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Creating social work competencies for practice in hospice palliative care

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Abstract

Social workers play an important role in the delivery of Hospice Palliative Care in many diverse settings. The profession brings a unique perspective to end-of-life care that reflects and supports the holistic philosophy of Hospice Palliative Care. Despite the prominent and longstanding position of social work in this area, the role and functions of social workers had not been clearly defined. A Canadian task group of social work practitioners and educators utilized a modified Delphi process to consult front line clinicians nationally, and thereby achieved consensus regarding the identification and description of eleven core competencies in Hospice Palliative Care. These competencies are relevant for social workers at different experience levels across care settings. They can be used to inform social work practice, as well as professional development and educational curricula in this area.

Keywords

social work competencies, social work practice, palliative care, end-of-life care, Delphi technique

Introduction

Social workers play an important role in the delivery of Hospice Palliative Care (HPC). In time, most social work practitioners will encounter adults, children, and families who are facing progressive life limiting illness, dying, death, or bereavement. Such social work interactions occur not only in health care settings, but in all locations where social workers practice. These include hospitals, hospices, nursing homes, adult daycare, and senior centers as well as non-health-care sites such as child and family services agencies, income assistance programs, schools, courts, and employee assistance services.¹

The profession of social work brings a unique perspective to end-of-life care that reflects and supports the holistic philosophy of HPC. It draws on an ecological

approach to problem-solving that considers the multi-dimensional impact of individual, family, and socio-cultural influences in our daily experiences.² This approach fits well with the focus of palliative care, which aims to alleviate suffering and improve the quality of living and dying by addressing physical, psychological, social, spiritual, and practical concerns.³ Both palliative care and social work reflect philosophies of caring that consider individuals in the full context of their lives.^{4–7}

As such, HPC is most effectively delivered by an interprofessional team with relevant expertise in each discipline.⁸ For social workers, the focus of practice within this collaborative approach is centered primarily on psychosocial needs at end of life and during bereavement.^{9,10} They bring to the team an expertise regarding

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health and social systems, individual and family dynamics, cultural diversity, grief and loss, communication, advocacy, ethics, and interdisciplinary practice.^{1,8,11–13} As Brandsen¹¹ points out, ‘social workers are integral participants in developing and delivering end-of-life care, and have been for quite some time’ (p. 58).

Despite the prominent and long-standing position of social work in HPC, the role and functions of social workers have not been clearly defined. In Brandsen’s¹¹ literature review of the social work profession’s involvement in end-of-life care, she found that empirical documentation of social workers’ roles and responsibilities was weak. This gap was also identified in pediatric palliative and end-of-life care.¹⁴ The lack of a clearly defined identity has contributed to other professionals’ confusion about what social workers actually do in HPC, and, consequently, other professions often have inadequate knowledge about the complexity and value of social work practice in this area.^{5,10,15} The resulting ambiguity has contributed to boundary and role issues between social workers and other health care professionals, particularly nurses and physicians.^{12,16} Furthermore, without a clearly articulated role, social workers have questioned their adequacy and competence to provide professional care to individuals and families during the dying process and after death.¹⁵

Therefore, it is crucial for the social work profession to coherently identify and outline its roles and competencies so that social work practice can be advanced in HPC, and adequate education and training be developed and offered to current practitioners and new students. Recently, efforts have been made to address this gap. For example, in the United States, an outcome of a social work leadership summit on end-of-life and palliative care was a description of competencies for social work practice in HPC, which became the source for national standards for social work practice in palliative and end-of-life care in America.^{1,17,18} Jones¹⁴ also produced a report of best social work practices for care of children and their families at end of life based on a survey of over 100 pediatric oncology social workers.

Until now, similar endeavors have not occurred in Canada, although the Canadian Senate Committee for Palliative and End of Life Care has underlined the importance of national standards and competency in end-of-life care, and the need for specific training for all professions to achieve these.^{19,20} The call to develop evidence-based norms and standards of professional practices in HPC was strongly reiterated by the Quality End-of-Life Care Coalition²¹ in light of the prediction that the number of deaths in Canada is expected to increase 33% by the year 2020. In response to this call, a national task group of social work practitioners and educators came together to identify

competencies that are essential to social work practice in HPC (Appendix 1). The group members recognized that a clear description of basic practice competencies was imperative to the development of professional practice standards and social work education in this area. This need was further underlined by the fact that other disciplines involved in HPC had already established descriptions of professional competencies.^{22,23} Therefore, the task group successfully applied for funding through Health Canada to accomplish this project.

Methods

The task group adopted a Delphi technique to identify and describe the competencies required for social work practice in HPC. The Delphi technique is a structured method that has been broadly used in the health sciences.²⁴ Its aim is to synthesize a diverse range of expert opinions about a particular topic, until a consensus is achieved. The Delphi technique is an iterative process that typically comprises two to three rounds of anonymous questionnaires. Information is collected from a panel of experts (people who are able to offer credible opinions) during each round. Responses are then analyzed and refined into a new questionnaire for the subsequent round with the same panel.²⁵ Panel sizes usually range from 15 to 35 members with the expectation that 35–75% invitees will actually participate.²⁶

Originally a postal method, the Delphi technique has been adapted to electronic mail. Consequently, experts from a large geographical area can easily participate. Another advantage of this technique is that it provides an opportunity for participants to confidentially present and respond to ideas without reacting to the group dynamics that sometimes impede face-to-face interactions. Moreover, it allows time for reflective consideration of the questions at hand.

There are differing forms of the Delphi technique and few researchers use a uniform method.^{27,28} The task group developed a modified Delphi process to meet the goals of this project. Instead of starting the first round of the process with a set of open-ended questions, the task group identified and described a number of competencies (Table 1) themselves, which they then presented to a panel of national experts for feedback. Because the Delphi technique can generate large volumes of data, the presentation of pre-existing information based on previous literature reviews or focus group data is an efficient way of using a technique that can be very time consuming otherwise.^{28–30}

The template for the competencies was modeled on the Canadian Hospice Palliative Care Association’s³¹ Norms of Practice and a related conceptual framework

Table 1. Task group competencies

Advocacy	Assessment
Care delivery	Care planning
Community capacity building	Decision making
Evaluation	Education and research
Information sharing	Interdisciplinary team
Self-reflective practice	

regarding levels of competency developed by the Victoria Hospice.³¹ The initial description of the competencies was based on a combination of the knowledge and skills of the task group members and a review of publications and websites of various HPC and oncology organizations in Canada and the United States regarding current practice standards.^{33–38}

The task group members worked in pairs to develop a description of each competency. When a version of a competency was completed, it was circulated to two other members for further review and input. The resulting framework of each competency provided specific details that included an overall description of the core competency, and the required attitudes and values, knowledge, and skills most pertinent to it.

The task group then identified and invited social work practitioners and educators across the country to review these competencies through two rounds of questionnaires. The goal was to establish consensus regarding the relevance and description of each competency, and to identify any other core competencies that should be added and developed. In the initial stage of recruitment for the panel, the task group sent out a general call to the British Columbia and the Canadian Social Work/Counseling HPC Interest Groups for participants for this project. They also identified a number of social workers and counselors currently working in the area of HPC. Two research assistants (RAs: HB and MJ) sent each social worker a letter of invitation, which was followed by a phone call as needed to determine whether or not the individual was able to participate. Completion of the initial request served as consent for Phase One and also for agreement to participate in the second round of the Delphi process.

Several of these respondents also suggested other individuals for the panel, who were then contacted as well. The use of both purposive and snowball sampling techniques ensured a panel with diverse experience and expertise in social work practice in the context of HPC. A deliberate effort was made to include participants from different practice settings and all regions of Canada. Thus, participants on this panel worked in a variety of locations such as hospitals, hospices, long-term care facilities, cancer care centers, community agencies, and universities in British Columbia,

Alberta, Manitoba, Ontario, Newfoundland, Nova Scotia, and the Yukon.

Data collection was done by email. This approach had both positive and negative aspects. Certainly, the electronic transmission of information and questionnaires facilitated efficient communication with panel members during each round of the study. However, difficulties occurred during the first round when the questionnaire was transferred into an Adobe format. Specifically, some participants did not have the computer software to enter responses directly into the document, and they were only able to access the document as a 'read-only' version. This required the participant to print out and manually complete the document, and then fax or mail the completed questionnaire to the research office. To address this problem, the Adobe format was discontinued in Round Two and the questionnaire was reformatted as a Word document, permitting easy data entry and electronic transmission.

The task group employed several strategies of data generation consistent with the consensus building process of the Delphi methodology. Task group members identified and developed the first version of the 11 core competencies. This was followed by a peer review process whereby all competencies were reviewed by two other members. The RAs read all the final comments and incorporated the edits for each competency for this initial process and the subsequent panel rounds; they consulted with two members of the task group (SC and WW) as needed. The RAs, who were doctoral students and research trainees with two CIHR New Emerging Teams (NETs): *Transitions in Pediatric and End of Life Care* and *Palliative Care in a Cross-Cultural Context*, also had relevant clinical social work experience in HPC. The study extended over a period of 10 months and involved two phases of data collection and analyses.

Results

Round One

A response rate of 66% (20/30) was achieved in the first round of this research study. One emailed questionnaire was not received and was designated as missing data. In Round One, 16 participants (80%) agreed that all 11 competencies listed are essential to social work practice in HPC. Two of the competencies were listed as non-essential by three participants: one participant identified *community capacity building* as non-essential, and two participants identified *education and research* as non-essential.

Six additional competencies were suggested as essential to social work practice in HPC. *Cultural competency* was suggested twice as essential and the

following five new competencies were suggested once: (1) *competency in understanding the multidimensional nature of health and wellness*; (2) *competency in understanding the social determinants of health*; (3) *adaptability to work environment*; (4) *spirituality of self, team, and others*; (5) *counseling and treatment planning* (Table 2).

Round Two

All responses were carefully reviewed by the RAs and compiled into a new questionnaire and emailed to the 20 respondents of Round One. The Round Two questionnaire included a list of the original competencies as well as all of the changes suggested in Round One regarding their descriptions. All changes were highlighted in red within the body of the 11 competencies. The list of additional competencies that were suggested by some panelists for further development was also included.

The participants were asked to complete three tasks for Round Two: (1) to state whether they agreed with the suggested changes to the competencies; (2) to indicate how essential each competency was to social work practice in HPC; (3) to indicate whether the six new competencies should be developed further. Panelists indicated their responses by clicking on an appropriate answer from a drop down menu as described below. They also had opportunities to enter additional remarks in comment boxes along the way.

Nineteen responses (95%) were received via email and fax. In the final analysis of the data, the total number of respondents fluctuates for several competencies as a result of missing data. Inclusion of missing data as part of the total sample translates statistically to assuming that the response was 'no.' After careful consideration by the task group as a whole, it was determined that the management of missing data according to the purpose of consensus building deemed it appropriate to have a fluctuating sample. Table 3 displays the consensus levels for the description of each aspect of each competency.

In the Round Two analysis, the RAs incorporated content changes to the competencies when the majority

of participants agreed with the proposed recommendations. For some competencies, a minority of participants suggested changes. The RAs incorporated these suggestions when such changes did not alter the overall meaning of a particular point, and, from their perspective, helped to clarify the point. For example, under the *interdisciplinary care* competency, the RAs agreed with the suggestion to remove the qualifier 'good' from 'good psychosocial care' as it was deemed that in the context of core competencies, 'good' care is implicit to 'psychosocial care.' The reviewers did not incorporate minority suggestions that significantly altered the meaning of a point. To include such changes would warrant a third round to provide an opportunity to all participants to respond to the recommended change.

In addition to reviewing the suggested changes, participants were asked to rate how essential each competency was according to a six-point Likert scale: *absolutely essential*, *very essential*, *essential*, *somewhat essential*, *not essential*, and *unsure* (Table 4).

Participants were also asked whether the new competencies that had been suggested in Round One should be developed further as stand-alone competencies. Participants were asked to consider whether or not each competency should be added, whether it was already included in an existing competency, or whether they were unsure about the suggested competency (Table 5).

Discussion

The Delphi method has facilitated an effective process to establish consensus among social work clinicians and academics across Canada regarding core competencies

Table 2. Suggested competencies for future development

Cultural competency ^a	Adapting to work environment ^b
Supporting spiritual needs of self, team and others ^b	Counselling and treatment planning ^b
Understanding social determinants of health ^b	Understanding multi-dimensional aspects of health and wellness ^b

^aSuggested twice.

^bSuggested once.

Table 3. Achieved consensus for descriptions of competency domains

Competency	Attitudes/ values	Knowledge	Skills
Advocacy	83%	83%	78%
Assessment	82%	72%	72%
Care delivery	100%	83%	94%
Care planning	82%	83%	94%
Community capacity building	94%	94%	94%
Evaluation	100%	94%	82%
Decision making	93%	94%	94%
Education	82%	100%	69%
Research	94%	94%	75%
Information sharing	77%	100%	88%
Interdisciplinary team	100%	100%	88%
Self-reflective practice	88%	100%	88%

Table 4. Scale rating results of 11 competencies

Competency	Absolutely essential	Very essential	Essential	Somewhat essential	Not essential	Unsure
Advocacy	50%	31%	13%			6%
Assessment	69%	6%	25%			
Care delivery	56%	19%	19%			6%
Care planning	62%	19%	19%			
Community capacity building	13%	37%	31%	6%	13%	
Confirmation	50%	6%	44%			
Decision making	50%	25%	25%			
Education and research ^a	13%	33%	40%	7%	7%	
Information sharing	56%	25%	19%			
Interdisciplinary team	62%	19%	19%			
Self-reflective practice	62%	13%	25%			

^aOne person rated 'education' (essential) and 'research' (not essential) separately.

Table 5. Response rating of adding suggested competencies

Competency	Add	Do not add	Already included	Unsure
Cultural competency	50%	6%	38%	6%
Multi-dimensional nature of health/wellness	19%	13%	62%	6%
Social determinants of health	31%	6%	44%	19%
Adaptability to work environment	6%	31%	44%	19%
Spirituality of self, team, and others	6%	13%	75%	6%
Counseling and treatment planning	6%	6%	75%	13%

for social work practice in HPC. Round One results demonstrate strong agreement among the participants regarding 11 specific competencies as essential to social work practice in end of life care. Round Two results reflect the consensus established among the panel of experts regarding the descriptions of each competency. Furthermore, several additional competencies have been identified in this process and suggested as also essential to social work practice in HPC. As expected, differences among panel member perspectives also emerged during this process, which are also valuable data. The following discussion addresses additional information received that is relevant for further consideration.

Specificity of theories

In the first round, specific theories were identified as required knowledge for several of the competencies. For example, for the competencies of *advocacy*, *care delivery* and *interdisciplinary team*, theories pertaining to communication and mediation, evaluation, systems, and group work were specifically included, although this level of detail does not occur in all possible instances. This prompted a discussion within the

comment section whereby participants questioned the need to specify theories. Questions were raised about why knowledge of specific theories is deemed a core skill in some areas but not others. The task group reviewed these comments and determined that the purpose of developing core competencies was not to outline a specific set of theories. However, the inclusion of some theories pertinent to particular competencies was deemed necessary by the panel and consensus was established. Therefore, mindful of the fact that the competencies do not include an exhaustive list of theories, it was determined that keeping the theories as part of the competencies may be helpful in informing practice and future curriculum.

Language

Several participants voiced concern regarding use of the word 'power.' However, in adhering to the principles of the Delphi process, we did not remove the word, as the majority of participants did not comment on it, or seek removal of it, during the Round Two data collection. We underline this point because the reaction to the use of this word seemed quite strong, and failure to mention the specific comments surrounding this term and

merely dismissing this concern would not be appropriate. Upon closer review, the main concern appears to be related to the actual use of the word within a specific context. For example, a participant questioned whether 'power differentials' fits with the competency *care planning*. Furthermore, a request was made to remove the word 'power' from a bullet referencing 'spirituality' as the participant deemed it inappropriate to link these two terms together. Due to the reaction to this specific word, the task group discussed the inclusion or removal of the word and decided to leave the word as part of the document.

In addition, the majority of respondents preferred use of the term 'evaluation' rather than 'confirmation' as the name for that competency. Those participants who advocated the ongoing use of the word 'confirmation' explained that this was the term used by the Canadian Hospice Palliative Care Association in its description of norms of practice. To maintain the integrity of the consensus building process, the competency was changed from 'confirmation' to 'evaluation.'

Core skills and level of education

The *education and research* competency generated the greatest amount of discussion and debate, which accounts for a lower level of consensus regarding the 'skills' domain of this competency (education 69%; research 75%). Specifically, respondents voiced concern that identification of research as a core competency would limit the scope of HPC practice to Masters prepared social workers. Similarly, inclusion of supervision as a core skill within this competency was viewed in the same way. This raises a larger question regarding differences between Bachelor and Masters prepared practitioners, and how those differences are apparent along a continuum of knowledge and skills.

These responses also represent the various perceptions among social workers regarding the appropriate scope of practice for each of these levels of education. They reflect a long-standing discussion in the profession regarding generalist versus specialist training for social workers in health care settings.³⁹ Many generalist social work skills regarding counseling, family systems, community resources, and psychosocial assessments are relevant to working with patients and families with terminal illness.¹² However, practitioners and educators have underlined the benefit of a combined generalist and specialist training for social workers who work primarily with dying individuals and families.^{18,39}

From the outset, the task group recognized that social work core competencies in HPC may not have direct application across all settings and for all practitioners. This perspective reflects the reality of different

resource levels that exist across care sites and geographic locations in Canada. Therefore, the task group emphasized that the final competencies should not be presented for use as an inflexible or uniform template of knowledge, values, and skills for all social workers who provide HPC. Rather the competencies are meant to be used as a recommended framework outlining desired social work practice components in end-of-life care. This echoes the Quality End-of-Life Care Coalition's (2005) recommendation that best practices be flexible enough to respond to different service programs and settings, but substantial enough to provide clear guidelines for appropriate care.

Additional competencies

As indicated above, six additional competencies were identified as important to social work practice in HPC. Although the majority of panel members indicated that several of these competencies, such as the *multidimensional nature of health and wellness, spirituality of self, team, and others, and counseling and treatment planning* were already included in the original 11 competencies, a significant number of respondents (50%) recommended that *cultural competence* should be developed as a stand-alone competency.

Implications

In the end, this information will be helpful to social workers to articulate their role and activities to other professionals, and serve as a basis to develop and evaluate outcomes of social work practice in HPC. Furthermore, the competencies can be used to inform social work professional development and educational curricula in this area. As Lawson⁹ emphasizes, we must develop and demonstrate our knowledge and skills so that we can contribute effectively 'to the shared responsibility of excellence in palliative and end-of-life care' (p. 17).

The building of consensus around these competencies has resulted in a comprehensive, descriptive document outlining 11 core competencies for social work practice in HPC.⁴⁰ These competencies can be used to facilitate the development of consistent practice goals and guidelines for social workers entering the field as well as those currently practicing in it. They are relevant across a range of practice locations and populations. Furthermore, social workers can draw on these competencies to clearly articulate their role and activities within interprofessional care teams, and to evaluate their contributions.

An important next step is to incorporate these competencies into social work education curricula at both

the undergraduate and graduate levels. Social workers report that they are inadequately prepared to work with dying and grieving clients.^{14,15,18,39,41} This assessment is reiterated by social work educators, who share the perspective that students receive little course content on care of the dying and bereaved.¹⁵ Insufficient educational preparation has been identified as a barrier to effective and ethical practice in end-of-life care.¹¹ These competencies can be used to build relevant curricula for Bachelor of Social Work (BSW) and Master of Social Work (MSW) courses as well as professional development and training programs. The incorporation of this knowledge into discipline curricula is one way to address this significant educational gap and enhance the contributions of social work to meaningful and effective end-of-life care.

Next steps

This project is currently being expanded into a subsequent phase of data generation through a national consultation process.^a The aim of this second initiative is to validate these 11 competencies, to explore how *cultural competence* can be integrated into them or established on its own, and to create a strategic plan for implementation into education and practice settings. This broad consultation process will engage social work practitioners, educators, and professional organizations, as well as individuals and families who are receiving end-of-life care. With an expanded representation of members involved in this next phase, these activities will address the limitations related to the small panel involved in the first project.

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Note

a National Consultation for Implementation of Social Work Competencies in Palliative Care Education Project. Canadian Partnership Against Cancer Rebalance Focus Education Subcommittee.

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