

LEARNING ESSENTIAL APPROACHES TO PALLIATIVE AND END-OF-LIFE CARE (LEAP) COURSEWARE RENEWAL PROJECT (2011)

**Canadian Open Call for Courseware User/
Evaluation Information**

Roll-up of feedback instruments received to April 14, 2011
[Unedited presentation/census of qualitative key informant self-reporting for
individuals and groups/teams/programs]

Preliminary reporting document used to guide interactive discussions at the
April 18, 2011 LEAP Inter-provincial/-professional courseware renewal planning
meeting.

Pallium Project Transition Office
Box 60639, University of Alberta RPO
Edmonton, Alberta CANADA T6G-2S8
Phone 1-888-475-4933 (leave message)
www.pallium.ca

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SELF-REPORT ON CONTEXT/SETTINGS LEAP IS USED

IN YOUR OWN WORDS TELL US ABOUT HOW YOU/YOUR PROGRAM/ORGANIZATION USES LEAP
(PAST, PRESENT, FUTURE... you decide, you tell us...)

LEAP2011-0001

We present the LEAP material over two days to a group of about 30. We have 10 from acute care, 10 from long term care, 10 from community and 2 (or more) clergy. We have used most of the materials depending on the group we are presenting too. We use as many of the case studies and video's as we need to get the points across. We have had really good reviews and have a list of people asking to do the course.

We plan to continue with the presentations and plan another one for spring. We have a group of presenters: several nurses with varies experiences, 2 doctors, clergy, social worker, & OT. The mix seems to work very well and we feel it is presenting a real team approach.

LEAP2011-0002

Our region participated in a weekend LEAP course in one of the rural areas. We also use the course as a basis for education for many workshops/in-services we conduct for nurses, physicians, medical residents, health aides and students nurses. We have used it as a reference in our Regional Palliative Care Services Resource Manual.

LEAP2011-0003

Our Program has decided to use LEAP as the main teaching tool for front line staff in all care settings, including, acute Care, LTC, home care.

The Team presents it in a interprofessional fashion.

Depending, on the site, we may use the "video's more or less, and use local cases and challenges.

We have also added some role play in the communication module (module 5), which has been challenging, but obviously has increased knowledge within the participants.

We will continue to use LEAP in the training of all staff delivering Palliative Care across [the province]. This standardized approach to teaching is certainly of value as we develop a Provincial approach/strategy to care delivery.

LEAP2011-0004

Used as intro education to LPN, RN working in residential care, acute hosp settings and home and community care. Given over 2 days which isn't enough time.

LEAP2011-0006

Our program uses LEAP both as an educational tool and a facilitator's guide. We are meeting on April 14, 2011 to development formation of [Canadian provincial capital city] Community Palliative and End of Life Care (PEOLC) Committee. We currently have a regional structure and are proposing this preliminary meeting to bring together those who have an interest in being a part of this venture to enhance collaborative palliative and end of life care practices across all sectors of the region, including community.

LEAP2011-0008

[Regional health authority] has used LEAP to foster a collaborative, interprofessional approach to palliative and end-of-life care. A training session organized by a core group in [provincial capital city], was held early last year for leaders in palliative care throughout the [health region]. The palliative care leadership of one of the areas of the region, [name of rural service area] organized themselves and they developed an interprofessional team who have offered the program three times to a variety of professionals within [health region] and the community. The [name of rural service area] area seems to have been a catalyst for creating a palliative care culture in this particular area of the region.

I am the bereavement coordinator for the region and I'm using LEAP opportunities to network with frontline people involved with the dying and the bereaved. In addition I have attended LEAP in [name of rural service region] and also a train-the-trainer session in [provincial capital city]. The latter offered an opportunity for me to actually work with colleagues to present two modules of the LEAP material.

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I see using this program in my work to foster collaborative, interprofessional care for palliative care and bereavement care. I hope to help people develop the psycho-social-spiritual aspect of LEAP. I also plan to help train people to present Module 7, Grief and Bereavement, as well as providing resources to enhance this module.

I am a proponent of clinical education and I see LEAP as an opportunity for people to learn through practice and to encourage constructive reflection on their own professional practice.

LEAP2011-0009

- Began in 2008 when LEAP educational offerings came to Atlantic Canada with [province] leading the first educational weekend to increase awareness re: LEAP content along with Module education on same (with Dr Jose Pereira)

- Familiarized invited interprofessionals across [province] with LEAP materials

- Increased knowledge of core components re: PEOLC and Best Practice (evidence, forms)

- Provided a forum for individual practice and beliefs

- Provided the key knowledge for the core essentials for PEOLC from an education point of view - essential knowledge/training necessary to provide care

2 LEAP facilitator training sessions took place:

- Session in 2009 with leaders **NAMES DELETED** which was taken and ran with by a [rural area of health region] PEOLC Interprofessional Committee who have offered educational sessions x 3 to interprofessionals in their region with great success. The same has happened to a local PEOLC community team in [central part of the province].

- second just recent in March 2011 facilitated by **NAMES DELETED** with a more CQI process plan to take place for follow up and mentoring on facilitation.

- Assisted to change attitudes re: PEOLC for participants regardless of whether they can actually continue on as a facilitator themselves. Of note [province] has very few actual totally titled or dedicated to palliative care and thus facilitator training is a challenge for those who we wish to follow through. Our vision is to mentor others to feel more competent and confident to facilitate in their regional (rural and urban) and sectors (LTC, acute care, community, PCU, Cancer care etc.) rather than a small handful of palliative care leaders trying to respond to do this (but would be available to assist/support with some of the medically intense Modules that require collaboration, guidance and expertise)

- FUTURE- to grow and develop LEAP across [province] with commitment by facilitator participants and to monitor through CQI processes (e.g. PDSA format etc) .

For all the sessions offered the Pallium Palliative Pocketbook was given out free from those purchased by [provincial HPC association]

- Challenge for those who have the passion to lead, organize and present to get org. support to get the time for the education and then the facilitation training and incorporate this into ongoing everyday job and responsibilities

LEAP2011-0010

Information from the modules have been use as reference but the whole LEAP program modules have not been use to facilitate a specific training program. I would like to be able to put together an education program using the modules but this has not occurred for a number of reasons (facility moving, renovations to site, accreditation education needed and no resources {space, staff to be liberated, etc}). Currently, the organization is looking to do more local education and there may be more of an opportunity to feature selected LEAP modules.

LEAP2011-0012

Use Leap to train facilitators for other areas of our province, as well as in the city. Our group is mostly representative of the Health Care Authorities but we have included members of our provincial organization. It is mostly composed of nurses, but other disciplines are involved. Our team which delivers the training consists of a nurse, doctor, nurse manager, nursing instructor, and myself. It is offered over a weekend.

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LEAP2011-0013

- We are in the process of developing a palliative care unit and have developed a training plan consisting of LEAP (full course provided over 3 days), 3 days of preceptorship (each LEAP nurse is connected with a Palliative Care Consult Nurse (PCN) who assigns them a palliative patient and the nurse does a comprehensive review, generates a problem list and plan of care. This is reviewed with the team. The mentorship will last for 3 months during which time LEAP nurses are to be preferentially given palliative patients to care for during their scheduled shifts. The PCN will work with the LEAP nurses during this time to review and enhance their knowledge base and skill set. Evaluation tools are used to identify learner needs and efficacy of the teaching system. The LEAP courses (minus the preceptorship and mentorship) have been open to other staff and have included SW, PT, OT and physicians all of whom have had positive comments on the course.
- We have been involved in teaching LEAP in other parts of our province and neighbouring provinces.
- Modules of LEAP have been used to educate students at all levels on individual basis

LEAP2011-0014

Our region has been using LEAP since 2005. I was a participant in the first workshop held in the region that year. Two physicians and two palliative care nurses subsequently trained as LEAP facilitators. Two from our group have helped with workshops across the province, working with other nurse and physician facilitators. We originally used funding from the HOPE Project to provide support for the workshops, however, over the past few years, we have run LEAP workshops without external support. Workshops have consistently filled to capacity, with a waitlist on several occasions. Our last LEAP weekend, held in March 2011, attracted seven physicians, which is the highest number of doctors we have had attend.

LEAP is a major thrust of our palliative care educational program. We have developed and deliver a number of other workshops, including day-long events in end-of-life care in advanced dementia, a general palliative care program suitable for LPNs, RNs and MDs, as well as more specific education days for our rural palliative care resource nurses. LEAP has always been considered more specifically targeted at doctors, RNs and pharmacists, with a higher level of clinical content, particularly in the pain management small group work. It is not unusual for nurses to attend one of our other educational workshops and then attend LEAP with the general consensus that each course increased their knowledge and comfort levels in palliative care.

As for the future, I would like to see LEAP used in the current weekend course format as well as a modular format that could be used to reach physicians who are unable to commit to a full weekend program, but who would still benefit from the content of LEAP. This is a common response that we hear from nurses: "If only our physicians knew this material". I would also like to see a more advanced program developed for LEAP alumni that spends more time on working through more complicated cases and more time on communication skills.

LEAP2011-0015

- Undergraduates and residents (medicine) doing their placements/rotations at our teaching hospital. We provide 1 hour teaching sessions every lunch hour.

LEAP2011-0016

- We held only one weekend course attended by 5 physicians, 18 nurses and 3 pharmacists several years ago. For a time after that we reaped the benefit of new knowledge for those who care regularly for Palliative Care patients but had not had the opportunity have a more in -depth specialized course. We really found that it facilitated team building even by phone as we could now identify resource people in those communities that we had met face to face. It made communication by phone a lot more personal and easier. (However since then, 4 of those physicians for instance have moved away as well as several of the nurses)
- I have used the Pain and Symptom sections for educational purposes as part of staff meetings, planned lunch and learn sessions, planned one hour in-services etc. many, many times.
- Most often we use sections of LEAP informally in our day to day work. For example, we have used the communication section many times in reference to delivering bad news, communicating with family, communicating with difficult families, using the ethical grid to help facilitate decision making, running care conferences.

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- We have purchased and given a Pallium handbook to each physician in our Region as well as placed one on each unit in the hospitals and in every facility and Home Care dept.. Often I will be in discussion with a physician (especially one less experienced in Palliative Care or with another staff member and we will refer over the phone to a certain page in that Handbook so that we are all "on the same page"

- I would love to host more two day weekends but there are so many complications related to time which I am sure will be discussed later in this document.

LEAP2011-0017

During the years 2004 to 2009 as the End of Life Clinical Nurse Specialist I facilitated the LEAP course in 11 areas in our extensive health region. As part of the LEAP goal is to teach a variety of disciplines I also encouraged the local palliative providers to co-facilitate with me whenever possible. If local providers could not facilitate then I would bring others to the community who had an interest in facilitating the course.

In 2007 I realized that I could not do all the teaching and organizing for all the LEAP courses across the region and that there were many people who were skilled in this area. So I planned and coordinated several 'train-the-trainer' (TTT) LEAP workshops in an effort to spread the facilitating role across communities and encourage local use. An invitation was sent to managers and directors about who they felt would be appropriate to take the TTT. We also wanted to be sure that the potential TTT participants had the requirements to facilitate the course so we sent a knowledge and skill check list to each potential participant so that they could 'evaluate' their own readiness and so that we could assess each person's ability. We would then offer the TTT to those who met our criteria but tried to be as inclusive as possible. At some of the TTT the participants themselves realized that they needed to learn more and most endeavored to do that so that they would become a more knowledgeable facilitator. In order to equip the new facilitators they each received a copy of the LEAP facilitator guide at each train-the-trainer course. I also worked with several other people to bring this to the communities: an expert in adult education (M.Ed.); an End of Life Nurse practitioner (NP) and a human resource person skilled in coaching. These TTT workshops were 1 day and consisted of principles of adult learning, facilitation tips and techniques and practice teaching of sections of the LEAP modules. They were well received and as a result there were 60 practitioners from a variety of disciplines (nursing [from a variety of settings], medicine, pharmacy, chaplaincy and social work) who were able to facilitate LEAP or at least some modules in LEAP. Some of these people went on to teach many LEAP courses, others taught sporadically, and others taught only occasionally. Those that taught the course frequently began to feel very comfortable with the material and were always keen to teach. I also started a LEAP NEWS newsletter to keep all our facilitators informed of updates, events and any suggestions for teaching, learning, facilitating that either I had or was sent to me from a LEAP facilitator (one of our facilitators called herself a LEAPER!).

As a result of having more facilitators our ability to offer more LEAP courses broadened. In fact, in 2009 we offered the course 7 times and as some people were waitlisted to take the course I was asked to organize 2 more. Each LEAP course had 25-30 participants so over the years hundreds of care providers have taken LEAP and the demand and response to the course continues to be very positive.

The course is always open to all care settings so at most of the courses we had practitioners from a variety of work sites, including home care, long term care, palliative care units, and acute care. This was a huge learning for the participants and facilitators as they shared their experiences, learned from each other and gained an appreciation of work in other areas.

Some of the LEAP course modules were integrated into orientation for nurses in several settings, e.g. home care. Acute medical units also offer LEAP regularly for their staff as the clinical nurse educator became a LEAP facilitator and promotes the course in this setting.

The majority of participants have been nurses (RN and LPN) but the course has also had social workers, pharmacists, care aides, volunteers and others. Volunteers often enjoyed the modules on psychosocial, communication and team but did not attend the symptom-based modules. Because some of the communities we taught LEAP in were very small the participants were a mixture of nurses, care aides, volunteers, local pharmacists. Not only did they learn together but they learned about each other and the role they can play in end of life care in that community! So the benefits of LEAP were more than just learning about end of life care. Needless to say that we have had a very successful implementation of LEAP in [regional health authority] and this renewal will be highly valued by both facilitators and participants.

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LEAP2011-0018

- We have had 3 offerings of a Weekend Pallium LEAP course in our rural community. These courses have been attended by RN's, LPN's, Social Workers, Physicians and Pharmacists and nursing students. The average attendance has been between 25 to 40 participants from across the [rural catchment of a western province] and across all health care sectors (ie: Acute, Residential and Community as well as newly graduated and about to graduate baccalaureate nursing students).
- We intend to offer this course at least once/year and may possibly take the course to another rural community in the [another rural catchment to the east of the province] who would like to have an on-site course available to them.
- Our desire/wish/hope/vision would be to have the Pallium LEAP course as foundational for the baccalaureate nursing program and offered as part of the regular curriculum at [name of comprehensive community college].
- We would really like to entice more physicians to attend the course as there has been an overwhelming lack of their presence at all of our course offerings.

LEAP2011-0019

Following the guidelines set out by the [provincial health ministry] (2005) the delivery of LEAP is collaborative in nature and involves (NAMES AND IDENTIFIERS REMOVED BY NB) The team follows Kelley's (2007) Developing Rural Palliative Care Conceptual Model and collaborates with local Palliative Care Committees and the [name] End-of-Life Care Network. Please see attached LEAP Forward Poster for more information on how LEAP is utilized in (IDENTIFIERS REMOVED BY NB)

[Geographical catchment] is a massive geographical area and educational opportunities can be limited in some of the rural and remote areas. Our interdisciplinary panel of facilitators (typically 1 palliative care physician, 1 nurse and 1 social worker) travel to rural communities to deliver LEAP face-to-face with health care practitioners. LEAP is typically run over a weekend (Friday, Saturday and Sunday) and is often hosted in a health care facility (ie: hospital boardroom) or at [regional university campus]. We have expanded the audience of participants in order to reflect a more interdisciplinary team approach. Our audience includes: Physicians, RNs, RPNs, Pharmacists, Social Workers, Occupational Therapists, Physiotherapists, and Spiritual Care Providers. LEAP is delivered 3-4 times per year. To date [regional city centre] has received 7 LEAP courses, and 7 communities in the [name] region have received LEAP. We have another LEAP scheduled for May 2011 in [smaller rural centre]. A total of 34 physicians, 126 nurses, and 40 other health care professionals (OT, PT, Spiritual Care, Social Workers, Pharmacists) have taken LEAP to date through our program.

Going forward we hope to continue to follow the above-mentioned model to deliver LEAP. We also hope to utilize videoconferencing technologies, where appropriate, to engage more rural and remote communities in this education. We are also looking at ways to engage more physicians in this education, perhaps by offering shorter sessions once a month as opposed to full weekend courses.

LEAP2011-0020

- advanced pc certification for nurses
- family physicians and nurses (Initiative 2)
- rural initiative 2 interprofessional
- medicine residencies
- some components in presentations, conferences
- orientation of nurses new to pall care unit, TOH
- planning - interprofessionals as we roll out our symptom management guidelines
- integration week at UO, with 1st? yr medical students
- for individual learning plans

LEAP2011-0022

- For this last year, we have been using the LEAP material every four weeks for each new set of residents do rotations in palliative care – typically residents in family medicine and internal medicine, but occasionally fellows in palliative care or oncology or residents in anesthesia, neurology, psychiatry, or medical students that also do rotations. At times, staff from internal medicine or nurses from palliative care also join us.

- We began by giving the communication module in hourly sessions distributed throughout the rotation, and the symptom management modules in a single day (the latter to allow residents from other hospitals to more

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easily join us). Over time we have used the communication module with videos less in the rotation (as the discussions would take place during daily review of patients being followed – the videos are being used though for specific classes from groups of second year medical students as part of their general teaching of communication skills, and we also tried giving the symptom management modules (theory bursts and cases) over four or five days, but lately we've come back to a single day or two days in the first week of the rotation for residents from other hospitals to have less travelling.

- There are about 5 staff palliative care physicians that divide up the modules, with each tending to specialize in certain modules.

OVERALL WHAT WORKS WELL

OVERALL, WHAT DO YOU FIND WORKS WELL ABOUT LEAP...

LEAP2011-0001

The material content is good. The slides are good and we give examples when possible as that is what makes it real and memorable to most people.

LEAP2011-0002

- Overall completeness of the modules - thorough discussion of subjects.
- Ease of delivery.
- Slide package.

LEAP2011-0003

- LEAP engages the participants in a series of ways that helps to keep interest in the group. The small and large group work, helps to build relationships, but also create a certain amount of tension which enhances ability to learn.
- I have found that it helps in "changing behaviors" which is the ultimate goal in teaching.
- LEAP has a certain amount of repetition, which helps learners to retain information.
- The ability to change the format a little (depending on the group), has had tremendous results in our setting.
- As a group, we always do a needs assessment, and add/adapt to ensure the learners got what they needed.

LEAP2011-0004

- Have 3 facilitators----GP, RN and Social worker/spiritual care specialist .
- Divide physical symptom management modules so GP and RN both present.
- During the communication/psychosocial modules, relate "stories" which demonstrate how to use suggestions in practice.
- Organize the agenda to have psychosocial and physical symptom modules on both days
- Videos are good but we never used them all. Have never used video number 4--compassion in less than a minute. Have tried to have group activities/discussions instead.

LEAP2011-0005

FYI the "ill-structured" scenarios were very useful for teaching purposes with residents and medical students and I frequently used them for this purpose.

LEAP2011-0006

- participation (i.e., discussions) that I provokes
- education of the topic
- learning objectives for each module
- involvement of multiple discipline professionals

LEAP2011-0008

I have found that the integration of the facilitators personal/professional stories bring the program alive. The fact that the facilitators have had to work together to develop the program brings a momentum or energy that inspires people to want to work collaborative and interprofessionally. LEAP seems to be designed to address the various learning styles and this is commendable. I believe the focus on collaboration and diverse learning styles connects philosophically and spiritually with the themes of "loneliness" and "community" within palliative care. Just as the interprofessional team of facilitators has to address the challenges of presenting the modules and LEAP program together, so too the palliative care clients and the bereaved have to address their "loneliness," their "fears," and their need for "community" in order to work through their losses, transitions, and their need for family and community support. The common focus as I see it is relationship building, including and embracing the diversity and accepting the unique talents and gifts of the participants.

LEAP2011-0009

- Local planning guide
- Facilitator's kit
- Manual: Facilitator notes (suggested questions, reminder of key points, theory & evidence)

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- Videos, cases
- Able to cherry pick modules to educate and tailor to particular groups re: CME, Physicians, Nurses, Nursing students, social workers, spiritual care, volunteers, allied health , GP's, orientation of new staff etc.)
- Used to enhance other presentations (although it could use a more interprofessional focus on the video clips as they are presently mainly physician lead)
- The ability to bring different levels of interprofessionals together to connect and learn
- Empowers individuals to learn themselves and educate others in their individual geographical locations
- Modules with slides very convenient to use, designed by experts and all the educational materials included thereby providing less preparation time – recognizing that it does need ongoing updating.
- Provides content validity and confidence for the facilitator when teaching.
- Portability - can present anywhere to any group - providing you have taken the time to identify your group.
- Strengthens interprofessional team building - supports a strong foundation from the standardized approach it offers.
- Can be offered with the Pallium Pocket Book - book can be used as an individual reference at any time in practice.

LEAP2011-0010

LEAP has benefits in that the program is structured so that guest speakers can present the materials and do not have to develop slides, etc. LEAP also is a great program in that it is designed to be given by an INTER-Professional team of facilitators and not just one or two persons presenting i.e. Physicians. Materials are all together in one efficient fashion. The content is current and relevant to actual case studies. Because the material is structured then are able to say that persons who have completed the modules all have the same training thus are able to certify in one way.

LEAP2011-0012

I find that it is very well thought out and organized so that it is easy to use. Good information on the different types of learners, Very practical, useful information, that one can take away to the bedside. The combination of slides, video clips etc. keeps participants involved. The facilitator's guide is very good, explaining the what and why. I like the many useful suggestions for the challenging things like the quiet participant or the one who monopolizes the discussion. Time frames keep us moving forward.

LEAP2011-0013

The flow is excellent. The mixture of didactic and case based learning with group work makes it an enjoyable learning experience. All participants comment on how the days just fly by (not bored). The teaching materials overall are excellent. It is not too cancer focused and we find it builds on itself as you go thru the material.

LEAP2011-0014

- LEAP is an immersion into the philosophy of palliative care as much as it is about the clinical content. The inter-professional environment helps to develop the "team approach" and often leads to a better understanding of the difficulties faced by our colleagues within the team, particularly the challenges nurses face dealing with physicians and the issue of moral distress when trying to advocate for their patients.
- The two-day format allows for time for reflection on whole person care with the concept of "total suffering" being reinforced several times. The course frequently reminds us to "back up" from just focusing on physical symptoms and look at the bigger picture of the multidimensional aspects of suffering, including the suffering of families and caregivers.
- LEAP provides a forum for personal reflection and sharing some of the struggles and joys of doing this work. Not many other CPD courses provide for this.
- It has always been a practical course and I feel the small group work is a particularly effective part of this. The case study in pain management is very effective.

LEAP2011-0015

- Overall LEAP is a superb undertaking and for undergrads and residents learners has been a valuable source of education and learning.

LEAP2011-0016

- Generally, I find workshops or in-services using the modules an excellent tool to introduce health care providers to the basics of Palliative Care.
- I like the case study format especially.
- In the communication module the video vignettes are great to get a discussion going.

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LEAP2011-0017

- The strengths are many, including the variety of topics, facilitator tools, teaching tips, integration of case studies, an interdisciplinary approach to the teaching and learning of the course, the flexibility of the course modules.
- The modules cover all the 'basics' of palliative education and incorporate a variety of tools for facilitating. The power point slides are very helpful to guide the facilitator. All the participants LOVED the video clips and even if we did not have time to show them all, the participants often wanted us to leave to other pieces so that they could see all the clips. So, because of the flexibility of the course we were often able to do that. Sometimes we offered to show them at a break if there really wasn't time.
- The cases are always a great way to ground theory learned into real practice situations and enhance the transferability to care.

LEAP2011-0018

- It is a nice balance between the psychosocial care and symptom management.
- The course materials are relevant and well laid out.
- The framework allows for good interdisciplinary discussion, perspectives and problem solving
- Evaluative events are well thought out and planned (eg: pre-course, and post course).
- The participant book is very well laid out and useful
- Facilitators book is also very well laid out and easy to follow (love the icons)

LEAP2011-0019

- Interdisciplinary team approach for facilitators and participants (including ALL members of the team)
- Good participant and facilitator curriculum materials
- Case studies are very positively received by participants
- Videos are good resources
- Pre-course survey is valuable if a summary is provided to facilitators ahead of time; facilitators can then highlight issues ID'd by the participants at the beginning on a flip-chart, try to ensure that these are covered during the course and then summarize at the end of the course ("were these issues covered?")

LEAP2011-0020

- Consistency of the message between groups of learners
- Flexibility - use portions of it, add our own stuff, can use it in addition with updated info and with local info.
- Evidence-based

LEAP2011-0022

- Good overview and basic information to provide consistent foundation for all trainees
- Good consistency with Pallium Palliative Pocketbook, which we recommend as a resource

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OVERALL – IMPROVED, CHANGED OR ABANDONED

OVERALL, WHAT WOULD YOU LIKE TO SEE IMPROVED, CHANGED OR ABANDONED IN LEAP...

LEAP2011-0001

- The video's could be better - we have had complaints about them.
- The psychosocial needs could be expanded. Many staff are requesting more ethical information and examples.

LEAP 2011-0002

- Depression, Anxiety, and Suffering and Grief & Bereavement modules need a weekend course of their own preferably taught by a Social Worker/ Psychologist/ Counselor.
- Delete the ethical grid in the GI module.
- The videos could be improved.

LEAP2011-0003

- With new medications available(relistor, onsolis, etc,) LEAP needs an update.
- Otherwise, certain scales, such as "confusion rating scales" and mini mental, Cage questionnaire should be added as part of LEAP.
- participants manual should have a "conversion chart" for Duragesic, as this always creates a challenge for the participants.
- I would consider having a few scenario's for possible role play as part of module 5 (communication)
- As the importance of Advanced Care Planning Increases, I would incorporate some of the findings (benefits/ how to discuss) within module 5 as well as the last days and hours module10.

LEAP2011-0004

- Develop separate module and info for use in residential care settings.
- Add PPS scale to creating context module (prognosis slides)
- Develop medication calculation sheet for use in the pain module (for learners to practice medication calculations).
- Include dignity related questions developed by Harvey Chochinov for the module on difficult communication.
- We have had a lack of GP's attend.

LEAP2011-0005

- The slides with the modules need proof-reading, as does some of the text in the modules (Note – respondent is using LEAP version 1.0).

LEAP2011-0006

- More referral back to Pallium pocketbook

LEAP2011-0008

I appreciate that LEAP was originally designed for medicine, nursing and pharmacy, and I can appreciate what I consider an emphasis in the program on the medical approach to care. I am concerned about this emphasis on the medical approach, specifically pain management, GI problems, and respiratory, all at the beginning of the program, compared to the less than adequate psycho-social-spiritual. If you look at the diagram entitled, "Total Suffering: Woodruff," slide 21 in Module 1, you will see the balance I believe needs to be reflected in this program. In the note with this slide reference is made to a term used by Dr. Michael Kearney, "soul pain," and I believe this needs more emphasis in the LEAP Program. This discrepancy is also reflected in the time allocation for the psycho-social-spiritual compared to the medical topics, where you see at least a two to one ratio in favour of the medical compared to the psycho-social-spiritual. I believe a more interprofessional approach and great emphasis placed on the interprofessional team, Module 11, would help balance out the palliative care learning in LEAP.

Module 11 needs to be towards the beginning rather than at the end, since it underlies all the other sessions.

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I think much can be learned from "problem-based-learning" (PBL) and the use of cases for instance, and I see some of this in the program. I have found the presentations too technical and I'd prefer a priority of having to work with the material instead of having it presented in lecture format. My experience has been on communicating the content rather than on the learning objective. I'd much prefer having to read some background material and then having to bring my unique professional perspective to a case. My medical knowledge is limited, but I still see aspects of pain management that the medically trained professional might not see. Likewise the medical professionals see things in the psycho-social-spiritual approach to care that I might not see because of personal emotional blocking for instance. I would recommend resources such as the following:

- EFPPEC (Ottawa) created resource, "The Total Pain Module;" the Cancer Care: A Program of Eastern Health, Module entitled, "Grief and Bereavement."

- I think the LEAP program could have a more positive, life-giving, approach. I welcome the approach taken by the Victoria Hospice in their materials, which appears to me to encourage hope.

LEAP2011-0009

- To have a process in place to evaluate and ensure that trained facilitators have the comfort level to present all the modules even though they may not be an expert in a particular module. The process to include when and how the facilitator has to upgrade if has not used their skills in ? number of months, /year etc.

- Process guidance to reconnect with participants to ensure that they are educated to the appropriate levels on each of the modules, and are acting as effective facilitators passing on appropriate information - this can be time consuming.

- References need updating

- More interprofessional video clips

- Length of medical modules is long - at times not able to cover complete module even within the timeframes suggested. GI module contains ethical circle - this could be presented on its own. And used throughout the Modules

- Language can be simplified for the getting started session - realize that facilitators will come with various educational backgrounds. Consider writing tips in simpler language and make use of slide development on this portion as well. Language and length may be a tune out factor.

- Endeavour to create/provide slides for communication module.

- Need to recognize that all modules are necessary for whole-person care - this needs to be understood by facilitators to ensure that medical practitioners (physicians, nurses, etc.) understand that that all modules are important. Needs to be more interprofessionally driven and equal as opposed to top heavy on medical.

- Alter the module presentation sequence so that you are alternating between medical and social and other modules.

- Needs to be adapted to include all care settings - not just community care.

- Copy cost re: color vs. black and white. Some items do not stand out as well when not in color for facilitator kit but is what we use in order to save on color cost.(and often facilitators do not have not access to color printers etc.)

- Can it be better revamped to fit and flow with the Pallium Palliative Pocketbook Chapters so that people can intertwine and follow the flow to use in education, facilitation and daily practice?

- Module timelines could come out and let local teams decide

- Advance Care Planning be a beginning Module as well- tie in with new ACP 2011 work and web site www.advancecareplanning.ca

- Connect to National HPC Accreditation Standards in some way as well

- Work for more collaboration and interaction with Modules- some much information to cover a tendency to work to get through the materials thus diminishing discussion and input and practice

- Guidance on how to keep our skills updated

- Making sure and modifying the materials so can be used across all sectors (LTC, acute, community) with teams and volunteers

LEAP2011-0010

- Inclusion of modules on advance directives or advance care planning.

Reorganization so that the beginner basics could be facilitated in one day as a lot of health care professional reflect that they want a more advance level of detail/indepthness (how to handle the complicated/extreme cases. Flexibility in adding or taking away slides or adding slides takes away the ability to state that all persons who have had the training could be LEAP certified.

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- Ability to use different styles of interaction other than lecture, although a lot of participants prefer lecture style.

LEAP2011-0012

While I realize that medical issues are paramount, I do feel it is slanted more towards that aspect. I understand. On GS16 it states, "LEAP supports delivery with blended participant groups of physicians, registered nurses and pharmacists, and seeks to incorporate other disciplines as guest resources." I have participate in the training with other disciplines, and also facilitated the training with more inclusive groups, and found it worked well. Even as a volunteer there was much I could take modules like palliative sedation, that is useful to me.

LEAP2011-0013

Some clinical content needs to be updated as expected over time. The sections on Anxiety, depression and grief needs work. We have modified our presentation to combine Setting the Context, Anxiety Depression and Grief in the first session to establish the philosophy of what it means to work in palliative care. We feel the primary goal of palliative care is to help people have a good death. We spend time getting participants to think and understand the "process of dying". We try to get the participants to think about what it means to be dying and what people want and need to know given our death denying society.

LEAP2011-0014

- Some of the weaknesses of the course have been our own undermining of the original program to try to shorten it to a more manageable weekend for participants. The original format is probably too long with too much information for people to absorb in a short period of time. Physicians seem more reluctant to give up an entire weekend for a course.

- I would like to see LEAP even more interactive than it is now with more variety in educational strategies used. The PowerPoint theory bursts can become quite tedious. I would like to see more multi-media used, interactive quizzes embedded into the content, role play in the communication module, cast studies as part of the theory bursts and more small group (3-4 participants) sharing, etc.

- One of the weaker aspects from past evaluations has been the communications module. I think we try to cover too much using the videos, and would do better with a more focused approach, choosing a few key areas identified by participants, with more opportunity to practice skills rather than just critique what they have seen.

- I think an earlier discussion of decision making in palliative care is needed - developing goals of care and basing treatment decisions upon those goals. I find the process/flow in the Latimer Ethical Decision-Making model easier to visualize when considering the whole person than the Ethical Grid. It also seems to flow better into the formulation of GOC, with the ongoing revision of those goals as the illness progresses. This discussion would be best early in the course, perhaps in the first module.

LEAP2011-0015

- For undergrads and resident learners, 1 hour is max for a teaching session, however, some of the modules do not fit well in this time frame, e.g. pain, communication. Perhaps they can be tweaked to have a specific cut off point for the one hour mark.

- Information needs to be more up to date, e.g. palliative rehab gets little focus in any of the modules.

- Please make them more explicitly evidence based, e.g. identifying relevant literature on the bottom of each slide. Also, indentifying level of evidence for some of the interventions, e.g. dyspnea, to distinguish what is in practice vs what has strong evidence.

- There needs to be some precaution with the guided imagery - having used it many many times with medical learners, and uncovering some very intense and painful experiences, users need to be careful of how they introduce this, how they give options to participants re how they wish to engage (or not) in the module, how much time they leave for discussion, and how much support they offer. I feel quite strongly on this one, having had some people intensely disturbed by the guided imagery.

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- I have specific interest in the dyspnea section and the guided imagery if you are looking for 'volunteers' to revisit these sections.

END OF COMMENTS for instrument for 2011-0015

LEAP2011-0016

- The information needs to be up-dated certainly - there are newer medications/agents etc. since this information and other best-practise guidelines to be incorporated.

- It is great to have a pre-test and results available but not always possible. Perhaps at the beginning of an in-service we could spend a few minutes documenting the learning needs of the group for that particular module on a flip chart.

- I think the case studies are one of the most important tools for learning. Many of the staff I work with have stated that they learn better by "doing" so time to practise opiod dosage titrations and rotations would be helpful. Also some more role plays practising how to help clients make the difficult transition from curative to palliative.

- More information on malignant would care.

- More emphasis throughout the entire course on working together as a team, including ideas on how to work with physicians who are not "on board" with the goals of care or who refuse to follow established Palliative Care pain management protocols.

- I find the index for the Pallium Handbook a real "pain in the butt." It is bulky and unwieldy. I am assuming when it is updated that an index will be included in the handbook itself.

- While the course is intended for physicians, RNs and pharmacists we include LPNs as participants with good results. Social workers attend and participate especially in the modules around Communication and using an Ethical Grid.

- I would like to see the theory bursts shortened a little.

- It would be great to have DVDs available of shortened versions of the modules presented by an experienced team. The staff in my region generally express that they don't have time to go to even a one day workshop because of short staffing, or they want to be paid to attend which is not happening etc. They would be willing to watch an hour or so DVD on nights when there might be a bit of down time. Then I could invite them to come to a bag lunch meeting to discuss the segment they watched, have discussion, questions etc, maybe even a practise of something that was presented on the DVD.

LEAP2011-0017

- The whole course needs an update in terms of adding recent research where applicable, integrating more up-to-date practice. Each module needs more references or at least a reference list/bibliography at the end. There is a great lack of referencing the material in this course.

- Who are the intended learners in this course? What is the intended setting? I know it was initially intended for rural physicians, nurses and pharmacists.

- Need to re-examine the teaching/learning pedagogies within the course.

For example some questions that need to be addressed:

-Is this a learner-centered course or a facilitator-centered course or a mix of both? -What are the specific teaching/learning activities that incorporate all the styles so that the course is as user-friendly as possible?

-How is this course linked to the way in which palliative end of life care is organized in Canada and is it serving the practitioners working in all settings?

-What are the teaching/learning philosophies behind this course? Are these interdisciplinary or are they 'medicine' focused?

-Can competencies be added? ideally interdisciplinary but also discipline specific so that learners can build their knowledge based on competencies.(ref: Reeves et al 2008. interprofessional education: effects on

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professional practice and health care outcomes, Cochrane database found at:
<http://www.hpme.utoronto.ca/Assets/hpme/events/hsr07/reeves2.pdf>)

- I also think that the cases need to be re-done, perhaps have 2-3 cases so that facilitators can choose one that is the most appropriate in that setting (rural, urban, cancer, chronic end stage disease, etc.).

- Is there a resource bank that the facilitator can refer to, such as to Virtual Hospice or the CHPCA Education Commons or others?

- Although we have been hugely successful in bringing LEAP to our area there is always a demand for a variety of ways to offer the course.

Here are some of the suggestions:

- Addition of tools:
 - o to identify knowledge gaps so that learners can utilize modules to meet their own needs.
 - o self evaluation tool for learners once they have completed the modules or the whole course
 - o for learners to think about KT- how do they envision bringing this learning in their own practice, who needs to be involved; how will it happen, etc.
- Add the Palliative Performance Scale (PPSv2) into the modules as it is now widely used and a valuable tool.
- Self-paced modules to meet adult learner needs.
- Psychosocial modules need to be complemented with more experiential opportunities so could some be grouped together, for example modules 1, 11 & 5 together using 5 as the experiential component (e/g/ role playing).
- Similarly to the previous item, the physical symptom modules should be linked with psychosocial because the experience is holistic and when we present them as separate the linkages may be missed (this is a typical 'medical' way of teaching but is not a nursing or social work way and since there are many more nurses taking this course than anyone else I wonder if a new approach is needed that is more holistic in nature)
- Regular telephone/videoconferencing for discussion of case studies.
- Opportunities for participants to bring/send the facilitators their own case studies that may be more relevant to their patients; or include a variety of cases for each module that are more representative of different ways people experience end of life (cancer, dementia, end stage disease, etc.)
- Consider putting voice to PowerPoint presentations and offer these both on-line and in DVD form

LEAP2011-0018

Improved

- A mechanism for updates around medications, changes in current treatment options
- Some of the "ill-structured" video clips are a little hokey
- There is a tremendous amount of material for a 20 hour course which leads to the course discussion suffering as there is such pressure to get through the content.
- The commitment to change exercise at the end of the course, we find it is hard to follow up, so we are not sure about the relevance.
- Citations for all of the studies on the slides should be referenced at the end of each chapter.

Changed

- Could some of the module 5 communication topics be blended together to shorten the content in order to allow for more discussion.
- Module 9 is at the end of the weekend, not sure that it gets fair attention and clarity and a chance to really have the participants understand the intent of palliative sedation and how this is different than euthanasia.
- Module 11 - Working as a team could be woven in to the communication module or threaded through many of the other modules to highlight the importance of the team approach to palliative care.

LEAP2011-0019

- update the content and medications cited to reflect the most current practices for ALL modules, particularly: grief and bereavement, GI, pain management, respiratory problems, and delirium)
- should include a greater opportunity for inclusion of compassion fatigue and moral residue which are challenges often faced by palliative care practitioners

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LEAP2011-0020

- Needs more references to confirm evidence, where to go for evidence, put references at the bottom of each slide.
- Needs to be adaptable locally - more flexibility. We want to be able to deviate from the content, depending on the audience, and their expertise. Too basic for experienced learners.
- Needs to specifically designed to be flexible to be able to teach one hour only or at a time.
- Incorporate basic and advanced sections for each module.
- Slices of content allows us to integrate our own culture
- Need a precaution with self-reflection guided imagery exercise can be dangerous for those who uncover painful and intense experiences, need to be careful how they engage the learners. Would be willing to work on this with LEAP.
- Have more detail that we can pick and choose from depending on audience, e.g. basic vs advanced learners. You may need to allow us to modify slides.
- All the cases need to be put into slides to make discussion easier. We don't always use the workbook.

LEAP2011-0022

- All cases available in powerpoint for group presentation and discussion
- Since sometimes only theory burst or case presentation is used, depending on background of the residents, would be helpful if any teachings in the case presentation are also in theory burst, and vice versa.
- Update clinical therapies as approach (as I'm sure you're planning)
- Many presenters state that the modules, which not overly in-depth, provide a good, basic overview of the subject which is useful for the resident with little clinical experience in Palliative Care. Some would welcome some optional slides with more advanced facts that can be used on appropriate occasions (just like there are some optional slides with more basic facts in the pain module).

MODULE ONE - CREATING CONTEXT

CURRENT (v1.1) Learning Objectives - Upon completion of Module 1, participants will be able to:

In the context of hospice palliative care as a core primary health care service and philosophy:

Define hospice palliative care and its basic elements.

Explain why hospice palliative care and treatments directed at controlling the disease (e.g. chemotherapy, radiotherapy, hormonal therapy, surgery, etc) are not mutually exclusive entities.

Distinguish between administrative and clinical definitions of when a patient is deemed to be palliative and identify the potential tension between the two definitions.

Describe the needs of dying people and what they want from their health professionals.

In the context of self-awareness and the response to suffering:

Analyze how past experiences with suffering, dying, and death may influence how they care for terminally-ill patients and their families.

Describe the importance of self-awareness in caring for terminally-ill patients.

PLEASE DOCUMENT THINGS THAT WORK WELL WITH THE MODULE AS WELL AS SPECIFIC AREAS/ITEMS THAT YOU WOULD LIKE TO HAVE TAKEN UNDER CONSIDERATION FOR IMPROVEMENT/RENEWAL

LEAP2011-0002

- Slide 17 (CHPCA Model) and slide 21 (Woodruff) need to be kept and discussed.

- The module could be shortened - eg: remove "Self awareness" and introduce it throughout the course in a brief reflection.

- The disease specific markers would be more appropriate in the Last Days and Hours module.

LEAP2011-0003

The slides in this section are very well done. This leads to discussion on depression and sadness and the difference between and when depression should be treated. Supportive and dignity conserving work section is very well done and adds a good lead into the grief and bereavement module.

LEAP2011-0004

No time to share personal stories when taught over 2 days. Add PPS scale under determining prognosis.

LEAP2011-0006

Work well

- Defining palliative care and hospice

- Self-awareness discussion (section 26)

- Appendix – disease specific markers

- References

Areas/items I would like taken under consideration

- Self awareness exercise – section 2a (page 1-3)

LEAP2011-0008

I found this to be a good overview of the program. It places the focus on knowing yourself which is critical in delivering good palliative and end-of-life care.

I would like to see Hospice Palliative Care CHPCA Model, Slide 16 in Module 1, include anticipatory grief, rather than only addressing bereavement care that happens after death. Mention could be made here of the use of the Victoria Hospice, Bereavement Risk Assessment Tool, to identify people who are at risk of experiencing complicated grief. The administering of the tool with the family and friends prior to the death of the palliative care client may help them to address some of the issues contributing to the complicated grief.

I appreciate that the program includes some chronic illnesses that are considered palliative such as dementia.

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LEAP2011-0009

- Good job done- triad sharing very effective - provides participants with safe setting at the beginning of the workshop.
- Flows well, and allows for a minute of silence - engaging
- Difficult to do justice to self-awareness due to length. Could be a Module on its own.
- Slide 22 predicting life expectancy really important information, but does not fit in this module. Does not fit elsewhere, but is very important - could it be a separate module and made more disease specific. Perhaps could be placed with Pain and Symptom Management along with the appendix.
- Section 3 “defining PC” - could also be a module on its own - could combine with holistic approach to care slide, care of family, and some of the medical information. It is very valuable information - needs to be reviewed as to where it is placed.

LEAP2011-0012

- 1-2 Sharing the stories is a great way to start, and leads well into the self awareness piece that it truly important.
- 1-6 Good explanation of hospice/palliative care.
- 1-10 I like the mentioning of the wishes of the patient and total suffering.
- 1-11 I think the video really helps focus us on the importance of being there for the moment. That is an important lesson.
- 1-12 I like the helpful hints.

LEAP2011-0013

I make a point of talking about a period of time often encountered that I call the "quiet time before death". This is a time when the patient is unable to respond to the family or does so very rarely. This can be for hours or days. It is often during this time families ask or at least think about wishing their loved one would die quickly. This can lead to feelings of guilt. We try to help families think about where there may be value in this time. We share from our experience how many families despite finding the time difficult had someone within the family need the time to prepare for the death. I also challenge the learners to think about what they think the dying person is doing during this time. Are they oblivious to all around them or doing some work preparing to die. This is one of the key areas we as palliative care workers need to have done some serious thinking and explore our feelings about what is happening. We need to know what the family may be thinking so we can anticipate what information they may want or need. Again this is often the first time they may be experiencing a death.

LEAP2011-0014

- The self-awareness exercise at the beginning of the workshop is good. It sets the stage for self-reflection and discussion, often bringing up a lot of issues and feelings. I think the concept of seeing the patient in a whole-person context is also important here. Perhaps could introduce some of Dr Chochinov's work on the ABCDs of Dignity Conserving Care (Attitude, Behavior, Compassion, and Dialogue). It is important that we remember that palliative care education needs to balance the education of the mind with the education of the heart. ("The dying need the friendship of the heart - its qualities of care, acceptance, vulnerability; but they also need the skills of the mind - the most sophisticated treatment that medicine has to offer. On its own, neither is enough." Dame Cicely Saunders)

- Defining Palliative Care: What makes PC different than caring for other patients? What makes it more challenging? What makes it rewarding? What struggles do you face in your workplace?

- Diagram in Slide 17 is confusing. Perhaps using a diagram showing the typical disease trajectories of cancer, end-stage heart and lung disease and dementia would be more helpful.

LEAP2011-0016

Palliative Care Context, telling our stories, self- awareness and defining palliative Care all good. Perhaps at the beginning we could ask for specific learning needs from the group and specific things that cause concerns for them as front line workers. (because pre-tests are wonderful and it is great if one can have the results of that on hand but it isn't always possible).

LEAP2011-0019

Module 1 - no specific comments.

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LEAP2011-0020

- Like slide #18 - use it all the time.
- Love the vignette - use it a lot.

Needs improvement:

- P. 1-5 no reference for theory of past experiences of human beings influence how we care for them
- p. 7 old reference (1993) needs to be updated.
- Insert a diagram of the 2002 chpca model
- Reference of patients surviving longer if pall care referred earlier
- Good literature has been written since last version
- Add dementia in slide #12. Are there other diseases missing?
- Delete AIDS from slide #12
- Statement re pall care = active care needs to be stronger on slide #12 and 13
- Pall care is now recognized as a specialized service in nursing, medicine (fellowships)
- Slide #14 needs to be reworded. Hospice and palliative care are not synonymous (complexity may differ? Hospice is a place). Need to talk about origins of both words and how they are now used, to set the context instead of a definition.
- Slide #16 & 17 - is diagram complete? Dotted line for terminal phase?
- Slide 18 - definition of terminal phase should be changed to 'last few weeks'. Imminent death should be changed to 'last days and hours'
- Slides 19 & 20 - need more recent theory, e.g. david kuhl or whatever else is out there.
- Slide 21 - total suffering - would like to see chpca 8 domains of care here. Would like to see our Pie (circle divided into 4 with 8 domains fit in).
- Slide 22 - should be expanded into 2-3 slides to talk about chapter 4 in Pallium Handbook
- At end of module - put all the references.

LEAP2011-0022

- Creating context: good introduction. Video is appropriate introduction to self awareness, even if it uses large part of time for this module. Have added some of the ethics discussion from GI section, as we don't always follow the order of the modules.

MODULE TWO – GASTRO-INTESTINAL (GI) PROBLEMS

CURRENT (v1.1) Learning Objectives - Upon completion of Module 2, participants will be able to:

In the context of managing nausea, vomiting, and malignant bowel obstruction:

- List five common causes of nausea and vomiting in palliative patients.
- Develop an initial management plan for a palliative patient with chronic nausea and vomiting and/or constipation.
- Select an anti-emetic on the basis of the inferred underlying mechanisms for the nausea or vomiting.
- Develop an initial management plan for a patient with malignant bowel obstruction

In the context of managing cachexia, anorexia, and artificial hydration and nutrition in terminally-ill patients:

- Describe the roles of artificial hydration and nutrition (enteral or parenteral) in palliative patients.
- Describe the clinical implications of the pathophysiological mechanisms of cachexia and anorexia in patients with advanced cancer and AIDS.
- Identify situations in palliative patients where artificial hydration may be useful.
- List three pharmacological agents that could improve appetite in patients with advanced cancer or AIDS.

In the context of ethical decision-making:

- Describe a framework for making ethically-sound decisions at the end of life.

PLEASE DOCUMENT THINGS THAT WORK WELL WITH THE MODULE AS WELL AS SPECIFIC AREAS/ITEMS THAT YOU WOULD LIKE TO HAVE TAKEN UNDER CONSIDERATION FOR IMPROVEMENT/RENEWAL

LEAP2011-0001

- Need more emphasis on "GOALS OF CARE" throughout all of the modules.
- The Theory Bursts are good.

LEAP2011-0002

- Remove ethical grid.
- Otherwise a good module.

LEAP2011-0003

- This module is very well done. The graphics are beautiful
- I would suggest to add a detailed graphic of the neurotransmitters and drugs used for the participants. It would be helpful to have such a graphic available in a printed form, on the Palliative care units, as this symptoms can be complex and nausea in palliative care is something GP's have very little knowledge of.
- The area on artificial nutrition and hydration is well done and I would not change it.

LEAP2011-0004

- Divide slides for GP and RN to present together.
- Ethics is so important and needs its own module. Case study too long. Perhaps use the food/flids info under examples of ethical dilemma.
- Add principle of 'double effect' as it is something discussed in palliative care alot.

LEAP2011-0006

Works well

- Theory burst good for medical professionals (section 1, p2-2)
- Case discussion and question – good (section 2)
- Ethical grid (section 3)
- Discussing goals of care for an incapacitated patient video (section 5)

Items/areas to be taken into consideration

- Nausea/vomiting mechanisms – difficult slide with lots of info
- Artificial hydration/hypodermoclysis (slide 19) – may be skipped depending on the group

This whole module presents lots of info helpful to medical professionals; some words may need to be defined; take home points wrap up module really well

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LEAP2011-0008

I would like to emphasize the use of the cases rather than the facilitators feeling they have to cover the detail of the theory burst. The participants will learn some of the theory through the case discussion and I think this is helpful for the participant's learning.

I also appreciate the reference to Ethical Decision-Making, slides 21 and 22 of Module 2, (2-16) and the use of the ethical grid and the cases that are provided. This is complemented in the Helpful Tips for Working with Families of Incapacitated Patients, 2-27, where it encourages the interprofessional team to engage the family. I see this as including the family in the circle of care, emphasizing the inclusion of the family in the health care team.

LEAP2011-0009

- More time needs to be allotted, need to include time for discussion, also need time for questions and to have them properly addressed as there are many hot topics included in this section.
- Ethics and Ethical grid needs a separate module while still Integrating & intertwining throughout other Modules
- Constipation section needs to be updated
- Anorexia and Cachexia section very important

LEAP2011-0012

Not being involved in the medical aspect, this unit is challenging for me to comment on in terms of what might be working well, or missing.

LEAP2011-0013

Slide 11

- Mineral oil should be avoided
- Docusate - no evidence for use

- Add peripheral opioid antagonists
- I like the section on artificial hydration and the cases/ethical decision making grid works well.
- Slide 41 Cincinnati Stroke scale
- Do we need a small section on Neurologic conditions - Stroke/MS/ALS/Parkinsons?

LEAP2011-0014

Theory burst on constipation needs major revisions, particularly the pharmacology. There should be clearer guidelines regarding the prevention and treatment of constipation, introducing newer agents such as PEG 3350 and methylnaltrexone.

Consider introducing the case study on nausea and vomiting before the theory burst and then returning to it afterwards to apply new learning to solve problems.

Consider the Latimer model of decision making rather than the Ethical Grid. The process of working through this model, developing goals of care and then basing treatment options on GOC, with constant reevaluation as the disease progresses gives a better framework for people to use.

Perhaps using role play to discuss common family concerns such as IV hydration, anorexia-cachexia, and "starvation" would be helpful in this module.

LEAP2011-0016

- Constipation section needs revision. Info about sodium phosphate products and associated risks would be helpful.

LEAP2011-0017

- Separate out the ethical piece from the GI module. Maybe it can be added to first module instead of the self awareness piece as a way to sensitize participants about EOL care and our ethical role and responsibility in that care?

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- Update the drugs used with references. There is a new palliative pharmacology book just printed which would be a great resource. Pharmacist Bruce Kennedy from Fraser Health in BC is a co-author and would be a great resource for all the pharmacology updates in this course.

- If we could have less emphasis on cancer and more for end stage disease that would add to this module. So we need to ask ourselves what are the GI issues in non-cancer patients at end of life and how do we approach these?

- Every slide needs an accompanying facilitator note.

- This module is very medically focused and I think we can improve it a lot without losing the essential medical components. Can we somehow incorporate other aspects of the person's experience into the symptom modules so that practitioners see patients as whole beings and not just a physical symptom? Can we have a slide on how to engage patients in their experience of whatever GI symptom they are having and what is important to them? What are their goals? I think we have missed this entirely... a focus on what the patients goals are... this should be asked in every module so that it is patient-centered care and not practitioner-centered care. If we can bring all the learners together and focus on the patient and not the part of the patient that is the most interesting to individual learners then maybe we can also contribute to working as a fully functional interdisciplinary team and not each of the team members doing their own thing. Maybe the physicians won't agree with this but I think we can make a stand here in this course in bringing everyone together utilizing the principles of interprofessional education: 'any type of educational, training, teaching or learning situation where two or more health and social care professionals are learning interactively' (ref: Reeves et al 2008. interprofessional education: effects on professional practice and health care outcomes, Cochrane database found at: <http://www.hpme.utoronto.ca/Assets/hpme/events/hsr07/reeves2.pdf>)

LEAP2011-0018

- Really appreciate the presentation of hypodermoclysis as a realistic short term therapy.
- Really like the ethical decision making grid and then the case studies following and having the group decide if they would start artificial feeding and hydration. (Section 4) Anorexia/Cachexia and Artificial Feeding and Hydration).
- The section on Cachexia (slide 29 on ward) is really well presented as this is an area that is often very misunderstood and leads to great patient and family suffering and conflict.
- We have found that there wasn't much time to include Section #5 Video and Case study on CVA.

LEAP2011-0019

- slide 16: slide in binder does not match the slide on the PPP

LEAP2011-0020

Like:

- Separate sections are good, we can take them separately.
- Love the 3 cases - they inspire good discussion around teaching points.
- Good video on stroke patients

Needs improvement:

- Delete quote from Shakespeare. Need to say to learners that they need to talk about importance of nutrition with patients and families.
 - Prefer to see antiemetics in a matrix format rather than a list. Matrix shows cause and what to use.
 - Slide #5 is wrong and not a good diagram. Update and/or find another diagram. Use a consistent, algorithm format as in slide #11 of Delirium, throughout binder.
 - Slide 7, 8 & 9 is confusing. Treatments need to be associated with causes. Change to one slide with categories as cause. Also need examples.
 - List of meds with power of receptors (ie. Twycross 1998) good but old
 - Pallium chapter 8-9 and 8-3 have lists of meds that should be incorporated into LEAP.
 - Slide 10 - constipation - needs updated references in light of new evidence on laxatives
 - Slide 11 needs a major update
 - Slide 12 needs references
 - Slide 13 - add question: What is the goal of care?
 - Slide 15 - needs a major revision. Dosage of dexamethazone is wrong. Dose of octereotide seems low.
- False statement: gravol is too irritating... etc.

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- How old is the Cochrane Review for dexamethazone?
- References are old.
- Slide 17 - Hydration is not a black and white decision. Does hydration extend life??? What about culture? Should we add a slide that says it's a very grey area with cultural and individual influences? Slide 17 - could be turned into questions instead of statements to help stimulate discussion.
- Are there more recent references?
- Case needs to be made into a slide
- Slide 31 - Can it be updated using Pallium section 8-27 on cachexia syndrome?
- Slide 32 & 33 - Need to update the experience with TPN and palliative care, and need evidence.
- Take chapter from appetite stimulation from Pallium and add it to LEAP.
- Slide 41 and 42 on prognostication should be moved to Module 1 on setting the context.
- Slide 10 and 11 - Integrate the national consensus protocol on constipation management.

LEAP2011-0022

- much important info – usually rushed or use more time
- polyethylene glycol and methylnaltrexone

MODULE THREE – PAIN MANAGEMENT

CURRENT (v1.1) Learning Objectives - Upon completion of Module 3, participants will be able to:

- Categorize pain according to the inferred underlying mechanism and explain the clinical utility of this classification system.
- Explain the concept of “total pain”.
- Undertake an assessment (history and examination) of a patient with pain, with the aim of devising an effective management plan.
- Use a standardized tool to assess pain and other symptoms.
- Describe the factors that may predict difficulty in controlling pain.
- Apply the WHO Ladder in selecting an appropriate analgesic regimen for a patient with pain.
- List the types, formulations, and routes of administration of opioids available to you for pain management.
- List two indications for switching from one opioid to another.
- Initiate an opioid (codeine, morphine, hydromorphone, oxycodone, and fentanyl) at an appropriate starting dose.
- Address fears and concerns that the patient or family may have about opioids.
- Effectively prevent and treat common opioid-induced side effects.
- Demonstrate appropriate opioid dose titration.
- Explain when one would initiate treatment with a short-acting versus a long-acting opioid.
- Demonstrate basic management of “breakthrough pain”.
- Demonstrate appropriate conversion to long-acting formulations from short-acting formulations, and *vice versa*, when using the following opioids: Fentanyl, Morphine, Hydromorphone, Oxycodone
- Describe the clinical presentation of opioid neurotoxicity and three strategies to manage the problem.
- Using an opioid dose conversion table, correctly determine the dose of a new opioid when switching between morphine, hydromorphone, oxycodone, and fentanyl.
- List three adjuvant analgesics for the management of neuropathic pain and describe their respective roles (i.e. first line adjuvant versus second or third line).
- List three adjuvant therapies for the management of malignant bone pain and describe their respective roles.
- Describe one adjuvant analgesic for managing visceral pain from metastatic liver involvement.

PLEASE DOCUMENT THINGS THAT WORK WELL WITH THE MODULE AS WELL AS SPECIFIC AREAS/ITEMS THAT YOU WOULD LIKE TO HAVE TAKEN UNDER CONSIDERATION FOR IMPROVEMENT/RENEWAL

LEAP2011-0001

This section is very informative for physicians and nurses but is often more detailed than many want. Could provide alternative section for other disciplines. Especially more emphasis on alternative methods of pain controls they could be involved with.

LEAP2011-0002

- Cannabinoid section (page 3-21) requires updating.
- Need some slides about specific opioids used in palliative care including some of the “newer” eg: Fentanyl sublingual, Tramacet,

LEAP2011-0003

- Copies of the “brief pain inventory could be added in the annex area.
- In a novice audience, more conversions need to be done to “cement” that skill. I have been taking more time for this module and adding examples depending on the target audience.
- This module is very well done otherwise. The concept of “total Pain” is well communicated through the case used (Fred).

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LEAP2011-0004

Case study too long. Divide slides up for GP and RN to present together. Add a medication conversion sheet for learners to practice what they have learnt. This is a heavy module but all concepts are important. Have shorter case studies.

LEAP2011-0006

- Excellent module – everything seems to work well – would be hard pressed to change anything.
- maybe definitions of some words would help

LEAP2011-0008

Pain management is a vital dimension of palliative care. I appreciate the inclusion of sensitivity to the "fears and concerns of the patient and family," as stated in the objectives, 3-1. Even though I have identified this module as being too medical, I also recognize the interprofessional content in the cases.

LEAP2011-0009

- **Not near enough time** allotted for this module - needs at least a half day
- Needs to be updated in terms of latest newest medications, protocols, practices
- Needs to be presented by a palliative clinician who is practicing in the field
- Like for more time to integrate application, being interactive and putting into practice with use various validated assessment tools etc.

LEAP2011-0012

- I felt the material was quite good, covered many issues. Case study works well to illustrate, and get people thinking. Glad that total pain is there. It got people involved. Felt that it offered a lot to the medical participants.
- Seemed like quite a lot- time frame may be too short.

LEAP2011-0013

- The module works well. Especially like starting with the case and prescription. The case does need to be modified as one could argue the need to get an MRI and steroids right from the start given new back pain and history of vertebral mets a year earlier.

- Slide 13 - add faces scale

- Slide 20 - weak opioids - tramadol, buprenorphine

Discuss max acetaminophen doses

New - dexmedetomidine

- Slide 26 - change neurotoxicity to common side effects in the palliative population

- Slide 30 - See above new meds, other preparations of fentanyl

- Slide 34 - Fentanyl patch - never start in opioid naive

Stop using ranges "q1-3h prn" redundant - if you can give q1h don't need to have the 3 there.

- Slide 41 - Cardiac risks for NSAIDS

- Page 3-28 (version 1.0)

Case 1 scene 3

Morphine 5mg po q4h and 2.5 - 5mg q1h prn.....I recommend not giving the range. Only confuses those who don't understand the doses. The breakthrough will look after any need for the range and if you are undershooting by alot the patient or family should be calling if they require several breakthroughs in the first day.

- Don't use Docusate

- Q3-16 Spinal cord compression - should we have a small section on oncological emergencies.

LEAP2011-0014

- I think the small group work on pain management is one of the strongest, most practical aspects of LEAP.

- A lot of the issues that are important in pain management are only covered in the small groups, not in the theory burst, such as issues concerning Fentanyl patches (a huge issue of concern in rural practice), spinal cord compression (often missed or poorly managed) and incident pain.

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- Some of the newer agents could be included in the discussion of the WHO ladder (Tramadol, Butran for example).
- Incident pain should be covered and methods of opioid delivery need to be updated, such as intranasal and topical methods (wound management). The use of Pregabalin needs to be included in treatment of neuropathic pain.
- It may be worthwhile to be sure participants understand how to do opioid rotations, convert from oral to SC dosing, manage pain crises, and understand how to convert to or from Fentanyl patches.

LEAP2011-0016

- Case study is so important. However they are very detailed. Sometimes, I have to leave some parts out to fit in time allotted.
- More emphasis needed on assessment and use of assessment tools ie. PQRSTUV acronym for pain assessment)
- Make sure that critical information is evident. ie spinal cord compression is mentioned in the long and detailed case study on p. 3-40 but not in the theory burst. Sometimes there is not time to work through the entire case study so we need to be sure that it is all mentioned. (students just get copies of the slides, not the answers) so they may not have this information for future reference if we don't get to complete the case study.
- More information needed, re newer agents and also why some of them may not always be suitable for palliative patients.
- We'd like more info on incident pain protocols and pain crisis protocols.
- As I mentioned before, more practise examples re dosage titrations and rotations.

LEAP2011-0017

- Again... very physically and medically focused so we need to ensure a more holistic way of approaching this subject. The Total Suffering introduces this but that is where it ends.. the psychosocial, spiritual and existential components of pain need to be covered.
- Include a discussion on what are the goals of the patient in the plan of care for pain management and how as a team those goals can be met.
- A couple more cases with different scenarios would be great. For example, dealing with pain in someone with dementia is a common issue and needs to be included.
- I did not find the slides on investigation helpful or meaningful (plain xray and CT scan) to most of the learners.
- I like that the module covers opioids quite thoroughly including the myths. Add a slide on the definitions: addiction, tolerance, dependence, withdrawal. This section likely could be updated with recent studies.
- Opioid neurotoxicity is rare and while should be mentioned I think not in much detail.
- More time and emphasis needed for the equianalgesic table and conversions. Practice is good and giving learners a practice sheet including regular dosing and BTP dosing would be great. Nurses especially love this and I find that most physicians are lacking in this area.
- I think by defining what level this course is will help in how much theory and detail one goes into in regards to pain management, i.e how much detail for methadone?
- The adjuvants are all pharmacology... include the non-pharm adjuvants with as much importance.
- I think having the supplementary slides with more detail is a good idea so if learners want more than it is there.

LEAP2011-0018

- Need some updates on medications available (eg: Tramacet,)
- For LPN's and new RN graduates taking this course, we found that Slide 3, prescription writing was problematic and felt overwhelming.
- Good threading in of the total suffering piece by Woodruff.
- The slides of the X-rays are too hard to see when they are enlarged and projected. (Slides 15 & 16, Section 3).
- Could we add a glossary for participants that defines some of the terms (like dysethesia and allodynia etc.)
- Update of Slide #31- (eg, new fentanyl dosages, tramacet)
- Slide on the use of sufentanyl for severe or episodic pain in regular pain management section not in supplementary section.
- Move the starting doses for frail elderly to main section of pain and not in the supplementary section
- Slide #32 - Very practical and useful

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- It would be handy to have a sample of a breakthrough calculation on a slide (somewhere between slide #38 & 39).
- The ESAS shows up in the case study by people may not be familiar with it so may need a bit of description of this tool prior to using it in the case study.

LEAP2011-0019

- slide 20: "Percocet" should not be considered weak
- slide 20: under "Strong Opioids" should include tramacet
- slide 26: slide title in powerpoint does not match title in manual ("Common Opioid Adverse Effects" VS "Opioid Side Effects"); should list "urinary retention" as well

LEAP2011-0020

Like:

- Like the quote
- Like the case and that it's on the slide
- Like slide 12.
- Like slides 21-26.

Needs improvement:

- Order of slides - they have to read the case before writing a case. Delete slide #3.
- Why do we mention CAGE? If you leave it in, then we need a slide on CAGE.
- Slide 9 - needs updating and needs references.
- Slide 10 on total pain - use the ones from Module 1 on context, slide 21.
- Slide 11 - needs references
- Slide 12 - last sentence should be bolded.
- Need a statement that we need to constantly re-assess pain, not just at the beginning
- Slide 13 - need to update the scales.
- Slide 14 - we don't teach this anymore. Turn it into a matrix with type of pain. Need to differentiate Nerve Intact and Nerve not Intact. Remove dysesthetic and lancinating.
- Slide 18 - WHO ladder needs updating. We do not teach that mild is associated with a number. We need to ask patient's goals, which may be a number or something they want to do. We can't promise 0 pain. Do not put in ESAS numbers on ladder.
- Slide 19 - Don't like differentiation between 'weak' and 'strong' opioids. It's the dose not the drug.
- Slide 20 - may need updating . Should we add new rapid onset opioids?
- Slide 21 - needs a reference
- Add a slide - differentiate between allergy and side effects. Need to educate in case they have had a bad experience with a drug reaction. Need to talk about dose-related side effects.
- Slide 27 - delete delirium from list of clinical presentations of opioid neuro toxicity
- Slide 28 - when pain is well controlled, decrease qh dose or increase interval to qh6
- Slides 28 and 29 are duplicating each other.
- Slide 30 - needs updating (codeine subq doesn't exist anymore). Do suppositories still exist?
- Slide 31 - timelines are wrong! What is there for oral, we would put as subq.
- Slide 34 - dose for frail patient is much lower! Something not right in the text.
- Slide 36 - "if unable to swallow,.. " add rectal.
- Slide 38 - slide is dangerous. Need to say 'Caution re rapid escalation may cause opioid toxicity.'
- Slide 39 - contains mistakes. Some things don't exist. Remove range of oxycodone. Remove things about fentanyl and oxycodone.
- Slide 42 - need to clarify role of bisphosphonate.
- Slide 43 - need to agree that we don't want to differ between dysethetic and neuralgic pain.
- Facilitator guide around slide 43 - specify that usefulness of steroids is for cancer pain.
- Slide 46 - comprehensive assessment and ongoing assessments required.

LEAP2011-0022

- the main presenter tends not to use the slides, but leads residents through practical examples and has them practice conversions, rotations, which the residents find very useful, even if he doesn't complete the module.

MODULE FOUR – RESPIRATORY PROBLEMS

CURRENT (v1.1) Learning Objectives Upon completion of Module 4, participants will be able to:

- Categorize and list the causes of dyspnea in palliative patients.
- Explain the clinical implications of dyspnea being a subjective symptom.
- Describe the role of oxygen and opioids in the management of dyspnea in palliative patients with: cancer, end-stage heart failure, neurological illnesses (e.g. motor neuron diseases/ALS) and end-stage chronic lung diseases
- Utilize a management plan that includes: selecting appropriate pharmacological agents, selecting non-pharmacological approaches, addressing the underlying causes and communicating with families and caregivers to effectively control shortness of breath in palliative patients, including those with: cancer, end-stage heart and lung diseases and motor neuron disease/ALS
- Describe the limited role of nebulized opioids for managing dyspnea in hospice palliative care.
- List two pharmacological treatments for the management of intractable coughing in patients with cancer-induced intractable coughing.

PLEASE DOCUMENT THINGS THAT WORK WELL WITH THE MODULE AS WELL AS SPECIFIC AREAS/ITEMS THAT YOU WOULD LIKE TO HAVE TAKEN UNDER CONSIDERATION FOR IMPROVEMENT/RENEWAL

LEAP2011-0001

The theory burst is well done.

LEAP2011-0002

- Respiratory Congestion (page 4-9) - add "Scopolamine patch 1.5 mg i - ii q 72 hrs" to treatment

LEAP2011-0003

- good module

LEAP2011-0004

- At the beginning, give all learners a straw to breathe through (plug nose) while walking around. Add another straw. Ask learners how it felt--reinforces the first few slides in the module regarding SOB is a subjective experience.

- Too much info on palliative sedation and use of Midazolam. This is a specialized drug which isn't appropriate for all palliative SOB.

- Move sedation info to ethics or review if this should be included as intro to LEAP when GP don't attend. This may only be an issue in our communities.

LEAP2011-0006

Items/areas to be taken into consideration

- More info r.e. oxygen usage – e.g., when it is best used, type of oxygen used/required

- More info r.e., dyspnea or exertion at rest

LEAP2011-0008

The content of this module is very good. I like the reference to Shirley's fear in Case 1 Scene 2, 4-13. I again stress the importance of emphasizing the use of the case in the facilitation of this module. The theory burst may have to be shortened in order to insure that there is time for the interprofessional discussion of the case.

LEAP2011-0009

- More suggested time needs to be allotted - should be 1.5 hours at least

LEAP2011-0012

- 4-10 Case discussion /questions worked well.

- Slides comprehensive throughout.

LEAP2011-0013

- Hit all the relevant topics.

Version 1.0 courseware

- Slide 15 - Small doses - may want to go as low as 1mg morphine in frail copd as starting dose

- Slide 16 - Review the evidence for neuroleptics in dyspnea

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- Slide 21 - Octreotide - limited evidence at last check but have found it helpful
- Discuss pulmonary edema - Lasix sc

LEAP2011-0014

- Slide 9 (Approach to Dyspnea) should be moved closer to the beginning of the theory burst as it is the main concept - screen, identify and treat underlying causes if appropriate and possible, treat the symptom itself and communicate.
- Managing Underlying Causes (Slide 10) - introduce the idea of the PleurX catheter for the management of malignant effusions as most participants are not familiar with this.
- Add slide in theory burst on hiccoughs.

LEAP2011-0016

- We like it all

LEAP2011-0017

- The slide with the COPD patient is excellent and has been very useful in discussions about dyspnea.
- Another cause is hyperinflation in COPD patients; important for learners to understand that physiology because the more hyperinflated the alveoli get the more anxious and more gasping for air the patient gets; thus practitioners need to know that a calm approach and companion breathing are helpful; also pulmonary rehab so that patients know how to breath in these situations. Consulting with a respiratory therapist may be a good idea for this module.
- Can we include some new research on the use of opioids in patients with end stage disease, esp COPD. There is still a wide spread belief that morphine should not be used in these patients. We need research literature to support the claim that it helps not harms the COPD patient. Some researchers that I am aware of in this area are Graham Rocker and Randy Curtis.
- Add calmness to the slide on non-pharm management.
- What is the latest research on the use of anxiolytics in dyspnea? What about the use of Subcut diuretics at home for CHF patients?
- Another population of patients who are living into adult hood and are now being cared for in adult care settings are the Cystic Fibrosis people. These folks are dying young, usually waiting for a transplant and offer a particular challenge to care providers.
- Can there be a section on how to support people waiting for an organ transplant but also dying? Many of the CF patients will die as there are so few lungs available.

LEAP2011-0018

- X-ray on slide #8 in Module 4 does not project well.
- Management approach (slide #9) - great slide!!
- Add lymphangitic carcinomatosis to the glossary (slide #10)
- Cite the study (Cochrane Review) regarding the use of oxygen vs air
- Slide #17 - Patterned breathing - (ie: modelling how to slow breathing), can this be added to the slide
- Need somewhere to talk about the management of hiccups

LEAP2011-0019

- slide 13: "Not clear whether it is the oxygen or the airflow that is helpful" old information - use fans, turn temperature down, remove heavy blankets, open window, moisturize the air, keep traffic in room down, keep anxiety down. Opportunity to discuss that oxygen isn't necessarily going to work - facilitators notes can address usefulness of fan/airflow, etc. (re: slide 17)
- slide 19: "Sodium cromoglycate neb/inhaler qid" rarely/if ever used - this is area specific - avoid using geographic specific examples.
- slide 19: "Nebulize lidocaine 5ml of 2% solution qid" no evidence supports this - delete
- slide 20: "Hemoptysis" include use of hemostatic agent (fibro inhibitors)

LEAP2011-0020

Note the informant(s) indicated they did not have time to complete the same detailed review as Mod 1, 2, & 3

LEAP2011-0022

- main presenter has no particular suggestions – does tend to use on theory burst, and adds her own information depending on residents' level of experience and interest. I have seen recent studies showing the effectiveness of benzodiazepines with or without narcotics for dyspnea.

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MODULE FIVE – COMMUNICATION

CURRENT (v1.1) Learning Objectives - Upon completion of Module 5, participants will be able to: Demonstrate effective communication skills in a way that is sensitive, honest, compassionate, and attentive when engaging terminally ill patients and their families; this includes communicating in the following situations:

- delivering bad news
- transitioning from curative to palliative
- responding to the question, “How long do I have to live?”
- discussing advanced directives
- establishing goals of care and code status
- exploring a patient’s fears
- conducting a family conference
- facilitating the “difficult” family conference
- Describe the considerations and current controversies surrounding establishing code status.
- Differentiate between - enduring power of attorney, personal directives, guardianship and trusteeship as components of advanced planning.

PLEASE DOCUMENT THINGS THAT WORK WELL WITH THE MODULE AS WELL AS SPECIFIC AREAS/ITEMS THAT YOU WOULD LIKE TO HAVE TAKEN UNDER CONSIDERATION FOR IMPROVEMENT/RENEWAL

LEAP2011-0001

The video's could be improved (*note: 3rd party rep to seek additional input about specific nature of concerns*)

LEAP2011-0002

- Overall a good module.

LEAP2011-0003

- This section has a number of strategies and comments that are very effective when facing the challenges in communication with patient and family members. The samples of "what to say" are good tools for participants to be able to apply to their work in palliative care. In this section, some local cases were given to the group and they were asked to role play how they would respond. It would depend on the site whether or not we would use the videos.

- In the training sessions there are participants from acute care, long term care and home care and it is essential to have the standardized approach to teaching communication.

LEAP2011-0004

- Add info from Chochinov's article on Dignity Conserving Care---especially the questions in his article.

- Videos are good.

- Very helpful to have a Social Worker present this info.

LEAP2011-0005

This module needs to refer back to Module 1, specifically the emphasis on self-awareness, since this is an important aspect of communicating appropriately and sensitively to the dying and their families and friends.

A workshop resource that may be helpful here is a workshop developed in Ottawa by the Champions Project, entitled, "Healing Presence." This places responsibility on the palliative care professional to care for himself or herself in order to be truly present to the client and their families. This will specifically address Q5-3, 5-14, in reference to "transition discussions." Unless the professional is comfortable with their own personal transitions then it will be difficult for them to listen to and address the transitions encountered by the client and his/her family and friends.

I appreciate the emphasis on "engaging culture," since this is critical as Canada becomes more multi-cultural.

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Section 7, "Maintaining Hope in Advanced Illness," falls within the spiritual domain of Total Suffering. It is important here for consideration to be given for the front-line HCP to consider making a referral to the spiritual care specialist.

- The reference in Section 10, "Compassion in Less Than a Minute," to being "with a patient in the moment and for the extra moment," reminds me of the importance of professionals learning "mindfulness practice." This connects with the significance of the model put forward by nursing for professionals to maintain a reflective practice. This again connects with "self-awareness" and "self-care."

LEAP2011-0009

- Everyone needs to complete this very good, very important module
- Module suggested time is again not long enough - more time needs to be added
- Definitely need to develop and include slides
- Many good points brought forward on many issues such as : family conference - can also be enhanced by Pallium Pocketbook
- Update breaking bad news to include SPIKES (Pallium Pocketbook) and FIFE
- Goals of Care are an important inclusion and need to be emphasized from the beginning Modules in keeping with HPC accreditation standards
- Advance Directives - could be included in an Legal/Ethical Module

LEAP2011-0012

Thought the following was especially good:

5-5 Selection

5-7 Scenarios 5-8...Protocol and explanation.

5-13 Scenarios

5-19 ...chart, especially the samples of what to say.

5-29 good outline

5-33 good to see this included.

5-39...Q5-24 really good

Only concern- too much material, or too short a time?

LEAP2011-0013

- Very good video clips. We use the Tolstoy selection. It is very powerful.
- We have modified how we deliver this section by interspersing it throughout the sessions.
- Q5-8 New terminology - Substitute decision maker.
- Q5-21 How do you provide realistic hope
- Should we be providing "hope" or should we provide education, guidance and emotional support.
- "Hope should be a consequence of what we do not the goal". The Cancer world has changed "hope", previously a lovely word to use, into a commodity traded for money (donations for "research").
- Hope is always looking to the future when dying people need to spend some time in today.
- The opposite of hopeful doesn't need to be hopeless it can be hope free.
- I very much like Harvey's [Chochinov] dignity conserving work.

LEAP2011-0014

This module is one that is often identified by participants at the beginning of the workshop as an area they really want more expertise in, but then often it is evaluated as one of the weaker modules. I think we try to cover too many topics and would be better off focusing on fewer, but incorporating the practice of skills with role play, rather than just critiquing the videos. Breaking bad news using the SPIKES guidelines, discussing resuscitation, transitioning to palliative intent from curative intent with a focus on "hope", and managing a family conference are probably the core content, but should always be guided by requests from the group.

How to deal with request for futile treatment is a commonly requested topic. This builds into a early discussion about formulating goals of care and basing treatments on those goals. Understanding why patients and families request things that seem unreasonable to us ties into communication skills, in being able to assess their understanding concerning their disease and treatments, and then gently providing information that will help guide further decisions that are consistent with goals of care.

An area that almost inevitably comes up is the issue of communication within the health care team. Nurses need some help knowing how to communicate with doctors for the sake of their patients, and how to deal with situations of moral distress they find themselves in. I often wonder about providing LEAP to nurses and then sending them back to their rural hospitals where they work with physicians who have little palliative care education, poor communication skills, and have a hard time "allowing" people to die.

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LEAP2011-0016

- I mentioned several things already I guess in general comments.
- Some of the videos are a little overwhelming. We pick and choose depending on the learning needs of the group that day.

LEAP2011-0017

- Is there a way of integrating communication into every module so that it is not seen as separate?
- What I did was just ask the learners what the difficult communications issues were for them, make a list (this is the suggested activity) and went from there using the videos and group discussions. This always went well and in fact many times needed more time. I rarely used the teaching material in the facilitators guide/
- I think the module is (again) very medically focused. Can a counsellor/social worker with some expertise in teaching/facilitating be invited to offer suggestions for improving this? I ask because the counsellor/social worker facilitators that I worked with had some real issues with this module so I am thinking there is a better way!
- Keep the video clips as these are the best aides to introduce open discussion.
- Bring in a section about strength based care. How do providers discover the strengths of a patient and family and use that knowledge to support them through the illness? We are always focused on what is needed, gaps, weaknesses, problems but if we also look at the positive and the strengths that would be a nice balance.
- We need more discussion about conflict resolution between team members and between patient/family and team. Also, nurse/physician communication is often a huge issue and well documented in the literature. Can we provide a section dedicated to that? So often (nearly every time I taught) I heard about this issue so I think it would be highly valued.
- Although sometimes learners shy away from role playing I find that this is a great learning activity and also can be a lot of fun.

LEAP2011-0018

- We did not find this section as easily laid out as the other sections.
- There is a lot of content here. Is there some way of combining some of the topics? Could a video clip encompass more than one topic and then the discussion could bring up some of the key points in the video.
- There is some very helpful information in the appendix that we can then refer the participants to this section.
- Section 10 - Compassion in less than a minute - leave out. This section has so much already.
- Generally, this section seems to need more than a two hour time block for good discussion.

LEAP2011-0019

Module 5 - no specific comments.

LEAP2011-0020

Note the informant(s) indicated they did not have time to complete the same detailed review as Mod 1, 2, & 3

LEAP2011-0022

- effective stimulus to discussion of typical challenges in communication, even if some appear to be 'acted'.
- The use of two versions for many (a more 'typical' encounter, and more effective encounter) is helpful, especially with time for discussion in between. Some question the use of the term 'ill-structured'.
- Some complain that there is too much difference in what the man post-operative admits to knowing during the discussion about 'spread to the intestine' with this GP to have made the discussion worthwhile, though a few suggest that was meant to show how under stress, people can deny what they know [Project note – informant(s) are referring to *Discussing Bad News* companion communication video segment from *Clinical Communication in Hospice Palliative Care* video segments which are bundled with LEAP on DVD]
informant(s) are referring to *Discussing Bad News* companion communication video segment from *Clinical Communication in Hospice Palliative Care* video segments which are bundled with LEAP on DVD]
- Some point out that their experience does not match the second version of the 'culture' video, with the Indian [male of south Asian descent] being more explicit and aware about the role of culture and more ready to accept letting mother know if she asked as a sign of respect (compared to the more difficult discussions they have had, including needing to address firm beliefs that the patient would become depressed and die more quickly with bad news unrelated to culture) [Project note - informant(s) are referring to *Engaging Culture* companion communication video segment].

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MODULE SIX – DEPRESSION, ANXIETY, AND SUFFERING

CURRENT (v1.1) Learning Objectives - Upon completion of Module 6, participants will be able to:

- Describe the challenges of diagnosing major depression.
- Summarize the frequency of a major depression in patients with advanced incurable illnesses.
- Explain the role of psychostimulants (e.g. methylphenidate) versus more traditional antidepressants such as selective serotonin reuptake inhibitors (SSRIs) in the management of major depression.
- Describe a framework to understand suffering.
- Discuss the role of hope when facing death and strategies that allow physicians to nurture and maintain hope in a realistic yet compassionate way in the palliative setting.
- Identify local resources that could be helpful in providing psychospiritual care for terminally ill patients.
- Describe the key questions that physicians may ask of patients in the course of providing dignity-conserving/spiritual work in hospice palliative care (as postulated by Dr Harvey Chochinov).

PLEASE DOCUMENT THINGS THAT WORK WELL WITH THE MODULE AS WELL AS SPECIFIC AREAS/ITEMS THAT YOU WOULD LIKE TO HAVE TAKEN UNDER CONSIDERATION FOR IMPROVEMENT/RENEWAL

LEAP2011-0002

- See comments above (in Depression,etc....)

- THIS SECTION (DEPRESSION,...) SHOULD BE INCLUDED IN A WEEKEND COURSE DEDICATED TO THIS MODULE AS WELL AS THE "GRIEF & BEREAVEMENT" MODULE.

LEAP2011-0003

The slides in this section are very well done. This leads to discussion on depression and sadness and the difference between and when depression should be treated. Supportive and dignity conserving work section is very well done and adds a good lead into the grief and bereavement module.

LEAP2011-0008

I believe the theory burst for Module 6, "Depression, Anxiety, and Suffering," needs to address spiritual distress with more than reference to a spiritual assessment tool, FICA. I found there is too much emphasis on "dignity" and not enough on "meaning making" in this Module 6. I recommend that there be consultation with the "Spiritual Advisors Interest Group," of the CHPCA, specifically Dan Cooper, (Regina Qu'Appelle Health Region Palliative Care Services), for development of this module.

A helpful resource in the expansion of this section is the work of the Consensus Conference 2009 as referenced in the Journal of Palliative Medicine, Vol. 12, No. 10, entitled, "Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference." Another excellent resource is the book entitled, "Making Health Care Whole: Integrating Spirituality into Patient Care," by Christina Puchalski, MD, and Betty Ferrell, RN,PhD.

LEAP2011-0009

- Very physician oriented - needs to be improved and extended to be more interprofessional
- Important that total suffering is included - keeps to holistic approach
- Pallium Pocketbook sections around these subjects to be better interwoven with this
- Needs more equal time and content improvement in tune with the top heavy Medical Modules

LEAP2011-0012

- 1-2 Sharing the stories is a great way to start, and leads well into the self awareness piece that it truly important.
- 1-6 Good explanation of hospice/palliative care.
- 1-10 I like the mentioning of the wishes of the patient and total suffering.
- 1-11 I think the video really helps focus us on the importance of being there for the moment. That is an important lesson.
- 1-12 I like the helpful hints.

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LEAP2011-0014

The following is my input on the modules concerning Depression, Anxiety and Suffering:

In the area of depression, I think it is helpful to provide examples (quotations) of patients with true depression with pervasive feelings of hopelessness, desire for death, despair and contrast with someone who is experiencing sadness or a sense of loss because of their illness. The use of atypical antipsychotic meds could be included in the discussion of the management of anxiety, especially if associated with sleep disturbance or nausea.

Would like to see more discussion in the theory burst regarding a definition of dignity and the importance in our role as caregivers in the conserving of dignity.

LEAP2011-0016

- There is a chapter on Psychological and Psychiatric Distress in the Pallium Handbook that I find helpful to teach this module.
- I also believe that we can alleviate suffering as care providers during our everyday care encounters - through respectful listening, silence, stopping to look and listen etc

LEAP2011-0019

- slide 5: "Derogatis et al. 1987" dated reference
- slide 5 description: new stats? lower rates?
- slide 7: "Beck's Depression Inventory" and "HADS" - are there others? Review and update ie: Trevor Smith
- slide 12: In description: "(e.g. paroxetine, sertraline, fluoxetine, fluvoxamine)" should include "efexor with neuropathic pain"

LEAP2011-0020

Note the informant(s) indicated they did not have time to complete the same detailed review as Mod 1, 2, & 3

LEAP2011-0022

- very little on anxiety.
- Good overview of meds, though more info that in the in the Pallium Palliative Pocketbook could be useful.
- Section on suffering could be more than a list of Chochinov's items, as leaves need for more discussion to clarify overall views and approaches to suffering.

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MODULE SEVEN – GRIEF AND BEREAVEMENT

CURRENT (v1.1) Learning Objectives - Upon completion of Module 7, participants will be able to:

- Differentiate between a “normal” grief reaction and an abnormal or complicated grief reaction.
- Identify patients at risk for developing complicated grief.
- Describe the principles of grief counselling and management, particularly from a primary health care perspective.

PLEASE DOCUMENT THINGS THAT WORK WELL WITH THE MODULE AS WELL AS SPECIFIC AREAS/ITEMS THAT YOU WOULD LIKE TO HAVE TAKEN UNDER CONSIDERATION FOR IMPROVEMENT/RENEWAL

LEAP2011-0001

- This module is good but could be expanded.

LEAP2011-0002

- A good module.

LEAP2011-0003

- This works well,
- Specifics here vary depending on the province or even site.
- Could be added here, is comment on Organ and Tissue donation.
- At the end of this module, I would like to see added a short section on "closure" for families as well as staff. The condolence card is helpful in this process. A short write up or example on how a condolence letter can be written in such a way that it can promote healing would add to either modules

LEAP2011-0008

I like the theory burst for this Module 7. It emphasizes that the grief process is very helpful. It is good that reference is made to complicated grief, and I think mention could be made of the Bereavement Risk Assessment Tool that has been developed by the Victoria Hospice. One aspect of grief that is missing is "anticipatory grief," which in some ways is addressed in Module 5 and 6.

This module could also be supplemented with additional resources and the inclusion of an interprofessional case for discussion.

LEAP2011-0009

- Nice as an introduction however the Module is extremely lacking - more information needs to be included – many good resources out there to take from- e.g. Transitions in Dying Book.
- Could have more resources on anticipatory grief, and practical exercise for teams to address the subject and assess for complicated grief that needs follow up etc.

LEAP2011-0012

- 7-4 -7-6 slides good
- Seems like this unit could be developed more.

LEAP2011-0013

- I struggled with this section and we have had our grief counselor cover this section.
- It is important to review that grief is normal and should not be pathologized.
- We should be careful of the language we use when "defining" grief. I am concerned that our colleagues in psychiatry are coming up with the definitions without much input from the Palliative care world.

LEAP2011-0016

- You can't have a rainbow in your soul without tears in your eyes.- I don't know the author but its meaningful to me. I would like some little thoughts for reflection in the modules here and there.
- We like the end of the module where it states work with the learners to list local resources for grieving family members.

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LEAP2011-0017

- This section also feels quite medically focused and prescriptive, e.g. naming the DSM IV in slide 4. The module only talks about patient and family grief and not about care provider grief (which is also part of suffering).
- In addition to the lists of classifications, risk factors, etc. I wonder if a case would work for this module. The key to translating this theory to practice is for it to come alive and having a case is one way of doing that.
- Input from the social work expert would be great.

LEAP2011-0018

- This is an important section. Both because of the anticipatory grief aspect and also after death care of the family.
- It is hard to talk about this when in many of the rural areas we don't have the resources in order to provide much in the way of bereavement care.
- On the other hand it is important to identify and differentiate between normal, complicated and anticipatory grief.

LEAP2011-0019

- slide 7: should include “substance abuse” and/or “alcohol abuse”
- slide 9: change wording “gone” to “dead”
- slide 14: include - “use a team approach” and “know your community resources”
- increase time and content

LEAP2011-0020

Note the informant(s) indicated they did not have time to complete the same detailed review as Mod 1, 2, & 3

LEAP2011-0022

- very brief
- Can add some of the controversy over DSM V r.e., grief versus major depression.
- Consider some recent studies suggesting more diversity in grief reactions, including resolution of grief that can include active connection to deceased, and the work on intuitive versus instrumental grief responses.

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MODULE EIGHT – DELIRIUM

CURRENT (v1.1) Learning Objectives - Upon completion of Module 8, participants will be able to:

- Describe the impact of delirium on patient comfort, family distress, and caregiver burden.
- Explain the importance of systematically screening for delirium.
- Describe the clinical presentations of delirium.
- List the common causes of delirium.
- Describe how it is possible to reverse delirium in palliative patients and when it is appropriate to attempt to reverse the delirium.
- Utilize a management plan that includes:
 - Selecting appropriate neuroleptic agents and doses
 - Addressing the underlying causes
 - Communicating with families and caregiversto effectively manage delirium in palliative patients.

PLEASE DOCUMENT THINGS THAT WORK WELL WITH THE MODULE AS WELL AS SPECIFIC AREAS/ITEMS THAT YOU WOULD LIKE TO HAVE TAKEN UNDER CONSIDERATION FOR IMPROVEMENT/RENEWAL

LEAP2011-0001

- This module is well done.

LEAP2011-0003

- Again, in this module, scales need to be added, such as CRS< mini mental< etc....
- We do emphasise the need for "screening and recognition" but do not suggest any tools. again, it would be valuable to be able to print those tools and use them in the clinical practice. Other tools may be more practical at the bedside??
- This module (the case) connects nicely with the Palliative sedation module.
- This module also gives the facilitator the ability to discuss delirium in specific diseases and its management...which is valuable.
- I believe that a little more emphasis could be put on dementia care here as it is and will become a bigger part of palliative and end of life care in the future (statistics are for doubling of the numbers every 20 years..)

LEAP2011-0004

- Case study is really good.

LEAP2011-0008

The theory burst for this Module 8 is very good and I appreciate the case found on page 8-9. A review of the work that has been done on delirium in seniors may also be useful here. (CCSMH National Guidelines on the Assessment and Treatment of Delirium in Seniors for Implementation and Research in Palliative Care Settings)

LEAP2011-0009

- Identification and assessment tools for delirium needs to be emphasized and practiced

LEAP2011-0012

- Not being medical I find it hard to comment on this unit.

LEAP2011-0013

- Slide 10 - tools - Journal of Palliative Medicine - 14(3):275-279; Ease of Screening for Depression and Delirium in Patients Enrolled in Inpatient Hospice Care
- Slide 13 drop loxapine

LEAP2011-0014

- Once again, bring Slide 11 (Management Approach to Delirium) closer to the start of the module as a foundation for everything else in it.

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- Other screening tools such as CAM are being used more and more in geriatrics and long-term care settings.
- Incorporate palliative sedation into this module as an extension of management of severe, irreversible delirium in final days, but also stress that it is used in the management of other intractable, uncontrollable symptoms.

LEAP2011-0016

- I was taught an acronym to identify causes of delirium that I find really helpful.
- I read about a screening tool for delirium over the continuum that I would like to know more about.
- The case study is helpful

LEAP2011-0017

- Since delirium, depression and dementia are completely different but can be confused clinically I wonder about adding a slide on this differentiation.
- As stated in the module delirium is highly disturbing for family members to witness and yet there is little discussion about this aspect. Can we add a part about supporting families through this? Also, supporting each other as care providers? such as what are the non-drug measures that can be done to keep the patient safe, dignified and comfortable?
- Many areas have educated staff in delirium, especially in acute care and thus they may be quite familiar with this topic, except for the difference being end of life and how to approach it when not reversible. That said would it be an idea to continue on with this module and add palliative sedation?

LEAP2011-0018

- Delirium - Very important, often not recognized or treated adequately.
- Need to add leptomeningeal in glossary as many people don't know what this is.
- In Slide 12 - What isn't there is to manage unfinished business or a psychologically based delirium and this needs to be considered too.
- Typo on in workbook and facilitator's manual related to slide #10 - says "slice 10"
- Slide #10 - the other assessment tool that should be mentioned is the CAM - Confusion Assessment Method which is more commonly used.

LEAP2011-0019

- slide 3: first 2 bullets - show evidence
- slide 8: "Brain disease: metastases or primary brain tumours" - show the evidence
- slide 10: "MMSE or DOMC" and "Confusion Rating Scale" are not effective (ie: Trevor Smith)
- slide 13: the lists of "New atypical neuroleptics" (olanzapine, risperidone, quetiapine) and "Benzodiazepines" aren't used - dated - update (remove "new" language as it dates the whole curriculum)
- slide 15: "Consider indefinite palliative sedation if agitation/hallucinations are severe and intractable" this is an inappropriate management strategy (facilitator's notes: description of what is meant by this bullet); typo on last bullet

LEAP2011-0020

Note the informant(s) indicated they did not have time to complete the same detailed review as Mod 1, 2, & 3

LEAP2011-0022

- good basis approach – often choose case study along if residents have some experience and can offer answers in discussion, or theory burst alone if residents seem to need a more structured introduction.

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MODULE NINE – PALLIATIVE SEDATION

CURRENT (v1.1) Learning Objectives Upon completion of Module 9, participants will be able to:

- Define palliative sedation (terminal sedation) and categorize the various levels of palliative sedation.
- Describe the indications for palliative sedation.
- Describe the incidence of the need for palliative sedation.
- Identify and explain the ethical and legal issues surrounding palliative sedation.
- Describe the steps for implementing palliative sedation.
- Describe how to use midazolam for providing palliative sedation for a hospice palliative care patient.

PLEASE DOCUMENT THINGS THAT WORK WELL WITH THE AS WELL AS SPECIFIC AREAS/ITEMS THAT YOU WOULD LIKE TO HAVE TAKEN UNDER CONSIDERATION FOR IMPROVEMENT/RENEWAL

LEAP2001-0001

- This section is good but could be expanded as expertise in this field develops.

LEAP2011-0002

- Needs to be completely redone in view of the upcoming paper from the Society of Palliative Physicians.

LEAP2011-0003

- I have not found a module on Palliative sedation therapy that is better done than the LEAP module.
- Again, examples of protocols (or a basic protocol) could be added as an example of charting in cases of Palliative Sedation therapy.

LEAP2011-0004

- This is good info but not as an intro to palliative care.
- Not enough time to discuss the ethics of palliative sedation. This info can be dangerous for the inexperienced practitioner. Important info is that consultation with a Palliative Physician is mandatory!

LEAP2011-0008

This Module 9 is adequate and the case is a good tool.

LEAP2011-0009

- This module should be presented by skilled medical/nursing teams due to its nature
- Emphasize Understanding of drugs being prescribed and implication of drugs
- Ethical grid is a good fit into this module as well
- Assessment and screening practice and decision making needs to be highlighted
- Cases a good help

LEAP2011-0012

- 9-2 Case study is an important piece
- Slides throughout comprehensive

LEAP2011-0013

- Should have a look at the Canadian guidelines being developed by Doreen Oneschuck et al.

LEAP2011-0017

- There has been much controversy about palliative sedation. Are low doses of midazolam (i.e. lighter sedation) that are used for symptom management (e.g. dyspnea) considered palliative sedation?
- Is this a skill that a GP, generalist nurse, community pharmacist can/should take on? Or is this a specialty skill done only by specialist palliative care providers (in a PCU).
- What setting should palliative sedation be done in and do these care providers have the knowledge and skill after taking the LEAP course?
- Maybe this module should be added to the delirium (or another) module as an FYI and in much less detail with an emphasis that this intervention requires the expertise of palliative experts either in a PCU or at the very least close consultation for people in remote areas.

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- the slide on double effect (12) is needed so that the learners, even though they may not participate in pall sed, are aware that this is not euthanasia. This is extremely important for facilitators to be clear about as well because we do not want learners going away either confused or with the wrong message.

LEAP2011-0018

Not much to say here. Not done very often in our setting.

LEAP2011-0019

Module 9 - no specific comments.

LEAP2011-0020

Note the informant(s) indicated they did not have time to complete the same detailed review as Mod 1, 2, & 3

LEAP2011-0022

- Good overview including slides on controversial aspects – does often lead to longer discussions.
- Could consider making explicit the risk of the practice of euthanasia being labelled palliative sedation.
- Could include more explanation of what is the controversy over principle of double effect

MODULE TEN – LAST DAYS AND HOURS

CURRENT (v1.1) Learning Objectives Upon completion of Module 10, participants will be able to:

- Describe the physical changes that would indicate that a patient is in the final hours of life.
- Prepare loved ones and caregivers for the death of a patient, including what to expect just prior to death, and what to do when a patient dies.
- Describe how one would pronounce the death of a patient.
- Describe local regulations related to pronouncing death, referring to a medical examiner, and transferring patients to funeral homes.

PLEASE DOCUMENT THINGS THAT WORK WELL WITH THE MODULE AS WELL AS SPECIFIC AREAS/ITEMS THAT YOU WOULD LIKE TO HAVE TAKEN UNDER CONSIDERATION FOR IMPROVEMENT/RENEWAL

LEAP2011-0003

The slides in this section are very well done. This leads to discussion on depression and sadness and the difference between and when depression should be treated. Supportive and dignity conserving work section is very well done and adds a good lead into the grief and bereavement module.

LEAP2011-0004

- Good info.

LEAP2011-0008

This is a helpful module as people often don't know what to expect in the last days of a loved ones' life. I'm wondering if a case would be a helpful addition since participants might find it very helpful to discuss their experiences with last days of people they have companioned.

LEAP2011-0009

- Video good to have the discussion and use the words
- Use local pamphlets that present the dying process in lay person's terms of the last hours etc.
- Include issues of grief and bereavement as a follow up
- Needs revamping to include the interprofessional team approach that is not just clinical but also from the whole person of the physical, emotional and spiritual components of care
- Have this Module before the grief and bereavement module

LEAP2011-0017

- The physical signs of the last hours are well laid out and the videos are a great prompt for group discussions. the use of medications is also done well (typo in atropine dose?) but may need updating according to recent research.

- However I wonder about only having the discussion on the suffering aspect. What about a section on engaging families positively. Like asking them what their hopes are in these final days and hours and how can care providers support that. What are some of the 'final gifts' that they may have experienced during this process? More can be added to slide 11 in the facilitators notes to enrich this discussion and provide some guidance for families at this stage. The book 'Transitions' by Victoria Hospice would be an excellent reference here.

LEAP2011-0018

- Do not like the term "death rattle". Is there something else this could be called in order to try and change the culture of calling it "the death rattle".

- Slide 11 - Maybe talk about forewarning families about the possibility of their family member dying when they are not present as this happens fairly frequently and how to frame this potential in advance of it happening. Reminder that is this does happen, families can be very distraught and do need support.

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LEAP2011-0019

- slide 8: First three bullets “scopolamine” “glycopyrrolate” “atropine” all three can be sedating and/or psychosis; monitor, watch for over-sedation - add to speaker comments
- slide 12: “Death from asbestos exposure (mesotheliomas) - in Ontario managed as work-related and requires autopsy” incorrect information; must contact coroner
- slide 13: “Be prepared for when the patient is unable to swallow” module should be expanded

LEAP2011-0020

Note the informant(s) indicated they did not have time to complete the same detailed review as Mod 1, 2, & 3

LEAP2011-0022

- Good overall discussion
- Some repetition with other sections (such as Respiratory), not too much of a concern

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MODULE ELEVEN – WORKING AS A TEAM

CURRENT (v1.1) Learning Objectives Upon completion of Module 11, participants will be able to:

- Describe the respective roles and challenges of various disciplines or professions (including nurses, pharmacists, physicians, social workers, volunteers, chaplains, local ministers, etc.) when caring for palliative patients.
- Define an effective team and describe how teams may be used in the community setting, in the context of caring for palliative patients and their families.
- Effectively involve, in a collaborative way, other disciplines when caring for palliative patients and their families in various settings.
- Describe the challenges and barriers to providing primary hospice palliative care in different settings, including those generated by:
 - Health professionals
 - Patients and their families
 - Administration/bureaucracy (i.e., the system).

PLEASE DOCUMENT THINGS THAT WORK WELL WITH THE MODULE AS WELL AS SPECIFIC AREAS/ITEMS THAT YOU WOULD LIKE TO HAVE TAKEN UNDER CONSIDERATION FOR IMPROVEMENT/RENEWAL

LEAP2011-0001

- We like this module and do it right after the introduction and as we are a team presenting and that really gets the point across.

LEAP2011-0002

- The danger of doing this module is that it can turn into a venting session which may not be productive.

LEAP2011-0003

- Should this module be earlier in the LEAP???

LEAP2011-0008

I would like to pick up on the point I made in the initial section where I addressed "improved, changed or abandoned." This module on team work needs to lead the way rather than be situated at the very end of the program. Resources like the interprofessional competencies will assist with stressing the importance of the collaborative, interprofessional care, approach to the delivery of palliative care in all venues in institutions and community.

LEAP2011-0009

- Seems like an "afterthought" Module when TEAM is the mantra of palliative and end of life care
- Change title to Interprofessional Team
- Based on a medical model - needs to be more indepth and based on a interprofessional palliative care team approach
- Needs to be more in the beginning than at the end....it is the team that makes for the striving for the best palliative and end of life care that comes to guide and affect the practice ALL of the Modules.

LEAP2011-0012

- While the slides are good- the unit is relatively just that- needs something else- video clips- scenarios.

LEAP2011-0017

- I wonder if this section could be combined with communication?
- We need a discussion of conflict resolution as stated previously in section 2 (cut and pasted her)...
- Teams need to focus on what the patients goals are... this should be asked in every module so that it is patient-centered care and not practitioner-centered care. If we can bring all the learners together and focus on the patient and not the part of the patient that is the most interesting to individual learners then maybe we can also contribute to working as a fully functional interdisciplinary team and not each of the team members doing their own thing. Maybe the physicians won't agree with this but I think we can make a stand here in this

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course in bringing everyone together utilizing the principles of interprofessional education: 'any type of educational, training, teaching or learning situation where two or more health and social care professionals are learning interactively' (ref: Reeves et al 2008. interprofessional education: effects on professional practice and health care outcomes, Cochrane database found at:

<http://www.hpme.utoronto.ca/Assets/hpme/events/hsr07/reeves2.pdf>)

The following from : <http://interprofessionalhealth.wisc.edu/whatis.cfm>

Multiprofessional education occurs when students from the health-related occupations with different educational backgrounds are brought together to understand a particular problem or experience.

Interprofessional education occurs when students from various professions learn from and about each other to improve collaboration and the quality of care.

Their interactions are characterized by integration and modification reflecting participants understanding of the core principles and concepts of each contributing discipline and familiarity with the basic language and mindsets of the various disciplines (Clark, P.G. (1993).

Clark, P. G. (1993), Journal of Interprofessional Care, 7(3), p. 219-220.

Rationale for Interprofessional Health Care Teams

I. Interprofessional health care team work can facilitate:

- More effective and efficient patient care, patients benefit from receiving care from the health care health professional with the expertise specific to the patient's individual problem, team work can provide coordination which can prevent any aspect of the patient's care from being overlooked or shortchanged
- Professional growth and job satisfaction, which results from doing the work you have studied and trained for
- Understanding of how the health professions can work together to enhance health promotion, public health, prevention, interdisciplinary research, community based participatory research and many other health related but not specifically patient care oriented activities
- Economy in health care costs, e.g., eliminating duplication, and delays in care provision
- Enhanced breadth of knowledge and appreciation for the skills and knowledge of other health professionals, above and beyond roles in team work

LEAP2011-0018

- Would like to see the concept of team introduced very close to the beginning and woven through all of the modules and not left until the end.

- Slide 15 - There is no mechanism for ongoing follow-up re: team development and support in rural areas.

LEAP2011-0019

- Teamwork module - does not work well at the end; consider combining it with Module 1 or 5 and incorporating teamwork/IP framework throughout all modules/videos

LEAP2011-0020

Note the informant(s) indicated they did not have time to complete the same detailed review as Mod 1, 2, & 3

LEAP2011-0022

- important, but our particular rotation has a different home care team, with different public structures, so we often skills this module and have the residents experience team in work on PCU and clinics.

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SPECIFIC CONCERNS NOT CAPTURED ABOVE

PLEASE LIST ANY SPECIFIC CONCERNS THAT YOU OR YOUR TEAM HAVE ABOUT LEAP THAT YOU FEEL OUGHT TO BE TAKEN INTO CONSIDERATION IN A MAJOR REVISION AND THAT YOU FEEL YOU HAVE NOT HAD AN OPPORTUNITY TO CAPTURE IN THE SECTIONS ABOVE (E.G., DESIGN, CONTENT, EASE-OF-USE, FORMATTING, FURNISHED LEARNING EVALUATION TOOLS, FACILITATOR QUALITY CONTROL, CONTINUOUS IMPROVEMENT UPDATES, INTEGRATION WITH PALLIUM PALLIATIVE POCKETBOOK, OTHER CONTEXT/SETTING-OF-CARE CONSIDERATIONS, ETC.)

LEAP2011-0001

- The module Anxiety and Depression is more detailed than needed. # 12 slide is too detailed and busy.
- The module Last Days and Hours is really good for those who have never witnessed a death.

LEAP2011-0002

- Excellent tool!!

LEAP2011-0003

It would be of major value to have integration with the Pallium pocketbooks. Unfortunately, our site has long run out of the pocketbooks which has been a loss for participants in the last year.

The Pallium needs to be revised to include the "changing face of palliative care which include diseases, such as dementia, heart, lung, kidney, etc...."

LEAP2011-0009

- Is a wonderful tool, resource and now needs to be made more wonderful !!!!!
- Need to change and enhance this to be more inclusive of all disciplines, not just physicians, nursing, and pharmacy.
- Equal emphasis and time to be placed on psychosocial, spiritual, bereavement modules alongside the medical
- If we believe and we say that PEOLC is facilitated through the work of the whole interprofessional team, including volunteers across all sectors then the education/training needs to reflect this belief through equal emphasis on all disciplines and sector

LEAP2011-0017

My most pressing concern is the need to regularly (yearly) review, revise and update the material. How will that be done when Pallium gets one-time funding or a gift of funding? I do not think that Pallium itself can commit to supporting this and think a partnership with another organization is necessary. Perhaps some funding should be garnered towards a collaborative between all the organizations across Canada trying to provide palliative education but not working together as yet in a comprehensive way. Could someone lead this and perhaps develop a plan for sustainability? Maybe Health Canada can support this longer term? Can a joint proposal between willing organizations be done to pursue this? Would CHPCA, Virtual Hospice or another more sustainable organization work with Pallium towards this end? Are there possibilities of philanthropy supporting this long term?

There are several Canadian reference pocket books available now (all great resources) that I am aware of: LEAP, Medical Care of the Dying (VHS), and 99 Common Questions. Care providers want to know which one to get? Which one is best? How do we answer this?

LEAP2011-0019

Going forward we hope to continue to follow the above-mentioned model to deliver LEAP. We also hope to utilize videoconferencing technologies, where appropriate, to engage more rural and remote communities in this education. We are also looking at ways to engage more physicians in this education, perhaps by offering shorter sessions once a month as opposed to full weekend courses.

LEAP2011-0022

- would be helpful to have more frequent updates for new advances
- For us, we highly encourage the use of PPP [Pallium Palliative Pocketbook], and almost all will buy it, so for us, greater integration of PPP would be appropriate

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ANYTHING ELSE TAKEN INTO ACCOUNT DURING RENEWAL

PLEASE USE THIS SPACE TO TELL US ANYTHING ELSE THAT YOU BELIEVE IS IMPORTANT FOR THE LEAP RENEWAL TEAM TO TAKEN INTO CONSIDERATION DURING THE COURSEWARE RENEWAL PROCESS.

LEAP2011-0009

Recognize that this great project was intended for MD's, Nursing and Pharmacy and with such great materials we now really need it in provinces such as [name of province] that put the emphasis across the interprofessional rural and urban context as we want to continue on to grow and make it better to enhance the skills of those who are generalists as well as specialists in palliative and end of life care.

LEAP2011-0010

General Comment:

It would be nice to have a additional module i.e. slides and sample case studies on how to use either the two books ie Pallium Book or the 99 Question book..

What about a few speciality modules on Pediatric Palliative Care issues and one on Palliative Care for Neonates, or one on specific issues that can arise in the community home care setting or Nursing Homes.

LEAP2011-0012

- I would like to say it is a very useful, and comprehensive tool that does a lot. Thank you.

LEAP2011-0016

- I would like to see a one day format developed that could perhaps be divided into two or more presentation segments.

- As mentioned before have DVDs or another format developed with experienced teams presenting the content in sessions that could be viewed in about one hour each.

LEAP2011-0017

- Expand on the teaching/learning aides in the models. I think adding more to this gives facilitators more choices and can reach diverse learner needs.

- Poetry can be useful: - An Elephant in the room by Terry Kettering found at:

<http://www2.bartow.k12.ga.us/psych/crisis/elephant.htm>

- Movies can be learning resources as well: Angela's Ashes; Beaches; Terms of Endearment; Philadelphia, etc. (Would have to be 'homework' as not enough time in class)

- Writing (journals, dear diary, obituaries, letters, songs, poetry) brings a creativeness to learning and helps people to know and understand themselves better. This would be good in the first module or suffering or communication modules.

- Doing a collage (could be done at a meal break); we had a group do this and it was hugely successful.

- Also gathering media portraits of death/dying; literature (stories) all contribute to learning.

Modules 2, 3, 4, 8

- I wonder about offering a standard tool for assessing all the symptoms, like the PQRSTUV (see below), the PPS v2, ESAS and incorporate those tools in all the symptom modules? If the learners already have a tool that is used in their work setting then that is fine but I found that many don't have one so this may be helpful.

- There are other fairly common issues at end of life that should be at least mentioned:

Fatigue

Skin and wound care

Lymphedema

O - onset

P- provoking & palliating

Q - quality

R - region/radiating

S - severity

T - treatment

U - understanding/impact on you

V – values

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LEAP2011-0019

Content:

- too physician/medically focused; incorporate more re: interprofessional practice/teamwork in Powerpoint content and case studies
 - cover more LTC issues; dementia, resident in LTC, family dynamics, Advance Care Planning
 - heavy focus on cancer; include other chronic disease foci (ie: renal disease, diabetes, dementia, CHF)
 - other content additions to consider: decision making and issues of competence, non pharmacological treatments, grief for those left behind, children and grief
 - enhance content on psychosocial issues (grief & bereavement, depression, anxiety and suffering) and include content on spiritual needs; modules are not allocated enough time, content or opportunity for discussion
 - more content on planned death at home
 - more content on ethical decision making
-
- more discussion around cultural issues particularly as they pertain to Aboriginals at the end of life; consider working with Gaye Hanson to incorporate more Aboriginal content into the curriculum, and use the already developed "Culturally Responsive Hospice Palliative Care with Aboriginal Clients in Rural and Remote Settings"
 - some modules are very long (ie: Pain and GI); consider reducing content and having a post-LEAP course for those who want more detail in these areas; this would also free up time that could be used to enhance the psychosocial modules
 - overall content needs to be updated to reflect current research and best practice and match with Pallium Palliative Pocketbook

Delivery

- embed videos in powerpoints; current process is time consuming and distracting to sync up to a particular point
- strongly support interprofessional team of facilitators (MD, nurse and social worker) for the whole course; we are using this model in the Northwest and we believe involvement of a social worker supports discussion of psychosocial issues in all modules; LEAP provides an opportunity for this Facilitator Team or regional PC experts/clinicians to make connections with local primary care providers and this encourages follow-up referrals for information and problem solving
- in rural communities try and include local facilitators (ie: people who have completed LEAP and/or are palliative care leaders in their community)
- strongly support cross sector participation (ie: community, LTC, acute care, CCAC) as this is especially important in smaller communities and to develop team work in a community
- 13 hours is too short a time-frame to cover all material; not sure how others can do Theory Bursts, large group, small group and videos within the time allocated
- pre/post knowledge quiz is medically focused; low return rate and likely reduces participants willingness to complete other forms (pre-course survey, post course evaluation)
- consider use of simulation labs/mannequins
- we provide handbook to all participants and encourage them to use it in their ongoing practice
- establish a Pallium Facilitator training process; initial orientation & training; mentoring; on-going education for experienced facilitators; regional facilitators travel to other geographic areas to facilitate (a LEAP exchange)

Physician Participation

- good experience in getting participation for physicians in small rural communities
- challenge in getting participation from urban family physicians
- develop a common Pallium messaging for family physicians (ie: parallel ACLS analogy suggested from Alberta)
- In our one urban Centre we will try targeting Family Health Teams (FHT = IP community) and see if they are receptive to us delivering courses for the FHT staff
- consider offering flexibility in delivery (ie: full course 1/week (3hr) or 1/month (4-5 hrs) to target an IP mix including urban MDs; consider offering just some of the modules rather than the full course

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LEAP2011-0022

- Thank you for the great work done. It has been a valuable framework for starting a formal structured educational process in palliative care.
- The residents frequently praise this formal teaching, which they say they do not get in any other rotation.
- More advanced information would be useful when more experienced learners.