presentations, pressure on acute hospital beds is growing (Murray 2016). Occupational therapists are uniquely trained to work across health and social care settings and can achieve reduced length of stay and avoidance of unnecessary admission to hospital by providing a quality, safe discharge (College of Occupational Therapists 2016).

The introduction of the new palliative occupational therapy team, working across A&E, acute medical wards, base wards, outpatient clinics and community settings, is enabling these issues to be addressed. By sharing our experiences of building key acute, community and voluntary sector relationships, we can demonstrate reduced duplication, increased efficiency and seamless patient care. We aim to demonstrate how to develop palliative specific skills, including self-management of symptoms, advance care planning, emotional support and rapid discharge planning. We aim to share strategies to collect qualitative and quantitative outcome data to evidence improved patient and carer outcomes and cost savings, essential in driving services forward in an everchanging, pressurised NHS.

*Volunteer navigation partnerships: Piloting a compassionate community approach to early palliative care* BMC Palliative Care, July 2017

BACKGROUNDA compassionate community approach to palliative care provides important rationale for building community-based hospice volunteer capacity. In this project, we piloted one such capacity-building model in which volunteers and a nurse partnered to provide navigation support beginning in the early palliative phase for adults living in community. The goal was to improve quality of life by developing independence, engagement, and community connections.METHODSVolunteers received navigation training through a three-day workshop and then conducted in-home visits with clients living with advanced chronic illness over one year. A nurse navigator provided education and mentorship. Mixed method evaluation data was collected from clients, volunteer navigators, the nurse navigator, and other stakeholders.RESULTSSeven volunteers were partnered with 18 clients. Over the one-year pilot, the volunteer navigators conducted visits in home or by phone every two to three weeks. Volunteers were skilled and resourceful in building connections and facilitating engagement. Although it took time to learn the navigator role, volunteers felt well-prepared and found the role satisfying and meaningful. Clients and family rated the service as highly important to their care because of how the volunteer helped to make the difficult experiences of aging and advanced chronic illness more livable. Significant benefits cited by clients were making good decisions for both now and in the future; having a surrogate social safety net; supporting engagement with life; and ultimately, transforming the experience of living with illness. Overall the program was perceived to be well-designed by stakeholders and meeting an important need in the community. Sustainability, however, was a concern expressed by both clients and volunteers.CONCLUSIONSVolunteers providing supportive navigation services during the early phase of palliative care is a feasible way to foster a compassionate community approach to care for an aging population. The program is now being implemented by hospice societies in diverse communities across Canada.

*To be a trained and supported volunteer in palliative care - a phenomenological study* BMC Palliative Care, March 2017

BACKGROUNDIt has been found that including volunteers in palliative care is a positive contribution to seriously ill patients. It is, however, recommended that the volunteers are trained and supported. The aim of this study was to describe a group of trained and supported volunteers' lived experiences as volunteers in palliative care within the community health care services.METHODSThis study adopted a descriptive phenomenological approach featuring individual interviews with nine volunteers. The interviews were analysed using the descriptive phenomenological research method according to Giorgi.RESULTSBeing a volunteer in palliative care was both a positive and meaningful experience. It was a privilege being able to help those in need, which yielded positive returns. As a volunteer, it was important to be present for the ill persons and to follow them in their various physical and psychical states, which also implied that the volunteer had to face and deal with challenging situations. However, volunteers stated it was crucial to possess knowledge and life experience, as well as a clarified role, and they stressed the importance of being followed up by a mentor.CONCLUSIONSThe findings showed that trained and supported volunteers among seriously ill or dying people within the realm of community health care services play an independent and important role in the palliative care team. A coordinator in palliative care is especially suitable for training and supporting the volunteers.

*How effective are volunteers at supporting people in their last year of life? A pragmatic randomised wait-list trial in palliative care (ELSA)* BMC Medicine, December 2016

BACKGROUNDClinical care alone at the end of life is unlikely to meet all needs. Volunteers are a key resource, acceptable to patients, but there is no evidence on care outcomes. This study aimed to determine whether support from a social action volunteer service is better than usual care at improving quality of life for adults in the last year of life.METHODSA pragmatic, multi-centre wait-list controlled trial, with participants randomly allocated to receive the volunteer support intervention either immediately or after a 4 week wait. Trained volunteers provided tailored face-to-face support including befriending, practical support and signposting to services, primarily provided within the home, typically for 2-3 hours per week. The primary outcome was rate of change of quality of life at 4 weeks (WHO QOL BREF, a general, culturally sensitive measure). Secondary outcomes included rate of change of quality of life at 8 weeks and Loneliness (De Jong Gierveld Loneliness Scale), social support (mMOS-SS), and reported use of health and social care services at 4 and 8 weeks.RESULTSIn total, 196 adults (61% (n = 109) female; mean age 72 years) were included in the study. No significant difference was found in main or secondary outcomes at 4 weeks. Rate of change of quality of life showed trends in favour of the intervention (physical quality of life domain: b = 3.98, CI, -0.38 to 8.34; psychological domain: b = 2.59, CI, -2.24 to 7.43; environmental domain: b = 3, CI, -4.13 to 4.91). Adjusted analyses to control for hours of volunteer input found significantly less decrease in physical quality of life in the intervention group (slope (b) 4.43, CI, 0.10 to 8.76). While the intervention also favoured the rate of change of emotional (b = -0.08; CI, -0.52 to 0.35) and social loneliness (b = -0.20; CI, -0.58 to 0.18), social support (b = 0.13; CI, -0.13 to 0.39), and reported use of health and social care professionals (b = 0.16; CI, -0.22 to 0.55), these were not statistically significant. No adverse events were reported.CONCLUSIONSClinicians can confidently refer to volunteer services at the end of life. Future research should focus on 'dose' to maximise likely impact.TRIAL REGISTRATIONThe trial was prospectively registered. ISRCTN Registry: ISRCTN12929812 , registered 20 May 2015.

*Factors affecting rural volunteering in palliative care - an integrated review* The Australian Journal of Rural Health, December 2016

To review factors shaping volunteering in palliative care in Australian rural communities using Australian and International literature. Identify gaps in the palliative care literature and make recommendations for future research. A comprehensive literature search was conducted using Proquest, Scopus, Sage Premier, Wiley online, Ovid, Cochran, Google Scholar, CINAHL and Informit Health Collection. The literature was synthesised and presented in an integrated thematic narrative. Australian Rural communities. While Australia, Canada, the United States (US) and the United Kingdom (UK) are leaders in palliative care volunteer research, limited research specifically focuses on volunteers in rural communities with the least occurring in Australia. Several interrelated factors influence rural palliative care provision, in particular an increasingly ageing population which includes an ageing volunteer and health professional workforce. Also current and models of palliative care practice fail to recognise the innumerable variables between and within rural communities such as distance, isolation, lack of privacy, limited health care services and infrastructure, and workforce shortages. These issues impact palliative care provision and are significant for health professionals, volunteers, patients and caregivers. The three key themes of this integrated review include: (i) Geography, ageing rural populations in palliative care practice, (ii) Psychosocial impact of end-end-of life care in rural communities and (iii) Palliative care models of practice and volunteering in rural communities. The invisibility of volunteers in rural palliative care research is a concern in understanding the issues affecting the sustainability of quality palliative care provision in rural communities. Recommendations for future Australian research includes examination of the suitability of current models of palliative care practice in addressing the needs of rural communities; the recruitment, training, ongoing education and support of volunteers in rural palliative care provision to ensure equitable care for all communities in Australia regardless of location.

## Coaching and Mentoring

*A Novel Use of Peer Coaching to Teach Primary Palliative Care Skills: Coaching Consultation* Journal of Pain and Symptom Management, October 2017

BACKGROUNDWe aim to address palliative care workforce shortages by teaching clinicians how to provide primary palliative care through peer coaching.INTERVENTIONWe offered peer coaching to internal medicine residents and hospitalists (attendings, nurse practioners, and physician assistants).MEASURESAn audit of peer coaching encounters and coachee feedback to better understand the applicability of peer coaching in the inpatient setting to teach primary palliative care.OUTCOMESResidents and hospitalist attendings participated in peer coaching for a broad range of palliative care-related questions about pain and symptom management (44%), communication (34%), and hospice (22%). Clinicians billed for 68% of encounters using a time-based billing model. Content analysis of coachee feedback identified that the most useful elements of coaching are easy access to expertise, tailored teaching, and being in partnership. CONCLUSION/LESSONS LEARNEDPeer coaching can be provided in the inpatient setting to teach primary palliative care and potentially extend the palliative care work force.

*Training the Workforce: Description of a Longitudinal Interdisciplinary Education and Mentoring Program in Palliative Care* Journal of Pain and Symptom Management, April 2017

CONTEXTThe rapid increase in demand for palliative care (PC) services has led to concerns regarding workforce shortages and threats to the resiliency of PC teams.OBJECTIVESTo describe the development, implementation, and evaluation of a regional interdisciplinary training program in PC.METHODSThirty nurse and physician fellows representing 22 health systems across the Chicago region participated in a two-year PC training program. The curriculum was delivered through multiple conferences, self-directed e-learning, and individualized mentoring by expert local faculty (mentors). Fellows shadowed mentors' clinical practices and received guidance on designing, implementing, and evaluating a practice improvement project to address gaps in PC at their institutions.RESULTSEnduring, interdisciplinary relationships were built at all levels across health care organizations. Fellows made significant increases in knowledge and self-reported confidence in adult and pediatric PC and program development skills and frequency performing these skills. Fellows and mentors reported high satisfaction with the educational program.CONCLUSIONThis interdisciplinary PC training model addressed local workforce issues by increasing the number of clinicians capable of providing PC. Unique features include individualized longitudinal mentoring, interdisciplinary education, on-site project implementation, and local network building. Future research will address the impact of the addition of social work and chaplain trainees to the program.

*See one, do one, coach one: How clinical coaching can help trainees and colleagues just when they need it with just what they need* Journal of Pain and Symptom Management, February 2017

Objectives * Describe and demonstrate a clinical coaching model for teaching primary palliative care skills. * Illustrate how the clinical coaching model can be used in different settings and with different types and disciplines of learner, ranging from faculty to medical students. * Explore challenges of clinical coaching including how to measure outcomes, find resources, and develop a program. With severe palliative care workforce shortages and growing needs of an aging population with serious illness, the demand for specialty level palliative care will greatly exceed availability within the current established models of palliative-care delivery. The solution proposed here is, through clinical coaching, to teach front-line clinicians how to provide primary palliative care. The goal of clinical coaching is to use expert teaching and communication practices to make it easier for clinicians of all levels to ask for and receive help. In this session, we will describe a basic model of clinical coaching and illustrate how this model can be used with individual learners in the workshop or clinical setting. We will then describe three different applications of clinical coaching currently used at 2 different institutions across multiple disciplines and specialties: (1) family meeting communication coaching through two methods, i.e. direct observation of palliative care fellow trainees and an easy-access office hours approach for attendings; (2) a structured communication coaching intervention with oncologists in the outpatient setting; and (3) a service-delivery model that offers "coaching consultation" to inpatient clinicians. Finally, we will discuss challenges of implementing clinical coaching including how to find resources, develop a program for referring clinicians, and measure outcomes.

*Helping palliative care healthcare professionals get the most out of mentoring in a low-income country: a qualitative study*
BMC Palliative Care, November 2016

BACKGROUNDBeing a mentor in any setting brings challenges in addition to recognised benefits. Working in a low-income country confers specific challenges including logistical and communication issues. The need to adequately support UK-based international health volunteers prior to, during and after their trip is recognised at government level. Whilst the need to support mentors is recognised little is known about their support needs. This study aims to explore the lived experience of mentorship in a low-income country and gain insight into mentors' support and information needs and the barriers and facilitators to mentoring.METHODSPurposive sampling was used to recruit UK-employed, palliative care clinicians: four consultants, two specialty trainees, and two nurses, who were mentors with an international palliative care project. Semi-structured telephone interviews were recorded and analysed using interpretive phenomenological analysis.RESULTSParticipants became mentors to help others. Uncertainty about their achievements constituted a significant challenge. This study highlights the need to prepare mentors before their in-country visits by exploring motivation, describing the reality of international volunteering and ensuring realistic expectations. Post-trip debriefing is important for reducing uncertainty around trip outcomes and maximising transferable impacts. Challenges to mentoring were logistical, related to the concept of mentorship and cultural. Facilitators included shared passion, mentor credibility and serendipity.CONCLUSIONAwareness of the support needs of mentors and the facilitators and challenges to mentoring can improve mentor preparation and support. This may minimise potential negative emotional impact of being a mentor, maximise positive personal and professional impacts and improve in-country project impact.

*Sustaining the workforce through team engagement: A regional training and mentoring program for interdisciplinary palliative medicine providers* Journal of Pain and Symptom Management, February 2016

Objectives * Describe components of a regional palliative care training program for interdisciplinary providers. * Explain the composition and impact of a longitudinal mentoring program on development of the interdisciplinary palliative medicine team. * Describe practice improvement projects, the engagement of hospital leaders, and the impact of both on creating institutional change. Like many parts of the country, the greater Chicago area has experienced rapidly changing healthcare environments with increased demand for hospice and palliative medicine services (HPM). Limited resources and personnel to meet this need have led to great concern over interdisciplinary team (IDT) sustainability and provider burnout. In response, local HPM leaders, with support from the Coleman Foundation, developed and implemented the Coleman Palliative Medicine Training Program. This 2-year program utilizes multimodal educational strategies, including biannual workshops, evening group sessions, e-learning, and experiential training. From 2013 to 2015, the program trained 29 physicians and nurses from over 20 adult and pediatric healthcare systems seeking to start or improve HPM programs. Another cohort of 28 clinicians, which included social workers and chaplains, was added in 2015. Individual and group mentoring is provided by 39 regional IDT experts from academic and community-based HPM programs. Thirteen trainees from the first cohort also remained in the program as "junior mentors." A leadership conference directed at HPM program directors and hospital leadership was convened in May 2015 aimed at aligning institutional goals and clinical initiatives to address the Institute of Medicine priorities. During this session we will describe unique features of this program including 1) IDT longitudinal mentoring support to ensure adequate clinical skill development and team resiliency; 2) individual and group practice improvement projects completed by program participants that address educational gaps, quality improvement efforts, or clinical program developments at their respective health institutions; 3) strategies used to engage hospital administrators and foster regional collaboration. Finally, we will explore the strengths, weakness, opportunities, and challenges of applicability of this program to other HPM professionals through an interdisciplinary small group discussion.

## Technology

Using Technology to Create a More Humanistic Approach to Integrating Palliative Care into the Intensive Care Unit
American Journal of Respiratory and Critical Care Medicine, February 2016

*Athens log in required*

A decade ago, the major obstacles to integration of palliative care into the intensive care unit (ICU) were the limited number of providers trained in palliative care, an immature evidence base, and a lack of appreciation for the importance of palliative care in the ICU. In 2016, the palliative care workforce has expanded markedly and there is growing appreciation of the benefits of palliative care, whether provided by a generalist (intensivist, nurse, social worker) or palliative care specialist. However, there is evidence that the quality of ICU-based palliative care is often suboptimal. A major barrier to more broadly addressing this quality problem is the lack of scalable ICU-based palliative care models that use technology to deliver efficient, collaborative palliative care in the ICU setting to the right patient at the right time. To address these challenges, we first review strengths and limitations of current care models as the basis for our novel conceptual framework that uses the electronic health record as a platform on which external innovations can be built, including: (1) screening for patients at risk for poor outcomes, (2) integrating patient- and family-reported needs, (3) personalizing care, and (4) directing generalist versus specialist triage algorithms. In the approaches considered, we describe current challenges and propose specific solutions that use technology to improve the quality of the human interaction in a stressful, complex environment.

## Competency Frameworks

*End of Life Care Core Skills Education and Training Framework* Health Education England, 2017
Health Education England (HEE) commissioned the The framework classifies key skills and knowledge into three tiers, ranging from general end of life care awareness to the in-depth knowledge needed to care for and support an individual approaching the end of their life, and their family. It describes core skills and knowledge that are common and transferable across services. Enabling greater consistency in the training and assessment of end of life care core skills and knowledge.

*RCN Competencies: Caring for Infants, Children and Young People requiring Palliative Care* Royal College of Nursing (RCN), July 2018
This newly updated competence framework will be helpful for all health care professionals that contribute to the nursing care of infants, children and young people requiring palliative care.

*Career and education framework for cancer nursing*
Royal College of Nursing (RCN), February 2017
The Career and Education Framework for Cancer Nursing (‘the Framework’) has been developed by the Royal College of Nursing (RCN) Cancer and Breast Care Forum, RCN Children and Young People Specialist Care Forum, and the United Kingdom (UK) Oncology Nursing Society (UKONS). The Framework incorporates cancer-specific nursing outcomes for pre-registration nursing students, support workers and registered nurses. The development of this Framework has been supported by a grant from the Higher Education Academy Health and Social Care Cluster (HEA).

*Common Core Principles and competences for social care and health workers working with adults at the end of life* Skills for Care and Skills for Health, 2014
People nearing the end of their life often need specialist care and support that is provided by experts working in the field. Increasingly though, people working in social care and health who are not specialists in this area find

themselves working with people who are dying. This document, while relevant for everyone, is aimed at those non specialist workers.1 It sets out the principles for working with adults at the end of their life, and describes the underpinning competences, knowledge and values they should have. Used alongside occupation-specific guidance, these ‘common core principles’ form a framework to guide managers and workers, helping to define the additional knowledge and competences needed when supporting someone who is dying.

*Recommended Core Education Standards for Care and Support for the dying person in the last days and hours of life* Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks, 2014
One purpose of this document is to provide a basis for commissioners and providers within localities to continue and further develop mandatory education and training to support care in the last days and hours of life  It is also hoped that this document can be used by managers and individual professionals to reflect on an individual’s knowledge, competencies and practice, within their role in delivering the priorities for care in the last days of life. This reflection should include the skills and competencies that professionals already possess as well as areas for development. These discussions could then be included within an individual’s wider professional development reviews.  Although this document outlines core areas of knowledge for Group A,B and C Staff, it is NOT expected that every professional, within their own role, would need all of these core areas of knowledge – as these areas of knowledge are role and profession dependent.

## Help accessing articles or papers

Where a report/ journal article or resource is freely available the link has been provided. If an NHS OpenAthens account is required this has been indicated. It has also been highlighted if only the abstract is available. If you do not have an OpenAthens account you can self-register here.

If you need help accessing an article, or have any other questions, contact the Knowledge Management team for support KnowledgeManagement@hee.nhs.uk