

# Core competencies in palliative care: an EAPC White Paper on palliative care education – part 2

In the second part of this consensus White Paper issued by the European Association for Palliative Care (EAPC), **Claudia Gamondi, Philip Larkin** and **Sheila Payne** describe in more detail the ten core interdisciplinary competencies in palliative care

This article follows on from part 1 published in the previous issue of the *European Journal of Palliative Care* and looks at the ten core interdisciplinary competencies in palliative care in more detail. For each competency, a short description of its rationale and focus is followed by a list of its constituents. Each constituent may be relevant to more than one competency, but, for clarity, it has been placed where its impact is likely to be the most evident.

## The ten core competencies

### *1. Apply the core constituents of palliative care in the setting where patients and families are based*

Palliative care should be delivered in the place of the patient/family's choice, adapting to that environment as necessary. When this is not possible, advice should be given on alternative options. Most palliative care can be dispensed in generalist/non-specialist settings. Adaptation is key to the successful integration of palliative care principles, but it should be the palliative care professionals who adapt, rather than patients and families making significant changes to their life circumstances.

Palliative care professionals should be able to:

- 1a: Understand the meaning of life-limiting and life-threatening illness
- 1b: Apply the principles of palliative care, which affirm life and offer a support system to help patients live as actively as possible until death, focusing on quality of life and help for families during illness
- 1c: Understand the significance of the physical, psychological, social and spiritual issues that affect people with life-limiting conditions and their families

- 1d: Recognise the values, beliefs and culture of patients and families
- 1e: Demonstrate the ability to incorporate the palliative care approach as early as is appropriate
- 1f: Recognise patients' and families' needs for appropriate comprehensive care in the dying phase and provide such care.

### *2. Enhance physical comfort throughout patients' disease trajectories*

Physical comfort represents an essential component of quality of life for people with a life-limiting illness and their families. A tailored plan of care should include anticipation, assessment, treatment and re-evaluation of the physical symptom burden all along the disease trajectory.

Palliative care professionals should be able to:

- 2a: Demonstrate a clinical practice that promotes the prevention of suffering, whatever their level of experience is
- 2b: Demonstrate the ability to actively support patients' well-being, quality of life and dignity
- 2c: Implement the assessment of physical symptoms and well-being into routine clinical work
- 2d: Anticipate potential complications, which may exacerbate suffering, and prepare a responsive care plan
- 2e: Offer excellence in end-of-life care regardless of the setting.

### *3. Meet patients' psychological needs*

All palliative care professionals need to have an understanding of patients' psychological needs and should be able to offer a supportive intervention according to their discipline and

skills. Good psychological care requires sound case assessment skills, sensitive questioning skills and clinical discernment (for example, if a patient requires referral to psychological services). It is recognised that not all patients and families require a formal counselling intervention. Good communication skills are essential to meet patients' psychological needs. The ability to know when to refer and to whom is essential.

Palliative care professionals should be able to:

- 3a: Acknowledge patients' emotions and support them sensitively
- 3b: Foster patients' coping mechanisms
- 3c: Provide a diagnosis, care plan and, when appropriate, an intervention applied systematically and skillfully, with ongoing evaluation of patients' psychological and psychiatric symptoms, considering their prognosis, personal wishes and the environment in which they live.

#### 4. Meet patients' social needs

A life-limiting illness impacts on the interpersonal relationships of patients and families, who need additional resources (both internal and external) to be able to maintain good quality of life. Patients' concerns over relationships, finances, housing and personal affairs can challenge the practitioner to provide optimum care in the clinical setting. Again, understanding when and how to refer patients for specialist help is key.

Palliative care professionals should be able to:

- 4a: Appreciate the social context of patients and families and its impact on their experience of receiving palliative care
- 4b: Provide patients with information about available benefits and entitlements from health- and social care
- 4c: Enable patients to manage personal affairs as necessary.

#### 5. Meet patients' spiritual needs

Life-limiting illness can provoke questions about deeper existential issues, such as the meaning of life. Spiritual care should be integral to palliative care provision. Spiritual needs may or may not be addressed through a religious practice. Being able to raise spiritual issues in a supportive and caring environment may help patients, and a willing healthcare professional can provide them with the opportunity to do so. Healthcare professionals should have the confidence to discuss

spiritual issues with patients and families if desired. Referral to an appropriate spiritual advisor may also benefit patients and families.

Palliative care professionals should be able to:

- 5a: Demonstrate the reflective capacity to consider the importance of spiritual and existential dimensions in their own lives
- 5b: Integrate the patients' and families' spiritual, existential and religious needs in the care plan, respecting their choice not to focus on this aspect of care if they so wish
- 5c: Provide opportunities for patients and families to express the spiritual and/or existential dimensions of their lives in a supportive and respectful manner
- 5d: Be conscious of the boundaries that may need to be respected in terms of cultural taboos, values and choices.

#### 6. Respond to the needs of family carers in relation to short-, medium- and long-term patient care goals

Patient care should incorporate family carers, taking into account their local environment, healthcare system and, of course, their relationships with healthcare professionals who are now part of their lives. Family carers are often the providers of care and the link between patients and professionals. It is essential that their role is supported and enhanced wherever possible, and that the challenges and potential conflicts of caring are acknowledged and addressed appropriately, including referral for specialist guidance as needed. This support should extend into the early bereavement phase. Professionals' ability to seek expert advice is essential.

Palliative care professionals should be able to:

- 6a: Recognise and support family carers in their tasks as care-givers, identifying those who may be at risk of experiencing undue distress or burden
- 6b: Acknowledge family carers' decisions in relation to paid employment and the implications of relinquishing such roles
- 6c: Recognise other roles of, and demands on, family carers (who may, for example, also care for children or other people)
- 6d: Offer to family carers psychological and emotional support separate from that offered to patients, where necessary
- 6e: Foster family carers' ability to interact with different healthcare professionals

**Understanding when and how to refer patients for specialist help is key**

- 6f: Develop strategies within the care team to manage family conflicts
- 6g: Facilitate short-term bereavement counselling if considered appropriate
- 6h: Identify complex bereavement needs and refer as appropriate.

### **7. Respond to the challenges of clinical and ethical decision-making in palliative care**

Palliative care professionals face challenging ethical and moral dilemmas, including questions around hydration and nutrition, sedation, physician-assisted suicide and/or euthanasia. Many of the skills needed to address these dilemmas are taught during

professional training and it is, therefore, the application of these skills in the palliative care context that is important. However, certain areas of practice (for example, the use of palliative sedation as proposed

by the EAPC<sup>1</sup>) may require additional knowledge and training. It is deemed the responsibility of each practitioner to ensure that they hold the necessary competency to address the ethical challenges posed by current palliative care practices. Equally, all practitioners should have a thorough understanding of their own professional code of practice and how that relates to the delivery of palliative care. The EAPC has issued a range of position papers and consultation documents on these challenging issues, which provide guidance to professionals in the assessment of complex ethical situations.

Palliative care professionals should be able to:

- 7a: Act in respect of bioethical principles, national and international legal frameworks and patients' wishes and values
- 7b: Foster patients' autonomy, in balance with other ethical principles such as benevolence, non-maleficence and justice
- 7c: Support patients to express their preferences and wishes about their care and treatments during the disease trajectory
- 7d: Enable patients, families and carers to be part of the decision-making process
- 7e: Be aware that the most appropriate ethical care may not always coincide with patients' wishes and preferences.

### **8. Practise comprehensive care co-ordination and interdisciplinary teamwork across all settings where palliative care is offered**

To provide continuity of care between different clinical services and places of care, it is necessary to ensure that there is a clear pathway delineating the specific roles of team members and the responsibilities for the co-ordination of care, and acknowledging the actual and/or potential contributions of others to the care of patients and families. We recognise the important role that volunteers can play in the co-ordination of care. Interdisciplinary learning also contributes to a better understanding of responsibilities, roles and functions.

Palliative care professionals should be able to:

- 8a: Provide all necessary support during patients' transitions between care settings
- 8b: Foster interprofessional teamwork
- 8c: Be able to identify the responsibilities of the different team members in the planning and delivery of care to patients and families
- 8d: Strengthen, where feasible, the role of volunteers in the supportive care of patients and families
- 8e: Offer to patients and family carers the most appropriate model of care in relation to their current palliative care needs.

### **9. Develop interpersonal and communication skills appropriate to palliative care**

Effective communication skills are essential to the application of palliative care principles and to the delivery of palliative care. They are particularly important when bad news need to be broken, when difficult decisions regarding treatment continuation or withdrawal need to be made, when circumstances are ambiguous or uncertain and when strong emotions and distress arise.

Palliative care professionals should be able to:

- 9a: Demonstrate ways of building a therapeutic relationship with patients and family carers
- 9b: Foster greater communication within the team and with other professional colleagues
- 9c: Choose appropriate methods of relating and interacting according to age, wishes and intellectual abilities, verifying the understanding of decisions taken
- 9d: Interpret the different types of communication (for example, verbal, non-verbal, formal and informal) of patients and family carers appropriately
- 9e: Use guidelines for breaking bad news, where available

## **Ways to strengthen resilience and prevent burnout should be identified**

- 9f: Adapt language to the different phases of the illness, be sensitive to cultural issues and avoid the use of medical jargon
- 9g: Support people's informed decisions regarding the level of information they wish to receive and share with their family
- 9h: Pace the provision of information according to the preferences and cognitive abilities of patients and family carers.

### ***10. Practise self-awareness and undergo continuing professional development***

Continuing professional development, the requirements of which are usually defined by each professional discipline, should be an integral part of clinical practice. Opportunities to acquire further knowledge should be sought where available. Part of this learning should be about self-awareness (for example, knowing how to develop safe practice; understanding the limits of one's own skills and abilities; and knowing when referral is in patients' and families' best interest). The impact, on the healthcare professional, of caring for people with life-limiting illness should be acknowledged and ways to strengthen resilience and prevent burnout should be identified. This may be achieved through structured or informal peer supervision strategies.

Palliative care professionals should be able to:

- 10a: Engage in lifelong educational activities to maintain and develop their own professional competencies
- 10b: Practise self-awareness, being conscious of their personal strengths, frailties, and moral and spiritual beliefs
- 10c: Recognise early signs of burnout and seek appropriate help
- 10d: Act as a resource to others in the team
- 10e: Be aware of the needs of colleagues who are in distress but are unaware of the impact this can have on themselves and on those they care for.

### **Desired outcomes and behaviours**

The overall outcome of implementing these ten core competencies should be a better experience for patients and families. In terms of behaviours, the aim is to see healthcare professionals grow in confidence so that they are able to anticipate palliative care needs, respond effectively, and understand their own limitations and the need to seek help. A future development of this work would be to ensure

that outcomes and behaviours clearly reflect the expectations of the regulatory bodies who govern the clinical practice of each discipline (medicine, nursing, social work, etc) in every European country.

### **How to provide interdisciplinary learning in palliative care**

The core components of quality palliative care education have been addressed in various EAPC publications – which, so far, have always reflected the needs of specific disciplines. Many of these components can equally apply to any education programme designed to address interdisciplinary learning needs.

Although the evidence for, and evaluation of, interdisciplinary learning are relatively scarce,<sup>2</sup> and the development of interdisciplinary curricula challenging, the benefits in terms of role appreciation and knowledge acquisition are compelling. However, at generalist level, it is acknowledged that interdisciplinary learning may not be achievable, and that integrating palliative care principles into the core curricula of each specific discipline may be more advantageous. At specialist level, interdisciplinary learning has noted benefits and there are learning models that incorporate shared and discipline-specific learning.<sup>3,4</sup>

We think that the following elements, detailed in the five paragraphs below, should be part of any education programme that has shared learning content across professional groups – however this list is not exhaustive.

#### ***Using appropriate adult-learning teaching methods and concepts, including single, discipline-specific learning where necessary***

All professionals should learn the principles of good communication. Similarly, they should all learn the principles of good symptom management. However, physicians and nurses may require further in-depth training in the latter.<sup>5-7</sup> Social workers and psychologists may require advanced skills to respond to the specific needs of family carers.<sup>8</sup>

#### ***Using an interdisciplinary team of educators, comprising both clinicians and academics, to dispense the education programme***

An education programme dispensed by healthcare professionals from different backgrounds is more likely to teach students the core skills needed in the delivery of care,

such as negotiation, clarification, precision, context-setting and evaluation skills. Using real casework from clinical practice and involving practitioners in the planning, delivery and evaluation of the academic programme strengthens its intrinsic value. Teaching palliative care is as much about getting students to reflect on their personal attitudes, beliefs and behaviours as about enhancing their skills and knowledge.<sup>9,10</sup>

#### ***Consider the possibilities that modern learning technologies offer***

It is advisable that continuing education should be based on different learning modalities.<sup>11</sup> There is evidence that using digital learning tools – for example, videoconferences – can enhance the understanding of palliative care theory and its application to practice.<sup>12–14</sup> E-learning enables students to learn at their own pace and use an array of resources that would not be available to them in the classroom setting.<sup>15</sup>

However, in palliative care education, online learning does not meet students' needs for practical training, particularly training in the skills required for sensitive communication and interprofessional interaction. Further, the EAPC acknowledges that access to e-learning may vary considerably across Europe. In order to support the development of palliative care education, we would encourage shared learning opportunities across countries.

A mixed learning approach, where certain aspects of the programme are taught in the classroom, may be the best solution. This also supports a camaraderie that can be beneficial to students, who learn about the world views of fellow students from different professional backgrounds. Whether outside the classroom or beside the online programme, informal discussion between students can be fruitful in terms of learning.

#### ***Encourage clinical placements***

The importance of being able to link theory to practice is essential in all clinical learning programmes.<sup>16</sup> Students need the opportunity to refine and hone skills learnt in theory in a safe and supportive learning environment, which encourages self-reflection and critical thinking. Clinical placements offer the student time to experience practices that are different from their own. In some cases, if students are required to undergo a

competency-based assessment and facilities are not available in their own work setting, the assessment can be carried out while the student is working in an environment conducive to good practice.

Palliative care can be taught and learnt in a number of settings, including accident and emergency departments and intensive care units. With appropriate support, a placement in a non-palliative care setting may be of equal benefit to a placement in a specialist palliative care setting. Learning from other settings is a valuable way of determining the quality of one's own work and spotting opportunities for service improvement at a local level.

#### ***Provide a proper evaluation of the quality of the education programme***

It is essential to offer evidence for the successful outcome of the education programme, not only for the funders, but also for the future marketing of the programme and its viability.<sup>17</sup> It is important that the views of the different disciplines are represented in any evaluation and that, if core concerns are identified, these are addressed in the planning for the next programme. Key to the evaluation, however, is the extent to which interdisciplinary learning has benefited students and how they will be able to translate it into practice in the future.

### **Conclusions**

The ten core competencies presented in this White Paper are based on the key principles that working in partnership as a team, sharing discipline-specific skills with colleagues and having a willingness to learn from each other will improve the overall outcomes of palliative care for patients and families. The proposed competencies are intended to complement skills and attitudes the healthcare professionals have already acquired through clinical practice. In this way, it is hoped that they will be able to integrate their new competencies into daily practice.

As with any competency, the degree to which the ten palliative care competencies may be achieved depends as much on the professional's own view of how competent they are as on how they are perceived by others. Competencies should never be seen as a tool to judge practitioners, but rather as a benchmark that all should aspire to reach over time. Further, we reiterate the importance of

developing competencies appropriate to the level of palliative care service provision in each European country. Some aspects of a competency may initially be aspirational, and fully achievable only once palliative care services have developed. We nonetheless propose that the ten core competencies identified in this White Paper may assist in scoping the roles and responsibilities of palliative care teams as they strive to provide care within different healthcare systems.

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## Book review

# The Syringe Driver – Continuous Subcutaneous Infusions in Palliative Care, 3rd edn

*Dickman A, Schneider J. Oxford: Oxford University Press, 2011; 496 pages, £24.99*



**Giving a combination of medicines by continuous subcutaneous infusion via a syringe driver is an important way of managing the symptoms of patients with palliative care needs. This book provides relevant and practical information in a user-friendly style to support this process.**

The practicalities of, and rationale for, using syringe drivers make up the first chapter. Different types of syringe drivers are described and there is a helpful 'frequently asked questions' section.

In this third edition, the drug monographs that make up the second chapter have been expanded, both in number and content, providing useful supplementary information.

Commonly encountered symptoms and their management make up the third chapter of the book.

The final and largest chapter features the compatibility tables for combinations of between two and six drugs, supported by laboratory data and evidence from clinical observation for a range of concentrations and diluents. Where possible, chemical compatibility data from published literature are also included and referenced. The layout makes this useful chapter easy to read, and each drug combination has a succinct summary as well as practical tips.

This book is well written and easy to navigate. It is a comprehensive resource in an area where professionals often lack confidence. The practical sections and referenced compatibility tables provide useful information on drug combinations that is sure to aid the decision-making process. A highly recommended, essential reference for any palliative care practitioner ■

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**The practical sections and referenced compatibility tables provide useful information on drug combinations**