Postgraduate Education programmes – correct planning and implementation

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SIXTY-SEVENTH WORLD HEALTH ASSEMBLY WHA67.19

Agenda item 15.5 24 May 2014

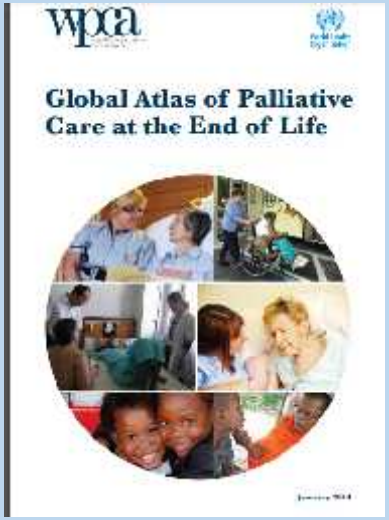
Strengthening of palliative care as a component of comprehensive care throughout the life course

The Sixty-seventh World Health Assembly,

Include palliative care as integral part of ongoing education and training to care providers:

1. Basic training at undergraduate level for all
2. Intermediate to all health care workers routinely working with patients with life limiting illness
3. Specialist training for those who managed integrated care for more than routine symptom management needs

Why?

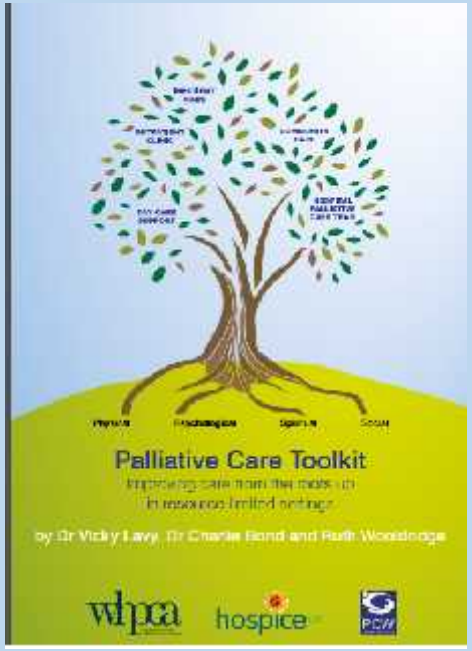


The need for palliative care is increasing as the burden of life limiting illness and suffering is increasing

There is an urgent need to increase the number of palliative care aware health care professionals at all levels

The patient and their family have to be the focus of all education

What?


Palliative Care Toolkit
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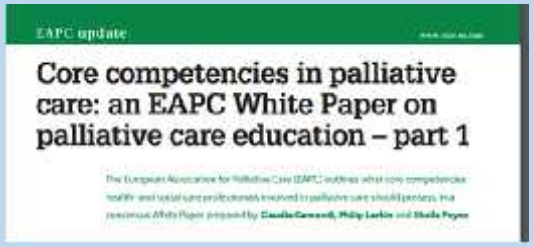
EAPC update
Core competencies in palliative care: an EAPC White Paper on palliative care education – part 1


Specialisation
in Palliative Medicine
for Physicians in Europe 2014
A supplement of the EAPC Atlas
of Palliative Care in Europe


EAPC
European Association for Palliative Care - onlus
www.eapcnet.eu
European Association for Palliative Care
Core competencies for education in
Paediatric Palliative Care
November 2013

EAPC update

Table 1. Agreed levels of education currently adopted by the EAPC to reflect the scope and focus of professionals involved in the delivery of palliative care

Palliative care approach	A way to integrate palliative care methods and procedures in settings not specialised in palliative care. Should be made available to general practitioners and staff in general hospitals, as well as to nursing services and nursing home staff. May be taught through undergraduate learning or through continuing professional development
General palliative care	Provided by primary care professionals and specialists treating patients with life-threatening diseases who have good basic palliative care skills and knowledge. Should be made available to professionals who are involved more frequently in palliative care, such as oncologists or geriatric specialists, but do not provide palliative care as the main focus of their work. Depending on discipline, may be taught at an undergraduate or postgraduate level or through continuing professional development
Specialist palliative care	Provided in services whose main activity is the provision of palliative care. These services generally care for patients with complex and difficult needs and therefore require a higher level of education, staff and other resources. Specialist palliative care is provided by specialised services for patients with complex problems not adequately covered by other treatment options. Usually taught at a postgraduate level and reinforced through continuing professional development

Gamondi C, Larkin P , Payne S
EJPC 2013:20(2) 86-90

Box 1. Core constituents of palliative care

- Autonomy
- Dignity
- Relationship between patient and healthcare professionals
- Quality of life
- Position towards life and death
- Communication
- Public education
- Multiprofessional approach
- Grief and bereavement

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Box 3. Definition of competency[12]

'A competency is: a cluster of related knowledge, skills and attitudes that affects a major part of one's job (a role or responsibility), that correlates with performance on the job, that can be measured against well-accepted standards, and that can be improved via training and development'

Box 4. The ten core competencies in palliative care

1. Apply the core constituents of palliative care in the setting where patients and families are based
2. Enhance physical comfort throughout patients' disease trajectories
3. Meet patients' psychological needs
4. Meet patients' social needs
5. Meet patients' spiritual needs
6. Respond to the needs of family carers in relation to short-, medium- and long-term patient care goals
7. Respond to the challenges of clinical and ethical decision-making in palliative care
8. Practise comprehensive care co-ordination and interdisciplinary teamwork across all settings where palliative care is offered
9. Develop interpersonal and communication skills appropriate to palliative care
10. Practise self-awareness and undergo continuing professional development

EAPC

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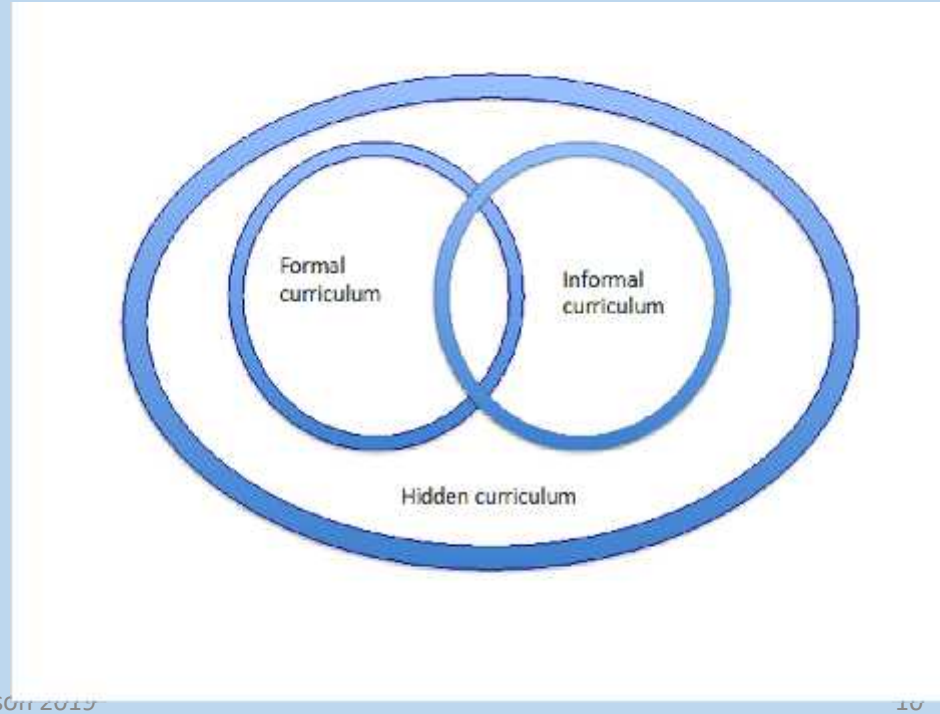
- But consider the setting and context?
- Can you survey learners before ?
- Single topic or collection of topics?
- Is it important to create a qualification or certification for the sessions? – for the learners? For the organisation? – but beware duplication !
- Consider the variety of learning styles of the learner group

The hidden curriculum

A **hidden curriculum** is a side effect of an education - lessons which are learned but not openly intended" such as the transmission of norms, values, and beliefs conveyed in the classroom and the social environment



Who - learners?

- Consider priorities for the setting and aspiration of the educating organisation….
- Multiprofessional teaching models multiprofessional working but needs care on content and variable learning styles and abilities
- Single profession delivers learning but may not enhance the team ethos
- Ideally a combination of both

Who - Educators?

- Inspiring
- Know the topic
- Ideally still clinicians if teaching clinical issues
- Can you collaborate with other faculties and organisations?
- There is a need to ‘grow’ educators. Using past learners can help

- Sharing knowledge is crucial!

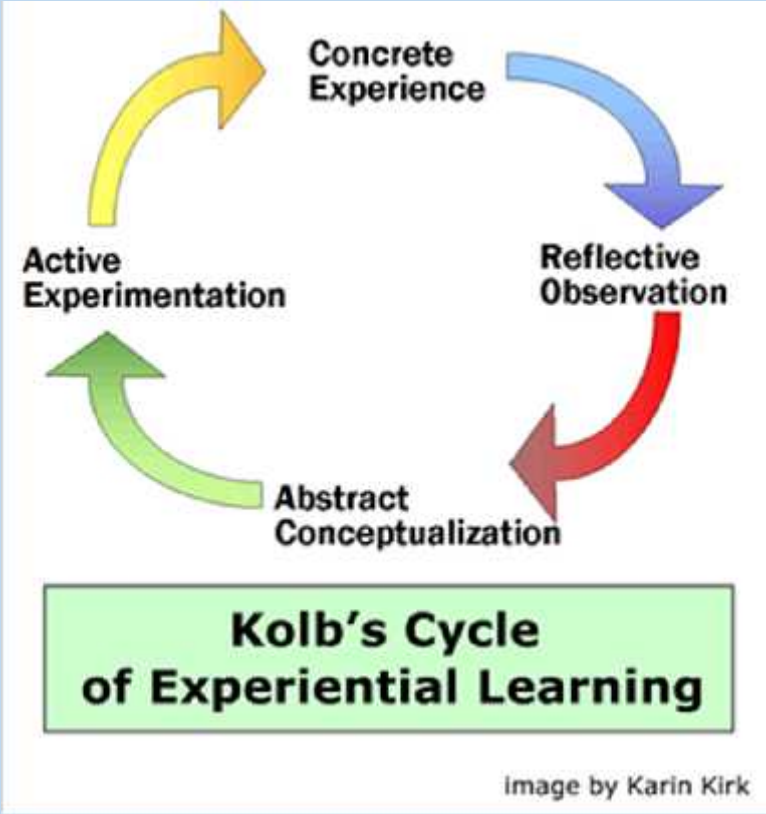
When?

Consider the needs of the learners. Do the sessions need to be:

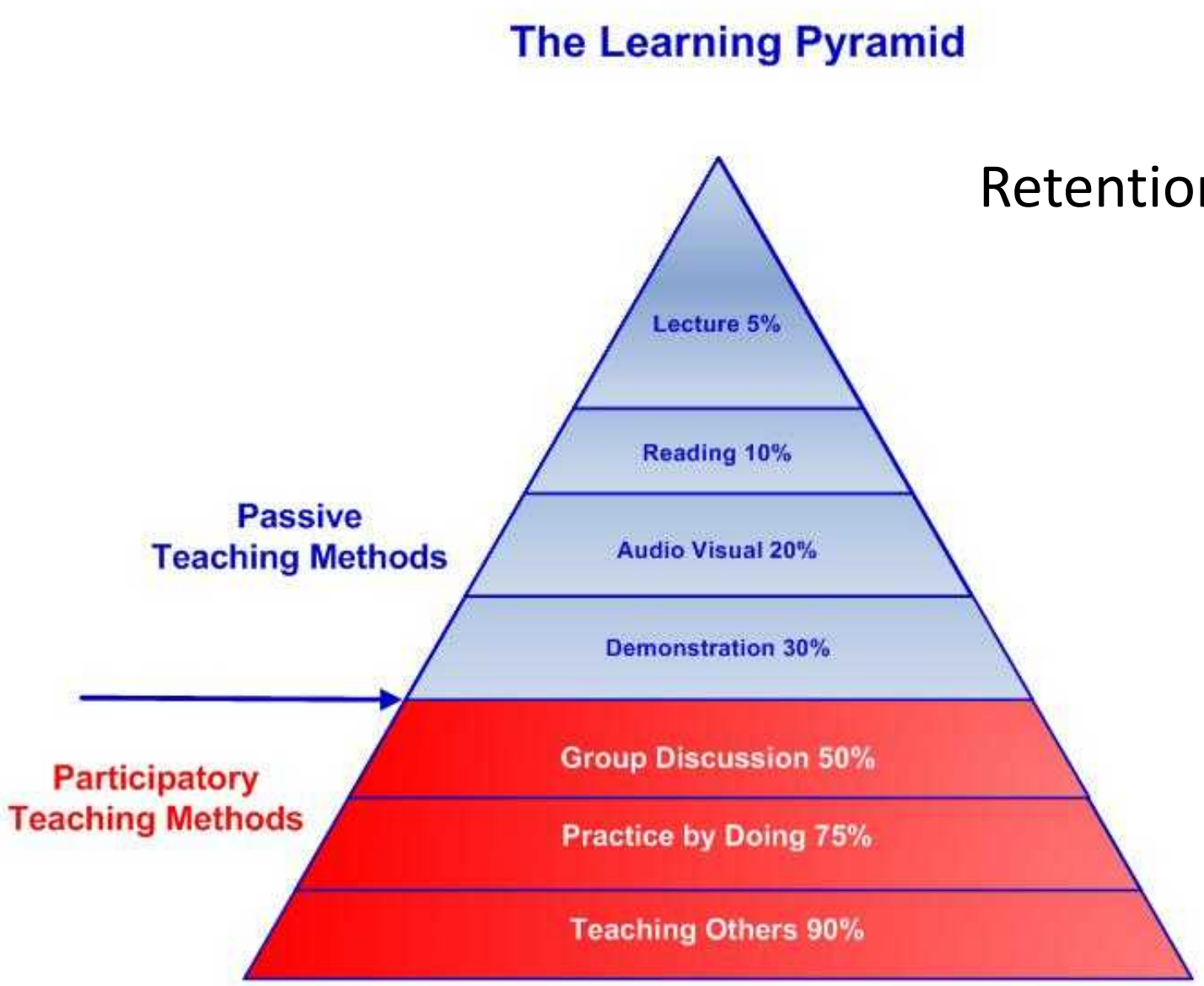
- Regular sessions?
- Early in career or professional development?
- Part of an ongoing qualification?
- Flexible according to need, with the risk that they might not happen
- In general – a syllabus or curriculum with some potential for flexibility to capture immediate learning needs that arise

How? – think of practicalities and necesssary resources

Reflective practice



Retention of knowledge



One to one

- Focussed
- opportunities for feedback
- Direct observation
- Role modelling by the facilitator
- In real time

- Permissions
- Language
- Unskilled ‘practice’
- Know when to stop
- Need to set it up
- Group
- TIME
- Feedback

In consultations – outpatients or at the bed side….

- Direct observation
- Role modelling by the facilitator
- In real time

- Permissions
- Language
- Unskilled ‘practice’
- Know when to stop
- Need to set it up
- Group
- TIME
- May not know what is learnt…?

Small groups

- Engagement
- Peer learning
- Think of optimal size

- Facilitation
- Group dynamics
- Managing group dynamics
- Need ground rules

1. *Defining and structuring procedures*
2. *Confirming to procedures and getting acquainted*
3. *Recognising mutuality and building trust*
4. *Rebelling and differentiating*
5. *Committing to and taking ownership for the goals, procedure and other members*
6. *Functioning maturely and productively*
7. *Terminating*

Johnson and Johnson 1987

Role play

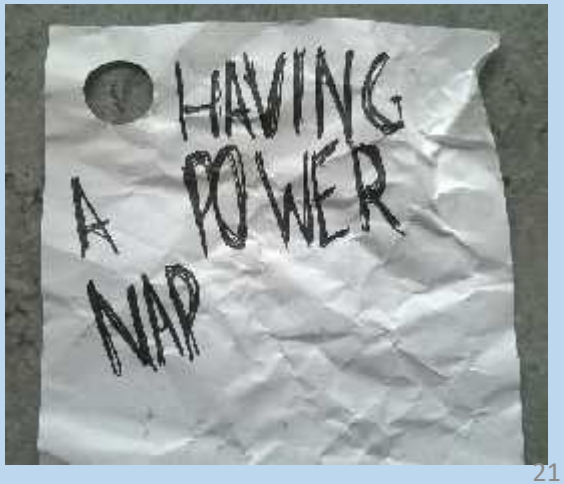
- Allows ‘ play’ in communication skills or scenarios
- Can try highly charged situations safely without patient harm

- Not real life
- Non engagement
- Not suiting all topics
- Safety of the group
- Rules of role play

Large groups

- Good for establishing facts are delivered in the same way at the same time to a large group of people
- Some control over knowledge checking

- Can depend on the speaker
- Can depend on the content



E-learning

- Can reach a lot of people (MOOC)
- Own pace, own time

- Takes skill to develop
- Should not be regarded as a substitute for lectures
- Initial start up cost
- Needs the same planning and metciuluous attention to detail as other education initiatives
- TIME to develop

What can be controlled within an education session?

- preparation (mostly!)
- The environment
- Your communication and facilitation skills
- Your ability to give feedback
- Start on time, finish on time

Try to use evidence based teaching techniques for topics and situations

Where?

- Face to face within the team?
- Face to face within the organisation?
- Local centre?
- National centre?
- International centre?

What will be gained by the location? What might the disadvantages be?

Is there scope for collaboration?

EVALUATION AND REVIEW

- Is the content fit for purpose?
- How do you know it has made a difference?
- What would you change next time as an educator?
- Are you using the most up to date and effective evidence based teaching techniques ?
- Have you had an independent peer review of content and assessment?

Check list for programmes

- Have you used appropriate adult learning teaching methods and concepts , including single discipline specific learning where necessary?
- Have you used an interdisciplinary team of educators?
- Have you considered opportunities of modern learning technologies?
- Can you encourage clinical placements?
- Have you evaluated and reviewed the quality of the programme? (and had a peer review?

Gamondi C, Larkin P, Payne S. EJPC 2013(3) 140-144

The journey so far

The patient and their family have to be the focus of all education

How can we improve the quality of palliative care our patients receive ?

What’s the next step?

thankyou

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