INSTITUTE
OF MEDICINE

ROYAL COLLEGE OF
PHYSICIANS OF IRELAND

HIGHER SPECIALIST TRAINING IN

PALLIATIVE MEDICINE

OUTCOME BASED EDUCATION CURRICULUM

This Curriculum of Higher Specialist Training in Palliative Medicine was developed in 2023 by a working group led by Dr Aisling O'Gorman, Consultant in Palliative Medicine and the RCPI Workplace Education Team. The Curriculum undergoes an annual review process by the National Specialty Director(s) and the RCPI Workplace Education Team. The Curriculum is approved by Prof Karen Ryan, National Specialty Director, the Specialty Training Committee, and the Institute of Medicine.

Version	Date Published	Last Edited By	Version Comments
3.0	July 2026	Stephen Capper	Minor edits to: - Teaching Attendance - Summary of Expected Experience - Teaching Appendix - Assessment Appendix Updates to the Core Professional Skills section to explicitly align with the *Eight Domains of Good Professional Practice*.

National Specialty Directors' Foreword

Palliative Medicine is the branch of medicine involved in the treatment of patients with life-limiting illness. The palliative care approach should be used by all doctors, but palliative medicine specialists provide care to patients with complex problems related to life-limiting illness, This includes; patients with complex and difficult to manage pain and other symptoms; patients and families with severe psychosocial problems associated with a diagnosis of life-limiting illness; complex decision making in relation to appropriate goals of care, and addressing issues of near futility, withholding and withdrawing of treatment; current, future and advance care planning in the context of life-limiting illness; conflict within and between teams, patients and families about clinical decisions. Palliative medicine specialists, through consultation services and formal and informal education, support other health care staff in providing the palliative care approach.

Palliative medicine specialists therefore need expertise in the management of life-limiting illnesses, and the associated symptoms; excellent communication skills with patients, families, and other health care staff; expertise in legal and ethical concepts relevant to the field.

The Palliative Medicine HST curriculum is now structured to support an outcomes-based programme of training. Specialty goals are aligned to key areas of practice and mirror the six domains of practice described in the National Palliative Care Competence Framework (2014). Each goal is associated with several training outcomes that reflect the sum of day-to-day practice in Palliative Medicine. Trainees should demonstrate proficiencies in each outcome matched to the level of their training; over time, Trainees should progress to achieve independent competence in each outcome and associated goal. Trainers will link closely with their Trainees assisting them and evaluating their progress on a regular basis. Upon satisfactory completion of specialist training, Trainees will be competent to undertake comprehensive medical practice in the specialty of Palliative Medicine in a professional manner, unsupervised and independently and/or within a team, in keeping with the needs of the healthcare system.

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INTRODUCTION

This section includes an overview of the Higher Specialist Training programme and of this Curriculum document.

Purpose of Training

This programme is designed to provide training in Palliative Medicine in approved training posts, under supervision, to fulfil agreed curricular requirements. Each post provides a Trainee with a named Trainer and the programme is under the direction of two National Specialty Directors in Palliative Medicine.

Purpose of the Curriculum

The purpose of the curriculum is to define the relevant processes, contents, outcomes, and requirements to be achieved. The curriculum is structured to delineate the overarching goals, outcomes, expected learning experiences, instructional resources and assessments that comprise the Higher Specialist Training (HST) programme. It provides a feedback framework for successful completion of HST programme.

In keeping with developments in medical education and to ensure alignment with international best practice and standards, the Royal College of Physicians (RCPI) have implemented an Outcomes Based Education (OBE) approach. This curriculum design differs from traditional minimum based requirement designs in that the learning process and desired end-product of training (outcomes) are at the forefront of the design to provide the essential training opportunities and experiences to achieve those outcomes.

How to Use the Curriculum

Trainees and Trainers should use the Curriculum as a basis for goal-setting meetings, delivering feedback, and completing assessments, including appraisal processes (Quarterly Assessments/End of Post Assessment, End of Year Evaluation). Therefore, it is expected that both Trainees and Trainers familiarise themselves with the Curriculum and have a good working knowledge of it.

Trainees are expected to use the curriculum as a blueprint for their training and record specific feedback, assessments and training events on ePortfolio. The ePortfolio should be updated frequently during each training placement.

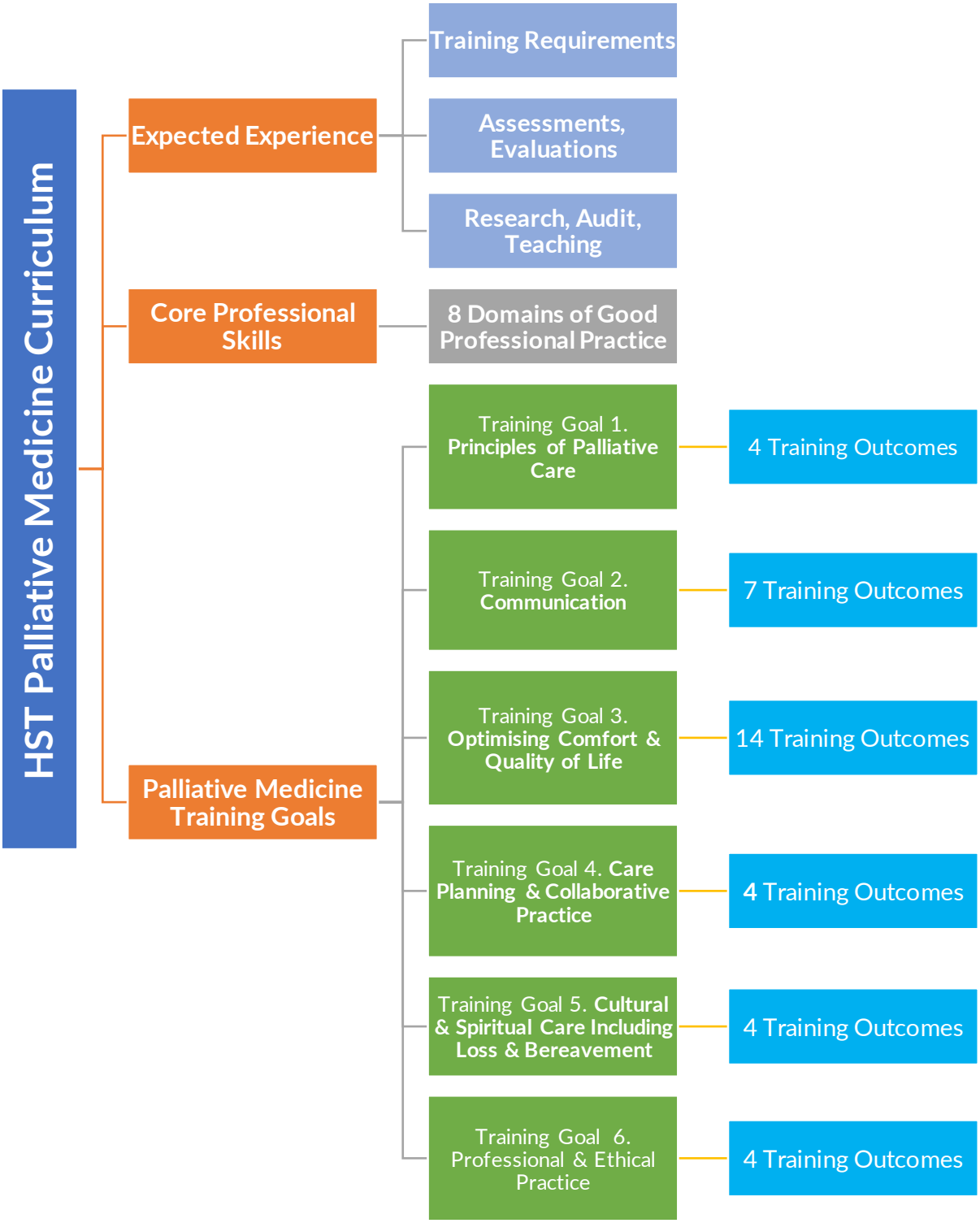
It is important to note that ePortfolio is a digital repository designed to reflect curriculum requirements. It facilitates recording of progress through HST and evidence that training is valid and appropriate. While a complete ePortfolio is essential for HST certification, Trainees and Trainers should always refer to the curriculum in the first instance for information on the requirements of the training programme.

Please note: It is the responsibility of the Trainee to keep an up-to-date ePortfolio throughout the programme as it reflects their individual training experience and it documents that they have successfully met training standards as expected by the Medical Council.

Reference to Rules & Regulations

Please refer to the Training Handbook for rules and regulations associated with training. Policies, procedures, relevant documents, and Training Handbooks can be accessed on the RCPI website by following this link.

Overview of Curriculum Sections & Training Goals



EXPECTED EXPERIENCE

This section details the training experience that all Trainees are expected to complete over the course of Higher Specialist Training.

Duration & Organisation of Training

The duration of HST in Palliative Medicine is 4 years. A minimum of three years must be spent in clinical posts provided by the Palliative Medicine HST scheme; while all 4 years can be completed in HST training posts, Trainees may also consider Out of Clinical Programme Experience (OCPE) training opportunities as part of their programme (see below).

Core Training

Trainees must spend the first two years of training in HST clinical posts in Ireland. The programme aims to be flexible in terms of sequence of training after this time.

Out of Programme Experience (OCPE)

Trainees can undertake one, or more years out of their HST programme to pursue research, further education, special clinical training, lecturing experience or other relevant experiences.

OCPE must be preapproved, and retrospective credit cannot be applied.

It must be noted that even if Trainees can undertake more than one year to complete their OCPE of choice, RCPI would award a maximum of 12 months of training credits towards the achievement of CSCST. In certain circumstances, RCPI may award no credits. The decision of whether to award credits for one year may differ from specialty to specialty and it is discretionary by the NSDs of each respective specialty.

For more information on OCPE, please refer to the RCPI website (here).

Training Principles

During the period of training the Trainee must take increasing responsibility for seeing patients, undertaking ward consultations, making decisions, and operating at a level of responsibility which would prepare him/her/ them for practice as an independent Consultant. New patients should be seen throughout the training period under suitable supervision in in-patient, community, day hospice, out-patient and hospital settings and the consultant Trainer should review specialist palliative care in-patient admissions directly with the Trainee. Supervision should be particularly close during the first one or two years. Particularly experienced Trainees may undertake the running of an outpatient clinic on their own without direct consultant supervision later in the programme. Over the course of HST, Trainees are expected to gain experience in a variety of hospital settings, including regional posts where possible. At the start of each post, fill out a Personal Goals form with their Trainer and upload it on ePortfolio; the form should be agreed and signed by both Trainee & Trainer.

Core Professional Skills

Generic knowledge, skills and attitudes support competencies that are common to good medical practice in all the medical and related specialties. It is intended that all Trainees should re-affirm those competencies during Higher Specialist Training. No timescale of acquisition is imposed, but failure to make progress towards meeting these important objectives at an early stage would cause concern about a Trainee's suitability and ability to become an independent specialist.

Recording of Evidence of Training

Training in Palliative Medicine requires expert knowledge and skill in assessment and management of palliative care problems occurring in a broad range of conditions. Problems may be experienced by patients located in home, hospital, or hospice-based settings. Palliative Medicine physicians may provide care on a consultative basis, as part of a shared-care arrangement, or as the Most Responsible Physician. The fundamental basis of training in Palliative Medicine, therefore, is rotation with experience developed from exposure to different services, different settings of care, different specialties, and different Trainers.

To complete the HST Training Programme in Palliative Medicine, Trainees are expected to spend a minimum of three years in clinical practice in specialist palliative care settings. During this time, Trainees are expected to observe the following rotations requirements:

1. **Adult palliative care clinical experience**:

   - A minimum of 12 months in a high-intensity specialist palliative care in-patient unit (SPC IPU) post (see table 1 below for guidance on 'high-intensity' versus 'low intensity' posts)
   - A minimum of 6 months in a high-intensity community palliative care (CPC) post **or** a minimum of 12 months in low-intensity community palliative care posts.
   - A minimum of 12 months in a high-intensity hospital palliative care (HPC) post **or** a minimum of 18 months in low-intensity hospital palliative care posts.

2. **Paediatric palliative care clinical experience:**

   All adult posts may be described as providing 'high intensity' paediatric care or 'low intensity' paediatric palliative care (PPC) training. It is expected that over the course of training, Trainees should acquire a minimum of one year of high intensity PPC training. In all posts is expected that Trainees should gain experience in the provision of palliative care to at least two children and/ or adolescents or young adults per year through observation or direct engagement of care provision. See table 2 below.

Table 1: Adult palliative care clinical experience

	High intensity	**Low intensity**
In-patient unit (IPU)	The Trainee is afforded opportunity to gain in-depth experience working with an IPU MDT and providing care to a broad range of in-patients from point of admission to discharge or death. High-intensity SPC IPU posts must afford Trainees opportunity to participate in a minimum of: • Two consultant-led ward rounds per week, • One Trainee-led ward round per week, • One family meeting per week, • One admission meeting per week, • One handover meeting per week • One MDT per week. • One consultant-led ward round per month that occurs the morning after the Trainee has been on call. High-intensity IPU posts should provide Trainees with opportunity to participate in the provision of paediatric palliative care e.g., through attendance at local paediatric clinics on study half-days.	Not applicable
Community palliative care (CPC)	The Trainee is afforded opportunity to gain in-depth experience working with a CPC MDT and providing care to a broad range of CPC patients from point of clerking to discharge, transfer or death. High-intensity CPC posts must afford Trainees opportunity to participate in a minimum of:	The Trainee is afforded opportunity to gain in-depth experience working with a CPC MDT and providing care to a broad range of CPC patients from point of clerking to discharge, transfer or death. Low-intensity CPC posts must afford Trainees opportunity to participate in a minimum of:

	• One consultant-led 'dry round'/ 'indirect case review' and/ or CPC MDT per week, • One handover meeting, • Four patient reviews per week (can be either new patients or review patients; can comprise in-person and virtual consultations). High-intensity CPC posts should also afford Trainees opportunity to conduct family meetings and chair MDT meetings on a regular basis according to Trainee acquired competences. High-intensity CPC posts should afford Trainees opportunity to engage with GP, primary care, and other community-based teams (e.g., residential care teams, integrated care teams). High-intensity CPC posts should provide Trainees with opportunity to directly participate in the provision of paediatric palliative care.	• Two consultant-led 'dry rounds'/ 'indirect case reviews' and/ or CPC MDTs per month. • One handover meeting, • Eight patient reviews per month (can be either new patients or review patients; can comprise in-person and virtual consultations). Low-intensity CPC posts should also afford Trainees opportunity to conduct family meetings and chair MDT meetings on a regular basis according to Trainee acquired competences. Low-intensity CPC posts should afford Trainees opportunity to engage with GP, primary care, and other community-based teams (e.g., residential care teams, integrated care teams). Low-intensity CPC posts should provide Trainees with opportunity to participate in the provision of paediatric palliative care. In a low-intensity CPC post, the Trainee may spend the remainder of the week in SPC IPU/ OPD or hospital-based services.
Hospital palliative care (HPC)	The Trainee is afforded opportunity to gain in-depth experience working with an HPC MDT and providing care to a broad range of in-patients from point of admission to discharge or death. High-intensity HPC posts must afford Trainees opportunity to participate in a minimum of: • Two consultant-led consultation rounds per week, • One Trainee-led consultation round per week, • One family meeting per week, • One handover meeting per week • One MDT per week. High-intensity hospital posts should provide Trainees with opportunity to participate in the provision of paediatric palliative care e.g., through attendance at local paediatric clinics on study half-days.	The Trainee is afforded opportunity to gain in-depth experience working with an HPC MDT and providing care to a broad range of in-patients from point of admission to discharge or death. Low-intensity HPC posts must afford Trainees opportunity to participate in a minimum of: • One consultant-led consultation round per month • Two Trainee-led consultation round per month, • One family meeting per month, • One handover meeting per month • Two MDTs per month. In a low-intensity CPC post, the Trainee may spend the remainder of the week in SPC IPU/ OPD or hospital-based services. Low-intensity hospital posts should provide Trainees with opportunity to participate in the provision of paediatric palliative care e.g., through attendance at local paediatric clinics on study half-days.

Table 2: Paediatric palliative care clinical experience

	High intensity	**Low intensity**
Paediatric palliative care	High intensity posts are those posts where Trainees are likely to be involved in the care of a child or adolescent or young adult (AYA) with palliative care needs (e.g., CPC settings or posts with opportunity to attend CHI/ Temple St placements). • In high intensity posts, Trainees should avail of the opportunities that present themselves to be directly involved in the care of a child or AYA who is receiving specialist palliative care. In high-intensity posts, Trainees must: • Spend a minimum of 4 protected half-days 'study half-days' a year attending settings where paediatric care is provided (e.g., local paediatric OPD settings, paediatric palliative care ward rounds, Laura Lynn Hospice) • Attend a minimum of one paediatric palliative care study day organised by the national Paediatric Specialist Palliative Care team. • Present a minimum of one journal article related to paediatric palliative care at journal club per year • Engage in one teaching activity related to paediatric palliative care per year.	Low intensity posts are those posts where Trainees are unlikely to encounter a child or AYA with palliative care needs as part of the usual patient population served in that setting (e.g., specialist palliative care adult in-patient unit). In low intensity posts, Trainees must: • Spend a minimum of 4 protected half-days a year attending external settings where paediatric care is provided (e.g., local paediatric OPD settings, paediatric palliative care ward rounds, Laura Lynn Hospice) • Attend a minimum of one paediatric palliative care study day organised by the national Paediatric Specialist Palliative Care team. • Present a minimum of one journal article related to paediatric palliative care at journal club per year • Engage in one teaching activity related to paediatric palliative care per year. Trainees should also avail of any opportunity that may present itself to gain practical experience in paediatric palliative care within the organisation that they are working (e.g., a Trainee's placement may be based in the IPU, but a paediatric patient may receive care from CPC thus affording educational opportunity to be directly or indirectly involved in care).

Other rotational requirements:

- Trainees may spend two years based in one specialist palliative care service only when:

    1. The Trainee has a different Trainer assigned each year
    2. The service is organised such that the training experience afforded to the Trainee on the second year is substantially different to the training experience afforded in the first year, and offers new learning opportunities in the opinion of the STC (e.g., the MDT attached to each Trainer functions independently and separate ward rounds/ MDTs are held for high intensity IPU posts; a Trainee works in a high intensity IPU post for the first year and a high intensity CPC post for the second year within the same SPC service).

- Trainees may not spend three years based in one specialist palliative care service regardless of number of Trainers present in that SPC service. It should be noted that hospital and hospice services that are closely linked (i.e., where consultants have shared working arrangements across neighbouring hospices and hospitals) are considered as single functional SPC services for the purposes of Higher Specialist Training.

- Rotation experience should be gained across a minimum of two Regional Health Areas.

- At the start of each post, Trainees are expected to fill out a Personal Goals form with their Trainer and upload it on ePortfolio; the form should be agreed and signed by both Trainee & Trainer

- Regular participation in on-call rota

Clinics, Ward Rounds, Consultations, Training Activities

Attendance at Clinics, participation in Ward Consults, performing specific procedures, are required elements of HST. The timetable and frequency of attendance should be agreed with the assigned Trainer at the beginning of the post.

Hospital-Based Learning & In-House Commitments

Trainees are expected to attend in-house commitments:

- At least one **Grand Rounds** per month
- At least one **Journal Club** per month
- At least three **MDT meetings** per month

Research, Audit & Teaching Experience

Trainees are expected to complete the following activities:

- Deliver **12 teaching sessions** (to include tutorials, lectures, bedside teaching, etc.) over the course of 4 years of HST
- Deliver **2 oral presentation**, over the course of HST
- Complete **1 Audit or Quality Improvement Project**, per year
- Attend **1 National or International Meeting**, per each year of HST
- Engage in **1 policy procedures guideline** (ppg) development or revision over the course of 4 years

In addition, it is recommended that Trainees aim to:

- Complete **1 research project**, over the course of 4 years of HST
- Complete **1 publication**, over the course of 4 years of HST

Teaching Attendance

Specialist Registrars are expected to attend courses and study days as detailed in the Teaching Appendix, Teaching Appendix, at the end of this document.

Evaluations, Assessments & Evaluations

Trainees are expected to:

- Complete **4 quarterly assessments per training year** (1 Assessment per quarter)
- Complete **1 end of post assessment at the end of each post** (this can replace the quarterly Assessment if happening at the end of a post, for more information, please check the Assessment Appendix at the end of this document)
- Complete **1 end of year evaluation at the end of each training year**
- Complete all the **workplace-based assessments** as outlined in the table below and as agreed with Trainer.

For more information on evaluations, assessment, and examinations, please refer to the Assessment Appendix at the end of this document.

Summary of Expected Experience

Experience Type	Expected	ePortfolio form
Rotation Requirements	Complete all requirements related to the posts agreed	n/a
Personal Goals	At the start of and midway through each post complete a Personal Goals form on ePortfolio, agreed with your Trainer and signed by both Trainee & Trainer.	Personal Goals
On-call Commitments	Partake in on-call commitments in Palliative Medicine for the full duration of the programme and record attendance on ePortfolio	Clinical Activities
Clinics	Attend Palliative Medicine (or appropriate) Medicine outpatient and or related Clinics as agreed with your Trainer and record attendance per each post on ePortfolio	Clinics
Ward Rounds/Consultations	Gain experience in clinical handover and ward rounds as agreed with your Trainer and record attendance per each post on ePortfolio	Clinical Activities
MDT	Gain experience in presentation at and participation in multidisciplinary team meetings	
Deliver Teaching	Record on ePortfolio all the occurrences where you have delivered Tutorials (at least 1 per Year), Lectures (at least 1 per Year), and Bedside teaching (at least 1 per Year).	Delivery of Teaching
Research	Desirable Experience: actively participate in research, seek to publish a paper and present research at conferences or national/international meetings	Research Activities
Publication	Desirable Experience: complete 1 publication during the training programme	Additional Professional Activities
Presentation	Deliver 2 oral presentation or poster over the course of the training programme	Additional Professional Activities
Audit	Complete and report on an audit or Quality Improvement (QI)per each year of training, either to start, continue or complete	Audit and QI
Attendance at In-House Activities	Regular attendance at in house activities, depending on training site, for example, Grand Rounds, Journal Clubs, Radiology Conferences, MDT Meetings. Record attendance on ePortfolio	Attendance at In-House Activities
National/International Meetings	Attend 1 per year of training	Additional Professional Activities
Teaching Attendance	Attend courses and Study Days as detailed in the Teaching Appendix	Teaching Attendance
Evaluations and Assessments	Complete a Quarterly Assessment/End of post assessment with your Trainer 4 times in each year. Discuss your progress and complete the form.	Quarterly Assessments/End-of-Post Assessments
Workplace-based Assessment	Complete all the workplace-based assessment as agreed with your Trainer and complete the respective form.	CBD/DOPS/Mini-CEX
End of Year Evaluation	Prepare for your End of Year Evaluation by ensuring your portfolio is up to date and your End of Year Evaluation form is initiated with your Trainer.	End of Year Evaluation

CORE PROFESSIONAL SKILLS

This section includes the Irish Medical Council guidelines for medical professional conduct.

*The Medical Council has defined **eight domains of good professional practice**.*

These domains describe a framework of competencies applicable to all doctors across the continuum of professional development from formal medical education and training through to maintenance of professional competence. They describe the outcomes which doctors should strive to achieve and doctors should refer to these domains throughout the process of maintaining competence.

These principles are woven into training practice and feedback is formally provided in the Quarterly Assessments, End of Post, and End of Year Evaluation.

Core Professional Skills

The Core Professional Skills (CPS), updated in 2026, define the standards of professional practice expected of all doctors in postgraduate training across RCPI specialties. Aligned with the *Eight Domains of Good Professional Practice* (**Irish Medical Council, 2024**), they provide the standards of practice across the continuum of professional development, from formal medical education and training through the maintenance of professional competence.

The CPS are embedded within the formal structures of training and are developed through clinical practice, workplace-based learning, supervision, and structured educational activity. CPS are assessed through workplace-based assessment, quarterly assessments, and ePortfolio evidence, ensuring that Trainees embed professionalism in their practice. Within this, the RCPI Taught Programme provides structured educational content through which CPS standards are addressed and contextualised across all levels of training.

Within each domain identified by the Medical Council, the cross-speciality RCPI Clinical Working Group has articulated key areas of professional practice and relevant expectations for training. Collectively, the domains support professionalism as a core component of safe, effective, and patient-centred care.

1 Patient Safety and Quality of Patient Care

Doctors must place patient safety and quality of care at the centre of practice, ensuring accountability to patients, their profession, and their organisation. This requires addressing risks, managing incidents, preventing infection, and driving continuous improvement within governance and ethical standards. By embedding safety and accountability into practice, doctors protect patients from preventable harm, strengthen trust, and uphold professional integrity.

Quality Improvement

- Apply quality improvement methods (e.g., audit, evaluation) to monitor and enhance care.
- Analyse and interpret patient, staff, and system data to inform service improvements.

Patient Safety and Incident Management

- Apply safe practices in prescribing, procedures, referrals, infection prevention and control, care transitions, and near-patient diagnostics.
- Identify, escalate, and report risks, incidents, near-misses, and notifiable events in line with statutory and professional duties.
- Participate in open disclosure after adverse events, in line with statutory duty.

Infection Prevention and Control

- Implement evidence-based infection prevention and control, including hand hygiene, aseptic technique, safe PPE use, and safe management of medical devices and clinical environments.

System Safety and Governance

- Demonstrate understanding of local governance structures, reporting systems, and escalation pathways.
- Recognise and escalate organisational or service barriers (e.g., unsafe premises, processes, or systems) that compromise patient safety or timely access to care.

Antimicrobial Resistance

- Understand behavioural, social, environmental, and geographic drivers of antimicrobial resistance in clinical decision-making.

2 Relating to Patients

Doctors must foster respectful, person-centred clinical relationships that uphold patient autonomy, dignity, and trust. This requires clear communication, protection of confidentiality, and supporting informed consent, while recognising individual needs and potential barriers to care. By practising with fairness and shared responsibility, doctors enable patients to participate meaningfully in decisions about their care and contribute to safer, more equitable outcomes.

Person-Centred Care

- Deliver care that upholds dignity, autonomy, and individual preferences, considering cultural context and social determinants of health.
- Communicate clearly and accessibly, adapting to patients' language, literacy, cognitive ability, and circumstances.

Confidentiality

- Protect confidentiality across all communications, applying data-protection legislation and managing required disclosures appropriately.
- Explain limits to confidentiality where required (e.g. safeguarding, public health, or legal duties).

Informed Consent and Shared Decision-Making

- Assess capacity and ensure discussions allow sufficient time to explain risks, benefits, and alternatives, and, where relevant, the purpose and implications of complex or sensitive procedures (e.g., genetic testing).
- Support patient autonomy through informed consent and shared decision-making, respecting valid Advance Healthcare Directives when capacity is lacking.
- Identify, address or escalate cultural and social barriers to participation in healthcare decisions.

Information and Care Navigation

- Provide clear, balanced, and evidence-based information to help patients understand their care options, make informed decisions, and access appropriate services or supports.
- Coordinate referrals and share relevant information to support continuity and navigation of care pathways.

Relationships and Boundaries

- Build respectful relationships with patients while maintaining professional boundaries.
- Be clear about the limits of competence and refer patients when required.

Health Promotion and Preventive Care

- Provide evidence-based health promotion and preventive care advice, tailored to individual risk factors.

3 Communication and Interpersonal Skills

Doctors must communicate clearly, compassionately, and safely with patients, families, and colleagues to support trust, understanding, and shared decision-making. This requires adapting communication to meet individual needs, handling challenging conversations with sensitivity, upholding professional boundaries, and ensuring accuracy in records, correspondence, and handovers. By communicating effectively across all settings, doctors reduce risk, ensure patient understanding, and promote safe, coordinated care.

Clinical Communication and Documentation

- Take accurate, structured histories and explain diagnoses, care plans, and clinical decisions with clarity and empathy.
- Apply handover protocols to ensure safe care transitions.
- Maintain complete, timely, and legible documentation to support continuity, safety, and compliance

Patient Communication and Comprehension

- Confirm and document patient understanding of information shared, including risks, benefits, alternatives, and limitations.
- Apply health literacy principles across verbal, written, digital, and visual formats.
- Deliver difficult news clearly and with empathy.
- Adapt communication to patient capacity, language, literacy, cognitive ability, or culture, involving interpreters, advocates, or supports (e.g., written materials) as required.

Safeguarding

- Conduct safeguarding discussions respectfully, protecting dignity, confidentiality, and legal compliance.
- Escalate safeguarding concerns through appropriate channels.

Complaints and Regulatory Communication

- Respond promptly and professionally to patient complaints and enquiries.
- Reduce complaint risk through clear communication, accurate records, and timely follow-up.
- Engage constructively with organisational and regulatory complaint processes and contribute to service learning.

Open Disclosure

- Participate in supervised open disclosure discussions after adverse events using honest, transparent, and compassionate communication, in line with statutory and professional standards.

Team Dialogue

- Engage in respectful and constructive dialogue with colleagues to support shared understanding and safe decisions.
- Identify and escalate communication breakdowns that may compromise patient safety.

4 Collaboration and Teamwork

Doctors must work collaboratively with colleagues across disciplines and services to deliver safe, coordinated, and high-quality care. This requires contributing to shared decisions, respecting team roles, and maintaining open and constructive communication. By promoting collaboration and teamwork, doctors strengthen service delivery, promote shared accountability, and foster continuous improvement in team-based care.

Governance and Organisational Awareness

- Understand local governance and leadership structures relevant to your role, including responsibilities and lines of accountability.
- Raise clinical, safety, resource, or organisational concerns through appropriate channels in line with governance and escalation policies

Team Coordination and Integrated Care

- Build effective working relationships with interprofessional teams, recognising the roles of all members.
- Share accountability for decision-making and care coordination, recognising the risks of fragmentation.
- Ensure continuity of care by providing timely, accurate discharge summaries.

Organisational Leadership and Team Culture

- Contribute to leadership by facilitating shared decision-making, coordinating care, and supporting junior colleagues.
- Foster psychological safety by promoting respectful communication, shared learning, and open dialogue.
- Manage conflict to support respectful, functional, and safe team environments.

Team Learning and Development

- Engage in structured team-based learning (e.g., case reviews, safety forums), to inform service improvement and professional development.
- Provide and receive feedback constructively to support team development and patient care quality.

5 Management (Including Self-Management)

Doctors must manage workload, time, and personal wellbeing to ensure safe and effective clinical practice. This requires prioritising tasks, recognising limits, escalating concerns appropriately, and engaging constructively with organisational systems and processes. By balancing personal capacity with service demands, doctors protect patients from harm, prevent burnout, and support the safe and sustainable delivery of healthcare.

Health, Wellbeing, and Development

- Monitor personal health and performance, recognising fatigue or burnout, and seek support when needed.
- Set and review professional development goals informed by reflection, supervision, and feedback.

Workload and Task Management

- Prioritise tasks to deliver timely, safe, and effective care.
- Coordinate rotas, leave, handovers, and cover to maintain service continuity.
- Communicate availability and scheduling clearly to colleagues.

Administrative Competence

- Complete documentation and administrative tasks accurately and on time.
- Engage with training and professional development, including preparation, participation, and submission of required materials.
- Fulfil supervisory and/or line-management responsibilities where appropriate (e.g., supporting colleagues, approving leave, and contributing to performance assessments).
- Use operational tools (e.g., rotas, workflows, IT systems) effectively to support safe and coordinated care.

Sustainability and Environmental Stewardship

- Order, prescribe, investigate, and deliver care responsibly, ensuring clinical necessity while adopting resource-conscious and sustainable approaches.
- Be aware of organisational sustainability initiatives (e.g., green prescribing, waste reduction).

Systems and Safety Engagement

- Recognise how system pressures (e.g. staffing levels) affect patient safety.
- Contribute to local safety monitoring, governance, and service improvement activities within role and training scope.

6 Patient Safety and Quality of Patient Care

Doctors should maintain and advance their professional competence through lifelong learning, supervision, reflection, teaching, and research. This requires engaging critically with evidence, translating learning into practice improvement, and contributing to the education and development of colleagues. By integrating inquiry, reflection, and shared learning into their work, doctors strengthen decision-making, enhance patient safety, and uphold professional standards.

Evidence-Based Practice

- Apply research evidence, guidelines, and clinical data appropriately to inform patient care.
- Use audit, service evaluation, and quality improvement data to evaluate and improve practice.

Lifelong Learning and Scope of Practice

- Comply with training and development requirements within your training programme (e.g., maintaining your ePortfolio).
- Set and evaluate learning goals informed by reflection, feedback, and supervision.
- Use insights from audits, reviews, and adverse events to improve practice.
- Recognise limits in knowledge or skill and seek supervision or escalate when required.

Teaching and Role Modelling

- Teach, supervise, and support colleagues and teams using effective communication and evidence-based practice.
- Share clinical knowledge to strengthen team learning and service improvement.
- Model professionalism, clinical integrity, critical thinking and reflective practice in everyday work.

Research and Dissemination

- Undertake audit, research, or service evaluation, disseminating and communicating findings through professional or academic channels.
- Comply with legal, institutional, and ethical standards in research activities.

Innovation and Digital Literacy

- Apply health informatics, telehealth, and emerging technologies with attention to safety, evidence base, and ethical considerations.
- Evaluate risks, benefits, and limitations of digital innovations, including AI, to ensure safe and effective patient care.

7 Professionalism

Doctors must uphold integrity, accountability, and respect in all aspects of clinical care, leadership, and professional practice. This requires complying with legal and regulatory duties, maintaining confidentiality and professional boundaries, and acting with fairness in healthcare delivery. By modelling professionalism, doctors build trust, protect patients, and promote safe, inclusive healthcare systems.

Statutory and Ethical Duties

- Comply with legal and regulatory requirements, reporting unsafe or unprofessional behaviours, and engaging with investigations and complaints.
- Fulfil safeguarding duties, including mandatory reporting of child protection and vulnerable adult concerns.
- Uphold professional boundaries across all settings to protect patient dignity, autonomy, and trust.
- Protect patient data in line with GDPR and professional standards.
- Declare and transparently manage conflicts of interest in clinical, research, and public activities.

Resource Use and Stewardship

- Use diagnostic, prescribing, and other clinical resources responsibly and fairly, ensuring clinical justification.
- Integrate sustainability principles into practice, balancing immediate patient needs with long-term system and environmental responsibility.

Advocacy, Equity and Fair Practice

- Treat patients and colleagues with dignity and respect, ensuring care is free from discrimination.
- Advocate for fair access to, and equitable experience within, healthcare by recognising and addressing diverse needs and social or structural barriers, inclusive of disability and socioeconomic disadvantage.

Antimicrobial Stewardship

- Prescribe antimicrobials responsibly, selecting agents, dosing, and duration appropriately.
- Participate in stewardship initiatives, such as audits, surveillance, and outbreak management.

Professional Leadership and Accountability

- Represent the profession with integrity, modelling leadership that promotes a culture of safety, openness, and professional accountability.
- Take responsibility for patient safety by identifying and escalating risks, and contributing to learning (e.g., AAR, NIMS).
- Manage personal or team workload pressures, escalating where necessary to maintain safe practice.
- Recognise and respond to signs of stress or impaired performance in self and colleagues, addressing appropriately to safeguard wellbeing and team function.

Public and Online Professional Conduct

- Uphold professional standards in all online and social media activity, recognising that the same expectations apply as in face-to-face communication.
- Maintain patient confidentiality and clear boundaries, separating personal and professional use, and directing patient contact through formal channels.
- Ensure that public communications are accurate, evidence-based, and compliant with regulatory standards.

8 Clinical Skills

Doctors must maintain and apply clinical skills that enable safe, accurate, and effective assessment, diagnosis, and treatment across all stages of patient care. This requires integrating patient history, examination findings, investigations, and patient context to inform clinical reasoning, safe prescribing, and appropriate escalation or referral. By applying these skills responsibly, doctors support patient safety, ensure continuity of care, and deliver high-quality outcomes across healthcare settings. This Domain addresses the professional and ethical responsibilities that underpin the safe application of practice, complementing specialty-specific technical competencies.

Assessment and Reasoning

- Conduct comprehensive assessments, with consent, integrating history, examination, investigations, and patient context.
- Apply structured reasoning to generate differential diagnoses and safe management plans, using evidence and guidelines.
- Recognise uncertainty, limits of competence, or impaired performance, and escalate or seek supervision when required.
- Take account of the patient's psychological, social, and contextual factors where clinically relevant to safe decision-making.
- Use digital tools responsibly to support assessment, decision-making, and care delivery.

Transfer of Care

- Refer or transfer patients as required, contributing to collaboration, coordination, and continuity across services.

Records and Communication

- Maintain accurate and timely records and correspondence to support safe handover, discharge, and care transitions, complying with legal and data protection standards.

Complex Care Planning

- Initiate and participate in discussions regarding high-risk or complex care, including end-of-life care and advanced planning, ensuring shared decision-making.
- Provide person-centred care for patients with life-limiting illness, including pain and symptom control, and family support.

Safe Prescribing

- Prescribe safely and appropriately, selecting the correct drug, dose, route, and duration, and ensure monitoring or handover where required.

SPECIALTY SECTION – PALLIATIVE MEDICINE TRAINING GOALS

This section includes the Palliative Medicine Training Goals that the Trainee should achieve by the end of Higher Specialist Training.

Each Training Goal is broken down into specific and measurable Training Outcomes.

Under each Outcome there is an indication of the suitable and recommended training/learning opportunities and assessment methods.

In order to achieve the Outcomes it is recommended to agree on the most appropriate type of training and assessment methods with the assigned Trainer.

Training Goal 1 – Principles of Palliative Care

By the end of HST the Trainee will understand the role of Palliative Medicine as a speciality within the wider health service. Trainees will demonstrate ability to develop and lead a palliative care service, educate other healthcare professionals about palliative care, and promote the concept of palliative care amongst wider society.

Outcome 1 of 4 – Practice according to the principles of palliative care

Practice according to the principles of palliative care, demonstrating appropriate self-awareness and taking account of the origins and evolution of the specialty.

What this outcome means

Trainees will be able to:

- Describe the historical development of palliative care services
- Understand the evolution of palliative care e.g., early integration and chronic disease management.
- Demonstrate personal and professional skills that engage in critical examination of personal attitudes, values, and beliefs with regards to life and death

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX)
- RCPI Taught Programme
- Study Day(s)

Outcome 2 of 4 – Contribute to the development of Palliative Care as a specialty

Acquire knowledge and understanding to contribute to the further development of Palliative Medicine as a specialty (including understanding resourcing and organisation of services, public health approach to palliative care, overcoming barriers to care, facilitating equitable access to palliative care for all who need it)

What this outcome means

Trainees will be able to:

- Outline the structures, funding, and organisation of palliative care services in Ireland and the interface between HSE/ statutory services and voluntary groups including the role of volunteers and fundraising teams
- Demonstrate awareness of health inequities in palliative care both nationally and internationally and the factors that contribute to this
- Recognise the effect of health inequities on palliative care access, quality, and outcomes
- Analyse individual and structural barriers to care, including system gaps
- Understand how the Irish palliative care health system compares with other health systems across the globe and how these impacts on health outcomes
- Apply population perspective to the development and management of palliative care services
- Be aware of societal expectations and perceptions regarding life-limiting conditions and death.
- Understand health promoting concepts in palliative care
- Support community engagement in health-promotion about end of life
- Promote palliative care for all – understand the role of patients, families, and communities in enhancing quality of life for people with life limiting conditions

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX)
- Domiciliary Visits
- Family Meetings
- RCPI Taught Programme
- Study Days

OUTCOME 3 OF 4– CONTRIBUTE TO EDUCATION, RESEARCH, AND QI

Able to contribute to palliative care education, research, and quality improvement

What this outcome means

Trainees will be able to:

- Engage in quality improvement activities relevant to palliative care
- Apply the principles of lifelong learning to own practice in Palliative Medicine
- Demonstrates a strong commitment to continuing education to maintain and further develop skills and knowledge
- Develop, implement, and critically review new knowledge and research relevant to field of palliative care
- Contribute to the development of palliative care by research

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX)
- RCPI Taught Programe
- Study Days

OUTCOME 4 OF 4 (PAEDIATRIC) – APPLICATION OF ADULT PALLIATIVE CARE PRINCIPLES TO PAEDIATRIC CARE

Understand the appropriate application of the principles of adult palliative care practice to the paediatric setting, including the special considerations involved in adopting a shared care approach with paediatricians, paediatric palliative care specialists and general practitioners in this setting

What this outcome means

Trainees will be able to:

- Be familiar with national policies and guidance documents that refer to paediatric palliative care
- Understand what is meant by the 'core paediatric palliative care team'
- Understand the role and responsibilities of a community or hospital-based palliative care physician who is acting as a member of the core paediatric palliative care team
- Advise, liaise, and collaborate with hospital, hospice, and community teams to promote robust planning and processes are in place for quality symptom management and end-of-life care
- Understand that children are not 'small adults' and that care, consideration and reflective practice are integral to the practice of paediatric palliative care, including knowledge of where to seek advice or support when required
- Demonstrate understanding of age and development on the child's understanding of the illness

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX)
- Domiciliary Visits
- Family Meetings
- RCPI Taught Programme
- Study Day(s)

Training Goal 2 – Communication

By the end of HST the Trainee is expected to become proficient in advanced communication skills with a wide variety of people that will be engaged with in day-to-day practice. These include fellow Palliative medicine specialists, other specialists, patients, families, and carers, patient support groups, health, and social care professionals. Trainees will develop and demonstrate sensitive and specific communication skills using a person-centred approach.

Outcome 1 of 7 – Communicate sensitively and effectively with patients and families

Able to communicate sensitively and effectively with patients and families using a person-centred approach, active listening and using the communication style most appropriate to the situation, taking account of the patient / family member's age, life experience and health status, using technology and communication aids as appropriate.

What this outcome means

Trainees will be able to:

- Communicate using a person-centred approach that respects autonomy and is characterized by empathy and compassion
- Communicate sensitively, using active listening, consulting, negotiating, and engaging patients and those close to them in their care
- Adapt the style of communication that most appropriately considers the impact of health conditions on patients' and carers' ability to process and understand information
- Use expert communication as a therapeutic intervention to manage care
- Assess the needs of children, adolescents, and young adults (either as patients or family members) at different development stages and communicate according to their needs
- Be aware of factors which may impact an individual's ability to communicate (e.g., Life experience, health status) and communicate according to their needs
- Apply technology to aid clinical assessment and communication in palliative care

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX)
- Domiciliary Visits
- Family Meetings
- RCPI Taught Programme
- Study Days

Outcome 2 of 7 – Support healthcare professionals

Able to support healthcare professionals to care for patients with life limiting conditions across all care settings through effective written and verbal communication.

What this outcome means

Trainees will be able to:

- Recognise the importance of effective communication to the care of patients with life limiting conditions who have multiple healthcare professionals involved in their care
- Communicate effectively with healthcare professionals in written/verbal formats

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX)
- Domiciliary Visits
- Family Meetings
- RCPI Taught Programme
- Study Days

OUTCOME 3 OF 7 – FACILITATE INTER AND INTRADISCIPLINARY COMMUNICATION

Facilitate effective inter and intradisciplinary communication, including providing feedback and/or mediation when needed

What this outcome means

Trainees will be able to:

- Understand roles and responsibilities within the MDT, elicit, input, and engage in bidirectional feedback.
- Anticipate, mediate, and manage complex and challenging situations within the MDT
- Facilitate effective communication across teams, organisations, and care settings

Learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX)
- Domiciliary Visits
- Family Meetings
- RCPI Taught Programme
- Study Days

OUTCOME 4 OF 7 – TEACH HEALTHCARE PROFESSIONALS COMMUNICATION

Able to teach healthcare professionals regarding communication in palliative care practice

What this outcome means

Trainees will be able to:

- Support the development of healthcare professionals' skills in effective and sensitive communication through integrated care and expert communication and education
- Identify opportunities for reflective practice and experiential learning in communication

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX)
- Domiciliary Visits
- Family Meetings
- RCPI Taught Programme
- Study Days

OUTCOME 5 OF 7 – (PAEDIATRICS) EFFECTIVE COMMUNICATION WITH PROFESSIONALS FOR PROVISION OF PALLIATIVE CARE

Able to communicate effectively with professionals involved in the provision of palliative care to children and young people with progressive, life-limiting conditions

What this outcome means

Trainees will be able to:

- Engage with the pre-hospital discharge process including an MDT meeting to coordinate the discharge of a child home for end-of-life care
- Understand the mechanisms through which teams collaborate and share written information such as "my story folder" or secure email threads, and contributes to such mechanisms
- Interpret and implement individual paediatric care plans including day to day clinical management plans, out-of-hours plans, treatment escalation plans and Emergency Care Plans and Ambulance Care Directives
- Communicate sensitively and effectively with children and young people using a person-centred approach and using appropriate psychosocial assessment tools e.g., HEEADSSS
- Work collaboratively as part of the core team of paediatric palliative care providers, which may include seeking advice about the most appropriate communication style appropriate to the child's age and developmental stage, referring to literature, and arranging joint paediatric / palliative medicine consultations where appropriate

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX)
- Domiciliary Visits
- Inpatient consultations
- Family Meetings
- RCPI Taught Programme
- Study Days

OUTCOME 6 OF 7 – (PAEDIATRICS) COMMUNICATION WITH CHILDREN AND YOUNG PEOPLE IN APPROPRIATE MANNER

Able to communicate with children and young people who have progressive, life limiting conditions in an age and developmentally appropriate manner

What this outcome means

Trainees will be able to:

- Demonstrate awareness of neurocognitive and emotional development during childhood, adolescence and into adulthood, and how it can affect a person's understanding of their illness and their ability to communicate with care givers on their needs and wants.
- Understand the importance of acknowledging the experience and expert knowledge of the parents.

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX)
- Domiciliary visits
- Inpatient consultations
- Family meetings
- RCPI Taught Programme
- Study Days

OUTCOME 7 OF 7 – (PAEDIATRICS) EMPOWER AND ASSIST OTHER MEMBERS OF THE MDT

Able to empower and assist other members of the MDT, with caring for the child or young person with a progressive life limiting condition.

What this outcome means

Trainees will be able to:

- Understand the role of each member of the MDT caring for a child or young person with LLC from the statutory and voluntary sector and the importance of communication in the care of patients with life limiting conditions who have multiple healthcare professionals involved in their care
- Understand role delineation and the limitations of a specialist palliative care team in caring for a child or young person with a life limiting condition.

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX)
- Domiciliary Visits
- Inpatient consultations
- Family meetings
- RCPI Taught Programme
- Study Days

Training Goal 3 – Optimising Comfort & Quality of Life

By the end of HST the Trainee is expected to demonstrate the ability to perform a comprehensive specialist palliative medical assessment on patients with complex specialist palliative care needs, to manage complex symptoms in patients with life limiting conditions across all care settings.

OUTCOME 1 OF 14 – HOLISTIC ASSESSMENT OF PALLIATIVE CARE NEEDS

Able to undertake a holistic assessment of palliative care needs that is consistent with best practice, taking account of relevant contextual factors such as illness trajectory, and forming appropriate conclusions regarding plan of care.

What this outcome means

Trainees will be able to:

- Identify and advocate for the palliative care needs of patients and families
- Understand the evolving needs of patients and families over the course of illness
- Understand the impact of Illness in patients with pre-existing health problems (social, psychiatric, psychological, physical)
- Recognise transition points during illness and the need for reassessment and review of patients
- Identify the level of palliative care service provision that is required to address need
- Recognise the need for regular review of symptom response and adverse effects of treatment
- Demonstrate knowledge of national and international clinical guidelines, position papers etc.

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- Clinical experience in other specialties (e.g., Interventional Pain Medicine, Radiation Oncology, Interventional Radiology)
- Study Days

OUTCOME 2 OF 14– ASSESSMENT OF PAIN DUE TO LIFE LIMITING CONDITIONS

Able to assess pain due to life limiting conditions, taking account of pathophysiology, concept of total pain, contextual factors such as history of substance misuse; and manage pain using safe and appropriate pharmacological and non-pharmacological strategies.

What this outcome means

Trainees will be able to:

- Formulate clear, individualised management plan considering patient preferences and reversibility
- Engage with patients and carers in setting SMART goals and manage expectations
- Demonstrate advanced understanding of pathophysiology of pain
- Appropriately use investigations in the assessment of pain
- Apply evidence based pharmacological management of complex pain including safe prescribing
- Prescribe safely in patients with organ failure, frailty, and low body weight
- Demonstrate appropriate knowledge of interventional pain techniques to effectively manage complex pain
- Refer to and work collaboratively with other pain services
- Safely manage pain in the context of substance use disorder
- Safely manage pain in the context of co-morbid psychiatric illness
- Demonstrate knowledge of the use non-pharmacological strategies to manage pain
- Demonstrate knowledge of the role of HSCPs in the management of pain
- Recognise intractable pain and adopt appropriate management strategies
- Understand the concept of total pain and strategies to support patients and families
- Support teams in caring for patients who choose to have suboptimal management of their pain

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- Clinical experience in other specialties (e.g., Interventional Pain Medicine, Radiation Oncology, Interventional Radiology)
- Study Days

OUTCOME 3 OF 14 – MANAGEMENT OF NON-PAIN SYMPTOMS DUE TO SECONDARY LIFE LIMITING CONDITIONS

Able to assess and manage non-pain symptoms secondary to life limiting conditions using pharmacological and non-pharmacological strategies, taking appropriate account of factors such as illness, frailty and treatment escalation plan, patient's preferences, reversibility of underlying cause(s) of symptoms and roles and responsibilities within the interdisciplinary team
What this outcome means

Trainees will be able to:

- Formulate a clear, individualised management plan considering patient preferences and reversibility
- Demonstrate knowledge and skills to recognise, assess and manage symptoms in patients with life limiting/life threatening conditions across a range of systems
- Understand the pathophysiology of symptoms in serious illness
- Manage symptoms in the context of uncertain trajectory
- Identify patients with symptoms caused by complications of cancer and anticancer treatments and refer when appropriate
- Understand the impact of multi-morbidity, advanced ageing, and frailty in people with life limiting illness
- Consider the benefits, burdens and risks of investigations and treatments to aid decision making regarding appropriateness of these for individual patients
- Demonstrate understanding of the indications and complication of, and gains experience through observation of paracentesis and tracheostomy management in patients with life limiting conditions
- Set up and manage continuous subcutaneous infusion, and have expert knowledge of medication compatibility
- Demonstrate knowledge of the effective use of non-pharmacological interventions for symptoms
- Recognise one's own limitations of individual knowledge and experience
- Support teams in caring for patients who chose to have suboptimal management of their symptoms

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- Clinical experience in other specialties (e.g., Interventional Pain Medicine, Radiation Oncology, Interventional Radiology)
- Study Days

OUTCOME 4 OF 14– MANAGEMENT OF PSYCHOLOGICAL CONDITIONS SECONDARY TO LIFE LIMITING CONDITIONS

Able to assess and manage psychological symptoms secondary to life limiting conditions

What this outcome means

Trainees will be able to:

- Recognise the psychological response to illness
- Understand the impact of co-morbid psychological and psychiatric illness on the psychological response to illness
- Manage patient and family hopes, fears, and expectations
- Recognise of the psychological impact of pain and intractable symptoms
- Recognise the impact of illness on interpersonal relationships, body image, sexuality, employment
- Demonstrate knowledge of therapeutic interventions for psychological distress e.g., CBT
- Recognise and manage psychiatric illness in patients with life limiting conditions
- Know when and how to refer to specialist mental health services
- Differentiate between sadness and clinical depression
- Differentiate between expressions of death wish, requests for assisted dying and suicidal ideation and manage appropriately
- Undertake an assessment of suicidal ideation
- Support individuals at risk of harm to themselves or others

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- Clinical experience in other specialties (e.g., Interventional Pain Medicine, Radiation Oncology, Interventional Radiology, liaison with psychiatry, pyscho-oncology as appropriate)
- Study Days

OUTCOME 5 OF 14– IDENTIFICATION OF MEDICAL EMERGENCIES IN ALL PALLIATIVE CARE SETTINGS

Identify medical emergencies across all palliative care settings, and management of same as appropriate to the individual patient's circumstances

What this outcome means

Trainees will be able to:

- Assess, identify, and manage a range of emergencies including but not limited to:
  - Delirium
  - Spinal Cord Compression
  - Superior Vena Cava Obstruction
  - Massive Haemorrhage
  - Hypercalcaemia
  - Status Epilepticus
  - Pathological Fractures
  - Overwhelming pain & distress
  - Sepsis
- Adopt a palliative care approach to management of emergencies and to determine when attempts at reversibility and/ or intervention are inappropriate

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- Clinical experience in other specialties (e.g., Interventional Pain Medicine, Radiation Oncology, Interventional Radiology)
- Study Days

OUTCOME 6 OF 14– UNDERSTAND PHARMACOLOGY OF OPIOIDS AND OTHER MEDICATIONS AND PRESCRIBE SAFELY

Understand pharmacology of opioids and other medications used to manage symptoms in life limiting conditions, and ability to prescribe same safely and effectively taking account of relevant practical, legal and supply issues

What this outcome means

Trainees will be able to:

- Demonstrate understanding of opioid metabolism and use of opioids in the context of hepatic and renal impairment
- Apply regulation and legislation relevant to controlled drugs including strong opioids and methadone
- Apply medication prescription requirements e.g., High Tech Drugs Scheme, Hardship Scheme, drugs not reimbursed on the GMS scheme
- Assess, anticipate, deprescribe and negotiate required medications
- Recognise opioid use disorder in patients, sensitively assess and refer to addiction services as appropriate
- Prescribe and monitor medications used in continuous subcutaneous infusions/syringe drivers
- Demonstrate appropriate knowledge of use of drugs outside their product licence and legislation relevant to safe prescribing

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- Clinical experience in other specialties (e.g., Interventional Pain Medicine, Radiation Oncology, Interventional Radiology)
- Study Days

OUTCOME 7 OF 14 – RECOGNISING WHEN DEATH IS IMMINENT AND DEVELOPING INDIVIDUALISED CARE PLANS

Able to manage End of Life Care across all care settings, recognising when death is imminent and developing appropriate individualised care plans to effectively optimise comfort and facilitate patients' wishes

What this outcome means

Trainees will be able to:

- Recognise the dying phase
- Understand clinical uncertainty and limited reversibility in people with progressive life-limiting conditions
- Plan anticipatory care for patients who are approaching the last days of life

- Prescribe medication safely and effectively in the dying phase to manage common and complex symptoms
- Judge the appropriateness of interventions in dying patients
- Provide on-going care for dying patients and their families
- Identify and support patient preferences at end of life and work with patient, family and HSCPs to support achievement of realistic goals
- Facilitate discharges including rapid discharges for patients at end of life

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- Study Days

OUTCOME 8 OF 14 – UNDERSTANDING HOW AND WHEN TO ADOPT A PALLIATIVE REHABILITATION APPROACH

Understand how and when to adopt a palliative rehabilitation approach to care of people with life limiting conditions, engaging effectively with health and social care professionals, and agreeing goals with patients as appropriate

What this outcome means

Trainees will be able to:

- Promote patient independence and support patients and families to adapt to changes that occur due to their life-limiting condition
- Manage distressing symptoms whilst attempting to maximise the individual's ability to function
- Identify patients who would benefit from a palliative rehabilitation approach as distinct from a traditional restorative rehabilitation approach
- Understand the role of the individual members of the health and social care professions in relation to palliative rehabilitation

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- Clinical experience in other specialties (e.g., Interventional Pain Medicine, Radiation Oncology, Interventional Radiology)
- Study Days

OUTCOME 9 OF 14 – EMPOWER HEALTHCARE PROFESSIONALS TO ASSESS AND MANAGE SYMPTOMS

Empower healthcare professionals in their clinical practice to assess and manage patients with life limiting conditions

What this outcome means

Trainees will be able to:

- Support other professionals in developing effective management strategies and plans for the care of patients across all settings

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- Clinical experience in other specialties (e.g., Interventional Pain Medicine, Radiation Oncology, Interventional Radiology)
- Study Days

OUTCOME 10 OF 14 – CONTRIBUTE TO CLINICAL SERVICE DEVELOPMENT ACTIVITIES

Contribute to clinical service development activities in response to evidence / research as well as end-user experiences

What this outcome means

Trainees will be able to:

- Participate in practice-based learning and quality improvement activities that involve investigation and evaluation of patient experiences, evidence, and resources
- Assess and evaluate the experiences of patients and family members with respect to quality of care and adjust the delivery of care as needed including measuring patient satisfaction and healthcare outcomes

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- Clinical experience in other specialties (e.g., Interventional Pain Medicine, Radiation Oncology, Interventional Radiology)
- Study Days

OUTCOME 11 OF 14 – EDUCATION, RESEARCH, AND QI IN PALLIATIVE CARE

Able to engage in education, research, and quality improvement in palliative care

What this outcome means

Trainees will be able to:

- Teach HSPCs how to optimise comfort and quality of life
- Contribute to development and updating of local or national clinical guidelines, policy, or procedure document
- Participate in and conduct research where possible, emphasizing need for focus on patient experiences
- Identify and utilise evidence to inform practice and care

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- Clinical experience in other specialties (e.g., Interventional Pain Medicine, Radiation Oncology, Interventional Radiology)
- Study Days

OUTCOME 12 OF 14 – (PAEDIATRIC) WORK IN THE PALLIATIVE CARE TEAM TO OPTIMISE COMFORT AND QUALITY OF LIFE

Able to work in partnership with other members of the core paediatric palliative care team to optimise the comfort and quality of life of children and young adults with progressive, life-limiting illness

What this outcome means

Trainees will be able to:

- Demonstrate ability to contribute to the symptom management of children and young adults as a member of the identified core team of paediatric palliative care providers

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Inpatient consultations
- Family Meetings
- Clinical experience in other specialties (e.g., paediatrics, primary care, disability care)
- Study Days

OUTCOME 13 OF 14 – (PAEDIATRIC) TAILOR KNOWLEDGE AND SKILLS TO SUPPORT PALLIATIVE CARE FOR CHILDREN AND/OR YOUNG ADULTS

Able to tailor the knowledge and skills acquired through the care of adult patients, to support the provision of palliative care to children and young adults with progressive, life limiting illness

What this outcome means

Trainees will be able to:

- Conduct a palliative care symptom assessment of a child and/or adolescent or young adult as a member of the core team where the role of the adult palliative care team member is to optimise comfort.

- Demonstrate understanding of the trajectory of illness in children and AYA, including their ability to respond to intervention.

- Recognise when it is appropriate to seek assistance from General Practitioner or Primary Paediatric Team to consider the possibility of reversible conditions or presentations that may be treatable to aid symptom management

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Inpatient consultations
- Family Meetings
- Clinical experience in other specialties (e.g., paediatrics, primary care, disability care)
- Study Days

OUTCOME 14 OF 14 – (PAEDIATRIC) MANAGEMENT OF A RANGE OF SYMPTOMS EXPERIENCED BY CHILDREN AND/OR YOUNG ADULTS

Able to recognise, assess, anticipate, and support the management of a range of symptoms experienced by children and/or young adults as disease and illness progress, considering their impact on physical, psychological, and emotional health

What this outcome means

Trainees will be able to:

- Recognise differences between adult and paediatric patients in the pharmacology of pain medications, differences in medication clearance and routes of administration and knows when to seek additional input to support his/ her own practice.
- Demonstrate understanding of common side effects/ unwanted effects of medication commonly used in palliative care in a paediatric population and knows when to seek additional input to support his/ her own practice
- Demonstrate an ability to calculate weight-based medication doses
- Use the APPM formulary as a reference in the pharmacological dosing of frequently encountered symptoms such as pain, nausea, and vomiting
- Demonstrate awareness of nationally endorsed paediatric reference guides for the management of common symptoms, and applies theses within limitations of own practice and knows when to seek additional input to support his/ her own practice
- Recognise the strengths and limits of one's own competence in symptom management and to know when to consult with consultant paediatrician/ consultant paediatrician with an interest in palliative medicine / consultant in paediatric palliative medicine

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- Clinical experience in other specialties (e.g., paediatrics, primary care, neurodevelopmental disability)
- Study Days

Training Goal 4 – Care Planning & Collaborative Practice

By the end of HST the Trainee will demonstrate the ability to coordinate and integrate person-centred care to promote quality of life for people with life-limiting conditions and their families in their individual social context. The Trainee will be able to understand the needs of patients, families and others and be able to organise the most appropriate care, using leadership, management, teamwork, and influencing skills.

OUTCOME 1 OF 4 – COORDINATE PATIENT CARE ACROSS PATIENT SETTINGS

Able to coordinate patient care across care settings in collaboration with patients, families, hospital, and community-based healthcare professionals to enhance the quality of care for patients with life limiting conditions

What this outcome means

Trainees will be able to:

- Understand and promote the importance of family meetings, involving other team members and services as appropriate
- Understand and promote advance care planning and ability to engage in discussions about preferences for care with people with life-limiting conditions and their families
- Identify and support patient preferences at end of life and work with patient, family, and HCPs colleagues to support achievement of realistic goal
- Demonstrate respect for an individual's values, needs and emotions and challenge where appropriate
- Facilitate management of competing and changing priorities in goals of care
- Support individuals in adapting to or challenging change and overcoming adversity.
- Provide an expert opinion in situations where there is clinical uncertainty or conflict with patients and/or those close to them
- Understand the role of environment in caring for the dying patient
- Be aware of the social and financial impact on partners and families in caring for patients with life limiting illness across all settings
- Triage referrals to the service and appropriately plan patient care in line with available resources within a specialist palliative care service
- Recognise when it is appropriate to consider discharge from specialist palliative care and be aware of issues to be considered in future care planning e.g., use of opioids post discharge

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- RCPI Taught Programme
- Study Days

OUTCOME 2 OF 4– APPLY MANAGEMENT AND TEAM WORKING SKILLS

Apply management and team working skills appropriately, including supporting and influencing inter and intra team working

What this outcome means

Trainees will be able to:

- Understand the principles of team dynamics and group processes
- Develop and maintaining effective relationships with referring doctors, other HSPCs, related services and the public

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- RCPI Course HST Leadership in Clinical Practice
- Study Days

OUTCOME 3 OF 4 – HOLD A LEADERSHIP ROLE WITHIN A SPECIALIST PALLIATIVE CARE SERVICE

Able to hold a leadership role within a specialist palliative care service and apply leadership principles that support a collaborative proactive model

What this outcome means

Trainees will be able to:

- Understand the need to develop and adapt one's personal leadership style according to the situation and team context
- Contribute to the professional development of students, peers, colleagues and others through consultation, education, leadership, mentorship, and coaching
- Understand the roles, responsibilities, and professional boundaries of individual members of the interdisciplinary team within scope of practice
- Identify team-based strategies to sustain and promote team member well-being
- Identify and manage distress in oneself, the team and other HSCPs
- Demonstrate awareness of and ability to work alongside community and social services to support marginalised and hard to reach patient groups
- Appropriately challenge other senior healthcare professionals in multi-professional discussions to support decision making

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- RCPI Taught Programme
- Audit/QI Activity
- Study Days

OUTCOME 4 OF 4 – SUPPORT, EDUCATE, INFLUENCE, AND DEVELOP MEMBERS OF THE WIDER MULTI-PROFESSIONAL TEAM

Able to support, educate, influence, and develop members of the wider multi-professional team to deliver high quality palliative care across all care settings

What this outcome means

Trainees will be able to:

- Contribute to the education and development of the Specialist Palliative Care multi-disciplinary team
- Engage with palliative care research, audit & quality improvement to inform service development & evaluation across settings

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- RCPI Taught Programme
- Study Days

Training Goal 5 – Cultural & Spiritual Care Including Loss, Grief, & Bereavement

By the end of HST the Trainee is expected to be able to demonstrate ability to support patients and families/carers in dealing with distress, loss, and grief and be able to respond to spiritual concerns and recognise and respond to spiritual distress.

OUTCOME 1 OF 4 – AWARENESS AND RESPECT FOR THE SOCIAL AND CULTURAL VALUES OF PATIENTS

Demonstrate awareness of and respect for the social and cultural values of patients facing life-limiting illness and their families.

What this outcome means

Trainees will be able to:

- Assume a stance of cultural humility to understand the needs of individuals
- Understand the impact of culture and ethnicity on the meaning of illness for patients and their families
- Anticipate, recognise, and manage conflict between patient and family beliefs and values, and those of the clinical team
- Demonstrate comprehensive knowledge of the context for and the role of on the advocate in the health care service, especially, for vulnerable groups
- Demonstrate commitment to engage in anti-discriminatory practice in relation to end of life care and service delivery

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- Study Days

OUTCOME 2 OF 4 – PREPARE INDIVIDUALS FOR BEREAVEMENT AND SUPPORT THE GRIEVING PERSON OR FAMILY

Able to prepare individuals for bereavement, to support the grieving person or family and identify those who require additional bereavement supports

What this outcome means

Trainees will be able to:

- Support patients and families in dealing with distress, loss, and grief
- Understand bereavement theories including the process of grieving, adjustment to loss and the social model of grief
- Anticipate and recognise complicated grief and utilize resources appropriately
- Work in partnership with parents, guardians, and other family members to prepare and support children and vulnerable adults for bereavement
- Act as a resource to support the multidisciplinary team in the management of loss, grief, and bereavement
- Be aware of dying as a social process and understand the impact of community engagement in end-of-life care

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Participation in bereavement information event/remembrance service
- Domiciliary Visits
- Family Meetings
- Study Days

OUTCOME 3 OF 4– AWARENESS AND RESPECT FOR THE RELIGIOUS AND SPIRITUAL BELIEFS AND PRACTICES OF PATIENTS AND FAMILIES

Demonstrates awareness of and respect for the religious and spiritual beliefs and practices of patients and families

What this outcome means

Trainees will be able to:

- Understand the role of spiritual care in relation to life-limiting illness
- Recognise the importance of hope and the ability to reframe it
- Recognise and respond to spiritual distress
- Demonstrate knowledge of the major cultural and religious practices which relate to clinical practice, dying, mourning and bereavement
- Demonstrate knowledge of support systems within different religious and cultural communities and ability to work with their representatives within the multidisciplinary team
- Demonstrate ability to accommodate differences in beliefs and practices

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- Study Days

OUTCOME 4 OF 4– EXPLORE AND ASSESS THE IMPACT OF ILLNESS ON SEXUALITY

Able to explore and assess impact of illness on sexuality and gender identity

What this outcome means

Trainees will be able to:

- Describe the impact of illness on body image, sexuality, and role
- Elicit and respond to concerns about body image and sexuality
- Sensitively explore sexual orientation or gender history including an ability to use appropriate language in communication

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- Study Days

Training Goal 6 – Professional & Ethical Practice

By the end of HST the Trainee is expected to be able to demonstrate skills in ethical reasoning and decision making in serious and life limiting illness and to practise Palliative Medicine within a legal framework with understanding of relevant legislation and processes that guide practice.

OUTCOME 1 OF 4 – DEMONSTRATE EXPERT SKILLS IN ETHICAL REASONING AND DECISION MAKING

Demonstrate expert skills in ethical reasoning and decision making in serious and life limiting illness

What this outcome means

Trainees will be able to:

- Demonstrate knowledge and understanding of ethical and legal frameworks and legislation supporting decision making in serious and life limiting illness
- Facilitate the discussion and contribute towards resolution of ethical dilemmas in practice in a manner that is socially and culturally appropriate for individual patients and their families
- Anticipate and address potential ethical issues that may be encountered at end of life such as: Do Not Attempt Cardio-pulmonary Resuscitation Orders; Withdrawal and withholding of treatment; Treatment Escalation Plans; use of artificial hydration and feeding; palliative sedation and requests for assisted dying
- Use available resources fairly in the context of providing appropriate care to the person with life-limiting illness

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- RCPI Taught Programme
- Study Days

OUTCOME 2 OF 4 – PRACTICE PALLIATIVE MEDICINE WITHIN A LEGAL FRAMEWORK

Able to practice palliative medicine within a legal framework, demonstrating understanding of relevant legislation and processes that guide practice

What this outcome means

Trainees will be able to:

- Apply in practice the legislation and processes as applicable to palliative care including but not limited to
  - Undertake an assessment of patients' capacity
  - Understand decision making process in settings where patient lacks capacity to engage in decisions
  - Engaging in assisted decision making with patients
  - Demonstrate understanding and appropriate application of the Assisted Decision-Making (Capacity) (Amendment) Act 2022 including role of decision-making assistants, co-decision-makers, and decision-making representative, power of attorney, enduring power of attorney and advance health care directives
  - Demonstrate understanding of certification of death procedures, including definition and procedure for confirming brain death
  - Demonstrate understanding of Coroner's Law and rules of reporting of deaths

- Demonstrate understanding and proficiency regarding procedures for post-mortem and cremation
- Demonstrates understanding of safeguarding and role and responsibility as a mandated person
- Demonstrate ability to work within a clinical governance framework and the ability to contribute to creating an environment where excellence in care flourishes by:
  - Providing evidence-based care
  - Engaging with risk assessment, patient safety initiatives, and patient safety improvement strategies
  - Conducting audit and engaging with quality improvement activities
  - Collecting and using data to improve patient care
  - Supporting patient and public involvement in the design and delivery of services

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- RCPI Taught Programme
- Study Days

OUTCOME 3 OF 4 – KNOWLEDGE, SKILLS AND ATTITUDES REQUIRED OF A PALLIATIVE MEDICINE CONSULTANT AS A LEADER

Demonstrates the knowledge, skills and attitudes required of a palliative medicine consultant as a leader in delivering and developing palliative care services

What this outcome means

Trainees will be able to:

- Work in partnership with healthcare managers and providers to assess, coordinate, promote and improve safety in the context of palliative care
- Engage in the process of quality improvement in the context of palliative care
- Promote a culture of open disclosure by maintaining a no fault/no blame
- Demonstrate a commitment to advancing palliative care through the generation and application of knowledge and research
- Demonstrate leadership through advocating for on-going and continuous service development
- Facilitate appropriate engagement of service users in the development of palliative care services
- Demonstrate awareness of societal expectations and perceptions regarding life-limiting conditions and death
- Be aware of one's own personal values and belief systems and how these can influence professional judgements and behaviours
- Understand the essential elements of professional relationships and the dangers associated with boundary crossing
- Demonstrate the discipline, determination, and resilience necessary to achieve goals in the face of setbacks, obstacles, or challenging environments.

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- RCPI Taught Programme
- Study Days

OUTCOME 4 OF 4 – PALLIATIVE CARE IN THE WIDER SOCIAL CONTEXT

Demonstrate awareness of palliative care in the wider societal context, knowledge, and application in practice of palliative care policy and a commitment to advancing the field of palliative care

What this outcome means

Trainees will be able to:

- Be aware of current issues relating to palliative care in the context of wider society e.g., issues being discussed in the media, legislation being debated by the Oireachtas
- Communicate and advance the distinct contribution of palliative medicine
- Demonstrate knowledge of national and international stakeholders relating to palliative care policy
- Demonstrate knowledge of key policy documents relating to palliative care in Ireland
- Demonstrate ability to contribute to a discussion regarding the future development of palliative care in Ireland

Assessment and learning opportunities

- Informal feedback (Informal discussion or informal observation)
- Workplace Based Assessments (CBD, Mini-CEX, DOPS)
- Domiciliary Visits
- Family Meetings
- RCPI Taught Programme
- Study Days

APPENDICES

This section includes two appendices to the Curriculum.

The first one is about Assessment (i.e. Workplace Based Assessments, Evaluations etc).

The second one is about Teaching Attendance (i.e. Taught Programme, Specialty-Specific Learning Activities and Study Days)

ASSESSMENT APPENDIX

Workplace-Based Assessment & Evaluations

The expression "workplace-based assessments" (WBA) defines all the assessments used to evaluate Trainees' daily clinical practices employed in their work setting. It is primarily based on the observation of Trainees' performance by Trainers. Each observation is followed by a Trainer's feedback, with the intent of fostering reflective practice.

Relevance of Feedback for WBA

Although "assessment" is the keyword in WBA, it is necessary to acknowledge that feedback is an integral part and complementary component of WBA. The main purpose of WBA is to provide specific feedback for Trainees. Such feedback is expected to be:

- **Frequent**: the opportunities to provide feedback are preferably given by directly observed practice, but also by indirectly observed activities. Feedback is expected to be frequent and should concern a low-stake event. Rather than being an assessor, the Trainer is an observer who is asked to provide feedback in the context of the training opportunity presented at that moment.
- **Timely**: preferably, the feedback should be a direct conversation between Trainer and Trainee in a timeframe close to the training event. The Trainee should then record the feedback on ePortfolio in a timely manner.
- **Constructive**: the recorded feedback would inform both Trainee's practice for future performance and committees for evaluations. Hence, feedback should provide Trainees with behavioural guidance on how to improve performance and give committees the context that leads to a rating, so that progression or remediation decisions can be made.
- **Actionable**: to improve performance and foster behavioural change, feedback should include practical and contextualised examples of both Trainee's strengths and areas for improvement. Based on these examples, it is necessary to outline a realistic action plan to direct the Trainee towards remediation/improvement.

Types of WBAs in use at RCPI

There is a variety of WBAs used in medical education. They can be categorised into three main groups: *Observation of performance*; *Discussion of clinical cases*; *Feedback*; *Mandatory Evaluations*.

As WBAs at RCPI we use *Observation of performance* via MiniCEX and DOPS; *Discussion of clinical cases* via CBD; *Feedback* via Feedback Opportunity.

Mandatory Evaluations are bound to specific events or times of the academic year, for these at RCPI we use: Quarterly Assessment/End of Post Assessment; End of Year Evaluation; Penultimate Year Evaluation; Final Year Evaluation.

Recording WBAs on ePortfolio

It is expected that WBAs are logged on an electronic portfolio. Every Trainee has access to an individual ePortfolio where they must record all their assessments, including WBAs. By recording assessments on this platform, ePortfolio serves both the function to provide an individual record of the assessments and to track Trainees' progression.

Formative & Summative Assessment

The Trainee can record any WBA either as formative or summative with the exception of the Mandatory Evaluations (Quarterly/End of Post, End of Year, Penultimate Year, Final Year evaluations). If the WBA is logged as formative, the Trainee can retain the feedback on record, but this will not be reviewed by the assessment panel, and it will not count towards progression. If the WBA is logged as summative it will be regularly recorded and it will be fully visible to assessment panels, counting towards progression.

WORKPLACE-BASED ASSESSMENTS	
CBD **|***Case Based Discussion***	This assessment is developed in three phases: 1. Planning: The Trainee selects two or more medical records to present to the Trainer who will choose one for the assessment. Trainee and Trainer identify one or more training goals in the Curriculum and specific outcomes related to the case. Then the Trainer prepares the questions for discussion. 2. Discussion: Prevalently, based on the chosen case, the Trainer verifies the Trainee's clinical reasoning and professional judgment, determining the Trainee's diagnostic, decision-making and management skills. 3. Feedback: The Trainer provides constructive feedback to the Trainee. It is good practice to complete at least one CBD per quarter in each year of training.
DOPS **|** *Direct Observation of Procedural Skills*	This assessment is specifically targeted at the evaluation of procedural skills involving patients in a single encounter. In the context of a DOPS, the Trainer evaluates the Trainee while they are performing a procedure as a part of their clinical routine. This evaluation is assessed by completing a form with pre-set criteria, then followed by direct feedback.
MiniCEX **|** *Mini Clinical Examination Exercise*	The Trainer is required to observe and assess the interaction between the Trainee and a patient. This assessment is developed in three phases: 1. The Trainee is expected to conduct a history taking and/or a physical examination of the patient within a standard timeframe (15 minutes). 2. The Trainee is then expected to suggest a diagnosis and management plan for the patient based on the history/examination. 3. The Trainer assesses the overall Trainee's performance by using the structured ePortfolio form and provides constructive feedback.
Feedback Opportunity	Designed to record as much feedback as possible. It is based on observation of the Trainees in any clinical and/or non-clinical task. Feedback can be provided by anyone observing the Trainee (peer, other supervisors, healthcare staff, juniors). It is possible to turn the feedback into an assessment (CDB, DOPS or MiniCEX)
MANDATORY EVALUATIONS	
QA **|***Quarterly Assessment***	As the name suggests, the Quarterly Assessment recurs four times in the academic year, once every academic quarter (every three months). It frequently happens that a Quarterly Assessment coincides with the end of a post, in which case the Quarterly Assessment will be substituted by completing an End of Post Assessment. In this sense the two Assessments are interchangeable, and they can be completed using the same form on ePortfolio. However, if the Trainee will remain in the same post at the end of the quarter, it will be necessary to complete a Quarterly Assessment. Similarly, if the end of a post does not coincide with the end of a quarter, it will be necessary to complete an End of Post Assessment to assess the end of a post. This means that for every specialty and level of training, a minimum of four Quarterly Assessment and/or End of Post Assessment will be completed in an academic year as a mandatory requirement.
EOPA **|** *End of Post Assessment*	
EOYE **|** *End of Year Evaluation*	The End of Year Evaluation occurs once a year and involves the attendance of an evaluation panel composed of the National Specialty Directors (NSDs); the Specialty Coordinator attends too, to keep records of and facilitate the meeting. The assigned Trainer is not supposed to attend this meeting unless there is a valid reason to do so. These meetings are scheduled by the respective Specialty Coordinators and happen sometime before the end of the academic year (between April and June).
PYE **|** *Penultimate Year Evaluation*	The Penultimate Year Evaluation occurs in place of the End of Year Evaluation, in the year before the last year of training. It involves the attendance of an evaluation panel composed of the National Specialty Directors (NSDs) and an External Member who is a recognised expert in the Specialty outside of Ireland; the Specialty Coordinator attends too, to keep records of and facilitate the meeting. The assigned Trainer is not supposed to attend this meeting unless there is a valid reason to do so.
FYE **|** *Final Year Evaluation*	In the last year of training, the End of Year Evaluation is conventionally called Final Year Evaluation, however, its organisation is the same as an End of Year Evaluation.

TEACHING APPENDIX

RCPI Taught Programme

The RCPI Taught Programme consists of a series of modular elements spread across the years of training.

Delivery will be a combination of self-paced online material, live virtual tutorials, and in-person workshops, all accessible in one area on the RCPI's virtual learning environment (VLE), RCPI Brightspace.

The live virtual tutorials will be delivered by Tutors related to this specialty and they will use specialty-specific examples throughout each tutorial. Trainees will be assigned to a tutorial group and will remain with their tutorial group for the duration of HST.

Trainees will receive their induction content and timetable ahead of their start date on HST. Trainees must plan the time to complete their requirements and must be supported with the allocation of study leave or appropriate rostering.

As the HST Taught Programme is a mandatory component of HST, it is important that Trainees are released from service to attend the Virtual Tutorials and, where possible facilitated with the use of teaching space in the hospital.

Specialty-Specific Learning Activities (Courses & Workshops)

Trainees will also complete specialty-specific courses and/or workshops as part of the programme.

Trainees should always refer to their training Curriculum for a full list of requirements for their HST programme. When not sure, Trainees should contact their Programme Coordinator.

Study Days

Study days vary from year to year; they comprise a rolling schedule of hospital-provided topic-specific educational days and national/international events selected for their relevance to the HST Curriculum. Trainees should discuss available study days with their Trainer and determine if attendance will aid the Trainee in achieving learning outcomes as set out in the Trainee's personal goals plan. There is no expectation that Trainees will attend all available study days.

Palliative Medicine Teaching Attendance Requirements