



June 29, 2010

Michael Aherne
Box 60638, U Alberta RPO
Edmonton, Alberta
T6G-2S8

UNSOLICITED C.O.I.
FEEDBACK FOR LEAP V1.1,
ALBERTA HOPE PROJECT
RECEIVED & ACKNOWLEDGED
JULY 2010

Dear Michael;

* | Members of the HOPE Working Group would like to request consideration of an update to the LEAP curriculum. We have 35 LEAP facilitators in Alberta and have used the curriculum to educate approximately 550 health care providers in the past 3 years. Facilitators have found LEAP workshops especially useful in helping to reach those health care providers, who serve palliative care clients on a regular basis but for whom palliative care is not their specialty area. It also gives us an excellent avenue to form multidisciplinary teams, even "virtual teams", in rural areas where other opportunities to do so have not previously existed.

AGREED & HAVE BEEN WORKING ON FUNDING SINCE LATE 2008 (P.E.I.)

The curriculum, however, does stem from work completed in 2006 and since then, as with all areas of health care, there have been many changes and updates to best practices in palliative care. Those facilitating LEAP workshops, wish to be able to offer participants the most up-to-date best practices based on current research and knowledge to take back to their daily work. With the release of the Pallium Pocketbook, the need for an update has become even more evident. Most facilitators use the Pocketbook as *the resource* at LEAP workshops, encouraging participants to have one on hand at all times. As such, the curriculum needs updating to be consistent with the information found in the Pocketbook.

We asked for feedback about the need to update the LEAP curriculum from facilitators of palliative care programs from across Alberta. Attached are suggestions for revisions from facilitators that practice palliative care on a regular basis and have facilitated many LEAP workshops.

Please let us know if we can be of further assistance in ensuring the ongoing life of this valuable resource.

Lynn Whitten, BN, MSA, CHPCN(c)
Evidence Based Palliative Care Lead
Senior's Health, Alberta Health Services

Jacquie Peden RN MN
Project Manager, H.O.P.E

JUNE 2010

Attachment - Comments from [REDACTED]

PHYSICIAN A

Back to a full two day format to allow more time for active learning activities, such as communication role plays, more time for case studies and specific question and answer sessions to address learner needs.

Consider a second level of LEAP for alumni, focusing more on difficult pain syndromes, communication issues, malignant wound care, incorporating spiritual care, and other topics. Consider using audience response system to identify needs using pre- and post test format and building questions into the content of the program as well as the testing.

I think it would be beneficial for facilitators to know where the learning needs are greatest right at the outset of the course.

Format: Day 1

- Start with PC context, including telling our stories, self-awareness, defining PC but also to get a better idea about specific things that are problematic for front line care providers from them.
- Decision making module - to include ethical decision making model - perhaps using the Latimer model instead of the Ethical Grid. Introduce assessment tools such as PPS, ESAS, Screening for Distress. Whole person care. Incorporating family into decisions - how to do this. This lays a foundation for all the rest of the weekend as far as goals of care, etc.
- Working as a team, including how to deal with doctors who are not on board with goals of care.
- Pain module with adequate time for the case study, which is one of the most valuable parts of LEAP. Discussion of newer agents and brief look at use of ketamine, methadone, topical agents, incident pain protocols and pain crisis protocols. Incorporate more practice on rotations, dosage titrations - work in pairs on some problems and then discuss as a larger group.

Format: Day 2

- GI and Respiratory modules in the morning.
- Spend the rest of the day on more psychosocial issues - communication skills, family conferencing, depression/anxiety and delirium. Last days. How do discuss changes that family will see. You could follow a single patient through different stages of illness, from breaking bad news, transition to palliation, final days.
- Build palliative sedation into the module on last days.
- I would like to see the entire program use more interactive teaching methods with the idea of enhancing transfer of knowledge to practice. If you have opportunity to do a couple of opioid rotations for practice, you will probably feel more comfortable doing it when you get back to your work setting. If you can role play discussing transition to palliative care from curative care in a safe environment, etc. etc. Use an audience response system to safely venture an answer to a question anonymously, and then have immediate feedback on the correct answer.
- I saw an excellent video produced by the Australians for teaching communication skills that we can get from Phyllis Butow, University of Sydney. It shows an interview with a couple and then a separate interview with the spouse of the patient that is about as close to flawless as you can get.

[REDACTED] COMMUNITY-BASED PHYSICIAN
CHAMPION, CENTRAL ALBERTA
WITH RECOGNIZED, ENHANCED
PALLIATIVE CARE MEDICINE SKILL SET

2 | Page

| OF 1

Lexicon: Add new trade and generic names

Butrans, Suboxone, Lyrica, Relistor, Lax-a-day, Golytely, Colyte, Journista, Sativex, Tramadol containing products, P.E.G. powder containing products

Module 1 or add an additional module

- Assessment of the palliative patient introducing the different assessment tools
- (ESAS, PPSv2, MiniMental/BOMC, CAGE, Contipation Score, ect), seeking for symptom clusters and what is considered appropriate special investigations.
- (I know this is all suppose to be coming out in the case studies, but participants don't always catch on, and a few theory burst slides will be helpful)
- Prognostication
- Ethical grid moved to Module 1?

Module 2 (GI)

- Constipation section needs total revision
- Methylalntrexone and PEG now widely used.
- Appetite stimulation, other options available than those mentioned (Thalidomide, omega 3 fatty acids, olanzepine)

Module 3 (Pain)

- A few schematic slides showing the anatomy of pain pathways and cell membrane physiology to demonstrate the different receptors acting on a molecular level.
- Include the new opioids on the market and why they are not always suitable for palliative patients: Butran, Suboxone, Tramadol containing products.
- Topical agents for analgesia.

Module 8 and 9 (Delirium and Palliative Sedation)

- I usually do these 2 modules as 1 session and combine it with a review of the palliative care emergencies chapter in the Pallium Pocketbook. I know that the emergencies is supposed to be coming out in the case studies but again participants could benefit from a few theory burst slides on the emergencies.
- Screening for delirium: introduce a screening tool that screen over the continuum eg. Nursing Delirium Screening Scale (NuDESC)
- New Calgary palliative sedation guidelines are available.

Module 6 (Depression, anxiety and suffering)

- I use the chapter on Psychological and Psychiatric Distress in the Pallium pocket book to teach this module.
- Revised DSM IV/DSM V is also coming soon.
- Suffering section can be improved with elements from the Total suffering, Spirituality, ect. chapter in the Pallium pocketbook.

General Comments

- The LEAP workshop is an excellent tool to introduce health care providers to entry level palliative care expertise. I usually explain to physicians asking what it is about, that I can compare it with ACLS. We are not all cardiologists but ACLS teach us what is important to

do and when to call the cardiologist. LEAP does the same for creating comfort with palliative care.

- Some participants can then go on to expand their knowledge and become experts themselves or they can stay as "first responders" and continue to hand over to the experts.
- I find I can facilitate the course easily over two days. The 2 ½ days are too long and the Friday evening, Saturday day format is too short. Physicians prefer courses over the weekend, nurses and nursing management prefer courses during the week, so a Friday day and Saturday day might be the compromise.
- Modules can certainly be combined in the interest of time. See suggestions above. I want to add that Module 10 (Last days and hours) can easily flow into Module 11 (Working as a team) when you get to planning a home death. Also the whole course can be a team building experience as people that work in "virtual teams" sometimes see each other for the first time.
- The video's can be overwhelming when you initially start facilitating, there are almost too many and they are so rich in content. I think it would be a good idea to indicate which "core video's" facilitators should try and include.
- We should develop a policy for allowing repeat participants. I allowed one of our home care RN's to participate again after 2 years lapsed since her first LEAP specifically for her feedback. The comments were that she was not bored with the repeat and actually learnt new things (updating done by facilitators) and the refresher was very helpful to confirm knowledge gained previously. (Again to use the ACLS example, we update those skills regularly for all health care providers, why not update palliative care skills in the same way?)
- We include LPN's as participants on a regular basis with good feedback. I can see the difference in the Acute care setting caring for a patient with an LPN that did the LEAP vs one that did not.
- It is essential for participants to have access to the Pallium pocketbook to continue using the knowledge gained during the course. I think we should make sure we give everybody one or have copies available for purchase at each course.
- I was approached by pharmacists about getting LEAP accredited for CME credits by their college/s.
- Maintaining accreditation for Mainpro C (or M1) credits for family physicians is important.
- Some participants (especially nurses, but not exclusively) mentioned the value of the theory bursts. Some participants just never had instruction in these topics, so it is important to keep a balance between theory and case studies.
- I would be willing to work on a revision project.

[REDACTED]

COMMUNITY BASED PHYSICIAN
CHAMPION, NORTHERN ALBERTA
WITH RECOGNIZED, ENHANCED
PALLIATIVE CARE MEDICINE
SKILL SET

CNA DESIGNATED (CHPCN(C)) RN, 2

Attachment - Comments from [REDACTED]

PROGRAM MANAGER
PHYSICIAN A PHYSICIAN B

As a Registered Nurse facilitator, I agree with all both [REDACTED] and [REDACTED] have made note of, as well as feel that the curriculum might be better broken into two parts – an initial course for those who are attending the first time, and a more advanced course, for those returning to update their skills and add to their “toolbox” for practice.

I agree that we need to have most learning occur more interactively or case-based, as I often get comments from people that they learn much more by *doing*. At the advanced level, I think participants would even be willing to do some lead work prior to the actual course so we could dive right into the work. As all of our time becomes more precious, it is important that we find ways to educate our providers well with minimal interruption to their work life.

For facilitators, we could also consider integrating the information presented by Dr. Periera in Edmonton for HOPE on how to better present the LEAP materials, as this was very valuable experience that all facilitators should benefit from.

Each time we facilitate the LEAP course, we learn things that shape and advance our practice at the frontlines. It is a very important resource that should continue to be available in an up-to-date format for future clinicians. I would be most willing to be part of any working group looking at the updating process.

[REDACTED]

RN / MANAGER
CENTRAL ALBERTA

CNA DESIGNATED (CHPCN(CS)) RN

Attachment - Comments from [REDACTED]

I have had the opportunity to facilitate several LEAP sessions with experienced facilitators in the last 18 months, and would like to add a view comments on needed revisions.

Process:

Two full day format is definitely preferable. The Friday evening, Saturday format makes for a very pressed schedule, where content needs to be rushed through, participants (and facilitators) often attend after a full work day and have limited energy for learning on the Friday, and the Saturday is a long day for both facilitators and participants.

While it is clear that this course is intended for physicians, RNs and pharmacists, the reality is that many participants are LPNs, and we need to be able to present content at a variety of levels.

Distributing and reviewing the pre surveys in advance is logistically challenging, but worthwhile if it lets facilitators target the content more closely to the needs of the group.

As others have commented, interactive activities are important, both to be consistent with adult learning principles, and because most participants are not accustomed to long periods of sitting.

Practice change is the desired outcome, so opportunities to practice drug calculations, developing treatment plans with available resources, conversations with patients and families etc would be helpful. Expanding the collection of activities to choose from would provide facilitators more flexibility to respond to the interests of the group and the mix of participants. Experienced facilitators might be prepared to offer some examples for cases, activities etc that could go into a "toolbox" of teaching strategies.

Content:

Module one: Wallerstedt & Andershed (2007) make some interesting observations on the experience of nurses caring for palliative patients in non palliative settings, might be a useful addition to slide 7, which comments on physician experience

Module two: Constipation section is not reflective of current practice. Dr. Librach discussed new constipation guidelines that were under review at the time of the CHPCA palliative conference (Oct 2009), not sure if these have been released yet. Reference to use of sodium phosphate products and associated risks may be appropriate.

Module three: reference to assessment and management of pain in cognitively impaired clients would be helpful. In the case study, reference to a multidimensional pain assessment tool, might be helpful, ie the PQRST mnemonic or Brief Pain Inventory may emphasize that more than severity is important.

Module six: Ferrel & Coyle (2008) have some very good thoughts on suffering and how care providers can alleviate some of it during routine care encounters, and they provide some good case studies, that might enhance this unit.

Module 11: the content in module 11 is seldom used in the presented form. I wonder if incorporating it into module 5 would work, perhaps as a follow up to the family conference video ie a video or case study about what happens when the team isn't working well or does not exist.

Thank you



REGISTERED NURSE WITH
PALLIATIVE PRACTICE IN
CENTRAL AND NORTHERN ALBERTA

Reference:

- Wallerstedt, B. & Birgitta Andershed, B. (2007). Caring for dying patients outside special palliative care settings: experiences from a nursing perspective (p 32-40), Published Online: DOI: 10.1111/j.1471-6712.2007.00430.x
- Ferrel, B. & Coyle, N. (2008) The Nature of Suffering and the Goals of Nursing. Oncology Nursing Forum 35 (2) 241-247 DOI: 10.1188/08.ONF.241-247.

Attachment - Comments from [REDACTED]

PHYSICIAN C

I would like the ability to spend more time on pain management and even discuss more complex management including adjuvant therapies as pointed out. I like putting the palliative sedation into the Last Days session. I like the increased interactivity with more emphasis on putting knowledge into practice, however that would look. Maybe interesting to consider how the trauma modules are taught using simulations and mannequins. I like increasing the session on teamwork with time for docs not on board, primary/secondary linkages, etc

I am worried about extending the time. Even though 2 days is not a lot more than we have done at 1 1/2 days, there is a psychological barrier for some. Have to be careful here.

[REDACTED]

COMMUNITY - BASED
PHYSICIAN CHAMPION,
SOUTHERN ALBERTA WITH
RECOGNIZED, ENHANCED
PALLIATIVE CARE MEDICINE
SKILL SET.

RURAL TEAM

Attachment - Comments from [REDACTED]

The Rural Palliative Care Consultation Team has delivered the LEAP course 7 times in a variety of rural communities within the [REDACTED] Zone between April 2006 and April 2010. LEAP facilitators and observers of this course concur with suggestions / comments in letters from [REDACTED]. Additional suggestions / comments from the [REDACTED] group are summarized below.

Physician A,
Physician B, F,
RN/Program Mgr

Course Content

- At beginning of course (Module 1), delineate the approach to symptom management in palliative care (regardless of symptom) (as per approach for management of nausea & vomiting in slide 6 of GI module).
- Increase emphasis on non-pharmacologic measures to treat symptoms, in addition to medications (e.g. non-pharmacologic measures to treat nausea & vomiting only mentioned within case study – not in theory burst).
- Include more focus on assessment and use of assessment tools (e.g. PQRSTU acronym for pain assessment).
- Consider reducing amount of detail in case studies and in video discussion guides – very difficult to get through all content in time allotted. Another option is to prioritize content as *core* and *optional*.
- Ensure critical content not buried deep in case studies – should also be addressed in theory bursts or at least included in participant workbook somewhere. There is not always time to work through entire cases and learners only get copies of slides - not case study answers – so they do not have this content for future reference if the case is not completed in the course. For example, spinal cord compression is only discussed within the very long case study in the pain module, hypercalcemia is only discussed in the case study on delirium.
- Reduce repetition of content in various modules (e.g. respiratory congestion at EOL covered in Respiratory Problems and Last Days & Hours modules).
- Whole area of ethical dilemmas and ethical decision making in palliative care needs significant expansion and more central focus – e.g. move to Module 1. Suggest inclusion of relational ethics and ethical principles approaches with application of ethical decision-making framework. Ethical grid is really only a tool for assessment and data collection – not a decision-making framework per se. An excellent algorithm was developed by PHEN (Provincial Health Ethics Network) in Alberta called: Decision making framework for end of life choices – something like this would be a valuable tool for learners.
- Content needs to be more interdisciplinary in focus. Several sections / cases / examples / questions clearly geared to physician audience.
- Expand focus on spirituality, spiritual needs, spiritual assessment in Module 6. We have taught this section using framework of 5 spiritual needs – Hope; Meaning and purpose; Love and relatedness to self, others, and a Higher Being; Forgiveness or acceptance; Transcendence.
- Decrease emphasis on catastrophic events and pharmacologic symptom management in Module 10 – Last Days and Hours. Include more holistic perspective on the provision of care and comfort to the patient and family in the final days and hours. Expand information on death at home, including Expected Death at Home protocols (presently somewhat acute care focused).
- Like the focus of the module *Working as a Team* but perhaps this would be more appropriate in Module 1 as part of the overview/principles of palliative care and then team approach integrated throughout course – i.e. include more emphasis throughout the course

on various roles, responsibilities, scopes of practice, and contributions of disciplines represented in the audience.

- Modify pre and post tests to reduce emphasis on cancer and on medications and dosages, especially if physicians are not primary audience.
- Strengths – Case study format, Communication module (comprehensive content, video vignettes are great discussion starters).

Process and Format

- Need to strongly encourage facilitators to help learners apply content to clinical work (i.e. focus on practical application) and use more small group case study discussion to deepen learning.
- Encourage facilitators to incorporate local algorithms and tools to help enhance learning and facilitate practice changes (e.g. hydration algorithm, DELIRIUM acronym to identify causes of delirium).
- Provide tips/guidance to facilitators on how to adapt course content to meet needs of disciplines / care settings represented in the audience.
- Integrate communication principles throughout course.
- Reduce lecture (theory burst) – too much detail to cover in 2 days.
- Consider course modifications for varied audiences (e.g. less focus on prescriptions if no physicians in audience). NOTE: We have developed and piloted a 1 day version of LEAP (Concepts in Palliative Care) geared to allied health professionals (i.e. non-physician, RN, pharmacist) with reduced emphasis on pharmaceutical management of symptoms. Learner feedback was very positive, indicating information was very relevant to their roles and they had the opportunity to discuss how to embed learning into their practice. In future, we would like to incorporate allied health facilitators if possible.

[REDACTED]

RN, CNS ON BEHALF OF TEAM

Compiled by [REDACTED]

[REDACTED] June 29, 2010.

[REDACTED]