Palliative Care Competence Framework

Psychology
Palliative Care Competence Framework
2014

This report should be cited as follows:


Or

“As a society, perhaps the most sensitive measurement of our maturity is the manner in which we care for those who are facing the ultimate challenge – the loss of life.”
(Report of the National Advisory Committee on Palliative Care, 2001)

The provision of high quality palliative care is a central responsibility of the whole health care system. It is essential that health and social care workers possess the right competences to effectively meet the needs of people with life-limiting conditions as they are among the most vulnerable of populations served by our health service. The development of the Palliative Care Competence Framework is a valuable tool in supporting staff to achieve this goal and serves as a signal of the areas of performance that are valued by the Department of Health.

Competences represent a dynamic combination of knowledge, understanding, skills and abilities. The purpose of continuing professional development is to foster competences and it is envisaged that the framework will initially be used by individuals and managers to identify specific training needs. The framework will also serve to focus dialogue when evaluating practice needs or demands.

Furthermore, the development of the framework affords a valuable opportunity to articulate and further our understanding of discipline-specific and inter-professional competences. This is particularly important as teamwork is an integral part of the philosophy of palliative care. Effective coordination and collaboration can occur only when each profession knows and uses the others’ expertise and capabilities in a patient-centred way.

I would like to thank all the individuals and representative professional organisations who gave so generously of their time and expertise in the development of this framework.

As we work to meet the challenges posed by increasing demands for palliative care associated with our ageing population and greater incidence of chronic illness, I encourage you to read and share this document with your colleagues.

Kathleen Lynch T.D.
Minister for Primary Care, Social Care (Disabilities & Older People) and Mental Health
Joint Message from the National Director of Clinical Strategy and Programmes and the Clinical Lead, National Clinical Programme for Palliative Care

The National Clinical Programme for Palliative Care continues to make a significant contribution to improving the care for patients, their families and society as a whole by focusing on our most important resource, our staff.

The development of the Palliative Care Competence Framework highlights the ability of the National Clinical Programmes to bring key stakeholders and professions together to work collaboratively. The framework supports health care staff in all care settings to self assess, develop and maintain skills, knowledge and attributes required for the provision of palliative care. This framework will help to embed a culture within our services to ensure high quality safe services for patients. It also provides a template for our partners in education and professional development to support health care professionals by including palliative care competences in education programmes at all levels.

This framework places a focus on the person with a life-limiting condition and their family. It helps in determining what health care staff can do to alleviate distress, pain and discomfort whether this is physical, emotional, spiritual or psychological. Applying the core and specific competences in practice, will help all health care staff (based in a hospital, hospice, GP practice, primary care centre or a community based setting) working with social care partners, to recognise their role in palliative care and to develop their own quality improvements.

The National Clinical Programme for Palliative Care and its partners will work with all stakeholders in order to ensure palliative care is at the heart of our health care service.

We are grateful for the support and enthusiasm from all stakeholders to date and look forward to building on this to meet our objective of improving the quality of life of people with life-limiting conditions.

Dr Áine Carroll,
National Director, Clinical Strategy and Programmes

Dr. Karen Ryan, FRCPI
Clinical Lead, National Clinical Programme for Palliative Care
In my role as Chairman of the Forum of Irish Postgraduate Medical Training Bodies I am very happy to both endorse and congratulate all those who have put together this Palliative Care Competence Framework. The Forum was established in 2006 with the aim of enhancing the effectiveness of the training bodies in maintaining the highest standards of medical education and training. Since that time its remit has expanded beyond matters solely to do with education and training but also into areas of professionalism and service provision, specifically focusing on the development of clinical leadership; whilst recognising, at the same time, the importance of team working and the pivotal roles of all those health care disciplines that are our partners in providing all that is the very best for our patients.

Few topics in medicine extend so widely across so many health care disciplines and care settings as Palliative Care. This kind of care is not simply about managing the physical symptoms of life threatening illness but extends necessarily into psychological, social, pastoral and spiritual support. Furthermore, the image and aspiration of the discipline of Palliative Care has changed from one of, not simply managing terminal illness and soothing the symptoms of disease and disorders, to a more positive one of wellness.

As in so many areas of medicine, change and knowledge is moving apace and it is difficult enough to keep abreast with one's own area of interest let alone what is available across other fields and what other skills can be brought to the table. It is in this context that this Palliative Care Framework document sets out, so helpfully, the core competences as to the knowledge, attitudes and skills that should be required, not just by specialists and part-time practitioners, but by all health care workers who look after patients with life-threatening illnesses. These competences are set out against six domains and across ten disciplines ranging from medicine and nursing to dietetics and nutrition and pharmacy. Providing this information under the umbrella of a single document will not only promote better, harmonious and standardised care but will, I have no doubt, significantly improve the quality of life of patients and their families across Ireland and who are faced with all the problems associated with such a life-threatening illness.

Professor Frank Keane
Chairman, Forum of Irish Postgraduate Medical Training Bodies

The Nursing and Midwifery Board of Ireland (NMBI) welcome the development of the competency framework document for palliative care as a guide to ensure a common expectation of practice in all settings.

Nursing and Midwifery Board of Ireland

The Office of Nursing and Midwifery Services Director is very pleased to endorse the palliative care competency framework. The Nursing and midwifery profession acknowledge that professional competence is far more complex than demonstrating behaviour aspirations or undertaking a task. Collaborative decision making with service users and their families in care planning and provision requires a level of knowledge and skills that engages with values, beliefs and attitudes to make competent and effective decisions. The continuum of contemporary palliative care from early provision, concurrent with disease modifying treatments, to sole palliation recognises the increasing competency requirements on all health and social care providers. As partners in the advancement of the competences for nursing, midwifery and health care assistants we are confident of the potential of this framework to enhance knowledge, skills and development in providing positive palliative care outcomes for service users and their families.

Dr Michael Shannon
Office of Nursing and Midwifery Services Director

I welcome the opportunity to support the publication of the Palliative Care Competency Framework. This document will be an invaluable resource that will support standards of clinical practice in Palliative Care and ultimately enhance the quality of patient care and experience. Additionally, it will assist education providers and influence curriculum development in the relevant therapy professions in the future. For clinicians and employers it will be a positive tool that will help identify professional development and training needs to ensure high standards of service delivery to patients with life-limiting conditions. It will also promote interprofessional understanding of the multidisciplinary and holistic framework of Palliative Care service delivery. My thanks to the experienced clinicians & educators from the disciplines of Occupational Therapy, Physiotherapy, Dietetics & Clinical Nutrition, Speech & Language Therapy who have contributed to the production of this fine document.

Emma Benton
Therapy Professions Advisor, HSE Clinical Strategy and Programmes Directorate
As President of The Psychological Society of Ireland (PSI), I welcome and fully support the Palliative Care Competence Framework. The framework is an exciting and inspiring invitation to work with our colleagues from different disciplines and ensure that living and dying in Ireland is the best it can be. The framework clearly sets out the current expectations for psychologists working with individuals with life-limiting conditions and also provides a terrific guide to inform undergraduate and postgraduate curricula for the profession.

I wish to congratulate all those who contributed to this very important and excellent work. I am happy to endorse the Framework and I wish it great success. I believe that it will continue to be useful, challenging and inspiring for many years to come.

The document is an excellent example of collaborative practice and all who contributed should be proud of its clear communication, its practical utility and its enormous potential to bring compassionate and competent care to our citizens at life’s most vulnerable times.

Dr Margaret O’Rourke
President, The Psychological Society of Ireland

The development of the Palliative Care Competence Framework is welcomed by the following professional bodies and group who have approved the discipline specific competences for their respective disciplines.

- Association of Occupational Therapists of Ireland (AOTI)
- Irish Nutrition and Dietetic Institute (INDI)
- Irish Society of Chartered Physiotherapists (ISCP)
- Irish Association of Speech and Language Therapists (IASLT)
- Hospice and Palliative Care Social Work Group

The development of the Palliative Care Competence Framework is welcomed by the Healthcare Chaplaincy Board (HCB), The Chaplaincy Accreditation Board (CAB), The National Association of Healthcare Chaplains (NAHC) and the Association of Clinical Pastoral Education (Ireland) Ltd, who have approved the discipline specific competences for chaplains."

- Healthcare Chaplaincy Board (HCB)
- Chaplaincy Accreditation Board (CAB)
- National Association of Healthcare Chaplains (NAHC)
- Association of Clinical Pastoral Education (Ireland) Ltd

Irish Institute of Pharmacy is happy to support the Palliative Care Competence Framework
# STEERING GROUP MEMBERSHIP

Dr Karen Ryan (Chair) - HSE Clinical Lead Palliative Care, Palliative Medicine Consultant, St Francis Hospice and Mater Misericordiae University Hospital

### Health Service Executive Representatives

- Dr Regina McQuillan - Palliative Medicine Consultant, St. Francis Hospice & Beaumont Hospital
- Liz O'Donoghue - Clinical Nurse Specialist in Palliative Care, Our Lady's Children's Hospital Dublin
- Morna O’Hanlon - Clinical Nurse Specialist in Palliative Care, St. James’ Hospital Dublin
- Sheilagh Reaper-Reynolds - Health Service Executive General Manager Palliative Care
- Deirdre Rowe - Occupational Therapist Manager/Deputy Head of Clinical Services, Our Lady’s Hospice & Care Services Harold’s Cross
- Mary Wynne - Interim Area Director Nursing and Midwifery Planning & Development DNE

### All Ireland Institute of Hospice & Palliative Care Representatives

- Dr Michael Connolly - Head of Education, All Ireland Institute of Hospice & Palliative Care
- Karen Charnley - Programme Manager Education, All Ireland Institute of Hospice & Palliative Care
- Dr Joan Regan - Palliative Medicine Consultant, Marie Curie Hospice and the Belfast Trust

### Irish Association for Palliative Care Representatives

- Mary Ainscough - Chief Executive Irish Association for Palliative Care
- Cliona Hayden - Senior Pharmacist, Our Lady’s Hospice and Care Services
- Prof Philip Larkin - Professor of Clinical Nursing (Palliative Care) University College Dublin and Our Lady’s Hospice and Care Services
- David McEvoy - Medical Social Worker Specialist Palliative Care Services Meath

### Irish Hospice Foundation Representatives

- Jackie Crinion - Acting Manager of the Hospice Friendly Hospice Programme
- Orla Keegan - Head of Education, Research & Bereavement Services
- Marie Lynch - Programme Development Manager
The development of the Palliative Care Competence Framework would not have been possible without the commitment of the Palliative Care Competence Framework Steering Group, Mary Ainscough, Karen Charnley, Dr Michael Connolly, Jackie Crinion, Cliona Hayden, Orla Keegan, Prof Philip Larkin, Marie Lynch, David McEvoy, Dr Regina McQuillan, Liz O’Donoghue, Morna O’Hanlon, Sheilagh Reaper-Reynolds, Dr Joan Regan, Deirdre Rowe, Mary Wynne, all of whom have played a crucial role in making this framework a reality.

Thanks are due to the following:

• Chairs of the Discipline Specific Working Groups: Dr Regina McQuillan (Medicine), Prof Philip Larkin (Nursing, Midwifery and Health Care Assistants), David McEvoy (Social Work), Deirdre Rowe (Occupational Therapy, Physiotherapy, Speech and Language Therapy and Dietetics/Clinical Nutrition), Cliona Hayden (Pharmacy), Dr Paul D’Alton (Psychology), Brian Gough (Chaplaincy/Pastoral Care)

• Brian Lee - National Programme Manager (Palliative Care, Obstetrics & Gynaecology) – for co-ordinating meetings of the Steering Group and Discipline Specific Working Groups

• Sinéad Fitzpatrick - Programme Manager, National Clinical Programme for Palliative Care– for assisting with finalising and editing the framework document.

• Colleagues from the Forum of Irish Postgraduate Medical Training Bodies, the Royal College of Physicians of Ireland, the Nursing and Midwifery Board of Ireland, the Therapy Managers Advisory Group, the Pharmacy Society of Ireland, the Association of Occupational Therapists of Ireland (AOTI), Irish Association of Speech and Language Therapists (IASLT), the Irish Nutrition and Dietetic Institute (INDI), the Irish Society of Chartered Physiotherapists (ISCP), the Psychological Society of Ireland, the Healthcare Chaplaincy Board, the Chaplaincy Accreditation Board (CAB), the National Association of Healthcare Chaplains (NAHC) and the Association of Clinical Pastoral Education (Ireland) Ltd and for their contributions and comments during the development of the framework

• Dr Claudia Gamondi - Palliative Care Physician, Palliative Care Department, Oncology Institute of Southern Switzerland, Ticino, Switzerland - for her critical review and constructive comments on the framework document

• Elaine Wilson – Lecturer, School Of Applied Social Science, University College Dublin - for her constructive comments on the social work section of the framework document

• Dr Michael Connolly and Karen Charnley (AIHPC) – for their tireless work in bringing the entire document together

• Gareth Wescott (AIHPC) – for final editing and graphic design of the framework document

Thanks are extended to the All Ireland Institute of Hospice and Palliative Care (AIHPC), the Irish Association for Palliative Care (IAPC) and the Irish Hospice Foundation who provided both financial and personnel support for this project. The contribution of the Office of the Nursing and Midwifery Services Director to the publication of this document and their expert input to the project is gratefully acknowledged.
INTRODUCTION

The Health Service Executive (HSE) Palliative Care Programme Briefing Document (2012) identified the development of a Palliative Care Competence Framework as a key objective for the coming year.

The Health Service Executive’s Palliative Care Programme convened a Project Steering Group to support, guide and oversee the development of the Palliative Care Competence Framework. The steering group comprises members from the Health Service Executive (HSE), All Ireland Institute of Hospice and Palliative Care (AIHPC), the Irish Association for Palliative Care (IAPC) and the Irish Hospice Foundation (IHF).

The purpose of this project was to develop a Palliative Care Competence Framework for health and social care professionals working in various health care settings. The framework is intended to provide for core competences in palliative care whilst also detailing individual competences for each health and social care discipline. It is envisioned that the framework will inform academic curricula and professional development programs, and so will enhance the care of people with a life-limiting condition, fostering greater inter-professional and inter-organizational collaboration in palliative care provision.

The Palliative Care Competence Framework reflects a move to standardisation of undergraduate and postgraduate education in Europe and how this relates to the development of competence using the Tuning Approach. The Tuning Approach provides a guide for attainment of knowledge, skills and attributes for practice in the health and social care professions.

The Palliative Care Competence Framework was developed using the Tuning Approach which provided flexibility and autonomy to develop both core and discipline specific competences for generalist and specialist palliative care. The outcome is a clear framework for evidence-based, safe and effective palliative care for generalist and specialist practitioners irrespective of place of practice.

Palliative Care

The World Health Organisation (WHO) defines Palliative Care as:

- an approach that improves the quality of life of individuals and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of individual care;
- offers a support system to help individuals live as actively as possible until death;
- offers a support system to help the family cope during the individuals illness and in their own bereavement;
- uses a team approach to address the needs of individuals and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.
Palliative care, both generalist and specialist, is provided in all care settings, including the community, nursing homes, hospitals, and specialist palliative care units. In recent years, the scope of palliative care has broadened so that palliative care is now provided at an earlier stage in the trajectory of both malignant and non-malignant disease.

<table>
<thead>
<tr>
<th>Table 1: Levels of Palliative Care Specialisation (NACPC, 2001: 32)</th>
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<tbody>
<tr>
<td><strong>Level 1 – Palliative Care Approach</strong></td>
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<tr>
<td>Palliative care principles should be practiced by all health care professionals. The palliative care approach should be a core skill of every clinician at hospital and community level. Many individuals with progressive and advanced disease will have their care needs met comprehensively and satisfactorily without referral to specialist palliative care units or personnel.</td>
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<tr>
<td><strong>Level 2 – General Palliative Care</strong></td>
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<tr>
<td>At an intermediate level, a proportion of individuals and families will benefit from the expertise of health care professionals who, although not engaged full time in palliative care, have had some additional training and experience in palliative care, perhaps to diploma level. Such intermediate level expertise may be available in hospital or community settings. Health care professionals who wish to undertake additional training in palliative care should be supported in this regard by the health board or other employing authority.</td>
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<tr>
<td><strong>Level 3 – Specialist Palliative Care</strong></td>
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<td>Specialist palliative care services are those services whose core activity is limited to the provision of palliative care. These services are involved in the care of individuals with more complex and demanding care needs, and consequently, require a greater degree of training, staff and other resources. Specialist palliative care services, because of the nature of the needs they are designed to meet, are analogous to secondary or tertiary health care services.</td>
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In order to prepare health and social care professionals to apply the principles of palliative care in practice, irrespective of setting, education and training are important. Education for practice must ensure that health and social care professionals are competent to practice. In recent years competence-based education for health and social professionals has been promoted across the European Union.
Introduction

Competence Framework Development

Competence assessment has evolved and been influenced by the learning taxonomy devised by Bloom (1984). Competence development takes into account the incremental nature of knowledge attainment for skills based on experience and education. It also provides a basis for the development of clinical knowledge and career progression in health and social care.

In a number of jurisdictions the development of competence frameworks has been influenced by the publication of a number of key documents

- **The NHS Cancer Plan (2000)** – determined a ‘strategic direction development of a national, high quality, uniform and equitable cancer service’ (Becker, 2007:14);
- **RCN Core Competency Framework (2003)** – attempted to bring together a uniform framework for cancer nursing across four levels of practitioner and a wide variety of skills;
- **Canadian Hospice Palliative Care Nursing Standards of Practice (2009)** – defined the standard of care that can be expected by all persons receiving HPC nursing and looked to guide, support and promote the provision of further education and training;
- **National Association for Social Workers Standards for Palliative & End of Life Care (2004)** (US) - standards were designed to enhance social workers’ awareness of the skills, knowledge, values, methods and sensitivities needed to work effectively with clients, families, health care providers, and the community when working in end of life situations;
- **Royal Australian College of General Practitioners Curriculum for Australian General Practice (2011)** (Australia) Palliative Care – Sets out the training outcome of the five domains of general practice including details of learning outcomes across the GP professional life;
- **Educating Future Physicians in Palliative and End of Life Care (EFPPEC) Canada (2006)** – details palliative and end of life care undergraduate curriculum which was developed to integrate end of life competencies into existing curriculum. The curriculum was approved on a Pan-Canadian basis by the 17 faculties of medicine.

Educators have attempted to define the notion of competence for many years, but there is still a lack of consensus about a standard definition for competence (Becker, 2007). Competence standards do exist for pre-registration education and the proposed Palliative Care Competence Framework can assist health and social care programme co-ordinators in the updating and further development of curricula. In the context of continuing professional development, legislation now exists to ensure the maintenance of professional competence for health and social care professionals. However in some instances the legislation has specified a lead in period, so that statutory bodies have time to develop systems to support the maintenance of professional competence. Post-graduate education in Palliative Care can also be informed by the Palliative Care Competence Framework, which can provide guidance on the knowledge, attitudes and skills needed to provide palliative care in particular contexts and settings and at specialist level.

Method

A steering group was convened by the National Clinical Programme for Palliative Care programme to support, guide, and oversee the development of the Palliative Care Competence Framework.

The purpose of the project was to develop a Palliative Care Competence Framework for health and social care professionals working in various health care settings. The framework provides for core competences in palliative care whilst also detailing individual competencies for each health and social care discipline. It is envisaged that the framework will inform academic curricula and professional development programs, and so will enhance the care of people with life-limiting conditions and their families, fostering greater inter-professional and inter-organizational collaboration in palliative care provision.

An initial objective of the steering group was to analyse and evaluate existing competence frameworks, to agree the framework appropriate and applicable to the Irish context and to agree an approach to the framework development in light of this analysis. AIIHPC undertook a review of available international palliative care competence frameworks. The purpose of the review was to consider frameworks already in use in other jurisdictions in order to make an appropriate and informed recommendation to the Project Steering Group. A number of palliative care competence frameworks from the UK, US, Canada, Australia and Northern Ireland were reviewed and summarised. All frameworks reviewed
identified domains of competence with specific indicators for each. Many of the frameworks reviewed failed to indicate how the framework could inform curriculum development or support continued professional development and lifelong learning in the clinical environment. The review recommended that the Palliative Care Competence Framework should be developed in line with Tuning Competences, which provide flexibility and autonomy to develop both core and discipline specific competences for generalist and special palliative (Connolly et al., 2012).

Over a series of meetings the Steering Group developed Six Domains of Competence and indicators (core competences) which describe what each health and social care professional should know at point of registration or first place of work.

The core competences formed the basis for the next phase of development which focused on the development of Discipline Specific indicators for health and social care professionals providing more than generalist palliative care. To proceed with the discipline specific work, a number of Development Working Groups were established in order to develop indicators for each distinct discipline (Phase 1). Over the period from August (2012) to February (2013) development working groups for Medicine, Social Work, Physiotherapy, Occupational Therapy and Pharmacy, met to develop discipline specific indicators.

The Development Working Group for Nursing, Midwifery and Health Care Assistants emerged from an already constituted group that had been brought together for a related project. This group was assisted in the work of developing discipline specific indicators within the divisions of nursing and midwifery and for health care assistants, by a project team from the School of Nursing and Midwifery at Trinity College Dublin led by Dr Honor Nicholl and funded by the Irish Hospice Foundation and the Office of the Director of Nursing and Midwifery Services HSE.

Discipline Specific Working Groups were established in January 2013 to facilitate work with Speech and Language Therapy and Dietetics/Clinical Nutrition (Phase 2), and in January 2014 to facilitate work with Psychology and Chaplaincy/ Patoral Care. The Working Groups for these disciplines met over a period of several weeks to develop discipline specific indicators. Their work concluded in March 2013 and April 2014 respectively.

The context of the Palliative Care Competence Framework

The complexity of the health care system sometimes leads to fragmented services and care and collaborative practice has a vital role in enhancing continuity of care for people with life-limiting conditions. This is particularly true in the context of caring for people with life-limiting conditions who may access services from multiple agencies and have a range of complex care needs that require attention.

In most cases these complex needs are using a multidisciplinary approach to care that includes opportunities for discussions and care planning with members of the multidisciplinary team. Multidisciplinary care is characterised by a collaborative and person-centred approach to care planning and delivery and can lead to the achievement of realistic care goals. The multidisciplinary approach to care can lead to increased individual satisfaction with care and increase perception that the care of the individual with a life-limiting condition and their family is being managed by a team. The multidisciplinary approach to care can also ensure access to information and support for the person with a life-limiting condition and their family.

It is important to note that the Palliative Care Competence Framework recognises that health and social care professionals adhere to professional codes of conduct and guidelines and may also be required to work within an employer organisation’s ethos, policies and practice.

Domains of Competence

The Domains of Competence are:

- Domain of Competence 1 - Principles of palliative care
- Domain of Competence 2 - Communication
- Domain of Competence 3 - Optimising comfort and quality of life
- Domain of Competence 4 - Care planning and collaborative practice
- Domain of Competence 5 - Loss, grief and bereavement
- Domain of Competence 6 - Professional and ethical practice in the context of palliative care
Each Domain of Competence is defined with a statement. The core competences are common to all health care professionals and represent the primary level of understanding required to provide Palliative Care, also described as using the Palliative Care Approach in daily work.

The domain statement remains the same irrespective of the level at which or the setting where palliative care is provided. However the domain indicators outline the competences required by health care professionals in the context of their role and at the level at which palliative care is provided irrespective of care setting.

In the context of the Palliative Care Competence Framework the level of expertise is key and is influenced by the critical mass of individuals treated, advanced palliative care knowledge, understanding and skills, the currency of this knowledge and maintenance of palliative care evidence base, access to on-going palliative care clinical, multidisciplinary expertise in the daily work environment and involvement in the area of education and professional development at local and national level.

ALL – In the context of individual disciplines, further indicators are identified for “ALL”. These reflect the particular competences required for that discipline at point of registration or related to current role. The indicators are applicable irrespective of the care setting or the staff grade. The goal is competence to provide care using a palliative care approach.

SOME - Specific Competences are for “SOME” health care professionals irrespective of the care setting or the staff grade. The goal is the provision of care applying the principles of palliative care and using a palliative care approach. This is achieved through additional preparation for professional practice and increased clinical engagement with people with life-limiting conditions, developing deeper knowledge, understanding and application of competences in palliative care.

FEW - Discipline Specific Competences are for “FEW” health care professionals irrespective of the care setting or the staff grade, whose core activity is limited to the provision of palliative care. The competences at this level are those required for the care of individuals with complex and demanding palliative care needs. The goal is to demonstrate knowledge and application of palliative care skills at specialist level.

**Figure 1: Competence Framework Model – adapted from Australian Model for Nursing in Cancer Control**
Core Competences for Palliative Care

**DOMAIN OF COMPETENCE 1 - PRINCIPLES OF PALLIATIVE CARE**

Palliative care aims to improve the quality of life of people with life-limiting conditions and their families, not only by treating their physical symptoms but also by attending to their psychological, social and spiritual needs. Palliative care is applicable for people of any age and may be integrated at any point in the disease trajectory from diagnosis through the continuum of care to bereavement.

**Indicators**

As a health care professional you should:

- Understand and be able to describe the meaning of the term ‘life-limiting condition’
- Understand and be able to apply the principles of palliative care that affirm life, offer people with life-limiting conditions a support system to help them live as actively as possible until death with optimal quality of life and help families cope during illness
- Understand the significance of the physical, psychological, social and spiritual issues that affect people with life-limiting conditions and their families throughout the continuum of care
- Demonstrate the ability to use the palliative care approach as early as is appropriate in order to facilitate person-centred practice that recognises the concerns, goals, beliefs and culture of the person and her/his family
- Provide empathetic care to individuals with life-limiting conditions and their families, with clear regard to the individuality of each person
- Show a commitment to one’s own continued professional development and learning and facilitate the learning and development of others, in order to improve care for those with life-limiting conditions and their families
- Show a commitment to developing self-care strategies and to attending to any impact that working with people facing life-limiting conditions and their families may have on you.

**DOMAIN OF COMPETENCE 2 - COMMUNICATION**

Effective communication is essential to the application of palliative care principles and to the delivery of palliative care. Communication is also important where circumstances are ambiguous or uncertain and when strong emotions and distress arise. Specific consideration should be given to communication as a method of:

- Supporting and enabling therapeutic relationships with the person with a life-limiting condition and her/his family;
- Ensuring that the person and her/his family understand and participate in decision-making regarding care to the extent that she/he is able to and wishes to be involved
- Enabling inter-professional teamwork.

**Indicators**

As a health care professional you should:

- Understand the essential role communication plays in palliative care
- Understand the different types of communication e.g. verbal, non-verbal, visual, written, and interpersonal interaction (either one-to-one or with a group or team)
- Demonstrate the ability to communicate effectively with the person with a life-limiting condition, their family and the interdisciplinary team in order to establish, maintain and conclude a therapeutic relationship
- Demonstrate the ability to communicate effectively with individuals and families from diverse cultures and different backgrounds, using professional interpreters (Appendix 1) where necessary and/or assistive communication technology where necessary
- Be able to modify your own communication style to facilitate communication with individuals with a range of communication impairments or seek facilitation in this area if required.
- Understand the importance of using strategies that empower effective communication e.g. active listening, plain language, appropriate tone, clarifying statements, inviting questions
- Demonstrate an ability to be attentive to the person through careful listening to help the person and their family feel they have been heard
- Support individuals (or parents in the case of children and minors) to make informed decisions regarding the level of information they wish to receive and want to share with their family
- Act as an advocate for the person and their family to ensure appropriate and timely palliative care intervention
Introduction

DOMAIN OF COMPETENCE 3 - OPTIMISING COMFORT AND QUALITY OF LIFE
Individuals with life-limiting conditions and their families can be affected not only in physical, but also in psychological, social and spiritual ways. Optimising comfort and quality of life for the person with a life-limiting condition and her/his family is a dynamic process that involves anticipating, acknowledging, assessing and responding to a range of symptoms and needs in a proactive and timely manner in order to prevent and relieve suffering.

Indicators
As a health care professional you should:
- Understand the significance of anticipating and responding to the needs of people with life-limiting conditions and their families (e.g. physical, psychological, social and spiritual) in a proactive and timely manner
- Understand how the palliative care approach can enhance the assessment and management of symptoms
- Exhibit an ability to apply a range of assessment tools to gather information
- Be able to evaluate non-complex interventions and propose alternative actions if deemed necessary
- Recognise the importance and benefit of multidisciplinary working in optimising comfort and enhancing the quality of life of the person with a life-limiting condition and her/his family
- Recognise the ways in which people with life-limiting conditions and their families can be engaged in self-management of their condition
- Demonstrate professional awareness of the scope of, and benefits of timely and appropriate access to specialist palliative care services
- Be aware of the uniqueness of a good death and facilitate the achievement of this as much as possible

DOMAIN OF COMPETENCE 4 - CARE PLANNING AND COLLABORATIVE PRACTICE
Care planning in palliative care is characterised by coordinating and integrating person-centred care in order to promote quality of life for people with life-limiting conditions and their families. It involves assessing need, promoting and preserving choice, predicting likely problems and planning for the future in the context of a changing and deteriorating disease trajectory. Care planning ensures that multiple disciplines and agencies can be accessed and referred to as required in a timely manner. People with life-limiting conditions should be helped to engage with care planning to the extent that they are able to and wish to be involved. The concerns of families and carers should be taken into account as part of this process.

Indicators
As a health care professional you should:
- Recognise the impact of a life-limiting condition on the person and her/his family and be able to provide support in order to help the individual to adapt to the changes in her/his condition
- Recognise the impact of a life-limiting condition on the person and her/his family’s mental health and coping mechanisms and be able to provide support in order to help the individual to adapt to the bereavement and loss
- Appreciate the roles, responsibilities and professional boundaries of individual members of the interdisciplinary team
- Understand the collaborative relationship between the person with life-limiting conditions, the health care professional, the family and all the other agents of care involved with the person and the family in order to develop an individualised and coherent plan of care to assist the person and the family to attain realistic goals and outcomes in all care settings
- Collaborate effectively with others as a member or leader of a multidisciplinary team
- Be able to identify priorities or concerns for the individual with a life-limiting condition and their carers, taking account of the individual's coping strategies and how the person perceives their diagnosis
- In the context of professional scope of practice be able to critically evaluate outcomes of interventions against established standards and guidelines
- Demonstrate an understanding of advance care planning and an appreciation of the appropriate time(s) to engage in discussions about preferences for care with the person with a life-limiting condition and her/his family
- Demonstrate an ability to communicate sensitively and clearly about advance care planning with the person, the family and the range of professionals and agencies involved.
DOMAIN OF COMPETENCE 5 - LOSS, GRIEF AND BEREAVEMENT
Dealing with loss, grief and bereavement for the person themselves, their family and the professionals who care for them is intrinsic to palliative care provision. Most people manage their loss by combining their own resources with support from family and friends. However, a minority of people are at risk of developing complications or difficulties in their grieving. Professionals using the palliative care approach have an important role to play in supporting bereaved people by providing information and support to all and by identifying those who require bereavement therapy or counselling.

Indicators
As a health care professional you should:
• Understand that grief is a normal and appropriate response to loss which has physical, psychological, spiritual, emotional and social aspects that affect how it is experienced
• Recognise the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief
• Recognise the factors which may put a person at risk of encountering difficulties in their grief, whilst also remaining aware of the resources and resiliencies that are particular to each person and family
• Demonstrate an ability to engage with a person who is experiencing loss in the context of professional scope of practice and/or role
• Assist the family to access bereavement information and support at a level that is appropriate to their needs
• Be cognisant of the psychological impact of death and dying on individuals with increased stress vulnerability
• Understand the personal impact of loss, grief and bereavement and recognise your own loss responses and engage in activities that maintain your resilience on an on-going basis
• Possess a level of self-awareness that prevents your own experiences of loss from negatively impacting on the person with a life-limiting condition or their family.

DOMAIN OF COMPETENCE 6 - PROFESSIONAL AND ETHICAL PRACTICE IN THE CONTEXT OF PALLIATIVE CARE
The goal of health care is to help people sustain health that is essential to their well-being. However, there comes a time when specific treatments or interventions may be futile or overly burdensome. Integrity in palliative care practice refers to the importance of respecting the person’s values, needs and wishes in the context of a life-limiting condition. It guides all health care professionals to reflect on the relationship between their contribution to a person’s care and the necessary contributions of other professionals. Professional and ethical practice is about considering how best to provide continuing and integrated care to people as their health care needs change in the course of life-limiting conditions.

Indicators
As a health care professional you should:
• Work within your current Code of Professional Conduct and engage ethically, knowledgably and respectfully with other disciplines.
• Recognise and respect your professional responsibility to care for people with life-limiting conditions and their families to ensure their comfort and dignity
• In the context of your current professional role establish collegial partnerships and in the context of palliative care contribute to the professional development of students, peers, colleagues and others through consultation, education, leadership, mentorship and coaching
• Use the resources available fairly in the context of providing appropriate care to the person with a life-limiting condition
• In the context of professional scope of practice and/or role anticipate and demonstrate the ability to address potential ethical issues that may be encountered when caring for the person with a life-limiting condition and her/his family such as: Do Not Attempt Resuscitation Orders, withdrawal and withholding of treatment, use of artificial hydration and feeding, palliative sedation and requests for euthanasia
• Be able to establish and respect person’s wishes about their care and options/preferences. This includes:
  • Recognising the person’s right to make informed decisions to refuse additional treatment(s)
  • Seeking, responding to and implementing people’s preferences about where they are cared for (e.g. in their own homes) if this is practicable
  • Respecting advance care plans made by people where the decision is an informed choice and relates to the situation that has arisen (Medical Council, 2009)
  • Demonstrate a commitment to engage in anti-discriminatory practice in relation to end of life care and service delivery
MEMBERSHIP OF DISCIPLINE SPECIFIC WORK GROUP PSYCHOLOGY

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DOMAIN OF COMPETENCE 1
PRINCIPLES OF PALLIATIVE CARE

Palliative care aims to improve the quality of life of people with life-limiting conditions and their families, not only by treating their physical symptoms but also by attending to their psychological, social and spiritual needs. Palliative care is applicable for people of any age and may be integrated at any point in the disease trajectory from diagnosis through the continuum of care to bereavement.

INDICATORS
As a health care professional you should:

• Understand and be able to describe the meaning of the term ‘life-limiting condition’
• Understand and be able to apply the principles of palliative care that affirm life, offer people with life-limiting conditions a support system to help them live as actively as possible until death with optimal quality of life and help families cope during illness
• Understand the significance of the physical, psychological, social and spiritual issues that affect people with life-limiting conditions and their families throughout the continuum of care
• Demonstrate the ability to use the palliative care approach as early as is appropriate in order to facilitate person-centred practice that recognises the concerns, goals, beliefs and culture of the person and her/his family
• Provide empathetic care to individuals with life-limiting conditions and their families, with clear regard to the individuality of each person
• Show a commitment to one’s own continued professional development and learning and facilitate the learning and development of others, in order to improve care for those with life-limiting conditions and their families
• Show a commitment to developing self-care strategies and to attending to any impact that working with people facing life-limiting conditions and their families may have on you.

ALL
All applied psychologists should:

• Assess the person’s subjective experience and meaning of their illness trajectory
• Recognise dying as a normal process in life
• Have an awareness of the psychological aspects of life-limiting conditions and potential mental health needs arising from these
• Be aware of the importance of empathic and responsive relationships between those experiencing life-limiting conditions and their health care team
• Demonstrate an understanding of palliative care issues, which may impact on subsequent interactions with individuals and their families
• Be aware of the role of specialist palliative services in supporting staff when providing a palliative care approach to a person with a life-limiting condition

SOME
All applied psychologists whose work involves increased engagement with people with life-limiting conditions and their families should:

• Demonstrate an understanding of the mental health needs of those with life-limiting conditions and by virtue of the scientist-practitioner framework ensure that clinical practice is both informed by and informs this understanding
• Maintain a thorough understanding of psychological theories of death, dying and living with life-limiting conditions
• Maintain a thorough understanding of specific psychological issues pertaining to the clinical practice of palliative care, such as impact of integrating palliative care with active treatment and the significance of transition periods
• Demonstrate an understanding of and capacity to work in a self-reflective way with existential issues that impact upon people with life-limiting conditions, their families and psychologists themselves
• Engage in psychological assessment, formulation and intervention with people with life-limiting conditions and their families within personal competency limits, referring on as appropriate.
• Critically evaluate the effectiveness of any psychological intervention and modify or refer on for more specialist support, as appropriate.
• Engage in research pertaining to palliative care within the context of the local work environment.
• Identify and critically appraise research evidence relevant to practice as it pertains to living with life-limiting conditions.
• Demonstrate cultural competence in academic or applied practice, for example maintain a critical understanding of the dominant discourses in palliative care.
• Understand the relevant national policy, practice, and legislation pertaining to palliative care.
• Raise awareness of a psychological perspective on death and dying and mental health needs of people with life-limiting conditions at all levels including but not limited to: among people with life-limiting conditions, caregivers, within teams and work organisations.
• Be involved as team members, or leaders, in the design and conduct of staff support and training programmes in issues pertaining to life-limiting conditions.
• Demonstrate understanding and competence to plan and engage in service audit.

**FEW**

All applied psychologists whose core role is the provision of care to people with life-limiting conditions and their families should:

• Engage in specialist psychological assessment, formulation and intervention with people with life-limiting conditions and their families presenting with complex and often multiple clinical conditions.
• Work with and consult on various psychological protective functions such as death denial and death anxiety, as appropriate to palliative care.
• Consult with teams in the management of people with life-limiting conditions with complex needs such as organic brain damage, toxicity, dual mental health diagnosis and personality difficulties, which may interfere with their ability to engage with services.
• Possess a knowledge of the historical development and role of psychology in palliative care nationally and internationally and the challenges associated with the adoption of a holistic model of care within dynamic health care systems.
• Lead and facilitate research addressing issues pertaining to palliative care.
• Provide leadership in the development and delivery of palliative care policy at local and national levels.
• Demonstrate a commitment to continuous professional training centred on that pertaining to the evolving field of palliative care.
• Provide leadership in the psychology of palliative care by contributing to the knowledge base of society via talks, conferences, media.
• Demonstrate leadership in palliative care education as it pertains to psychology up to and including 3rd level post-graduate programmes.
• Provide a board range of evidence-based therapeutic interventions (e.g. Cognitive Behavioural Therapy (CBT), Meaning Centred Therapy) to service users and family members.
DOMAIN OF COMPETENCE 2

COMMUNICATION

Effective communication is essential to the application of palliative care principles and to the delivery of palliative care. Communication is particularly important where bad news has to be relayed, when difficult decisions regarding treatment continuance and/or cessation are to be made and where the communication needs of the person with a life-limiting condition and their family differ. Communication is also important where circumstances are ambiguous or uncertain and when strong emotions and distress arise. Specific consideration should be given to communication as a method of:

- Supporting and enabling therapeutic relationships with the person with life-limiting condition and her/his family;
- Ensuring that the person and her/his family understand and participate in decision-making regarding care to the extent that she/he is able to and wishes to be involved
- Enabling inter-professional teamwork

INDICATORS

As a health care professional you should:

- Understand the essential role communication plays in palliative care
- Understand the different types of communication e.g. verbal, non-verbal, visual, written, and interpersonal interaction (either one-to-one or with a group or team)
- Demonstrate the ability to communicate effectively with the person with a life-limiting condition, their family and the interdisciplinary team in order to establish, maintain and conclude a therapeutic relationship
- Demonstrate the ability to communicate effectively with individuals and families from diverse cultures and different backgrounds, using professional interpreters (Appendix 1) where necessary and/or assistive communication technology where necessary
- Be able to modify own communication style to facilitate communication with individuals with a range of communication impairments or seek facilitation in this area if required
- Understand the importance of using strategies that empower effective communication e.g. active listening, plain language, appropriate tone, clarifying statements, inviting questions
- Demonstrate an ability to be attentive to the person through careful listening to help the person and her/his families feel they have been heard
- Support individuals (or parents in the case of children and minors) to make informed decisions regarding the level of information they wish to receive and want to share with their family
- Act as an advocate for the person and their family to ensure appropriate and timely palliative care intervention

ALL applied psychologists should:

- Demonstrate awareness that effective communication is a fundamental underpinning of applied psychological practice
- Be able to assess a person’s current understanding of their life-limiting condition
- Cultivate and support effective communication skills among individuals with life-limiting conditions, their families and other health care providers
- Provide compassionate communication, general psychological support to individuals with life-limiting conditions and their carers, including individual, family and group
- Demonstrate a working knowledge of the therapeutic alliance and the importance of building rapport with individuals with life-limiting conditions, their carers and family members
- Recognise communication challenges in individuals with life-limiting conditions and refer on for further clinical assessment and intervention as appropriate
- Proactively communicate to the individual with a life-limiting conditions and their family, the limits of confidentiality and the need for a joint patient record and team
communication about care planning
  • Have an awareness of specialist palliative supports in relation to communication: professional interpreters, sign language and assistive technology.

**SOME**
All applied psychologists whose work involves increased engagement with people with life-limiting conditions and their families should:

  • Support parents/guardians/families in sharing difficult or bad news relating to illness or death and facilitate direct supportive communication, where appropriate
  • Demonstrate competence in communication with individuals with life-limiting conditions, displaying a wide range of cognitive ability, sensory acuity and modes of communication
  • Communicate effectively with individuals with life-limiting conditions and their families from diverse cultures and different backgrounds, using professional interpreters and/or assistive communication technology where necessary
  • Demonstrate an ability to communicate sensitively and clearly about advance care planning with the individuals with life-limiting conditions, their family and the range of professionals and agencies involved
  • Demonstrate awareness of the different levels of communication (such as verbal and non-verbal; conscious and unconscious) of individuals with life-limiting conditions
  • Demonstrate theoretical knowledge of evidence-based models of psychotherapeutic intervention and outcome measures appropriate to individuals with life-limiting conditions
  • Facilitate effective intra and interdisciplinary communication among individuals with life-limiting conditions, their families and other health care providers within the multidisciplinary team.

**FEW**
All applied psychologists whose core role is the provision of care to people with life limiting conditions and their families should:

  • Provide training and support to enable health and social care staff working in palliative care to communicate with people with life-limiting conditions clients and their families sensitively and effectively
  • Communicate clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences; including professional colleagues, individuals with life-limiting conditions and their carers
  • Demonstrate an understanding of and clinical ability to work with the broader aspects of psychological theory; including but not limited to; the unconscious, the intra-psychic and other non-verbal communication as it applies to individuals with life-limiting conditions
  • Demonstrate an understanding and awareness of medications, physical pain, organic or cognitive impairment and its impact on the individual with a life-limiting condition
  • Provide additional training and consultation with regard to the normal and complicated adjustment and systemic processes
  • Demonstrate leadership in communication, such as facilitating team communication, staff support, debriefing and case reviews.
DOMAIN OF COMPETENCE 3

OPTIMISING COMFORT AND QUALITY OF LIFE

Individuals with life-limiting conditions and their families can be affected not only in physical, but also in psychological, social and spiritual ways. Optimising comfort and quality of life for the person with a life-limiting condition and her/his family is a dynamic process that involves anticipating, acknowledging, assessing and responding to a range of symptoms and needs in a proactive and timely manner in order to prevent and relieve suffering.

INDICATORS

As a health care professional you should:

- Understand the significance of anticipating and responding to the needs of people with life-limiting conditions and their families (e.g. physical, psychological, social and spiritual) in a proactive and timely manner
- Understand how the palliative care approach can enhance the assessment and management of symptoms
- Exhibit an ability to apply a range of assessment tools to gather information
- Be able to evaluate non-complex interventions and propose alternative actions if deemed necessary
- Recognise the importance and benefit of multidisciplinary working in optimising comfort and enhancing the quality of life of the person with a life-limiting condition and her/his family
- Recognise the ways in which people with life-limiting conditions and their families can be engaged in self-management of their condition
- Demonstrate professional awareness of the scope of, and benefits of timely and appropriate access to specialist palliative care services
- Be aware of the uniqueness of a good death and facilitate the achievement of this as much as possible

ALL

All applied psychologists should:

- Demonstrate an understanding that psychological assessment and treatment should take place in the context of multidisciplinary care team
- Have a working knowledge of the factors underpinning psychosocial adjustment to life-limiting condition and recognise the potential role of palliative care in enhancing the care of the individual and their family
- Have the ability to pre-empt potential problems and apply psychological approaches, such as Cognitive Behaviour Therapy (CBT), Brief Solution Focused Therapy based on assessment or refer on as appropriate

SOME

All applied psychologists whose work involves increased engagement with people with life-limiting conditions and their families should:

- Recognise how disease progression and associated medical treatments can adversely affect the quality of life of a person with a life-limiting condition by virtue of their potential to impact on the person’s emotional wellbeing, interpersonal relationships, material wellbeing, personal development, physical well-being, self-determination, social inclusion and human rights
- Support people with life-limiting conditions to psychologically process the implication and impact of moving from curative care to palliative care
- Knowledge and understanding of the diagnosis and treatment of mental health difficulties, with onward referral for more specialist assessment as appropriate
- Conduct standardised assessment of the psychological adjustment of an individual with a life-limiting condition
- Develop psychological formulations based on assessment findings and communicating
these formulations, as appropriate, to relevant stakeholders in order to shape and support patient care pathways

- Deliver evidence-based psychotherapeutic interventions to people with life-limiting conditions and their families
- Provide education to people with life-limiting conditions, their families and carers and the wider health professional network on the psychological aspects of pain, fatigue, anxiety and other presentations associated with the experience of end of life.

**FEW**

All applied psychologists whose core role is the provision of care to people with life limiting conditions and their families should:

- Demonstrate advanced clinical knowledge of complex mental health presentations through assessment, diagnosis and treatment
- Demonstrate competence in the use of classification systems for mental health disorders such the Diagnostic and Statistical Manual of Mental disorders (DSM) and in treating mental health disorders in people with life-limiting conditions
- Support and educate individuals with life-limiting conditions and their families on quality of life decisions and the psychological implications of decisions
- Provide specialist evidence-based psychotherapeutic interventions based on on-going psychological assessment
- Support teams in the management of individuals with life-limiting conditions who present with organic brain damage, toxicity, dual mental health diagnosis and personality disorders which may interfere with their engagement with services
- Provide consultation to the team when considering the care and treatment options for a person with a life-limiting condition, with due regard to the persons wishes and how their psychological state may influence this.
- Provide consultation and direct support to families with complex dynamics and staff to facilitate care provision
- Support health and social care professionals as appropriate such as debriefing, supervision, case management
DOMAIN OF COMPETENCE 4
CARE PLANNING AND COLLABORATIVE PRACTICE

Care planning in palliative care is characterised by coordinating and integrating person-centred care in order to promote quality of life for people with life-limiting conditions and their families. It involves assessing need, promoting and preserving choice, predicting likely problems and planning for the future in the context of a changing and deteriorating disease trajectory. Care planning ensures that multiple disciplines and agencies can be accessed and referred to as required in a timely manner. People with life-limiting conditions should be helped to engage with care planning to the extent that they are able to and wish to be involved. The concerns of families and carers should be taken into account as part of this process.

INDICATORS
As a health care professional you should:
• Recognise the impact of a life-limiting condition on the person and her/his family and be able to provide support in order to help the individual to adapt to the changes in her/his condition
• Recognise the impact of a life-limiting condition on the person and her/his family's mental health and coping mechanisms and be able to provide support in order to help the individual to adapt to the bereavement and loss
• Appreciate the roles, responsibilities and professional boundaries of individual members of the interdisciplinary team
• Understand the collaborative relationship between the person with life-limiting conditions, the health care professional, the family and all the other agents of care involved with the person and the family in order to develop an individualised and coherent plan of care to assist the person and the family to attain realistic goals and outcomes in all care settings
• Collaborate effectively with others as a member or leader of multidisciplinary team
• Be able to identify priorities or concerns for the individual with a life-limiting condition and their carers, taking account of the individual's coping strategies and how the person perceives their diagnosis
• In the context of professional scope of practice be able to critically evaluate outcomes of interventions against established standards and guidelines
• Demonstrate an understanding of advance care planning and an appreciation of the appropriate time(s) to engage in discussions about preferences for care with the person with a life-limiting condition and her/his family
• Demonstrate an ability to communicate sensitively and clearly about advance care planning with the person, the family and the range of professionals and agencies involved.

ALL
All applied psychologists should:
• Demonstrate understanding of the relationship between medical illnesses and treatment of mental health presentations in palliative care
• Demonstrate an ability to build empathic, responsive relationships and maintain physical and emotional presence with individuals with life-limiting conditions
• Demonstrate an ability to gather and analyse information from a variety of sources and evaluate this information to make well-founded decisions with respect to care planning and communicate samethrough compassionate communication
• Have awareness of the essential multidisciplinary nature of care in palliative care and therefore, the need for consultation with other agencies caring for the person
• Have knowledge and understanding of how to resource and refer an individual with a life-limiting conditions or their carer or family member, for support and guidance on contemporary issues in palliative care
• Understand that the person with a life-limiting condition may lose (sometimes temporally) capacity to make decisions towards end-of-life
• Have awareness of the Pharmaceutical Society of Ireland Guidelines on Equality and Inclusive Practice (2008) and the impact that membership of minority groups may have on care plan formulation.

**SOME**

All applied psychologists whose work involves increased engagement with people with life-limiting conditions and their families should:

• Recognise that psychological care planning takes place in a dynamic field of changing health and care where care plans have regularly been revised and reformulated
• Be able to refer a person with a life-limiting condition or their family members to other mental health professionals for issues outside the scope of palliative care practice (such as family therapy)

**FEW**

All applied psychologists whose core role is the provision of care to people with life-limiting conditions and their families should:

• Demonstrate psychological formulation and re-formulation of care planning in the context of changing health status of the patient
• Consult and support conversations about Advanced Care Planning, capacity, and contemporary end-of-life issues in line with current Irish policies
• Demonstrate awareness of reputable on-line resources and assist individuals with life-limiting conditions and their families to inform themselves and appropriately use self-help resources and support groups
• Demonstrate understanding that psychological assessment and treatment takes place in the context of multidisciplinary care team. Pro-actively communicate to individuals with life-limiting conditions and their families the limits of confidentiality and the need for a joint patient record and team communication about care planning
• Work collaboratively with other professionals to ensure a realistic care plan so that services do not place an undue burden on the individual with a life-limiting condition
• Model and provide consultation with regard to building empathic, responsive relationships and maintain physical and emotional presence with individuals with life-limiting conditions
• Consult on the application of the international best practice guidelines on end-of-life care and demonstrate ability to apply these guidelines in practice
• Awareness of one’s own existential issues, as well as those of people with life-limiting conditions and their families and the impact of such issues on counter transference and self-care.
DOMAIN OF COMPETENCE 5
LOSS, GRIEF AND BEREAVEMENT

The knowledge and skills base which a psychologist brings to end of life and bereavement care is both broad (for example, an ability to understand and apply different approaches to care) and deep (for example, an ability to be expert in specific models of therapy, research and clinical areas) Psychologists approach each service user and situation from a discipline which is firmly rooted in research and theoretical understanding. Psychologists bring a detailed understanding of human development across the lifespan including cognitive functioning, personality development, behaviour and group dynamics and utilise this information to ensure best service delivery.

INDICATORS

As a health care professional you should:

• Understand that grief is a normal and appropriate response to loss which has physical, psychological, spiritual, emotional and social aspects that affect how it is experienced
• Recognise the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief
• Recognise the factors which may put a person at risk of encountering difficulties in their grief, whilst also remaining aware of the resources and resiliencies that are particular to each person and family
• Demonstrate an ability to engage with a person who is experiencing loss in the context of professional scope of practice and/or role
• Assist the family to access bereavement information and support at a level that is appropriate to their needs
• Be cognisant of the psychological impact of death and dying on individuals with increased stress vulnerability
• Understand the personal impact of loss, grief and bereavement and recognise your own loss responses and engage in activities that maintain your resilience on an on-going basis
• Possess a level of self-awareness that prevents your own experiences of loss from negatively impacting on the person with a life-limiting condition or their family.

ALL

All applied psychologists should:

• Be familiar with contemporary theories and models of loss and grief (for example; Dual Process, Continuing Bonds, Meaning Making)
• Provide culturally competent bereavement support to individuals with life-limiting conditions and their family members
• Use appropriate referral pathways for individuals and family members requiring more specialised psychological interventions
• Be aware of appropriate supports and resources for people with life-limiting conditions and their family members
• Utilise supervision and other support strategies to maintain well-being and effective practice.

SOME

All applied psychologists whose work involves increased engagement with people with life-limiting conditions and their families should:

• Be proficient in applying contemporary, evidence-based models of bereavement support and counselling across a broad range of individuals with life-limiting conditions; adjusting for differences in cognitive level and learning style and demonstrating sensitivity to gender, sexual orientation, religious and cultural differences
• Be able to communicate therapeutically with individuals with life-limiting conditions, and their families, noting normal and pathological loss responses and attending to individual
styles of coping and grieving
• Stay abreast of published literature in the area of grief, loss and bereavement and disseminate this information to colleagues and individuals with life-limiting conditions as appropriate
• Demonstrate good self-care practice and include an emphasis on work impact on self when giving and receiving supervision.

FEW
All applied psychologists whose core role is the provision of care to people with life limiting conditions and their families should:
• Apply an in-depth understanding of the grief and loss literature to the care of people with life-limiting conditions and their families and provide consultation and training updates for mental health professionals
• Understand the complexity and dynamic nature of responses to loss, and provide expert input to the multidisciplinary team on the psychological aspects of people with life-limiting conditions and family care.
• Demonstrate proficiency in using validated assessment tools to diagnose and differentiate between ego-syntonic sadness and mental health issues such as; anxiety, depression and Post Traumatic Stress Disorder
• Formulate and deliver a broad range of evidence-based therapeutic interventions to people with life-limiting conditions and their family members who present with increased stress vulnerability and/or complex grief responses
• Demonstrate ability to use recognised and validated tools to diagnose Post Traumatic Stress Disorder and other pathological grief responses in individuals with life-limiting conditions and family members
• Assess the efficacy of treatment interventions and adjust accordingly
• Provide additional training and consultation with regard to the normal and complicated adjustment and systemic processes
• Provide bereavement intervention to family members and carers.
• Engage in research that adds to the body of literature on psychology, loss, grief and bereavement and disseminate research findings
• Contribute to teaching curricula on loss, grief and bereavement up to and including 3rd level education across a range of disciplines
• Lead and develop strategies and practice that enhance well-being and effective practice amongst individual staff members and teams.
DOMAND OF COMPETENCE 6
PROFESSIONAL AND ETHICAL PRACTICE IN THE CONTEXT OF PALLIATIVE CARE

The goal of health care is to help people sustain health that is essential to their well-being. However, there comes a time when specific treatments or interventions may be futile or overly burdensome. Integrity in palliative care practice refers to the importance of respecting the person’s values, needs and wishes in the context of a life-limiting condition. It guides all health care professionals to reflect on the relationship between their contribution to a person’s care and the necessary contributions of other professionals. Professional and ethical practice is about considering how best to provide continuing and integrated care to people as their health care needs change in the course of life-limiting conditions.

INDICATORS
As a health care professional you should:
• Work within your current Code of Professional Conduct and engage ethically, knowledgably and respectfully with other disciplines
• Recognise and respect your professional responsibility to care for people with life-limiting conditions and their families to ensure their comfort and dignity
• In the context of your current professional role establish collegial partnerships and in the context of palliative care contribute to the professional development of students, peers, colleagues and others through consultation, education, leadership, mentorship and coaching
• Use the resources available in the context of providing appropriate care to the person with a life-limiting condition
• In the context of professional scope of practice and/or role anticipate and demonstrate the ability to address potential ethical issues that may be encountered when caring for the person with a life-limiting condition and her/his family such as: Do Not Attempt Resuscitation Orders, withdrawal and withholding of treatment, use of artificial hydration and feeding, palliative sedation and requests for euthanasia
• Be able to establish and respect people’s wishes about their care and options/preferences. This includes:
  • Recognising peoples right to make informed decisions to refuse additional treatment(s) seeking, responding to and implementing people’s preferences about where they are cared for (e.g. in their own homes) if this is practicable
  • Respecting advance care plans made by people where the decision is an informed choice and relates to the situation that has arisen (Medical Council, 2009)
  • Demonstrate a commitment to engage in anti-discriminatory practice in relation to end of life care and service delivery.

ALL
All applied psychologists should:
• Be aware and act according to the Code of Ethics and Professional Conduct of the Psychological Society of Ireland
• Adopt the Psychological Society of Ireland (PSI) Guidelines on Equality and Inclusive Practice in relation to caring for people with life-limiting conditions

SOME
All applied psychologists whose work involves increased engagement with people with life-limiting conditions and their families should:
• Promote and provide access to psychological therapies for people with a life-limiting condition
• Demonstrate ability to understand and apply the PSI Guidelines on Equality and Inclusive Practice (2008)
• Contribute to education of health care professionals and general public about the psychology of death and dying (such as promote a bio-psycho-social understanding of death promote an understanding of the unconscious mind)
• Provide and participate in professional supervision and peer review processes to monitor personal and professional responses to clinical situations and to ensure best practice in providing care to people with life-limiting conditions and their families
• Actively participate in the discussion and resolution of ethical and legal issues in conjunction with the multidisciplinary team, individuals with life-limiting conditions and families that may arise in relation to factors which impact on living with a life-limiting condition
• Use recognised ethical, legal and professional frameworks to guide end of life decision making.

**FEW**

**All applied psychologists whose core role is the provision of care to people with life limiting conditions and their families should:**

• Demonstrate a commitment to working to promote the provision of comprehensive palliative care services at local, regional and national levels across all clinical settings including primary, acute, tertiary and residential care
• Demonstrate leadership through advocating for on-going and continuous service development with particular emphasis on the often unmet mental health needs of people with a life-limiting conditions and advocate for the provision of psychological services for people with life-limiting conditions
• Be committed to advancing the role of psychology in palliative care through the application of knowledge and generation and dissemination of research at national and international conferences
• Demonstrate skills in bridging the biomedical and social sciences research paradigm by leading multidisciplinary research projects and publications.
• Facilitate discussion and resolution of ethical issues that may arise in palliative care
• Apply an advanced understanding of contemporary legal, ethical and professional standards in the provision of quality palliative care with particular emphasis on issues such as capacity and euthanasia
REFERENCES


Canadian Hospice Palliative Care Nursing Standards of Practice (2009) http://www.chpca.net/media/7505/Canadian_Hospice_Palliative_Care_Nursing_Standards_2009.pdf


British Psychological Society


USEFUL RESOURCES FOR INTERPRETING SERVICES & CULTURAL AWARENESS

Health Service Executive (2009) On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services
http://www.hse.ie/eng/services/Publications/services/SocialInclusion/emaspeaking.pdf

Health Service Executive (2009) Health Services Intercultural Guide: Responding to the needs of diverse religious communities and cultures in health care settings
http://www.hse.ie/eng/services/Publications/services/SocialInclusion/InterculturalGuide/

PAIN
The World Health Organisation defines pain as “an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage”.
It should be remembered that pain is ‘whatever the experiencing person says it is, existing wherever the experiencing persona says it does’ (McCaffery, 1968).

NAUSEA
Is a subjective symptom involving an unpleasant sensation in the back of the throat and the epigastrum, which may or may not result in the person experiencing nausea vomiting.

VOMITING
Is the forced expulsion of the contents of the stomach through the mouth.

CONSTIPATION
‘A decrease in the frequency of passage of formed stools and characterized by stools that are hard and small and difficult to expel.’ (Caraccia Economou, 2010).

ANOREXIA
The loss of desire to eat (Wholihan & Kemp, 2010)

CANCER CACHEXIA
‘Cancer cachexia is a complex, multifactorial wasting syndrome involving loss of skeletal muscle and fat that is caused by an abnormal host response to tumor presence or tumor factors.’ (Stewart et al., 2008)

FATIGUE
NCCN defines fatigue as a persistent, subjective sense of tiredness related to cancer or cancer treatment that interferes with usual functioning.

SWEATING
‘The secretion of fluid onto the skin surface to aid cooling. Sweating is a normal phenomenon in the regulation of body temperature, but in illness can be a troublesome and distressing symptom.’ (Watson et al., 2009:359)

FEVER
‘A rise in body temperature exceeding 38oC (100.4oF) from the norm (37o ± 1o C) (98.78oF).’ (Larkin, 2010)

BREATHLESSNESS
Is an unpleasant sensation of difficulty in breathing and is a common, disabling, and distressing symptom (Galbraith et al., 2010)

COUGH
‘Cough is an explosive expiration that can be a conscious act or a reflex response to an irritation of the tracheobronchial tree.’ (Dudgeon, 2010)
ACTIVE LISTENING:
Involves being fully attentive to another person without being distracted. It also involves the ability to demonstrate that the person has been heard and understood by re-stating or paraphrasing what has been said in order to confirm what they have heard and the understanding of both parties.

ADVANCE CARE PLANNING:
Advance care planning is a process of discussion and reflection about goals, values and preferences for future treatment in the context of an anticipated deterioration in the individual’s condition with loss of capacity to make decisions and communicate these to others.

ANTI-OPPRESSIVE PRACTICE:

BEREAVEMENT:
Bereavement is the total response to a loss and includes the process of ‘recovery’ or healing from the loss. Although there are similarities in people’s responses, there are also marked differences. Each person will grieve and ‘recover’ in their own way.

COMPLEX PALLIATIVE CARE PROBLEMS:
Complex palliative care problems are defined as those that are severe and intractable, involving a combination of difficulties in controlling physical and/or psychological symptoms, the presence of family distress and social and/or spiritual problems. They exceed the resources of the generalist palliative care provider to meet the needs and expectations of the individual/carer/family.

CHILDREN’S PALLIATIVE CARE:
Palliative care for children and young people with life-limiting conditions is an active and total approach to care, embracing physical, emotional, social and spiritual elements. It focuses on enhancement of quality of life for the child and support for the family and includes the management of distressing symptoms, provision of respite and care through death and bereavement.

END OF LIFE CARE*:
End of life care is a continuum of palliative care and is usually used to describe the care that is offered during the period when death is imminent, and life expectancy is limited to a short number of days, hours or less.
* “End-of-life care” is an imprecise term but implies time-defined care. It is a quantitative rather than qualitative descriptor that excludes the purpose of care. In contrast, palliative care is not time-confined but goal-oriented.(4) The discipline of palliative care helps individuals to “live until they die” whenever that occurs.(5) The Palliative Care programme is of the opinion that promotion of the term ‘end of life care’ as a descriptor of palliative care practice will send a message to the general public that care is limited to the imminently dying. We also are concerned that the phrase will promote among potential referring physicians a transitional “discontinuous” care model rather than a more desirable seamless “collaborative” care with early referral.(6) Therefore, the programme recommends that the term ‘end of life care is used to describe the care that is offered during the period when death is imminent, and life expectancy is limited to a short number of days, hours or less. ‘Palliative care’ is the preferred term of the programme when describing care which is focused on improving the quality of life of individuals and their families facing the problems associated with life-threatening illness.

APPENDIX THREE
GLOSSARY OF TERMS
Adapted from Health Service Executive (2014) Glossary of Terms. Palliative Care Programme, Clinical Strategy and Programme Directorate
http://www.hse.ie/eng/about/who/clinical/natclinprog/palliativecareprogramme/glossary.pdf
FAMILY:
‘A family is defined as those who are closest to the individual in knowledge, care and affection. The family may include the biological family, the family of acquisition (related by marriage/contract), and the family of choice and friends (including pets).’ (Palliative Care Australia (2005) Standards for Providing Quality Palliative Care for all Australians, Page 11).

GENERAL PALLIATIVE CARE:
Care provided by health and social care professionals who, although not engaged full time in palliative care, apply the principles of palliative care in the course of their work. Some health and social care professional providing general palliative care will have additional training and experience in palliative care.

GENERALIST PALLIATIVE CARE PROVIDERS:
Generalist providers refer to all those services, health and social care providers who have a primary or ‘first contact’ relationship with the person with a life-limiting condition and palliative care needs. The use of the term ‘generalist’ in this context refers to general practitioners, primary care team members and staff of residential care services. It also includes other specialist services and clinical staff of emergency departments and acute care hospitals.

HOSPICE CARE:
Hospice care is a term that is often used to describe the care offered to individuals when the disease process is at an advanced stage. The term may be used to describe either a place of care (i.e. institution) or a philosophy of care, which may be applied in a wide range of care settings.

INDICATORS:
‘… describe the evidence that is to be produced for assessing competency in that domain.’
http://www.nursingboard.ie/competency/comp2/competency.asp

Indicators describe the knowledge, skills and behaviour necessary for competence in that domain.

INFORMED CONSENT:
Informed consent is given voluntarily by the individual when decisions about care are being made or when permission is needed for an intervention to be carried out by competent professionals. In order to exercise their right to make informed decisions, individuals should be provided with sufficient understandable information, which will inform their judgement.

LIFE-LIMITING CONDITION:
Life-limiting condition means a condition, illness or disease which:
• Is progressive and fatal; and
• The progress of which cannot be reversed by treatment.

MOST RESPONSIBLE PHYSICIAN:
The physician who has final responsibility and is accountable for the medical care of a individual.

MULTIDISCIPLINARY TEAM:
A team of health and social care professionals who work together to develop and implement a plan of care. Membership varies depending on the services required to address the identified needs of the individuals and families being care for. A multidisciplinary team typically includes members from the following disciplines:
• Medicine
• Nursing
• Social Work
• Occupational Therapy
• Physiotherapy
• Psychology
• Chaplaincy
• Pharmacy
• Volunteers
• Other disciplines, such as a Speech and Language Therapy, Dietetics, Complimentary and Creative Arts Therapy may also be part of the team.

NON-COMPLEX INTERVENTIONS:
Represent the response to palliative care problems by the generalist palliative care provider. Normally non-complex interventions are used to respond to problems which are not severe or intractable, do not represent difficulties in controlling symptoms or represent excess family distress.

OCCUPATIONAL THERAPY:
Occupational therapy is a client-centred health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement. (World Federation of Occupational Therapists 2012)

OCCUPATIONAL PERFORMANCE:
The ability to perceive, desire, recall, plan and carry out roles, routines, tasks and sub-tasks for the purpose of self-maintenance, productivity, leisure and rest in response to demands of the internal and/or external environment (Chapparo & Ranka, 1997).

OCCUPATIONAL PERFORMANCE ROLES:
Are the patterns of occupational behaviour composed of configurations of self-maintenance, productivity, leisure and rest occupations. Roles are determined by individual person-environment-performance relationships. They are established through need and/or choice and are modified with age, ability, experience, circumstance and time (Chapparo & Ranka, 1997).

PALLIATIVE CARE:
Palliative care is an approach that improves the quality of life of individuals and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care:
• Provides relief from pain and other distressing symptoms;
• Affirms life and regards dying as a normal process;
• Intends neither to hasten or postpone death;
• Integrates the psychological and spiritual aspects of individual care;
• Offers a support system to help individuals live as actively as possible until death;
• Offers a support system to help the family cope during the individuals illness and in their own bereavement;
• Uses a team approach to address the needs of individuals and their families, including bereavement counselling, if indicated;
• Will enhance quality of life, and may also positively influence the course of illness;
• Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.
(WHO, 2002)

PALLIATIVE CARE FOR CHILDREN:
Palliative care for children represents a special, albeit closely related field to adult palliative care. Palliative care appropriate for children and their families is as follows; the principles apply to other paediatric chronic disorders
• Palliative care for children is the active total care of the child’s body, mind and spirit, and also involves giving support to the family.
• It begins when illness is diagnosed, and continues regardless of whether or not a child receives treatment directed
at the disease.

• Health providers must evaluate and alleviate a child’s physical, psychological, and social distress.
• Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited.
• It can be provided in tertiary care facilities, in community health centres and even in children’s homes. (WHO, 1998)

PALLIATIVE CARE APPROACH:
The palliative care approach aims to promote both physical and psychosocial wellbeing. It is a vital and integral part of all clinical practice, whatever the illness or its stage, informed by a knowledge and practice of palliative care principles.

PALLIATIVE CARE REHABILITATION:
• Helps individuals gain opportunity, control, independence and dignity;
• Responds quickly to help people adapt to their illness;
• Takes a realistic approach to defined goals;
• Is continually evolving, taking its pace from the individual.

PALLIATIVE CARE SUPPORT BEDS:
Terms such as ‘level 2 beds’ and ‘intermediate palliative care beds’ have been used as synonyms for palliative care support beds. It is recommended that the term ‘palliative care support beds’ replace all other descriptors.

PALLIATIVE MEDICINE:
Palliative medicine is the appropriate medical care of individuals with active, progressive and advanced disease, for whom the prognosis is limited, and the focus of care is the quality of life. Palliative medicine includes consideration of the family’s needs before and after the individual’s death.(13)

SPECIALIST PALLIATIVE CARE SERVICES:
Specialist palliative care services are those services with palliative care as their core speciality and which are provided by an interdisciplinary team, under the direction of a consultant physician in palliative medicine.

THERAPEUTIC RELATIONSHIPS:
‘Therapeutic relationships require that the carer individualises care for the person with end-of-life needs as well as the individual’s family.’ (Baldwin M.A. (2011) Attributes of Palliative Caring. In Key Concepts of Palliative Care (M.A. Baldwin & J. Woodhouse Eds.) London, Sage. Page 7)

ROLE DELINEATION:
Role delineation is a process which determines what support services, staff profile, minimum safety standards and other requirements are provided to ensure that clinical services are provided safely and appropriately supported.

UNSTABLE:
Unstable is where the individual experiences the development of a new problem or rapid increase in the severity of existing problems, either of which require an urgent change in management or emergency treatment, and/or the family/carers experience a sudden change in their situation requiring urgent intervention by the specialist palliative care team.