ESTABLISHMENT OF THE CENTRAL ZONE PALLIATIVE CARE NURSES' GROUP

An Evaluation Report
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"Education and research
are the most important platform from which
the quality of palliative care to all Australians
will be improved."
(Palliative Care Australia, 2002:12)

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EXECUTIVE SUMMARY

In early 2001, the Queensland Health Central Zone Management Unit [CZMU] developed a palliative care service model to improve palliative care service provision and strategic allocation of resource enhancements across the Central Zone. To address the palliative care training and education needs of nurses in the Zone, the formation of a Central Zone Palliative Care Nurses' Group [CZPCNG] was proposed. The aim of this formal network of specialist palliative care nurses practising across the Central Zone in both government and non-government services would be to maintain and enhance the quality of palliative care delivery.

The Centre for Palliative Care Research and Education [CPCRE] was contracted by CZMU to establish the CZPCNG and make recommendations regarding the ongoing sustainability of the group.

Three key strategies were employed by CPCRE to facilitate the establishment of the CZPCNG, including:

- planning and delivery of a two-day professional development workshop by CPCRE;
- development of mechanisms for facilitating ongoing communication and networking between group members;
- advising and supporting CZPCNG members to plan and deliver a one-day education seminar in the Sunshine Coast District for generalist nurses.

These strategies were evaluated to enable recommendations to be made regarding the potential role for and ongoing sustainability of the group in enhancing palliative care services.

RECOMMENDATIONS.

On the basis of this evaluation, key recommendations include:

1. The implementation of strategies for sustainability of the CZPCNG including:
    - identification of leaders within the group and formation of a co-ordination/leadership sub-group
    - the formation of an education sub-group
    - clarification of eligibility for group membership
    - identification of financial support options for the group
    - maintaining strong links between this group and the CZMU;
2. Re-evaluation of this group one year after commencement of its activities ;
3. Conduct of a comprehensive educational needs analysis amongst specialist palliative care practitioners providing end of life care;
4. The inclusion into professional development activities for nurses, particularly those in leadership, of subjects not directly regarding clinical care, such as reflective practice, and Evidence-Based Practice;
5. The promotion of mentorship through strategies such as provision of learning in mentoring skills, and linking of group members with each other in mentoring relationships;
6. Development of CD-based educational resources in palliative care leadership, teaching and learning;
7. Development of a list of useful palliative care and other professional development resources that can be accessed on the CPCRE website;

8. Encourage further use of the electronic bulletin board via Central Queensland University;
9. Encourage ongoing formal links with the NSW Palliative Care Nurses' Group through the leadership sub-group;
10. The linking of the group with active research centres to assist this group to develop research skills and identify a pool of research mentors; and,
11. Exploration of issues of standardised practice and processes in palliative care, particularly the development of Clinical Practice Guidelines in palliative care.

CHAPTER I: INTRODUCTION

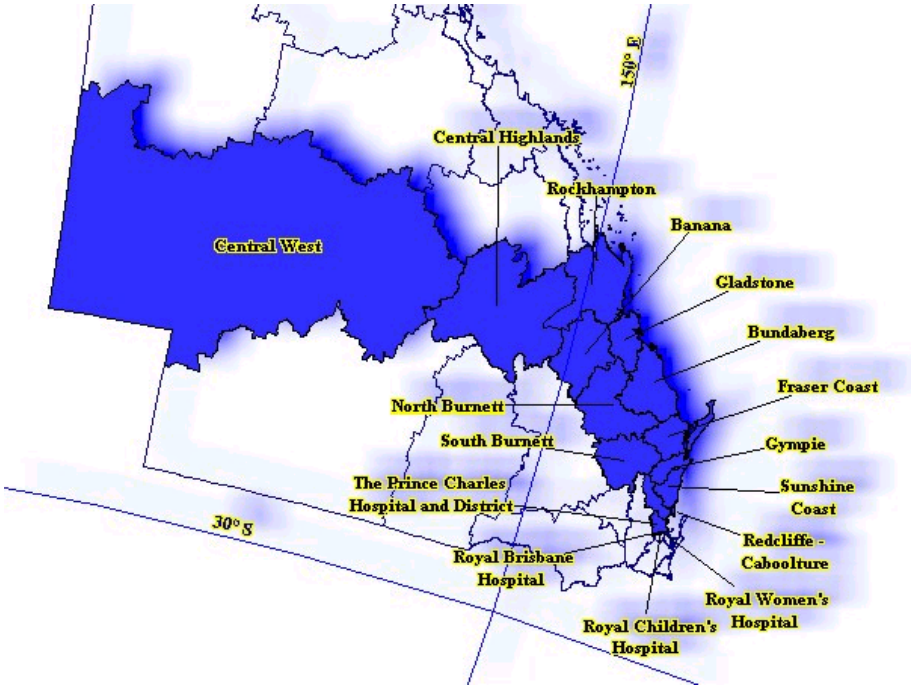
1.1 PREAMBLE

In early 2001 the Queensland Health CZMU developed a palliative care service model to improve palliative care service provision and strategic allocation of resource enhancements across the Central Zone (for a map of Central Zone Health Districts, see Figure 1 below). The model was the result of a consultative process with a palliative care reference group, which was comprised of a number of palliative care representatives from across the Zone.

To achieve the deliverables of this model, a total of six recommendations and strategies were put forward by the reference group which addressed issues of clinical support, training, education and performance improvement throughout the Zone (Central Zone Management, Service Development Plan 2001-2004).

To address the training and education needs of nurses in the Zone, the formation of a CZPCNG was proposed. This group would meet annually for a two-day professional development workshop at a nominated site, followed by their provision of a one-day education seminar for generalist nurses from surrounding districts. This model is based on the very successful and still active NSW Palliative Care Nurses Group, which was formed in 1992.

Figure 1: Map of Central Zone



It was proposed that the composition of the group could include:

- specialist palliative care nurses from government and non-government organisations;
- personnel of the CPCRE;
- representatives from the Central University of Queensland (School of Arts and Health Sciences), Queensland University of Technology (School of Nursing); and,
- an officer of the CZMU.

The CPCRE was initially consulted by the Central Zone to assist with the development of Terms of Reference, which is attached as Appendix 1. The Centre was subsequently contracted by CZMU to establish the CZPCNG and make recommendations regarding the ongoing sustainability of the group.

Three key strategies were employed by CPCRE to facilitate the establishment of the CZPCNG, including:

- planning and delivery of a two-day professional development workshop by CPCRE;
- development of mechanisms for facilitating ongoing communication and networking between group members; and,
- advising and supporting CZPCNG members to plan and deliver a one-day education seminar for generalist nurses.

These strategies were evaluated to enable recommendations to be made regarding the potential role for and ongoing sustainability of the group in enhancing palliative care services.

1.2 AIMS

The project aims were to:

- maintain and enhance the quality of palliative care delivery through the development of a formal network of specialist palliative care nurses practising across Central Zone in both government and non-government services; and,
- provide a formal program of professional development to such a group, to encourage the role modelling of leadership, collaborative networking and mentoring to each other and to generalist nurses practising across Central Zone.

1.3 OBJECTIVES

This project addressed these aims by assisting specialist palliative care nurses to:

1. identify their strengths, diversity and experience;
2. use reflective practice to explore the effectiveness and efficiency of their roles as professional care givers, peers and community representatives;
3. review the major components of palliative care practice in the domains of knowledge, skill and attitude, through the use of Problem-Based Learning and Evidence-Based Practice review;
4. negotiate a collaborative means for the group to develop a consistent and evidence based framework to optimise standards of clinical practice, policy and procurement and utilisation of equipment;
5. identify how annual group forums might provide constructive professional and clinical advice/feedback, on issues such as change management, role transition, leadership, palliative care practice and palliative care service delivery;
6. enhance leadership and mentoring opportunities, and utilise the collective knowledge and expertise of group members through the provision of formal palliative care education to other nursing staff within the Health Districts; and,
7. optimise opportunities for research and evidence based practice through the review of current literature, and identification of potential research activities generated by collaborative activity of the group and in partnership with the participating tertiary facilities.

1.4 ANTICIPATED BENEFITS

It is expected that this project will:

- enable the CZMU to provide more cohesive, flexible and localised palliative care training and education for nurses;
- enable a broader base of nurses to obtain a good understanding and knowledge of palliative care issues and care approaches; and,
- provide data to CZMU regarding potential strategies to employ in the support and development of their nursing staff towards provision of palliative care.

1.5 FUNDING

A grant of $25,000 was allocated by CZMU. A Table of Expenditure is shown in Appendix 2.

CHAPTER II: LITERATURE REVIEW

> *"Education and research are the most important platform from which the quality of palliative care to all Australians will be improved."*
>
> *(Palliative Care Australia, 2002:12)*

This statement describes an indispensable link between education and research with practice, whose beneficiaries are the recipients of care. Succinctly, Kelly (2001:401) states:

> *"Good clinical practice is inextricably bound to education, so one cannot be developed without the other."*

The overall aim of this project was to enhance the professional and leadership expertise of a selected group of palliative care nurses. As such, a central element of the project was a two-day workshop professional development workshop focusing on enhancing the leadership capabilities of these nurses. The development of the workshop was underpinned by two key assumptions. Firstly, it is acknowledged that learning in palliative care requires more than the "simple conveyance of knowledge and skills" (ISNCC, 2002:12). The multifaceted and complex nature of palliative care requires the application of an array of approaches to learning.

Secondly, Benner's (1994) foundational work on the development of expertise in nursing was used to identify the core concepts to be addressed within the program. Specifically, Benner's application of the Dreyfus model of skill acquisition provides the basis for use of necessarily broad approaches to learning. In particular, examination of the nature of leadership, mentoring, and reflective practice were central to the educational program adopted for this project.

Reflective Practice

It has been asserted that the development of clinical knowledge and skills is facilitated through reflective practice (Duke & Appleton, 2000; Paget, 2000; Taylor, 2000). Reflective practice is understood to be a process of critical examination of experience, and informed by relevant knowledge, in order to clarify personal and professional perspectives (Williams, 2001). With its basis in transformative learning theory, reflective practice is viewed as pivotal in connecting theory with practice (Williams, 2001; Scanlan *et al* 2002). Indeed, effective reflective practice can lead to profound change and heightened awareness of conflicts in practice (Rich & Parker, 1995).

One teaching method linked to reflective practice is that of problem-based learning [PBL] (Williams, 2001), which utilises practice problems to elicit reflection upon underlying perceptions, as well as the application of clinical knowledge and skills. Participants have reported numerous benefits from the use of such learning processes, including the promotion of critical thinking and problem solving, active learning, peer respect and networking, and broad application of collective knowledge to practice (Cooke & Moyle, 2002). Mok *et al* (2001) found the use of PBL an effective teaching strategy in the area of death and dying, given the complex and multifaceted nature of palliative care.

Johnston & Tinning (2001) assert the need for adequate preparation of PBL facilitators who must themselves undertake processes of reflection and self-examination in order to effectively assist learners through this means.

Leadership roles

Benner and Wrubel (1989) have provided valuable insight into the relationship between clinical expertise and leadership:

> *"By being experts in caring…nurse must take over and transform notions of expertise. Expert caring has nothing to do with possessing privileged information that increase one's control and domination of another. Rather, expert caring unleashes the possibilities inherent in the self and the situation."*
>
> *(Benner & Wrubel, 1989:137)*

The influence of successful leadership upon patient care outcomes is a persuasive argument for its inclusion in education of specialist nurses. Indeed, Deal (1991:540 in Cooke, 2001) puts it bluntly:

> *…without wise leaders and artistic managers…we will continue to see misdirected resources, massive ineffectiveness and unnecessary human pain and suffering."*

The various interpretations and characteristics inherent in leadership have been discussed at length, with Hanna (1999) offering a succinct summary in defining a leader as not simply one who inspires others to follow, but one who "captures the idea of guiding others toward accomplishment" (p.36). In this sense, one's ability to inspire is augmented by the capacity to envisage possibilities in others and assist them in fulfilling their potential.

Peer Support and Mentorship

Formal and informal networking groups have been variously described (Fitzpatrick, 2001). These networks play an important role in the support of practitioners, particularly those who feel isolated (Willson *et al,* 2001; Pearson & Care, 2002). The concept of mentoring has been identified to have different meanings to different nurses, along with different applications (Hall, 1997). It has also been noted that mentoring is a new concept for nursing in Australia despite there being a plethora of literature highlighting its particular importance in the development of nurse leaders (Hall, 1997; Pelletier & Duffield, 1994 in Lo & Brown, 2000).

Mentors have been described as 'trusted guides, teachers, role models, counsellors, supporters, confidantes, advocates and advisers' (Murray, 2002, p.46). They are also noted to be professionals willing to share their knowledge and experience and are recognised as leaders in the profession and their communities (Murray, 2002). The goal of mentoring goes beyond merely role modelling (Tomlinson *et al* 2001). A mentor is understood as one with appropriate:

- vision, knowledge, skills and experience;
- attitudes and personal characteristics; and,
- energy and actions

to facilitate the professional and personal development of another (Murray, 2002). Mentors are typically described as those who kickstart life-long learning and aid increased confidence in others through their positive encouragement and shared knowledge (Murray, 2002; Gray & Smith, 2000). Mentoring is viewed by some as a means of providing the clinical, emotional and psychological assistance needed particularly by those in geographically or professionally isolated practice (Fitzpatrick, 2001).

CHAPTER III: PROJECT COMPONENTS

Addressing the project aims and fulfilling the objectives of the project required the implementation of the project components:

- planning and delivery of a two-day professional development workshop by CPCRE;
- development of mechanisms for facilitating ongoing communication and networking between group members;
- advising and supporting CZPCNG members to plan and deliver a one-day education seminar for generalist.

The formation of CZPCNG was proposed by CZMU as a key strategy in addressing its aim of improving palliative care service provision and strategic allocation of resource enhancements across the Central Zone.

CPCRE identified specialist palliative care nurses in both government and non-government health care services located in the Central Zone. Twenty practitioners were located primarily using *Palliative Care in Queensland – The State Defined* (Adams & Schweizer, 2001). Each was then contacted by telephone by CPCRE to explain the project and its aims, and to extend an invitation to them to attend a two-day workshop at Hervey Bay. A key strategy for establishing the CZPCNG was this workshop. Eighteen of these nurses indicated their ability to attend.

3.1 COMPONENT ONE: WORKSHOP

All potential CZPCNG members were asked to review the draft Terms of Reference and suggest amendments, for endorsement at the workshop. They were also asked to complete an RSVP that included two questions (see Appendix 3) regarding accessibility and use of library resources and preferences for palliative care resources, which helped to guide planning of the workshop and project procurement.

The workshop program is summarised in Table 1 below. The workshop utilised a variety of learning approaches to assist in the professional development of its members.

Table 1: Workshop Program Topics

• Exploring the synergies and differences of the group
• The lessons of adult learning
• Role clarification using reflective practice
• Problem-based learning
• Benchmarking best practice through standardised procedures
• Leadership and mentoring
• Evidence-based practice
• Planning the education day
• Strategies for sustainability for the group

Implementation of Networking Strategies

To facilitate sustainability of the CZPCNG, an electronic discussion board was established, hosted by the Central Queensland University. A CD-based resource was developed with planning, promotional, and evaluation processes explained, and sample presentations. CZPCNG members who have taken responsibility for the

implementation of the next scheduled workshop and education day hold the CDs. Liaison with the NSW Palliative Care Nurses' Group has begun and potential for contact between the two groups is being explored.

3.2 COMPONENT TWO: EDUCATION DAY

The Education Day planning group was formed at the CZPCNG workshop, where seven attendees volunteered to participate in the planning, delivery and evaluation of a one-day education day for generalist nurses to be held in June 2003. Two team members were unable to continue on the planning group due to personal commitments.

As this was the first education day to be facilitated by the CZPCNG, the role of the CPCRE was to mentor the group in developing their own processes, using their collective skills, experience and knowledge. Any resources developed during the planning of the event would be recorded and left with the group for future use.

The planning group collaborated on three occasions via teleconference to:

- develop program content;
- identify speakers;
- devise an evaluation method;
- plan promotional strategies; and,
- organise other logistical issues, such as venue, catering, registration and sponsorship.

The education day program was developed and is summarised in Table 2 below.

Table 2: Education Day Program Topics

• The State We're In – Palliative Care in Context
• A Caregiver's Experience
• Pain Assessment and Management
• Pharmacology in Palliative Care
• "I Don't Know What To Say!" – Communication Skills
• The Latest in Symptom Management
• Panel Discussion – Case Study
• Using Sunshine Coast District Palliative Care Services

A promotional brochure was developed and distributed electronically and by post throughout the Redcliffe-Caboolture, South Burnett, Sunshine Coast, and Gympie Health Districts, targeting generalist registered, enrolled and assistant nurses. Wider distribution was required after an initially poor response.

The education day was conducted on Saturday 21 June 2003 at Nambour Hospital Auditorium. Speakers were drawn from the CZPCNG with two exceptions – a caregiver and a pharmacist. Sponsorship was provided by Abbott Australasia, Janssen-Cilag and Norgine who conducted trade displays. Promotional material was also available regarding Cittimani Hospice, Blue Care Palliative Care, CPCRE and the Queensland Cancer Fund.

CHAPTER IV: EVALUATION

An evaluation process was formulated utilising mixed method pre- and post-workshop evaluations (see Appendices 4 and 5) of CZPCNG members, and follow-up in-depth interviews (see Appendix 6).

4.1 WORKSHOP EVALUATION

CZPCNG members who registered for the workshop completed a brief RSVP that included two questions about written and material resources (see Appendix 3). It demonstrated:

- Both *The Blue Book of Palliative Care* and *Therapeutic Guidelines - Palliative Care* were present in around two thirds of participants' workplaces; and,
- The majority of workshop registrants indicated that *Clinical Practice Guidelines* in palliative care would enhance continuity across the Central Zone.

CZPCNG participants were asked to complete mixed method pre- and post-workshop evaluations. The pre-workshop evaluation included demographic information, and sought the views of the participants regarding the key areas of:

- leadership roles;
- mentorship;
- peer support;
- skills and knowledge; and,
- standardised practice.

The post-workshop evaluation repeated the questions in these five key areas, added an evaluation of the workshop content, and sought comment regarding the future of the group. The pre- and post-test evaluation tools consisted of:

- 18 and 22 (respectively) six-point Likert scale questions weighted on a scale of 1=disagree to 6=agree; and,
- 11 and 15 (respectively) open-ended questions to obtain qualitative descriptions.

The evaluation tools are attached as Appendices 4 and 5.

4.1.1 Response Rate

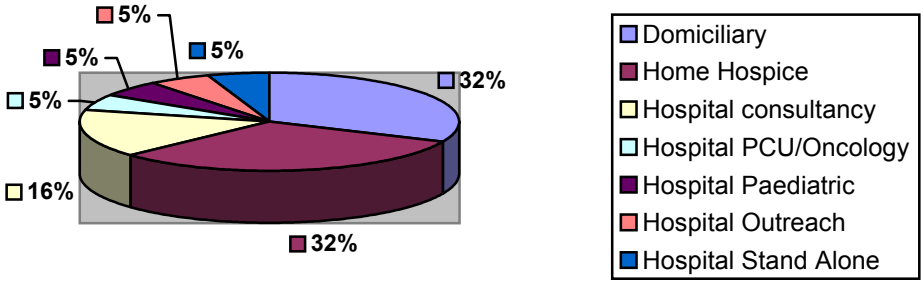
All 18 workshop participants were sent a pre-test evaluation by e-mail one week in advance, accompanied by a request to bring the completed document with them to the workshop. Following the early departure of one participant, the remaining 17 attendees were given a post-test evaluation and evaluation for completion upon conclusion of the program. All 18 pre-test evaluations were returned (100%) and 17 post-test evaluations and evaluations (94%).

4.1.2 Demographic Data

56% of workshop participants were from regional centres, with 44% from the urban environment. Workplaces were represented roughly in thirds – domiciliary, home hospice, and hospital. The latter group specified the nature of their hospital workplace; these are represented in Figure 2 below.

More than half the respondents indicated that, in an average month, 75-100% of their patients required palliative care. Interestingly, amongst this group, the majority had between 5-10 years experience in specialist palliative care roles, yet nearly 40% had less than five years experience. Most had undertaken postgraduate studies, although fewer than half had proceeded beyond the certificate level. Three were Masters graduates.

Figure 2: Workplaces of Workshop Attendees



Health library facilities were accessible to 78% of respondents, which they would access less than once per week. Most respondents felt confident using electronic databases and literature search engines, with fewer being aware of document delivery services.

4.1.3 Evaluation Results

1. Leadership Roles

Responses demonstrated an increase in mean scores between pre- and post-workshop evaluations, reflecting stronger agreement that their work involved leadership and advanced practice roles.

Table 3: Attitudes to Leadership Roles

Statement	**Pre n=18 Mean (SD)**	**Post n=17 Mean (SD)**
I consider my job in palliative care to be a leadership role.	5.26 [0.90]	5.41 [0.87]
My role as a palliative care leader is clear to me.	5.06 [1.03]	5.29 [1.10]
I have an advanced level of knowledge about palliative care.	4.97 [0.80]	5.26 [0.83]*
I practice at an advanced level in clinical palliative care.	4.97 [0.87]	5.26 [0.83]
It's my responsibility to assist others to adapt to changes to their work practices when the need arises.	5.12 [0.99]	5.56 [0.80]

*n=16

Themes which emerged from analysis of responses to open-ended questions are presented in the following summaries.

What qualities do you believe make an effective leader?
Respondents consistently identified four core themes of sound knowledge, skilled communication, vision, and empowerment/motivation in the pre- and post-tests. Generic descriptions such as *"…in depth knowledge of area of work"* and *"…ability and willingness to share knowledge"* were provided. Similarly, respondents mostly described skilled communication in generic terms, such as *"…sound communication skills",* although some identified specific skills like *"observational and listening skills."*

Vision was an attribute nominated with increased frequency from pre- to post-test. It was typically qualified by mention of one who "…*sees the bigger picture."* Correspondingly, descriptions of empowerment and motivation usually accompanied comments about vision. Unlike previous comments, however, these were expressed in specific terms, such as:

"…ability to pass on info or guide others without taking over."

and

"…ability to build confidence."

Post-test responses appeared much more succinct in their descriptions of the ability of leaders to assist others to develop their own potential. Interestingly, these descriptions of empowerment and motivation included comments such as:

"…ability to assist followers to develop own skills and become leaders of the future."

Similarly, post-workshop evaluations nominated role modelling as a quality of a leader.

What do you believe are some of the benefits of effective leadership?

WORKPLACE: Respondents noted the identification of common goals as a key benefit of effective leadership. Key words such as *cohesion* and *harmony* were used. Similarly, effectiveness and efficiency of service delivery were nominated as another benefit. The promotion of excellence for good patient outcomes was a third emergent theme, with descriptions such as *"positive impact on health outcomes"* being used.

WIDER PROFESSIONAL COMMUNITY: disparate comments were made around this aspect, although issues of cohesiveness and respect were mentioned.

COMMUNITY: Respondents described increased public awareness and profile as a key benefit, with comments such as *"enhances awareness and interest."* As was the case above, improved outcomes were seen as another benefit for the community, as this comment shows:

"…public able to identify the benefits of services to them and perceive some 'value added'." (sic)

No discernible difference was noted in themes from pre- and post-test descriptions.

What aspects of your role might be/now appear similar to other palliative care nurse leaders in the Zone?

"Preparing and delivering education" was an aspect frequently and consistently nominated in pre- and post-tests as a key similarity. Likewise, respondents mentioned management of financial and human resources, and the provision of clinical consultancy, in both evaluations.

Interestingly, despite no mention made in the pre-test, *"leadership"* was nominated following the workshop, although all examples of this offered no further explanation. Additionally, a few respondents commented on the similar problems they encounter in their role.

In what ways do you think your role might differ from other palliative care nurse leaders in the Zone?

Respondents provided numerous responses to this question with little homogeneity.

Individual respondents nominated a number of significant differences, such as *"sole-practitioner"* and *"responsibility across district."*

One respondent offered this post-test comment which well summarises this disparity:

"We all have similarities in the role, with perhaps smaller or larger line management, cost centre responsibilities, however clinical issues are congruent."

Notably, however, one respondent identified the differing levels of expertise as a key difference.

2. Mentorship

When responding to concepts of mentorship, group members' views demonstrated little change between pre- and post-evaluation scores.

Table 4: Attitudes to Mentorship

Statement	Pre n=18 Mean (SD)	Post n=17 Mean (SD)
It's an important part of my role to advise, guide and promote the professional development of others.	5.21 [0.95]	5.30 [0.85]
It is important to me to have formalised support and guidance in my professional life.	5.26 [1.19]	5.24 [0.97]

Themes emerging from responses to open-ended questions are presented in the following summary.

What do you believe are some of the qualities of an effective mentor?
Respondents identified *"approachability"* and *"knowledge at an advanced level"* as key qualities of a mentor, amongst others. However, a much more concrete understanding of the qualities of an effective mentor was demonstrated in the post-workshop evaluation. The *"…ability to inspire and encourage"* was nominated more frequently, as were specific descriptions of the promotion of the development of mentees. For example:

"Being able to advise, guide and promote the professional development of others.

What do you believe are some of the individual benefits to recipients of effective mentorship?
Respondents provided many comments regarding increased confidence across a range of actions, including their ability to ask for assistance, problem-solve or to admit to the limitations of their knowledge. Personal growth through mentoring was a benefit mentioned:

"Increased self-confidence, reflective practice, develop potential."

and

"Development of self at personal level."

Professional growth and increased skills were similarly a recurrent theme, shown in comments such as this:

"…growth in areas of interest and building up of areas needing assistance."

The post-test responses demonstrate an increased mention of *"guidance"* as a benefit. One respondent described the individual benefits of mentoring as reaching beyond the mentee:

"…challenge/develop the professional ability of both mentee/mentor."

3. Peer Support

There was greater agreement with core statements regarding peer support following the workshop.

Table 5: Attitudes to Peer Support

Statement	Pre n=18 Mean (SD)	Post n=17 Mean (SD)
It is important to me to be an active participant of a palliative care peer group.	5.24 [0.97]	5.60 [0.72]
It is important for palliative care peer groups to have professional development activities that are not directly related to clinical care.	5.56 [0.73]*	5.68 [0.59]
It is important for a peer group of leaders to have opportunities for networking, sharing and debriefing when they meet.	5.70 [0.59]	5.79 [0.40]

- n=16

Themes emerging from responses to open-ended questions are presented in the following summary.

What benefits do you think there may be/have you found in linking with other specialist palliative care nurse leaders?
Two themes strongly emerged from the qualitative data. The benefits of networking were frequently mentioned in both pre- and post-tests, with the specific benefits summarised in this comment:

"*Forming a network for sharing, advice giving, mentorship, acknowledgment, pooling of ideas."*

Secondly, the opportunities for sharing ideas, knowledge and resources was strongly reported. Descriptions of the "…s*haring of ideas and strategies"* were frequent. Respondents also demonstrated a lessened sense of isolation in the post-test:

"I no longer feel there is no real support…"

4. Research and Education Skills and Knowledge

Respondents demonstrated greater agreement with statements regarding skills and knowledge relating to research and education in the post-workshop evaluation.

Table 6: Perceived Research and Education Skills and Knowledge

Statement	**Pre n=18 Mean (SD)**	**Post n=17 Mean (SD)**
It is important to consult the available evidence to guide practice and teaching.	5.59 [0.69]	5.77 [0.44]
Research activities form an integral part of my leadership role.	4.03 [1.48]	4.71 [1.11]
I have sufficient knowledge to plan, deliver and evaluate education activities as part of my role.	4.47 [1.23]	5.00 [1.17]
The use of teaching methodologies, which enhance critical thinking and evidence based practice, enhances learning outcomes in palliative care.	5.47 [0.80]	5.59 [0.71]
It is important to measure the effectiveness of education activities.	5.59 [0.62]	5.65 [0.61]

Themes emerging from responses to open-ended questions are presented in the following summary.

Other than time constraints, what are the most difficult barriers you experience in the provision of educational activities in your workplace/community?
Respondents nominated the difficulty of *"getting people to the inservice"* as a key barrier to education provision. Problems in promoting interest and attendance amongst staff was consistently reported in pre- and post-tests, and two comments demonstrated some speculation as to their causes:

"Nurses unwilling to commit own time to professional development."

and

"Motivating nurses to attend education sessions and accept responsibility for own professional development – especially in their own time."

Some concern was demonstrated regarding the difficulties encountered when seeking replacement during leave of absence for educational activities.

Pre-testing showed some concern for lack of *"access to current research and information"*, however in the post-workshop evaluation *"…finding evidence"* was stated more frequently as a barrier.

A third theme shown in the data as a barrier to provision of education was a lack of access and knowledge about technological resources for teaching.

What strategies do you believe might address these barriers?
Despite the identification of barriers, respondents did not consistently offer homogenous strategies to address their concerns, in either the pre- or post-test. Rather, these were specific to individual work places. Occasional mention was made of *"upskilling in technology use"* and "*networking with other group participants"*, however data were disparate.

How would you access current evidence required to plan educational activities?
The use of the Internet, or other electronic databases, was mentioned by most respondents as a source of current evidence:

"Review current literature via search, utilising databases" [examples given].

'Traditional' sources of information such as *"textbooks"* and *"current nursing journals"* were included. Collaborative consultation and peer networking were similarly mentioned, with increased frequency in the post-test.

5. Standardised Practice

An increased level of agreement with the need for standardised practice was demonstrated in the post-workshop evaluation.

Table 7: Attitudes to Standardised Practice

Statement	**Pre n=18 Mean (SD)**	**Post n=17 Mean (SD)**
It is important to have single method of referral between agencies involved in palliative care.	4.65 [1.41]	4.94 [1.03]
It would be beneficial to have a common framework to guide palliative care policies and procedures between agencies in the zone.	5.18 [1.02]	5.59 [0.62]
It is important to have single method of procurement and utilisation of equipment used in palliative care delivery between agencies in the zone.	4.41 [1.37]	4.65 [1.12]

Other comments (pre-workshop):

Other issues that are relevant to my role as a palliative care nurse leader include:
Issues raised in this question were varied. Some mention was made of the difficulties experienced with colleagues:

"…providing education to GPs, aged care facilities, training/education including RNs, AINs, and ENs etc."

Evaluation of Workshop Processes:

Responses suggested that participants generally viewed the workshop as beneficial, with high mean score for all relevant items.

Table 8: Evaluation of Workshop Processes

Statement	**Post n=17**
My attendance at Hervey Bay workshop in March assisted me in my professional development and networking.	5.65 [0.61]
The workshop gave me the opportunity to develop strong and supportive networks with other nurses and resources throughout the zone.	5.65 [0.49]
I found the workshop to be a useful strategy to link nurses within the zone and foster professional support and development.	5.71 [0.47]
I was able to offer and receive mutual support and pool ideas about work and resources during the workshop.	5.53 [0.72]

In addition, respondents were asked to respond to items asking about the most and least helpful aspects of the program. Examples of typical responses are presented below.

The most helpful aspects of the workshop were:
Networking was overwhelmingly viewed as the most helpful aspect of the workshop, with most respondents identifying the benefits inherent in *"problem sharing"* and *"networking with nurses from different areas."*

The Evidence-Based Practice session was mentioned most frequently in response to this question.

The least helpful aspects of the workshop were:
Whilst little homogeneity was found in their answers, there were nearly a third of respondents who indicated that *"all was valuable."*

Respondents were also asked to respond to three open questions designed to assess their perceptions of the Central Zone Palliative Care Nurse Specialist Group. Responses are summarised below.

Do you see the CZPCNSG as being of particular value? If so, in what ways? If not, why not?
Again, networking and support mechanisms were overwhelmingly viewed as the most valuable aspect of the group, with specific benefits identified by some:

"Great support – lessen feeling of isolation."

and

"It is great to be able to link with other nurses working in the same field and encountering the same problems."

Opportunities to share knowledge was also seen by many as a value of the group:

"…advancing body of knowledge via subgroups."

The potential for shared education and research activities were mentioned by a few respondents also.

Given the group's discussions in this workshop on the nature of leadership, do you see yourself as a leader within this group? What contribution do you believe you can make to the group to contribute to its longevity?

Yes = 6; Conditional = 4; No = 5

Two comments in particular demonstrated the sorts of conditional answers offered by some:

"I feel the expertise within the group will help me to develop into participating more in this role."

and

"I see myself as having significant skills and experience in some particular areas, but feel we are peers with varied skills."

What do you believe are the areas you require specific development in?
The acquisition of more advanced research skills (such as accessing the evidence base) was an emergent theme. Similarly, increased familiarity with particularly educational methods was mentioned. This comment demonstrated how these developmental needs were viewed not as an end in themselves, but to serve a separate purpose:

"Research/education – would like to be able to contribute to awareness of the more holistic, person-centred form of care that I believe in and practice – ways to do that."

4.1.4 Other Information from Workshop

As part of the two-day workshop, CZPCNG members were asked to undertake a analysis of the group's strengths, weaknesses, opportunities and threats. These are summarised below in Table 9.

Table 9: SWOT Analysis – CZPCNG

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
• multifocus • networking • cohesive teams • specialist nursing and medical (urban) • 24 hour service • communication • innovative, resourceful, visionary	• decreased awareness in professions & community • professional isolation • fragmentation • inadequate medical backup • 24hr duplication • inadequate funds • inadequate access to resources inc. education • blurred roles • relationship between NGO & QH	• development of performance indicators for PC • community fundraising • access to professional supervision • education • encouragement to delivery good PC	• time • management vs clinical responsibilities • funding • burn out • demographic changes • marginalisation • uncertainty • non-quarantined PCP monies • definitions of disease • unsupportive GPs

Workshop participants also brainstormed tactics for the CZPCNG resulting in the following strategies for operationalising the group:

- on-line discussion board;
- sub-groups;
- annual meetings; and,
- education days.

4.2 PARTICIPANT EVALUATION OF EDUCATION DAY

Planning group members designed and implemented a participant evaluation form given to all attendees of the Education Day. This enabled members of the CZPCNG to apply skills in the evaluation of educational activities. The results are included in Appendix 6. Overall, responses indicate the day was evaluated positively by those attending the day.

4.3 FOLLOW-UP INTERVIEWS

Following the Education Day, half hour telephone interviews were scheduled with 14 members of CZPCNG who had consented to being interviewed. Metropolitan and regional areas were evenly represented in this cohort. The issues to be discussed were e-mailed to all participants prior to the interview, so that they might have time to consider their responses and think of pertinent examples related to the topics. A copy of the issues document is attached as Appendix 5. The nine issues to be discussed were:

- leadership;
- mentoring;
- peer support

- in-service education;
- the use of evidence-based and standardised practices
- personal areas of specific skill development;
- the electronic discussion board;
- the sustainability of CZPCNG; and,
- any other additional issues.

A researcher not involved with the running of the workshop carried out the interviews in order to facilitate the de-identification process, preserve anonymity and enhance objectivity.

Before the interview commenced, it was explained to participants that they might withdraw at any time. It was also explained that the responses would be typed as the participants spoke. The process of de-identification was also discussed, whereby responses were recorded only by participant number and demographic location. Themes from the interviews would be described in the report, and although some quotations might be included, these would not be attributable to any individual. All participants agreed to this.

Content analysis was used as a research tool to determine the presence of concepts and themes in the comments made by participants.
The content analysis involved multiple steps. The transcripts of the interviews were re-organised by category, so that all responses regarding the each topic were grouped together. The topics in the interviews formed the basis of the analysis. Themes within each category were identified. Not all comments were categorised if they did not seem to fit in with a theme. Some comments related to more than one category and were also included in that other category. Relational analysis was also used to identify superordinate overarching themes that were relevant to more than one category.

Key themes emerging from analysis of the interview data are presented in the following summary.

Leadership

Discussions with participants about what constituted leadership ranged across a diverse number of activities. These included:

- caring for the team;
- providing interpersonal support, both personally and professionally; being a role model; fostering leadership qualities in others;
- empowering team members;
- learning strategies to manage staff;
- promulgating the philosophy of palliative care which should also permeate the values espoused by the leader;
- dealing with problems then following up to make sure the problems are dealt with;
- taking the initiative to make sizeable changes in the running of services and the deployment of staff; and,
- increased self-monitoring of one's role as a leader.

The image presented by the leader was seen to be related to the effectiveness of the leadership. One participant, perceived a barrier to effective leadership being that she was seen as 'other'. To overcome this barrier, she described:

> *"keeping my ear to the ground, to keep in touch with what's happening, in the management position",*

being able to predict situations and pre-empting problematic conflicts. She also reported spending time with staff in an informal way so that they can open up to her and express their opinions.

Another participant took a very different approach, feeling that with increased recognition of her being a leader she had to instigate a clearer role delineation, which had previously been a bit blurred.

Mentoring
Existing informal relationships were reviewed and identified by some as mentoring activities. Since the workshop some participants have adopted roles of mentor and mentee. Views about what constituted mentoring were changed during the workshop:

> *"that it actually can be a touch and go thing, you only request mentoring when you need it, it's not this formal form of attack of becoming what you want to become, it's changed my thinking about what mentoring is".*

Perceptions of mentoring
There was an interesting range of interpretations of what comprised the activity of mentoring:

> *"I've assisted them, encouraged them to go and gain further qualifications, I've provided clinical opportunities for people from outside the area, allowed people for career paths, and allowed them to reflect on their careers";*
>
> *"some people think that they're going to be your mentor because they have a position above you, from a point of view it is greater than that";*
>
> *"mentoring is purely about confidence boosting, having a sense of my abilities … and that things can be changed, …. the sense that things can be moved on, giving me vision";*

Mentoring was also seen as a form of political advantage, as "another voice in executive".

Perceived barriers to mentoring
One of the major difficulties cited was the lack of time. Another barrier was the idea that formal mentoring is not a common activity in nursing:

> *"I think nursing hasn't traditionally explored that but it certainly needs to, that's something I will do in the future".*

It was discussed whether a mentor should be sought from within the nursing profession or outside of it. One participant commented:

> *"nurses tend to stick to their professional silos and that's not always a good thing either, but I wouldn't say there hasn't been an exclusive mentor but I have been able to find some sort of support and what I need from a very eclectic range of professionals …"*

Informal mentoring
Whilst mentoring wasn't common practice in this group, many participants identified existing relationships that could be seen as a form of informal mentoring. One participant commented:

> *"I guess basically she's doing that role but in a sort of informal way"*.

After the workshop
After the workshop many participants expressed the view that mentoring could be greatly beneficial. Some participants described mentoring relationships that have recently developed:

> *"in a debriefing type manner, I've been able to share my concerns, bounce my ideas, and she has also given me more clarity about decision making, and I'm learning to plan, and that's another thing that came from the conference";*
>
> *"Since the workshop I actively approached and sought a mentor for myself, another Level 2 and that's been good";*

"I've always had someone I considered my mentor, with her giving more direction, I did seek it out, sought it out more since the workshop";

"I did bring away with me the thought that I should think about it more seriously. Somebody has offered me mentorship and I've thought, 'oh no, no, no' but the main thing that I that I've brought away is that I'm important enough to be mentored… and I thought I should take it up, that is was valid for me to consider to be mentored… She's actually thinking of mentoring me in leadership and management";

"I actually have sought mentoring myself since the conference, that developed through the conference, a colleague who works nearby offered…. She is the most wonderful, wonderful person, she was my previous boss."

Some participants have established processes for mentoring for their staff since the workshop:

"Since the conference I met a nurse at a nearby hospital who was feeling very down and not valued and I've invited her to come and have a chat, it's not really formal, she'd just come over when she felt like a chat, and she's recently applied for redeployment in Queensland Health, and she's really happy about that";

"I brought lots away from the workshop, we have a palliative care on call service here and there have been two staff members who have just joined that service and we've done a lot of mentoring with them".

One participant described a form of mentoring that she had implemented, a mentoring group:

"Since the workshop I have actually started a mentoring group within the other roving clinical nurse consultants in divisional oncology. A mentoring group supports each other but one of the members is much more senior in terms of professional issues. We meet weekly, there's peer support, but its mentoring because one of them knows an awful lot more".

Peer Support

There were two strands to the discussions with participants about peer support- support that was engendered within CZPCNG, and peer support they experienced in their organisations. There was also many references made to the electronic bulletin board in relation to peer support.

Experiences of peer support in CZPCNG

One participant said:

"networking was excellent, it was nice just listening to the fact that other people have problems, that was of extreme value".

Another commented that *"it was good to get feedback from others".* One participant described the relationships with other members of the group as having a different quality to those that she experienced in her workplace. The workshop was also described as strengthening relationships with palliative care colleagues, and further to establishing a:

"collective interest in organising the support of the CZ generalist nurses, it has brought that goal to us now."

Particularly the sole practitioners seemed to find great benefit from the group:

"for me it resolved the isolation issue because I'm a sole practitioner and I previously felt very isolated".

The electronic bulletin board was often referred to in relation to the issue of peer support;

"I find my peer relationships where I'm working difficult, at times I don't find I'm getting much peer support at times, … I think if the discussion board continues then that provides some good peer support."

For one participant the workshop made her realise that there is a:

"wider group of people that you could look for different support, the support in doing the seminar, the awareness of the CPCRE for help with education was something that I hadn't thought of in the past".

Experience of peer support in the workplace

There was some evidence that, in specific organisations, the quality of peer support is very high. One participant described a weekly meeting in their organisation and a regular meeting every second month of a palliative care working party in the region. She said:

> *"there's a lot of peer support in palliative care [in this region]… we're constantly feeding back and supporting each other".*

These activities were described by another participant, in a different area, as the "really good things up the coast" and she plans to build some bridges and form alliances with this established support network.

Another participant described very good peer support in her workplace, where they have:

> *"professional supervision once every 6 weeks by a qualified external psychologist, case management meetings every fortnights, …meetings as necessary about complex cases … and a culture of caring for each other, and … also a culture of recognising how your own personal issues can impact on work".*

In-Service Training

One participant described a practice already established in their workplace where the organisation takes 50% of the responsibility of ensuring that staff get to training sessions, and staff are expected to also use their own initiative in their own time. Employees then feed back to their colleagues once a week about any training or conferences that they have attended, in order to keep the knowledge of all organisational members up to date.

Another participant described a very different scenario where she runs courses in the ward and there is very poor attendance, due to other work being of higher priority, and staff being too tired and busy. Other types of difficulties described by a participant include the fact that there is an overload of in-service education available and the courses are competing for time.

Overcoming the barriers

One participant suggested that in order to overcome these difficulties, videos and CDs, perhaps supplied by the CPCRE, might be available when there is down time available. One participant described a way of tackling these difficulties, by making:

> *"in-service training an outing, incorporating a bit of fun with it, especially if we have to travel away".*

One participant felt that she was not providing sufficient in-service training and that the workshop:

> *"flagged the issue for me, that's one of the next goals I've got is to increase the amount of in-service that I'm giving."*

Another participant said that,

> *"One of the nurses is quite interested in paediatric palliative care and have arranged for her to do some time at the RBH increasing her knowledge in the area, wouldn't have known how to do it if I hadn't done the weekend workshop and got that personal connection."*

Professional and Skill Development

Generally, participants seemed very clear about their individual needs for professional and skill development. A number of participants stated that they needed more practice and training in the area of public speaking and this often included some training in the use of PowerPoint. One participant explained the need for such skill development arose from the fact that:

> *"nurses are not renown for being public speakers, we're bedside or one-to-one with families, we're not generally public speakers, we're probably very good at it but we don't do it."*

Some participants felt confident in their teaching and presentation abilities but expressed a desire to learn more about doing research. There was considerable enthusiasm for the idea of doing research but a great awareness of the need for further training in this area. One participant said:

> *"We should know how to do research as we're supposed to be acting as mentors to generalists who are research naïve."*

Implementing Evidence Based and Standardised Practice

There was support for the idea of evidence based and standardised practice but perceptions of what this constituted were divergent. Some participants seemed a little unclear about what actually constituted evidence-based practice and standardised practice. One participant said:

> *"I think that would be helpful … for Queensland Health to be able to get those education sessions, on a format, to be able to run a programme instead of writing every single document, would have saved an awful lot of time. To actually standardise the practice so that all the volunteers in the zone run on a standard, so that everyone is dancing to the same tune and getting at the same goal."*

Another participant commented:

> *"I do believe that there is room for evidence based practice because you don't want to be reinventing the wheel, seems to be the problem and people or some facilities are not keen on sharing information, do have access to databases and journals and perhaps as a group perhaps someone could access information and pass it on."*

Another participant clearly stated that an EBP approach:

> *"gives me more confidence with medical staff and GPs, and allows them to listen if you've got an issue with them".*

The varied perception of EBP also included such issues as collegial responsibility and ownership of intellectual property. Discussions on this issue seemed to raise more questions than provide conclusive ideas:

> *"so it's our collegial responsibility but we also need to look into the ownership, the intellectual property of Queensland Health, looking at crossing the boundaries the government and the non-government, how can we initiate better cross pollination, is it up to the group to lobby Queensland Health about that, maybe we could go through the Queensland Health representative?"*

Suggestions for other workshop approaches

One participant suggested that there was a need for basic education, that might practically support the needs of members, looking at the processes and practice, with a further workshop more about themes and theories.

Future topics

Comments about topics such as research, negotiation and financial skills that might be presented in future workshops included:

> *"learning how to evaluate research and also how to find good websites";*
>
> *"I've been frightened of research up until recently, now I feel we could tackle it and find out more about it, I guess there's always this fear that there's this world we don't know anything about";*
>
> *"get down to the tin tacks of research, how do you actually get the resources to the time into it, .. also working up budgets, having a bit more financial knowledge would be good";*
>
> *"financial planning skills, budgeting stuff, applying for funding";*

More intrinsically psychological and spiritual topics included such comments as:

"we need to look at the areas of spirituality, scratching below the surface, talking to people about their death, all those kinds of issues";

"bereavement issues, … I don't think we do it very well, some ideas about how to do that differently, bereavement of the staff, but also looking after the carers, how are the children of parents who have died";

"burnout is a big issue, when you feel burnt out its such a difficult area, people get a lot of satisfaction and they still leave nursing".

One participant was concerned with how palliative care professionals relate to the wider community and suggested that the group needs to look at:

"how we can increase the community access to palliative care, there's still a huge percentage of the population who don't know that we exist, or what we do, as senior nurses we need to know how to push our role to the community".

Benefits of the workshop

The major theme that emerged regarding the benefits of the workshop was an increase in the level of individuals' confidence. This increased confidence related to the development of enhanced identity:

"we had a lot more to offer than perhaps we'd realised".

One participant said that the workshop was a "form of validation" that she was a leader and that she should act like a leader. Leadership also related to speaking out at meetings, being more forthcoming with views that might not be well received, feeling worthwhile to contribute, and having more confidence when talking to medical staff.

Criticisms of the content of the workshop

Some took the view that the content of the workshop was at too low a level, and one said:

"I've been in leader positions for so long it's become second nature, I'm a leader all the time. I have to be honest it was OK, but I've heard it all before."

It was suggested that a training needs analysis was needed prior to the workshop.

Sustainability of the group

There were a number of issues discussed in relation to the sustainability of the group: *"people need to be committed to each other and the group".* Ways in which this could be accomplished included subgroups and regular meetings, the electronic bulletin board, funding, more workshops and education, and formalisation of the group. The future of the group was envisaged and also issues of who should be included and who should be excluded.

It was generally agreed that subgroups and regular meetings would facilitate the sustained activity of the group:

"somebody's got to do the legwork, subgroups geographically would be helpful "

"[with reference to the NSW group] what they do is meet for dinner once a year and they talk to each other fairly frequently so it's a general support for each other";

"meetings should be regular in order not to lose momentum".

The electronic bulletin board was frequently mentioned:

"discussion board is necessarily going to be a way to organise things";

"we've got to keep on using the bulletin board, and I think that will get better, more ideas being bounced around, and I can see that happening already with the more things that are coming through".

The CPCRE was also envisaged as having a role in maintaining the group:

"some input from the CPCRE perhaps to keep the thing flowing".

It was generally agreed that funding would be very helpful:

> *"We need to go and look for sponsorship, the NSW group gets sponsored and that's been posted on the discussion board for everyone to see, and I think its something companies who have got the bucks, nurses are the people who are worthwhile to sponsor";*
>
> *"We could lobby for funding and also using our representatives, the drug companies".*

More workshops and educational activities were considered desirable:

> *"one of the things to sustain the group wants to standardise some practices then at a meeting we bring some of the practices and spend some time discussing them and looking at different things and using it as a forum to discuss different things, something to include in a future workshop program, … if we've got all the heads together in one room then surely at the end of the workshop we can walk out with a draft document that we can go out and trial";*
>
> *"it has to have some educational component for me, something more relevant to my level of expertise, new drugs, nursing practices that have been found to be successful, some things at a higher level … possibly participants presenting to each other";*
>
> *"There is the idea that the Central Zone group would present on different things, I feel that in the future we need to stretch people more, make it more challenging, it was nice and warm and friendly and a good way of introducing people without it being threatening, but stretch them, stimulate them to extend themselves, perhaps need a training needs analysis for the next one"*

There were somewhat opposing views on the issue of who should be included or excluded from the group. Inclusion on the bulletin board was one level, and inclusion in the actual CZPCNG was another:

> *"To open it up to all levels might not make it sustainable, in NSW its only 2s and level 3s so it is the specialist nurses, whereas our terms of reference was anyone who was interested in palliative care and I think that's broadening it too far";*
>
> *"Maybe it would be a good idea to open the discussion board up to others who might be interested, there's more chance of keeping it going if you keep the original group, the discussion board could however be opened up to those who are level 2, they've got a lot to bring to that group as well, a lot of them are the ones who are working in the clinical areas, a lot of the levels 3 are working in admin";*

The formalisation of the group was seen as a mechanism to ensure sustainability:

> *"I would think that it would make sense there needs to be some sort of actual linkage to provide support on a continual basis, you can't accept that something that is going to be ad hoc is going to be sustained.";*
>
> *"there's got to be some sort of formalisation of linkage, that this area is going to be linked with that area, so at the same time it's a sharing of the resources, if you know that's part of your responsibility, or they know that that is the best person for their line of contact, then you probably know that that's going to be easily sustained and if that happens there needs to be some sort of resources put into it, one of the big issues is time, this is the responsibility and this is the outcome, we're looking for better service to our clients, that needs to be acknowledged in relation to time allocated to actually do that"*

Electronic Bulletin Board

Discussions about the electronic bulletin board linked in with a number of other issues that have been previously reported, including peer support, development of standardised practices, the sustainability of the group, and the inclusion of a wider group of nurses.

Benefits of the bulletin board

All but two of the participants expressed overwhelming support for the idea of a discussion board. It was seen as *"where the future lies".* Positive comments included:

> *"the board is the thing that ties us all together and provides good patient outcomes"*
>
> *"there's an obvious benefit in terms of sharing information and benchmarking"*
>
> *"I think it will increase our ability to get to know everybody, its going to open another communication route, I think for problem solving particularly, for the individual sole practitioner, it could be more helpful"*

The bulletin board was also likened to a "safety net" where participants could go for advice.

Difficulties with the bulletin board

One participant was not keen on the bulletin board because of the need to do it in her own time, and many participants reported that initially they had great difficulty registering. Problems ranged from the bulletin board itself, to access problems. This included both issues of no Internet facilities in the workplace, or staff being blocked from accessing the site.

Other Issues

Most of the discussion regarding other issues focused on topics that members of the group felt could usefully be addressed at future workshops or Central Zone events. These topics included research, financial planning, negotiation skills, spirituality, bereavement, burnout, and the promotion of palliative care in the wider community. There were also some thoughts on the compilation of a resource list, how bridging relationships between government and non-government organisational members had been formed, and the ways in which the group might promote prescribing rights for nurse practitioners.

Practical consequences

Participants described some practical outcomes from the workshop, including:

- Running a number of extra workshops as a consequence of the workshop;
- Choosing to speak herself at a workshop, rather than inviting an outside speaker;
- Confirming her belief in the practice of not withholding information;
- Following the principles of giving information freely to lessen the anxiety of employees undergoing organisational change;
- Taking the decision to entirely revamp the volunteer service;
- Completely reorganising the way in which chemotherapy is scheduled, which also involves a greater use of community nurses, freeing up her own staff for other duties; and,
- Instituting new types of processes in the way that she deals with decision making, promoting staff ownership of collective decisions.

Practical and political issues

On a practical note one participant suggested that a resource list be compiled:

> *"the other thing I was thinking about would be a resource list, people who would be available, if we had a resource list of people with what topics they like to do… we've all have pet subjects".*

On a more political level another participant commented on the overall benefit of the workshop in terms of overcoming barriers between government and non-government organisational members:

> *"I think it's good that this group has brought together people from the government and non-government as there's a recognition that we're working towards achieving a better palliative care service in the community, seeing ourselves as one, rather than two very separate, entities."*

Another issue mentioned was looking at the nurse practitioner role and:

> *"at getting limited prescribing rights, so that we can prescribe some schedule 5 and 4s. This group could do something as a lobby group, first of all explore the role of what this would mean to us, formalise this."*

Overarching Themes

Several important superordinate themes were identified through the discourse of group members. One of these themes was the way in which the philosophy of palliative care inspired practice. Another was the potential political power of the group in terms of moving forward the professional practice of palliative care nurses. There were also ideas about overcoming barriers and divisions between palliative care professionals.

One participant explicated the way in which ideals, values and morals influence the practice of palliative care professionals with this comment:

> *"I look at the big picture, because of working in palliative care I think about what's really important, that links into the philosophy of palliative care, looking for the positives, looking at what is important in life, people who have a terminal illness look at the big things in life. Material things are not on the top of the list."*

This was also an implicit theme in the way that participants described their roles as leaders and mentors.

One of the greater benefits of the workshop was the way in which individuals overcame the barriers between members of different organisations who compete for beds and funding. There was discussion about the way in which interpersonal relationships were established on the basis of personal values and beliefs. One participant described this in this way:

> *"within palliative care there are a number of forces that kind of push, divide us apart, elements of competition for funding, [this workshop] helped to counteract that, to do something to cooperate together, to counteract the forces that tend to make you more isolated from one another".*

There is an indication that this overcoming of barriers may continue on the bulletin board, which one participant described as

> *"a place where we could work things out when we argue about funding and access to beds. Sometimes we don't have a chance to find out what each one personally thinks, all fighting over the same pot of money, that was something that I found out about these people, and these people who were very hard headed and their personal beliefs were in some cases very different, that was their organisational faces, and their personal beliefs were very different"*

Where some participants found the content of the workshop to be hugely helpful, others felt that it was pitched at too low a level. But as one participant said,

> *"It wasn't what I learned, but the informal stuff was absolutely huge, what it began was bigger than can be measured."*

CHAPTER V: OUTCOMES OF PROJECT

5.1 DISCUSSION

The establishment of this formal network of specialist palliative care aimed to enhance support and professional development opportunities for group members, including their development as leaders. The Central Zone Palliative Care Nurses' Group workshop represents one strategy in an overall process to address the aims and objectives of this project. The Group subsequently organised a one-day educational program for generalist nurses in June 2003.

The pre- and post-workshop evaluations and the follow-up interviews outlined in this report sought to assess the value of the two-day workshop, as well as assess the participants' views of the core concepts around their professional development as leaders in palliative care. An overarching theme became clear in the course of the interviews – the philosophy of palliative care and the set of values held in common by individual practitioners in this group continues to underpin practice. Additionally, responses indicate that participation in the workshop and establishment of the Group appears to have assisted participants to gain further insights into their role as leaders and advanced practitioners.

The key outcomes from the project are summarised in the following sections.

Leadership roles

The possession of a clear, future-focussed and practical vision emerged as a key quality of effective leaders in the analysis of respondents' qualitative data. A number of pre-test responses indicated effective leaders were fair, caring and compassionate. Such qualities have been aligned more to leadership in the Australian context, where the *person* is more significant than the position he or she holds (James, 2001). The qualities of approachability and role modelling were nominated as important characteristics of leaders as well as mentors.

In follow up interviews, respondents also identified role modelling and empowerment as components of leadership roles. For example, one nurse understood her role was to inform those she leads of the values of palliative care, and to model them in her own professional behaviour. Strategies of self-reflection, such as those included in the workshop, may have assisted these leaders to identify the values-base for their leadership role and as such may be a valuable component of professional development programs.

Although being a change agent was identified in both pre- and post-workshop and interview responses, risk taking was not identified by any participant, a quality of leadership noted in some literature (Vance, 1994, in Lo & Brown, 2000). Yet participants also described the workshop as influential in inspiring them to effect workplace change. There may be some benefit in future evaluations in exploring the extent to which facilitating change has been integrated into nurses' understandings of leadership.

Interestingly, descriptions in the pre-test regarding the benefits of leadership in the workplace tended to relate more generally to a greater environmental harmony and enthusiastic teamwork, leading to enhanced patient outcomes and improved standards of care, rather than more specific individual benefits. This perhaps reflects

the importance of teamwork to palliative care, despite the fact that most participants worked predominantly as sole practitioners. This common response supports the argument that the inclusion of leadership development in the education of specialist nurses, may contribute to more effective patient outcomes (Deal, 1991 in Cooke, 2001).

In regards to the benefits of leadership for the wider professional community, qualitative responses were very general, with some referring more to the individual than to the profession at large. However, post-test benefits were more clearly articulated, suggesting an increased awareness of the positive impact individual palliative care leaders might have on nursing and other health care disciplines.

In summary, while there seemed to be some variation in perceptions of the leadership role, mean scores for all items relating to leadership were higher in the post-test ratings. This increase was especially notable for participant's ratings of their level of advanced knowledge and clinical experience. In the post-test, there was also greater agreement amongst participants regarding their responsibility to assist others to adapt to changes in their workplace.

Indeed, post-test descriptions of the leadership roles were more succinct, suggesting that participants had, in the course of the workshop, developed a greater understanding of core components of leadership as defined in the literature. However, there remained some confusion about the differences between management and leadership in comments made during follow up interviews. Nevertheless, these findings suggest that the opportunity for reflection on issues relating to their roles as leaders may have been helpful for enabling participants to appraise this important aspect of their role as advanced practitioners.

Mentorship

Consistent with literature in this field, two of the most frequent qualities of an effective mentor identified in participants' responses were '*approachability*', and '*the possession of advanced knowledge and skills*' (Gray & Smith, 2000). This might relate to the documented 'awe factor' that is often experienced by mentees, who can feel intimidated or overwhelmed by those practising at an advanced level whom they consider to be leaders in their profession (Shea, 1999). Such responses also highlight how important it is for effective leaders to communicate skilfully with those around them to enable the sharing of knowledge, empowerment, and enhanced motivation of mentees (Vance, 1994 in Lo & Brown, 2000; Murray, 2002).

Participants' post-test definitions of mentorship changed from a focus on *'approachability'* to features such as *'encouragement'*, a common quality outlined in the literature (Murray, 2002; Gray & Smith, 2000, Hall, 1997). However, mean scores for both the pre- and post-workshop evaluation on this subject were largely unchanged, although there was stronger agreement that it was important for the participant to have formalised professional support and guidance.

Also of note, *'guidance'* was strongly identified in the post-test as being a benefit that highlights the clear link between leadership and mentoring. As outlined in the literature, the role of a mentor is that of providing guidance to the follower towards their full potential and identifying strengths and possibilities (Hanna, 1999). Participants also articulated a clearer understanding of the individual benefits of effective mentoring, such as goal clarification, helping to formalise objectives and in

particular, professional and personal growth. A number of those interviewed described this in detail.

However, responses did not reflect other documented benefits of a mentoring relationship, including assistance with role transition, particularly developing from novice to advanced practitioner (Murray, 2002), improved preparation for leadership roles (Lo & Brown, 2000; Clare *et al*, 2002), and an overall strengthening of the profession (Lo & Brown, 2000; Hall, 1997). Mentoring is arguably a relatively unfamiliar concept to nurses , and requires research into its importance to the development of the profession (Hall, 1997; Pelletier & Duffield, 1994 in Lo & Brown, 2000). By developing the required skills and abilities, programs such as the Central Zone Mentoring Framework and the CZPCNG may provide a framework for facilitating the development of mentoring relationships amongst palliative care nurses throughout Queensland.

Peer support

The sharing of resources, advice, knowledge and ideas were nominated by the participants as possible benefits resulting from linking with other palliative care nurse specialists. It was also suggested that such networking could enable cross fertilisation rather than *'reinventing the wheel'* and lead to support. Responses indicated support for strategies such as the Central Zone Palliative Care Nurses' Group, including the inclusion of professional development opportunities not directly related to clinical care (Russell *et al*, 1997).

In the post-test responses, networking and support were confirmed as benefits of linking with peers. Whilst some identified peer support through their workplace, others have identified the CZPCNG itself as a key source of peer support, where the relationships with peers have a distinctly different quality. Although peer support in the workplace appears inconsistent, it is suggested that peer support within the CZPCNG has both offered support to sole practitioners and further encouraged others.

Some participants identified a reduction in their feelings of professional isolation and the lack of perspective such isolation can generate. It could be suggested that the sole practitioners of this group, particularly those operating across districts and in rural/provincial areas, are at a greater risk of being overwhelmed by this lack of peer support (Elsey & McIntyre, 1996). Indeed, sole practitioner support is mentioned as a means of providing the psychological, clinical and emotional assistance identified as a need by rural and remote nurses (Fitzpatrick, 2001). Significantly, of this group, those practising as palliative care sole practitioners have less than five years experience in such a specialist role.

The establishment of an electronic bulletin board hosted by the Central Queensland University, has been identified by the vast majority of the group to be a significant means of providing and potentially sustaining, peer support.

Further exploration of the value of such models as the CZPCNG to this professional support needs to be undertaken to measure its impact particularly on rural and remote practitioners and on issues such as retention and recruitment.

Teaching and Learning

The relationship between clinical expertise and leadership and its importance in facilitating the sharing of knowledge and expertise with others has been acknowledged (Benner & Wrubel, 1989). However, some participants reported an inability to motivate other nurses to attend and embrace inservice and other education activities. Contributing factors identified include time constraints and conflicting priorities on the part of general nurses. Leaders are on the other hand noted to be able to inspire others (Hanna, 1999).

There was less agreement amongst the group regarding their knowledge to plan, deliver and evaluation educational activities as part of their specialist role. Indeed both pre- and post-test means were lower than the overall mean scores for responses to other items. Whilst some participants articulated less experience and confidence, others had significant experience in running comprehensive multidisciplinary outreach programs. This was also supported in the post interviews.

One could argue that less experienced nurse specialists, particularly those in sole practitioner roles, would find it difficult to gain the skill and confidence required without having formal peer support. As nearly 40% of this group had less than five years experience in their specialist palliative care role it is possible that they are most likely to benefit from the sharing of experience and insights held by their more experienced peers through the formal network of the CZPCNG.

Whilst opportunities for professional development need to be made available to various members of this group, the data indicates a diversity of needs across the entire group. For example, only one third of participants nominated themselves to be a leader within the group. A further third identified themselves as 'conditional' leaders with the remainder not seeing themselves as leaders within the group. This suggests that careful planning including a future needs analysis will be required by the group to facilitate growth and sustainability particularly regarding professional development.

In regards to strategies that might address the barriers identified, responses were very focussed on being given quarantined time to undertake the education activities, skills development in public speaking or having improved access to technology. One participant reported in the post interview how the organisation was being utilised to develop a learning culture across the workplace. The planned annual education seminar to be provided by the CZPCNG will provide opportunities for such development to take place. As noted in the post interviews, some participants identified a number of creative strategies that they were considering to enhance a learning culture in their own environments.

Interestingly, only two participants looked to the peer group as a means of assisting them to overcome the numerous challenges identified. The development of formal education mentor relationships from within the group could be a positive strategy for those who consider themselves 'novice practitioners' in this area.

Despite there being a diversity of knowledge and experience in the planning, delivery and evaluation of education, there was a high level of agreement regarding the use of teaching methodologies to enhance learning outcomes in palliative care, together with the importance of evaluating education activities. This implies that despite such differences in teaching experience, a majority of the group is familiar with the

principles of teaching and learning and therefore have a strong foundation of knowledge to build upon.

A CD-based resource was developed through this project to demonstrate planning, promotional, and evaluation processes. It also offers sample presentations to assist CZPCNG members to develop their own presentations when teaching in subsequent education days. CZPCNG members who have taken responsibility for the implementation of the next scheduled workshop and education day will hold the CDs. It provides a foundation for further development of similar resources by the group such as the comprehensive education resource entitled "One Hand Over" developed by the NSW Palliative Care Nurses'.

Evidence Based Practice/Research/Standardised Practice

There was extremely strong support from the participants in the pre- and post-workshop evaluations regarding the importance of using available evidence to guide their practice and teaching. However, some respondents indicated in the RSVP document that access to evidence based resources was problematic for non-government organisations. Although 78% indicated they had access to a health library facility, only two participants utilised them more than once a week, with the majority accessing these facilities less than once a week. 50% indicated they were confident in the use of electronic databases and literature searching. However, the data indicated that some of those less confident felt frustrated by either lack of access to such resources, and/or the necessary skills. This may be a significant professional development topic for the group to persue in the future. However, it appears that research and the use of evidence in practice are not viewed by some as inextricably linked but rather quite separate activities. Despite some apparent confusion as to the benefits of evidence based practice, post interviews revealed the group had considerable enthusiasm for the idea of undertaking research. Specifically, one respondent noted the significance of needing such development when being in a specialist and mentoring role. Further, skills development in research was nominated as a topic to be explored in future workshops. The linking of the group with active research centres may be one way of assisting this group to develop such skills or identify a pool of research mentors. Further, the group should be encouraged to work towards developing such links as part of its ongoing development.

The majority of the group was positive about having common frameworks to guide practice. In particular, group members supported the notion of clinical practice guidelines as a key strategy in promoting continuity between services within the Central Zone. However, there still appears to be a strong desire for services to maintain their independent status. In regard to having equipment synergies, there was less agreement. Indeed, some feared such a strategy would come at a cost to the patient.

The reality of the group having combined government and non-government representation was raised in the post interviews. The logistical reality of this diversity will need to be carefully considered as it will impact on resource accessibility, information sharing, intellectual property, financial transactions and other issues that may negatively impact on sustainability of the group. This issue could perhaps be further explored by the group at future forums in collaboration with supporting members of the CZPCNG.

Workshop evaluation

There was strong support reported in the post-workshop evaluation for the workshop and its positive influence on professional development and peer support. One particular benefit identified was the level of networking that took place, enabling problem sharing and peer support to be facilitated across diverse geographical and somewhat isolated professional locations (Willson *et al*, 2001; Pearson & Care, 2002).

However, post interviews again highlighted the diversity of the group in terms of perceived levels of advanced nursing and leadership experience. Where one respondent reported the workshop enabled her to more clearly identify her role as one of a leader together with the attributes and behaviours that correlated with such a role, others found the level of the workshop to be too low. As suggested by one participant, this may have been minimised through the use of a pre-workshop needs analysis. This would ensure workshop activities and methodology would be more appropriately pitched to meet the leadership and professional development needs across the group. Nevertheless, the focus upon non-clinical aspects of professional practice was widely supported, with suggestions made for further topics of relevance.

Purpose and Sustainability of the CZPCNG

Post interviews highlighted a range of contrasting views from a level of scepticism regarding the sustainability of the group and potential strategies, to that of great enthusiasm. For some, post-workshop evaluation data identified a particular value of the CZPCNG being its ability to enhance networking and peer support. Greater potential was identified by one participant in the group's ability to advance palliative care knowledge, specifically through the development of subgroups.

However, the group still appears to need some support to be self-sustaining. Specific strategies to promote sustainability may be encouraging leadership in action by those within the group who identify themselves as specialist nurses practising at an advanced level. Forming a subgroup to plan each year's workshop and education day could operationalise such a strategy. Indeed in the post interviews several participants reported that due to the diversity of settings and geographical spread, coordination and leadership by nominated members from within the group was important for sustainability.

The implications of the diversity of the CZPCNG membership also requires further consideration. Concern was raised regarding a further broadening of the diversity of the group as per the group's terms of reference. However, the terms of reference clearly identifies a specialist palliative care nurse as one operating in a designated role, and not 'anyone interested in palliative care'. This may need to be made clearer to the group.

The issue of not having recurrent funding is an obvious practical reality, which needs to be addressed by the group if sustainability is to be achieved. Whereas strategies such as seeking funding from drug companies was flagged as a way to fund the group's activities, there was no uniform confidence evident in overcoming this issue. Leadership from within the group again may be an important strategy in guiding the membership in this area. Further guidance and advice from support members may be required (eg: CZMU) particularly in regard to financial processes and requirements related to both government and nongovernment systems.

Maintaining ongoing communication and networks were identified as the life force of the group. Whilst the electronic bulletin board was generally viewed as a positive strategy in this regard, some were concerned to ensure that the geographical range of the group did not quell the momentum generated thus far, nor impede future development. Even so, there were few suggestions to how ongoing communication and momentum could be sustained, just as only a few raised the importance of commitment as being a vital component to the group's sustainability.

Further, although the concept of the CZPCNG is based on the NSW Palliative Care Nurses' model, it has distinct differences to its precursor, and requires specific strategies to guarantee its sustainability. This includes the number of community non-government services represented in the group and the significant number of 'novice' specialist nurses. Formalised communication between the CZMU and the specialist nurses is recommended to gauge the health of the group, and identify any issues that may need to be addressed until the mid- and longer-term health of the group has been realised. This could be facilitated via the Electronic Bulletin Board, or in a more formal way.

The project has established a formal network of specialist palliative care nurses through the creation of the Central Zone Palliative Care Nurses' Group. A formal program of professional development has begun, incorporating processes that encourage leadership, mentoring, and collaboration within the group and to generalist nurses practising across Central Zone.

REFERENCE LIST

Adams E & Schweizer Y (2001) *Palliative Care in Queensland – Volume II: The State Defined.* Palliative Care Queensland: Brisbane, QLD.

Benner P (1984) *From Novice to Expert.* Addison Wesley: Menlo Park, US.

Benner P & Wrubel J (1989) *The Primacy of Caring.* Addison Wesley: Menlo Park, US.

Clare, J., White, J., Edwards, H. & van Loon, A. (2002) *Learning Outcomes and Curriculum Development in Major Disciplines: Nursing. Final Report. Phase One Focus: Curriculum, Clinical Education, Recruitment, Transition and Retention in Nursing*. School of Nursing & Midwifery, Flinders University: Adelaide.

Cook M (2001) 'The renaissance of clinical leadership.' *International Nursing Review,* **48**: 38-46.

Cooke M & Moyle K (2002) 'Students' evaluation of problem-based learning.' *Nurse Education Today,* **22**: 330-9.

Duke S & Appleton J (2000) 'The use of reflection in a palliative care programme: a quantitative study of the development of reflective skills over an academic year.' *Journal of Advanced Nursing,* **32**(6): 1557-68.

Elsey, B. and J. McIntyre (1996). "Assessing a support and learning network for palliative care workers in a country area of South Australia." Australian Journal of Rural Health **4**: 159-164.

Fitzpatrick L (2001) *Enhancing rural and remote health care by making better use of remote nursing in practice.* National Association of Rural Health Education and Research Organisations.

Gray MA & Smith LN (2000) 'The qualities of an effective mentor from the student nurse's perspective: findings from a longitudinal qualitative study.' *Journal of Advanced Nursing,* **32**(6): 1542-9.

Hanna LA (1999) 'Lead the way leader.' *Nursing Management,* **30**(11): 36-9.

International Society of Nurses in Cancer Care (2002) *A Core Curriculum for Palliative Nursing. [2nd Ed.]* Mediate Health Consulting Ltd: Macclesfiled, UK.

Johnstone AK & Tinning RS (2001) 'Meeting the challenge of problem-based learning: developing the facilitators.' *Nurse Education Today,* **21**: 161-9.

Kenny LJ (2001) 'Education in palliative care: making a difference to practice?' *International Journal of Palliative Nursing* **7**(8): 401-7.

Lo, R. & Brown, R. (2000). A Clinical Teaching Project: Evaluation of the Mentor-Arranged Clinical Practice by RN Mentors. *Collegian*, **7**(4): 8-13,42.

Mok E, Lee WM & Wong FK (2002) 'The issue of death and dying: employing problem-based learning in nursing education.' *Nurse Education Today,* **22**: 319-329.

Murray RB (2002) 'Mentoring' *Journal of Psychosocial Nursing* **40**(4): 44-51.

Paget T (2001) 'Reflective practice and clinical outcomes: practitioners" views on how reflective practice has influenced their clinical practice.' *Journal of Clinical Nursing,* **10**: 204-14.

Palliative Care Australia (2002) *Palliative Care Service Provision in Australia: a planning guide.* PCA: Canberra.

Pearson C & Care W (2002) 'Meeting the continuing education needs of rural nurses in role transition.' *The Journal of Continuing Education in Nursing* **Jul/Aug**: 174-181.

Queensland Health (2001) Central Zone Management Unit Service Development Plan 2001-2004.

Rich A & Parker DL (1995) 'Reflection and critical incident analysis: ethical and moral implication of their use within nursing and midwifery education.' *Journal of Advanced Nursing,* **22**: 1050-7.

Russell RL, Gething L & Convery P (1997) *National Review of Specialist Nurse Education.* Commonwealth of Australia: Canberra, ACT.

Scanlan JM, Care WD & Udod S. (2002) 'Unravelling the unknowns of reflection in classroom teaching.' *Journal of Advanced Nursing,* **38**(2): 136-143.

Shea, G. (1999). *Making the most of being mentored: How to grow from a mentoring partnership.* Crisp Publications: USA

Taylor B (2000) *Reflective Practice: a guide for nurses and midwives.* Allen & Unwin: St Leonards, NSW.

Tomlinson PS, Tomlinson E, Peden-McAlpine C & Kirschbaum M. (2002) 'Clinical innovation for promoting family care in paediatric intensive care: demonstration, role modelling and reflective practice.' *Journal of Advanced Nursing,* **38**(2):161-70.

Williams B (2001) 'Developing critical reflection for professional practice through problem-based learning.' *Journal of Advanced Nursing,* **34**(1): 27-34.

Willson L, Fawcett T *et al.* (2001) 'An evaluation of a clinical supervision program.' *British Journal of Community Nursing,* **6**(12): 614, 616-617, 620-623.

APPENDICES

APPENDIX 1: CZPCNG TERMS OF REFERENCE

CENTRAL ZONE PALLIATIVE CARE NURSES GROUP

Terms of Reference

AIM
To maintain and enhance the quality of palliative care delivery through:

- the formalised professional development and collaborative networking of Specialist Palliative Care Nurses within the Health Districts of Central Zone; and,
- leadership and professional networking demonstrated by the group to generalist nurses working within the Health Districts of Central Zone.

This group endorses the World Health Organisation's definition of Palliative Care and recognises that clients requiring palliative care also include those with a diagnosis other than cancer.

COMPOSITION
Specialist Palliative Care Nurses from government and non-government organisations, CPCRE Director of Education or delegate; Central University of QLD, School of Arts and Health Sciences; QLD University of Technology School of Nursing representative; Central Zone Management Unit representative.

DEFINITIONS

- Specialist Palliative Care Nurse refers to those registered and enrolled nurses who are practising in a designated specialist role, in which palliative care is their core focus;
- Generalist Nurse refers to those registered and enrolled nurses who are practising in a general role, in which there is limited or infrequent exposure to palliative care.

COMMUNICATION
To be formalised following feedback and review of first Meeting in 2003.

MEETINGS
Forum in the form of a three (3) day Mentoring Meeting to be held in March each year. The host district to be negotiated at previous meeting. Meeting to be divided into:

1. two day forum for specialist nurses to identify strategies to meet deliverables;
2. one day Palliative Care Nursing Education for the generalist staff of the district to be conducted by specialist nursing group.

OBJECTIVES
The purpose of this palliative care group is to:

1. utilise the diversity and experience of the group to explore the effectiveness and efficiency of palliative care services and their role as professional care givers, peers and community representatives through reflective practice;
2. optimise the quality of palliative care nursing practice (knowledge, skills and attitude) through the use of clinical review and problem based learning;

3. collaboratively develop a framework of principles utilising current data/guidelines eg National Palliative Care Standards, under which standardisation of clinical practice, policy and procurement and utilisation of equipment can be optimised;
4. provide a regular forum through which constructive professional and clinical advice and appraisal can be given and received concerning such issues as change management, role transition, leadership, palliative care practice and palliative care service delivery;
5. facilitate targeted education and development opportunities for the specialist group;
6. enhance leadership and mentoring opportunities utilising the collective knowledge and expertise of group members through the provision of palliative care education to other nursing staff within the Health Districts; and,
7. optimise opportunities for research and evidence based practice through the:
   - review of current literature;
   - identification of potential research activities generated by collaborative activity of the group; and,
   - evaluation of strategies undertaken by the group to meet objectives described above.

APPENDIX 2: TABLE OF EXPENDITURE

KEY ACTIVITY	EXPENDITURE	AMOUNT
CZPCNG workshop – Hervey Bay	CPCRE consultancy	2850.00
	Educational resources and material	200.00
	Accommodation	2516.00
	Catering	2349.00
	Venue Hire	600.00
	Travel	355.20
Education Day – Nambour	CPCRE consultancy	3399.00
	Educational resources and material	100.00
	Catering	2200.00
	Travel	100.00
Resource development	CPCRE consultancy (Research Officer)	1736.00
	Blue Book/Therapeutic Guidelines	4883.70
	Printing reports	1211.10
Evaluation		2500.00
	TOTAL EXPENDITURE	**25000.00**

After discussion with the planning group and CZMU, it was agreed that sponsorship monies and registration fees should be collected and held in Sunshine Coast Palliative Care Services' trust fund to support the ongoing activities of CZPCNG, in particular the workshop and education day planned for March 2004. Receipting was undertaken by Sunshine Coast Palliative Care Services.

APPENDIX 3: RSVP RESULTS
(Excerpt)

n=18

There are some monies available to purchase common written resources and equipment to supply each of the districts/organisations represented at the workshop.

Educational resource information:
Please indicate which of the following resources are already available:

- ❍ Blue Book of Palliative Care **(12)**
- ❍ Therapeutic Guidelines – Palliative Care **(11)**
- ❍ Other (please name): **Woodruff = 5** **+7 individual texts**

Service provision resource information:
To enhance continuity of care across the Zone, please indicate which resources would be helpful:

- ❍ Graseby syringe drivers **(3)**
- ❍ Clinical Practice guidelines **(13)**
- ❍ Internet **(5)**
- ❍ How to do literature searches **(6)**
- ❍ Hospital beds **(6)**
- ❍ Portable air conditioners **(2)**
- ❍ Other:

- **Service agreements**
- **Alpha X-cell mattresses (2)**
- **Direct phone contact with a resource person for guidance and when needed**
- **Outcome measurement benchmarking**
- **Electronic journals and access to such databases as MIMs online or similar**
- **Benchmarking data - ?Joanna Briggs access (or similar)**
- **Oxygen concentrators**
- **Palliative Care Programme scripting District Guidelines and criteria review**
- **Gemstar PCAs**
- **Portable oximeter**

APPENDIX 4: PRE-WORKSHOP EVALUATION
Some reformatting has been done to save space.

PRE-WORKSHOP EVALUATION

Thank you for taking a moment to fill out this form prior to the workshop. Some of the questions invite your comment on a particular topic, whilst others ask you to indicate your level of agreement with a specific statement. Please answer as truthfully as possible.

You will notice a coding system is in place for this evaluation – this is for pre- and post-measurement only. Your responses will remain completely confidential and will only be reported as those of a group. You will be asked to complete a second evaluation at the conclusion of the workshop.

Demographic Information

- ***Which option/s best describe/s your workplace location?***

❍ Urban ❍ Regional centre ❍ Rural

- ***Which option/s best describe/s your workplace?***

❍ Domiciliary service ❍ Home hospice service ❍ Nursing home

❍ Hospital – consultancy ❍ Hospital – PCU/Oncology ❍ Hospital – paediatric

❍ Hospital – outreach

- ***In an average month, what percentage of your patients require palliative care?***

❍ Less than 25% ❍ 25-50% ❍ 50-75% ❍ 75-100%

- ***What is your length of experience as a palliative care nurse specialist?***

❍ Less than 5 years ❍ 5 to 15 years ❍ More than 15 years

- ***Have you undertaken any of the following education activities relating to palliative care? Tick as many as apply.***

❍ Continuing education subjects
❍ Postgraduate certificate ❍ Postgraduate diploma ❍ Masters degree

- ***Do you have access to health library facilities?***

❍ No ❍ Yes

- **If yes, how often do you use health library facilities in an average month?**

❍ Less than once a week ❍ Weekly ❍ More than once a week

- ***Which library resource/s would you consider yourself confident in using?***

❍ Electronic databases ❍ document delivery ❍ literature searching

Leadership Roles

1.1 What qualities do you believe make an effective leader?

1.2 What do you believe are some of the benefits of effective leadership?
- workplace
- wider professional community
- community

Indicate your level of agreement with these statements by circling the answer that most closely reflects your view.

1.3 I consider my job in palliative care to be a leadership role.

Disagree ◄——————► Agree
1 2 3 4 5 6

1.4 My role as a palliative care leader is clear to me.

Disagree ◄——————► Agree
1 2 3 4 5 6

1.5 I have an advanced level of knowledge about clinical palliative care.

Disagree ◄——————► Agree
1 2 3 4 5 6

1.6 I practice at an advanced level in clinical palliative care.

Disagree ◄——————► Agree
1 2 3 4 5 6

1.7 It's my responsibility to assist other to adapt to changes to their palliative care work practice when the need arises.

Disagree ◄——————► Agree
1 2 3 4 5 6

1.8 What aspects of your role might be similar to other palliative care nurse leaders in the Zone? (eg: managing change, preparing and delivering education)

1.9 In what ways do you think your role might differ from other palliative care nurse leaders in the Zone?

2. Mentorship

2.1 What do you believe are some of the qualities of an effective mentor?

2.2 What do you believe are some of the individual benefits to recipients of effective mentorship?

2.3 It is an important part of my role to advise, guide and promote the professional development of others.

Disagree ◄——————► Agree
1 2 3 4 5 6

2.4 It is important to me to have formalised support and guidance in my professional life.

Disagree ◄——————► Agree
1 2 3 4 5 6

3. Peer support

3.1 It is important to me to be an active participant of a palliative care peer group.

Disagree ◄——————► Agree
1 2 3 4 5 6

3.2 It is important for palliative care peer groups to have professional development activities that are not directly related to clinical care

Disagree ◄——————► Agree
1 2 3 4 5 6

3.3 It is important for a peer group of leaders to have opportunities for networking, sharing and debriefing when they meet.

Disagree ◄——————► Agree
1 2 3 4 5 6

3.4 What benefits do you think there may be in linking with other specialist palliative care nurse leaders?

4. Skills and Knowledge

4.1 It is important to consult the available evidence to guide practice and teaching.

Disagree ◄——————► Agree
1 2 3 4 5 6

4.2 Research activities form an integral part of my leadership role.

Disagree ◄——————► Agree
1 2 3 4 5 6

4.3 I have sufficient knowledge to plan, deliver and evaluate educational activities as part of my role.

Disagree ◄——————► Agree
1 2 3 4 5 6

4.4 The use of teaching methodologies, which enhance critical thinking and evidence based practice, enhances learning outcomes in palliative care?

Disagree ◄——————► Agree
1 2 3 4 5 6

4.5 It is important to measure the effectiveness of educational activities.

Disagree ◄——————► Agree
1 2 3 4 5 6

4.6 Other than time constraints, what are the most difficult barriers you experience in the provision of educational activities in your workplace/community?

4.7 What strategies do you believe might address these barriers?

4.8 How would you access current evidence required to plan education activities?

5. Standardised Practice

5.1 It is important to have a single method of referral between agencies involved in palliative care.

Disagree ◄——————————► Agree
1 2 3 4 5 6

5.2 It would be beneficial to have a common framework to guide palliative care policies and procedures between agencies in the Zone.

Disagree ◄——————————► Agree
1 2 3 4 5 6

5.3 It is important to have single method of procurement and utilisation of equipment used in palliative care delivery between agencies in the Zone.

Disagree ◄——————————► Agree
1 2 3 4 5 6

6. Other comments

Other issues that are relevant to my role as a palliative care nurse leader include:

Follow-up Interviews by the CPCRE

I would be willing to take part in a follow up evaluation (telephone) interview to further explore the benefits of participating in a Palliative Care Specialist Nursing Peer Group and strategies to enhance my practice and professional development. Please tick your preference.

Yes_____ No_____

Thank you for taking a moment to complete this evaluation.

It is essential you bring this completed evaluation with you to the workshop at Hervey Bay

APPENDIX 5: POST-WORKSHOP EVALUATION

The post-workshop evaluation tool repeated the questions in the pre-workshop evaluation tool sections 1-5. These are not replicated here, however the amended sections 6 and 7 are attached.

POST-WORKSHOP EVALUATION

Thank you for taking a moment to fill out this form now that the workshop is about to conclude. You will see that much of the evaluation resembles the first – please fill it out even if your answers are the same as before. Please answer as truthfully as possible.

Again, you can be reassured that your comments will remain confidential for both evaluations.

6. Workshop

Indicate your level of agreement with these statements by circling the answer that most closely reflects your view.

6.1 My attendance at the Hervey Bay workshop in March assisted me in my professional development and networking.

Disagree ◄——————————► Agree
1 2 3 4 5 6

6.2 The workshop gave me the opportunity to develop strong and supportive networks with other nurses and resources throughout the zone.

Disagree ◄——————————► Agree
1 2 3 4 5 6

6.3 I found the workshop to be a useful strategy to link nurses within the zone and foster professional support and development.

Disagree ◄——————————► Agree
1 2 3 4 5 6

6.4 I was able to offer and receive mutual support and pool ideas about work and resources during the workshop

Disagree ◄——————————► Agree
1 2 3 4 5 6

6.5 The most helpful aspects of the workshop were:

6.6 The least helpful aspects of the workshop were:

7. Central Zone Palliative Care Nurse Specialist Group

7.1 Do you see the Central Zone Palliative Care Nurse Specialist Group as being of particular value? If so, in what ways? If not, why not?

7.2 Given the group's discussions in this workshop on the nature of leadership, do you see yourself as a leader ***within this group***? What contribution do you believe you can make to the group to contribute to its longevity?

7.3 What do you believe are the areas you require specific development in?

Thank you for taking the time to complete this evaluation

APPENDIX 6: EDUCATION DAY EVALUATION RESULTS

The planning group developed an evaluation tool, which was given to each attendee upon their arrival at the event. The tool was comprised of a twelve-question, six-point Likert scale with two additional open-ended questions. It sought feedback on each session of the education day regarding the quality of presentation and relevance of content to each attendee.

4.3.1 Response Rate

The education day was attended by a total of 72 nurses from surrounding districts and comprised 35 Registered Nurses, 18 Assistants-in-Nursing/Personal Care Workers; four were Endorsed Enrolled Nurses, and five nominated other professions.

4.3.2 Demographic Data

Hospital personnel comprised 52% of attendees, aged care nurses 24%, and community nurses 23%.

4.3.3 Evaluation Results

The results demonstrated a high level of satisfaction with both presentation and relevance to practice, with each attaining an average mean score of 5.4 (of 6.0). The presentation by a caregiver was particularly well scored, as was the concurrent session on pharmacology. Descriptive statistics are noted in Appendix 5.

Description	Circle your Response: 1 - 6	Disagree ↔ Agree
1	**The State We're In…**	
This was well presented.	n=60	5.6 [0.59]
This was relevant to my work.	n=61	5.4 [0.82]
2	**A Caregiver's Experience**	
This was well presented.	n=62	5.8 [0.39]
This was relevant to my work.	n=62	5.6 [0.78]
▪ Excellent and very personal. ▪ Beautiful and courageous. Many thanks for Patrick's sharing. ▪ Fantastic.		
3	**Pain Assessment and Management**	
This was well presented.	n=60	5.5 [0.62]
This was relevant to my work.	n=58	5.4 [1.00]
▪ Very good overall, comprehensive for my own knowledge. ▪ Would have like more, realise is time limited.		
4	**Concurrent Sessions**	
Pharmacology		
This was well presented.	n=18	5.4 [0.92]
This was relevant to my work.	n=17	5.8 [0.88]
▪ Excellent: some handouts would have been helpful. ▪ Handouts would have been really good?		
Communication		
This was well presented.	n=12	5.3 [1.14]
This was relevant to my work.	n=11	5.6 [0.67]
▪ Bronwyn appeared uncomfortable and wanting it over and done with. Patrick rescued this session. Really looked forward to it. Last 15 mins very good.		
Common symptoms		
This was well presented.	n=25	5.1 [0.81]
This was relevant to my work.	n=25	4.8 [1.47]
5	**Case Study Panel Discussion**	
This was well presented.	n=59	5.4 [0.75]
This was relevant to my work.	n=57	5.1 [0.89]
6	**Using Sunshine Coast Palliative Care Services**	
This was well presented.	n=53	5.4 [0.72]
This was relevant to my work.	n=48	5.2 [1.30]

- Fantastic.
- N/A for me as I am not from the Sunshine Coast.
- N/A
- Not from this area.

Respondents were asked to comment on possible topics for future education and to provide any other comments regarding the day. A significant number declined to take up this opportunity or only filled in one of the sections.

Topics for future education: spirituality was the most frequently nominated topic, followed by grief, loss and bereavement issues across the age trajectories. Communication skills and several other more diverse topics from wound care to resource information were also nominated.

Other Comments: Several main themes emerged from the qualitative data regarding the education day:

- Benefits of the day: comments about the seminar were very positive, particularly in regards to the content, the topics chosen, and the quality of the presentations.

  " This was fantastic - thoroughly enjoyed all topics. Many discussions new to me, very hungry to learn more. Caregiver's experience had a [sic] profound effect on all".

  "I found today very informative and very well structured in presentation and guest speakers".

A number of respondents saw the day as "very informative" as well as enjoyable, with networking being also mentioned as a positive outcome.

- Choice of day: comments indicated a strong preference for such education events to be held on similar days ie Saturdays:

  "Saturday is a good day and cost-effective - no need to involve work for time off or funds".

Others also reminded of the importance of being given enough notice about the event whatever day is chosen.

- Financial costs: comments suggest a positive response in regards to the value of the day, from both a financial and information point of view.

  "A well run workshop. Good trade exhibits. Good time management. Low cost - good value".

One respondent went further to suggest how the next seminar might be enhanced:

"Congrats - well done! This has been a well-planned seminar - excellent value for money. You can afford to increase the cost if your next one is of this high quality and maybe make it 1.5 days and attendants can sort out their own accommodation….."

- Concurrent Sessions: some attendees recorded a degree of frustration at having their choices limited through the use of con-current sessions.

  "I would have liked to have been able to attend all 3 concurrent sessions" ;

However, suggestions were also offered to minimise this concern.

"When there are concurrent sessions, it would have been helpful to have a handout/summary on what was discussed at the other sessions"

APPENDIX 7: FOLLOW-UP INTERVIEWS ISSUES GUIDE

INTERVIEW QUESTIONS

CODE	

Questions are formulated: **issue-example-benefits-barriers-strategies.**

Seek concrete examples of situations where the following were demonstrated since the Hervey Bay workshop.

1. At the workshop in Hervey Bay, the group explored the qualities of effective **leadership** particularly in the workplace, the wider profession, and the community. Can you describe a concrete example of a situation where you have demonstrated leadership qualities in the time since then? How did it come about? What were the benefits? What were the shortcomings/barriers? How might the group build in strategies to address this? What might they be?
   (self-identity; skilled communication; vision)

2. The workshop also discussed the place of **mentoring**. Since then, have you sought or provided formal mentorship? How did it come about? What were the benefits? What were the shortcomings/barriers? How might the group build in strategies to address this? What might they be?
   (self-identity; promoting independence; commitment to share within group re novice-expert)

3. **Peer support** emerged as a key issue in the workshop. In the time since then, has your level of peer support improved/increased? If so, in what ways? Can you give an example of where peer support was a key element in a situation you faced recently? How did it come about? What were the benefits? What were the shortcomings/barriers? How might the group build in strategies to address this? What might they be? Without the formal group, what might happen to level of support?
   (enhanced networking; identification of own learning needs; communication)

4. Issues of **skills and knowledge** were raised in the evaluations. Difficulties in getting staff to inservice education were a key barrier to palliative care education. Are there any strategies you've tried since then which are bringing about improved participation in educational activities? If yes, how did it come about? What were the benefits? What were the shortcomings/barriers? If no, what were the reasons? How might the group build in strategies to address this? What might they be?
   (use of adult learning principles; use of practice based learning; use of evidence based practice)

5. The Central Zone Palliative Care Nurses' Group looked at the diversity of its members and asked whether **evidence-based, standardised practices** in palliative care provision might be beneficial. What might these benefits be? What are the shortcomings/barriers? How might the group build in strategies to address this? What might they be? How might this be addressed by the Group on an ongoing basis?
   (frameworks for practice; shared resources)

6. The evaluation form asked workshop participants to identify areas **of specific skill development**, and this yielded:
    - teaching skills
    - research skills/EBP skills
    - public speaking skills

    In what ways might the Central Zone Palliative Care Nurses' Group contribute to your **professional development** in these and other areas?

    What *new* strategies to further your own skill and knowledge in palliative care have you used since the workshop? What were the benefits? What were the shortcomings/barriers? If none, what were the reasons?
    (*identification of own learning needs; the place of Rockhampton workshop March 2004)*

7. The meeting in Hervey Bay resulted in the establishment of an electronic **discussion board**. Have you registered for this? If not, what were the barriers to registration and ongoing use? If you are registered, what benefit do you see it having? What other ways would enable enhanced communication between the group members?
(group processes; longevity; leadership)

8. What strategies/actions do you see will be most important to ensure the CZ group continues to achieve its goals in the **longer term**?
(sub-groups; funding; leadership; communication)

9. Are there **particular issues** in your role in palliative care that we haven't raised here?