This survey was commissioned by the SHPCA. The items on the survey were adapted from a previous provincial evaluation conducted by Sakundiak (2004) and from documents from the Canadian Hospice and Palliative Care Association, the Centre to Advance Palliative Care in the U.S. and the Victoria Palliative Care Group in Australia.

These data were collected during the provincial conference held on June 2nd and 3rd, 2011 and are based on information from 60 respondents. Response categories were collapsed into agree and disagree. The survey was not a representative sampling of providers from across the province and represents only the persons attending the conference who chose to complete the survey. Nonetheless, the following document highlights perceived gaps in palliative care service that could potentially be addressed through SHPCA education and policy initiatives as well as through health region support.

The majority of respondents felt pain and other symptoms were generally well managed within their health region, although timeliness of pain management seemed to be problematic for more than one quarter of respondents.

Psychosocial support in general was poorly rated overall. Only 48% of respondents felt there was adequate support for patients and families. Almost 70% of respondents reported inadequate levels of psychosocial support for staff. Just over one third of respondents disagreed that spiritual, cultural and ethical values of patients and families were respected, suggesting additional work is needed in these areas.

In terms of programs, several critical issues were flagged. Over 60% of respondents responded that patients and families did not have 24/7 access to palliative care services and an equal proportion indicated that respite services were inadequate to meet the needs of the patients and families they served.

Approximately 60% of respondents agreed there was open and timely communication between providers and patients, while 54% reported open and timely communication between providers. Opportunities to improve communication exist within both of these domains.

Pharmacy support appeared to be available in most settings.
Opportunities for enhancing palliative care teams were evident in the responses. Sixty per cent of respondents indicated that volunteers played appropriate roles in their programs. Just over half of respondents reported access to an ethics consultation service, which provides key support in dealing with difficult end of life issues. A palliative care consultation team was available to 70% of respondents, suggesting that many providers do not have access to consultation services.

In terms of education, 60% reported adequate access to palliative care education for providers, while only 40% believed there was adequate education for patients and families.

Finally, in terms of quality improvement initiatives, less than half of the respondents indicated they were familiar with quality indicators for palliative care in their own programs and a similar proportion felt they had no input into the use of these indicators.

In summary, there are significant gaps in the quality of palliative care services reported by providers across the province of Saskatchewan. Most notably, there is inadequate psychosocial support for providers, a lack of 24/7 access to palliative care services for patients and families and inadequate access to respite services. Access to ethics consultation services is not widely available. Education opportunities for providers, but most critically for patients and families, are lacking and represent a deficit in palliative care service. There is significant potential to improve palliative care within Saskatchewan through a concerted effort to address the deficits highlighted in this report.

**Quick Stats on Respondents**

**Age**
- 7% were 18-30 years old
- 38% were 31-50 years old.
- 53% were over 50 years old.

**Sex**
- 5% were male.
- 92% were female.
- 3% did not report.

**Employment**
- 52% are employed as Registered Nurses
- 15% are employed as Licensed Practical Nurses
7% are employed as Health Care aids
3% are employed as Physicians
2% are employed as Social Workers
2% are employed as Pharmacists
20% described themselves as Other.

Type of Health Region
- 47% work in a Rural Health Region
- 47% work in a Urban Health Region
- 3% work in a Northern Health Region
- 3% did not report

Number of Years of Experience in Palliative Care
- 54% have more than 15 years experience
- 20% have 5-10 years experience
- 17% have 2-5 years experience
- 5% have less than 2 years experience
- 4% have 11-15 years experience
- 2% did not report
Figure 1. Responses to Survey Items: Perceived Quality of Pain and Symptom Management

Symptoms

- Pain is Effectively Managed
- Pain is managed in a timely manner
- Other symptoms are effectively managed.
- Other symptoms are managed in a timely manner.
Urban vs. Rural

Figure. Responses to Survey Items: Perceived Quality of Psychosocial Support

Psychosocial Support
The spiritual, cultural and ethical values of patients and families are respected and incorporated into care by all team members.

Psychosocial support is provided at an adequate level for patients and families.

Psychosocial support is provided at an adequate level for palliative care staff.

Grief and bereavement counseling is available at no cost to families.

Urban vs. Rural

There are written protocols related to palliative care to which I can refer.

Patients have equitable access to palliative care services, including medications, respite care, transportation and equipment.

There is 24/7 patient and family access to programs and services (for advice, intake, referral, coordination and consultation).

Respite services are adequate to meet families' needs.

Alternative sites for dying and respite care are available (e.g. hospital, home, long-term care).

Program
There are written protocols related to palliative care to which I can refer. 

Patients have equitable access to palliative care services, including medications, respite care, transportation and equipment.

There is 24/7 patient and family access to programs and services (for advice, intake, referral, coordination and consultation).

Respite services are adequate to meet families’ needs.

Alternate sites for dying and respite care are available (e.g. hospital, home, long-term care).

There is open and timely communication between formal providers (e.g. physicians, staff).

There is open and timely communication between formal providers and patients/families.

Urban vs. Rural

Urban
Other

Agree
Disagree
Urban vs. Rural

Appropriate Pharmacy Support

There is open and timely communication between formal providers (e.g. physicians, staff).

There is open and timely communication between formal providers and patients/families.

I have access to appropriate pharmacy support

Patients have access to the medications they require.
I have access to appropriate pharmacy support.

Patients have access to the medications they require.

Volunteers play an appropriate role in our program.

A well informed interdisciplinary palliative care team is available for consultation.

An ethics consultation service is available to help me deal with challenging issues.

Role of the Team
Urban vs. Rural

Volunteers play an important role in our program.

A well-informed interdisciplinary palliative care team is available for consultation.

An Ethics Consultation service is available to help me deal with challenging issues.

There is access to ongoing education related to palliative care for all formal care providers, including nurses, physicians, social workers and auxiliary staff.

There is adequate education related to issues at the end of life for family members.
Urban vs. Rural

There is access to ongoing education related to palliative care for all formal care providers, including nurses, physicians, social workers, and auxiliary staff.

There is adequate education related to issues at the end of life for family members.

There are regional standards for end of life decisions and directives.

I am familiar with the quality improvement indicators used to monitor palliative care services within my health region.

I have input into the quality improvement indicators used to monitor palliative care services within my health region.

Quality Improvement
There are regional standards for end of life decisions and directives.

I am familiar with the quality improvement indicators used to monitor palliative care services within my health region.

I have input into the quality improvement indicators used to monitor palliative care services within my health region.