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AN EVALUATION FRAMEWORK FOR COMPLEX PALLIATIVE CARE PROJECTS

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INTRODUCTION

Democratic governments that invest public funds increasingly mandate accountability from executing agencies through Program Evaluation processes. The goal is accountability for results and to demonstrate that citizens receive value for money in their capacity as taxpayers.

The Government of Canada's, Primary Health Care Transition Fund (PHCTF) was a one-time, focused investment in Primary Health Care renewal of €525 million. A €2.9 million national investment for Hospice Palliative Care capacity was made through Pallium Project (Phase II).

The PHCTF required accountability for five common objectives and seven national project objectives. The study's aim was to design and implement a robust evaluation framework applicable to demonstrating goal attainment across the Project's diverse portfolio of 72 strategic activities, initiatives and subprojects.

METHODOLOGY

An external evaluator with past experience evaluating Government of Canada, Primary Health Care projects (i.e., Health Transition Fund) was retained early in the Phase II project. The evaluator worked in a collaborative and consultative relationship with the Project team to design an evaluation framework that balanced Phase II complexity with Health Canada reporting accountabilities.

Quantitative and qualitative methods were employed to validate Project objective attainment consistent with the Government of Canada's accountability expectations. Analytic methods included work product and final deliverable analyses arising from strategic activities, initiatives and subprojects; descriptive variance analyses (i.e., account for variance between what was proposed/ declared as intent and what was actually delivered); process evaluation and continuous improvement tracking as part of formative evaluation; observation and impact/outcome mapping guided by Health Canada's, Participatory Evaluation Framework questions (see below). The Government of Canada's, Results Based Management and Accountability Framework and The World Bank's, LOGFRAME (Logical Framework) also informed project evaluation design.

EVALUATION QUESTIONS

1) How did we do this work?
2) Did we do what we said we would do?
3) What did we learn about what worked and what didn't work?
4) What difference did it make that we did this work?
5) What could we do differently?
6) Were there any unintended outcomes?
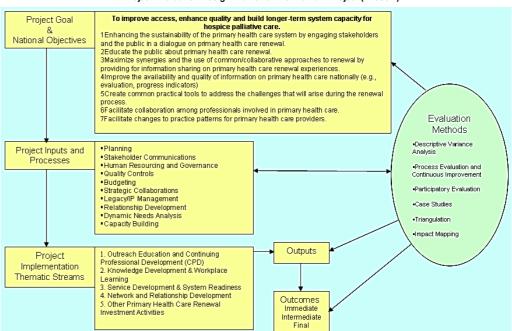7) How do we plan to use evaluation findings for continuous learning?

NATIONAL OBJECTIVES OF THE PHCTF

1) Enhance the sustainability of the primary health care system by engaging stakeholders and the public in a dialogue on Primary Health Care renewal.

2) Educate the public about Primary Health Care renewal.

3) Maximize synergies and the use of common/collaborative approaches to renewal by providing for information sharing on Primary Health Care renewal experiences.

4) Improve availability and quality of information on Primary Health Care nationally.

5) Create common practical tools to address the challenges that will arise during the renewal process.

6) Facilitate collaboration among professionals involved in Primary Health Care.

7) Facilitate changes in practice patterns for Primary Health Care providers.

DISCUSSION/IMPLICATIONS

- It is possible to accountably evaluate a complex, multi-faceted capacity-building project with otherwise seemingly disparate operational and programmatic elements.
- Early engagement of independent/external evaluators, as well as facilitative rather than authoritative/punitive relationships (e.g., audit) can result in considerable value added from an evaluation investment.
- Many existing program evaluation models and methodologies proved unsuitable to the Project portfolio approach used for Phase II. A defensible hybrid framework and process had to be developed for project evaluation.
- Integration of impact/outcome mapping is a critical component in order to evaluate "ripple effect" impact (i.e., order removed/ second/third, etc., generation changes resulting from strategic interventions).
- Emerging constructs for meaningful project evaluation of complex social change projects may have elements of a "social ecology." Our team found the concept of a lush Boreal forest, rich with expansive biodiversity and great interdependence, a useful metaphor to discuss how Phase II operated and how it could be understood and reported back to stakeholders.

FIGURE 1
Project Evaluation Design Framework for Pallium Project (Phase II)

FIGURE 2
Tabular Representation of Inter-relationship of Key Evaluation Framework Elements

Poster abstracts

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is now fully computerized and there is a routine for immediate validation of data. Different kinds of reports are automatically generated online. Several reports are open for the public, some are open for caregivers only. A pilot study was conducted during summer 2005 and the registry is now fully working.Result: At present (Nov 2006) the registry covers 7 % of all deaths in Sweden. It is spread all over the country and to all kinds of caregivers even though palliative care services dominate. Conclusion: The board of the registry has managed to develop a real-time concept based on a set of patient oriented objectives. Filling in the questionnaires has started a debate in the local clinics concerning care given. A systematic work to improve routines locally has started. Several examples of improvement over time can now be shown in the registry.

903. Barriers to the development of palliative care in Central and Eastern Europe and Commonwealth of Independent States

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Background: The EAPC Task Force for the Development of Palliative Care in Europe Eurobarometer Survey has produced comprehensive information on the provision of palliative care across Europe. This paper focuses on one part of the survey relating specifically to 22 countries in Central and Eastern Europe (CEE) and Commonwealth of Independent States (CIS) **Aims**: To identify barriers to the development of palliative care in CEE and CIS **Method**: A qualitative survey was undertaken amongst boards of national associations, eliciting opinions on opportunities for, and barriers to, palliative care development. By July 2006, 44/52 (85%) European countries had responded to the survey. We report here on the results from 22/27 (81%) countries in CEE and CIS **Analysis**: Data from the Eurobarometer survey were analysed thematically by geographical region and by the degree of palliative care development **Results**: From the varied data contained within the Eurobarometer, we identified four significant barriers to the development of palliative care in CEE and CIS: (i) lack of funding (ii) lack of opioid availability and choice (iii) lack of public awareness and government recognition of palliative care as a field of specialisation (iv) lack of palliative care education and training programmes **Conclusion**: Despite huge variations in the levels of provision across many countries, data collected in the Eurobarometer survey reveal many common barriers to development of palliative care in CEE and CIS.

904. A cross-national and regional analysis of palliative care provision in Central and Eastern Europe and Commonwealth of Independent States - progress 2002-2005

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Background: The *International Observatory on End of Life Care* (IOELC) website contains 27 country reports for Central and Eastern Europe (CEE) and Commonwealth of Independent States (CIS). Originally prepared in 2002, the reports are being updated in a project funded by the *Open Society Institute*. The work is being undertaken in close collaboration with the *EAPC Task Force for the Development of Palliative Care in Europe* **Aim**: To map changes in palliative care provision in CEE and CIS between 2002-2005 **Method**: A common template is used to facilitate a multi-method approach. Each country report draws on several research traditions in the social and health sciences, both quantitative and qualitative **Analysis**: A cross-national and regional analysis is undertaken to highlight changes in palliative care provision in the region. Variation in the definition of palliative care services is fully considered **Results**: Between 2002 and 2005 total services across the whole of CEE and CIS increased from 467 to 823 (+76%); in CEE from 378 to 601 (+59%); in the CIS from 89 to 222 (+150%). A notable increase in services occurred in Bulgaria, Hungary, Poland and Romania (CEE); and in Armenia, Kazakhstan, Republic of Moldova, Russian Federation and Ukraine (CIS) **Conclusion**: Several barriers to the development of palliative care still exist in CEE and CIS, but the significant increase in services between 2002 and 2005 is a source of much encouragement.

905. Enabling Patients in Cancer clinics: a cross-sectional survey using the Patient Enablement Instrument (PEI)

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Aims
• To explore the use of the PEI in cancer care outpatient clinics
• To determine principle factors associated with enablement as an outcome measure in cancer care consultations
Method
Cross sectional postal questionnaire based survey in cancer outpatient clinics,in a UK Cancer Network Outcome measures: Patient Enablement Instrument (PEI), EORTC QLQ-C30, HADS
Results
Response rate 78%(936/1205) (49% male, mean age 63, 46% cancer diagnosis). Mean PEI score 3.17. Enablement scores were higher if patients felt clinic staff knew them well ($p \leq 0.001$), or intended to discuss their illness/treatment with their GP following clinic (p=0.001). PEI scores were lower (p=0.003) and anxiety scores higher ($p \leq 0.001$) in females; however, there was no significant correlation between PEI and HADS or EORTC QLQ-C30. Significant clinic variables associated with higher PEI were a review by consultant surgeon/oncologist, junior doctors with communication training, clinic slot length >30mins.
Conclusions
The PEI may be a useful tool for assessing cancer care consultations as it appears to be independent of psychological distress and quality of life. There is an association between high PEI score, patients feeling that staff knew them well or intend discussing issues with their GP, pointing to a possible link between enablement and continuity of care. PEI is associated with clinic factors which could be expected to improve consultations.

906. Validation of a system to prioritize first visits to the Palliative Care Outpatients Clinic

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A series of factors have been related to a higher risk for palliative care (PC) patients to fail outpatients follow up. These factors are: a Palliative Performance Status <50, Age <60 years, Anxiety >5 on a Numeral Analogue Scale as well as invalidating dyspnoea, social constraints and uncontrolled symptoms
Aim
to validate an appointment system to prioritize first visits to the PC outpatients clinic based on risk factors
Objectives
to optimise the appointment process in the PC outpatients clinic
Method
Patients referred to the PC outpatients clinic were assessed on the phone for the above mentioned risk factors by the specialist nurse. Based on this assessment, a score system was designed to arrange patients into three groups: high risk, to be visited within 48 hours; intermediate risk, to attend during the first week and low risk, to be seen within 15 days.
At the first consultation, a patient record was taken as whether any other type of hospital resource was used.
Preliminary results
Between August 1st and October 30th 2006, 105 patients were referred to the PC outpatients clinic. Fifteen patients were excluded from the study as they were referred to the home care team. Ninety patients were included. A total number of 80 patients (89%) attended the first visit.
ConclusionThis system allows to effectively assess patients according to risk factors as well as to optimize patients first visit allocation.

908. AN EVALUATION FRAMEWORK FOR A COMPLEX PALLIATIVE CARE PROJECT

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AIM: Governments investing public funds mandate accountability through evaluation. The goal is accountability for results and to demonstrate citizens receive value for money. The Government of Canada 's, Primary Health Care Transition Fund (PHCTF) invested 2.8 million in a palliative care capacity-building project (Pallium Project) as part of its investment in primary health care renewal. The PHCTF required accountability for five common objectives. The study's aim was to design and implement a robust evaluation framework applicable to demonstrating goal attainment across diverse subprojects. **METH:** An evaluation team designed a multi-faceted program evaluation framework. Quantitative and qualitative methods included document and product content analyses, descriptive variance analysis, process evaluation and continuous improvement, impact/outcome mapping and Participatory Evaluation from Health Canada's, Participatory Evaluation Framework. The Government of Canada's, Results Based Management and Accountability Framework and The World Bank's LOGFRAME (Logical Framework) also informed design. **RESULT:** A comprehensive evaluation was produced with the necessary information to meet PHCTF requirements. A meaningful synthesis was produced for summative evaluation which provided a comprehensive project overview emerging from 70 subprojects and initiatives. **CONCL:** Large scale, complex palliative care projects require a sufficiently robust program evaluation framework and supporting protocols to achieve accountability for large public investments

909. Methodological issues in the evaluation of educational initiatives

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Background: In evaluating educational initiatives (EI) pre-post designs are often used, which are prone to bias given the changes in the students internal standards (*response shift*). Hence, *then-test* evaluations have been advocated.
Objective:To evaluate an EI by using two different ways of time-series analysis (pre-post test *vs.* pre-then test).
Method: In agreement with the objectives of a multidisciplinary palliative care course in Buenos Aires, knowledge, skills and attitudes (KSA) about end of life issues were evaluated through a structured questionnaire. Every student filled the questionnaire a)at the beginning (*pre*) and b)the end of the course (*post*), both questioning about current KSA and; c)at the end of the course, although questioning about KSA at the course starting (then-test). Changes in the mean differences of *pre-post* versus *then-post* questionnaires were compared by non-parametric tests.
Results: All the students finishing the course filled the 3 questionnaires(n61). There were improvements (p<0.05) in 15/24 and 19/24 items in the pre-post and then-post comparisons respectively. Mean difference for questions related to knowledge and skills was also significant (p<0.05).
Discussion: This study suggests that response shift might account for differences in the evaluation of EI. Those changes could impact on the results of the evaluation itself, making necessary to adequately evaluate the methodology to use when planning this type of studies.

910. Development of a computer based questionnaire for assessment of physical function (PF) in palliative cancer patients

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858. The conception of the 'Nankya model of palliative care development' in Africa

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Aim of Study An evaluation was undertaken of a HIV/AIDS palliative care education strategy in rural Uganda which aimed to evaluate the impact of the programme and the health models used in developing palliative care. **Method** The evaluation of the training was undertaken from 2004-2006. Based on a case-study design, multiple sources of qualitative data were identified and a grounded theory approach used. **Results** Having identified that change in practice had occurred through the training, it was important to determine what had happened to enable this to take place. Throughout the programme key milestones were identified, along with changes that had occurred. In order to achieve these milestones and make the changes, advocacy was needed for palliative care at different levels, along with working with other stakeholders. Out of this a model for the development of palliative care in the rural African context emerged: the 'Nankya model of palliative care development'. This outlines what needs to happen in order for a service to move from no palliative care provision, to the provision of palliative care. **Conclusion** Palliative care currently receives much attention in Africa and APCA is trying to promote the development of palliative care in different countries. The Nankya model will help guide this work. The model may be generalisable and useful in the development of palliative care services in Africa. Further work needs to be done on validating this model.

855. Learning in Clinical Practice – An Innovative Palliative Care Open Learning Resource.

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This poster depicts the production and implementation of an innovative open learning resource which is intended to increase participants' knowledge and understanding and skills in palliative care whilst they continue to work in their own clinical area. The resource is aimed at nurses, who work in a non-specialist palliative care setting e.g. care homes, community and psychiatric units. Learning is undertaken in learning sets i.e. groups of nurses who work in the same clinical area. Learning set members work through the resource in some parts individually and in others as a team. The learning of the set is supervised by a facilitator who meets with them at regular intervals. This allows for the discussion of learning and the implementation of new ideas. Not only does the resource allow participants to examine the essential components of palliative care it provides an in depth discussion of best practice in the management of four symptoms of advanced disease. It also provides information on quality assurance related to palliative care. The poster shows how one pilot site utilised the learning resource to develop a comprehensive palliative care system within their own clinical environment. This ex-servicemen's care home has recently been commended on the standard of palliative care provision following completion of learning and the implementation of new palliative care standards.

859. A Guideline for Nurse education in palliative care in the Netherlands

Paul Vogelaar, Arianne Brinkman, Marianne Kamphuis, Wendy Pree de, Els Prikker, Herlin Woldberg

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In October 2005 the Dutch translation of the European Guideline appeared.Subsequently in 2004 the Professional Profile for Nurses working in Palliative Care was developed and the Professional Nursing Educational Act was established. The NVVPZ has attempted to integrate and transform these three pieces into the Dutch situation. The committee has developed a quality criterion for nursing education by describing the competences necessary for the diverse levels of expertise. By using this approach, the NVVPZ wants to give recognition for Palliative Care education for nurses in the Netherlands. In following the European Guideline, there are three course levels differentiated: basic, advanced en specialized. The basic level is for nurses in training and registered nurses. On the secondary level, there is a distinction made between the nurses who regulary come in contact with palliative care and nurses who have specific team and organisational tasks in palliative care. The tertiary level is specifically for nurses who are engaged in policy making and involved in research in palliative care.
On the poster, the NVVPZ will present its viewpoint and what it understands of the three described levels. The

application of the European Guideline in the Dutch situation has led to a concrete plan of competences for every professional level and description of the quality criterion for education. The poster will also cover the problems and queries the committee came across during their developments.

860. Interagency collaboration. A model of shared learning between Palliative Care and Mental Health Nurses

Philip Larkin [1], Siobhan Smyth [1], Clodagh Cooley [1], Kate Kelly [1]

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This presentation reports on an education programme using a problem-based learning (PBL) approach designed to explore interagency collaboration with a group of qualified experienced nurses undertaking postgraduate education in palliative care and mental health. Participants (N = 17) undertook a 12 week programme exploring team, collaboration and shared working based a round a series of clinical cases studies. The programme was facilitated by PL and SS as Progamme Directors for their respective specialist programmes - PL (Palliative Care) and SS (Mental Health). Students were given the opportinuty to develop skills in assessment, joint planning and partnership, team roles, giving and receiving feedback presentation and peer and self-assessment.

The programme was evaluated through both written evaluation and focus groups. Students identified shared learning as a very positive experience and could equally identify ways of adapting thier learning into clinical practice. Students gained confidence in challenging complex situations.

A problem-based approach to shared learning is particularly suited to adult learners with considerable clinical experience, seeking ways to adapt knowledge to practice, We conclude that shared learning is of particular benefit to palliative care as it enables practitioners to seek new ways of intergrating their discipline into established main-stream health care.

861. Physicians view on competences and training in palliative care

Birgitt Van Oorschot [1], Christine Schleussner [2], Ulrich Wedding [2], Winfried Meissner [3]

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Training physicians in fundamental principles of palliative care is essential to improving care of patients with life-threatening illnesses in hospitals. We wanted to know more about hospital physicians' interests in improving their competences in palliative care and about their views on deficiencies in palliative medicine. Methods: In November 2005, a self-leading questionnaire (16 items) was sent to all clinical physicians working in the hospital of Friedrich-Schiller University, Jena (n=500). Results: 141 questionnaires were sent back (28 %), mostly from younger physicians (78 % younger than 40 years) and working in non-surgical areas. 48 % expressed uncertainty in palliative care. As difficult / very difficult were labelled: psychosocial aspects (57 %), lack of time (57 %), ethics (49 %), organisation and communication (48 %), financial aspects (52 %) and medical aspects. They desired training in pain-therapy (87 %), communication skills (57 %), interdisciplinary cooperation (52 %) advanced directives (50 %), teamwork (48 %) and general symptom control (30 %). The vast majority of the respondents anticipated the most benefit through bedside-teaching and consulting (91 %) or hospitation (51 %). Conclusion: Although the low-yield prevents general statements, great interest in palliative-care training became apparent. The conception of training programmes should take the high interests in bedside teaching and consulting into consideration. The results from a comparative survey in Würzburg (planned for 2/07) will be presented and discussed too.

862. Changes in education of palliative carein the Hungarian Oncology

Agnes Ruzsa

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The palliative therapy is necessary for the terminally ill cancer patients. The Hungarian educational books of the clinical oncologists did not have chapter about palliative care before 1990. It was not allowed telling truth to the patients suffering from any kind of cancer, receiving a false final report. Medical oncologists

abandoned breaking bad news not only the dying patients but also they did not tell the diagnosis of cancer for any cancer patients. The drug availability was very poor, only the morphine injection. After the law 1994 the palliative care education and practice changed. The author reviews the development of education of clinical oncologist, the changes in drug availability the telling truth, breaking bad news.

863. Changes in Skills, Knowledge and Attitudes of Family Medicine Registrars: Measuring the Impact of a Palliative Care Course

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Aim: The goal of this study was to assess whether the knowledge, attitudes and skills of rural family medicine residents (2005) changed as a result of a 4-month long palliative care course that used a combination of classroom (3 days)- and web-based learning (4 mths), but no clinical rotation. **Methods:** Knowledge, attitudes and self-perceived comfort were evaluated by a 16-item MCQ quiz, 12-item survey and 22-item scale respectively, all developed specifically for this study. Three objective standardized clinical examination stations (OSCEs). All the instruments underwent testing and psychometric assessment. Identical quizzes, surveys and OSCEs were conducted pre- and post-course. **Results:** 16/20 residents participated in both the pre- and post-course evaluations. The internal reliability values of the OSCE scoresheets ranged from 0.65 to 0.82. A significant improvement was noted in OSCE 2 (t= 2.9, p=0.01, d effect sizes 1.94 respectively). Although the change in OSCEs 3 was not significant, the effect size was large (d=1.34). (OSCE 1 d= 0.21) There were significant improvements in knowledge levels (t= 8.99; p<0.01; effect size d=2.24) as well as in comfort levels (t=4; p<0.01; d=1.64). Attitudes improved but did not reach significant levels; the effect size was acceptable (t=1.82; p=0.09; d=0.65). The internal reliability (Cronbach) of the knowledge, attitudes and comfort scales were 0.29, 0.68 and 0.92 respectively. **Conclusions:** Significant improvements were demonstrated in knowledge, self-perceived comfort levels and some skills.

864. Schooling of children with severe life-limiting illness

Helene Porchet

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Aim: Investigate the school follow-up for severely ill children and identify their educational needs + identify the hospital teacher's work, their role and competences **Method** Semi-structured interviews with 11 ill children-their parents-3 teachers who integrated a severely ill child in class-3 hospital teachers'1 regional director of education
Results Serious illness affects the child's schooling at different levels: physical (frequent hospitalizations, side-effects therapy) psychological (motivated ++ by school, need to feel accepted by others through keeping contact with them, need for information within the class) practical (adaptations to the school environment) Parents feel unsupported and complain about a lack of communication from the teachers and school management systems. The hospital teacher's job is not well recognized, overlapping the 2 worlds of instruction and care. The hospital teacher should be competent to integrate and balance the needs of children, parents, school programs, usual teacher and current hospital life. **Propositions** Create an individualized integration plan through networking (family - teachers - health and school professionals - hospital teacher). Hospital teachers working with children who face life-limiting disease also need to develop communication networks at a national and European level.
Conclusion Enabling a severe ill child to keep up with his schooling, according to Childrens' rights, is a key element for his quality of life by giving him hope and meaning to his life.

865. EMERGING E-LEARNING TECHNOLOGIES IN PALLIATIVE CARE

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AIM: Generational transition in the health workforce, convergence of Information and Communications

Technologies (ICTs), increased demands of busy professionals for flexible learning opportunities and demand for palliative care among geographically dispersed, drives e-learning innovation. This report links several e-learning technologies for palliative care capacity-building. **METHOD:** Effective e-learning is practical and sensible about how people learn and work, while considering available institutional and consumer ICTs which are accessible and used. Several models field-tested in palliative care will be highlighted, including a "POTS to PodCast" model for translating large participant-volume telephony-based professional development sessions into MP3/.wav on-demand resources; use of digital video across multiple platforms including classroom-based DVD, web-based streaming media and MP4 for video iPod based on-demand learning/reinforcement. A learning object repository, the Palliative Learning Commons, will be featured as well as an Independent Learning System (ILS) to support individualized, self-directed learning. **RESULT:** E-learning responses are being employed to provide flexible learning and decision support for busy professionals so they may provide better access and quality in palliative care services. **CONCLUSION:** Practical e-learning technologies are important tools transforming when, where and how practitioners learn to develop and maintain palliative care competence.

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866. The Psychometric Properties of Palliative Care (PC) OSCE Instrument to Measure Changes in Knowledge and Skills

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Aim: The goals were to develop 3 long (each 20 min.) objective structured clinical examination stations (OSCEs) and score sheets to assess a variety of PC competencies and establish their psychometric properties. **Methods:** Guidelines for developing OSCEs were followed. Actors/actresses followed scripts and underwent training, as did raters (6 PC consultants). Each OSCE score sheet consists of an itemized checklists and a global scale -"fail", "borderline" or "pass". 20 rural family medicine registrars completed pre and post-course OSCEs as part of a PC course. Surveys and focus groups were conducted post-course. Earlier testing of the OSCEs on a similar group of learners had revealed good inter-rater reliability scores (0.87 to 0.92). **Results:** Face and content validity was acceptable. Internal-reliability values of the score sheets ranged from 0.65 to 0.82 across the 3 stations. The correlations between the total checklist scores and the global scores were significant (r=0.47 to =.77; p=0.001 to p=0.07). Inter-item coefficient correlations identified several items that appeared redundant and others that provided evidence for divergent and convergent validity of the scales. **Conclusions:** The 3 palliative care OSCEs possess acceptable psychometric properties and are useful for evaluating skill-related competencies in formative and summative evaluations. They also support experiential learning. Potential limitations are recognized. A generic standardized score sheet for palliative care OSCEs (Pal-OSCE) is proposed.

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867. Reflective Video Vignettes to Change Attitudes of Primary Health Professionals in Managing Difficult Family Situations in Vaud, Switzerland.

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Aim: Evaluating and changing attitudes is elusive. The goals was to develop short video vignettes and evaluate them alongside small group learning in a 3-hour interdisciplinary course aimed at changing attitudes of primary health professionals towards managing difficult family situations. **Method:** Seven video vignettes based on real life experiences involving difficult family situation were developed. Based on reflective learning principles, they weave inept skills amongst exemplary behaviour and integrate communication, ethical and psychosocial issues, and medical problems. A 6-item attitude survey was developed, distributed pre- & post-course and compared using paired sample t-tests. Learners also evaluated the videos. **Results:** 45/55 learners completed the pre- & post-course evaluations (38 nurses & nurse aides, 4 physicians, 3 others). Attitudes changed significantly on 4/6 items (p: 0.04,

0.03, 0.01, and 0.03; SD: 0.3, 0.7, 0.1 and 0.8 respectively). Support for the inclusion of patients in family conferences increased, as did the inclusion of families in decision-making and responses to the question "How long does he have to live"" All respondents felt that the videos were realistic and stimulated discussion. Psychometric testing of the instrument was limited by the number of items. **Conclusions:** The course resulted in significant attitude changes amongst participants. The videos appeared to enhance the learning experience. Future research should assess the psychometric properties of the survey and compare the course with and without videos.

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868. Interprofessional learning and the effect on the collaboration among different professions in palliative care

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Background: In Slovenia, communication skills in palliative care are traditionally organized as an interprofessional learning. Effects of the workshop on the teamwork were examined.
Methods: The questionnaire was developed to evaluate the subjective opinion on team collaboration change after the workshop. Knowing other team members, team conflict management, learning from mistakes, quality of meetings and process of accepting new ideas in team work were explored. 30 participants of two-day workshops answered the questionnaire 2 to 8 months later.
Results: The majority of team members became more aware of their colleagues' skills, and became more respectful and appreciative of each other. Knowing other team members better and building a common vision were crucial effects to develop some better collaboration. More open atmosphere in team meetings and conflict management was possible after the workshop. They found important to know each other in different professions also on the personal level. Those participants who were from the same working department together on the same workshop reported better results on interprofessional relationships.
Conclusions: Results are suggesting that interprofessional learning is effective in supporting better team work. It is especially effective when sensitively organized in one working setting. More effort should be given to the interprofessional learning in the undergraduate education.

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869. The impact of a multi-disciplinary education initiative on the attitudes and behaviours of non-specialist health care professionals delivering palliative care.

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The aim of this study was to assess the impact of attendance at a two-day, locality-based, multi-disciplinary palliative care course on confidence, team-working and innovative practice amongst primary care professionals. The course was specifically designed, not only to equip participants with palliative care skills, but also to challenge practice by encouraging teamworking and addressing local issues.

The attitudes and behaviours of course participants were assessed by a questionnaire sent to all attenders (n=293). Respondents were asked to rate their confidence in five different areas of palliative care practice, and to give examples of how their practice had changed as a result of their attendance. Scale data were analysed using SPSS and free text responses subjected to simple content analysis.

Return rate was 45%. Scale data confirmed that respondents experienced improved levels of confidence in each of the five areas of practice. Respondents also reported improved ability to work with colleagues, and greater preparedness to deliver palliative care locally. Thematic analysis of free text confirmed these findings and provided fascinating examples of real improvements in practice.

The data generated by this study confirm that a carefully targeted education initiative can deliver tangible benefits for non-specialists delivering palliative care in primary care settings. Perhaps more importantly, there is also evidence that these health and social care practitioners changed the way they worked as a result of attending the course.

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870. "Palliative Care: The Essentials" Evaluation of a multidisciplinary education program.

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The WHO promotes a team approach to address needs of palliative care pts & their families. Australian Commonwealth funding was secured to educate clinicians from a range of settings. Aim: To develop, deliver & evaluate a multidisciplinary education program focusing on core elements of palliative care. A 2-day program was developed based on a literature review and input from an expert panel. Evaluation consisted of a pre-post test q/aire for each session and overall program assessment. Participants evaluated changes to perceived levels of knowledge, skill & confidence in eight key areas: 1) recognising the need for palliative care 2) team work, 3) patient & caregiver support 4) communication skills, 5) symptom management, 6) legal & ethical issues, 7) spiritual & cultural concerns and 8) grief & bereavement. The program was delivered 4 times in metropolitan & regional areas to a total of 537 participants incorporating a range of disciplines & care settings. Participants reported statistically significant improvement in each of the eight key areas, with some variability between disciplines. The program was successful in meeting the learning needs as identified by the majority of participants. The findings demonstrate multidisciplinary educational approaches can be effective in the context of palliative care. The high demand to attend the program suggests the need for ongoing education in this area.

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871. The development of a competency based model for nurses working in specialist palliative care

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The challenge of developing a defined rôle and career pathway for specialist palliative care nurses has been met at St Christopher's Hospice through the development of a competency model. Initially for Community Clinical Nurse Specialists, it looked in detail at the components of the rôle, analysing the task, skills and knowledge needed and the evidence required to demonstrate that the skills had developed to complete the task. It also outlined the training needed to fulfil the competency. A measuring tool was developed which involved self and managerial assessment. Despite initial reservations amongst staff, it proved an effective and efficient management tool. The framework has 6 domains 1) Clinical practice and leadership, 2) education and training,3) grief, loss and bereavement, 4)quality, 5)communication 6) management. The essence of assessing competency is to gather evidence through observing the individual at work, listening to others who have observed, considering products of the work e.g. documentation, listening to claims from the nurse and by questioning the nurse about their effectiveness.The framework has now extended into the inpatient unit. It is linked to the NHS Knowledge Skills Framework, meaning that it is transferable to other health care settings. The framework defines Agenda for Change bands 2 8A - each nurse now knows what is expected of them at their grade and is aware of what to expect of their colleagues

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872. A distance learning course in palliative medicine for General Practitioners

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Studies have shown that General Practitioners (GPs) have limited access to palliative care education and often lack the necessary knowledge and skills to care for palliative care patients (Barclay S 1997, Macleod 1991, Oliver 1998).
Aim/Method
To describe the development of a six-month education programme for GPs.
Results
The CRISIS criteria for effective continuing education were used to develop the course; convenience, relevance, individualisation, self-assessment, interest, speculation/systemic (Harden & Laidlow 1992). Course comprises of;
1. Independent study modules with clear aims, objectives and competencies, including journal articles and case studies to be completed each month. 7 different topics addressed; principles of palliative care, pain, GI symptoms, end-of-life care, respiratory symptoms, palliative care emergencies, and communication.
2. Monthly attendance at a half day 'consultant teaching clinic' based on SNAPPS model of learner-centred

Poster abstracts

439. Social care interventions for hospice referral in a university hospital without palliative care unit

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The aim of this study was to evaluate the transfer rates to a hospice for palliative patients of all departments of our University Clinic Hamburg-Eppendorf without palliative care unit or palliative care team.

The data base of the social care department comprehends all in-patients in the year 2005 and from January to October 2006 who were referred from hospital to hospices or were advised about hospice care. In 2005 118 consultations concerning hospice care were performed.

20 patients received psychosocial and social judicial interventions concerning palliative care and information about the options of patient care outside the hospital. In 98 consultations the intention of the care givers was to discharge the patient to a hospice. 56 patients could be transferred to a hospice. 42 patients died prior to discharge or could be cared for in the family setting with the support of the social worker.

In 2005 32 patients and in 2006 (10 mths) 39 patients from the Department of Medical Oncology were referred to a hospice. For 8 patients in 2005 and 12 patients in 2006 an alternative decision was made.

From January to October 2006 the social worker received calls 118 times for hospice care, of these in 18 cases psychosocial and judicial interventions were required and from 100 calls for referral to a hospice 61 patients were transferred from hospital to hospice.

Palliative care interventions for assistance transferring patients to a hospice increased from 2005 to 2006.

440. The problems of transition from voluntary hospice teams activities to modern hospice teams integrated into the existing health care system

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The Croatian Association of Hospice Friends (CAHF) was founded in 1999 to provide logistic support, first of all to the educative and promotive activities of the Croatian Society for Hospice/Palliative Care,CMA. CAHF endeavours to provide practical palliative medical, psychosocial and spiritual care during hospice home visits by interdisciplinary teams in Zagreb and Zagreb region. As soon as a provision about palliative care was included into the new health reform law in summer 2003, CAHF started the administrative procedure necessary to establish an Institute for Palliative Care. - All efforts were blocked by changes in the Government and by the subsequent radical personal and organisational reforms in autumn 2003. As. CAHF a civil association, can't conclude contracts with the Croatian Institute for Health Insurance, we had to start with the procedure all over again. Palliative care can't develop on an almost exclusively voluntary basis. It should be stressed that our palliative care team is the only palliative care unit in the modern sense in Croatia and has been functioning for almost 7 years continuosly in facilities rented by the city of Zagreb. So far, the Association's activities have been financed by projects and national and foreign donations. From 12/1999 until 06/2006, palliative care services were provided for 879 people and their families.

441. Specialised palliative home care in Bonn - which factors lead to referral to inpatient settings previous to death

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Introduction: Specialised palliative home care services (SPHCS) aim at accomplishing that patients can die at home. It is well acknowledged that this is not achieved in all patients. This study analyses, which factors lead to referral to inpatient settings (IS) previous to death. **Methods:** Data of every patient of the SPHCS at the Malteser Hospital in Bonn is documented in a computerised data base. For this study, the period from 1/2002 to 6/2006 was analysed. Patients who died in IS

were compared to patients who died at home (DH) by testing for differences (‾_Ç_) in symptom prevalence and availability of family members as informal carers.**Results:** Data sets of 567 patients were included, of these 362 (64%) died at home and 205 (36%) did not die at home. Higher symptom prevalence was detected in IS patients for dyspnoea (27%, DH 19%; p=.028) and nausea (13%, DH 7%; p=.019). No differences were found for e.g. pain. Relatives as informal carers were less common in IS patients (62%, DH 86%, p<.001). **Conclusion:** The presented study shows that certain factors have a significant influence on the place of death. Social preconditions like lack of family structures cannot be changed, but an improvement of symptom management in the outpatient setting, e.g. better qualification, closer cooperation (e.g. with physician) and better coordination, may increase the number of terminally ill patients in SPHCS in this area that can stay at home for dying. This can be a focus for further research.

442. PROJECT FOR SAFE DISCHARGE AND HOME CARE SERVICE IN PALLIATIVE CARE BY THE 9th ONCOLOGICAL PROVINCIAL INTERCOMPANY DEPARTMENT OF LOMBARDIA (Italy)

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Project Purpose:
Most of the home care oncological patients don't need any specialized oncological therapy. It is therefore necessary to plan, set up and manage a service care programm which allows the patients to enter a national health insurance network with a territorial integration. The network will provide the following :
the Hospital as promoter of safe discharge process
the Local Health Unit as guarantee of different territorial social and health levels
The Municipal Social Services
Volountary Service
The project is for adult and paediatric patients with oncological and oncohematological diseases. The aim of the project is to promote a continuative relation between the hospital and the region of the involved patients by a safe discharge process from the hospital and/or day-hospital or outpatient healthcare insurance.
Methods:
The continuity model of health care consists of:
-a computerized case report form . All the involved professionals in the assistance can communicate together easily and can be constantly updated.
-a specific training of all the involved professionals
-a pilot study for three years with a final inspection using suitable markers.
Results:
The Lombardia Region has approved and sponsored the project. Data processing systems have been implemented and training being performed. The effectiveness of the training will be evaluated after one year and also the case recruiting will begin at that time.

443. Developing an early intervention supportive and palliative care pathway for adults with intellectual disabilities

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Despite policy/legislation the healthcare needs of British intellectually disabled people are poorly met and particularly so within palliative care.Thus service providers are often inexperienced in communicating with and meeting the needs of this client group when someone with an intellectual disability (ID) is referred to them. Research has demonstrated that many people with ID with life threatening conditions do not access hospices or the full range of palliative interventions. This is related to the late diagnosis of illness and a reluctance to 'hand over' care to non ID professionals. It is clear that late referral has a deleterious effect on all aspects of care, not least the ability to develop trusting relationships with the patient and those closest to them. This presentation will detail work undertaken within a London hospice to develop accessible and appropriate supportive and palliative care for people with intellectual disabilities. This endeavour is the consequence of developing partnerships between community ID and palliative care professionals; it has resulted in the development of a patient pathway for early referral and intervention across a continuum of supportive and palliative care. The implementation of the pathway has highlighted significant training and support needs for staff within

each area of care. The model of care developed is transferable to a range of hospice and community palliative care settings.

444. Accelerating Change In Complex, Public-Funded Health Systems: The Canadian Pallium Project

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AIM: From 2004 - 2006, the Government of Canada invested ¤ 2.8 million in the Canadian Pallium Project to improve patient access through primary care renewal. **METHOD:** The Project employed established social science and educational research from the literature, including; Action Research; Continuing Professional Development informed by Situated Cognition/Learning, Workplace Learning, Critical Reflection and Social Constructivism theory; Communities of Practice; Complexity Theory, and project management practices informed by international capacity-building models. Through development and change management projects in outreach education and continuing professional development; knowledge translation/ diffusion; and health delivery system change, the Project (Phase II) generated and catalyzed transferable lessons/innovations. **RESULT:** Phase II of the Pallium Project completed 72 projects in a 24 month period with results including demonstrable clinical practice change from local inter-professional education, a competency-based palliative care courseware package being used in medical schools, a nationally-validated, competency-based curriculum kit for Spiritual Care, 12 other national education resources and multiple innovations in e-learning and e-health to support improved palliative care in community setting. **CONCLUSION:** Phase II demonstrates the possibilities for inter-sectoral collaboration among academic, government, civil society (NGO) and health service delivery partners to produce demonstrable change and useful legacies for palliative care capacity-building.

445. What Affects Adherence by Internal Medicine Nurses (IMNs) of Recommendations Made by Palliative Care Consult Nurses in a Swiss Tertiary Hospital

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Aim: The goal was to explore the factors that influence adherence by internal medicine nurses (IMNs) to recommendations provided by a palliative care consult nurses (PCN) in a Swiss teaching hospital. **Method:** A qualitative approach, using case study design, was applied. Following convenience sampling, IMNs were interviewed one-on-one (semi-structured questions). Two conceptual frameworks (Zay et al 1997 ; Sauve 2001) were used as a starting point for data coding. New categories and themes then emerged. **Results:** Data saturation was achieved after 5 interviews. 5 categories emerged, including alterity; transparency; communication; time; and sense of ownership. Adherence requires a personal rapport and trust between the IMNs and PCNs. Developing this requires time. Frequent staff changes hinders this. IMNs view the consultation at times as an intrusion by the PCNs and feel that they are better acquainted with the patients. Explicit recognition by the PCN of the personal distress that IMN experience when caring for palliative patients enhances the rapport. A focus on supporting the IMNs rather than focussing only on the patient enhances adherence. IMNs experience (whether real or perceived) a sense of inferiority during the consultation process. **Conclusions:** Our PC team needs to review its model of consultation, possibly adopting one that focuses more on supporting the primary teams. Formal and informal strategies to improve the rapport with IMN will be sought. Awareness by the PCN of the inferiority felt by the IMNs may enhance rapport building.

446. CLINICAL AUDIT IN A HOME PALLIATIVE CARE SERVICE:Auditing the audit

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Clinical audit intends to improve current practice, use of resources and team education. Therefore, it is essential in the palliative care setting as a mean to reach an excelent care.
Objectives Ensuring the effectiveness of an audit project and discuss methodological issues able to impact in the efficacy of the audit.
Methods The Pallium-Hostal de Malta Home PC Service (HMHPCS), developed an organizational and clinical audit programme based on standards developed by the Trent Hospice Audit Group. In the first phase, the audit