

Evidence Brief: End of Life Care

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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.

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Key publications – the big picture

**National audit of care at the end of life (NACEL): round two findings* Age and Ageing, March 2021

NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the final admission in acute and community hospitals in England and Wales. Key findings include Recognising the possibility of imminent death: The possibility that the patient may die was documented in 88% of cases. The median time from recognition of dying to death was 41 hours (36 hours in the first round). Individual plan of care: 71% of patients, where it had been recognised that the patient was dying (Category 1 deaths), had an individualised end of life care plan. Of the patients who did not have an individualised plan of care, in 45% of these cases, the time from recognition of dying to death was more than 24 hours. Families' and others' experience of care: 80% of Quality Survey respondents rated the quality of care delivered to the patient as outstanding/excellent/good and 75% rated the care provided to families/others as outstanding/excellent/good. However, one-fifth of responses reported that the families'/others' needs were not asked about.

Palliative and end-of-life care: More work is required International Journal of Environmental Research and Public Health, October 2020

There is currently growing recognition of the complex care needs of patients with life-limiting conditions and their family members, prompting the need to revisit the goals of medicine. This Special Issue reflects a broad research agenda in the field of palliative and end-of-life care. A total of 16 papers of empirical studies and systematic review are included spanning five domains, namely, patient, caregiver, healthcare provider, policy, and methodology. The results generally suggest the merits of palliative care and reveal room for further improvement in palliative care education, manpower, infrastructure, and legal and policy frameworks.

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, 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

**Turf Wars: Integrating Palliative Care Social Work into a Large Pediatric Hospital* Journal of Palliative Medicine, April 2021

The article focuses on largest children's hospitals in the country, defining what palliative care social workers do and how interventions are distinct from those in similar roles is a regular concern. Topics include the social worker on the palliative care team at pediatric hospital in 2016 and transitioning to two social workers in 2020, and the small palliative social work team has worked hard to collaborate with inpatient and outpatient social workers at our institution at any given time.

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

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 “**Upskilling**” section of the [HEE Star](#) (search for “end of life care”)

Statistics

You can find relevant statistics on the [Health and Care Statistics Landscape](#) under “**End of Life Care**”

HEE National Data Programme

HEE staff can look at the [National Data Warehouse \(NDL\)](#) SharePoint site to find out more about datasets and Tableau products.

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

**Paramedics delivering palliative and end-of-life care in community-based settings: A systematic integrative review with thematic synthesis* Palliative Medicine, December 2021

There is a growing demand for community palliative care and home-based deaths worldwide. However, gaps remain in this service provision, particularly after-hours. Paramedics are a highly skilled workforce capable of helping to deliver palliative and end-of-life care to people in their homes and reducing

avoidable hospital admissions, particularly for palliative emergencies. Future research should focus on investigating the efficacy of palliative care clinical practice guideline implementation for paramedics, understanding other healthcare professionals' perspectives, and undertaking health economic evaluations of targeted interventions.

**Anticipatory prescribing in community palliative and end-of-life care: a realist review* Kai Tiaki Nursing Research, November 2021

Developing and maintaining expertise in primary palliative care, developing better interdisciplinary teamwork, and the prioritising of this prescribing practice are the factors underpinning effective anticipatory prescribing in palliative and end-of-life care. There is an ethical responsibility to anticipate the likely deterioration and end-of-life needs of palliative patients, so timely care can be provided and symptoms managed. Anticipatory prescribing should be individualised, approached with an equity lens, and delivered through an interdisciplinary health workforce to effectively meet population needs.

Role of the clinical nurse specialist as a non-medical prescriber in managing the palliative care needs of individuals with advanced lung cancer International Journal of Palliative Nursing, June 2021

The clinical nurse specialist as a non-medical prescriber is an evolving role. There are a range of factors that may influence the clinical nurse specialist to confidently and competently undertake this role. These include the perception that there will be an escalation in the workload, concerns about increased accountability and inadequate mentoring for this new role. To incentivise this role, multidisciplinary support is essential in promoting the clinical nurse specialist's confidence for

developing this service to individuals with advanced lung cancer.

Integration of Palliative Care in the Role of the Oncology Advanced Practice Nurse Journal of the Advanced Practitioner in Oncology, March 2021

Numerous organizations have cited the increasing demand for palliative care in oncology and the challenge of a limited workforce to deliver specialty palliative care. Advanced practitioners in oncology can provide generalist or primary palliative care to complement the care provided by specialists and enhance the overall provision of care. This article reports on a National Cancer Institute-funded training program to prepare advanced practice nurses to incorporate palliative care within their practice. One-year follow-up of the first three national cohorts (N = 276) included evaluation of goal achievement as these nurses integrated palliative care within their oncology practice. Goal analysis reported here demonstrates the success of the training program in impacting practice as well as the barriers to implementation efforts. The advanced practice registered nurses' implemented goals included extensive training of clinicians across disciplines and numerous systems changes to improve delivery of palliative care. Advanced practice nurses will continue to be a valuable source of extending palliative care into oncology care to support patients and families across the disease trajectory.

**Expanding the Concept of End-of-life Care in Long-term Care: A Scoping Review Exploring the Role of Healthcare Assistants* International Journal of Older People Nursing, March 2021

The context of care provided in long-term care homes is changing, as an increasing number of older adults are entering long-term care with advance stages of illness and higher care needs. Long-term care homes are quickly becoming the place

of death for an increasing number of older adults, despite recent literature identifying inadequate and suboptimal levels of end-of-life care. Within long-term care, healthcare assistants represent 60%-70% of the unregulated workforce and provide 70%-90% of the direct care to residents. Research indicates that a high level of uncertainty exists surrounding the role of healthcare assistants in end-of-life care, with numerous studies reporting the role of healthcare assistants to be 'unclear' with varying levels of responsibilities and autonomy. Findings from this scoping review highlight the numerous behaviours healthcare assistants perform outside their role description in order to provide end-of-life care to dying residents in long-term care. These findings could inform policymakers and managers of long-term care homes.

[Health policy guiding palliative care for patients with noncancer diagnosis: A systematic scoping review](#) Palliative Care and Social Practice, 2021

Deaths from a noncancer diagnosis pose a challenge for clinical practice with evidenced barriers in the provision of palliative care (PC) being reported for patients with chronic obstructive pulmonary disease (COPD), dementia, heart failure, and Parkinson's disease. Responding to the evidenced inequalities in access to services, the World Health Organisation (WHO) (1) stated that a major obstacle to the implementation of PC worldwide was the lack of health policy (HP). In response to the WHO commentary, influential organisations developed statements (2-4) urging governments to develop HP that ensures equality of access to PC. This scoping review aims to map current HP in the EU that specifically respond to the PC needs of patients with COPD, dementia, heart failure, and Parkinson's disease.

[Social work in hospice and palliative care in Europe: Findings from an EAPC survey](#) Palliative & Supportive Care, December 2020

Social work is considered to be a key player in Hospice and Palliative Care. To prove this claim, the Social Worker Task Force within the European Association for Palliative Care (EAPC) decided to carry out a survey. The aim of this survey was to generate basic data and thus to create a basis for further development of Palliative Care Social Work (PCSW) in Europe. The study reveals a very mixed picture of PCSW in Europe. This could be due to the high adaptability of social work, which is to be as flexible as possible to the needs of its clients. However, significant patterns, similarities, and differences emerge. The present study may, therefore, serve as a basis for further in-depth studies.

[*The role of learning disability nurses in providing end-of-life care](#) Nursing Times, December 2020

People with learning disabilities experience increased levels of health inequality compared with the general population and, in end-of-life care, many die without having their individual preferences met, despite carers articulating these needs to those providing professional care. In addition, the number of learning disability nurses in the UK is decreasing. This article recommends progressive change through the development of a new role - that of learning disability nurses with a specialism in end-of-life care.

**Outcomes of Inpatient Hospice and Palliative Care Unit, and Role of Physician Assistants as Emerging Work Force in Upstream Inpatient Palliative Care (RP523)* Journal of Pain and Symptom Management, July 2020

The models for inpatient palliative care units tend to evolve based on institutional settings, funding mechanisms or professional backgrounds of clinician champions. The palliative care unit at the Montefiore Medical Center as few other units distinguishes itself from the traditional inpatient hospice and palliative care units by employing physician assistants since 2007, with the same administrative regulation and standard of clinical competence. Palliative Care Units can be effectively run by employing physician assistants to provide upstream palliative care.

[The Role of the Palliative Care Registered Nurse in the Nursing Facility Setting](#) Journal of Hospice and Palliative Nursing, April 2020

There is a growing recognition of significant, unmet palliative care needs in nursing facilities, yet limitations in the workforce limit access to palliative care services. Attention to palliation is particularly important when there are efforts to reduce hospitalizations to help ensure there are no unintended harms associated with treating residents in place. A specialized palliative care registered nurse (PCRN) role was developed as part of the OPTIMISTIC (Optimizing Patient Transfers, Impacting Medical quality, and Improving Symptoms: Transforming Institutional Care) program, a federally funded project to reduce potentially avoidable hospitalizations. Working in collaboration with existing clinical staff and medical providers, the PCRN focuses on managing symptoms, advance care planning, achieving goal concordant care, and promoting quality of life. The PCRN serves as a resource for families through education and support. The PCRN also provides education and

mentorship to staff to increase their comfort, knowledge, and skills with end-of-life care. The goals of this article are to provide an overview of the PCRN role and its implementation in nursing facilities and describe core functions that are transferrable to other contexts.

[Workforce Development in Hospice and Palliative Nursing \(FR431\)](#) Journal of Pain and Symptom Management, February 2020

Innovative solutions to increase the palliative nursing workforce capacity are critical. The future of the discipline-and the health care system's capacity to care for our most vulnerable patients-therefore rests on our ability to build a strong palliative care nursing workforce. New registered nurses, new advanced practice registered nurses, and experienced RNs and APRNs transitioning from another practice area to palliative care, are not equipped to provide primary, much less specialty-level, palliative care (ANA Call to Action: Nurses Lead and Transform Palliative Care; 2017, p. 12). The aim of this session is to increase the learner's knowledge of advances needed to secure the palliative nursing work force necessary to promote health equity and improve access, safety, and quality of palliative care.

[The voices of death doulas about their role in end-of-life care](#) Health & Social Care in the Community, January 2020

Death doulas have emerged not only as a response to the overwhelming demands on families and carers, but also demands placed on health care professionals (including palliative care) at the end-of-life. They have identified gaps in health and social care provision, perhaps taking on tasks that health professionals don't have responsibility for. However, the roles and scope of practice of death doulas is not clear-cut even within their cohort, which can then make it hard for patients and families when choosing a death doula, especially as a lack of

regulation and standardised training means that doulas are working without oversight, and often in isolation.

**The Role of the Physician Assistant in Hospice and Palliative Medicine* Physician Assistant Clinics, 2020

Within hospice and palliative medicine, physician assistants have established important roles. Physician assistants are established clinicians, educators, and leaders despite a number of barriers that have historically existed. Aiding in overcoming these barriers are physician assistants education and collaboration, which have allowed physician assistants to enter and expand into these fields. Physician assistants serve as clinicians, educators, researchers, and leaders for both primary and specialist-level palliative medicine. Physician assistants are well-positioned to help fill some of the current and anticipated gaps created by workforce shortages existing in hospice and palliative medicine.

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

End 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. 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.

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

The 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.

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

Working with patients and families is complex, but the family meeting is a promising tool and a potential quality indicator in palliative care. The 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

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. NMPs 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

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. This 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

The 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.

**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

Participants 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. This 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

Of 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. One 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

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. 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

**Increasing the visibility of palliative care nursing* International Journal of Palliative Nursing, February 2021

The author reflects on issues and developments in palliative care nursing worldwide as of February 2021. Topics include the challenges posed by the COVID-19 pandemic in the nursing profession during the International Year of the Nurse and Midwife in 2020, the key role of nurses in achieving universal health coverage, as well as the anxiety, insomnia, and physical exhaustion experienced by nurses at personal level.

Meeting the Hospice and Palliative Care Registered Nurse Workforce Challenge: Hospice Nurse Residencies as a Case Study (TH362) Journal of Pain and Symptom Management, February 2020

In this presentation, we will examine workforce challenges that face hospice and palliative registered nurses, administrators, and educators and discuss potential opportunities for growth

both locally and nationally to increase the palliative nurse workforce. In response to these challenges, two hospice agencies have recently begun Hospice Nurse Residencies to provide opportunities for new graduate nurses to enter directly into community based hospice care. In this presentation, both agencies will offer perspectives on residency development details and lessons learned in implementation. Addressing and prioritizing the hospice and palliative registered nurse workforce is paramount to the success of all initiatives aimed at providing optimal, evidence-based care for those with serious illness.

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

Current 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

Primary care staff's willingness to participate in compassionate community network and palliative care and the barriers they face: A mixed methods study BMJ Open, September 2021

This study explored primary care staff's willingness to participate and factors associated with their participations in compassionate community education and network, palliative care education, providing palliative care and the barriers they faced. To encourage primary care staff to participate more in compassionate community education and network and palliative care education and to provide palliative care, policymakers should pay more attention towards removing the barriers to their engagement.

*Exploring the attitudes, beliefs, and values of the long-term care workforce towards palliative care: A qualitative evidence synthesis protocol Progress in Palliative Care, 2021

The long-term care workforce is a significant provider of palliative care. The majority of older people being admitted to long-term care have palliative care needs and many are approaching end of life. The long-term care workforce comprises both registered health care professionals and unlicensed health care workers (UHCW) who provide most direct care. Studies that have examined palliative care competence in long-term care have focused on staff knowledge. However, it is also important to understand staff attitudes, beliefs, and values towards palliative care because these attributes influence behaviours related to care provision. The aim of the qualitative evidence synthesis is to identify and appraise the best available qualitative evidence on the attitudes, beliefs, and values of the long-term care workforce towards palliative care.

**Front-Line Hospice Staff Perceptions of Barriers and Opportunities to Discussing Advance Care Planning With Hospice Patients and Their Families* Journal of the American Medical Directors Association, 2021

To understand the facilitators and barriers to hospice staff engagement of patients and surrogates in advance care planning (ACP) conversations. Capability was facilitated by interdisciplinary teamwork and specified clinical staff roles and inhibited by lack of self-perceived skill in engaging in ACP conversations. Opportunities for ACP occurred during admission to hospice, acute changes, or deterioration in patient condition. Opportunity-related environmental barriers included time constraints such as short patient stay in hospice and workload expectations that prevented clinicians from spending more time with patients and families. Motivation to discuss ACP was facilitated by the employee's goal of providing personalized, patient-centered care.

**Rural community-based nurses' self-reported knowledge and skills in the provision of psychosocial care to palliative and end-of-life clients and carers* Palliative and Supportive Care, 2021

Gaps and areas of consolidation were in the use of client and carer assessment tools, the care of specific populations such as children, supporting carers with appropriate referrals, resources, and grief, and facilitating the processes of reporting a death to the coroner. Lack of formal training and lower years of experience were found to be associated with practice gaps. Significance of results Our study found rural nurses were confident in their knowledge and skills in the majority of psychosocial care. As generalist nurses make up the majority of the rural nursing workforce, further research should be undertaken on what educational strategies are needed to

support and upskill rural community-based nurses to undertake formal training in palliative care.

Allied Health Clinicians' Understanding of Palliative Care as It Relates to Patients, Caregivers, and Health Clinicians Journal of Allied Health, June 2019

This study sought to elicit allied health (AH) clinicians' understanding and views about palliative care and its relevance to their clinical practice and to identify their educational needs. Results from analysis of free text survey responses to a single openended question from a larger survey are presented. Four themes were identified: 1) palliative care employs a client-centred model of care, 2) acknowledgement of living whilst dying, 3) interdisciplinary palliative care interventions provide active care in a range of domains, and 4) characteristics of palliative care teams and settings.

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

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.

**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*

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. 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.

**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*

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*

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

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

[Does national policy in England help deliver better and more consistent care for those at the end of life?](#) Journal of Health Services Research & Policy, October 2020

To explore the extent to which national policy in end of life care in England influences and guides local practice, to ensure that care for patients over the age 75 years is of a consistently good quality. Factors influencing the quality of end of life care were

stratified into three system levels: meso, macro and micro. The links between the existence of policy at the macro-level of the system and the effective enactment of good practice remain unclear, although strategies are suggested to help achieve greater national consistency in end of life care outcomes. Policymakers must pay attention to the following: controlling the rise in localism and its contribution to regional inequalities; the impact of continuous infrastructural change together with increasing workforce pressures; encouraging broader professional and public responsibility for recognition and care of those at the end of life.

[Filling the gap: A geriatrics and palliative care leadership needs assessment](#) Journal of General Internal Medicine, May 2019

Recruited participants saw the added value of a healthcare leadership track. Interviewees emphasized the need for fellows to have practical, diverse experiences during training to help prepare them for future leadership positions. Knowledge deficits emphasized were healthcare finance literacy and healthcare policy. Important skills a junior faculty should acquire included: negotiation, mentorship, and networking. Working in interdisciplinary teams and across professions was seen as a strength among Geriatricians and Palliative Care providers.

[*Palliative nursing leadership intensive](#) Journal of Pain and Symptom Management, February 2017

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

[*Developing the Future End-of-Life Health Care Workforce: Lessons Learned from a Survey of Advanced Health Professions Students](#) American Journal of Hospice & Palliative Care, July 2021

To examine health professions trainees' end-of-life (EOL) care knowledge, attitudes, and intentions. Sufficient knowledge of palliative care was reported by 25% while sufficient knowledge of advance care planning (ACP) was 17%. Ninety-six percent

thought it important to discuss EOL issues in training; 92% believed their professions played important roles in EOL care. Managing pain was chosen as the best example of palliative care by 93.6% and designating healthcare proxies was reported as the best example of ACP (5.8%). Pharmacy, public health, and rehabilitation therapy students were less likely than physician and physician assistant trainees to report intent to work in EOL care. Among those who want to work in EOL care, 65% reported having clinical experience with seriously ill or dying patients/clients. We discuss other findings related to perceptions of didactic preparation in palliative care, palliative care knowledge access/function, death/dying attitudes, and intentions toward seriously illness care.

[A critical realist evaluation of advance care planning in care homes](#) Journal of advanced nursing, June 2021

It was evident that in some cases care home staff's unmet emotional needs led them to rushing and avoiding discussions about death and dying with residents and relatives. A sparsity of mechanisms to support care home staff's emotional needs was noted across all three care homes. Furthermore, a lack of training and knowledge appeared to inhibit care home staff's ability to engage in meaningful care planning conversations with specific groups of residents such as those living with dementia. The lack of training was principally evident amongst non-registered care home staff and those with non-formal caring roles such as housekeeping.

[Workforce Planning for Community-Based Palliative Care Specialist Teams Using Operations Research](#) Journal of Pain and Symptom Management, May 2021

Many countries have aging populations. Thus, the need for palliative care will increase. However, the methods to estimate optimal staffing for specialist palliative care teams are

rudimentary as yet. Historical, current, and projected data can be used with operations research to forecast staffing levels for specialist palliative care teams under various scenarios. The forecast can be updated as new data emerge, applied to other populations, and used to test alternative delivery models.

[Transitions in Labour Force Participation over the Palliative Care Trajectory](#) Healthcare Policy, November 2020

Home-based palliative programs rely on family caregivers, who often miss time from employment. This article identified changes in caregivers' labour force participation over the palliative trajectory. Methods: Family caregivers (n = 262) were interviewed biweekly to measure transitions across four employment categories. Results: More than half of the caregivers had one employment transition and 29% had three or more. The highest proportion of transitions occurred for caregivers who were employed part-time. Interpretation: Understanding these transitions is critical to the development of strategies tailored to caregivers to contain labour force losses and to support caregivers during a time of high caregiving demands.

[Equity and the financial costs of informal caregiving in palliative care: a critical debate](#) BMC Palliative Care, May 2020

The aim of this critical debate paper was to review and critique some of the key evidence on the financial costs of informal caregiving and describe how these costs represent an equity issue in palliative care. Various groups of informal end of life carers are systematically disadvantaged financially. Addressing these, and other, determinants of end of life care is central to a public health approach to palliative care that fully recognises the value of carers. Further research exploring these areas of inequity in more depth and gaining a more detailed

understanding of what influences financial burden is required to take the next steps towards meeting this aspiration.

**When to Integrate Palliative Care in the Trajectory of Cancer Care* Current Treatment Options in Oncology, April 2020

Palliative care provides an extra layer of support to patients and families facing a serious illness. To date, several studies support the use of early, integrated palliative care for patients with cancer, based upon documented improvements in quality of life, symptoms, mood, satisfaction, utilization, and even overall survival. Despite this, patients with cancer continue to have unmet palliative care needs, and palliative care services are often engaged late in their care, if at all. Amid this under-utilization, questions remain about the optimal timing and nature of palliative care integration. To answer this question, we briefly review the evidence based for palliative care in oncology, and discuss three approaches to optimizing the timing of palliative care integration: (1) prognosis-based, (2) needs-based, and (3) trigger-based models.

A Narrative Literature Review on Human Resource Planning for Palliative Care Personnel Indian Journal of Palliative Care, 2020

A literature search was started with the objective of finding works pertaining to the use of operations research techniques in planning for human resources in palliative care. Since the search indicated that there is no such work, in this paper, we report on the literature on workforce planning and human resource planning for palliative care personnel. Using our findings, we discuss the factors that influence the supply and demand for the palliative care workforce. Our results show that the enhancement of efficiency, training more primary caregivers to deliver palliative care, and allowing for mid-career specialist

training are practical ways to compensate for the gap between the supply and demand in the palliative care workforce.

Policy Changes Key To Promoting Sustainability And Growth Of The Specialty Palliative Care Workforce Health Affairs (Project Hope), June 2019

We used 2018 clinician survey data to model risk factors associated with palliative care clinicians leaving the field early, and we then projected physician numbers from 2019 to 2059 under four scenarios. Our modeling revealed an impending "workforce valley," with declining physician numbers that will not recover to the current level until 2045, absent policy change. However, sustained growth in the number of fellowship positions over ten years could reverse the worsening workforce shortage. There is an immediate need for policies that support high-value, team-based palliative care through expansion in all segments of the specialty palliative care workforce, combined with payment reform to encourage the deployment of sustainable teams.

Population-based palliative care planning in Ireland: how many people will live and die with serious illness to 2046? HRB Open Research, 2019

The global population is ageing, although significant differences in intensity of ageing can be seen between countries. Prevalence of palliative care need in Ireland will nearly double over 30 years, reflecting Ireland's relatively young population. People living with a serious disease outnumber those in the last year of life by approximately 12:1, necessitating implementation of integrated palliative care across the disease trajectory. Urgent steps on funding, workforce development and service provision are required to address these challenges.

**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.

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

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

A 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. Palliative 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

**Palliative care healthcare professionals' work-related stress: A national cross-sectional survey* Palliative Medicine, September 2021

Providing palliative care can lead to work-related stress and ultimately to burnout. The need for palliative care will further increase due to population aging and people living longer with life-threatening diseases. Therefore, a healthy palliative care workforce is vital. This study aims to get insight into the experienced work-related stress among health care professionals providing palliative care in the Netherlands and

their strategies and needs in relation to maintaining a healthy work-life balance. Symptoms of burnout are quite prevalent among health care professionals providing palliative care in the Netherlands. Health care professionals express a need for team and organisation approaches in addition to their individual coping strategies to maintain a healthy worklife balance.

**Mixed-methods systematic review: Cultural attitudes, beliefs and practices of internationally educated nurses towards end-of-life care in the context of cancer* Journal of Advanced Nursing, September 2021

The distinct gap in research on understanding the cultural attitudes and beliefs of internationally educated nurses in end-of-life care in the context of cancer demands further research. Several aspects of end-of-life care were in conflict with internationally educated nurses' cultural attitudes, beliefs and practices. As these nurses are integral in achieving culturally competent care, further understanding of this phenomenon is required to advance the delivery of culturally sensitive care to patients. Stakeholders, including the nursing workforce, need to play an active role in providing a culturally inclusive workplace. Support measures are necessary to reduce the impact of cultural conflicts experienced by internationally educated nurses.

[Empowering the Health and Well-Being of the Palliative Care Workforce: Evaluation of a Weekly Self-Care Checklist](#) Journal of Pain and Symptom Management, April 2021

Workplace interventions are needed to prevent burnout and support the well-being of the palliative care workforce. We conducted a survey of all palliative care clinical staff to evaluate the usefulness and feasibility of checklist items and the checklist itself. We collected demographics, perceptions of professional satisfaction and burnout, and qualitative feedback

aimed at improving the checklist. We implemented a 13-item self-care checklist, included in a handbook on palliative care carried in the laboratory coat of all clinical personnel, to remind them to care of their own well-being. Exercise was the most highly ranked item, whereas watching visual arts was the lowest ranked item.

[Burnout syndrome in nurses working in palliative care units: An analysis of associated factors](#) Journal of Nursing Management, January 2018

A 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. Our 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. Nurses 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

The 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, $p = 0.017$). Personality 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

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. 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. 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. 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. 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 group how 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

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-building model 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, meeting monthly 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

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

Many 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. We sought to understand the prevalence and predictors of burnout using a discipline-wide survey. We 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. We 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. Burnout 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

**Palliative and End-of-Life Care in the Home in Regional/Rural Victoria, Australia: The Role and Lived Experience of Primary Carers* SAGE Open Nursing, 2021

This study aimed to explore the role and lived experience of primary carers who are providing palliative and end-of-life care in the home in regional/rural Victoria, Australia. Two themes emerged: "Negotiating healthcare systems" which described the needs for multidisciplinary supports and "The caring experience" which discussed daily tasks, relationships, mental and physical exhaustion, respite, isolation, medication management, and grief and loss. Providing palliative and end-of-life care in the home is an exhausting and emotionally draining role for unpaid, primary carers. Multiple supports are

needed to sustain primary carers, as they play an essential role in the primary health care system.

**Optimizing the Global Nursing Workforce to Ensure Universal Palliative Care Access and Alleviate Serious Health-Related Suffering Worldwide* Journal of Pain and Symptom Management, July 2021

Palliative care access is fundamental to the highest attainable standard of health and a core component of universal health coverage. Forging universal palliative care access is insurmountable without strategically optimizing the nursing workforce and integrating palliative nursing into health systems at all levels. The COVID-19 pandemic has underscored both the critical need for accessible palliative care to alleviate serious health-related suffering and the key role of nurses to achieve this goal.

**Advance care planning: the who, what, when, where and why* British Journal of Hospital Medicine, February 2020

Advance care planning is an opportunity for patients to express their priorities for future care. NHS England has outlined a commitment to end-of-life care, advocating a shift towards more patient-centred care. The NHS is encouraging the workforce to engage patients in conversations about what is important to them, shifting the focus from 'what is wrong with you' to 'what matters to you'. Traditionally, this was seen as the doctor's role but this conversation can and should happen with the wider skilled medical workforce. The key to advance care planning is to have these conversations early on when patients have the capacity to discuss their preferences for care. Advance care planning can occur in any setting where the patient is comfortable to have the conversation, be that at home, in the GP surgery, in hospital or another setting. Patients with advance care plans are more likely to have their wishes

respected, have fewer unwanted interventions, experience reduced transitions between care settings and are more likely to die in their preferred place of death. Healthcare professionals have a duty to offer advance care planning to patients nearing the last phase of life so that care can be delivered to honour individual needs at the end of life.

*Transforming the Workforce for Primary Palliative Care Through a System-Wide Educational Initiative Journal of Nursing Administration; October 2019

Palliative care (PC) is a national and global priority, yet there is insufficient knowledge regarding PC among generalist clinicians. An interdisciplinary educational initiative was implemented to enhance a hospital workforce's PC knowledge and skills. More than 1000 clinicians attended at least 1 of 27 educational offerings. Measurable gains were evident in key outcome measures including PC referrals and advanced directive documentation. Changes reflected a transformation of workforce culture and resulted in 2 national awards for improving PC.

*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

An 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

Little 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. Further 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

Results 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. 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

We 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. The 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

The 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. The 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

**A virtual geriatrics and palliative care immersion course for inter-professional teams* Journal of the American Geriatrics Society, April 2021

We have successfully conducted a 1.5-day virtual immersion course for interprofessional trainees and clinicians. The course 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 training the existing workforce to better care for vulnerable adults during this unprecedented pandemic time and beyond.

**Facing the Inevitable: Preparing Nurses to Deliver End-of-Life Care* Journal of Pain and Symptom Management, March 2021

Healthcare providers have an ethical obligation to reduce suffering during a patient's end of life (EOL) but few receive formal education on EOL care principles. Deficiencies in EOL care can compromise the quality of EOL care received by patients, increase resource utilization, and increase moral distress experienced by providers. The long-term goal of this project is to develop a healthcare workforce that is more adept at providing patient-centered, effective EOL care. As an initial step, the objective of this project was to determine the feasibility and potential benefits of offering workshops in which principles of EOL care were taught to senior-level nursing students and practicing nurses.

Development, feasibility and acceptability of an online course to teach primary palliative care skills to hepatology providers

Hepatology, November 2020

This online course demonstrates a feasible and innovative way to improve PC knowledge of HP particularly on hospice and goals of care. This addresses workforce challenges and HP's unmet needs. How much the improvement in knowledge gets translated into improvement in patient outcomes is under testing. Further research must assess the scalability of this training program for future HPs.

*Palliative Care in Nephrology: The Work and the Workforce

Advances in chronic kidney disease, July 2020

Kidney palliative care is a growing subspecialty of clinical practice, education, and research in nephrology. It is an essential aspect of care for patients across the continuum of advanced kidney disease who have high symptom burden, multidimensional communication needs, and limited life expectancy. Training in kidney palliative care can occur in a variety of ways, from didactic curricula and clinical experiences embedded in nephrology fellowship training to the pursuit of additional dedicated fellowship training in palliative care. At this time, a minority of nephrologists pursue formal fellowship training in specialty palliative care. This article will discuss opportunities and challenges in building a skilled workforce that will address the palliative needs of patients living with advanced kidney disease.

*Role and support needs of nurses in delivering palliative and end of life care

Nursing Standard, November 2021

This article explores the definitions of palliative and end of life care, as well as the changes and challenges in service provision brought about by the COVID-19 pandemic. It also considers how nurses who have not specialised in this area of

practice can be supported to care effectively for patients with life-limiting conditions, and their families, notably through workforce development initiatives such as training programmes and clinical supervision. This could not only increase the skills of the nursing workforce but also improve patient care.

*Lack of Exposure to Palliative Care Training for Black Residents: A Study of Schools With Highest and Lowest Percentages of Black Enrollment

Journal of Pain and Symptom Management, May 2021

The palliative medicine workforce lacks racial diversity with <5% of specialty Hospice and Palliative Medicine (HPM) fellows identifying as black. Little is known about black trainees' exposure to palliative care during their medical education. Residents at schools with the highest black medical student enrollment lack access to palliative care training opportunities. Efforts to reduce health disparities and underrepresentation in palliative care must begin with providing palliative-focused training to physicians from under-represented minority backgrounds.

*Training physicians to provide basic-level palliative care: an evaluation of a novel training programme

Progress in Palliative Care, 2021

We developed a novel training programme for basic palliative care using didactic and participatory learning methods, along with a mentoring system. The programme was delivered over 6 months. 38 physicians were trained. A survey to evaluate the participants' interest and knowledge of palliative care, as well as their preparedness to provide palliative care was conducted at 3 timepoints-pre-training, post-training, and 3 months post-training. Improvements in the interest (4.05 vs 4.24, $p<0.05$) and knowledge of palliative care (83.05 vs 93.10, $p<0.001$), and the preparedness to provide various aspects of palliative care

were observed post-training. These improvements were sustained after 3 months post-training.

[*Achieving beneficial outcomes for children with life-limiting and life-threatening conditions receiving palliative care and their families: A realist review*](#) Palliative Medicine, March 2020

Narrative synthesis and realist analysis led to the proposal of context-mechanism-outcome configurations in four conceptual areas: (1) family adaptation, (2) the child's situation, (3) relationships with healthcare professionals and (4) access to palliative care services. The presence of two interdependent contexts, the 'expert' child and family and established relationships with healthcare professionals, triggers mechanisms, including advocacy and affirmation in decision-making, which lead to important outcomes including an ability to place the emphasis of care on lessening suffering. Important child and family outcomes underpin the delivery of palliative care.

[*Advanced Practice Palliative Immersion \(APPI\): An Innovative Educational Modality for Workforce Expansion \(S759\)*](#) Journal of Pain and Symptom Management, February 2020

This regional APPI training program utilizes a mixed methods educational format, including in-person didactics and remote learning, shadowing, SP training, and mindfulness skills. Preliminary data show positive quantitative and qualitative results. Implications for Research, Policy or Practice: Innovative methods for delivery of educational programming are necessary to increase the PC workforce.

[*GiTalk: A Novel Palliative Care Communication Curriculum for Gastroenterology Fellows \(Q1619\)*](#) Journal of Pain and Symptom Management, February 2020

Presession surveys resulted in an average score of 3.35 out of 5 in self-reported preparedness to discuss prognosis and goals of care. At the conclusion of the course, the average score increased to 4.30, and the overall course rating was 4.86 out of 5. All learners reported that they would recommend the training to others and that the training should be a required part of fellowship training. Conclusions and Implications: A full-day communication curriculum for GI fellows could be an effective way to enhance communication skills for clinicians who provide care to a patient population with substantial unmet palliative care needs. All participating GI fellows felt the communication curriculum should be a required part of their fellowship training.

[*Mentored Learning Communities \(MLC\) in a Regional Interdisciplinary Palliative Care Training Program \(S754\)*](#)

Journal of Pain and Symptom Management, February 2020

Ten-month training (Jan-Oct 2019) offers multimodal education including: full-day communication skills workshop; standardized patient training; monthly webinars; monthly mentored learning communities (MLC); professional seminar series for social workers and chaplains; and mindfulness/resilience workshop. MLCs are discipline-specific and faculty-facilitated for small groups of 4-5 trainees. MLC leaders utilized teaching guides for case-based discussions delving deeper into monthly webinar subjects. Monthly evaluations rated 5 criteria: faculty expertise, relevance to practice, ability to incorporate material into practice; conducive learning environment, and overall educational value. Qualitative evaluation solicited feedback on new skills learned, knowledge gained from peers, and goal setting per topic. MLCs piloted in an interdisciplinary training program provided valuable learning from faculty and peers.

Limitations included scheduling issues. Implications for Research, Policy or Practice: Expert, committed faculty educators utilizing shared teaching materials were keys to success in this reproducible educational format.

[An instrument to assess the education needs of nursing assistants within a palliative approach in residential aged care facilities](#) BMC Palliative Care, July 2019

This study provides preliminary evidence for the validity and reliability of three new questionnaires that demonstrate sensitivity for nursing assistants' level of education and required knowledge, skills and attitudes for providing a palliative approach. Implications for practice include the development of palliative care competencies through structured education and training across this workforce, and ongoing professional development opportunities for nursing assistants, especially for those with the longest tenure.

[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, May 2019

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. Two main themes were identified: learning to teach and building skills to change teaching practice. Participants felt more confident and better prepared to teach. It 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. Quality 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.

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

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.

[Drilling It Down: Designing Workshops to Practice Generalist Palliative Care Skills \(TH361\)](#) Journal of Pain and Symptom Management, February 2019

Drills can be an efficient and effective alternative in which learners can obtain and practice the most fundamental skills flexibly in different settings. Given the time constraints and workforce shortage in palliative medicine, drill based teaching and practice can provide an interactive method for learners that can be done in a short amount of time and can be utilized for interprofessional learning settings. Some examples of drills that have been designed are converting opioids, recognizing and

responding to emotion, and introducing palliative care to patients.

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

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.

[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

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. 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

Two main themes were identified; learning to teach and building skills to change teaching practice. Participants felt more confident and better prepared to teach. It 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. Quality 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.

Improving quality in hospital end-of-life care: honest communication, compassion and empathy BMJ Open Quality, 2019

The National Consensus Statement on Essential Elements for Safe and High-Quality End-of-Life Care has been translated into e-learning modules by the End of Life Essentials project. The modules were developed by a palliative care educator with the support of a peer review group and were piloted with 35

health professionals. Pre-post module evaluation data were collected and during a 10-month period from 2016 to 2017 a total of 5181 individuals registered for the project accessing one or more of the six modules. Five themes are derived from the data: communication, emotional insight, professional mindset, person-centred care and professional practice.

Allied Health Clinicians' Understanding of Palliative Care as It Relates to Patients, Caregivers, and Health Clinicians: A Cross-Sectional Survey Journal of Allied Health, 2019

The scope of hospice or palliative care has expanded since its inception, which has significant ramifications for the AH workforce. This study sought to elicit allied health (AH) clinicians' understanding and views about palliative care and its relevance to their clinical practice and to identify their educational needs. A total of 217 AH clinicians responded to an email survey and 187 useable responses were analysed. Four themes were identified: 1) palliative care employs a client-centred model of care, 2) acknowledgement of living whilst dying, 3) interdisciplinary palliative care interventions provide active care in a range of domains, and 4) characteristics of palliative care teams and settings. AH clinicians plan an active role in physical, social, and psycho-spiritual care of palliative care patients and caregivers. Burgeoning numbers of palliative care patients in nonspecialist palliative care settings require AH clinicians to develop skills and competencies to work with people who have advanced disease.

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

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

The 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

Curricula 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

Cancer 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

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. 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. 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. 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

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 videotaped 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. 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. 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

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 psychosocial/spiritual 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).

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

Newly 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. There 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

Early 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. We

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.

[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.

Our 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. An 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. Environmental scan findings focused on content of training, desirable qualities of training, prominence of "homegrown" products, and feasibility of commercial e-learning. This 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

*[*New paths forward for palliative nursing](#)* International Journal of Palliative Nursing, October 2021

The author reflects on the opportunities opened by the COVID-19 pandemic to palliative nurses to develop new programmes to improve palliative nursing and expand access to symptom

management and psychosocial services. Topics include the need to focus on schemes that will maximise the capacity and capability of the nursing workforce and the use of technology like tele-palliative care delivery services and address the barriers to technology access.

[Minority Residents' Palliative Care Training Quality Trails Other Medical Education](#) Medical Ethics Advisor, October 2021

The 91 residents surveyed reported receiving less training on palliative care than they did on sepsis management. Half the residents reported receiving negative messages about palliative care. Two-thirds said they considered care for dying patients to be depressing.

[*"If You Built It, They Could Come": Opportunities to Expand Access to Palliative Care](#) Journal of palliative medicine, October 2021

There are growing calls to broaden palliative care access to more populations, diseases, and care settings and to earlier in the disease process; yet, supply of specialty palliative care is not likely to keep pace with demand. This article discusses possible solutions by which to bridge the gap between limited palliative care supply and demand. The proposed solutions include: (1) specialist workforce development; (2) alternate models of care; (3) triaging systems; and (4) telemedicine. Education/training, research, and policy mechanisms could operationalize these solutions. With the solutions in hand, the field may be able to increase the reach, sustainability, and equity of palliative care, thereby improving access and enabling a multitude of positive patient, family, and health care system outcomes.

[*Reimagining the inpatient palliative care consult: lessons from COVID-19](#) American Journal of Managed Care, July 2021

As the number of inpatients with advanced age and chronic conditions rises, so too does the need for inpatient palliative care (PC). Despite the strong evidence base for PC, less than 50% of all inpatient PC needs are met by inpatient consults. Over the past several months in epicenters of the COVID-19 pandemic, PC providers have responded to the increased need for PC services through innovative digital programs including telepalliative care programs. In this article, we explore how PC innovations during COVID-19 could transform the PC consult to address workforce shortages and expand access to PC services during and beyond the pandemic. We propose a 3-pronged strategy of bolstering inpatient telepalliative care services, expanding electronic consults, and increasing training and educational tools for providers to help meet the increased need for PC services in the future.

[Shifting palliative care paradigm in primary care from better death to better end-of-life: a Swiss pilot study](#) BMC health Services Research, July 2021

Patients suffering from advanced cancer often lose contact with their primary care physician (PCP) during oncologic treatment and palliative care is introduced very late. The aim of this pilot study was to test the feasibility and procedures for a randomized trial of an intervention to teach PCPs a palliative care approach and communication skills to improve advanced cancer patients' quality of life. While the intervention was acceptable to PCPs, recruitment was a challenge and a follow up trial was not deemed feasible using the current design but PCPs reported a change in paradigm about palliative care. They moved from a focus on helping patients to die better, to a new role helping patients to define the conditions for a better end-of-life.

[Advantages and Challenges in Using Telehealth for Home-Based Palliative Care: Protocol for a Systematic Mixed Studies Review](#) JMIR research protocols, May 2021

The aim of this systematic mixed studies review is to critically appraise and synthesize findings from studies that investigated patients' use of telehealth in home-based palliative care with a focus on the advantages and challenges experienced by the patients. Following the ethos of patient-centered palliative care, this systematic mixed studies review could lead to recommendations for practice and policy, enabling the development and implementation of telehealth applications and services that align with patients' preferences and needs at home.

[Constructing a new role for family carers and volunteers providing care towards the end of life: an action research approach exploring a new model of hospice care](#) Health & Social Care in the Community, May 2021

The objective of this study was to understand the conceptualisation and development of a novel way of providing end-of-life care in a Cottage Hospice setting, with a focus on the role of family carers and volunteers within this care model. A participatory action research design enabled a situational analysis, together with change processes. At the core was a focus on disruption of the norm of professionally provided and mediated care, with three main themes: imagining the future of Cottage Hospice (growing demand, a home-like space, innovative roles for families and volunteers); developing the role of family caregivers (making agreements, meeting needs, social inclusion and the 'unknown' expectations) and quality and safety issues (negative perceptions, personalised care and volunteer roles). Change was viewed as both a threat and an opportunity. Cottage Hospice represents the possibility of a truly

new way of meeting the needs of dying people and their families, and could act as a template for progressive service developments elsewhere.

[*Identifying Trends in Published Palliative Care Research: A 5-Year Review \(RP514\)](#) Journal of Pain and Symptom Management, July 2020

The authors reviewed every issue of the three US HPM journals with the highest impact factors (Journal of Pain and Symptom Management, Journal of Palliative Medicine, and American Journal of Hospice and Palliative Medicine) from 2013 to 2018 and the year 2004. Brief reports and original articles were included, all other publication types were excluded. The majority of published papers in HPM peer-reviewed journals are quantitative, which remains unchanged over the past 5 years. Although there is a trend towards increasing female first authorship, the overall percentage is not proportional to the percentage of women in the HPM workforce. Senior female authors remain underrepresented. Future work will include more years of publications with expanded characteristics.

[*The Effect of a Standardized Triage Process on Efficiency and Productivity of an Inpatient Palliative Care Team](#) American Journal of Hospice & Palliative Care, June 2020

Studies have shown that palliative care involvement delivers a multitude of benefits to patients and caregivers. The existing palliative care workforce is inadequate to meet growing demand. Innovative strategies to triage inpatient consults are necessary. An efficient and streamlined consult triage process had a positive impact on our palliative care team's ability to reach patients. We were able to generate more physician visits and RVUs despite a decrease in physician clinical time, and our penetration rate per physician clinical FTE improved. Our findings highlight the importance of thoughtful and appropriate

triage, not to mention teamwork, in helping to augment patient access to palliative care.

[Defining 'specialist palliative care': findings from a Delphi study of clinicians](#) Australian Health Review, April 2020

This paper offers, for the first time, an evidence-based definition that distinguishes specialist palliative care from non-specialist palliative care. End of life care and bereavement support are not just the remit of specialist palliative care clinicians. Clinicians from beyond specialist palliative care should lead discussions about futile or burdensome treatment. What are the implications for practitioners? The findings of this study can facilitate implementation of palliative care strategies by enabling practitioners and patients to distinguish who should be delivering what care.

[Comparing Specialty and Primary Palliative Care Interventions: Analysis of a Systematic Review](#) Journal of palliative medicine, March 2020

Investigators have tested interventions delivered by specialty palliative care (SPC) clinicians, or by clinicians without palliative care specialization (primary palliative care, PPC). Compared to PPC, SPC interventions were more comprehensive, were more often delivered in clinical settings, and demonstrated stronger evidence for improving physical symptoms. In the face of SPC workforce limitations, PPC interventions should be tested in more trials with low risk of bias, and may effectively meet some palliative care needs.

[Dissemination and Implementation of Palliative Care in Oncology](#) Journal of Clinical Oncology, March 2020

Palliative care began in academic centers with specialty consultation services, and its value to patients, families, and

health systems has been evident. The demand for palliative care to be integrated throughout the cancer trajectory, combined with a limited palliative care workforce, means that new models of care are needed. This review discusses evidence regarding the need for integration of palliative care into routine oncology care and describes best practices recognized for dissemination of palliative care. The available evidence suggests that palliative care be widely adopted by clinicians in all oncology settings to benefit patients with cancer and their families. Efforts are needed to adapt and integrate palliative care into community practice. Limitations of these models are discussed, as are future directions to continue implementation efforts. The benefits of palliative care can only be realized through effective dissemination of these principles of care, with more primary palliative care delivered by oncology clinicians.

[Availability of home palliative care services and dying at home in conditions needing palliative care: A population-based death certificate study](#)

Avoiding inappropriate care transition and enabling people with chronic diseases to die at home have become important health policy issues. Availability of palliative home care services may be related to dying at home. After controlling for the presence of hospital beds and primary care physicians, we examined the association between availability of home palliative care services and dying at home in conditions requiring such services. Specialised home palliative care services may be suboptimal, and primary care services may serve as a key access point in providing baseline palliative care to people with conditions needing palliative care. Therefore, primary care services should aim to enhance their palliative care workforce.

[A Social Worker-Led Primary Palliative Care Model for Hospitalized Patients Admitted to the Hospital Medicine Service](#)

Palliative Medicine Reports, 2020

Due to the growing number of patients with serious illness and the specialty palliative care workforce shortage, innovative primary palliative care models are essential to meet this population's needs. Patients with serious illness admitted to hospital medicine at a quaternary urban academic medical center in New York City and received an embedded palliative care social worker consultation in 2017. Patients who received a primary palliative care consultation were seen earlier in their illness trajectory, based on their higher functional impairment, and the majority had capacity to participate in goals-of-care discussions, compared with those who were seen by specialty palliative care. The consultation increased goals-of-care documentation and the hospice referral rate was comparable with that of the specialty palliative consultation team.

[A realist evaluation of a "single point of contact" end-of-life care service](#)

Journal of Health Organization and Management, May 2020

Following the development of a service that consisted of a "single point of contact" to coordinate end-of-life care (EoLC), including EoLC facilitators and an urgent response team, we aimed to explore whether the provision of coordinated EoLC would support patients being cared or dying in their preferred place and avoid unwanted hospital admissions.

[Improving palliative and end-of-life care for rural and remote Australians](#)

Public Health Research & Practice, March 2020

Recent reports highlight an inconsistent provision of palliative and end-of-life (palliative) care across Australia, particularly in regional, rural and remote areas. Palliative care improves

quality of life and the experience of dying, and all people should have equitable access to quality needs-based care as they approach and reach the end of their lives. A palliative approach to care is crucial in rural and remote Australia where there is a reliance for such care on generalist providers amid the challenges of a limited workforce, poorer access, and vast geography. This article describes the development and implementation of the Far West NSW Palliative and End-of-Life Model of Care, a systematic solution that could drive improvement in the provision of a quality palliative approach to care and support from any clinician in a timely manner, for patients, their families and carers anywhere.

[Design and implementation of a clinical decision support tool for primary palliative Care for Emergency Medicine \(PRIM-ER\)](#)

BMC Medical Informatics and Decision Making, January 2020

The emergency department is a critical juncture in the trajectory of care of patients with serious, life-limiting illness.

Implementation of a clinical decision support (CDS) tool automates identification of older adults who may benefit from palliative care instead of relying upon providers to identify such patients, thus improving quality of care by assisting providers with adhering to guidelines. The Primary Palliative Care for Emergency Medicine (PRIM-ER) study aims to optimize the use of the electronic health record by creating a CDS tool to identify high risk patients most likely to benefit from primary palliative care and provide point-of-care clinical recommendations. CDS can be an effective tool in the implementation of primary palliative care quality improvement best practices. Health systems should thoughtfully consider tailoring their CDSs in order to adapt to their unique workflows and environments. The findings of this research can assist health systems in effectively integrating a primary palliative care CDS system seamlessly into their processes of care.

[Approaches to community-based palliative care provision by children's hospices in the UK](#) Nursing Children and Young People, September 2019

The number of children in the UK with life-limiting conditions and the demand for home-based palliative care is increasing. Children's hospices remain a dominant provider of palliative care. This study aimed to determine the approaches taken by children's hospices across the UK in meeting the planned and unplanned health needs of children and their families who receive palliative care at home. In addition, the survey aimed to identify the professional composition of community teams and the number of children and families supported by each service. An internet-based questionnaire survey was sent to all children's hospices in the UK, comprising ten questions exploring the size of the team, geographical areas covered, workforce composition, services offered and approaches to managing unplanned, out of hours care. Responses were received from 14 (26%) of the hospices. A total of 1,618 children and their families were being cared for by these hospices, of whom 825 received care at home. Registered nurses constituted the greatest proportion of staff and were employed by all teams. Care provided at home was broadly split into two categories: planned short breaks and responsive palliative nursing. The latter comprised advance care planning, anticipatory prescribing and active symptom control. Out of hours care was usually offered in the form of telephone support. Models of community-based care are evolving to include nurses practising at specialist and advanced levels, allowing more children with increasingly complex conditions to be cared for at home.

**[Rural palliative care to support dying at home can be realised: experiences of family members and nurses with a new model of care](#)* The Australian Journal of Rural Health, August 2019

The aim of this study was to describe the experience of families and nurses with extended rural palliative care to support dying at home. All patients in the project died at home. The families were very positive about the extended palliative care; it increased their familiarity with dying, and had a positive impact on bereavement. The nurses were equally positive, but also commented on the need to debrief and on the heavy emotional toll the work takes. Rural care support for dying at home can be realised. This study has demonstrated the positive impact of an end-of-life service, while at the same time pointing to concerns of the nursing staff on the suitability of the model of care. Health care workers and communities alike need to be educated and have conversations on end-of-life care.

[Alternate method to provide palliative care where there are short caregivers](#) Supportive Care in Cancer, June 2019

Since initiation cancer patients were contacted by mobile phone every two weeks to enquire about their difficulties. In 76% of the situation trained social workers could give necessary advice by phone regarding management of their physical symptoms. Moreover patient's family were really overwhelmed by the emotional support offered by the team over phone. Only 24% of cancer patients has to attend the nodal centre for expert advice from Palliative Care specialists. This novel approach helped: In providing regular physical and emotional support to the patients and their families. In significantly reducing the financial and manpower problems of carrying patients to the nodal units. In improve the quality of life of patients by continuous guidance.

[Identifying Palliative Care Champions to Promote High-Quality Care to Those with Serious Illness](#) Journal of the American Geriatrics Society, May 2019

To address the workforce shortage, stronger alignment is needed between intensity of patient needs and provision of palliative care services. Such an alignment better harnesses the talents of those in a position to deliver core palliative care services (such as discussing goals of care with patients or managing their symptoms) while engaging palliative care specialists to address more complex issues. We introduce the concept of "Palliative Care Champions," who sit at the nexus between specialty palliative care and the larger clinical workforce. Acknowledging that the needs of most patients can be met by clinicians who have received basic palliative care training, and that specialty palliative care is not always available for those with more complex needs, there exists an important opportunity for those with additional interest to scale training and quality improvement to fill this void.

[Palliative connect: Triggered palliative care consultation using an EHR prediction model](#) Journal of Palliative Medicine, April 2019

The Palliative Connect risk stratification model accurately identifies patients with high risk of six-month mortality at admission who would not otherwise have received a palliative care consult and shows great promise as a trigger for consultation to improve important outcomes and quality metrics. An expanded evaluation of Palliative Connect across three hospitals and qualitative assessments of clinicians' attitudes towards triggered consults are ongoing.

[Successes and Challenges in One Organization's Process of Implementing Multiple System-Wide Primary Palliative Care Quality Improvement Projects \(TH310D\)](#) Journal of Pain and Symptom Management, February 2019

While challenging, simultaneously rolling out multiple primary palliative care QI initiatives was made possible through standardization tools such logic model templates as well as the use of common data elements whenever possible.

[Development of a Social Work-Led Primary Palliative Care Model in Hospital Medicine \(FR481C\)](#) Journal of Pain and Symptom Management, February 2019

In 2017, 184 patients received a primary palliative care consultation; those patients seen had an average age of 70 years, 43% were female and the median Karnofsky performance status of 40%, as compared to 20% for those seen by specialty palliative care. Overall, 51% of the patients seen met palliative care solid tumor oncology trigger criteria, 20% were triaged from the specialty palliative care team and 15% were direct referrals from hospitalists. Of those evaluated, 5% had documented goals of care in the electronic medical record before the consultation and 92% after the consultation. The hospice referral rate was 25% and the specialty palliative care referral rate was 25%. Reasons for referral to specialty palliative care were transfer to the palliative care unit (51%) and complex symptom management (49%). Of those who received the consultation, 30-day readmission rate was 5.3%, as compared to those who did not (16%).

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

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

A 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. Seven 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.

[To be a trained and supported volunteer in palliative care - a phenomenological study](#) BMC Palliative Care, March 2017

It 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. Being 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. The 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

Clinical 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. A 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. In 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. Clinicians can confidently refer to volunteer services at the end of life. Future research should focus on 'dose' to maximise likely impact.

[*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-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

[Expanding the Interdisciplinary Palliative Medicine Workforce: A Longitudinal Education and Mentoring Program for Practicing Clinicians](#) Journal of Pain and Symptom Management, September 2020

The disparity between gaps in workforce and availability of palliative care (PC) services is an increasing issue in health care. To meet the demand, team-based PC requires additional educational training for all clinicians caring for persons with serious illness. Teaching PC and program development knowledge and skills to an interdisciplinary regional cohort of practicing clinicians yielded improvements in clinical skills, implementation of practice change projects, and a sense of belonging to a supportive professional network.

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

We aim to address palliative care workforce shortages by teaching clinicians how to provide primary palliative care through peer coaching. We offered peer coaching to internal medicine residents and hospitalists (attendings, nurse practitioners, and physician assistants). An 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. Residents 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.

Peer 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

The rapid increase in demand for palliative care (PC) services has led to concerns regarding workforce shortages and threats to the resiliency of PC teams. To describe the development, implementation, and evaluation of a regional interdisciplinary training program in PC. Thirty 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. Enduring, 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. This 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

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

Being 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. Purposive 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. Participants 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. Awareness 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

. 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

[Improving palliative care access through technology \(ImPAcTT\) in nursing homes: Preliminary pilot study findings](#) Journal of the American Geriatrics Society, April 2020

Preliminary findings suggest this upstream PC telehealth intervention that provides early identification, outreach, education and support to NH residents, families, and staff is acceptable, feasible and may reduce symptom burden, improve quality of life and facilitate goals of care discussion.

[Video visit implementation from the perspective of home-based palliative care clinicians-survey results](#) Journal of the American Geriatrics Society, April 2020

Frontline clinicians' perspectives on the use of telehealth are of critical importance to practice, research, and policy. Our survey findings provide insights into clinician perspectives; however, further research and development is needed to understand the value of video visits among clinicians and to optimize the use of video visits in HBPC.

[Use of video visits in home-based palliative care, qualitative perceptions from clinicians](#) Journal of the American Geriatrics Society, April 2020; vol. 68

Overall, participants suggested that video visits are most appropriate for follow-up visits in HBPC. Thematic analysis yielded six themes. (1) Clinicians find video visits useful in the right situations, but the overall reception to video visits was neutral. (2) Clinicians' perceptions of video visits can change over time with greater use in both positive and negative directions. (3) Physicians may experience enhanced productivity and efficiency with video visits. (4) Nurses may experience challenges to productivity and efficiency with video

visits, primarily due to the increased time that nurses spend to facilitate the video visit connection between the patients/family and physician. (5) Clinicians reported that patients and caregivers appreciate video visits; however, they may still prefer in-person visits. (6) Scheduling and coordination of the video visits between the nurse and physician presents persistent challenges. Conclusion Further study and improvements in video visit technology and implementation within HBPC may enhance the benefits and experience of frontline clinicians.

[Breaking Access and Distance Barriers: Using Innovative Modalities of Tele-Palliative Care \(TH364\)](#) Journal of Pain and Symptom Management, February 2020

A growing workforce shortage in palliative care professionals as well as access issues in remote areas are significant barriers to patient-centered, serious illness care. Efforts to bring palliative care interprofessional expertise to patients in the community have proven successful in increasing early goals-of-care discussions, improving complex symptoms, and even delivering specialty palliative care to patients living with chronic conditions in rural areas. An innovative way of providing palliative care access and expertise is tele-palliative care. Tele-palliative care provides substantial benefits to patients who live in remote areas with limited access to care, patients with high appointment burden, homebound patients, or patients who would prefer to receive care and continuous monitoring at home. The insertion of technology into palliative care requires awareness and intentional inclusion of four areas of evaluation that would otherwise be automatic in an in-person visit. This session will discuss several established clinical models of tele-palliative care, including tele-hospice, provision of complex symptom management, and tele-palliative care geared to specialty care patients receiving maintenance hemodialysis. Through case-based studies, presenters will emphasize a

stepwise approach on how to operationalize tele-palliative services. Small group sessions will focus on the different modalities of tele-palliative care and a discussion panel will address barriers, payment systems, equipment and technology needs, stakeholders' roles, and interprofessional team approaches.

**[Using mobile digital technology for enhanced community palliative support services \(Encompass\)](#) International Journal of Clinical Practice, April 2019*

This talk will introduce mobile technology that is being used to transform palliative and end of life care in the UK; to provide more efficient services, improve patient experiences and address workforce shortages. The technology is a platform that had been previously used to support whole shifts at people's homes in Canadian paediatric care (EShift) and has been adapted to support community nurses and Care Assistants providing hospice-based care and making several visits in one day. The technology allows a completely new model of care, in which junior nurses and health care assistants are remotely supported to perform delegated tasks, whilst being in constant communication with senior medical staff at the hospice. We will discuss the benefits that have been realised through deployment of the technology, including the effects on acute hospital use, service delivery and workforce training and development.

[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

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.

COVID-19

[Prohibit, Protect, or Adapt? The Changing Role of Volunteers in Palliative and Hospice Care Services During the COVID-19 Pandemic. A Multinational Survey \(Covpall\)](#) International journal of health policy and management, September 2021

Volunteers are common within palliative care services, and provide support that enhances care quality. The support they provided, and any role changes, during the coronavirus disease 2019 (COVID-19) pandemic are unknown. The aim of this study is to understand volunteer deployment and activities within palliative care services, and to identify what may affect any changes in volunteer service provision, during the COVID-19

pandemic. Volunteers were mostly prevented from supporting many forms of palliative care which may have quality and safety implications given their previously central roles. Volunteer re-deployment plans are needed that take a more considered approach, using volunteers more flexibly to enhance care while ensuring safe working practices. Consideration needs to be given to widening the volunteer base away from those who may be considered to be most vulnerable to COVID-19.

[Palliative Care Consultation in Hospitalized Patients With COVID-19: A Retrospective Study of Characteristics, Outcomes, and Unmet Needs](#) Journal of Pain and Symptom Management, August 2021

Few studies have described the characteristics and palliative care needs in hospitalized patients with coronavirus disease 2019 (COVID-19). Describing characteristics, consultation demands, patients' needs, and outcomes of hospitalized patients with COVID-19 who received a palliative care evaluation. During this pandemic, understanding inpatient specialized palliative care needs and the vulnerable populations driving these causes may encourage health-care agencies and local, state, and federal governments to support the dedicated palliative care workforce.

[*End-of-life care in a pandemic: a primary healthcare perspective](#) Journal of Prescribing Practice, April 2021

This article will explore end-of-life care in the COVID-19 pandemic in north east Essex from the perspective of general practice. This article shows the new approaches that have been adopted to support people in the community at the end of life. These new ways of working demonstrated the resilience of healthcare professionals working together with the use of video to ensure that patients received the optimum care and treatment in their home at the end of their lives. It demonstrated

that community teams such as district nurses, hospice staff, GPs and the lead nurse for end of life care could implement new ways of working to ensure joined up care and treatment. It also shows new models of working in the future.

[The impact of COVID-19 on palliative care workers across the world: A qualitative analysis of responses to open-ended questions](#) Palliative & Supportive Care, April 2021

The pandemic has had a huge impact on palliative care workers including their ability to work and their financial status. It has generated increased workloads and placed them in vulnerable positions that affect their emotional well-being, resulting in distress and burnout. Counseling and support networks provide important resilience-building buffers. Coping strategies such as team and family support are important factors in workers' capacity to adapt and respond. The pandemic is changing the concept and praxis of palliative care. Government officials, academia, providers, and affected populations need to work together to develop, and implement steps to ensure palliative care integration into response preparedness plans so as not to leave anyone behind, including health workers.

[*The Creation of a Psychiatry-Palliative Care Liaison Team: Using Psychiatrists to Extend Palliative Care Delivery and Access During the COVID-19 Crisis](#) Journal of Pain and Symptom Management, September 2020

By training and supervising psychiatrists and advanced psychiatry trainees in specific palliative care roles, palliative care teams could more effectively meet markedly increased service needs of varying complexity during the COVID-19 crisis. As new geographic regions experience possible COVID-19 surges in the coming months, this may serve as a model for rapidly increasing palliative care workforce.

[Expanding the Palliative Care Workforce during the COVID-19 Pandemic: An Evaluation of Core Palliative Care Skills in Health Social Workers](#) Journal of Palliative Medicine, November 2021

Meeting the needs of seriously ill SARS-CoV-2 (COVID-19) patients requires novel models of deploying health social workers (SWs) to expand the palliative care workforce. To inform such expansion, understanding the current state of health SWs' core palliative care skills is necessary. Methods: Following minimal training, health SWs in one New York City hospital were surveyed about their frequency, competence, and confidence in using core palliative care skills. Results: Of the 170 health SWs surveyed, 46 (27%) responded, of whom 21 (46%) and 24 (52%) had palliative care training before and during the COVID-19 surge, respectively. Health SWs reported a "moderate improvement" in the use of three skills: "identify a medical decision maker," "assess prognostic understanding," and "coordinate care." There was "minimal decrease" to "no improvement" to "minimal improvement" in competence and confidence of skill use. Conclusion: Our findings suggest that educational initiatives can improve health SWs' use of core palliative care skills.

[The impact of COVID-19 on the hospice and palliative care workforce](#) Public Health Nursing, May 2021

Our findings suggest that the COVID-19 pandemic has strained the palliative and hospice care workforce as it provides increased services at an unprecedented rate to patients and families. The implications of these findings are important for public health nurses who are skilled in disaster management and quickly responding to emergencies. The expertise of public health nurses can be leveraged to support palliative care agencies as they strive to manage the pandemic in the communities they serve.

[The role and response of primary healthcare services in the delivery of palliative care in epidemics and pandemics: A rapid review to inform practice and service delivery during the COVID-19 pandemic](#) Palliative Medicine, October 2020

As the COVID-19 pandemic progresses, there is an urgent need for research to provide increased understanding of the role of primary care and community nursing services in palliative care, alongside hospices and community specialist palliative care providers.

[*Management of COVID-19 pandemic in the intensive care under scarce of resources with palliative care approach](#) Systematic Reviews in Pharmacy, August 2020

Coronavirus has been shaking the world since 31 December 2019, with its world-wide pandemic impact since 11 March 2020. Although its impact on mortality rate against the total incidents is relatively small, the fatality rate against critical care admission due to the event of ARDS remains relatively high. The 2019 Coronavirus Disease (COVID-19) has a serious consequence in the Intensive Care Unit care, which leads to a high demand for more ICU staffs, isolation rooms, equipment (mainly ventilators). These limitations along with the recently unavailable definitive treatment require an adapted ICU care system for the provided services. ICU care should therefore more aimed at improving the quality of life (patients, families, and staff). This can be done by providing symptomatic therapy, advance care planning, and end of life / dying care in an unusual circumstances (isolation). All of these services may refer to the application of palliative care principles, which have not been extensively applied in the critical care. This review is aimed to offer application of palliative care in intensive care in during pandemic with scarce of resources.

[Recommendations to Leverage the Palliative Nursing Role During COVID-19 and Future Public Health Crises](#) Journal of Hospice and Palliative Nursing, August 2020

Throughout the evolving COVID-19 pandemic, palliative nurses will increasingly exercise their expertise in symptom management, ethics, communication, and end-of-life care, among other crucial skills. The literature addressing the palliative care response to COVID-19 has surged, and yet, there is a critical gap regarding the unique contributions of palliative nurses and their essential role in mitigating the sequelae of this crisis. Thus, the primary aim herein is to provide recommendations for palliative nurses and other health care stakeholders to ensure their optimal value is realized and to promote their well-being and resilience during COVID-19 and, by extension, in anticipation of future public health crises.

[Response and role of palliative care during the COVID-19 pandemic: A national telephone survey of hospices in Italy](#) Palliative Medicine, July 2020

The hospice sector is capable of responding flexibly and rapidly to the COVID-19 pandemic. Governments must urgently recognise the essential contribution of hospice and palliative care to the COVID-19 pandemic and ensure these services are integrated into the health care system response. Availability of personal protective equipment and setting-specific guidance is essential. Hospices may also need to be proactive in connecting with the acute pandemic response.

[Characteristics, Symptom Management, and Outcomes of 101 Patients With COVID-19 Referred for Hospital Palliative Care](#) Journal of Pain and Symptom Management, July 2020

Hospital palliative care is an essential part of the COVID-19 response but data are lacking. We identified symptom burden,

management, response to treatment, and outcomes for a case series of 101 inpatients with confirmed COVID-19 referred to hospital palliative care. Palliative care is an essential component to the COVID-19 response, and teams must rapidly adapt with new ways of working. Breathlessness and agitation are common but respond well to opioids and benzodiazepines. Availability of subcutaneous infusion pumps is essential. An international minimum data set for palliative care would accelerate finding answers to new questions as the COVID-19 pandemic develops.

[*The state of palliative care during COVID-19](#) Middle East Journal of Anesthesiology, June 2020

Delivering palliative care to COVID-19 infected patients is an integral part of any comprehensive care in mass casualty events. It addresses patients' suffering by providing comfort medicine helping isolated patients connect with their family members, and paving the way for advanced care planning. Nevertheless, patients, families, health care system, and health professionals face a vast array of social, psychological, physical, economic, and existential challenges. The palliative care workforce is working at full capacity to respond to the increased demand and to secure the needed resources to attend to the psychosocial and medical needs of infected COVID-19 patients. This manuscript will summarize the challenges faced by patients, families, healthcare professionals during this pandemic and the action plan developed in response to it.

Competency Frameworks

[*A Conceptual Framework of Palliative Care across the Continuum of Advanced Kidney Disease*](#) Clinical Journal of the American Society of Nephrology, April 2019

Currently, access to kidney palliative care is lacking, whether delivered by trained kidney care professionals or by palliative care clinicians. These barriers include a gap in training and workforce, policies limiting access to hospice and outpatient palliative care services for patients with ESKD, resistance to integrating palliative care within the nephrology community, and the misconception that palliative care is synonymous with end-of-life care. As such, addressing kidney palliative care needs on a population level will require not only access to specialized kidney palliative care initiatives, but also equipping kidney care professionals with the skills to address basic kidney palliative care needs. This article will address the role of kidney palliative care for patients with advanced kidney disease, describe models of care including primary and specialty kidney palliative care, and outline strategies to improve kidney palliative care on a provider and system level.

[*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.

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