

A report on Palliative Care and Cancer Nurses' Educational Needs

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Executive Summary

This report provides comprehensive information on the cancer and palliative care nursing workforce in New Zealand, with particular emphasis on education. National, regional and local data have been presented, which will serve as baselines against which future evaluations of the workforce can be made. The report arose from an initial stock take undertaken as part of the Implementation Programme for the New Zealand Cancer Control Strategy Action Plan 2005 – 2010. The specific remit was to determine the educational needs of nurses working in New Zealand with patients receiving either palliative or cancer care.

Many nurses, in many different settings, work with patients who have cancer or palliative care needs, and with their families and whanau. Some of these nurses work in specialist services, others encounter these patients in general clinical settings. Core knowledge and skills are needed for all nurses, which are supplemented by, for the advanced nurses, their possession of specialist skills and knowledge. This review of the cancer and palliative care nursing workforce and its education needs captures levels of practice (actual and perceived), activities undertaken (clinical, educational and research), academic levels, and education provision, as well as the key issues facing nurses across the country in relation to life-long learning. However, this is just a snapshot picture of the cancer and palliative care workforce, their existing skills and knowledge, and their educational needs and intentions at the current time. Limitations with the data collected include the low availability of data nationally, and a lower than expected response rate to the survey, and different response rates in different locations

and services. The fact that further information collected during key informant consultations agreed with survey results did, however, ameliorate the low response rate to some extent.

Methodology

Four interrelated research approaches were utilised within an overall framework involving:

- A national stock take of available nursing workforce data on numbers, roles and education levels for those working with cancer and palliative care patients, and education availability.
- A case study of four DHBs that involved surveys of nurses and interviews with key informants regarding nurses and their educational needs working in cancer and palliative care services in DHB regions.
- A review of New Zealand and international literature on recommended benchmarks for numbers and skill mix in cancer and palliative care nursing.
- A gap analysis in which study findings were benchmarked against international practices and national key informants were consulted.

Educational Preparation of Nurses

- Nursing curricula preparing students for registration as nurses were described as integrated in nature, and very crowded. The programmes did not intend to, nor could be expected, to prepare nurses for specialty practice in pre-registration studies. In addition there is variation across the country on availability of clinical placements in cancer and palliative care.
- Coherent educational programmes at postgraduate certificate and diploma levels are offered by 2 universities in both cancer and palliative care, and by a polytechnic in palliative care. In addition a few institutions offer a course relevant to the specialties, many offer generic postgraduate programmes and courses relevant to advanced nursing in the specialties, and nurses can build on these using specialty courses, and continue on to Masters and Doctoral studies.
- Graduate study that is not articulated with postgraduate study is also offered, at the time of the study by a South Island polytechnic and by other organisations; such advanced education in the specialties is attractive particularly to older nurses wanting to upskill.

National Stocktake of Cancer and Palliative Care Nursing Workforces

- In the absence of accurate, current national data availability, multiple approaches and sources were used to provide a picture of the nursing workforces in cancer and in palliative care. The main sources were: the Nursing Council, Directors of Nursing, specialty organisations employing nurses and associations to which nurses in the specialties belonged.
- In spite of these efforts, the national nursing workforce data is partial, for reasons that include Nursing Council data describing only the palliative care and not cancer nursing workforce, not all DHBs supplied data, and that its accuracy, therefore, has to be questioned.
- There are three main explanations for the latter: 1) because nurses are not classified according to specialisation; 2) because of differences in how nurses providing cancer and palliative care services were defined and counted; and 3) the state of flux affecting nursing services as services are developed and changed.

District Health Board Case Studies-Surveys

- Surveys were completed by 649 nurses working in four district health board regions, including the DHBs themselves and NGOs with contracts with the DHBs.
- Demographic profile indicated the nurses were older, predominantly European, and less than half worked full-time. The larger proportion had been educated as nurses in hospital based programmes. Many reported very long periods of service in the specialty area.
- A key finding was that less than 20% overall described themselves as 'beginner' nurses; a high 44% described themselves as 'competent (i.e. experienced practitioner without specialist qualifications), nearly 30% as 'proficient (i.e. experienced practitioner with specialist qualifications) and 7% as 'advanced' (highly competent) practitioners.
- Many nurses reported an overall low uptake of graduate and especially postgraduate education. Only 19% of all participants reported they held a postgraduate qualification; the remainder with post-registration qualifications had graduate qualifications. Many had prepared through informal education for the role including in-house sessions and short (not-for-credit) courses. An exception was those nurses who worked in palliative care who overall had a higher uptake of postgraduate education.

- About a quarter of participants said they were currently studying for a postgraduate qualification. A close examination of subjects revealed that while some study was in the specialty area, others were not, reflecting general clinical nursing subjects and non-clinical study such as in management.
- Paradoxically, in spite of nurses' extensive experience and high ratings of their competence and proficiency, it was the specialised activities they felt less confident in performing, and were more confident in generic nursing activities.
- Between 50% and 64% of nurses indicated that they intended to engage in further study in cancer or palliative care nursing in the future, and a further third indicated they may do so.
- Barriers to such study were identified, and the main barriers affecting all nurses were release from clinical duties to participate in education, and nurses' lack of time (noting the multiple responsibilities including family responsibilities of the largely female, mid-aged workforce). Lack of available, relevant courses was not a major barrier, and nor was funding now that CTA funding is administered by DHBs. However there were differences across the specific groups and regions: available courses, access and travel were greater barriers for nurses away from main population centres; cost was also greater when nurses had to travel; differential access to funding by DHB and NGO employees, and; differences in course availability in cancer and palliative care.

District Health Board Case Studies-Interviews

- Interviews with 40 senior nurses in the four DHBs. complemented and extended survey results. These interviews involved clinical nurse educators, clinical nurse specialists, nurse managers and leaders.
- Interviews indicated that service development and models of care have not kept pace with the treatment advances for the patient populations that have transformed cancer from an acute, often terminal, disease to a chronic condition. They felt that services need to shift from being episodic and biomedically based in character, and nursing workforce development to change accordingly.
- Increasingly treatment interventions are now being carried out by nurses as overall demand for services has grown. Nursing skill levels and nursing team skill mix need to be redesigned to reflect these developments. Advanced educational preparation to

meet these identified needs is agreed, but there is less agreement on the levels and modes of delivery of advanced education.

- Cross-cultural communication and cultural health-related beliefs and practices were seen as subjects of nurses' education to care for increasingly diverse patient populations. On the other hand, overseas-trained nurses, particularly from non-English speaking backgrounds, need further education to prepare them to meet the needs of Māori and Pacific patients.
- The importance of employer and organisational recognition and support for advanced nurse education, including clinical release and equitable access to available courses, was highlighted.

Consumer Perspectives

- A series of focus group interviews were held with consumers to complement nurses' perspectives with those of individuals and communities they work with.
- Consumers emphasised the importance of nurses with the specialised skills working with them in partnership. A related theme was the importance of good communication skills, and also reflecting person-centred care was cultural skills.
- Consumers also reflected on the greater confidence they had in those nurses working in specialised services compared with the general services.
- Where consumers needed to interface with many services and personnel, nurses' management and case management skills were valued.
- While much of what consumers valued in nurses reflected interpersonal and relational skills, technical skills including assessment and screening skills were also raised.

Consultation with Key Stakeholder Groups

The consultation process confirmed many of the results of the survey of nurses and interviews in four DHBs and expanded on issues identified.

- The demographic profile of the nursing workforces in cancer and palliative care services attracted comment, in particular the rising median age. A largely New Zealand European nursing workforce caring for an ethnically diverse population of patients and their families and whānau has significant implications for both nurse recruitment and for advanced education. The increasing representation of overseas trained nurses in the

nursing workforce highlights the need to be educated on New Zealand and Māori culture, including the Treaty of Waitangi and cultural safety.

- There was a wide range of views on the topics, types of programmes and mode of delivery of educational courses. Overall it was agreed that a range of opportunities was needed, including postgraduate, graduate, continuing education and in-house, to meet the diversity of nurses' circumstances and preferences. There was also agreement that flexible learning, including technology-assisted learning, needed to be further developed.
- The success of decentralizing CTA funding to DHBs to administer, in addressing many previous barriers to postgraduate education, was widely confirmed. Despite the funding of release time, finding nurses to fill in remains a barrier.
- Many stakeholders confirmed the importance of general nurses, working in hospital, primary health and community settings where they are caring for patients with cancer and palliative care needs, also having the education needed to give them the skills and confidence needed to work with these patients. Increasingly, unregulated nurses such as health care assistants are also involved in patients' care and have educational needs.
- There is a need for the coherent development of career pathways for cancer and palliative care specialties, involving standards and competencies, the educational pathways to support specialty practice and the employment recognition of specialty practice.
- Arising from this, collaboration among the professional, employer and educational stakeholders was identified as of key importance, along with open engagement and improved understanding of each others' contributions and constraints.
- Some, but not all, stakeholders believed nursing leadership in both cancer and palliative care had suffered due to an emphasis on clinical competence and needed further development.
- There were different views on how to achieve improved nursing workforce data. Some were opposed to following the medically specialisation model as this could limit nursing workforce flexibility. Another perspective was that nursing practice categories, developed historically, had become incoherent over time and needed review. A suggestion is that Nursing Council workforce categories are reviewed and changed to

articulate with the Australia-New Zealand Classification of Occupations, as used by Statistics New Zealand and the Department of Labour in their labour surveys.

Gap Analysis

Findings from the survey of nurses in the four DHBs, interviews with nurse leaders in those four DHBs and consultations with national key informants were then examined in the light of international benchmarks on nursing workforce development and educational preparation of nurses based on the literature review. Caution is needed as differences between New Zealand society and its health system with those of other countries, even those fairly similar, mean that other countries' experiences and guidelines need to be adapted to New Zealand's environment.

Recommendations Arising from the Report

Arising out of the study and its findings, the following recommendations have been prepared by the Ministry of Health in consultation with the project steering group.

1. Competency frameworks are produced for each specialty, defining levels of nursing knowledge and skill to create a professional development pathway.
2. Educational requirements are outlined to support professional development within these competency frameworks for each specialty.
3. Collaboration between nursing leaders and educationalists (from DHBs, NGOs and education providers) aligns education programmes, from undergraduate to specialty post graduate, to support the professional development pathway.
4. DHB senior nursing management work with the Ministry of Health to develop strategies to address ongoing constraints (in particular release time) to nurses participating in specialty education.
5. Specialty education programmes are oriented to respond to the range of different needs of those working in the two specialties.

6. Nurses working in general clinical settings (ie not specialised cancer and palliative care services) have access to appropriate specialty educational opportunities (resources, courses and/or elements of specialist education programmes).
7. Different cultural needs of clients are addressed through appropriate cultural safety education for nurses in these specialties.
8. Leadership within each specialty is promoted through support for networking, education and national and international collaboration.
9. A strategic approach to specialty workforce nursing development, based on skill mix requirements, is adopted by the DHBs, Ministry of Health and NGOs.
10. Specialty nursing workforce data is improved by the relevant agencies to enable better forecasting.