Supportive Care of the Dying: A Coalition for Compassionate Care

Organizational Assessment: Personnel Competency / Performance

The competency statements in this document are derived from the messages of the participants in the Living and Healing During Life-threatening Illness research work. They were described by participants as important competencies for caregivers to possess. They are presented along with assumptions about their use.

Objectives:

• To describe competencies required for care giving professionals who care for those affected by life-threatening illness
• To build on the Data from Living and Healing During Life-threatening illness in developing those competencies
• To create a set of measurable criteria and standards of performance

Assumptions:

• Criteria must be flexible and adaptable
• Organizations already have tools that can be modified to include these criteria and feedback mechanisms
• Criteria must include non burdensome evidence strategies

Definitions

• Performance: Includes knowledge, skills, capability, and consistent demonstration of indicator.
• Evaluation of Performance: Objective criteria with feedback from appropriate sources including self.

AREAS:
Competency areas are drawn from the Modified City of Hope Questionnaires
Physical
Spiritual
Emotional
Relationship
Communication and sub categories
System Negotiation
Care Delivery
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Competency Standards

These standards are written so they may be applied to all professionals who provide care at the end of life. This includes physicians, nurses, unlicensed personnel, social workers, therapists, spiritual care staff, volunteers, and others as appropriate within their scope of practice. It is assumed that these are supplementary to competencies required of the person to provide excellent clinical care.

Evidence of competency and performance may be obtained as follows:

- Observation of person’s performance
- Interview / feedback from patients and families
- Case presentations
- Self rating
- Peer review
- Chart reviews of specified patients

We recommend review of performance annually, semi annually, or with significant evidence of excellence in performance and / or opportunities for performance improvement. This feedback mechanism will assist professionals to continue to develop their competencies and create an organizational environment of outstanding care for those facing the end of life.

These competencies are described as core competencies for ALL professional caregivers since all practice areas may deal with death and dying.

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<tr>
<th>Competency Focus</th>
<th>Description of Competency</th>
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<tbody>
<tr>
<td>Pain and Symptom Management</td>
<td>Appropriately manages patient pain and other distressing physical symptoms of disease, illness or treatment in a timely manner and achieves outcomes acceptable to the patient / family. Management may include referral to appropriate</td>
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<tr>
<td>Mobile Specialty</td>
<td>Description</td>
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<td>specialist and / or acceptance and support of the patient’s decision to include complementary therapies in treatment.</td>
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| Emotional | Supports patient and family expression of emotional needs. Listens actively, supports as appropriate, and refers to support groups, other patients and families with similar conditions, and / or professionals with expertise in this area. May use open-ended questions such as "How are you doing? How are things going in your life? What, if anything, are you feeling anxious about?" |

| Psychosocial | Provides an environment to support patient and family expression of psychosocial needs. Listens actively, supports as appropriate, and refers to support groups, other patients and families with similar conditions, and / or professionals with expertise in this area. Integrates this area with each interaction. May use open-ended questions such as "How are you doing? How are things going in your life? How have things changed for you in your life? How are your spirits?" |

| Spiritual / Cultural | Manages interactions to support patient and family expression of spiritual needs and strengths and cultural practices. Creates environment that allows integration of dialogue about spiritual issues within care experience. Refers to spiritual care staff and community resources as congruent with patient / family values. Communicates cultural care preferences to others. May use questions such as "What is the meaning of this illness to you and for your life? What lessons would you want to share? How has your sense of time changed? What strength have
| Relationship - Family and Community | Addresses desires and needs for support from family and friends. Determines if there has been a change in family communication. Facilitates family communication of specific issues by structure of interactions. Provides anticipatory guidance for family as they focus on their relationships. This may include reconciliation of relationships. Provides helpful tools and / or refers for assistance with family communication. May use questions such as "How have things been within your family? What messages do you want to give to each other before death occurs? How much change has occurred with your social relationships outside the family?"

| Honoring Patient Care Wishes | Understands and communicates patient and family end of life care wishes prior to crises or impending death. Honors wishes as care goals change from cure to comfort care. Only carries out interventions that make a difference for patient comfort and / or recovery. Supports patient and family when treatments are refused. Provides welcoming environment for family to stay with patient.

| Dying and Death | Identifies those who are approaching last days of living. Communicates honestly to patient / family about approaching death and gifts of last days. Speaks of death as natural process not failure of treatment. Determines patient / family wishes regarding place of death and seeks to have death occur where desired. Assists family to give patient permission to die. to say "good bye", and to bring
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<th>After Death</th>
<th>Prepares family for events that occur immediately following death, i.e. select funeral home, make funeral arrangements, notify agencies such as SRS, Medicare, Attorney who handles Estate, financial issues, canceling appointments etc. Hints: This could be presented to the family in a packet of information.</th>
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<tr>
<td>Bereavement</td>
<td>Manages interactions with the bereaved that support communication of clinical concerns and questions as appropriate. Actively initiates referrals for support during bereavement.</td>
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<td>Relationship</td>
<td>Establishes rapport with patient and family. Is viewed as &quot;present, really listening, caring, and trustworthy&quot;. Initiates contact with bereaved family as appropriate to relationship.</td>
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<td>Communication</td>
<td>Is available physically and mentally for patient and family communication. Delivers difficult information in honest clear manner. Maintains hope by focusing on palliative care when cure no longer possible. Focuses on helping patient / family live in way meaningful to them.</td>
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<td>Teaching</td>
<td>Assesses for knowledge and questions. Refers to appropriate resources for additional information and support. Provides anticipatory guidance about illness, treatments, possible outcomes, and health system issues.</td>
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<td>Team Collaboration</td>
<td>Provides care with a team approach that includes patient and family as integral and essential members of the care team.</td>
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