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Examining the Importance of Advance Care Planning and Therapy Supervision Models within a
Cancer Centre.

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Abstract

This advanced practicum document reviews my experience with the Supportive Care Program (SCP) at the Northeast Cancer Centre (NECC) in Sudbury, Ontario. This practicum provided both project work and clinical opportunities. The project work consisted of two advance care planning projects: an environmental scan of cancer centres across Ontario and a chart audit that was specific to the NECC. These projects demonstrate the need for standardizing the process of advance care planning (ACP), as both projects demonstrated inconsistencies of current advance care planning standards within healthcare settings. An overview of current literature demonstrates the importance of incorporating ACP into every day healthcare conversations, as it can help promote patient care. In addition to the ACP projects, I also worked in collaboration with the social workers of the Supportive Care Program to create a new therapy supervision model. This model incorporated practices of reflectivity and debriefing, promoting supportive supervision. Through a combination of the literature as well as discussions with the social workers, together we were able to determine how supportive supervision would not only benefit the social workers but would also aid in patient service. This document also explores my shadowing and clinical experiences. Reviewing my work within a multidisciplinary team, I demonstrate how this work model added to my clinical experience, while aiding in patient care. This document also discusses the professional and personal growth that I gained through working with persons with cancer and their family's, through reviewing my reflection of my experience.

L'abstrait

Ce document de stage avancé passe en revue mon expérience avec le programme de soins de soutien (SCP) au nord-est du Centre du Cancer (CCEN), Sudbury, Ontario. Ce stage a fourni à la fois du travail de projet et des possibilités cliniques. Le travail de projet était composé de deux projets de planification de soins avancés : une analyse environnementale des centres du cancer à travers l'Ontario et une vérification des dossiers spécifiques au CCEN. Ces projets démontrent la nécessité de normaliser le processus de planification avancée des soins (ACP), car les deux projets ont démontré l'incohérence des normes actuelles de planification des soins avancés dans les milieux de soins de santé. Un aperçu de la documentation actuelle démontre l'importance d'intégrer l'ACP dans les conversations quotidiennes des soins de santé, car cela peut aider à promouvoir les soins aux patients. En plus des projets ACP, j'ai aussi travaillé en collaboration avec les travailleurs sociaux du programme de soins de soutien afin de créer un nouveau modèle de supervision thérapeutique. Ce modèle a intégré des pratiques de réflexion et de débriefage, tout en promouvant la supervision de soutien. Grâce à une combinaison de la documentation ainsi que les discussions avec les travailleurs sociaux, ensemble, nous avons pu déterminer comment la supervision de soutien profiterait, non seulement aux travailleurs sociaux, mais elle aiderait également le service aux patients. Ce document explore également mes observations et mes expériences cliniques. En examinant mon travail au sein d'une équipe multidisciplinaire, je démontre comment ce travail modèle a ajouté à mon expérience clinique, tout en aidant les soins aux patients. Ce document traite également à la croissance professionnelle et personnelle que j'ai acquise en travaillant avec des personnes atteintes de cancer et leur famille, en examinant le reflet de mon expérience.

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Chapter 1: Introduction

There are many variations of cancer. The most common types are lung, breast, colorectal, and prostate (Canadian Cancer Society, 2011). These forms of cancer account for over half of all new diagnosed cases of cancer in Canada (Canadian Cancer Society, 2011). No two cancers are the same; even cancers of the same disease site vary in stages and treatment modalities (Canadian Cancer Society, 2016). The three main cancer treatments are surgery, radiation therapy, and chemotherapy. Other types of treatments include hormonal therapy, biological therapy, and stem cell transplant (Canadian Cancer Society, 2016). Similarly, no patient experiences the exact same side effects even with the same treatment regime (Canadian Cancer Society, 2016). There are different physical symptoms that a patient may experience such as fatigue, nausea, pain, skin irritation, constipation, etc. (Canadian Cancer Society, 2016). Patients may experience a combination of these symptoms, all of the symptoms, or none at all. It is a very individualized disease that effects each patient differently.

Cancer can also cause emotional and psychological symptoms which include shock/disbelief, uncertainty, guilt, sadness, anxiety, depression, anger/frustration, feelings of isolation, and helplessness (Cancer Treatment Centers of America, 2016). To cope with the emotional and psychological symptoms, it is suggested that cancer patients participate in counselling, support groups, education sessions, and practice relaxation and meditation techniques (National Cancer Institute, 2016). Caregivers and family members of cancer patients can also experience emotional and physical symptoms (Canadian Cancer Society, 2016). It is suggested that caregivers should also receiving counselling, join a support group, ask friends and family for help, and to not be afraid to express their feelings (Canadian Cancer Society, 2016).

Cancer care and cancer treatment(s) can also cause stress in terms of financial burdens. This can stem from medication costs, travel expenses, and a decrease in pay from work (Canadian Cancer Society, 2016). Not all patients will have a benefit plan that will cover their cancer related expenses. People with cancer can go into debt, or depend on government-funded programs for which not all patients will qualify. Unfortunately, this leaves some patients having to choose between paying for their cancer-related costs or paying for things such as their mortgage and/or hydro, which can be a large challenge for patients and their families, as many organizations can only provide short-term financial assistance.

In this Introduction, I will first explain the rationale behind my practicum, exploring why I chose to complete my practicum at the Northeast Cancer Centre (NECC). I will then introduce the programs and services offered within the Northeast Cancer Centre specifically focusing on the Supportive Care Program. This will lead into a discussion of the biopsychosocial model and how the NECC follows this model to provide the best patient care. I will conclude this chapter by introducing the goals of this practicum report, which includes (1) standardizing the process of advance care planning in the healthcare setting, (2) promoting supportive supervision for social workers, (3) reviewing the importance of multidisciplinary teams in cancer care, and (4) examining the practice of reflexivity in my social work practice.

Rationale Behind Practicum

Completing the Master of Social Work (MSW) program at Laurentian University, Sudbury, Ontario, provided me with two options: I could complete an advanced practicum or a research thesis. I decided that the completion of an advanced practicum would be the most beneficial for me. Entering the undergraduate BSW program from high school and returning to

complete my MSW two years after, I did not have the opportunity to gain a lot of clinical experience. I knew it would be important to gain more clinical experience as it is a requirement for many social worker positions. Through choosing an advanced practicum, I would provide myself an opportunity to gain further experience which would be necessary as I enter the social work field.

When deciding where to complete my MSW advanced practicum, I had two influential people that directed me towards the NECC. The first influential person was back in my second year of my undergraduate degree, where my professor, Traci Franklin, discussed her work at the cancer centre. Her work sounded very empowering and rewarding and I immediately thought that I would enjoy working with cancer patients and their families. Fast forward five years and my second influential person emerged, my mom. My mom was diagnosed with Hodgkins Lymphoma in October, 2014. During the months of December and January, I moved home to be with her and to support her in anyway I could. Through taking her to appointments, I became more familiar with cancer and the effects that it can cause from physical pain to emotional distress. During this time, I was also working on my MSW application to Laurentian University. In my application, I was asked to write about where I would like to complete the advanced practicum, and the answer became quite clear.

Witnessing my mom on her cancer journey was similar to a roller coaster ride; it was full of ups and downs. I saw her go through bi-weekly rounds of chemotherapy for six months and celebrated with her when she was deemed 'cancer free'. Sadly, the cancer returned only one month later and she had to undergo a new chemotherapy regime. Then, for a chance of remission, she had to complete a stem-cell transplant. All of these events encouraged me to

pursue a practicum with the cancer centre, and although my mom was not treated at the NECC, I viewed it as my way to give back. Her oncologist was wonderful; her nurses were amazing; and the entire staff was very supportive. I wanted to be this support for other families who were experiencing the same obstacles. I saw it as my way of saying thank you, as I know how hard all staff and volunteers work each and every day, and the passion they bring to their work and to their patients.

I felt very fortunate when Dr. Leigh MacEwan connected me to Dr. Carole Mayer who is the Director of Research and Regional Psychosocial Oncology Lead of the Supportive Care Program (SCP) at the Northeast Cancer Centre. I was able to meet with Dr. Mayer on two occasions to discuss what an MSW practicum would consist of within the SCP. These discussions led to the opportunity to complete my advanced practicum within the SCP. Completing my advanced practicum with the SCP allowed me to complete both project and clinical work which broadened my learning experience.

Introduction to the Northeast Cancer Centre and the Supportive Care Program

The Northeast Cancer Centre is the central hub of the North, where patients travel from districts of Algoma, Nipissing, Cochrane, Kenora, Manitoulin, Parry Sound, Rainy River, Timmins, Timiskaming, and Thunder Bay to receive treatment, attend appointments, participate in clinical trials, etc. (NECC, 2016). NECC includes services such as dental oncology, palliative care, radiation treatment, surgical oncology, systemic therapy, and supportive care services (NECC, 2016). Although I had the opportunity to shadow many areas in the NECC, my practicum was centred within the Supportive Care Program. The purpose of the SCP is to help patients and their family cope with psychological, emotional, social, spiritual, physical, and day-

to-day care (NECC, 2016). This is done through a multidisciplinary approach as the SCP hosts social workers, dietitians, physiotherapists, speech language pathologists, an Aboriginal navigator, a psychologist, an Aboriginal coordinator, and a medicine lodge keeper.

Beyond the clinical services offered by the SCP team, there are also other services that focus on research and communication. The Supportive Care Oncology Research Unit completes research on various topics that affect the quality of life of cancer patients and their family (NECC, 2016). The research that is conducted by this department includes the development and testing of psychosocial and psychoeducational interventions, description of patients' issues and experiences, quality of life assessment, effective and efficient use of health care resources, and evaluation of various oncology programs (NECC, 2016). The results of these studies can help with service delivery by teaching service providers more about social, physical, psychological, informational, and spiritual needs of cancer patients and their families (NECC, 2016). There is also a Supportive Care Oncology Network (SCON). This network helps communities in Northeastern Ontario provide support and services to patients and families who are going through cancer (NECC, 2016). This can include resources for caregivers, regional/provincial news, health care webinars, along with a variety of additional information. Through research and networking, greater service and care can be provided to staff, patients, and families.

NECC and Biopsychosocial Services

To aid in all areas of patient care, NECC follows a biopsychosocial model. This model founded by Engel (1978), focuses on three levels, biological, psychological, and social, and all areas must be considered in every health care decision. This model is a comprehensive way of reaching patients in all areas of the disease by effectively helping patients with psychosocial

interventions along with medical assistance (Novy & Aigner, 2014). In a study completed by Novy and Aigner (2014), they found that greater depression, anxiety, distress, and a lower quality of life were related to more intense physical pain in cancer patients. A biopsychosocial model helps to provide preventive measures which could assist with pain management and other side effects. It has been proposed that the biopsychosocial practice stands on seven pillars “ (1) self-awareness; (2) active cultivation of trust; (3) an emotional style characterized by empathic curiosity; (4) self-calibration as a way to reduce bias; (5) educating the emotions to assist with diagnosis and forming therapeutic relationships; (6) using informed intuition; and (7) communicating clinical evidence to foster dialogue, not just the mechanical application of protocol” (Borell-Carrio, Suchman, & Epstein, 2004, p. 576). All of these areas are critical in creating a proper biopsychosocial model, as they promote communication and education with the patients. At NECC, where the biopsychosocial model is followed, many disciplines work closely to ensure the best patient care.

Goals of the Advanced Practicum Report

I will highlight the four main goals of my advanced practicum report which will be discussed in detail in later chapters. This includes standardizing the process of advance care planning within the healthcare setting, recognizing the importance of supportive supervision in social work practice, the importance of the multidisciplinary teamwork, and practicing reflexivity in all areas of social work. Together these four areas, helped me to learn and grow in my advanced practicum.

My first goal in this document is to promote advance care planning (ACP) and goals of care discussions (GOCD). This was an area of health care that I was unfamiliar with before

beginning my practicum at the NECC. ACP/GOCD are not standardized processes within most healthcare settings. The second goal of this report is to discuss the importance of supervision in social work. This report will discuss different supervision models and why they are necessary in the social work field. Supportive supervision is very important as it can prevent burnout, encourage better relationships among staff, and more effective practice (Bogo & McKnight, 2005). An important goal for me was to collaboratively develop a model of supervision that would benefit the SCP social workers. The third goal of this report is to demonstrate the importance of multidisciplinary teams in cancer care. Through research, shadowing, and case consultation, it became apparent that multiple disciplines are required to provide the best care for cancer patients. The combination of oncologists, nurses, social workers, dietitians, and various other professionals such as physiotherapists, speech language pathologists, and administrative staff are required to provide care in all areas of the patient's healthcare. Without referring or relying on other services, patients may not receive the care that is required. The importance of this team model was apparent in all areas of my practicum, particularly in advance care planning, as it can take the help of many professionals to implement the ACP process.

Practicing reflexivity and reflectivity were necessary in all areas of my practicum process which is why I consider this practice to be the fourth and final goal of my practicum report. I had to practice reflexivity in my research and project work to ensure that I was not influencing the final product by focusing solely on my opinions. This was a very good learning tool as it helped me develop how I completed research and how it is implemented into practice. Reflectivity was important in my clinical work through ensuring that my feelings and emotions were not influencing how I was handling my case work. Without the use of reflexivity and reflectivity, I

do not think I would have been successful in fulfilling other areas of my practicum, as this practice allowed me to successfully complete my goals with greater confidence and skill. This is also an area of practice that will continue to develop and benefit me as I move forward in my career.

This report will also discuss all the opportunities I was given during my 12 weeks with the Supportive Care Team. I will explore the shadowing and clinical opportunities I was given, which includes work with various disciplines. I will also describe the project work I completed through discussing my advance care planning projects and the therapy supervision project. The next chapter of my report will consist of a literature review that will explore cancer care, advance care planning/goals of care discussions, supervision, and multidisciplinary team work.

Chapter 2 – Literature Review

This literature review will be focused on three main areas of cancer care. The first section will provide an overview of cancer care. There will be a discussion of advance care planning (ACP) and goals of care (GOCD), with specific attention on persons with cancer. Next will be a summary of supervision in social work, with particular concentration on peer supervision models and quality assurance measures. Finally, there will be a discussion on working with a multidisciplinary team.

Multidisciplinary databases were used to gather information for this review including social work and social service work databases from Laurentian University and Health Sciences North. The key words that were used included supervision, advance care planning, peer work, palliative care, oncology, and social work.

An Overview of Cancer Care

According to the Canadian Cancer Society the most common types of cancer are lung, breast, colorectal, and prostate (Canadian Cancer Society, 2011). These forms of cancer account for over half of all new diagnosed cases of cancer (Canadian Cancer Society, 2011). The three main cancer treatments are surgery, radiation therapy, and chemotherapy (Canadian Cancer

Society, 2016). Other types of treatments include hormonal therapy, biological therapy, and stem cell transplant (Canadian Cancer Society, 2016). Within each of these core treatments there are specialized and individualized treatments. Within chemotherapy there are many combinations that are created to best suit a patient's diagnosis (Canadian Cancer Society, 2016). These are often difficult steps for people who have been diagnosed with cancer as many experience side effects (Canadian Cancer Society, 2016). Chemotherapy can cause issues such as loss of hearing, difficulty remembering detailed information, as well as loss of appetite, nausea, and issues with sleeping (Canadian Cancer Society, 2016). Cancer care treatment can also cause financial burdens because of medication, hospital trips, and a decrease in pay from work (Canadian Cancer Society, 2016). According to Cancer Care Ontario, one in four Ontarians will die from cancer. It is predicted that 29,167 Ontarians will die from cancer in 2016 (North East

Quick Statistics: 2016 (projected) data	
Total Population	
North East:	563,436
Ontario:	13,948,757
Percentage of population over 50	
North East:	45%
Ontario:	38%
Projected new cancer cases	

North East:	4,498
Ontario:	85,616
Projected number of deaths	
North East:	1,743
Ontario:	29,167

LHIN, 2016).

Table 1. *Projected North East Cancer Statistics for 2016*

Table 1

Note: According to Table 1, 5.2 % of Ontario's new cancer cases will be diagnosed in the Northeast. Furthermore, when examining the mortality rates, the Northeast will account for 6% of cancer related deaths in Ontario. These numbers may not seem significant, however, with Northeastern Ontario only making up for 4% of Ontario's population, these numbers are quite substantial (North East LHIN, 2016).

Advance Care Planning and Goals of Care Discussions

Advance care planning (ACP) provides patients with an opportunity to consider, discuss, and plan their future with healthcare professionals (Barnes et al., 2011). However, the process of ACP is quite different in the United States than it is in Canada. There will be ACP information provided on both countries in order to address any myths as ACP practices in Canada are often very misunderstood due to the practices that are completed in the USA (Hospice Palliative Care Ontario, 2016). It is important to recognize these differences to ensure that healthcare providers, patients, and families are performing and/or receiving ACP best practices that are in line with Canadian healthcare standards. The overall goal of ACP is similar across the globe which will be noted throughout the literature review.

ACP in the United States

In the United States, specific documentation processes are utilized when initiating ACP with patients. The first document is an advanced health directive (AHD) also referred to as a

living will (Mitchell, 2014). Advanced health directives are not universal across patients and can range from general statements of values to specific orders such as do not resuscitate (DNR), and do not hospitalize (Billings, 2011). In the United States, an AHD can direct healthcare professionals in completing treatment. Along with AHD documents, there is a lot of focus on power of attorney (POA) documentation (Zhou, Stolfus, Houldin, Parks, & Swan, 2010). Patients must assign someone to be their POA to make healthcare decisions on their behalf if they are incapable to make decisions themselves (Black, 2007). In combination, this documentation (AHD and POA) allows patients to express their wishes as they approach end-of-life. This allows the physician to move forward in making decisions based on the completed documentation (Black, 2007).

ACP in Canada

In Canada, specifically in Ontario, ACP is conducted very differently due to the Health Care Consent Act (Hospice Palliative Care Ontario, 2016). The purpose of the Hospice Palliative Care Ontario (HPCO) is to strive for a future where everyone in Ontario has access to quality hospice palliative care. HPCO promotes research and education in the field of hospice care, along with the development and expansion of hospice services. Palliative care services are not only appropriate as a person is nearing end-of-life but when a person is at the earlier stages of an illness. Palliative care services are used to improve quality of life for both the patient and their family. HPCO is able to provide information for patients and their family that can be utilized as beneficial resources, such as ACP information, information on funeral services, and assisted suicide information (Hospice Palliative Care Ontario, 2016). In Ontario, ACP discussions lead to a documentation process in which the patient will appoint a person to become their substitute

decision maker (SDM) (Barnes et al., 2011). Documents such as a living will or an advanced health directive do not exist under Ontario health laws as legal documents (Hospice Palliative Care Ontario, 2016). Wishes and values can be documented on ACP forms or noted within a patient's medical chart but they are not considered to be legal forms of documentation (Hospice Palliative Care Ontario, 2016). ACP forms act as a guideline to direct conversations between healthcare professionals and patients and/or act as a guide for SDM's when making decisions on behalf of the patient (Hospice Palliative Care Ontario, 2016). It is extremely important for a patient's wishes to be clear and understood by the SDM since the documentation is not legally binding. This gives more responsibility to the patient and their SDM (Hospice Palliative Care Ontario, 2016).

The purpose of the Ontario Health Care Consent Act is to provide rules in respect to treatment that can apply to all health care settings and to provide services for persons lacking the capacity to make decisions and to ensure a significant role for family members when a person is incapable, which is often the role of the SDM (Ontario Health Care Consent Act, 2016). The Act demonstrates the importance of knowing your family members wishes because if the SDM refuses medical advice such as the admission to a health care facility, they must present to the board and demonstrate that their family member, if capable, would choose not to go to the facility (Ontario Health Care Consent Act, 2016). This demonstrates the importance of asking questions and taking notes while the person is still capable because even though the information is not legal, it will provide more evidence when speaking to the health board.

Focusing in on Advance Care Planning and Goals of Care Discussions

The idea of ACP remains consistent across the board and has many areas of importance. An important aspect of ACP is proactive planning, such as making decisions for end-of-life care which can extend from medical decisions to practical decisions, distribution of goods and wealth, and funeral preferences (Bern-Klug, Ekerdt, & Wilkinson, 1999). Social workers, especially those working in palliative care, are very responsive to the need of ACP and are often the professionals initiating the conversation (Kramer, 2013). There is a greater need for attention on ACP and end-of-life care through other medical professionals (Johnson, Hong, Inoue, & Adamek, 2016). It is suggested that 27% of adults have put little to no thought into their end-of-life care (Pew Research Centre, 2013). ACP demonstrates that proactive planning is not only for people as they get older or when they become unwell. It is a process that allows everyone, unhealthy/healthy and young/old, to start the course of planning which includes contemplation, discussion, and documentation (Sudore et al., 2008).

ACP can go beyond medical decisions. This is often referred to as the goals of care discussion (GOCD) (You, 2014). There can be some confusion on the differences between ACP and GOCD, and the two are often used interchangeably. GOCD focuses more on current care and turning wishes and values into goals, where ACP focuses more on future care and uses wishes and goals to help outline guidelines for future decision making (see Appendix 1 for diagram) (Myers, 2015). With GOCD, the patient's needs are accounted for including feelings and concerns regarding the future, preferences for place of death (Barnes et al., 2011), understanding of the illness and treatment, and areas that bring quality and meaning to the patient's life (Myers, 2015). This process helps to ensure that patients receive the healthcare they

desire at the end of their lives (Tinetti, 2012). The six key GOCD questions that should be asked are as follows:

1. What is your understanding of your illness? What have you been told?
2. What information is important to you?
3. What brings quality to your life? What do you value?
4. If critically ill or if end-of-life, what worries and fears come to mind?
5. What trade-offs are you willing to make for the possibility of added time?
6. If you were near the end of your life, what would make it meaningful? (Myers, Standardized ACP Conversation, 2015)

For the patient to receive their desirable healthcare, their SDM must be fully aware of their wishes and what those wishes mean to them, since the majority of the time the SDM is the person making the decisions at the end-of-life, and not the patient (Hospice Palliative Care Ontario, 2016). Studies have shown that a substitute decision maker's perception of what the patient would want may not always be in line with the patient's actual preferences (Sudore et al., 2008; Barrio-Cantalejo et al., 2009). It is important to include the SDM in goals of care discussions to ensure the patient's wishes are heard and validated (You, 2014). It is often challenging for SDMs to separate 'doing what the patient would want me to do' from 'doing what I want to do for the patient' (You, 2014). If the SDM is unable to attend these discussions, proper documentation becomes even more important.

Decisions about goals of care should be clearly documented in the patient's medical record and should include values that are informed by the patient and in the patient's own words. The use of the patient's own words increases the likelihood of the patient's wishes being

successfully accounted for (You, 2014). Allowing the patient to have the key role in the documentation process, calls for greater engagement and empowerment and gives them a sense of control over their health care decisions (Hilliard, Washington, Hines, & McGill, 2013). Since 76% of decisions made in the last week of life are not facilitated by the patient, it is even more important to ensure that the patient's wishes are clear and are followed through by their SDM (Myers, 2016). Although these documents are not legally binding, providing a guideline of one's wishes will allow the SDM to make decisions more comfortably (Hospice Palliative Care Ontario, 2016).

The ACP/GOCD documentation needs to be properly shared. It is recommended that this documentation is highly visible and transportable across the entire patient's care setting, such as an electronic record that is accessible to all care providers (You, 2014). This helps facilitate proper communication about the patient's wishes amongst the entire healthcare team (You, 2014). Instead of healthcare providers writing notes in their own specific format within a patient's chart, it is important for documentation to be familiar across the board such as utilizing 'Speak Up' resources and planning tools. 'Speak Up' is a public awareness campaign that demonstrates how to start the ACP conversation. It is led by the Canadian Hospice Palliative Care Association and provides resources to healthcare providers, patients, and families (Speak Up, 2016). These planning tools allow patients to document who their substitute decision maker is, their wishes and values, and other important personalized details that are specific to their healthcare plans (Speak Up, 2016). While 'Speak Up' documents are not considered to be 'legal documents, they do help guide the patient's healthcare decisions and offer consistency across healthcare providers (Speak Up, 2016).

Along with the empowerment piece that patients receive through documenting their healthcare wishes, there are many other benefits to ACP and/or GOCD. ACP was thought to have contributed to ‘good’ deaths since patients and families were able to discuss their concerns and wishes before the patient began to deteriorate (Mitchell & Dale, 2015). The majority of patients who participated in ACP conversations were shown to receive significantly more patient-focused care in regards to physical and emotional comfort, informed decision-making, and self-efficacy (Mori et al., 2013). Patients vary in how they would like to be cared for and have different priorities and preferences when it comes to their choices. Since the process is very patient-focused, the patients have the opportunity to discuss areas that are specific to their needs, allowing them to feel prioritized (Tinetti, 2012).

There are many barriers and challenges that interfere with the ACP and/or GOCD process. One of the most common barriers is that physicians are often reluctant to have the conversation (Zhou et al., 2010). Evidence has suggested that healthcare professionals believe that end-of-life discussions can destroy a patient’s hope and may deter them in having future discussions about their health and treatments (Munday, Petrova, & Dale, 2009). Physicians often delay the conversation or discuss other treatment options to avoid having to discuss ACP (Zhou et al., 2010). Healthcare staff will also often avoid discussing ACP to prevent patients and staff from getting upset or from patients believing that the staff have ‘given up on them’ (Zhou et al., 2010). Time is one of the largest barriers in staff implementing the ACP conversation. Healthcare staff have very limited time to see each patient. They feel as though they do not have the necessary time to have these conversations in an in-depth manner (Zhou et al., 2010). Physicians often take too much time in deciding when to initiate the conversation. They typically

overestimate a patient's prognosis which results in planning for palliative care after the patient has already reached the palliative stage (Mitchell, 2014).

There are also barriers and challenges that are influenced by patients as well. In a study completed in 2011, patients were asked to participate in an ACP discussion. Over a third of patients said it was too soon for them to have these types of conversations but would talk more to their physician if their health began to deteriorate (Barnes et al., 2011). Family dynamics can play a large role in implementing the ACP conversation. If there are family frictions or if the family is in denial or reluctant to discuss the patient's care, ACP can become delayed (Zhou et., 2010). Patients may also fear that they are signing their life away once these conversations and documentation is completed, which causes hesitation and reluctance (Elpern, Barry, Stoeckle, Ettelson, & Emanuel, 1993).

There are a few key barriers that go beyond the physician or the patient. Areas such as accessibility, transferability, interpretability, and representation can also act as challenges when implementing ACP conversations (Winzelberg, Hanson, & Tulsky, 2005). There are often gaps in ACP among racial/ethnic minorities due to a lack of understanding, language barriers, and opposing cultural beliefs and values (U.S Department of Health & Human Services, 2012). Approaches to death and dying differ significantly across language, culture, and socioeconomic status. These factors can cause barriers in patients engaging themselves in ACP conversations (Hilliard, Washington, Hines, & McGill, 2013). Death remains a taboo subject among various cultures, which often prevents the ACP conversation from being initiated (Mitchell & Dale, 2015). Physicians and other healthcare providers must learn how cultural factors can influence patient's health beliefs, behaviours, and responses to medical issues (Austerlic, 2012).

Acknowledging and accommodating these pieces of a patient's life is a critical part of delivering culturally-competent, patient-centred end-of-life care (Castanares, 2012).

Planning for ACP in Northeastern Ontario

When having ACP conversations with communities in Northeastern Ontario, it is important to place special concentration on the Aboriginal population, as well as the French population. Nurses and social workers have expressed the desire to provide culturally appropriate end-of-life health care since lack of cultural awareness increases the barriers that patients face in the health-care-delivery system (Hamptom, Baydala, Drost, & McKay-McNabb, 2009). For example, Elders have discussed the importance of Aboriginal patients having family close by at end-of-life and that contact should not be limited. Families should be allowed to have time for smudging ceremonies as well as other traditional ceremonies which should be respected by the healthcare staff (Clarke & Holtslander, 2010). Families have often experienced policy restrictions when attempting to gather as a community within a hospital room. They have experienced disrespectful and racist treatment when attempting to perform ceremonies (Hamptom et al., 2010). Reviewing feedback from Elders and Aboriginal patients, the most common suggested solution would be for hospitals to provide larger family rooms that can accommodate large groups of people. This would allow families to gather in peace and would be a preventive measure against the discrimination that they currently feel (Hamptom et al., 2010). It is important not to assume that every Aboriginal patient follows traditional practices and that not all Aboriginal patients will want the same services offered to them. It is very important for healthcare providers to not assume bias behaviours and to avoid culturally based assumptions. (Clements et al., 2003).

There are also guidelines to follow for French communities. Those who belong to a French rural community often prefer to die in their rural home communities surrounded by their family and loved ones (Veillette, Fillion, Wilson, Thomas, & Dumont, 2010). A study that took place in 1999 modelled the importance of a 'good' death as the quality of a person's death is determined by both the nature of their experiences and the values that are attached to those experiences (Stewart, Teno, Patrick, & Lynn, 1999). Four main dimensions that were considered to be important aspects of a good death according to participants in rural Quebec included physical, emotional/psychological, social, and spiritual aspects (Fillion, Vielleite, Wilson, Dumonte, & Lavoie, 2009). Patients focused on their quality of life and their overall well-being as important experiences in receiving the end-of-life care that they desired (Veillette et al., 2010).

Advance Care Planning with Persons with Cancer

Although advance care planning should take place in all areas of healthcare, there is a significant amount of research that takes place within the fields of cancer and palliative care. According to Zhou et al. (2010), there are many Americans who are dying with unmet needs and they are spending their last days in life with not only physical pain but with emotional and psychological pain as well. Zhang et al. (2009) said that only 31% of patients with advanced cancer reported having discussions involving end-of-life care issues with their oncologist. If these ACP discussions were initiated by the oncologist, 60-70% of cancer patients were willing to participate (Jackson, Rolnick, Asche, & Heinrich, 2009). This is due to the discomfort of palliative care professionals because, although the majority of professionals find ACP useful in treatment decisions, only 62% feel comfortable in having the conversation with their patients

(Voltz, Akabavashi, Reese, Ohi, & Sass, 1998). Oncologists are pivotal members in caring for their patients and although they may not always be role models for ACP (Weissman, 2003), they are capable of helping patients explore their preferences when discussing end-of-life care options (Zhou et al., 2010).

Although there are concerns that discussing ACP with patients who have cancer will cause unnecessary stress (Jones et al., 2011), there have been cases that have shown that patients with recurrent progressive cancer who have taken part in these conversations show no undue depression or anxiety, and rather they show interest in participation (Jones et al., 2011). There is some controversy in deciding the appropriate time to have the ACP conversation with cancer patients. There are indications that such discussions should not be initiated too early but rather after recurrence or if the patient's health becomes more poor (Barnes, Jones, Tookman, & King, 2007). The United Kingdom guidelines suggested that ACP discussions should begin in the outpatient setting before the patient becomes too unwell (Royal College of Physicians, 2009). A systematic review completed in 2008 recommended that discussions should happen within a month of a patient's new diagnosis of advanced cancer (Walling et al., 2008). There is no correct answer about the timing of ACP. The conversation often occurs dependent on patient and health care provider preferences (Barnes et al., 2011).

There are barriers that affect the success of implementing the ACP conversation and there are specific barriers with persons with cancer. One example is that patients may believe that discussing ACP equates to 'giving-up' and ending their treatment to live in a hospice (Nelson et al., 2006). Other patients may have unrealistic expectations of medical advances and are convinced that there is a cure for their cancer and refuse to participate in ACP conversations

because of this (Harris, 2008). There are also barriers created by oncologists who believe that they have ‘failed’ as a physician if they need to introduce ACP measures because they were unsuccessful in helping the patient live (Jackson et al., 2008). This stems from society’s culture of the ‘don’t go there’ approach which represents an idea that death and dying are taboo subjects. Society also has the culture of ‘do everything’ which has been used to avoid the conversation of death or dying in that everything must be done before the idea of death can even be mentioned (Running, Shumaker, Clark, Dunaway, & Tolle, 2009). There are ways to help cure this fear which can be achieved through education. Providing health care professionals with training and support in initiating the conversation allows more patients’ wishes to be properly identified (Morrison et al., 2005).

A final component of advance care planning that is becoming popularized in today’s society is medical assistance in dying (MAID). On June 6, 2016, new legislation to the criminal code was passed to allow for MAID procedures to occur in Canada (Government of Canada, 2016). Strict eligibility criteria must be met in order for a person to qualify: the person must be an adult; they must have the capability/capacity to initiate the request; there must be informed consent; it must be a voluntary request; they must have a serious or incurable illness; and they must have psychological or physical suffering (Watkins, Summary Bill C-14, 2016). Due to these specific qualifications, the largest numbers of MAID requests are being initiated by cancer patients. Since the legislation was passed on June 6, 2016, there have been 133 physician-administered cases and 2 patient-administered cases, and 87 of these cases were cancer-related (Huyer, Statistics as of November, 2016). The subject and questions surrounding MAID have become incorporated into ACP conversations due to the person expressing their wish to die.

Similar to discussing ACP and/or GOCD, many healthcare professionals do not feel comfortable to discuss aspects of MAID. There are many physicians who refuse to perform the procedure (Jarvis, MAID: Current Legal Issues, 2016). The legislation does not force physicians to perform MAID but it is an obligation of the physician to connect the patient with another physician who would be willing to do this (Watkins, College Guidelines, 2016). This is a very new practice that has demonstrated the need for education and support.

Advance care planning is a crucial component of the health care system which provides critical services to patients and their families. It is a patient-centred communication process which promotes the importance of patient-centred care through all disciplines (Kass-Bartelmes, Hughes, & Rutherford, 2003). This should be a responsibility of all health providers. It will increase patient engagement, open communication, and give opportunity to populations that are typically underserved due to the race, age, and sexual orientation (Hilliard et al., 2013).

Practicing ACP with varying populations will help build a larger professional development piece, as well as a better standard for cultural competence (Hilliard et al., 2013).

Advance care planning is an important component of the healthcare system and is a mandatory aspect of the Ontario healthcare standards (Hospice in Palliative Care Ontario, 2016). It allows patients and their families the comfort they deserve and require when making difficult end-of-life decisions. It not only prepares the patient but it also helps healthcare staff maintain best practice standards by doing all that they can to ensure that their patient's wishes are fulfilled (Speak Up, 2016). It is a practice that is becoming more incorporated into healthcare routines and it will continue to grow as more patients and staff become comfortable discussing future care.

Supervision

The development of social work supervision began as an administrative practice in the years of the Charity Organization Society. There were training programs arranged by universities which allowed for a body of knowledge to be created which helped to build supervision frameworks (Tsui, 2005). This led supervision to become an important educational process, which grew in support as social work became a more developed profession. Supervision can fall back to the original meaning and become administration focused as the social work profession becomes more demanding, and as workers are ensuring tasks are done and lists are checked (Tsui, 2005).

As time went on, social work supervision has played an important role in the development of the social work profession (Kadushin, Berger, Gilbert, & De St.Aubin, 2009). Social work supervision can improve service delivery, develop skills, increase one's understanding of social work ethics, improve job satisfaction, and provide a defense against social worker burnout and/or emotional exhaustion (Mor Barak, Travis, Pyun, & Xie, 2009). Social work supervision is often seen as a forum that offers an ongoing process and structure that is available to social workers for professional development through a supervisory relationship (Pack, 2012). Supervision is one of the main methods of becoming more aware of one's practice (Pack, 2012). The long-term objective of supervision is to prepare the supervisee to deliver effective and efficient services to their clients that is consistent with social work professional practice standards (Tsui, 2005).

There are many variations and models of supervision that are used within organizations. The four core types of supervision that are the most commonly utilized are individual, group,

peer, and team supervision (Kadushin & Harkness, 2002). Individual supervision is the most widely used model, especially for social workers who are new to practice (Kadushin & Harkness, 2002). This model is delivered one-on-one and often occurs on a weekly basis for a one hour time span, which can be quite time consuming and demanding for the supervisor involved, especially if the supervisor is facilitating these sessions with various social workers (Kadushin, Berfer, Gilbert, & De St. Aubin, 2009). Group supervision is known as the second most adopted model of supervision in which a supervisor will facilitate the core functions of supervision (administrative, educational, and support) within a group setting (Kadushin et al., 2009). This format allows for time and resources to be conserved due to supervision occurring within a group format (Kadushin & Harkness, 2002; Tsui, 2005). Peer supervision occurs when supervision is led by a peer group with no supervisor oversight or higher authority; all members are of equal status in terms of their responsibilities within the group (Kadushin et al., 2009). The purpose of this model is to allow members to provide their clinical guidance and expertise to their colleagues through the exchange of case conferences (Kadushin et al., 2009). Finally, there is team supervision which often involves intradisciplinary workers who may discuss aspects such as professional development, educational guidance, and allocation of work assignments (Kadushin & Harkness, 2002).

By providing supportive supervision, there will be reduced job-related stress as well as self-awareness of the stress that social workers may be experiencing within the work place (Bogo & McKnight, 2005). In order for supervision to be supportive, it is important to recognize that the supervisor and supervisee may have different thoughts on supervision, and that these ideas must be recognized and discussed to confirm that supervision is being delivered in a supportive

and satisfactorily manner. For example, in a study completed by Pack (2012), supervisors' definition of supervision involved the effectiveness of the supervisee's work along with ensuring that safe practice was occurring within their organization. Supervisees viewed supervision as a safe place where they could discuss any obstacles they have been facing, along with any achievements they have had with their clientele (Pack, 2012). In this sense, the two parties had similar definitions, in that they were focusing on the service provided to the client. Within this particular study, supervisees mentioned that they often felt that supervision was strictly dedicated to the client, and that they were never able to discuss their feelings as a worker and how their work may be affecting them personally (Pack, 2012). It is important for supervisors to provide an emotional safety net within the supervisory relationship which is "untainted by power relations and issues of confidentiality" (Beddoe, 2012, p. 205), which is often the argument for receiving external support where social workers may feel they can speak more openly.

It is important that social workers can express their feelings. Some may struggle to express their personal feelings within group supervision settings (Pare, 2016). When there are multiple people within one space, there are more areas for judgment which can cause the social worker to feel critiqued or evaluated by their colleagues (Pare, 2016). If staff can overcome feelings of self-judgment or feelings of worry, they may be able to see that group supervision can offer a wide range of professional and personal perspectives that will allow for personal reflection and opportunities to learn and grow both professionally and personally (Pare, 2016). This is why it is suggested to structure group supervision in a way that makes people feel less vulnerable to discourse that may be unhelpful to their professional needs (Pare, 2016).

Peer Supervision

Peer supervision is led by a peer group, all members are accountable for their own work and all members are responsible for providing education through their clinical experiences (Kadushin et al., 2009). This model also encourages staff to be more sensitive to the needs of their colleagues, and to create a space that is open for sharing and understanding (Tsui, 2005). For peer supervision to work effectively there must be experienced members who are participating in order to have enough adequate knowledge to make the group useful for all members involved (Tsui, 2005). All of the members should take on equal initiatives in finding and providing resources that will be effective for group learning and education (Kadushin et al., 2009).

One of the model structures that was suggested by Pare (2016) focuses on acknowledgement and generativity, based on Andersen's and White's innovations of reflective supervision. This model is divided into three phases and concisely demonstrates how social workers can mentor each other in a reflective and encouraging matter. These three phases include sharing, reflection, and debriefing (Pare, 2016). Within the first phase, sharing, one group member would interview the sharing group member to gain a thorough amount of information on the case they would like to discuss. The sharing member would be specific in what they are looking for during the group process, which allows the interviewing member to ask rich questions that are in direct relation to the presenting concern/issue. This should encourage other group members to adjust their reflections accordingly and focus on the area that the sharing member is requiring assistance with. Once the interview phase is complete, the remaining group members can ask questions for clarification purposes but they are not to pursue other areas of

interest. The second phase of the group involves more critical reflection but first the process begins with acknowledgment. When the sharing group member is speaking, they can feel overwhelmed and/or judged since they are sharing their vulnerabilities (Andersen, 2007). It is important to acknowledge positive aspects of their practice such as the way they communicate, and the way they care about their clients (Pare, 2016). Once this is complete, the members can begin on their reflections, drawing on personal experience to ensure that they do not become overly critical and remain open to other's interpretations (Pare, 2016). After everyone has reflected and shared, the interviewing member will debrief with the sharing member to ensure that all their needs were met. This type of model is also very educational because members can take turns being the interviewing member of the group which allows members to work on critical social work skills. The interviewing member must be able to actively listen, ask appropriate questions, and re-direct questions to stay on track (Pare, 2016).

Supervision and Burnout

Supervision tends to focus on the clients, leaving the emotions, the stresses, and the fears of the social workers to become lost in the overall social work process (Kadushin & Harkness, 2002). Burnout is considered to be a serious hazard in the helping profession, often resulting from emotionally demanding work (Hombrados-Mendieta & Cosano-Rivas, 2013). Social workers are at risk to experience burnout, which can be a result of demanding work in which there are high case loads, insufficient resources, lack of time to complete work, and an increased work load demand (Hombrados-Mednieta & Cosano-Rivas, 2013). Experiencing burnout can impair the physical and emotional well-being of the service provider (Kim, Ji, & Kao, 2011).

This can hinder their overall satisfaction with their work and helping others which can compromise their satisfaction with their work (Stamm, 2010).

Supportive supervision can reduce aspects of burnout (Bogo & McKnight, 2005). Having an effective supervisor can help build resilience and reliance on each other that can reduce the risk of burnout (Boyas, Wind, & Kang, 2012). Structured approaches in reducing burnout are often directed at both the individual and the organization (Wagaman, Geiger, Shockley, & Segal, 2015). Individuals are responsible for participating in education, skill development, and increasing their personal coping skills to better prepare for burnout (Awa, Plaumann, & Walter, 2010). Organizations should make changes in their work processes, supervision evaluations, and support with decision making to provide preventive measures for burnout (Awa, Plaumann & Walter, 2010). It is suggested that supervision should also allow time for social workers to speak about their own difficulties within their work environment (Bogo & McKnight, 2005). This is important because it allows for preventive measures such as information and education about burnout symptoms and signs to be shared before burnout surfaces (Newell & MacNeil, 2010).

In a study completed in 2016 (Savaya, Beatov, Melamed, & Alschuler, 2016), it was demonstrated that perceived social worker burnout was negatively connected with perceived change. If service users viewed their social workers as burned-out, the less improvement they reported (Savaya et al., 2016). Service users' perception of burnout can also effect their perception of social work. In the study, participants made statements such as "my social worker is emotionally drained by her work" and "I feel my social worker treats me like an impersonal object" (Savaya et al., 2016, p.186). These statements reflect how burnout can affect the relationship between social worker and client.

In order to become more preventive, a creative arts-based project was conducted in Hong Kong to alleviate burnout, nurture emotional awareness, and allow for a comfortable space for colleagues to communicate (Potash, Chan, Ho, Wang, & Cheng, 2015). Groups that evolve around art-therapy assist in emotional expression, as well as intrapersonal, interpersonal, and transpersonal understanding, which are effective measures in better understanding one's emotions and stress (Slayton, D'Archer, & Kaplan, 2010). Since social workers tend to focus on the needs of their clients rather than their own needs, participating in self-expression art groups can act as a preventive measure for burnout (Swetz et al., 2009).

The project in Hong Kong took place over six sessions: self-care, stress management, professional reflection, death memories, and meaning making (Potash et al., 2015). The first session, self-care, involved the creation of a mandala. Before beginning, the participants of the group were given a brief history of what the mandala represented and how to view it as a symbol of the present moment based on the work by Jung (1989). Once the participants were familiar with what the mandala represented, they then were asked to think about how they were feeling in the present moment and to create a mandala based on that moment. One participant drew a sinking ship to represent how it can feel when working in end-of-life care; the pictures resonated with the group and group members were able to share commonalities (Potash et al., 2015). In the second session, stress management, participants were asked to create an image that represented stress; they were then given the opportunity to change their image in a way that would make it less stressful. This allowed participants to form ideas that would help alleviate their stress. Some participants drew a new picture from a different angle, where stress could be less apparent,

where others added colour to their pictures, which represented seeing the good in bad situations (Potash et al., 2015).

In sessions three and four, professional reflection, participants were asked to discuss both a strength and a challenge they face when working with the dying and bereaved populations. Although participants admitted that they did not want to boast or admit any defeat, they were able to draw about these feelings. In terms of a strength, one participant drew a rock because she saw herself as stable and tolerable to change. In the challenge section, one participant created an image that represented being surrounded by smoke and feeling as though her efforts was meaningless and that she needed further support (Potash et al., 2015). This session allowed the participants to take time to view each other's images and to write down words or phrases that they felt when they viewed the image, which enabled open and honest conversations, demonstrating to participants that they were not alone in their feelings (Potash et al., 2015). In session five, death memories, participants were asked to create an image that represented how they feel working with clients who are dying and what that represents to them. Afterwards, they were able to share their images and participate in a small discussion surrounding what their image represented (Potash et al., 2015). The sixth and final session, meaning making, brought the group back to the mandala. They were able to create images based on their learnings from the six sessions. Participants reflected that they gained more emotional awareness, they felt as though they were not alone, and felt supported throughout the experience (Potash et al., 2015).

The peer supervision model, as well as the arts-based model both demonstrate the importance of reflection in practice (Pare, 2016 & Potash et al., 2015). Reflection provides the opportunity for social workers to consider how their fellow colleagues may be feeling when

expressing their difficult cases and encourages them to spend time processing their thoughts before giving their opinion (Pare, 2016). Reflection gives social workers an opportunity to pause and look back on their work, which can give them the opportunity to better understand how their work may be effecting their practice as a whole (Potash et al., 2015). This practice can be used as a supportive measure, through sharing and reflecting, commonalities can arise which provide a greater level of comfort between colleagues (Potash et al., 2015).

Supervision and Social Work Students

Supervision with social work students is also a critical area of clinical supervision. This is an area in which members can develop their teaching and supervisory skills while contributing to the future development of social workers (Code of Ethics and Standards of Practice, 2008). In the social work program, field education is recognized as a key vehicle for developing core skills, professional values, and social work knowledge (Teigiser, 2009). Students have described their practicum experience as the most significant aspect of their education (Maidment, 2006). One of the largest identified factors of the success of a social work practicum is the relationship between the student and their practicum supervisor (Todd & Schwartz, 2009). Although students have shown to value other components of their practicum experience, it was shown that the relationship with their supervisor was pivotal to their learning. Aspects such as structured time for supervision to review skills, values, and professional development, along with actively involving students in the learning process showed great satisfaction among students (Fortune, McCarthy, & Abramson, 2001). Apart from the supervisor-student relationship, students also indicated that they valued the learning activities that were provided to them, i.e., observing their supervisor's practice and in return having their own work supervised (Bogo & McKnight, 2006).

Quality Assurance

A final aspect of supervision that will be examined is the importance of quality assurance and meeting best practice standards. It is important that social workers fully engage in efforts to define quality practices which allow them to create methods of ensuring better quality care (Mergivern et al., 2007). Quality in social services can be defined as “the degree to which interventions influence client outcomes in desired ways in applicable domains while being delivered in a sensitive manner consistent with ethical standards of practice and the best available practice knowledge” (Mergivern et al., 2007, p.118). By providing quality interventions, it involves incorporating interpersonal skills, cultural competence, and technical knowledge, which allows quality care to be both technically sound and sensitively provided (Mergivern et al., 2007). By incorporating quality assurance measures as part of social worker’s overall therapy supervision it is ensuring that the client is receiving the best care possible and also ensures the care provider the confirmation that they are meeting best practice standards.

It is suggested that quality assurance plays two roles in improving how practice is implemented. Quality assurance can be used to monitor and improve how a delivery system is managed (Meyers, Durlack, & Wandersman, 2012). Quality assurance can be applied through communication between the support system and delivery system, which can measure the quality of support and apply the necessary improvements (Meyers et al., 2012). For example, the use of quality assurance strategies can be used to improve work performance through the use of checklists and visual management resources (Wandersman et al., 2008). Organizations may also rely on their clients to improve their practices as well. It was suggested that quality assurance in mental health practice settings is often measured through the use of surveys or reviews, where in

behavioural managed care organizations, quality assurance undertakes profile analyses. This is when descriptions of client responses and behaviours are compiled and evaluated (McMillen, Zayas, Lee, & Books, 2013).

One of the largest struggles of quality assurance (QA) is determining who is responsible if a quality assurance member is not present within the organization or how much authority is warranted if a quality assurance member is present. In a survey, social workers admitted to feeling insecure in QA work due to lack of experience and training, and others admitted that they did not possess the necessary skills to properly assess their services in a QA manner (Zayas, McMillen, Lee, & Books, 2013). Quality assurance professionals expressed that they did not have enough influence over staff members. One respondent expressed concern that they did not have the authority to tell staff that they were not doing their job correctly, as well that their limited influence prevented them from receiving the necessary support from management to do their job properly (Zayas et al., 2013). It is suggested that both front-line and supervisory staff should participate in focus groups to discuss QA measures. Administrators believed that it was important for staff to understand where they and their agency stood in terms of performance standards because it will identify good practice or barriers in their work, which will allow for future improvement (Garstka, Collins-Camargo, Hall, Neal, & Ensign, 2012).

Supervision can come in many forms, it can be used as a supportive tool, for case consultation or personal support, and it can help educate students but for it to be successful, multiple components are necessary. By utilizing measures of quality assurance, along with the provision of support through peer reflection, social workers will have a more positive experience

in the work place and provide better care to their clients (Bogo & McKnight, 2005; Potash et al., 2015).

Working with a Multidisciplinary Team

Multidisciplinary teams include professionals from different disciplines who come together to review cases and to address any necessary concerns that the cases present (Teaster & Nerenbeg, 2003). The rationale behind the multidisciplinary approach is to offer comprehensive assessments and treatments from a variety of disciplines (Garven, 2011). It also helps to create reflective practice in which professionals from all disciplines become aware of links between each other's practices (Garven, 2011). Acknowledging how viewpoints can influence practice is the trademark of ethical practice which allows for proper reflexivity between disciplines as everyone is aware of their influence on the patient (Gilgun, 2005). Sharing the knowledge and language with fellow professionals allows different disciplines to connect their ideas and ask questions of each other in order to deepen their understanding of each other's roles (Garven, 2011). In the study completed by Garven (2011), effective approaches to working with a multidisciplinary team were identified. This included, the involvement of outside professionals joining the team in coordinating new approaches to discussing clients, recording the client reviews to share with other disciplines in order to coordinate the best care, and including team members to be observers to watch the reflection process and share their observations with the group at the end, which may help shed light on any potential biases or important highlights (Garven, 2011).

A multidisciplinary approach is necessary for both the diagnosis and treatment of cancer patients for quality of life to be optimized (Guler & Canturk, 2014). Multidisciplinary teams

have been considered to be essential in order for patients to receive the best treatment and care (Flessig, Jenkins, Catt, & Fallowfield, 2006). This approach is particularly important when working with complex cases where more disciplines would be involved, especially when timing of treatment modalities is crucial (Flessig et al., 2006). Multidisciplinary teams could also improve the coordination of services because through communication different disciplines will become more aware of efficient treatment planning, referral processes, and can learn to avoid any potential duplication of services (Ruhstaller, Roe, Thurlimnn, & Nicoll, 2006). There are resources available that can be utilized to increase the improvement of clinical teams. This includes websites that can measure quality improvement of cancer care through self-assessment and peer review (Cancer Quality Improvement Network System, 2006), as well as guides for multidisciplinary teams that demonstrate how to make improvements based on available case studies (Cancer Services Collaborative Improvement Partnership, 2004).

There are also staff benefits when working with a multidisciplinary team. A study of breast cancer teams suggested that working in teams could be beneficial to the mental health of the staff members (Haward et al., 2003). It was also shown that staff could experience a decrease in job satisfaction if the meetings were not held during protected sessions. Sessions that were not held during protected sessions showed a lack of attendance from medical oncologists which decreased the necessary sharing of information to improve both client and staff outcomes (Haward et al., 2003). For meetings to be effective all members need to be in attendance with sufficient administrative support to help coordinate, review, document, and implement the meeting findings (Flessig et al., 2006). The benefits of disciplines working together to benefit all aspects of a patients visit from the coordination of appointments to managing treatments to

ensuring all aspects of the patient's biopsychosocial care are being taken care of allows for the best holistic care for the patient.

The inclusion of multidisciplinary cancer councils is also necessary to enable a platform for appropriate diagnostic tests, discussion of treatment options, operations, and recommendations for patients (Wright, De Vito, Langer, & Hunter, 2006). This enhances communication and education within all disciplines (Guler & Canturk, 2014). In Garven's (2011) study it was recommended that an outside person chairs the council meetings in order for meetings to stay on track and to prevent any biases or judgemental opinions (Guler & Canturk, 2015). The most important factor is that there is enough time scheduled at meetings to discuss the clinical aspects of all patients before and after their first cancer treatment as well as their eligibility for clinical trials (Flessig et al., 2006). These meetings will also improve communication between disciplines which will allow for an increase in the clarity of information, promote information sharing, and decrease conflict between members (Flessig et al., 2006).

Summary

In the literature that I reviewed, there was a significant amount of research on advance care planning. The majority of the research was done outside of Canada. ACP is very different in Canada compared to the United States. In terms of supervision, the research that I found was very diverse. There were few articles on social workers working in oncology, the supervision methods that they use, and a model for a multidisciplinary team that might include social workers, managers, and psychologists. I also came across a few limitations when searching quality assurance measures and social work as most of the data appeared to be inconsistent.

Definitions of quality assurance in social work varied. There were many articles on multidisciplinary teams but few on cancer care and the disciplines involved. The challenge in this literature review was finding articles that were both relevant in subject matter and current in terms of publication date.

Chapter 3- A Description of the Practicum and Placement Site

This chapter will review my practicum experience focusing on the placement site and the supervision I was provided. I will describe my training goals and how I was able to achieve each goal during my practicum. There will also be a review of my clinical and shadowing experiences. I will end by discussing how the supportive expressive therapy model and the cultural competency model aligned with these experiences by connecting theory to practice.

Description of the Cancer Centre

I completed my M.S.W advanced practicum at the Northeast Cancer Centre (NECC), Health Sciences North, in Sudbury, Ontario. NECC is the central hub for patients in the districts of Algoma, Nipissing, Cochrane, Kenora, Manitoulin, Parry Sound, Rainy River, Timmins, Timiskaming, Thunder Bay, and Sudbury (NECC, 2016). Patients of all ages travel from the listed areas for radiation and chemotherapy treatments. NECC is also a large research centre that takes part in various clinical trials and supportive care research (NECC, 2016).

Within the Cancer Centre, there is a Supportive Care Program that offers a variety of services to the patients and their families. This includes educational classes, support groups, and psychosocial services. There are also genetic counselling services for cancer patients and their family which are offered through the Sudbury Outpatient Centre (NECC, 2016). The patients who utilize these services are individuals with cancer as well as their loved ones (NECC, 2016). Classes and groups are facilitated by a range of disciplines (physiotherapists, dietitians, social workers, etc.) which provides a wide array of information and resources to patients and families (NECC, 2016).

The SCP provided me with the opportunity to complete two projects, as well as clinical work with patients. The first project was on the subject of Advance Care Planning (ACP), which led to the completion of an environmental scan with cancer centres across Ontario, as well as a chart audit within NECC. The second project involved researching therapy supervision models and implementing a new model for the social workers and the psychologist to utilize during their weekly therapy supervision sessions. The clinical work involved working with cancer patients who had instrumental needs, primarily those requiring financial assistance. The projects and clinical work will be explained in-depth throughout the remainder of this document.

I completed the required 450 hours over a 12-week time span with the Supportive Care Program (SCP). I was supervised by Dr. Carole Mayer and was also supported by the social workers from SCP. I completed the required forms and began my practicum on October 3, 2016, and completed my hours on December 21, 2016.

Supervision

I was provided the opportunity to have weekly supervision sessions in intervals of one-

two hours for the duration of my practicum. The supervision sessions allowed for both clinical guidance, as well as direction for the projects on which I was working. I was provided with a supervision schedule at the beginning of my practicum that allowed me to have adequate time to properly prepare for the scheduled meetings. A second supervisor, Traci Franklin, M.S.W, was assigned to me for clinical supervision to allow for adequate support for the duration of my practicum. This allowed for my clinical work to be supervised by Mrs. Franklin, and Dr. Mayer supervised my project work. This process offered consistency and allowed me to direct questions to the appropriate supervisor, which was very helpful. As a student, it was also very beneficial to experience two different types of supervision styles. I learned that supervision styles can vary across the social work environment and, by participating in two different styles, I feel more prepared to participate in future supervision. The social workers in the Supportive Care Program also offered me assistance with any questions, navigating electronic charting, writing proper case notes, preparing funding documentation, and sharing their experiences to benefit my project work.

The Role of My Supervisors

Dr. Carole Mayer is the Director of Research and Regional Psychosocial Oncology and Lead of the Supportive Care Program at the Northeast Cancer Centre, Health Sciences North (HSN), in Sudbury, Ontario. She is also the Regional Lead for the Ontario Cancer Symptom Management Collaborative. Dr. Mayer has 30 years of healthcare experience with 27 years of specialization in the field of oncology. She has held sessional teaching positions at Laurentian University in the Social Work Department, and Northern Ontario School of Medicine (NOSM) in Clinical Sciences (CAP0, 2016).

Dr. Mayer has received many honours and awards over her career. She recently received the excellence-recipient innovation award through the Canadian Association of Psychosocial Oncology (Health Sciences North, 2016). Dr. Mayer has been the recipient of several research grants and has been the lead for many projects. Dr. Mayer led one of the first Canadian initiatives in implementing screening for distress in 14 community Oncology Chemotherapy Clinics in Northeastern Ontario (Health Sciences North, 2016). Dr. Mayer works in collaboration with the Aboriginal Cancer Care Unit at Cancer Care Ontario to better implement and evaluate patient outcomes when working with the Aboriginal population (Health Sciences North, 2016).

In addition, Dr. Mayer has been co-author on many oncology publications. This includes the delivery of person-centred care, psychosocial care for persons with cancer, evaluation of cancer patient education and services, and women's experience with distress at the time of breast biopsy and diagnosis (Health Sciences North, 2016). Dr. Mayer informed and shaped my research and practice through her experience, which allowed me to gain more confidence in myself and the work I was completing.

Mrs. Traci Franklin also provided clinical supervision. Mrs. Franklin has been a social worker in the Supportive Care Program for 10 years. She is the clinical coordinator for the SCP, providing leadership support in advancing the goals and objectives within the NECC. She also is the patient educational lead; this role helps improve the patient experience through education and resources. Mrs. Franklin offered her time and experience as my clinical supervisor and together we worked on patient cases, where she gave me the opportunity to shadow her work and complete all of the necessary follow-ups. She provided me with constant encouragement which helped to build my self-confidence when working with patients. Mrs. Franklin was one of my

professors during the second year of my undergraduate degree and she would often discuss her role as a social worker at the cancer centre. This is part of the reason that I became passionate about the work that is done at NECC.

Learning Goals and Activities

My advanced practicum consisted of three core parts: understanding advance care planning, engaging in supervision, and clinical shadowing of practitioners' sessions. The main goal of my project work was to gain a better understanding of how research is used and implemented into everyday practical use. This will be showcased through reviewing advance care planning and implementing a standardized process for this, and by implementing a new therapy supervision model within the Supportive Care Program. My goal when participating in clinical sessions was to build on skills that I learned during my B.S.W. such as active listening, facilitating groups, and debriefing. I will be reviewing the initial training goals that I drafted before entering my practicum and how I was successful in fulfilling each goal.

Training Goals

The first six training goals listed below were my initial goals when entering my advanced practicum. I was successful in meeting my goals and I also added to my first goal with work related to my therapy supervision project. Each goal will be discussed and how it was successfully achieved during my practicum.

1. To gain a better perspective on supervision by engaging in, and reflecting on, the process. Also, to gain a better understanding of therapy supervision models and quality assurance standards.

2. To understand the importance and benefits of working within a multidisciplinary team.
3. To learn group work theory, facilitation, and evaluation.
4. To gain a better perspective on evidence-based practices and how to incorporate these into my research project and social work practice.
5. To learn the importance of advanced care planning along with research and implementation.
6. To further understand the importance of reflexivity in social work practice.

Role of Supervision / Therapy Supervision Project

Supervision has been recognized as having many benefits for social workers across all areas of healthcare. Supervision provides workers the opportunity to meet with an experienced supervisor on a regular basis to discuss and review skills, knowledge, and practice (Best et al., 2014). Effective supervision consists of an agreement between the supervisor and supervisee about the goals of supervision, the tasks that will be completed to meet these goals, and a mutually positive relationship between the supervisor and supervisee (Dow, Hart, & Nance, 2009). Supervision encompasses a wide range of functions which can include professional development, educational development, and management of service delivery (Bogo & McKnight, 2005). The four core types of supervision that are the most commonly utilized are, individual, group, peer, and team supervision (Kadushin & Harkness, 2002). Within the SCP, group supervision was the primary form that was used, which is when a supervisor will facilitate the core functions of supervision (administrative, educational, and support) within a group setting (Kadushin et al., 2009). During my practicum, I had the opportunity to participate in weekly supervision sessions with the Supportive Care Program social workers, which they

referred to as therapy supervision. The term therapy supervision has existed within the SCP since its creation and has become the common language that is used with the social workers. This was a very beneficial learning opportunity because I was able to witness how group supervision was facilitated and managed. By participating weekly, I was also able to see what may be missing from the weekly therapy supervision sessions and was able to incorporate this information into my final project.

The weekly group therapy supervision sessions were an hour in duration. The two main components of concentration were discussing complex and/or urgent cases, and updating the patient list for quality assurance purposes. The sessions would begin with allowing any of the social workers to share any patient cases, which included both ‘good news stories’ as well as cases which required feedback from peers and managers. After case consultation, the social workers would then review and update the patient check-list. The check-list would indicate patient wait-times, when the patient was seen, and their diagnosis. The social workers would then add why the patient came in, if they are still being seen, and if any referrals were made. Due to the volume of referrals, the quality checklist was often being reviewed two to three months in arrears, which did not allow for current quality assurance measures to take place.

The goals of my therapy supervision project were to explore how the process of therapy supervision could be altered to enable the social workers to have adequate time to address all of their needs (administrative, client, and personal). One of my goals in reviewing the current therapy supervision format that was used by the social workers was to prevent the issue of falling behind schedule, and to create a plan that would be more beneficial to the social workers’ overall well-being. I noticed that there was not adequate time in group therapy supervision for debriefing

and reflection, and that the social workers never had the opportunity to discuss the emotional impact of their work. The issue of falling behind schedule, was an area that Dr. Mayer wanted to address when creating a new model. Falling behind schedule made it difficult for administration purposes, as patient wait-times and referrals were not being promptly reviewed. In terms of debriefing and reflection, I noticed that the social workers were often discussing very difficult cases but only ever spoke of the patient, and never spoke about their thoughts and feelings. It has been suggested that supervision should also allow time for social workers to speak about their own difficulties within their work environment (Bogo & McKnight, 2005). I thought this was an area that needed greater attention, as the social workers often lose many of their patients to cancer. This is why I focused on incorporating these aspects in my therapy supervision project. I will be discussing this project at length during the next chapter.

In summary, I recommended a model of therapy supervision that would allow for greater reflection, increased time management, and more accurate quality assurance. This will be created with the use of weekly huddles and the considered introduction of art-therapy sessions.

Working within a Multidisciplinary Team

There are many organizations within helping professions that utilize multidisciplinary teams (Garven, 2011). By using multidisciplinary teams, organizations are able to offer an “in house” assessment and treatment plans that are comprehensive from various disciplines including psychiatrists, medical practitioners, nurses, social workers, dieticians, and speech therapists (Garven, 2011). Clinical review meetings with the team are regularly arranged in order to allow for various skills and roles to be held by different members; this process is to help

harmonize the variety of skills, roles, and models (Rhodes et al., 2011). Using this referral process for case review can help the worker gain multiple perspectives and utilize the perspectives of multiple experts (Twoney et al., 2010).

The Supportive Care Program is staffed with disciplines that include social workers, dietitians, physiotherapists, speech language pathologists, a psychologist, an Aboriginal coordinator, an Aboriginal navigator, and a medicine lodge keeper. There are many opportunities for different disciplines to coordinate their services to allow for best patient outcomes. There is also opportunity to network with nurses, oncologists, and other members of the cancer centre to allow for the patient to receive seamless service. The dietitians and social workers would often see their patients in the clinic alongside the oncologist especially if the patient was unable to make a separate appointment, if they were travelling from a distance, or if they were in need of immediate care. This allows for a seamless process for the patient and provides the opportunity for different disciplines to work together in a very effective manner. Every Wednesday morning, all staff of SCP would gather together for a 20-minute check-in where they had the opportunity to discuss their wait times, address any administrative issues, and to review any news items. These weekly meetings provided opportunities for staff to coordinate services which allowed for more effective client service.

Group Work

The group modality is designed to bring individuals together who share a common concern and create a mutual support system to help each other (Toseland & Rivas, 2012). There are many types of groups that are used in social work such as support, education, therapy, growth, and socialization (Comer & Rao, 2016). A common result of group-based psychological

interventions is decreasing cancer patients' feelings of alienation through interacting with others in similar circumstances; in addressing feelings of helplessness and hopelessness; and, it also may encourage patients to take more of an active role in the process (McKinnerarn, Steggle, Guerin, & Carr, 2010). Educational groups provide a means to gain information such as knowledge, behavioural skills, and problem solving techniques that allow for managing and coping with conditions; these groups present opportunities for members to learn that others share their concerns and problems (Sands & Soloman, 2003).

I was given the opportunity to sit in on a variety of groups, both support and educational, which were facilitated by different disciplines. This allowed me to gain a better perspective on how different groups were facilitated, especially when there were multiple facilitators. Each group also had their own evaluation survey, which provided me with the opportunity to see how the groups were being evaluated and how the evaluations assisted in developing the group. The groups that I was invited to sit in on were the following:

Breast Cancer Information Session: This session has three facilitators, a social worker, a genetic counselor, and a physiotherapist. The session focused on the emotional, social, and physical issues that a patient may experience during their breast cancer journey. Having three different disciplines facilitating allows for a large range concerns to be discussed and a variety of questions to be answered.

Eating Well After Cancer: This session is facilitated by a dietitian who explored the types of food that one should consume to regain and maintain energy after cancer. The session also had a myth-busting section which was extremely interesting because it taught the participants (and me) the truth behind food myths through evidence and practice. The dietitian

provided a variety of meal suggestions, making the group very inclusive to all types of eaters. There is also an eating well during cancer group which provides a similar service for patients, teaching them what to eat during cancer treatment to keep them as healthy and as strong as possible.

Fighting Fatigue: This session is facilitated by a social worker, a physiotherapist, and a dietitian. The goal of this group is to discuss ideas and strategies that may help alleviate cancer related fatigue. The group focuses on nutrition, exercise, as well as socialization. The variety of disciplines is very beneficial because it allows different aspects of a patient's life to be discussed thoroughly while providing very rich answers to participant's questions.

Returning to Work: I was able to sit in on the first session of this group, which takes place over four sessions. This group offers assistance in transitioning back to work after being off for cancer treatment. This group is led by a social worker with additional facilitation from project leaders when necessary. This group provides participants with what to expect as they begin the transition back to work. The group touches on what to expect physically, emotionally, socially, and mentally during the transition.

Genetic Counselling Information Session: This session took place at the Sudbury Outpatient Centre. It consisted of a brief information session explaining genetics, specifically focusing on breast cancer and genetics. It was not a requirement for participants to presently have cancer but participants did need to have a previous diagnosis or have concerns of developing cancer due to their family history. After the group session, patients received an individual session with a genetic counsellor. I was also given the opportunity to shadow an individual session. I observed the genetic counsellor review family history, medical

conditions/concerns, as well as discuss a number of areas that must be reviewed to determine qualification for genetic testing.

Chemotherapy Teaching: This teaching takes place two times weekly and is a required session for new patients before they begin their chemotherapy treatment. The teaching is facilitated by a nurse and a pharmacist. The session reviews what to expect when beginning chemotherapy such as what to expect when coming for treatment, potential side effects of the treatment, general information about cancer and chemotherapy, etc. The session also provides resources on other services that may be beneficial to the patient during their cancer journey such as services offered through the Supportive Care Program.

Radiation Teaching: This session is very similar to chemotherapy teaching but is focused on radiation. It is facilitated by a radiation therapist and provides patients with the ins and outs of what to expect during radiation treatment. This includes how radiation works, the potential side effects, and helpful suggestions that may make treatment more comfortable.

Evidence-Based Practice (EBP)

Social workers are increasingly seeking evidence-based knowledge as a guide to the development of social policies and practices (Mullen, 2014). In evidence-based practice, evidence is often considered to be research-based. Social workers may see information that they gain from interactions with patients as evidence as well, which is why they may be resistant to research-based knowledge (Gilgun, 2005). According to Gilgun (2005), evidence-based practice in social work rests on four cornerstones: (1) research and theory, (2) practice wisdom, (3) our personal assumptions, values, biases, and world views, and (4) what patients bring to practice situations. It is important to be able to analyze and understand the patient's needs, while

critically evaluating the literature, to successfully begin the process of evidenced-based work.

Other aspects of EBP that are often used in social work are environmental variables, organizational variables, intervention focused variables, available technologies, and patient system variables; many of these variables must be considered in order to demonstrate successful evidence (Mullen, 2014).

Some social workers may resist EBP because they do not see it as practical and do not want to abandon their current treatment modalities that are working for their patients (Amodeo, Ellis, & Samet, 2006). Evidence-based practices were extremely important during my practicum both with my project work and clinical work. This was critical since the work I was completing was going to be incorporated into practice and shared across networks. It was also important that my clinical work was grounded in evidence. The discussion of evidence-based practices came up when patients were considering clinical trials or when they were looking into alternative forms of treatment such as consulting a naturopath. It was important to advise the client to check their sources, to see if the information was based on evidence and if the information was written by a legitimate and credible person/organization.

Advance Care Planning

Advance care planning (ACP) provides patients with an opportunity to consider, discuss, and plan their future with healthcare professionals (Barnes et al., 2011). This area of healthcare is very relevant as social workers, especially those working in palliative care, are very responsive to the need of ACP and are often the professionals initiating the conversation (Kramer, 2013). Through researching ACP, I learned that there is a large empowerment piece that patients receive through documenting their healthcare wishes because they are in control of their future care

giving them the power to choose what is best for their individual needs (Mitchell & Dale, 2015). The implementation process of ACP is a much more challenging piece as 27% of adults have put little to no thought into their end-of-life care (Pew Research Centre, 2013). Physicians also challenge the implementation process, as they are reluctant to have the conversation about future care (Zhou et al., 2010) and believe that these discussions could destroy a patient's hope and may deter them in having future discussions about their health and treatments (Munday, Petrova, & Dale, 2009). Through research and conversations with staff at NECC and other Ontario cancer centres, it appears that there is no standard for ACP conversations. The importance of developing a standardized process will be discussed in the following chapter through the analysis of my environmental scan and chart audit.

Shadowing and Clinical Opportunities

I was extremely fortunate with the shadowing and clinical opportunities I was given. This section will describe my shadowing and clinical experiences, as well as a discussion of my goal of learning about, and applying, reflexivity in my work. I shadowed the following disciplines and areas.

Social Work

I had the opportunity to shadow five social workers in the Supportive Care Program. I shadowed sessions that were instrumental, as well as sessions that involved more emotional support. Instrumental sessions primarily involved learning about how to gain financial support, where sessions requiring emotional support consisted of learning coping mechanisms, and gaining bereavement support. I assisted the social workers with follow-up phone calls, documentation, case notes, and research that allowed for feedback and learning opportunities.

Physiotherapy

I shadowed one physiotherapy session which allowed me to gain an understanding of the importance of exercise and proper physical movement when battling cancer. I also learned about lymphedema which was a term I was unaware of before. Lymphedema is the swelling of soft tissues that can begin during or after cancer treatments (Lymphedema Association of Ontario, 2016). This term was discussed quite often as many patients with lymphedema require compression therapy and require funding to receive proper compression garments. These cases often involved the physiotherapist and social worker collaborating together to gain the necessary funding for the patient.

Speech Language Pathology

I had the opportunity to sit in on two patient swallow-tests. This was a very interesting experience because I was not aware of this procedure. This involved watching patients with head and neck cancer swallow three different textures. The swallowing was monitored through an x-ray machine. The purpose of the test was for the speech language pathologist to monitor if the patients could properly swallow after experiencing radiation and/or surgery to the head and neck. The results of the test would provide the patient with further dietary information such as if they could move from a liquid diet to a solid diet.

Chemotherapy Oncology

I was given the opportunity to shadow an oncologist in the chemotherapy clinic. I shadowed well-follow-ups, check-in appointments, and new patient appointments. It was important to be able to shadow these appointments because they are often the start of a patient's cancer journey, allowing me to better understand the cancer journey from the beginning. I was

also able to witness the large caseloads that oncologists experience in one day and grew a greater understanding of the importance of referrals, as the oncologist does not have adequate time to discuss many areas such as advance care planning, nutrition or finances.

Radiation Oncology

I was given the opportunity to shadow two-half days with an oncologist in the radiation department. One day consisted of shadowing review appointments, which is when patients who are currently on treatment were seen to see how they were coping with treatment and to answer any patient questions/concerns. The second day consisted of shadowing in the radiation clinic where new patients were seen and given their treatment regime. In both cases, I witnessed patients being given palliative statuses which led to very challenging conversations. This was a very eye-opening experience which gave me better insight of the conversations that oncologists are responsible for having.

Radiation Technology

I was given the opportunity to shadow radiation technologists during a radiation planning appointment. This appointment involved a patient being fitted for a mask which would ensure that the patient would receive radiation in the same spot during each treatment. This allowed me to better understand the process of radiation and how radiation technologists prepare their patients for the process.

Hospice Grieving Group

I spent a day at the Maison Vale Hospice in Sudbury, Ontario. I learned about the services offered at the Hospice, as well as how referrals to the Hospice are made and what makes a patient eligible, such as they must have a prognosis of 3 months or less to live. I also sat in on a

grief and bereavement group where people who had lost a love one were able to find support and express how they were coping with the loss. There were participants who had lost loved ones very recently, as well as others who had lost loved ones in prior years. The group was very inclusive to all individual circumstances and was emotionally moving for me.

Clinical Cases

I was given the opportunity to assist with five patient sessions and was responsible for any additional follow-ups. The patients I worked with had instrumental needs, primarily financial requests. Since my practicum took place over three months, it was important that I worked with patients who could be assisted in the time I was there to ensure their concerns were completely seen through. These sessions gave me the opportunity to communicate with different organizations such as the Ontario Disability Support Program, Wheels of Hope, Service Canada, War Amps, and the Northern Cancer Foundation. Before starting my practicum, I was more familiar with the emotional side of cancer and I was not aware of the financial strain that cancer can cause. I was not aware that many patients could not afford their medications and/or their travel expenses. This could lead to missed mortgage payments, hydro arrears, and poor living conditions due to spending all their resources on their cancer treatment. By assisting patients with instrumental needs, I became more aware of the importance of programs that can provide financial assistance to cancer patients.

During my shadowing and clinical work, I learned about an effective measure that is used at NECC to help with individualized care, the Edmonton System Assessment Scale (ESAS-r). The ESAS-r is a requirement for all patients to complete upon their visit to the cancer centre. The ESAS-r is a tool that was created to help assess nine common symptoms within the cancer

population (Cancer Care Ontario, 2016). These symptoms include pain, appetite, nausea, shortness of breath, tiredness, fatigue, depression, anxiety, and overall well-being (Cancer Care Ontario, 2016). Patients are asked to rate the symptoms on a scale of 0-10, which can help the professional they are seeing initiate a conversation about how the patient is coping. An important aspect that I learned from examining various ESAS-r scales is that even if the number is rated low, it is still very important to ask the patient their perspective on the rating. For example, a depression rating of a three may appear to be low but it could be an extremely high rating in that patient's life, making it very important to investigate and to ask questions. This scoring process is very individualized and allows the patient to bring fourth areas that they are concerned with which gives them the opportunity to be an agent of change in their life. By having a conversation about their scores, the patient can make a difference in their health.

Reflectivity/Reflexivity in Social Work Practice

In this section, I will discuss both reflectivity and reflexivity with a section on reflexivity in research. Reflectivity involves “reflecting upon the ways in which our own values, experiences, interests, beliefs and political commitments shape our identities” (Ben-Ari & Enosh, 2010, pp.154). Reflexivity pertains to “an individual's considered response to an immediate context and making choices for further direction” (D'Cruz et al, 2006, p.76).

The concept of reflectivity is a crucial component for social work practice and can be defined under a few lenses. One of the common variations is focusing on an individual's response to his/her situation often looking at self-development and self-reflection (D'Cruz, Gillingham, & Melendex, 2007). The terms reflectivity, reflection, self-reflection, and critical reflection are used interchangeably to describe the same concept (Ruch, 2002). Keenan (2004)

identified self-reflection as the defining feature of clinical practice where workers can describe themselves, their patients, and their clinical relationship. In anti-oppressive social work, workers are positioned as powerful and patients are seen as powerless (Mullally, 1997). Critical reflection is necessary to examine the dominance of the social worker-client relationship (Heron, 2005). Reflectivity is also necessary when considering power, whiteness, and privilege. These areas must always be 'checked' to ensure that power imbalances are not being demonstrated throughout a session (Badwell, 2016).

This area of reflective practice was especially highlighted both clinically and within the project components of my practicum. In my clinical work, reflecting allowed me to have a better understanding of my thoughts and feelings, and how those emotions may be adding or taking away from my work. For example, when I worked with patients who were in great financial need, I would write down how these cases affected me. I realized that my mom was very financially fortunate during her experience with cancer as the majority of her expenses were covered through her benefits plan. I was able to witness the unfortunate realities that many patients have choosing between medical expenses and mortgage payments. This reaffirmed the importance of policy in social work practice as I believe patients should not have to pay for parking, travel accommodations, and cancer-related drugs. Through writing down my thoughts and feelings, it has encouraged me to be even more aware of policies and how they can influence my ability to successfully assist a patient. I was also able to ask questions about programs that exist to help patients financially such as government funded and privately funded programs. Through reflecting, I became better aware of what I could do assist patients.

By keeping a reflective journal throughout my practicum, I was able to recognize areas

that required improvement. My journal helped me focus on each patient's individual experience rather than comparing patient's experiences to my mother, who has been through cancer herself. I did keep the majority of my reflection to myself as it often focused on my personal thoughts and feelings of cancer but if I experienced questions or uncertainty during my reflection process, I would present these areas to my supervisor. This type of practice was very beneficial from a clinical perspective because I was able to write down my thoughts and feelings that surrounded the sessions that I shadowed and how they influenced me as a social worker. I looked at areas of countertransference that I experienced when working with a very vulnerable population and how debriefing with the social workers was very helpful in the reflectivity process. For example, I shadowed a caregiver session where the social worker was helping prepare the wife for her husband's passing. Together they were discussing hospice care, spending time with family, and funeral arrangements. The discussion also included how the patient experienced a failed stem cell transplant, leaving him with very few treatment options. This session made me feel very sad yet grateful.

At the end of the session, when the client left, the social worker asked me for my thoughts on the session. I explained that I thought it was very sad that someone so young, with young children had to experience such poor health. I also explained to her that my mom has gone through a stem cell transplant and that, as a daughter, I feel fortunate for my experience, as I could not imagine how his children were coping. Through discussing this with her and reflecting on the idea during therapy supervision sessions, I became further educated on stem cell transplants, such as the different types, how they can be effective/ineffective, and how they may only be considered successful for a certain length of time. By educating myself and listening to

the professional experience of the social workers, I gained a better sense of how to react and/or reflect upon these client sessions and how to be more aware of my reactions and reflections.

Reflection caused me to acknowledge all the components of my research and to reflect upon all the minor intricacies to ensure that the research was sound. Writing down my thoughts and feelings allowed for clarity and a better perspective on the work I was doing. I was able to determine if I was influencing my projects through my experience and bias, as I reflected on the work I accomplished within that week. I would review the area of the project I worked on, and how I accomplished it. I would determine if all my work was grounded in research to confirm that I did not add in or take away information based on my opinion. Looking at my projects from a reflective position allowed me to see how the project came together and if areas needed to be altered to further demonstrate the research.

Reflexivity is an immediate response that directs how social workers proceed within a session (D'Cruz et al., 2007). Acknowledgment of how personal values and viewpoints influence practice is the hallmark of ethical practice; to connect with patients, social workers must hold their opinions lightly, examine them, modify them, and even discard them when working with new patients (Gilgun, 2005). Being conscious of your background along with personal experiences and feelings of the area/population you are working with must be taken into account (Newbury, 2011). To have proper practitioner reflexivity, it is important to understand that the patients are the ones who will be able to generate new knowledge and perspectives which can cause interpretations to be shifted and influenced (Newbury, 2011).

Reflexivity in my practice was very important for me during my practicum, as I had to be aware of any personal experiences that I could be bringing into my client sessions. My mother

was diagnosed with cancer in October, 2014, and I witnessed many of the battles she had to face. I had to ensure that I was not comparing anyone's cancer journey to that of my mother's as everyone has a different experience. I also had to be conscious of my emotions and feelings especially if a patient had the same type of cancer, the same treatment regime, and a similar story. I did share my personal experience with my supervisor and with the social workers I was shadowing, which was very helpful in the reflection process because I was able to have an objective person to debrief with and to explain my feelings to. I think being aware of my emotions was very helpful because I was cognizant of how I was feeling and was constantly reflecting on if it was affecting my work. I do not believe my personal experience hindered my work. I personally believe it added to it because the most common type of support that cancer patients require is emotional support (Mattioli, Repinski, & Chappy, 2008). I thought my personal experience helped with my ability to empathize with the patients and their family. I also understood what happens outside of the social work session, such as the number of tests that are required, and the travelling that occurs. This allowed me to have a stronger grasp of everything that goes beyond a single appointment which was very beneficial in successfully connecting with the patient.

Reflexivity: Analysis of Myself

When reflecting on my experience during my practicum, I am aware that I was affected both professionally and personally. During my shadowing and clinical work, I experienced thoughts and feelings that will forever change how I practice social work and how I am as a person. Walking throughout the cancer centre I saw many patients who were there alone, and I found that to be very difficult. I was challenged with the idea of 'how could someone go through

this process alone' and it did affect me personally. I was sad to think of how many patients travel to NECC alone, sit in chemo alone, and receive 'bad' news alone. I question if over time this would have impacted my work, such as would I have experienced burnout because of this? Beyond the challenge of seeing clients alone, I shadowed sessions with patients who were given palliative statuses. These sessions encouraged me to further develop skills such as debriefing, self-care techniques, and of course reflection. Although, I was not their primary social worker and had only met them one time, it was hard to think that the individual in front of me may pass away in the very near future. Knowing this prompted the importance of being in the present moment and to always be aware of what is around you.

I found that the majority of my reflection occurred outside of social work sessions. For example, when shadowing in the clinic alongside an oncologist, I found many of the conversations difficult. It was difficult witnessing conversations where patients were given very difficult news, especially since the oncologist did not have a lot of time to spend with the patient due to their busy schedule. I found this very hard, as many patients may not have been given the time to ask questions or to fully process the news. This was very challenging for me as I did not know how to process what I saw and found myself thinking, 'how will they tell their family', 'how will they manage', and 'do they have the financial means to cover their expenses'. Through witnessing appointments in the clinic, I feel like I was better prepared in social work sessions as I had a greater understanding of what they may have experienced. I also think my personal experience helped as well, as I understood how some, not all, family members may be feeling when they hear that their loved one received a cancer diagnosis. I think my personal experience helped to prepare me for this practicum and, in turn, this practicum has helped prepare me for my

future as a social worker. This experience has guided me into a direction that I am completely passionate about, as well into areas that I never considered before, such as working in the area of grief and bereavement.

I also had to consider my thoughts and feelings during my project work. Learning about advance care planning caused me to become very passionate on the topic. I thought it was a very important area of healthcare that should be discussed more often. It was hard for me to accept that many healthcare professionals do not participate in ACP conversations, which added a challenge when completing my projects. This was especially a challenge when I was completing my chart audit, as I found it very difficult to read about the pain and suffering that a patient was in, and see that they were not having the conversations about their future care. I questioned why ACP conversations were not occurring when the patient was at end-of-life, and it encouraged me to work even harder to help standardized the process of ACP to prevent this from happening again.

Reflexivity in Research

Reflexivity in research is generally understood as awareness of the influence the researcher has on the people or topic being studied while also recognizing how the researcher's experience is affecting the researcher (Gilgun, 2008). In research, there can be issues on how researcher bias can cause someone to unconsciously influence the research; this is why it is important for the researcher to constantly reflect on their work and be cognizant of their biases (Probst, 2015). This area of reflexivity was especially important during my therapy supervision project, which will be further explored during the next chapter, as I suggested models of supervision that I thought would be appropriate for the social workers in the SCP. At first I was

unaware of how I was influencing the research until I realized that the models I was reviewing were areas of my interest and not necessarily suitable for everyone else.

With the two projects I worked on, I had to engage in reflexivity to ensure that the ideas I was presenting were true to the research and not influenced by my personal opinion or bias. When I contacted different cancer centres throughout Ontario to discuss advance care planning measures within their organization, I had to ensure that I clarified each area that we discussed to ensure that I was not interpreting their thoughts in a different way. I had to be cognizant when asking questions because I did not want to influence their answers by stating my opinion or what other professionals had suggested during earlier conversations. I was continuously ‘checking myself’ to make sure that I was being true to the information that I collected and not influencing it with my opinion. My opinion is that advance care planning should happen earlier in a patient’s diagnosis, as waiting too long to have this conversation could be detrimental to one’s well-being. I also believe that professionals should be encouraged to promote these conversations and not hide from them. Sharing these opinions could have influenced conversations and altered the results of my project, as many of the professionals I spoke to believed that conversations should occur at the palliative stage. Once my project was complete, I sent the completed power point to all the professionals I spoke with to ensure that there were no inconsistencies or false information, which assisted with the validity of the project. The final section of this chapter will describe how my clinical experience best aligned with theory through discussing the supportive expressive therapy model and the cultural competency model.

Connecting Theory to Clinical Work

Through my experience of shadowing and clinical work, there were two models that

highlighted the work that the social workers did on a daily basis; a supportive expressive therapy model, and the cultural competency model. Although, many models could apply to the work that is done within the Supportive Care Program, these were the two that I personally witnessed the most during my practicum. Within the SCP the social workers work closely with the supportive expressive therapy model, especially when the patient is at end-of-life. I also had discussions about the importance of cultural competency with my supervisors, especially when working in the North with Indigenous populations. These models placed the client at the forefront and they became the sole focus of the session. This section will describe each model and how I believe they are relevant to my practicum experience.

The goal of the supportive expressive therapy model is to help patients feel comfortable in discussing their personal experiences, as well as to help patients identify and work through interpersonal relationship issues (Luborksy, 2000). This therapy is used with patients with metastatic cancer to create a discussion often focusing on fears of dying and death, concentrating on life priorities, improving support and communication with friends and family, integrating a changed self and body image, and improving communication with physicians (Splegal & Classen, 2000). This type of therapy is also used with women with breast cancer to reduce depression, helplessness, and hopelessness (Kissane et al., 2007). The addition of supportive expressive therapy groups have also been used to promote support and sharing between members. The groups can be open to all cancer patients, be based on stages of cancer, or focus on a theme such as forgiveness and spirituality (Shapiro, McCue, Heyman, Dey, & Haller, 2010). This method is utilized both in advance care planning conversations and in support sessions. The social workers at the SCP often initiated ACP conversations where they would focus on a lot of

these areas, such as how to express feelings to family and friends, and how to prepare for the future. Expressing thoughts and feelings can help a patient determine their goals and wishes, encouraging the ACP conversation. In terms of supportive sessions, work around self-image, sexual experiences, and forgiveness were often conversations that I had the opportunity to witness. I also sat in on a Lunch and Learn, where we discussed how to encourage patients to have a conversation about how their diagnosis is affecting their sex life and how to provide support in this area. This type of model is utilized in the educational groups as well because it brings together groups of people with similar concerns, allowing them to share their experiences and support each other through their cancer journeys.

Cultural competency is also a critical skill in working with patients (Stein, Sherman, & Bullock, 2009). Cultural competence in social work practice refers to the process of how individuals respond respectfully to people of all cultures, languages, classes, races, ethnic backgrounds, and religions in a manner that recognizes the worth of these individuals (Rego, 2014). To develop cultural competence, social workers have to be aware of their own biases and attitudes (Kohli, Huber & Fuel, 2010). It is important to understand and support client values and engage in conversations based on these values (Park, Roh, & Yeo, 2011). A client may have a different cultural understanding of their illness than that of their social worker. This difference could influence the social worker-client relationship which could negatively affect culturally competent practice if not properly managed (Karel, 2007). Through understanding cultural differences, the social worker will help the client with decision making that will best suit them and their overall well-being (Karel, 2007). At NECC, it was a requirement for staff to complete Aboriginal cultural competency courses to provide better care for Aboriginal patients. These

courses help professionals of all disciplines understand the history, the stigma, and the importance of culture. Being aware of this knowledge, gives the opportunity for greater cultural competency to effectively assist the clients in making decisions that benefit their care.

Conclusion

This practicum offered me opportunity to complete my goals, along with two compelling projects, and clinical work. I shadowed and worked with many different disciplines which added even greater knowledge to my practice and research. I was given valuable tools and supportive supervision that provided me with great confidence when completing my work. Completing both clinical and project components was a large advantage, as I was given more areas of social work to focus on. The next chapter describes my experience working with a multidisciplinary team, an explanation of my ACP/GOCD projects, and a review of my therapy supervision project.

Chapter 4- Critical Analysis of my Practicum

In this chapter I will begin by discussing my experiences working with a multidisciplinary team in the Supportive Care Program at the Northeast Cancer Centre. My project work will then be discussed in detail. This includes two advance care planning projects: an environmental scan, and a chart audit. I will conclude by discussing my therapy supervision project. First, I will discuss, how working with a multidisciplinary team can improve patient care by using examples of how the Supportive Care Program works in collaboration to promote the best patient care. I then will discuss my environmental scan and chart audit projects, and review how these projects can be used to help promote advance care planning within the healthcare setting and encourage better patient care. I will conclude this chapter by discussing the

importance of supervision in social work. I review peer supervision models and discuss the importance of debriefing, arts-based methods, and self-care in social work.

Working with a Multidisciplinary Team

Multidisciplinary teams include professionals from different disciplines who come together to review cases and to address any necessary concerns that those cases may present (Teaster & Nerenbeg, 2003). The rationale behind the multidisciplinary approach is to offer comprehensive assessments and treatments from a variety of disciplines (Garven, 2011). Within the Supportive Care Program, I primarily worked with the social workers but I did have opportunity to shadow other disciplines. Discussions of multidisciplinary team work were often shared within therapy supervision through the discussion of case examples.

When social workers would present their critical or urgent cases, they would often discuss the involvement of other disciplines. This usually included dietitians, oncologists, nurses, and the pain and symptom management team. For instance, with urgent cases, the social workers would often be paged to the clinic to assist the oncologist and the nurse with a patient who was panicking and/or not coping well within the clinic setting. Having the oncologist work with the social worker allows them both to share their knowledge and connect their ideas to provide the best care possible for the patient (Garven, 2011). When complex patient cases were discussed during therapy supervision, the social workers would often discuss their coordination with other disciplines. For example, the social worker may use their skills to assist with emotionally driven work, where they may rely on the dietitian for their patient's physical health. Both disciplines are needed to assist the patient fully, as multidisciplinary teams have been considered to be essential in order for patients to receive the best treatment and care (Flessig et al., 2006). Another example

is that social workers may refer their patients to the pain and symptom management clinic for pain control, something that is beyond the scope of practice for social work. Without the coordination of professionals working together, the patient would not be able to benefit from all of the available services.

The Supportive Care Program (SCP) team would try to coordinate their services around the patient and their treatment regime. For example, the social workers and dietitians may see these patients in clinic alongside oncology appointments. This approach is particularly important when working with complex cases where more disciplines would be involved, especially when timing of treatment modalities is crucial (Flessig et al., 2006). This may happen when the oncologist must give a palliative diagnosis and requires the assistance of a social worker to support with the coping process. The multidisciplinary process also helps in avoiding repeat services. For example, it may be easier for dietitians to discuss the patient's weight and progress during their check-in with the oncologist, rather than repeating the service in their office. I had an opportunity to shadow a dietitian and oncology appointment, where together they were able to assist the patient with two areas of their health, nutrition and treatment modalities, within one appointment. This avoided additional appointments and wait-times since the patient could be cared for by two professionals at the same time. In my shadowing experiences with the oncologists, I witnessed referrals to social workers, dietitians, the Aboriginal Navigator, and the pain and symptom management clinic. This demonstrated the importance of working within a multidisciplinary team as many professionals are needed to provide the best circle of care.

Within the SCP, the dietitians also work closely with the speech language pathologist (SLP) to create the best nutrition plan for the patient. This collaboration is very important as the

SLP knows what the patient can swallow, which helps the dietitian create a food plan based on that information. Through collaborating together, they are able to provide the best services for the patient which will benefit not only their diet but their overall health and wellbeing. This also enhances communication and education between the two disciplines (Guler & Canturk, 2014) because the SLP is able to learn about different diets that will work for the patient's swallowing abilities, and the dietitian is able to adjust diets based on the communication and information provided by the SLP. Without proper communication, the patient would not receive the best care possible which could be detrimental to their health.

There can also be challenges when working within a multidisciplinary team such as time restraints, unavailability of all members to participate, lack of communication, and additional administrative work (Lamb, Jalil, Sevdalis, Vincent, & Green, 2014). I did not see any challenges within the Supportive Care Team, as they all shared the same workspace and worked very closely with each other. The largest challenge that I did see is when patients would mention that they were not aware that social work, nutrition, or physio services were available. This demonstrated that there can be a lack of information or referrals provided to patients between the cancer centre and the Supportive Care Program. This delayed patients from receiving necessary services at time of need.

Project Work Discussion and Analysis

Before beginning my projects, I was provided with educational tools to help in the process. This included an action plan, a 4-step problem solving process, and the '5 why's' template (LEAN, 2017). These were very effective tools in organizing and completing my projects. The action plan provided me with a template to write down all of the tasks that I needed

to complete, as well as a timeline to keep my work on track. The four-step problem solving template helped me demonstrate the importance of my projects. This template looks at a wide array of aspects from what the concern is to how it can be solved. I concentrated on the big vague concern, what should be happening, what is actually happening, the measurable gap, the impact of the gap, the point of cause, the direct cause, the root cause, and the hypothesis. This learning tool demonstrated the need for both my ACP and therapy supervision projects because I was able to demonstrate that a gap existed and how it was affecting all areas of the hospital, including the patients, the staff, and the hospital itself.

The ‘5 why’s’ template describes the problem and why it is happening through a series of statements. The goal of this template is to reach the overall problem in five statements or less. The statements that I used for my therapy supervision project were ‘there is no real time reporting of psychosocial oncology within the SCP team’, ‘there is no specific method to report cases in a real-time format’, and ‘there is no standard for reporting cases in a timely manner’. Through these statements, I was able to demonstrate that a standard for therapy supervision did not exist, which was the core issue. By identifying what lead to the core issue, I could determine what was needed to fix it.

All of these templates are based on LEAN methodology, whose mission statement is to “make things better through lean thinking and practice” (LEAN, Mission Statement, 2017). The Lean Enterprise Institute (LEI) was founded in 1997. It is a non-profit, education, publishing, research, and conference organization. According to LEI, LEI is not a ‘think’ tank but rather a ‘do’ tank (LEAN, 2017). LEI develops hypotheses in regards to lean thinking and tests the approaches to see what would be effective in the real world. These approaches are then taught to

service providers in order for them to transform their organization and cause managers to become change agents within their organization (LEAN, 2017). Educational opportunities can include lean learning materials, co-learning partnerships, lean summit conferences, and utilizing the lean website for tools and techniques (LEAN, 2017). This methodology is used throughout HSN, including NECC. By using the provided materials, it allows for work to be completed more efficiently and effectively. The next section of this document will review my advance care planning projects.

Advance Care Planning Projects

I completed two advance care planning projects; an environmental scan, and a chart audit. The environmental scan consisted of contacting the Psychosocial Oncology (PSO) Leads across Ontario and requesting interviews to discuss how advance care planning (ACP) and goals of care (GOCD) is implemented within their cancer centre. My goal with this project was to use the information provided with research to inform a standardized program that could be implemented and sustained throughout NECC and be shared with cancer centres across Ontario. It was explained to the PSO leads that the purpose of my project was to assist in the standardized process of ACP and that the information I was gathering could be used to help their organization begin the standardized process. The chart audit project was specific to NECC, where 20 charts from four different disease sites were reviewed to see if advance care planning conversations were utilized. The goal of this project was to see if conversations about ACP were actually occurring at NECC and how these conversations were being documented.

Environmental Scan. The first step of this project was to draft a questionnaire to send to the Psychosocial Oncology (PSO) Leads. This included the 14 LHIN sites, Erie St. Clair, South

West, Waterloo Wellington, Hamilton Niagara, Central West/Mississauga Halton, Toronto Central North and South, Central, Central East, South East, Champlain, North Simcoe Muskoka, North East, and North West. Based on the literature on ACP, I arrived at nine areas of focus for my questionnaire. I developed the questionnaire with support from Dr. Mayer. Together we discussed areas of focus that would provide us with a wide range of information, from how to begin the conversation to how to document the conversation. The following is from the questionnaire that was sent to the PSO leads:

1. Who initiates the conversation of advance care planning and/or goals of care setting within your organization (doctors, nurses, social workers, etc.)?
 - Who is involved during the conversation, i.e., family members, substitute decision maker, etc.?
 - At what point would this conversation occur within the patient's cancer journey?
2. Do you have different practices or guidelines in place for your Indigenous clients?
3. Are there educational opportunities or educational materials that have helped guide the advance care planning conversation/goals of care for health care professionals (HCP)?
 - If yes, what has been the delivery method of the educational opportunities? (Power Point presentations, course training, case studies, etc.)
 - In addition, are there educational opportunities and materials available for patients and their family/caregivers? If yes, can you share what those are (information booklets, fact sheets, educational classes, etc.)
4. When conversations happen with patients and/or caregivers about advance care planning, how much time is allocated for discussion? Are separate appointments

scheduled with physicians/other HCP or is the conversation taking place during the clinical visit?

5. How is documentation being kept about advance care planning/goal of care discussions?
 - Would this be kept in an electronic or paper chart?
 - Do you keep a copy of signed advanced care documents within the patient's medical chart?
6. Are the advance care documents being regularly checked to ensure that the patient's wishes are current? Is this information shared with the patient's primary care physician or any external stakeholders such as with the Community Care Access Centre?
7. Do you see any barriers in implementing the advance care planning/goals of care conservation?
8. Are there any champions within your organization that lead the conservation or programming on advance care planning/goals of care? Is there anyone else within your organization that I should speak to regarding advance care planning/goals of care?
9. Is there anything else that you think I should know about your organization and how advance care planning/goals of care are applied? Are there any final comments?

After sending my questionnaire, I contacted all the PSO leads to arrange a phone interview.

In some cases, I was redirected to other professionals within the organization who would be better suited to answer my questions. I spoke to a range of professionals including, nurses, social workers, and managers. I was able to speak to 12 different individuals from eight LHIN sites.

It is said that although the majority of professionals working in palliative settings find ACP useful in the treatment decision making process, only 62% feel comfortable having these

conversations (Voltz, Akabavashi, Reese, Ohi, & Sass, 1998). I was curious to see who initiates the conversation within each cancer centre to determine who is taking on this role. In the information that I was able to gather, the role was described as being taken on by oncologists, nurses, and social workers. An important piece of information that was shared with me is that everyone can have this conversation and that everyone should initiate it. This was a very powerful statement as it showed that all healthcare professionals should be promoting ACP. When asked who is part of these conversations, all the cancer centres mentioned the importance of the substitute decision maker (SDM). The majority of the time, the SDM is the person making the decisions at the end-of-life, and not the patient (Hospice Palliative Care Ontario, 2016). The substitute decision maker's perception of what the patient would want may not always be in line with the patient's actual preferences (Sudore, et al., 2008; Barrio-Cantalejo et al., 2009), which is why it is important to include the SDM in goals of care discussions to ensure the patient's wishes are heard and validated (You, 2014). The professionals I spoke with stated it was especially important to include the SDM as the patient nears end-of-life or is no longer capable of answering questions about their health.

The cancer centres did vary when answering the question about when ACP/GOCD conversations should occur within a patient's cancer journey. Many of the professionals I spoke with stated that ACP conversations usually occur when the patient has a change in diagnosis or reaches the palliative stage. This point does coordinate with some of the research as there are indications that such discussions should not be initiated too early but rather after recurrence or if the patient's health becomes poorer (Barnes, Jones, Tookman, & King, 2007). There are other suggestions such as the United Kingdom guidelines, which suggest that ACP discussions should

begin in the outpatient setting before the patient becomes too unwell (Royal College of Physicians, 2009). Although many of the professionals I spoke to said that conversations do not happen early, many believed that in order to meet best practice standards, the conversation should be happening earlier in the diagnosis to better prepare the patient and their family for future care.

When asked if any practices were in place for Indigenous patients, most of the cancer centres answered that there were not. The Indigenous community was the only specific population on which I concentrated. Every cancer centre has an Aboriginal Navigator and it was important to see if any additional services were being implemented with the introduction of this position. The NECC serves a large Indigenous community. By focusing on this population solely, it would allow us to understand if different practices were in place and how to standardize these practices within the NECC. The cancer centres mentioned that they would invite their Aboriginal Navigator to join ACP conversations if patients identified themselves as being Indigenous and/or asked for additional services, but for the most part ACP conversations were directed in the same manner. Clements et al., (2003) suggested that it is important not to assume that every Indigenous patient follows traditional practices and that not all Indigenous patients will want the same services offered to them. This is why many healthcare providers should not assume that their patient will want different services (Clements et al., 2003). If the patient did identify, there is specific Indigenous ACP information provided by the 'Speak Up' campaign which can be utilized by the staff and the patient (Speak Up, 2016).

Providing health care professionals with training and support in initiating the conversation allows more patients' wishes to be properly identified (Morrison et al., 2005). I was

very impressed by the amount of great learning opportunities and initiatives that were taking place across Ontario. This included Lunch and Learns, workshops, attending nursing rounds, providing educational material, creating posters, watching You-Tube videos, and going into retirement homes within the community to discuss areas of ACP. Education is the greatest tool in helping healthcare providers start the conversation, as many healthcare staff will often avoid discussing ACP to prevent patients from getting upset or prevent them from believing that the staff have 'given up on them' (Zhou et al., 2010). Education is also equally as important for patients as they may also fear that they are signing their life away once they agree to participate in ACP conversations (Elpern, Barry, Stoeckle, Ettelson, & Emanuel, 1993). By researching and reviewing all of the educational resources that were discussed in my interviews, I was able to share all of the work across Ontario by sending my Power Point to the PSO leads from the 14 LHIN sites. These sources may be used to help benefit all of the cancer centres and their current educational approaches to ACP/GOCD.

The importance of timing is very critical when having ACP conversations. When asked when the conversation would happen, it was suggested that the oncologist will attempt to have the conversation in their clinic but often do not have the necessary time to have the conversation fully. Time is one of the largest barriers in staff implementing the ACP conversation. Healthcare staff have very limited time to see each patient and feel as though they do not have the necessary time to have these conversations in an in-depth manner (Zhou et al., 2010). The professionals I spoke with also noted 'time' as being one of the largest barriers in implementing the ACP process. In my interviews, it was suggested that the patient will begin the conversation with their oncologist but will often receive a referral to a social worker to complete the conversation. This

highlighted the importance of having social work involved to develop the best care for the patient.

In my environmental scan, how ACP/GOCD was documented was the largest area I focused on as it appeared to be the largest barrier in both the literature that I reviewed and in conversations I was having with the SCP staff. It has been recommended that documentation is highly visible and transportable across the entire patient's care setting, such as an electronic record that is accessible to all care providers (You, 2014). All the cancer centres stated that they used electronic charting which, as stated by You (2014), helps facilitate proper communication about the patient's wishes amongst the entire healthcare team. Many mentioned their use of 'Speak Up' documents because it allows them to follow a specific guideline, allowing the conversation to be less intimidating. They can also gain all the necessary information based on the questions provided (Speak Up, 2016). These planning tools allow patients to document who their substitute decision maker is, their wishes and values, and other important personalized details that are specific to their healthcare plan (Speak Up, 2016). While 'Speak Up' documents are not considered to be legal documents, they do help guide the patient's healthcare decisions and offer consistency across healthcare providers (Speak Up, 2016). This process also provides an easier opportunity for healthcare providers to share consistent information to others who are involved with the patient's care such as their family physician and Community Care Services. This does make the process easier yet not all cancer centres agreed on who the information would be shared with as many did not think community care services should receive ACP information.

I was also curious about how often the patient's Advance Care Planning and Goals of Care Discussions (ACP/GOCD) documents were revisited. Patients' choices vary and they can have different priorities and preferences (Tinetti, 2012). These can change as a patient moves on in their diagnosis, which is why it is important that their wishes stay up to date in their chart. Most cancer centres stated that the information was only reviewed if the patient had a change in diagnosis but, otherwise, their wishes were left as is. This question did help trigger best practice standards amongst the professionals with whom I spoke with. They stated how patients' wishes should be reviewed more frequently. Discussing documentation also sparked conversation about technology and the importance of accessibility which You (2014) suggested is very important within the healthcare setting. Three of the cancer centres I spoke with stated how they have specific areas within their electronic charting that is used for ACP/GOCD. This allows the information to be more accessible and encourages the conversation to happen. Through showing the benefit of accessible documentation and how it can benefit ACP/GOCD, I am hopeful that other cancer centres will examine this approach to provide a better service to their staff and their patients.

The largest range of answers in the interviews with which I was involved were in regards to the barriers and challenges that prevented the implementation process of ACP/GOCD. One of the most common barriers is that physicians are often reluctant to have the conversation (Zhou et al., 2010). This was also true based on the conversations I had through my interviews. It was stated that the oncologists would often delay the conversation until the patient reaches the palliative stage. Another barrier were the gaps in ACP among racial/ethnic minorities due to staff lacking the understanding, language barriers, and opposing cultural beliefs and values (U.S

Department of Health & Human Services, 2012). This was apparent in my interviews with staff working with Indigenous populations as they did not always have the resources to implement ACP in a way that would incorporate the needs of Indigenous people such as not having adequate spaces for families to discuss future care decisions. Other barriers included conversations not being properly documented, documentation being difficult to find in the patient chart, and not knowing who is responsible for initiating the ACP/GOCD conversation.

I ended the interview by asking who was a champion of ACP/GOCD in their cancer centre and if they had any final thoughts that they would like to share. This allowed the professionals with whom I spoke to, recognize all of the people within their workplace that promote ACP/GOCD such as oncologists, nurses, palliative physicians, pain and symptom management teams, family physicians, and social workers. Final comments that were shared were the importance of having conversations about ACP, the desire to change the ACP name to make it more familiar and less intimidating, eliminating the stigma of ACP, and bringing the conversation out of the hospital and into the community to make the concept more familiar to individuals who are not ill, and to promote the conversation to begin earlier. One interviewee shared that my questions caused her to think about how she can promote ACP and make a change within her workplace.

My final Power Point presentation was shared via e-mail with the Psychosocial Oncology Leads across Ontario, as well as each individual person I interviewed, in hopes of standardizing ACP/GOCD. This was also a very large opportunity as a student, as my work was being shared provincially and could be used to help create a standardized process. The Power Point was very

well received and I was asked if my presentation could be shared with an ACP champion group in Toronto.

The information gathered in the environmental scan was very consistent with the literature (You, 2014; Myers, 2016; Barnes et al., 2011; & Hospice Palliative Care Ontario, 2016). The barriers and challenges section was especially similar. The scan also reaffirmed the importance of having the ACP/GOCD conversations as both the literature review and interviews demonstrated how important the ACP process is, and how it should be occurring more regularly to promote better patient care.

Chart Audit. To see how the Northeast Cancer Centre was implementing ACP/GOCD, I was asked by the Vice President of NECC, Mr. Mark Hartman, to complete a chart audit. This consisted of auditing 20 patient charts from four different disease sites (breast, prostate, head and neck, and lung). My audit consisted of looking at the age of the patient, date of diagnosis, treatment regime, referrals, as well as Dr. Jeff Myer's six goals of care discussion questions, which were listed earlier in my literature review. It was important to see if these conversations were taking place, who was initiating these conversations, and when these conversations were occurring within the patient's cancer journey.

It was determined through the chart audit that 40% of patients did have an ACP/GOCD of some form. The goal of the NECC is for 100% of patients to have this conversation. After completing my chart audit, I formed a hypothesis based on the information that I found. My hypothesis was, "If health care providers begin to utilize the "surprise question" (would you be surprised if this patient died within the next year) in their clinical practice by April, 2017, and there is evidence of documentation within the NECC (EMR) documenting the patient's

wishes/goals of care, it will reduce unnecessary treatment being provided in the last 3 months of life". This hypothesis was created with support from Dr. Mayer and I included it in my 4-step problem solving document. At the end of my practicum, I presented my hypothesis to Mr. Mark Hartman who approved the hypothesis. This permitted Dr. Mayer and I to post my chart audit findings as well as my hypothesis to an education board within NECC. This would help the implementation process of ACP within the cancer centre by demonstrating what is currently happening within the NECC and the difference that ACP can make within the healthcare setting. Since my hypothesis was based on future clinical practice, I am unaware if my hypothesis will be correct but I am hopeful that if implemented it will be proven successfully.

Much of what I was seeing in the patients' charts was consistent with the literature that I reviewed (You, 2014; Zhou et al., 2010; Barnes et al., 2011) and the information received in the environmental scan, as my audit demonstrated that there is no standard in how ACP/GOCD conversations were taking place at NECC. This further proved the need for a standardized process in order for patients to receive better care as many patients within the chart audit did not have documented conversations about their goals or wishes. It was quite difficult to review charts where the documentation clearly showed that the patient was at end-of-life and still they were not given the opportunity to discuss their goals and wishes. This made me question if the patient had arrangements in place, if they had the opportunity to express their feelings with their family, and if they had decided where they would like to pass away such as in a hospice, at home, or in a hospital. A standardized process would ensure that each and every patient would have the opportunity to have a conversation about their future care, along with their wishes and

goals. Without a standardized process, it is unknown if patients are having the opportunity to address these areas.

I summarized my findings of the environment scan and the chart audit, and presented them to the Vice President of the Cancer Centre to help with the development of ACP/GOCD. I was able to provide information on who was initiating the conversations, when the conversations were occurring within the cancer journey, and what aspects of ACP/GOCD were being discussed. This included discussions on hospice care, funeral arrangements, and finalizing decisions on how to proceed with treatment. This information can help develop guidelines in creating a better standardized process. The information from the chart audit can also help further develop the ACP/GOCD process as barriers/challenges were recognized and champions of the work were identified. This information can be used to help create a standard by taking direction from the champions of the work and working with the existing barriers.

I also presented my entire ACP/GOCD Power Point presentation (see Appendix B) during a program council meeting, where I was able to present to the entire staff of the SCP as well as other invited staff members who were involved with an ACP pilot project within Health Sciences North. This was a separate project from mine that began in March 2016. It was important to invite these staff members to my presentation as they were very knowledgeable on the subject. The pilot project was initiated in order for conversations around ACP/GOCD to become more frequent and normalized with HSN. It began on one floor at HSN, the in-patient cardiology unit, and is currently being expanded to other floors of the hospital. The pilot project began with having ACP/GOCD with patients who are 85 years and older within the first 24 hours of being admitted to the unit. The project is encouraging staff to be comfortable in initiating the

ACP/GOCD conversation through normalizing the conversation and providing resources. The goal of the pilot project was to provide patients with information and support, which would allow them to make informed choices about their health care. My presentation was able to show a connection to this pilot project by promoting the need for ACP conversations. This sparked a conversation amongst the Supportive Care team of how we can standardize the conversation within the NECC, and who should be responsible for promoting these conversations with patients and families.

Therapy Supervision Models

The project that I was asked to work on was to change the current therapy supervision model to make it more beneficial for the social workers in the Supportive Care Program. The current therapy supervision model consisted of social workers discussing their urgent/critical cases, updating the quality assurance checklist, and discussing any administrative issues. The quality assurance list, which is how the social work referrals are tracked, was falling two to three months in arrears, which was one of the main reasons why the model needed to be reviewed, as most of the supervision hour was spent trying to ‘catch up’ by reviewing and updating the list. There was not adequate time during the hour of therapy supervision for the social workers to debrief their cases which was another aspect that needed to be incorporated into the new supervision model, as the social workers stated they never had time to reflect on the cases they were presenting.

I researched various group and peer supervision models and I asked the social workers their opinion on what they would like to see. I took the advice of the social workers and directed my research towards models that would incorporate their suggestions. Together this helped to

direct our vision for the new model. The social workers stated that they were very interested in peer supervision, which helped guide my research into the peer supervision realm. Peer supervision is led by a peer group, all members are accountable for their own work, and all members are responsible for providing education through their clinical experiences (Kadushin et al., 2009). It was also mentioned by the social workers that it would be beneficial to incorporate a piece that would allow them to discuss how their work is affecting them personally by incorporating time for reflection and debriefing. Reflection would allow the social workers to consider how their cases may be affecting them both professionally and personally, and what type of impact it could be causing. Debriefing is an intervention that has been used in a wide range of areas to assist people in coming to terms with negative feelings and emotions that are associated with traumatic experiences (Raphael & Wilson, 2000).

A successful debriefing process that I believe would work well for the social workers in the SCP is Critical Incident Stress Debriefing (CISD). This form of debriefing is a 7-phase, small group, supportive crisis intervention process (Mitchell and Everly, 1996). The CISD intervention is directed to individuals who have become victims of trauma, such as workers who are in a high-risk environment (Mitchell & Everly, 1995). The CISD process may be defined as group meetings or discussions about a traumatic event or series of events, where seven stages are worked through. These seven stages include 'introduction, fact, thought, reaction, symptom, teaching, and re-entry' (Mitchell & Everly, 1993). These stages help prepare the worker to introduce an incident that has caused some form of distress, explain how they felt about the incident and how it has affected them, provide opportunity to address their symptoms, and help prepare the worker to follow-up (Mitchell & Everly, 1993). This form of debriefing employs a

group education model and Yalom (1985) suggested this format provides numerous healing factors to group members. Although this model shows great promise, there are individuals who believe that this model offers little to no value. One criticism is that CISD may prevent the natural emotional process that often follows a traumatic event and could cause trauma survivors to rely heavily on healthcare professionals for support (Van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002).

For debriefing to be effective, the reactions and understandings of the social workers needs to be explored (Rudolph, Simon, Raemer, & Eppich, 2008). This must be accomplished in a safe environment, where everyone is free is to express their emotions in a group setting (Pendleton, Schofield, Tate, & Havelock, 1984). This is how debriefing will be utilized within the new therapy supervision model. The social workers would be able to express the emotions that are associated with their cases in a safe and comfortable environment. Peers and management can assist the social worker in the debriefing process by helping them reflect on their emotions, and by providing support as they move forward, creating a supportive supervision process.

In reviewing the current therapy supervision method utilized by the SCP social workers, our goal was to prevent the issue of falling behind schedule, and to create a plan that would be more beneficial to the social workers' overall well-being. As the social workers mentioned, I noticed that there was not adequate time in therapy supervision for debriefing and reflection. This is why I focused on incorporating these aspects in our collaborative therapy supervision project. Often the conversation during therapy supervision tends to focus on how the clients are coping and how the case is progressing, leaving the emotions, the stresses, and the fears of the

social workers to become lost in the overall social work process (Kadushin & Harkness, 2002). Social workers are at risk to experience burnout, which can be a result of demanding work in which there are high case loads, insufficient resources, lack of time to complete work, and an increased work load demand (Hombrados-Mednieta & Cosano-Rivas, 2013). Experiencing burnout can impair the physical and emotional well-being of the service provider (Kim, Ji, & Kao, 2011).

After understanding the current supervision model and realizing the changes that needed to be made, I began to work on the new model. I started this project by completing a literature review, and examining different supervision models with particular concentration on peer supervision and reflection orientated models. A peer model would be a fitting model for the SCP team as many of the social workers have over 10 years of social work experience. However, Dr. Mayer and I discussed the importance of referring to the model as a “group model” rather than a “peer model” as it was important to show inclusion for the psychologist and the managers, as naming it “a peer model” could appear to be exclusionary. This caused me to take aspects of peer supervision models and alter them to encourage the inclusion of other members.

For example, Pare (2016) described a model of supervision that focused on acknowledgement and generativity. This model is divided into three phases and concisely demonstrates how social workers can mentor each other in a reflective and encouraging manner. These three phases include sharing, reflection, and debriefing (Pare, 2016). After explaining this model to the social workers, some adjustments were made to better incorporate their ideas and experience. The model suggested that within the first phase, sharing, one group member would interview the sharing group member to gain a thorough amount of information on the case they

would like to discuss. At the same time, the sharing member would be coming to the interview with specific details in what they are looking for, which allows the interviewing member to ask rich questions that are in direct relation to the presenting concern/issue (Pare, 2016). When I presented this model, half of the social workers expressed that they would feel uncomfortable with overseeing the question process, especially when other team members would be present, such as management. One social worker mentioned that she would not be confident in directing the question process in front of managers and the psychologist, as she is newer to the social work field and was concerned that her abilities may be judged.

Based on the input from the social workers, I was able to work on phase one and create a process with which everyone could work, but there were some aspects of phase one that would remain the same. For example, the sharing member would still be specific in what they were looking for during the supervision process, as this aspect was very well-received. The social workers believed that this would help keep the conversation on track and be helpful to the person presenting their case. For the interviewing process, it was suggested that there would be multiple interviewers to make the process less intimidating. This would mean that three or four people may be directing questions, allowing the process to be more inclusive. The second and third phases of this model focused on acknowledgement, reflection, and debriefing. These phases were well received by the social workers. They appreciated that there would be time for them to reflect and debrief on the cases that they were presenting, as there was not time for this in their current therapy supervision process. After the reflection process both the sharing member and the rest of the team would have an opportunity to reflect on their work and debrief on how their work was affecting them. This process provides greater support between staff and opens conversation for

sharing. Supportive supervision can reduce aspects of burnout (Bogo & McKnight, 2005). Having an effective supervisor can help build resilience and reliance on each other that can reduce the risk of burnout (Boyas, Wind, & Kang, 2012).

I also suggested an arts-based group as part of the new supervision model, as it could assist in sharing and supporting each other. Supervision often takes on a talk-based approach but there are other methods such as an arts-based supervision approach that can also be very beneficial (Franklin, 1999). Art making can be used to not only allow difficult feelings to ‘get out’ but also allows feelings to ‘get in’, allowing feelings to be unearthed and to reach emotional depth that could not be accessed before (Tilly & Caye, 2005). Art making can also be used to overcome issues of communication and offer an alternative way of expressing feelings and emotions that may be difficult to express otherwise (McFerran-Skewes, 2005). It can also be used to inhabit others’ worlds, as it is a sensory activity that can activate emotion where lived experiences can be imagined (Sinding, Warren, & Paton, 2014). Furthermore, incorporating art making can be used to express experiences in a safer way (Kozłowska & Hanney, 2001). The use of arts-based practices can be of great benefit, especially in the realms of self-discovery and expression (Van Lith, Scholfield, & Fenner, 2013). “The use of art and other creative activities provides a medium through which expression and learning can occur in a more comfortable and relevant and meaningful manner” (Coholic, 2011, p. 195). Based on this literature, I believe the addition of arts-based groups would be very beneficial to the SCP team as they show great benefits by enabling group members to successfully express their thoughts and feelings in an environment free of judgment.

Social workers tend to focus on the needs of their clients rather than their own needs, participating in self-expression art groups can act as a preventive measure for burnout (Swetz et al., 2009). As described in the literature review, the project that took place in Hong Kong took place over six sessions: self-care, stress management, professional reflection, death memories, and meaning making (Potash et al., 2015). This project was specific to individuals working in oncology which is why I thought it would be an appropriate fit. At first, the social workers were very skeptical of an arts-based program and did not think it would be suitable for their supervision process. Once I explained the sessions and the activity that went with them, perspectives on the model began to change. It was even suggested that this program should be open to all of the staff in the SCP, as everyone could benefit from the arts-based session.

As explained earlier, the first session was focused on self-care where the participants were asked to complete a mandala based on how they were feeling (Potash et al., 2014). The participant in the study drew a sinking ship to show how they were feeling against all the work they had to complete (Potash et al., 2014). This drawing was a piece that many participants in the study were able to relate to due to their heavy caseloads. The social workers could relate to all of the sessions but in my opinion, sessions one and five were the most fitting. Session five showed a participant's perspective on death through the process of meaning making. The participant's interpretation of death was a small droplet of water entering into a larger body of water and returning to the natural world. The participant believed water was a good example of death as it causes immediate ripples but that the disturbance will eventually lessen, just as water changes (Potash et al., 2014). The social workers within the SCP did appear to like the art work that was demonstrated in this study and were open to having an arts-based session. They appreciated how

the participants in the study were able to share their thoughts and feelings with each other which provided an open, non-judgmental session but the fear was the vulnerability that the staff could experience if their drawings were very personal and gave away a bigger story than they were willing to share. It was decided that if this group were to happen, it would be an optional group for any of the SCP staff, as some may be uncomfortable in completing these activities. As the first activity in the Potash et al. (2104) study suggested, the concept of self-care can be very important for both personal and professional reasons.

The overall goal of self-care and self-care activities is to maintain an equilibrium within a system where the professional self does not impinge on the personal self (Bressi & Vaden, 2017). When a social worker experiences an infringement of the professional self, on the personal self, it is often known as 'bringing one's work home at night' (Lee & Miller, 2013). On the other hand, one's professional self can be influenced by one's personal self, if one is employing too much of their self into their work or if their emotional functioning is poor (Bressi & Valden, 2017). The social work profession has a strong tradition of encouraging the social worker to use their self in-conjunction with their professional self, to promote client growth and to create a meaningful engagement (Shulman, 2012). The first goal of self-care is no longer focused on decreasing anxiety in one's personal self from effecting one's professional self, the function of self-care is now to allow social workers to tolerate the expected identity dysregulation related to entering a client's world (Miehls & Moffat, 2000). The second goal of self-care is the need to include mechanisms for meaning making and self-discovery (Miehls & Moffat, 2000), which demonstrates the connection to arts-based groups.

The concept of self-care can go beyond the individual and into a broader context. “The person-in-environment perspective recognizes the impact of societal systems such as natural support networks and the formal structures within communities that may enhance or inhibit individual social well-being” (CASW, 2008, p. 2). The person-in-environment perspective is to consistently work towards social justice and well-being for all, by having social workers engage in activities that will improve the social well-being structures and enhance individual, family, and social functioning at local, national, and international levels (CASW, 2008). Social workers are taught to monitor and evaluate their own personal and professional influences and use themselves as social change agents in practice situations (CASW, 2008). By being aware of one’s own personal and professional influences, it can create greater accountability and awareness in how one is servicing their clients (CASW, 2008).

Without promoting self-care, it could not only effect the individual social worker but the agency as well. It is not only the individual social worker’s responsibility but the responsibility of the agency setting to provide a healthy work environment (Papia, 2014). When a work environment expects their employers to carry a heavy case load, it can create additional stressors (Papia, 2014). This could create less time for social workers to focus on their personal well-being. The consequences of not promoting self-care could be very dire (Jackson, 2014), as social workers are increasingly working within an environment with doing more with less, which can create burnout (Bressi & Vaden, 2017).

The new model that we developed collaboratively with support from Dr. Mayer for therapy supervision has three components: quality assurance, therapy supervision (case consultation), and care for the care giver. The quality assurance piece would be completed

through the use of weekly huddles. The social workers would meet weekly for 15 minutes apart from therapy supervision to discuss any administrative issues such as on-call hours, patient case loads, and vacation hours. Through having these discussions during weekly huddles, it will open up more time during therapy supervision to discuss patient cases. The huddles would also be used to update the quality assurance list in order to keep the list current and on track. The quality assurance piece is very important as it allows social workers to fully engage in efforts to define quality practices which allow them to create methods of ensuring better quality care (Megivern et al., 2007). Quality assurance strategies can be used to improve work performance through the use of checklists, and visual management resources. (Wandersman et al., 2008).

With the quality assurance aspect taking place during huddles, this allows for the weekly peer group therapy supervision session to focus more on case consultation, the second component of the new therapy supervision model. The social workers will have the opportunity to present more cases and they can be discussed more thoroughly. I also developed an extension of therapy supervision. This was an idea of Dr. Mayer's and will be the addition of individual supervision for new employees to the SCP. As of now, all of the social workers participate in group supervision and although each social worker has the opportunity to meet with a manager on an individual basis, it is not mandatory. Dr. Mayer suggested that new employees also have individual supervision for their first year working within the SCP, as well as weekly group therapy supervision.

The third component of supervision focuses on reflection and debriefing. This component can be completed through two parts. First, I suggested that there is time at the end of each session for social workers to discuss and reflect on any client cases. This could be specific to

those who shared cases or it could be in the form of general check-in questions to see how everyone is managing their case loads. It was decided that the social workers do not have to share a lot of information, as it may become personal, but that it would be important to reflect in order to support each other. I think this is a very effective approach and I was able to witness this conversation during a therapy supervision session when one of the social workers described her experience of losing a patient. Seeing the social workers discuss how they cope with their work appeared to be very effective in assisting their peer, as she was able to open up about how she was coping and how the loss of the patient was affecting her. This demonstrated how important it is to leave time for debriefing and reflection as the work can be quite difficult and can leave a large impact on the worker. The second approach for debriefing and reflection was through the inclusion of arts-based sessions. These sessions would be optional for all staff in the SCP. I suggested that the sessions could occur monthly and it would provide an opportunity for all of the staff to reflect on their work and support each other through shared experiences.

Conclusion

In conclusion, all of my projects taught me something new. The concept of advance care planning was introduced to me during my practicum and through completing two projects on the topic, I have become very passionate about it and what it involves because it helps patients live the life they want to live. It has encouraged me to promote the importance of ACP/GOCD and to have these conversations with people in both my professional and personal life. My therapy supervision project confirmed the importance of supervision and how support from peers and managers can help build skills and confidence. I am confident that I will be a better social worker because of my practicum project work.

Chapter 5: Conclusion

To accomplish part of the requirements for the Laurentian University M.S.W. program, I completed an Advanced Practicum (SWRK 6024) from October 3, 2016, to December 21, 2016. This practicum setting was within the Northeast Cancer Centre, specifically the Supportive Care Program. My objective for completing this advanced practicum was to improve my clinical social work practice. In this chapter, I will begin with an overview of my advanced practicum experience at the Northeast Cancer Centre with a section specific to working with a multidisciplinary team. I will then discuss my advance care planning projects, the environmental

scan and the chart audit, as well as an overview of my therapy supervision project. I end with a discussion of implications for social work practice.

Multidisciplinary Team Work

My experience during my practicum was nothing short of incredible. I am extremely grateful for the opportunities I was given as they impacted me both professionally and personally. The clinical skills that I gained will benefit me throughout my future career as a social worker as I learned how to properly document case notes, how to practice reflexivity/reflectivity, and how to work within a multidisciplinary team. Shadowing different disciplines was not only rewarding, but also added valuable learning experiences. I learned about the work that is completed by volunteers, nurses, doctors, social workers, dietitians, and other professionals, understanding all of these disciplines is essential in cancer care, as it is important to rely on other health care team members in order to provide the best patient care.

During my time with the SCP, I had the opportunity to shadow multiple disciplines. The rationale behind the multidisciplinary approach is to offer comprehensive assessments and treatments from a variety of disciplines (Garven, 2011). The disciplines I shadowed included oncologists, physiotherapists, speech language pathologists, and social workers. It was very beneficial shadowing a variety of disciplines, as it taught me about areas of cancer with which I was previously unfamiliar. Multidisciplinary teams have been considered to be essential in order for patients to receive the best treatment and care (Flessig, Jenkins, Catt, & Fallowfield, 2006). Understanding each discipline provided me with a better idea of the patient experience, as I witnessed the countless different appointments that a patient must attend. Witnessing all of these different areas assisted with my clinical abilities because I could empathize with the amount of

time and effort it takes for a patient to attend each and every appointment. Beyond shadowing clinical appointments, I was given the opportunity to work on instrumental patient cases where I assisted patients with accommodation expenses, Ontario Disability Support forms, and Northern travel grant forms. Working on instrumental cases provided me with the opportunity to learn more about the financial side of cancer, while granting me a chance to connect with other agencies in Sudbury.

Advance Care Planning/Goals of Care Discussion Projects

Another learning experience for me was advance care planning. During my practicum, I became very interested in this area of healthcare. I would like to be an advocate for this process in the future. I shared my passion of advance care planning with my family and asked them about their goals and wishes. I realized that I was unaware of my family's wishes and the healthcare decisions that they would want to be made. I do not think I would have been prepared to have these conversations and make such decisions before completing this practicum.

Advance care planning (ACP) provides patients with an opportunity to consider, discuss, and plan their future with healthcare professionals (Barnes et al., 2011). Goals of care discussions (GOCD) focuses more on current care and turning wishes and values into goals (Myers, 2015). ACP and GOCD were very important components of my practicum. Completing two projects on the topic demonstrated that this area of healthcare requires more attention. The first project I completed was an environmental scan. The environmental scan consisted of contacting the Psychosocial Oncology Leads in cancer centres across Ontario. I conducted interviews with various disciplines to gather information on how ACP/GOCD was conducted within their cancer centre. This included how conversations of ACP/GOCD were documented,

educational opportunities for staff and patients, as well as barriers that affect the implementation process. The second project I completed was a patient chart audit. The chart audit was specific to the NECC. I reviewed 20 patient charts to determine if ACP conversations and GOCD were occurring. I reviewed four different disease sites of cancer, breast, lung, prostate, as well as head and neck. I looked at the patient's treatment regime, their diagnosis, and if any referrals were made. Beyond that, I was examining the charts to see if conversations about the patient's wishes, goals, and future care were occurring and being documented. The overall goal of both projects was to help create a standardized process to ensure that all patients have the same opportunity to participate in advance care planning and goals of care discussions.

Therapy Supervision

My second project was to create a new therapy supervision model that would be more inclusive to the needs of the social workers, while maintaining proper quality assurance. When I began my practicum, the current therapy supervision model focused on case consultation and updating the client quality assurance list, which was often two to three months in arrears. With collaboration from the SCP social workers and my supervisor, we created a supervision model that would allow the quality assurance list to remain up to date. We also incorporated a reflective piece to allow the social workers to personally reflect on how their cases were affecting them. It has been suggested that supervision should also allow time for social workers to speak about their own difficulties within their work environment (Bogo & McKnight, 2005). This is important because it allows for preventive measures such as information and education about burnout symptoms and signs to be shared before burnout surfaces (Newell & MacNeil, 2010). The new model would incorporate the addition of huddles, which would allow the social workers

to gather together to discuss any administrative issues and to update the quality assurance list in a more timely manner. This supervision model would also include more time for social workers to reflect on their cases. This would be completed by leaving time at the end of therapy supervision for an open reflective discussion. This collaborative model also suggested the benefits of incorporating art-based sessions that would allow the social workers to discuss their work through art, as art making can also be used to overcome issues of communication and offer an alternative way of expressing feelings and emotions that may be difficult to express otherwise (McFerran-Skewes, 2005).

Implications for Social Work Practice

There are many ways that my practicum learning could have implications for social work practice. I think the three largest implications for social work practice in my practicum would be the importance of social work supervision, the inclusion of advance care planning in social work practice, and working within a multidisciplinary team. These areas not only can influence the social work practice overall but they also impacted how I will practice social work in the future.

Supervision can change how social workers are able to work within their organization. Social work supervision can improve service delivery, develop skills, increase one's understanding of social work ethics, improve job satisfaction, and provide a defense against social worker burnout and/or emotional exhaustion (Mor Barak, Travis, Pyun, & Xie, 2009). The long-term objective of supervision is to prepare the supervisee to deliver effective and efficient services to their clients that is consistent with social work professional practice standards (Tsui, 2005). Unfortunately, supervision tends to focus on discussing the facts about client cases, leaving the emotions, the stresses, and the fears of the social workers to become lost in the

overall social work process (Kadushin & Harkness, 2002). This can often result in burnout, which is considered to be a serious hazard in the helping profession (Hombrados-Mendieta & Cosano-Rivas, 2013). Experiencing burnout can impair the physical and emotional well-being of the service provider (Kim, Ji, & Kao, 2011). By providing supportive supervision, there may be reduced job-related stress as well as self-awareness of the stress that social workers may be experiencing within the work place (Bogo & McKnight, 2005). The therapy supervision model that was created during my practicum may help to prevent burnout by allowing the social workers to reflect on their cases while receiving support from their colleagues. The incorporation of art within the supervision session may also allow the social workers to express their feelings in a new and creative way.

Working through this project provided me with great insight on how social work supervision can function, and how it should ideally function. In my current place of employment, I am not provided with any supervision. This has proved to be very difficult at times as it has caused me to question my abilities, which has the potential to impact my ability to deliver effective services. For example, when clients have demonstrated suicidal ideations and/or other depressive behaviours, it can become quite difficult to work alone, as it is easy to lose insight and begin to personalize and internalize the situation. For instance, I saw a client who was experiencing thoughts of suicide and although I completed a safety plan, provided the client with alternative resources, and took every measure that I could think of, I still had a very challenging time once I left the office for the day. Although, logically, I knew I would not be to blame if something were to happen to the client, I continued to go over every detail of the session, questioning if I had done enough. If I had the opportunity to have a supervision meeting after

seeing this particular client, I think I would have felt reassured with the work that I had done and the measures I had taken. However, since this was not provided to me, I struggled with taking on all of the responsibility for this client's safety. This demonstrates how important supervision can be and how big of a role it can play. The implications of not having supervision is not limited to my personal feelings but also has the ability to interfere with my professional career; I could be delayed in learning and achieving success with clients if I am not fully confident in my work.

Being able to participate in a supervision experience through my practicum, I was able to recognize all of the areas of social work practice that I was missing such as opportunities for debriefing, reflection, and both individual and peer supervision sessions. I believe that all social workers, especially those who are new to the practice, should have mandatory supervision provided to them on a weekly to bi-weekly basis. The supervision I received in my practicum provided me with greater confidence, reassurance, and a wider range of knowledge and insight. For instance, receiving feedback from a supervisor about the work I was completing provided me with encouragement as I moved forward in client sessions. This time also provided me an opportunity to ask questions which I found to be very beneficial when working with more complex cases. Without all of these gains through supervision, my work could have been compromised which had the potential to impact my clients. I have discussed the importance of supervision with my current colleagues and we have had individual discussions on how the lack of supervision has impacted us both personally and professionally. For example, we have discussed how it becomes easy to lose perspective on difficult cases and begin to internalize the emotions and feelings of the client, when there is no one to discuss and debrief with, and how this can lead to feelings of burnout. It is much easier to 'take work home' when you are unable to

discuss and process the details with a supervisor. This can lead to emotional exhaustion, poor job satisfaction, and additional stressors that can impact the ability to successfully serve clients.

These aspects also have the potential to lead to more absences at work due to the stress of the work environment. This demonstrates how the implications of not providing supervision can come at a greater cost than the cost of paying an individual to fulfill this role; the role of one supervisor has the potential to assist many individuals, allowing for greater job satisfaction and less emotional strain and absences.

I am very grateful that I have been able to experience workplaces with and without supervision, as it has taught me what to strive for as I continue to embark on a career of social work. In the future, if supervision is not provided to me within my workplace, I hope to discuss this with my supervisor and seek outside supervision as an option for me. If this is not an option, I will seek supervision from peers who are more experienced in the field. During my practicum, one of the social workers from the Supportive Care Program mentioned that a social worker from the hospital came to her for support as supervision was not available to her on her unit. This demonstrated the importance of reaching out to peers for feedback and support when other options are not made available, as the implications of not feeling supported can cause a social worker to feel insecure in their position. Shadowing peer supervision sessions during my practicum demonstrated how effective peer supervision can be, and I am hopeful that as I move forward in my social work practice, I will be able to connect and learn from my peers. If this also presents as an issue in future positions, I will have to make my own arrangements such as contracting with someone in private practice for regular consultation as I believe it is my duty to

seek supervision as required to meet the professional practice standards of the College of Social Workers and Social Service Workers.

A second area of implications for social work practice is that of advance care planning and goals of care discussions. Incorporating these areas into social work practice could be very beneficial in the patient-social worker relationship. Social workers, especially those working in palliative care, are very responsive to the need of ACP and are often the professionals initiating the conversation (Kramer, 2013). ACP is thought to have contributed to 'good' deaths since patients and families were able to discuss their concerns and wishes before the patient began to deteriorate (Mitchell & Dale, 2015). The majority of patients who participated in ACP conversations were shown to receive significantly more patient-focused care in regards to physical and emotional comfort, informed decision-making, and self-efficacy (Mori et al., 2013). Cancer centres, including NECC, often rely on the skills of social workers to initiate these types of conversations. A standardized process may be seen as promoting better patient care.

If a standardized process can be put in place, this may allow social workers and other healthcare providers to participate in training on how to provide ACP conversations. I believe training in this area is necessary, as it is a sensitive yet critical area of healthcare. This training can be provided by any healthcare providers who are familiar with ACP as it is often those who are considered to be champions of that work who provide the training. The healthcare members that should be trained in this area include doctors, nurses, and social workers, as they are the healthcare members who primarily have the ACP conversation with patients. It is an area that requires the 'right' questions to be asked, yet it is important that those questions are delivered in a way that doesn't come across as a survey, as the answers can have great impact on the patient's

future healthcare decisions. Since the area of ACP can truly be asked to anyone, at any time, I think it is important to ask ourselves these questions. When I considered the question ‘if the patient is at end of life, what would make it meaningful’, I thought about how I would answer this question, and how I would want this question asked to me. Having the ability to empathize with the patient and understand their wishes is one the biggest components of this practice, and I personally believe that reflecting on the questions for oneself will enable a practitioner to deliver the questions to others in a more thoughtful and respectful manner. In my experience, advance care planning is very similar to advocacy work because it is ensuring that the client’s voice is being heard, recognized, and validated. Using ACP as an example of how to advocate on a client’s behalf can help current and future social workers to develop skills to complete ACP conversations effectively.

The final area of implications for social work practice is multidisciplinary teamwork. A multidisciplinary approach is necessary for both the diagnosis and treatment of cancer patients for quality of life to be optimized (Guler & Canturk, 2014). This approach is particularly important when working with complex cases where more disciplines would be involved, especially when timing of treatment modalities is crucial (Flessig et al., 2006). In addition, multidisciplinary teams could also improve the coordination of services because, through communication, different disciplines will become more aware of efficient treatment planning, referral processes, and can learn to avoid any potential duplication of services (Ruhstaller, Roe, Thurlimn, & Nicoll, 2006). Completing my advanced practicum within the Supportive Care Program, I often witnessed the importance of coordinating services and working with a team setting, in order for the patient to receive the best care. From working out of the clinic, to

scheduling appointments around treatment regimes, to referring patients to other professional disciplines, all of these tasks were necessary in creating the best care for the patient. Not only is this approach beneficial to the patient but to the staff as well. A study of breast cancer teams suggested that working in teams could be beneficial to the mental health of the staff members (Haward et al., 2003).

During my practicum experience I was pleasantly surprised to see the impact that social workers had within the multidisciplinary team. We often see social worker's opinions being marginalized by those who hold a more powerful position within a team, which makes it very difficult to exert influence. Through conversations I had with the social workers this was still the case in some instances. For example, in some cases, the social workers would wait days for important paper work regarding the patient to be signed or for e-mails to be returned which prolonged any work that the social worker was attempting to accomplish, making their work feel undervalued and unimportant. However, I must say the social workers that I had an opportunity to work with constantly stood their ground. They were able to make a case for their opinion and they always ensured that the voice of their patient was heard. Frustrations would often come with this, as other members of the healthcare team who were higher on the hierarchy would dismiss their opinions but the social workers would continue to advocate for their patients. I believe the care that the social workers had for their patients caused them to continue to stand their ground even when their ideas and thoughts were dismissed. This has the potential to be more difficult for new social workers but I believe if they have proper peer and managerial support, they will be able to develop a greater confidence in this area of social work. From what I experienced during my practicum, the social workers who were new to the field were very supported by their peers.

Experienced social workers would always give their peers suggestions on how to gain the necessary respect that is needed to find their place on the hierarchy, whether that be going to the clinic to have a conversation with an oncologist in person, to researching the necessary information to support their opinion.

Beyond managerial and peer support, I believe research and understanding evidence-based practices plays a role in finding a place on the hierarchy. During my practicum, I witnessed the social workers who were newer to the field continuously researching articles and clinical trials to ‘prove’ and justify their work and professional beliefs to others. For example, during a therapy supervision the discussion of medical marijuana was brought up. The social workers were having some difficulty advocating on behalf of their patients who wanted to access medical marijuana, as not all of the oncologists were in support of its use. One of the newer social workers researched articles that supported its use and she was able to use the information in the article to demonstrate why her opinion should be considered valid and important. Apart from what I witnessed in my practicum, I also found myself continuously having to ‘prove myself’ within my workplace to those who are higher up on the hierarchy. This can quickly become frustrating but through consulting with my peers and reaching milestones with clients, my opinion was beginning to be recognized, as it was clear that I was successful in my position. It is often a workplace reality that new social workers have to prove themselves on a regular basis but I believe that with gaining support from peers, continued research, and striving to do effective work in clinical practice, new social workers will be able to demonstrate to other members of the hierarchy that they have just as much to offer and that they should be considered to be valued members of the team.

Although continuously advocating can become challenging, once the social workers were successful in gaining that respect, it became apparent that many of the oncologists valued their opinions. Even though getting to the point of mutual respect can be a complicated and political process, once the skills of both parties are recognized it enables better care for the patient. It is important for social workers to demonstrate why they can be of such value in a healthcare team. For example, without providing emotional, mental, and financial support, many patients would not have attended their cancer treatments, which demonstrated the crucial need for social workers. Although some may argue that a doctor or nurse could provide care for a patient's emotional needs, in most healthcare settings they do not have adequate time and/or training to fully address these needs in a clinical setting, as a social worker would. Beyond the consideration of time, social workers provide the necessary tools, resources, and interventions that a patient can use outside of the healthcare setting that may not be in the common realm of practice for nurses or doctors. This may include meditation techniques, journaling, and mindfulness exercises. In addition to this, social workers can often connect with a client on a deeper level that goes beyond their healthcare. For example, when my mom was first diagnosed with cancer she decided not to see a social worker because she did not think it was necessary. Once she was in remission she decided to attend social work sessions and it really helped her open up on areas that she had not discussed before. She never spoke to her oncologist, her nurse, or anyone else about the fear of dying that she experienced during her cancer journey. However, she was able to discuss this fear with her social worker and through discussing that experience fully, it allowed her to gain some sense of closure. I am aware that not every member of the healthcare team may view social work as an important role but from my practicum and personal experience, the social

workers were critical in assisting the patient. The implications that a patient may face without the assistance of a social worker, such as financial burdens, lack of external resources, and insufficient family support, have the opportunity to affect the overall health of the patient.

My practicum taught me to stand-up for what I think is right, advocate for the patient, and to not let my opinion become lost as social work does have a place in the healthcare field. Although I did not have an opportunity to voice my opinion to members of the hierarchy myself, hearing stories from the other social workers provided me with an insight on just how powerful my opinion could be.

Conclusion

The experiences and opportunities provided by the Supportive Care Program have helped me to understand why I have always wanted to be a social worker. Helping patients and their families through difficult times in my advanced practicum at NECC was a very empowering and rewarding experience. Research projects and clinical work were just a few ways that I was able to grow during my advanced practicum both professionally and personally.

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Appendices

Appendix A: Figure 1

KEY FEATURES	
ADVANCE CARE PLANNING	GOALS OF CARE DISCUSSION
Planning for future care	CONTEXT Decision-making for current care
SDM is clarified; Patient outlines values & other info helpful to SDM in guiding future decisions (should patient become incapable)	AIM Clarifying, aligning and reconciling patient's values and goals to inform process of consent for treatment plans & care decisions
Good evidence for values-based, conversations	EVIDENCE Limited evidence; Approach, process and potential outcomes are variable among several disciplines
Decisions are not an element of ACP however any expressed wish/preference re: specific treatments should be documented	DECISIONS Specific decisions or direction of care may be desired outcomes; Each decision is preceded by GoC but not all GoC result in decisions
Translating values in to information that is helpful to SDM if decision-making is needed	CLINICIAN'S SKILLS 1. Translating values, beliefs and wishes into goals 2. Aligning and reconciling goals with consent for offered treatments and care decisions
<ul style="list-style-type: none"> • A process, often iterative • Address illness understanding • Assess information needs • Values & beliefs • Worries & fears; Trade offs 	<ul style="list-style-type: none"> • A process, often iterative • Address illness understanding • Assess information needs • Values & beliefs • Worries & fears; Trade offs
	SIMILARITIES

Figure 1: This chart defines the key features of advance care planning and goals of care discussions (Dr. Jeff Myers, 2015)

Appendix B: Advance Care Planning: Environmental Scan and Chart Audit Power Point Presentation



The image shows a PowerPoint slide with a light beige background. At the top, there is a grey rounded rectangle containing the logos for Northeast Cancer Centre and Centre de cancerologie du Nord-Est. Below this is a dark blue horizontal bar with white text. At the bottom, there is a white rounded rectangle containing the presenter's name and supervisor information.

Northeast Cancer Centre
Health Sciences North
a Cancer Care Ontario partner

Centre de cancerologie du Nord-Est
Horizon Santé-Nord
un partenaire d'Action Cancer Ontario

Advance Care Planning & Goals of Care Discussion
Environmental Scan of Cancer Centres Across
Ontario, HSN programming, & NECC Chart Audit

Kelsey Marshman, MSW (Candidate)
Placement Student, Supportive Care Program
Supervisor: Dr. Carole Mayer, RSW

Objectives

- Defining advance care planning (ACP) and goals of care discussions(GOCD)
- Present results of environmental scan of Cancer Centres in Ontario
- Present highlights of Health Sciences North advance care planning pilot project
- Present results of chart audit of the Northeast Cancer Centre

Reviewing Advance Care Planning & Goals of Care Discussion



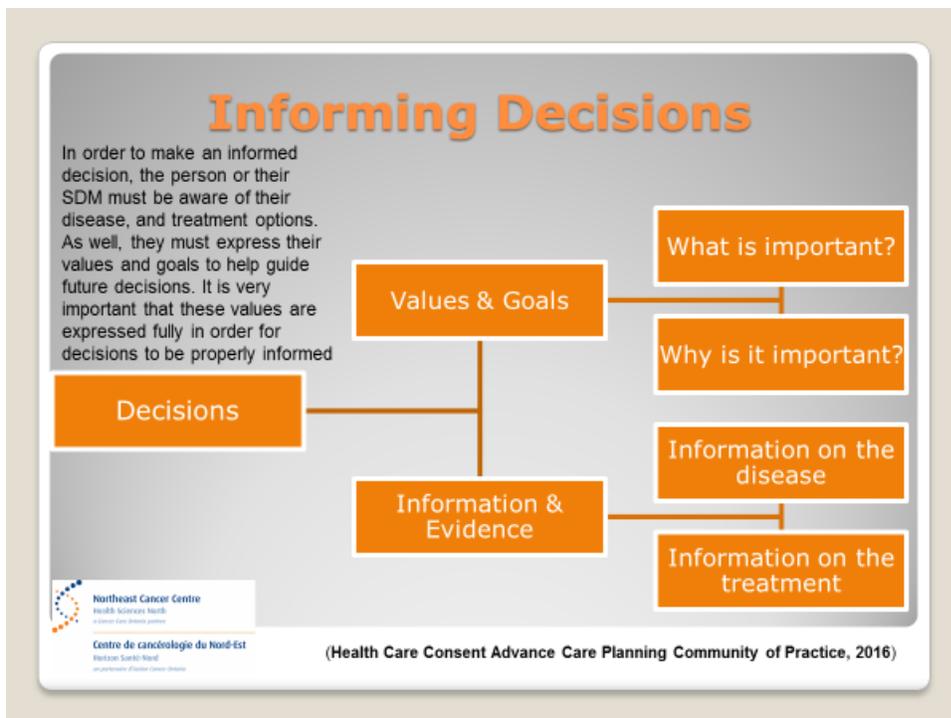
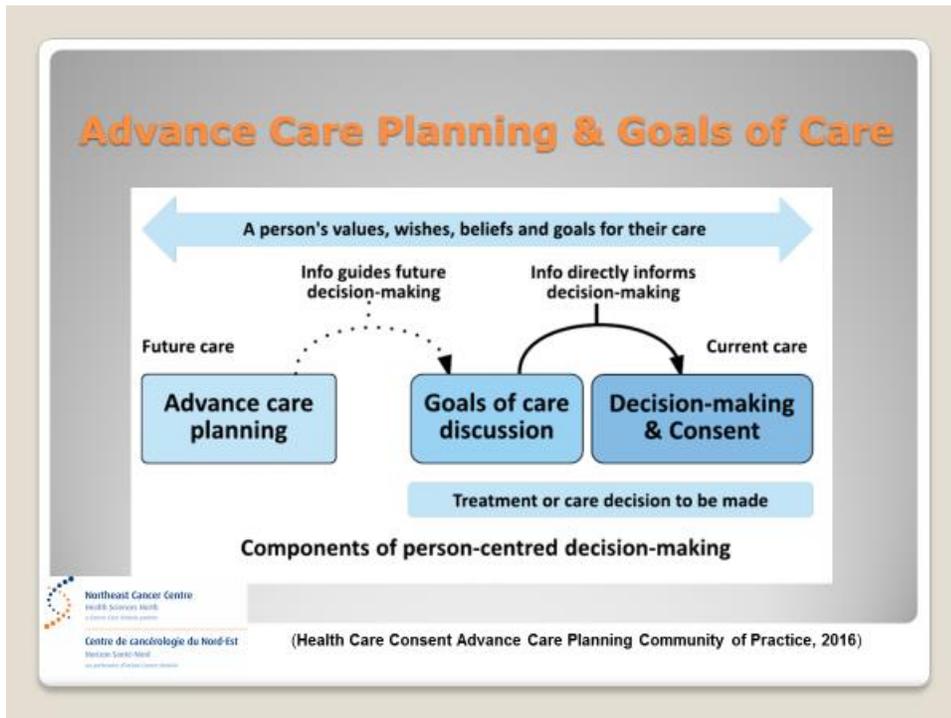
Three Tasks in Completing ACP

- 1. Assess Readiness
 - Is the person ready to discuss ACP?
 - Are they able to discuss ACP?
- 2. Confirm Substitute Decision Maker(SDM)
 - Does the person have a SDM? Who is it? Are they aware of the person's wishes?
- 3. Uncover the 'right' information about the person
 - What are their values and goals?
 - Why are they important?

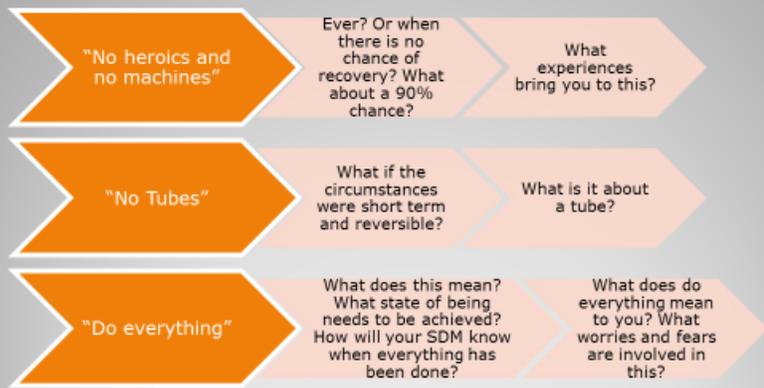
Advance Care Planning & Goals of Care Discussion

For the purpose of this project, the following diagram was used to help define the differences between Advance Care Planning and Goals of Care Discussion.

KEY FEATURES	
ADVANCE CARE PLANNING	GOALS OF CARE DISCUSSION
Planning for future care	CONTEXT Decision-making for current care
SDM is clarified; Patient outlines values & other info helpful to SDM in guiding future decisions (should patient become incapable)	AIM Clarifying, aligning and reconciling patient's values and goals to inform process of consent for treatment plans & care decisions
Good evidence for values-based, conversations	EVIDENCE Limited evidence; Approach, process and potential outcomes are variable among several disciplines
Decisions are not an element of ACP however any expressed wish/preference re: specific treatments should be documented	DECISIONS Specific decisions or direction of care may be desired outcomes; Each decision is preceded by GoC but not all GoC result in decisions
Translating values in to information that is helpful to SDM if decision-making is needed	CLINICIAN'S SKILLS 1. Translating values, beliefs and wishes into goals 2. Aligning and reconciling goals with consent for offered treatments and care decisions
<ul style="list-style-type: none"> • A process, often iterative • Address illness understanding • Assess information needs • Values & beliefs • Worries & fears; Trade offs 	SIMILARITIES <ul style="list-style-type: none"> • A process, often iterative • Address illness understanding • Assess information needs • Values & beliefs • Worries & fears; Trade offs



Ensuring Values and Wishes



(Health Care Consent Advance Care Planning Community of Practice, 2016)

It is very crucial that values are clear and understood, in order to provide the best care

Environmental Scan

Conducting interviews with Cancer Care Ontario PSO leads and other healthcare providers across Ontario



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Centre de cancérologie du Nord-Est
Horizon Santé-Nord
un partenaire d'Action Cancer Ontario

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- Sari Greenwood – *Central East Regional Cancer Program*
- Carla Girolametto- *Grand River Regional Cancer Centre*
- Kristie Clarke & Melissa Read – *Simcoe Muskoka Regional Cancer Program*
- Lina Gagliardi – *Sunnybrook*
- Janet Riehl- *HSN, Inpatient Cardiology Unit*



Environmental Scan

- The Psychosocial Oncology Leads across Ontario were contacted and were provided with a questionnaire in regards to ACP/GOCD
 - I spoke with PSO Leads and/or was referred to other parties who were champions of ACP/GOCD within their organization
 - In total eight cancer centres were interviewed
 - Questions were focused on the following domains:
 - Initiating the conversation
 - Family involvement
 - Timing the conversation
 - Indigenous populations
 - Education
 - Incorporating ACP into the patient visit
 - Documentation
 - Barriers of implementation
 - Champions



Initiating the Conversation

Who initiates the conversation of advanced care planning (ACP) and/or goals of care discussions (GOCD) within your organization?

- The majority of the answers reflected the following:
 - Physicians
 - Nurses
 - Social workers
- Pathways varied:
 - For Example: Physician will begin the conversation in the clinic and refer the patient to a social worker for a more in-depth conversation
 - Or the physician will initiate the conversation and palliative nurses will continue to the conversation with the patient and family
- However, a common theme was that everyone **can** have the conversation and that everyone **should** have the conversation, it should be a shared responsibility across the healthcare team.

Family Involvement

Who is involved during the conversation, i.e.- family members, substitute decision maker, etc. ?

- It was identified that the family/caregiver involvement was up to the patient's discretion
 - Patients may be encouraged to include family members for support or clarity when discussing ACP/GOCD
 - As the patient nears end-of-life, family participation becomes more important in order for the patient to have their wishes confirmed and reviewed
 - Capacity, is also a very important component to consider. Family members/SDM will be included in the conversation if patient is deemed incapable.

When to have the Conversation

At what point would this conversation occur within the patient's cancer journey?

- The majority of the responses reflected the following:
- It was noted that the conversation normally occurs when the patient receives a change in their diagnosis
 - Patient's status changes from curative to non-curative, disease has metastasized
 - Patient is determined to be at end-of-life
- It was also noted that to meet best practice standards, staff should be having the ACP conversation earlier in the patient's diagnosis.
- **Initiative:** At Sunnybrook hospital, the introduction of ACP/GOCD is introduced within the standard first assessment of the patient. Patients are asked if an Substitute Decision Maker (SDM) or Power of Attorney (POA) is in place. They are also asked if they have discussed their wishes with their SDM, to ensure the patient's wishes are respected to ensure a good quality of life.

Indigenous Patients

Do you have different practices or guidelines in place for your Indigenous patients?

- The majority indicated that no specific practices or guidelines were in place. Important aspects to consider:
 - Indigenous populations were not necessarily identified, therefore no additional clinical pathways are in place for Indigenous peoples
 - Other centres identified that their Aboriginal Navigator played a large role in having the ACP/GOCD conversation
- **Initiative :** In the Windsor Regional Cancer Program, the Aboriginal Navigator is addressing the gap in ACP/GOCD within the Indigenous populations. An example of this could be introducing Elders within the GOCD conversation.

Educational Opportunities/Materials- Staff

Are there educational opportunities or educational materials that have helped guide the ACP/GOCD conversation for Health Care Professionals?

- There was a great variety of tools that were being utilized throughout the Cancer Centres
 - Speak UP <http://www.advancecareplanning.ca/>
 - de Souza Courses on ACP <https://portfolio.desouzainstitute.com/courseCodes/index/1>
 - "Don't be surprised if we ask" http://www.palliativecareswo.ca/learning_initiatives/CPR/docs/PlanOfTreatmentCPR_SampleBrochures.pdf
 - Dying with Dignity <http://www.dyingwithdignity.ca/>
 - You Tube Videos
 - How to Break Bad News <https://www.youtube.com/watch?v=ftgNapAfV6Q>
 - Palliative Care: The Patient Experience <https://www.youtube.com/watch?v=z2fQuTSrhic>

Educational Opportunities/Materials- Patients

Are there educational opportunities and materials available for patients and their family/caregivers?

- Similar material provided to staff is also available for the patient population:
 - Speak Up Documentation
 - "Don't be surprised if we ask" brochure
 - " I have cancer, now what"
 - POA documentation
 - Bulletin Boards that discuss what ACP is, the importance of an SDM and POA, resources, etc.
 - Posters displayed to showcase the importance of ACP/GOCD
 - There were ACP educational classes available within a cancer centre but due to little to no attendance, the class was cancelled
- **Initiative:** In Ottawa, hospital staff are going into retirement homes and explaining the importance of ACP. They address; what is ACP, they facilitate a workshop using the Speak Up workbooks, and they assist the person and their SDM in raising awareness & questions about ACP/GOCD.

Educational Opportunities/Materials- Staff Cont'd

- POA kits <https://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/poa.pdf>
- " I have cancer, now what" pocket guidebook <https://www.ons.org/store/books/i-have-cancer-now-what>
- Indigenous ACP Brochures <http://www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/advance-care-planning> and <http://www.eolfn.lakeheadu.ca/>
- Lunch and Learns: Social Workers will put on Lunch and Learns and talk about the importance of ACP/GOCD
- Training Courses to better understand how to participate in ACP/GOC conversations
- **Initiative:** There is an ACP Championship Group at Princess Margaret that attends rounds to discuss the importance of ACP/GOCD with other health professionals.
- **Initiative:** Sunnybrook has developed two guide books on ACP (one for clinicians and one for patients). Sunnybrook also has provided training for social workers to become ACP facilitators

Finding Time for ACP/GOCD

When conversations happen with patients and/or caregivers about ACP/GOCD, how much time is allocated for discussion? Are separate appointments scheduled with physicians/other HCP or is the conversation taking place during the clinical visit?

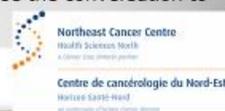
- There was a common theme in regards to this question, **"time"** was considered to be a large factor in initiating ACP/GOCD
 - It was stated that the conversation will usually happen during a patient's clinical visit with the physician, in which the physician may have 5 minutes that he/she can allocate to ACP/GOCD. If the client requires more time:
 - The nurse may answer a few more questions and provide educational material to the patient
 - The physician may refer the patient to a social worker who is able to have a more in-depth conversation of ACP/GOCD
 - A follow-up appointment may be scheduled with the physician where there will be time dedicated to ACP/GOCD



Documentation

How is documentation being kept about ACP/GOC discussions? Would this be in a paper or electronic chart? Do you keep a copy of signed advanced care documents within a patient's medical chart?

- Primarily documentation is kept in the patient's electronic chart but they are encouraged to keep a hard copy of any information pertaining to ACP/GOCD, SDM, POA, etc.
- Documentation kept in the patient's electronic chart often difficult to locate the information
- Signed Documentation is kept within the patient's chart when it is completed by the patient
 - For instance, if the patient completes Speak Up documentation, POA documentation, DNR documentation, SDM documentation, that information will be scanned and uploaded to the patient's electronic chart
- Another consistent point was that, not all healthcare providers review information in the patient's chart which can present a challenge
 - This can lead to the conversation being repeated, or cause the conversation to not happen at all.



Documentation Cont'd

Initiatives

- At Princess Margaret, an icon will show in the electronic record if POA was discussed and if Speak Up documentation has been completed. Additionally, under the "Note" section, there is a dropdown menu where ACP/GOCD can be easily reviewed.
- At Sunnybrook, there is a tab on a patients electronic chart that is specific to ACP/GOCD. This allows for care providers to find the information easily.
- The Ottawa Cancer Centre is reviewing staff surveys to see where barriers effect ACP conversations and working on breaking down those barriers for better patient service.



Documentation Cont'd

Are the advanced care documents being regularly checked to ensure that the patient's wishes are current?

- Primarily, it was noted that ACP wishes were only being checked/reviewed when :
 - there was a change in diagnosis
 - if the patient was readmitted to the hospital
 - or if the patient brought it to the attention of the Physician
- 6 cancer centres mentioned that the patient's wishes are being reviewed on a regular basis by a member of their healthcare team



Documentation Cont'd

Is this information shared with the patient's primary care physician or any external stakeholders, such as CCAC?

- Primary care physician would receive dictations from the Oncologist
- Health care providers that has access to the patients electronic record would be able access information from physicians, nurses, social workers, etc.
- Organizations such as CCAC:
 - Hospitals were not allowed to share information with CCAC
 - CCAC has access to information if the patient belonged to the pain and symptom management clinic
 - CCAC has access if the patient had signed consent, and discussion took place during community rounds
 - CCAC would be informed of a DNR order but that they would not be privy to other information



Barriers & Challenges

Do you see any barriers in implementing the ACP/GOC discussion?

- This question led to a lot of great discussion and critical reflection of how we can better implement ACP/GOCD.
 - **Lack of time:** Often there is not enough time to have this conversation fully especially for physicians and nurses
 - **Cultural aspect:** This can effect both staff and patients . For instance, staff may not be comfortable discussing ACP or GOCD if it doesn't fit within their cultural norms, as it can still be seen as "taboo". The same applies to patients who do not believe in having a conversation about the "what if's" of death
 - **"Comfort" piece:** Many staff are still uncomfortable having the conversation about ACP/GOCD, they are worried about how the patient may act, they aren't sure of how to get out of the conversation once they start it, and they become concerned of how it will change the patient/care provider relationship. In addition, it is very important to have the skills to complete these conversations, which is an area that many staff need more practice and education on.
 - **Determining the role:** Many staff struggle with whose role it is to have this conversation, which often can cause the conversation to become delayed.



Barriers & Challenges Cont'd

- **Patient's lack of initiative:** Patient may continue to delay the conversation until it is too late; in addition family members may be in denial and choose not to participate in the conversation
- **Technology :** Electronic charts can become a challenge because information can become hidden within a patient's chart which it makes it difficult for HCP to determine if the ACP/GOCD conversation took place, the results of the conversation, and so forth
- **Double Documentation:** Social workers are noting in their charts and have to copy information to ACP/GOCD in the patients chart which can lead to additional time and work that the social workers do not have
- **When to begin the conversation :** One of the most prominent barriers is, when to actually have the conversation.
 - One example that was given was: if a patient has been diagnosed as stage one, and a healthcare provider begins the ACP/GOCD conversation, will the patient start to think "what aren't they telling me... the doctor said I would be okay... why do they want me to plan for the future"
- On the other hand, if the conversation is delayed too long the patient and they may be too unwell to answer the questions about ACP which could have large implications for them.
- The importance of **normalizing** the conversation was emphasized.



Champions

Are there any champions within your organization that lead the conversation or programming on ACP/GOCD? Is there anyone else within your organization that I speak to in regards to ACP/GOC?

- Various staff members were considered champions within their organizations, which included
 - Social Workers
 - Nurses
 - Oncologists
 - Palliative Physicians
 - Palliative Nurses
 - Pain & Symptom Management Teams
 - Quality in Dying Champions
- Many of the participants who were interviewed defined themselves as champions of ACP/GOCD



Health Sciences North

Inpatient Cardiology Unit
Advanced Care Planning Pilot Project
Conversation with Janet Riehl



Northeast Cancer Centre
Health Sciences North
et Centre d'Care Oncologie

Centre de cancérologie du Nord-Est
Horizon Santé-Nord
en partenariat d'Action Cancer Ontario

Final Thoughts

Is there anything else that you think I should know about your organization and how ACP/GOCD are applied? Final Comments?

- In this section there were a lot of positive thoughts as well as great reflection pieces
 - Staff need to have better education and to be consistently trained
 - Staff need to recognize when the patient is ready to have the conversation
 - ACP/GOCD should apply to everyone
 - It is important to address the myths that surround ACP/GOCD
 - The terminology of Advance Care Planning can be intimidating, use of other language may be more appropriate
 - There needs to be a public campaign that explains what is ACP/GOCD
 - Supports need to be in place in the community to continue the conversation
 - Government, society, and staff need address the gap and provide patients with better education and conversations
 - Important to validate and confirm the patients wishes, let the patient know that you understand
 - People need to know that it is not about how you want to die but about how you want to live
 - This was a very good reflection on showing what needs to change to better implement ACP/GOCD conversations



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Health Sciences North Inpatient Cardiology Unit

- **Advanced Care Planning Pilot Project**
 - For patients 85 + (in review to change age to 80)
 - Encouraging them to look at Substitute Decision Maker, Power of Attorney
 - Reviewing wishes and asking them to think about how they would want to spend the last days of their life
 - Providing the patients with questions that they can review at home or with their family
 - This project hopes to reach patients within the first 24 hrs of being admitted on to the unit
 - The nurses on the unit are being trained to have these conversations with patients and their family, the unit's social worker also addresses ACP/GOCD and can provide more in-depth conversations
 - This unit is working on normalizing the conversation in hopes that it will encourage the general population to discuss ACP, in and out of the hospital setting
 - This unit will be the first unit to complete electronic charting on ACP



NECC Chart Audit

Review of 20 Patient Charts



Northeast Cancer Centre
Health Sciences North
à votre côté, dans votre parcours

Centre de cancérologie du Nord-Est
Horizon Santé-Nord
en partenariat d'adhésion-cancer Québec

Objectives

- Examining Edmonton Symptom Assessment System (ESAS-r) scores within the last 3 months of life
- Determine if advance care planning and/or goals of care discussions occurred within the patient's cancer journey
 - Determining when the conversation was first initiated
 - Reviewing the 6 goals of care discussion questions

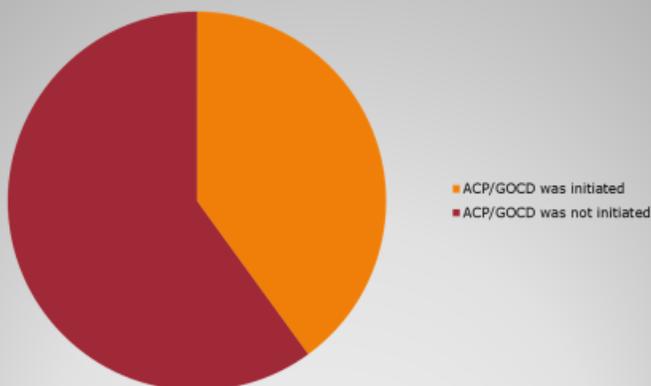
ESAS-r Scores

- Reviewed the last 3 months of ESAS-r Scores
 - 9 out of the 20 patients did not complete an ESAS-r within the last 3 months of life
 - Within the 11 patients who did complete in an ESAS-r during the last 3 months of life:
 - 5 patients completed 3 ESAS-r
 - 3 patients completed 2 ESAS-r
 - 3 patients completed 1 ESAS-r

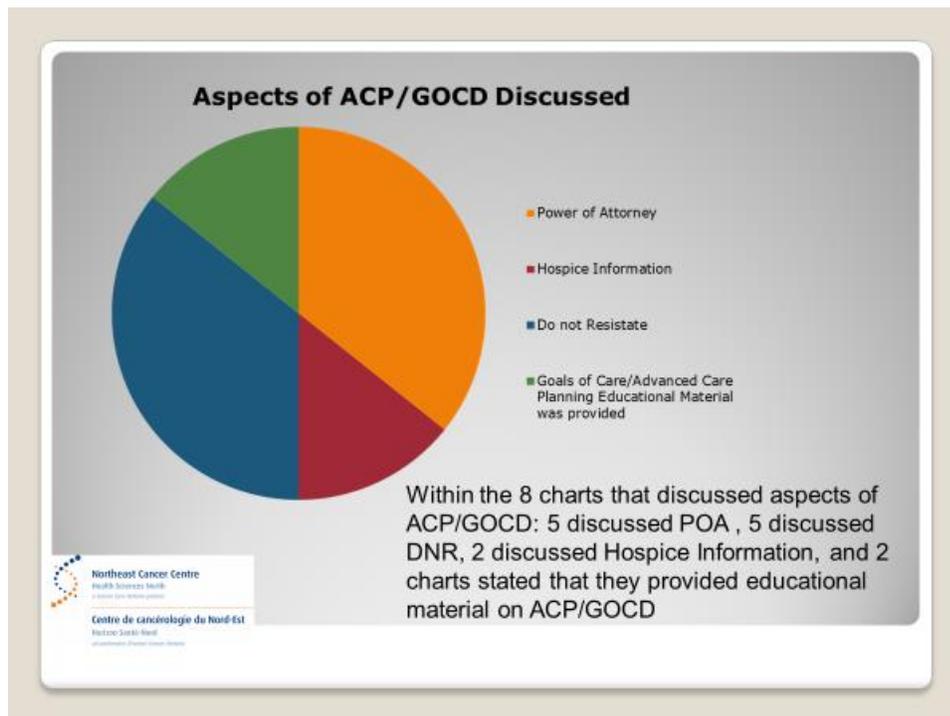
ESAS-r Scores Cont'd

- Within the completed ESAS-r, the mean scores were as followed:
 - Pain - 4 (range= 0-10)
 - Tired- 5 (range=0-10)
 - Drowsy- 3 (range=0-10)
 - Nausea- 2 (range=0-7)
 - Appetite- 2 (range=0-7)
 - Shortness of Breath-4 (range=0-10)
 - Depression-2 (range=0-9)
 - Anxious-3 (range=0-10)
 - Well-Being-3 (range=0-10)

Advance Care Planning & Goals of Care Discussion



Within the 20 charts, 8 charts had a form of ACP/GOCD incorporated into their care plan



Reflection

The following is a poem written by Laura Leblanc who is a nurse on the Inpatient Cardiology Unit at Health Sciences North in Sudbury. This poem is specific to a pilot project that she is participating in, however it is quite applicable to everyone.

*Advance care planning is a unique way for those 85 & older to have their say
It's about knowing and sharing and how to discern
It's a conversation for us to talk and learn
This interaction will give patient's a voice
What are they prepared to leave behind?
What kind of things would give them piece of mind?
What are they willing to sacrifice?
What are their thoughts about end of life?
We'll record a copy of this plan
So their wishes will be known to their fellow man
Bring to the surface their hopes and fears
What are some wishes they've thought about over the years?
So write it down, record, and review
So everyone will know what to do
Advance care planning is about living life while you're in it
It's about your last days and how you want to spend it*

(Northern Life, 2016)

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