



*Helping Operationalize Palliative Expertise*

# **Local Planner's Guide: *Learning Essential Approaches to Palliative and End-of-Life Care (LEAP) Workshop***

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## Table of Contents

Acknowledgements.....	3
Introduction.....	4
Background.....	4
Workshop Benefits.....	5
Facilitators.....	5
Resources.....	6
Evaluation.....	6
Main ProC Credits.....	7
Venue.....	7
Workshop Costs.....	7
Organization of Workshop.....	7
References.....	8
Appendices.....	9
Appendix A - LEAP Facilitators.....	10
Appendix B – Evaluation Forms.....	14
Appendix B-1.1 – Pre-Course Survey.....	15
Appendix B-3.1 – Pre/Post Knowledge Quiz.....	22
Appendix B-4 – Pre/Post-Knowledge Quiz Answers.....	28
Appendix D – Organization of Workshop.....	29
Appendix D-1 - Timeline for Organizing Workshop.....	30
Appendix D–2 – Local Planner’s Checklist.....	31
Appendix D-3 - Delivery Support Kit.....	32
Appendix D-4 - Instructional Supply List.....	33
Appendix D-5 - Advertising Poster Template.....	34
Appendix D-6 - Course Registration Form.....	35
Appendix D-7 - Agenda Template.....	36

## Acknowledgements

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## Introduction

This guide is intended to help individuals from health care delivery organizations plan and implement a successful LEAP Course. Background information about the development and a description of LEAP courseware and a LEAP workshop is provided. Information that pertains to the organization of a workshop including benefits and costs of a LEAP workshop is also discussed.

## Background

LEAP was developed by the Pallium Project. It was designed specifically for Family Physicians, Registered Nurses and Pharmacists. In the past few years, Licensed Practical Nurses have participated in these workshops. The focus of the course is to provide the tools and education locally that are helpful to build better skills and local capacity for delivery of hospice palliative care that alleviates undue pain and suffering, and that promotes comfort, dignity and peace-of-mind<sup>1</sup>.

There are 11 modules that focus on improved management of advanced, end-stage illness in the community by interprofessional teams. Topics include: GI problems, pain, respiratory, depression, and sedation. LEAP is usually presented by physician and nurse facilitators over one evening and a day or two days. LEAP can also be presented via telehealth and each module can be presented at separate times over a period of several months.

Delivery methods include: theory bursts, case studies, group discussions and supporting DVDs. These delivery methods provide an opportunity for small groups (up to 25) of local physicians, registered nurses, licensed practical nurses and pharmacists to learn collaboratively, by reflecting on their own practice in providing care and palliative care services with the seriously-ill and dying<sup>1</sup>. An in-depth case study approach, instructional media and skilled facilitators promote in-depth discussion and reflection on current and desired practice<sup>1</sup>.

Two facilitators, usually a physician and a registered nurse deliver a LEAP workshop. Facilitators can access the Facilitator Kit from their Health Services Zone. This kit includes: 11 print based modules and a Microsoft PowerPoint slideshow CD of the same material, a pre and post knowledge test with a test exam key, *A Clinical Communication in Hospice Palliative Care* CD and a participant workbook.

## Workshop Benefits

LEAP workshops have been designed to meet several needs of particular importance to rural and remote health service delivery organizations<sup>1</sup>. These include:

- ✓ Addressing a growing need to promote awareness of Hospice Palliative Care (HPC) services, including end-of-life and bereavement support, as an achievable service delivery goal for all Canadian health service delivery organizations<sup>1</sup>.
- ✓ Addressing the need to promote an awareness of common pain and symptom management practices as an achievable team-based solution in *resource constrained* primary-care service delivery environments<sup>1</sup>.
- ✓ Introducing an approach to serving the seriously-ill and dying in ways that address the ethical and practical dimensions of care in primary care (especially rural) environments<sup>1</sup>.
- ✓ Creating accessible opportunities for continuing professional development explicitly linked to improving care provision across settings of care (e.g., home, hospital, long-term/continuing care, hospice and settings of marginalization)<sup>1</sup>.
- ✓ Creating opportunities for local professionals from the disciplines of medicine, pharmacy and nursing to come together and learn about the clinical aspects of hospice palliative care in ways that highlight the interconnectedness of each others' contributions to service delivery<sup>1</sup>.
- ✓ Creating opportunities to engage local citizens in raising awareness about quality hospice palliative care, and illustrating the leadership local health regions are taking to address the need to provide care at the local level<sup>1</sup>.

## Facilitators

Facilitators provide assistance as course directors and facilitators for outreach education and professional development... Facilitators also serve as resources within their own Health Services Zone, applying skills in coaching and facilitation... to help advance local hospice palliative care capacity-building<sup>2</sup>.

As part of their professional practice, facilitators are expected to be actively engaged in hospice palliative care locally within their health zone.... Facilitators are expected to keep up-to-date with new advances in hospice palliative care that improve the quality and appropriateness of care that they and colleagues can provide<sup>2</sup>.

The following disciplines are eligible to be trained as a LEAP Facilitator:

**Physicians** - currently involved in the practice of hospice palliative care, whether in an academic or clinical position in a facility or community setting, are eligible to be a facilitator.

**Registered Nurses** - must be able to demonstrate a current clinical management and patient care/coordination practice in hospice palliative care<sup>2</sup>. Certification in hospice palliative care as a specialty through the Canadian Nurses Association is suggested.

**Guest speakers** - Colleagues from a variety of disciplines (e.g., social work, spiritual care, pharmacists, etc.) can be invited as guest resources. This is helpful in balancing the strong medical management orientation within LEAP with the range of physical, psychosocial, social, spiritual and practical issues practitioners encounter in working with patients and families in end-stage care scenarios<sup>3</sup>.

See Appendix A, LEAP Facilitators for a list of individuals trained as facilitators in Alberta.

## Resources

The Pallium Project has provided access to LEAP resources that can be downloaded at the following website, <http://www.pallium.ca/leap.html>. These resources include:

- V1.1 Facilitator Kit Upgrade
- LEAP (V1.1) Participant Workbook
- PDF versions of the LEAP modules
- LEAP Courseware Goals and Objectives

## Evaluation

Participants are asked to complete four evaluation forms (Pre-course Survey, Post Course Evaluation, Pre and Post Knowledge Quiz) that are part of the LEAP package; see Appendix B Evaluation Forms to review the different surveys. The Pre-course Survey and Pre Knowledge Quiz can be sent to workshop participants prior to the workshop with the following message: “The results of the Pre-Course Survey and Knowledge Quiz will help the facilitators tailor the course to better meet participants' learning needs. Participants are NOT expected to know all the answers on the Knowledge Quiz. If they did, they would not need to take the course!”

Compiling and analyzing the data from the surveys is the responsibility of the organization or facility hosting the workshop. Excel databases that were developed to assist the host compile and analyze data from the participant evaluation forms are available on the provincial palliative web site. The information from these surveys is useful in evaluating organization and delivery of the workshop, palliative care knowledge and comfort level of the participants in providing palliative care.

## **Main ProC Credits**

Physicians, who complete the workshop, can receive 2 Main ProC credits at the College of Physicians and Surgeons Canada website by reflecting on what they have learned and what changes have occurred in their practice due to this learning.

## **Venue**

It is important to book a room big enough for about 25 participants with two break out rooms for small group discipline specific discussions. The workshop can be held over 2 consecutive days or a Friday evening and all day Saturday.

## **Workshop Costs**

There is often no registration cost for participants to attend the LEAP workshops but a fee can be charged to pay hospitality or photocopying costs. It may be possible to obtain funding to support the costs of hosting a workshop from local organizations, palliative care councils etc The cost of hosting a workshop includes the following expenses:

- Facilitators (e.g. travel, accommodations, stipend). These costs depend on whether the facilitator is local.
- Hospitality (e.g. refreshments, meals). This could be the responsibility of the participant.
- Room rentals this may not be necessary if held in facility rooms.
- Photocopying (e.g. participant manual, agenda, evaluation forms, completion certificate)
- Binders for participants workbook (The pdf of the workbook can be sent to the participants for them to download, print, put in binder if desired and bring to the workshop)
- Resources e.g. 99 Common Questions (and more) About Hospice Palliative Care: A nurse's handbook, 3<sup>rd</sup> edition, The Pallium Palliative Pocketbook and A Caregiver's Guide: A handbook about end-of-life care may be given to participants. These resources can be purchased through the Canadian Hospice Palliative Care Association web site <http://www.chpca.net/home.html> at the Marketplace.

## **Organization of Workshop**

Organization of a LEAP workshop should start 2-3 months prior to the workshop date, a table outlining the activities and timeline associated with planning a workshop can be found in Appendix D, Organization of Workshop. A Local Planner's Checklist, Delivery Support Kit, Instructional Supply List and templates of an Advertising Poster, Registration Form and Agenda can also be found in Appendix D.

## References

1. Pallium Project. (2004). Local planning guide: Learning Essential Approaches to Palliative and End-of-Life Care (LEAP). The Pallium Project – Phase II.
2. Aherne, M. (2004). *Palliative Care Facilitator Network (PCFN) - Questions and Answers*. The Pallium Project – Phase II.
3. Aherne, M. (2006, August). Learning essential approaches to palliative and end-of-life (LEAP), version 1.1 – update information. The Pallium Project – Phase II.

## Appendices

## Appendix A - LEAP Facilitators

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LEAP Facilitator	Contact Information
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LEAP Facilitator	Contact Information
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## Appendix B – Evaluation Forms

Appendix B-1.1 – Pre-Course Survey

**Learning Essential Approaches to Palliative and End-of-Life Care (LEAP)  
Pre-course Survey**

Name (ID Number): \_\_\_\_\_

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

Course Location: \_\_\_\_\_

1. I am a:

- a. Physician
- b. Registered Nurse
- c. Pharmacist
- d. other : (please specify) \_\_\_\_\_

2. The percentage of my overall caseload that is made up of palliative patients is approximately:

- a. Less than 5%
- b. 5% -19%
- c. 20-39%
- d. 40-59%
- e. 60-79%
- f. 80-100%
- g. NOT APPLICABLE – I am involved in palliative care but do not carry a case load

3. I have been in practice for:

- a. Less than 1 year
- b. 1-5 years
- c. >5 years but ≤10 years
- d. > 10 years ≤ 20 years
- e. > 20 years

4. I have attended other education in palliative care in the last 3 years:

- a. Yes
- b. No
- c. Uncertain

**If yes, please describe the type of program you participated in**

5. My main reason for taking the course at this time is:

6. The course is designed to allow disciplines to learn within their own disciplines and also to experience collaborative interdisciplinary learning when the opportunities present themselves. Please indicate your response to the following question:

**I have concerns about learning with colleagues from other disciplines?**

- a. Yes **If yes, please describe your concerns**
- b. No
- c. Uncertain

**7. My current comfort level in dealing with each of the following problems and issues related to palliative care is (please circle the number that best applies to you):**

	Not at all comfortable	Not comfortable	Neutral	Comfortable	Very comfortable
a. Determining when a patient is palliative or not	1	2	3	4	5
b. Addressing patient concerns about weight and appetite loss	1	2	3	4	5
c. The role of radiation therapy in palliative care	1	2	3	4	5
d. The World Health Organization Analgesic Ladder	1	2	3	4	5
e. Selecting between different opioids	1	2	3	4	5
f. Managing cancer pain in general	1	2	3	4	5
g. Managing a patient in a pain crisis.	1	2	3	4	5
h. Managing opioid neurotoxicity	1	2	3	4	5
i. Breaking bad news	1	2	3	4	5
j. Discussing code status (DNR)	1	2	3	4	5
k. Talking to dying patients about dying.	1	2	3	4	5
l. Responding to patients'/families' requests for alternative treatments	1	2	3	4	5
m. Instilling hope in the palliative setting.	1	2	3	4	5
n. Caring for bereaved family and friends	1	2	3	4	5
o. Managing chronic nausea	1	2	3	4	5
p. Managing delirium in the palliative setting	1	2	3	4	5
q. Managing shortness of breath	1	2	3	4	5
r. Diagnosing depression in terminally ill patients	1	2	3	4	5
s. Palliative Sedation	1	2	3	4	5

Appendix B-2 – Post-Course Survey

**Learning Essential Approaches to Palliative and End-of-Life Care (LEAP)**

**Post Course Evaluation**

Name (ID Number): \_\_\_\_\_

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

Course Location: \_\_\_\_\_

1. I am a:

- a. Physician
- b. Registered Nurse
- c. Pharmacist
- d. other : (please specify) \_\_\_\_\_

2. Overall, I rate this course as?

- a. Excellent
- b. Very good
- c. Good
- d. Fair
- e. Poor

3. Overall, this course:

- a. Exceeded my expectations
- b. Met my expectations
- c. Did not meet my expectations

4. The extent to which I agree with the following statements is:

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
a. The course met my learning needs	1	2	3	4	5
b. The course objectives were clear	1	2	3	4	5
c. The course objectives were met	1	2	3	4	5
d. The content was relevant to my rural practice	1	2	3	4	5
e. The small group sessions are effective for learning	1	2	3	4	5
f. Sufficient time was allocated for discussions	1	2	3	4	5
g. The sessions were facilitated well	1	2	3	4	5
h. There was enough time allocated to breaks	1	2	3	4	5
i. The course ran smoothly	1	2	3	4	5

5. The following present barriers for me to attend continuing education courses (check all that apply)

- Busy work schedule
- Family responsibilities
- Lack of practice coverage when I am away
- Lack of funding for travel/accommodation to attend education outside my region
- Other \_\_\_\_\_

6. This course has allowed me to overcome the barriers I indicated above

- a. Yes
- b. No
- c. Not sure

If no, then please explain how it has or has not overcome the barriers

8. The effectiveness of each of the individual modules measured with respect to how much I learned from them was

Session	Not all effective	Not effective	Neutral	Effective	Very Effective
1. Creating Context	1	2	3	4	5
2. GI Problems	1	2	3	4	5
3. Pain Management	1	2	3	4	5
4. Respiratory Problems	1	2	3	4	5
5. Communication	1	2	3	4	5
6. Depression, Anxiety and Suffering	1	2	3	4	5
7. Grief and Bereavement	1	2	3	4	5
8. Delirium	1	2	3	4	5
9. Palliative Sedation	1	2	3	4	5
10. Last Days and Hours	1	2	3	4	5
11. Working as a Team	1	2	3	4	5

9. The extent to which I wish to see future retreats incorporate or exclude the following features/formats of this course:

	Remain as is	Include more	Include less	Leave out altogether
a. Large group discussions	1	2	3	4
b. Small group discussions	1	2	3	4
c. Case studies	1	2	3	4
d. Instructional video segments	1	2	3	4

10. I have concerns about learning with colleagues from other disciplines?

- a. Yes
- b. No
- c. Uncertain

If yes, please describe concerns

11. Now that I have completed the course, my comfort level in dealing with each of the following problems and issues related to palliative care is (please circle the number that applies)

	Not at all comfortable	Not comfortable	Neutral	Comfortable	Very comfortable
a. Determining when a patient is palliative or not	1	2	3	4	5
b. Addressing patient concerns about weight and appetite loss	1	2	3	4	5
c. The role of radiation therapy in palliative care	1	2	3	4	5
d. The World Health Organization Analgesic Ladder	1	2	3	4	5
e. Selecting between different opioids	1	2	3	4	5
f. Managing cancer pain in general	1	2	3	4	5
g. Managing a patient in a pain crisis.	1	2	3	4	5
h. Managing opioid neurotoxicity	1	2	3	4	5
i. Breaking bad news	1	2	3	4	5
j. Discussing code status (DNR)	1	2	3	4	5
k. Talking to dying patients about dying.	1	2	3	4	5
l. Responding to patients'/families' requests for alternative treatments	1	2	3	4	5
m. Instilling hope in the palliative setting.	1	2	3	4	5
n. Caring for bereaved family and friends	1	2	3	4	5
o. Managing chronic nausea	1	2	3	4	5
p. Managing delirium in the palliative setting	1	2	3	4	5
q. Managing shortness of breath	1	2	3	4	5
r. Diagnosing depression in terminally ill patients	1	2	3	4	5
s. Palliative Sedation	1	2	3	4	5

12. Since completing this course, my comfort levels have changed in the following ways:

	Much less comfortable	Less comfortable	No change in comfort level	More Comfortable	Much more comfortable
a. Determining when a patient is palliative or not	1	2	3	4	5
b. Addressing patient concerns about weight and appetite loss	1	2	3	4	5
c. The role of radiation therapy in palliative care	1	2	3	4	5
d. The World Health Organization Analgesic Ladder	1	2	3	4	5
e. Selecting between different opioids	1	2	3	4	5
f. Managing cancer pain in general	1	2	3	4	5
g. Managing a patient in a pain crisis.	1	2	3	4	5
h. Managing opioid neurotoxicity	1	2	3	4	5
i. Breaking bad news	1	2	3	4	5
j. Discussing code status (DNR)	1	2	3	4	5
k. Talking to dying patients about dying.	1	2	3	4	5
l. Responding to patients'/families' requests for alternative treatments	1	2	3	4	5
m. Instilling hope in the palliative setting.	1	2	3	4	5
n. Caring for bereaved family and friends	1	2	3	4	5
o. Managing chronic nausea	1	2	3	4	5
p. Managing delirium in the palliative setting	1	2	3	4	5
q. Managing shortness of breath	1	2	3	4	5
r. Diagnosing depression in terminally ill patients	1	2	3	4	5
s. Palliative Sedation	1	2	3	4	5

13. What did I like most about this course?

14. What did I like least about this course?

15. My suggestions for improving this course are?

16. I feel the following topics/issues were not covered in the course but should be included in future courses?

17. Would I recommend this course to my colleagues?

- a) Yes
- b) No
- c) Uncertain

Appendix B-3.1 – Pre/Post Knowledge Quiz

**Learning Essential Approaches to Palliative and End of Life Care (LEAP)  
Knowledge Quiz**

Please **circle** the letter of that response that you feel is the **correct answer** to each of the following questions. Select only one response for each question.

Pre Test \_\_\_\_\_ Post Test \_\_\_\_\_

Name (ID Number): \_\_\_\_\_

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

Course Location: \_\_\_\_\_

**Discipline:**

- a. Physician
- b. Nurse
- c. Pharmacist
- d. Other

**1. Which one of the following opioids is not recommended for chronic pain management in advanced cancer patients?**

- a. Meperidine
- b. Codeine
- c. Methadone
- d. Oxycodone
- e. Fentanyl

**2. A patient who has been diagnosed with pancreatic cancer metastatic to the liver asks you: “How much time do you think I have?” With respect to his life expectancy, which one of the following would be the most appropriate response?**

- a. “I am not sure. It is difficult to predict. On average patients with this condition live for about 6 months”
- b. “I am not sure. It is difficult to predict. Only God can determine how long someone has to live.”
- c. “I am not sure. It is difficult to predict. But I believe your time is unfortunately short, probably several weeks to a few months”.
- d. “I really cannot tell how much time you have left, but miracles do happen and you could live much longer than expected”.
- e. “We are very inaccurate at predicting how long people with illnesses such as yours have to live, but it must be an important question for you so I would say 3 months.”

**3. A 72-year-old woman with diffuse metastatic bone disease from breast cancer (lung, liver and spinal metastases) presents with a sudden escalation of pain in her mid back. The pain radiates to her flanks. She complains of some weakness and numbness in her legs and some difficulties with controlling her bladder. In addition to a comprehensive history and examination and adjustments in her analgesic regimen, which one of the following is the ideal initial management plan?**

- a. Urgently order an augmented CT scan of the brain to exclude brain metastases.
- b. Urgently order an augmented CT scan of the brain to exclude brain metastases and start dexamethasone treatment.
- c. Urgently order an MRI of the spine and start dexamethasone treatment.
- d. Urgently order a plain X-ray of the spine and start dexamethasone treatment.
- e. Admit the patient to hospital, start dexamethasone and monitor her neurological status closely (twice a day).

**4. A 38-year-old man with metastatic renal cell cancer is found to have a severe major depression. He has a very flat affect and admits to pervasive feelings of hopelessness, guilt and worthlessness. He denies feeling suicidal. His life expectancy is estimated to be in the order of a few weeks to perhaps many weeks.**

**Which of the following would be the most appropriate management of his depression?**

- a. A tricyclic antidepressant such as amitriptyline
- b. A stimulating selective serotonin reuptake inhibitor (SSRI): e.g. sertraline
- c. A newer norepinephrine serotonin reuptake inhibitor NSRI. e.g. venlafaxine
- d. A psychostimulant; e.g. methylphenidate
- e. Supportive counselling only- no medications needed.

**5. A 44-year-old woman with advanced gastric cancer is being cared for at home. She develops an agitated delirium and starts to vomit. Her wish is to die at home. On examination she is dehydrated and has generalized myoclonus. She is on hydromorphone 6mg orally every 4 hrs and 4mg every hour as needed (prn).**

**With respect to artificial hydration (intravenous or subcutaneous fluids), which of the following statements best describes the role of artificial hydration in this patient?**

- a. Artificial hydration is futile treatment and should therefore not be offered.
- b. Artificial hydration constitutes a basic standard of care and should be offered
- c. Artificial hydration may improve this patient's delirium and opioid toxicity and should be offered.
- d. Artificial hydration may improve this patient's delirium but, because adequate volumes cannot be given subcutaneously, hydrating her at home will not be possible.
- e. The adverse effects of artificial hydration (including increased airway secretions and edema) far outweigh the potential benefits in this patient and should therefore not be offered in this patient.

**6. In a patient who no longer has the capacity to make decisions about his or her health care and finances, which one of the following best describes “guardianship”?**

- a. Guardianship relates to finances. Prior to becoming incapacitated he/she had formally identified someone to make those decisions on his or her behalf.
- b. Guardianship relates to health care. Prior to becoming incapacitated he/she had formally identified someone to make those decisions on his or her behalf.
- c. Guardianship relates to finances. Prior to becoming incapacitated he/she had not formally identified someone to make those decisions on his or her behalf. The court has therefore appointed someone to make those decisions.
- d. Guardianship relates health care. Prior to becoming incapacitated he/she had not formally identified someone to make those decisions on his or her behalf. The court has therefore appointed someone to make those decisions.
- e. Guardianship relates to health care as well as finances. Prior to becoming incapacitated he/she had formally identified someone to make those decisions on his or her behalf.

**7. A 45-year-old, 60-kg cancer patient with severe pain related to metastatic bone disease is in need of a strong opioid. You decide to initiate him on a morphine regimen. He has not previously been on a strong opioid. What starting dose would you use?**

- a. Morphine (long acting formulation) 30mg orally twice a day and morphine (short-acting formulation) 5mg orally every hour as needed (prn) for breakthrough pain.
- b. Morphine (short-acting) 5-20mg orally every 4 hours and morphine 5mg orally every hour as needed (prn) for breakthrough pain.
- c. Morphine (short-acting) 5mg orally every 4 hours and 5mg orally every hour as needed (prn) for breakthrough pain
- d. Morphine (short-acting) 5mg orally every hour as needed (prn) for pain.
- e. Morphine (short-acting) 5mg orally four times a day and 5mg orally as needed (prn) for breakthrough pain).

**8. The dose conversion ratio of morphine to oxycodone in the setting of advanced cancer is?**

- a. 10 mg po of morphine = 5 mg to 7.5 mg po of oxycodone
- b. 10 mg po of morphine = 15 mg po of oxycodone
- c. 10 mg po of morphine = 20 mg po of oxycodone
- d. 10 mg po of morphine = 10 mg po of oxycodone
- e. 10 mg po of morphine = 1 mg po of oxycodone

**9. A 68 year old man with progressive amyotrophic lateral sclerosis (ALS) presents with increasing weakness and shortness of breath, even at rest. He has no symptoms or signs to suggest a pneumonia. Which one of the following would be the most appropriate first-line symptomatic management of his dyspnea at this time?**

- a. Morphine 5mg nebulized (via an airway mask) every 4 hrs and every hour as needed (prn).
- b. Morphine 5mg orally every 4 hrs and 5mg orally every hour as needed for dyspnea.
- c. Lorazepam 1mg orally or sublingually three times a day.
- d. Non-invasive airway support with BIPAP.
- e. Tracheostomy with artificial ventilation.

**10. A 67 year-old man with advanced lung cancer and bone metastases is taking slow release morphine 90 mg orally every 12h. In the last two days he has complained of increased pain and his family have noticed that he has developed severe generalized myoclonus (muscles twitching) and has started “picking at the air”.**

**Which one of the following is the most appropriate change to make to his opioid regimen?**

- a. Switch his morphine to short acting hydromorphone at a dose of 8 mg orally every 4h
- b. Switch his morphine to short acting hydromorphone at a dose of 4 mg orally every 4h
- c. Increase the morphine dose to 120mg orally twice a day.
- d. Switch his opioid to transdermal fentanyl at a dose of 25 micrograms/hr every 3 days.
- e. Do not adjust the morphine dose at all but treat him symptomatically for delirium.

**11. A patient with advanced colon cancer and liver metastases presents to you with severe somnolence. Up until yesterday he was alert, lucid and active. He is on morphine 180 mg orally twice a day (controlled release formulation). His dose was increased a few days previously from 150 mg twice a day to control his abdominal pain. His respiratory rate is 10/min and his pupils are 2-3mm wide. They respond to light. You also note some myoclonus in his limbs.**

**Which of the following options is the most appropriate management at this time?**

- a. Discontinue his morphine and monitor him closely for signs of opioid withdrawal. When he is more alert or shows signs of opioid withdrawal, restart the morphine.
- b. Institute palliative sedation with a continuous subcutaneous midazolam infusion with the aim of controlling his myoclonus and keeping him comfortable.
- c. Administer naloxone intravenously immediately (0.4mg) and then be prepared to re-administer it as naloxone’s half-life is shorter than that of the morphine.
- d. Switch his morphine to hydromorphone, reduce the dose of the new opioid by 20% to 50% and search for other causes of somnolence.
- e. Administer a single dose of methylphenidate 5mg orally immediately and then continue it every 8 hours until he is more awake.

**12. A 48 year-old man with refractory, advanced leukemia presents with mild delirium. He has mild cognitive impairment and is a little agitated. He is also experiencing some visual hallucinations. He is on a regular regimen of oxycodone 20mg orally every 4 hours. Which one of the following regimens would be the most appropriate initial pharmacological management to control his delirium?**

- a. Haloperidol (Haldol®) 2.5mg orally or subcutaneously every 12hrs and haloperidol 2.5mg every hour as needed (prn).
- b. Diazepam (Valium®) 5 mg to 10 mg orally twice a day and 5mg every hour as needed (prn).
- c. Lorazepam (Ativan®) 2mg orally or sublingually three times a day and 1mg every hour as needed (prn)
- d. Methotrimeprazine (Nozinan®) 12.5mg orally or subcutaneously every 12hrs and 12.5mg every hour as needed (prn).
- e. Midazolam (Versed®): a bolus dose of 2.5mg subcutaneously or intravenously followed by a continuous infusion of 1mg to 4mg/hour titrated to control his agitation.

**13. Which one of the following is the most appropriate anti-emetic for opioid-induced nausea?**

- a. Dimenhydrinate (Gravol®)
- b. Metoclopramide (Maxeran®)
- c. Ondansetron (Zofran®)
- d. Cannabinoid derivative (Marinol® or Cesamet®)
- e. Prochlorperazine (Stemetil®)

**14. An anxious patient with pancreatic cancer, metastatic to liver, asks you for artificial nutrition (feeding by tube or through an intravenous line) as he has lost a lot of weight and is concerned that he is “starving” to death. Which one of the following best describes your response to his request for artificial feeding?**

- a. Suggest he try an appetite stimulant such as megestrol acetate, a cannabinoid derivative or a steroid in the hope that this would increase his weight.
- b. Refer him to a nutritionist for nutritional counselling.
- c. Refer him for the placement of a gastrostomy tube and initiate enteral feeding.
- d. Sensitively explain to him that artificial feeding would not improve his quality of life or life expectancy.
- e. Even though you suspect that artificial nutrition would not improve his quality of life, you would offer it to him so as to provide him with some hope and diminish his anxiety.

**15. A 37-year-old man with AIDS refractory to antiretroviral treatment starts experiencing burning pain in his feet and hands. The pain is getting worse. He is already taking a slow release formulation of morphine at 30 mg every 12h for pain.**

**Adjuvant therapies that have been found useful in the treatment of this type of pain include all of the following except for:**

- a. Tricyclic antidepressants
- b. Anticonvulsants (e.g. carbamazepine, gabapentin)
- c. Bisphosphonates
- d. Oral local anaesthetics
- e. Corticosteroids

**16. A 52 year old man whose wife died 8 weeks previously from cancer comes to see you in your office. He is tearful and admits that occasionally he sees glimpses of her in the house. He also finds that he cannot stop thinking of her. His yearning is even more pronounced when he sits down for supper alone or goes to bed. He is back at work half-time and finds that it is a helpful distraction. He is concerned about these glimpses.**

**What is he most likely experiencing?**

- a. A complicated grief reaction.
- b. A delayed grief reaction.
- c. A normal grief reaction.
- d. A major depression.
- e. An adjustment disorder.

**Thank you for completing this quiz.**

**\*\*Please Return Completed Test to Course Director\*\***

## Appendix B-4 – Pre/Post-Knowledge Quiz Answers

### Correct Answers

1. A
2. C
3. C
4. D
5. C
6. D
7. C
8. A
9. B
10. B
11. D
12. A
13. B
14. D
15. C
16. C

## **Appendix D – Organization of Workshop**

## Appendix D-1 - Timeline for Organizing Workshop

ACTIVITIES	TIMELINE
Select tentative dates – 2-3 months prior to selected workshop dates	
Arrange facilitators for workshop	2-3 months prior
Book facility (1 large room and 2 breakout rooms)	2 months prior
Advertise Workshop	2 months prior
Book equipment (TV/DVD player, LCD projector, Projection screen, 4 flip charts)	1 month prior
Send template of agenda to facilitators.	3 weeks prior
Facilitators' complete agenda for workshop; adding which facilitator is presenting a specific topic. Return completed agenda.	3 weeks prior
Collect registration forms and confirm registration.	2 weeks prior
Copy participant workbooks, evaluation forms, certificates, agenda and supplies, arrange delivery	2 weeks prior
Set-up room, equipment and handouts	1 hour prior
Deliver LEAP workshop	Workshop day
Ensure pre and post tests, and post course evaluation completed	End of Workshop
Provide certificate of workshop completion to participants	End of Workshop
Arrange payment for facility use, transportation, accommodations & meals of facilitators	Within 1 week of Workshop
Compile data and send results of Post Course Evaluation to facilitators	2 months after

## Appendix D–2 – Local Planner’s Checklist

### **A Local Planner’s Checklist**

- Dates booked
- Facilitators selected
- Venue booked
- Equipment booked and organized
- Advertising poster distributed
- Registration forms distributed
- Meals and refreshments arranged
- Hotel rooms booked for facilitators
- Travel arrangements completed for facilitators
- Confirmation letters sent
- Pre-course survey and Pre-knowledge Quiz sent to participants
- Agenda organized by facilitators
- Participant Workbooks, Agenda, Surveys, and Completion Certificates photocopied
- Room set up with equipment and handouts
- Pre-course survey and Pre-knowledge Quiz completed and collected
- Certificate of workshop completion provided
- Post-knowledge Quiz and Post Course Evaluation completed and collected
- Facilitators paid
- Hospitality costs paid
- Evaluations compiled, analyzed and results distributed

## Appendix D-3 - Delivery Support Kit

### **Delivery Support Kit**

- 1 - Roll of masking tape or Wall putty
- 1 - package Recipe cards (index cards 3"x5")
- Black ink pens
- Stapler
- 2 - Boxes of Felt Markers (various colours) for flip charts
- 1 - box of Large Tent Cards for participants names on tables
- 1 box of Adhesive Name Badges
- 1 - Envelope containing LEAP Certificates of Completion
- 4 - Large envelopes labelled as follows:
  - o *Pre Course Survey*
  - o *Pre Course Knowledge Quiz*
  - o *Post Course Evaluation,*
  - o *Post Course Knowledge Quiz*
- Blank Copies of the Knowledge Quizzes, Pre-Course Survey, Post-course Evaluation and Knowledge Quiz Answer Key

Appendix D-4 - Instructional Supply List

<b>Instructional Supply List</b>
TV/DVD player
Laptop computer
4 Flip Charts
LCD projector
Cart for LCD Projector with power supply
Projection screen
Participant tables set to half rounds or other interactive setting that suits the space
Podium (optional)
Lavelier microphone (optional depending on size of room)
Delivery supports (manuals, resource books etc.)
Table for Registration



## **Learning Essential Approaches to Palliative & End-of-Life Care (LEAP)**

Two Day Workshop

DATES

Friday Evening

And Saturday

Location

This workshop offers an opportunity for active learning about current best practices in caring for patients with life-threatening and life-limiting illnesses. Topics of discussion include GI issues; pain management; respiratory problems; delirium; palliative sedation, and more. The topics are presented with a special focus on family practice and community settings

There is no cost for participants. Registration is limited to a maximum of 25 participants.

Physicians who complete the course can apply for 2 MAINPRO C credits

If you are interested in attending or require further information please contact at:

E-mail:

Telephone



## Learning Essential Approaches to Palliative & End-of-Life Care (LEAP)

**Dates**  
**Times Friday**  
**Times Saturday**  
**Location Name**  
**Location Address**

### COURSE REGISTRATION FORM

Participant's Name: \_\_\_\_\_ Professional Designation: \_\_\_\_\_  
(i.e. RN, LPN, MD, etc)

Employer: \_\_\_\_\_ Workplace Environment: \_\_\_\_\_  
(i.e. Clinic, Acute Care, Home Care, etc)

Business Telephone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Physicians who complete the course can apply for 2 MAINPRO C credits

Confirmation of enrolment will be sent electronically to the EMAIL address you provide.

Any questions can be directed to:

Please fax this completed registration form to:  
Name, Fax number

**DEALINE FOR REGISTRATION IS xxxxx**

**A G E N D A**

**Learning Essential Approaches to Palliative and End-of-Life Care (LEAP)**  
Location, Dates

Your facilitators are:

**Friday, Date**

5:30 p.m. to 6:00 p.m.	Introductions, Pre-Course Survey
6:00 p.m. to 7:00 p.m.	Module 1 - Introduction to Palliative Care Problems [Name of Facilitator]
7:00 p.m. to 9:30 p.m.	Module 2 - GI Problems [Name of Facilitator]

**Saturday, Date**

8:30 a.m. to 9:45 a.m.	Module 3 – Pain [Name of Facilitator]
9:45 a.m. to 10:00 a.m.	Coffee Break
10:00 a.m. to 11:00 a.m.	Module 3 – Pain (Small Groups)
11:00 a.m. to 12 noon	Module 4 - Respiratory [Name of Facilitator]
12:00 p.m. to 1:00 p.m.	Lunch Break
1:00 p.m. to 2:30 p.m.	Module 5 - Tough Questions [Name of Facilitator]
2:30 p.m. to 2:45 p.m.	Coffee Break
2:45 p.m. to 3:45 p.m.	Module 6 - Depression and Anxiety [Name of Facilitator]
3:45 p.m. to 4:45 p.m.	Modules 8 & 9 – Delirium and Palliative Sedation [Name of Facilitator]
4:45 p.m. to 5:15 p.m.	Evaluations/Wrap Up