The Pallium Project (Phase II)

A community of clinical, education, academic, and voluntary sector leaders
engaged in building Canada's hospice palliative care capacity together.

www.pallium.ca

Professional Hospice Palliative Care Spiritual Care Provider

PROFILE OF MAJOR AREAS OF RESPONSIBILITY AND RELATED TASKS

MARCH 2005 (PARTICIPANT REVIEW COMMENTS REFLECTED HEREIN)

Facilitated by:
Wilson Associates - Education Consultants Inc.

The Pallium Project

The Pallium Project is based on the idea that *many hands make light work*. The Project is a collective of leaders and interested people who collaborate in developing tools, learning resources, continuing professional development (CPD) and strategic initiatives for hospice palliative care. Their efforts are focused on improving access, enhancing quality and building longer-term system capacity.

The Project functions as a Community of Practice (CoP). Communities of Practice are self-organized, deliberate collaborations of people who share common practices, interests and aims and want to advance their specific domain of knowledge. Most of the Project's current collaborators are located in western and northern Canada. The Project actively develops and tests tools, resources and initiatives in British Columbia, Alberta, Saskatchewan, Manitoba, Yukon, Northwest Territories and Nunavut. The Project also provides pan-Canadian leadership in facilitating development of learning resources and its many collaborator leader/champions contribute to dialogue and advancing hospice palliative care issues of national concern.

The Project helps empower providers to become more self-aware and skillful, facilitating reflection on deeply-rooted assumptions and promoting safe, ethical and effective practices. It also promotes thoughtful system change and mutually-respectful collaboration among paid providers, family/friends and volunteers.

The Project generally makes the results of it's collaborative work available on a licensed basis across Canada to health science educators, health service delivery organizations and voluntary sector organizations. The Project's collaborators come from universities located in Vancouver, Edmonton, Calgary, Saskatoon, Regina and Winnipeg, most regional health authorities in western Canada and various governments and voluntary sector organizations.

The Pallium Project continues to evolve from its roots as an applied health human resources (HHR) research project in rural health. It is currently a focused capacity-building initiative. It links a range of learning, development, knowledge management and collaborative initiatives to population health improvement and health system sustainability. Collaborators are committed to building on the vision of *Quality End-of-life Care* for every person in Canada – one which assures comfort, dignity, peace of mind, reduces the burden of undue pain and suffering associated with life-threatening and life-limiting illness, and supports the health status of all caregivers and the bereaved.

In late 2003, the Project was awarded $4.3 million in Contribution Agreement funding under the aegis of Health Canada's, Primary Health Care Transition Fund (PHCTF), National Envelope for a project entitled *Pallium Integrated Care Capacity Building Initiative* (Pallium Phase II). This initiative has been funded for outreach education and professional development; knowledge management and workplace learning; and service development, system readiness (service delivery enabling) and community collaboration. A significant emphasis is being placed on improving supports to regional health authorities (RHAs) and community-based, voluntary-sector partners to improve local and regional capacity and inter-sectoral collaboration as part of Canada's primary-health care system renewal.

The Alberta Cancer Board, Medical Affairs and Community Oncology (MACO) division serves as the Project's sponsor and administrative hosting authority associated with implementing Primary Health Care Transition Fund (PHCTF) related project activities. The Project works through a variety of hospice palliative care content expert and other process resource people located throughout Canada. It coordinates the Project activities from a Project Development Office which is located at the University of Alberta's, Research Transition Facility (RTF), a special-purpose facility designed to incubate research-based initiatives.

Appreciation is extended to the following professional hospice palliative care spiritual care providers for developing this profile:

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PROFILE OF MAJOR AREAS OF RESPONSIBILITY AND RELATED TASKS

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 professionals providing spiritual care in a hospice palliative care setting (as defined by the Canadian Hospice Palliative Care Association's, (CHPCA) *Model to Guide Hospice Palliative Care Based on National Principles and Norms.*)

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.

Intended use of this document: This DACUM chart is used as a companion to other curriculum development activities to verify that essential competencies have been addressed. DACUM charts are also used by human resources professionals when completing job design activities, drafting/review of position descriptions and development of performance management/assessment processes for specific roles.

Note on final production and presentation: No changes have been made to the DACUM chart since its initial production in January 2005, however, the reader is advised to consider both the chart and the key informant's review comments for a deeper appreciation of the context within this work has been undertaken/reported.

Scope Statement

The professional hospice palliative care spiritual care provider

practices the art of skilled spiritual companionship

entering into the lives of the suffering and dying.

DISCERN, IDENTIFY & UNDERSTAND SPIRITUAL & RELIGIOUS HISTORY, RESOURCES AND CARE NEEDS **A**	Respect patient's choice to accept or decline spiritual or religious care A1	Establish rapport A2	Gather information relevant to spiritual/religious history A3	Explore spiritual orientation A4	Determine patient's goals and expectations of spiritual care A5
	Document and revise a spiritual care plan A6				
PROVIDE APPROPRIATE, CULTURALLY SENSITIVE, SPIRITUAL CARE **B**	Be compassionately present B1	Adapt presence and communication in ways that are appropriate to patient's health status B2	Create a safe place that holds the whole person B3	Establish the therapeutic relationship B4	Engage with patients in their experience of suffering B5
	Listen for the meaning, emotion, intention behind the words and reflect back to speaker for clarification/ verification B6	Listen for that which is sacred to the patient B7	Nurture inner spiritual resources for well-being B8	Journey with patients and their family members B9	Help patients and families to explore their perceptions of death and dying as and if appropriate B10
	Honor, include and engage symbols, prayer, meditation and other practices that are meaningful to the patient B11	Protect patient and family from inappropriate or unwanted spiritual intervention B12	Seek to enhance quality of living and dying as defined by the individual B13	Design appropriate ceremonies B14	
PROVIDE FOR APPROPRIATE RELIGIOUS CARE **C**	Explore images of God and the sacred as they inform the experience of illness and dying C1	Discuss conflicts experienced between beliefs and illness C2	Invite use of symbols, artifacts, writings, music and art that are sacred to the patient and family C3	Liaise with community, spiritual and religious representatives C4	Facilitate provision of religious rites as appropriate to patients health status C5

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PROVIDE FOR APPROPRIATE RELIGIOUS CARE	Monitor and address issues of religious abuse				
C	C6				

PROVIDE SPIRITUAL COUNSELLING	Create an accepting supportive environment to hold spiritual struggles and dark emotions	Provide crisis counselling	Facilitate the interpretation of experience and existence	Ameliorate suffering as appropriate and possible	Facilitate reconciliation
D	D1	D2	D3	D4	D5
	Facilitate support groups				
	D6				

COLLABORATE AS A MEMBER OF INTER-DISCIPLINARY TEAM	Integrate spiritual care within clinical case management	Help team to articulate values	Interpret and explore cultural taboos and ambiguities around death and dying	Document spiritual care activities in the patient's health record	Express spiritual needs and resources of patient to the team
E	E1	E2	E3	E4	E5
	Participate in inter-disciplinary rounds	Make and receive referrals and consults in a timely manner	Facilitate advance care planning		
	E6	E7	E8		

PROVIDE LEADERSHIP IN ETHICAL DECISION MAKING	Participate in ethical decision making process	Educate, encourage and support ethical decision making at end of life	Assist patient's and family's decision making in choosing to obtain, accept or decline medical treatment	Mediate conflictual requests for rituals and other end of life care	Provide support for organ and tissue donation situations
F	F1	F2	F3	F4	F5
	Encourage open and conciliatory responses to error				
	F6				

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ADVOCATE ON BEHALF OF PATIENT AND FAMILY **G**	Identify patient's primary needs in order to ascertain and engage appropriate resources G1	Advocate for appropriate spiritual care G2	Advocate on behalf of the patient to obtain medical treatment G3	
PROVIDE GRIEF AND BEREAVEMENT CARE **H**	Facilitate and provide bereavement support services H1	Facilitate memorial services for individual patients H2	Provide for group memorial services H3	
FACILITATE FUNCTIONAL RELATIONSHIPS **I**	Use role and authority respectfully, effectively and appropriately I1	Assist with conflict management I2	Cultivate relationship between organization and community I3	Nurture team spirituality I4
PROVIDE SUPPORT TO STAFF **J**	Make self available J1	Facilitate formal and informal activities that promote positive working relationships J2	Provide for examination of conscience J3	Join in debriefing activities J4	Provide counselling J5
NURTURE THE ORGANIZATIONAL SOUL **K**	Recognize symbolic significance of role K1	Create a safe, hospitable space K2	Call upon the organization to act with dignity and respect regarding the spiritual values and worth inherent in each person K3	Equip and encourage other team members to provide appropriate spiritual care K4	Participate in designing and conducting corporate memorial observances K5
PROVIDE EDUCATION AND ENGAGE IN RESEARCH **L**	Design and deliver learning and development opportunities L1	Educate others on diverse spiritual care and cultural expressions L2	Undertake supervisor and mentorship roles for learners L3	Write for publication L4	Participate in and conduct research L5

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PERFORM ADMINISTRATIVE DUTIES **M**	Ensure a religious care referral system is in place **M1**	Develop policies, procedures, protocols as required **M2**	Evaluate, improve and develop services **M3**	Contribute to development of spiritual care profession **M4**	Participate in appropriate committees **M5**
	Perform administrative and management duties as required **M6**				
COMMIT TO PERSONAL AND PROFESSIONAL INTEGRATION **N**	Practice self care **N1**	Discover and recreate self as an instrument of spiritual care **N2**	Engage in reflective practice **N3**	Practice within a code of ethics and standards of practice **N4**	

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CHARACTERISTICS

☐ Sensitivity

☐ Sensibility to a range of circumstances, family contexts and traditions and how those interact in
complex end-of-life care situations

☐ Compassionate

☐ Covenant-based presence *(Note: During the document review two informants expressed concern that
this is open to challenges about meaning and may be poorly understood)*

☐ Non-judgmental

☐ Reflective practitioner

☐ Ability to contain/tolerate ambiguity

☐ Tolerance for sadness

☐ Courage for moving into the suffering of others

☐ Humility – no easy answers/quick solutions – mutual search for meaning

☐ Trust that meaning within chaos/suffering exists *(note: During the document review one informant
expressed concern that this bullet point may not be universally applicable)*

KNOWLEDGE

☐ Range of religious traditions and rituals/rites

☐ Flags for a range of "abuse" circumstances/history

☐ Major non-western cultural considerations/"Flags" in your catchment (e.g., taboos, ambiguities)

☐ Bioethical decision frameworks

☐ Grief and bereavement theory and practices

☐ Family dynamics theory

☐ Self-care strategies

☐ Conflict management theory and practices

☐ Service and program development models and practices

☐ Organizational dynamics in large health care environments

☐ Constructs of "being" "hope" "suffering" and "redemption"

☐ Assessment/protocols appropriate to spiritual care

SKILLS

☐ Leadership in ethical decision making

☐ Patient advocacy and "interests" representation

☐ Mediation

☐ "Boundary" management in personal, family and inter-professional/provider relations

☐ Generic negotiation skills

☐ Active listening and restating/rephrasing for confirmation of understanding

☐ Empathetic listening

☐ Asking open questions to invite open responses for building understanding

☐ Generic counselling skills applied to several different circumstances

☐ Coordination – of people, resources within different care settings

☐ Team work and team building

☐ Effective teaching-learning strategies and methods

☐ Brokering of diverse interests

☐ Generic crisis intervention skills applied to a variety of contexts

☐ Modeling humanistic and compassionate behaviour

☐ Consultative skills

☐ Generic facilitation skills

☐ Facilitate reconciliation

☐ Plan and design interventions for a range of circumstances

☐ Plan/design/conduct applied research

☐ Build and maintain functional caring relationships.

PROFESSIONAL HPC SPIRITUAL CARE PROVIDER

COMMENTS FROM THE KEY INFORMANT (PARTICIPANT) REVIEW AND VALIDATION PROCESS (March 2005)

Introduction

All key informants who were involved in identifying the Major Areas of Responsibility, the Major Tasks, and the Knowledge, Skills, and Characteristics for a Professional HPC Spiritual Care Provider were also asked to review and comment on the output. All participants (see page 03) 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**
RESULTS
Of the 11 DACUM workshop key informants, nine completed the invitation to review the final work product as reflected herein. Of those nine, eight confirmed the document was consistent with their insights shared during the DACUM process. The one key informant who reported the document as inconsistent with personal and professional insights confirmed that B12, E4 and E5 would need to contain "spiritual <u>and religious</u>" in the descriptor language to be consistent with their personal and professional insights. This informant also noted that C5 should contain the language "rites <u>and rituals</u>" to be consistent with their insights. One other key informant, while indicating "consistent" in the report back, also made similar notes about the inclusion of "spiritual/<u>religious</u>" language for G2. The same respondent suggested that H2 incorporate language "memorial/<u>funeral</u>" services. The chart has not been altered as that is inconsistent with the consensual and jointly negotiated nature of the DACUM workshop process, but rather this space accommodates contextual notes to table dissenting views and clarifying comments.

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)?**
RESULTS
Integrated as explanatory notes in #1 above.

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

RESULTS *Note: Each bullet represents a discrete response from a different key informant. Use of [ ] is added for meaning/linkage.*
- ☐ I have been thinking that we did not have the chance to consider palliative care with children and all of the dynamics and differences with them and their families. Also, HPC for children/adults with intellectual disabilities, or even the elderly with neurological conditions such as Alzheimer Disease, dementias, Parkinson Disease, etc. We need to think of other communication methods – often non-verbal – and other ways of "caring" and understanding the needs of these patients.

- ☐ I think it is important to distinguish between hospice and palliative care since they are different sometimes in urgency, content and process. Often palliative care occurs in acute settings and is spiritual crisis oriented. Hospice care occurs in a more home-like setting and often is related to issues of spiritual formation/growth. I recognize that there is also overlap in both settings. I would suggest a small but important wording change on the title page to read "Professional hospice <u>and</u> palliative care spiritual care provider."

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PROFESSIONAL HPC SPIRITUAL CARE PROVIDER

COMMENTS FROM THE KEY INFORMANT (PARTICIPANT) REVIEW AND VALIDATION PROCESS (March 2005) Continued

☐ I have one main critique about process. I think what is missing is <u>who</u> we are <u>as rooted in ministry.</u> DACUM is a valuable exercise in detailing and distilling our function as chaplains. However, what we do and why we do what we do is rooted in our <u>way of being.</u> This foundational understanding is missed in the document. I believe that it needs to be visited by the group and developed as a necessary prologue. I summed up this critique at the end of the DACUM session: Is there room for the religious soul? I do not feel that there is." What I meant is that I did not feel that we, as a whole, <u>gave enough credence to the religious nature of our identity, roots and mission.</u> Why, in other words, are we chaplains doing this and not psychologists? What makes us different from physicians who can adopt these practices or social workers? I believe the answer is an ontological one; it lies in <u>Who</u> we are rather than what we do; I am a chaplain rather another HCP [provider] and it is <u>the difference in identify</u> that I feel is missing from this document. The discussion around identity is, I believe, a crucial one.

☐ It seems that our role as "religious" care providers has been gravely overlooked. I know we decided to call ourselves as spiritual care providers for many reasons but that does not mean that we are not divorcing ourselves of our religious obligations. The document reads as though we are trying hard not to offend the people of multi-faiths that we serve but I still think that many see us as religious care providers as well. It has to be both. The arts has [also] been missed throughout. [Should have a task that reads] "Provide art or music therapy (interventions) to help patients tap into their soul/spiritual well being."

☐ I feel it is important to include the term "multi-faith" in this document. Perhaps in [band] "A" or "B" – culturally sensitive and multi-faith spiritual care. I realize that there will be further discussions about this so if this is not the place for such comments I will bring it up in [the future].

☐ I think the DACUM chart fairly reflects the output of the workshop.

I believe under *Appendix A: Knowledge* it would be helpful to add the following:

- o Developmental landmarks and tasks for the end of life (e.g., work Dr. Ira Byrock & Rev. Carl Nighswonger).
- o Construct of *spiritual pain* and/or *spiritual distress*
- o Knowledge of spiritual practices that connect the dying to the sacred.

I believe under *Appendix A. Characteristics* the following could be added:
- o Comfort in addressing spiritual and religious issues
- o Recognition that dying and caring for the dying can be transformative

☐ The purpose of the four categories at the end of the document "Characteristics," "Knowledge," "Skills" and "Parking Lot" [removed] within the context of the whole chart seems unclear. They are, of course, incomplete because they were only incidental to our discussion.

Future Development of this Document

This DACUM report is intended as a "living document," representing a snap shot in time of a representative group of primary health care professionals from primary care and rural practices with a significant palliative care component. Comments and suggestions about the Major Areas of Responsibilities, Major Tasks, and Knowledge, Skills, and Characteristics of HPC Spiritual Care Providers can be sent by email to: Michael Aherne at michael.aherne@pallium.ca