

Courage, heart and brain

by Carole Beals and Lynne Penton

When we accepted the Schering Lectureship, we looked at the conference title and reflected upon the experiences we had during the development, implementation and dissemination of a regional preprinted order set for palliative patients. We recognized that we had certainly used our hearts, minds and voices. However, along with these, for us, a nursing driven practice change also required an element of courage.

This paper will incorporate the core elements of courage, heart and brain, linked to the conceptual framework of enabling evidence-based practice developed by Alison Kitson and colleagues (Kitson, McCormack, & Harvey, 1998). As we travel “somewhere over the rainbow,” otherwise known as North Simcoe Muskoka and describe our pilgrimage, come with us to find the Wonderful Wizard of Oz (Baum, 1939).

Creating the unrest

Our story began during an open forum on current issues at a Canadian Association of Nurses in Oncology (CANO) chapter meeting where the first stirrings of discontent emerged as a theme. Nurses from numerous organizations and different practice roles expressed a unified message of frustration and distress at the fragmented and

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This paper is dedicated to Brenda Smith (1954–2008), Director of the North Simcoe Muskoka Palliative Care Network. Valued and respected friend and colleague who walked the walk and is sadly missed.

inconsistent symptom management they sometimes witnessed in the care of patients with incurable cancer. It became apparent that those with authority to prescribe effective treatment were not always doing so. Nurses felt powerless and disheartened at the lack of knowledge and evidence-based care. One potential solution to this need was to develop a preprinted set of admission orders that would address each component of palliative symptom management, encourage interdisciplinary practice, prompt efficient and timely access to nurses and to the medical interventions that patients needed, and support consistent practice across the region. How could we, two nurses without authority and with minimal influence, change the care for our patients in an entire region? Did we have the personal attributes, the tenacity of spirit and the courage to enter unfamiliar territory?

Setting the scene

In 2004, the Ontario Government announced its intent to support the development of a comprehensive provincial end-of-life strategy (Cancer Care Ontario [CCO], 2006). Included in the focus were improving access, coordination, consistency of services and supports across the province. In November of the same year CCO published the Ontario Cancer Plan, they outlined a comprehensive document to address gaps in cancer care delivery across the province. They also identified the need for a greater strategic direction to improve the quality of palliative care for patients. Embedded in the steps to achieve this vision was the need for timely and appropriate symptom management and to increase the use of evidence by developing, implementing and disseminating evidence-based guidelines and standards.

CCO includes in the mandate for Regional Cancer Programs a responsibility to bring care providers and community members within a region together to create solutions to local cancer issues. It is important regionally to maximize the opportunities afforded by these provincial initiatives (Cancer Care Ontario [CCO], 2004).

In August 2006, CANO published the Practice Standards and Competencies for the Specialized Oncology Nurse. The language of the third practice domain includes “the ability to successfully manage and understand the treatment of cancer symptoms and side effects of therapies” (Canadian Association of Nurses in Oncology [CANO], 2006). Understanding the disease process, disease progression, prognosis, and clinical presentation demonstrates that the competency has been met. We hoped that this work would support nursing to enact this competency.

In March 2006, the Ontario Government implemented a new model for health care delivery. Fourteen “not for profit” corporations were formed designed to work with local health care providers and community members to determine health priorities of the region. These 14 corporations are known as Local Health Integration Networks (LHINs). The new regional model was implemented to address the fragmentation of health care services. The mandate of the LHINs is to plan, integrate and fund regionally (North Simcoe Muskoka Local Health (LHIN 12) Integration Network [NSMLHIN], 2006). Impressively, the LHINs oversee almost two-thirds of the province’s health care budget of \$37.9 billion. During the development of the LHIN, community focus groups were held to identify key strategic initiatives in LHIN 12. Improving access to palliative care across the region was identified as a priority. In the last several years, there has been an informal network of palliative care providers who have successfully undertaken initiatives such as bringing symptom relief kits into the home. Also, there are proposals underway for the creation of 24/7 palliative care consult teams. The development of the

Palliative Care Network in North Simcoe/Muskoka and the projected opening of the new regional cancer centre in 2011 will provide greater access to services for all cancer patients.

Challenges facing the region

In July 2006, the LHIN 12 population profile indicated that the annual population growth for the region almost doubled over the past 10 years, as compared to the annual provincial growth rate. In the last 10 years, the cumulative population growth in Barrie was 66%, 97% in Wasaga Beach, and 40% on the First Nation Reserve. The population in many of the Muskoka municipalities is estimated to increase by 50% during each tourist season (North Simcoe Muskoka Local Health Integration Network [NSMLHIN], 2006).

LHIN 12 encompasses a large geographical area, which means that cancer patients requiring palliative radiation for control of symptoms may have to travel up to three hours each way to access treatment.

There are currently no residential hospice beds in the region. In 2005, Health Minister Smitherman announced new operational funding for residential hospice services in Ontario. Hospice Simcoe has been targeted to receive this funding. A capital campaign is underway to raise the balance of the several million dollars required for the building of a 10-bed residential facility.

Caring for patients at the end of life requires both economic and human resources to care for patients in their own home. For many people, this can be an insurmountable challenge, as they are not financially able to take an unpaid leave from work. The government-funded benefits allow for six weeks of subsidized income. However, the question for families remains when is the last six weeks of life?

The Canadian Home Care Human Resources Study (Canadian Home Care Association, 2004) indicates that 65% of informal caregivers are under 50 years of age and 64% are currently employed. Within the LHINs, not only is there a shortage of physician resources, but also there is a shortage of allied health care professionals, other supportive care providers, and a critical shortage of all experienced nurses including specialized oncology nurses (<http://www.living-lessons.org/main/hospice.asp>).

Canadian Hospice Palliative Care Association 2006 states there “is a growing recognition that given a choice, most people would prefer to die at home or in a hospice” (Canadian Hospice Palliative Care Association [CHPCA], 2006). Only between 5% to 15% of Canadians have access to hospice palliative care services, 25% of palliative patients receive supportive care with physician house calls at the end of life, and 75% of deaths today take place in hospitals or long-term care facilities.

End of life issues in NSM... What we know

The most recent statistics available from CCO (2002–2003) demonstrate that LHIN 12 has one of the highest utilization rates in the province for emergency room (ER) visits at the end of life. The ER at Royal Victoria Hospital (RVH), Barrie is the busiest in the region and reports 73,000 patient visits annually. Orillia Soldiers Memorial Hospital (OSMH) reports in excess of 50,000 patient visits annually. The redirecting of ambulances in our region is not permitted.

The close proximity of cottage country and ski hills in our LHIN impacts the demands on our ER services. Consequently, palliative patients are managed in the same mix as acute trauma, urgent cardiac presentations, and minor injuries. Consistent with the trends in much of the province, physician house calls are becoming a way of the past. In LHIN 12, there is an acute shortage of family physicians (FP). In Barrie alone, there are 30,000 people without a FP (Barrie Advance, 2007). This results in palliative patients left with no alternative but to access the acute care hospital system when their symptom burden and functional status can no longer be managed at home.

The travellers join together

In LHIN 12, there are five hospital organizations: RVH (designated to open in 2011 as a Regional Cancer Centre), OSMH, the Muskoka Algonquin Health Care Services (this includes Huntsville, Bracebridge and Burk’s Falls Hospitals), Collingwood General and Marine Hospital, and North Simcoe Health Alliance (includes Huronia District and Penetanguishene General Hospitals). We don’t have an academic health science centre.

In LHIN 12 Palliative Care Network there are four standing committees. One of these is dedicated to issues related to patients and families. The chair of this committee was contacted by us and the idea of developing a LHIN-wide preprinted order set for palliative care was endorsed by them. An invitation was extended before the initial meeting to other disciplines to be involved, however, due to the extremely limited resources of the other allied health teams, we proceeded with nurses alone.

The concept of the creation of an evidence-based preprinted order set was favourably received by the other disciplines, as some of them, too, had expressed concern with the lack of consistency in the care of palliative patients. We hoped that a committee of nurses from all sectors, united in a common purpose, might have the leverage to influence practices that each of us could not accomplish alone. Included in this initial meeting were all hospitals and community agencies. It soon became apparent that the scope of our project was too ambitious to be accomplished with the current resources. So, with open discussion and group consensus we agreed to limit this work to in-patient palliative units. We fully acknowledge that much remained in other areas of practice.

Finding our way

Frameworks and theories provide direction for us when we attempt to use evidence to change practice. We can also look to our leaders in nursing research and learn from them successful strategies for implementation. We chose Kitson’s model for enabling evidence into practice (Kitson et al., 1998). We felt supported in this choice since esteemed Canadian nursing researchers including Carole Estabrooks and Greta Cummings have utilized Kitson’s theory in their own areas of interest (Cummings, Estabrooks, Midodzi, Wallin, & Hayduk, 2007). We found Kitson’s model relevant to practice because each core element was simply worded and clearly explained. We also found the notion of a continuum from low to high criteria created for a visual measure of our practice environment and a checklist for what we needed to accomplish in order to successfully implement the preprinted order set.

Furthermore, it was meaningful to our nursing experience to have affirmation that arming yourself with the best evidence was no guarantee that you can successfully accomplish practice change.

Evidence, context and facilitation

The Kitson theory teaches us that successful implementation of evidence into practice is the interplay of three core elements: 1. the level and nature of the evidence, 2. the context or environment into which the evidence is to be placed, and 3. the method or way in which the process is to be facilitated.

Evidence is defined by Kitson as a combination of research, clinical expertise and patient choice. Context is the forces at work that give the physical environment a character and feel. Facilitation is the technique by which one person makes things easier for others.

Kitson describes the highest level of evidence as randomized controlled trials, systematic reviews and evidence-based guidelines. The lowest level is anecdotal and descriptive information. Clinical expertise moves along the continuum from the low region of divided camps to the high levels of consensus and consistency of view. The area of patient preference continuum encompasses no involvement to high partnerships.

When there were no published guidelines to support our decision-making, we relied on anecdotal evidence that our nursing colleagues strongly felt had been effective in their practice experience. In the absence of high levels of evidence, clinical experience did not surface as a barrier during the development, we found all nurses were unanimous in their decisions. We did, however, encounter some divisions of opinion when we attempted to gain organizational approval. We were fully aware that not including patients in this process compromised our ability to address all aspects of Kitson's Model. We did not have the dedicated resources, the academic links, and the research expertise within our group to include palliative patients at the table.

Most of the organizations of LHIN 12 had attempted the development of an order set in the past incorporating different levels of expertise. Some had been initiated for many years without review or update. In one practice setting the order was more than six pages long and was never used. It had been designed to meet physician preference rather than evidence-based patient-centred care.

Current publications were reviewed including Victoria Hospice Medical Care of the Dying (Downing & Wainwright, 2006) and the Alberta Palliative Care Resource (Alberta Cancer Board, 2001). We also drew extensively on the work done by Kingston and Windsor in the Provincial Palliative Care Integrated Project (PPCIP) (CCO, 2006).

The symptom management guidelines linked to the project provided direction for evidence-based protocols for pain, breathlessness, nausea and vomiting, agitation, and bowel care. We used the symptom categories to frame our order sets. On the reverse side of the one-page order set we added an Equianalgesic Chart and further treatment suggestions to prompt further symptom management. We added a category for referral to all other members of the health care team to encourage more interdisciplinary practice.

It is important to note that we didn't conduct a complete systematic review of current publications, nor engage academia in the gathering of our evidence. We relied, rightly or wrongly, on previous quality work developed by others.

We drafted a template, reviewed it in our practice settings and reconvened to edit, edit and, finally, more edits. This concluded the work of the group whose job was now to take it back into their practice setting for approval and implementation. This group work proved to be the easiest part of the process. We had a motivated and committed working group, our common goal was clearly defined and we shared a unified purpose. The cohesiveness of the group surprised us and, as a consequence, we did not anticipate the challenges that were facing us. We expected the approval and implementation would go as smoothly.

Obstacles on the way

No matter what path you take, there are always unexpected twists and turns in the road. For us, it was the obstacles that were less obvious that proved to be the most difficult. Included in the obstacles that we encountered were: apathy, beliefs governing practice rather than evidence, lack of processes, lack of effective technology, and ineffective communication.

Kitson describes the core elements of context as culture, leadership and measurement. These components of context described by Kitson helped us to anticipate where the challenges lay and where the opportunities existed (McCormack, Kitson, Rycroft-Malone, Titchen, & Seers, 2002).

We are exploring the concept of context in this paper because it was the practice context that we struggled with the most when attempting to implement our practice change. Kitson says that it is necessary to capture the complexity of factors that enable effective practice. Developing this understanding using nursing research, some of it conducted in Canadian context, informed, enlightened, and clarified for us why we were having difficulties. This reflective learning process allowed us to comprehend the different components of practice environments and enabled us to take a structured approach to implementation.

Rapid population growth without parallel infrastructure development has impacted the context in which palliative patients are cared for in organizations in LHIN 12. There is some limited capacity to facilitate direct admission to hospital for palliative patients. The reality is in most areas nurses practise as generalists and not specialized. Therefore, patients cared for at home and in hospital do not have the benefit of specialized oncology nursing practice. At present, there is no residential hospice to support end-of-life care, and regionally we are without a formal palliative care team at the moment. Most palliative patient care relies heavily on the good will of already overburdened FPs if the patients are fortunate to be linked to an established practice. Many physicians have relinquished hospital privileges. Therefore, these admitted orphaned patients are managed by hospitalists who rotate on a weekly basis and few have palliative care expertise.

Each of the hospitals does attempt to admit palliative patients into the areas of the hospital where nurses have the most knowledge. In times of bed alert when ER departments are filled to capacity with admitted patients, philosophically, adult cancer palliative patients should receive the first available bed, but sometimes this is just not possible when there are competing priorities from other patients with equally pressing needs.

In both Barrie and Orillia, there are situations where admitted patients lie on stretchers in the ER department waiting for an available inpatient bed. There are many days when there is a gridlock in the ER department. On these days, a bed alert is initiated to alleviate the stress on the ER through the immediate transfer of admitted patients to the most appropriate acute care unit. As a consequence, at RVH up to two additional patients may be nursed in the hallway and nurses at OSMH nurse patients at ratios way above manageable limits. We hoped that the initiation of this order set in the ER department might facilitate earlier intervention, more appropriate care, and alleviate palliative patient suffering from inadequate or inappropriate symptom management. Kitson's exploration of the meaning of context helped us to comprehend that context is composed of culture, leadership, and measurement. It is the setting into which evidence is implemented. So, when Kitson is referring to culture it means organizational culture "the way things are done around here" (McCormack et al., 2002). We are all guilty of being complacent and not challenging the status quo. It requires energy, determination, and persistence to motivate and enable sustainable practice change. Sometimes it is just safer to stay in Kansas and not take on those obstacles. Kitson says the interplay and interdependence of many factors influence the uptake of evidence into practice. Gerrish et al., 2006, describe factors influencing the development of an evidence-based environment. They imply that much of the responsibility of evidence-based practice change has been placed squarely on the shoulders of individual practising nurses, although we fully acknowledge that all nurses have a professional responsibility to base their care on the best available evidence, implementing evidence-based practice in health care settings is a highly complex undertaking (Bryant-Lukosius & DiCenso, (2004).

Culture

Up until the development of the LHIN there was little incentive for hospitals to work in partnerships. Several hospital mergers had not resulted in a unified set of values and beliefs. One of the hospitals traditionally run by Catholic nuns was required to merge with a non-denominational community hospital that supported practices and conducted certain procedures that were not performed at the other institution. Three years ago, the Ministry of Health and Long-Term Care (MOHLTC) merged three smaller hospitals situated in the most northern part of the LHIN. Huntsville, Bracebridge and Burk's Fall were now required to function with one board of directors, one chief executive officer and one director of nursing. At the time, all three were duplicating surgical services and delivering babies. This amalgamation remains a work in progress.

We anticipated that we would meet greatest resistance in the organizations that had been previously forced to merge, because historically they had not embraced different ways of conducting business. However, what we found was that in small rural hospitals word spreads quickly and diploma-based nurses and FPs who have limited time and resources to dedicate to such a project were, in fact, appreciative to have access to a level of expertise that is not readily available to them. In the two larger hospitals, we encountered challenges in moving the process forward due to the number of committees that must be consulted before a practice change can be implemented. It became apparent that the process was lengthy and, at times, unclear and this impeded the process of the final approval.

Leadership

Ward and McCormack (2000) in a two-year research study found that the dominant organizational culture had a significant impact on the ability of nursing leaders to bring about changes in practice. Kitson identifies that leadership is in the nature of human relationships. Successful leadership gives rise to a clear understanding of each practice role, the ability to work in teams, useful decision-making process, and effective organizational structure. This remains a key facet of the framework for the enabling of the implementation of evidence into practice.

McCormack et al. (2002) have highlighted the importance of the leadership styles of senior clinical nurses in promoting a culture that is patient-centred, values members, and promotes a learning environment in supporting evidence-based care. It is important to note we had the full support of nursing leadership in all organizations in the LHIN. Despite this support, our challenge lay in gaining organizational approval in contexts where the approval bodies were either unfamiliar with the needs of palliative patients, didn't necessarily see the contribution of nurses as a highly valued entity, or within their own professional bodies had a competing agenda.

We were unpleasantly surprised to encounter overt resistance from the emergency room (ER) physician group, which was originally a supporter of the work. It became clear to us when we understood that in the time between the development and implementation of the order set, there had been a change in the mandate of the ER physician practice regarding the care of the admitted patient. The professional body of ER physicians had decided to revisit the admission orders that they were prepared to write. In hospitals where general practitioners admitted and managed their own patients, ER physicians were assuming the burden of responsibility for an increasing number of admitted patients even after they were transferred to the in-patient unit. Although they supported the concept in principle, in order for the approval process to proceed we had to recognize that even though best practice would dictate the earliest possible intervention of cancer symptoms, the orders would not be initiated by physicians in the ER department.

Cummings et al. (2007) ask the question, "Does the workplace influence the nurse's use of research?" They state that "research use does not happen in a vacuum without resources, without being sanctioned within the organizational culture, without being convenient, when multiple priorities face the practitioner and without having some perceived benefit" (p. 7).

Nursing leaders at the unit level can be critical in developing workplace environments where research use is expected and there is protected time to allow nurses the opportunity to participate in activities related to research use such as journal clubs and practice council. Benner et al. (1999) speak to the clinical aspect of leadership in the context of clinical wisdom. They include habits of thought and action, problem identification, and anticipating and preventing potential problems. The use of a preprinted order set should enhance patient care because it allows for clinical problem solving by addressing anticipated medical interventions needed to support effective symptom management.

Measurement

Kitson et al. (1998) say that measurement is the organizational approach to systems and services. Chart audits conducted on 40 in-patient charts in two hospitals pre-implementation showed that based on documentation, symptom control in palliative patients was inconsistently managed and poorly evaluated. We hoped that post-implementation of the preprinted order set each organization chart review would reflect a positive change in practice and staff would receive feedback on the results. We optimistically predicted that this would reflect in a better sense of well-being for our patients. As Aranda in 2006 reminds us, many of the issues that cause psychological suffering in patients are the endpoint of physical deterioration.

Facilitation

When it comes to the skills and attributes required of a facilitator, a wide repertoire of skills, processes, and strategies are needed, which they can draw on depending on the particular context and purpose. The trick is having the flexibility to recognize the requirements of any given situation and react accordingly. Kitson (1998) says facilitators make things easier by helping others achieve goals, encouraging others, and promoting action. They use interpersonal and group skills to achieve change. Facilitators have a key role in helping individuals and teams understand what they need to change and how they need to change in order to apply evidence into practice.

The research evidence suggests that the most effective implementation strategies are those that adopt a multifaceted approach combining numerous techniques. Facilitation includes a clear understanding of the facilitation process, an appropriate role to enable the process, and the right set of skills to achieve effective facilitation.

To be successful, we need to understand that each different discipline perceived a change in practice related to their particular viewpoint. We had many insightful conversations with our colleagues to determine how they might see a benefit in using an order set. We tailored our interactions with each of the disciplines identifying a particular aspect of their practice that would be positively impacted by using preprinted orders. We used our established relationships with individuals and teams to promote the value of the work. We leveraged the conversations with reference to the fact that this order set was developed using the best available evidence and was endorsed by committees and organizations from within the LHIN.

Conclusion

It is frustrating if you find you are having difficulties getting your message across, but we found that reading the literature, listening to colleagues, and drawing on past experiences helped us find our way. Using a model such as Kitson's helped us to understand that enabling an evidence-based practice change is possible for any practitioner. We learned that there is not one single variable that is the key to success. It requires developing an understanding of the complexities of the environment, the gathering of evidence and the personal attributes of individuals that all play a role.

Established regional cancer centres and academic settings may have the practice environment, the human and economic resources, and the culture to support an initiative such as ours. We recognize our endeavours may seem commonplace to others. We certainly had limited financial and human resources. We did, however, have a committed community of palliative care nurses. We saw a chance to improve patient care and we embraced it.

We now know that working together is more effective than working alone. If nurses believe strongly that a change needs to occur, then they can be successful in accomplishing it. We have used this partnership to continue other alliances and nursing supports throughout the LHIN. We are the co-chairs of the Simcoe Muskoka Chapter of CANO. As a result of creating nursing partnerships with our community palliative colleagues, we are now hosting joint chapter gatherings. Just as Dorothy et

al. discovered, finding a magical solution to a complex problem is simply grounded in common sense (Baum, 1939).

Coming together regionally was a new experience for us that benefited both the larger and smaller organizations. It enabled resources, expertise, and the development of the professional relationships necessary to create successful future collaborations. The vision of the group was to create a regional environment that values and supports the use of a current evidence-based practice approach and the continuous delivery of high-quality and cost-effective palliative care for patients in our region.

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