

EXPLORING PALLIATIVE CARE  
EDUCATION IN  
IRELAND:

A RESOURCE AND DISCUSSION  
DOCUMENT

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On behalf of the Baseline in Palliative Care Steering  
Committee

Final Draft  
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# **Forward**

## **IRISH HOSPICE FOUNDATION PALLIATIVE CARE EDUCATIONAL NEEDS ASSESSMENT**

Ireland is responding to the national challenge of improving palliative care services in a number of ways. One very important aspect of this overall programme is ensuring that the workforce is adequately prepared to deliver high quality services. The delivery of high quality palliative care is dependant upon a skilled, knowledgeable workforce that is committed to the pursuit of excellence through continued learning.

People affected by chronic and life threatening illnesses, such as cardiac, liver and respiratory failure, multiple sclerosis, cancer and many others have contact with health professionals in every health care setting across the complete healthcare pathway from primary health promotion through primary, secondary and tertiary care to bereavement support. A large amount of their contact is with professionals who are not palliative care specialists, yet these professionals make an invaluable contribution to the patient and family's experience. The ways and settings in which palliative care services are delivered in the future will undoubtedly be different to current practice, but the fundamental needs of the people affected will remain largely the same. In essence as stated by Dr. O'Brien 'Palliative care is about people: it is concerned with ordinary people who find themselves facing extraordinarily difficult situations' (1).

This Educational Needs Assessment takes account of the total remit of palliative care needs, interprofessional services, changing roles and service delivery to provide a guide which should enable managers to assess the competence of their workforce.

It was conducted under the umbrella of the baseline study on the provision of hospice specialist palliative care services in Ireland, supported by the HSE and The Atlantic Philanthropies and conducted at the Irish Hospice Foundation. It is a retrospective review up to 2004 and as such, becomes a baseline in itself of educational provision.

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## **Glossary**

### **Palliative Care Approach**

The approach is linked to palliative care that is used by primary care services and acute services to improve the quality of life for individuals with a life limiting illness, their carers and family. The palliative care approach incorporates a concern for the holistic needs of patients and carers that is reflected in assessment and in the provision of physical, psychological, social and spiritual care. Application of the approach to the care of an individual patient is not delayed until the end stages of the illness. Instead it provides a focus on active comfort and a positive approach to understanding of loss and bereavement in the wider community (1). Underlying the philosophy of a palliative approach is the view that death dying and bereavement are all an integral part of life. It is this principle that forms the important distinction between the care provided by health care professionals in general and the role played by Specialist Palliative Care providers.

### **Life limiting Illness**

The term is used to describe illnesses where it is expected that death will be a direct consequence of the specific illness. The definition is inclusive of illnesses of both a malignant and non-malignant nature. A life limiting illness might be expected to shorten an individual's life expectancy. This differs from chronic illness where, even though there may be significant impact on the patient's abilities and quality of life, there is less likely to be a direct relationship between the illness and the person's death (2).

### **Terminal care**

Terminal 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. It is crucial that all practitioners can recognise when person moving from palliative to terminal phase – often relatives need to be explicitly told what is happening and what to expect, especially if person been unwell for long period.

### **Hospice care**

Hospice care is a term that is often used to describe the care that is offered to patients when the disease process is at an advanced stage. The term may be confusing to many as it is used to describe both a place (i.e. institution) and a philosophy of care which may be applied in a wide range of settings.

### **Quality of Life**

Technological advances and insights into the causes and treatment of chronic/palliative illnesses have increased survival and cure rates. These advances have not always been matched by ensuring that longer life is one of quality and fulfilment (3). Patients may now have live longer through extended periods of mild to severe physical and psychological symptoms caused by the disease itself and repeated treatment episodes. Often these patients live with the knowledge of a fatal outcome through a journey of partial or transient remissions and progressive deterioration with loss of physical and social function (4). As the number of people with these conditions increase, and advances in

medical science continues, the challenge is to provide quality of life throughout the patient journey.

Quality of life is a subjective term and will be different for each individual. Interventions offered should be tailored to meet the expectations of the patients' quality of life (5). Considerations of quality of life issues must include: health, functional ability, comfort, emotions and economic factors.

### **Multi-professional working**

Specialist palliative care services are those services with palliative care as their core speciality and which are provided by an inter-disciplinary team, under the direction of a consultant in palliative medicine. Membership varies depending on the services required to address the identified expectations and needs of the target population

It is widely acknowledged in the fields of cancer, palliative care and other speciality areas such as stroke that a multi-professional team afford the best way of providing a seamless service. They offer greater opportunities for coordinated care, effective communication, education, research and service development (6,7)

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## **Exploring Palliative Care in Ireland: Resource and discussion document**

### **Executive Summary**

#### **Introduction**

The report of the National Advisory Committee for Palliative Care (2001) identifies three levels of palliative care. Level One palliative care, a palliative care approach, should ideally be provided at Foundation level in pre-qualification undergraduate programmes. Level Two palliative care provision requires focused post-qualification training provided in a continuing professional development model, or through incorporating palliative care modules to other postgraduate specialties (e.g. as currently evidenced in SPR training for Gerontology and Oncology amongst others). Level Three specialist palliative care training for medicine and nursing is well-developed in Ireland through post-graduate accredited courses with defined practice components.

Education needs must be assessed relative to strategic policy in palliative care and in broader health care in Ireland. General recommendations should guide local planning and this is the model used in the current study.

Education strategies should include non-clinical staff including care attendants, and communication skills training should be available for all staff. Continuing education is identified as being the responsibility of both employers and staff, and education provision should be convened by collaboration between the universities and service providers. Academic departments of palliative medicine and nurse planning and development units were recommended in the report of the National Advisory Committee for Palliative Care (2001)

#### **The Wider Healthcare and Education context in Ireland**

The 2001 health strategy 'Quality and Fairness - a health system for you' prioritises a person-centred health system and is consistent with principles of palliative care.

Palliative care needs to have a presence within key action plans for cancer, cardiovascular disease, other chronic diseases and the elderly if it is to be seen as more than an 'added extra'. The integration of palliative care education at level one and level two for non-cancer illness is particularly relevant.

Professionals at all levels of palliative care specialisation should be able to add incrementally to their knowledge, skills and competence using the National Qualifications Framework (National Qualifications Authority of Ireland).

Palliative care education should be informed by principles and tools of adult education.

Other factors influencing education and curriculum development include changes in social values and accountability, accreditation systems, external review, and policy changes. The availability of new tools, knowledge or media may influence the delivery of education (e.g. e-learning, tele-conferencing). Digital technology could provide an overarching platform through which education is disseminated, developed, implemented and evaluated.

#### Palliative care provision and associated education programmes internationally

Different international national approaches to education were identified, some linked to standards and competencies in service delivery (e.g., Australia). Canada has a collaborative model for medical education involving 17 medical faculties developing a common undergraduate curriculum relating to palliative care competencies. In England, local education requirements are framed through the Cancer Networks for levels 1 and 2 while Level 3 specialist palliative care education is university provided and outlined in policy documents through DOH. The role of patient and user in the development of service provision is key and the importance of patient and public education has consequently also assumed a priority. A similar emphasis for broad public as well as professional education is evident in the World Health Organisation's publication 'Palliative care: the Solid Facts'.

Across countries national service aims and objectives were identified; collaboration between education providers, palliative care and other service providers, and the wider community allows programmes to be developed that meet local need. Competencies should be 'stepped' – this is in line with the approach to life long learning and allows individual professionals to appreciate the need and relevance for changing practice; a wide variety of tools for education and learning support access to education and these should be exploited.

#### **Current palliative care education provision in Ireland**

An overview of formal undergraduate provision through universities and training through specialist palliative care inpatient units showed:

- Most specialist palliative care units offer non-formal education in palliative care. Palliative care education needs to take into account and integrate all aspects of learning: formal, non-formal and informal.
- There are currently no consistent and comprehensive ways that generalists in palliative care (Level 1 or 2) can access updates in palliative care. There are insufficient structured educational programmes to meet the needs of generalists in palliative care within the specialist palliative care education units.
- There is no education in specialist palliative care specifically aimed at Allied Healthcare Professionals. There are no specialist multiprofessional or profession-specific opportunities for these groups either through the hospice education departments or universities.

- There is no access to Specialist Palliative Care education at Masters Level and above for any professionals within Ireland; although the interdisciplinary approach, up to Masters Level, is key to the success of education provision. Greater attention is needed to the value of multiprofessional learning.
- There are few opportunities for Health Care Assistants to gain palliative care education, unless their role specifically relates to specialist palliative care. This is particularly important when considering the increasing role of Health Care Assistants to provide care within nursing homes and the community settings.
- Some areas of the country are isolated from both specialist palliative care education centres and higher education. Most noticeable are the old Health Service Executive Regions of the Midlands, North East and Eastern. All these have limited access to specialist palliative care education, but there is also a large section of the Midlands and North Eastern region that does not have easy access to higher education.

#### *Medical Education in Palliative Care*

To date there is no academic department of palliative medicine in an Irish university despite NACPC recommendation (2001). Research in palliative medicine is undertaken with little formal support or resources.

There is no national competency document that encompasses the knowledge and skills needed by doctors at all three levels of palliative care. The baseline needs assessment, based on the report of the National Advisory Report for Palliative Care, recommends Ireland will need a minimum of 75.8 'other doctor' posts. Apart from the SPR training scheme, there is no national standard of training/knowledge or competence for the other groups of doctors.

Ireland has manpower issues relating to both the number of doctors in general and to those working within specialist palliative care.

In the Baseline study The numbers of doctors required to meet specialist palliative care need is reported as a minimum and is based on current population figures. As the population is likely to increase over the next few years, the number of specialists required is likely to increase proportionally.

#### *Level One Medical Education*

Early exposure to chronic illness and dying in community and hospital settings socialises medical students to the needs of an increasingly ageing population. While palliative care is represented on the curriculum of each medical school the time allotted and placement in specialist palliative care inpatient units is variable and is not formally evaluated. The review of medical education outlined in the Fottrell report represents an opportunity for the formal integration of palliative care into the core medical curriculum.

### *Level Two Medical Education*

Optional placements of up to six months are offered at recognised specialist palliative care sites through the Royal College of Physicians in Ireland as part of a two-year postgraduate General Professional Training.

There are palliative care components explicitly represented in the Higher Medical Training (HMT) curricula for General Internal Medicine, Haematology, Medical Oncology, Neurology, Obstetrics and Gynaecology and Geriatric Medicine (where an optional placement applies). Palliative care content is listed as optional for Gastroenterology and Rehabilitation Medicine and was not featured in the documentation for Cardiology and Respiratory medicine.

The Irish College for general Practitioners runs a distance learning Certificate in Palliative care and 50 doctors have undertaken this course since 2002, with an average of 15 per year. This is 2% of the current number of GPs on the register.

There are limited learning opportunities in palliative care for all doctors within Ireland. The current provision tends to be provided in study day format, which can limit an individual practitioner's ability to attend due to a variety of reasons.

### *Level Three Medical Education*

The implications of the Buttiner Report will have an impact on both specialist palliative care education and those working within non-consultant hospital doctor (NCHD) roles. It recommends that post graduate education needs to be based on the ability to meet competencies and a higher emphasis needs to be placed on protected learning time. It also recommends that specialist training should be based within a strong research environment.

### *Nursing and Palliative Care*

The European Association for Palliative Care (EAPC) recommends that palliative care education for nurses needs to be well structured, focused and efficient, rather than delivered by isolated courses without links to available resources. Programmes should have clear objectives linked to the continuum of the three levels of palliative care and associated nurses' need.

An Bord Altranais (ABA) is the main registration body for nursing within Ireland, and as such regulates the provision of undergraduate nurse training as well as governing the continuing registration of nurses throughout Ireland.

### *Level One Nursing Education*

ABA identifies five domains of competence for general nurses which effectively relate to a palliative care approach (e.g. holistic care, ethical practice, care management). Demonstration of the competencies relates to meeting the goals of nursing, amongst them the ability to '*Assist individuals, families and groups achieve health, independence, recovery or a peaceful death in a professional caring manner*'.

Training for general nursing is delivered through 14 separate programmes within 13 education institutions and 21 healthcare agencies in Ireland. Although An Bord Altranais oversees the framework for education, each programme is delivered independently and there is no absolute requirement for a student nurse to spend time in a specialist palliative care environment. In 2004, 1,038 newly qualified nurses registered to practice from Ireland with an additional 582 from other EU countries and 1,018 from the rest of the world.

### Level Two Nursing Education

The total number of nurses registered to practice in Ireland is 78,552 (with 15,913 denoted as inactive). Nurses working at level 2 palliative care include public health nurses, those working in medical, surgical and radiation oncology, those working in nursing homes and others who work with patients with life limiting illnesses such as cardiac, respiratory, multiple sclerosis, motor neurone disease and other degenerative disease.

*A framework provided by the EAPC for level two education defines competencies in seven domains – the patient; the patient and family, the interdisciplinary team; self-awareness/ethical issues; death in society/palliative care in the healthcare system; training for educators in palliative care; training in palliative care research.*

While a number of CPD education courses have been identified through specialist palliative care education centres in Ireland the extent to which they are integrated around a framework such as the EAPC example is limited. Similarly current capacity is also limited.

### Level Three Nursing Education

Definitions of competencies and accredited pathways exist for the preparation of clinical nurse specialists in palliative care. To operate as a specialist in palliative care nurses should be educated to postgraduate diploma, higher diploma, graduate diploma or equivalent level with a minimum of 500 clinical hours in the specialist area, 250 of which must be supervised clinical practice with explicit justification for the amount and level of supervision. A second tier is the Advanced Nurse Practitioner (ANP), educated to Masters level with a minimum of 1000 clinical hours, of which 500 must be supervised. The ANP is seen as being competent, accountable and responsible for their own practice with a broader knowledge and skills base than a CNS.

The Baseline Study for the Provision of Specialist Palliative Care identifies a deficit of 322.5 nurses to work in specialist palliative care settings. Allowing that a large proportion of inpatient nurses may not require Clinical Nurse Specialist status a deficit of 71 specialist nurse posts for community, hospital and daycare settings is apparent. Given that the total number of newly registered nurses in Ireland, is 2638, the requirement for additional palliative care posts is over 11% of this total. This means palliative care will need to attract a substantial number of the total 'new' recruits to fill the proposed requirements, and in turn, educational

systems are going to need to ensure sufficient capacity to facilitate this career progression.

#### *Allied Health Professionals*

Allied Health Professionals from a number of disciplines make up the core multi-disciplinary team in palliative care services (i.e. physiotherapists, social workers, occupational therapists and pharmacists). The report of the National Advisory Committee for Palliative Care makes recommendations on the numbers of each profession required. In addition other professions allied to medicine will complement the team approach, but through sessional input – e.g. dietician.

#### *Physiotherapy*

*There is a considerable deficit in physiotherapists working within specialist palliative care; with 55 new posts required for inpatient and community settings - this is equivalent to 37% of all new physiotherapists qualifying from Irish colleges next year. Specialist Palliative Care physiotherapists will make up approximately 3% of the total physiotherapy workforce in Ireland when the projected figures are met. The published information on physiotherapy curriculum available from the four schools of physiotherapy in Ireland does not explicitly make reference to palliative care content.*

#### *Occupational Therapy*

There is a considerable deficit in occupational therapists working within specialist palliative care, with a total of 59 posts required to serve inpatient and community palliative care settings; this is equivalent to 51% of all new occupational therapists qualifying from Irish colleges next year. Occupational Therapists working in Specialist Palliative Care will make up approximately 12% of the Occupational Therapy workforce once the projected figures are reached. There are no specific references to palliative care within the core curriculum or placement examples for undergraduate courses.

#### *Social Work*

The reported deficit for social workers operating in specialist palliative care environments is 72 posts nationally. This deficit would require 36% of all newly qualified social workers to take on a career in specialist palliative care. Aspects of loss and bereavement are part of the core curriculum for social workers.

#### *Pharmacy*

A deficit of 7.5 pharmacy posts has been identified in Ireland. These posts would serve inpatient units. No specific recommendation was made for pharmacy and palliative care services in hospitals or in the community. The published curricula for pharmacists bear no specific reference to palliative care material.

#### *Other staff*

The recommendations for staffing levels for dieticians, speech and language therapists, psychological support and chaplaincy are less explicit in the report of

the National Advisory Committee for Palliative Care (2001). While access to each of these services is required, the exact staffing arrangements are not specified.

### **Conclusion**

In order for palliative education to be delivered in the most efficient way possible, integrated into existing programmes and translated into everyday practice, it is essential that a strong partnership arrangement exists between specialist palliative care, education institutions and healthcare organisations. This process would benefit from a national strategic plan to avoid individual courses from becoming isolated and to ensure that learning is accredited and cumulative. The priorities and activities outlined in the principles and action points of the national health strategy should be framed with explicit reference to level one and two palliative care.

## **CHAPTER ONE: INTRODUCTION**

### **KEY POINTS**

**Policy and decision makers should ensure that palliative care is a core part of the training and continuing professional education of doctors, nurses, social workers, chaplains and other health professionals.**

**Sufficient palliative care specialists should be trained and supported to facilitate this education.**

**Health care organisations need to invest in supporting health professionals in keeping up to date with palliative care, especially in pain and symptom management, in developing and maintaining their assessment and communication skills, and in using all available resources.**

**Health care organisations need to develop cultures and working practices that allow the best use of palliative care skills of health professionals, including spending sufficient time with patients and families.**

Although the concept of hospice care goes back for many centuries, palliative medicine was first recognised in the UK as a defined sub-speciality of medicine in 1987. The first modern 'hospice' was opened in France in the mid nineteenth century followed by Our Lady's Hospice in Dublin in 1879, however the modern hospice movement is generally regarded as being started by Dame Cicely Saunders in 1967 when St. Christopher's hospice opened. Dame Saunders stressed that it would give not only high quality care, but also that it would be scientifically based and committed to professional education and research. Doyle (1) proposes that defining palliative medicine as a distinct sub-specialty was the key to achieving this aim as this would lead to:

- More professional credibility and authority;
- Palliative care having a higher profile, channelling more funding into research;
- Promoting better education and training in the discipline;
- More robust research;
- Encouraging and enabling all doctors to accept and incorporate its principles into everyday clinical practice.

These aims are important in the context of reviewing the position of palliative care in general. However, it is also important to note that many health care workers practice the principles of general palliative care without actually using the vocabulary.

In Ireland, the Medical Council approved the recognition of the specialty of palliative medicine in 1995 (2). This is worth noting as it has only been possible to attain a specific higher qualification for doctors within Ireland for the past 10 years, and this is a relatively short space of time. There will be many professionals who have been working within speciality for many years who will not have undertaken this route to qualification. It is important that education developments in new areas make provision for previous



practice (e.g. 'grandfathering' clause). This principle also extends to other practitioners within the multi-disciplinary team, and is acknowledged in general education literature through the principles of 'life long learning' and 'prior learning' accreditation schemes. Palliative care has traditionally not had a high profile within general education and training of health professionals (3). Many medical and nursing textbooks have virtually no information on care towards the end of life (4). A review in 1996 of Palliative Care in the UK (5) describes a general lack of confidence and competence within all disciplines of healthcare professionals (HCPs), even though, many of those working in health, social and pastoral care accept their responsibility to provide good palliative care. The review states that 'training of HCPs should do more to prepare them for the weighty ethical responsibilities which they carry, by giving greater priority to health care ethics, counselling and communication skills'. The inadequacies highlighted by this report included:

1. Palliative care was seen as a low priority to the subject of healthcare as a whole with the exception of certain elements such as pain control;
2. Lack of an integrated approach, which is especially evident during undergraduate training;
3. Failure to demonstrate palliative care as a dynamic process;
4. Economic constraints and competing priorities within the workplace;
5. Lack of recognition of the role of palliative care within non-specialist units;
6. Lack of understanding of the multidisciplinary approach to palliative care and;
7. Failure to make use of teaching aids such as computer generated interactive learning and self directed distance learning with a high emphasis on formal, classroom based teaching.

A similar study undertaken in Australia questioned palliative care providers, asking them to describe their education and training needs (6). As in the UK, the main areas where education was required related to pain and symptom management, caring for people at home, the shift from hospital to death at home, loss and grief and drug therapies. Deficiencies of current education programmes included cost, travel and distance.

Even when health care professionals do receive training on issues such as communication skills, it is not easy for them to sustain the skill over longer periods given the realities of their everyday practice (7). This may mean that professionals need more training with constructive feedback over longer periods of time, or that health care organisations need to do more to develop cultures and working practices where these skills are routinely used. This includes making extra time available to deliver high quality care as well as suitable facilities.

It is unrealistic to expect the wider emerging needs for palliative care to be met by simply expanding the workforce of specialists in palliative care (8). The UK review of services concluded that although those working within specialist palliative care undoubtedly played an important role in education, they should be regarded as 'exemplars' rather than the sole providers of education. It is necessary to expand the knowledge and skills of health professionals generally. Knowles claims that learners need to feel a necessity to learn and that identifying their own learning needs was an essential part of self learning (9). In short, a health care worker's motivation to learn is derived from needs identified during their experience of clinical practice.

Therefore, the objective of this paper is to draw together examples of good practice from across Ireland, and other parts of the world, allowing these examples to form the basis of

a comprehensive plan for providing palliative care education. The development of evidence based practice in all professions should be supported as an important tool in the continuous improvement of care (10).

In order to reach specific recommendations relating to this objective, it will be necessary to consider the following areas:

- The historical background to the provision of palliative care education, both in Ireland and worldwide;
- The policy framework within which palliative care services are delivered;
- The policy framework within which adult education, and specifically education for the relevant professionals, is delivered;

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## **CHAPTER TWO: WHAT IS A NEEDS ASSESSMENT?**

### **KEY POINTS**

**A Needs Assessment is a systematic process to collect and analyze information on what is required to achieve the highest standards.**

**The review will identify deficiencies in knowledge, skills, behaviour or attitude in current educational provision and to anticipate deficiencies that will arise based on expected changes in health care needs.**

A Needs Assessment can be undertaken for any aspect of a service, both on a national or local level. A national assessment should be a strategic review of the current situation on a macro level, and should offer broad outcomes and recommendations, which serve as a guide to local delivery. It should promote equity and equality of service between areas, rather than dictate particular formats or models. Therefore, needs assessment is a systematic process to collect and analyze information on what a target group requires to achieve the highest standards (1).

The concept of 'strategy' can be defined as 'a pattern or plan that integrates an organisation's major goals, policies and action sequences into a coherent whole'(2). The ultimate purpose is to help marshal and allocate resources into a bespoke and viable structure, based on the system's competencies, shortcomings, anticipated changes in the environment and contingent moves.

This paradigm will need to integrate both the long and medium term corporate goals of governing bodies alongside the more immediate operational changes required at an organisational level to ensure the national standards are met. Consequently, it is important that each organisation has a common start point from which to assess its position. Thus, a learning needs assessment has a role in the clinical governance of a service and is therefore much more than an educational undertaking (3).

In order for the recommendations of a national review to be implemented on a local level, it is prudent for an in-depth examination of local need to be undertaken both at an area and institutional level. Failure to accurately address educational needs at this level can lead to inappropriate development of courses and ineffective learning outcomes (4). The development of education often focuses heavily on 'value for money' at the expense of innovation and change. A comprehensive review would need to include:

'A learning needs assessment to identify deficiencies in knowledge, skills, behaviour or attitude in the current teaching practices, or to anticipate deficiencies based in expected changes in health care needs' within a specified area (5).

A review of this nature could include: an in-depth review of individual practitioners through methods such as questionnaires, focus groups, clinical audit or chart-stimulated recall; a gap or discrepancy analysis which compares performance with stated intended competencies; self assessment by diaries, journals, log books and reviews; peer review;

observation; and critical incident review and significant event auditing. These are neither possible nor appropriate within the realms of this project. However this can be viewed as the first point for consideration made by this report.

A national strategic approach requires systematically considering each piece of relevant policy and documentation, and setting it into a local framework that complements the goals and mission statement. The strategy must have clear and decisive objectives that maintain the initiative, setting the pace for change rather than dominating it, to ensure the key players retain ownership of the process (6). It should acknowledge any relevant partnerships.

The interaction between these multiple factors is why effective change within complex situations can be difficult to achieve and sustain. It is often easier to ignore the seemingly peripheral issues and concentrate on the more obvious 'bottlenecks' without considering that this may cause the forgotten elements to become more urgent as time passes (7). An example of this within palliative care education would be only considering the education provision required for clinical nurse specialists without putting into place measures that ensure student nurses have an appropriate element of education within their training. Without appropriate education at undergraduate level, palliative care may find it more difficult to attract new nurses into the specialty due to a lack of insight and/or the new recruits may lack the basic skills to even start within the specialty. The overall effect would be detrimental to sustaining and increasing numbers of specialist posts. In turn, this becomes demoralising as the achievement of the goals within the specialty never seeming to get closer.

It could be surmised that the creation of palliative care itself seems to have 'created a positive feedback loop that has fuelled an insatiable demand for more services'(8). The demand is fed as patients, society, providers of care and the Government continually ask for higher and more complex standards of care.

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  6. as 2.
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## **CHAPTER THREE: Historical Background To Palliative Care In Ireland And Impact Of Recent Policy Agenda**

### **KEY POINTS**

**The goal of palliative care is the highest possible quality of life for the patient, their families and carers.**

**True patient focused palliative care, with the aim of improving quality of life, is dependant on an effective multi-professional team, with a common knowledge base, goals and effective lines of communication.**

**The demand for palliative care services within Ireland can be expected to increase in the coming years.**

This chapter describes the main issues relating to the development of palliative care services in relation to education and training. Further information on these areas can be found in both the Report of the National Advisory Committee on Palliative Care (1) and the National Baseline Needs Assessment for Palliative Care Services (2). However, it is important to define the key elements of palliative care as they relate to services within Ireland at the start of this document.

### **Palliative Care**

Palliative care is defined by the World Health Organisation (3) as:

‘the active, total care of patients whose disease is no longer responsive to curative treatment. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is the achievement of the best possible quality of life for patients and their families’.

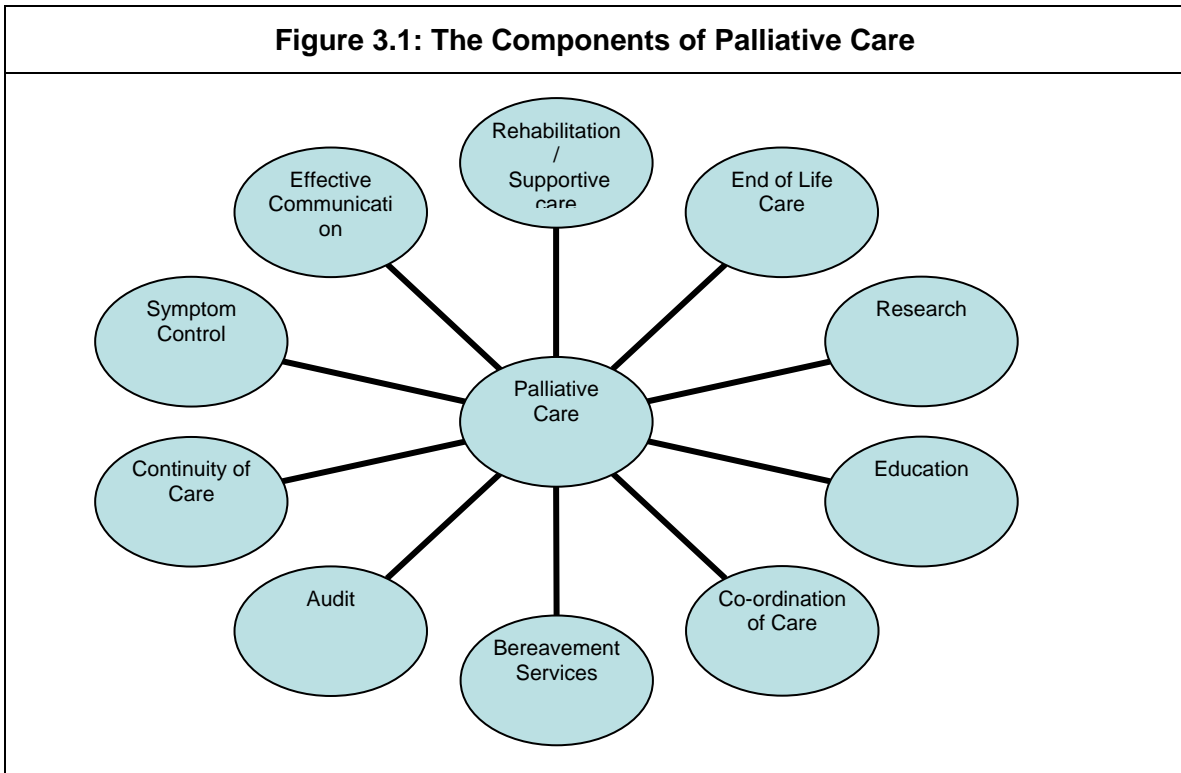
In 2002 WHO elaborated the definition identifying the importance of assessment as well as treatment:

‘Palliative care is an approach that improves the quality of life of patients 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’ (4).

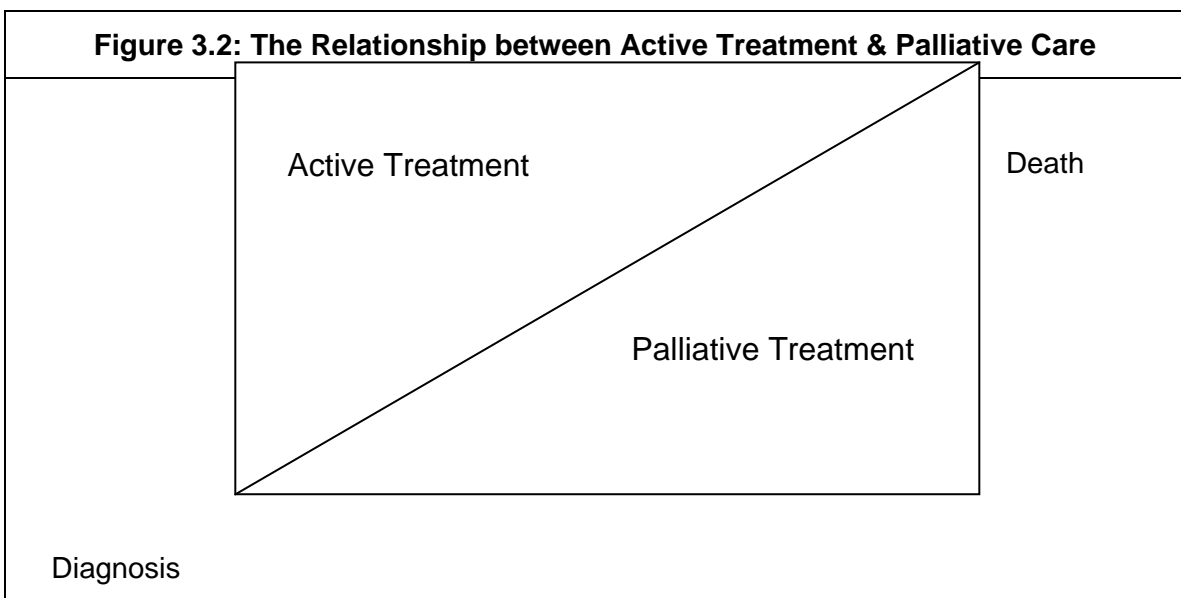
It is important to note that while the discipline has grown largely from the domain of cancer, the constituency of palliative care is not limited by diagnosis. A more succinct definition for the specialty states that:

‘Palliative medicine is the care and study of people with active, progressive, far-advanced illness for whom the life expectancy is short and the focus of care is quality of life.’ (5)

Figure 3.1 illustrates the various components that come together to form palliative care.



Therefore, the provision of palliative care can be seen as part of the continuum of healthcare with the level of input and specialty increasing as death approaches (Figure 3.2). Palliative care, rehabilitation and supportive care should be integrated from the point of diagnosis.



This does not mean that every person who dies will require Specialist Palliative Care services, but that all patients require the highest quality of care from all health and social care professionals. A gradual increase in need can lead to confusion about roles and responsibilities, not only for many patients and carers, but also between health care professionals. It is important to have a clear definition about the key elements of service provision to ensure education is targeted appropriately and to ensure that every health care professional has a consistent assessment of the patient’s position.

### Levels of Palliative Care Specialisation within Ireland

Palliative Care is delivered by many health care professionals throughout all care setting with varying degrees of specialty. The National Advisory Committee report recommended that palliative care services should be structured in three levels. These are detailed in Table 3.1 that adds the corresponding modes of education delivery and details of the Irish context.

**Table 3.1: Defining Levels of Palliative Care Provision within the Healthcare System**

	Description	Education focus and delivery	Irish Context
<p><b>LEVEL ONE</b></p> <p><b>The Palliative Care Approach</b></p>	<p>All health care professionals should <b>apply basic palliative care principles</b> as appropriate. Some patients with advanced, progressive disease will have their needs satisfactorily addressed at this level.</p>	<p>Foundation knowledge within pre-qualification professional preparation</p>	<p>Assumed to be provided at undergraduate level due to graduate entry for professional practice</p>
<p><b>LEVEL TWO</b></p> <p><b>General Palliative Care</b></p>	<p>At an intermediate level, a proportion of patients and families will benefit from the expertise of health care professionals who, although not engaged full time in palliative care, <b>have undertaken additional approved training and gained additional expertise</b> in palliative care.</p>	<ul style="list-style-type: none"> <li>- Continuing education for professional development.</li> <li>- Postgraduate palliative care modules; e.g. in medicine the SPR programmes for oncology, gerontology</li> <li>- Need for ‘catch up’ on principles of palliative care for professionals with no input in pre-qualification programmes.</li> </ul>	<p>Local/regional/national provision of sessions by specialist palliative care centres and organisations. Both uni-and multi – professional targeting of courses and sessions. Sometimes with a nursing or medical statutory accreditation, but usually not with academic accreditation.</p>

<p><b>LEVEL THREE</b></p> <p><b>Specialist Palliative Care</b></p>	<p>Specialist palliative care services are those services whose core activity is limited to the provision of palliative care.</p>	<p>Post-graduate accredited courses with defined practice component.</p>	<p>Unidisciplinary programmes in: Nursing (HDip) and Advanced Nurse Practitioner (MSc) Medicine has defined curriculum for Higher Specialist Training in PC Currently no specified palliative care qualifications for other professional groups</p>
<p>Based on DOHC (2001) Report of the National Advisory Committee on Palliative Care (5)</p>			

The policy directive Report of the National Advisory Committee on Palliative Care envisaged competence to practice at Level One for all clinicians and this level of education would best be delivered pre-registration. Examples of professionals that would require Level two education included general practitioners, public health nurses and professionals working within areas such as medicine for the elderly and chronic care.

It will be important for each health authority to decide on how it intends to ensure that patients within its region receive the highest standard of palliative care, and in doing so, to identify which staff groups will possibly require additional education and training. In the long term, this may have an effect on the provision and delivery of courses/training, particularly at Level Two. The Needs Assessment on Education in Palliative Care in the HSE South conducted in 2005 used the level framework to identify local training and needs across disciplines. In addition the framework proved useful for identifying core curriculum and syllabus areas (6). This is the only document uncovered in the Irish context which seeks to strategically identify and plan for education provision across all levels of palliative care.

As the National Advisory report (6) suggests in order for Ireland to develop the speciality to its full potential, any education strategy has to draw together all the current stakeholders. The National Council report made these specific recommendations relating to education (Table 3.2).



**Table 3.2: Key Education Points from the National Advisory Group on Palliative Care**

<p><b>OVERVIEW</b></p>	<ul style="list-style-type: none"> <li>• Continuing education should be the joint responsibility of both staff and employers;</li> <li>• Specialist palliative care libraries should be developed, with up to date technology to facilitate the access of specialist information.</li> </ul>
<p><b>MEDICAL EDUCATION</b></p>	<ul style="list-style-type: none"> <li>• The development of academic departments of palliative medicine facilities in each school of medicine. This will primarily support the overall development of the speciality as well as offering inter-disciplinary educational opportunities to all health care providers;</li> <li>• A core curriculum for medical undergraduates should be developed and introduced throughout all medical undergraduate training. This will alter the current provision, which is limited to a small number of formal lectures and visits by a few to their local palliative care unit;</li> <li>• It recommends the continued development of the ICGP palliative care programme to supplement the existing teaching and distance learning module for palliative care;</li> <li>• Further training for all hospital doctors especially with regards to communication skills;</li> <li>• A new lecturer post at specialist register level to allow increased opportunities for education and research. This should supplement the existing defined curriculum and training programme already in place.</li> </ul>
<p><b>NURSING EDUCATION</b></p>	<ul style="list-style-type: none"> <li>• Each palliative care unit should set up a nursing practice development unit to develop, implement and monitor nursing practice;</li> <li>• A clinical development coordinator should be employed to develop nursing practice and quality assurance programmes as well as to coordinate student placements.</li> <li>• Specific palliative care university courses should be developed in collaboration with service providers, which should meet the needs of nurses wishing to acquire different levels of academic education.</li> <li>• The specialist nurse workforce should work towards to levels of practice:             <ul style="list-style-type: none"> <li>○ CNS – educated to Diploma/Bachelor level with at least five years in clinical experience in the area of speciality;</li> <li>○ Advanced Nurse Practitioner – educated to Masters Level and holding at least 10 years of experience.</li> </ul> </li> </ul>

<b>ALLIED HEALTH PROFESSIONAL EDUCATION</b>	<ul style="list-style-type: none"> <li>• Placements of undergraduate professionals would be of benefit.</li> <li>• The development of university based courses, such as inter-disciplinary diploma in palliative care, would also improve access to educational opportunities.</li> </ul>
<b>CARE ATTENDANTS</b>	<ul style="list-style-type: none"> <li>• Specific recognised courses in core caring skills should be offered, especially to those working in SPC units, community hospitals, nursing homes and those working in the home environment.</li> </ul>
<b>COMMUNICATION</b>	<ul style="list-style-type: none"> <li>• All staff involved in the care of patients with progressive illnesses and their families should receive specific training in communication skills. This is particularly difficult in the area of breaking bad news.</li> </ul>
Adapted from National Advisory Group on Palliative Care Report (1)	

In order to develop the speciality to its full potential, any education strategy should draw together all the current stakeholders, namely specialist palliative care services, universities, professional bodies and charities to work together towards supporting one common goal, the provision of a seamless palliative care service for patients and their carers (1).

In order to develop palliative care appropriately, it is important to outline the policy context within which these services are set. It will be important for any developments within the specialty to link into the aims and objectives of the main health services strategy.

The purpose of the following chapters is to assess the level to which these objectives are currently being met and to develop points for discussion as how best to tackle the gaps in knowledge and provision of education.

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  2. Irish Hospice Foundation (pending) 'Baseline Needs Assessment for Palliative Care in Ireland', IHF: Dublin
  3. World Health Organisation (1990) 'Cancer Pain Relief and Palliative Care: report of a WHO expert committee', WHO: Geneva
  4. World Health Organisation (2002)
  5. Doyle D (2005) 'Palliative medicine: the first 18 years of a new sub-speciality of General Medicine', Journal of the Royal College of Physicians 35: 199-205
  6. HSE -S (2005) Report of Working Group 6 - Training Needs Assessment

## **CHAPTER FOUR: THE WIDER HEALTHCARE AND EDUCATION CONTEXT IN IRELAND**

### 4.1 The wider context for healthcare in Ireland

It is important that any developments in palliative care are framed with relevance to health policy, in particular the following:

- The National Health Strategy 'Quality and Fairness: A Health System for you (1);
- Report of the National Advisory Group on Palliative Care (2).
- Initiation of new Health Service Executive
- Baseline study on provision of specialist palliative care in Ireland (3)

4.1.1 *The National Health Strategy 'Quality and Fairness: A Health System for you*  
The National Health Strategy sets out 'a comprehensive blueprint for developments, setting out core principles for the whole system and detailed plans for development and reform (3).' These principles are:

- Equity and fairness
- A people centred approach
- Quality of care
- Clear accountability

The strategy has as its key principle the development of 'people-centredness' suggesting that the system need to adapt to patient need rather than the other way around. Therefore in order to improve 'patient focus', the aim is for a seamless service.

There were a number of factors identified as obstacles:

- The type and number of organisations with inadequate linkages between them;
- Inadequate information technology systems, data and information sharing, which could integrate support;
- Professional barriers and structures that may hinder the integration of services for patients and clients;
- Job specialization and the absence of inter-disciplinary teams which result in patient needs not being addresses in an integrated holistic way.

Similarly these are key elements that need to be in place to enable the delivery of high quality, palliative care (4). The strategy acknowledges that the health system does not currently have the mechanisms and infrastructure to support quality and continuous improvements that must be embedded in daily practice due to:

- Inadequate and poorly integrated information systems to support the measurements of inputs and outcomes on a quantitative and qualitative basis;
- Insufficient investment in the development of intellectual and organisational capacity to carry out comprehensive research and analysis of policy options;
- Lack of overriding national structure for the development, dissemination and evaluation of the impact of agreed national quality protocols and standards (5);

The strategy lays out four main goals with specific objectives and action that will be required to achieved them. These goals are: better health for everyone; fair access; responsiveness and appropriate care delivery and; high performance. It is vital that any developments in palliative care education support the specific objectives in a number of areas. Specific goals and objectives of the National Health Strategy have implications for palliative care and education. A number of these are outlined below in Table 4.1:

**Table 4.1: Goals of the National Health Strategy and their relationship to palliative care**

<b>National Goal No 1: Better health for everyone - Implications of Palliative Care</b>
<p><b>Objective 2: The Promotion of health and well-being is intensified</b>  <b>Point 12: A revised implementation plan for the National Cancer Strategy will be published (2006)</b>  <b>Point 13: The Heart Health Task Force will monitor and evaluate the implementation of the prioritised cardiovascular health action plan</b></p>
<p><b>Objective 4: Specific quality of life issues are targeted</b>  <b>Point 26: An integrated approach to meeting the needs of ageing and older people will be taken</b>            The key actions include:</p> <ul style="list-style-type: none"> <li>• a coordinated action plan between the Departments of Health, Environment and Local Government, Social, Community and Family Affairs and Public Enterprise</li> <li>• Funding to facilitate volunteers to provide support services</li> </ul> <p>In 1996 402,000 or 11.5% of the Irish population were aged 65 and over. By 2031 forecasts suggest that this will have more than doubled to between 837000 and 858000, representing between 18 and 21% of the population. Age is a contributory factor in all five of the most common causes of death in Ireland, and this will have a profound impact on the need for both generalist and specialist palliative care provision (5). There are also issues relating palliative care within the training and support of the community volunteers.</p> <p><b>Point 29: Chronic disease management protocols to promote integrated care planning and support self-management of chronic disease will be developed</b>            This section covers a wide spectrum of illnesses. It is often hard to recognise when the illness in this group of patients move from being chronic to palliative/terminal. Therefore, there are implications for palliative care education, both for the professionals involved with these patient groups as well as the patient, family, carers and wide community.</p>

**Point 30: An action plan for rehabilitation services will be prepared**

Effective rehabilitation draws on a broad range of services to meet the particular needs of patients. It offers a major route to improving the quality of life for people with life limiting illnesses, no matter how long or short the timescale (6). The report acknowledges there is currently a deficit of these services, both within the acute and community sectors. It is important that the needs of palliative care patients appears within this action plan otherwise there is a potential for the needs of this group of patients not to be a priority and/or there is a possibility that it may effect the recruitment of allied health care professionals into palliative care.

**Point 31 A national palliative care service will be developed**

This speaks for itself!

The above points are some of the key issues that relate directly to the amount and type of palliative care education that will be required if a comprehensive approach to 'people centred care is to be achieved by these reforms. However, there are many other points relating to equitable access, integrated care planning, clinical pathways, the appointment of key workers, user involvement and standardised quality systems that will be integral to the content and context of palliative care curriculum planning and education delivery (7). Palliative care needs to have a national voice from the beginning within the development of key action plans for cancer, cardiovascular disease, other chronic diseases and the elderly if it is to be seen as more than an 'added extra'.

*4.1.2 Initiation of new Health Service Executive (2005)*

Reforms to the Health Service Executive (HSE) also have the potential to impact on palliative care services, particularly in terms of relationships/networks between specialist palliative care providers. The HSE seeks to deliver greater clarity and consistency in healthcare provision through three main objectives (8):

1. Connected service delivery - The HSE will have three clearly defined interdependent areas; Health Services, Support Services and Reform & Innovation. The HSE will have three pillars or health service delivery units; Primary, Community and Continuing Care (PCCC), the National Hospitals Office (NHO) and Population Health.
2. Administrative Areas - The services delivered by PCCC, NHO and Population Health will be organised through the four administrative areas: Western, Southern, Dublin/North East and Dublin/Mid-Leinster (see Figure 4.1).
3. Expert Advisory Groups - These new independent groups will enable health professionals, clinical experts, patients, clients and service user groups play an active role in health care policy development, implementation and monitoring within the HSE. Each group will focus on a specific area such as diseases (e.g. Cancer), conditions (e.g. Mental Health), practice (e.g. Surgery) and users (e.g. Community Care).

**Figure 4.1: Map of new Health Service Executive Administration Areas in relation to Specialist Palliative Care In-Patient Providers**



The above map highlights the challenges the new Health Service Executive Areas will have in fulfilling their core aims and objectives of 'promoting a seamless integration' whilst promoting national consistency. Specialist Palliative Care inpatient facilities are not uniformly distributed across areas. It may be surmised from this map that staff working in these areas will have problems with accessing the full range of interdisciplinary support and education for the same reason.

#### 4.1.3 *Report of the National Advisory Group on Palliative Care (2001) and Baseline study on provision of specialist palliative care (2005)*

The Report of the National Advisory Committee for Palliative Care is a blueprint for the development of palliative care in Ireland. Its education directives have been referred to earlier. The report details an explicit structure for palliative care service provision outlining the necessity for specialist palliative care inpatient units to act as 'hubs' and centres of expertise for regional palliative care services. In addition it enumerates recommendations for number of staff of all disciplines required to provide a full national service.

The Baseline Study (3) took the recommendations from the 2001 report of the National Advisory Committee and investigates the extent to which investment has been made in palliative care services nationally and regionally. The Baseline study forms a framework for this education review as, building on the NACPC report, it provides projections for the numbers of specialist staff required to populate a first class service.

## 4.2 The wider context for education in Ireland

This section will give a brief overview of the governing educational bodies and the key roles they perform as well as an outline of the generic education issues (e.g. adult learning and curriculum planning) which are pertinent to the design of education.

### 4.2.1 *Generic Education Overrunning Bodies*

In Ireland, three main organisations govern higher and further education. Within the healthcare setting, individual professional bodies, such as the Royal college of Physicians, An Bord Altranais, Irish Society for Chartered Physiotherapists, etc. work with the governing bodies to ensure that each of their members are properly equip to undertake their specific professional roles. The main governing bodies include:

1. **The National Qualifications Authority of Ireland (NQAI)** was set up in 2001 with the task of developing the National Framework of Qualifications. The framework signals 'significant progress in the creation of a single, coherent, more easily understood qualification system for all levels of education and training within the state' (9). The framework does not espouse a particular philosophy of education and training, but embodies a vision for the recognition of learning based on the life long learning process. It will allow employers to more easily compare Irish qualifications with those from other countries, which is particularly important in the context of healthcare when so many workers are recruited from abroad. The three principal objectives (10) of the Authority are:

- The establishment and maintenance of a framework of qualifications leading to the recognition and award of qualifications based on standards of knowledge that acquired by learners;
- The establishment and promotion of the maintenance of these awards for the further and higher education and training sector other than universities;
- The promotion and facilitation of access, transfer and progression through education and training provision.

The framework itself comprises of 10 levels, with each level based on specified knowledge, skills and competence, allowing a clear definition of the outcomes to be achieved by learners. The framework will accommodate awards gained in schools, the workplace, the community, training centres, colleges and universities, from the most basic to the most advanced levels of learning. It also recognises learning achieved through experience in the workplace or other non-formal settings, which is important when considering the provision of health care. There are two main examples of how this will be helpful: firstly for professionals from all disciplines who come from countries that do not have similar post graduate education programmes, but the professionals themselves have experience and expertise in palliative care and; secondly when considering health care assistants who may have had experience of caring for someone in their family.

Within education in general as well as Palliative Care, it is important that a national approach is taken to the recognition of prior learning; a definition of which has been adapted by the NQAI (11) from the Commission of European Union paper on life long learning. Prior Learning is defined as:

- **Formal learning** – which takes place through programmes of study or training that are delivered by education or training providers, and which attract awards;
- **Non formal learning** – that which takes place alongside mainstream systems of education and training. It may be assessed but does not normally lead to formal certification. Examples of non formal learning are: learning and training activities undertaken in the workplace, voluntary sector or trade union and in community based learning;
- **Informal learning** – that which takes place through life and work experience. (And is sometimes referred to as experiential learning). Often, it is learning that is unintentional and that the learner may not recognise at the time of the experience that it contributed to his or her knowledge, skills and competencies.



**Table 4.2: Initial Major Award Types and Awarding Bodies.**

10 Level Framework									
1	2	3	4	5	6	7	8	9	10
Cert	Cert	Cert	Cert	Cert	Advanced certificate	Ordinary Bachelor Degree	Honours Bachelor Degree	Masters Degree	Doctoral Degree
		Junior Cert	Leaving Certificate	Higher Certificate			Higher Diploma	Post Graduate Diploma	
Further Education and Training Council (FETAC)									
		State Examinations Commission							
						Higher Education and Training Awards (HETAC)			
						Dublin Institute of Technology			
							Universities		

Each level currently has at least one award type, but it is anticipated that additional major award-types as well as various minor, special-purpose and supplemental award types will be defined as the framework unfolds. This is important in the context of palliative care, as training and education initiatives, needs to take advantage of this framework. Professionals at all levels of palliative care specialisation should be able to add incrementally to their knowledge, skills and competence using this framework, allowing for flexibility in both delivery of education as well as learning. Individuals who can show previous relevant learning in the broadest sense, will not have to start from scratch and can gain credits towards an award, or even full eligibility.

2. **Higher Education Authority (HEA) (12)** is the statutory planning and development body for higher education and research in Ireland, and as such, will be fundamentally important in the planning and development of education for all levels of palliative care, but especially for those wishing to practice at level 3 in specialist palliative care. The HEA has wide advisory powers throughout the whole of the third level education structure as well as being the funding authority for universities. The HEA allocates both capital and recurrent funding to the universities and designated institutions. Within the remit of recurrent funding, the HEA identifies initiatives such as quality assurance, post graduate skills conversion, train the trainers and targeted/strategic initiatives as being appropriate areas of development; all of these may be appropriate to the development of multiprofessional palliative care education.

The HEA also provides financial support at all levels of development for research within higher education, including the provision of core capacity and capability to conduct such advancements. This is important in the context of specialist palliative care where the resources and facilities to undertake research within any discipline throughout Ireland are limited.

Its principal functions include:

- To further the development of higher education whilst continually reviewing the demand/need for higher education;
- To assist in coordinating state investment in this sector as well as to allocate grants voted by the Oireachtas;
- To promote the attainment of equality of opportunity in higher education and democratisation of higher education.

Therefore the HEA funds the following institutions:

- a. **Universities** – University College Cork, University College Dublin, National University of Ireland Galway, National University of Ireland Maynooth, University of Dublin (Trinity), University of Limerick and Dublin City University;
- b. **Designated Institutions** – Royal College of Surgeons Ireland, National College of Art and Design, Royal Irish Academy, Mater Dei Institute of Education, St. Patrick's College Drumcondra and Mary Immaculate College Limerick.

Finally, the HEA has been facilitating since 2003 the review of Undergraduate Medical Education and Training, covering all aspects of curriculum planning, clinical training and transition between undergraduate and postgraduate training. The Fottrell Report (13) was published earlier this year and will be discussed further in the review of medical education.

Two new awards councils (Table 4.2) were also created at the same time as the National Framework of Qualifications. These were:

3. **The Higher Education and Training Awards Council (HETAC) (14)** is the qualifications awarding body for third-level educational and training institutions outside the university sector. While it will undertake the validation of programmes, and set and monitor standards, HETAC will take a more strategic view of Quality Assurance in higher education and training. HETAC awards qualifications at all levels of higher education and training up to PhD level.

The principal functions are:

- Setting standards for higher education and training awards;
- Validation of higher education and training programmes;
- Monitoring of institutional quality assurance procedures;
- Delegation of awarding powers to recognised institutions;
- Ensuring that students assessment procedures are fair and consistent and;
- Ensuring that arrangements are in place in commercial education and training institutions to protect learners where programmes validated by HETAC cease to be provided.

4. **The Further Education and Training Awards Council (FETAC) (15)** gives people the opportunity to gain recognition for learning in education or training centres and in the community. Programmes leading to FETAC awards are offered nationwide by a wide range of providers in diverse settings. Its mission is to make quality assured awards in accordance with national standards within the national arena, creating opportunities for all learners in further education and training by providing access to systematic progression pathways.

These four organisations work together to promote mobility and transferability of knowledge and skills between the different levels of education, allowing each individual to make the most of their educational opportunities. It is also hoped that using these systems in conjunction with a credit system will remove the confusion for both employers and employees with regards to differing awards such as diploma, post graduate certificate/diploma or higher diploma, allowing each award to be comparable. This is particularly pertinent when considering professionals who have gained their qualifications in other countries.

Credit systems have been in operation in higher education in Ireland for some time; many are based on the European Credit Transfer and Accumulation System (ECTS). Now the NQAI has recognised the benefits of taking this one step further by developing a national approach to credits throughout all the stages of the 10 level framework (see Table 4.2). It is intended to establish a stable and clearly understood national currency in learning that will help foster mobility amongst Irish learners and help attract internationally students more readily.

The operating principles set out in the approach will: support the attainment of awards as well as indicating achievements of smaller units of learning; maintain the quality of standards of awards in the national framework of qualifications; facilitate the development of education and training systems; facilitate the design and/or redesign of learning units and awards (16).

In order to achieve coherence, clarity and compliance between ECTS and the National Framework, the following guidelines were proposed in November 2004 (17).

1. Credits will only be earned by the learner after appropriate assessment and the successful achievement of specified learning outcomes;
2. One credit = 20-30 hours of notional time
  - a. Level 7 Ordinary Bachelor Degree = 180-240 credits
  - b. Level 8 Honours Bachelor Degree = 180-240 credits  
Level 8 Higher Diploma = 60 credits
  - c. Level 9 Masters Degree (taught) = 60-120 credits  
Level 9 Postgraduate Diploma = 60 credits
3. Credit shall not be earned twice for the same learning achievement;
4. In order to facilitate progression, it should be possible for a learner to use some credit from an award at one level in the framework towards an award at a higher level – the processes and protocols for recognising previously achieved credit in order to give exemptions or to transfer, will be determined by the receiving providers and/or awarding bodies

#### *4.2.2 Principles of Adult and Life-Long Learning Strategies*

In Ireland, adult learners make up 48% of part time and 4.8% of full time students, 57% are male (18). The following characteristics have been identified as the characteristics of adult learners and as such are worth considering when looking at developing and assessing palliative care education (19):

1. Adults are autonomous and self directed i.e. they must be actively involved in the learning process, free to direct themselves and work on project that reflect their interests. Teachers act as facilitators, guiding participants rather than supplying them with facts and help participants realise their own goals. Here the learner

retains control and relies heavily on social networks and peer groups for support (20).

2. Adults have accumulated a foundation of life experiences and knowledge that they need to connect to the learning. They must be able to relate theories and concept to their own experiences. Critical reflection is a useful tool in helping an individual replace or reframe an assumption.
3. Adults are goal orientated i.e. they usually know what they want to achieve from the education before hand.
4. Adults are relevancy orientated and, therefore, they must see the reason for learning something. Learning has to be applicable to their own work. It can be assumed that experiential learning is a continuous experience; this can happen both in work, but can also be replicated in the more formal education setting through activities such as role play, simulations, case studies and work shadowing.
5. Adults are practical and may not be interested in knowledge for its own sake.
6. Adults need to be shown respect and teachers need to acknowledge the wealth of experience students bring with them into learning situations.

The concept of 'life long learning' implies that learners will be able to take up learning opportunities at chosen stages in their lives, with varying rates of progress, and not all in a continuous process; that is, it should be possible to receive recognition for learning achievements in units that are smaller than many existing recognised awards (21).

There seems to be evidence that postgraduate education is moving towards a more informal format. In the UK, post graduate medical education is now competency-based training programmes, with both educative elements and workplace assessments (14). One important factor that has a significant impact on the learners experience is ensuring that students participate meaningfully in this process. Therefore, although a competency framework is a useful tool, feedback and support are central to the process of building and maintaining learner confidence. There are a number of activities that have been identified as assisting learning, these include: participation in group activities; working alongside others; tackling challenging tasks; problem solving; and working with clients.

#### *4.2.3 Curriculum Planning and Delivery of Education*

There are a number of key reasons why organisations decide to change a curriculum, these include:

- Social accountability – changes in society means new knowledge is required;
- Innovations in education;
- Need for early clinical exposure;
- Introduction of community based clinical placements;
- Internal or external review;
- Adoption of more valid and reliable assessments;
- Accreditation issues.

While this project has not undertaken to review the curricula of the current palliative care courses outlined below, a number of the above criteria may have an impact. Ireland as a society is changing rapidly, both culturally and demographically. Most people now have a clear view of what they expect from the healthcare service. The other main change to healthcare provision is the development of internet and digital technologies. Many healthcare professional already use the internet as a source of information and education.

E-learning, or electronic learning, can be defined as a system in which materials and services are delivered through digital means either by a stand alone computer application or using digital communications. The range of products that are currently available include:

- Multi-media CD Rom or DVD;
- Online resources such as journal articles, links to webpages;
- Specialised software packages;
- Online conferences;
- Learning groups and communities;
- Coaching and mentoring;
- Chat rooms;
- Bulletin boards.

Therefore e-learning can be seen as either as a very broad concept, 'a convergence in the use of technology for learning, teaching, training, wider knowledge management, performance and supporting decision making' or as a much narrower concept by providing a 'social learning activity using internet based technologies to provide interactive, communication facilities'(23). There are many organisations that currently use the internet as a major source of disseminating their education and information packages, including the Open University, the British Medical Association, the NHS University and, most importantly in the realms of this project, the Canadian Virtual Hospice (24). These internet sites provide a range of functions including a virtual campus, opportunities for national strategy development, public and professional information and standards for consistent learning.

Within the speciality of palliative care, the Canadian Virtual Hospice provides comprehensive access to information, advice and education for patients, the wide community and all levels of health care professionals (25). It was hoped that technology would enhance human contact by providing all Canadians, from children with cancer through to the elderly, with expert palliative care within all settings including their home. As well as providing clinical information, the website was designed to foster collaborative research and the development of best practice. The development began in 2002 with a grant from the central Government of \$100,000.

The initial objectives of the project were to (26):

1. Identifying existing resources and initiatives in internet applications in palliative care;
2. Evaluating best practice in the use of the internet for evidence based palliative care information and service delivery;
3. Creating mutual support opportunities for all key stakeholder groups with a vested interest in end of life care;
4. Enhancing the role of telehealth initiatives in the field of palliative care;
5. Identifying the training needs of healthcare professionals for effective and efficient utilization of information and communication technologies (ICTs) in the provision of palliative care and;
6. Fostering partnerships that cross intersectorial boundaries by working collaboratively with partners from the public and private sectors.

This was to be achieved through: establishing focus groups with key stakeholders in palliative care and e-health; developing best practices for the use of the internet by

healthcare professionals in end of life care and; developing, implementing and evaluating the interactive palliative care website. In summary, it provides both professionals and communities with a single site from where they can gather palliative care information or to contact relevant specialist palliative care providers for further assistance. This is only one example of a growing number website which aim to draw together information and education relating to palliative care; other examples include Help the Hospice (UK) (19) who host an e-learning facility of fifteen minute tutorials on-line and relate to a wide range of palliative care topics.

## **CONCLUSION**

- A. The key principles of the National Health Strategy mirror the primary aims of a high quality, palliative care service.
- B. Patient and Public Involvement are an important factor in ensuring palliative care service delivery for all communities within Ireland.
- C. Palliative care need to have a national voice from the beginning within the development of key action plans for cancer, cardiovascular disease, other chronic diseases and the elderly if it is to be seen as more than an 'added extra'. It would also make it more difficult to ensure that general palliative care education is placed high on everyone's agenda.
- D. To ensure those who need palliative care services receive appropriate and equitable access, integrated care planning, high quality clinical pathways and standardised quality systems, requires facilitation at a national level. This would enable specialist palliative care resources to be utilised effectively and allow information and education to be disseminated throughout all the HSE regions.
- E. Palliative care education at all levels would need to encompass a wide range of disease pathways.
- F. Education at levels 1 & 2 would need to ensure health care individuals were able to combine the palliative care philosophy with the specialist needs of the patients and families within their area of expertise, for example cardiology or respiratory. Currently most palliative care experience and knowledge is directly related to care of patients with cancer.
- G. Consequently education at Level 3, that is for professionals providing specialist palliative care, would need to ensure it incorporated the needs of other care groups and setting.

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## **CHAPTER FIVE :A Review of Palliative Care Provision and Associated Education Programmes internationally.**

For ease, this review has been listed alphabetically, by country. Each of these countries, or group of countries in the case of the European review, have started to consider the issues relating to the provision of palliative care and the education that is required to meet these aims. The individual countries are at different stages of this process and, indeed, they have not undertaken this process in the same way. For example, Canada has primarily focused on the provision of education whereas England and Australia have focused more on the structure of service delivery.

### **5.1 AUSTRALIA**

In Australia, over the past three decades, interest in improving the care of dying patients, has progressed from being the concern of a few health care professionals to being a widespread social concern (1). The provision of palliative care to individuals with a wide range of illnesses has prompted palliative care providers and health policy leaders to distinguish between: a palliative care approach; specialist palliative care services and; end of life care. The Council of Palliative Care Australia has developed a set of national standards (see Table 5.1) that set out a vision of care that is relevant to 'consumers (patients and families), general practitioners, community nurses, staff of acute care facilities, as well as specialist palliative care staff' (2). Combined with 'A guide to Palliative Care service development: A population approach' (3) and the 'Service Provision in Australia: A Planning Guide' (4), these documents provide a platform to ensure consistent advice and direction to the entire health care sector and as such, they represent a whole-of-sector approach to ensuring high, quality, needs based care at the end of life.

The standards (Table 5.1) can be used to support quality management and improvement activities or bench marking at a local, state or national level. They are framed within an education/learning framework and encourage health care professionals to:

- 'reflect on and evaluate current practice, and incorporate new evidence into protocols, policies and procedures; and
- 'participate in continuing professional development in the knowledge, attitudes, and skills required to deliver quality palliative care as this relates to the standards' (5).

The Australian model describes similar categories of Levels of Specialty as the Irish Report of the National Advisory Committee document (6) with levels of competence and education increasing as appropriate. The standards are linked to both formal education accreditation processes, as well as forming the basis of organisational performance review. They describe a circular approach to delivery of care, quality assurance and provision of education. This process is still in its infancy within Australia. This has been complemented by the development of a set of national multidisciplinary palliative care competencies for undergraduate training (developed for both Australia and New Zealand) which are currently being piloted within 7 university sites (7). It is hoped that these competencies will allow all health care disciplines to address their role in delivering the national standards. Pre-registration education for all healthcare professionals is now based in higher education institutions.



Additionally, the nursing workforce has generic national competencies accredited by the Australian Nursing Council, which were developed in the early 1990's (8) and they are beginning to see how developing nursing specialist fits into a framework of postgraduate education delivery. Currently each state works independently, however the Office of the Chief Nursing Officer and the Nursing Board of Western Australian are currently undertaking a project to develop educational opportunities in clinical practice.

The standards themselves are not prescriptive about how care is delivered by regions, organisations or individual teams and, as such, should not be viewed as constraining clinical practice and service innovations. This is particularly important within palliative care where many breakthroughs have come for the creativity of individuals or teams, particularly within the voluntary sector. The standards provide a baseline on which to develop high quality care for everyone.

<b>Standard 1</b>	Care, decision-making and care planning are each based on a respect for the uniqueness of the patient, their caregiver/s and family. The patient's, their caregiver's and families needs and wishes are acknowledged and guide decision-making and care planning.
<b>Standard 2</b>	The holistic needs of the patient, their caregiver/s and family, are acknowledged in the assessment and care planning processes, and strategies are developed to address those needs, in line with their wishes.
<b>Standard 3</b>	Ongoing and comprehensive assessment and care planning are undertaken to meet the needs and wishes of the patient, their caregiver/s and family.
<b>Standard 4</b>	Care is coordinated to minimise the burden on patient, their caregiver/s and family.
<b>Standard 5</b>	The primary caregiver/s is provided with information, support and guidance about their role according to their needs and wishes.
<b>Standard 6</b>	The unique needs of dying patients are considered, their comfort maximised and their dignity preserved.
<b>Standard 7</b>	The service has an appropriate philosophy, values, culture, structure and environment for the provision of competent and compassionate palliative care.
<b>Standard 8</b>	Formal mechanisms are in place to ensure that the patients, their caregiver/s and family have access to bereavement care, information and support services.
<b>Standard 9</b>	Community capacity to respond to the needs of people who have a life limiting illness, their caregiver/s and family is built through effective collaboration and partnerships.

<b>Standard 10</b>	Access to palliative care is available for all people based on clinical need and is independent of diagnosis, age, cultural background or geography.
<b>Standard 11</b>	The service is committed to quality improvement and research in clinical and management practices.
<b>Standard 12</b>	Staff and volunteers are appropriately qualified for the level of service offered and demonstrate ongoing participation in continuing professional development.
<b>Standard 13</b>	Staff and volunteers reflect on practice and initiate and maintain effective self-care strategies.

## 5.2 CANADA

The need for excellent palliative care was recognised by a Senate committee report 'Quality End of Life Care: The Right of every Canadian' in 2000 (10). Canada has a well established palliative care and end of life programme that is coordinated through the Association of Medicine of Canada. This organisation brings together all 17 of the country's medical faculties to ensure there is a unified voice for advancing practice (11) under a sub-committee called 'Educating Future Physicians in Palliative Care' (EFPPEC). This organisation, in conjunction with the Canadian Hospice Palliative Care Association, has undertaken a national programme in the area of educating healthcare professionals in end of life care. This has included developing specific education packages as well as developing and evaluating undergraduate competencies in palliative care.

Three examples of work that has been undertaken are:

- 2.1. The EFPPEC program primarily focuses on the needs of undergraduate medical students and key clinical post graduate posts, but has since combined the needs of other health care disciplines as well as primary care. If this programme were to be transferred into the Irish healthcare system, it would focus on the provision of education at levels 1 & 2.

The organisations involved stated collaborative, interdisciplinary care was required for best practice, and, that although the project was national in scope, it should remain sensitive and responsive to local needs, challenges and opportunities. This was achieved by ensuring consensus between experts in care provision, curriculum reform and project management as well as including stakeholders from the bottom up and the top down. Effective programmes already in existence were identified, reviewed and, where appropriate, promoted as models for adoption.

The aims of this project were to:

- Develop an interdisciplinary team at each university to identify the gaps and opportunities related to palliative and End of Life care, develop a strategy to address the gaps and implement;

- Develop a network of education opinion leaders across the country that can develop, implement and evaluate these education programmes;
- Support the development of consensus based common competencies for undergraduate trainees in medicine and for post graduate trainees in specific clinical specialities;
- Facilitate the introduction of a curriculum based on these common competencies;
- Empower the faculty in various specialities to become palliative and end of life mentors/role models;
- Facilitate the introduction of palliative and end of life questions in licensing and certification exams.

The project identified 6 core competency areas which are outlined in Table 5.2.

<b>Table 5.2 Undergraduate Medical Education Competencies and Learning Outcomes in Palliative and End of Life Care (12)</b>	
<b>Medical Expert:</b>	<ol style="list-style-type: none"> <li>1. When graduating from medical school, students will be able to address and manage pain and symptoms.               <ol style="list-style-type: none"> <li>1.1. Assess pain and symptoms effectively via a pain history, appropriate physical exam and relevant investigation;</li> <li>1.2. Propose evidence-based opioid therapies, including effective prescribing, titration, breakthrough dosing and side effects;</li> <li>1.3. List and justify adjuvant modalities and medication for pain;</li> <li>1.4. Recommend evidence-based plans for other symptoms including fatigue, anorexia and cachexia, constipation, nausea and vomiting, delirium, anxiety and depression;</li> <li>1.5. Assist in monitoring the efficacy of treatment plans;</li> <li>1.6. Contribute to recording a holistic management plan.</li> </ol> </li> </ol>
	<ol style="list-style-type: none"> <li>2. When graduating from medical school, students will be able to address psychological and spiritual needs.               <ol style="list-style-type: none"> <li>2.1. Assess psychological and spiritual issues in end of life care including grief;</li> <li>2.2. Develop and propose a care plan in collaboration with other disciplines;</li> <li>2.3. Self assess one's own attitudes and beliefs in caring for the dying;</li> <li>2.4. Demonstrate cultural, religious and aboriginal sensitivity in addressing end of life care.</li> </ol> </li> </ol>

<b>Manager</b>	<p>3. When graduating from medical school, students will be able to address end of life decision making and planning bioethical and legal framework.</p> <p>3.1. Assist in determining, recording and implementing goals of care through effective communication with patients and care givers;</p> <p>3.2. Propose advance care plans, including developing and discussing advance directives with patients and families;</p> <p>3.3. Describe models of end of life care;</p> <p>3.4. Distinguish between physician assisted suicide and euthanasia and palliative/terminal sedation, and withdrawing therapy;</p>
<b>Communicator</b>	<p>4. When graduating from medical school, students will be able to communicate effectively with patients, families and caregivers.</p> <p>4.1. Communicate information about the illness effectively (including bad news);</p> <p>4.2. Participate effectively in patient and family meetings;</p> <p>4.3. Assist in the education of patients and families about end of life care issues and pain and symptom management;</p> <p>4.4. Keep adequate medical records.</p>
<b>Collaborator</b>	<p>5. When graduating from medical school, students will be able to collaborate as a member of an interdisciplinary team.</p> <p>5.1. describe the complementary roles of physicians and other formal caregivers in end of life care;</p> <p>5.2. Demonstrate an interdisciplinary approach to formal and informal teaching.</p>
<b>Health Advocate</b>	<p>6. When graduating from medical school, students will be able attend to suffering.</p> <p>6.1. Describe the elements of suffering in end of life care for patients, families and care givers;</p> <p>6.2. Describe a supportive approach to suffering;</p> <p>6.3. Demonstrate self awareness and self care in caring for terminally ill patients.</p>

Evaluation was carried out looking at the impact these competencies had on undergraduate medical students' confidence levels (13). A questionnaire found that 94% felt adequately prepared to address 1.1 whereas only 83% felt able to complete 1.6. Similarly they felt less equipped to address issues relating to psychosocial issues, however over 93% felt they were able to meet all the communication competencies.

A common theme that emerged from the evaluation was the competencies were at too high a level for undergraduates and could only be completed at residency level. It was felt that they would benefit from being more detailed with a stepped approach to specific levels of achievement. The students particularly valued the interdisciplinary

teaching/discussions and felt opportunities for this should be found throughout their training. They also wanted more input around ethics and self awareness.

2.2 The second example of the work that was developed through this process is Pallium (14). This project, founded in 2001, with the desire to improve 'tools, resources and continuing professional development for primary care professionals working in rural and remote care settings'. Again, this package of education addresses the needs of clinicians who are operating at level 2; this package is specifically aimed at those clinicians who work either in geographical isolation or within a community setting and have to make decision about care whilst in the patients home. This is not to say the programme is not being used more widely.

The key elements of Pallium are seen as: building palliative care capacity (skills, knowledge, awareness/attitudes) by; coordinating palliative care education and continuing professional development resources; collaborating in adapting/adopting existing (& creating) new learning resources and; communicating 'best evidence' and available learning opportunities.

Phase 1 included the development of the LEAP programme (Learning Essential Approaches in Palliative Care), which is a modular, integrated course as well as the development of a webportal/online system and telehealth. Once these areas were evaluated and refined, Phase 2 is looking at a variety of options including:

- 'Physicians in Office Clinical Practice', which is an introductory course based on LEAP;
- Audio-conference CPD programme, which takes a monthly topic and allows individuals access from their work;
- Service development and system readiness – helping individual teams/regions design and implement practical responses to palliative care delivery;
- Knowledge and Workplace Learning Support including the Canadian Virtual Hospice, a palliative care e-learning tool, a national palliative care nursing call centre protocol development;
- Clinical communication in Hospice including the development of Palliative Care Reflective Discussion scenarios, which are 4-8 minute teaching video.

All of this work is in the process of being evaluated in relation to the changes they make to patient care. The major barriers that were found to palliative care education included a lack of awareness within the healthcare system for the need for education as well as the professional's perception that acknowledging palliative care meant they were 'giving up' and that this was not appropriate for their patient group. It was compounded by the fact there was an insufficient pool of qualified staff and educators to help build capacity within the general workforce. The other significant barrier was the public perception of palliative care where a lack of understanding of the broad philosophy of care led to resistance to referrals.

2.3 The third example of collaborative working from Canada focuses on the role of health care assistants (12). This project was again support by the Canadian Hospice Palliative Care Association who developed a training manual in palliative care for support workers in 1997. The training manual supported the implementation of the national palliative care priorities and a subsequent three year project undertook to train

2100 support workers in 5 different provinces as well as 140 experienced health care practitioners became palliative care instructors, using the 'Train the Trainer model'.

Evaluation of the course found that training had a broader impact than just palliative care, enhancing team communication and increasing support workers confidence in anticipating patient needs and problem solving. There is now a network of instructors in place who will now be able to coordinate extending the training as well as providing updates. The next step of the project will look at how resources are updated and shared between these instructors, and how the ongoing training of instructors will happen. The evaluation concluded that this method was sound, flexible and user friendly.

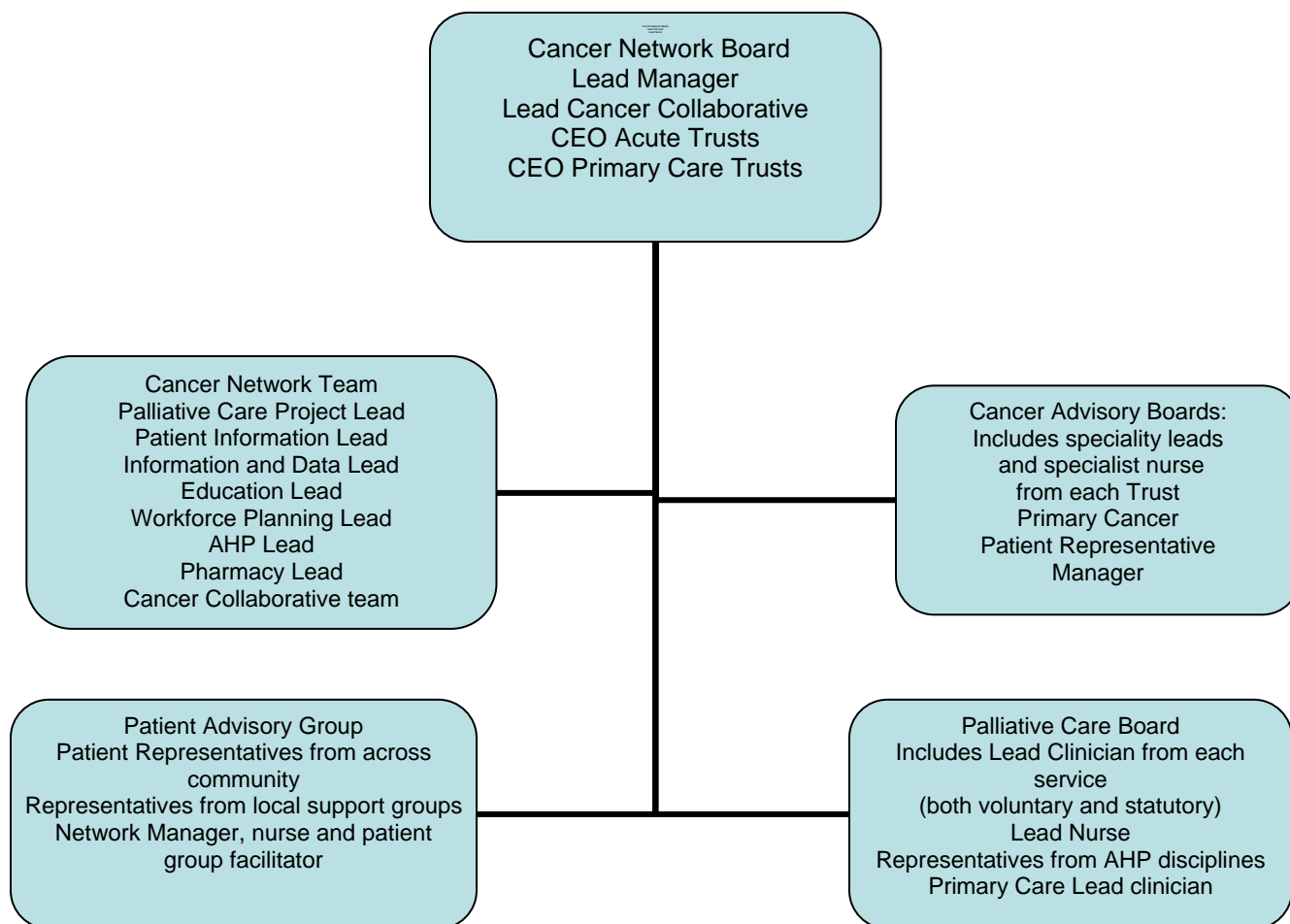
It is worth noting that specialist training for palliative medicine in Canada takes the format of a one year residency for doctors who are already certificated as a family practitioner or to the Royal College of Surgeons and Physicians. Undertaking this training is seen adding competencies to an existing role, as well as forming the basis of an academic career in palliative medicine.

### **5.3 ENGLAND**

This review relates directly to the changes that have taken place in England, rather than the UK as a whole. Over the past 10 years, there have been several key documents that have shaped the changes to the way cancer care is delivered. Care of patients with cancer and their families are now based on Cancer Networks, which are partnerships of organisations (both statutory and voluntary) working to secure the effective planning, delivery and monitoring of cancer services (17). As part of this process, the profile of palliative care has increased both for healthcare professionals and the general public.

A Cancer Network (see Figure 5.1) is described as a virtual organisation that facilitates the coordination and delivery of care to a specific community. The management of the network is made up of a core multidisciplinary team, some who work full time in facilitating change within the network, others who also continue to provide clinical services and a public/patient group. It is hoped this integration allows the change management process to remain sensitive to the needs of the community as well as local service delivery. A Cancer network would normally serve a population between 1.5 and 2 million people. Palliative care networks are now starting to emerge, and are coterminous with the cancer networks. However, because of the breadth of diversity of care provided by palliative care services, they are starting to interact more closely with additional national service frameworks such as cardiology.

**Figure 5.1: Cancer and Palliative Care Organisational Structure within the UK**



The 'Improving Supportive and Palliative Care for Adults with Cancer' (18) is a comprehensive strategy document that sets out a framework for supporting cancer patients throughout their journey. Supportive Care is an 'umbrella' term for all services, both generalist and specialist, that may be required to support people with cancer and their carers and is based on the assumption that people have needs for supportive care from the time that the possibility of cancer is first raised. It was a strategic decision to use this term to highlight that patients and their families need to draw on a range of services throughout their cancer journey. Often the 'soft' elements of care are not seen as important during the diagnostic or curative phases of care and are primarily the remit of palliative care. It was perceived that this added to the confusion over role and responsibilities between health care professionals in general and the role of specialist palliative care services.

This document establishes standards of practice and service delivery for topics such as information, patient involvement, rehabilitation and palliative care, both general and specialist.

Palliative care education is becoming more structured within England with specific programmes being tailored to meet the needs of the national initiatives and standards outlined in the national strategy document. This is particularly relevant for those working at level 2 within palliative care. There has been a national education programme for district nurses, which was delivered flexibly at a local level but had to incorporate core national aims and objectives. The same philosophy is now being undertaken for others working within primary care with the introduction of the Gold Standards Framework in the community(19), within hospitals with the introduction of integrated pathways such as the Liverpool care pathway (20) and for communication issues. Communication education is starting at level three and combines a ‘train the trainer’ model to allow education to be disseminated to those at Levels one and two by specialist palliative care providers. This initiative is being coordinated centrally.

There is national guidance on educational requirements for those professionals identified as being core to specialist palliative care. These can be found within the Manual for Core Standards for Cancer Services. Education for this level is now situated at university level with a move for it to be provided within a multidisciplinary ethos. However, many courses focused traditionally on a unidisciplinary approach and this is still more the norm. The numbers of courses currently available are (22):

**Table 5.1: Availability of Formal Academic Courses in Palliative Care within England and Wales**

<b><u>Academic Level of Course</u></b>	<b><u>No of Courses in England and Wales</u></b>
Masters Course	= 12
Masters module	= 5
Degree Courses	= 16
Postgraduate Diploma	= 17
ENB (Nursing) Certificate 931	= 8
ENB (Nursing) Certificate 285	= 3

There are also an array of stand-alone modules that can be incorporated into all of the above academic levels as part of a generic course, therefore adding a speciality element to advanced practice. The majority of the degree courses tend to be aimed at one speciality, whereas the post graduate diplomas and masters level courses tend to focus on multidisciplinary education. The courses are delivered in a variety of formats from traditional taught modules though to distance learning. Understandably the number, location and academic levels of these individual courses is constantly changing, therefore updated information can be found via the Hospice Information Service at St. Christopher’s Hospice as well as the University Admissions system.

The need to ensure systematic user involvement in cancer services was recognized with the implementation of the Cancer Partnership Project in England, a joint Department of Health and Macmillan Cancer Relief initiative (23). The Cancer Services Collaborative ‘Improvement Partnership’ Patient Experience project (24) is actively promoting patient and carer involvement in the change process. These, combined with the current Public and Patient Involvement Policy (25), which established the Patient Advice and Liaison Service (PALS) and the Expert Patient Programme (26), are creating a significant



infrastructure to support the process. There are now national education packages in place for both patients and users representative as well as for professionals to aid the integration of these initiatives in palliative care.

The Guidance forms a key element of the Supportive Care Strategy for England and is part of a series of initiatives designed to improve the experience of care (27,28,29,30). These initiatives include information, national standards for palliative care, palliative care in the community and advanced communication.

#### **5.4 WORLD HEALTH ORGANISATION: REVIEW OF PALLIATIVE CARE IN EUROPE**

'Palliative Care: The Solid facts' (32) is a effort to comprehensively review the scientific evidence relating to palliative care and makes overarching policy recommendations that the organisation feels are relevant to all countries within Europe. It draws on the expertise, suggestions and inputs of individuals from many academic centres and disciplines. It is linked to another WHO publication 'Better Palliative Care for Older People'.

The paper states that the introduction of palliative care into mainstream medicine and a determined programme of both professional and public education is essential.

Evidence relating to education in palliative care suggests that 'health professionals need to be trained well in palliative care, to have opportunities to extend their knowledge, and to work within organisations that promote attitudes and behaviours to sustain these skills'. The broad policy recommendations of this European report highlight need for public education 'to increase awareness of palliative care issues' and recommends that innovative adult education and multi-media education be explored.

The education policy recommendations for health care providers are consistent with a strategic approach rolling out palliative care skill and nurturing specialists - i.e. ensure palliative care is core part of training and CPD for all health professionals; ensure supply of specialists and support them in providing education; develop organisations which support palliative care as a process of care and organisations which support learning.

A second European document published in 2003 was the recommendation of the Committee of Ministers to member states on the organisation of palliative care also addressed education needs and made recommendations consistent with the WHO document. In particular, it identifies three levels of education

- Basic level - to be taught to all health care professionals

- Intermediate level- to be taught to those within a profession who want to acquire specific expertise an

- Advanced level - intended for those who want to become specialists in palliative care.

While not incorporated into this scheme, the document highlights the need to educate the public about palliative care.

## **CONCLUSION**

The following points draw together the main areas of interest for palliative care education within Ireland and suggest a strategic approach to developments:

- A. National aims and objectives with the flexibility for local responsiveness and sensitivity are common to each country;
- B. Education, competencies and curriculum planning can then be developed to meet the national aims and objectives for delivery high quality palliative care to all;
- C. Collaboration between education providers, palliative care and other service providers, and the wider community allows programmes to be developed that meet local need;
- D. This has to be undertaken using a 'bottom up & top down approach' to allow all opinions to be considered equally;
- E. Competencies should be 'stepped' – this is in line with the approach to life long learning and allows individual professionals to appreciate the need and relevance for changing practice;
- F. A wide variety of tools for education and learning support access to education are beginning to be available;
- G. The five predicted biggest cause of death (heart disease, cerebrovascular disease, chronic respiratory disease, respiratory infections and cancer) give a signpost for where palliative care should concentrate its attention as well as give a focus for concentrating education on the generalist in palliative care. However, it may be worth considering to add those who care for the elderly as another sub-group as this is where these diseases are most prevalent.

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# CHAPTER SIX : A REVIEW OF THE PALLIATIVE CARE EDUCATION SYSTEM IN IRELAND

Specifically this chapter will identify the provision of palliative care education in Ireland.

## **6.1 CURRENT PROVISION OF PALLIATIVE CARE EDUCATION IN IRELAND BY SPECIALIST PALLIATIVE CARE PROVIDERS AND ASSOCIATED ORGANISATIONS**

The following table shows the availability of formal/non formal palliative care education to the end of 2005; the formal courses have a consistent structure, whereas the topics of the non-formal study days may change annually to meet local demand. Undoubtedly, there will be numerous more ad-hoc study day and education sessions provided in many other locations given by specialist palliative care teams and others. There are obvious benefits to this form of education as it is often delivered locally and reflects individual situations and circumstances, however little accredited recognition is currently given to it. It is possible that many health care professionals, but it more likely to be 'general' nursing staff, have undertaken a number of one day or short courses on issues relating to palliative care. Sheldon (20) in her study of models for palliative care education concluded that the development of a large number of short courses with no linking structure, made little sense when considering a broader framework of accumulating learning into a coherent package.

The format of formal courses is currently evolving, and certain aspects of course provision will have changed by the end of 2006. Most notable of these changes, are the Higher Diploma in Nursing Studies, which are becoming Graduate diploma/Masters at Level 9 in September 2006 as well as some changing focus to adopt a more inter disciplinary approach e.g. a proposed graduate diploma/masters in Interdisciplinary Palliative care.

**Table 6.1: Overview of Formal and non-formal Palliative Care Education in Ireland**

Key for table

- N = Nurses
- D = Doctors
- SPC = Specialist Palliative Care Providers
- CA = Care Assistant
- ALL = any health care professional

INSTITUTION	WHO	COURSE PROVISION	Accrediting organisation.	NQAI Level	NUMBER S (per year)
St. Francis Hospice, Centre for	N	Higher Diploma in Nursing Studies (Palliative Care)	Trinity College Dublin	8 (60 credits)	8

<b>Continuing Studies</b>	D	Medical Ethics for Doctors	CME credits (RCPI & ICGP)	-	30
	D	General Medicine Issues for Palliative Care Doctors	CME credits (RCPI & ICGP)	-	30
	D/N SPC	Advanced Pain and Symptom Management	CME credits (RCPI & ICGP) An Bord Altranais Cat. 1	-	30
	N	Introduction to Palliative Care for Registered Nurse	An Bord Altranais Cat. 1	-	30
	N	Preceptorship, teaching and Facilitating in the Clinical Setting	An Bord Altranais Cat. 1	-	30
	N/CA	Palliative Care of the Older Person	An Bord Altranais Cat. 1	-	30
	N	Syringe Driver Workshop	An Bord Altranais Cat. 1	-	30
	CA	Part 1 (Symptom Management, Communication & Teamwork)		-	30
	CA	Part 2 (Spirituality, Bereavement & Loss, Self Care)		-	30
	ALL	Ethical Issues in Palliative Care	CME credits (RCPI & ICGP) An Bord Altranais Cat. 1	-	30
	ALL	Complementary Therapies in Palliative Care	An Bord Altranais Cat. 1	-	30
	ALL SPC	Annual Hospice Day Care Study Day	An Bord Altranais Cat. 1	-	30
In House training programme- also holds an annual conference that is open to all disciplines within specialist and non-specialist palliative care, and will have continuing professional development points attached as appropriate.					
<b>Milford Care Centre</b>	CA	Care Assistants and Palliative Care -4 days	Not externally accredited	-	100 (25 x 4 courses)
	N	Palliative Care Course -4 days	An Bord Altranais Cat. 1	-	100 (25 x 4 courses)

	N	Care of the Older Person – 4 days	An Bord Altranais Cat. 1	-	50 (25 x 2 courses)
The following study days are open to all and are subject to the same criteria: Syringe Drivers; Pressure Sore Management; Carers workshop; Grief at Work; Ethic and Law; Reflective Practice; Pain Management; Advancing Palliative Care. Bereavement training			Not externally accredited	-	25
In house Training programme -also holds an annual conference that is open to all disciplines within specialist and non-specialist palliative care, and will have continuing professional development points attached as appropriate.					
<b>Our Lady's Hospice, Dublin</b>	N	Higher Diploma in Palliative Nursing	University College, Dublin	8 (60 credits)	15
	N	Higher Diploma in Gerontological Nursing	University College, Dublin	8 (60 credits)	15
	N	Introduction to Palliative Care – 5 days			
	N	Professional update in Palliative Nursing –3 days			
	ALL	Introduction to Palliative Care – 5 Days			
	N	Hospice Care for the Older Person – 5 days	An Bord Altranais Cat. 1	-	
	D	Palliative Medicine for Physicians			
In house education programme. - also holds an annual conference that is open to all disciplines within specialist and non-specialist palliative care, and will have continuing professional development points attached as appropriate.					
<b>Galway Hospice</b>	All	In-house training			15
<b>NUI Galway</b>	N	Higher Diploma in Palliative Nursing	NUI Galway	8 (60 credits)	15
<b>Marymount Hospice</b>	N	Introduction to Palliative Care – 5 days	An Bord Altranais Cat. 1	-	25
	N	Care of the Older Person -5 days	An Bord Altranais Cat. 1	-	25
The following study days are open to all and are subject to the same criteria: syringe driver management; management of pain in palliative care; multicultural issues in palliative care			Not externally accredited	-	25
<b>Irish College</b>	D	Certificate in Palliative	ICGP 80-120	-	15

of General Practitioners		Care	CME credits?		
Irish Hospice Foundation	ALL	Higher Diploma in Bereavement Studies	NUI/ RCSI	8 (60 credits)	18
	ALL	Certificate in Children and Loss	An Bord Altranais Cat. 1; RCSI Certificate; Psychological Society Ireland CPD	-	25

The following workshops are open to all: Overview of Loss and Bereavement, Supporting the Bereaved; Exploring Anticipatory Grief; Children and Loss; Loss and Bereavement in the Workplace; Working with Bereaved Families; Bereavement and Sexuality; Cultural Frameworks; Gender, Grief and Loss; Loss and Bereavement in People with Intellectual Disabilities; An Introduction to Art Therapy in Loss and bereavement; Adjustment to Loss in Later Life; Crossing the rivers – A spiritual approach in Bereavement and Loss.	An Bord Altranais Cat. 1	-	25 per workshop
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<b>Roscommon Hospice Foundation</b>	- provide principles of palliative care workshop; symposia to promote palliative care education; training to volunteer 'sitters'; and provision of education material to a wide range of disciplines.
<b>Sligo/NorthWest</b>	- acts as an educational resource.
<b>Donegal Hospice</b>	Has an active in house education programme, which uses videolink to include local acute hospital.
<b>North East Palliative Care Service</b>	- has an active professional development programme for both specialist palliative care team and those working with them at Level 2. Offers multidisciplinary placements for those wishing to gain experience in palliative care.
<b>Midlands Palliative Care Service</b>	
<b>Irish Cancer Society</b>	Offers a range of educational opportunities around cancer and its treatments. Palliative care is included as part of its 'Introduction to Cancer Care' course for nursing staff. These courses are accredited by An Bord Altranais (cat 1) for cancer care.

In summary, it is important to consider both the location of the formal/non-formal education within each of the new HSE regions as well as their position in relation to other providers of higher/further education. The following information aims to give a

summary of each HSE area and identify who is delivering specialist palliative care education currently as well as who may be able to do so in the future.

### **Health Service Executive – Southern Area**

The Southern Area covers the counties of Kerry, Cork, Tipperary South, Waterford, Kilkenny, Carlow and Wexford, and has a combined population of 1,003,972.

The main specialist palliative care education centre for this region is based in Marymount Hospice, Cork.

A needs assessment focusing on palliative care in the old Southern Health Board area was conducted in 2005 and the report has been used to inform the current discussion document. (24)

### **Health Service Executive – Dublin/ Mid Leinster Area**

The Dublin/Mid Leinster Area covers the following counties: Dublin (South of the Liffey), Longford, Westmeath, Offaly, Laois, Kildare and Wicklow, and has a combined population of 1,065,394.

The main specialist palliative care education centre for this region is based in Our Lady's Hospice, Dublin.

### **Health Service Executive – Dublin/North East Area**

The Dublin/North East Area covers the following counties: Dublin (North of the Liffey), Monaghan, Cavan, Louth and Meath, and has a combined population of 906,567.

The main specialist palliative care education centre for this region is based in St. Francis Hospice, Raheny.

### **Health Service Executive – Western Area**

The Western Area covers the counties of Donegal, Leitrim, Sligo, Roscommon, Galway, Mayo, Clare, Tipperary North and Limerick, and has a combined population of 941,270.

The specialist palliative care inpatient units in this area include the Milford Care Centre in Limerick, which has an education department; Galway Hospice Foundation, the Northwest Hospice and Donegal Hospice.

The map shows the geographical location of specialist palliative care education providers and institutions providing higher education at the end of 2005. When considering the amount and range of palliative care education that may need to be delivered within all three levels of the specialty, it will be important for specialist palliative care to work with both the universities and the Institutes of technology.

This map also serves to highlight areas within the country which are isolated from both specialist education centres and higher education. Most noticeable are the old Health Service Executive Regions of the Midlands, North East and Eastern. All these have limited access to specialist palliative care education, but there is also a large section of



the Midlands and North Eastern region that does not have easy access to higher education.

The following table offers a key for the numbers contained within the map as well as highlighting which institutions offer entry level education to selected groups of health care professionals. Much of this education is at undergraduate level however it is worth noting that a number of allied health care professionals enter their professions at post graduate level.

Only two higher education institutions within Ireland currently offer the education at all levels and across all professional groups. These are University College, Dublin and NUI Galway. University College Cork is not currently running its specialist palliative care programme but this is likely to change in the near future.

**Map 6.1: Location of Higher Education Institutions and Centres of Specialist Palliative Care Education**



**Table 6.2: Identifies institutions on map 6.1 and highlights providers of pre-registration medical, nursing and allied health care professional education and those involved in specialist palliative care (level 3) education.**

Key	Institution	SPC	Medical	Nursing	SW	OT	Physio	Phar
1.	Athlone Institute of Technology (www.ait.ie)			*				
2.	Institute of Technology, Blanchardstown (www.itb.ie)							
3.	Institute of Technology, Carlow (www.carlowit.ie)							
4.	Cork Institute of Technology (www.cit.ie)							
5.	Dublin Institute of Technology (www.dit.ie)							
6.	Dun Laoghaire Institute of Art, Design & Technology)							
7.	Dundalk Institute of Technology (www.dkit.ie)			*				
8.	Galway Mayo Institute of Technology (www.gmit.ie)			*				
9.	Letterkenny Institute of Technology (www.lyit.ie)			*				
10.	Limerick Institute of Technology (www.lit.ie)							
11.	Institute of Technology Sligo (www.itsligo.ie)							
12.	Institute of Technology Tallaght (www.ittallaght.ie)							
13.	Institute of Technology Tralee (www.ittralee.ie)			*				
14.	Waterford Institute of Technology (www.wit.ie)			*				
15.	Tipperary Institute (www.trbi.ie)							

16.	Royal College of Surgeons Ireland (www.rcsi.ie)		*	*			*	*
17.	University College, Cork	(*)	*	*	*	*		*
18.	Dublin City University			*				
19.	National University, Galway	*	*	*	*	*		
20.	Trinity College, Dublin		*	*	*	*	*	*
21.	National University, Maynooth							
22.	University of Limerick			*			*	
23.	University College, Dublin	*	*	*	*	*	*	
24.	St. Francis Hospice, Dublin	*						
25.	Donegal Hospice							
26.	North West Hospice, Sligo							
27.	Galway Hospice	*						
28.	Milford Care Centre, Limerick	*						
29.	Marymount Hospice	*						
30.	Our Lady's Hospice Dublin	*						
31.	St. Angela's Sligo			*				

(\*) The Higher Diploma in Palliative Care Nursing is currently not running in UCC.

SW = Social Worker; OT = Occupational Therapy; Physio = Physiotherapy; Phar = Pharmacy

## **CONCLUSION**

- A. In order for palliative education to be delivered in the most efficient way possible and translated into everyday practice, it is essential that a strong partnership arrangement exists between specialist palliative care, education institutions and healthcare organisations. This process would benefit from a national strategic plan to avoid individual courses from becoming isolated;
- B. Palliative care education needs to take into account and integrate all aspects of learning: formal, non-formal and informal;
- C. Curricula should contain knowledge required to support the specific competencies of the area of practice (22) and by incorporating an integrated approach to theory and

practice with recognition of their mutual significance to specialist and advanced practice;

- D. A strategy of lifelong learning would allow learners to accumulate knowledge over a period of time and through a variety of formats. This may prevent generalists in palliative care becoming overwhelmed by the volume of knowledge and skills required within the field;
- E. Healthcare organisations need to examine how they would support and facilitate a life long learning environment for their workforce;
- F. E-learning is a valuable tool with the opportunity to provide palliative care education and information to a wide range of stakeholders. This area is worth further debate and consideration with respect to palliative care within Ireland;
- G. Digital technology could provide an overarching platform through which education is disseminated, developed, implemented and evaluated. However, to ensure this method was effective, each healthcare professional , in both the statutory and voluntary sectors, would need access and training in the technology;
- H. There are currently no consistent and comprehensive ways that generalist in palliative care (Level 1 or 2) can access ongoing/updates in palliative care. There are insufficient structured educational programmes to meet the needs of generalists in palliative care within the specialist palliative care education units;
- I. There is no access within Ireland to education in palliative care specifically aimed at Allied Healthcare Professionals. There are no specialist multiprofessional or profession specific opportunities for these groups either the hospice education departments or universities, The focus of this education is usually either nursing or medicine;
- J. There is no access to Specialist Palliative care education at Masters Level and above for any professionals within Ireland; It is notable that the interdisciplinary approach, up to Masters Level, is key to the success of education provision. Greater attention is needed to the value of multiprofessional learning (23);
- K. There are few opportunities for Health Care Assistants to gain palliative care education, unless their role specifically relates to specialist palliative care. This is particularly important when considering the increasing role of HCAs to provide care within nursing homes and the community settings.

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## **CHAPTER SEVEN: REVIEW OF MEDICINE**

The aim of this chapter is to consider the key recommendations from the National Palliative Care Advisory Group (1) as they relate to medicine, and to assess the impact they may have in relation to the provision of education. It is important that these recommendations are considered with respect to other issues that are currently effecting the medical profession within Ireland as a whole.

The following statements have been taken directly from the national advisory document. It is important to note that they primarily relate to the needs of those working within specialist palliative care.

**The development of departments of academic medicine facilities in each school of medicine. This will primarily support the overall development of the speciality as well as offering inter-disciplinary educational opportunities to all health care providers;**

**A core curriculum for medical undergraduates should be developed and introduced throughout all medical undergraduate training. This will alter the current provision, which is limited to a small number of formal lectures and visits by a few to their local palliative care unit;**

**It recommends the continued development of the ICGP palliative care programme to supplement the existing teaching and distance learning module for palliative care;**

**Further training for all hospital doctors especially with regards to communication skills;**

**A new lecturer post at specialist register level to allow increased opportunities for education and research. This should supplement the existing defined curriculum and training programme already in place.**

The European Association of Palliative Care is currently undertaking to develop clinical competences for medical staff at all levels of practice; unfortunately these have not been available during this process. As with nursing, these competencies would be an ideal place to start assessing the curricula of current education provision. Examples of work from other parts of the world have been included in previous chapters.

Therefore, the key aspects of this chapter will include:

- Level One – the role of undergraduate training in medicine and the key competencies that may be expected at this level;
- Level Two – consideration of which specific groups of doctors would particularly benefit from education at this level;

- Level Three – The education that is currently offered to doctors working within specialist palliative care services.

### **7.1 Level One: Introduction to Palliative Care**

Each medical doctor requires a basic knowledge of the philosophy and practice of palliative care, even if this allows only them to refer patients and their families on to the most appropriate practitioner quickly and effectively. This education would best be undertaken whilst at medical school, and should encompass an interprofessional outlook. This approach is currently rare at undergraduate education. The Medical Council (2) sees 'future doctors need a balance of clinical learning opportunities in order to allow them to respond to the changing needs of society'. This mirrors the view of work undertaken in New Zealand (3,4,5), where specialist palliative care input into curriculum planning has meant undergraduate doctors experience caring for patients within the community early in their training, including following through a patient who is dying. In many cases, this has been before a hospital placement. This aim is to change the socialization of medical students so they no longer see 'hospital medicine' as the norm, and to increase their perception of patients as 'whole' people living ordinary, complex lives, and not merely someone in nightclothes in a bed. The changes have been introduced along side a national core curriculum, however the work is not yet at the evaluation stage.

There are currently five undergraduate medical schools within Ireland, offering an average of 782 places each year, however over 60% are from non EU applicants and the vast majority of these leave the Irish healthcare system soon after qualifying. The Medical Council has undertaken a series of reports looking into the provision of education, culminating in the publication of the Fottrell Report (6). There have been concerns regarding the quality of education offered at undergraduate level as well as the ability of the current system to increase capacity to meet future manpower demands. As well as concerns relating to the formal teaching aspects of this education, the report had serious concerns relating to clinical training. The Report has made numerous recommendations including:

- Education should be delivered in more diverse settings and an increase in multidisciplinary forums;
- There should be a defined set of programme outcomes regarding knowledge, skills, competencies, values and attitudes, with an emphasis that these should be based on a national basis;
- The introduction of a national medical education consultative body who have an 'oversight' on all courses;
- There was particular emphasis on the development of communication skills as well as the 'recognition of a partnership ethos that underpins all decision making and interactions with patients'.

These recommendations offer many opportunities to integrate palliative care education into mainstream undergraduate medical education. As the percentage of the population over 65 is steadily increasing (predicted to be over 774,000 by 2015) (7) and therefore the numbers requiring treatment for long term and life limiting illnesses increases, many of the skills and competencies that are integral to the philosophy of palliative care will become more important. As every aspect of medical school training is being reviewed,



this represents an ideal opportunity for specialist palliative care. The greatest impact on quality of care throughout level 2 palliative care setting would be achieved from ensuring graduates had a high level of general palliative care skills and knowledge.

A review of undergraduate medical school teaching in palliative care was undertaken in 2003 (8). A questionnaire was sent to 26 individuals identified as having responsibility for palliative care in the five Irish medical schools, asking about aspects of curriculum covered, the years and the setting in which the teaching appears. The results showed most schools had specific dedicated time; however this may be limited to a day or less. The majority of the teaching was by didactic lecture, although all the schools had some teaching in the hospice setting, but this varied greatly. Students from the Royal College of Surgeons Ireland have a half day visit to the hospice, whilst NUI Galway offered a full day. Trinity College students have a two week clinical attachment, while 50% of University College Dublin undergraduates are allocated to the same attachment. University College Cork allocates 12-15% of students to a four week clinical attachment in the local hospice. At the point of this study, NUI Galway did not offer a clinical attachment to specialist palliative care. Students now have the opportunity to spend time with the Specialist Palliative Care team in Year three.

The study states that there was little evaluation of palliative care learning. This is also true of the education provided by many UK medical schools (9), however in contrast to Ireland, much of the education was case based learning and small group discussion allowing for an more individualised approach to gaining knowledge and skills. The study concluded by stating further work needs to be undertaken to establish whether this teaching is meeting the needs of qualified clinicians.

## **7.2 Level Two: General Palliative Care**

Numerically, this is by far the largest group when considering provision of palliative care education. Within this group, there is a wide variety of experience, knowledge, skills and competencies; some will have had direct experience of specialist palliative care through one of the following programmes. Following registration, postgraduate medical training is conveniently organised in two phases, namely General Professional Training (GPT, "basic specialist" or "core" training), followed by Higher Medical Training (HMT or "higher specialist training") (10).

The GPT is undertaken over a minimum of 2 years at Senior House Officer level, and has to be completed prior to advancing to any HMT course. Experience in emergency medicine is mandatory, but access to a wide variety of clinical settings is encouraged for the remaining clinical time. As well as clinical skills and competencies, emphasis is placed on leadership, team working, basic management and audit. Placements have to be approved by the RCPI, and currently Blackrock Hospice, Marymount Hospice, Milford Care Centre, Our Lady's Hospice and Our Lady's Hospital for Sick Children are recognized for placements of up to 6 months as part of this scheme. This information allows us to make an assumption that those who opt to undertake a placement within specialist palliative care will start to develop the skills necessary to operate effectively at level 2.

Higher Medical Training (i.e. training for consultancy position) in Ireland is now conducted exclusively in the grade of Specialist Registrar (SpR). The basic approach of

the revised arrangements is that each trainee should proceed as a Specialist Registrar (SpR) through pre-planned specialty programmes, at the end of which, subject to satisfactory achievement throughout, he/she will be awarded the ICHMT'S Certificate of Satisfactory Completion of Specialist Training (CSCST). Programmes will be constructed in such a way as to provide experience in both teaching and district general hospitals that meets all the curriculum requirements of the chosen specialty or specialties, ensuring the availability of opportunities to acquire the full range of competencies deemed necessary. Many curricula offer trainees some measure of choice in their programmes so that special interests within the specialty can be developed. Provided the core requirements are met, there is no reason why further modules should not be available on an optional basis. In fact, it is possible in some instances, with only a modest increase in the overall length of the programme, to train in two specialties and thereby achieve dual certification. The most common linked training will be between General (Internal) Medicine and a second specialty, but other combinations will be possible.

For each specialty the contents of the Training Record (logbook) mirror the curriculum and record the fulfillment of its requirements and the acquisition of all the competencies that it specifies. The Training Record will play an essential part in the assessment process at annual review. There is increasing emphasis on the responsibility that each individual specialist trainee must assume for his/her own learning. However, strict monitoring arrangements exist with are overseen by an external supervisor.

The specific HMT course that relates to specialist palliative care will be discussed later in this chapter, however it may be useful to consider the emphasis places on acquiring palliative care skills on other HMT schemes (See Table 7.1)

Table 7.1 . *Examples of Level “ Palliative Care - Palliative Care References in Curricula for Higher Medical Training programmes (Royal College of Physicians in Ireland; College of Anaesthetists)*

<b>SPECIALTY</b>	<b>ESSENTIAL / ADDITIONAL/OPTIONAL</b>	<b>FOCUS</b>
Anaesthesia	Essential	Demonstrate competency in end-of-life decisions, diagnosis of brain-stem death, organ donation management; ethical issues in withdrawing/withholding care and palliative care
Gastroenterology	Optional	Pain relief, hospice, terminal care, palliative endoscopic techniques
General Internal Medicine	Essential	Pain, vomiting, distress, terminally ill, immediate grief, DNR orders, organ donation
Geriatric medicine	Essential	Demonstrable understanding of principles of palliative care
GU medicine	Essential	HIV - terminal care, pain relief
Haematology	Essential	Part of Haematological

		Practice - palliative care, communication skills
Medical Oncology	Essential	Pain, symptom control, hospice & home care
Neurology	Essential	A component of general skills
Obstetrics & Gynaecology	Essential	A component of gynaecological oncology
Rehabilitation Medicine	Optional	Optional 3 moth short attachment. additional training in spinal paralysis
General Paediatrics	Additional training in oncology module	Component to oncology/ personal experience not required
Public Health Medicine	Essential	Part of the 'standard of care' module
Immunology	No reference	
Infectious diseases	No reference	
Cardiology	No reference	
Nephrology	No reference	
Occupational Medicine	No reference	
Respiratory Medicine	No reference	
Rheumatology	No reference	
Radiology	No Data Found	
Psychiatry		
Surgery		

Therefore following completion of HMT, doctors should have acquired a wide range of knowledge and competences relating to palliative care to practice at level 2, however, the specifics are not clear from the available literature. There is currently very few formal palliative care learning opportunities open to this group following the completion of their speciality training, particularly when considering the range and diversity of speciality areas. However, it would be prudent for each consultant to consider their individual speciality caseload as patients with chronic cardiac & respiratory conditions, some neurological, medicine for the elderly and cancer specialist surgeons may also play a significant role in delivering a broad spectrum of palliative care input.

An example continuing Professional Development (CPD) once specialty training is completed is the Distance Learning Certificate of Palliative Care (11) run by the Irish College of General Practitioners. It may be completed in one academic year and consists of eight units: Introduction to Palliative Care; Management of Pain; Ethics and decision-making; Bereavement; Management of Respiratory Symptoms; Palliative Care in Non-malignant conditions; the Terminal Phase and Miscellaneous Symptoms. It is estimated that there are over 2,500 GP within Ireland although some may not be currently practicing. It is difficult to be more specific as the Medical Council is currently drawing up a definitive register. There have been 50 doctors who have undertaken this course since 2002, with an average of 15 per year. This is 2% of the current number of

GPs on the register. The number of applications is limited by the college due to the number of places available on the compulsory workshops.

Other opportunities of CPD are available through the education centres in specialist Palliative Care Centres and may carry CME credits, both from the Royal College of Physicians in Ireland and the Irish College of General Practitioners.

### **7.3 Level Three: Specialist Palliative Care**

At the end of 2004, there were 12 Consultants in position throughout Ireland – with the implementation of the National Advisory Group report for Palliative Care (12), it is hoped to bring that number up to 25 which means a minimum of thirteen new personnel. There are no academic departments of palliative care within Ireland.

The number of individual places for the Specialist Registrar programme is currently 10. These posts are situated at Blackrock Hospice/St. Vincent's, Marymount Hospice, Milford Care Centre, Our Lady's Hospital Drogheda, St. Francis Hospice, St. Luke's Hospital, UCG/Galway Hospice and Waterford Regional Hospital with Our Lady's Hospice Dublin having 2 posts allocated to them. This programme currently takes a minimum of four years to complete. Therefore, if the SpR programme is viewed as the main pathway for recruiting to the additional consultant posts, there is potentially a large time delay before suitable candidates will be available to take up post. This delay would increase further if those who had completed the training undertook a research fellow post prior to becoming a consultant.

Within the SPR training scheme, there is a clear outline of what an individual is expected to achieve on completion of the course. The expectation is that doctors will achieve this through practical experience within the course of their placements. SPR participants organise a programme of educational meetings approved and overseen by the Royal College of Physicians in Ireland. Attendance at these meetings is mandatory with protected time provided.

The baseline needs assessment, based on the report of the National Advisory Report for Palliative Care, recommends Ireland will need a minimum of 75.8 'other doctor' posts – It is important to recognise that these posts have traditionally been filled by individuals with a range of skills such as those undertaking GP training, SPR in Palliative Care as well as 'career' staff grade doctors. Apart from the SPR training scheme, there is no national standard of training/knowledge or competence for the other groups of doctors.

The implications of the Buttiner Report (13) will have an impact on both specialist palliative care education and those working within non-consultant hospital doctor (NCHD) roles. It has recommended that post graduate education needs to be based on the ability to meet competencies rather than time spent working in a particular job and a higher emphasis needs to be placed on protected learning time. It was also recommended that specialist training should be based within a strong research environment.

## **SUMMARY**

- A. In order to achieve the recommendations of the Advisory group report, five departments of academic departments of palliative medicine would need to be established. They would be situated in Trinity College (Dublin) University of Cork, National University, Galway, University College (Dublin) and the Royal College of Surgeons (Dublin).
- B. Research in palliative medicine in undertaken with little formal support or resources, and in a generic sense this has been identified through the Buttimer report.
- C. There is no national competency document that encompasses the knowledge and skills needed by doctors at all three levels of palliative care.
- D. There is no defined palliative care curriculum at undergraduate level. This includes the availability of clinical placements.
- E. Ireland has manpower issues relating to both the number of doctors in general and to those working within specialist palliative care. However, these problems are likely to increase disproportionately in Ireland over the next decade as the number of non EU students currently in medical school means a lower percentage of the overall group stay within the Irish healthcare system. Currently the numbers of training places equals 195/million pop, which is the same as the UK, however only 10% of UK graduates leave on completion of the course, compared 60% of Irish medical students.
- F. The numbers of doctors required to meet specialist palliative care need is reported as a minimum and is based on current population figures. As the population is likely to increase over the next few years, the number of specialists required is likely to increase proportionally.
- G. There are limited learning opportunities in palliative care for all doctors within Ireland. The current provision tends to be provided in study day format, which can limit an individual practitioner's ability to attend due to a variety of reasons.
- H. The need to undertake post graduate education in palliative care is not seen as a priority for those who deliver palliative care at level 2. This may limit their ability to deliver general palliative care across a wide variety of patient groups.

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11. Irish College of General Practitioners (2006) 'Courses, Projects and Programmes' [www.icgp.ie](http://www.icgp.ie) accessed October 15<sup>th</sup> 2005
12. as 1.
13. Department of Health and Children (2006) 'Preparing Ireland's Doctors to meet the health needs of the 21<sup>st</sup> Century (The Buttimer Report)', DOHC: Dublin

## **CHAPTER EIGHT :EXPLORING THE ISSUES RELATING TO NURSING AND PALLIATIVE CARE WITHIN IRELAND**

The aim of this chapter is to consider the key recommendations from the Report of the National Advisory Committee for Palliative Care (1) which specifically relate to nursing, and to review the impact of these recommendations in conjunction with the information provided within the Baseline assessment. It is also important to consider these recommendations in light of the general issues that are affecting nursing as a whole within Ireland.

Therefore the key aspects of this chapter will include an examination of the education requirements for each of the Levels of Practice within Palliative Care, and the specific issues that arise at each level. These will include Level One - General Nurse training and the key competencies that are expected at this level; Level Two – consideration of what skills and knowledge are included at this level; and Level Three - The role of the Clinical Nurse Specialist.

The following statements have been taken directly from the policy document and primarily relate to the needs and role of the specialist Palliative care providers.

- Each palliative care unit should set up a nursing practice development unit to develop, implement and monitor nursing practice;
- A clinical development coordinator should be employed to develop nursing practice and quality assurance programmes as well as to coordinate student placements.
- Specific palliative care university courses should be developed in collaboration with service providers, which should meet the needs of nurses wishing to acquire different levels of academic education.
- The specialist nurse workforce should work towards to levels of practice:
  - CNS – educated to Diploma/Bachelor level with at least five years in clinical experience in the area of speciality;
  - Advanced Nurse Practitioner – educated to Masters Level and holding at least 10 years of experience.

There have been numerous studies worldwide examining the educational needs of nurses with regards to palliative care (2,3,4,5,6,7 & 8). Common challenges for linking education to practice included: fragmented services, poor pain and symptom control, lack of education (the nurses), lack of public awareness, problems with the continuity and coordination of care and communication skills, including bereavement care.

The European Association for Palliative Care published 'A Guide to the Development of Palliative Nurse Education in Europe' in 2004 (9), and the recommendations from this report could be deemed as the 'gold standard' when considering the model for provision of nurse education. Although the focus of the paper is solely nursing, the task force 'advocates interdisciplinary co-operation and recognises palliative nursing as an area of

specific practice, requiring a strong educational foundation'. The report states that 'the nurse should always recognise their limitations and refer to colleagues practicing at a higher level for further guidance as need arises.

The EAPC recommend that palliative care education needs to be well structured, focused and efficient, rather than being delivered by isolated courses without links to available resources. As learning is a life long process based upon individual interest, motivation, need, values and competency, it is important that the nursing community as a whole understands clearly why palliative care is crucial to their practice. It has been suggested that there are six areas for consideration in evaluating the effectiveness of an education programme. These include: clear objectives; focused content; prescribed method; comprehensive evaluation structure; evidence of transfer of knowledge and skills to the clinical area; and a sense of the ethical dimensions to practice and planning. In effect, this means that every aspect of the programme needs to be justified in terms of what it purports to offer (10). There are seven key dimensions of care relating to that particular level; within the EAPC document, these dimensions are linked to a set of key competencies that each nurse will need to achieve in order to be able to deliver care within these dimensions to the highest standards.

The task force concurs with the National Advisory document (11) that palliative nursing practice is not just about creating specialist and that it is necessary to provide differing levels of education according to their needs. The report advocates three levels of specialisation which match the levels within the National Advisory group report and each level will be discussed in further depth below. The document also outlines the specific competencies and skills that they feel are required at each level of practice.

### **8.1 LEVEL ONE – Minimum level of Palliative Care**

The knowledge and skills that every nurse should have acquired by the end of their training forms the baseline from which all other formal palliative care education may be developed. In Ireland An Bord Altranais has as one of its primary goals for nurse education the aiding of 'a peaceful death', as well as providing and managing 'supportive care'.(12). The European Association of Palliative Care report (13) suggests two groups of nurses make up Level One of practice. These include:

**Table 8.1: EAPC Recommendations relating to Level One Practice**

<b>Level One</b>	<b>Basic (Undergraduate)</b>	Future health care professionals during their initial training.
	<b>Basic (Postgraduate)</b>	Qualified Nurses working in the general health care setting, who may be confronted with situations requiring palliative care.

At this level, the EAPC makes the following statements relating to practice, which it relates to 7 specific dimensions of care:

**1. THE PATIENT:** The nurse should understand the multidisciplinary nature of pain, specifically the concept of total pain and the tools used to guide pain assessment.



**2. THE PATIENT AND FAMILY:** The nurse should be able to identify the impact of serious illness on all members of the family, as well as the social consequences which may follow. They should also be able to understand and respond to the normal processes of grief and loss, such as inter-familial conflict, identifying appropriate support mechanisms to assist the family at this time of uncertainty and change.

**3. THE INTERDISCIPLINARY TEAM:** The nurse should clearly identify the roles of each differing team member and be able to articulate their own unique contribution to the palliative care team.

**4. SELF AWARENESS – ETHICAL ISSUES:** The nurse should be able to demonstrate their understanding of key ethical issues which may affect the care of the palliative patient and family. This would include issues of respect, autonomy and dignity and the principles of ethical decision making. In order to do this, the nurse must be able to reflect on their own personal life view and the need to develop and maintain a sense of self-respect, as well as respect for the other. The nurse should also be able to differentiate between personal self-awareness programmes for developing better clinical practice and the role of psychotherapy, which may require a deeper and more intense reflective process.

**5. DEATH IN SOCIETY: PALLIATIVE CARE IN THE HEALTHCARE SYSTEM:** The nurse should clearly define the core values of palliative care, including the quality of life and the role of palliative care within the bio-medical approach to care. This should also include an understanding of societal taboos around death and an overview of how death and dying are perceived in society. Information on the epidemiology of non-curable illness would be a necessary part of understanding the relationship between palliative care and the healthcare system in order to discuss the structure and models of different palliative care services offered in the region.

**6. TRAINING FOR EDUCATORS IN PALLIATIVE CARE:** The nurse's practice should reflect the fact that education is directed towards the empowerment of patients and families to gain a deeper understanding of their illness and its consequences. The nurses should demonstrate, through their clinical practice, that education is about facilitating learning and takes place as much at the bed side as in the classroom.

**7. TRAINING IN PALLIATIVE CARE RESEARCH:** Although formal training and education in research methods for palliative care is not expected, the nurse should be encouraged to seek opportunities to develop research awareness and applied reading in the field to increase their existing clinical practice and promote professional development.

### **8.1.2 General Nurse Training**

An Bord Altranais is the main registration body for nursing within Ireland, and as such regulates the provision of undergraduate nurse training as well as governing the continuing registration of nurses throughout Ireland.

An Bord Altranias has defined 5 domains of competence, which forms the baseline for nursing education within the country. These domains are:

1. Professional/ ethical practice;
2. Holistic approaches to care and the integration of knowledge;
3. Interpersonal relationships;
4. Organisation and management of care;
5. Personal and professional development. (14)

Achieving competence within these domains should enable the student to meet the following goals:

- Assist individuals, families and groups achieve health, independence, recovery or a peaceful death in a professional caring manner;
- Provide and manage direct, practical nursing whether health promotional, preventative, curative, rehabilitative or supportive to individuals, families or groups;
- Demonstrate a knowledge base and a level of competence in clinical practice skills essential for safe practice which are grounded in recent evidence based nursing research, where available;
- Identify and meet the nursing care needs of the individual, families or communities in all health care settings;
- Demonstrate the development of skills of analysis, critical thinking, problem solving and reflective practice;
- Act as an effective team member of the healthcare team and participate in the multidisciplinary approach to care of patients/ clients. (15)

It is clear from both these domains and goals that 'palliative care' is viewed as an important component of nurse training. Although this is not explicit, it is possible to surmise that all nurses should be competent to level one standard on completion of their training.

Training for general nursing is delivered through 14 separate programmes (see table 8.1) within 13 Higher Education Associations and 21 main healthcare agencies, and although An Bord Altranais oversees the framework for education, each programme is delivered independently, and as with many other areas of nursing, there is no absolute requirement for a student nurse to spend time in a specialist palliative care environment. Undoubtedly, they will meet palliative care patients in the majority of the clinical settings, but this makes it difficult to assess the exact amount of direct exposure each nursing student has to palliative care. The following are a list of the courses available:

**Table 8.2: Higher Education Intuitions offering Undergraduate Nurse Education**

Higher Education Institute	Healthcare Agency	Places	
Athlone Institute of Technology	MHB General Nursing Services	42	
Dublin City	Beaumont Hospital James	75	Optional Module 36

Unversity	Connolly Memorial	27	hours/5 credits Optional week placement
Dundalk Institute of Technology	Our Lady of Lourdes, Drogheda	55	
Galway –Mayo IT	Mayo General Hospital	40	
Tralee IT	Tralee General Hospital	60	PC subsumed into oncology introduction (8 hours) and older adult with cancer (10 hours)
NUI - Galway	Portiuncula Hospital University College Hospital, Galway	20 75	Palliative care integrated into general modules
St. Angela's College Sligo	Sligo General Hospital	40	
Trinity College Dublin	Adelaide School of Nursing Meath School of Nursing St. James Hospital	35 35 78	Palliative care integrated into general modules
NUI Cork	Bon Secour Hospital Cork University Hospital	25 70	10 lectures, 2 tutorials and 3 hours of Marymount Hospice speakers
NUI Dublin	Mater Misericordiae University Hospital St. Michaels Hospital (linked to Royal College of Surgeons) St. Vincent's Hospital	75 40 65	
University of Limerick	Regional Hospital	65	
Waterford IT	Waterford General Hospital	55	
Adapted from (12).			

In 2004, 1,038 newly qualified nurses registered to practice from Ireland with an additional 582 from other EU countries and 1,018 from the rest of the world (16). It is not possible to assess whether nurses have gained the suggested competencies during their undergraduate training. The reasons for this are two fold: there is no common framework for delivering this education nor is there an agreed, common set of competencies through which to judge the education currently provided. Nurses who are registering from other countries will have differing levels of experience, and it is important that they are also assessed against a common framework for palliative care competence.

The total number of nurses registered to practice in Ireland is 78,552 (with 15,913 being denoted as inactive). It is this number that will need to be considered within the context of Level 2 education.

## **8.2 LEVEL TWO – THE GENERALIST IN PALLIATIVE CARE**

This group is defined as needing ‘general palliative care’ skills and are seen as working in areas where a proportion of their patients would benefit from health care professionals who have had some additional training and experience in palliative care (17). This includes nurses working in all healthcare setting from acute hospitals through to the community and long term care . Nurses who may be considered as working at this level include public health nurses, those working in medical, surgical and radiation oncology, those working in nursing homes as well as others who work with patients with life limiting illnesses such as cardiac, respiratory, multiple sclerosis, motor neurone disease and other degenerative disease. This list is not meant to be all-inclusive and as services may differ between health board areas.

Within Ireland, there has been specific work undertaken on the role of nursing homes and the role they play delivering palliative care (18). This area is of particular interest within delivering level 2 palliative care as Ireland’s demographics move steadily towards a more aging population. The exact figure of deaths in nursing homes in Ireland is not known, however work in the UK shows 18% of deaths in the over 65 years die in care homes (19) and in USA this figure is upwards of 25% (20).

An example of how palliative care education can be delivered to those practicing at level 2 can be found in a study undertaken to assess the impact of structured palliative care education within nursing homes (21). This work found that all grades of staff improved the care they were able to give to residents and their relatives, even when the resident was not perceived to be imminently dying. However, the impact of the project was broader than the direct delivery of care, but also had an impact on the culture and organisation of the nursing home. It was recognised through the study that if improvements in palliative care were to be established then education and support needed to be extended to managers/home owners. The study also found that if specialist palliative care input was to be effective then assessment work needed to be carried out collaboratively between the SPC services and the managers before any initiatives were established.

The UK study has now formed the basis of a learning package supported by Macmillan Cancer Relief and the Open University (22). This training pack is learner-centred using activities that draw on participant’s experiences and understanding, and can be used with staff of differing levels of experience and ability. It comprises of four modules: first principles; communication; pain and symptom management; and bereavement care, enabling staff to address the national minimum care standards for care homes around the issue of dying. The role of facilitator is supported by an extensive learning package and could be undertaken by an experienced nurse or allied healthcare professional as appropriate. This type of programme is ideally suited to being adapted for local need and can be delivered independently with few additional resources.

With respect to education of specialist palliative care, the report also found these services often required further support with respect to:

- Disease conditions other than cancer;
- Different dying patterns among older people;
- Care needs of older people;
- Organisational culture of nursing homes.

This led the UK Study to recommend the introduction of new specialist roles such as Palliative Care Nurse Practitioner in Nursing Homes or Facilitator in Palliative Care for Older People.

The other main issue this report highlights is that for many areas of practice within level 2, the provision of palliative care will need to be viewed as a collaborative process between SPC services and other specialists to ensure the patient has access to the full range of skills and knowledge. These areas of specialty will include cardiac, respiratory, neurology and other chronic illnesses, where the educative process may be deemed as being a two way process. The European Association of Palliative Care (23) define this group as:

**Table 8.3 The EAPC Recommendations for Level Two Practice**

<b>Level B</b>	<b>Advanced (postgraduate)</b>	<p>Qualified health care professionals who either work in specialist palliative care, or in a general setting where they fulfil the role of resource person.</p> <p>Qualified health care professionals who are frequently confronted by palliative care situations (e.g. Oncology, community care, paediatrics and elderly care).</p>
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At this level, the EAPC makes the following statements relating to practice, which it relates to 7 specific dimensions of care. The document makes the assumption that the acquisition of knowledge is cumulative and those nurses who practice at this level will have met all the competencies at level one.

1. **THE PATIENT:** The Nurse should be able to demonstrate their ability to evaluate patient response to care through clinical assessment, examination and reflection. The nurse should clearly demonstrate their understanding of physiological systems, including applied pharmacology and pharmacokinetics. They should identify and respond to difficult symptoms associated with palliative disease and influence the team approach by appropriate referral to colleagues from other disciplines involved in the patient care. They should also be able to demonstrate knowledge on the palliative care of specific care groups e.g. children and the elderly, and advise colleagues on these and other aspects of care as requested.
2. **THE PATIENT AND FAMILY:** The nurse should obtain additional training in verbal and non-verbal communication, specifically around the issue of breaking bad news and the cessation of treatment, demonstrating skills at supporting families at this time. Such support would include family meetings, one to one and group education and setting up or modifying structures to meet complex situations, such as the specific religious rites and customs as needed.
3. **THE INTERDISCIPLINARY TEAM:** The nurse should be cognisant of the team dynamic and the leadership potential of the nurse in this. They should be able to influence and proactively support change within the team and family when and where it is required.

4. **SELF-AWARENESS – ETHICAL ISSUES:** The nurse must identify and respond to the differing coping mechanisms used by patients and families during care, as well as the impact of stress on personal well-being and practice.
5. **DEATH IN SOCIETY – PALLIATIVE CARE IN THE HEALTHCARE SYSTEM:** The nurse should be able to discuss the structure and function of national and international organisations involved in the planning and delivery of end of life care as well as the factors which influence change, both positively and negatively. The nurse should use this knowledge to influence their practice around the cultural and spiritual needs of communities who seek and require palliative care.
6. **TRAINING FOR EDUCATORS IN PALLIATIVE CARE:** Knowledge about differing teaching methods and styles are necessary, specifically the value of multi-disciplinary education in palliative care. The need for evidence based practice should be encouraged through an understanding of palliative research in practice, both nationally and internationally.
7. **TRAINING IN PALLIATIVE CARE RESEARCH:** A deeper understanding of the value of evidenced based practice is essential as well as a further exploration of involvement in research initiatives, such as research methodology courses, journal clubs and assisting in research studies where possible.

This is an extremely large group of professionals, with a wide remit to deliver care throughout every healthcare setting. There is no country who currently attempting to address this group in a comprehensive and structured way. From the examples shown in previous chapters, education packages tend to be aimed specifically at one group of nurses such as public health nurses or those working within oncology or care of the elderly. Ireland already has good examples of courses provided within the specialist palliative care setting for other groups such as the elderly, and it will be important to build on these foundations.

However, as the review of current education shows, the number of available places on these courses are relatively tiny compared to the numbers of individuals who may benefit. There are no other existing courses that address the needs of nurses working within specialities such as cardiology, respiratory and other life limiting illnesses. If 'best practice' relating to palliative and end of life care is to be achieved throughout the Irish healthcare arena, then undoubtedly, education for this group of nurses will need to be expanded dramatically.

Other countries have started to address this by first working towards a common set of standards or competences. Examples of these can be found in Canada, Australia and England. In Canada, this work has been taken forward by universities and specialist palliative care providers working together to provide a wide variety of flexible and easily accessible education packages through a variety of media. Within the other two countries, more time has been spent on developing the standards and competencies and work is only just beginning to set in place education packages to complement these initiatives.

### **8.3 LEVEL THREE – THE ROLE OF THE SPECIALIST**

There are 2 categories of nurse that are allocated to Level 3. These are:

**8.3.1 Clinical Nurse Specialist (CNS)** - these nurses should be educated to postgraduate diploma, higher diploma, graduate diploma or equivalent level with a minimum of 500 clinical hours in the specialist area, 250 of which must be supervised clinical practice with explicit justification for the amount and level of supervision.

The role is associated with the following core competency areas: clinical focus; patient/client advocacy; education and training of others; audit & research and; consultancy (24).

- will encompass a major clinical focus, which comprises assessment, planning, delivery and evaluation of care in hospital, outpatient and community settings.
- May make alterations in prescribed clinical options along agreed protocols of driven guidelines.
- Will participate in nursing research and audit and act as a consultant in education and clinical practice to other nursing colleagues and the wider MDT team. Education should be formal and informal.

A review of the CNS role within Ireland in 2004 found that 39% of all CNS postholders felt that a lack of access to continuing professional development hindered their role and 20% of these postholders did not have the appropriate academic qualifications as outlined above.

When considering one of the key functions of the CNS role, the report also found that, on average a CNS provides 10 hours of education per month to other nursing staff with an additional 4 hours to other members of the multidisciplinary team. The remit for education and training consisted of structured and impromptu educational opportunities to facilitate staff development and patient education.

**8.3.2 Advanced Nurse Practitioner (ANP)** - This role should be educated to Masters level with a minimum of 1000 clinical hours of which 500 must be supervised

The ANP is seen as being competent, accountable and responsible for their own practice with a broader knowledge and skills base than a CNS (25). Therefore they will deliver care at a more advanced level even though they may have a similar clinical background and experience to a CNS. To this end, curriculum planning will need to be innovative with the content delivered through a multidisciplinary framework. It should be competency based, strengthened by specialist clinical supervision and dynamic in nature.

As this is a relatively new area, it is more problematic to define the core competencies, however they will probably reflect those of the CNS role, including: expert clinical practice; ethical decision making; consultation and; education, coaching and guidance skills. Research and audit is an important component of these roles as they should be seen to advance practice in their speciality, developing new models of care with positive outcomes. The main challenge for these roles will be to achieve this aim in a cost effective manner.

The National Council for the Professional Development of Nurses and Midwives (2004) identified four main areas of practice (26):

- Autonomy in clinical practice – advanced levels of decision making which occur through the management of a specific patient caseload; comprehensive health assessment skills in diagnosis and treatment;
- Expert Practice – practical, theoretical knowledge and critical analysis skills;
- Professional & Clinical Leadership – initiate and implement change in response to patient need and service demand; educating others through role modelling, mentoring, sharing and facilitating knowledge exchange.

Research – initiate and coordinate high quality patient care which advances nursing and health policy development, implementation and evaluation; initiating and participating in audit. The European Association of Palliative Care (EAPC) define this group as:

**Table 8.4 The EAPC Recommendations for Level Three Practice**

<b>Level C</b>	<b>Specialist (postgraduate)</b>	Qualified health care professionals who are responsible for palliative care units, or who offer a consultancy service and/or who actively contribute to education and research.
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At this level, the EAPC makes the following statements relating to practice, which it relates to 7 specific dimensions of care. The document makes the assumption that the acquisition of knowledge is cumulative and those nurses who practice at this level will have met all the competencies at level one and two.

- 1. THE PATIENT:** The nurse should take the lead in providing an evidence based approach to palliative nursing practice for their unit, acting as a resource for patients, families, colleagues and the wider community. Liaison with the interdisciplinary team, they should provide a critical evaluation of patient care, identify and implement the need for clinical change in patient care. They should provide an educational resource through both formal and informal education which increases the potential for patient involvement in the planning and implementation of their care, as well as setting up a system of outcome measures to assess patient satisfaction and well being.
- 2. THE PATIENT AND FAMILY:** The nurse should be responsible for the development of a system of individual and family support in the bereavement phase of care, based on their additional education and training in this area of care and acting as guide/role for other staff. They should also clarify the ways of determining a family centred approach through proactive working with the interdisciplinary team and highlighting the significant role of nursing in this aspect of care.
- 3. THE INTERDISCIPLINARY TEAM:** The nurse should be competent to provide advice and consultation to the team and the wider community on teamwork, supervision, conflict resolution and negotiation.



4. **SELF-AWARENESS – ETHICAL ISSUES:** The nurse must have developed skills in the sensitive care of patients who may request euthanasia or cessation of supportive measures, e.g. hydration and be able to formulate an appropriate palliative response to this need. Education of other professionals and the public on this response is a vital component at this level of practice, as is skill at working with a media dimension.
5. **DEATH IN SOCIETY – PALLIATIVE CARE IN THE HEALTHCARE SYSTEM:** The nurse should demonstrate their understanding of legal aspects of care and the importance of public communication on palliative issues through the media. Nurses should also be aware of the economic issues allied to palliative care and how funding is sought, administered and audited for equity and transparency. The focus of practice is on quality initiatives which require clear demonstration of a research based approach, grounded in applied research methods, which reflect quality, evaluation and audit of patient care and clinical nursing practice.
6. **TRAINING FOR EDUCATORS IN PALLIATIVE CARE:** A deeper knowledge of the principles of adult and education and the national education system is required to enable the nurse to formulate formative and summative education programmes which are responsive to the needs of healthcare professionals in their region.
7. **TRAINING IN PALLIATIVE CARE RESEARCH:** The nurse should be fully involved in research initiatives, which would include involvement in and initiation of research at both the uni- and multidisciplinary level to enhance the development of palliative care in their area. This would require the nurse to have undergone formal training in the area of research methodology.

The Palliative Care Baseline Needs Assessment (27) details the number of specialist palliative care posts currently in place within Ireland relative to the numbers that will be required if the recommendations from the National Advisory Committee (28) are to be met. The following chart shows the relevant numbers for each area of practice:

<b>Table 8.5: Specialist Palliative Care Nurse posts within Ireland as defined by National Advisory Group report (2001) (information taken from the Baseline Assessment)</b>	
	<b>Deficit</b>
<b>Specialist Palliative Care Inpatient Units</b>	251.5
<b>Community*</b>	23.5
<b>Hospital*</b>	35.5
<b>Daycare*</b>	12
<b>Total</b>	322.5
<b>(Deficit) at Level 3*</b>	71

These figures are worth further clarification. The majority of inpatient nurse posts will not be classed as clinical nurse specialists and as such, may not be considered as working

at level 3. This is not unusual as within hospice wards, there will be a skill mix of experienced palliative care nurses and nurses who are learning about palliative care. It may be relevant to suggest that around 80% of inpatient nurses have not undertaken the required training or gained the relevant experience to be considered as working at level 3. This situation does not apply to the other areas of specialist palliative care as nurses working within the fields of community, daycare and hospital services will be acting within a consultancy/specialist advisory role to others and will need to fulfil the criteria set out by the National Council for Professional Development of Nursing & Midwifery.

Table 8.5 above calculates the deficit of specialist palliative care nurses in community, hospital and daycare settings as 71 posts. When an appropriate proportion of inpatient specialist palliative care is applied the total deficit will increase by a minimum of 20% of the inpatient nurse deficit total of 251.5.

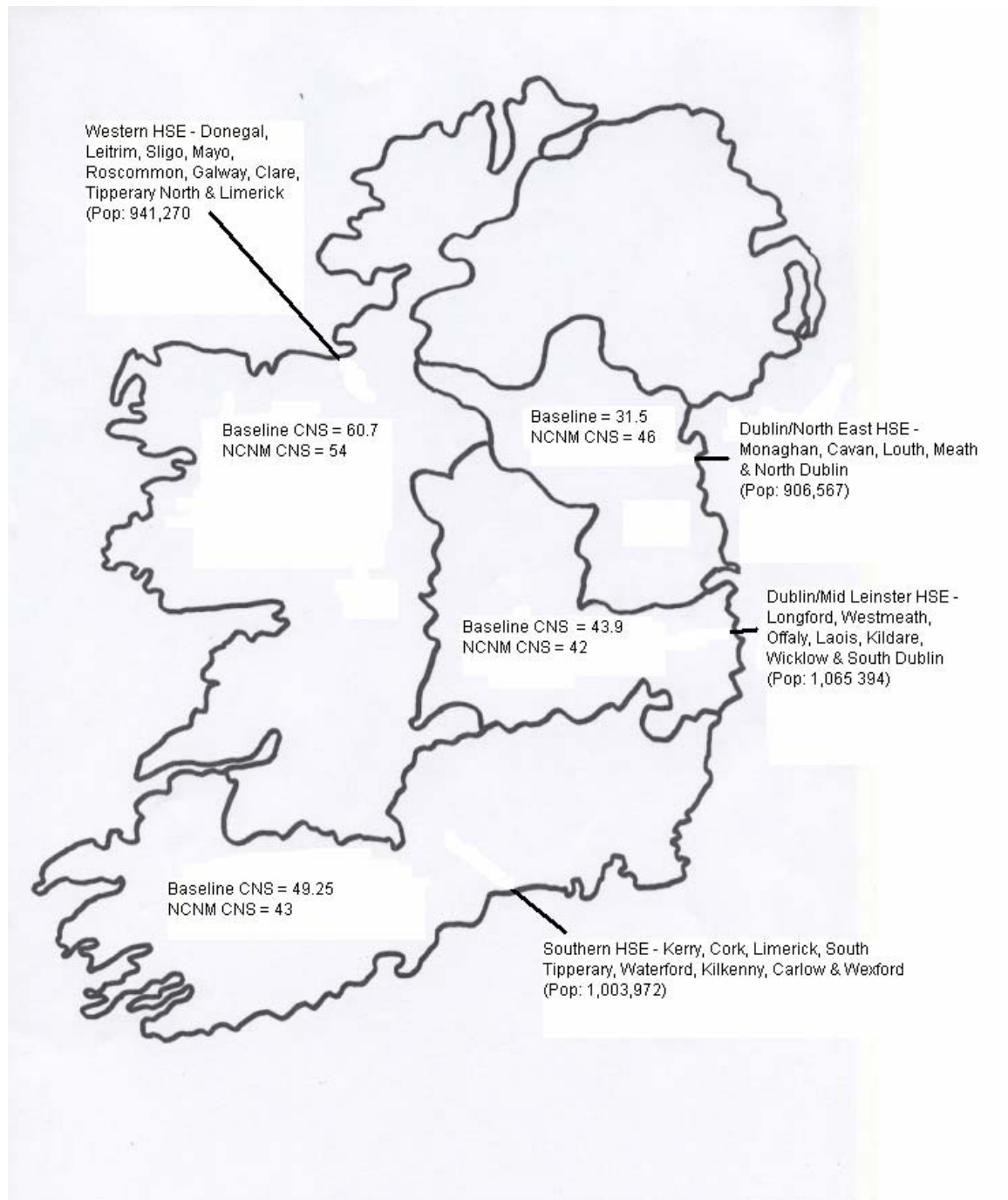
When considering all the nursing posts who already defined at level 3 within the inpatient unit, community, hospital setting and daycare, it is important that an additional 10 - 20% will have to be factored in to these numbers for succession planning, (to compensate for those who will leave their posts for a variety of reasons, such as retirement, maternity leave or simply leaving the profession)

The other source of information directly relating to the number of nurses who have the relevant skills, knowledge and experience to work at level 3 can be obtained directly from the National Council for the Professional Development of Nursing and Midwifery. This data gives information relating to how many posts currently fulfil the nurse specialist criteria, however it is not possible to assess how many of these posts are vacant at any one time.

The total number of Specialist Palliative Care posts that are approved throughout Ireland is 185. The map that follows highlights in which areas these posts have been agreed and compares this number to those posts identified within the Baseline Assessment of Palliative Care.

It is not clear why the two sets of numbers do not match.

**Map 8.1 A Comparison of Specialist Palliative Care Nurse posts for each HSE area between the Baseline Study and the posts validated by the National Council for Nursing & Midwifery (NCNM).**



The most important issue that needs to be considered when comparing either of these figures is the number of education places available for specialist palliative care as this will give an indication of how long, it may take 3-4 years to fill the additional posts without taking into account individuals who will leave.

One factor becomes very apparent when considering the overall requirements for specialist palliative care posts; when comparing the above figure with the total number of newly registered nurses within Ireland, which is 2638, the initial requirement for additional posts is over 11% of this total. This means palliative care will need to attract a substantial number of the total 'new' recruits to fill the proposed requirements, and in turn, educational systems are going to need to ensure sufficient capacity to facilitate this career progression.

The other key issue regarding this data is the numbers have been calculated relating to nursing posts rather than individuals in post. This means the process is likely to require more individuals than posts, as flexible working practices allow for part time and job sharing. This will be a key activity within local educational needs assessments.

## **CONCLUSION**

- A. There were 29,177 nurses working within the public health sector in 2000 (DOHC). There will be considerably more working within the private and voluntary sectors such as voluntary hospices and private nursing homes.
- B. The European association of Palliative Care has developed core standards and competencies for nursing practice that encompasses all three levels of palliative care provision. These may form the basis of a national model for Ireland as well as forming a basis on which to assess both current and future educational developments.

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## **CHAPTER NINE : ALLIED HEALTH CARE PROFESSIONALS**

This chapter will be divided into two sections:

1. Section 1 includes those professionals groups whose roles are considered a core part of the specialist palliative care team, i.e. social work, occupational therapy, physiotherapy, psychological support, specialist education providers and spiritual care.
2. Section 2 includes those professionals groups which the National Advisory report (1) identified as having a sessional commitment within specialist palliative care, but whose main role lays outside this remit.

For allied professionals who may be offering a number of sessions per week to SPC services, palliative care may not be viewed as a core part of their role. It is not feasible to recommend that these professionals undertake SPC education to level 8. However, if for example, the sessional commitments were amalgamated to create a single post across a number of SPC services, then these individual posts may operate as the other AHP roles within section 1 of this chapter.

Many of the allied health care professional groups may have undertaken education at Masters level in order to qualify for generic practice. Any educational initiatives for AHPs in either section 1 or 2 would need to acknowledge this fact and be flexible enough to ensure these professionals add to their existing level of knowledge base, filling in gaps in their skills and competence rather than duplicating previous effort.

### **9.1 Overall Policy and Review of Allied Health Professional Role**

The social impact of chronic and palliative illness is considerable (3). People affected can have a range of needs for social care and support at different stages of the pathway. These include:

- Emotional support, which may be derived from engaging in social activities, companionship or befriending, and making contact with health and social care professionals;
- Help with personal care, such as bathing and dressing;
- Advice on work and employment issues and assistance to secure financial support;
- Help inside and outside the home, such as cleaning and shopping;
- Practical aids, including wheelchairs and other equipment;
- Help to care for children and other dependants such as older relatives.

The social implications may extend beyond the patient's immediate family and carers to relatives, friends, employers and work colleagues. Patients' needs may be best served by the adoption of an agreed assessment tool with basic interventions initiated or a referral made to the next appropriate level of care (4).

Patients and carers rarely experience a coherent, integrated system of social support. The number of agencies involved in planning and delivering services makes

collaboration difficult and services are neither well known nor well understood by health care professionals. Assessment of need can be difficult because some patients and carers may be reluctant to ask for help, arising from a desire to maintain independence and dignity. While professional interventions can be seen as supportive by some, others may see them as intrusive (5).

For the purpose of this report, the term 'allied health care professional' (AHP) covers a broad number of professionals including social workers, physiotherapists, pharmacists, occupational therapists, nutritionists/dieticians, speech & language therapists and chaplaincy as well as staff specialising in psychological support. This list is not meant to be exhaustive. It is important to accept that these professions should not be viewed as one group as each will have its own unique profile of educational needs, especially when relating to staff operating at Level 3.

It is difficult to find many studies that primarily concentrate on the educational needs of AHPs in either cancer or palliative care, although they have been included in the aspects of other research (6&7). A review was undertaken in Scotland in 2004 (8), and although this review relates specifically to cancer related palliative care, there is no reason why the findings cannot be used in relation to a broader palliative care approach. This report concentrated primarily on the needs of physiotherapists, Occupational therapy, dietetics and speech & language.

There is little doubt that the contribution of AHPs has a positive benefit on the quality of life for many patients with palliative care needs, through rehabilitative and supportive interventions. However, many patients do not receive timely or equitable access to high quality AHP services, leading to a growing recognition that a large unmet need exists. The reasons the unmet need is so large and continues to go unmet is due to: poor awareness of AHP services; poor integration of services; lack of appropriate education; and limited resources.

In the Scottish study, AHP clinicians felt there was a need for education, tailored to suit their level of practice as well as the need to improve the understanding about palliative care as an approach throughout the AHP workforce. The recognition of the benefits of agreed competencies and professional standards combined with increased sharing of good practice within disciplines was also a high priority. All the disciplines questioned in this survey felt they were least knowledgeable and confident about communication of difficult issues, as well as 86% (n= 305) of the respondents requesting more palliative care education in general. There was no difference between grade or speciality in relation to this request of training. In conclusion, the report found the main barriers to palliative care education included: limited training budgets, lack of study leave and education not felt relevant to position.

Additionally, the other overwhelming issue was a lack of knowledge of the roles and responsibilities of AHPs by other health care professionals. Poor interprofessional communication and co-ordination lead to suboptimal care (9). In turn, this may lead to inappropriate and untimely referrals as well as unrealistic expectations on the part of patients and families.

The following sections aim to give an overview of the current situation relating to the current numbers of each professional group practising within Ireland, both generally and

within specialist palliative care. There are issues relating to establishing the true numbers of some discipline who may be working as at the present moment, there is no statutory responsibility for Allied Healthcare Professionals to register to practice. It will consider the education routes and level through which each discipline is trained, giving a brief overview of any palliative care input where appropriate. This information will then be measured against the information contained within the National Advisory Group report (10). All figures relating to both current and projected numbers of practitioners required within specialist palliative care have been taken directly from the Baseline Study (11).

Health and social care professionals bill 2004 will come into force over the coming years requiring that allied healthcare professionals be registered.

## **9.2 CORE ALLIED HEALTHCARE PROFESSIONALS**

### **9.2.1 Physiotherapy**

**NATIONAL ADVISORY GROUP RECOMMENDED:**

There should be at least one WTE physiotherapist per 10 beds in the specialist palliative care inpatient unit with a minimum of one physiotherapist in each unit.

There should be a minimum of one WTE community physiotherapist specialising in palliative care per 125,000 population. This post should be based in a specialist palliative care unit.

<b>Table 9.1 Physiotherapy numbers currently practicing in Ireland</b>	<b>2000+ (12)</b>	
<b>Physiotherapists working in specialist pall care</b>	<b>Current posts</b>	<b>Recommended posts (and deficit)</b>
<b>Inpatient</b>	10.5	36.5 (-26)
<b>Community</b>	2	31 (- 29)
<b>Total deficit for Physiotherapists at Level 3</b>	55	



<b>Current Number of Educational Places annually at Undergraduate Level:</b>	
<ul style="list-style-type: none"> <li>• Trinity College, Dublin <ul style="list-style-type: none"> <li>○ BSc. (Hons) Level 8</li> </ul> </li> </ul>	= 40
<ul style="list-style-type: none"> <li>• University College, Dublin <ul style="list-style-type: none"> <li>○ BSc. (Hons) Level 8</li> </ul> </li> </ul> <p>(also have post graduate H Dip/Masters Level courses)</p>	= 56
<ul style="list-style-type: none"> <li>• University of Limerick <ul style="list-style-type: none"> <li>○ BSc. (Hons) Level 8</li> </ul> </li> </ul>	= 30
<ul style="list-style-type: none"> <li>• Royal College of Surgeons <ul style="list-style-type: none"> <li>○ BSc. (Hons) Level 8</li> </ul> </li> </ul>	= 24
Total Places = 150	
<b>Education specific to Palliative Care</b>	
There are no specific references to palliative care within the course curriculum or placement examples.	
<b>Irish Association view (13)</b>	
Irish Society of Chartered Physiotherapists ( <a href="http://www.iscp.ie">www.iscp.ie</a> )	
No specific statements or information relating to physiotherapy and palliative care, but has as part of its mission statement a commitment to continuing education for both its members and the general public.	
<b>Others (14):</b>	
Association of Chartered Physiotherapists in Oncology and Palliative Care ( <a href="http://www.acpopc.org.uk">www.acpopc.org.uk</a> )	
This organisation has a membership of 410 and accepts students. It consists of 13 regional groups that meet regularly, publishes 4 journals per annum, develops an extensive reading list and undertakes two specialist conferences or events. Although it makes no formal recommendations relating to specific education, it does promote specific standards and outcome measures. The organisation also enables its members to access grants for both education and research as well as providing a forum for advertising specific education such as lymphoedema management, pain control and acupuncture.	

**Conclusion:** There is a considerable deficit in physiotherapists working within specialist palliative care; with 55 new posts required for inpatient and community settings - this is equivalent to 37% of all new physiotherapists qualifying from Irish colleges next year. Specialist Palliative Care physiotherapists will make up approximately 3% of the total physiotherapy workforce in Ireland when the projected figures are met. The published information on physiotherapy curriculum available from the four schools of physiotherapy in Ireland does not explicitly make reference to palliative care content.

## 9.2.2 Occupational Therapy

### **NATIONAL ADVISORY GROUP RECOMMENDED:**

There should be at least one WTE occupational therapist per 10 beds in a specialist palliative care unit, with a minimum of one occupational therapist per unit.

There should be a minimum of one WTE community occupational therapist specialising in palliative care per 125,000 population. This post should be based in a specialist palliative care unit.

Table 9.3 Occupational Therapists currently practicing within Ireland	<b>550 (15)</b>	
<b>Occupational Therapists in specialist palliative care</b>	<b>Current nos</b>	<b>Projected nos</b>
Inpatient	6.5	36.5 (-30)
Community	11.5	31 (-29)
<b>Total deficit for Occupational Therapists at level 3</b>	59	

<b>Current number of educational places annually:</b>	
Trinity College Dublin BSc (Hons) Level 8	=40
University College Cork BSc (Hons) Level 8	=25
University of Limerick Masters Level 9	=25
NUI Galway BSc (hons) Level 8	=25
	Total places =115
<b>Education specific to palliative care</b>	
There are no specific references to [palliative care within the course curriculum or placement examples for undergraduate courses.	
<b>Irish Association view: (16)</b>	
Association of Occupational Therapists in Ireland ( <a href="http://www.aoti.ie">www.aoti.ie</a> ) No specific statements or information relating to occupational therapy and palliative care, but has as part of its mission statement a commitment to continuing education for both its members and the general public.	
<b>Others (17)</b>	
Occupational therapists in HIV/AIDS, Oncology, palliative care and education ( <a href="http://www.cot.org.uk">www.cot.org.uk</a> ) This organisation provides an education forum which enables networking at local, national and international levels. It has also developed clinical guidelines, core standards	

and outcome measures for occupational therapists working within these specialist areas, which is hoped will inform education at all levels.

This organisation represents the largest group of social workers in the world. They have a special interest group specifically related to palliative and end of life care.

**Conclusion:** There is a considerable deficit in occupational therapists working within specialist palliative care, with a total of 59 posts required to serve inpatient and community palliative care settings ; this is equivalent to 51% of all new occupational therapists qualifying from Irish colleges next year. Occupational Therapists working in Specialist Palliative Care will make up approximately 12% of the Occupational Therapy workforce once the projected figures are reached.

### 1.2.3 Social Worker

#### **NATIONAL ADVISORY GROUP RECOMMENDED:**

There should at least one WTE social worker per 10 beds in the specialist palliative care inpatient unit with a minimum of one physiotherapist in each unit.

There should be a minimum of one WTE community social worker specialising in palliative care per 125,000 population. This post should be based in a specialist palliative care unit.

All social workers, regardless of practice settings, will inevitably work with clients facing acute or long-term situations involving life-limiting illness, dying, death, grief, and bereavement. Using their expertise in working with populations from varying cultures, ages, socioeconomic status, and nontraditional families, social workers help families across the life span in coping with trauma, suicide, and death, and must be prepared to assess such needs and intervene appropriately. As such, the role of the social worker is now viewed as core to palliative care at all levels of specialty. Social work practice settings addressing palliative and end of life care include health and mental health agencies, hospitals, hospices, home care, nursing homes, elderly day care, schools, courts, child welfare and family service agencies, correctional systems, agencies serving immigrants and refugees, and substance abuse programs. Thus, social work is a broadly based profession that can meet the needs of individuals and families affected by life-limiting illness and end of life issues. Palliative and end of life care is a growing area of practice, and social workers may feel unprepared to deal with the complex issues it encompasses (18 & 19). A large amount of work has been undertaken in both Canada and the USA looking into the competencies and education required by social worker to enable them to undertake their role. The National Association of Social Worker in America (20) have developed 11 standards relating to palliative and end of life care including ethics, knowledge, attitudes, assessment, interdisciplinary teamwork and education. The standards operate across the full spectrum of the specialty helping to

reinforce practice for those working within SPC through to providing an objective to achieve and guidance to assist practice for those in other areas.

The Irish Association of Palliative Care Social Workers group has started to consider their own educational needs, and this group seems ideally placed to offer expert advice on the knowledge, skills and competencies required by social workers at all levels of palliative care. This group may be viewed as a good template for other AHP disciplines to take forward their issues relating to education. However, it is important to note from the figures found below, this group of staff is already considerably under-resourced and it is unfeasible for them to undertake a project with such far reaching consequences without additional support and resources, even if these resources are concentrated over a short period of time.

<b>(21)</b>		
Table 9.3 Social worker numbers currently practicing within Ireland		
<b>Social workers in specialist palliative care</b>	<b>Current nos</b>	<b>Projected nos</b>
Inpatient	10.5	37 (-26)
Community	11.5	32 (-19.5)
Hospital	8.5	36 (-27.5)
<b>Total deficit for social workers at level 3</b>		73

<b>Current number of educational places annually:</b>	
Trinity College Dublin BSc (Hons) Level 8 Masters Level 9	=30 =24
University College Cork BSc (Hons) Level 8 Masters Level 9	=15 =62
University College Dublin Masters Level 9	=50
NUI Galway Masters Level 9	=20
<b>Education specific to palliative care</b>	
There are no specific references to [palliative care within the course curriculum or placement examples for undergraduate courses, although loss and theoretical frameworks such as attachment theory run through individual courses and some have specific inputs on the nature of work in health settings including palliative care.	
<b>Irish Association view: (22)</b>	
Irish Association of Social Workers ( <a href="http://www.iasw.iw">www.iasw.iw</a> )	
No specific statements or information relating to social work and palliative care, but has as part of its mission statement a commitment to continuing education for both its members and the general public. The association is encouraging all its members to undertake a formal process with regards to collecting intonation on their continuing professional development which relates directly to competencies and skills.	

Competencies listed by Head Medical Social Workers Group in Ireland include an expectation that social workers can work with loss and bereavement and within a multidisciplinary team. Social workers currently employed in palliative care settings in Ireland meet together as the Palliative Care Social Workers group and liaise with the Irish Association for Palliative Care and the Irish Association of Social Workers.

Others (23)

**National Association of Social Workers ([www.socialworkers.org](http://www.socialworkers.org))**

This organisation represents the largest group of social workers in the world. They have a special interest group specifically related to palliative and end of life care.

**Conclusion:** The number of new social workers required to fulfil the proposed requirements for specialist palliative care is equal to 36% of the total number of graduate places.

## 9.4 Pharmacists

### NATIONAL ADVISORY GROUP RECOMMENDED:

There should be at least one WTE pharmacist in each specialist palliative care unit.

<b>Table 9.4 Pharmacist numbers currently practicing within Ireland</b>	<b>3,546</b> (24)	
<b>Palliative Care Pharmacists working in specialist pall care</b>	<b>Current numbers</b>  <b>3.5</b>	<b>Recommended posts</b>  <b>11</b>
<b>Total deficit for Pharmacists at Specialist at Level 3</b>	7.5	
<b>Current Number of Educational Places:</b>		
<ul style="list-style-type: none"> <li>• Trinity College, Dublin               <ul style="list-style-type: none"> <li>○ BSc. (Hons) Level 8</li> </ul> </li> </ul>	= 70	
<ul style="list-style-type: none"> <li>• Royal College of Surgeons               <ul style="list-style-type: none"> <li>○ BSC (Hons) Level 8</li> </ul> </li> </ul>	= 50	
<ul style="list-style-type: none"> <li>• University College, Cork               <ul style="list-style-type: none"> <li>○ BPharm. (Hons) Level 8</li> </ul> </li> </ul>	= 55	Total Places = 175
<b>Education specific to Palliative Care</b> There are no specific references to palliative care within the course curriculum or placement examples within the undergraduate or post graduate programmes.		
<b>Association view (25)</b> <b>Irish Centre for Continuing Pharmacy Education (<a href="http://www.iccpi.ie">www.iccpi.ie</a>)</b> is running two study days on palliative care this year (one in Limerick and the other in Donegal)		
<b>Others:</b> <b>American Society Of Health System Pharmacists (26)</b> ( <a href="http://www.ashp.org">www.ashp.org</a> ) -has published 'good practice' guidelines for hospice and palliative care pharmacists. <b>Palliative Care Pharmacists Network (27)</b> ( <a href="http://www.helpthehospice.org.uk">www.helpthehospice.org.uk</a> ) This group was founded in late 2005 and aims to create a 'virtual library' of resources including educational material, job descriptions and competencies. It aims to provide information for practitioners working across all three levels of palliative care and also has an active discussion forum.		

**Conclusion:** Pharmacists makes up a relatively small part of the total palliative care workforce. However, the Baseline Study (28) has only accounted for work within dedicated units and this implies that further personnel will be required to address needs within both the community and the hospital settings.

## 9.5 Psychological Support

**‘Professionals involved in the psychological aspects of palliative care services should be suitably trained and experienced in this role.’**

The National Advisory Report (29) is not explicit about how each professional group should operate within this role. The definition of what constitutes psychological support is complex and will, undoubtedly, include any health care professional who encounters a patient with palliative care needs. Patients at every stage of their illness can find themselves dealing with difficult and distressing issues. They can develop problems ranging from sadness or worry to psychological symptoms sufficiently intense to interfere with their ability to function on a day to day basis. In the year following diagnosis around one in ten patients will experience symptoms severe enough to warrant interventions by specialist psychological/psychiatric services. Such services can also be seen in 10-15% of patients with advanced disease (30). Health and social services professionals offering day-to-day care provide much general psychological support to patients and carers, and play a key role in the psychological assessment, prevention and amelioration of distress. However, the depth and intensity of patients’ psychological symptoms are often not recognised, with the result that they are not offered access to needed services (31). This issue is compounded by the fact that there are insufficient numbers of professionals equipped to offer support to patients and carers in psychological distress, and no uniform agreement exists on the services that should be provided by relevant professional bodies.

While there is no formal evidence of the benefits of implementing a uniform agreement, the national service framework for supportive and palliative care in the UK advocates a four level model of psychological assessment and intervention. This document found evidence that each element within the proposed model were supported by considerable evidence. These benefits included:

- Reductions in psychological distress;
- Improvements in overall quality of life and other functional outcomes;
- Making the experience of illness more acceptable;
- Improvements in concordance with treatment.

The model can be related directly to the Levels of Specialisation outlined in the National Advisory report with an additional fourth level of specialty that relates primarily to mental health needs that extend beyond the scope of Specialist Palliative Care services (Table 9.5).

Self help and Support	Level	Group	Assessment	Intervention
	1	All health and social care professionals	Recognition of psychological need	Effective information; Honest & Compassionate communication; Treat patients & carers with kindness, dignity & respect; Establish supportive relationships General Psychological Support Information patients & carers about the wide range of emotional/support services available to them.
	2	Health And social care professionals with additional expertise	Screening for psychological distress at key stages of illness.	Psychological techniques such as problem solving; Management of acute situational crisis.
	3	Trained and accredited professionals	Assessed for psychological distress and diagnosis of some psychopathology	Counselling and specific psychological interventions such as anxiety management and solution-focused therapy, delivered according to an explicit theoretical framework. Managing anxiety, depression and anger; Responding to mild to moderate concerns such as worries about treatment, personal relationships (including sexual relationships), relationships with hospital staff and spiritual issues.
	4	Mental Health Specialists	Diagnosis of psychopathology	Specialist psychological and psychiatric interventions such as psychotherapy, including cognitive behavioural therapy.; Management of severe depression and anxiety, organic brain syndromes, severe inter-personal difficulties (including severe psychosexual problems), alcohol and drug related problems, personality disorder and psychotic illness.

Adapted from (5)



It may not be possible to make clear distinctions between the boundaries of expertise of various professionals (particularly between Levels two and three), and there is likely to be some overlap between the levels. It is also possible for individual members of the Specialist Palliative Care team to be working at different levels. For example, it is likely that the knowledge and skills of a specialist social worker would allow this individual to operate more comfortably at Level 3 than those of a specialist nurse or physiotherapist, due to the content and direction of each professional group's initial training.

The other primary issue relating to psychological support relates to the development of mechanisms of communication to co-ordinate service provision to ensure that interventions offered are most appropriate to the person's needs. This point and the specific interventions outlined in figure 9.1 give an ideal framework through which a comprehensive interprofessional competency and education package may be developed to ensure the National Advisory reports initial recommendation may be delivered.

### **9.2.6 Spiritual Care**

**Each specialist palliative care unit should have at least two suitably trained chaplains to meet the spiritual needs of patients and families.**

**The pastoral care service should be available to patients and families 24 hours a day.**

Palliative care needs to take a holistic view of patient and family life (32). Beliefs can be religious, philosophical or broadly spiritual in nature. Formal religion is a means of expressing an underlying spirituality, but, spiritual belief, concerned with the search for the existential or ultimate meaning of life, is a broader concept and may not always be expressed in a religious way (33). It follows that spiritual care should not be viewed solely in terms of the facilitation of appropriate ritual, which has implications for education concerning spiritual need. This issue is becoming increasingly challenging from the perspective of education and provision of holistic care, with the increasing numbers of immigrants into Irish society.

Chaplaincy services hold an important role in the education and support of both patients and health care professionals when it comes to spiritual care. Health and social care workers often feel awkward about discussing, or even considering, their own spiritual needs as professional carers, and this has an impact on how they are able to deal with the difficult issues that arise for their patients and families (34).

Care may be provided by:

- The patient's own family, friends or faith group;
- Staff groups (of any discipline) within all care settings;
- Officially appointed faith leaders selected and trained to work within a palliative care setting.

There are areas of good practice with respect to defining competencies and standards in this area which could be drawn upon to help develop education and training initiatives for

all health care professionals (35&36). An example of this was developed by Marie Curie Cancer care and may be helpful when examining the education that may need to be provided at each level of practice within palliative care. As such, levels 1 & 2 may be viewed as generic to all health care workers and others working with these patients.

**Level One**

This level seeks to ensure that all staff and volunteers understand that all people have spiritual needs, and distinguishes between spiritual and religious needs. It seeks to encourage basic skills of awareness, relationships and communication, and an ability to refer concerns to members of the multidisciplinary team. For professional health care staff, this training would be best facilitated at undergraduate level, or at the very least, during their initial period of clinical practice.

**Level Two**

This level should enhance the competencies developed at level one, especially around identifying and responding to a wide breadth of spiritual and religious needs. For specific groups of professionals, such as medical and nursing staff, an indepth knowledge of the practicalities surrounding managing the death and burial of people from different faiths is important. They need to be able to refer patients and families to the most appropriate source of help.

**Level Three**

This level moves to the area of assessment of spiritual and religious need, developing a plan for care and recognising complex spiritual, religious and ethical issues. It is possible that a further subsection within this level that is directed primarily at specialist palliative care chaplain services. In particular, they will need to deal with the existential and practical needs arising from the impact on individuals and families of illness, life, dying and death. These services will also act as a resource for the support, education and training of health care professionals and volunteers, and may form a core resource for the development of national and local initiatives.

Within this there is a clear overlap between these services and those within the psychological support services.

**9.3 PROFESSIONAL GROUPS WITH A SESSIONAL COMMITMENT TO SPECIALIST PALLIATIVE CARE**

**9.3.1 Clinical Nutritionists**

There should be at least one clinical nutritionist session in each palliative care unit per week.

<b>Table 9.6 Numbers currently practicing within Ireland</b>	<b>(37)</b>	
<b>Dieticians/Clinical Nutritionists working in</b>	<b>Current Nos</b>	<b>Projected Nos.</b>

<b>specialist palliative care</b>	<b>1.5</b>	<b>2</b>
<b>Total for Dieticians at Level 3</b>	-0.5	
<b>Current Number of Educational Places:</b>		
<ul style="list-style-type: none"> <li>• Dublin, Institute of Technology/Trinity College, Dublin <ul style="list-style-type: none"> <li>○ BSc (Hons) Level 8</li> </ul> </li> </ul>	= 20	
<ul style="list-style-type: none"> <li>• University College, Cork <ul style="list-style-type: none"> <li>○ BSc (Hons) Level 8</li> </ul> </li> </ul>	=20	Total Places = 40
<b>Education specific to Palliative Care</b>		
There are no specific references to palliative care within the course curriculum or placement examples for undergraduate courses.		
<b>Association view</b>		
Irish Nutrition and Dietetic Institute (38) ( <a href="http://www.indi.ie">www.indi.ie</a> ) - has a special interest group for Oncology and Haematology, but not directly related to palliative care.		
<b>Others:</b>		
Canadian Oncology Nutrition Society (39) ( <a href="http://www.bccancer.bc.ca">www.bccancer.bc.ca</a> ) This society has developed standards of practice for dieticians working within this field which includes standards for counselling and public education, participation in education and training as well as quality assurance.		

### 9.3.2. Speech and Language Therapist

There should be regular speech and language therapy sessions in each palliative care unit, with a minimum of one session per week.

<b>Table 9.7 Numbers currently practicing within Ireland</b>	<b>446.9 (40)</b>
<b>Current Number of Educational Places:</b>	
<ul style="list-style-type: none"> <li>• Trinity College, Dublin <ul style="list-style-type: none"> <li>○ BSc. (Hons) Level 8</li> </ul> </li> </ul>	= 25
<ul style="list-style-type: none"> <li>• NUI, Galway <ul style="list-style-type: none"> <li>○ BSc. (Hons) Level 8</li> </ul> </li> </ul>	=25
<ul style="list-style-type: none"> <li>• University of Limerick <ul style="list-style-type: none"> <li>○ Masters Level 9</li> </ul> </li> </ul>	= 25
<ul style="list-style-type: none"> <li>• University College, Cork <ul style="list-style-type: none"> <li>○ BSc. (Hons) Level 8</li> </ul> </li> </ul>	= 25
Total Places = 100	
<b>Education specific to Palliative Care</b>	

There are no specific references to palliative care within the course curriculum or placement examples within the undergraduate or post graduate programmes.

**Association view**

Irish Association of Speech and Language Therapists (41) ([www.iaslt.com](http://www.iaslt.com))  
 No specific statements or information relating to speech and language therapy and palliative care. However, it has as part of its mission statement the requirement to: support continuing education and professional development through education and research and; to coordinate the gathering and dissemination of information.

**Others:** Royal College of Speech & Language Therapists (42) ([www.rcslt.org](http://www.rcslt.org))

This organisation has undertaken extensive work on clinical guidelines and core competency development. Although, this are not specifically related to palliative care, they do include work on head & neck cancers and quality of life issues relating to dysphagia. The documents discuss the role within multidisciplinary teams, long term management and general palliative care issues such as quality of life. Excellent information on CPD and available education.

**Conclusion:** It is estimated that there will need to be 8 sessions of Speech and Language Therapy across all the inpatient units within Ireland. It is difficult with such small numbers to quantify the educational requirements for these posts. However the report does not identify numbers of practitioners working at Level 2 within palliative care, and, due to the type of work this group undertakes, this group may have considerable educational needs. This is true of those who are working within cancer, neurological and long stay/rehabilitation environments.

**Summary - Specialist Posts**

Table 9. below shows the deficits in specialist palliative care disciplines and the corresponding education programmes currently available. At the end of 2005 specialist training was only available for nurses and this to HDip level. Other professions allied to medicine engaged in generic education courses. The table shows that unfeasibly large proportions of new graduates would need to opt for palliative care specialty if the current deficits are to be filled.

<b>Level 3 Specialist Palliative Care</b>	<b>Deficit - number of specialist posts required</b>	<b>Appropriate training in Ireland</b>	<b>No of Education Centres</b>	<b>No of Education places per annum</b>
Nursing	71	H Dip Palliative Care	3	38
Social Work	72	<b>Generic</b> Bachelor and Masters level	4	201
Physiotherapy	55	<b>Generic</b> Bachelor level	4	150
Occupational Therapy	59	<b>Generic</b> Bachelor and Masters level	4	115

Pharmacy	7.5	<b>Generic Bachelor Level</b>	3	175
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#### **9.4 CONCLUSION**

1. AHPs have a major role to play in the rehabilitation and supportive care of patients with palliative care needs.
2. AHPs interventions, when provided at the correct time, prolong the onset of disability and maximise function for as long as possible.
3. AHP input is diluted by large caseloads and the number of clinical areas required to be covered.
4. The non-specialist AHP workforce is providing a large proportion of palliative care services.
5. AHPs need a level of palliative care competency relevant to the requirements of their post – this should be in line with the level of practice they undertake as defined by the National Advisory Committee Report.
6. To allow capacity building, a small number of clinicians must be supported to practise at an advanced level.
7. Social care encompasses: practical help; personal care for patients; preservation or enhancement of social networks; emotional support; income maintenance; provision of information on local and national resources; and access to safe living environments.

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## **10. ISSUES FOR DISCUSSION AND FURTHER DEVELOPMENT**

The key aim of any education programme within a healthcare setting is to ensure the workforce is adequately prepared to deliver a high quality service. This education has to be delivered at both pre- and post registration level. If palliative care, in the broadest sense, is to be successfully integrated into all aspects of patient and family care, it must be viewed as an overarching principle of good practice rather than as a priority for only a few professionals or service areas. Delivering education to match this need is an ambitious undertaking which will need a high level of central policy prioritization, commitment and funding if it is to succeed.

Other countries have found identifying the key areas of palliative care education is facilitated if a national framework of standards and competencies are developed through which individual areas/networks can devise common educational frameworks. This has enabled education providers (either within specialist palliative care or further/higher education) to tailor their courses to meet these demands. By having a set of core standards for service delivery, it has also made it easier for government, individual health authorities or institutions to assess whether they are providing a high quality service.

The questions for discussion at this point include:

- Do we know whether the education currently provided enables staff at all levels to offer high quality care?
- How is 'best practice' in palliative care measured in the context of Irish healthcare?
- How do we ensure that staff sustain the knowledge they have learnt and can they turn this knowledge into skills and competence?

This document has evaluated the current position relating to healthcare provision and education in general within Ireland. The main policy documents relating to health care provision highlights the fact that there is a lack of an overriding national structure for development, dissemination and evaluation of national quality protocols and standards. These documents also acknowledge a lack of linkages and shared information between organisations and teams, professional barriers and few interdisciplinary teams. This is important for specialist palliative care when considering the breadth of healthcare setting within which they are expected to work as well as the diversity of their potential patient groups. The main areas of care emphasised include cancer, heart disease, the elderly, other chronic diseases and rehabilitation. The other issue highlighted by this review is there are a number of geographical areas that do not have easy access to Specialist Palliative Care Inpatient unit facilities.

The National Advisory Committee Report on Palliative Care and the Baseline Study on the Provision of Hospice/Specialist Palliative Care Services in Ireland recommends there should be 22.5 Library and Education personnel within the specialist palliative care units throughout Ireland. There were 10 employed in 2004.

In order to put perspective on the capacity required to fulfil the Advisory Group recommendation, there are a number of key examples:

1. Nursing – There are approximately 1,000 newly qualified nurses who register to practice in Ireland each year and 200 places on the 4/5 day ‘Introduction to Palliative Care’ courses around the country. If it is accepted that this is the main avenue of formal palliative care education that facilitates movement between level one to level two, it indicates there is an 80% shortfall in places available for this group. This is without considering nurses who register to practice from other countries or those who may require an opportunity to update their skills;
2. Medicine – There are approximately 300 medical graduates entering practice in Ireland each year, however there is little formal palliative care education that they can access. Many of the HMT Specialist registrar programmes also highlight the need for palliative care skills, and although specialist palliative care will offer placements and rotations, these are often dependant on first fulfilling the other requirements of their programme.

The following questions remain to guide future developments or initiatives in palliative care education:

- How can we identify the appropriate level of knowledge, skill and competence for those working at Level two in other specialist areas?
- How can we ensure each healthcare professional at Level 2 has access to the appropriate education?
- How can we ensure there is sufficient capacity and flexibility within palliative care education to meet the needs across Level 2?
- If considering Adult & Life Long Learning as a continuum, would Ireland benefit from a National Competency Framework across all three levels on which individual professionals can consider their own education needs?
- If this is the case, would it be beneficial to make this framework as interdisciplinary as possible, allowing different professionals/grades to work to a level of competence relevant to them and their position?

In planning how to meet the multitude of differing needs within Level Two (General Palliative Care), it will be important to consider the role of organisations outside specialist palliative care, i.e. Higher Education institutions, and the opportunities for them to develop areas of palliative care expertise. Considering the issues relating to educating an entire workforce is an overwhelming task, therefore it may be advisable to identify a list of core subject areas, such as communication skills, that can be undertaken in discrete section. It will also require a variety of resources that can be used to support this learning such as distance learning packages, e-learning and self-directed learning packages.

Education for professionals working within Level Three (Specialist Palliative Care) is currently undergoing review and change to allow access by the interdisciplinary team. Capacity within level of education will need to be increased to meet the recommendations within the National Advisory Committee report, but it is unclear whether this increased capacity will need to continue indefinitely. The indications are that specialist palliative care services will need to expand to meet the growing population, especially as the percentage of elderly within the population continues to grow. Currently there are only two Higher Education institutions and their specialist palliative care partners that offer the widest interdisciplinary remit within pre-registration and post registration education (Table 6.1). These are University College Dublin and NUI Galway.



Within the new education awards structure, there is also the opportunity to ensure all formal and non-formal palliative care education is brought into the remit of the credit system, allowing specialist knowledge gained to be valued within this framework. This may help prevent duplication of effort by professionals when considering what education is required in order for them to fulfil a specialist role.

The National Advisory Committee also recommends that interdisciplinary research within the speciality needs to be established and coordinated. This is certainly important to those undertaking the HMT Specialist Registrar programme, who are likely to leave the healthcare system in Ireland in order to gain this experience. Therefore:

- Considering the limited number of personnel available, how can Specialist Palliative care education provision be coordinated in order to prevent duplication of effort in developing and maintaining high quality education programmes?
- What would this overarching coordination look like?

One suggestion when considering the models found in other countries such as Canada and Australia would be a National Centre of Excellence that could provide a range of facilities. This could be considered in the context of a 'virtual' organisation drawing on resources from around the country. It may include initiatives such as:

- Interdisciplinary Research facilities offering a supervisory role and support to those undertaking higher degrees;
- Coordination of working groups relating to overarching education and research issues such as curriculum planning, competency frameworks and standard/quality frameworks;
- A single point of access for all professionals relating to information and education, such as sign posting available courses, education packages, e-learning and self directed learning packages/resources. These could be gathered from appropriate resources both internationally and nationally;
- Electronic discussion forums for professional groups and/or particular issues.

In conclusion, it is not the remit of this report to give a single direction or solution to the issues confronting the development of palliative care education, but to draw together the main strands into one document and to open discussion around the best way forward. It is likely that this will only be achieved through continued effort and evaluation over a sustained period of years, which will require funding and support from those managing the health service at a high level.