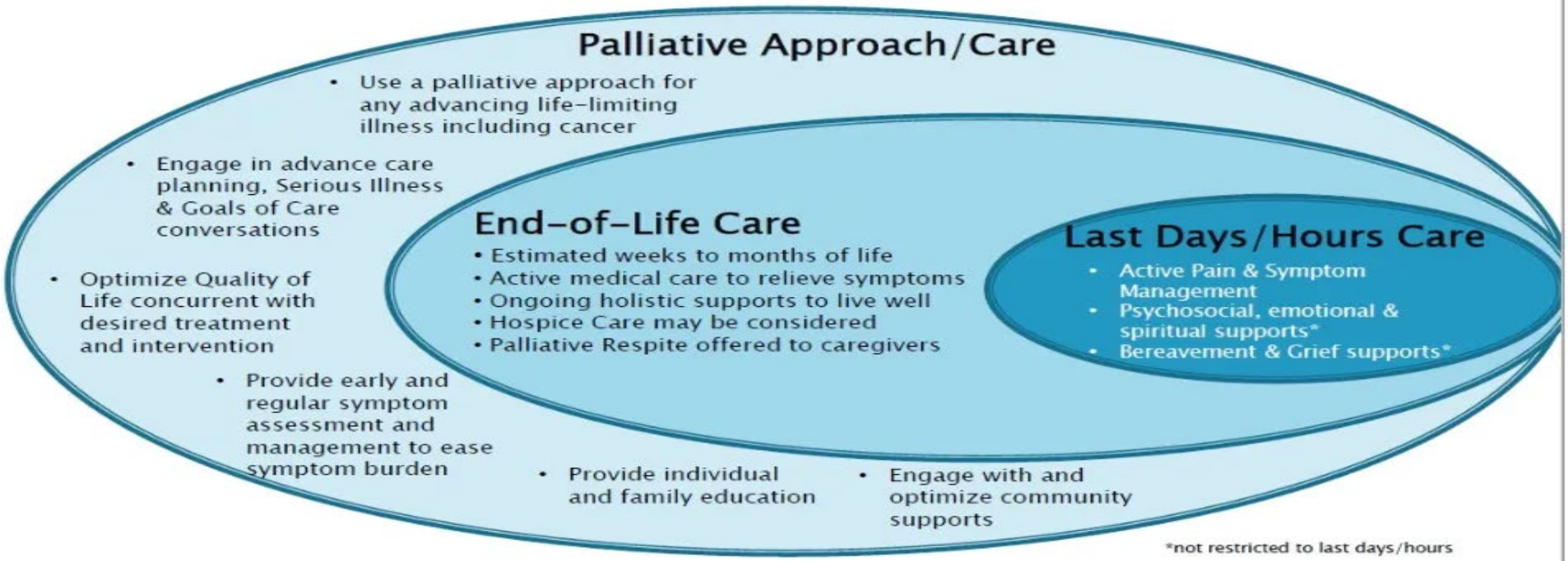
Roles of the Community Nurse in Timely Palliative Care for the Frail and Chronic Sick Elders

Who are the Community Nurses

‘Integrated’ Regional Health System (RHS)

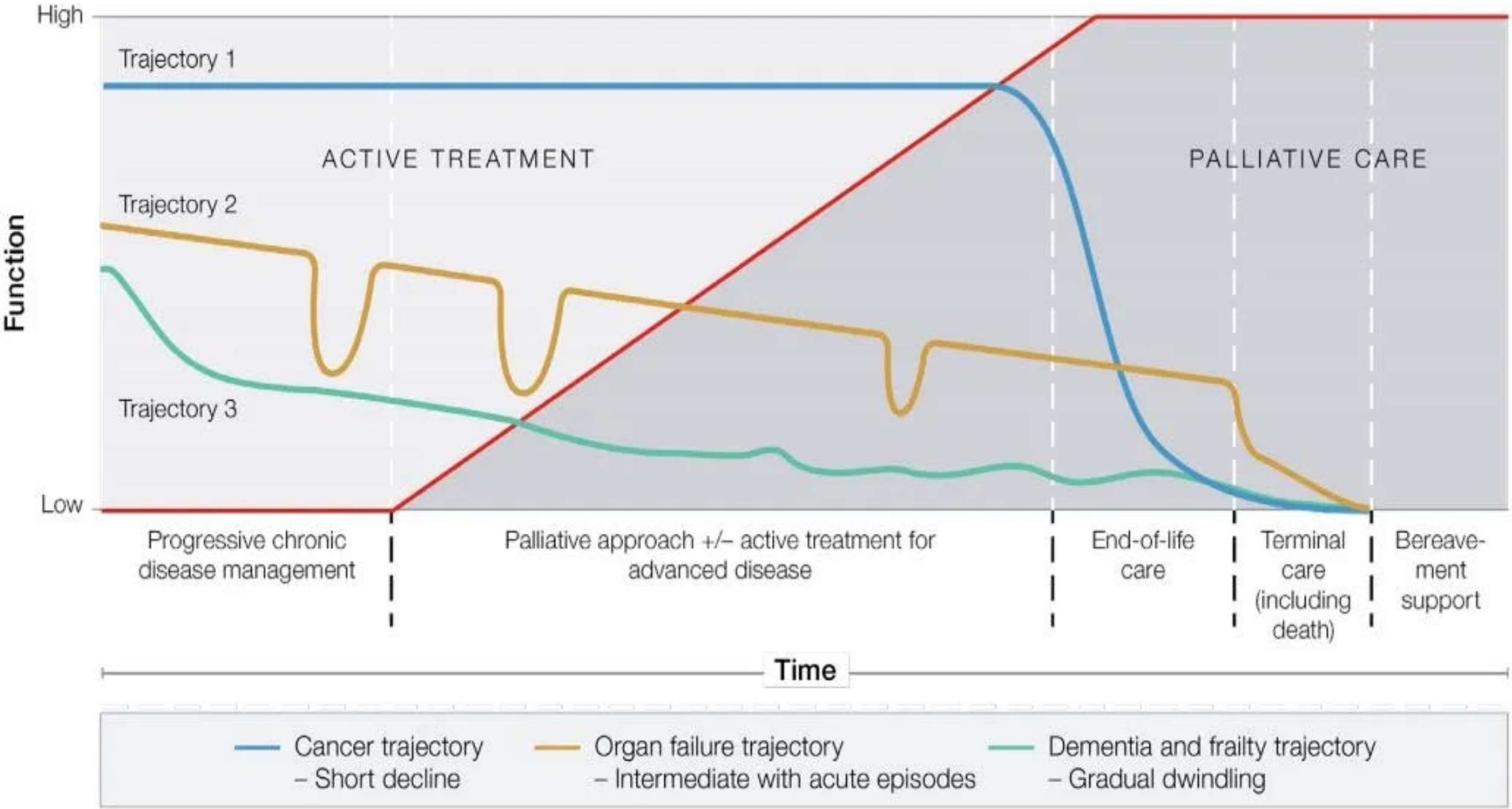
Differentiating and Understanding the Palliative Continuum:

Palliative Approach/Care vs. End-of-Life Care vs. Last Days/Hours Care



*not restricted to last days/hours

Original Source:
BC Palliative Centre for Excellence, June 26th, 2013
Updated: Interior Health, July 2019


High
Low
Function
Trajectory 1
Trajectory 2
Trajectory 3
ACTIVE TREATMENT
PALLIATIVE CARE
Progressive chronic disease management
Palliative approach +/– active treatment for advanced disease
End-of-life care
Terminal care (including death)
Bereave-ment support
Time
Cancer trajectory – Short decline
Organ failure trajectory – Intermediate with acute episodes
Dementia and frailty trajectory – Gradual dwindling

Frailty degree and illness trajectories in older people towards the end-of-life: a prospective observational study

Jordi Amblàs-Novellas ,[1,2,3,4] Scott A Murray ,[5] Ramon Oller ,[6] Anna Torné ,[1,3] Joan Carles Martori ,[6] Sébastien Moine,[5] Nadina Latorre-Vallbona,[1,3] Joan Espaulella ,[1,2,3] Sebastià J Santaeugènia ,[1,4] Xavier Gómez-Batiste [1,2]

ABSTRACT

Objectives To assess the degree of frailty in older people with different advanced diseases and its relationship with end-of-life illness trajectories and survival.

Methods Prospective, observational study, including all patients admitted to the Acute Geriatric Unit of the University Hospital of Vic (Spain) during 12 consecutive months (2014–2015), followed for up to 2 years. Participants were identified as end-of-life people (EOLp) using the NECPAL (*NECesidades PALiativas*, palliative care needs) tool and were classified according to their dominant illness trajectory. The Frail-VIG index (*Valoración Integral Geriátrica*, Comprehensive Geriatric Assessment) was

Strengths and limitations of this study

- To our knowledge, this is the first study that evaluated the degree of frailty using a frailty index in older patients with different advanced illness trajectories.
- This is a real-life study, using tools routinely applied in the Acute Geriatric Unit conducting this study, the NECPAL, to identify people with palliative care needs, and the Frail-VIG index, to measure the degree of frailty and personalisation of the interventions.
- In this context, assessing frailty degree may contribute to establish a common language between geriatric and palliative knowledge, with the goal of

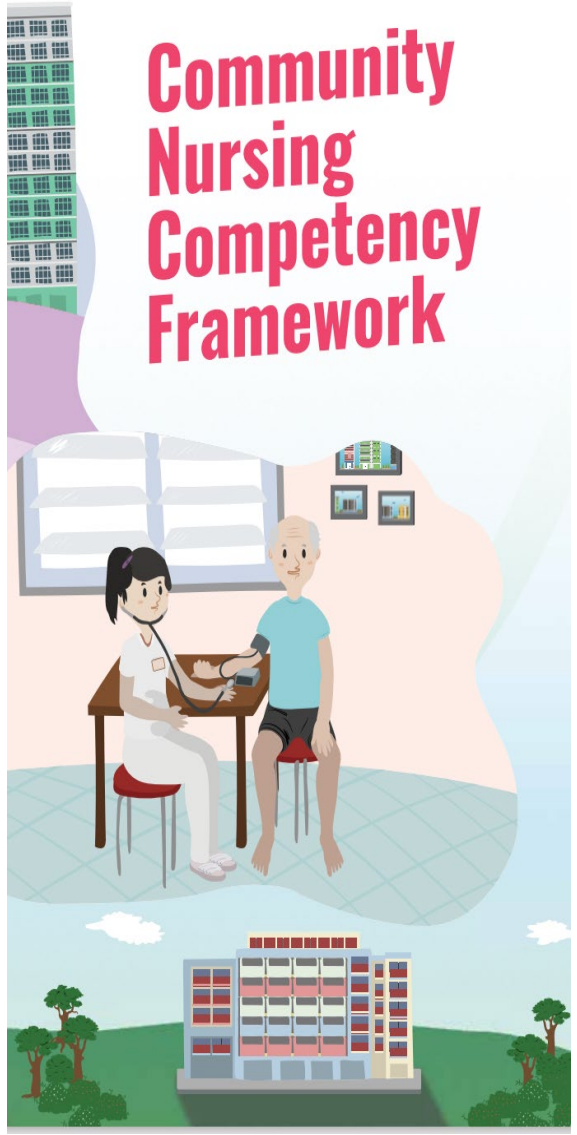
Comprehensive Palliative Care

- Symptom Assessment & Management
- Psycho-emotional Assessment & Care
- Social Assessment & Care
- Spiritual Assessment & Care
- Financial Assessment & Assistance

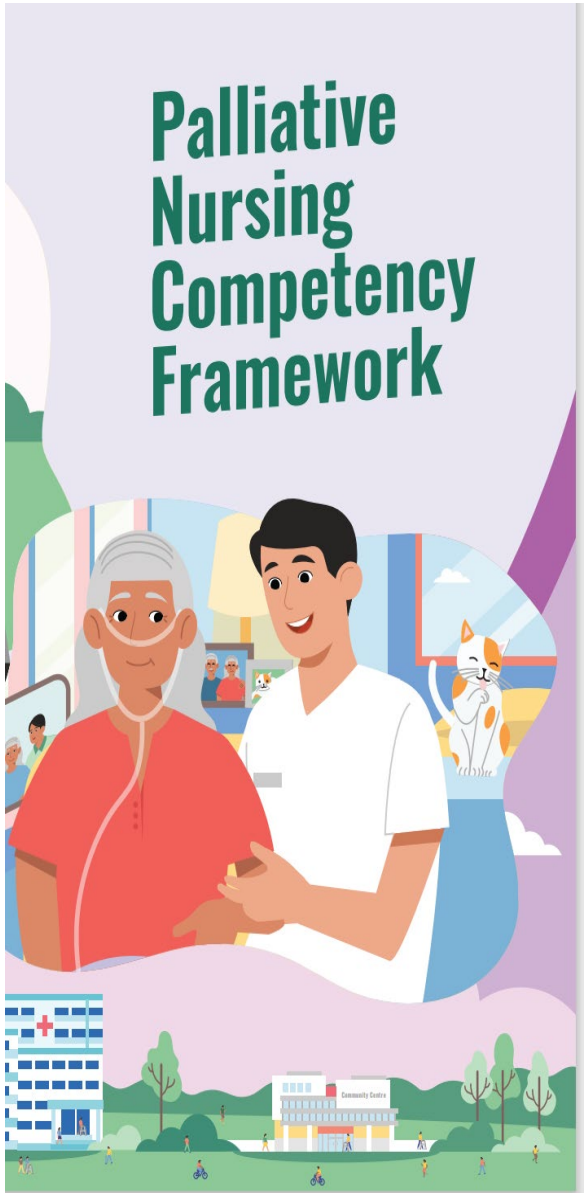
(Picture taken from DPH Annual Report, 2013)

- Therapies, e.g. PT, OT, MT, AT
- Nursing Care

- Advance Care Planning
- Case Management/ Collaboration
- Patients/ Primary Caregivers Education
- Death Preparation
- Grief & Bereavement Support



+



=

Professional Competencies for Community Nurses providing 'Generalist Palliative Care'?

Community Nursing Competency Framework

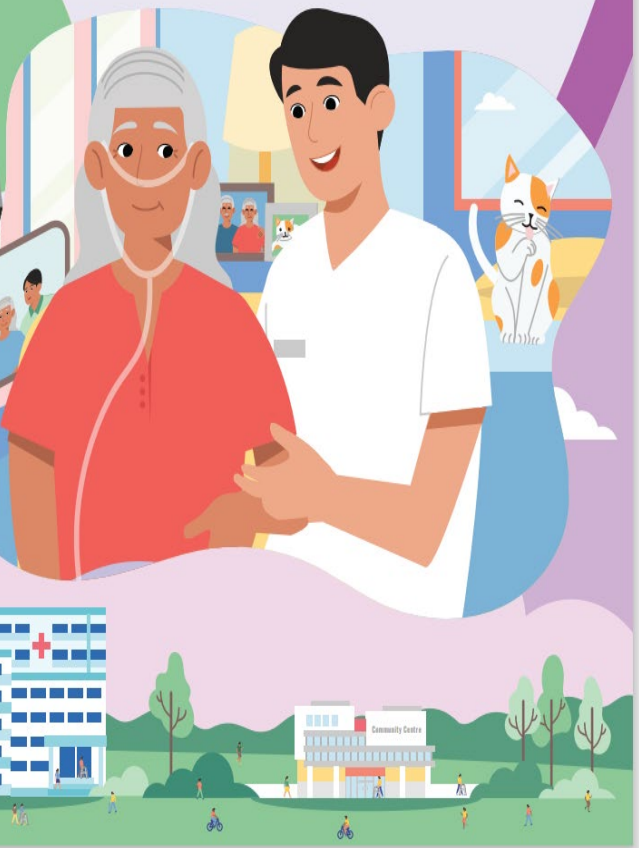
PROFESSIONAL COMPETENCIES (PC)

A total of 12 PCs have been developed for the community nursing sector. All PCs that are developed for this framework are organised into 4 competency domains. The Person-Centred Care competency domain is further organised into 5 competency sub-domains which reflect the focus of this framework as aforementioned.

Overview of the Community Nursing Competency Framework (CNCF)

COMPETENCY DOMAIN		COMPETENCY ELEMENT	DEFINITION OF COMPETENCY ELEMENT
D1. Person-Centred Care*			
D1.1 Clinical Care Management	E1	Client Assessment and Care Planning	Perform biopsychosocial and environment assessment of clients in order to develop an individualised care plan
	E2	Management of Individuals with Health Conditions	Implement holistic evidence-based nursing interventions to manage clients' heath conditions in consideration of care goals and preferences
	E3	Medication Management	Perform and advocate safe use, administration and prescription of medication in accordance with policies, procedures and regulations
D1.2 Engagement and Empowerment	E4	Client, Family and Caregiver Education and Empowerment	Enable clients, families and/or caregivers to recognise assets and responsibilities to promote self-management of health and wellbeing
D1.3 Care Transition and Integration	E5	Care Transition Across Care Continuum	Facilitate and manage the transition of clients across care settings and/or levels of care to ensure coordination and continuity of care
D1.4 Communication and Collaboration	E6	Communication, Collaboration And Teamwork	Utilise engagement strategies to work together on a common goal towards the health and well-being of clients and the community
D1.5 Safety and Risk Management	E7	Client and Environment Safety and Risk Management	Identify and mitigate factors affecting clients' care, well-being and safety
D2. Population-based Practice	E8	Population-based Practice	Assess and prioritise health risks, needs and resources to develop, implement and evaluate strategies for optimising health outcomes of population segments
D3. Professional Development and Leadership	E9	Develop and Lead Self	Develop awareness of one's role and abilities, enhance capabilities and manage behaviours and practice to achieve professional and/or organisational goals
	E10	Develop and Lead Others	Drive change, foster a collaborative culture; cultivate dynamic and competent care teams and networks to shape the community care landscape
D4: Improvement, Innovation and Research	E11	Innovation and Quality Improvement	Develop and implement new and improved technologies, services, delivery methods and processes to drive value-based care in the community
	E12	Evidence-based Practice and Research	Integrate best practices and research evidence in the delivery of care to achieve optimal client and population outcomes

Palliative Nursing Competency Framework



Overview of the Palliative Nursing Competency Framework (PNCF)

COMPETENCY DOMAIN		COMPETENCY ELEMENT	DEFINITION OF COMPETENCY ELEMENT
D1. Person-Centred Care *	**E1**	Client Assessment and Care Planning	Perform biopsychosocial, spiritual and environmental assessments of clients in order to develop an individualised care plan using a person-centred care approach
	E2	Management of Individuals with Health Conditions	Implement holistic, evidence-based nursing interventions to manage clients' health conditions requiring palliative care, considering care goals and client preferences
	E3	Medication Management	Perform and advocate safe use, administration and prescription of medication in accordance with policies, procedures and regulations
	E4	Client, Family and Caregiver Education and Empowerment	Enable clients, families and / or caregivers to recognise assets and responsibilities to promote self-management of health and wellbeing
	E5	Care Transition Across Care Continuum	Facilitate and manage the transition of clients across care settings and / or levels of care to ensure coordination and continuity of care
	E6	Communication, Collaboration and Teamwork	Utilise engagement strategies to work together on a common goal towards the health and wellbeing of clients, families and the community
	E7	Client and Environment Safety and Risk Management	Identify and mitigate factors affecting clients' care, wellbeing and safety
D2. Wellbeing and Supportive Care *	**E8**	Grief and Bereavement Support	Identify and facilitate grief and bereavement support and maintain client and caregivers' wellness
	E9	Client, Family and Caregiver Mental Wellbeing	Enable clients, families and caregivers to reflect and recognise assets and responsibilities to support their own wellbeing and self-care
	E10	Staff Support	Support staff by providing team members opportunities for self-reflection, effective self-care strategies, and organisational staff support structures
D3. Professional Development and Leadership	**E11**	Develop and Lead Self	Develop awareness of one's roles, responsibilities and abilities, enhance capabilities and manage behaviour and practice to achieve professional and / or organisational goals
	E12	Develop and Lead Others	Drive change and foster a collaborative culture; cultivate dynamic and competent care teams and networks to shape the palliative care landscape
D4. Improvement, Innovation and Research	**E13**	Innovation and Quality Improvement	Develop and implement new and improved technologies, services, delivery methods and processes to drive value-based care for clients and families facing life-limiting illnesses
	E14	Evidence-based Practice and Research	Integrate best practices and research evidence in the delivery of palliative care to achieve optimal outcomes

Palliative Care Provider Class Descriptions

Class A Providers are those whose substantive work is not in caring for patients with life--limiting illnesses, but who will encounter them in the course of work. E.g., Polyclinics, outpatient clinics, GW in restructured and community hospitals

Class B Providers are those who routinely care for a substantive number of patients with life--limiting illness. These include staff of chronic disease management programs, intensive care units, specialist cancer units, geriatric units, home care providers and nursing homes.

Class C Providers are those who care solely for patients with life--limiting illness. These include palliative care teams in restructured and community hospitals, inpatient hospices and hospice home care and hospice day care.

 ***Level 1 - Palliative Care Approach****	Palliative care principles should be practised by all levels of the nursing team. The palliative care approach should be a core skill of every nursing team at the hospital and community level. For difficult or complex cases, referral to a specialist palliative care unit will be needed.
 ***Level 2 - Trained Palliative Care***	At an intermediate level, a proportion of individuals and families will benefit from the expertise of healthcare professionals who, although not engaged full time in palliative care, have had some additional training and experience in palliative care. This level of expertise may be available in restructured and community hospitals or community settings. Healthcare professionals who wish to undertake additional training in palliative care should be supported in this regard by the employing organisation and approved by the Singapore Nursing Board.
 ***Level 3 - Specialist Palliative Care***	Specialist palliative care services are those services whose core activity is limited to the provision of palliative care. Complex needs will warrant specialist care, and staff at this level will require advanced training. Specialist palliative care services will mostly be found at the restructured hospitals, inpatient hospice, day care and home care.

Objectives of the Palliative Nursing Competency Framework

- Provide up-to-date and forward-looking information on existing and emerging job roles, skills and competencies
  - Clarity on expectation
  - Align the industry standards in palliative nursing care in Singapore

- Guide the enhancement of education and training programmes for the sector
  - Set reference and expectation
  - Identify skills and manpower gaps
  - Identify training needs
  - Review and strengthen existing education and training programmes
  - Develop training roadmaps for greater professional development
  - Guide the planning and capability building of the palliative care workforce

2 Key components of PNCF:

1. Job role profiles (JRPs)

- Job role description
- Key responsibility areas and activities
- Professional competencies

2. Professional Competencies (PCs)

- Competency domain
- Competency element and definition
- Definition of the 4 proficiency levels
- PCs for each competency element

Overview of the Palliative Nursing Competency Framework (PNCF)

COMPETENCY DOMAIN		COMPETENCY ELEMENT	DEFINITION OF COMPETENCY ELEMENT
D1. Person-Centred Care	**E1**	Client Assessment and Care Planning	Perform biopsychosocial, spiritual and environmental assessments of clients in order to develop an individualised care plan using a person-centred care approach
	E2	Management of Individuals with Health Conditions	Implement holistic, evidence-based nursing interventions to manage clients' health conditions requiring palliative care, considering care goals and client preferences
	E3	Medication Management	Perform and advocate safe use, administration and prescription of medication in accordance with policies, procedures and regulations
	E4	Client, Family and Caregiver Education and Empowerment	Enable clients, families and / or caregivers to recognise assets and responsibilities to promote self-management of health and wellbeing
	E5	Care Transition Across Care Continuum	Facilitate and manage the transition of clients across care settings and / or levels of care to ensure coordination and continuity of care
	E6	Communication, Collaboration and Teamwork	Utilise engagement strategies to work together on a common goal towards the health and wellbeing of clients, families and the community
	E7	Client and Environment Safety and Risk Management	Identify and mitigate factors affecting clients' care, wellbeing and safety
D2. Wellbeing and Supportive Care	**E8**	Grief and Bereavement Support	Identify and facilitate grief and bereavement support and maintain client and caregivers' wellness
	E9	Client, Family and Caregiver Mental Wellbeing	Enable clients, families and caregivers to reflect and recognise assets and responsibilities to support their own wellbeing and self-care
	E10	Staff Support	Support staff by providing team members opportunities for self-reflection, effective self-care strategies, and organisational staff support structures
D3. Professional Development and Leadership	**E11**	Develop and Lead Self	Develop awareness of one's roles, responsibilities and abilities, enhance capabilities and manage behaviour and practice to achieve professional and / or organisational goals
	E12	Develop and Lead Others	Drive change and foster a collaborative culture; cultivate dynamic and competent care teams and networks to shape the palliative care landscape
D4. Improvement, Innovation and Research	**E13**	Innovation and Quality Improvement	Develop and implement new and improved technologies, services, delivery methods and processes to drive value-based care for clients and families facing life-limiting illnesses
	E14	Evidence-based Practice and Research	Integrate best practices and research evidence in the delivery of palliative care to achieve optimal outcomes

Definition of the 4 Proficiency Levels

Within each competency domain are specific competency elements expressed in ascending levels of expertise, where Level 1 marks the most basic level of proficiency and Level 4, advanced level proficiency.

LEVEL	RESPONSIBILITY (Degree of supervision and accountability)	AUTONOMY (Degree of decision-making)	COMPLEXITY (Degree of difficulty of situation and tasks)	KNOWLEDGE AND ABILITIES (Required to support work as described under Responsibility, Autonomy and Complexity)
4	Accountable for significant area of work, strategy or overall direction	Empowered to chart direction and practices within and outside of work (including professional field / community), to achieve / exceed work results	Highly Complex	• Synthesise knowledge in a field of work and the interface between different fields, and create new forms of knowledge • Employ advanced skills to solve critical problems and formulate new structures, and / or redefine existing knowledge or professional practice • Demonstrate exemplary ability to innovate and formulate ideas and structures • Demonstrate ability to lead both individuals and teams in promoting best practices • Lead research to inform evidence in clinical care and quality management
3	Accountable for achieving assigned objectives, decisions made by self and others	Provide leadership to achieve desired work results; manage resources, set milestones and drive work	Complex	• Evaluate factual and advanced conceptual knowledge within a field of work, involving a critical understanding of theories and principles • Select and apply an advanced range of cognitive and technical skills, demonstrating mastery and innovation, to devise solutions for complex and unpredictable problems in a specialised field of work • Manage and drive complex work activities
2	Work under broad direction May hold some accountability for performance of others, in addition to self	Use discretion in identifying and responding to issues, work with others and contribute to work performance	Non-routine (may not have precedence)	• Select and apply a range of cognitive and technical skills to solve non-routine / abstract problems • Apply relevant procedural and conceptual knowledge and skills to perform differentiated work activities and manage changes • Able to collaborate with others to identify value-adding opportunities
1	Work with some supervision Accountable for tasks assigned	Use limited discretion in resolving issues or enquiries. Requires occasional to frequent guidance	Routine (has precedence)	• Understand and apply factual and procedural knowledge in a field of work • Apply basic skills to carry out defined tasks • Identify opportunities for minor adjustments to work tasks

Each PC document includes the following:

- **Competency Domain**
- **Competency Element**
- **Definition of Competency Element**
- **Proficiency Level Description of Competency Element**
- **Knowledge**
- **Abilities**
- **Sources of Information**

The 14 PCs developed for the PNCF are shown in the following pages.

Competency Domain	Competency Element	Definition of Competency Element		
D1 Person-centred Care	E1 Client Assessment and Care Planning	Perform biopsychosocial, spiritual and environmental assessments of clients in order to develop an individualised care plan using a person-centred care approach		
Proficiency Level	**Level 1**	**Level 2**	**Level 3**	**Level 4**
Description of Competency Element	Assist in biopsychosocial and spiritual assessments for clients to contribute to the formulation of individualised care plans	Formulate individualised care plans by conducting biopsychosocial, spiritual and environmental assessments	Formulate individualised care plans by conducting biopsychosocial, spiritual and environmental assessment for clients with complex care needs	Develop and review protocols for assessment, review outcomes and revise care plans appropriately
Knowledge	• Principles and philosophy of palliative care • Concept of quality of life • Stage of dying • Common trajectory of life-limiting conditions • Concept of person-centred care • Basic pain assessment • Basic assessment of other common symptoms • Basic spiritual assessment • Basic psychosocial and cultural assessment • Basic environmental assessment for safety • Different types of palliative care services and community resources	• Principles and philosophy of palliative care • Concept of quality of life • Stage of dying • Common trajectory of life-limiting conditions including cancer and non-cancer • Concept of person-centred care • Knowledge of prognostication • Comprehensive pain assessment including total pain • Holistic assessment • Comprehensive assessment for common symptoms • Spiritual distress screening tool • Types of psychosocial and cultural assessment tools • Comprehensive environmental	• Principles and philosophy of palliative care • Concept of quality of life • Stage of dying • Common trajectory of life-limiting conditions including cancer and non-cancer • Concept of person-centred care • Advanced knowledge of prognostication • Comprehensive pain assessment including total pain • Comprehensive assessment for common symptoms • Assessment for psychosocial, spiritual and cultural wellbeing using appropriate tools • Comprehensive environmental assessment	• Principles and philosophy of palliative care • Concept of quality of life • Assessment of complex issues on the stage of dying • Common trajectory of life-limiting conditions including cancer and non-cancer • Concept of person-centred care • Knowledge of prognostication* • Advanced knowledge of pain and symptom assessment • Advanced knowledge of psychosocial, spiritual, cultural and environmental assessment • Advanced clinical reasoning • Comprehensive assessment on care crisis in palliative care Track emerging palliative care

Competency Domain	Competency Element	Definition of Competency Element		
D1 Person-centred Care	E1 Client Assessment and Care Planning	Perform biopsychosocial, spiritual and environmental assessments of clients in order to develop an individualised care plan using a person-centred care approach		
Proficiency Level	**Level 1**	**Level 2**	**Level 3**	**Level 4**
Abilities	• Recognise clients' disease trajectories • Identify appropriate assessment tools and techniques to assist in biopsychosocial and spiritual assessment • Recognise signs and symptoms of active dying • Recognise and support each client's unique needs, strengths and preferences to ensure individualised care planning • Recognise any abnormalities or distress and report to clinical team where appropriate • Recognise red flags and highlight to care team the need to assess psychosocial and spiritual wellbeing where appropriate • Assist in assessment of pain, dyspnoea and other common symptoms	• Recognise the common life-limiting disease trajectories (cancer and non-cancer) and clients' care needs • Recognise signs and symptoms of active dying • Recognise clients nearing end-of-life and discuss clients' prognosis with clinical team • Initiate assessment for psychosocial, spiritual and cultural needs and concerns at initial consultation and regular intervals, particularly with changes in clinical conditions • Identify early signs of care crisis and suggest solutions or escalate as necessary • Recognise and highlight to care team the need for family conference • Establish goals of care that	• Describe the common life-limiting disease trajectories (cancer and non-cancer) and institute anticipatory care plans • Recommend the use of appropriate assessment tools based on clients' clinical presentation • Perform assessment for psychosocial, spiritual and cultural needs and concerns at initial consultation and regular intervals, particularly with changes in clinical conditions • Use prognostic tools to estimate prognosis with guidance from the clinical team • Formulate and evaluate individualised care plans for clients with complex care needs in collaboration with clients, families and / or caregivers	• Describe the common life-limiting disease trajectories (cancer and non-cancer) and institute anticipatory care plans • Perform comprehensive assessment, diagnostic reasoning and recommend differential diagnosis for clients* • Order investigations, interpret investigation results and recommend basic interventions* • Prescribe non-pharmacological intervention to achieve optimum pain and symptom control • Use prognostic tools to estimate prognosis • Prioritise care goals, develop and evaluate individualised client management plans • Manage clients with care crisis in collaboration with the transdisciplinary team

Competency Domain	Competency Element	Definition of Competency Element		
D2 Wellbeing and Supportive Care	E8 Grief and Bereavement Support	Identify and facilitate grief and bereavement support and maintain client and caregivers' wellness		
Proficiency Level	**Level 1**	**Level 2**	**Level 3**	**Level 4**
Abilities	• Identify the grief and bereavement needs of clients, families and caregivers • Explains and normalises to client, families and caregivers the emotional reactions related to life-threatening illness and loss • Provides emotional support to clients, families and caregivers, referring to other multi-disciplinary teams as appropriate • Recognise the need to refer to a specialised team member for maladaptive coping • Assist in providing brief guidance, support and information to families before, at times of and after death with respect and compassion • Assist in organising and providing information on support services within the organisation for grief and bereavement support • Support using active listening to help bereaved clients, families and caregivers adjust to their grief • Explore and respect the wishes, beliefs and practices associated with loss, grief and bereavement of clients, families and caregivers • Identify and deals with own grief separately from clients, families and caregivers	• Identify the grief and bereavement needs of clients, families and caregivers • Explains and normalises to client, families and caregivers the emotional reactions related to life-threatening illness and loss • Provides emotional support to clients, families and caregivers, referring to other multi-disciplinary teams as appropriate • Recognise the need to refer to a specialised team member for maladaptive coping • Assist in providing brief guidance, support and information to families before, at times of and after death with respect and compassion • Assist in organising and providing information on support services within the organisation for grief and bereavement support • Support using active listening to help bereaved clients, families and caregivers adjust to their grief • Explore and respect the wishes, beliefs and practices associated with loss, grief and bereavement of clients, families and caregivers • Identify and deals with own grief separately from clients, families and caregivers	• Identify signs of complicated grief in clients and manage or refer family to inter-professional team and specialists as needed • Perform a comprehensive assessment of grief and bereavement needs and manages complex situations • Develop and demonstrate an enhanced understanding of the needs of individuals, including children at various development stages, in dealing with grief and loss • Analyse and evaluate grief reactions in clients and their families or caregivers, which may occur from the time of diagnosis until bereavement • Provide guidance, support and information to families before, at times of and after death, and make referrals to bereavement services as required • Develop a care plan for clients, families & caregivers coping with their unique grief reactions to loss and death • Take part in bereavement follow-up with bereaved family or caregiver following the client's death with respect and compassion • Practise critical reflection in managing complicated grief and seek transdisciplinary team support when needs arise • Participate in evidence-based research on grief and bereavement nursing care	• Engage with effective strategies in responding to loss, grief and bereavement • Perform a comprehensive assessment of grief and bereavement needs and manages complex situations • Demonstrate comprehensive understanding of the needs of individuals, including children at various development stages, in dealing with grief and loss • Recognise the differences between grief and depression, provide intervention and refer client and / or family to inter-professional team and specialists as needed • Perform interventions to manage complex grief using advanced skills and / or with the transdisciplinary approach • Support individuals experiencing pathological responses to grief as part of the inter-professional team • Conduct grief counselling for clients and their families or caregivers, which may occur from the time of diagnosis until bereavement • Support and mentor colleagues in the management of loss, grief and bereavement • Facilitate discussion for a proper referral with transdisciplinary team for complicated grief • Facilitate bereavement follow-up with bereaved family or caregiver following the client's death

Fig 1: Illustration of Linkage Between Job Role Profiles and Professional Competencies

Job Role Profile

JOB ROLE PROFILES

NURSE CLINICIAN / SENIOR NURSE CLINICIAN

Job Role Description	The Nurse Clinician / Senior Nurse Clinician is responsible for providing clinical supervision, evaluating care standards and integrating evidence-based practice into their palliative nursing practice. S/He demonstrates clinical expertise and manages clients with complex care needs through direct care or by coaching the care team members. S/He has an understanding of the palliative care population's needs to ensure service alignment.	The Nurse Clinician / Senior Nurse Clinician manages a team of palliative care nurses and is responsible for their professional development. S/He leads quality improvement and research projects within the organisation. S/He cultivates a collaborative team culture and effective learning environment for palliative nurses to achieve clinical excellence and deliver positive client experiences.

	Key Responsibility Area	Key Activities
Responsibilities and Activities (Cont'd)	Nursing Practice Management and Operational Excellence	Analyse health profiles and needs of clients and / or populations and implement services to meet these needs
		Be involved in developing palliative nursing guidelines and protocols to guide clinical and professional practices
		Monitor the palliative nursing team's practice on resource management and recommend strategies to reduce waste in service delivery, care and treatment
		Ensure the appropriateness and cost-effectiveness of practices, equipment and products used for the clients
		Lead quality audits, quality improvement and evidence-based projects e.g. death reviews
		Analyse data from death review and recommend initiatives as required to maintain standard of care practices
		Identify and report potential threats to the practice of ethical and legal principles in palliative nursing service delivery
		Conduct risk assessment to identify risks and safety hazards of palliative nursing practice and implement measures to mitigate risks identified
		Execute responsibilities as per emergency protocols in the event of public health threat or emergency
	People and Personal Development	Conduct formal and informal palliative continuing education and training based on team's learning and professional development needs
		Articulate and communicate the team's purpose and individual's roles and responsibilities
		Identify and support the learning needs of individuals or the team in response to personal development or service needs
		Develop training roadmap for the palliative nurses in one's area of clinical practice
		Encourage the care team to adopt strategies for reflective learning
		Provide clinical supervision and coaching in one's area of clinical practice e.g. onboarding of new staff
		Implement strategies to promote welfare and wellbeing of palliative nurses

	Competency Domain	Competency Element (Proficiency Level)
Professional Competencies	D1. Person-centred Care	E1. Client Assessment and Care Planning (Level 4) E2. Management of Individuals with Health Conditions (Level 4) E3. Medication Management (Level 4) E4. Client, Family and Caregiver Education and Empowerment (Level 4) E5. Care Transition Across Care Continuum (Level 4) E6. Communication, Collaboration and Teamwork (Level 3-4) E7. Client and Environment Safety and Risk Management (Level 3-4)
	D2. Wellbeing and Supportive Care	E8. Conduct Grief and Bereavement Support (Level 3-4) E9. Client, Family and Caregiver Mental Wellbeing (Level 3-4) E10. Staff Support (Level 3)
	D3. Professional Development and Leadership	E11. Develop and Lead Self (Level 3) E12. Develop and Lead Others (Level 3)
	D4. Improvement, Innovation and Research	E13. Innovation and Quality Improvement (Level 3) E14. Evidence-based Practice and Research (Level 3)

20

21

Professional Competencies

PROFESSIONAL COMPETENCIES

Competency Domain	Competency Element	Definition of Competency Element		
D2 Wellbeing and Supportive Care	E10 Staff Support	Support staff by providing team members opportunities for self-reflection, effective self-care strategies, and organisational staff support structures.		
Proficiency Level	**Level 1**	**Level 2**	**Level 3**	**Level 4**
Description of Competency Element	Support team members and provide opportunities for self-reflection and self-care	Coach and support team members; provide opportunities for self and team reflection and self-care	Lead and support team members; provide opportunities for self and team reflection and self-care	Develop and lead the organisation by developing long-term staff support strategies and programmes
Know	• Concepts of compassion fatigue	• Compassion fatigue and burnout	• Compassion fatigue and burnout	• Compassion fatigue and burnout

Competency Domain	Competency Element	Definition of Competency Element		
D2 Wellbeing and Supportive Care	E10 Staff Support	Support staff by providing team members opportunities for self-reflection, effective self-care strategies, and organisational staff support structures.		
Proficiency Level	**Level 1**	**Level 2**	**Level 3**	**Level 4**
Abilities	• Recognise signs of compassion fatigue and burnout in self and others • Recognise spiritual distress in self and peers • Recognise staff who require support and encourage to seek help • Participate and assist in support programmes that are designed to promote staff wellbeing • Build trust and rapport among transdisciplinary team members with open communication • Participate in team debrief • Apply self-care strategies, engage in activities that build resilience and seek help when needed • Contribute in creating a supportive working environment	• Assess for compassion fatigue and burnout in self and others • Identify spiritual distress in self and others • Identify and support staff who require support and seek for help when needs arise • Participate and contribute in support programmes that are designed to promote staff wellbeing • Build trust and rapport among transdisciplinary team members with open communication • Contribute in team debrief • Apply and promote self-care strategies, engage in activities that build resilience and seek help when needed • Promote a supportive working environment	• Develop plan to prevent compassion fatigue and burnout in self and others • Assess spiritual distress in self and others • Provide and evaluate staff support and counselling • Plan, develop and lead support programmes that are designed to promote staff wellbeing • Foster a team culture for open communication • Facilitate team debrief • Mentor and support team on self-care strategies • Build team resilience • Lead a supportive working environment	• Drive programmes to create awareness on compassion fatigue and burnout in the organisation • Evaluate strategies in preventing compassion fatigue and burnout • Drive and evaluate support programmes that are designed to promote staff wellbeing • Evaluate the team culture in the organisation • Lead team debrief • Mentor and coach team on self-care strategies • Collaborate with inter-departments to create policies on staff support programmes • Drive strategies to build team resilience • Create policies to promote a supportive working environment

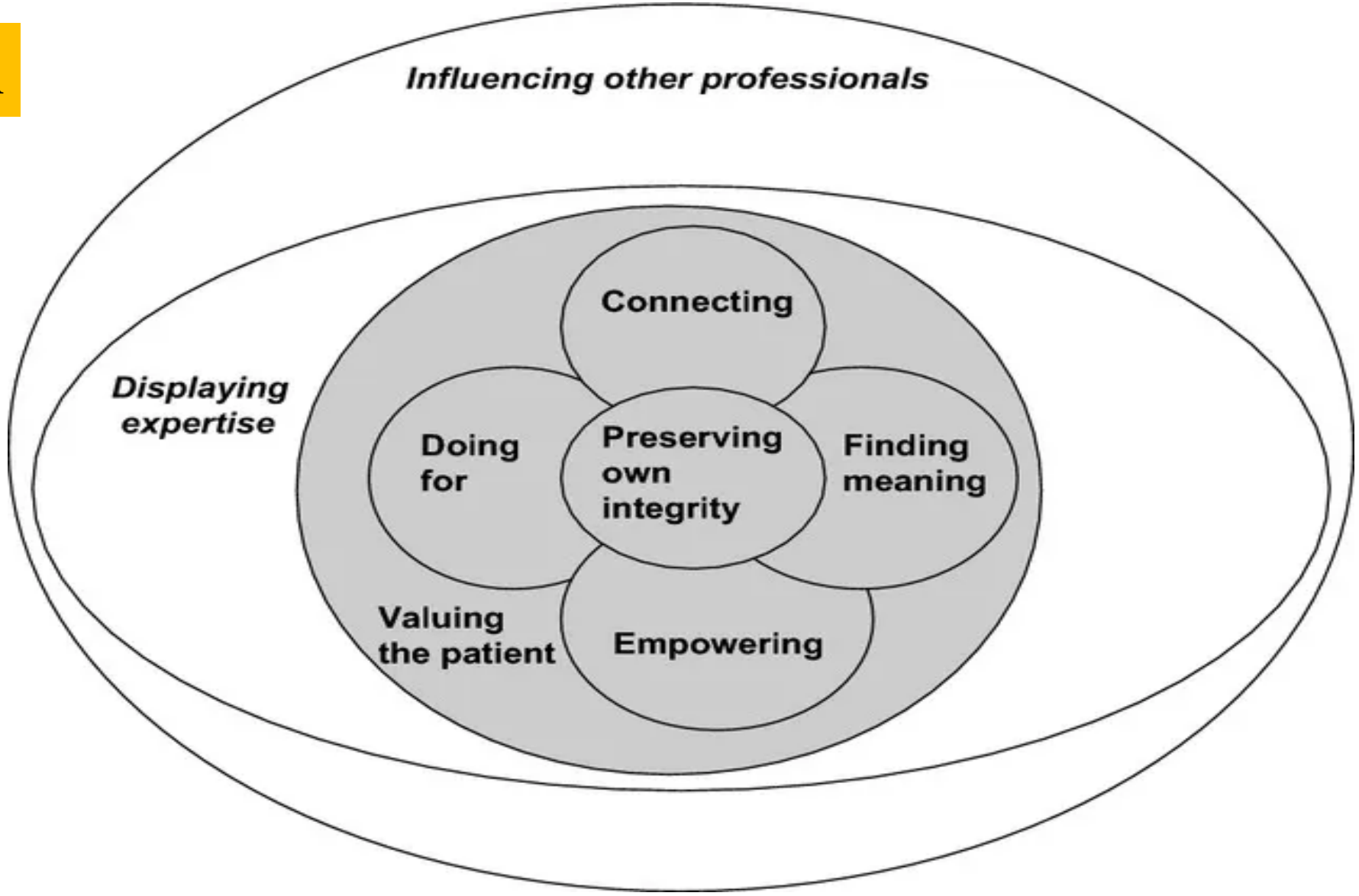
Sources of Information

1. Canadian Partnership Against Cancer & Health Canada. (2021). *The Canadian interdisciplinary palliative care competency framework.* https://s22457.pcdn.co/wp-content/uploads/2021/07/palliative-care-competency-framework-EN.pdf
2. Canning, D., Yates, P., & Rosenberg, J. P. (2005). *Competency standards for specialist palliative care nursing practice.* Brisbane: Queensland University of Technology. https://www.pcna.org.au/PCNA/media/docs/competystds_1.pdf

52

Being a ‘bridge’

Individual Level



(Davies & Oberle, 1990; Newton & McVicar, 2014)

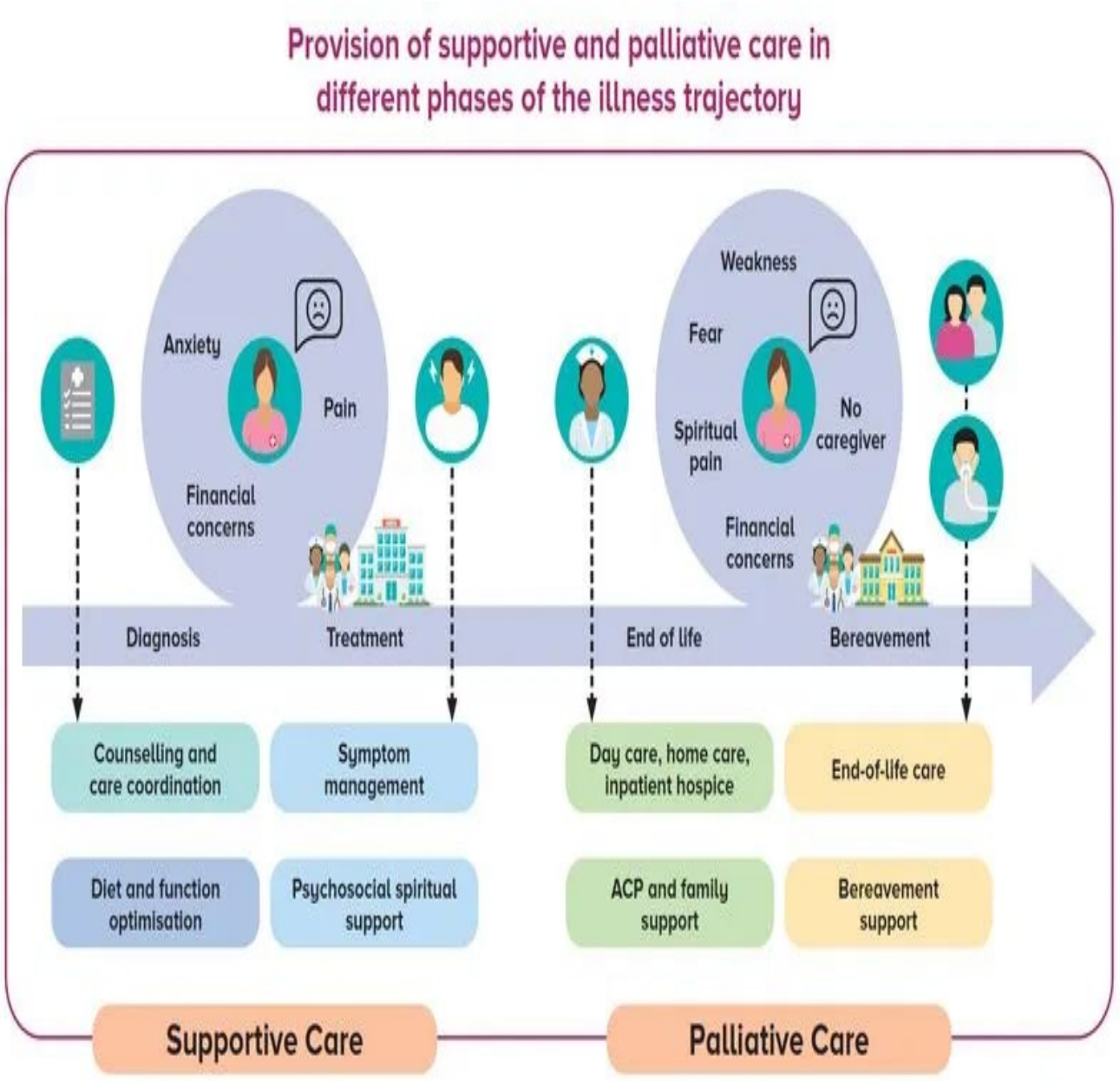
Organizational Level

- Population/ RHS collaboration/ service model – Health & Social sectors

'Finding Champions'

- Generalist-specialist shared care
  - Challenges in ILTC sector (Gaps)
  - Palliative Care knowledge and skills translation/application
    - Clinical mentorship

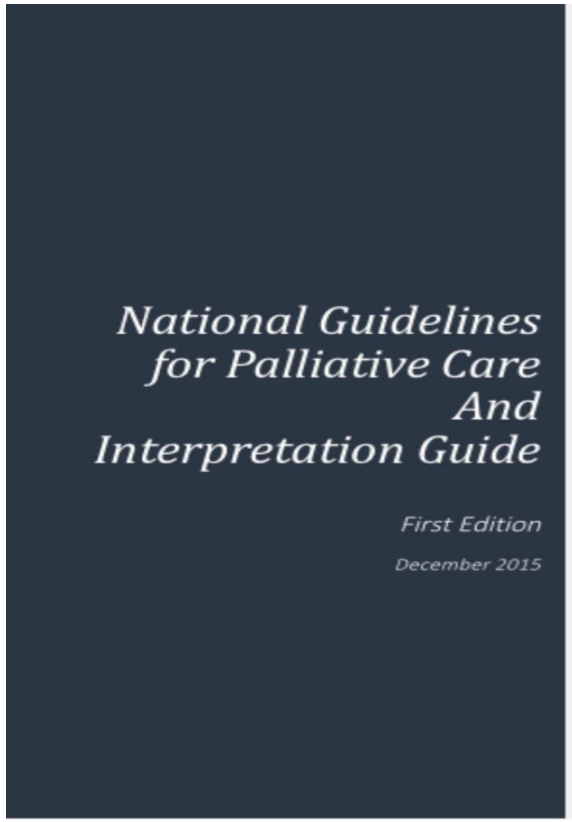
'Collaborative Relationships'

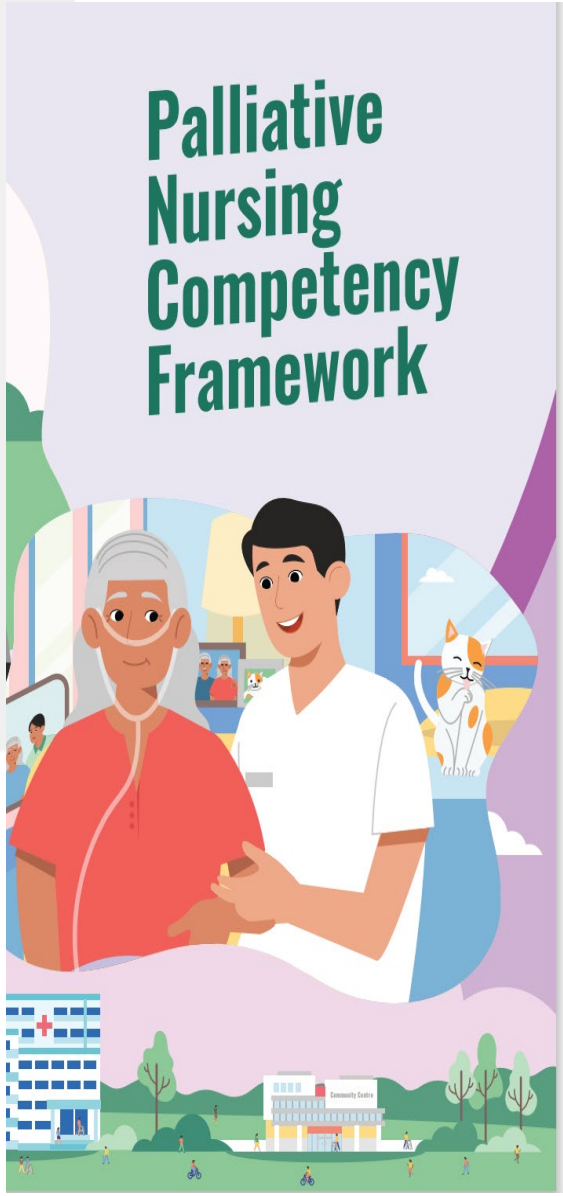


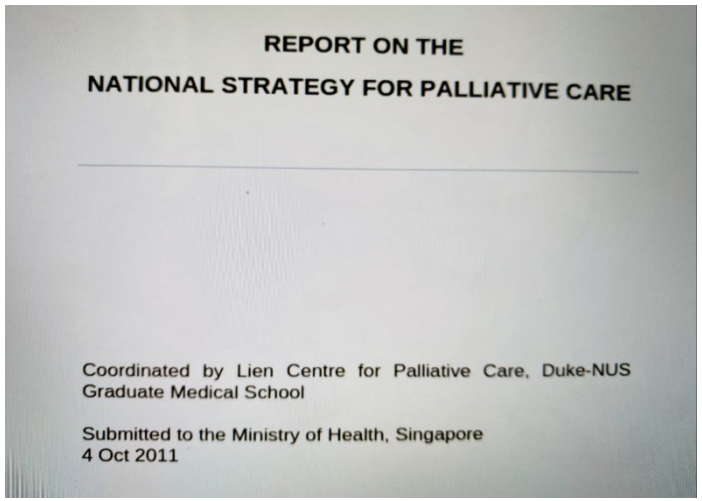
https://www.singhealth.com.sg/news/defining-med/supporting-patients-life-limiting-illness#

National Level

- Palliative Nursing Competency Framework (Oct 2022)
- National Guidelines for Palliative Care and Interpretation Guide (1st Ed, Dec 2015)
- MOH National Strategy for Palliative Care 2011 (currently under review)







References:

- Amblàs-Novellas, J. et al. (2021). Frailty degree and illness trajectories in older people towards the end-of-life: a prospective observational study. BMJ Open;11:e042645. doi:10.1136/bmjopen-2020-04
- Community Nursing Competency Framework (2017). https://www-nna-gov-sg-admin.cwp.sg/docs/default-source/default-document-library/community-nursing-1-6.pdf
- Davies, B. & Oberle, K. (1990). Dimensions of the supportive role of the nurse in palliative care. *Oncol Nurs Forum,* 17(1): 87-94.
- National Strategy for Palliative Care 2011. https://library.singaporehospice.org.sg/?docs=national-strategy-for-palliative-care-2011
- National Guidelines for Palliative Care and Interpretation guide (1st Edition, Dec 2015). https://library.singaporehospice.org.sg/?docs=national-guidelines-for-palliative-care-and-interpretation-guide-1st-edition-dec-2015
- Newton, J. & McVicar, A. (2014). Evaluation of the currency of the Davies and Oberle (1990) model of supportive care in specialist and specialized palliative care settings in England. *Journal of Clinical Nursing, 23(*11-12*):* 1662-76. doi:10.1111/jocn.12301.Epub 2013 Jul 22.
- Palliative Nursing Competency Framework (2022). https://www.nna.gov.sg/resources-tools/nursing-competency-framework/palliative-nursing-competency-framework
- SingHealth Duke-NUS Supportive & Palliative Care Centre (2022, August 15). Supporting patients with life-limiting illness from hospital to community. https://www.singhealth.com.sg/news/defining-med/supporting-patients-life-limiting-illness

Caring till the very end