PALLIUM

THE PALLIUM PROJECT

A professional community of clinicians, educators, and academics
engaged in building Canada's palliative care capacity together.

Palliative Care Leaders

PROFILE OF MAJOR AREAS OF RESPONSIBILITY AND RELATED TASKS

MARCH 2002 (REVIEWED BY PARTICIPANTS)

Facilitated by:
Wilson Associates - Education Consultants Inc.

The PALLIUM Project

PALLIUM is a health human resource project focused on significantly improving access to system-linked education and professional development in palliative and end-of-life care for Canadian health care professionals and citizen-consumers, particularly in Alberta, Saskatchewan, Manitoba and North West Territories. The PALLIUM Project has received catalytic funding by Health Canada, under Budget '99 provisions creating the Rural and Remote Health Innovations Initiative (RRHII).

Major Funder (2001-2002)

Health Canada,
Rural and Remote Health Innovation Initiative

Project Hosting Authority

Alberta Cancer Board, Research Administration

Founding Academic Partners

University of Alberta

- Division of Palliative Medicine, Department of Oncology
- Academic Technologies for Learning, Faculty of Extension
- Institute for Professional Development, Faculty of Extension
- Division of Continuing Medical Education
- Division of Outreach Pharmacy Education, Faculty of Pharmacy and Pharmaceutical Sciences

University of Calgary

- Division of Palliative Medicine, Department of Oncology
  - Office of Continuing Medical Education and Professional Development

University of Manitoba

- Section of Palliative Care, Department of Family Medicine

University of Saskatchewan

- Palliative Medicine Program, Department of Family Medicine and Department of Oncology

Founding Health Service Partners

Alberta Cancer Board, Research Administration
Calgary Regional Health Authority (CRHA)
Capital Health Authority, Edmonton
Caritas Health Group, Edmonton
Chinook Health Authority (Alberta)
East Central Health (Alberta)
Inuvik Regional Health and Social Service Board
Lakeland Regional Health Authority (Alberta)
Regina Health District
Saskatoon Health District
Stanton Regional Health Board, Yellowknife
Winnipeg Regional Health Authority

Other Founding Partners

Rural Physician Action Plan (RPAP), Alberta
Alberta Palliative Care Association

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A Note on the Application of Occupational Analysis Methods to Health Professions' Education and Professional Development

The DACUM approach to educational program development has become widely known in Canada and the United States over the last 30 years as an effective means to involve front-line staff and leaders in the design of learning. It is based on the assumption that the people who actually perform a role or oversee it being done are the people who can best describe the role functions. The purpose of this modified DACUM workshop was to identify Major Areas of Responsibility and Major Tasks for health care professionals providing primary-level palliative and end-of-life care.

The DACUM approach is a systematic, analytic and descriptive process of gathering, documenting and analyzing information about actions that people in a particular role or job take in performing the tasks incumbent in that role. In this sense it is both explanatory and predictive as a needs assessment protocol. It also has the potential to lend itself well to the goal of designing education and professional development that is clearly linked to better patient care and quality and compassionate care outcomes.

This profile chart lists the *major areas of responsibility* and related *tasks* performed in this occupation.

The *major areas of responsibility* are listed vertically along the left-hand margin, in bolded boxes. These bolded boxes contain the title and alphabetical designation for each major area of responsibility (such as A, B, C, etc.).

The *tasks* that are performed within each major area of responsibility are listed in boxes and placed in horizontal bands beside the relevant major area of responsibility. Each task box contains the task description and an alphabetical and numerical designation (such as A1, A2, A3, etc.).

Professionals in this field provided the information in this profile chart. This analysis is a living document, which should be revisited, refined, and updated in future years.

DEFINITION

Recognizing the uniqueness of the rural and remote communities they serve, palliative care leaders enhance palliative care, including end-of-life care, and bereavement support for individuals and their families/support systems by working collaboratively with primary palliative care professionals.

This may include:

- clinical consultation
- education
- advocacy
- program development/management
- collegial support
- caregiver support
- promotion and integration of evidence-based practice
- research

PROVIDE CLINICAL EXPERTISE **A**	Perform clinical multi-dimensional assessment of individual e.g. address cultural, spiritual, physical and psychosocial needs A1	Perform clinical multi-dimensional assessment of family and support system e.g. address cultural, spiritual, physical and psychosocial needs A2	Recognize and manage total suffering and chemical coping A3	Develop integrated plan of care based on best evidence A4	Manage complex pain A5
	Manage complex symptoms and problems A6	Manage non-cancer palliative conditions A7	Manage pediatric palliative care A8	Address ethical dilemmas A9	Engage in advance planning with individual, family/support system (e.g. nausea, bleeding, etc.) A10
	Conduct formative and summative evaluations of plan of care A11	Engage in innovative and creative problem-solving (out-of-box-thinking) A12			
FACILITATE EFFECTIVE COMMUNICATION **B**	Identify and verify perceived and real needs of individual, family/support system B1	Engage in therapeutic conversation e.g. truth telling, listening, aligning, breaking bad news B2	Encourage end-of-life decision making e.g. affairs in order, directives, living wills B3	Engage in family and team conferences B4	Facilitate conflict resolution among family/support system and professionals B5
	Negotiate plan of care with involved persons B6	Encourage use of a common language B7			
PROVIDE GRIEF AND BEREAVEMENT SUPPORT **C**	Raise awareness regarding the grief continuum C1	Recognize and support normal grief C2	Recognize and treat complicated grief C3	Identify resources to support the grieving individual (children and adults) C4	Encourage ritual C5

FULFILL ROLE OF CLINICAL CONSULTANT **D**	Build strong relationships e.g. - to primary palliative care professionals - health authorities - families/support systems D1	Consider/choose the appropriate consultancy model e.g. situational D2	Identify and use communication strategies to engage primary professional, individual, family/support system D3	Participate as a member of the team D4	Clarify roles and responsibilities - palliative care leaders and palliative care professionals - individual and family/support system D5
	Serve as a role model D6	Mentor others D7	Engage in ongoing collegial support D8	Share information with individual, family/support system, health care professionals D9	Ground activities within broader perspective/ philosophy D10
PROMOTE CARE FOR THE CAREGIVER (FORMAL AND INFORMAL) **E**	Foster self awareness E1	Reflect on own capabilities E2	Identify coping and self care strategies for formal/informal caregivers E3		
DEVELOP AND PROVIDE EDUCATION **F**	Develop/obtain learning materials for individual, family/support system e.g. pamphlets, videos, computer-based learning literature, audio tapes F1	Organize and participate in public education F2	Act as a preceptor for trainees in professional program F3	Develop and/or deliver training for caregivers F4	Develop and/or deliver education and/or professional development for palliative care professionals F5

DEVELOP AND MAINTAIN PROGRAMS/ SERVICES G	Advocate for individuals and family/support systems G1	Perform "needs" assessment G2	Develop Business Plan G3	Engage regional administrators and government G4	Identify and access local and external resources G5
	Mobilize and support community G6	Develop community partnerships e.g. Health Authorities, Service Clubs G7	Engage in community fund raising projects G8	Participate in the creation, selection and providing support to the professional community G9	Integrate national standards G10
	Manage funds and budgets G11	Evaluate effectiveness of program/service G12	Enhance program through continuous quality improvement and innovation G13		
ADVANCE PALLIATIVE CARE PRACTICE AND INFRASTRUCTURE H	Promote professional integrity H1	Eliminate professional isolation H2	Integrate standards of practice e.g. Apply and disseminate Canadian Hospice Palliative Care Norms of Practice and Canadian Nursing Association's, Hospice Palliative Care Nursing Standards of Practice H3	Support continuum of care throughout the illness trajectory H4	Integrate/interface and develop linkages with other resources/programs e.g. geriatric, psychiatric, social work H5
	Participate in and promote research H6	Commit to continuous learning and professional development H7			

KNOWLEDGE

- Various models of consultation - pros and cons
- Principles of group dynamics
- Conflict resolution strategies
- Understanding family dynamics
- Principles of adult learning
- Knowledge of local resources
- Bereavement
- Overview of non-cancer palliative conditions
- Pediatric palliative care
- Cultural issues surrounding end of life
- Spiritual care within palliative care

PALLIATIVE CARE LEADERS

QUALIFICATIONS/LICENSES

- Methadone license

CHARACTERISTICS

- Leadership abilities
- Mentor/role model
- Skilled clinicians
- Accountability
- Encourager
- Risk taker
- Effective communicator
- Ability to multi task
- Humor, diplomacy and tact
- Aware of vulnerabilities of being an advocate (able to say no)

PALLIATIVE CARE LEADERS

CHARACTERISTICS

- Good relational/interpersonal skills
- Team builder
- Responsiveness, creativity, and flexibility
- Ability to delegate
- Time management
- Empathy

AREA OR QUESTIONS REQUIRING FURTHER CONSIDERATION

- Reviewing the definition for primary palliative care professional, is there adequate emphasis on the role of individual and family? Does it sound as though the professional is at the centre?
- We need human support systems
- Focus group of citizen-consumers. Have we got it? If not, what and what priority.
- Role of PALLIUM/C.V.H. in supporting
  (1) Compilation of knowledge-linked resources
  (2) Stuff for patients/family/community

PALLIATIVE CARE LEADERS

COMMENTS FROM THE PARTICIPANT REVIEW AND VALIDATION PROCESS (February 2002)

Introduction

All participants who were involved in identifying the Major Areas of Responsibility, the Major Tasks, and the Knowledge, Skills, and Characteristics for a Palliative Care Leader were also asked to review and comment on the output. All participants (see page i) were invited to respond to these three questions:

1) Are the findings presented in the attached document consistent with your personal and professional insights as shared during the DACUM process? _____ Consistent _____ Not consistent

2) If you answered "not consistent," what clarifying/explanatory notes would you add that might contribute to a final refinement of this document (please be concise and make reference to the question/questions/points you are addressing)?

3) Do you have any other suggestions or insights that you would like to share since you participated in the initial interview?

Results

The results were reported by respondents as consistent with what they developed during the modified DACUM workshop process. There was one minor editorial change requested to Box H3, to accurately reflect the correct name and connection to the Canadian Nurses' Association's, Hospice Palliative Care Nursing Standards of Practice.

Future Development of this Document

This DACUM report is intended as a "living document," representing a snap shot in time of expert opinion leaders and their informed opinions about what constitutes Major Areas of Responsibility, Major Tasks, and Knowledge, Skills, and Characteristics for rural Palliative Care Leaders. Comments and suggestions about the Major Areas of Responsibilities, Major Tasks, and Knowledge, Skills, and Characteristics of rural Palliative Care Leaders can be sent by email to: Michael Aherne, PALLIUM Project Consultant, at maherne@ualberta.ca and/or Jose Pereira, PALLIUM Project Leader, at pereiraj@ucalgary.ca.