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# Palliative Care Nurse Practitioner Candidate Clinical Competencies

VICTORIAN PALLIATIVE CARE NURSE PRACTITIONER COLLABORATIVE

THE UNIVERSITY OF MELBOURNE

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# Contents

# Introduction

The purpose of this document is to provide Palliative Care Nurse Practitioner candidates in Victoria (and potentially candidates in other states of Australia), with a framework to ensure they meet core clinical competencies, to be achieved before they consider applying to the Nursing and Midwifery Board of Australia for Endorsement as a Nurse Practitioner.

The process for developing the clinical competencies was in six stages and included the following:

1. Establishment of a core writing group and undertaking a literature review
2. Developing a draft of the competencies in consultation with Nurse Practitioners
3. Review of the draft by members of the Victorian Palliative Care Nurse Practitioner Collaborative
4. Revising and refining the document by the writing group
5. National and international expert opinion (including local and international nurse practitioners, members of the Victorian Palliative Care Nurse Practitioner Collaborative, palliative care physicians, policy developers, academics, a pharmacist and members of allied health) to further develop and refine the competencies with the use of a purpose designed questionnaire
6. Final version of the Victorian Palliative Care Nurse Practitioner Candidate Clinical Competencies developed

These competencies aim to provide guidance to Palliative Care Nurse Practitioner Candidates and their services about how clinical competence in palliative care may be identified and assessed in the workplace. It builds on the Australian Nursing and Midwifery Council's document: *Australian Nursing and Midwifery Council National Competency Standards for the Nurse Practitioner, 2004*.

Nurse Practitioner Competencies provide a guide to a set of standards to demonstrate evidence of safe practice that align with the requirements, expectations and regulations of the role (Gardner, G. et al, 2006).

For further information on the Victorian Palliative Care Nurse Practitioner Collaborative visit: www.vpcnpc.centreforpallcare.org.

# Palliative Care Nurse Practitioner

## What is a Palliative Care Nurse Practitioner?

A Nurse Practitioner (NP) is a registered nurse educated and endorsed to practice autonomously and collaboratively in an advanced and extended clinical role (Australian Nursing and Midwifery Council, 2009). The NP title is protected and only those nurses endorsed by the Nursing and Midwifery Board of Australia may call themselves a NP. From 1 July 2010, under national registration, Victorian palliative care (PC) NPs will be endorsed with a notation in the category of 'acute and supportive care'. The notation is for the purpose of prescribing authority under *Medicines, Poisons and Controlled Substances Act 1981*.

The PC NP is able to demonstrate and deliver comprehensive assessment and management of palliative care patients (inclusive of client, consumers etc.) who have complex needs, using advanced nursing knowledge and skills informed by best practice principles. The practice of a PC NP may include, but is not limited to, the direct referral of patients to other health care professionals, prescribing medicines and ordering diagnostic investigations (Australian Nursing and Midwifery Council, 2004). The NP practises in a clinical leadership role, incorporating research, education and management into the role. "The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practice" (Australian Nursing and Midwifery Council, 2004).

A PC NP's practice is defined by the nationally agreed NP competency framework that identifies three standards: dynamic practice, professional efficacy and clinical leadership.

Dynamic practice is demonstrated by the NP's high level knowledge and skills in extended practice across stable, unpredictable and complex situations.

Professional efficacy demonstrates that practice is grounded in a nursing model and enhanced by autonomy and accountability.

Clinical leadership influences and progresses clinical care, policy and collaboration through all levels of health care (Australian Nursing and Midwifery Council, 2006).

Underpinning the extended clinical practice of a NP are the key essential criteria of:

- Demonstrated well-developed communication skills to build therapeutic relationships with patients, families, colleagues and the community that recognise the patient's needs, circumstances, preferences and geographical contexts
- A commitment to ongoing professional development of self, other nurses and other health professionals
- Demonstrated capacity to undertake research/quality improvement activities relevant to enhancing the practice environment.

## What is a Palliative Care Nurse Practitioner Candidate?

In Victoria, nurses who have been appointed by an employer to become a NP are referred to as NP Candidates (NPC). A PC NPC is a registered nurse employed by a service/organisation as they work toward meeting the academic (eg. approved NP Masters) and clinical requirements for endorsement as a Nurse Practitioner (NP). During the period of candidature, which can vary in length, the nurse consolidates his/her competence at the level of a nurse practitioner, learning his/her new role while engaging with mentors and other learning opportunities both within and outside the candidate's organisation.

Mentorship in terms of medical and senior nursing support, management skills and clinical teaching are essential components for effective skill development of the nurse practitioner candidate. A registered nurse engaged as a nurse practitioner candidate shall be classified and paid their substantive (usual) salary (Australian Industrial Relations Commission 2006).

## Role clarification

What are the differences between advanced practice nurses (including Clinical Nurse Specialists and Clinical Nurse Consultants) and Nurse Practitioners?

In Australia, the title of 'Nurse Practitioner' is protected by legislation and encompasses unique expanded practice privileges, which include authorisation to independently diagnose, prescribe medicines, order diagnostic tests and make referrals to other health care professionals (Gardner, Chang & Duffield 2007).

While advanced practice nurses are encouraged to complete postgraduate qualifications specific to the specialty area in which they work, they are not currently a requirement for the role. Advanced practice roles in Australia currently lack national consistency with regard to practice standards, unlike the NP role.

# Policy context

Victorian PC NPs have been appointed to better meet the Government's palliative care policy objectives, specifically to ensure that all Victorians with a progressive, life-limiting illness and their families and carers have access to a high quality service system which fosters innovation (Strengthening Palliative Care: a policy for health and community care providers, 2004–2009). Building capacity within the nursing workforce with appropriately skilled and educated PC NP ensures the Government can meet its aims of:

- improving the equity of access to specialist palliative care services for people with life-threatening illness
- building effective and efficient links between hospitals and specialist palliative care services
- building effective and efficient links between specialist palliative care services and other relevant community, health and allied health providers, including disability services and residential aged care (Strengthening Palliative Care: a policy for health and community care providers, 2004–2009).

PC NPs will be a pivotal link to realising priority three of the Victorian Cancer Action Plan (2009–2011), which is to increase capacity of palliative care services to provide care for patients in the place of their choice.

# Key documents

Key documents underpinning the development of these competencies:

- Australian Nursing and Midwifery Council National Competency Standards for the Nurse Practitioner, 2004.
- Australian Nursing and Midwifery Council Standards and criteria for the accreditation of Nursing and Midwifery courses leading to registration, enrolment, endorsement and authorisation in Australia – with evidence guide, 2009.
- Queensland Government Queensland Nurse Practitioner: implementation guide, 2008.
- Canning D, Yates P, Rosenberg J. (2005) *Competency standards for specialist palliative care nursing practice*. Brisbane, Queensland University of Technology.
- Gardner G, Carryer J, Gardner A, Dunn S. (2006). Nurse Practitioner competency standards: findings from collaborative Australian and New Zealand research. *International Journal of Nursing Studies* 43(5): pp601-610.
- Canadian Nurses Association Canadian Nurse Practitioner Core Competency Framework, 2005.
- Gardner G, Chang A, Duffield C. (2007). Making nursing work: breaking through the role confusion of advanced practice nursing. *Journal of Advanced Nursing* 57(4), 382-391.
- Eagar K, Senior K, Fildes D, Quinsey K, Owen A, Yeatman H, Gordon R and Posner N, 2003. The Palliative Care Evaluation Tool Kit: A compendium of tools to aid in the evaluation of palliative care projects. Centre for Health Service Development, University of Wollongong.

# Guiding principles

The guiding principles underpinning the Palliative Care Nurse Practitioner Candidate Clinical Competencies are as follows.

## Generic NP guiding practice principles:

1. PC NP candidates work within the agreed scope of practice for NPs within their employment context
2. The practice of a PC NP candidate is, wherever possible, based on best available evidence-based practice principles
3. Medical and nursing clinical supervision, management and education mentorship are all critical to the development of the PC NP candidate
4. The scope of an patient NP's prescribing practice is supported by their employer's clinical governance framework. As registered nurses, NP practice will also be guided by the Nursing and Midwifery Board of Australia's professional practice framework that details how professional decision-making within a sound risk management, professional, regulatory and legislative framework is to be managed

## Specific Palliative Care NP guiding practice principles:

5. The practice of a PC NP candidate is informed by clinical experience specific to the context of palliative care
6. Developing a plan of care should involve the patient, their family and other relevant health professionals
7. PC NP candidates have highly developed verbal and written communication skills essential to communicate assessment and management plan, including medicines, to the patient, carer/s, care team and other health professionals
8. PC NP candidates recognise the palliative care phase of illness of the patient and use this knowledge to inform their assessment and management. For example:
    - If the patient has been stable and an acute exacerbation of symptom issues occurs, a full and thorough assessment should be undertaken to determine

any reversible causes. It would also be appropriate to initiate investigations (pathology and radiology) or referral to aid the diagnosis

- If the patient has been unstable and an acute, new problem or unexpected deterioration occurs, a full and thorough assessment should be undertaken to determine any reversible causes. It would also be appropriate to initiate investigations (pathology and radiology) or referral to aid the diagnosis. Candidates need to be able to recognise whether the new problem is related to the underlying disease process or a new, unrelated problem requiring referral
- If the patient has been deteriorating in a predictable and expected way, the assessment may be modified and investigations limited
- If the patient is in the terminal phase with evidence of well advanced disease and little possibility or expectation of recovery, it would be inappropriate to initiate a full assessment or investigations and the focus should be on the comfort of the patient
- A planned bereavement support program is available including counselling as necessary (Eagar K, Senior K, Fildes D, Quinsey K, Owen A, Yeatman H, Gordon R and Posner N, 2003)

# The Clinical Competencies

| Competency and ANMC Competency Reference | Key elements | Process | Performance indicators | Assessment principles required to demonstrate competence |
|---|---|---|---|---|
| **1. Comprehensive general physical assessment/examination and implementation of a patient-focused management plan including relevant diagnostics** | | | | |
| ANMC Competency<br>1.1<br>1.2<br>1.4<br>2.2<br>3.1<br>ANMC National Competency Standards for the Nurse Practitioner (Appendix 2) | Examination of patient including:<br>• Respiratory<br>• Cardiac<br>• Gastro Intestinal<br>• Abdominal<br>• Hepatic<br>• Renal<br>• Neurological<br>• Musculo-skeletal<br>• Genitourinary<br>• Integument<br>• Endocrine<br>• Haematological | Observe and undertake patient physical assessments. For example:<br>• Chest examination and assessment of respiratory function relevant to a range of symptoms and conditions including, but not limited to, dyspnoea, bronchospasm, infection, pulmonary embolus<br>• Cardiac auscultation and assessment of circulatory function relevant to a range of conditions including, but not limited to, arrhythmias, congestive cardiac failure, and hypertension | • Independently performs comprehensive physical assessment and postulates cause of symptom/condition<br>• Sources, gathers and interprets relevant information from referral and other health care professionals<br>• Interprets findings in the context of identifying the impact of illness on patient<br>• Ability to diagnose aetiology of condition<br>• Orders appropriate investigations to inform diagnosis (including radiology, pathology, ECG). Where outside scope of practice, liaises with appropriate medical colleague/s | Medical mentorship essential to achieve competence.<br>Medical mentor required to confirm competence (Department of Health logbook mandatory requirement).<br>Assessed by medical and professional supervisors.<br>Suggest using Mini-Clinical Evaluation Exercise (mini-CEX) (Royal Australian College of Physicians), which would allow for full observation of cases including history taking, examination, formulation of a plan and, importantly, opportunity for debrief/discussion. |

*Continued…*

| Competency and ANMC Competency Reference | Key elements | Process | Performance indicators | Assessment principles required to demonstrate competence |
|---|---|---|---|---|
| 1. Continued | | • Full abdominal examination and palpation relevant to a range of symptoms including, but not limited to, constipation, anorexia, nausea, vomiting, nutritional status hepatic dysfunction, bowel obstruction<br>• Assessment of renal function<br>• Musculo/skeletal examination relevant to a range of symptoms and conditions including but not limited to fractures, bone metastases, spinal cord compression<br>• Neurological examination to recognise components such as motor sensory reflexes/sensation | • Provides rationale, articulates process and liaises as appropriate with other health professionals as relevant to the outcomes of the assessment<br>• Ability to formulate assessment priorities to inform management plan<br>• Articulates comprehensive knowledge of the medication options to treat condition<br>• Identifies and implements a range of non-pharmacological management strategies<br>• Articulates clinical indications for and prescribes medications appropriate to the condition<br>• Demonstrates thorough evaluation of treatment plan | Evidence of competence to be logged in logbook and signed by medical supervisor.<br>Individual candidate's level of experience will influence actual number of assessments required to achieve competency.<br>Consider using a Bondy scale (Appendix 1) to assess competence. |

| Competency and ANMC Competency Reference | Key elements | Process | Performance indicators | Assessment principles required to demonstrate competence |
|---|---|---|---|---|
| **2. Comprehensive assessment and management of physical symptoms and implementation of a patient-focused management plan including relevant diagnostics** | | | | |
| ANMC Competency 1.1<br>1.2<br>1.3<br>1.4<br>2.1<br>2.2<br><br>ANMC National competency standards for the Nurse Practitioner (Appendix 2) | Obtain clinical history of the symptom.<br>Undertake a full systems-based physical assessment.<br>Order appropriate investigations.<br>Review previous and current treatments and their effectiveness.<br>Ascertain/identify patient expectations.<br>Demonstrate understanding of underlying pathology and its impacts on the current symptoms. | Patient interview.<br>Use of relevant assessment tools eg. tools for screening/ diagnosing/assessing delirium, fatigue, pain, nausea and vomiting, constipation, dyspnoea.<br>Conduct relevant physical examination.<br>Interpret/evaluate results of investigations and examinations.<br>Differential diagnosis.<br>Formulate a plan of care including necessary referrals to other health care professionals as required. | Autonomously performs comprehensive symptom assessments.<br>Articulates knowledge and ability, including interpretation, of screening tools to assist with assessment.<br>Performs full systems-based approach to physical assessment.<br>Interprets and articulates collective findings from physical examination, history, investigations.<br>Findings are comprehensively documented, communicated and incorporated in a comprehensive care management plan.<br>Differential diagnosis is identified. | Medical mentorship essential to achieve competence.<br>Medical mentor required to confirm competence (Department of Health logbook mandatory requirement).<br>Assessed by medical and professional supervisors.<br>Suggest using Mini-Clinical Evaluation Exercise (mini-CEX) (Royal Australian College of Physicians), which would allow for full observation of cases including history taking, examination, formulation of a plan and, importantly, opportunity for debrief/discussion.<br>Evidence of competence to be logged in logbook and signed by medical supervisor. |

*Continued…*

| Competency and ANMC Competency Reference | Key elements | Process | Performance indicators | Assessment principles required to demonstrate competence |
|---|---|---|---|---|
| 2. Continued | | | Leads case discussion in context of health care team meeting. | Individual candidate's level of experience will influence actual number of assessments required to achieve compete.<br>Consider using a Bondy scale (Appendix 1) to assess competence. |

| Competency and ANMC Competency Reference | Key elements | Process | Performance indicators | Assessment principles required to demonstrate competence |
|---|---|---|---|---|
| **3. Comprehensive psychological, social, spiritual and cultural assessment and implementation of a patient-focused care plan** | | | | |
| ANMC Competency 1.1<br>1.2<br>1.3<br>1.4<br>2.2<br>3.1<br>ANMC National Competency Standards for the Nurse Practitioner (Appendix 2) | Determine the patient's psychological, social, spiritual and cultural context (including the family). | Conduct a comprehensive psychological, social, cultural and spiritual assessment of current status and risk of poor psychosocial well-being including:<br>• a genogram<br>• family history<br>• social support and networks<br>• psychological history and assessment<br>• identifying most significant person to the patient<br>Use of relevant validated tools.<br>Identification of patients requiring ongoing support. | Evaluates efficacy of treatment plan and intervention.<br>Articulates knowledge and ability, including interpretation of screening tools to assist with diagnosis of disorders including:<br>• depression<br>• anxiety<br>• distress<br>• quality of life<br>• delirium<br>Articulates process and initiates referral to address/manage psychological, social, spiritual and cultural issues. | Medical mentorship essential to achieve competence.<br>Medical mentor required to confirm competence (Department of Health logbook mandatory requirement).<br>Assessed by medical and professional supervisors.<br>Suggest using Mini-Clinical Evaluation Exercise (mini-CEX) (Royal Australian College of Physicians), which would allow for full observation of cases including history taking, examination, formulation of a plan and importantly, opportunity for debrief/discussion. |

*Continued…*

| Competency and ANMC Competency Reference | Key elements | Process | Performance indicators | Assessment principles required to demonstrate competence |
|---|---|---|---|---|
| 3. Continued | | Make referral to specialist service, where appropriate. | Provides relevant and appropriate information and education to the patient and primary family carer/s.<br>Leads case discussion in context of health care team meeting.<br>Initiate treatment. | Evidence of competence to be logged in logbook and signed by medical supervisor.<br>Individual candidate's level of experience will influence actual number of assessments required to achieve competence.<br>Consider using a Bondy scale (Appendix 1) to assess competence. |

| Competency and ANMC Competency Reference | Key elements | Process | Performance indicators | Assessment principles required to demonstrate competence |
|---|---|---|---|---|
| **4. Preparation for safe and appropriate prescribing of medicines** | | | | |
| ANMC Competency<br>1.4<br>2.2<br>2.3<br>3.1<br>3.2<br><br>ANMC National competency standards for the Nurse Practitioner (Appendix 2) | Observe practice of medical colleagues in relation to decision-making process regarding prescribing of medicines.<br>Become familiar with medicines that can be prescribed.<br>Each nurse practitioner will only prescribe from the medicine formulary as determined by the NMBA and consistent with their scope of practice. This is supported by clinical governance structures such as clinical practice guidelines at their workplace. | Under supervision (discussion and mentorship):<br>Select medicine appropriate to patient and symptom being treated, patient preference and stage of disease.<br>Consider access to medicine, care setting of patient and financial impact when prescribing medicines.<br>Consider the Quality Use of Medicines as part of the decision-making framework.<br>Identify appropriate dose, route, frequency and titration plan for each medicine.<br>Prescribe according to legislation guidelines. | Articulates clinical indications of medicines that can be prescribed and are consistent with the scope of practice.<br>Demonstrates comprehensive knowledge of pharmacology, pharmacokinetics and side-effects of classes of medicines from PC NP prescribing list.<br>Demonstrates ability to select medicines appropriate to treat a range of symptoms commonly seen in palliative care.<br>Demonstrates ability to assess efficacy of medication. | Individual candidate's level of experience will influence actual number of assessments required to achieve competency required.<br>Medical and pharmacy mentorship essential to achieve competence.<br>Suggest using Mini-Clinical Evaluation Exercise (mini-CEX) (Royal Australian College of Physicians), which would allow for full observation of cases including history taking, examination, formulation of a plan and, importantly, opportunity for debrief/discussion including discussion of medicines appropriate to case. |

*Continued…*

| Competency and ANMC Competency Reference | Key elements | Process | Performance indicators | Assessment principles required to demonstrate competence |
|---|---|---|---|---|
| 4. Continued | | | Demonstrated awareness of principles of dose adjustment with regard to: frail, elderly, children, altered metabolism, organ failure and imminent death | Consider using a Bondy scale (Appendix 1) to assess competence (self-assessed by candidate and then by mentor). |

# Appendix 1: Bondy Scale

| Grade | Performance criteria | Quality of performance | Assistance required |
|---|---|---|---|
| Independent (I) | Level of clinical practice is of a high and safe standard | • sound level of theoretical knowledge applied effectively in clinical practice<br>• coordinated and adaptable when performing skills<br>• achieves intended purpose<br>• proficient and performs within expected time frame<br>• initiates actions independently and in cooperation with others to ensure safe delivery of patient care | Without supporting cues |
| Supervised (S) | Level of clinical practice is of a safe standard but with some areas of improvement required | • correlates theoretical knowledge to clinical practice most of the time<br>• coordinated and adaptable when performing skills<br>• achieves intended purpose<br>• performs within a reasonable time frame<br>• initiates actions independently most of the time and in cooperation with others to ensure a safe delivery of patient care | Requires occasional supportive cues |

* (Bondy 1983)

Appendix 1 (continued)

| Grade | Performance criteria | Quality of performance | Assistance required |
|---|---|---|---|
| Assisted (A) | Level of clinical practice is of a safe standard but with many areas of improvement required | • demonstrates limited correlation of theoretical knowledge to clinical practice<br>• at times lacks coordination when performing skills<br>• achieves intended purpose most times<br>• performs within a delayed time period<br>• lacks initiative and foresight | Requires frequent supportive cues and direction |
| Dependent (D) | Level of clinical practice is unsafe if left unsupervised | • unable to correlate theoretical knowledge to clinical practice<br>• lacks coordination when performing skills<br>• unable to achieve intended purpose<br>• unable to perform within a delayed time period<br>• no initiative or foresight | Requires continuous supervision and direction |

Bondy, K. N., (1983). Criterion-referenced definitions for rating scales in clinical evaluation. *Journal of Nursing Education*, 22(9), 376-382.

# Appendix 2:
# Australian Nursing and Midwifery Council Nurse Practitioner Competencies

## Competency Framework

**Standard 1: Dynamic practice that incorporates application of high-level knowledge and skills in extended practice across stable, unpredictable and complex situations**

Competency 1.1: Conducts advanced, comprehensive and holistic health assessment relevant to a specialist field of nursing practice.

Competency 1.2: Demonstrates a high level of confidence and clinical proficiency in carrying out a range of procedures, treatments and interventions that are evidenced-based and informed by specialist knowledge.

Competency 1.3: Has the capacity to use the knowledge and skills of extended practice competencies in complex and unfamiliar environments.

Competency 1.4: Demonstrates skills in accessing established and evolving knowledge in clinical and social sciences, and the application of this knowledge to patient care and the education of others.

**Standard 2: Professional efficacy whereby practice is structured in a nursing model and enhanced by autonomy and accountability**

Competency 2.1: Applies extended practice competencies within a nursing model of practice.

Competency 2.2: Establishes therapeutic links with the patient/client/community that recognise and respect cultural identity and lifestyle choices.

Competency 2.3: Is proactive in conducting clinical service that is enhanced and extended by autonomous and accountable practice

**Standard 3: Clinical leadership that influences and progresses clinical care, policy and collaboration through all levels of health service**

Competency 3.1: Engages in and leads clinical collaboration that optimise outcomes for patients/clients/communities.

Competency 3.2: Engages in and leads informed critique and influence at the systems level of health care.

# Centre for Palliative Care

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