



Continuing professional development programmes for rural nurses involved in palliative care delivery: An integrative review

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SUMMARY

Purpose: To review published studies evaluating the impact of continuing professional development (CPD) programmes on rural nurses palliative care capabilities in order to inform the development of targeted learning activities for this population.

Design: An integrative review.

Methods: Searches of key electronic databases and the World Wide Web was undertaken using key words, followed by hand searching for relevant articles. All studies were reviewed by two authors using a critical appraisal tool and level of evidence hierarchy.

Results: The search strategies generated 74 articles, with 10 studies meeting the inclusion criteria. All of these studies evaluated palliative care CPD programmes involving rural nurses which focused on increasing palliative care capabilities. The evidence generated by this review was limited by the absence of randomised controlled trials. A level III-1 study, with a small sample size provided the highest level of evidence, but the lack of control negated the investigators' capacity to confirm causality. Few studies measured the impact of CPD on the quality of care or utilised novel technology to address the tyranny of distance. Despite, these limitations valuable insights into the barriers and facilitators to engaging rural nurses in palliative care learning opportunities were identified.

Conclusions: Evidence that CPD impacts positively on patient and families outcomes is necessary to sustain an on-going investment in learning activities. In order to optimise the opportunities afforded by emerging web-based technology rural nurses' need to develop and maintain their computer competencies. Further investigation of the impact of specialist clinical placements on rural nurses' palliative care capabilities is also indicated.

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Introduction

Globally, people are living longer and often with progressive chronic conditions. Access to palliative care helps minimise the distress caused by any physical and psychological symptoms that people with these progressive illnesses frequently experience, (Murray et al., 2004; Janssen et al., 2008). Yet many people continue to have unmet palliative care needs, with the most frequent complaints tending to be related to lack of timely information; poor symptom management; inadequate access to psychological and social support; too few opportunities to plan for the future; and inappropriate or inadequate end-of-life care (Weissman and Meier, 2011). The delivery of suboptimal palliative care contributes to increased health care costs and causes unnecessary suffering, especially when

clinically futile treatments are administered or symptoms are poorly managed (Davidson and Phillips, 2010).

Strategies to address unmet palliative care needs are reflected in various international and national palliative care policy documents (Department of Health, 2008; Australian Government Department of Health and Ageing, 2010). This reform has emerged largely in response to the World Health Organisation's (2003) edict that quality palliative care be made available to all who need it, regardless of diagnosis or care setting. These policies acknowledge that the majority of people with progressive chronic illnesses will be managed by doctors and nurses, for whom care of the dying is not their speciality (Al-Qurainy et al., 2009). This underscores the need for reforms aimed at reorientating existing health services and increasing the health workforces' palliative care capabilities. Including reconfiguring existing limited speciality palliative care services to ensure that they are reserved firstly for patients and families with the most complex needs, and secondly to provide support for health professionals as they seek to deliver evidence based palliative care to people with less complicated needs (Palliative Care Australia, 2005). Additional

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reforms have also been implemented globally to ensure palliative care content is integrated across undergraduate health professional curricula (Ramjan et al., 2010). As nurses are the discipline that will spend the greatest amount of time with dying patients and their families, significant emphases have been placed on enhancing their palliative care capabilities (Gibbins et al., 2009; Wallace et al., 2009). As an example, in the United Kingdom, the End of Life Strategy identifies the need for palliative care content to be embedded into all nursing education programmes (Department of Health, 2008). Similarly, the Australian Government has funded the development of palliative care curricula and provided support to universities to integrate this material into nursing courses (Australian Government Department of Health and Ageing, 2005). However, the existing nursing workforce has received little palliative care education in their pre-registration curriculum or through continuing professional development (CPD) opportunities (Schlairet, 2009). All of which makes focusing on the CPD learning opportunities for the existing nursing workforce an important aspect of any end-of-life care reform agenda.

Continuing Professional Development

Continuing professional development is a term that is frequently interchanged with: professional development, continuing professional education, continuing education, life-long learning and, knowledge translation (Hegney et al., 2010). In this paper, CPD is defined as 'a process of planned activities based on performance review and setting of explicit targets for good clinical practice with the aim of improving actual quality of patient care' (Bynum et al., 2010, p. 559). In many parts of the developed world, minimal CPD requirements have been linked with the national registration process as way of ensuring ongoing nursing competency (Nursing and Midwifery Board of Australia, 2009). These processes frequently seek to make nurses accountable for maintaining and developing their professional knowledge and capabilities through a range of learning opportunities. Personal and professional growth can thus occur through participation in relevant learning and development programmes, such as formal accredited courses and non-accredited workplace learning (Munro, 2008). Learning enhances nurses' self efficacy, which in turn improves decision making and information sharing (Bandura, 1997). Self efficacy is especially relevant to palliative care where the acquisition and maintenance of specialist nursing knowledge and skills are critical to ensuring equitable patient outcomes.

Rural Nurses

Nurses are the largest and most geographically distributed discipline within the health workforce (Lenthall et al., 2009). Given this coverage, rural nurses are in a unique position to make a significant difference to palliative care outcomes for people living in rural communities by providing care in accordance with the best available evidence. Despite nurses having similar basic information requirements for providing effective patient care and undertaking their professional duties, geographical location appears to impact on how information is accessed (Dorsch, 2000). Rural nurses often have more limited access to medical libraries, and are more likely to seek information from a textbook, as opposed to a journal, and ask fewer clinical questions (Dorsch, 2000). As the palliative care evidence is evolving rapidly, with 1 in every 122 published clinical trials by 2005 undertaken in this speciality (Tiemann et al., 2008), textbooks do not always reflect the most current evidence. Yet rural nurses are less likely to access on-line data bases where much of the evidence is located (Dorsch, 2000). In dynamic specialities, such as palliative care, where knowledge is constantly expanding it is estimated that a nurses' professional half life from graduation may be as little as 2–5 years (Lysaght and Altschuld, 2000).

Rural nurses also have fewer learning opportunities than nurses based in metropolitan settings as a result of location (Hegney et al., 2010). For example, a recent Australian study found that rural nurses were significantly more likely to report not being able to fund CPD activities as well as having more difficulties accessing learning opportunities than their metropolitan counterparts (Hegney et al., 2010). This study also reported a fall in availability of CPD workplace funding during the period 2004–2007 for nurses (Hegney et al., 2010). The rural nursing workforce also tends to be older (Lenthall et al., 2009). Previous research has demonstrated that length of time in clinical practice and age are both risk factors for poorer knowledge and health care outcomes (Choudhry et al., 2005). The reasons behind these observed links are likely to be complex, but nonetheless addressing any inverse relationship between years of practice and care quality requires a commitment on the part of health professionals to lifelong learning and ensuring their practice is grounded in the best evidence. However, nurses need to have been taught the skills, and have the ability, to identify and critically evaluate the body of evidence for translating new knowledge into practice (Lysaght and Altschuld, 2000). Although, knowledge translation is a complex process, it is critical to improving care outcomes as it helps in facilitating the adoption of effective scientifically proven practices, whilst also enabling practices that have been shown to be ineffective or harmful to be disbanded. This evidence highlights that regular participation in structured learning activities is an essential requirement for all nurses, regardless of geographical or clinical setting.

In many rural communities there are fewer palliative care specialists with the majority of palliative care being provided by general practitioners and community nurses (Phillips et al., 2006). A lack of specialist services highlights the importance of maintaining, developing and increasing rural nurses' palliative care knowledge, problem-solving skills, technical competencies and professional performance standards. Yet, previous research has identified that for rural nurses: distance to learning activities, stress due to lack of support, emotional demands of work, role diversity, family commitments and personal burdens all impact adversely on their ability to participate in CPD opportunities (Rosenberg and Canning, 2004). Consequently there is little consensus on how best to provide palliative care CPD to rural nurses to optimise participation and learning.

Aim

A comprehensive review of the evidence was undertaken in order to inform the development of a palliative care CPD programme for nurses working in rural Australia. The purpose of this integrative review was to identify CPD programmes designed to increase rural nurses palliative care capabilities in order to improve clinical outcomes. This integrative review aimed to address the following questions: (a) Will rural nurses' participation in a palliative care CPD programme improve patient care outcomes? (b) Which palliative care CPD formats best meet the needs of rural nurses? (c) Is there evidence to support the use of technology to deliver palliative care CPD to rural nurses? (d) What are the barriers and facilitators to rural nurses participating in palliative care CPD programmes? And (e) What are the gaps in the evidence and future research directions?

Method

An integrative review was adopted for this study to allow for the synthesis and systematic presentation of the results of primary studies (Greenhalgh, 1997). A separate search strategy was developed for each of the major health, education and social science bibliographic databases, including: Cumulative Index of Nursing and Allied Health Literature (CINAHL) 1982–June 2010; Medline 1950–June 2010; Embase 1980–June 2010; PsycINFO 1806–June 2010; Scopus

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