The Rural Palliative Care Program South Burnett Region

SQRDGP

A Palliative Care Intervention Within the Kingaroy District.

The Kingaroy Palliative Care Educational Day, 9th October, 2004.

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Report and Evaluation of the Kingaroy Palliative Care Educational Day 9th October, 2004

Executive Summary

The Southern Queensland Rural Division of General Practice (SQRDGP) has been successful in gaining a three-year grant to implement the Rural Palliative Care Program in the South Burnett Region. The Program Coordinator, Linda Rudorfer, in collaboration with stakeholders has developed an ongoing education strategy for all health practitioners, volunteers, family and carers within the South Burnett region.The first activity of this strategy was the Palliative Care Educational Day held on 9th October, 2004.The Day was based on interactive workshops designed to increase the palliative care capacity of GPs and nurses working in and around Kingaroy. The workshops were developed by Associate Professor Liz Reymond and Ms Fiona Israel from the Palliative Care Research Unit at the Mt Olivet Hospital and delivered by a specialist palliative care team from the Mt Olivet Hospice, working in conjunction with local service providers.

Forty-one health care providers (10 GPs and 31 nurses) attended parallel daylong workshops, the content of which was tailored to reflect local clinicians' perceived educational needs, as identified from pre-workshop survey responses, and incorporated into case discussions based on typical palliative patients living within the Kingaroy area. Workshops were evaluated to assess educational (knowledge), clinical (skill and confidence) and satisfaction outcomes as well as cost per participant. Educational and clinical outcomes were evaluated using pre and post workshop questionnaires. Within each occupational grouping, the same questions were presented before and after the workshop to enable assessment of improvements post-workshop. For GPs, a further follow-up questionnaire was mailed out 3 months after the workshop to assess whether the benefits gained from workshop attendance were robust enough to be sustained into future practice.

GP evaluations showed significant improvements across most of the self selected educational and clinical issues, and they indicated a high level of satisfaction with the workshop presentation and outcomes. Importantly the statistically significant improvements were sustained when re-tested 3 months later. GPs indicated that their preferred delivery format for follow-up palliative care up-skilling was further workshops. Nurse evaluations showed significant benefit of workshop attendance across every educational and clinical area evaluated. The average cost, including daytime catering and a three course post-workshop networking dinner, per participant for the intervention was $340.

In conclusion, the Palliative Care Education Day was a success. It represents a model of an educationally and clinically effective, clinician acceptable and cost efficient means of up-skilling for primary health care providers in palliative care within the South Burnett region.

Report and Evaluation of the Kingaroy Palliative Care Educational Day 9th October, 2004

Introduction

Palliative care service providers in rural and remote areas of Australia provide proportionately more palliative care, though receive less palliative up-skilling and education, than their urban colleagues.[1] One of the aims of the Rural Palliative Care Program, a cornerstone of the Australian Government National Palliative Care Strategy, is to redress this educational imbalance. Last year the Southern Queensland Rural Division of General Practice (SQRDGP) was successful in gaining a three-year grant to implement the Rural Palliative Care Program in the South Burnett Region. The Program Coordinator, Linda Rudorfer, in collaboration with stakeholders has developed an ongoing education strategy for all health practitioners, volunteers, family and carers within the South Burnett region.

The first activity of this strategy was the Palliative Care Educational Day held on 9th October, 2004.The Day was based on interactive workshops designed to increase the palliative care capacity of GPs and nurses working in and around Kingaroy. The workshops were developed by Associate Professor Liz Reymond and Ms Fiona Israel from the Palliative Care Research Unit at the Mt Olivet Hospital and delivered by a specialist palliative care team from the Mt Olivet Hospice. A report of the activity including an evaluation of the workshop intervention is presented below.

The Workshops

Educationalists appreciate that traditional forms of education, such as lectures, are not particularly effective in changing clinical behaviour. To positively affect clinical outcomes education needs to be interactive, personalised to individual clinicians in their particular environment and case based.[2] Accordingly, Kingaroy workshop content was tailored to reflect local clinicians' perceived educational needs, as identified from pre-workshop survey responses, and incorporated into case discussions based on typical palliative patients living within the Kingaroy area. Workshops were facilitated by a palliative care medical specialist, a specialist palliative care nurse and a palliative care counsellor.

Survey responses contributed to the production of a local palliative care service directory indicating how to access specialist palliative care service providers and other resources in regional and major Queensland cities. This directory was included in a sample bag of palliative readings, products and related documents distributed to each workshop participant.

Workshops were evaluated to assess educational (knowledge), clinical (skill and confidence) and satisfaction outcomes as well as cost per participant. Educational and clinical outcomes were evaluated using pre and post workshop questionnaires. Questionnaires were tailored to participants' occupational status, and differed for GP and nursing participants. Within each occupational grouping, the same questions were presented before and after the workshop to enable statistical assessment of improvements post-workshop. For GPs, a further follow-up questionnaire was mailed out 3 months after the workshop.

Linda Rudorfer organised a post-workshop dinner to facilitate networking between attending service providers.

Workshop Process

Primary health care providers were approached via the SQRDGP, local hospitals, residential and aged care facilities and Blue Care for expressions of interest to attend the workshops. Expression of interest involved completion of a survey concerning demographics, palliative case loads, perceived palliative education and learning needs, knowledge of availability of palliative resources, referral patterns and desired workshop topics and composition. Appendix 1 lists topics requested by GPs, in order of preference.

Two parallel daylong workshops were provided as participants requested that workshops were segregated according to profession. The GP workshop concentrated on the use of opioids in palliative care and management of palliative symptoms in the elderly residing in residential and aged care facilities, followed by a session on the advantages of radiotherapies for cancer patients. A copy of the case discussion is included in Appendix 2. The GP workshop was accredited for continued professional development (CPD) points with the RACGP and ACRRM.

The registered, enrolled and assistant-in nursing workshop involved an introductory session on symptom management (including pain, nausea and vomiting, constipation, wound management and the terminal phase) followed by discussions devoted to grief and loss issues including theories of bereavement, grief reactions, children and loss, rituals and compassion fatigue and concluding with small group case management work. A copy of the case discussion is included in Appendix 3.

Workshop Evaluation

The workshops were attended by 41 local service providers: 10 GPs and 31 nurses including 24 RNs, 5 EENs, 1 EN and 1 “other”.

GPs

Questionnaires (see Appendix 4) were administered to GPs before and after the workshop, as well as at three months post workshop, and were designed to elicit information about educational, clinical and workshop satisfaction outcomes.

Pre and Post Workshop Questionnaires

1. **Educational and clinical outcomes**

GPs were asked about their overall confidence in the practice of palliative care, then about confidence in managing specific symptoms, namely neuropathic pain, non-neuropathic pain, constipation, nausea and vomiting, dyspnoea, and delirium on a 4 point scale ranging from 1 (not confident) to 4 (strongly confident).

Ten GPs submitted the pre – and post-workshop questionnaires. The data were analysed as repeated measures using paired t-tests to evaluate changes in confidence from pre to post workshop.

Results, shown in Table 1, indicate that for most items, statistically significant improvements in confidence (p value less than or equal to .05) could be demonstrated as a result of attending

the workshop, despite the small sample sizes. On two items, constipation and nausea and vomiting, the change in confidence was increased, but the increase was not statistically significant. However, in the pre-test questionnaire, GPs had expressed a high base-line confidence in dealing with these symptoms and this may explain the lack of significance.

Table 1. Changes in confidence in treating specific symptoms pre and post workshop for GPs (N = 10)

Symptom	*Pre-workshop Mean*[a]	*Post-workshop Mean*[a]	*t-value*	*p-value*	*95% CI of the difference*
Neuropathic pain	2.4	3.2	3.2	.01	0.24-1.36
Non-neuropathic pain	2.7	3.1	2.4	.04	0.03-0.77
Constipation	2.9	3.1	1.5	.17	-0.10-0.50
Nausea & vomiting	3.0	3.2	1.5	.17	-0.10-0.50
Dyspnoea	2.6	3.1	3.0	.02	0.12-0.88
Delirium	2.2	3.1	5.0	<.01	0.49-1.31

a. Maximum confidence rating was 4.

In addition to confidence in dealing with specific symptoms, GPs were asked more general questions, about their overall confidence in the practice of palliative care, and in managing palliative patients living in residential aged care facilities. These items were assessed on a 4-point scale, as above. Knowledge about the side effects of opioids and the equianalgesic conversion of one opioid to another was also assessed pre- and post-workshop, on a 4-point scale from 1=poor to 4= excellent. Ratings for these items are shown in Table 2.

Table 2. GP ratings pre and post workshop for more general items (N=10)

	Pre-workshop Mean[a]	*Post-workshop Mean*[a]	*t-value*	*p-value*	*95% CI of the difference*
Overall confidence in practice of palliative care	2.5	3.1	3.7	.01	0.23-0.97
Confidence about managing patients in RACF	2.5	3.0	2.2	.05	-0.01-1.01
Knowledge of side effects of opioids	2.6	3.2	2.7	.02	0.10-1.10
Knowledge of equianalgesic conversion of opioids	2.2	3.0	4.0	<.01	0.35-1.25

a. Maximum confidence rating was 4.

Table 2 indicates that for overall confidence in the practice of palliative care and knowledge pertaining to opioids there were significant improvements from before to after the workshop. The increase in confidence for managing patients in RACFs was marginally significant (p=.053).

2. Workshop Satisfaction Outcomes

GPs were also questioned about their perceptions of the usefulness of the workshop: ratings on a 5 point scale (1=poor to 5=excellent) were obtained for questions about the extent to which the learning objectives were met, the relevance of the content for their particular practice of palliative care, the style of workshop presentation and presenter and the overall quality of topics as a learning experience. These ratings are presented in Table 3.

Table 3. GP ratings concerning satisfaction with workshop (N=10)

Assessment of Workshop	*Mean Rating*	*95% CI*
Learning objectives met	4.40	4.03-4.77
Relevance for practice	4.30	3.95-4.65
Presentation style	4.50	3.99-5.01
Quality of topics for learning experience	4.60	4.23-4.97

On all items the mean was high, indicating that the workshop was perceived to be of great benefit to the GPs.

A final question asked GPs about preferred delivery formats for follow-up palliative care education, GPs were provided with 3 options: workshops, one-on-one discussions with a palliative care specialist, or video/teleconferencing. Of the 8 GPs who answered this question, all 8 indicated workshops as the preferred format. One GP also included one-on-one discussions with a palliative care specialist.

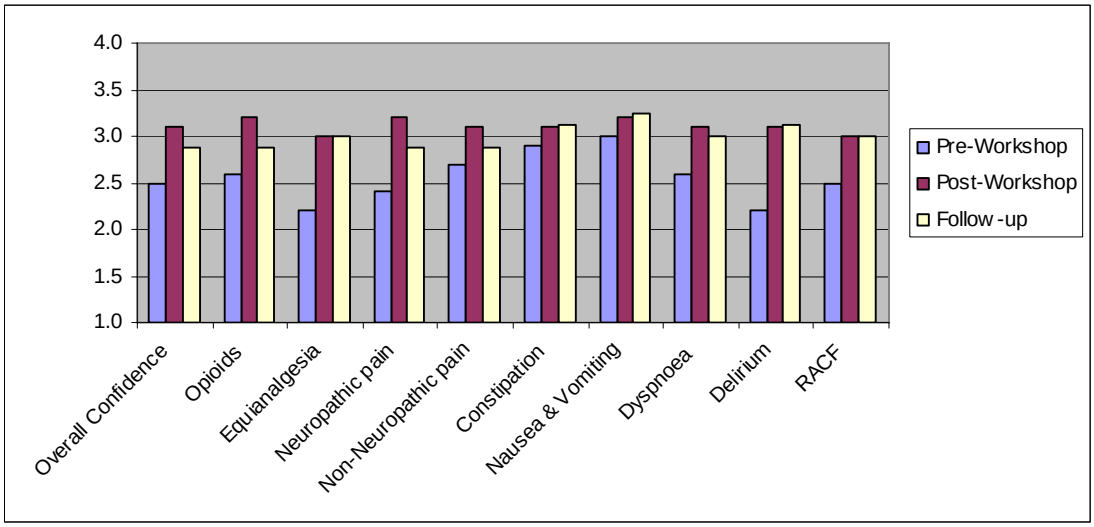
Follow-Up Questionnaires

It was considered important to assess whether the benefits of the workshop were robust enough to be sustained into future practice, consequently, GPs were sent a follow-up questionnaire 3 months after the workshop. Ratings were assessed and analysed in the same way as the previous questionnaires.

In all cases there was no significant change in rated confidence or knowledge from that shown at the post-workshop questionnaire, indicating that the benefits of workshop attendance were robust and maintained.

Table 4 compares average pre, post and follow-up ratings.

Table 4. Average pre, post and follow-up questionnaire ratings.



In this questionnaire GPs were also asked whether they had cared for palliative patients in the time since the workshop to assess whether workshop attendance had influenced their management of those patients. Six GPs had cared for a total of 31 palliative patients in the intervening time. Four GPs answered the question: "Did you find any advantages or disadvantages in managing your recent palliative care patient(s) as a result of receiving palliative care education in October 2004?" Answers included:

- I am much more confident now about pain relief in palliative patients
- Yes it was an excellent presentation and very useful to the GP setting
- Great confidence changing from oral to topical narcotics
- Advice re pain relief and converting oral opioids – advantage plus

Nurses

Specific aspects of the workshop questionnaires were related to knowledge, skill and confidence of participants regarding palliative care. Knowledge was evaluated by questions about self-ratings of participants' knowledge in the treatment of the symptoms of pain, nausea and vomiting, constipation, delirium and dyspnoea, and in the use of pharmaceuticals for palliative care patients (see Appendix 5).

Five items assessed self-rated skills in assessing and managing pain and wounds, and developing management plans for palliative care patients.

A further two items assessed confidence in communicating with palliative care patients and their families, and with bereaved individuals.

The ratings were all on a 5-point scale, with anchored endpoints; 1 = "Not at all" and 5 = "Significant extent".

Four of the nurses returned incomplete questionnaires, so the tests reported are based on 27 or 28 cases.

There is evidence of significant benefits of workshop attendance for nursing staff across all items. Paired-t tests were conducted to evaluate changes in ratings, and the means before and after the workshop, together with 95% confidence intervals for the change in ratings, are shown in Table 5. The benefit of the workshops is apparent in the fact that for all items, whether referring to knowledge in treatment of specific symptoms, skills in dealing with issues that arise in palliative care, or confidence in communication, the mean rating has moved from below the midpoint to above the midpoint of 3 on the 5-point scales.

Table 5: Comparison of pre and post Kingaroy workshop ratings for nurses

	Pre-workshop Mean	*Post-workshop Mean*	*t-value**	*N*	*95% CI of the difference*
Rated Knowledge in treatment of symptoms of:					
Pain	2.93	3.93	6.9	28	0.70-1.30
Nausea & Vomiting	2.86	3.96	7.5	28	0.80-1.41
Constipation	2.93	4.07	5.8	28	0.74-1.55
Delirium	2.25	3.54	9.9	28	1.01-1.56
Dyspnoea	2.64	3.89	8.3	28	0.94-1.56
Knowledge in use of pharmaceuticals	2.30	3.56	11.0	27	1.02-1.49
Rated Skills in:					
Assessing pain	2.71	3.71	7.3	27	0.72-1.26
Managing pain	2.64	3.71	6.6	27	0.74-1.40
Assessing wounds	2.70	3.78	7.1	27	0.77-1.38
Managing wounds	2.59	3.67	6.7	27	0.75-1.40
Developing management plans	2.37	3.52	7.3	27	0.82-1.47
Rated Confidence in communication with:					
Palliative care patients and families	2.85	3.78	6.6	27	0.64-1.21
Bereaved individuals	2.67	3.74	7.6	27	0.79-1.36

* All t-values were highly significant, with p-values less than .001.

Nurses were invited to include comments about the workshop. A total of 9 responded. Comments included:

- Excellent and informative day. Thank-you to all
- Excellent day. Very good and much needed information
- Thank you for presenting this information in the bush. Well done
- Thankyou to everyone
- Would like more information on some of the newer morphine mixtures and combinations eg Fentanyl patch and tabs or S/C morphine etc thank you
- Thank you
- Knowledge base extended. Thank you very much. Also knowing where to go for help and networking
- Would be good to have some combined time with doctors (multidisciplinary) as we should all have similar goals – just from different directions. Overall excellent. Thanks.
- Well organised and would recommend it to any of my colleagues

3. Cost per participant

Cost per participant was calculated by adding workshop costs (including presenter fees, travel costs, accommodation, venue hire, catering, cost of resource packs, advertising, workshop dinner, evaluation fee and office expenses) and dividing that total by the number of health care professionals who attended workshops. The cost per participant for the Palliative Care Educational Day was $340.

Conclusion

The Palliative Care Education Day held on October 9th, 2004 as part of the Rural Palliative Care Program in the South Burnett region was a success. Parallel workshops were attended by a total of 41 local health care providers: 10 GPs and 31 nurses. Rigorous evaluations indicated that participants gained significant benefits, across both educational and clinical domains, from attending the workshops. For GPs these benefits were robust and continued to influence their palliative care practice. GPs indicated that their preference for follow-up palliative care up-skilling is further workshops. The cost per participant for the daylong workshop was $340.

References

1. Reymond L, Mitchell G, McGrath B, Welch D. *Research into the educational, training and support needs of general practitioners in palliative care.* Report to the Commonwealth of Australia, Mt Olivet Health Services. Brisbane. 2003

2. Haynes RB, Davis DA, McKibbon A, Tugwell P. *A critical appraisal of the efficacy of continuing medical education.* Journal of the American Medical Association 1984; 251: 61-64.

Appendix 1: Kingaroy GP Informing Content Questionnaire Analysis

Responses from a sample of 13 GPs from the Kingaroy district

Content requested for workshop – in order of preference

1.Pain management in palliative care patients with cancer or other diseases
2.Other symptom control eg delirium, dyspnoea, nausea
3.Use of palliative pharmaceuticals
4.Management of palliative patients in RACF
5.Use of EPC items in palliative care
6.Stress management / self care
7.Communication skills
8.Bereavement issues, eg. depression
9.Ethical & legal aspects
10.Cultural care

Most challenging aspects of providing palliative care from a personal perspective

1.Dealing with relatives
2.Pain management
3.Organising resources and/or help in the home
4.Own feelings for patients
5.Other symptom management, eg. nausea, weakness, dietary issues, constipation

Appendix 2: G P Case Study

Bert is a 69 year old Catholic gentleman with diagnoses of chronic obstructive pulmonary disease, dementia and prostate cancer. He has been living at a local Residential Aged Care Facility (RACF) for the past 5 years, and has recently been moved to the dementia unit. He considers the Facility his home.

Bert was a farmer. His wife died from a stroke 7 years ago. He has 3 children. The eldest, Jimmy, is married with 2 children and living in Wondai. The second son Robert, lives on the sunshine coast hinterland, is unemployed, has a substance abuse problem and has not visited his father since he moved to the RACF. His youngest child Helen lives alone in Kingaroy and has worked in the kitchen of her father's RACF for the past 17 years.

Past medical history:

- Tuberculosis as a child
- Oxygen dependent chronic obstructive pulmonary disease, secondary to smoking, diagnosed 1990
- Right heart failure
- Prostate cancer, diagnosed 1995, treated with radiotherapy and chemotherapy and now hormone independent with boney metastases
- Multi-infarct dementia, secondary to atherosclerosis, diagnosed 2000

Current medications:

- Clopidrogel (Plavix) 75mg po daily
- Atorvastatin (Lipitor) 40mg po daily
- Irbesartan 150mg, hydrochlorothiszide 12.5mg (Avapro HCT 150/12.5) po daily
- Salmeterol 50mcg, fluticasone 500mcg (Seretide accuhaler 50/500) inhalation bd
- Salbutamol (Ventolin) 5mg and ipratropium (Arovent) 500mcg in 3mls saline nebulised qid
- Codeine phosphate 60mg, paracetamol 1g (Panadeine forte, 2 tablets) po qid
- Immediate release morphine (Ordine) 2mg/ml 2.5mls po PRN q3hrly
- Docusate 50mg and sennosides 8mg (Coloxyl and Senna) po 2 nocte
- Oxygen 2L/min via concentrator PRN

Allergies:

- Asprin causes asthma

Bert's current problems include:

- ❑ Intermittent grimacing with movement
- ❑ A reluctance to transfer from his bed to the chair
- ❑ Apparent increasing shortness of breath
- ❑ Increasing restlessness with periods of crying out
- ❑ 3 episodes of vomiting in the past week and decreased oral input

In view of her father's deteriorating condition, Helen has requested that her father be transferred to the hospital. What is your management plan?

Appendix 3: *Nurse Case Study*

Clive is a 56-year-old local councillor who has been married to Shirley for 30 years. They have 4 children. The eldest, Jimmy, is married with 2 children and living in Wondai. Lesley and Robyn are students and live in Brisbane together. The youngest, Ben, is about to complete his grade 12 exams at the local high school.

Clive was diagnosed with colon cancer three years ago. He underwent a bowel resection followed by chemotherapy. He returned to work for 12 months and presumed he was cured. In May 2004 he experienced severe abdominal pain. He was found to have a subacute bowel obstruction and CT indicated local tumour recurrence at the site of the anastomosis, as well as peritoneal involvement and liver metastases. The surgeons treated the obstruction conservatively and the visiting oncologist was of the opinion that further chemotherapy was not indicated. All future treatment was to be palliative.

Over the past four weeks Clive has deteriorated and spends most of his day in bed dozing. His symptoms have been difficult to control and he was admitted to Kingaroy Hospital 3 days ago for symptom assessment and family respite and support. It is clear to staff that Clive is dying.

Current Medications

Regular	PRN
Morphine Sulphate 100mg & Maxolon 20mg / 24hrs via syringe driver	*Morphine Sulphate inj 10mg 2/24 subcut*
Paracetamol 2 tabs QID	Ordine syrup 25mg 2/24 prn
Dexamethasone 4mg mane	Buscopan tab 20mg 6/24
Somac 40mg mane	Loperamide tab 2mg – 4mg prn
Temazepam 10 –20 mg nocte	Coloxyl and senna 2 tabs prn
	Oxazepam tabs 7.5 – 15mg prn

Current Symptoms

- Intermittent abdominal pain described varyingly as a deep ache or a severe cramp.
- Fluid faecal incontinence and occasional pr blood loss
- Pain from perianal area which is excoriated, with 3 bleeding skin tears.
- Restless, anxious and teary particularly at night; drifts off during conversations and sometimes appears to not fully comprehend when spoken to.
- Anorexia with associated nausea & vomiting.
- Increasing shortness of breath particularly when lying flat.
- Increasing drowsiness with some confusion.

Current Social Factors

- Family members are at different stages of understanding the progression of the disease process. Lesley still believes that her father can be cured and is angry that the doctors are not offering curative treatment and that her father is not fighting the illness.
- Shirley has been on 2 weeks leave from her job and comes to you for advice about how long Clive has to live as she needs to organise her work commitments. She is also concerned about when to advise the girls to come home from Brisbane.
- Clive has always said that he wants to die at home, but is concerned about his symptom control.
- Clive and Shirley discuss with you their fears about the family at this time. They are particularly concerned about Ben who is about to sit his year 12 exams

Clive is a well-known local figure and was an active member of the hospital board. Outline a management plan for Clive and his family.

Appendix 4: GP Questionannaires

Pre-workshop Questionnaire

Name: _____ Practice location: _____

ACRRM /RACGP Reference number _____

1. Please give an indication of your overall level of confidence in your practice of palliative care. *Please tick.*

not confident somewhat confident confident strongly confident

a). Rate your knowledge concerning the side effects of opioids

poor average good excellent

b) Rate your knowledge concerning the equianalgesic conversion of one opioid to another.

poor average good excellent

2. How confident do you feel in managing the following symptoms?

a) neuropathic pain

not confident somewhat confident confident strongly confident

b) *non- neuropathic pain*

not confident somewhat confident confident strongly confident

c) constipation

not confident somewhat confident confident strongly confident

d) nausea and vomiting

not confident somewhat confident confident strongly confident

e) dyspnoea

not confident somewhat confident confident strongly confident

f) *delirium*

not confident somewhat confident confident strongly confident

3. How confident do you feel about managing palliative patients living in residential and aged care facilities?

Not applicable

not confident somewhat confident confident strongly confident

4. Are you able to access suitable specialist palliative care providers for discussion of management issues when required?

yes no with great difficulty unsure

5. How many palliative care patients have you treated in the past three months?

_____

6. Was / were the patient(s)able to die in the environment of their choice?

yes no unsure

If yes, where was this, i.e. where did the patient(s) choose to die?

_____
_____
_____

7. If the patient(s) was / were unable to die in the environment of their choice, could you briefly explain the circumstances?

_____
_____
_____
_____
_____

8. Did you need to discuss the management of your palliative patient(s) with anybody else?

Yes If so, with whom, and from which organisation?

_____
_____

No

Thank you

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Post-workshop Questionnaire

Name: _____ Practice location: _____

1. Please give an indication of your overall level of confidence in your practice of palliative care. *Please tick.*

not confident somewhat confident confident strongly confident

a). Rate your knowledge concerning the side effects of opioids.

poor average good excellent

b) Rate your knowledge concerning the equianalgesic conversion of one opioid to another.

poor average good excellent

2. How confident do you feel in managing the following symptoms?

a) neuropathic pain

not confident somewhat confident confident strongly confident

b) *non- neuropathic pain*

not confident somewhat confident confident strongly confident

c) constipation

not confident somewhat confident confident strongly confident

d) nausea and vomiting

not confident somewhat confident confident strongly confident

e) dyspnoea

not confident somewhat confident confident strongly confident

f) *delirium*

not confident somewhat confident confident strongly confident

3. How confident do you feel about managing palliative patients living in residential aged care facilities?

not confident somewhat confident confident strongly confident
not applicable

Workshop Satisfaction

Presentation Feedback:	Poor				Excellent
Learning objectives met	1	2	3	4	5
Relevance of content for your practice of palliative care	1	2	3	4	5
Presentation style	1	2	3	4	5
Overall quality of topics as a learning experience	1	2	3	4	5

Thank you for completing this questionnaire. A repeat evaluation questionnaire will be posted in 3 months time, completion of which is required to be eligible for claiming RACGP QA&CPD points or ACRRM CME points.

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3 Month Evaluation

Following the palliative care education you attended in October last year, we would be grateful if you could complete this questionnaire; it is mandatory for those general practitioners wishing to claim CPD or CME points. A reply paid envelope is enclosed for your convenience. Alternatively, you could fax it directly to the Research Unit on 3391 2071

Name: _____ Practice location: _____

ACRRM /RACGP Reference number _____

Please return this questionnaire to the palliative care research unit in the envelope provided by **Friday, 4th February 2005.**

1. Please give an indication of your overall level of confidence in your practice of palliative care. *Please tick.*

not confident somewhat confident confident strongly confident

a) Rate your knowledge concerning the side effects of opioids.

poor average good excellent

b) Rate your knowledge concerning the equianalgesic conversion of one opioid to another.

poor average good excellent

2. How confident do you feel in managing the following symptoms?

a) neuropathic pain

not confident somewhat confident confident strongly confident

b) *non- neuropathic pain*

not confident somewhat confident confident strongly confident

c) constipation

not confident somewhat confident confident strongly confident

d) nausea and vomiting

not confident somewhat confident confident strongly confident

e) dyspnoea

not confident somewhat confident confident strongly confident

f) *delirium*

not confident somewhat confident confident strongly confident

3. How confident do you feel about managing palliative patients living in residential aged care facilities?

Not applicable

not confident somewhat confident confident strongly confident

4. In the past three months have you been able to access suitable specialist palliative care providers for discussion of management issues when required?

yes no with great difficulty unsure

5. How many palliative care patients have you treated in the past three months?

_____

6. Was / were the patient(s) able to die in the environment of their choice?

yes no unsure

If yes, where was this, i.e. where did the patient(s) choose to die?

_____

_____

7. If the patient(s) was / were unable to die in the environment of their choice, could you briefly explain the circumstances?

_____

_____

_____

_____

_____

8. Did you need to discuss the management of your palliative patient(s) with anybody else?

Yes If so, with whom, and from which organisation?

_____
_____
_____

No

9. Did you find any advantages or disadvantages in managing your recent palliative care patient(s) as a result of receiving palliative care education in October 2004?

Please state:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

12. Would you prefer to receive palliative care education via:

a workshop format;

one-on-one discussions with a palliative care specialist, or

video / teleconferencing.

Thank you

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Appendix 5: Nurses Questionnaires

Kingaroy Pre-workshop Questionnaire

Please circle your response: I am a RN EEN EN Other _____

1. How do you rate your knowledge in the treatment of the following symptoms in palliative care patients with chronic or malignant illnesses?

(a) Pain

1	2	3	4	5
Not at all				Significant extent

(b)Nausea & Vomiting

1	2	3	4	5
Not at all				Significant extent

(c) Constipation

1	2	3	4	5
Not at all				Significant extent

(d) Delirium

1	2	3	4	5
Not at all				Significant extent

(e) Dyspnoea

1	2	3	4	5
Not at all				Significant extent

2.(a) How do you rate your skills in **assessing** pain in palliative care patients with chronic or malignant illnesses?

1	2	3	4	5
Not at all				Significant extent

2.(b) How do you rate your skills **managing** pain in palliative care patients with chronic or malignant illnesses?

1	2	3	4	5
Not at all				Significant extent

3.(a) How do you rate your skills in **assessing** wounds in palliative care patients with chronic or malignant illnesses?

1	2	3	4	5
Not at all				Significant extent

3.(b) How do you rate your skills in **managing** wounds in palliative care patients with chronic or malignant illnesses?

1	2	3	4	5
Not at all				Significant extent

4. How do you rate your skills in developing management plans for palliative care patients?

1	2	3	4	5
Not at all				Significant extent

5. How do you rate your knowledge in the use of pharmaceuticals for palliative care patients?

1	2	3	4	5
Not at all				Significant extent

6.(a) How do you rate your confidence communicating with palliative care patients and their families?

1	2	3	4	5
Not at all				Significant extent

6.(b) How do you rate your confidence communicating with bereaved individuals?

1	2	3	4	5
Not at all				Significant extent

Thank-you for completing this questionnaire

PALLIATIVE CARE RESEARCH UNIT
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MT OLIVET COMMUNITY SERVICES LTD.

Under the Care of the Sisters of Charity

Kingaroy Post-workshop Questionnaire

Please circle your response: I am a RN EEN EN Other _____

1. How do you rate your knowledge in the treatment of the following symptoms in palliative care patients with chronic or malignant illnesses?

(a) Pain

1	2	3	4	5
Not at all				Significant extent

(b)Nausea & Vomiting

1	2	3	4	5
Not at all				Significant extent

(c) Constipation

1	2	3	4	5
Not at all				Significant extent

(d) Delirium

1	2	3	4	5
Not at all				Significant extent

(e) Dyspnoea

1	2	3	4	5
Not at all				Significant extent

2.(a) How do you rate your skills in **assessing** pain in palliative care patients with chronic or malignant illnesses?

1	2	3	4	5
Not at all				Significant extent

2.(b) How do you rate your skills **managing** pain in palliative care patients with chronic or malignant illnesses?

1	2	3	4	5
Not at all				Significant extent

3.(a) How do you rate your skills in **assessing** wounds in palliative care patients with chronic or malignant illnesses?

1	2	3	4	5
Not at all				Significant extent

3.(b) How do you rate your skills in **managing** wounds in palliative care patients with chronic or malignant illnesses?

1	2	3	4	5
Not at all				Significant extent

4. How do you rate your skills in developing management plans for palliative care patients?

1	2	3	4	5
Not at all				Significant extent

5. How do you rate your knowledge in the use of pharmaceuticals for palliative care patients?

1	2	3	4	5
Not at all				Significant extent

6.(a) How do you rate your confidence communicating with palliative care patients and their families?

1	2	3	4	5
Not at all				Significant extent

6.(b) How do you rate your confidence communicating with bereaved individuals?

1	2	3	4	5
Not at all				Significant extent

Any other comments:

_____
_____
_____
_____

Thank-you for completing this questionnaire