Dr. Patricia Coward: Remembering an exemplary nurse leader, colleague and friend
1948-2016

Dr. Patricia Coward may have left this world but her steadfast spirit, gentle patience, commitment to patients, nurses, and the health care system will always be remembered.

Pat was the inaugural Chair of the iPANEL Advisory Board. Graduating from nursing in 1968, she began her career in pediatrics, moved into management and executive leadership roles, holding VP and CEO positions, worked as a Dean and Director in post-secondary education, and in research at the Michael Smith Foundation for Health Research. As a trusted leader in these positions, she was a role model and mentor for many. But her love was parish nursing and along with that, palliative care. Rooted in a deep desire to be of service to others, Pat ended her career where it had begun – back at school, completing the Parish Nurse program after many years of executive leadership. It is what we always admired in Pat – her ability to sit at Boardroom tables and never lose sight of what her important work as a nurse was.

We miss you Pat and feel forever grateful for your presence in our lives, in our work, and for all that you gave to patients and families in the name of excellent nursing practice.

Kelli Stajduhar, RN, PhD, iPANEL Co-Lead
Christine Penney, RN, PhD, iPANEL Advisory Board

iPANEL RESEARCH TEAM
LEAD-INVESTIGATORS
Kelli I. Stajduhar
University of Victoria
Carolyn M. Tayler
BC Centre for Palliative Care

CO-INVESTIGATORS
Richard (Rick) Sawatzky
Trinity Western University
Barbara McLeod
Fraser Health Authority
Pat Porterfield
University of British Columbia
Barbara (Barb) Pesut
UBC Okanagan
Elisabeth Antifeau
Interior Health Authority
Gweneth Hartrick Doane
University of Victoria
Jill Gerke
Island Health Authority
Kara Schick Makaroff
University of Alberta
Ella Garland
Providence Health Care

COLLABORATOR
BC Ministry of Health

STAFF
Ami Bitschy
Project Coordinator

WWW.iPANEL.CA
Self-care begins with Self-awareness

While I know that self-care is essential, I believe that self-awareness is necessary before one can embark on self-care. Through my experience of providing retreats for professional caregivers wanting to avoid caring fatigue/burnout, I have discovered several self-awareness practices that are helpful for improving self-awareness in health-care providers. A pediatric palliative care physician, Dr Gerri Frager, shared in an editorial letter to her colleagues that “reflective practice and self-care should be something that is part of one’s ongoing routine, similar to keeping up to date with attending conferences and reading journals.” Moreover, organizations and institutions recognize the mounting research about the importance of self-care to protect against burnout (emotional exhaustion, depersonalization, sense of low personal accomplishment). Self-awareness practices are learnable skills that set the practitioner up to know what is going on within and then change his/her actions accordingly.

Meditation and mindfulness

Though not everyone will engage in a daily practice of meditation, it has been shown to have enormous benefits including bringing emotional balance to the practitioner. Thich Nhat Hanh reminds us that “to meditate means to go home to yourself. Then you know how to take care of the things that are happening inside you, and you know how to take care of the things that happen around you”. Regardless of daily practice or a deep connection to meditation, however, few would argue that mindfulness as described by Jon Kabat-Zinn as a means “to pay attention in a particular way; on purpose, in the present moment, and nonjudgmentally” could be harmful. In fact, as care providers in stressful, emotionally charged and complex relational systems, we can only benefit from making space to not only care for others, but care for ourselves.

STOP Practice

A practice that I try and implement several times a day, especially when I am feeling particularly overwhelmed, triggered or stressed by a specific work (or family) circumstance is to STOP. This practice takes only a few minutes and again the intention is to “make space” and to reconnect mind to body. S—Stop. Pause, open, and reflect on what is going on in your mind and body. T—Take a breath. I am often surprised that I haven’t really been breathing and that simple but complex act relaxes muscles and clears the mind. O—Observe. What am I thinking, judging, reacting to? What is that feeling, thought, or decision I believe is ‘right’. Take another breath and label the thought or feeling or judgement and notice by doing this the attachment to it is lessened and self-compassion or compassion for other can be expanded (hopefully). P—Proceed. Proceed can mean so many things. It might mean doing what you intended in the first place. It might mean asking for help, expanding the agenda, or even doing nothing.
Reconnect

The STOP technique is a way to reconnect with self, often in a silent way that others can’t see. Health care settings also have an obligation to their staff to create cultures of self-care and team-care that enables them to have awareness practices. At my place of work, there are both regular opportunities as well as ‘as needed’ connections. For example, checking in with the team prior to a start of shift or a family team meeting, are practices that are embedded in everyday care. These opportunities are based on listening non-judgmentally and compassionately to ourselves and others and allowing for reflection about the suffering or the accomplishments we experience. Any staff member can call for a ‘reconnect’ at any time. It only takes minutes to assemble and typically less than 30 minutes to conduct. It seems that with each of these, staff members leave feeling supported and heard, with a set plan that ultimately better serves the patient and family.

Self-assessment

Many writers have spoken about the wounded caregiver and that our woundedness actually draws us to the work and impacts our practice (Frank, 1995). It can be used to build compassion but can also, if not recognized, be harmful to our patients (Kuhl, 2003). So just as we assess our patients and families for their own physical, emotional, social and spiritual challenges and gifts and create a plan of care, we too have an obligation to examine our own whole person. Through reflective practice (journaling, retreats, mindful walking or sitting, talking with friends – to name a few) we will learn about ourselves and know what to do and what not to do to care for ourselves. It may be yoga, meditation, vacations, or time with friends……but it may not. Assess, experiment with different techniques, and reassess to determine what you really need to do to care for yourself and realize that it may change over time.

—Camara van Breeman

PUBLICATIONS


A Scoping Review on Palliative Care and Health Promotion

As part of my work with iPANEL, and as my culminating project for my Master of Public Health program, I completed a scoping review on palliative care and health promotion, with the goal to find information relevant to a palliative approach. I conducted a systematic literature review, and then thematically analyzed the articles I found. Four key themes emerged:

1. Health promotion over the life course: It is important to promote health and well-being throughout life, even in the presence of a serious illness. This concept extends right to the end of life and to the idea of promoting a good death.

2. Universal, social experiences: Interpersonal social support is vital, particularly during serious illness and bereavement. People spend most of their time in their communities, therefore workplaces, businesses and community gathering places should be sources of support.

3. Sharing information and working together: Health care service providers and community organizations can work together to empower citizens to participate more fully in health care. Building a public dialogue around serious illness and death can normalize these experiences, reduce stigma and increase support.

4. Reorientation of health care services: Population aging, increasing chronic disease prevalence and fiscal restraint all necessitate changes to the way health care services are offered.

Taking a public health perspective, these articles argue for community capacity building and meaningful collaboration between health care providers and the communities and individuals they serve.

These findings are relevant to a palliative approach in several ways. A palliative approach may be akin to the health promotion concept of tertiary prevention, which aims to intervene early in an illness to improve quality of life and prevent avoidable suffering. Both concepts advocate for an integrated approach so that support is available in different settings, wherever people spend their time and receive care. Additionally, providing support is not just the responsibility of health care specialists. Communities become supportive by raising awareness and creating a dialogue around serious illness and death. Within the health care system, a palliative approach means that care providers in all settings are equipped to give care that is timely and appropriate to each person’s situation. Education and capacity-building are required in both of these contexts to ensure that people suffering from serious illness can receive support wherever they spend their time.

FOUR THINGS YOU SHOULD KNOW ABOUT iPANEL

1. Three quarters of the British Columbians who die, do so without being identified as people who could benefit from the services associated with palliative care.

2. Through research we create new knowledge about how nurses can further integrate palliative philosophies and services into non-specialized settings which provide end-of-life care.

3. Our research is informed by and informs clinical practice.

4. Our ultimate goal is to advance the further integration of the palliative approach into every care setting.