



# The Ontario Palliative Care Competency Framework

A Reference Guide for Health Professionals and Volunteers

April 2019

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OPCN's Provincial Palliative Care Education Steering Committee also acknowledges the contributions of the many individuals and groups who reviewed draft versions of this document and provided valuable input, those who validated the competencies and the authors of the source documents that informed the development of this document.

Several new competencies, specific to First Nations, Inuit, Métis and urban Indigenous have been incorporated into the Ontario Palliative Care Framework, to ensure a comprehensive and inclusive framework. The Provincial Education Steering Committee would like to extend appreciation to the Indigenous Cancer Control Unit at Cancer Care Ontario for coordinating input from various stakeholders who participated in the development and validation of these competencies:

- Lakehead University, Centre for Education and Research on Aging & Health (CERAH)
  - The competencies were drawn from the Participant Guide of the Palliative Care for Front-line Workers in First Nations Communities developed by the CERAH, Education Project Team. Foundational to the curriculum was the Improving End-of-Life Care in First Nations Communities research Project funded by the Canadian Institutes of Health Research and led by Dr. Mary Lou Kelly and Holly Prince.
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- Government of Nunavut, Susie Pearce, Manager, Home Community Care
- Chiefs of Ontario, Donna E. Loft, Home Care Advisor

In addition to stakeholder organizations, several individuals reviewed and validated the competencies within this document including:

- Jennifer Wong, Speech-Language Pathologist, Sunnybrook Veterans Centre, Sunnybrook Health Sciences Centre

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### Document Preparation:

In addition to the members of the OPCN Provincial Palliative Care Education Steering Committee, this document was prepared by:

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## VALIDATION AND ENDORSEMENT PROCESS

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### Validation from Health Professional Colleges and Associations

We were pleased to receive confirmation of the relevant profession-specific and shared competencies from the following organizations:

- Canadian Association for Spiritual Care
- Canadian Society of Palliative Care Physicians
- College of Medical Radiation Technologists of Ontario
- College of Nurses of Ontario
- College of Occupational Therapists of Ontario
- College of Psychologists of Ontario
- College of Respiratory Therapists of Ontario
- Emergency Health Regulatory and Accountability Branch, Ministry of Health and Long-Term Care
- Hospice Palliative Care Ontario
- Nurse Practitioners Association of Ontario
- Ontario Association of Social Workers
- Ontario Association of Speech-Language Pathologists & Audiologists
- Ontario College of Family Physicians
- Ontario College of Pharmacists
- Ontario College of Social Workers and Social Service Workers
- Ontario Community Support Association
- Ontario Personal Support Workers Association, along with several additional stakeholders to capture PSWs across care settings
- Ontario Physiotherapy Association
- Ontario Psychological Association
- Ontario Society of Occupational Therapists

- Provincial Palliative Consultant Network
- Provincial Pediatric Steering Committee
- Registered Nurses' Association of Ontario
- Registered Practical Nurses' Association of Ontario

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### **Endorsement from Health Professional Colleges and Associations**

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- Canadian Association for Spiritual Care
- College of Medical Radiation Technologists of Ontario
- College of Respiratory Therapists of Ontario
- Hospice Palliative Care Ontario
- Nurse Practitioners Association of Ontario
- Ontario Association of Social Workers
- Ontario Association of Speech-Language Pathologists & Audiologists
- Ontario Personal Support Workers Association
- Ontario Physiotherapy Association
- Ontario Psychological Association
- Ontario Society of Occupational Therapists
- Provincial Palliative Consultant Network
- Provincial Pediatric Steering Committee
- Registered Nurses' Association of Ontario
- Registered Practical Nurses' Association of Ontario

## INTRODUCTION

The Ontario Palliative Care Network (OPCN) is committed to improving the way palliative care is provided for patients in Ontario. In 2017, OPCN released its first three-year [Action Plan](#)<sup>1</sup> to improve access to high-quality palliative care for all Ontarians. The Plan identifies seven areas of action, aligned with the goals of The Declaration of Partnership and Commitment to Action, and one of these is “Building Provider Competencies in Hospice Palliative Care.” A key focus of this action area is the development of the Ontario Palliative Care Competency Framework, led by the Provincial Education Steering Committee (Steering Committee). The Ontario Palliative Care Competency Framework describes the appropriate knowledge, and skills that providers require to deliver high-quality palliative care.

Importantly, this work complements two key OPCN initiatives: Health Quality Ontario’s (HQO) quality standard, [Palliative Care: Care for Adults with a Progressive, Life-Limiting Illness](#)<sup>2</sup> (‘Palliative Care Quality Standard’); and the Health Services Delivery Framework (Delivery Framework) recommendations.

The Palliative Care Quality Standard was developed by Health Quality Ontario in partnership with the OPCN and in collaboration with clinical experts, patients, residents, and caregivers across the province. Quality standards are concise sets of statements that help patients, residents, families, and caregivers know what to ask for in their care. They also help health care professionals know what care they should be offering, based on available evidence and expert consensus. The Ontario Palliative Care Competency Framework supports implementation of one of the quality statements, which identifies the importance of competency-based education when delivering palliative care<sup>2</sup>.

The Health Services Delivery Framework aims to provide guidance on how to optimize the current palliative care delivery model to ensure that the right care is provided by the right provider at the right time. This document focuses on adults with a progressive, life-limiting illness, who would benefit from palliative care along with the supports required for their families and caregivers. The document emphasizes the important role of education in building capacity for palliative care, as well as the need for providers to have the necessary competencies<sup>3</sup>.

Competencies refer to the range of knowledge, personal attributes, and skills that enable the behaviours needed to effectively perform a role within an organization<sup>4</sup>. Academic curricula and professional development programs that include palliative care competencies can prepare health and social care professionals to apply the principles of palliative care in practice, irrespective of settings. Inclusion of these competencies will enhance the care of people with a life-limiting condition and foster greater interprofessional and inter-organizational collaboration in the palliative care provision<sup>5</sup>.

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### Glossary of Terms & Explanation of Abbreviations

To ensure a common understanding of the terminology used in this document, a glossary of terms is included in **Appendix C** and a list of abbreviations is included in **Appendix D**.

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## An Overview of Palliative Care

The Ontario Palliative Care Network (OPCN) endorses the definition provided by [Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action](#)<sup>6</sup>. This document states:

Hospice palliative care is a philosophy of care that aims to relieve suffering and improve the quality of living and dying. It strives to help individuals and families to:

- Address physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears;
- Prepare for and manage end-of-life choices and the dying process;
- Cope with loss and grief;
- Treat all active issues;
- Prevent new issues from occurring; and
- Promote opportunities for meaningful and valuable experiences, and personal and spiritual growth.

Hospice palliative care:

- Is appropriate for any individual and/or family living with, or at risk of developing, a life-limiting illness, at any time they are prepared to accept this type of care and support;
- May enhance other types of care – including restorative or rehabilitative care – or may become the total focus of care;
- Is most effectively delivered by an inter-professional team of health care providers skilled in all aspects of palliative care – including volunteer staff;
- Is most effective when the care is integrated at the clinical, organizational and overall system level;
- Is person- and family-centred, respecting people's social, spiritual and cultural practices; and
- Includes end-of-life care, but is not limited to the time immediately preceding death.

To learn more about who provides palliative care and related key principles, please refer to our [Key Palliative Care Concepts and Terms](#)<sup>7</sup> (also known as the Common Language Guide) located on the Ontario Palliative Care Network website.

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## Establishing Palliative Care Competencies

Recognizing the comprehensive process the Nova Scotia Health Authority (NSHA) implemented to develop their recent Palliative Care Competency Framework (2017)<sup>8</sup>, the Steering Committee elected to leverage their document and validation process to adapt their work to the Ontario context. The Palliative Care Competence Framework developed by the Irish Health Service Executive serves as the foundation for the Nova Scotia Competency Framework. Of importance, the Irish Framework has driven a number of palliative care programmatic, quality improvement and quality monitoring initiatives<sup>5</sup>.

For the Ontario Palliative Care Competency Framework, the competencies were adapted for local applicability and terminology was revised to reflect the Ontario practice context. As with the Nova Scotia Framework, the competencies in the Ontario Palliative Care Competency Framework are aligned with Accreditation Canada's Standards for Hospice, Palliative Care and End-of-Life Services, Accreditation Canada's Community, Critical Care, Cancer Care and

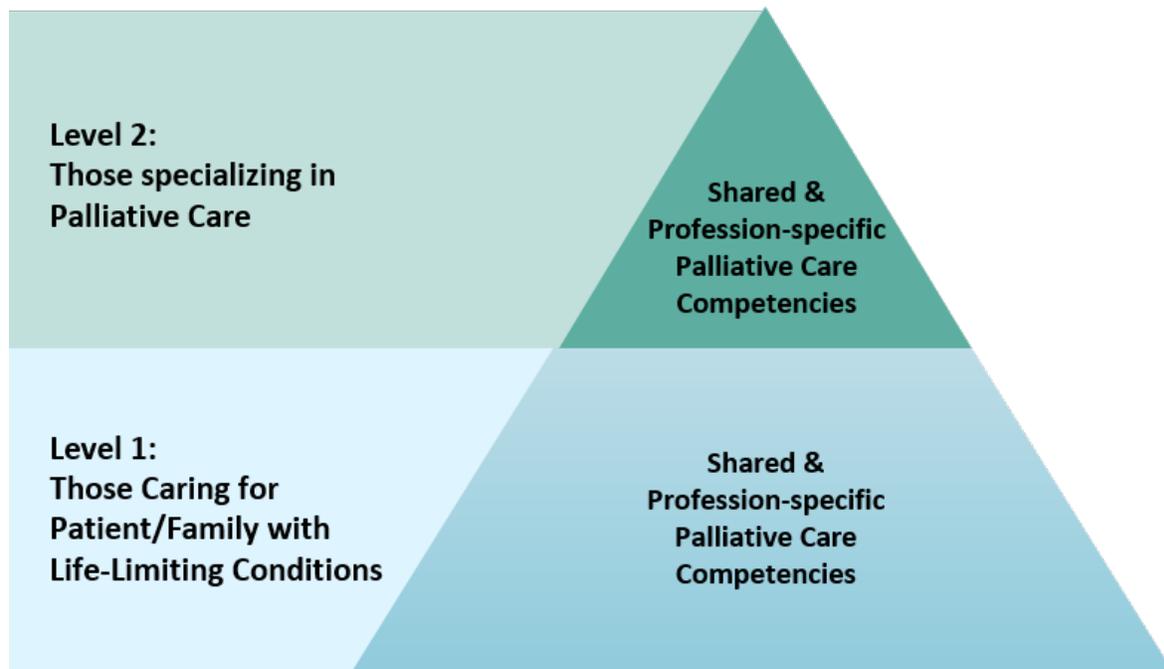
Emergency Care Standards, as well as documents from the Canadian Hospice Palliative Care Association<sup>9,10,11,12,13,14,15</sup>.

Additionally, the competencies in the Ontario Palliative Care Competency Framework are aligned with Health Quality Ontario's Palliative Care Quality Standard<sup>2</sup>, and are underpinned by the same key principles of respect, beneficence, autonomy, justice and equity. All health care providers must work to ensure that individuals and their family/caregivers are offered and receive equitable, culturally and linguistically appropriate palliative care. Health care providers will need to address barriers in access to palliative care and respects the rights and dignity of the individual, their family, and their caregiver, which includes being respectful of gender, sexual orientation, socioeconomic status, housing, age, background (including self-identified cultural, linguistic, ethnic, and religious backgrounds), and disability. This would include providing care to First Nations, Inuit, and Métis people, who are distinct constitutionally recognized peoples with Aboriginal and treaty rights. Furthermore, through the French Languages Services Act, Ontarians have the right to receive services in French through the government and associated agencies, notably in designated areas.

The Ontario Palliative Care Competency Framework uses the same simplified two level model as Nova Scotia to represent the various profession's palliative care competencies. There is recognition that the national *Model to Guide Hospice Palliative Care*<sup>16</sup> divides provider roles into three levels: primary providers, secondary experts, and tertiary experts. However, given the important role secondary experts play in supporting primary providers, it was determined that these providers require the same advanced competencies as the tertiary experts, resulting in a two level model for the purposes of the Ontario Palliative Care Competency Framework.

**Figure 1** illustrates the levels of palliative care competencies. The first level includes the shared and profession-specific palliative care competencies for health professionals and volunteers who care for people with life-limiting conditions and their families. The second level outlines the shared and profession-specific competencies for health professionals and volunteers who specialize or have a practice focused in palliative care. The competencies apply to all settings of care (e.g. hospital, collaborative care clinic, ambulatory clinic, long-term care facility (LTC), hospice and home).

**Figure 1. Levels of Palliative Care Competencies**



**Professional associations and colleges have established profession-specific core competencies and/or standards for their members, which are required in order to be licensed, or registered to practice by their regulatory body. As such, profession-specific core competencies and/or standards that are more general, or do not relate to palliative care have not been included in the document. Each profession member should consider these palliative care competencies in the context of in their respective professional code of ethics and profession-specific core competencies/standards.**

In addition to the profession-specific core competencies/standards outlined by the professional colleges/associations, the practice of those caring for patients with life-limiting conditions should be guided by the shared and profession-specific palliative care competencies outlined in the Ontario Palliative Care Competency Framework. Due to the interdisciplinary nature of palliative care service delivery, there is consistency in the shared competencies across professions. The shared competencies help to establish a common knowledge and skills base that will promote and enable team-based care.

It is important that the shared competencies always be considered within the profession-specific scope of practice. For example, while all professions play a role in optimizing comfort and quality of life, the profession-specific functions related to optimizing comfort and quality of life vary amongst professions. Given these variations in competencies, the Ontario Palliative Care Competency Framework is divided by profession, with shared and profession specific competencies outlined for each.



Throughout the document, the profession-specific competencies are highlighted by a shared background like this one, Please refer to **Figure 2** below, for an example.

**Figure 2: Example of Profession Specific Competencies**

Shaded backgrounds highlight the profession specific competencies

**ADDITIONAL COMPETENCIES FOR DIETITIANS WITH A PRACTICE FOCUSED IN PALLIATIVE CARE**

**Principles of Palliative Care**

- Facilitates empathic and responsive relationships between those experiencing life-limiting conditions and their care team
- Demonstrates leadership that encourages colleagues to foster a caring environment that supports all staff working in sensitive situations
- Applies the Dignity Conserving Care approach when providing support
- Practices person-centred palliative care that incorporates the unique contributions of the family in routine care giving
- Demonstrates an understanding of palliative care standards, guidelines and policies
- **Demonstrates an advanced knowledge and understanding of the full spectrum of trajectories of life-limiting conditions and their impact on nutritional management when responding to complex and multidimensional care needs**

**Communication**

- Uses a variety of strategies to engage in highly skilled, compassionate, individualized and timely communication with the person, their family, their caregiver(s) and members of their care team
- Maintains ongoing communication with the person, their family and their care team regarding end-of-life plan of care
- Demonstrates expertise as a mediator and advocate for the **to** access appropriate and timely palliative care
- Demonstrates self-awareness of responses to communication challenges and remains engaged in meaningful contact with the person, their family, and their caregiver(s)

**Optimizing Comfort and Quality of Life**

- Applies a comprehensive understanding of the clinical presentation and disease trajectories of life-limiting conditions when responding to complex and multidimensional care needs, in order to comprehensively identify current and prospective clinical issues in palliative care
- Discusses the benefits and burdens of palliative treatment options to assist the person in meeting their goals of care
- Contributes to decision making with the person, family and Substitute Decision Maker regarding withdrawing or withholding interventions.
- **Acts as an expert resource to other staff regarding the role of discipline-specific interventions in symptom management and optimizing quality of life**

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## Ontario's Competency Framework Development Process

The development process in Ontario was comparable to the process used in Nova Scotia. Please refer to **Appendix A** for a full description of Nova Scotia's development process. However, following the adaptation of the framework to the Ontario context, a Health Equity Impact Assessment (HEIA) was conducted to ensure that equity was adequately addressed in the competencies. The aim of the HEIA was to identify potential unintended health impacts of the Ontario Palliative Care Competency Framework on vulnerable or marginalized groups, and to develop recommendations for adjustments that would mitigate negative impacts and optimize positive impacts that would support equity-based improvements in palliative care service delivery. The HEIA included assessment of the following populations for unintended health impacts: First Nations, Inuit, Métis and urban Indigenous peoples, Age-related groups, Ethno-racial communities, Homeless, Francophone and other linguistic communities, Disability, Low income, Religious/faith communities, Rural/remote or inner-urban populations, Sex/gender, and Sexual orientation.

An important gap that was identified was a lack of focus on the needs First Nations, Inuit, Métis and urban Indigenous communities. To ensure a comprehensive and inclusive framework, several new competencies, specific to First Nations, Inuit, Métis and urban Indigenous have been incorporated into the Ontario Palliative Care Competency Framework. The development of these competencies involved a separate review and validation process and included engagement with various First Nations, Inuit, Métis and urban Indigenous stakeholder organizations. For further information about the process, and to see the full list of recommended First Nations, Inuit, Métis and urban Indigenous competencies, please refer to **Appendix B**.

To validate the Ontario Palliative Care Competency Framework, the colleges and associations representing the various professions involved in the delivery of palliative care were sent the relevant sections of the framework for review. These organizations were asked to validate the competencies, as well as to make any necessary changes to ensure they were reflective of the Ontario context. Feedback was collated and synthesized, and was used to inform revisions to the document. If comments or requests for changes were unclear, follow up occurred with the stakeholder to obtain clarification. The final Ontario Palliative Care Competency Framework was then sent back to the professional colleges/associations for their endorsement.

The Ontario Palliative Care Competency Framework was then shared with the OPCN's Clinical Advisory Council for their endorsement, and then finally, it was shared with the OPCN's Executive Oversight Committee for their approval.

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## Competency Domains

The Ontario Palliative Care Competency Framework uses the six competency domains as originally defined in the Irish Framework<sup>5</sup>. The seven additional domains incorporated into the Nova Scotia Framework<sup>8</sup> have also been added. The domains are defined as follows:

### ***Principles of Palliative Care:***

Palliative care aims to improve the quality of life of people with life-limiting conditions and their families, by treating physical symptoms and attending to psychological, social and spiritual needs. Palliative care is appropriate for people of any age and may be integrated at any point in the disease trajectory, from diagnosis through the continuum of care to bereavement<sup>5</sup>.

***Cultural Safety and Humility:***

Cultural safety is predicated on understanding the power differentials inherent in health service delivery and redressing these inequities through educational processes. Addressing inequities, through the lens of cultural safety, enables health professionals to improve health care access for clients or individuals, aggregates and populations; acknowledge that we are all bearers of culture; expose the social, political and historical contexts of health care; enable practitioners to consider difficult concepts, such as racism, discrimination and prejudice; understand that cultural safety is determined by those to whom health professionals provide care; understand the limitations of “culture” in terms of having people access and safely move through health care systems and encounters with care providers and challenge unequal power relations<sup>17</sup>.

Cultural humility is a process of self-reflection to understand personal and systemic conditioned biases, and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility enables cultural safety. Cultural humility involves humbly acknowledging oneself as a life-long learner when it comes to understanding another’s experience<sup>18</sup>.

***Communication:***

Effective communication is essential in palliative care. Communication is also important where circumstances are ambiguous or uncertain or when strong emotions and distress arise. Specific consideration should be given to communication as a method of:

- Supporting and enabling therapeutic relationships with the patient and family
- Ensuring that the patient and family understand and participate in decision-making regarding care, to the extent that they are able and wish to be involved
- Enabling effective interdisciplinary teamwork<sup>5</sup>.

***Optimizing Comfort and Quality of Life:***

Patients with life-limiting conditions and families can be affected physically, psychologically, socially and spiritually. Optimizing comfort and quality of life for the patient and family is a dynamic process that involves anticipating, acknowledging, assessing and responding to a range of symptoms and needs in a proactive and timely manner in order to prevent and relieve suffering<sup>5</sup>.

***Care Planning and Collaborative Practice:***

Care planning in palliative care is characterized by coordinating and integrating person-centred care in order to promote quality of life for patients and families. It involves assessing needs, goals and wishes, promoting and preserving choice, predicting likely problems and planning for the future, in the context of a changing and deteriorating disease trajectory. Patients and families should be actively engaged in the care planning process to the extent that they are able and wish to be involved<sup>5</sup>.

***Loss, Grief and Bereavement:***

Dealing with loss, grief and bereavement for the patient themselves, their family and the professionals who care for them is intrinsic to palliative care. Families and caregivers benefit from support as they manage medication information, learn how to provide care, and develop coping strategies to deal with medical care, personal care, psychosocial care, loss, grief, and bereavement<sup>2</sup>. Professionals providing palliative care have an important role to play in addressing loss, grief, and bereavement needs, by providing information and support and by identifying those who require therapy or counselling<sup>5</sup>.

***Last Days and Hours:***

Patient and family care needs unique to the last days and hours of the patient’s life.

**Professional and Ethical Practice:**

The goal of health care is to help people sustain health that is essential to their well-being. However, at a certain point specific treatments or interventions may be futile or overly burdensome. Integrity in palliative care practice refers to the importance of respecting the patient's values, needs and wishes in the context of a life-limiting condition. It guides all health professionals to reflect on the relationship between their contribution to a patient's care and the necessary contributions of other professionals. Professional and ethical practice considers how best to provide continuing and integrated care to people as their health care needs change in the course of life-limiting conditions<sup>5</sup>.

**Self-Care:**

A spectrum of knowledge, skills, and attitudes including self-reflection and self-awareness, identification and prevention of burnout, appropriate professional boundaries, and grief and bereavement<sup>19</sup>.

**Education:**

Participating in palliative care continuing education initiatives, facilitating palliative care educational opportunities for health professionals, volunteers, patients, families and the public.

**Research:**

Leading or participating in palliative care research, keeping abreast of palliative care research and inviting patients and families to participate in relevant research projects.

**Evaluation:**

Leading or participating in the evaluation of palliative care services and patient and family experiences.

**Advocacy:**

Advocating for access to and funding for palliative care services and associated educational opportunities and advocating for enhancements to the social determinants of health.

Palliative care competency domains established by national and provincial health professional associations and colleges were also incorporated into the Framework (e.g. The Royal College of Physicians and Surgeons of Canada CanMEDS Framework). The definitions of these domains are self-evident and do not warrant separate definitions.

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**Scope of this Document**

The Ontario Palliative Care Competency Framework includes most of the key professions involved in palliative care in Ontario; however, there are some professions that are not represented. Defining competencies for all providers involved in palliative care was beyond the scope of this work. However, for many of these professions, palliative care competencies are reflected in their profession-specific core competencies. Professions not named in the document are expected to understand and apply the principles of palliative care in their practice.

For setting specific competencies, members of the interdisciplinary team are expected to apply principles set out in appropriate standards. As an example, teams within a residential hospice are encouraged to reference standards set by Hospice Palliative Care Ontario (HPCO).

Finally, while it is recognized that there is significant intersection between palliative care and Medical Assistance in Dying (MAID), competencies related to MAID services is outside the scope for the Ontario Palliative Care Competency Framework. Nonetheless, patients who may be considering or request MAID should receive high-quality palliative care. Health care professionals are expected to manage all requests for MAID in accordance with the expectations set out by their regulatory colleges. Health care professionals should refer to their regulatory colleges for more information and guidance on MAID.

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## Before you begin

Palliative care has been increasingly positioned as a key element in the health system in response to the aging population and the growing numbers of those dying from life-limiting illnesses. Patients and their families are often faced with complex needs resulting in new demands being placed on the healthcare system across settings of care and communities. As a result, there is a continual need to provide advanced education for those working in palliative care.

All leaders in health systems will need to support continuing education and robust quality improvement efforts to deliver timely, high-quality palliative care services. This framework will help to inform those efforts by outlining the range of core competences that providers should have if they are providing palliative care. It is envisioned that the Ontario Palliative Care Competency Framework will inform academic curricula and professional development programs, and so will enhance the care of people with a life-limiting condition.

## PALLIATIVE CARE COMPETENCIES FOR DIETITIANS

### Principles of Palliative Care

- Demonstrates understanding of the philosophy of palliative care
  - Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding that a palliative approach to care starts early in the trajectory of a progressive life-limiting condition, and may be appropriate at the time of diagnosis
- Demonstrates ability to describe the meaning of the term ‘life-limiting condition’
- Applies the principles of palliative care that affirm life, offers a support system to help individuals live as actively as possible until death, with optimal quality of life and helps the family cope
- Understands, recognizes and manages pathological responses to loss, referring appropriately to the Specialist Palliative Care Team, or other interdisciplinary team members as appropriate
- Conserves dignity of the person by facilitating expression of needs, hopes, feelings and concerns when planning palliative care
- Demonstrates understanding of the role and function of the Interdisciplinary Care Team in palliative care
- Demonstrates understanding of the role and function of the Specialist Palliative Care Team, including volunteers, and refers appropriately
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
  - Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community
- Demonstrates understanding of palliative care standards, guidelines and policies

### Cultural Safety and Humility

- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates understanding of the Indigenous Wellness Framework
- Validates and preserves cultural preferences and values by identifying ways to accommodate them into goal setting, decision making and care planning
- Recognizes and respects who the person identifies as family, and responds to family members’ unique needs and experiences
  - Considers the community, as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates openness and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preferences and accommodates these
- Recognizes personal biases and values that may influence care and identifies mechanisms to overcome these to ensure they do not impact care and treatment

### *Dietitian Specific Competency:*

- Assesses the dietary end-of-life needs unique to each person and family, considering the social determinants of health, ethnicity, culture, gender, sexual orientation, language, religion, age, ability and their preferences

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### **Communication**

- Demonstrates understanding of the essential role communication plays in palliative care
- Demonstrates understanding that communication regarding palliative and end-of-life care is an on-going collaborative process
  - Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
- Recognizes the multidimensional communication challenges that arise when caring for people with life-limiting conditions
- Assesses the person's and family's understanding of the life-limiting condition and its trajectory and uses this to inform their communication approach
- Provides culturally relevant information and resources to support individuals and families, particularly when caring for those from First Nations, Inuit, Métis and urban Indigenous communities
- Recognizes the potential for conflict in palliative care decision-making and contributes to its management
- Supports the person to make informed decisions on the depth of information about diagnosis, prognosis and disease progression they wish to receive and share with their family
  - Recognizes that communication and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Invites, facilitates and respects the involvement of the person, family and their care team in discussions regarding the plan of care
- Recognizes that family conversations may involve children and different communication approaches may be required
- Evaluates communication with the person and their family/caregiver to ensure their care plan meets the person's identified needs
  - Identifies the importance of community care plans when caring for First Nations, Inuit, Métis and urban Indigenous people
- Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous people
- Supports the discharge planning process to facilitate smooth transitions particularly when caring for First Nations and Inuit people and dual providers may be involved
- Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
  - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous

people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family

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### Optimizing Comfort and Quality of Life

- Recognizes how a palliative approach can enhance the assessment and management of symptoms
- Anticipates and predicts the needs of the person who has been diagnosed with a life-limiting illness based on known disease trajectories
- Evaluates non-complex interventions and proposes alternatives if necessary
- Demonstrates understanding of the concept of 'total pain'
- Demonstrates understanding of the potential barriers to providing pain management, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding of the causes of common non-pain symptoms at end-of-life
- Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Applies interprofessional approaches to optimize comfort and enhance quality of life of the person and their family
- Recognizes the ways a person can be engaged in self-management of their condition
- Understands the collaborative relationship between the individual, family, caregivers and community in supporting pain and symptom management
- Recognizes the need for a change in the focus of care and treatment goals at critical decision points in the course of a life-limiting condition
- Provides education and practical strategies to the person, their family and their caregivers regarding the management of pain and symptoms
- Uses non-pharmacological symptom management to promote comfort and quality of life
- Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous, and provides suggestions for non-pharmacological ways to address pain/promote comfort and quality of life
- Supports the person, family, Substitute Decision Maker (SDM) and care teams with end-of-life decision making, including withdrawing or withholding interventions
- Recognizes and anticipates the physical, psychological, social and spiritual issues that affect the person and their family
- Recognizes common trajectories of life-limiting conditions, including common symptoms
- Provides care in keeping with the person's expressed wishes and/or identified goals of care
- Understands how a Substitute Decision Maker (SDM) determined (based on the hierarchy in the Health Care Consent Act) and the role they play in making health care decisions on behalf of the incapable person.
- Demonstrates awareness of one's own responses in the presence of a person who is suffering
- Provides care in a compassionate manner

#### *Dietitian specific competencies:*

- Assesses the person's and caregivers' skills and need for dietary education and supports taking into consideration the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age, ability, and preferences
- Recognizes potentially reversible causes of dietary issues and employs appropriate dietary and nutrition support strategies for the person

- Assesses the benefits, burdens and risks of clinical nutrition interventions
  - Makes decisions regarding the appropriateness of interventions for each person living with a life-limiting condition, taking into consideration the person's expressed wishes and identified goals of care
- Provides individualized dietetic counselling to individuals with palliative care needs
- Provides education, advice and practical strategies to the person and caregivers regarding the management of dietary related symptoms, including: anorexia, cachexia, dysphagia, nausea, vomiting, constipation, diarrhea and taste changes, management of enteral and parenteral nutrition support and refusal to eat or drink
- Engages in dysphagia assessment and management according to the Alliance of Canadian Dietetic Regulatory Bodies Practice Competencies for Dysphagia Assessment and Management
- Interprets the impact of family role change when formulating relevant and realistic nutrition care plans in collaboration with the person with a life-limiting condition

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### Care Planning and Collaborative Practice

- Understands the collaborative relationship between the person, health professionals, family and caregivers
  - Recognizes that care planning and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Effectively collaborates with the care team to manage pain and symptoms
- Recognizes the overall impact of a life-limiting condition on the person, including their mental health and coping mechanisms, and provides support to address identified needs
- Identifies priorities and concerns in collaboration with the person and family, taking into account their coping strategies and perception of diagnosis
- Familiar with the Health Care Consent Act, and understands that a health provider must obtain informed consent from the person (or, if they are incapable, their Substitute Decision Maker) for any treatment or intervention proposed
- Understands how a Substitute Decision Maker (SDM) is determined (based on the hierarchy within the Health Care Consent Act) and the role the SDM plays in making health care decisions if the person is not capable
- Supports the person to express their wishes and/or identify goals of care by referring them to the most appropriate health professional
- Facilitates the active involvement of the person in goal setting, decision making and informed consent to support the best possible outcome and quality of life
- Demonstrates flexibility in relation to care planning, acknowledging that a person's priorities can shift as their condition changes
- Facilitates informed decision-making by the person regarding place of care, while identifying risks in a supportive manner
- When able, provides care in the person's preferred place, while recognizing the complexities and challenges involved for the person and their family/caregiver(s)
- Anticipates factors/conditions that may affect the individuals cognition and functional capacity to make decisions including health status changes, and towards end-of-life
- Identifies how interprofessional practice enhances individual outcomes
- Recognizes clinical limitations and professional boundaries and refers to other colleagues appropriately and in a timely manner

#### *Dietitian specific competency:*

- Actively participates in discussions with the person to determine their preferences for nutrition support and oral feeding

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#### **Last Days and Hours**

- Anticipates, recognizes and responds to the signs of imminent death
- Supports the family's wishes and death rituals

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#### **Loss, Grief and Bereavement**

- Demonstrates knowledge of diverse perspectives on loss, grief, bereavement and mourning, to support others from a cross-cultural perspective
  - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people
- Recognizes the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief
- Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief
  - Understands cumulative grief which can be particularly significant in First Nations and Inuit communities
- Provides appropriate guidance, support and information to families, caregivers, and others, based on an awareness of individuals culture and needs
- Makes referrals to bereavement services as required

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#### **Professional and Ethical Practice**

- Anticipates and addresses ethical and legal issues that may be encountered when caring for individuals with life-limiting conditions
- Establishes and respects people's wishes regarding their care options and preferences
- Respects the person's decisions regarding initiating, not initiating, withholding and withdrawing dialysis, hydration, nutrition support, resuscitation and other life-prolonging/life-sustaining interventions
- Understands distinctions among ethical and legal concepts, such as: the principle of double effect, Palliative Sedation Therapy and MAID
- Recognizes when beliefs, attitudes and values limit one's ability to be present and provide person-centred care; collaborates with others to ensure optimal care is provided
- Demonstrates knowledge of relevant legislation and policies, e.g. Bill C14 Medical Assistance in Dying (MAID), Bill 84 (Medical Assistance in Dying Statute Law Amendment Act, 2017) , Child, Youth and Family Services Act, Adult Protection Act, Health Care Consent Act, and Substitute Decisions Act
- Responds to inquiries regarding MAID in accordance with legislation, regulatory body's relevant guidelines and standards and employer policies
- Demonstrates awareness of ethical and legal issues that may arise regarding oral feeding and enteral and parenteral nutrition support
- Demonstrates the ability to actively participate in the discussion and management of ethical and legal issues regarding nutrition support with the person, their family and their care team

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#### **Self-Care**

- Demonstrates understanding of the impact of loss, grief and bereavement

- Recognizes own responses to loss and engages in activities that support well-being and resilience
- Explores own attitudes regarding death, dying and caring for individuals requiring palliative care
- Demonstrates awareness of the impact of past experiences of suffering, death and dying when providing palliative care
- Understands and attends to own emotional responses that result from caring for individuals with palliative care needs
- Recognizes compassion fatigue in self and colleagues; intervenes and refers appropriately
- Engages in healthy activities that help prevent compassion fatigue
- Demonstrates understanding of the concept of good “helping relationships” when working with First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding of the concept of companioning when working with First Nations, Inuit, Métis and urban Indigenous people
- Participates in community-driven debriefs when working with First Nations, Inuit, Métis and urban Indigenous people

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### Education and Evaluation

- Contributes to the monitoring and evaluation of the quality of palliative care
- Participates in palliative care continuing education opportunities
- Educates the person, their family, and their caregiver(s) about palliative care and the palliative approach
- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

## ADDITIONAL COMPETENCIES FOR DIETITIANS WITH A PRACTICE FOCUSED IN PALLIATIVE CARE

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### Principles of Palliative Care

- Facilitates empathic and responsive relationships between those experiencing life-limiting conditions and their care team
- Demonstrates leadership that encourages colleagues to foster a caring environment that supports all staff working in sensitive situations
- Applies a dignity conserving approach to care when providing support
- Practices person-centred palliative care that incorporates the unique contributions of the family
- Demonstrates understanding of palliative care standards, guidelines and policies

#### *Dietitian specific competency:*

- Demonstrates advanced knowledge and understanding of the full spectrum of trajectories of life-limiting conditions and their impact on nutritional management when responding to complex and multidimensional care needs

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### Communication

- Uses a variety of strategies to engage in highly skilled, compassionate, individualized and timely communication with the person, their family, their caregiver(s) and members of their care team

- Maintains ongoing communication with the person, their family and their care team regarding end-of-life plan of care
- Demonstrates expertise as a mediator and advocate for appropriate and timely access to palliative care
- Demonstrates self-awareness of responses to communication challenges and remains engaged in meaningful contact with the person, their family, and their caregiver(s)

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### Optimizing Comfort and Quality of Life

- Applies a comprehensive understanding of the clinical presentation and disease trajectories of life-limiting conditions when responding to complex and multidimensional care needs, in order to comprehensively identify current and prospective clinical issues in palliative care
- Discusses the benefits and burdens of palliative treatment options to assist the person in meeting their goals of care
- Supports the person, family, Substitute Decision Maker (SDM) and care teams with end-of-life decision making, including withdrawing or withholding interventions

#### *Dietitian specific competency:*

- Acts as an expert resource to other staff regarding the role of discipline-specific interventions in symptom management and optimizing quality of life

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### Care Planning and Collaborative Practice

- Develops therapeutic relationships with the person, family, caregivers and their care team to define goals of care and to develop, implement and evaluate a plan of care
  - Facilitates participation of the person in their care planning
  - Identifies and integrates strengths of the person in their plan of care
  - Safely and appropriately delegates aspects of care to the family
  - Assists the family in care giving and acquiring respite care
  - Engages in family and team conferences
  - Develops a plan of care for the family
- Collaborates with the person, and their family/caregiver(s) to identify resources that will provide support throughout their illness and during end-of-life care
- Facilitates conversations to support end-of-life decision making
- Identifies values, beliefs and preferences of the person, and their family regarding the various components of palliative care provision
- Uses shared scopes of practice to optimize care
- Collaborates within and between teams across the continuum of care to facilitate continuity in palliative care
- Safely and appropriately delegates aspects of care to the family
- Identifies the full range and continuum of palliative care services, resources and the settings in which they are available
  - Demonstrates knowledge of the range of palliative care services and resources
  - Provides relevant information and resources to the person and family
  - Identifies and accesses services and resources specific to the person's goals of care
  - Initiates referrals to and requests for resources, services and settings
  - Facilitates access for the person and their family to needed services and resources

#### *Dietitian specific competencies:*

- Demonstrates clinical expertise and sensitivity in facilitating safe, smooth and seamless transitions of care for the person

- Acts as an expert resource to other staff on the role of dietary and nutritional interventions in symptom management and optimizing quality of life
- Creates a holistic, person-centred plan, acknowledging the psychosocial impact of changing nutritional requirements and dietary intake

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### Loss, Grief and Bereavement

- Demonstrates a comprehensive knowledge of the grieving process and reactions in order to support the person and their family throughout the disease trajectory

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### Professional and Ethical Practice

- Applies a comprehensive understanding of contemporary legal, ethical and professional standards to the provision of quality palliative care
- Facilitates discussion and management of ethical and legal issues in conjunction with the person, their family/caregiver(s) and their care team
- Actively influences and promotes palliative care strategic initiatives and policy development

#### *Dietitian specific competency:*

- Acts as an expert resource contributing to palliative care development and delivery

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### Education, Research and Evaluation

- Educates the person, their family, and their caregiver(s) about palliative care and the palliative approach
- Applies knowledge gained from palliative care research
- Where possible, provides the family with opportunities to participate in palliative and end-of-life caregiving research
- Where possible, leads, facilitates and engages in palliative care education and research
- Critically evaluates outcomes against standards and guidelines
- Contributes to the evaluation of the quality of palliative care and the effectiveness of the interdisciplinary care team
- Develops, facilitates and provides palliative care related education, leadership and mentorship to members of the discipline and students

#### *Dietitian specific competency:*

- Where possible, identifies the opportunities for and barriers to discipline-specific research unique to palliative care

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### Advocacy

- Advocates for the needs, decisions and rights of the person by recognizing potential vulnerabilities
- Supports autonomous decision-making
- Promotes equitable and timely access to resources
- Recognizes and mitigates potential barriers and limitations to supporting transitions between specialty care and primary care particularly in First Nations, Inuit, Métis and urban Indigenous communities
- Advocates for the development, maintenance and improvement of health care and social policies related to palliative care
- Advocates for health professionals to participate in palliative care continuing education opportunities
- Advocates for health professionals to have adequate resource to provide palliative care

# PALLIATIVE CARE COMPETENCIES FOR MEDICAL RADIATION AND IMAGING TECHNOLOGISTS

## Principles of Palliative Care

- Demonstrates understanding of the philosophy of palliative care
  - Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding that a palliative approach to care starts early in the trajectory of a progressive life-limiting condition
- Demonstrates the ability to describe the meaning of the term ‘life-limiting condition’
- Applies the principles of palliative care that affirm life, offers a support system to help individuals live as actively as possible until death, with optimal quality of life and helps families cope during illness
- Understands, recognizes and manages pathological responses to loss, referring appropriately to the Specialist Palliative Care Team, or other interdisciplinary team members as appropriate
- Conserves the persons dignity by facilitating expression of needs, hopes, feelings and concerns when planning palliative care
- Demonstrates understanding of the role and function of the interdisciplinary care team in palliative care
- Demonstrates understanding of the role and function of the Specialist Palliative Care Team, including volunteers
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
  - Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community

## *Medical radiation and imaging technologist specific competency:*

- Demonstrates understanding of roles of all five specialties of medical radiation and imaging technology (radiography, radiation therapy, nuclear medicine, magnetic resonance and diagnostic medical sonography) in caring for individuals with palliative care needs

## Cultural Safety and Humility

- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates understanding of the Indigenous Wellness Framework
- Demonstrates openness and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preference and accommodates these
- Appreciates the unique needs and preferences of the individual and their family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age, and ability
- Validates and preserves cultural preferences and values

- Recognizes and respects who the person identifies as family, and responds to family members' unique needs and experiences
    - Considers the community, as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people
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### Communication

- Discusses the palliative approach with individuals and their families
  - Demonstrates understanding of the essential role communication plays in palliative care
  - Demonstrates understanding that communication regarding palliative and end-of-life care is an on-going collaborative process and not a single event
    - Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
  - Recognizes the multidimensional communication challenges that arise when caring for people with life-limiting conditions
  - Assesses the person's and family's understanding of the life-limiting condition and its trajectory and uses this to inform their communication approach
  - Provides culturally relevant information and resources to support individuals and families, particularly when caring for those from First Nations, Inuit, Métis and urban Indigenous communities
  - Supports the person to make informed decisions on the depth of information about diagnosis, prognosis and disease progression they wish to receive and share with their family
  - Respects the involvement of the person, their family and their care team in discussions regarding the plan of care
    - Recognizes that communication and decision-making may involve the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
  - Recognizes that family conversations may involve children and different communication approaches may be required
  - Evaluates communication with the person and their family/caregiver to ensure their care plan meets the person's identified needs
    - Identifies the importance of community care plans when caring for First Nations, Inuit, Métis and urban Indigenous people
  - Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous people
  - Supports the discharge planning process to facilitate smooth transitions particularly when caring for First Nations and Inuit people and dual providers may be involved
  - Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
    - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family
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- Uses a variety of strategies to engage in timely, compassionate communication with the person, their family, their caregivers and the interdisciplinary care team

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### Optimizing Comfort and Quality of Life

- Recognizes how a palliative approach can enhance the assessment and management of symptoms
- Anticipates and predicts the needs of the person who has been diagnosed with a life-limiting illness based on known disease trajectories
- Evaluates non-complex interventions and proposes alternatives if necessary
- Demonstrates understanding of the concept of ‘total pain’
- Demonstrates understanding of the causes of common non-pain symptoms at end-of-life
- Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Applies the principles of pain and symptom management
- Demonstrates understanding of the potential barriers to providing pain management, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Applies interprofessional approaches to optimize comfort and enhance quality of life of the person and their family
  - Understands the collaborative relationship between the individual, family, caregivers and community in supporting pain and symptom management
- Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous, and provides suggestions for non-pharmacological ways to address pain/promote comfort and quality of life
- Recognizes and anticipates the physical, psychological, social and spiritual issues that affect the person and their family
- Recognizes common trajectories of life-limiting conditions, including common symptoms
- Demonstrates awareness of one’s own responses in the presence of a person who is suffering
- Provides care in a compassionate manner
- Provides care in keeping with the person’s expressed wishes and identified goals of care

#### *Medical radiation and imaging technologist specific competency:*

- Acts as an expert resource regarding the role of discipline-specific interventions in symptom management and optimizing quality of life
- Provides clear and understandable information to the person or person’s substitute decision maker prior to, during and after the diagnostic or therapeutic procedure, using an interpreter is necessary
- Gives the person or their substitute decision maker an opportunity to ask questions and provides responses within the scope of the profession’s responsibility
- Refers questions of the person or person’s substitute decision maker that are outside the scope of the profession’s responsibility to an appropriate health professional for answers
- Makes modifications to procedures based on the person’s physical, medical and/or emotional status and needs
- Protects the person, as well as themselves, their colleagues, other members of the care team, and any other individuals who may be present from any unnecessary exposure to radiation

- Completes the procedure, advises the person and other members of the care team of any post-procedural care, and transfers the care of, or releases, the person

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### Care Planning and Collaborative Practice

- Understands the collaborative relationship between the person, health professionals, family and caregivers
  - Recognizes that care planning and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Demonstrates understanding of and respect for the roles, knowledge, expertise and unique contribution by other members of the care team for the provision of quality care
- Shares knowledge with other members of the care team to promote the best possible outcomes for the person
- Effectively collaborates with the care team to manage pain and symptoms
- Recognizes the overall impact of a life-limiting condition on the person, including their mental health and coping mechanisms, and provides support
- Identifies priorities and concerns in collaboration with the person and family, taking into account their coping strategies and perception of diagnosis
- Familiar with the Health Care Consent Act, and understands that a health provider must obtain informed consent from the person (or, if they are incapable, their Substitute Decision Maker) for any treatment or intervention proposed
- Understands how a Substitute Decision Maker (SDM) is determined (based on the hierarchy within the Health Care Consent Act) and the role the SDM plays in making health care decisions if the person is not capable
- Supports the person to express their wishes and/or identify goals of care by referring them to the most appropriate health professional
- Anticipates factors/conditions that may affect the individual's cognition and functional capacity to make decisions including health status changes, and towards end-of-life
- Identifies how interprofessional practice enhances individual outcomes
- Facilitates the active involvement of the person in goal setting, decision making and informed consent to support the best possible outcomes and quality of life

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### Last Days and Hours

- Anticipates, recognizes and responds to the signs of imminent death

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### Loss, Grief and Bereavement

- Demonstrates knowledge of diverse perspective on grief, loss, bereavement, and mourning to support others from a cross-cultural perspective
  - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people
- Recognizes the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief
- Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief
  - Understands cumulative grief which can be particularly significant in First Nations and Inuit communities

- Provides appropriate guidance, support and information to families, caregivers, and others, based on an awareness of individuals culture and needs

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### Professional and Ethical Practice

- Anticipates and addresses ethical and legal issues that may be encountered when caring for individuals with life-limiting conditions
- Establishes and respects the person's wishes regarding their care options and preferences
- Respects the person's decisions regarding initiating, not initiating, withholding and withdrawing dialysis, hydration, nutrition support, resuscitation and other life-prolonging/life-sustaining interventions
- Understands distinctions among ethical and legal concepts, such as: the principle of double effect, Palliative Sedation Therapy and Medical Assistance in Dying (MAID)
- Recognizes when beliefs, attitudes and values limit one's ability to be present and provide person-centred care; collaborates with others to ensure optimal care is provided
- Demonstrates knowledge of relevant legislation and policies, e.g. Bill C-14 (MAID), Bill 84 (Medical Assistance in Dying Statute Law Amendment Act, 2017) , Child, Youth and Family Services Act, Adult Protection Act, Health Care Consent Act, and Substitute Decisions Act
- Responds to inquiries regarding MAID in accordance with regulatory body's relevant guidelines and standards and employer policies

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### Self-Care

- Demonstrates understanding of the impact of loss, grief and bereavement
- Recognizes one's own responses to loss and engages in activities that proactively support well-being and resilience
- Explores own attitudes regarding death, dying and caring for individuals requiring palliative care
- Understands and attends to own emotional responses that result from caring for individuals with palliative care needs
- Recognizes compassion fatigue in self and colleagues; intervenes and refers appropriately
- Engages in healthy activities that help prevent compassion fatigue
- Demonstrates understanding of the concept of good "helping relationships" when working with First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding of the concept of companioning when working with First Nations, Inuit, Métis and urban Indigenous people
- Participates in community-driven debriefs when working with First Nations, Inuit, Métis and urban Indigenous people

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### Education and Evaluation

- Participates in the monitoring and evaluation of the quality of palliative care
- Participates in palliative care continuing education opportunities
- Educates individuals, their families and caregivers about palliative care and the palliative care approach
- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

## PALLIATIVE CARE COMPETENCIES FOR NURSES IN ALL PRACTICE SETTINGS (RN, RPN, CNS, AND NP)

Note: In Ontario, nursing is one profession with two categories: Registered Practical Nurse (RPN), and Registered Nurse (RN)<sup>20</sup>. The foundational knowledge base of RNs and RPNs "is different because of differences in basic nursing education."<sup>21</sup> In particular, RPNs have an approved Ontario college diploma program in practical nursing, while RNs have an approved Canadian university baccalaureate degree in nursing. There are also two advanced nursing practice roles recognized in Canada, Clinical Nurse Specialist (CNS),<sup>a</sup> and Nurse Practitioner (NP)<sup>b</sup>. The current minimum educational preparation for advanced practice nursing roles of CNS and NP is a graduate degree in nursing<sup>22</sup>.

All nurses may be involved in and contribute to palliative care service delivery through intra- and inter-professional collaborative, team-based, person and family-focused approaches. Nurses leverage their strengths and combine individual competence with nursing skill, knowledge and judgment based on their education and experience to enhance the holistic approach to palliative care.

The palliative care competencies outlined in this document are intended to build on foundational entry-to-practice competencies established by the College of Nurses of Ontario (CNO). Every nurse should consider these palliative care competencies in the context of individual competencies, legislative scope of practice, professional standards, and practice guidelines. For all nurses, the palliative care competencies should be considered within the context of the Regulated Health Professions Act, 1991 (RHPA), the Nursing Act, 1991, and the regulatory framework as outlined by the CNO.

The palliative care competencies also build on best practices outlined by the Canadian Hospice Palliative Care Association (CHPCA) Nursing Standards of Practice, the Canadian Nursing Association Hospice Palliative Care Nursing List of Assumptions and Competencies, and the Registered Nurses' Association of Ontario (RNAO) Clinical Best Practice Guidelines on *End-of-Life Care During the Last Days and Hours*<sup>23</sup> and a *Palliative Approach to Care in the Last 12 Months of Life*<sup>24</sup>.

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### Principles of Palliative Care

- Demonstrates understanding of the philosophy of palliative care
  - Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
- Demonstrates understanding that a palliative approach to care starts early in the trajectory of a progressive life-limiting condition, and may be appropriate at the time of diagnosis
- Demonstrates ability to describe the meaning of the term 'life-limiting condition'
- Identifies individuals who would benefit from a palliative approach early in a life-limiting condition

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<sup>a</sup> CNSs provide expert nursing care for specialized client populations by playing a leading role in development of clinical protocols and guidelines, consultation and support, and facilitation system change<sup>22</sup>.

<sup>b</sup>In Ontario, NPs are RNs in the extended class, who have met additional education, experience and exam requirements set by the College<sup>21</sup>. NPs provide direct clinical care for the treatment and management of health conditions as well as health promotion<sup>22</sup>.

- Applies the principles of palliative care that affirm life, offers a support system to help individuals live as actively as possible until death, with optimal quality of life and helps families cope during illness and bereavement
- Conserves and promotes dignity of the person by facilitating expression of needs, hopes, feelings and concerns when planning palliative care
- Recognizes the role of primary and acute care in the provision of palliative care across a variety of settings
- Demonstrates understanding of the role and function of the Interdisciplinary Care Team in palliative care
  - Demonstrates understanding of the role and function of the Specialist Palliative Care Team, including volunteers
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
  - Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each community
- Demonstrates understanding of palliative care standards, guidelines and policies
- Demonstrates understanding of the Ontario Drug Benefits Formulary, and the Palliative Care Facilitated Access mechanism<sup>c</sup>

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### Cultural Safety and Humility

- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates understanding of the Indigenous Wellness Framework
- Demonstrates openness and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preference and accommodates these
- Recognizes personal biases and values that may influence care and identifies mechanisms to overcome these to ensure they do not impact care and treatment
- Assesses the unique needs and preferences of the individual and their family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, spirituality, age, and ability
- Validates and preserves cultural preferences and values by identifying ways to incorporate them into goal setting, decision making and care planning
- Recognizes and respects who the person identifies as family, and responds to family members' unique needs and experiences
  - Considers the community as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous peoples
- Explores the person and their family's cultural and religious needs, beliefs and preferences as they relate to end-of-life

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<sup>c</sup>Only authorized Nurse Practitioners have access to the Palliative Care Facilitated Access Mechanism

- Creates an environment and provides opportunities for the person and their family to exercise religious, cultural and spiritual rituals, customs, rites and beliefs throughout the person's illness and through bereavement
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### Communication

- Introduces individuals and their families to the concept and benefits of palliative care, along with other disease ameliorating treatments, or as the main focus of care
- Demonstrates understanding of the essential role communication plays in palliative care
- Demonstrates understanding that communication regarding palliative and end-of-life care is an on-going collaborative process
  - Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
- Recognizes the multidimensional communication challenges that may arise when caring for people with life-limiting conditions
- Assesses the person's and family's understanding of the life-limiting condition
- Recognizes the potential for conflict in palliative care decision-making and contributes to its management
- Supports individuals to make informed decisions on the depth of information about diagnosis, prognosis and disease progression they wish to receive and share with their families
- Provides culturally relevant information and resources to support individuals and families, particularly when caring for those from First Nations, Inuit, Métis and urban Indigenous communities
- Invites, facilitates and respects the involvement of the person, their family and their care team in discussions regarding the plan of care
  - Recognizes that communication and decision-making may involve the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Recognizes that family conversations may involve children and different communication approaches may be required
- Evaluates communication with the person and their family/caregiver to ensure their care plan meets the person's identified needs
  - Identifies the importance of community care plans when caring for First Nations, Inuit, Métis and urban Indigenous peoples
- Applies requisite relational skills, (e.g. negotiating, listening, clarifying) to support decision making and suggesting modes of palliative care on an ongoing basis
- Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous peoples
- Influences the discharge planning process to facilitate smooth transitions particularly when caring for First Nations and Inuit people and dual providers may be involved
- Recognizes and mitigates potential barriers and limitations to supporting transitions between specialty care and primary care particularly in First Nations, Inuit, Métis and urban Indigenous communities

- Creates opportunities for the person to conduct a life review, either through use of individual skills or referral to other professionals.
- Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
  - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous peoples, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family
  - Recognizes translation is not interpretation and understanding
- Reviews and clarifies the person's and family's (and/or caregiver's) understanding of palliative care information presented by other providers
- Offers the individual and/or family an opportunity to connect with the Trillium Gift of Life Network to discuss eligibility for body, organ or tissue donation

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### Optimizing Comfort and Quality of Life

- Demonstrates understanding of how the palliative approach can enhance the assessment and management of symptoms
- Recognizes common trajectories of life-limiting conditions, including common symptoms
- Anticipates and predicts the needs of the person who has been diagnosed with a life-limiting condition based on known disease trajectories
- Applies intra- and inter-professional approaches to optimize comfort and enhance quality of life of the person and family
- Understands the concept of 'total pain' and associated impact to the person and family
- Understands common symptoms, other than pain, including but not limited to fatigue, cachexia, anorexia, muscle weakness and lymphedema.
- Demonstrates knowledge of the pathophysiology of pain
- Distinguishes pain classifications and their importance in effective management
- Applies the principles of pain and symptom management
- Demonstrates understanding of the potential barriers to providing pain management, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
- Regularly screens for symptoms and needs
  - Uses standardized instruments regularly and appropriately to screen and assess symptoms and needs
  - Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Uses investigations appropriately, according to the trajectory of life-limiting conditions
  - Evaluates the outcomes of pain and symptom management against baseline assessment
- Conducts assessments of the person's and their families' emotional, psychological, social, spiritual and practical strengths and needs
  - Identifies priorities and concerns in collaboration with the person and family, taking into account their coping strategies and perception of diagnosis
  - Attends to psychosocial and practical issues
  - Consults with and/or refers to other providers when identified needs are beyond individual competencies or legislative scope of practice

- Assesses and shares the benefits, burdens and risks of clinical interventions
  - Proposes options, based on the persons preferences and expressed wishes, and discusses these with the person, or if not capable to make decisions, with their Substitute Decision Maker
- Implements treatment plans that are consistent with the individuals expressed wishes, identified goals of care, and the trajectory of their life-limiting condition
- Uses non-pharmacological symptom management to promote comfort and quality of life
  - Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
- Discusses, teaches and assists the person and their family with the management of pain and symptoms, including the recognition of areas needing further assessment
- Recognizes the ways in which individuals can be engaged in self-management of their condition
- Recognizes the need for a change in the focus of care and treatment goals at critical decision points in the course of a life-limiting condition
- Interprets the impact of family role change when formulating relevant and realistic care plans
- Recognizes and anticipates the physical, psychological, social and spiritual issues that affect the person and their family
- Evaluates interventions within the care plan, discusses with the interprofessional team and proposes alternatives if necessary and as appropriate
- Demonstrates understanding of the pathophysiology of palliative care emergencies
- Identifies, assesses and manages palliative care emergencies including, but not limited to: biliary, bowel and urinary obstruction, catastrophic bleed, delirium, hypercalcemia, pain crisis, seizures, Spinal Cord Compression and Superior Vena Cava Obstruction
- Supports the person, family, Substitute Decision Maker (SDM) and care teams with end-of-life decision making, including withdrawing or withholding interventions
- Demonstrates awareness of one's own responses in the presence of a person who is nearing the end-of-life.
- Provides care in a compassionate manner

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### Care Planning and Collaborative Practice

- Identifies how interprofessional practice enhances individual outcomes
- Understands the collaborative relationship between the person, health professionals, family and caregivers
  - Recognizes that care planning and decision-making may need to involve the family and larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Collaborates with the care team to manage pain and symptoms effectively based on the persons identified goals of care
- Understands the Health Care Consent Act, 1996, and understands that a health provider must obtain informed consent from the person (or, if they are incapable, their Substitute Decision Maker) for any treatment or intervention proposed
- Understands how a Substitute Decision Maker (SDM) is determined (based on the hierarchy within the Health Care Consent Act, 1996) and the role the SDM plays in making health care decisions if the person is not capable

- Engages in conversations with individuals and their families about the role of the Substitute Decision Maker to help them understand the legislation
- Supports the person to express their wishes and/or identify goals of care
- Facilitates the active involvement of the person in goal setting, decision making and informed consent to support the best possible outcomes and quality of life
- Understands the importance of determining capacity prior to conversations with individuals regarding Advance Care Planning, Goals of Care, and Health Care Consent.
- Anticipates factors/conditions that may affect the individuals cognition and functional capacity to make decisions including health status changes, and towards end-of-life
- Demonstrates ability to incorporate the person's expressed wishes, values and goals into their plan of treatment, and reviews and revises the plan, as needed, to reflect the person's current condition
- Facilitates informed decision-making and consent by the person (or, if incapable, their Substitute Decision Maker) regarding place of care, while identifying risks in a supportive manner
- Demonstrates responsiveness to the person's needs and preferences, acknowledging that their priorities can shift as their condition and health status changes
- When able, provides care in the person's preferred place, while recognizing the complexities and challenges involved for the person, the family and their caregiver(s)
- Provides verbal and written information regarding the dying process, settings of death and after death care
- Recognizes clinical and personal limitations and professional boundaries and refers to other colleagues appropriately and in a timely manner

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### Last Days and Hours

- Aware of best practices for expected death, such as the Registered Nurses' Association of Ontario's Best Practice Guidelines<sup>23, 24</sup> as well as local and organizational policies and processes
- Assists the person and their family to prepare for the time of death
  - Supports planning for expected deaths, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples in the community
- Anticipates, recognizes and responds to the signs of imminent death
- Provides information and assurance to the person and family regarding expected changes, and comfort measures during the last days and hours of life
- Understands pronouncement of death (in accordance with regulations) in expected and unexpected deaths
- Facilitates discussion with appropriate professional if an autopsy is required or requested
- Assesses and respects the family's need for privacy at the time of death, offering presence as appropriate
- Supports the family's wishes and death rituals
  - Provides opportunities for family and the extended community to gather and be together, particularly when caring First Nations, Inuit, Métis and urban Indigenous peoples
- Identifies situations when the Coroner must be contacted, and discusses with families in advance if appropriate

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## Loss, Grief and Bereavement

- Identifies types of grief and recognizes associated signs and symptoms
- Demonstrates knowledge of diverse perspectives on grief, loss, bereavement and mourning to support others from a cross-cultural perspective
  - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous peoples
- Recognizes the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief in self and others
- Understands dimensions of grief and recognizes the factors that may increase the risk of complicated grief
  - Understands cumulative grief which can be particularly significant in First Nations and Inuit communities
- Uses therapeutic conversations when supporting individuals and families experiencing loss and grief.
- Accurately assesses, and manages individuals and families' loss, grief and bereavement needs, through interventions or referring to members of the interdisciplinary team.
- Provides appropriate guidance, support and information to families, caregivers, and others, based on awareness of culture and needs, and makes referrals to bereavement services, as required

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## Professional and Ethical Practice

- Anticipates and addresses ethical and legal issues that may be encountered when caring for individuals with life-limiting conditions
- Establishes and respects people's wishes regarding their care options and preferences
- Respects the person's decisions regarding initiating, not initiating, withholding and withdrawing dialysis, hydration, nutrition support, resuscitation and other life-prolonging/life-sustaining interventions
- Recognizes when personal beliefs, attitudes and values limit one's ability to be present and provide person-centred care; collaborates with others to ensure optimal care is provided
- Demonstrates knowledge of and proficiency with relevant legislation and policies, e.g. Medical Assistance in Dying (MAiD), Child, Youth and Family Services Act, Adult Protection Act, the Health Care Consent Act, 1996, and the Substitute Decision Act
- Understands distinctions among ethical and legal concepts, such as: the principle of double effect, Palliative Sedation Therapy and MAiD
- Responds to inquiries regarding MAiD in accordance with regulatory body's relevant guidelines and standards and employer policies<sup>d</sup>
- Accesses resources to ethically guide complex situations and implements possible resolutions

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## Self-Care

- Explores own attitudes regarding death, dying and caring for individuals with palliative care needs
- Demonstrates awareness of the impact of past experiences of suffering, death and dying when providing palliative care

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<sup>d</sup>RNs and RPNs can participate by providing nursing care and aiding an NP or physician to provide a person with MAiD in accordance with the law

- Demonstrates awareness of ways to manage and cope with the impact of dying and death
- Demonstrates awareness of the emotional and spiritual supports available
- Understands and attends to own emotional responses that result from caring for individuals with palliative care needs, including signs of loss, grief and bereavement
- Recognizes compassion fatigue in self and colleagues; intervenes and refers appropriately
- Engages in healthy activities that help prevent compassion fatigue
- Demonstrates understanding of the concept of good “helping relationships” when working with First Nations, Inuit, Métis and urban Indigenous peoples
- Demonstrates understanding of the concept of companionship particularly when working with First Nations, Inuit, Métis and urban Indigenous peoples
- Participates in community-driven debriefs, particularly when working with First Nations, Inuit, Métis and urban Indigenous peoples

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### **Education and Evaluation**

- Contributes to the evaluation of the quality of palliative care and the effectiveness of the palliative care system
- Critically evaluates outcomes against standards and guidelines
- Participates in palliative care continuing education opportunities
- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

## ADDITIONAL COMPETENCIES FOR NURSES SPECIALIZING IN PALLIATIVE CARE<sup>e,f</sup>

### Principles of Palliative Care

- Facilitates empathic and responsive relationships between those experiencing life-limiting conditions and their care teams
- Demonstrates leadership that encourages colleagues to foster a caring environment that supports all staff working in sensitive situations
- Applies a dignity conserving approach to care when providing support
- Practices person-centred palliative care that incorporates the unique contributions of the family and caregivers
- Identifies and addresses beliefs and attitudes of society and health professionals towards palliative care that undermine access to high quality palliative care
- Addresses misperceptions that the person, their family, their caregiver(s) and colleagues have about palliative care

### Communication

- Uses a variety of strategies to engage in compassionate, individualized and timely communication with the person, their family, their caregiver(s) and members of their care team
- Assesses the person's/family's understanding of the life-limiting condition, and its trajectory and uses this to inform their communication approach
- Maintains ongoing communication with the person, family and their care teams regarding end-of-life plan of care
- Identifies the person's and family's information needs and preferences prior to providing information and discussing diagnosis and prognosis
  - Assesses health literacy
  - During essential conversations, regularly inquires whether information is meeting the person's and family's needs
  - Responds to family requests not to share information with the person regarding diagnosis, prognosis and other information
  - Explores the person's/family's understanding of the expectations and wishes, prognosis and goals of care
- Assesses and discusses prognosis and trajectory of a life-limiting condition on an ongoing basis
- Supports patients and families through uncertainty, using knowledge of the impact of disease and associated treatments, to discuss care options and coping strategies
- Facilitates ongoing discussions regarding goals of care
  - Reviews goals of care, particularly when changes occur in disease status and functional level
  - Addresses conflicts between personal and family expectations regarding prognosis and treatment options

<sup>e</sup>Nurses specializing in palliative care may be members of a Specialist Palliative Care Consult Team, practice in a Palliative Care Unit or Hospice, or practice in settings where the vast majority of individuals require palliative care.

<sup>f</sup>These competencies are meant to build on the foundational palliative care competencies for nurses in all practice settings outlined on pages 29-36.

- Nurtures hope, relative to individual meaning and quality of life, in a way that is congruent with the trajectory of the life-limiting condition
- Promotes realistic goal setting in a way that is congruent with the trajectory of the life-limiting condition
- Discusses resuscitation preferences
- Discusses preferred settings of care and death
- Shares difficult news in a compassionate and supportive manner
- Identifies situations that may benefit from a family meeting, and facilitates when appropriate
- Responds to concerns regarding starvation and dehydration at end-of-life
- Responds appropriately to the person's and family's questions regarding expected death.
- Has knowledge of family dynamics and theories, including models for supporting families in crisis
- Has in-depth knowledge of dying, death, grief, loss and bereavement and can recognize and respond to grief reactions.
- Explores questions and concerns expressed by the person and their family regarding the dying process and provides information about what to expect
- Documents discussions and informs other care providers of key points of discussions

#### *NP specific competencies*

- Facilitates conversations to support end-of-life decision making and informed consent
  - Presents the person with care and treatment options and their anticipated benefits, burdens and risks, considering the person's identified Goals of Care
  - Discusses withholding and withdrawing treatments to ensure that treatment decisions are informed and align with identified goals of care
  - Establishes resuscitation preferences (if resuscitation as part of the treatment plan or not) and obtains consent when appropriate
- Informs the person and family of anticipated progression of disease and other complications

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#### **Optimizing Comfort and Quality of Life**

- Applies comprehensive knowledge and understanding of the clinical presentation and disease trajectories of life-limiting conditions when responding to complex and multidimensional care needs, in order to comprehensively identify current and prospective clinical issues in palliative care
- Uses evidence-based tools to facilitate earlier identification of individuals who may benefit from palliative care
- Draws from advanced education, knowledge and skill in palliative care to deliver holistic person-centred care
  - Integrates physical, social, psychological and spiritual domains
  - Explores the impact of a life-limiting condition on the different facets of a person's life and the lives of family and caregivers
  - Incorporates "quality of life", as defined by the person, as a key outcome of care
  - Uses research and audit to determine evidence of best practice as a rationale for care interventions
- Acknowledges the cumulative losses inherent in the experience of a life-limiting condition and its impact on the person and family
- Uses evidence informed tools to regularly screen for symptoms and needs
  - Performs comprehensive, systems-based, physical assessments and postulates causes of symptoms and conditions

- Conducts histories and physical exams specifically focusing on the impacts of a life-limiting condition
- Uses investigations appropriately, according to the trajectory of the life-limiting condition and in a manner that is consistent with goals of care and within the scope of practice
- Formulates assessment priorities to inform management plan
- Supports and guides junior or generalist staff with implementation of the care plan
- Demonstrates comprehensive knowledge of the special considerations of pain and symptom assessment and management for children, older adults and persons with special needs
- Demonstrates in-depth understanding of non-pharmacological interventions
  - Recognizes use and potential impact of Complementary and Alternative Medicines (CAM) for pain and symptom management
  - Supports the person's decision to use CAM
  - Reinforces the importance of accurate information and open communication to aid in decision-making
  - Addresses requests for information on CAM
  - Encourages the person to share CAM use with the team to assess compatibility and safety

### ***Screens, Assesses and Manages Pain***

- Knows underlying mechanisms of pain, pathophysiology and impact of total pain
- Applies appropriate medication administration techniques relative to the types and severity of the person's pain and condition, recognizing oral route is best practice if applicable
- Identifies and addresses barriers to pain assessment and management, including the misconceptions of the person, family and health professional
- Identifies and addresses health system barriers to pain assessment and management
- Demonstrates a comprehensive in-depth understanding of the pharmacological and physiological use of adjuvant medications in managing pain and symptoms
- Demonstrates a comprehensive knowledge of common pain and symptom management medications and consults with other providers to guide management of potential side effects, interactions or complications
- Evaluates and revises the individual's pain management goals and plan of care in collaboration with the individual and the interdisciplinary care team
- Understands mechanisms of action of opiate drugs.
  - Addresses fears and concerns that the person may have about opioid medications
  - Uses equianalgesic dose conversion tables for verifying opioid rotation or switching
  - Describes the indications for opioid rotation
  - Assesses for risk of substance use disorder and manages treatment plan accordingly
  - Identifies and differentiates opioid-induced neurotoxicity (OIN) from other conditions e.g. delirium
- Identifies individuals with difficult-to-control pain that requires further support, and refers to the Specialist Palliative Care Team or Pain Service as needed

### ***NP specific competencies***

- Uses accepted pain management guiding principles to select an appropriate analgesic regimen
- Prescribes an appropriate first-line opioid and dose when initiating opioid treatment
- Identifies individuals who may benefit from the addition of first-line adjuvant analgesics

- Prescribes an appropriate first-line adjuvant analgesic and dose in the management of neuropathic pain, visceral pain and malignant bone pain
- Prescribes second and third line analgesics, as required
- Identifies individuals who may benefit from palliative radiation therapy, and makes appropriate referrals
- Prevents and treats common opioid-induced side effects
- Titrates opioid doses appropriately
- Prescribes appropriate medications for breakthrough pain
- Switches between short-acting and long-acting formulations
- Implements appropriate strategies to manage Opioid Induced Neurotoxicity (OIN) as required
- Initiates and maintains a person on methadone for pain management in collaboration with a palliative care physician, or other specialist for methadone management, if required

### ***Screens, Assesses and Manages Delirium***

- Differentiates between delirium, dementia, depression and pain
- Identifies, where possible and appropriate, underlying etiology, contributing factors and reversible measures
- Implements interventions within individual competencies and legislative scope of practice, as appropriate, including hydration, antibiotics, medication changes and/or prescribes antipsychotics at appropriate doses, based on the severity of delirium, to control symptoms
- Uses non-pharmacological approaches where possible
- Consults with and/or refers to appropriate interdisciplinary team member(s) when beyond individual competencies, or legislative scope of practice

#### *NP specific competencies*

- Diagnoses and differentiates between subtypes of delirium

### ***Screens, Assesses and Respiratory Symptoms***

- Identifies underlying causes and contributing factors to dyspnea
- Manages dyspnea by addressing, when possible, underlying causes
- Uses non-pharmacological interventions to reduce dyspnea
- Manages upper and lower airway secretions and coughing
- Consults with and/or refers to appropriate interdisciplinary team member(s) when beyond individual competencies or legislative scope of practice

#### *NP specific competencies*

- Diagnoses dyspnea on the basis of a person's self-reporting, rather than clinical signs, lung function tests or oxygen saturation
- Prescribes non-pharmacological interventions to reduce dyspnea
- Prescribes opioids, oxygen and other appropriate pharmacological approaches to control dyspnea
- Prescribes second and third line approaches, as required
- Prescribes non-pharmacological and pharmacological interventions to help manage upper and lower airway secretions and coughing
- Identifies individuals who may benefit from a thoracentesis, and refers if appropriate

### ***Assesses and Manages Gastrointestinal Symptoms***

- Knows gastrointestinal biophysiology and associated nausea and vomiting pathways
- Identifies and addresses underlying causes and contributing factors of nausea and vomiting

- Assess and manages constipation
  - Identifies individuals with partial or complete malignant bowel obstruction
  - Initiates basic management of malignant bowel obstruction when surgery is not an option
  - Initiates constipation prevention with first-line laxative treatments
- Assesses and manages anorexia and cachexia
  - Explores individuals' and families' concerns regarding appetite and weight loss
  - Explains cachexia syndrome and its treatment implications
  - Identifies reversible versus non-reversible causes of appetite loss
  - Identifies individuals who could benefit from pharmacological appetite stimulation
  - Identifies individuals who could benefit from artificial nutrition and those who are unlikely to benefit
- Consults with and/or refers to appropriate interdisciplinary team member(s) when beyond individual competencies or legislative scope of practice

#### *NP specific competencies*

- Prescribes a first-line antiemetic drug, based on the inferred underlying mechanism and the associated neurotransmitters
- Diagnoses constipation
- Prescribes a laxative regimen to prevent and treat constipation
- Identifies individuals who may benefit from a paracentesis
- Prescribes pharmacological appetite stimulation for individuals who may benefit from this type of treatment in balance with the potential adverse effects of these therapies

#### **Assesses and Manages Fatigue**

- Identifies reversible versus non-reversible causes of fatigue
- Recommends evidence-based interventions for individuals with advanced disease experiencing fatigue
- Consults with and/or refers to appropriate interdisciplinary team member(s) when beyond individual competencies or legislative scope of practice

#### *NP specific competency*

- Prescribes pharmacological agents to stimulate energy when appropriate

#### **Manages Hydration and Nutrition Concerns**

- Describes the benefits and limitations of artificial hydration and nutrition
- Identifies individuals who could benefit from artificial hydration and those who would not
- Initiates hypodermoclysis when appropriate
- Consults with and/or refers to appropriate interdisciplinary team member(s) when beyond individual competencies or legislative scope of practice

#### *NP specific competencies*

- Prescribes hypodermoclysis when appropriate

#### **Assesses and Manages Bleeding and Thrombo-embolic Events**

- Identifies individuals at risk for a hemorrhage
- Ensures care plan includes interventions to manage a major hemorrhage, if the person is at risk based on diagnosis
- Refers to appropriate interdisciplinary team member when beyond scope of practice

#### *NP specific competencies*

- Identifies individuals who could benefit from anticoagulants and prescribes if appropriate
- Develops an approach to manage anemia and thrombocytopenia in those with advanced disease, based on goals of care and trajectory of a life-limiting condition

#### ***Palliative Sedation Therapy***

- Assesses for and recognizes intractable symptoms that may benefit from using sedation to support the person's quality of life and identified goals of care
- Uses evidence informed interprofessional approaches to discuss sedation in palliative care, benefits and burdens, goals of care and education and teaching needs of person and family
- Describes the ethical issues regarding Palliative Sedation Therapy
- Collaborates with the Specialist Palliative Care Consult Team or Pain Service as needed to provide Palliative Sedation Therapy
- Evaluates expected affects and side effects of treatment

#### *NP specific competency*

- Prescribes appropriate pharmacological medications and doses to initiate Palliative Sedation Therapy and assesses the individual's response

#### ***Assesses and Manages Conditions That Constitute Emergencies in Individuals with palliative care needs***

- Demonstrates in-depth biophysical and disease knowledge to anticipate which conditions are more at risk of palliative emergencies.
- Anticipates, recognizes and responds to signs and symptoms of common emergencies in palliative care, and transfers to appropriate health care providers or emergency room as required

#### ***Identifies and Addresses Psychosocial, Spiritual and Existential Needs***

- Uses strategies that promote personal and spiritual growth through living with a life limiting condition
- Assesses and manages depression and anxiety
  - Uses validated distress screening tools to identify depression and anxiety
  - Differentiates between normal and abnormal levels of anxiety and depression in individuals with advanced disease
  - Identifies individuals who could benefit from pharmacological management of depression and anxiety
  - Initiates appropriate treatment for individuals with depression and anxiety disorders given clinical context
- Nurtures hope and meaning in a supportive way that is congruent with the individual's identified goals of care
  - Assesses, identifies and addresses spiritual and existential needs of the person
  - Engages appropriate spiritual and religious care providers
- Assesses, identifies and addresses the social needs of the person and their family
  - Assesses, validates and acknowledges the person's and family's loss and grief throughout a life-limiting condition and into bereavement
  - Provides supportive counseling to the person and their family
  - Identifies individuals at risk for complicated grief reactions
  - Refers the person and their family to appropriate resources as needed

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### Safe and Appropriate Medication Practices

- Demonstrates knowledge of pharmacology, pharmacokinetics and side-effects of classes of medications commonly used in palliative care
- Assesses the efficacy of pharmacological treatments in alignment with the College of Nurses Medication Standard
- Demonstrates understanding of the principles of dose adjustment with regard to: the frail, elderly, children, those with altered metabolism or organ failure and individuals approaching imminent death
- Ensures the family, caregivers and care teams understand how to safely store medications and discard waste while the person is receiving care and how to safely remove medications from the home after the person has died

#### *NP specific competency*

- Demonstrates the ability to prescribe medications appropriate to treat a range of symptoms commonly seen in palliative care

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### Care Planning and Collaborative Practice

- Collaborates with interdisciplinary care teams, primary care providers, community agencies and volunteers to meet the physical, psychological, social and spiritual needs for each person
- Develops therapeutic relationships with the person, family, caregivers, and their care teams to define goals of care and to develop, implement and evaluate a plan of care
  - Facilitates participation of the person in their care planning
  - Identifies and integrates strengths of the person in their plan of care
  - Safely and appropriately delegates aspects of care to the family
  - Assists the family in care giving and acquiring respite care
  - Engages in family and team conferences
  - Develops a plan of care for the family
  - Periodically reviews treatments, including medications, to ensure congruence with goals of care and illness trajectory
- Assists with coordinating care and making referrals to other care team members and/or organizations e.g. visiting volunteers
- Collaborates within and between teams across the continuum of care to facilitate continuity in palliative care
- Identifies and supports navigation of the full range and continuum of palliative care services, resources and the settings in which they are available
  - Collaborates with the person and family to identify resources that will provide support throughout their illness and during end-of-life care
- Demonstrates expertise and sensitivity in facilitating safe, smooth and seamless transitions of care for the person
  - Recognizes transition points
  - Coordinates smooth transition between institutions, settings and services
  - Communicates with colleagues in other settings during transitions
- Provides palliative care in all settings where individuals reside including the home, Long-Term Care facilities and acute care settings, such as community hospitals and EDs in rural and remote settings, group/supportive housing, shelters, jail/prison etc.
- Effectively communicates the strengths and needs of the person and family with their care teams

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## Last Days and Hours

- Demonstrates a comprehensive knowledge of pain and symptom assessment and management unique to last days and hours of life
- Assesses and manages families' and caregivers' needs through end-of-life
- Anticipates and plans for end-of-life needs
- Identifies individuals who are in the end of life phase
- Assists the family to cope with emotional responses, maintain a desired level of control, share preferences and needs, determine place of death, contact significant others, access resources and communicate meaningfully in the person's last days
- Demonstrates in-depth knowledge of caregiver exhaustion and strategies to support family resiliency including referrals to appropriate providers including respite
- Encourages the person and their family to make timely preparations following death
- Discusses with the family and other caregivers who to call in case of an emergency, and clarifies when 911 calls may be appropriate
- Discusses with the family and other caregivers who to call when death occurs
- Educates the family about the changes to expect in a person's condition at end-of-life including signs of imminent death and associated comfort measures
- Anticipates the person's needs at end-of-life, ensuring medications and supplies are available

### *Nursing specific competency:*

- Pronounces and arranges for certification of death

### *NP specific competency:*

- Timely completion of death certificates

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## Loss, Grief and Bereavement

- Demonstrates a comprehensive knowledge of the grieving process and reactions in order to support patients and families throughout the disease trajectory
- Demonstrates understanding of the needs of children of various developmental stages in dealing with grief and loss of a parent or sibling
- Demonstrates the ability to proactively respond to complex grief reactions and processes using own skills or appropriate referral
- Assists the family in understanding the concepts of loss, process of grief and bereavement, considering developmental stages, referring as needed
  - Identifies types of grief
  - Recognizes the manifestations of grief
  - Identifies those experiencing or at risk for complicated or disenfranchised grief, and discusses, documents and refers
  - Recognizes the differences between depression and grief
  - Assists the family to anticipate and cope with their unique grief reactions to loss and death
  - Assists the family to recognize the person's legacy
  - Facilitates the family's transition into ongoing bereavement services, where indicated
- Mentors and educates colleagues regarding the personal impact of loss, grief and bereavement, supporting them to recognize their own loss responses and encouraging engagement in activities to maintain their resilience on an on-going basis

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### Professional and Ethical Practice

- Applies a comprehensive understanding of contemporary legal, ethical and professional standards to the provision of quality palliative care
- Facilitates discussion and management of ethical and legal issues in conjunction with the person, their family, and their care team
- Debriefs about ethical and legal issues individually and as a team, with appropriate professional(s)
- Actively influences and promotes palliative care strategic initiatives and policy development

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### Education

- Educates the person, their family, and their caregiver(s) about palliative care and the palliative approach
- Provides information appropriate to the uniqueness of the person and family regarding:
  - Disease process and illness progression
  - Pain/symptom assessment and management
  - Team roles
  - Opportunities and challenges of care in specific settings
  - Physical, psychosocial and spiritual support
  - Treatments
  - Dying process and death
  - Medication administration routes
  - Family dynamics and effective communication
  - Age-appropriate resources regarding death, dying, loss, grief and bereavement
- Develops, facilitates and provides palliative care related education, leadership and mentorship to members of the discipline and students

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### Research and Evaluation

- Understands principles of dissemination of research and best practices to build capacity in other team members
- Advocates for research related to the field of palliative care
- Applies and disseminates knowledge gained from palliative care research
- Where possible, provides the family with opportunities to participate in palliative and end-of-life caregiving research
- Where possible, leads, facilitates and engages in research in palliative care
- Acts as an expert resource contributing to palliative care development and delivery
- Where possible, identifies the opportunities for and barriers to discipline-specific research unique to palliative care

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### Advocacy

- Advocates for the needs, decisions and rights of the person by recognizing potential vulnerabilities
- Supports principles of autonomy and self-management
- Promotes equitable and timely access to palliative care resources
- Demonstrates expertise as a mediator and advocate for the person to access appropriate and timely palliative care
- Advocates for the development, maintenance and improvement of health care and social policies related to palliative care

- Identifies the determinants of health for the populations served and contributes to efforts to ensure equity, including, but not limited to: barriers to access to palliative care and resources, availability of Primary Care, Interdisciplinary Care Teams and Specialized Services, delayed or lack of identification of individuals who would benefit from palliative care, lack of availability of community-based resources, geographic inequities and inequities for vulnerable and marginalized populations, poverty, cost of dying at home
- Identifies vulnerable and marginalized populations and responds appropriately
- Identifies barriers to palliative care for vulnerable or marginalized populations, including, but not limited to: the homeless, First Nations, Inuit, Métis and urban Indigenous peoples, those who are incarcerated and those living in rural communities
- Promotes Advance Care Planning, Goals of Care, and Health Care Consent in alignment with Ontario legislation
- Identifies organizational issues that affect the delivery of palliative care
- Participates as a member of organizations which advocate for equitable, accessible, safe and quality palliative care
  - Describes the role of the Canadian Hospice Palliative Care Association, the Ontario Palliative Care Network, and Hospice Palliative Care Ontario in relation to advocating for high quality palliative care for individuals with palliative care needs
- Describes how changes in legislation could affect individuals with palliative care needs
- Describes how changes in funding and structure of the health system could affect delivery of palliative care
- Identifies points of influence in the health system that could advance palliative care issues
- Describes the moral, ethical and professional issues inherent in health advocacy related to palliative care
- Advocates for health professionals to participate in palliative care continuing education opportunities
- Advocates for health professionals to have access to adequate resources to provide palliative care

## ADDITIONAL COMPETENCIES FOR NURSES SPECIALIZING IN PEDIATRIC PALLIATIVE CARE<sup>g</sup>

### Principles of Pediatric Palliative Care

- Demonstrates understanding of the:
  - Developmental stages and biophysiology of neo-nates, infants, children, youth and adolescents
  - Life-limiting congenital and acquired conditions that present in the antenatal, perinatal, or neonatal period
  - Complications of extreme prematurity
  - Principles of managing common symptoms in newborns receiving palliative care
  - Strategies and practices to incorporate quality of life and support legacy creation after delivery of a newborn with a life-limiting illness
  - Unique considerations of families (including guardians, grandparents and siblings) experiencing or anticipating prenatal/perinatal loss, and available best practices/resources to help address them
  - Unique considerations of families (including grandparents and siblings) with prenatal diagnoses implying severe morbidity or mortality, and available best practices/resources to help address them
  - Unique considerations when working with individuals/families considering termination of pregnancy, and available best practices/resources to help address them
- Demonstrates understanding of the:
  - Principles of pediatric palliative care, similarities and differences in the provision of palliative care to children, adolescents and adults
  - Central role of the family, and considers the needs of the parents, siblings, and guardians when assessing and addressing the needs of the infant/child
  - Developmental stages in childhood and adolescence, and how these impact the concepts of illness and dying, the assessment of pain and symptoms, and the provision of pediatric palliative care
  - Effect of life-limiting conditions on child development, including, but not limited to: arrested development, developmental regression and loss of milestones
  - Importance of the larger community of care involved in the lives of children with life-limiting conditions (i.e. teachers, community caregivers, coaches, mentors, etc.)
- Recognizes that early referral to pediatric palliative care (that is, referral upon diagnosis or suspicion of a life-limiting condition) is beneficial in supporting the family along the continuum of pregnancy, delivery, and post-natal periods
- Demonstrates knowledge and understanding of the variety of life limiting conditions in perinatal and pediatric palliative care and their anticipated or unknown trajectories
- Demonstrates understanding of the Ontario Health Insurance Plan Plus (OHIP+), the Ontario Drug Benefits Formulary, the Palliative Care Facilitated Access mechanism, and the Exceptional Access Program<sup>h</sup>

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<sup>g</sup>These competencies are meant to build on the foundational palliative care competencies for nurses in all practice settings outlined on pages 29-36, as well as the additional competencies for nurses specializing in palliative care outlined on pages 37-46.

<sup>h</sup> Only authorized Nurse Practitioners have access to the Palliative Care Facilitated Access Mechanism

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### Optimizing Comfort and Quality of Life

- Demonstrates understanding of the:
  - Age appropriate symptom assessment tools for use in verbal and nonverbal children
  - Use of family reporting and physiological changes to support symptom assessment
  - Physiological differences in the pediatric population and implications for symptom management and therapeutic choice
  - Pharmacological, physical, behavioral and cognitive strategies for managing pain and other symptoms in the pediatric population
  - Benefits of respite for children/youth with complex chronic needs and supports families to obtain it when needed
  - Importance of play and education for children/youth with life-limiting conditions and their need to engage in childhood activities
  - Management of life-limiting conditions in adolescents and young adults supported by palliative care services who will likely require transition to adult palliative care services
  - Weight based dosing and procedural support for children/youth
- Demonstrates understanding of and proficiency in the use of pediatric equipment for addressing palliative care needs for infants, children, and youth (across all care settings, i.e. hospital, respite, home)

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### Communication

- Provides seamless and effective communication between hospital and community teams, as well as the family/guardian(s)
- Recognizes the use of play and other therapies e.g. art as a communication tool
- Understands importance of building trust and effective therapeutic relationships by recognizing parents as the experts in communicating with their children, and learning from their expertise
- Recognizes that a lack of expressive communication does not equate to a lack of understanding/lack of receptive communication
- Ensures that children are communicated with and to, and not about or around
- Facilitates access to specialist pediatric providers such as child life specialist to support siblings and children who are affected by life-limiting progressive illness

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### Care Planning and Collaborative Practice

- Works collaboratively with parents/guardians, professionals and other agencies, to determine the ideal location for the child/youth to receive care
- Works collaboratively with parents/guardians, professionals and other agencies, putting in place the supports to care for the child/youth
- Demonstrates knowledge of local, provincial and national resources and services for pediatric patients with palliative care needs
- Demonstrates knowledge and understanding of Advance Care Planning, Goals of Care, and Health Care Consent for children/youth/antenatal population

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### Loss, Grief and Bereavement

- Supports the family to understand the end-of-life process, and what to anticipate during death and dying using best practices/resources that are culturally and spiritually appropriate

- Supports the family to understand the end-of-life process, and what to anticipate during death and dying using best practices/resources that are culturally and spiritually appropriate
  - Recognizes the grief and bereavement needs of individuals and families experiencing loss during pregnancy (from preconception through postpartum), and selects appropriate interventions to address these.
  - Understands the factors that shape a child's/youth's experience of illness and death and the impact these experiences may have
  - Appreciates the impact of anticipatory grief for the family, including siblings, grandparents and the extended community of care (i.e. community care providers, teachers, coaches, etc.)
  - Understands various approaches to managing grief and loss
  - Recognizes the roles of the various members of the care teams in providing bereavement support
  - Demonstrates understanding of the needs of children of various developmental stages in dealing with grief and loss of a parent or sibling
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### **Professional and Ethical Practice**

- Demonstrates the ability to discuss and manage ethical dilemmas that may arise and supports parents/guardians in the outcomes of ethical dilemmas
- Debriefs about ethical and legal issues individually and as a team, with appropriate professional(s)
- Demonstrates understanding of the role mature minors may play in care decisions
- Strives to incorporate the voice of the infant/child in care and decision-making, including seeking assent (i.e. approval/agreement) if they are not capable of providing consent

# PALLIATIVE CARE COMPETENCIES FOR OCCUPATIONAL THERAPISTS

## Principles of Palliative Care

- Demonstrates understanding of the philosophy of palliative care
  - Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding that a palliative approach to care starts early in the trajectory of a progressive life-limiting condition, and may be appropriate at the time of diagnosis
- Demonstrates the ability to describe the meaning of the term ‘life-limiting condition’
- Applies the principles of palliative care that affirm life, offers a support system to help the person live as actively as possible until death, with optimal quality of life and help the family cope
- Understands, recognizes and manages pathological responses to loss, referring appropriately to the Specialist Palliative Care Team
- Conserves dignity of the person by facilitating expression of needs, hopes, feelings and concerns when planning palliative care
- Demonstrates understanding of the role and function of the Interdisciplinary Care Team in palliative care
- Demonstrates understanding of the role and function of the Specialist Palliative Care Team, including volunteers, and refers appropriately
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
  - Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community
- Demonstrates understanding of palliative care standards, guidelines and policies

## *Occupational Therapy Specific Competency:*

- Demonstrates awareness of the impact of multiple losses when formulating relevant and realistic treatment programs, in consultation with the person and their family

## Cultural Safety

- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates understanding of the Indigenous Wellness Framework
- Demonstrates openness and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preference and accommodates these
- Assesses the unique needs and preferences of the individual and their family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age, and ability

- Validates and preserves cultural preferences and values by identifying ways to accommodate them into goal setting, decision making and care planning, whilst assuring no assumptions are made about preferences that may be tied to a specific cultural group
- Recognizes and respects who the person identifies as family, and responds to family members' unique needs and experiences
  - Considers the community, as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people
- Recognizes personal biases and values that may influence care and identifies mechanisms to overcome these to ensure they do not impact care and treatment

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## Communication

- Demonstrates understanding of the essential role communication plays in palliative care
- Demonstrates understanding that communication regarding palliative and end-of-life care is an on-going collaborative process
- Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
- Recognizes the multidimensional communication challenges that arise when caring for people with life-limiting conditions
- Demonstrates skill in active listening and open-ended questioning to effectively elicit what the person is concerned about
- Assesses the person's and family's understanding of the life-limiting condition and its trajectory and uses this to inform their communication approach
- Recognizes the potential for conflict in palliative care decision-making and contributes to its management
- Supports individuals to make informed decisions on the depth of information about diagnosis, prognosis and disease progression they wish to receive and share with their family and caregivers
- Provides culturally relevant information and resources to support individuals and families, particularly when caring for those from First Nations, Inuit, Métis and urban Indigenous communities
- Invites, facilitates and respects the involvement of the person, their family and their care team in discussions regarding the plan of care
  - Recognizes that communication and decision-making may involve the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Evaluates communication with the person and their family/caregiver to ensure their care plan meets the person's identified needs
  - Identifies the importance of community care plans when caring for First Nations, Inuit, Métis and urban Indigenous people
- Recognizes that family conversations may involve children and different communication approaches may be required
- Demonstrates self-awareness of responses to communication challenges and remains engaged in meaningful contact with the person, their family and their caregivers

- Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous people
- Supports the discharge planning process to facilitate smooth transitions particularly when caring for First Nations and Inuit people and dual providers may be involved
- Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
  - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family

#### *Occupational Therapy Specific Competencies:*

- Demonstrates expertise in the assessment of cognitive, functional and psychosocial ability to enable individuals with life-limiting conditions to communicate their needs and engage with others
- Identifies and assists individuals to acquire assistive technology and modifies assistive technology as required

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### **Optimizing Comfort and Quality of Life**

- Recognizes how a palliative approach can enhance the assessment and management of symptoms
- Applies the principles of pain and symptom management
- Demonstrates understanding of the potential barriers to providing pain management, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Anticipates and predicts the needs of the person who has been diagnosed with a life-limiting illness based on known disease trajectories
- Evaluates non-complex interventions and proposes alternatives if necessary
- Demonstrates understanding of the causes of common non-pain symptoms at end-of-life
- Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Applies interprofessional approaches to optimize comfort and enhance quality of life of the person and their family
- Recognizes the ways in which individuals can be engaged in self-management of their condition
- Demonstrates understanding of the concept of 'total pain'
- Recognizes the need for a change in the focus of care and treatment goals at critical decision points in the course of a life-limiting illness
- Provides education and practical strategies to the person, family and caregivers about the management of pain and symptoms
- Uses non-pharmacological symptom management to promote comfort and quality of life
  - Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous
- Interprets the impact of family role changes when formulating relevant and realistic care plans

- Supports the person, family, Substitute Decision Maker (SDM) and care teams with end-of-life decision making, including withdrawing or withholding interventions
- Recognizes and anticipates the physical, psychological, social and spiritual issues that affect the person and the family
- Recognizes common trajectories of life-limiting conditions, including common symptoms
- Provides care in keeping with the person's expressed wishes and/or identified goals of care
- Understands how a Substitute Decision Maker (SDM) is determined (based on the hierarchy in the Health Care Consent Act, 1996) and the role they play in making health care decisions on behalf of the incapable person.
- Demonstrates awareness of one's own responses in the presence of a person who is suffering
- Provides care in a compassionate manner

#### *Occupational Therapy Specific Competencies:*

- Assesses the benefits, burdens and risks of clinical interventions
  - Makes decisions regarding the appropriateness of interventions for each person living with a life-limiting condition, taking into consideration the person's expressed wishes and identified goals of care
- Provides appropriate assessment and intervention for the management of the person's cognitive and perceptual disorders
- Identifies adaptive and compensatory strategies and environmental modifications that enhance or support the person's safety, occupational performance and functional independence
- Identifies risks related to positioning and provides intervention that aims to prevent or promote healing of pressure injuries
- Demonstrates proficiency in equipment prescription and provision to enable functional independence, facilitate the person's care needs and enable engagement in meaningful occupations
- Recognizes and promotes the importance of remaining engaged in occupations and activities that are values and provide a sense of purpose
- Demonstrates the ability to assess family's and caregivers' skills, needs and supports
- Effectively and sensitively educates caregivers in the skills required to assist with personal care and transfers

#### **Care Planning and Collaborative Practice**

- Understands the collaborative relationship between the person, health professionals, family and caregivers
  - Recognizes that care planning and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Effectively collaborates with care teams to manage pain and symptoms
- Recognizes the overall impact of a life-limiting condition on the person and family, including their mental health and coping mechanisms, and provides support to address identified needs
- Identifies priorities and concerns in collaboration with the person and family, taking into account their coping strategies and perception of diagnosis

- Familiar with the Health Care Consent Act, and understands that a health provider must obtain informed consent from the person (or, if they are incapable, their Substitute Decision Maker) for any treatment or intervention proposed
- Understands how a Substitute Decision Maker (SDM) is determined (based on the hierarchy within the Health Care Consent Act, 1996) and the role the SDM plays in making health care decisions if the person is not capable
- Supports the person to express their wishes and/or identify goals of care by referring them to the most appropriate health professional
- Facilitates the active involvement of the person in goal setting, decision making and informed consent to support the best possible outcomes and quality of life
- Demonstrates flexibility in relation to care planning, acknowledging that a person's priorities can shift as their condition changes
- Where possible, provides care in the person's preferred place, while recognizing the complexities and challenges for the person, the family and caregivers
- Anticipates factors/conditions that may affect the individual's cognition and functional capacity to make decisions including health status changes, and towards end-of-life
- Identifies how interprofessional practice enhances individual outcomes
- Recognizes clinical limitations and professional boundaries and refers to other colleagues appropriately and in a timely manner
- Recognizes the importance of honouring choices of the person and their family for care options and plans
- Collaborates with the person and their family to identify resources that will provide support throughout their illness and during end-of-life care

#### *Occupational Therapy Specific Competencies:*

- Facilitates discharge planning, and conducts functional and risk assessments, recognizing the complexities and challenges for the person, family and caregivers
- Supports the person to make an informed decision regarding place of care, while identifying functional and environmental risks
- Sets realistic goals in conjunction with the person and family and is responsive to the evolution of such goals as the condition progresses

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### **Last Days and Hours**

- Aware of best practices for expected death in the home including local policies and processes
- Supports planning for expected deaths particularly when caring for First Nations, Inuit, Métis and urban Indigenous in the community
- Anticipates, recognizes and responds to the signs of imminent death
- Supports the family's wishes and death rituals
- Provides opportunities for family and the extended community to gather and be together, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people

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### **Loss, Grief and Bereavement**

- Demonstrates knowledge of diverse perspectives on grief, loss, bereavement, and mourning to support others from a cross-cultural perspective
  - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people

- Recognizes the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief
- Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief
  - Understands cumulative grief which can be particularly significant in First Nations and Inuit communities
- Provides appropriate guidance, support and information to families, caregivers and others, based on awareness of culture and needs, and makes referrals to bereavement services as required

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### Professional and Ethical Practice

- Anticipates and addresses ethical and legal issues that may be encountered when caring for individuals with life-limiting conditions
- Establishes and respects people's wishes regarding their care options and preferences
- Respects the person's decision regarding initiating, not initiating, withholding and withdrawing dialysis, hydration, nutrition support and resuscitation
- Recognizes when personal beliefs, attitudes and values limit one's ability to be present and provide care; collaborates with others to ensure optimal care is provided
- Understands distinctions among ethical and legal concepts, such as: the principle of double effect, Palliative Sedation Therapy and Medical Assistance in Dying (MAID)
- Demonstrates knowledge of relevant legislation and policies, e.g. Bill C-14 (MAID), Bill 84 (Medical Assistance in Dying Statute Law Amendment Act, 2017) , Child, Youth and Family Services Act, Adult Protection Act, Health Care Consent Act, and Substitute Decisions Act
- Responds to inquiries regarding MAID in accordance with regulatory body's relevant guidelines and standards and employer policies
- Demonstrates the ability to evaluate outcomes of their interventions

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### Self-Care

- Demonstrates understanding of the personal impact of loss, grief and bereavement
- Recognizes one's own responses to loss and engages in activities that support well-being and resilience
- Explores own attitudes regarding death, dying and caring for individuals requiring palliative care
- Demonstrates awareness of the impact of past experiences of suffering, death and dying when providing palliative care
- Understands and attends to one's own emotional responses that result from caring for a person with palliative care needs
- Recognizes compassion fatigue in self and colleagues; intervenes and refers appropriately
- Engages in healthy activities that help prevent compassion fatigue
- Demonstrates understanding of the concept of good "helping relationships" when working with First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding of the concept of companionship particularly when working with First Nations, Inuit, Métis and urban Indigenous people
- Participates in community-driven debriefs when working with First Nations, Inuit, Métis and urban Indigenous people
- Recognizes ones' own responses to loss and engages in activities that proactively support well-being and resilience

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### Education and Evaluation

- Participates in the monitoring and evaluation of the quality of palliative care
- Participates in palliative care continuing education opportunities
- Educates the person, their family, and caregivers about palliative care and the palliative approach
- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

#### *Occupational Therapy Specific Competency:*

- Supports education and clinical fieldwork of students in order to promote competency and capacity within the health system

## ADDITIONAL COMPETENCIES FOR OCCUPATIONAL THERAPISTS WITH A PRACTICE FOCUSED IN PALLIATIVE CARE

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### Principles of Palliative Care

- Applies a dignity conserving approach to care when providing support
- Facilitates empathic and responsive relationships between those experiencing life-limiting conditions and their care teams
- Demonstrates leadership that encourages colleagues to foster a caring environment that supports all staff working in sensitive situations
- Practices person-centred palliative care that incorporates the unique contributions of the family
- Demonstrates understanding of palliative care standards, guidelines and policies

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### Communication

- Uses a variety of strategies to engage in highly skilled, compassionate, individualized and timely communication with the person, the family, their caregivers and members of their care team
- Maintains ongoing communication with the person, their family and their care team regarding their end-of-life plan of care
- Demonstrates expertise as a mediator and advocate for appropriate and timely access to palliative care
- Demonstrates self-awareness of responses to communication challenges and remains engaged in meaningful contact with the person, the family and caregivers

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### Optimizing Comfort and Quality of Life

- Applies a comprehensive understanding of the clinical presentation and disease trajectories of life-limiting conditions when responding to complex and multidimensional care needs, in order to comprehensively identify current and prospective clinical issues in palliative care
- Discusses the benefits and burdens of palliative treatment options to assist the person in meeting their goals of care

#### *Occupational Therapy Specific Competencies:*

- Acts as an expert resource regarding the role of discipline-specific interventions in symptom management and optimizing quality of life
- Recommends energy-sparing interventions for individuals with advanced disease
- Recognizes and values the person and their role within the family and community, proactively supporting individuals with life-limiting conditions to adapt to on-going changes in occupational performance and roles

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### Care Planning and Collaborative Practice

- Demonstrates a comprehensive understanding of the role of the Specialist Palliative Care Team and that of each member, including volunteers
- Develops therapeutic relationships with the person, their family, their caregiver(s) and their care team to define goals of care and to develop, implement and evaluate a plan of care
  - Facilitates participation of the person in their care planning
  - Identifies and integrates strengths of the person in their plan of care
  - Safely and appropriately delegates aspects of care to the family
  - Assists the family in care giving and acquiring respite care

- Engages in family and team conferences
- Develops a plan of care for the family
- Collaborates with the person and their family to identify resources that will provide support throughout their illness and during end-of-life care
- Facilitates conversations to support end-of-life decision making
- Identifies the persons'/families' values, beliefs and preferences regarding the various components of palliative care provision
- Uses shared scopes of practice to optimize care
- Collaborates within and between teams across the continuum of care to facilitate continuity in palliative care
  - Recognizes and mitigates potential barriers and limitations to supporting transitions between specialty care and primary care particularly in First Nations, Inuit, Métis and urban Indigenous communities
- Identifies the full range and continuum of palliative care services, resources and the settings in which they are available
  - Demonstrates knowledge of the range of palliative care services and resources
  - Provides relevant information and resources to the person and family
  - Identifies and accesses services and resources specific to the person's goals of care
  - Initiates referrals to and requests for resources, services and settings
  - Facilitates access to needed services and resources
  - Supports the discharge planning process to facilitate smooth transitions particularly when caring for First Nations and Inuit people and dual providers may be involved

*Occupational Therapy Specific Competency:*

- Demonstrates advanced level of clinical expertise and sensitivity in facilitating safe, smooth and seamless transitions of care for the person
- Demonstrates advanced level of clinical expertise in supporting individuals to adapt to changing presentation, creating a holistic, person-centred plan that acknowledges the psychosocial impact of diminishing function and roles in occupational performance
- Sets realistic goals that are continually adapted

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**Loss, Grief and Bereavement**

- Demonstrates a comprehensive knowledge of the grieving process and reactions in order to support the individual and their family throughout the disease trajectory

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**Professional and Ethical Practice**

- Applies a comprehensive understanding of contemporary legal, ethical and professional standards to the provision of quality palliative care
- Facilitates discussion and management of ethical and legal issues in conjunction with the person, the family, and their care teams
- Actively influences and promotes palliative care strategic initiatives and policy development

*Occupational Therapy Specific Competencies:*

- Acts as an expert resource contributing to palliative care development and delivery

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**Education, Research and Evaluation**

- Educates the person, their family, and their caregiver(s) about palliative care and the palliative approach
- Applies knowledge gained from palliative care research

- Where possible, provides the family with opportunities to participate in palliative and end-of-life caregiving research
- Where possible, leads, facilitates and engages in palliative care education and research
- Critically evaluates outcomes against standards and guidelines
- Contributes to the evaluation of the quality of palliative care and the effectiveness of the palliative care system
- Develops, facilitates and provides palliative care related education, leadership and mentorship to members of the discipline and students

*Occupational Therapy Specific Competencies:*

- Where possible, identifies the opportunities for and barriers to discipline-specific research unique to palliative care

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### **Advocacy**

- Advocates for the needs, decisions and rights of the person by recognizing potential vulnerabilities
- Supports autonomous decision-making
- Promotes equitable and timely access to resources
- Advocates for the development, maintenance and improvement of health care and social policies related to palliative care
- Advocates for health professionals to participate in palliative care continuing education opportunities
- Advocates for health professionals to have adequate resource to provide palliative care

# PALLIATIVE CARE COMPETENCIES FOR PRIMARY, ADVANCED AND CRITICAL CARE PARAMEDICS

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## Principles of Palliative Care

- Demonstrates understanding of the philosophy of palliative care
- Demonstrates understanding that a palliative approach to care starts early in the trajectory of a progressive life-limiting condition, and may be appropriate at the time of diagnosis
- Demonstrates the ability to describe the meaning of the term 'life-limiting condition'
- Applies the principles of palliative care that affirm life, offers a support system to help individuals live as actively as possible until death, with optimal quality of life and helps families cope during illness
- Identifies individuals who may benefit from a palliative approach
- Describes the common presentations associated with individuals receiving palliative care and end-of-life care
- Identifies disease processes that contribute to life-limiting conditions

### *Paramedic Specific Competencies:*

- Demonstrates understanding of community-based palliative care resources for individuals and their families
- Demonstrates appreciation of the array of palliative care resources available to Paramedics to enhance knowledge and practice

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## Cultural Safety and Humility

- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Aware of the misunderstandings surrounding palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates understanding of the Indigenous Wellness Framework
- Demonstrates openness and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preference and accommodates these
- Assesses the unique needs and preferences of the individual and their family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age, and ability
- Recognizes and respects who the person identifies as family, and responds to family members' unique needs and experiences
  - Considers the community, as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people

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## Communication

- Discusses the palliative approach with individuals and their families
- Supports the person to express their wishes and/or identify goals of care by directing them to the most appropriate health professional

- Recognizes that communication and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Demonstrates understanding of the communication challenges that may arise in the context of engaging in goals of care conversations with the person and/or their family
- Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
- Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous people
- Uses appropriate strategies to maintain hope in advanced life-limiting conditions
- Supports the family in their suffering
- Uses communication skills relevant to difficult situations
- Recognizes that family conversations may involve children and different communication approaches may be required
- Responds appropriately to inquiries regarding Medical Assistance in Dying (MAID) by directing the person to their family doctor or NP

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### **Optimizing Comfort and Quality of Life**

- Recognizes how a palliative approach can enhance the assessment and management of symptoms
- Applies the principles of pain and symptom management in accordance with current legislation, regulations and standards.
  - Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding of the potential barriers to providing pain management, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Anticipates and predicts the needs of the person who has been diagnosed with a life-limiting illness based on known disease trajectories
- Recognizes the ways in which individuals can be engaged in self-management of their condition
- Uses non-pharmacological symptom management to promote comfort and quality of life
  - Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous
- Provides care in keeping with the person's expressed wishes and/or identified goals of care
- Demonstrates awareness of one's own responses in the presence of a person who is suffering
- Provides care in a compassionate manner

### *Paramedic Specific Competencies:*

- Assesses the benefits, burdens and risks of clinical interventions
  - Makes decisions regarding the appropriateness of interventions for each person living with a life-limiting condition, taking into consideration the person's expressed wishes and identified goals of care

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### Care Planning and Collaborative Practice

- Familiar with the principles of health care consent, and understands that a health provider must obtain informed consent from the person (or, if they are incapable, their Substitute Decision Maker) for any treatment or intervention proposed
- Understands how a Substitute Decision Maker (SDM) is determined and the role the SDM plays in making health care decisions if the person is not capable
- Where possible, provides care in the person's preferred place, while recognizing the complexities and challenges for the person, the family and caregivers
- Anticipates factors/conditions that may affect the individual's cognition and functional capacity to make decisions including health status changes, and towards end-of-life
- Demonstrates the ability to assist in making appropriate clinical decisions related to palliative and end-of-life care
- Analyzes how age, gender, history and health status relate to the person's presentation
- Recognizes the many factors that influence decision making and care plans in persons with life-limiting conditions and those nearing the end-of-life
  - Recognizes that care planning and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Recognizes clinical limitations and professional boundaries and involves other colleagues appropriately and in a timely manner
- Recognizes the importance of honouring choices of the person and their family for care options and plans
- Adapts care based on the person's history, presentation and their identified goals of care

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### Pain

- Recognizes common opioid related side effects
- Provides appropriate opioid analgesia for patients in accordance with current legislation, regulations and standards
- Appreciates the concept of 'total pain'

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### Dyspnea

- Recognizes the subjectivity of dyspnea
- Identifies possible underlying causes of dyspnea
- Provides pharmacological and non-pharmacological interventions for dyspnea in accordance with current legislation, regulations and standards

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### Psychological Distress

- Appreciates the challenges in diagnosing depression in individuals with advanced disease
- Applies a dignity conserving approach to care when providing support

#### *Paramedic Specific Competencies:*

- With the support of a physician, initiates an initial treatment plan for individuals with major depression or anxiety in accordance with current legislation, regulations and standards

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### Gastro-Intestinal Symptoms, Hydration and Nutrition

- Identifies individuals who may benefit from artificial hydration
- Identifies possible underlying causes of nausea and vomiting

- Initiates treatment to manage nausea and vomiting in accordance to current legislation, regulations and standards
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### **Delirium**

- Recognizes delirium
  - Differentiates between delirium and dementia
  - Demonstrates understanding of managing delirium and uses pharmacological and non-pharmacological measures in accordance with current legislation, regulations and standards
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### **Last Days and Hours**

- Recognizes signs of imminent death
  - Aware of best practices for expected death, including local and organizational policies and processes
  - Prepares the person and their family for what to expect in last days and hours
  - Manages airway secretions in accordance with current legislation, regulations and standards
  - Provides comfort measures
  - Supports the family's wishes and death rituals
    - Provides opportunities for family and the extended community to gather and be together, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- 

### **Loss, Grief and Bereavement**

- Demonstrates knowledge of diverse perspectives on loss, grief, bereavement, and mourning to support others from a cross-cultural perspective
    - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people
  - Recognizes the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief
  - Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief
    - Understands cumulative grief which can be particularly significant in First Nations and Inuit communities
  - Provides appropriate guidance, support and information to families and caregivers, based on awareness of culture and needs, and makes referrals to bereavement services as required
- 

### **Professional and Ethical Practice**

- Anticipates and addresses ethical and legal issues that may be encountered when caring for individuals with life-limiting conditions
  - Respects the individuals wishes regarding their care and preferences
  - Respects the person's decisions regarding initiating, not initiating, withholding and withdrawing dialysis, hydration, nutrition support, resuscitation and other life-prolonging/life-sustaining interventions
  - Demonstrates knowledge of relevant legislation and policies, e.g. Bill C-14 (MAID), Bill 84 (Medical Assistance in Dying Statute Law Amendment Act, 2017) , Child, Youth and Family Services Act, Adult Protection Act, Health Care Consent Act, and Substitute Decisions Act
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### Self-Care

- Demonstrates understanding of the personal impact of loss, grief and bereavement
- Explores one's own attitudes regarding death, dying and caring for individuals requiring palliative care
- Recognizes one's own responses to loss and engages in activities that proactively support well-being and resilience
- Demonstrates awareness of the impact of past experiences of suffering, death and dying when providing palliative care
- Understands and attends to one's own emotional responses that result from caring for a person with palliative care needs
- Recognizes compassion fatigue in self and colleagues
- Engages in healthy activities that help prevent compassion fatigue

#### *Paramedic Specific Competencies:*

- Demonstrates awareness of ways paramedics can manage and cope with the impact of dying and death
- Demonstrates awareness of the emotional and spiritual supports available to paramedics

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### Education and Evaluation

- Participates in the monitoring and evaluation of the quality of palliative care
- Participates in palliative care continuing education opportunities
- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

### Principles of Palliative Care

- Demonstrates understanding of the philosophy of palliative care
  - Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding that a palliative approach to care starts early in the trajectory of a progressive life-limiting condition, and may be appropriate at the time of diagnosis
- Demonstrates the ability to describe the meaning of the term 'life-limiting condition'
- Applies the principles of palliative care that affirm life, offers a support system to help individuals live as actively as possible until death, with optimal quality of life and helps families cope during illness
- Conserves dignity of the person by facilitating expression of needs, hopes, feelings and concerns when planning palliative care
- Interprets the impact of family role change for the person and family in palliative care
- Demonstrates understanding of palliative care standards, guidelines and policies
- Demonstrates understanding of the role and function of the Interdisciplinary Care Team in palliative care
- Demonstrates understanding of the role and function of the Specialist Palliative Care Team, including volunteers, and refers appropriately
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
  - Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community

### *Pharmacist Specific Competencies:*

- Integrates the principles of palliative care into pharmacy practice
- Integrates the persons' physical, psychological and social needs into the provision of pharmaceutical care and pharmacy practice

### Cultural Safety and Humility

- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates understanding of the Indigenous Wellness Framework
- Demonstrates openness and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preference and accommodates these

<sup>i</sup> Pharmacists are required to practice within their own scope and ensure they have sufficient knowledge, skills and competency to do so safely. It is the responsibility of each professional to ensure they possess the competencies to practice according to the NAPRA Competencies for Entry to Practice and the NAPRA Standards of Practice<sup>25</sup>.

- Assesses the unique needs and preferences of the individual and their family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age, and ability
- Recognizes and respects who the person identifies as family, and responds to family members' unique needs and experiences
  - Considers the community, as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people

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## Communication

- Demonstrates understanding of the essential role communication plays in palliative care
- Demonstrates understanding that communication regarding palliative and end-of-life care is an on-going collaborative process
  - Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
- Recognizes the multidimensional communication challenges that arise when caring for people with life-limiting conditions
- Assesses the person's and family's understanding of the life-limiting condition and its trajectory and uses this to inform their communication approach
- Recognizes the potential for conflict in palliative care decision-making and contributes to its management
- Supports individuals to make informed decisions on the depth of information about diagnosis, prognosis and disease progression they wish to receive and share with their families
- Provides culturally relevant information and resources to support individuals and families, particularly when caring for those from First Nations, Inuit, Métis and urban Indigenous communities
- Invites, facilitates and respects the involvement of the person, their family and their care team in discussions regarding the plan of care
  - Recognizes that communication and decision-making may involve the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Effectively communicates with the person and their family to address the person's palliative care needs and communicates these plans to the care team
  - Identifies the importance of community care plans when caring for First Nations, Inuit, Métis and urban Indigenous people
- Recognizes that family conversations may involve children and different communication approaches may be required
- Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous people
- Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
  - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous

people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family

*Pharmacist Specific Competencies:*

- Communicates recommendations regarding appropriate use of palliative care medicines to the care team
- Provides advice to family members, caregivers and the care team regarding the safe, efficient and traceable removal of drugs from the person's home

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**Optimizing Comfort and Quality of Life**

- Recognizes common trajectories of life-limiting conditions, including common symptoms
- Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Recognizes how a palliative approach can enhance the assessment and management of symptoms
- Anticipates and predicts the needs of the person who has been diagnosed with a life-limiting illness based on known disease trajectories
- Evaluates non-complex interventions and proposes alternatives if necessary
- Demonstrates understanding of the concept of 'total pain'
- Demonstrates understanding of the causes of common non-pain symptoms at end-of-life
- Applies the principles of pain and symptom management
- Demonstrates understanding of the potential barriers to providing pain management, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Recognizes and anticipates the physical, psychological, social and spiritual issues that affect the person and their family
- Applies interprofessional approaches to optimize comfort and enhance quality of life of the person and their family
- Recognizes the ways in which the person can be engaged in self-management of their condition
- Recognizes the need for a change in the focus of care and treatment goals at critical decision points in the course of a life-limiting condition
- Provides education and practical strategies to the person, family and caregivers regarding the management of pain and symptoms
- Recognizes, uses and recommends non-pharmacological pain and symptom management strategies to promote comfort and quality of life
  - Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Supports the person, family, Substitute Decision Maker (SDM) and care teams with end-of-life decision making, including withdrawing or withholding interventions
- Provides care in keeping with the person's expressed wishes and identified goals of care
- Recognizes and takes appropriate action to address emergencies that may arise in palliative care
- Demonstrates awareness of one's own responses in the presence of a person who is suffering
- Provides care in a compassionate manner

### *Pharmacist Specific Competencies:*

- Assesses the benefits, burdens and risks of clinical interventions
  - Makes decisions regarding the appropriateness of interventions for each person living with a life-limiting condition, taking into consideration the person's expressed wishes and identified goals of care
- Demonstrates knowledge of treatment choices for palliative pain and symptoms and the associated pharmaceutical care issues
- Provides pharmaceutical care for the management of pain and symptoms throughout the disease trajectory and at the end-of-life
- Addresses and resolves any concerns that the person and family may have regarding medications being used to treat pain and symptoms at end-of-life
- Demonstrates knowledge and clinical application of pharmacological treatment options for pain and symptoms in those with life-limiting conditions
- Provides expert advice on compatibility and stability when multiple drugs are being administered
- Demonstrates the ability to locate, assess and interpret information regarding medicines used in palliative care

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### **Care Planning and Collaborative Practice**

- Understands the collaborative relationship between the person, health professionals, family and caregivers
  - Recognizes that care planning and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Effectively collaborates with the care team to manage pain and symptoms
- Recognizes the overall impact of a life-limiting condition on the person and family and provides support to address identified needs
- Identifies priorities and concerns in collaboration with the person and family, taking into account their coping strategies and perception of diagnosis
- Familiar with the Health Care Consent Act, and understands that a health provider must obtain informed consent from the person (or, if they are incapable, their Substitute Decision Maker) for any treatment or intervention proposed
- Understands how a Substitute Decision Maker (SDM) is determined (based on the hierarchy within the Health Care Consent Act, 1996) and the role the SDM plays in making health care decisions if the person is not capable
- Supports the person to express their wishes and/or identify their goals of care by referring them to the most appropriate health professional
- Facilitates the active involvement of the person in goal setting, decision making and informed consent to support the best possible outcomes and quality of life
- Demonstrates flexibility in relation to care planning, acknowledging that a person's priorities can shift as their condition changes
- Facilitates informed decision-making by the person regarding place of care, while identifying risks in a supportive manner
- Anticipates factors/conditions that may affect the individual's cognition and functional capacity to make decisions including health status changes, and towards end-of-life
- Identifies how interprofessional practice enhances individual outcomes

### *Pharmacist Specific Competencies:*

- Recognizes the need and plans for alternate routes for medications as death approaches and the person loses the ability to consume anything by the oral route
- Recognizes clinical limitations and professional boundaries and refers to other colleagues appropriately and in a timely manner

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### **Last Days and Hours**

- Aware of best practices for expected death, including local and organizational policies and processes
- Supports planning for expected deaths, particularly when caring for First Nations, Inuit, Métis and urban Indigenous in the community
- Anticipates, recognizes and responds to the signs of imminent death
- Supports the family's wishes and death rituals

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### **Loss, Grief and Bereavement**

- Demonstrates knowledge of diverse perspectives on loss, grief, bereavement and mourning to support others from a cross-cultural perspective
  - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people
- Recognizes the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief
- Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief
  - Understands cumulative grief which can be particularly significant in First Nations and Inuit communities
- Provides appropriate guidance, support and information to families and caregivers, based on awareness of culture and needs, and directs them to bereavement services as required

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### **Professional and Ethical Practice**

- Anticipates and addresses ethical and legal issues that may be encountered when caring for individuals with life-limiting conditions
- Establishes and respects people's wishes regarding their care options and preferences
- Respects the person's decisions regarding initiating, not initiating, withholding and withdrawing dialysis, hydration, nutrition support, resuscitation and other life-prolonging/life-sustaining interventions
- Understands distinctions among ethical and legal concepts, such as: the principle of double effect, Palliative Sedation Therapy and Medical Assistance in Dying (MAID)
- Recognizes when personal beliefs, attitudes and values limit one's ability to be present and provide person-centred care; collaborates with others to ensure optimal care is provided
- Demonstrates knowledge of relevant legislation and policies, e.g. MAID, Child, Youth and Family Services Act, Adult Protection Act, the Health Care Consent Act, and the Substitute Decision Act
- Responds to inquiries regarding MAID in accordance with regulatory body's relevant guidelines and standards and employer policies<sup>j</sup>

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<sup>j</sup> Pharmacists are authorized to prepare and dispense MAiD medications<sup>26</sup>.

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### Self-Care

- Demonstrates understanding of the personal impact of loss, grief and bereavement
- Recognizes one's own responses to loss and engages in activities that proactively support well-being and resilience
- Explores own attitudes regarding death, dying and caring for individuals requiring palliative care
- Demonstrates awareness of the impact of past experiences of suffering, death and dying when providing palliative care
- Understands and attends to own emotional responses that result from caring for individuals with palliative care needs
- Recognizes compassion fatigue in self and colleagues; intervenes and refers appropriately
- Engages in healthy activities that help prevent compassion fatigue
- Demonstrates understanding of the concept of good "helping relationships" when working with First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding of the concept of companionship particularly when working with First Nations, Inuit, Métis and urban Indigenous people
- Participates in community-driven debriefs when working with First Nations, Inuit, Métis and urban Indigenous people

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### Education and Evaluation

- Participates in palliative care continuing education opportunities
- Educates the person, family and caregivers about palliative care and the palliative approach
- Critically evaluates outcomes against standards and guidelines
- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

## PALLIATIVE CARE COMPETENCIES SHARED BY PRIMARY CARE AND NON-PALLIATIVE CARE SPECIALIST PHYSICIANS<sup>k</sup>

### Medical Expert

*Applies the Principles of a Palliative Approach Across the Trajectory of a Life-Limiting Condition, From Diagnosis Through to Bereavement*

- Demonstrates understanding of the philosophy of palliative care
  - Applies an understanding that a palliative approach to care starts early in the trajectory of a life-limiting condition
  - Applies the principles of palliative care that affirm life, offers a support system to help individuals live as actively as possible until death, with optimal quality of life and helps families cope during illness
  - Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Uses evidence-based tools to facilitate earlier identification of individuals who may benefit from palliative care
- Identifies and anticipates the different trajectories of life-limiting conditions
- Identifies the various phases of palliative care, from the early ambulatory phase to the end-of-life phase
- Recognizes the role of primary and acute care in the provision of palliative care across a variety of settings
- Demonstrates understanding of the role and function of the Interdisciplinary Care Team in palliative care
- Demonstrates understanding of the role and function of the Specialist Palliative Care Team, including volunteers, and refers appropriately
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
  - Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community
- Provides holistic person-centred care
  - Integrates physical, social, psychological and spiritual domains
  - Explores the impact of the life-limiting condition on the different facets of a person's life and the lives of family members
  - Incorporates "quality of life", as defined by the person, as a key outcome of care
- Ensures treatment plans are consistent with a person's goals of care, preferences and the trajectory of their life-limiting condition
- Recognizes and addresses the sources of suffering and 'total pain'
- Conserves dignity of the person by facilitating expression of needs, hopes, feelings and concerns when planning palliative care

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<sup>k</sup> These competencies are shared by NPs, Primary Care Physicians and Non-Palliative Care Specialist Physicians (refers to acute care specialists – e.g. Oncologists, Geriatricians, Thoracic Surgeons, Cardiologists, etc.), to review the Specialist Palliative Care Team Physicians' competencies refer to the section of the Framework beginning on page 81.

- Supports the person, family, Substitute Decision Maker (SDM) and care teams with end-of-life decision making, including withdrawing or withholding interventions

*Physician Specific Competencies:*

- Assesses the benefits, burdens and risks of clinical interventions
  - Makes decisions regarding the appropriateness of interventions for each person living with a life-limiting condition, taking into consideration the person's expressed wishes and identified goals of care

*Integrates all of the CanMED Roles, applying medical knowledge, clinical skills and professional attitudes to provider Optimal, Ethical and Person-Centred Medical Care*

- Identifies and appropriately responds to relevant moral and ethical issues arising from the care of individuals with chronic or life-limiting condition
- Recognizes symptoms, issues and situations that require urgent or emergent palliative care
- Demonstrates skills in developing a shared understanding of person-centred goals of care
- Demonstrates awareness of own responses in the presence of a person who is suffering
- Provides care in a compassionate manner
- Demonstrates understanding of palliative care standards, guidelines and policies

*Assesses and Manages Pain and Other Symptoms*

- Uses evidence informed tools to regularly screen for symptoms and needs
  - Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
  - Performs comprehensive assessments throughout the trajectory of life-limiting conditions
  - Conducts histories and physical exams
  - Uses investigations appropriately, according to the trajectory of the life-limiting condition and in a manner that is consistent with goals of care
- Considers therapeutic trials when the potential benefits of an intervention are unclear
- Assesses and manages pain
  - Identifies underlying mechanisms of pain
  - Uses accepted pain management guiding principles to select an appropriate first-line analgesic regimen
  - Understands the potential barriers to providing pain management, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
  - Selects an appropriate first-line opioid and dose when initiating opioid treatment
  - Identifies individuals who may benefit from the addition of first-line adjuvant analgesics
  - Selects an appropriate first-line adjuvant analgesic and dose in the management of neuropathic pain, visceral pain and malignant bone pain
  - Identifies individuals who may benefit from palliative radiation therapy
- Uses opioids appropriately for pain management
  - Addresses fears and concerns that individuals may have regarding opioid medications
  - Safely uses routes of administration consistent with level of ability, or in consultation with other providers as required
  - Prevents and treats common opioid-induced side effects
  - Titrates opioid doses appropriately
  - Appropriately uses equianalgesic dose conversion tables for switching between opioids
  - Identifies aberrant behavior that may indicate misuse or elicit diversion of opioids

- Provides first-line management of breakthrough pain
- Switches between short-acting and long-acting formulations
- Identifies individuals who may experience difficulties managing pain
- Identifies and differentiates opioid-induced neurotoxicity (OIN) from other conditions (i.e. delirium)
  - Implements first-line strategies to manage OIN
- Identifies individuals with difficult-to-control pain that requires the support of the Specialist Palliative Care Team or Pain Service
- Maintains, with the support of the Specialist Palliative Care Team or Pain Service, a person on methadone for pain management

### ***Screens, Assesses and Manages Delirium***

- Differentiates between delirium, dementia, depression and pain
- Searches, where possible and appropriate, for underlying etiology, contributing factors, and reversible measures
- Diagnoses delirium and sub-syndromal delirium
- Uses non-pharmacological approaches where possible
- Uses first-line anti-psychotic medications, at appropriate doses, based on the severity of delirium, to control symptoms

### ***Assesses and Manages Respiratory Symptoms***

- Diagnoses dyspnea on the basis of the person's self-reporting, rather than clinical signs, lung function tests or oxygen saturation
- Identifies underlying causes and contributing factors to dyspnea
- Manages dyspnea by addressing, when possible, underlying causes
- Uses non-pharmacological interventions to reduce dyspnea
- Uses opioids, oxygen and other first-line pharmacological approaches to control dyspnea
- Manages upper and lower airway secretions and coughing
- Identifies individuals who may benefit from a thoracentesis

### ***Assesses and Manages GI Symptoms***

- Identifies the underlying causes and contributing factors of nausea and vomiting
- Differentiates between ileus and mechanical bowel obstruction as causes of vomiting
- Identifies individuals with partial or complete malignant bowel obstruction
- Initiates basic management of malignant bowel obstruction when surgery is not an option
- Selects a first-line antiemetic drug, based on the inferred underlying mechanism and the associated neurotransmitters
- Initiates constipation prevention with first-line laxative treatments
- Diagnoses constipation
  - Selects a first-line laxative regimen to manage constipation
  - Identifies individuals who may benefit from a paracentesis

### ***Assesses and Manages Anorexia and Cachexia***

- Explores the persons' and their family's concerns regarding appetite and weight loss
- Explains cachexia syndrome and its treatment implications
- Identifies reversible versus non-reversible causes of anorexia
  - Identifies individuals who could benefit from pharmacological appetite stimulation

- Identifies individuals who could benefit from artificial nutrition and those who are unlikely to benefit

#### ***Assesses and Manages Fatigue***

- Identifies reversible versus non-reversible causes of fatigue
- Recommends energy-sparing interventions for individuals with advanced disease

#### ***Manages Hydration and Nutrition Concerns***

- Describes the limitations of artificial hydration and nutrition
- Identifies individuals who could benefit from artificial hydration and those who would not
- Initiates hyperdermoclysis when appropriate

#### ***Assesses and Manages Bleeding and Thrombo-embolic Events***

- Describes the limitations of primary thromboprophylaxis in individuals at end-of-life
- Identifies individuals who could benefit from anticoagulants and those for whom it has limited benefit
- Identifies individuals at risk for a hemorrhage
- Institutes measures to manage a major hemorrhage should it occur at end-of-life
- Develops an approach to manage anemia and thrombocytopenia in those with advanced disease, based on goals of care and trajectory of the life-limiting condition

#### ***Palliative Sedation Therapy***

- Identifies individuals who could benefit from Palliative Sedation Therapy for the management of intractable symptoms at end-of-life
- Identifies individuals for whom Palliative Sedation Therapy may be helpful and ensures all criteria are met, and consults with the Specialist Palliative Care team prior to initiating Palliative Sedation Therapy
- Describes the ethical issues regarding Palliative Sedation Therapy
- Collaborates with the Specialist Palliative Care Team or Pain Service to assist with the provision of Palliative Sedation Therapy

#### ***Assesses and Manages Conditions that Constitute Emergencies in Individuals with Palliative Care Needs***

- Identifies emergencies at end-of-life
- Implements treatment plans consistent with the individuals expressed wishes, identified goals of care, and the trajectory of their life-limiting condition

#### ***Identifies and Addresses Psychosocial and Spiritual and Existential Needs***

- Gains an understanding of the roles and relationships within the family and how they may be impacted by a life-limiting condition
- Assesses and addresses a person's depression and anxiety
  - Differentiates between normal and abnormal levels of anxiety and depression in individuals with advanced disease
  - Identifies individuals who could benefit from pharmacological management of depression and anxiety
  - Initiates a first-line treatment for individuals with depression and anxiety disorders

#### ***Nurtures Hope and Meaning in a Supportive Way that is Congruent with Goals of Care***

- Assesses, identifies and addresses spiritual and existential needs of individuals

- Refers to appropriate spiritual and religious care providers

#### ***Assesses, Identifies and Addresses Social Needs at End-of-Life and Facilitates Support***

- Assesses, validates and acknowledges the person's and family's loss and grief throughout a life-limiting condition and into bereavement
- Demonstrates knowledge of diverse perspectives on grief, loss, bereavement and mourning to support others from a cross-cultural perspective
  - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people
- Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief
  - Understands cumulative grief which can be particularly significant in First Nations and Inuit communities
- Provides appropriate guidance, support and information to families, caregivers, and others, based on awareness of culture and needs, and makes referrals to bereavement services, as required

#### ***Cultural Safety and Humility***

- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates understanding of the Indigenous Wellness Framework
- Demonstrates openness and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preferences and accommodates these
  - Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Assesses the unique needs and preferences of the individual and their family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age, and ability
- Validates and preserves cultural preferences and values
- Recognizes and respects who the person identifies as family, and responds to family members' unique needs and experiences
  - Considers the community, as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people
- Explores the person's and family's cultural and religious needs, beliefs and preferences as they relate to end-of-life
- Provides opportunities for individuals and their families to exercise religious, cultural and spiritual rituals, customs, rites and beliefs throughout the person's illness and through bereavement

#### ***Care of the Dying***

- Anticipates and plans for end-of-life needs
  - Supports planning for expected deaths, particularly when caring for First Nations, Inuit, Métis and urban Indigenous in the community
- Identifies individuals who are in the end-of-life phase

- Identifies local hospice and palliative care resources and connects individuals as appropriate
- Educates the family about the changes to expect in the person's condition at end-of-life
- Anticipates the person's needs at end-of-life, ensuring medications and supplies are available
- Aware of best practices for expected deaths in the home including local policies and processes
- Demonstrates knowledge and understanding of professional, legal, moral and ethical codes of practice related to The Health Care Consent Act (HCCA), Substitute Decision Act (SDA) Palliative Sedation Therapy, MAID, and withdrawing and withholding of life-sustaining therapies
- Responds to inquiries regarding Medical Assistance in Dying (MAID) in accordance with regulatory body's relevant guidelines and standards and employer policies
- Demonstrates understanding of the potential management and ethical issues related to mechanical devices
- Addresses requests from the person or their family for body, organ or tissue donation, and connects them to the Trillium Gift of Life Network if/when they express interest in organ/tissue donation
- Facilitates discussion with appropriate professional if an autopsy is required or requested
- Encourages the person and their family to make timely preparations following death
- Assesses and manages families' and caregivers' needs through end-of-life
- Supports the family's wishes and death rituals
  - Provides opportunities for family and the extended community to gather and be together, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Discusses with the family and other caregivers who to call in case of an emergency, and clarifies when 911 calls may be appropriate
- Discusses with the family and other caregivers who to call when death occurs
- Identifies circumstances which warrant the involvement of the Coroner
- Undertakes death pronouncements and timely completion of death certificates, in a sensitive and compassionate way
- Ensures the family, caregivers and care teams understand how to safely store medications and discard waste while the person is receiving care and how to safely remove medications from the home after the person has died

#### ***Provides Continuity of Care***

- Where possible, provides palliative care across care settings, in collaboration with the Specialist Palliative Care Team, if required
- Provides timely access to clinics, given life expectancy of individuals with life-limiting conditions
- Identifies individuals early in the trajectory of a life-limiting condition so as to optimize benefits of palliation
- Maintains a registry of individuals in the practice requiring palliative care to ensure continuity in care and that changing needs are met
- Provides or arranges for after-hours care coverage

- Provides palliative care in the person's preferred location, whenever possible, including their homes, Long-Term Care facilities, hospice and acute care settings, such as community hospitals and EDs in rural and remote settings
- Identifies, connects or refers individuals to palliative care resources and supports
- Facilitates transitions in care for individuals
  - Recognizes transition points
  - Communicates with colleagues in other settings during transitions
- Supports the discharge planning process to facilitate smooth transitions particularly when caring for First Nations and Inuit people and dual providers may be involved Collaborates with colleagues, Palliative Care Specialist Physicians and Specialists from other disciplines
- Collaborates with the person and their family to identify needs and plan care
  - Identifies the importance of community care plans when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding for the need for home care and palliative care nurses to have rapid access to primary care physicians, NPs and specialists

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## **Communicator**

### *Communicates with Individuals, Families and Caregivers Regarding Palliative and End-of-life Care*

- Promotes palliative care and addresses barriers to care
- Introduces the person and their family to the concept and benefits of palliative care, along with other disease ameliorating treatments, or as the main focus of care
- Demonstrates understanding of Advance Care Planning (ACP), Goals of Care (GOC), and Health Care Consent (HCC), and an appreciation of the appropriate time(s) to engage in discussions regarding goals and preferences for care
- Conveys relevant information and explanations accurately to the person and their family, and develops a common understanding on issues, problems, and plans to develop a shared plan of care
  - Identifies the person's and family's information needs and preferences
  - Assesses and discusses prognosis and the trajectory of a life-limiting condition on an ongoing basis
  - Explores the person's and family's understanding of the life-limiting condition and its trajectory
  - Explores the person's and family's understanding of the expectations and wishes, prognosis and goals of care
  - Explores the person's and family's questions and information preferences regarding prognosis
  - Addresses unrealistic expectations regarding prognosis and treatment options
  - Nurtures hope in a way that is congruent with the trajectory of a life-limiting condition
  - Discusses dying, death, loss and bereavement
  - Explores the person's and family's questions and concerns regarding the dying process and what to expect
  - Discusses preferred settings of care and death
  - Provides families and caregivers with culturally relevant information and resources regarding what to expect at end-of-life, particularly when caring for those from First Nations, Inuit, Métis and urban Indigenous communities
  - Discusses organ, tissue and body donation

- Responds to concerns regarding “starving or dehydrating” at end-of-life
- Discusses withholding and withdrawing treatments that individuals and their families may consider to be life-sustaining
- Discusses grief, loss and bereavement
- Respects diversity and differences, including, but not limited to: the impact of ethnicity, culture, gender, sexual orientation, language, religion, age and ability on decision-making
- During essential conversations, regularly enquires whether information is meeting their needs
- Demonstrates ability to elicit what is important to the person, including their wishes, values and beliefs, in relation to their care to facilitate effective Advance Care Planning, Goals of Care and Health Care Consent discussions
- Demonstrates ability to incorporate the individuals expressed wishes, values and goals into their plan of treatment, and reviews and revises the plan, as needed, to reflect the person’s current condition
- Facilitates the active involvement of individuals in goal setting, decision making and informed consent to support the best possible outcomes and quality of life
  - Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
  - Recognizes that communication and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Presents individuals with care and treatment options and their anticipated benefits, burdens and risks, considering their identified goals of care
- Facilitates ongoing discussions regarding goals of care
  - Periodically reviews goals of care, and obtains consent for treatment, particularly when changes occur in disease status and functional level
- Shares difficult news in a compassionate and supportive manner
- Maintains or enhances, whenever possible, a person’s sense of dignity
- Informs the person and family of progression of disease and other complications
- Identifies situations that may benefit from a family meeting
- Facilitates family meetings
  - Recognizes that family conversations may involve children and different communication approaches may be required
- Responds appropriately to a person’s and family questions regarding expected death
- Addresses requests for information on Complementary and Alternative Medicine (CAM)
- Discusses and establishes resuscitation preferences (including Do Not Resuscitate orders)
- Documents discussions and informs other care providers of key points of discussions (e.g. consent obtained for DNR orders, or other treatments,)
- Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
  - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous

people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family

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### **Collaborator**

#### *Promotes an Interprofessional Approach to Care*

- Collaborates with the care teams to ensure the person's and family's needs are met
    - Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous people
  - Responds promptly to requests from Home Care/Palliative Care Nurses
  - Establishes a communication system to address urgent situations encountered by home care and palliative care nurses
  - Refers individuals with complex and more difficult needs to the Specialist Palliative Care Team or other specialists when appropriate
  - Identifies circumstances which warrant the involvement of the Coroner
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### **Professional**

#### *Practices Self-Care*

- Explores own attitudes and beliefs regarding death, dying and caring for individuals requiring palliative care
  - Demonstrates awareness of the impact of past experiences of suffering, death and dying when providing palliative care
  - Demonstrates awareness of ways to manage and cope with the impact of dying and death
  - Demonstrates awareness of the emotional and spiritual supports available
  - Understands and attends to own emotional responses that result from caring for individuals with palliative care needs
  - Recognizes compassion fatigue in self and colleagues; intervenes and refers appropriately
  - Engages in healthy activities that help prevent compassion fatigue
  - Demonstrates understanding of the concept of good "helping relationships" when working with First Nations, Inuit, Métis and urban Indigenous people
  - Demonstrates understanding of the concept of companionship particularly when working with First Nations, Inuit, Métis and urban Indigenous people
  - Participates in community-driven debriefs when working with First Nations, Inuit, Métis and urban Indigenous people
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### **Leader**

- Contributes to the evaluation of the quality of palliative care and the effectiveness of the palliative care system
  - Participates in palliative care continuing education opportunities
  - Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities
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### **Health Advocate**

- Promotes palliative care and addresses barriers to care
  - Addresses beliefs and attitudes of society and health professionals that undermine access to high quality palliative care
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- Addresses misperceptions that the person, their family, their caregivers and colleagues have of palliative care

## COMPETENCIES FOR PALLIATIVE CARE SPECIALIST PHYSICIANS

### Medical Expert

*Functions effectively as a Consultant, integrating all of the CanMED Roles, applying medical knowledge, clinical skills and professional attitudes to provide Optimal, Ethical and Person-Centred Medical Care*

- Identifies and appropriately responds to relevant moral and ethical issues arising from the care of individuals with chronic or life-limiting condition
- Recognizes symptoms, issues and situations that require urgent or emergent palliative care
- Demonstrates skills in developing a shared understanding of person-centred goals of care
- Demonstrates awareness of own responses in the presence of a person who is suffering
- Demonstrates the ability to manage uncertainty (with respect to prognosis, disease trajectory, etc.) and the effect that uncertainty may have on the person and family.
- Provides care in a compassionate manner
- Demonstrates understanding of palliative care standards, guidelines and policies

*Palliative Care Specialist Physician Specific Competencies:*

- Performs a Palliative Medicine consultation
- Demonstrates use of all CanMEDs competencies relevant to the practice of Palliative Medicine, across settings of care
- Demonstrates ethical and moral dimensions in medical decision making for individuals with palliative care needs
- Demonstrates medical expertise in situations other than care, such as providing expert testimony or advising governments

*Establishes and Maintains Clinical Knowledge, Skills and Behavior Appropriate to Palliative Medicine*

- Applies knowledge of the clinical, socio-behavioral and fundamental biomedical sciences

*Assesses and Manages Physical Symptoms and Conditions*

- Applies a dignity conserving approach to care when providing support
- Demonstrates understanding of the pathophysiology and management of the following physical symptoms and conditions common to palliative care, including, but not limited to: agitation at the end-of-life; anorexia and cachexia; bleeding and thrombosis; constipation; cough; delirium; dyspnea; edema; enteral feeding intolerance; nausea and vomiting; oral conditions, including: candidiasis, stomatitis and xerostomia; skin conditions, including: fistula, lymphedema, malignant wounds, pressure sores, pruritus and wound breakdown; respiratory and oropharyngeal secretions; sleep disturbances; and weakness and fatigue
- Demonstrates understanding of the pathophysiology and management of palliative care emergencies and urgencies, including, but not limited to: biliary, bowel and urinary obstruction; catastrophic bleed; delirium; hypercalcemia; intractable nausea and vomiting; pain crisis; seizures; severe dyspnea; SCC; and SVCO
- Initiates and maintains, a person on methadone for pain management
- Demonstrates understanding of common pain syndromes:
  - Neurophysiology of pain transmission
  - Medications used in the management of pain, opioids, adjuvants, including, but not limited to: nonsteroidal anti-inflammatory drugs (NSAIDs), anti-depressants,

- anticonvulsants, glucocorticoids and N-methyl-D-aspartate (NMDA) receptor antagonists
- Non-pharmacological approaches to pain management, including physical and psychological interventions
- Indications for and complications of interventional anesthetic techniques, including epidural, intrathecal and neurolytic block

### ***Psychological***

- Demonstrates understanding of the:
  - Psychological issues common to palliative care and strategies to address them
  - Role and application of therapeutic interventions used in the management of psychological issues, including: behavioral therapy, cognitive therapy, counseling, hypnotherapy, imagery and visualization
  - Responses and emotions of individuals, including, but not limited to: fear, guilt, anger, sadness and despair, and strategies to address them
  - Impact of psychological issues on decision-making, management of pain and other physical symptoms and outcomes
  - Role of a persons' coping styles on decision-making and outcomes
  - Impact of pain and intractable symptoms on well-being and quality of life
  - Impact of a life-limiting illness on relationships, body image, sexuality and roles
- Demonstrates understanding of the social issues common to palliative care, including, but not limited to:
  - Relational and financial issues and strategies to address them
  - Changing family dynamics and factors that contribute to distress
  - Needs of siblings of children with life-limiting conditions and strategies to provide support
  - Needs of children of parents with life-limiting conditions and strategies to provide support
  - Needs of caregivers, signs of caregiver distress and strategies to provide support

### ***Spiritual***

- Demonstrates understanding of the:
  - Issues of spirituality related to death and dying and the role of spiritual care
  - Difference between spiritual and religious needs
  - Importance of hope and nurturing hope while shifting goals of care from length of life to quality of life
  - Major cultural and religious practices which relate to health care, dying and bereavement
  - Existential needs and strategies to provide support
  - Factors contributing to existential distress
  - Suffering and its impact on the person and their care teams

### ***Cultural Safety and Humility***

- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples

- Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates understanding of the Indigenous Wellness Framework
- Demonstrates openness and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preferences and accommodates these
- Assesses the unique needs and preferences of the individual and their family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age, and ability
- Validates and preserves cultural preferences and values
- Recognizes and respects who the person identifies as family, and responds to family members' unique needs and experiences
  - Considers the community, as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people
- Provides opportunities for individuals and their families to exercise religious, cultural and spiritual rituals, customs, rites and beliefs throughout the person's illness and through bereavement

### ***Grief and bereavement***

- Demonstrates understanding of the:
  - Normal, anticipatory, atypical and complicated grief, including: identification of risk factors and strategies for supporting the person and their family
  - Diverse perspectives on grief, loss, bereavement and mourning to support others from a cross-cultural perspective
  - Impact of colonization, historical loss and trauma on grief, bereavement, loss, and mourning when caring for First Nations, Inuit, Métis and urban Indigenous people
  - Dimensions of grief and recognizes the factors that may increase the risk of complicated grief
  - Cumulative grief which can be particularly significant in First Nations and Inuit communities
  - Bereavement and strategies and services to support the person's family
  - Needs of children of various developmental stages in dealing with grief and loss of a parent or sibling
  - Complicated nature of guilt often experienced by parents of children with genetic conditions

### ***Therapies***

- Demonstrates understanding of:
  - Indications, dose selection, titration, routes of administration and drug interactions of medications commonly used in palliative care
  - Principles of pharmacokinetics and pharmacodynamics of medications commonly used in palliative care
  - Management of side effects of medications commonly used in palliative care
  - Management of opioid neurotoxicity
  - Tolerance, physical dependence and addiction to opioids
  - Safe prescribing
  - Commonly used Complementary and Alternative Medicine
  - The importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous people

- Demonstrates understanding of the Ontario Drug Benefits Formulary, and the Palliative Care Facilitated Access mechanism

### *Oncologic*

- Demonstrates understanding of the:
  - Epidemiology, natural history, pathophysiology, complications and symptom burden for various cancers
  - Principles of management of adult and pediatric cancers
  - Goals of therapy
  - Role of surgery, chemotherapy, immunotherapy, radiation therapy and targeted therapy
  - Management of side effects
  - Pain and symptom management, incorporating pharmacological and non-pharmacological strategies
  - Indications for and complications of interventions used to manage individuals with cancer, including, but not limited to: biliary drainage tubes; esophageal and colorectal stents; long-term intravenous lines, including: PICC lines, Hickmans, port-a-caths, renal and bladder drainage tubes, venting gastrostomy tubes, Ventricular Peritoneal (VP) shunts and vertebroplasty

### *Non-Oncologic*

- Demonstrates understanding of:
  - Epidemiology, natural history, pathophysiology, complications and symptom burden for progressive non-oncologic diseases including but not limited to, end-stage heart disease, chronic lung disease, COPD, and end-stage renal failure
  - Management of individuals with end-stage non-oncologic diseases, including: medical, surgical and rehabilitative therapies
  - Symptom management, incorporating pharmacological and non-pharmacological strategies
  - Indications for and complications of interventions, including, but not limited to: chest tubes, cough assist devices, enteric feeding tubes, esophageal and colorectal stents, hemodialysis and peritoneal dialysis, implantable pacemakers and defibrillators, invasive and non-invasive ventilation, LVAD, oxygen, paracentesis, pleurodesis, renal and bladder drainage tubes, suctioning, thoracentesis, tracheostomy, transplantation, venting gastrostomy tubes and VP shunts

### *Pediatric Medicine*

- Demonstrates understanding of the:
  - Principles of pediatric palliative care, similarities and differences in the provision of palliative care to children, adolescents and adults
  - Importance of shared care models in the context of pediatric palliative care, including the role of pediatric palliative care specialists in supporting generalist providers
  - Central role of the family, and considers the needs of the parents, siblings, and guardians when assessing and addressing the needs of the infant/child
  - Common life-limiting conditions of childhood and adolescence
  - Developmental stages in childhood and adolescence and how these impact the concepts of illness and dying, the assessment of pain and symptoms, and the provision of pediatric palliative care

- Age appropriate symptom assessment tools for use in verbal and nonverbal children
- Physiological differences in the pediatric population and implications for symptom management and therapeutic choice
- Pharmacological, physical, behavioral and cognitive strategies for managing pain and other symptoms in the pediatric population
- Management of common life-limiting conditions in adolescents and young adults supported by palliative care services who will likely require transition to adult palliative care services
- Effect of life-limiting conditions on child development, including, but not limited to: arrested development, developmental regression and loss of milestones
- Development over atypical trajectories, including autism spectrum disorders
- Importance of play and education for children/youth with life-limiting conditions and their need to engage in childhood activities
- Demonstrates understanding of:
  - The spectrum of disease conditions encountered in pediatric palliative care, ranging from curable but life-threatening, through non-curable, non-treatable and static conditions
  - The various tools and equipment required to address pediatric palliative care needs, including technology, enterostomy tubes, central lines, and long-term ventilation supports
  - How the spectrum of conditions impacts families' and health professionals' expectations of palliative care and the timing of consultation or interventions
  - The evolving epidemiology of youth with life-limiting conditions of childhood living into young adulthood
- Demonstrates understanding of the disease experience from the child/youth and parent's perspective
- Understands importance of building trust and effective therapeutic relationships by recognizing parents are as the experts in communicating with their children, and learning from their expertise
- Recognizes that a lack of expressive communication does not equate to a lack of understanding/lack of receptive communication
- Ensures that children are communicated with and to, and not about or around
- Demonstrates familiarity with the concept of respite, and counsels families about how and where to obtain it when needed
- Assesses pain and other symptoms in difficult to assess populations including neonates and infants, or children who are severely neurologically impaired
- Recognizes and accommodates for infant or child's diversities and differences
- Assesses the infant/child and their family's distress and resiliency
- Works collaboratively with parents/guardians, professionals and other agencies, to determine the ideal location for the child/youth to receive care
- Engages and assesses verbal and non-verbal children through the use of play, art and music
- Describes how various modalities provide insight into the child's world and explores avenues for therapeutic intervention or assistance
- Strives to incorporate the voice of the infant/child in care and decision-making, including seeking assent (i.e. approval/agreement) if they are not capable of providing consent

### ***Neonatal and Perinatal Palliative Care***

- Demonstrates understanding of the:
  - Life-limiting congenital and acquired conditions that present in the antenatal, perinatal, or neonatal period
  - Complications of extreme prematurity
  - Unique challenges of working with families with prenatal diagnoses implying severe morbidity or mortality
  - Planning for delivery, and comfort care methods at the time of delivery for neonates with life-limiting conditions
  - Medications for symptom management, including dosages and routes of administration for neonates requiring palliative symptom management
  - Planning for post-delivery care for neonates with life-limiting conditions, including, but not limited to: anticipated and unanticipated extended hospital stay, discharge home, or hospice, provision of appropriate normal newborn care and anticipated symptom needs
  - Strategies and practices to incorporate quality of life and support legacy creation after delivery of a newborn with a life-limiting illness
  - Care requirements for the mother's post-partum physical and mental health
  - Care and resources for parents and siblings of neonates with life-limiting conditions
- Supports the family to understand the end-of-life process, and what to anticipate during death and dying using best practices/resources that are culturally and spiritually appropriate

### ***Transition to Adult Care of Youth with Life-Limiting Conditions***

- Demonstrates understanding of the:
  - Principles of transition of care for youth between pediatric and adult services
  - Evolving needs, including, but not limited to: sexual and reproductive health, emotional well-being, social supports and services, spirituality, Advance Care Planning, and Goals of Care
  - Evolving needs for additional community supports in caring for a young adult with aging caregivers
  - Issues of achieving and maintaining independence for youth with typical or atypical development, including, but not limited to: independent living, meaningful occupation or employment, independent mobility, friendship, sexuality and transition of responsibility from parents

### ***Geriatric Medicine***

- Demonstrates understanding of the physiological and psychological differences in older adults and the implications for therapeutic choice
- Demonstrates understanding of frailty and its contribution to morbidity and mortality

### ***Prognostication***

- Demonstrates understanding of the:
  - Different trajectories common in chronic or life-limiting conditions and relevance to prognostication
  - Use of prognostication for recognizing transition points and access to appropriate palliative care resources
  - Disease-specific prognostic indicators

### *Palliative Care Specialist Physician Specific Competencies:*

- Demonstrates understanding of the:
  - Common validated tools used to assist in prognostication in Palliative Medicine
  - Limitations of using indicators and tools to prognosticate
  - Limitations of using adult indicators and tools for children

### *Rehabilitation*

- Demonstrates understanding of the common palliative care rehabilitation needs, including, but not limited to: physical function and social issues, maintenance of function through exercise and therapy throughout the disease trajectory to improve quality of life, strategies and services to address rehabilitation needs

### *Community-Based Care*

- Demonstrates understanding of the differences in community-based palliative care, including, but not limited to:
  - Availability and access to lab and investigative services, pharmacological and non-pharmacological therapies and interventions, as well as medical, nursing and support services
  - Expertise of palliative care providers
  - Family structure, dynamics and ability to cope with a death in the home
  - Issues of personal safety and the safety of other health care providers, individuals and their families
  - Economic and social costs
  - Time commitment
  - Providing care in individuals' homes and in rural communities
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
  - Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community

### *Care of the Dying*

- Demonstrates understanding and recognition of:
  - The dying phase of life-limiting conditions and specific issues associated with dying, including, but not limited to: physical symptoms, psychological issues and ethical and moral concerns
  - The concept of a good death as defined by the person and factors that contribute to a good death across settings of care
- Anticipates and plans for end-of-life needs
  - Supports planning for expected deaths, particularly when caring for First Nations, Inuit, Métis and urban Indigenous in the community
- Identifies individuals who are in the end-of-life phase
- Identifies local hospice and palliative care resources and connects the person and their family/caregiver(s) as appropriate
- Educates the family about the changes to expect in the person's condition at end-of-life
- Anticipates the person's needs at end-of-life, ensuring medications and supplies are available

- Aware of best practices for expected death, including local and organizational policies and processes
- Responds to inquiries regarding MAID in accordance with regulatory body's relevant guidelines and standards and employer policies
- Demonstrates understanding of the potential management and ethical issues related to mechanical devices
- Addresses requests from the person and/or their family for body, organ or tissue donation, and connects them to the Trillium Gift of Life Network if/when they express interest in organ/tissue donation
- Facilitates discussion with appropriate professional if an autopsy is required or requested
- Encourages individuals and their families to make timely preparations following death
- Assesses and manages families' and caregivers' needs through end-of-life
- Supports the family's wishes and death rituals
- Provides opportunities for family and the extended community to gather and be together, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Discusses with the family and other caregivers who to call in case of an emergency, and clarifies when 911 calls may be appropriate
- Discusses with the family and other caregivers who to call when death occurs
- Identifies circumstances which warrant the involvement of the Coroner
- Undertakes death pronouncements and timely completion of death certificates, in a sensitive and compassionate way
- Ensures the family, caregivers and care teams understand how to safely store medications and discard waste while the person is receiving care and how to safely remove medications from the home after the person has died

#### ***Performs a Complete and Appropriate Assessment***

- Uses validated age-appropriate tools in the assessment of pain and other symptoms, functional status and prognosis
- Performs a focused physical exam that is relevant and accurate, for the purposes of diagnosis, prognosis, management, health promotion and disease prevention
  - Selects medically appropriate investigative methods in a resource-effective and ethical manner
  - Selects investigative methods appropriate to stage of disease and concomitant with person-centred goals of care
  - Selects appropriate investigations for the purpose of prognostication

#### ***Demonstrates Effective Clinical Problem Solving and Judgment***

- Interprets data and integrates information to generate differential diagnosis and management plans
- Develops a management plan throughout the disease trajectory, balancing treatments and symptom management in accordance with person-centred goals of care

#### ***Develops Management Plans For:***

- Agitation at end-of-life
- Anorexia and cachexia
- Bleeding and thrombosis
- Constipation

- Cough
- Delirium
- Dyspnea
- Edema
- Emergencies and urgencies, including, but not limited to: biliary, bowel and urinary obstruction; catastrophic bleed; delirium; hypercalcemia; intractable nausea and vomiting; pain crisis; seizures; severe dyspnea; SCC and SVCO
- Nausea and vomiting
- Oral conditions, including, but not limited to: candidiasis, stomatitis and xerostomia
- Pain
- Psychological, social, spiritual and existential issues in palliative care
- Respiratory and oropharyngeal secretions
- Skin conditions, including, but not limited to: fistula, lymphedema, malignant wounds, pressure sores, pruritus and wound breakdown
- Sleep disturbances
- Weakness and fatigue

***Demonstrates Appropriate and Timely Application of Preventive and Therapeutic Interventions Relevant to Palliative Medicine***

- Works with individuals and their families to establish common, person-centred goals of care, ensuring responsiveness to needs, values, beliefs and wishes
- Identifies relevant priorities for management based on the person's perspective, medical urgency and clinical context
- Develops a proactive approach to managing the expectations and needs of the person by anticipating symptoms and issues and identifying appropriate services and resources
- Discusses the indications, use and discontinuation of therapeutic interventions
- Assess capacity to consent for treatment
- Recognizes the need for and the role of the Substitute Decision Maker for an incapable person
- Selects and obtains consent for pharmacological and non-pharmacological approaches to address physical symptoms and conditions and psychological, social, spiritual and existential issues that are evidence based and concomitant to person-centred goals of care
- Monitors and modifies the plan of care in response to side effects, toxicity, or efficacy of therapeutic interventions
- Demonstrates understanding of the potential management and ethical issues related to mechanical devices

***Palliative Care Specialist Physician Specific Competencies:***

- Provides medical care that is structured around person's needs, their level of understanding and their priorities, with the aim of relieving suffering, maximizing quality of life and providing support
- Ensures individuals receive care consistent with the standards of Palliative Medicine

***Palliative Care Specialist Physician Specific Competencies:***

***Demonstrates Proficient and Appropriate and Timely Use of or Appropriate Referral for Procedural Skills, Diagnostics and Therapeutics Relevant to Palliative Medicine***

- Performs diagnostic thoracentesis and paracentesis, or refers appropriately

- Inserts subcutaneous access catheters
- Initiates and manages CADD pumps
- Manages or appropriately refers individuals requiring: biliary drainage tubes, chest tubes, cough assist devices, enteric feeding tubes, epidural, intrathecal and regional block catheters, implantable cardiac defibrillators, long-term IV lines (including: PICCs, Hickmans and Port-a-caths), non-invasive ventilation, renal and bladder drainage, tracheostomy tubes and venting gastrostomy tubes
- Obtains appropriate informed consent for procedures
- Documents and disseminates information related to procedures and their outcomes
- Ensures adequate follow-up is arranged for procedures performed

***Seeks Appropriate Consultation from Other Health Professionals, Recognizing the Limits of Their Own Expertise***

- Demonstrates insight into limits of expertise
- Practices self-reflection
- Demonstrates effective, appropriate and timely consultation with another health professional, as needed for optimal care
- Arranges appropriate follow-up services for individuals and their families

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**Communicator**

Effectively facilitates the doctor-patient relationship and the dynamic exchanges that occur before, during and after the medical encounter

***Develops Rapport, Trust and Ethical Therapeutic Relationships***

- Demonstrates skills in eliciting concerns across physical, functional, psychological, social and spiritual domains
- Establishes positive therapeutic relationships with individuals and their families that are characterized by understanding, trust, respect, honesty and empathy
- Recognizes the value of maintaining hope
- Provides supportive counseling and resources to those coping with loss
- Facilitates a structured clinical encounter effectively
- Identifies the person's and their family's extent of awareness regarding the life-limiting condition and prognosis, and demonstrates empathic listening skills to establish person-centred Goals of Care.
- Organizes, participates in and when appropriate leads clinical encounters structured to achieve predetermined goals, while respecting individual autonomy and maximizing the involvement of the capable person (or, if incapable, their Substitute Decision Maker)
- Recognizes that family conversations may involve children and different communication approaches may be required
- Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
  - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family

***Accurately Elicits and Synthesizes Relevant Information and Perspectives of Individuals, Families, Colleagues and Other Professionals***

- Gathers information regarding the person and family, their beliefs, wishes, hopes, concerns, expectations and illness experience

***Conveys Relevant Information and Explanations Accurately to Individuals, Families, Colleagues and Other Professionals***

- Delivers information to the person, family, colleagues and other professionals in a humane and compassionate manner, that is understandable and encourages discussion and participation in decision-making
  - Recognizes that communication and decision-making may involve the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Identifies communication challenges and modifies approaches to ensure communication is effective
- Explains treatment options, both pharmacological and non-pharmacological, including: the benefits, risks, side effects and effectiveness

***Develops a Common Understanding of Issues, Problems and Plans with Individuals, Families and Health Professionals to Develop a Shared Plan of Care***

- Explains palliative care philosophy to individuals and their families
  - Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Respects diversity and differences, including, but not limited to the impact of ethnicity, culture, gender, sexual orientation, language, religion, age and ability on decision-making
  - Identifies the importance of community care plans when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates ability to elicit what is important to the person, including their wishes, values and beliefs, in relation to their care to facilitate effective Advance Care planning, Goals of Care, and Health Care Consent discussions
- Demonstrates ability to incorporate a person's expressed wishes, values and goals into their plan of treatment, and reviews and revises the plan, as needed, to reflect the person's current condition
- Educates individuals, families and health professionals about symptoms, conditions, issues and emergencies and strategies for management
- Educates individuals, families and health professionals about the differences in providing community-based palliative care, including care in homes and rural communities
- Addresses requests from the person or their family about body, organ or tissue donation, and connects them to the Trillium Gift of Life Network if/when they express interest in organ/tissue donation
- Explains the concept of brain death
- Participates in, or facilitates, family meetings to discuss issues, including goals of care and discharge planning
- Demonstrates skills in discussing emotionally difficult topics with adults, children, adolescents and families
- Effectively conveys oral, written and electronic information regarding a medical encounter

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## Collaborator

Works effectively within a healthcare team to achieve optimal care

### *Participates Effectively and Appropriately in a Specialist Palliative Care Team*

- Describes the roles and responsibilities of other professionals and volunteers within the Specialist Palliative Care Team
- Discusses the importance of role clarity in the provision of palliative care
- Respects the role of primary care physicians and the importance of continuity of care for individuals with palliative care needs
  - Recognizes and mitigates potential barriers and limitations to supporting transitions between specialty care and primary care particularly in First Nations, Inuit, Métis and urban Indigenous communities
- Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous people
- Supports the discharge planning process to facilitate smooth transitions particularly when caring for First Nations and Inuit people and dual providers may be involved
- Establishes with the referring team how care will be delivered: as consultative, primary, or shared care
- Participates effectively in and, when appropriate, leads family conferences and Specialist Palliative Care Team rounds and meetings
- Recognizes and respects an individual's right to object to performing and participating in acts on the basis of moral conscience

### *Palliative Care Specialist Physician Specific Competency:*

- Describes the Palliative Medicine Subspecialist's roles and responsibilities to other professionals

### *Works with Others Effectively to Prevent, Negotiate and Resolve Interprofessional Conflict:*

- Respects differences and scopes of practice of other professions
- Identifies the nature and cause(s) of conflict and employs strategies to resolve or mediate conflict

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## Manager

Serves as an integral participant in health care organizations, organizing sustainable practices, making decisions concerning the allocation of resources and contributing to the effectiveness of the health care system

### *Participates in Activities that Contribute to the Effectiveness of Health Organizations and Systems Related to Palliative Care*

- Works collaboratively with others within their organizations and those in institutional and community-based settings
- Participates in systemic quality process evaluation and improvement, including patient safety initiatives
- Describes the models of palliative care delivery and their utilization, advantages and disadvantages
- Discusses how palliative care fits within the broader health system

- Describes the principles of health financing, including: physician remuneration, budgeting and organizational funding
- Leads and develops clinical governance and quality assurance programs that are specific to palliative care
- Manages practice and career effectively

*Palliative Care Specialist Physician Specific Competencies:*

- Describes the structure and function of the health system as it relates to Palliative Medicine, including the roles of physicians
- Demonstrates awareness of specific skills required for different career paths in Palliative Medicine

*Allocates Finite Health Care Resources Appropriately*

- Demonstrates understanding of the importance of the just allocation of resources, balancing effectiveness, efficiency and access with optimal care
- Promotes timely Advance Care Planning, and Goals of Care discussions to ensure appropriate use of resources
- Describes the resources available to support individuals with palliative care needs

*Palliative Care Specialist Physician Specific Competency:*

- Describes how the various models of palliative care affect the health system, including human resource and fiscal resource allocation

*Serves in Palliative Care Related Administration and Leadership Roles*

- Participates effectively in committees and meetings
- Leads and implements change
- Describes organizational change theories
- Describes the characteristics of effective leadership
- Develops and maintains institutional and community-based standards of care
- Plans relevant elements of health care delivery, such as work schedules

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## **Health Advocate**

Uses expertise and influence responsibly to advance the health and well-being of individuals, communities and populations

*Responds to a Person's Health Needs and Issues*

- Describes physical, functional, psychological, social and spiritual issues of a person with palliative care needs and the impact on the family
- Defines the elements of suffering experienced by a person with palliative care needs
- Identifies and reflect upon opportunities for advocacy, health promotion and disease prevention
- Manages expectations and needs of the person and family receiving palliative care
- Reduces suffering and improve quality of life through identification of psychological, social and spiritual issues
- Addresses risk factors associated with atypical and complicated grief
- Demonstrates appreciation of the possibility of competing interests between individual advocacy issues and advocacy issues of the community at large

### *Responds to the Health Care Needs of the Community Served*

- Identifies opportunities for advocacy, health promotion and disease prevention in the communities served and responds appropriately
- Describes current and evolving societal attitudes regarding death and dying
- Identifies and advocates for individuals with palliative care needs
- Identifies issues regarding palliative care relevant to different ethnicities, cultures, religions, beliefs and traditions
- Describes the societal benefits of body, organ and tissue donation
- Demonstrates appreciation of the possibility of competing interests between the communities served and other populations
- Advocates for the development, maintenance and improvement of health care and social policies related to palliative care
- Identifies the determinants of health for the populations served and contributes to efforts to ensure equity, including, but not limited to: barriers to access to palliative care and resources, availability of Primary Care, Interdisciplinary Care Teams and Specialized Services, delayed or lack of identification of individuals who would benefit from palliative care, lack of availability of community-based resources, geographic inequities and inequities for vulnerable and marginalized populations, poverty, cost of dying at home
- Describes societal, environmental, financial and political factors relevant to the provision of palliative care

### *Identifies Vulnerable and Marginalized Populations and Responds Appropriately*

- Identifies barriers to palliative care for vulnerable populations, including, but not limited to: the homeless, indigenous peoples, the incarcerated and those living in rural communities
- Promotes Advance Care Planning, Goals of Care and Health Care Consent in alignment with Ontario legislation
- Identifies organizational issues that affect the delivery of palliative care
- Participates as a member of organizations which advocate for equitable, accessible, safe and quality palliative care
- Describes how changes in legislation could affect individuals with palliative care needs
- Describes how changes in funding and structure of the health system could affect delivery of palliative care
- Identifies points of influence in the health system that could advance palliative care issues
- Describes the moral, ethical and professional issues inherent in health advocacy related to palliative care

### *Palliative Care Specialist Physician Specific Competencies:*

- Describes the role of the CHPCA, Canadian Society for Palliative Care Physicians, and Canadian Network of Palliative Care for Children in advocating for individuals with palliative care needs
- Demonstrates appreciation of the possibility of conflict inherent in one's role as a health advocate with that of manager or gatekeeper

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## **Scholar**

### *Demonstrates a Lifelong Commitment to Reflective Learning and the Creation, Dissemination, Application and Translation of Medical Knowledge*

- Maintains and enhances professional activities through ongoing learning

- Facilitates the learning of individuals, students, residents, other health professionals and the public
- Contributes to the development, dissemination and translation of new knowledge and practice
- Contributes to the evaluation of the quality of palliative care and the effectiveness of the palliative care system
- Acts as an expert medical resource contributing to palliative care development and delivery
- Provides palliative care related education, leadership and mentorship to other members of the discipline, students, and other colleagues
- Critically evaluates medical information and its sources and applies this appropriately to practice decisions

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### **Professional**

#### *Demonstrates a Commitment to the Health and Well-being of Individuals and Society through Ethical Practice, Profession-led Regulation and High Personal Standards*

- Demonstrates a commitment to individuals, the profession and society through ethical practice
- Exhibits appropriate professional behaviors in practice
- Commits to delivering the highest quality of care and maintains competence
- Incorporates current standards of palliative care in practice
- Acts as a role model by demonstrating skillful care of individuals and their families
- Demonstrates sensitivity and responsiveness to a diverse population
- Recognizes moral and ethical issues and responds appropriately
- Applies an ethical approach when discussing issues related to the care of individuals and their families
- Identifies moral and ethical issues commonly encountered in pediatric palliative care
- Describe similarities and differences with adult care
- Recognizes and respects differences in conscience and moral distress experienced by members of the Specialist Palliative Care Team, individuals and their families
- Describes the availability of and access to resources to support ethically complex decision-making
- Identifies, declares and manages perceived, potential and actual conflicts of interest
- Demonstrates a commitment to individuals, the profession and society through participation in profession-led regulation
- Describes the medical, legal, moral and ethical issues regarding organ and tissue donation and transplantation
- Applies relevant legislation that relates to providing care
- Applies relevant protocols at the time of death
- Identifies different approaches in caring for individuals who are capable and incapable, including, but not limited to: moral, ethical and legal issues and the role of Substitute Decision Makers
- Advocates for health professionals to participate in palliative care continuing education opportunities
- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

- Advocates for health professionals to have access to adequate resources to provide palliative care
- Identifies circumstances which warrant the involvement of the Coroner

*Palliative Care Specialist Physician Specific Competencies:*

- Demonstrates knowledge and understanding of professional, legal, moral and ethical codes of practice related to the Health Care Consent Act (HCCA), Substitute Decision Act, Palliative Sedation Therapy, MAID and withdrawing and withholding of life-sustaining therapies
- Demonstrates ongoing commitment to the person, from the time of consultation until the person dies and to the family after the person dies
- Demonstrates advanced knowledge of regulations governing the prescribing of controlled drugs and other medications

*Demonstrates a Commitment to Physician Health and Sustainable Practice*

- Demonstrates strategies for managing stress associated with caring for individuals with palliative care needs
- Reflects on own emotional and spiritual well-being in response to providing care for individuals who are suffering
- Recognizes compassion fatigue and develops strategies to mitigate risk
- Identifies those at risk for or demonstrating compassion fatigue and strategies and resources to assist them
- Demonstrates understanding of the concept of good “helping relationships” when working with First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding of the concept of companionship particularly when working with First Nations, Inuit, Métis and urban Indigenous people

## PALLIATIVE CARE COMPETENCIES FOR PHYSIOTHERAPISTS

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### Principles of Palliative Care

- Demonstrates understanding of the philosophy of palliative care
  - Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding that a palliative approach to care starts early in the trajectory of a progressive life-limiting condition, and may be appropriate at the time of diagnosis
- Demonstrates the ability to describe the meaning of the term 'life-limiting condition'
- Applies the principles of palliative care that affirm life, offers a support system to help individuals live as actively as possible until death, with optimal quality of life and helps families cope during illness
- Conserves dignity of the person by facilitating expression of needs, hopes, feelings and concerns when planning palliative care
- Interprets the impact of family role change for the person and family in palliative care
- Demonstrates understanding of the role and function of the Interdisciplinary Care Team in palliative care
- Demonstrates understanding of the role and function of the Specialist Palliative Care Team, including volunteers, and refers appropriately
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
  - Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community
- Demonstrates understanding of palliative care standards, guidelines and policies

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### Cultural Safety and Humility

- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates understanding of the Indigenous Wellness Framework
- Demonstrates openness and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preference and accommodates these
- Recognizes personal biases and values that may influence care and identifies mechanisms to overcome these to ensure they do not impact care and treatment
- Assesses the unique needs and preferences of the individual and their family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age, and ability
- Validates and preserves cultural preferences and values by identifying ways to accommodate them into goal setting, decision making and care planning
- Recognizes and respects who the person identifies as family, and responds to family members' unique needs and experiences

- Considers the community, as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people

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## Communication

- Demonstrates understanding of the essential role communication plays in palliative care
- Demonstrates understanding that communication regarding palliative and end-of-life care is an on-going collaborative process
  - Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
- Recognizes the multidimensional communication challenges that arise when caring for people with life-limiting conditions
- Assesses the person's and family's understanding of the life-limiting condition and its trajectory and uses this to inform their communication approach
- Recognizes the potential for conflict in palliative care decision-making and contributes to its management
- Supports individuals to make informed decisions on the depth of information about diagnosis, prognosis and disease progression they wish to receive and share with their families
- Provides culturally relevant information and resources to support individuals and families, particularly when caring for those from First Nations, Inuit, Métis and urban Indigenous communities
- Invites, facilitates and respects the involvement of the person, their family and their care team in discussions regarding the plan of care
  - Recognizes that communication and decision-making may involve the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Recognizes that family conversations may involve children and different communication approaches may be required
- Evaluates communication with the person and their family/caregiver to ensure their care plan meets the person's identified needs
  - Identifies the importance of community care plans when caring for First Nations, Inuit, Métis and urban Indigenous people
- Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous people
- Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
  - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family

### *Physiotherapy Specific Competencies:*

- Obtains sufficient information from the care team on disease status as it impacts functional activity status

- Assesses functional status and capacity, and provides recommendations to maintain activities of daily living
- Assesses and provides recommendations for transferring care environment from home to hospital or hospice based on the assessed need and wishes of the person and their family

### Optimizing Comfort and Quality of Life

- Recognizes how a palliative approach can enhance the assessment and management of symptoms
- Recognizes common trajectories of life-limiting conditions, including common symptoms
- Anticipates and predicts the needs of the person who has been diagnosed with a life-limiting illness based on known disease trajectories
- Evaluates non-complex interventions and proposes alternatives if necessary
- Demonstrates understanding of the concept of ‘total pain’
- Demonstrates understanding of the causes of common non-pain symptoms at end-of-life including but not limited to fatigue, cachexia, anorexia, muscle weakness and lymphedema.
- Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Applies the principles of pain and symptom management
- Demonstrates understanding of the potential barriers to providing pain management, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Applies interprofessional approaches to optimize comfort and enhance quality of life of the person and their family
- Recognizes the ways in which the person can be engaged in self-management of their condition
- Provides education and practical strategies to the person, family and caregivers regarding the management of pain and symptoms
- Understands safety considerations and indications for use of non-pharmacological pain and symptom management strategies to promote comfort and quality of life
  - Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Interprets the impact of family role change when formulating relevant and realistic care plans
- Supports the person, family, Substitute Decision Maker (SDM) and care teams with end-of-life decision making, including withdrawing or withholding interventions
- Recognizes and anticipates the physical, psychological, social and spiritual issues that affect the person and their family
- Provides care in keeping with the person’s expressed wishes and identified goals of care
- Recognizes the need for a change in the focus of care and treatment goals at critical decision points in the course of a life-limiting condition
- Demonstrates awareness of one’s own responses in the presence of a person who is suffering
- Provides care in a compassionate manner

#### *Physiotherapy Specific Competencies:*

- Assesses the benefits, burdens and risks of clinical interventions

- Makes decisions regarding the appropriateness of interventions for each person living with a life-limiting condition, taking into consideration the person's expressed wishes and identified goals of care
- Recommends energy-sparing interventions for individuals with advanced disease experiencing fatigue
- Ensures emphasis of palliative treatment is on performance and pain and symptom management
- Demonstrates expert knowledge to identify complex interplay of factors that impact function
- Demonstrates expert knowledge in the management of pain and symptoms, functional changes and interventions
- Teaches families how to help with the person's care (e.g. positioning, transfers, etc.) ensuring they take care of themselves
- Actively participates in conversations with the person, their family and their care team about goals of care
- Understands the role of active and/or passive exercise interventions to retain performance status and sustain quality of life
- Recognizes the elements that contributes to dyspnea and implements strategies to control breathing and minimize discomfort during transfers and daily activities
- Understands the nature of bone metastasis and impact on function
- Recommends positioning, frequency in position changes, sleeping and seating surfaces as part of the skin care regime
- Implements fracture prevention strategies, including patient education.
- Prescribes ambulatory aids when necessary for safe mobility and to maintain quality of life
- Recognizes the development of lymphedema associated with advanced disease and refers to appropriate specialists for prevention of potential deterioration, medical complications and management
- Assesses the person for safe transfers and where appropriate, provides transfer training to minimize risk for the person and their caregiver(s)
- Understands the complex interplay of metabolic, cardiovascular and neurological factors which impact function
- Conducts comprehensive assessments of functional performance status, such as weight bearing tolerance and its impact on activities of daily living

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### Care Planning and Collaborative Practice

- Understands the collaborative relationship between the person, health professionals, family and caregivers
  - Recognizes that communication and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Effectively collaborates with the care team to manage pain and symptoms
- Recognizes the overall impact of a life-limiting condition on the person and family and provides support to address identified needs
- Identifies priorities and concerns in collaboration with the person and family, taking into account their coping strategies and perception of diagnosis

- Familiar with the Health Care Consent Act, and understands that a health provider must obtain informed consent from the person (or, if they are incapable, their Substitute Decision Maker) for any treatment or intervention proposed
- Understands how a Substitute Decision Maker (SDM) is determined (based on the hierarchy within the Health Care Consent Act, 1996) and the role the SDM plays in making health care decisions if the person is not capable
- Supports the person to express their wishes and/or identify their goals of care by referring them to the most appropriate health professional
- Facilitates the active involvement of the person in goal setting, decision making and informed consent to support the best possible outcomes and quality of life
- Demonstrates flexibility in relation to care planning, acknowledging that a person's priorities can shift as their condition changes
- Facilitates informed decision-making by the person regarding place of care, while identifying risks in a supportive manner
- When able, provides care in the person's preferred place, while recognizing the complexities and challenges involved for the person, their family and their caregiver(s)
- Anticipates factors/conditions that may affect the individual's cognition and functional capacity to make decisions including health status changes, and towards end-of-life
- Identifies how interprofessional practice enhances individual outcomes

#### *Physiotherapy Specific Competencies:*

- Demonstrates advanced level of clinical expertise and sensitivity in facilitating a safe, smooth, seamless transition of care for the person
- Creates a holistic, person-centred plan that acknowledges the psychosocial impact of diminishing function and sets realistic goals
- Recognizes clinical limitations and professional boundaries and refers to other colleagues appropriately and in a timely manner
- Educates the person and caregivers regarding possible changes to clinical presentation and function and the safest mobilization techniques and use of equipment to optimize function.
- Demonstrates awareness of services and resources available to the person and family within the community to aid with function and mobility
- Educates the person and their family on symptom management techniques including but not limited to massage, range of motion (ROM), gentle stretching- especially relevant in pediatrics palliative care
- Demonstrates knowledge of various secretion assessments and management techniques including medication, various suction options, positioning, positive air pressure, and oxygen administration and titration.
- Understanding the risks and benefits of using secretion clearance modalities and selecting the appropriate tools and referrals that align with the person's preferences.
- Applies knowledge within scope of practice to support the person in adapting to changing clinical presentation and functional levels
- Facilitates discharge planning, conducts in-depth functional and risk assessments

#### **Last Days and Hours**

- Aware of best practices for expected death, including local and organizational policies and processes
- Anticipates, recognizes and responds to the signs of imminent death

- Supports the family's wishes and death rituals
- 

### **Loss, Grief and Bereavement**

- Demonstrates knowledge of diverse perspective on loss, grief, bereavement, and mourning to support others from a cross-cultural perspective
  - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people
- Recognizes the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief
- Understands, recognizes and manages pathological responses to loss, referring appropriately to the Specialist Palliative Care Team, or other interdisciplinary care team members as appropriate
- Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief
  - Understands cumulative grief which can be particularly significant in First Nations and Inuit communities
- Provides appropriate guidance, support and information to families and caregivers based on awareness of culture and needs, and directs them to bereavement services as required

#### *Physiotherapy Specific Competency:*

- Demonstrates sensitivity and engagement with the different stages of grief and loss, including loss of functional independence
- 

### **Professional and Ethical Practice**

- Anticipates and addresses ethical and legal issues that may be encountered when caring for individuals with life-limiting conditions
  - Establishes and respects people's wishes regarding their care options and preferences
  - Respects the person's decisions regarding initiating, not initiating, withholding and withdrawing dialysis, hydration, nutrition support, resuscitation and other life-prolonging/life-sustaining interventions
  - Recognizes when personal beliefs, attitudes and values limit one's ability to be present and provide person-centred care; collaborates with others to ensure optimal care is provided
  - Understands distinctions among ethical and legal concepts, such as: the principle of double effect, Palliative Sedation Therapy and Medical Assistance in Dying (MAID)
  - Demonstrates knowledge of relevant legislation and policies, e.g. MAID, Child, Youth and Family Services Act, Adult Protection Act, the Health Care Consent Act, and the Substitute Decision Act
  - Responds to inquiries regarding MAID in accordance with regulatory body's relevant guidelines and standards and employer policies or refers inquiries regarding MAID to the most appropriate health care professional.
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### **Self-Care**

- Demonstrates understanding of the personal impact of loss, grief and bereavement
  - Recognizes one's own responses to loss and engages in activities that proactively support well-being and resilience
  - Explores own attitudes regarding death, dying and caring for individuals requiring palliative care
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- Demonstrates awareness of the impact of past experiences of suffering, death and dying when providing palliative care
  - Understands and attends to own emotional responses that result from caring for individuals with palliative care needs
  - Recognizes compassion fatigue in self and colleagues; intervenes and refers appropriately
  - Engages in healthy activities that help prevent compassion fatigue
  - Demonstrates understanding of the concept of good “helping relationships” when working with First Nations, Inuit, Métis and urban Indigenous people
  - Demonstrates understanding of the concept of companionship particularly when working with First Nations, Inuit, Métis and urban Indigenous people
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### **Education and Evaluation**

- Contributes to the evaluation of the quality of palliative care
- Participates in palliative care continuing education opportunities
- Educates individuals, families and caregivers about palliative care and the palliative approach
- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

## ADDITIONAL COMPETENCIES FOR PHYSIOTHERAPISTS WITH A PRACTICE FOCUSED IN PALLIATIVE CARE

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### Principles of Palliative Care

- Applies a dignity conserving approach to care when providing support
- Facilitates empathic and responsive relationships between those experiencing life-limiting conditions and their care team
- Demonstrates leadership that encourages colleagues to foster a caring environment that supports all staff working in sensitive situations
- Practices person-centred palliative care that incorporates the unique contributions of the family
- Demonstrates understanding of palliative care standards, guidelines and policies

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### Communication

- Uses a variety of strategies to engage in highly skilled, compassionate, individualized and timely communication with the person, their family, their caregivers and their care team
- Maintains ongoing communication with the person, their family and their care team regarding the end-of-life plan of care and also in setting goals related to function and mobility throughout the palliative trajectory
- Demonstrates expertise as a mediator and advocate for appropriate and timely access to palliative care
- Demonstrates self-awareness of one's own responses to communication challenges and remains engaged in meaningful contact with the person, their family and their caregivers

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### Optimizing Comfort and Quality of Life

- Applies comprehensive knowledge and understanding of the clinical presentation and disease trajectories of life-limiting conditions when responding to complex and multidimensional care needs, to comprehensively identify current and prospective clinical issues in palliative care
- Discusses the benefits and burdens of palliative treatment options to assist the person in meeting their goals of care

#### *Physiotherapy Specific Competencies:*

- Demonstrates the ability to recognize the elements of fatigue which relate to depression and loss of independence
- Understands the importance of substantial weight loss on medical and functional status, prescribes exercise, and refers to appropriate specialized resources
- Acts as an expert resource regarding the persons functional status and impact on family/caregiver burden
- Demonstrates the ability to understand radiographic reports on bone status as it impacts functional status
- Applies lymphedema management techniques to prevent medical status deterioration, pain and infection
- Acts as an expert resource regarding the role of discipline-specific interventions in symptom management and optimizing quality of life
- Demonstrates knowledge to alleviate and manage distressing symptoms while attempting to maximize the person's ability to function

- Ensures emphasis of palliative treatment is on performance and symptom management
- Demonstrates expertise regarding the complex interplay of factors that impact physical function and mobility
- Demonstrates expertise in the management of symptoms, functional changes and interventions to improve mobility and quality of life

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### Care Planning and Collaborative Practice

- Develops therapeutic relationships with the person, their family, their caregivers and their care team to define goals of care and to develop, implement and evaluate a plan of care
  - Recognizes that care planning and decision-making may involve the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
  - Facilitates participation of the person in care planning
  - Identifies and integrates the person's strengths in plan of care
  - Assists the family in care giving and acquiring respite care
  - Safely and appropriately delegates aspects of care to the family
  - Engages in family and team conferences
  - Develops a plan of care for the family
- Collaborates with the person and family to identify resources that will provide support throughout their illness and during end-of-life care
- Facilitates conversations to support end-of-life decision making
- Identifies the person's and family's values, beliefs and preferences regarding the various components of palliative care provision
- Uses shared scopes of practice to optimize care
- Collaborates within and between teams across the continuum of care to facilitate continuity in palliative care
  - Recognizes and mitigates potential barriers and limitations to supporting transitions between specialty care and primary care particularly in First Nations, Inuit, Métis and urban Indigenous communities
- Contributes to the evaluation of the quality of palliative care and the effectiveness of the Specialist Palliative Care Team
- Identifies the full range and continuum of palliative care services, resources and the settings in which they are available
  - Demonstrates knowledge of the range of palliative care services and resources
  - Provides relevant information and resources to the person and family
  - Identifies and accesses services and resources specific to the person's goals of care
  - Initiates referrals to and requests for resources, services and settings
  - Facilitates access for the person and their family to services and resources as needed

### *Physiotherapy Specific Competencies:*

- Supports the discharge planning process to facilitate smooth transitions particularly when caring for First Nations and Inuit people and dual providers may be involved Applies skills, knowledge and expertise in facilitating safe, smooth and seamless transition of care for the person
- Demonstrates clinical expertise in supporting the person in adapting to changing clinical presentation and functional levels

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### Loss, Grief and Bereavement

- Demonstrates a comprehensive knowledge of the grieving process and reactions in order to support individuals and families throughout the disease trajectory

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### Professional and Ethical Practice

- Applies a comprehensive understanding of contemporary legal, ethical and professional standards to the provision of quality palliative care
- Facilitates discussion and management of ethical and legal issues in conjunction with the person, their family and their care team
- Actively influences and promotes palliative care strategic initiatives and policy development

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### Research, Education and Evaluation

- Educates the person, their family, and their caregiver(s) about palliative care and the palliative approach
- Applies knowledge gained from palliative care research
- Where possible, leads, facilitates and engages in education and research
- Critically evaluates outcomes against standards and guidelines
- Contributes to the evaluation of the quality of palliative care and the effectiveness of the palliative care system
- Develops, facilitates and provides palliative care related education, leadership and mentorship to members of the discipline and students
- Where possible, identifies the opportunities for and barriers to discipline-specific research unique to palliative care
- Where possible, provides the family with opportunities to participate in research regarding end-of-life care giving
- Acts as an expert resource contributing to palliative care development and delivery

#### *Physiotherapy Specific Competency:*

- Educates and mentors the person and their family regarding self-management strategies to employ at home in order to maintain mobility and function

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### Advocacy

- Advocates for the needs, decisions and rights of the person by recognizing potential vulnerabilities
- Supports autonomous decision-making
- Promotes equitable and timely access to resources
- Advocates for the development, maintenance and improvement of health care and social policies related to palliative care
- Advocates for health professionals to participate in palliative care continuing education opportunities
- Advocates for health professionals to have adequate resources to provide quality palliative care

## PALLIATIVE CARE COMPETENCIES FOR PERSONAL SUPPORT WORKERS (PSWs)

### Principles of Palliative Care

- Demonstrates understanding of the philosophy of palliative care
  - Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding that a palliative approach to care starts early in the trajectory of a progressive life-limiting condition, and may be appropriate at the time of diagnosis
- Applies a dignity conserving approach to care when providing support
- Understands the use of evidence-based tools to facilitate early identification of individuals who may benefit from palliative care
- Interprets the impact of family role change for the person and family in palliative care
- Demonstrates understanding of the role and function of the Interdisciplinary Care Team in palliative care, including volunteers
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
  - Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community
- Demonstrates understanding of palliative care standards, guidelines and policies

### Cultural Safety and Humility

- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates understanding of the Indigenous Wellness Framework
- Demonstrates openness and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preference and accommodates these
- Validates and preserves cultural preferences and values
- Recognizes and respects who the person identifies as family, and responds to family members' unique needs and experiences
  - Considers the community, as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people
- Explores cultural and religious needs, beliefs and preferences of the person and their family, including as they relate to end-of-life
  - Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Provides opportunities for person and their family to exercise religious, cultural and spiritual rituals, customs, rites and beliefs throughout the person's illness trajectory and through bereavement

### Communication

- Demonstrates understanding of the essential role communication plays in palliative care

- Demonstrates understanding that communication regarding palliative and end-of-life care is an on-going collaborative process
  - Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
- Communicates promptly with registered staff about changing health status of the person
  - Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous people
- Supports and enables therapeutic relationships. Demonstrates the ability to advocate for the person and their family
- Communicates effectively with registered staff through use of all available reporting and documenting mechanisms to ensure the person's needs are promptly assessed and addressed
- Communicates effectively with the person and family about care needs, preferences, religious beliefs, cultural practices and values
  - Recognizes that communication and decision-making may involve the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Supports the person and family to talk about wishes
- Responds to questions regarding death and dying
- Listens and provides support and comfort to the person and family
  - Provides culturally relevant information and resources to support individuals and families, particularly when caring for those from First Nations, Inuit, Métis and urban Indigenous communities
- Provides opportunities for the person and their family to exercise religious, cultural and spiritual rituals, customs, rites and beliefs throughout the person's illness and through bereavement
- Recognizes that family conversations may involve children and different communication approaches may be required
- Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
  - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family

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## **Optimizing Comfort and Quality of Life**

### *Person Centered Assistance*

- Provides assistance with all personal care needs
- Understands the care needs of people with serious, chronic conditions, frailty and declining capacity
- Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous people

- Knows and understands the person's physical, emotional, and mental abilities and impairments, and continually adapts assistance to their changing needs and declining capacities, to maintain maximum independence, mobility, well-being, and quality of life.
  - Understands the potential barriers to providing pain management, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Provides an atmosphere of peace and safety and provides assistance in a way that maximizes the person's dignity and right to privacy, especially in intimate care
- Maximizes the person's participation in their own care, and enables choice to the fullest extent possible. When a person refuses assistance, the PSW pursues a balance between respect for the person's right to choice, and the need to provide a minimum standard of care
- Respects the rights of every person and problem solves to achieve a compromise, even if it means accepting a person's refusal of assistance
- Familiar with the Health Care Consent Act (HCCA), and understands that a health provider must obtain informed consent from the person (or, if they are incapable, their Substitute Decision Maker) for any treatment or intervention proposed
- Understands how a Substitute Decision Maker (SDM) is determined (based on the hierarchy within the HCCA) and the role the SDM plays in health care decision making if a person is not capable
- Supports the person who wishes to express their wishes or discuss their goals of care by referring them to the most appropriate health care professional
- Provides care in keeping with the persons' expressed wishes and identified goals of care.
- Demonstrates awareness of one's own responses in the presence of a person who is suffering
- Provides care in a compassionate manner

#### *Personal Support Worker Specific Competencies:*

- When a person is no longer able to contribute to their care, the PSW continues to provide care in a way that maintains the person's dignity, well-being and self-image
- Uses alternate/adaptive communication approaches as appropriate to the person

#### *Building a Relationship*

- Supports and enables a therapeutic relationship and tailors assistance by getting to know the unique care needs, preferences, cultural and religious customs of each person

#### *Specialized Care*

##### *Personal Support Worker Specific Competency:*

- Working alongside registered staff (including Registered Nurses and Registered Practical Nurses), the PSW provides specialized care as specified in the care plan, according to protocols, within scope of practice and in accordance with the employer's policies and procedures

#### *Care for the Family*

- Engages with the person's family
- Seeks to understand the family's desired level of involvement in the person's care, being sensitive to the family's wishes
  - Recognizes that caring for First Nations, Inuit, Métis and urban Indigenous people may involve the larger First Nations, Inuit, Métis and urban Indigenous community, beyond the individual/family
- Supports the family to provide aspects of care, while monitoring the quality of care provided

- Provides empathetic care to the person and their family and recognizes the need to guide, demonstrate, and emotionally support the family member

### **Ongoing Observation**

- Demonstrates understanding that the family may find visiting their dying loved one challenging, by recognizing signs of distress and providing supports
- Provides information regarding the process and stages of dying to support family members, based on awareness of culture and needs
- Particularly near end-of-life, anticipates and responds to the family's need for emotional support

### **Personal Support Worker Specific Competency:**

- Continuously monitors the person's daily physical, emotional and psychological functioning, adapts approaches within the PSW scope and promptly recognizes and reports changes to the most responsible provider

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### **Last Days and Hours**

- Acknowledges and accepts that the death of individuals in their care is natural and inevitable and emotionally prepares themselves for loss
- Aware of best practices for expected death, including local and organizational policies and processes
- Supports the person and family at end-of-life, in a way compatible with the person's values, customs and understandings.
- Explores and responds respectfully to residents' cultural, religious and spiritual practices.
  - Provides opportunities for family and the extended community to gather and be together, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Talks to the person and family regarding death and dying, to the degree they are able, explores their wishes for end-of- life care by listening and responding to questions, protects the person's and family's need for privacy when having these conversations
- When appropriate, encourages the person and family to talk with a spiritual advisor
- Ensures the family is notified near end-of-life and involved to the extent they wish, while providing support, facilitating conversations and protecting privacy
- Provides an atmosphere of peace, safety and unconditional regard for the person

### **Personal Support Worker Specific Competencies:**

- Demonstrates knowledge of the stages of dying, recognizes signs of active dying and communicates with the designated provider(s) regarding the person's changing needs
- Observes changes in the person's level of pain and distress, reports to the most responsible provider, and provides comfort
- Provides post-mortem care at the time of death, in accordance with the support plan

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### **Loss, Grief and Bereavement**

- Demonstrates knowledge of diverse perspectives on loss, grief, bereavement, and mourning to support others from a cross-cultural perspective
  - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people
- Recognizes the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief

- Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief
  - Understands cumulative grief which can be particularly significant in First Nations and Inuit communities

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### Professional and Ethical Practice

- Demonstrates understanding of the ethical issues pertaining to palliative care
- Demonstrates the ability to establish and respect a person's wishes about their care/options/preferences
- Demonstrates understanding of relevant legislation and policies, e.g. Bill C-14 (Medical Assistance in Dying (MAID)), Bill 84 (MAID Statute Law Amendment Act, 2017) Child, Youth and Family Services Act, Adult Protection Act, Health Care Consent Act, and Substitute Decisions Act
- Supports individual and family choices pertaining to end-of-life care in alignment with the Health Care Consent Act, and Substitute Decisions Act
- Responds to inquiries regarding MAID in accordance with legislation and employer policies

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### Self-Care

- Explores own attitudes regarding death, dying and caring for individuals with palliative care needs
- Demonstrates awareness of the impact of past experiences of suffering, death and dying when providing palliative care
- Understands and attends to own emotional responses that result from caring for individuals with palliative care needs
- Recognizes compassion fatigue; intervenes and refers appropriately
- Engages in healthy activities that help prevent compassion fatigue
- Demonstrates understanding of the concept of good "helping relationships" when working with First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding of the concept of companionship particularly when working with First Nations, Inuit, Métis and urban Indigenous people
- Participates in community-driven debriefs when working with First Nations, Inuit, Métis and urban Indigenous people

#### *Personal Support Worker Specific Competencies:*

- Recognizes the importance of personal awareness and self-care and commits to a plan of regular self-care in order to stay physically, mentally and emotionally healthy
- Understands grief is normal and an appropriate response to loss
- Demonstrates awareness of self-care strategies to manage impacts from working with individuals and their families facing life-limiting conditions
- Demonstrates awareness of strategies to cope and manage with death and dying
- Demonstrates awareness of the emotional and spiritual supports available to PSWs

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### Education and Evaluation

- Contributes to the monitoring and evaluation of the quality of palliative care
- Participates in palliative care continuing education opportunities
- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

## PALLIATIVE CARE COMPETENCIES FOR PSYCHOLOGISTS

### Principles of Palliative Care

- Demonstrates understanding of the philosophy of palliative care
  - Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding that a palliative approach to care starts early in the trajectory of a progressive life-limiting condition, and may be appropriate at the time of diagnosis
- Demonstrates the ability to describe the meaning of the term 'life-limiting condition'
- Applies the principles of palliative care that affirm life, offers a support system to help individuals live as actively as possible until death, with optimal quality of life and helps families cope during illness
- Conserves dignity of the person by facilitating expression of needs, hopes, feelings and concerns when planning palliative care
- Interprets the impact of family role change for the person and family in palliative care
- Demonstrates understanding of the role and function of the Interdisciplinary Care Team in palliative care
- Demonstrates understanding of the role and function of the Specialist Palliative Care Team, including volunteers, and refers appropriately
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
  - Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community
- Demonstrates understanding of palliative care standards, guidelines and policies

### *Psychologist Specific Competencies:*

- Demonstrates awareness of the psychological aspects of life-limiting conditions and potential mental health needs
- Engages in specialist psychological assessment, formulation and intervention with individuals with complex conditions
- Works with and consults on various psychological protective functions, such as death denial and death anxiety, as appropriate to palliative care
- Consults with the care team in the management of individuals with life-limiting conditions with complex needs such as: organic brain damage, toxicity, dual mental health diagnosis and personality difficulties, which affect their ability to engage with services

### Cultural Safety and Humility

- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates understanding of the Indigenous Wellness Framework
- Demonstrates openness and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preference and accommodates these

- Recognizes personal biases and values that may influence care and identifies mechanisms to overcome these to ensure they do not impact care and treatment
- Assesses the unique needs and preferences of the individual and the family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age, and ability
- Validates and preserves cultural preferences and values by identifying ways to accommodate them into goal setting, decision making and care planning
- Recognizes and respects who the person identifies as family, and responds to family members' unique needs and experiences
  - Considers the community, as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people

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### Communication

- Demonstrates understanding of the essential role communication plays in palliative care
- Demonstrates understanding that communication regarding palliative and end-of-life care is an on-going collaborative process
  - Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
- Recognizes the multidimensional communication challenges that arise when caring for people with life-limiting conditions
- Assesses the person's and family's understanding of the life-limiting condition and its trajectory and uses this to inform their communication approach
- Recognizes the potential for conflict in palliative care decision-making and contributes to its management
- Supports individuals to make informed decisions on the depth of information about diagnosis, prognosis and disease progression they wish to receive and share with their families
- Provides culturally relevant information and resources to support individuals and families, particularly when caring for those from First Nations, Inuit, Métis and urban Indigenous communities
- Invites, facilitates and respects the involvement of the person, their family and their care team in discussions regarding the plan of care
  - Recognizes that communication and decision-making may involve the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Recognizes that family conversations may involve children and different communication approaches may be required
- Evaluates communication with the person and their family/caregiver to ensure their care plan meets the person's identified needs
  - Identifies the importance of community care plans when caring for First Nations, Inuit, Métis and urban Indigenous people
- Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous people

- Supports the discharge planning process to facilitate smooth transitions particularly when caring for First Nations and Inuit people and dual providers may be involved
- Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
  - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family

*Psychologist Specific Competencies:*

- Demonstrates understanding of and clinical ability to work with the broader aspects of psychological theory as it applies to individuals with palliative care needs
- Demonstrates understanding and awareness of medications, physical pain, organic or cognitive impairment and its impact on the person
- Provides training for members of the Interdisciplinary Care Team regarding the normal and complicated adjustment and systemic processes

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**Optimizing Comfort and Quality of Life**

- Recognizes how a palliative approach can enhance the assessment and management of symptoms
- Recognizes common trajectories of life-limiting conditions, including common symptoms
- Anticipates and predicts the needs of the person who has been diagnosed with a life-limiting illness based on known disease trajectories
- Evaluates non-complex interventions and proposes alternatives if necessary
- Demonstrates understanding of the concept of ‘total pain’
- Demonstrates understanding of the causes of common non-pain symptoms at end-of-life
- Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Applies the principles of pain and symptom management
- Demonstrates understanding of the potential barriers to providing pain management, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Applies interprofessional approaches to optimize comfort and enhance quality of life of the person and their family
- Recognizes the ways in which the person can be engaged in self-management of their condition
- Recognizes the need for a change in the focus of care and treatment goals at critical decision points in the course of a life-limiting condition
- Provides education and practical strategies to the person, family and caregivers regarding the management of pain and symptoms
- Uses non-pharmacological symptom management to promote comfort and quality of life
  - Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Interprets the impact of family role change when formulating relevant and realistic care plans
- Supports the person, family, Substitute Decision Maker (SDM) and care teams with end-of-life decision making, including withdrawing or withholding interventions

- Recognizes and anticipates the physical, psychological, social and spiritual issues that affect the person and their family
- Demonstrates awareness of one's own responses in the presence of a person who is suffering
- Provides care in a compassionate manner
- Provides care in keeping with the person's expressed wishes and identified goals of care

#### *Psychologist Specific Competencies:*

- Assesses the benefits, burdens and risks of clinical interventions
  - Makes decisions regarding the appropriateness of interventions for each person living with a life-limiting condition, taking into consideration the person's expressed wishes and identified goals of care
- Demonstrates understanding of the factors underpinning psychosocial adjustment to life-limiting conditions
- Recognizes how disease progression and associated medical treatments can adversely affect quality of life by virtue of their potential to impact on the person's and family's emotional well-being, interpersonal relationships, material well-being, personal development, physical well-being, self-determination, social inclusion and human rights
- Supports people with life-limiting conditions to psychologically process the implications and impact of moving from life prolonging care to palliative care
- Provides evidence-based psychotherapeutic interventions to people with life-limiting conditions and their families
- Educates the person, their family, their caregiver, and health professionals about the psychological aspects of pain, fatigue, anxiety and other presentations associated with the experience of life-limiting conditions
- Supports and educates the person and their family about quality of life decisions and the psychological implications of decisions
- Supports the care team in the management of individuals with life-limiting conditions who present with organic brain damage, toxicity, dual mental health diagnosis and personality disorders, which may affect their engagement with services
- Provides consultation to the care team when considering the care and treatment options for a person with a life-limiting illness, with due regard to the person's wishes and how their psychological state may influence this
- Provides consultation and direct support to families with complex dynamics and to staff to facilitate care provision

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#### **Care Planning and Collaborative Practice**

- Understands the collaborative relationship between the person, health professionals, family and caregivers
  - Recognizes that care planning and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Effectively collaborates with the care team to manage pain and symptoms
- Recognizes the overall impact of a life-limiting condition on the person and family and provides support to address identified needs
- Identifies priorities and concerns in collaboration with the person and family, taking into account their coping strategies and perception of diagnosis

- Familiar with the Health Care Consent Act, and understands that a health provider must obtain informed consent from the person (or, if they are incapable, their Substitute Decision Maker) for any treatment or intervention proposed
- Understands how a Substitute Decision Maker (SDM) is determined (based on the hierarchy within the Health Care Consent Act, 1996) and the role the SDM plays in making health care decisions if the person is not capable
- Supports the person to express their wishes and/or identify their goals of care by referring them to the most appropriate health professional
- Facilitates the active involvement of the person in goal setting, decision making and informed consent to support the best possible outcomes and quality of life
- Demonstrates flexibility in relation to care planning, acknowledging that a person's priorities can shift as their condition changes
- Facilitates informed decision-making by the person regarding place of care, while identifying risks in a supportive manner
- When able, provides care in the person's preferred place, while recognizing the complexities and challenges involved for the person, their family and their caregiver(s)
- Anticipates factors/conditions that may affect the individual's cognition and functional capacity to make decisions including health status changes, and towards end-of-life
- Identifies how interprofessional practice enhances individual outcomes

#### *Psychologist Specific Competencies:*

- Recognizes the impact of a life-limiting condition on the person's and family's mental health and coping mechanisms and provides support
- Demonstrates understanding of the relationship between physical conditions and treatment of mental health presentations in palliative care

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### **Last Days and Hours**

- Aware of best practices for expected death, including local and organizational policies and processes
- Anticipates, recognizes and responds to the signs of imminent death
- Supports the family's wishes and death rituals
- Supports planning for expected deaths, particularly when caring for First Nations, Inuit, Métis and urban Indigenous in the community
- Provides opportunities for family and the extended community to gather and be together, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people

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### **Loss, Grief and Bereavement**

- Demonstrates knowledge of diverse perspectives on loss, grief, bereavement, and mourning to support others from a cross-cultural perspective
  - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people
- Recognizes the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief
- Understands, recognizes and manages pathological responses to loss, referring appropriately to the Specialist Palliative Care Team, or other interdisciplinary care team members as appropriate
- Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief

- Understands cumulative grief which can be particularly significant in First Nations and Inuit communities
- Provides appropriate guidance, support and information to families and caregivers, based on awareness of culture and needs, and directs them to bereavement services as required

#### *Psychologist Specific Competencies:*

- Demonstrates understanding of the needs of children of various developmental stages in dealing with grief and loss of a parent or sibling
- Demonstrates understanding of the psychological impact of death and dying on individuals with increased stress vulnerability
- Demonstrates understanding of contemporary theories and models of loss and grief
- Proficiently applies contemporary, evidence-based models of bereavement supports and counselling across a broad range of patients; adjusting for differences in cognitive level and learning style; and demonstrating sensitivity to ethnicity, culture, gender, sexual orientation, language, religion, age and ability
- Stays abreast of literature in the area of grief, loss and bereavement; and disseminates this information to colleagues, individuals and families, as appropriate
- Applies an in-depth understanding of the grief and loss literature to the care of people with life-limiting conditions and their families and provides consultation to other health professionals
- Demonstrates understanding of the complex and dynamic nature of responses to loss and provides expert input to the care team on the psychological aspects of people with life-limiting conditions and family care
- Accurately assesses the person's and family's loss, grief and bereavement needs
- Identifies those experiencing or at risk for complicated and disenfranchised grief, discusses, documents and refers as appropriate
- Demonstrates the ability to proactively respond to complex grief reactions and processes using own skills or appropriate referral
- Mentors and educates colleagues regarding the personal impact of loss, grief and bereavement, supporting them to recognize their own loss responses and encouraging engagement in activities to maintain their resilience on an on-going basis

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#### **Professional and Ethical Practice**

- Anticipates and addresses ethical and legal issues that may be encountered when caring for individuals with life-limiting conditions
- Establishes and respects people's wishes regarding their care options and preferences
- Respects the person's decisions regarding initiating, not initiating, withholding and withdrawing dialysis, hydration, nutrition support, resuscitation and other life-prolonging/life-sustaining interventions
- Recognizes when personal beliefs, attitudes and values limit one's ability to be present and provide person-centred care; collaborates with others to ensure optimal care is provided
- Understands distinctions among ethical and legal concepts, such as: the principle of double effect, Palliative Sedation Therapy and Medical Assistance in Dying (MAID)
- Demonstrates knowledge of relevant legislation and policies, e.g. MAID, Child, Youth and Family Services Act, Adult Protection Act, the Health Care Consent Act, and the Substitute Decision Act Responds to inquiries regarding MAID in accordance with regulatory body's relevant guidelines and standards and employer policies.

### *Psychologist Specific Competencies:*

- Promotes and provides access to psychological therapies for people with a life-limiting condition
- Contributes to education of health professionals and general public regarding the psychology of death and dying

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### **Self-Care**

- Demonstrates understanding of the personal impact of loss, grief and bereavement
- Recognizes one's own responses to loss and engages in activities that proactively support well-being and resilience
- Explores own attitudes regarding death, dying and caring for individuals requiring palliative care
- Demonstrates awareness of the impact of past experiences of suffering, death and dying when providing palliative care
- Understands and attends to own emotional responses that result from caring for individuals with palliative care needs
- Recognizes compassion fatigue in self and colleagues; intervenes and refers appropriately
- Engages in healthy activities that help prevent compassion fatigue
- Demonstrates understanding of the concept of good "helping relationships" when working with First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding of the concept of companioning particularly when working with First Nations, Inuit, Métis and urban Indigenous people
- Participates in community-driven debriefs when working with First Nations, Inuit, Métis and urban Indigenous people

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### **Education and Evaluation**

- Contributes to the evaluation of the quality of palliative care and the effectiveness of the palliative care system
- Participates in palliative care continuing education opportunities
- Educates individuals, families and caregivers about palliative care and the palliative approach
- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

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### **Advocacy**

- Advocates for the needs, decisions and rights of the person by recognizing potential vulnerabilities
- Supports autonomous decision-making
- Promotes equitable and timely access to resources
- Advocates for the development, maintenance and improvement of health care and social policies related to palliative care
- Advocates for health professionals to participate in palliative care continuing education opportunities
- Advocates for health professionals to have adequate resources to provide quality palliative care

# PALLIATIVE CARE COMPETENCIES FOR RESPIRATORY THERAPISTS

## Principles of Palliative Care

- Demonstrates understanding of the philosophy of palliative care
  - Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding that a palliative approach to care starts early in the trajectory of a progressive life-limiting condition, and may be appropriate at the time of diagnosis
- Demonstrates the ability to describe the meaning of the term ‘life-limiting condition’
- Applies the principles of palliative care that affirm life, offers a support system to help individuals live as actively as possible until death, with optimal quality of life and helps families cope during illness
- Practices person-centred palliative care that incorporates the unique contributions of the family
- Applies a dignity conserving approach to care when providing support
- Conserves dignity of the person by facilitating expression of needs, hopes, feelings and concerns when planning palliative care
- Facilitates empathic and responsive relationships between those experiencing life-limiting conditions and their care team
- Interprets the impact of family role change for the person and family in palliative care
- Demonstrates leadership that encourages colleagues to foster a caring environment that supports all staff working in sensitive situations
- Demonstrates understanding of the role and function of the Interdisciplinary Care Team in palliative care
- Demonstrates understanding of the role and function of the Specialist Palliative Care Team, including volunteers, and refers appropriately
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
- Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community
- Demonstrates understanding of palliative care standards, guidelines and policies

## *Respiratory Therapist Specific Competencies:*

- Describes the role of Respiratory Therapy in palliative care
- Recognizes that a palliative approach to care should be considered for individuals with end-stage chronic obstructive pulmonary disorder (COPD), cardiac disease and neuromuscular diseases

## Cultural Safety and Humility

- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society

- Demonstrates understanding of the Indigenous Wellness Framework
- Demonstrates openness and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preference and accommodates these
- Recognizes personal biases and values that may influence care and identifies mechanisms to overcome these to ensure they do not impact care and treatment
- Assesses the unique needs and preferences of the individual and their family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age, and ability
- Validates and preserves cultural preferences and values by identifying ways to accommodate them into goal setting, decision making and care planning
- Recognizes and respects who the person identifies as family, and responds to family members' unique needs and experiences
  - Considers the community, as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people

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### Communication

- Demonstrates understanding of the essential role communication plays in palliative care
- Demonstrates understanding that communication regarding palliative and end-of-life care is an on-going collaborative process
  - Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
- Recognizes the multidimensional communication challenges that arise when caring for people with life-limiting conditions
- Assesses the person's and family's understanding of the life-limiting condition and its trajectory and uses this to inform their communication approach
- Recognizes the potential for conflict in palliative care decision-making and contributes to its management
- Supports individuals to make informed decisions on the depth of information about diagnosis, prognosis and disease progression they wish to receive and share with their families
- Provides culturally relevant information and resources to support individuals and families, particularly when caring for those from First Nations, Inuit, Métis and urban Indigenous communities
- Invites, facilitates and respects the involvement of the person, their family and their care team in discussions regarding the plan of care
  - Recognizes that communication and decision-making may involve the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Recognizes that family conversations may involve children and different communication approaches may be required
- Evaluates communication with the person and their family/caregiver to ensure their care plan meets the person's identified needs
  - Identifies the importance of community care plans when caring for First Nations, Inuit, Métis and urban Indigenous people

- Uses a variety of strategies to engage in highly skilled, compassionate, individualized and timely communication with the person, their family, their caregiver(s) and their care team
- Maintains ongoing communication with the person, family and their care team regarding the end-of-life plan of care
  - Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates expertise as a mediator and advocate for appropriate and timely access to palliative care
- Demonstrates self-awareness of responses to communication challenges and remains engaged in meaningful contact with the person, their family and their caregiver(s)
- Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
  - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family

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### Optimizing Comfort and Quality of Life

- Recognizes how a palliative approach can enhance the assessment and management of symptoms
- Recognizes common trajectories of life-limiting conditions, including common symptoms
- Applies comprehensive knowledge and understanding of the clinical presentation and disease trajectories of life-limiting conditions when responding to complex and multidimensional care needs, in order to comprehensively identify current and prospective clinical issues in palliative care
- Anticipates and predicts the needs of the person who has been diagnosed with a life-limiting illness based on known disease trajectories
- Demonstrates understanding of the concept of ‘total pain’
- Demonstrates understanding of the causes of common non-pain symptoms at end-of-life
- Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Applies the principles of pain and symptom management
- Demonstrates understanding of the potential barriers to providing pain management, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Discusses the benefits and burdens of palliative treatment options to assist the person in meeting their goals of care
- Implements evidence informed pharmacological and non-pharmacological approaches for pain and symptom management to promote comfort and quality of life
  - Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Applies interprofessional approaches to optimize comfort and enhance quality of life of the person and their family

- Recognizes the need for a change in the focus of care and treatment goals at critical decision points in the course of a life-limiting condition
- Provides education and practical strategies to the person, family and caregivers regarding the management of pain and symptoms
- Interprets the impact of family role change when formulating relevant and realistic care plans
- Supports the person, family, Substitute Decision Maker (SDM) and care teams with end-of-life decision making, including withdrawing or withholding interventions
- Recognizes and anticipates the physical, psychological, social and spiritual issues that affect the person and their family
- Demonstrates awareness of one's own responses in the presence of a person who is suffering
- Provides care in a compassionate manner
- Provides care in keeping with the person's expressed wishes and identified goals of care

#### *Respiratory Therapist Specific Competencies:*

- Assesses the benefits, burdens and risks of clinical interventions
  - Makes decisions regarding the appropriateness of interventions for each person living with a life-limiting condition, taking into consideration the person's expressed wishes and identified goals of care
- Acts as an expert resource regarding the role of discipline-specific interventions in symptom management and optimizing quality of life
- Assesses dyspnea on the basis of a variety of considerations, including the person's self-reporting, clinical signs, lung function tests and oxygen saturation
- Uses pharmacological and non-pharmacological interventions to reduce dyspnea
  - Manages upper and lower airway secretions at the end-of-life
  - Manages coughing
  - Manages oxygen to control dyspnea
- Develops respiratory care plans for individuals with palliative care needs, taking into account the person's goals and expectations
- Implements respiratory care plans for individuals with palliative care needs
- Administers cardio-pulmonary diagnostic tests for individuals with palliative care needs
- When in keeping with the person's goals of care, performs invasive vascular procedures for individuals with palliative care needs
- When in keeping with the person's goals of care, implements or withdraws treatment, including invasive and non-invasive mechanical ventilation

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#### **Care Planning and Collaborative Practice**

- Understands the collaborative relationship between the person, health professionals, family and caregivers
  - Recognizes that care planning and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Effectively collaborates with the Interdisciplinary Care Team to manage pain and symptoms
- Recognizes the overall impact of a life-limiting condition on the person and family and provides support to address identified needs
- Identifies priorities and concerns in collaboration with the person and family, taking into account their coping strategies and perception of diagnosis

- Familiar with the Health Care Consent Act, and understands that a health provider must obtain informed consent from the person (or, if they are incapable, their Substitute Decision Maker) for any treatment or intervention proposed
- Understands how a Substitute Decision Maker (SDM) is determined (based on the hierarchy within the Health Care Consent Act) and the role the SDM plays in making health care decisions if the person is not capable
- Supports the person to express their wishes and/or identify their goals of care by referring them to the most appropriate health professional
- Facilitates the active involvement of the person in goal setting, decision making and informed consent to support the best possible outcomes and quality of life
- Demonstrates flexibility in relation to care planning, acknowledging that a person's priorities can shift as their condition changes
- Develops therapeutic relationships with the person, their family, their caregivers and their care team to define goals of care and to develop, implement and evaluate a plan of care
- Identifies the person's and family's values, beliefs and preferences regarding the various components of palliative care provision
- Effectively collaborates with care teams to manage pain and symptoms
- Collaborates with the person and family to identify resources that will provide support throughout their illness and during end-of-life care
- Facilitates conversations to support end-of-life decision making and informed consent
- Facilitates informed decision-making by the person regarding place of care, while identifying risks in a supportive manner
- When able, provides care in the person's preferred place, while recognizing the complexities and challenges involved for the person, their family and their caregiver(s)
- Anticipates factors/conditions that may affect the individual's cognition and functional capacity to make decisions including health status changes, and towards end-of-life
- Identifies how interprofessional practice enhances individual outcomes
- Uses shared scopes of practice to optimize care
- Collaborates within and between teams across the continuum of care to facilitate continuity in palliative care
- Recognizes clinical limitations and professional boundaries and refers to other colleagues appropriately and in a timely manner

#### *Respiratory Therapist Specific Competencies:*

- Demonstrates advanced level of clinical expertise and sensitivity in facilitating safe, smooth and seamless transitions of care for the person

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### **Last Days and Hours**

- Aware of best practices for expected death, including local and organizational policies and processes
- Anticipates, recognizes and responds to the signs of imminent death

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### **Loss, Grief and Bereavement**

- Recognizes a variety of psychological responses to diagnosis and the life-limiting condition
- Demonstrates knowledge of diverse perspectives on loss, grief, bereavement, and mourning to support others from a cross-cultural perspective
  - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people

- Recognizes the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief
- Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief
  - Understands cumulative grief which can be particularly significant in First Nations and Inuit communities
- Identifies those experiencing or at risk for complicated and disenfranchised grief, discusses, documents and refers as appropriate
- Demonstrates knowledge of networks and supports across a range of family needs into bereavement
- Provides appropriate guidance, support and information to families, caregivers, and others, based on awareness of culture and needs

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### Professional and Ethical Practice

- Anticipates and addresses ethical and legal issues that may be encountered when caring for individuals with life-limiting conditions
- Establishes and respects people's wishes regarding their care options and preferences
- Respects the person's decisions regarding initiating, not initiating, withholding and withdrawing dialysis, hydration, nutrition support, resuscitation and other life-prolonging/life-sustaining interventions
- Recognizes when personal beliefs, attitudes and values limit one's ability to be present and provides person-centred care; collaborates with others to ensure optimal care is provided
- Understands distinctions among ethical and legal concepts, such as: the principle of double effect, Palliative Sedation Therapy and Medical Assistance in Dying (MAID)
- Demonstrates knowledge of relevant legislation and policies, e.g. MAID, Child, Youth and Family Services Act, Adult Protection Act, the Health Care Consent Act, and the Substitute Decision Act
- Responds to inquiries regarding MAID in accordance with regulatory body's relevant guidelines and standards and employer policies.
- Applies a comprehensive understanding of contemporary legal, ethical and professional standards to the provision of quality palliative care
- Facilitates discussion and management of ethical and legal issues in conjunction with the person, their family and their care team
- Actively influences and promotes palliative care strategic initiatives and policy development

### *Respiratory Therapist Specific Competencies:*

- Demonstrates understanding of the potential management and ethical issues related to mechanical devices

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### Self-Care

- Demonstrates understanding of the personal impact of loss, grief and bereavement
- Recognizes one's own responses to loss and engages in activities that proactively support well-being and resilience
- Explores own attitudes regarding death, dying and caring for individuals with palliative care needs
- Demonstrates awareness of the impact of past experiences of suffering, death and dying when providing palliative care

- Understands and attends to own emotional responses that result from caring for individuals with palliative care needs
- Recognizes compassion fatigue in self and colleagues; intervenes and refers appropriately
- Engages in healthy activities that help prevent compassion fatigue
- Demonstrates understanding of the concept of good “helping relationships” when working with First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding of the concept of companioning particularly when working with First Nations, Inuit, Métis and urban Indigenous people
- Participates in community-driven debriefs when working with First Nations, Inuit, Métis and urban Indigenous people

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### Education and Evaluation

- Contributes to the evaluation of the quality of palliative care and the effectiveness of the palliative care system
- Critically evaluates outcomes against standards and guidelines
- Participates in palliative care continuing education opportunities
- Educates individuals, families and caregivers about palliative care and the palliative approach
- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

#### *Respiratory Therapist Specific Competencies:*

- Acts as an expert resource contributing to palliative care development and delivery

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### Advocacy

- Advocates for the needs, decisions and rights of the person by recognizing potential vulnerabilities
- Supports autonomous decision-making
- Promotes equitable and timely access to resources
  - Recognizes and mitigates potential barriers and limitations to supporting transitions between specialty care and primary care particularly in First Nations, Inuit, Métis and urban Indigenous communities
- Advocates for the development, maintenance and improvement of health care and social policies related to palliative care
- Advocates for health professionals to participate in palliative care continuing education opportunities
- Advocates for adequate resources to provide quality palliative care

## PALLIATIVE CARE COMPETENCIES FOR SOCIAL WORKERS

### Principles of Palliative Care

- Demonstrates understanding of the philosophy of palliative care
  - Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding that a palliative approach to care starts early in the trajectory of a progressive life-limiting condition, and may be appropriate at the time of diagnosis
- Demonstrates the ability to describe the meaning of the term 'life-limiting condition'
- Applies the principles of palliative care that affirm life, offers a support system to help individuals live as actively as possible until death, with optimal quality of life and helps families cope during illness
- Conserves dignity of the person by facilitating expression of needs, hopes, feelings and concerns when planning palliative care and throughout the course of palliative care delivery
- Interprets the impact of family role change for the person and family in palliative care
- Demonstrates understanding of the role and function of the Interdisciplinary Care Team in palliative care
- Demonstrates understanding of the role and function of the Specialist Palliative Care Team, including volunteers, and refers appropriately
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
  - Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community
- Demonstrates understanding of palliative care standards, guidelines and policies

### *Social Work Specific Competencies:*

- Demonstrates understanding of the impact that psychological responses, social stressors and spiritual dimensions of loss have on the mental health and decision making of the person and takes these into account when planning care
- Identifies and addresses specific barriers that impact the person, their family, and their caregiver(s)'s ability to access and make use of palliative care services

### Cultural Safety and Humility

- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates understanding of the Indigenous Wellness Framework
- Demonstrates openness and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preference and accommodates these
- Assesses the unique needs and preferences of the individual and their family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age, and ability

- Validates and preserves cultural preferences and values by identifying ways to accommodate them into goal setting, decision making and care planning
- Recognizes and respects who the person identifies as family, and responds to family members' unique needs and experiences
  - Considers the community, as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people
- Explores the person's and the families' cultural and religious needs, beliefs and preferences as they relate to palliative and end-of-life care
- Provides opportunities for the person and their family to exercise religious, cultural and spiritual rituals, customs, rites and beliefs throughout their illness trajectory, through end-of-life and bereavement

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### Communication

- Demonstrates understanding of the essential role communication plays in palliative care
- Demonstrates understanding that communication regarding palliative and end-of-life care is an on-going collaborative process
  - Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
- Recognizes the multidimensional communication challenges that arise when caring for people with life-limiting conditions
- Assesses the person's and their family's understanding of their life limiting condition
- Recognizes the potential for conflict in palliative care decision-making and contributes to its management
- Supports individuals to make informed decisions on the depth of information about diagnosis, prognosis and disease progression they wish to receive and share with their families
- Provides culturally relevant information and resources to support individuals and families, particularly when caring for those from First Nations, Inuit, Métis and urban Indigenous communities
- Invites, facilitates and respects the involvement of the person, family and their care teams in discussions regarding the plan of care
  - Recognizes that communication and decision-making may involve the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Recognizes that family conversations may involve children and different communication approaches may be required
- Evaluates communication with the person and their family/caregiver to ensure their care plan meets the person's identified needs
  - Identifies the importance of community care plans when caring for First Nations, Inuit, Métis and urban Indigenous people
- Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous people

- Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
  - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family

#### *Social Work Specific Competencies:*

- Assesses and reassess the person and their family's current understanding of the person's health status and their need for more information
- Supports colleagues to address questions regarding diagnosis and prognosis in an empathic manner, taking into account the person's needs and wishes
- Supports the person and their family/caregiver(s) to adjust to their life-limiting condition and to understand its potential impact on their welfare, mental health and well-being
- Assists in the mediation of conflict in decision-making in the palliative care setting and works towards consensus building amongst and between the person, their family/caregiver(s) and the care team in care planning
- Supports parents/guardians and families in sharing difficult or bad news, relating to illness or death with children and vulnerable adults, facilitating direct supportive communication with them, where appropriate

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#### **Optimizing Comfort and Quality of Life**

- Recognizes how a palliative approach can enhance the assessment and management of symptoms
- Recognizes common trajectories of life-limiting conditions, including common symptoms
- Anticipates and predicts the needs of the person who has been diagnosed with a life-limiting illness based on known disease trajectories
- Evaluates non-complex interventions and proposes alternatives if necessary
- Demonstrates understanding of the concept of 'total pain'
- Demonstrates understanding of the causes of common non-pain symptoms at end-of-life
- Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Applies the principles of pain and symptom management
- Demonstrates understanding of the potential barriers to providing pain management, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Applies interprofessional approaches to optimize comfort and enhance quality of life of the person and their family
- Recognizes the ways in which the person can be engaged in self-management of their condition
- Recognizes the need for a change in the focus of care and treatment goals at critical decision points in the course of a life-limiting condition
- Provides education and practical strategies to the person, family and caregivers regarding the management of symptoms
- Uses non-pharmacological symptom management to promote comfort and quality of life

- Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Interprets the impact of family role change when formulating relevant and realistic care plans
- Supports the person, family, Substitute Decision Maker (SDM) and care teams with end-of-life decision making, including withdrawing or withholding interventions
- Recognizes and anticipates the physical, psychological, social and spiritual issues that affect the person and their family
- Demonstrates knowledge of the goals, strengths and limitations of care options
- Demonstrates awareness of one's own responses in the presence of a person who is suffering
- Provides care in a compassionate manner
- Provides care in keeping with the person's expressed wishes and identified goals of care

#### *Social Work Specific Competencies:*

- Recognizes a variety of psychosocial responses to diagnosis of a life-limiting condition.
- Assesses the benefits, burdens and risks of clinical interventions, and helps to identify those which may be appropriate for individuals living with a life-limiting condition
- Demonstrates knowledge of diverse psychosocial interventions relevant to various and changing care needs including legacy work, life review, and purposeful conversations about suffering and meaning
- Recognizes and addresses the socio-economic impact of a life-limiting diagnosis on the person and family
- Facilitates access to and provides supports for benefits and services that may ease economic and social distress
- Demonstrates respect for a person's self-determination to die as they like and facilitates the achievement of this within the scope of applicable law
- Demonstrates understanding of the intersection of the social determinants of health and barriers to access services, and identifies strategies for advocacy

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#### **Care Planning and Collaborative Practice**

- Understands the collaborative relationship between the person, health professionals, family and caregivers
  - Recognizes that care planning and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Effectively collaborates with the care team to manage pain and symptoms
- Recognizes the overall impact of a life-limiting condition on the person and their family and provides support to address identified needs
- Identifies priorities and concerns in collaboration with the person and family, taking into account their coping strategies and perception of diagnosis
- Familiar with the Health Care Consent Act, and understands that a health provider must obtain informed consent from the person (or, if they are incapable, their Substitute Decision Maker) for any treatment or intervention proposed
- Understands how a Substitute Decision Maker (SDM) is determined (based on the hierarchy within the Health Care Consent Act, 1996) and the role the SDM plays in making health care decisions if the person is not capable

- Demonstrates understanding of Advance Care Planning (ACP), Goals of Care (GOC), and Health Care Consent (HCC), and an appreciation of the appropriate time(s) to engage in discussions regarding goals and preferences for care
- Encourages the person to engage in ACP with their Substitute Decision Maker, and to share their wishes with their family and their caregiver(s)
- Facilitates the active involvement of the person in goal setting, decision making and informed consent to support the best possible outcomes and quality of life
- Demonstrates ability to elicit what is important to the person, including their wishes, values and beliefs, in relation to their care to facilitate effective ACP, and GOC discussions.
- Demonstrates flexibility in relation to care planning, acknowledging that a person's priorities can shift as their condition changes
- Facilitates informed decision-making by the person regarding place of care, while identifying risks in a supportive manner
- When able, provides care in the person's preferred place, while recognizing the complexities and challenges involved for the person, their family and their caregiver(s)
- Anticipates factors/conditions that may affect the individuals cognition and functional capacity to make decisions including health status changes, and towards end-of-life
- Identifies how interprofessional practice enhances individual outcomes
- Recognizes clinical limitations and professional boundaries and refers to other colleagues appropriately and in a timely manner

#### *Social Work Specific Competencies:*

- Conducts a comprehensive psychosocial assessment of the person and with their consent, shares these findings with the team to inform care planning and delivery of services
- Shares professional knowledge and expertise regarding psychosocial issues in palliative care and at end-of-life, with the care teams to support best outcomes and a high quality of care
- Identifies barriers to care and plans for continuity of care as needs change along the trajectory of a life-limiting condition
- Ensures psychosocial care is core to caring for the person, their family, and their care teams
- Aware of and works within policies and regulations regarding patient confidentiality when sharing information with the person's family and the interdisciplinary care team
- Encourages, supports and facilitates discussions regarding ethical differences
- Educates team members regarding psychosocial assessment and care
- Engages the care teams in self-reflective practice
- Identifies and champions successful person-centred care, quality improvement, strategic thinking and program development initiatives

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#### **Last Days and Hours**

- Aware of best practices for expected death, including local and organizational policies and processes
- Assists the person and their family to prepare for the time of death
  - Supports planning for expected deaths, particularly when caring for First Nations, Inuit, Métis and urban Indigenous in the community
- Anticipates, recognizes and responds to the signs of imminent death
- Supports the family's wishes and death rituals

- Provides opportunities for family and the extended community to gather and be together, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people

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### **Loss, Grief and Bereavement**

- Demonstrates knowledge of current grief and bereavement theory and evidence based practice to support others from a cross-cultural perspective
  - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people
- Recognizes the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief
- Understands, recognizes and manages pathological responses to loss, referring appropriately to the Specialist Palliative Care Team, or other interdisciplinary care team members as appropriate
- Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief
- Understands cumulative grief which can be particularly significant in First Nations and Inuit communities
- Provides appropriate guidance, support and information to families and caregivers, based on awareness of culture and needs, and directs them to bereavement services as required

#### *Social Work Specific Competencies:*

- Demonstrates and articulates self-care strategies for coping with death, grief and loss
- Demonstrates understanding of the needs of children of various developmental stages in dealing with grief and loss of a parent or sibling
- Demonstrates the ability to work in partnership with parents, guardians and family to prepare and support children and vulnerable adults for the loss of family member and refers as needed
- Facilitates the person and their family to express their thoughts and feelings relating to illness and loss
- Assists the family to access bereavement information and support, at a level that is appropriate to their needs
- Demonstrates knowledge of networks and supports across a range of family needs into bereavement
- Provides bereavement support in individual and group settings, with referral to others, where appropriate
- Accurately assesses the person's and family's loss, grief and bereavement needs
- Identifies those experiencing or at risk for complicated and disenfranchised grief, discusses, documents and refers appropriately

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### **Professional and Ethical Practice**

- Anticipates and addresses ethical and legal issues that may be encountered when caring for individuals with life-limiting conditions
- Establishes and respects people's wishes regarding their care options and preferences
- Respects the person's decisions regarding initiating, not initiating, withholding and withdrawing dialysis, hydration, nutrition support, resuscitation and other life-prolonging/life-sustaining interventions

- Recognizes when personal beliefs, attitudes and values limit one's ability to be present and provide person-centred care; collaborates with others to ensure optimal care is provided
- Understands distinctions among ethical and legal concepts, such as: the principle of double effect, Palliative Sedation Therapy and Medical Assistance in Dying (MAID)
- Demonstrates knowledge of relevant legislation and policies, e.g. MAID, Child, Youth and Family Services Act, Adult Protection Act, the Health Care Consent Act, and the Substitute Decision Act
- Recognizes and respects responsibility to care for the person in a manner that ensures their comfort and dignity
- Recognizes the impact on self as the result of caring for the dying and bereaved

#### *Social Work Specific Competencies:*

- Establishes and respects the person's right to self-determination regarding care options and preferences, including, but not limited to:
  - Recognizing a person's right to make informed decisions to refuse treatment(s)
  - Seeking, responding to and implementing a person's preferences regarding place of care
  - Respecting the person's values, expressed wishes and identified goals of care
  - Recognizing palliative care ethical dilemmas and engaging all parties in a process to address dilemmas
  - MAID
- Ensures a focus on transference, counter-transference and self-care
- Demonstrates the ability to support the care teams in their efforts to be self-reflective, with a particular focus on understanding risks for compassion fatigue.

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#### **Self-Care**

- Demonstrates understanding of the personal impact of loss, grief and bereavement
- Recognizes one's own responses to loss and engages in activities that support well-being and resilience
- Explores own attitudes regarding death, dying and caring for individuals requiring palliative care
- Demonstrates awareness of the impact of past experiences of suffering, death and dying when providing palliative care
- Understands and attends to own emotional responses that result from caring for individuals with palliative care needs
- Recognizes compassion fatigue in self and colleagues
- Practices self-care to maintain resilience, competence and compassion
- Engages in healthy activities that help prevent compassion fatigue
- Demonstrates understanding of the concept of good "helping relationships" when working with First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding of the concept of companionship particularly when working with First Nations, Inuit, Métis and urban Indigenous people
- Participates in community-driven debriefs when working with First Nations, Inuit, Métis and urban Indigenous people

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### Education and Evaluation

- Critically evaluates outcomes against standards and guidelines
- Regularly evaluates clinical and program processes and outcomes to ensure the needs of the person are clearly identified and are responded to as effectively as possible
- Conducts evaluations with the person, their family, and their care team to enhance and assure consistent quality of care
- Uses various tools and strategies to evaluate individual, family and group interventions, program processes and goal attainment
- Participates in palliative care continuing education opportunities
- Educates the person, their family, and their caregiver(s) about palliative care and the palliative approach
- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

## ADDITIONAL COMPETENCIES FOR SOCIAL WORKERS SPECIALIZING IN PALLIATIVE CARE

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### Principles of Palliative Care

- Applies a dignity conserving approach to care when providing support
- Demonstrates leadership that encourages colleagues to foster a caring environment that supports all staff working in sensitive situations
- Demonstrates knowledge of theories that are pertinent to palliative care practice
- Demonstrates understanding of the impact of dying, death and bereavement on the person, their family, their caregiver(s) and health professionals
- Demonstrates understanding of micro and macro factors that promote or constrain palliative care
- Demonstrates understanding of palliative care resources and services
- Demonstrates understanding of palliative care standards, guidelines and policies

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### Cultural Safety and Humility

- Demonstrates knowledge of different cultural needs regarding access and utilization of palliative care and bereavement services
- Demonstrates understanding of the barriers for marginalized and vulnerable groups at end-of-life and in bereavement

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### Communication

- Demonstrates expertise as a mediator and advocate for appropriate and timely access to palliative care

#### *Social Work Specific Competencies:*

- Demonstrates knowledge of key stressors and conflicts often faced by the person and their family through the course of their illness, at end-of-life and in bereavement
- Demonstrates the ability to apply a framework that considers timing, readiness and approaches to sharing information that is consistent with the person and family's wishes and coping

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### Optimizing Comfort and Quality of Life

- Applies comprehensive knowledge and understanding of the clinical presentation and disease trajectories of life-limiting conditions when responding to complex and multidimensional care needs, in order to comprehensively identify current and prospective clinical issues in palliative care
- Discusses the benefits and burdens of palliative treatment options to assist the person in meeting their goals of care
- Demonstrates understanding of diagnoses, trajectories of life-limiting conditions, pain and symptom management and related psychosocial issues
- Demonstrates knowledge of assessment tools and strategies relevant to medical, psychosocial and spiritual dimensions of palliative care
- Acts as an expert resource regarding the role of discipline-specific interventions in symptom management and optimizing quality of life

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### Care Planning and Collaborative Practice

- Demonstrates a comprehensive understanding of the role of the Specialist Palliative Care Team and that of each member, including volunteers
- Identifies and supports the navigation of the full range and continuum of palliative care services, resources and the settings in which they are available
  - Demonstrates knowledge of the range of palliative care services and resources
  - Provides relevant information and resources to the person and family
  - Identifies and accesses services and resources specific to the person's goals of care
  - Initiates referrals to and requests for resources, services and settings
  - Facilitates access for the person and their family to needed services and resources

#### *Social Work Specific Competencies:*

- Demonstrates clinical expertise and sensitivity in facilitating safe, smooth and seamless transitions of care for the person
  - Supports the discharge planning process to facilitate smooth transitions particularly when caring for First Nations and Inuit people and dual providers may be involved
- Demonstrates understanding of social, cultural and spiritual issues and power differentials as integral to care planning
- Demonstrates knowledge of the bio-psychosocial processes and experiences of a person who is dying and their family/caregiver(s)

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### Care Delivery

- Demonstrates the ability to work with people at all ages (advanced knowledge of age-appropriate intervention for all developmental stages)
- Demonstrates the ability to regularly review and adjust care delivery according to changing needs throughout the course of a life-limiting condition, into bereavement
- Demonstrates understanding of barriers to accessing palliative care
- Demonstrates understanding of ethical and legal principles in providing care at the end-of-life
- Demonstrates understanding of the Ontario Drug Benefits Formulary and the Palliative Care Facilitated Access mechanism

#### *Social Work Specific Competency:*

- Provides both individual and family counselling through social work frameworks that involve: systems and ecological perspectives, strengths perspective, problem-solving approach, feminist approach and structural approach

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### Loss, Grief and Bereavement

- Demonstrates a comprehensive knowledge of the grieving process and reactions in order to support the person and their family throughout the disease trajectory
- Demonstrates the ability to proactively respond to complex grief reactions and processes using own skills or appropriate referral

#### *Social Work Specific Competency:*

- Mentors and educates colleagues regarding the personal impact of loss, grief and bereavement, supporting them to recognize their own loss responses and encouraging engagement in activities to maintain their resilience on an on-going basis

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### Professional and Ethical Practice

- Applies a comprehensive understanding of contemporary legal, ethical and professional standards to the provision of quality palliative care
- Facilitates discussion and management of ethical and legal issues in conjunction with the person, their family, and their care team
- Actively influences and promotes palliative care strategic initiatives and policy development
- Demonstrates knowledge regarding potential ethical and moral challenges in palliative care

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### Research, Education and Evaluation

- Applies knowledge gained from palliative care research
- Where possible, leads, facilitates and engages in education and research
- Contributes to the evaluation of the quality of palliative care and the effectiveness of the Specialist Palliative Care Team
- Where possible, provides the family with opportunities to participate in palliative and end-of-life caregiving research
- Demonstrates the ability to provide education to build palliative care capacity
- Demonstrates the ability to plan, implement and evaluate palliative care services
- Acts as an expert resource contributing to palliative care development and delivery

#### *Social Work Specific Competencies:*

- Where possible, identifies the opportunities for and barriers to palliative care research
- Demonstrates the ability to bring a psychosocial perspective to the development and implementation of both social work and the interprofessional education and, where possible research initiatives
- Demonstrates the ability to educate others regarding psychosocial palliative care
- Develops, facilitates and provides palliative care related education, research, leadership and mentorship to members of the discipline and students

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### Advocacy

- Applies knowledge gained from palliative care research
- Where possible, leads, facilitates and engages in palliative care education and research
- Advocates for health professionals to have adequate resources to provide quality palliative care
- Advocates for the development, maintenance and improvement of health care and social policies related to palliative care
- Identifies the determinants of health for the populations served and contributes to efforts to ensure equity, including, but not limited to: barriers to access to palliative care and resources, availability of Primary Care, Interdisciplinary Care Teams and Specialized Services, delayed or lack of identification of individuals who would benefit from palliative care, lack of availability of community-based resources, geographic inequities and inequities for vulnerable and marginalized populations, poverty, cost of dying at home
  - Recognizes and mitigates potential barriers and limitations to supporting transitions between specialty care and primary care particularly in First Nations, Inuit, Métis and urban Indigenous communities
- Promotes Advance Care Planning, Goals of Care, and Health Care Consent in alignment with Ontario legislation
- Identifies organizational issues that affect the delivery of palliative care

- Participates as a member of organizations which advocate for equitable, accessible, safe and quality palliative care
  - Describes the role of the Canadian Hospice Palliative Care Association, the Ontario Palliative Care Network, and Hospice Palliative Care Ontario in advocating for individuals with palliative care needs
  - Describes how changes in legislation could affect individuals with palliative care needs
  - Describes how changes in funding and structure of the health system could affect delivery of palliative care
  - Identifies points of influence in the health system that could advance palliative care issues
  - Describes the moral, ethical and professional issues inherent in health advocacy related to palliative care
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### **Community Capacity Building**

- Demonstrates understanding of formal and informal palliative care community resources and their strengths, limitations and gaps
- Demonstrates knowledge of the theory and practice of community development and palliative care models, including: community capacity building, social planning, locality development, social action and pragmatic community organizing
- Demonstrates the ability to apply the theory and evidence-based practice in community development to meet diverse palliative care needs in the community

## PALLIATIVE CARE COMPETENCIES FOR SPEECH LANGUAGE PATHOLOGISTS

### Principles of Palliative Care

- Demonstrates understanding of the philosophy of palliative care
  - Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding that a palliative approach to care starts early in the trajectory of a progressive life-limiting condition, and may be appropriate at the time of diagnosis
- Demonstrates the ability to describe the meaning of the term ‘life-limiting condition’
- Applies the principles of palliative care that affirm life, offers a support system to help individuals live as actively as possible until death, with optimal quality of life and helps families cope during illness
- Conserves dignity of the person by facilitating expression of needs, hopes, feelings and concerns when planning palliative care and throughout the course of palliative care delivery
- Interprets the impact of family role change for the person and family in palliative care
- Demonstrates understanding of the role and function of the Interdisciplinary Care Team in palliative care
- Demonstrates understanding of the role and function of the Specialist Palliative Care Team, including volunteers, and refers appropriately
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
  - Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community
- Demonstrates understanding of palliative care standards, guidelines and policies

### Cultural Safety and Humility

- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates understanding of the Indigenous Wellness Framework
- Demonstrates openness, sensitivity, and acceptance of social, spiritual and cultural values and practices that may influence individual and family preference and accommodates these
- Assesses the unique needs and preferences of the individual and their family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age, and ability
- Validates and preserves cultural preferences and values by identifying ways to accommodate them into goal setting, decision making and care planning
- Recognizes and respects who the person identifies as family, and responds to family members’ unique needs and experiences
  - Considers the community as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people

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## Communication

- Demonstrates understanding of the essential role communication plays in palliative care
- Demonstrates understanding that communication regarding palliative and end-of-life care is an on-going collaborative process
  - Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
- Recognizes the multidimensional communication challenges that arise when caring for people with life-limiting conditions
- Assesses the person's and family's understanding of the life-limiting condition and its trajectory and uses this to inform their communication approach
- Recognizes the potential for conflict in palliative care decision-making and contributes to its management
- Supports individuals to make informed decisions on the depth of information about diagnosis, prognosis and disease progression they wish to receive and share with their families
- Provides culturally relevant information and resources to support individuals and families, particularly when caring for those from First Nations, Inuit, Métis and urban Indigenous communities
- Invites, facilitates and respects the involvement of the person, family and their care teams in discussions regarding the plan of care
  - Recognizes that communication and decision-making may involve the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Recognizes that family conversations may involve children and different communication approaches may be required
- Evaluates communication with the person and their family/caregiver to ensure their care plan meets the person's identified needs
  - Identifies the importance of community care plans when caring for First Nations, Inuit, Métis and urban Indigenous people
- Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous people
- Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
  - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family

### *Speech Language Pathology Specific Competencies:*

- Communicates functional status regarding communication and disorders of feeding, eating, drinking and swallowing and likely progression in an accurate and compassionate manner, accounting for the person's needs and wishes and possible changes in function

- Demonstrates expertise as a mediator, educator and advocate for the person regarding initiating, withdrawing and withholding artificial hydration and nutrition
- Demonstrates expertise in supporting and teaching communication skills to the Interdisciplinary Care Team

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### Optimizing Comfort and Quality of Life

- Recognizes how a palliative approach can enhance the assessment and management of symptoms
- Recognizes common trajectories of life-limiting conditions, including common symptoms and how this impacts care delivery (e.g., expected prognosis, care planning, urgency of response to referrals, appropriate frequency or time for follow-up)
- Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Anticipates and predicts the needs of the person who has been diagnosed with a life-limiting illness based on known disease trajectories
- Evaluates non-complex interventions and proposes alternatives if necessary
- Demonstrates understanding of the concept of 'total pain'
- Demonstrates understanding of the causes of common non-pain symptoms at end-of-life
- Applies the principles of pain and symptom management
- Demonstrates understanding of the potential barriers to providing pain management, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Applies interprofessional approaches to optimize comfort and enhance quality of life of the person and their family
- Recognizes the ways in which the person can be engaged in self-management of their condition
- Recognizes the need for a change in the focus of care and treatment goals at critical decision points in the course of a life-limiting condition
- Provides education and practical strategies to the person, family and caregivers regarding the management of pain and symptoms
- Uses non-pharmacological symptom management to promote comfort and quality of life
  - Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Interprets the impact of family role change when formulating relevant and realistic care plans
- Supports the person, family, Substitute Decision Maker (SDM) and care teams with end-of-life decision making, including withdrawing or withholding interventions
- Recognizes and anticipates the physical, psychological, social and spiritual issues that affect the person and their family
- Demonstrates awareness of one's own responses in the presence of a person who is suffering
- Provides care in a compassionate manner
- Provides care in keeping with the person's expressed wishes and identified goals of care

### *Speech Language Pathology Specific Competencies:*

- Assesses the benefits, burdens and risks of clinical interventions

- Makes decisions regarding the appropriateness of interventions for each person living with a life-limiting condition, taking into consideration the person's expressed wishes and identified goals of care
- Demonstrates the ability to assess caregivers' skills and need for training and support, to assist with safe swallowing techniques, and communication strategies
- Demonstrates advanced ability to assess the benefits, burdens and risks of Speech language Pathology (SLP) interventions
- Demonstrates the ability to manage decisions regarding withdrawing or postponing SLP interventions.
- Demonstrates the ability to identify the psychosocial impact of diminishing communication and swallow function providing modifications to facilitate social participation
- Demonstrates expertise in facilitating persons' identification of personally significant functional communication activities, empowering participation through supportive conversation and total communication approaches
- Demonstrates expert knowledge of the impact of symptoms such as pain, dyspnea, nausea, anxiety and depression that effect swallowing function and communication performance, along with the strategies required to manage them
- Uses compensatory and rehabilitation approaches to alleviate symptoms and optimize effective, pleasurable and safe participation in activities
- Demonstrates expertise in assessing individuals for assistive communication technology
- Provides recommendations for devices and modifications that promote communicative autonomy for the person
- Assists the interdisciplinary care team in maximizing communicative access to promote autonomy for the person
- Seeks to identify the persons values and goals to understand what a good death means for the individual, particularly as it pertains to communication/swallowing

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### Care Planning and Collaborative Practice

- Understands the collaborative relationship between the person, health professionals, family and caregivers
  - Recognizes that care planning and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Effectively collaborates with the care team to manage pain and symptoms
- Recognizes the overall impact of a life-limiting condition on the person and family and provides support to address identified needs
- Identifies priorities and concerns in collaboration with the person and family, taking into account their coping strategies and perception of diagnosis
- Familiar with the Health Care Consent Act, and understands that a health provider must obtain informed consent from the person (or, if they are incapable, their Substitute Decision Maker) for any treatment or intervention proposed
- Understands how a Substitute Decision Maker (SDM) is determined (based on the hierarchy within the Health Care Consent Act) and the role the SDM plays in making health care decisions if the person is not capable
- Supports the person to express their wishes and/or identify their goals of care by referring them to the most appropriate health professional

- Facilitates the active involvement of the person in goal setting, decision making and informed consent to support the best possible outcomes and quality of life
- Demonstrates flexibility in relation to care planning, acknowledging that a person's priorities can shift as their condition changes
- Facilitates informed decision-making by the person regarding place of care, while identifying risks in a supportive manner
- When able, provides care in the person's preferred place, while recognizing the complexities and challenges involved for the person, their family and their caregiver(s)
- Anticipates factors/conditions that may affect the individual's cognition and functional capacity to make decisions including health status changes, and towards end-of-life
- Identifies how interprofessional practice enhances individual outcomes

#### *Speech Language Pathology Specific Competencies:*

- Demonstrates advanced level of clinical expertise and sensitivity in facilitating a safe, smooth and seamless transition of care between care settings for individuals with complex communication, cognitive-communication and feeding, eating, drinking and swallowing needs
- Provides expertise on the role of SLP in symptom management and optimizing quality of life
- Accesses expertise of the care team in the pharmacological, behavioural, and environmental management of secretions, dyspnoea and anxiety which may impact upon safe and pleasurable engagement in eating, drinking, swallowing and communication
- Provides expertise to the care team where communication or swallowing impacts symptoms E.g., when swallowing prohibits ability to manage oral medications.

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#### **Last Days and Hours**

- Aware of best practices for expected death, including local and organizational policies and processes
- Anticipates, recognizes and responds to the signs of imminent death
- Supports the family's wishes and death rituals
  - Provides opportunities for family and the extended community to gather and be together, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people

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#### **Loss, Grief and Bereavement**

- Demonstrates knowledge of diverse perspectives on loss, grief, bereavement, and mourning to support others from a cross-cultural perspective
  - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people
- Recognizes the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief
- Understands, recognizes and manages pathological responses to loss, referring appropriately to the Specialist Palliative Care Team, or other interdisciplinary care team members as appropriate
- Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief
  - Understands cumulative grief which can be particularly significant in First Nations and Inuit communities

- Provides appropriate guidance, support and information to families and caregivers based on awareness of culture and needs, and directs them to bereavement services as required

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### Professional and Ethical Practice

- Anticipates and addresses ethical and legal issues that may be encountered when caring for individuals with life-limiting conditions
- Establishes and respects people's wishes regarding their care options and preferences
- Respects the person's decisions regarding initiating, not initiating, withholding and withdrawing dialysis, hydration, nutrition support, resuscitation and other life-prolonging/life-sustaining interventions
- Recognizes when personal beliefs, attitudes and values limit one's ability to be present and provide person-centred care; collaborates with others to ensure optimal care is provided
- Understands distinctions among ethical and legal concepts, such as: the principle of double effect, Palliative Sedation Therapy and Medical Assistance in Dying (MAID)
- Demonstrates knowledge of relevant legislation and policies, e.g. MAID, Child, Youth and Family Services Act, Adult Protection Act, the Health Care Consent Act, and the Substitute Decision Act
- Responds to inquiries regarding MAID in accordance with regulatory body's relevant guidelines and standards and employer policies.

#### *Speech Language Pathology Specific Competency:*

- Demonstrates the ability to use recognized ethical, legal and professional frameworks to guide SLP intervention in end-of-life decision making related to initiating, withdrawing and withholding artificial hydration and/or nutrition, as a result of severe oropharyngeal dysphagia

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### Self-Care

- Demonstrates understanding of the personal impact of loss, grief and bereavement
- Recognizes one's own responses to loss and engages in activities that support well-being and resilience
- Explores own attitudes regarding death, dying and caring for individuals requiring palliative care
- Demonstrates awareness of the impact of past experiences of suffering, death and dying when providing palliative care
- Understands and attends to own emotional responses that result from caring for individuals with palliative care needs
- Recognizes compassion fatigue in self and colleagues; intervenes and refers appropriately
- Engages in healthy activities that help prevent compassion fatigue
- Demonstrates understanding of the concept of good "helping relationships" when working with First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding of the concept of companionship particularly when working with First Nations, Inuit, Métis and urban Indigenous people
- Participates in community-driven debriefs when working with First Nations, Inuit, Métis and urban Indigenous people

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### Education and Evaluation

- Contributes to the evaluation of the quality of palliative care and the effectiveness of the palliative care system

- Participates in palliative care continuing education opportunities
- Educates individuals, families and caregivers about palliative care and the palliative approach
- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

*Speech Language Pathology Specific Competency:*

- Educates individuals, families, caregivers, interdisciplinary care team members, and other colleagues on the role of the Speech Language Pathologist in palliative care

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## **Advocacy**

- Advocates for the needs, decisions and rights of the person by recognizing potential vulnerabilities
- Promotes equitable and timely access to resources
  - Recognizes and mitigates potential barriers and limitations to supporting transitions between specialty care and primary care particularly in First Nations, Inuit, Métis and urban Indigenous communities
- Advocates for the development, maintenance and improvement of health care and social policies related to palliative care
- Advocates for health professionals to participate in palliative care continuing education opportunities
- Advocates for health professionals to have adequate resources to provide quality palliative care

*Speech Language Pathology Specific Competency:*

- Advocates for Speech Language Pathology (SLP) services or involvement where
  - SLP is not yet acknowledged as part of the care team
  - The benefit of SLP is not well understood

## PALLIATIVE CARE COMPETENCIES FOR SPIRITUAL CARE PRACTITIONERS

### Principles of Palliative Care

- Demonstrates understanding of the philosophy of palliative care
  - Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding that a palliative approach to care starts early in the trajectory of a progressive life-limiting condition, and may be appropriate at the time of diagnosis
- Demonstrates the ability to describe the meaning of the term ‘life-limiting condition’
- Applies the principles of palliative care that affirm life, offers a support system to help individuals live as actively as possible until death, with optimal quality of life and helps families cope during illness
- Conserves dignity of the person by facilitating expression of needs, hopes, feelings and concerns when planning palliative care and throughout the course of palliative care delivery
- Interprets the impact of family role change for the person and family in palliative care
- Demonstrates understanding of the role and function of the Interdisciplinary Care Team in palliative care
- Demonstrates understanding of the role and function of the Specialist Palliative Care Team, including volunteers, and refers appropriately
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
  - Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community
- Demonstrates understanding of palliative care standards, guidelines and policies

### *Spiritual Care Practitioner Specific Competencies:*

- Demonstrates understanding of world faiths, philosophies, beliefs, practices, cultures and traditions regarding life, illness, dying, death and bereavement
- Demonstrates the ability to articulate important spiritual, existential and emotional concepts for the person and family
- Offers support and encouragement to the care teams in order to promote well-being and self-care
- Engages respectfully and sensitively with the person and their family regarding their beliefs, fears, hopes and uncertainties regarding death and afterlife
- While respecting the person’s and family’s beliefs and wishes, ensures that end-of-life spiritual and/or religious rituals and/or sacraments are available
- Through spiritual accompaniment, helps the person make their final journey with dignity, peace and compassion, while also supporting the family
- Integrates spiritual and/or religious care into the appropriate palliative care setting

### Cultural Safety and Humility

- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples

- Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates understanding of the Indigenous Wellness Framework
- Demonstrates openness, sensitivity, and acceptance of social, spiritual and cultural values and practices that may influence individual and family preference and accommodates these
- Assesses the unique needs and preferences of the individual and their family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age, and ability
- Validates and preserves cultural preferences and values by identifying ways to accommodate them into goal setting, decision making and care planning
- Recognizes and respects who the person identifies as family, and responds to family members' unique needs and experiences
  - Considers the community, as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people
- Explores the person's and the families' cultural and religious needs, beliefs and preferences as they relate to palliative and end-of-life care
- Provides opportunities for the person and their family to exercise religious, cultural and spiritual rituals, customs, rites and beliefs throughout their illness trajectory, through end-of-life and bereavement

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### Communication

- Demonstrates understanding of the essential role communication plays in palliative care
- Demonstrates understanding that communication regarding palliative and end-of-life care is an on-going collaborative process
  - Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
- Recognizes the multidimensional communication challenges that arise when caring for people with life-limiting conditions
- Assesses the person's and family's understanding of the life-limiting condition and its trajectory and uses this to inform their communication approach
- Recognizes the potential for conflict in palliative care decision-making and contributes to its management
- Supports individuals to make informed decisions on the depth of information about diagnosis, prognosis and disease progression they wish to receive and share with their families
- Provides culturally relevant information and resources to support individuals and families, particularly when caring for those from First Nations, Inuit, Métis and urban Indigenous communities
- Invites, facilitates and respects the involvement of the person, family and their care teams in discussions regarding the plan of care
  - Recognizes that communication and decision-making may involve the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Recognizes that family conversations may involve children and different communication approaches may be required

- Evaluates communication with the person and their family/caregiver to ensure their care plan meets the person’s identified needs
  - Identifies the importance of community care plans when caring for First Nations, Inuit, Métis and urban Indigenous people
- Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous people
- Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
  - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family

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### Optimizing Comfort and Quality of Life

- Recognizes how a palliative approach can enhance the assessment and management of symptoms
- Recognizes common trajectories of life-limiting conditions, including common symptoms
  - Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Anticipates and predicts the needs of the person who has been diagnosed with a life-limiting illness based on known disease trajectories
- Demonstrates understanding of the concept of ‘total pain’
- Demonstrates understanding of the potential barriers to providing pain management, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding of the causes of common non-pain symptoms at end-of-life
- Applies interprofessional approaches to optimize comfort and enhance quality of life of the person and their family
- Recognizes the ways in which the person can be engaged in self-management of their condition
- Recognizes the need for a change in the focus of care and treatment goals at critical decision points in the course of a life-limiting condition
- Uses non-pharmacological symptom management to promote comfort and quality of life
  - Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Interprets the impact of family role change when formulating relevant and realistic care plans
- Supports the person, family, Substitute Decision Maker (SDM) and care teams with end-of-life decision making, including withdrawing or withholding interventions
- Recognizes and anticipates the physical, psychological, social and spiritual issues that affect the person and their family
- Demonstrates awareness of one’s own responses in the presence of a person who is suffering
- Provides care in a compassionate manner
- Provides care in keeping with the person’s expressed wishes and identified goals of care

### *Spiritual Care Practitioner Specific Competencies:*

- Engages the person and the family in discussions about the existential/spiritual angst of illness and suffering, seeking ways to ameliorate agony of mind, spirit and body, which are intimately connected
- Recognizes and anticipates the need to adapt the focus of spiritual care at critical points, supporting the person and family through times of transition
- Articulates the appropriate use of authority at key transitional moments in the spiritual companionship of the dying

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### **Care Planning and Collaborative Practice**

- Identifies how interprofessional practice enhances individual outcomes
- Understands the collaborative relationship between the person, health professionals, family and caregivers
  - Recognizes that care planning and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Effectively collaborates with the care team to manage pain and symptoms
- Recognizes the overall impact of a life-limiting condition on the person and family and provides support to address identified needs
- Identifies priorities and concerns in collaboration with the person and family, taking into account their coping strategies and perception of diagnosis
- Familiar with the Health Care Consent Act, and understands that a health provider must obtain informed consent from the person (or, if they are incapable, their Substitute Decision Maker) for any treatment or intervention proposed
- Understands how a Substitute Decision Maker (SDM) is determined (based on the hierarchy within the Health Care Consent Act, 1996) and the role the SDM plays in making health care decisions if the person is not capable
- Supports the person to express their wishes and/or identify their goals of care by referring them to the most appropriate health professional
- Facilitates the active involvement of the person in goal setting, decision making and informed consent to support the best possible outcomes and quality of life
- Demonstrates flexibility in relation to care planning, acknowledging that a person's priorities can shift as their condition changes
- Enables the person to make an informed decision regarding place of care
- When able, provides care in the person's preferred place, while recognizing the complexities and challenges involved for the person, their family and their caregiver(s)
- Anticipates factors/conditions that may affect the individual's cognition and functional capacity to make decisions including health status changes, and towards end-of-life
- Recognizes clinical limitations and professional boundaries and refers to other colleagues appropriately and in a timely manner

### *Spiritual Care Practitioner Specific Competencies:*

- Demonstrates the ability to assess, plan and communicate the spiritual needs of the person and family to their care teams
- Articulates and advocates for the place of spiritual and religious care in palliative and end-of-life care

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### Last Days and Hours

- Aware of best practices for expected death, including local and organizational policies and processes
- Anticipates, recognizes and responds to the signs of imminent death
- Supports the family's wishes and death rituals
  - Provides opportunities for family and the extended community to gather and be together, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Supports planning for expected deaths, particularly when caring for First Nations, Inuit, Métis and urban Indigenous in the community

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### Loss, Grief and Bereavement

- Demonstrates knowledge of diverse perspectives on loss, grief, bereavement, and mourning to support others from a cross-cultural perspective
  - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people
- Recognizes the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief
- Understands, recognizes and manages pathological responses to loss, referring appropriately to the Specialist Palliative Care Team, or other interdisciplinary care team members as appropriate
- Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief
  - Understands cumulative grief which can be particularly significant in First Nations and Inuit communities
- Provides appropriate guidance, support and information to families and caregivers, based on awareness of culture and needs, and directs them to bereavement services as required

#### *Spiritual Care Practitioner Specific Competencies:*

- Demonstrates cultural awareness of the nuances of pain, suffering, loss, complicated and anticipatory grief and life review
- Works in partnership with parents/guardians and family members to prepare and support children and vulnerable adults for the loss of loved ones
- Accurately assesses the person's and family's loss, grief and bereavement needs
- Identifies those experiencing or at risk for complicated and disenfranchised grief, discusses, documents and refers appropriately
- Plans and leads appropriate services/rituals, suitable for the time of dying or after death, that offer hope and comfort to persons from a diversity of cultural and faith traditions and to persons who represent a diversity of world views
- Works in partnership with the person's faith group, faith leaders and other community religious, spiritual and cultural resources to ensure that all sacramental, religious, faith based and ceremonial rituals are met in a timely and appropriate manner

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### Professional and Ethical Practice

- Anticipates and addresses ethical and legal issues that may be encountered when caring for individuals with life-limiting conditions
- Establishes and respects people's wishes regarding their care options and preferences

- Respects the person's decisions regarding initiating, not initiating, withholding and withdrawing dialysis, hydration, nutrition support, resuscitation and other life-prolonging/life-sustaining interventions
- Recognizes when personal beliefs, attitudes and values limit one's ability to be present and provide person-centred care; collaborates with others to ensure optimal care is provided
- Understands distinctions among ethical and legal concepts, such as: the principle of double effect, Palliative Sedation Therapy and Medical Assistance in Dying (MAID)
- Demonstrates knowledge of relevant legislation and policies, e.g. MAID, Child, Youth and Family Services Act, Adult Protection Act, the Health Care Consent Act, and the Substitute Decision Act
- Responds to inquiries regarding MAID in accordance with regulatory body's relevant guidelines and standards and employer policies.

#### *Spiritual Care Practitioner Specific Competencies:*

- Demonstrates maintenance of one's integrity and authenticity in practice during the process of assisting others in moral and ethical decisions
- Participates in family meetings honouring diverse ethnic, cultural, religious and faith traditions and philosophical world views
- Facilitates the discussion and management of ethical issues that may arise in palliative care

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#### **Self-Care**

- Demonstrates understanding of the personal impact of loss, grief and bereavement
- Recognizes one's own responses to loss and engages in activities that support well-being and resilience
- Explores own attitudes regarding death, dying and caring for individuals requiring palliative care
- Demonstrates awareness of the impact of past experiences of suffering, death and dying when providing palliative care
- Understands and attends to own emotional responses that result from caring for individuals with palliative care needs
- Recognizes compassion fatigue in self and colleagues; intervenes and refers appropriately
- Practices self-care to maintain resilience, competence and compassion
- Engages in healthy activities that help prevent compassion fatigue
- Demonstrates understanding of the concept of good "helping relationships" when working with First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding of the concept of companionship particularly when working with First Nations, Inuit, Métis and urban Indigenous people
- Participates in community-driven debriefs when working with First Nations, Inuit, Métis and urban Indigenous people

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#### **Education and Evaluation**

- Demonstrates familiarity with research in palliative care and uses this to inform practice
- Critically evaluates outcomes against standards and guidelines
- Contributes to the evaluation of the quality of palliative care
- Participates in palliative care continuing education opportunities
- Educates individuals, families and caregivers about palliative care and the palliative approach

- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

## ADDITIONAL COMPETENCIES FOR SPIRITUAL CARE PRACTITIONERS SPECIALIZING IN PALLIATIVE CARE

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### Principles of Palliative Care

- Applies a dignity conserving approach to care when providing support
- Facilitates empathic and responsive relationships between those experiencing life-limiting conditions and their care teams
- Demonstrates leadership that encourages colleagues to foster a caring environment that supports all staff working in sensitive situations
- Practices person-centred palliative care that incorporates the unique contributions of the family
- Demonstrates understanding of palliative care standards, guidelines and policies

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### Communication

- Uses a variety of strategies to engage in highly skilled, compassionate, individualized and timely communication with the person, their family, their caregivers and their care teams
- Maintains ongoing communication with the person, their family and their care teams regarding the end-of-life plan of care
- Demonstrates expertise as a mediator and advocate for appropriate and timely access to palliative care
- Demonstrates self-awareness of responses to communication challenges and remains engaged in meaningful contact with the person, their family, and their caregivers

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### Optimizing Comfort and Quality of Life

- Discusses the benefits and burdens of palliative treatment options to assist the person in meeting their goals of care
- Acts as an expert resource regarding the role of discipline-specific interventions

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### Care Planning and Collaborative Practice

- Demonstrates a comprehensive understanding of the role of the Specialist Palliative Care Team and that of each member, including volunteers
- Develops therapeutic relationships with the person, family, caregivers and care teams to define goals of care and to develop, implement and evaluate a plan of care
  - Facilitates individual and family participation in care planning
  - Identifies and integrates strengths of the person and the family in the plan of care
  - Safely and appropriately delegates aspects of care to the family
  - Identifies families in need of respite care and refers appropriately
  - Engages in family and team conferences
  - Develops a plan of care for the family
- Collaborates with the person and family to identify resources that will provide support throughout their illness and during end-of-life care
- Facilitates conversations to support end-of-life decision making and informed consent
- Identifies the person's and family's values, beliefs and preferences regarding the various components of palliative care provision
- Collaborates within and between teams across the continuum of care to facilitate continuity in palliative care

- Identifies the full range and continuum of palliative care services, resources and the settings in which they are available
  - Demonstrates knowledge of the range of palliative care services and resources
  - Provides relevant information and resources to the person and family
  - Identifies and accesses services and resources specific to the person's goals of care
  - Initiates referrals to and requests for resources, services and settings
  - Facilitates access for the person and their family to needed services and resources

*Spiritual Care Practitioner Specific Competencies:*

- Demonstrates advanced level of expertise and sensitivity in facilitating safe, smooth and seamless transitions of care for the person

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## **Spiritual Assessment and Care**

*Spiritual Care Practitioner Specific Competencies:*

### Relational Approach

- Provides a relational, person-centred approach to assessment and care that sensitively engages the person and family in their healing process
- Facilitates expression of the person's and family's beliefs, values, needs and desires that shape the person's choices and interactions
- Encourages the person and family to share fears, concerns, hopes, dreams, creative expression, intuition and awareness of relationships, including the divine and transcendent

### Assessment

- Assesses for spiritual distress, meaningless or hopelessness
- Utilizes philosophical, spiritual, religious, socio-cultural and psychological perspectives on human development and life transitions to gain an understanding of the person's and family's source(s) of spiritual strength, hope, methods and ways of coping, needs, risks and wellness goals
- Recognizes when physiological or psychological symptoms are limiting care effectiveness and when there is need for consultation with others

### Planning

- Co-develops, with the person and their family, a spiritual care plan that complements and is integrated with their care plan, treatment and interventions

### Intervention

- Provides a variety of interventions and approaches to spiritual care related to needs assessment and co-developed interprofessional care plans
- Helps the person and their family evaluate the role and function of spiritual and religious identity in their lives
- Facilitates contextualized meaning-making and sacred/religious interpretation
- Enables reconciliation with the person, their family, communities and team members (e.g., conflict management, forgiveness and relational growth)
- Uses spiritual, cultural and religious reflection in exploring and making meaning of one's situation

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## Loss, Grief and Bereavement

- Demonstrates a comprehensive knowledge of the grieving process and reactions in order to support the person and their family throughout the disease trajectory
- Demonstrates the ability to proactively respond to complex grief reactions and processes using own skills or appropriate referral

### *Spiritual Care Practitioner Specific Competencies:*

- Mentors and educates colleagues regarding the personal impact of loss, grief and bereavement, supporting them to recognize their own loss responses and encouraging engagement in activities to maintain their resilience on an on-going basis

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## Professional and Ethical Practice

- Applies a comprehensive understanding of contemporary legal, ethical and professional standards to the provision of quality palliative care
- Facilitates discussion and management of ethical and legal issues in conjunction with the person, their family, and their care team
- Actively influences and promotes palliative care strategic initiatives and policy development
- Demonstrates knowledge regarding potential ethical and moral challenges in palliative care
- Facilitates ethical decision making with the person, their family, their care team and their community
- Respects and advocates for plans of care that accurately reflect the person's and family's stated beliefs, values, culture and preferences
- Articulates ethical issues regarding the use of Palliative Sedation Therapy

### *Spiritual Care Practitioner Specific Competencies:*

- Demonstrates awareness of faith tradition directives regarding MAiD, the provision, withholding and withdrawal of life-sustaining treatments
- Models behavior congruent with the values of the Canadian Association for Spiritual Care (CASC) Code of Ethics and Professional Conduct for Spiritual Care Practitioners and Psycho-Spiritual Therapists
- Acknowledges the person's right to self-determination, to forgo or withdraw treatment, to informed consent and relevant federal, provincial or faith community guidelines on medical decision-making

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## Research, Education and Evaluation

- Applies knowledge gained from palliative care research
- Where possible, leads, facilitates and engages in education and research
- Contributes to the evaluation of the quality of palliative care and the effectiveness of the Specialist Palliative Care Team
- Where possible, provides the family with opportunities to participate in research regarding end-of-life care giving
- Acts as an expert resource contributing to palliative care development & delivery

### *Spiritual Care Practitioner Specific Competencies:*

- Where possible, identifies the opportunities for and barriers to discipline-specific research unique to palliative care
- Participates in and/or promotes research and knowledge translation in spiritual care and palliative end-of-life care, where possible

- Develops, facilitates and provides palliative care related education, leadership and mentorship to members of the discipline and students

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### Advocacy

- Advocates for the needs, decisions and rights of the person by recognizing potential vulnerabilities
- Supports autonomous decision-making
- Promotes equitable and timely access to resources
- Advocates for the development, maintenance and improvement of health care and social policies related to palliative care
- Advocates for health professionals to participate in palliative care continuing education opportunities
- Advocates for health professionals to have adequate resources to provide quality palliative care

## PALLIATIVE CARE COMPETENCIES FOR THOSE WHO SUPERVISE PALLIATIVE CARE VOLUNTEERS

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### Principles of Palliative Care

- Demonstrates understanding of the philosophy of palliative care
  - Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates understanding that a palliative approach to care starts early in the trajectory of a progressive life-limiting condition, and may be appropriate at the time of diagnosis
- Demonstrates the ability to describe the meaning of the term ‘life-limiting condition’
- Demonstrates understanding of the principles of palliative care
- Demonstrates understanding of the role and function of the Interdisciplinary Care Team in palliative care
- Demonstrates understanding of the role and function of the Specialist Palliative Care Team, including volunteers
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
- Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community
- Demonstrates understanding of palliative care standards, guidelines and policies

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### Cultural Safety and Humility

- Demonstrates understanding of the influence of ethnicity, culture, gender, sexual orientation, language, religion, age, experiences of illness and caregiving and ability on palliative and end-of-life care issues
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates understanding of the Indigenous Wellness Framework
- Demonstrates openness, and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preference

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### Communication

- Demonstrates understanding of the essential role communication plays in palliative care
- Demonstrates understanding that communication regarding palliative and end-of-life care is an on-going collaborative process
  - Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
- Recognizes the multidimensional communication challenges that arise when caring for people with life-limiting conditions
- Recognizes the potential for conflict in palliative care decision-making

- Demonstrates understanding of the importance of the involvement of the person and their family in discussions regarding the plan of care
- Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
  - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family

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### **Optimizing Comfort and Quality of Life**

- Demonstrates understanding of common trajectories of life-limiting conditions, including common symptoms
  - Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Anticipates and predicts the needs of the person who has been diagnosed with a life-limiting illness based on known disease trajectories
- Demonstrates understanding of the concept of ‘total pain’
- Applies interprofessional approaches to optimize comfort and enhance quality of life of the person and their family
- Recognizes the role of non-pharmacological symptom management to promote comfort and quality of life
  - Recognizes the importance of Traditional Medicine particularly for First Nations, Inuit, Métis and urban Indigenous people
- Interprets the impact of family role change when formulating relevant and realistic care plans
- Recognizes and anticipates the physical, psychological, social and spiritual issues that affect the person and their family
- Demonstrates awareness of one’s own responses in the presence of a person who is suffering

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### **Care Planning and Collaborative Practice**

- Understands the collaborative relationship between the person, health professionals, family and caregivers
  - Recognizes that care planning and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this
- Recognizes the overall impact of a life-limiting condition on the person and family including their mental health and coping mechanisms
- Familiar with the Health Care Consent Act, and understands that a health provider must obtain informed consent from the person (or, if they are incapable, their Substitute Decision Maker) for any treatment or intervention proposed
- Understands how a Substitute Decision Maker (SDM) is determined (based on the hierarchy within the Health Care Consent Act, 1996) and the role the SDM plays in making health care decisions if the person is not capable

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### Last Days and Hours

- Aware of best practices for expected death, including local and organizational policies and processes

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### Loss, Grief and Bereavement

- Demonstrates knowledge of diverse perspectives on loss, grief, bereavement, and mourning to support others from a cross-cultural perspective
  - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people
- Recognizes the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief
- Understands, recognizes and manages pathological responses to loss, referring appropriately to the Specialist Palliative Care Team, or other interdisciplinary care team members as appropriate
- Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief
  - Understands cumulative grief which can be particularly significant in First Nations and Inuit communities

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### Professional and Ethical Practice

- Demonstrates awareness of ethical and legal issues that may be encountered when caring for individuals with life-limiting conditions
- Recognizes when beliefs, attitudes and values may limit the ability to be present and provide person-centred care; collaborates with others to ensure optimal care is provided
- Understands distinctions among ethical and legal concepts, such as: the principle of double effect, Palliative Sedation Therapy and Medical Assistance in Dying (MAID)
- Demonstrates knowledge of relevant legislation and policies, e.g. MAID, Child, Youth and Family Services Act, Adult Protection Act, the Health Care Consent Act, and the Substitute Decision Act
- Responds to inquiries regarding MAID in accordance with regulatory body's relevant guidelines and standards and employer policies.

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### Self-Care

- Demonstrates understanding of the impact of loss, grief and bereavement on caregivers, both formal and informal
- Recognizes one's own responses to loss and engages in activities that support well-being and resilience
- Explores own attitudes regarding death, dying and caring for individuals requiring palliative care
- Demonstrates awareness of the impact of past experiences of suffering, death and dying when providing palliative care
- Understands and attends to own emotional responses that result from caring for individuals with palliative care needs
- Recognizes compassion fatigue in self and colleagues; intervenes and refers appropriately
- Engages in healthy activities that help prevent compassion fatigue

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### Education and Evaluation

- Contributes to the evaluation of the quality of palliative care and the effectiveness of the palliative care system
- Participates in palliative care continuing education opportunities
- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

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### Supervision of Volunteers

#### *Spiritual Care Practitioner Specific Competencies:*

- Demonstrates understanding of the responsibilities and role boundaries of Palliative Care Volunteers
- Demonstrates understanding of the duty of care of the volunteer
- Articulates the attributes of effective Palliative Care Volunteers
- Manages conflict between volunteers and patients and/or Specialist Palliative Care Team members
- Addresses Palliative Care Volunteers performance issues

## COMPETENCIES FOR PALLIATIVE CARE VOLUNTEERS<sup>1</sup>

### Principles of Palliative Care

- Demonstrates understanding of the definition, values, philosophy and principles of hospice palliative care
  - Familiar with common misunderstandings surrounding palliative care when caring for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates the ability to describe the meaning of the term ‘life-limiting condition’
- Recognizes the continuum of hospice palliative care and different models of palliative care
- Recognizes the most common needs of the individual who is living with a progressive, life-limiting illness, as well as family members, friends and caregivers
- Demonstrates understanding of Advance Care Planning (ACP), Goals of Care (GOC), and Health Care Consent (HCC) in alignment with Ontario legislation
- Demonstrates understanding of the role a Substitute Decision Maker (SDM) plays in decision making regarding a person’s care
- Demonstrates understanding of the role of the Interdisciplinary Care Team in palliative care, and the role of the volunteer within that context
- Demonstrates understanding of the role of the Specialist Palliative Care Team
- Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams
  - Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community
- Demonstrates understanding of palliative care standards and policies which guide palliative care volunteer

### Cultural Safety and Humility

- Recognizes the impact of a life-limiting condition on familial roles
- Demonstrates understanding of the influence of culture on key issues in palliative and end-of-life care
  - Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples
  - Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous peoples/communities and how it compares to Western Views/Society
- Demonstrates openness and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preference, and accommodates these
- Recognizes a safe, respectful and culturally inclusive environment
- Demonstrates understanding of the Indigenous Wellness Framework

#### *Volunteer Specific Competency:*

- Recognizes the influence that personal culture, beliefs and values may have on the volunteer in their role

### Communication

- Demonstrates understanding of the characteristics of effective communication

<sup>1</sup> These competencies apply to volunteers in Long Term Care, Palliative Care Units, and other settings, **with the exception of Hospices**. Volunteers in hospices are trained according to Hospice Palliative Care Ontario Standards

- Demonstrates understanding that communication regarding palliative and end-of-life care is an on-going collaborative process
  - Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family
- Uses sensitive and effective communication skills in listening and responding to the person, their family, and their caregiver(s)
- Identifies the value and uses of silence
- Identifies and addresses barriers to effective communication
- Recognizes that family conversations may involve children and different communication approaches may be required
- Adapts communication and information sharing to the unique needs of the person and their family, and engages specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology)
  - Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family

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### Optimizing Comfort and Quality of Life

- Recognizes when a person is experiencing pain or discomfort and alerts health professionals
  - Understands that symptoms may be viewed differently or have different meanings for First Nations, Inuit, Métis and urban Indigenous people
- Demonstrates awareness of Complementary and Alternative Medicine (CAM) and their impact on health and well-being
  - Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous people
- Provides support to individuals and families facing a life-limiting condition in a compassionate and sensitive way
- Demonstrates awareness of own responses in the presence of a person who is suffering

#### *Volunteer Specific Competencies:*

- Demonstrates appreciation of the boundaries regarding identifying and reporting pain and symptoms and providing comfort care
- Recognize ways that volunteers can assist clients/families to cope with emotional and psychosocial issues
- Recognizes one's own emotional and psychosocial issues related to the volunteer role and the experience of supporting individuals and their families with illness, death, dying and loss
- Identifies the persons potential spiritual needs
- Identifies and adheres to the scope of the volunteer role in providing spiritual support to clients and families, friends and caregivers.

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### Care Planning and Collaborative Practice

- Understands the collaborative relationship between the person, health professionals, family and caregivers

- Considers the community as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people
- Effectively collaborates with the care team

*Volunteer Specific Competency:*

- Assists staff with supporting persons' needs (where union contracts permit) which may include bed making, shampoos, gentle back, foot and hand massages, shaving, feeding or ambulation

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### **Last Days and Hours**

- Recognizes and responds appropriately to the signs of imminent death
- Supports the family's wishes and death rituals
  - Provides opportunities for family and the extended community to gather and be together, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people

*Volunteer Specific Competency:*

- Understands the volunteer role at the time of approaching death

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### **Loss, Grief and Bereavement**

- Demonstrates awareness of personal attitudes and feelings regarding death and dying
- Demonstrates a respectful attitude to diversity and supports the person and family in an open and non-judgmental environment
- Demonstrates awareness of the common fears associated with death and dying, and understands various ways of responding to those fears
- Demonstrates awareness of the losses that a person and family may experience during the course of life-limiting conditions and the dying process
- Demonstrates understanding of the diversity and complexity of grief experiences and how they relate to the grieving process
  - Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people
  - Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief
  - Understands cumulative grief which can be particularly significant in First Nations and Inuit communities
- Demonstrates awareness of gender and cultural differences in the way people grieve and cope with bereavement
- Demonstrates awareness of what helps or hinders a grieving person as they adjust to significant loss, change and bereavement

*Volunteer Specific Competencies:*

- Understands the role of volunteers in supporting individuals who are dying and the bereaved
- Recognizes when a person may require grief and bereavement services and engages the supervisor to seek support as needed

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### **Professional and Ethical Practice**

- Demonstrates awareness of ethical issues related to palliative care
- Demonstrates understanding of the importance of maintaining privacy and confidentiality

*Volunteer Specific Competencies:*

- Demonstrates understanding of the Palliative Care Volunteer's rights and responsibilities
- Demonstrates understanding of the volunteer's responsibility to their organization and palliative care services
- Recognizes the scope of the volunteer role
- Demonstrates understanding of the volunteer role boundaries, their purpose, and some strategies for maintaining them
- Recognizes how to effectively communicate the role of the volunteer and one's limits and boundaries
- Demonstrates awareness of the Duty of Care of the volunteer

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### Self-Care

- Demonstrates awareness of the supports available from their organization and the interdisciplinary care team
- Practices self-care strategies
- Engages in healthy activities that help prevent compassion fatigue
- Participates in community-driven debriefs when working with First Nations, Inuit, Métis and urban Indigenous people

#### *Volunteer Specific Competency:*

- Demonstrates awareness of ways volunteers can manage and cope with the impact of dying and death

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### Research, Education and Evaluation

- Contributes to the evaluation of the quality of palliative care and the effectiveness of the palliative care system
- Participates in palliative care continuing education opportunities
- Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities

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### Additional Competencies for Pediatric Palliative Care Volunteers

- Demonstrates awareness of the similarities and differences in the provision of palliative care to children, adolescents and adults
- Demonstrates understanding of the developmental stages of childhood and adolescence
- Demonstrates appreciation of the impact of developmental stages on children's concepts of illness and dying
- Demonstrates awareness of the impact childhood life-limiting illness has on parents, siblings, friends and extended family
- Demonstrates appreciation of the importance of play and education for children/youth with life-limiting conditions and their need to engage in childhood activities
- Demonstrates awareness of the ethical/legal issues unique to pediatric palliative care

## APPENDIX A: NOVA SCOTIA COMPETENCY FRAMEWORK DEVELOPMENT PROCESS

The Nova Scotia Health Authority's (NSHA)'s Palliative Care Capacity Building and Practice Change Working Group (NSHA WG) leveraged the Palliative Care Competence Framework developed by the Irish Health Service Executive as the foundation for their Competency Framework<sup>8</sup>. The Irish Framework has driven a number of palliative care programmatic, quality improvement and quality monitoring initiatives, led by the All-Ireland Institute for Hospice and Palliative Care<sup>5</sup>.

The Nova Scotia Competency Framework was adapted for local applicability and in a number of cases, additional professions and competencies were added. Palliative care competencies established by national, provincial and, in some cases, American professional associations and colleges were incorporated, and efforts were made to ensure broader alignment with national standards and documents. The resulting competencies outlined in the Nova Scotia Framework are aligned with Accreditation Canada's Standards for Hospice, Palliative Care and End-of-Life Services, Accreditation Canada's Community, Critical Care, Cancer Care and Emergency Care Standards, as well as documents from the Canadian Hospice Palliative Care Association. The NSHA WG reviewed the competencies in detail. Terminology specific to the Irish practice context was altered to reflect the Canadian health care system. Any competencies that were not specific to palliative care were removed, unless emphasis was warranted. For example, documentation is considered a core competency for every profession practicing in any setting, so references to documenting palliative interventions were removed, unless emphasis was warranted.

In order to represent the professions involved in palliative care in Nova Scotia, the NSHA WG expanded upon the Irish Framework to include competencies for a number of additional professions. However, not every profession was included. For many of these professions, palliative care competencies are reflected in their profession-specific core competencies. Professions not named in the document are expected to understand and apply the principles of palliative care in their practice.

An initial draft was shared with stakeholders to review and validate the competencies. Any recommended adjustments deemed appropriate by the NSHA WG were incorporated into future drafts of the document. The NSHA WG then reviewed and refined the document. An updated draft was then re-circulated to the stakeholders who originally reviewed the document; any recommended changes were incorporated into the next draft of the document and the updated document was re-circulated to stakeholders. The final framework was sent to the professional colleges/associations for endorsement. **Figure 3** illustrates the review process undertaken.

Figure 3. Review Process



## APPENDIX B: FIRST NATIONS, INUIT, MÉTIS AND URBAN INDIGENOUS PALLIATIVE CARE COMPETENCIES

As every person is unique, so are the communities for which they live. We can use this framework as a guide, but we should never assume what is true for one person or community is the same for all.

Acknowledging that First Nations, Inuit, Métis and urban Indigenous people are distinct, constitutionally recognized groups with Aboriginal and treaty rights, the Indigenous Cancer Control Unit at Cancer Care Ontario engaged with various stakeholders to develop specific competencies. Below is the full list of recommended Palliative Care Competencies that a provider should have when caring for individuals from First Nations, Inuit, Métis and urban Indigenous communities. Some of the recommended competencies are applicable when caring for any individual with a life-limiting illness, and as such, these were already captured within the framework. However, these broader competencies will often need to be adapted when working with First Nations, Inuit, Métis and urban Indigenous people. Specific examples tailored for First Nations, Inuit, Métis and urban Indigenous communities are provided below. There were also a number of new First Nations, Inuit, Métis and urban Indigenous Palliative Care Competencies identified as important for all providers to develop, and these have been incorporated within the profession specific sections of the Ontario Framework. These new competencies are indicated in **bold italics**.

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### Principles of Palliative Care

- Defines the palliative approach to care
  - E.g., Recognize that among some First Nations, Inuit, Métis and urban Indigenous communities there may not be a word for 'palliative care' - other language may be needed to describe it to the individual/family/community. It may also be unacceptable to talk openly about death and dying in some communities.
- Introduces the philosophy and principles of palliative care
- ***Provides culturally relevant explanations about palliative care particularly when caring for First Nations, Inuit, Métis and urban Indigenous people***
  - E.g. Dying at home vs. hospital, palliative care is not only for people with cancer
  - E.g. The size and presence of Indigenous family members will vary. Multiple generations and extended family will be visiting and staying with the individual in the hospital/hospice until they pass
- ***Demonstrates understanding of the guiding principles of First Nations, Inuit, Métis and urban Indigenous care teams***
  - E.g. No one right way to do it, trust the group, support each other
  - ***Recognizes the contribution of community strengths, gaps and barriers in building palliative care teams within First Nations, Inuit, Métis and urban Indigenous communities and that care teams will be specific to each cultural community***

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### Cultural Safety and Humility

- ***Understands health, wellness, and serious illness from diverse perspectives particularly when caring for First Nations, Inuit, Métis and urban Indigenous people***
  - E.g. Current state of First Nations, Inuit, Métis and urban Indigenous health in Canada/Ontario – disparities

- ***Examines attitudes towards death particularly for First Nations, Inuit, Métis and urban Indigenous people/communities and how it compares to Western Views/Society***
- ***Demonstrates understanding of the Indigenous Wellness Framework***
- ***Considers the community as an essential component of the unit of care for First Nations, Inuit, Métis and urban Indigenous people***

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### Communication

- ***Understands and recognizes that for First Nations, Inuit, Métis and urban Indigenous communities, the individual and family are the most important members of the care team and acknowledges the importance of on-going communication between the health care providers and the family***
- ***Recognizes that communication and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous peoples, and supports facilitation of this***
  - E.g. The larger community may include Elders, Healers, Clan Mothers, Knowledge Carriers and community support services such as Indigenous Friendship Centre's and Aboriginal Health Access Centre's
- ***Understands the role and importance of experienced translators for individuals with language barriers, particularly First Nations, Inuit, Métis and urban Indigenous people, and how to access their services to ensure strong communication and understanding between health care providers and the individual/family***
- ***Identifies the importance of community care plans when caring for First Nations, Inuit, Métis and urban Indigenous people***
- ***Maintains open communication channels with First Nations, Inuit, Métis and urban Indigenous care teams when caring for First Nations, Inuit, Métis and urban Indigenous people***
  - E.g. Meeting regularly, care conferencing which may include the larger community supports beyond the patient and family
- ***Supports the discharge planning process to facilitate smooth transitions particularly when caring for First Nations and Inuit people and dual providers may be involved***
  - E.g. to support First Nations and Inuit people who are eligible for Non-Insured Health Benefits
- ***Provides culturally relevant information and resources to support individuals and families, particularly when caring for those from First Nations, Inuit, Métis and urban Indigenous communities***

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### Optimizing Comfort and Quality of Life

- Provides an overview of pain and components of the pain experience, including medications
- ***Demonstrates understanding of the potential barriers to providing pain management, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people***
  - E.g., Individual may not disclose pain, fear of addiction, and availability of medication. Important to pay additional attention to the non-verbal cues and body language of the individual/family.
  - E.g., Recognize First Nations, Inuit, Métis and urban Indigenous experience barriers travelling outside of their communities to access care (symptoms, transportation, and family escort). Every effort should be made to coordinate care in the comfort of their home community surrounded by their family.

- Offers some suggestions for non-pharmacological ways to address pain
- **Recognizes the importance of Traditional Medicine particularly when caring for First Nations, Inuit, Métis and urban Indigenous, and provides suggestions for non-pharmacological ways to address pain/promote comfort and quality of life**
  - E.g. Music, drumming, aromatherapy, acupuncture, Reiki
  - E.g. Referring individual/family to Indigenous organizations who can make recommendations for access to community-vetted healers/traditional people
- Understands the collaborative relationship between the individual, family, caregivers and community in supporting pain and symptom management
  - E.g. Administering non-drug treatments, watching for signs of pain, advocating for the persons pain, observing side effects of medication
  - E.g. Recognizes the stereotypes around addictions will not be a barrier to individuals pain management
- Discusses the management of other symptoms
- **Recognizes that symptoms and symptom meaning is highly subjective and should be assessed and understood from a person-centered perspective particularly when caring for First Nations, Inuit, Métis and urban Indigenous people**
  - E.g., there are often attempts to manage delirium that may be distressing to the person/family. Among some First Nations, Inuit, Métis and urban Indigenous delirium is viewed as a natural part of the dying process, whereby ancestors come to get the person who is dying. As such, interfering with these 'hallucinations' could be disrespectful and harmful to the family
- Reviews food intake and hydration at end-of-life

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### Care Planning and Collaborative Practice

- Define advance care planning
- Discuss the benefits and importance of advance care planning
- Define substitute decision makers
- **Recognizes that care planning and decision-making may involve the family and the larger community, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people, and supports facilitation of this**

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### Last Days and Hours

- **Provides opportunities for family and the extended community to gather and be together, particularly when caring for First Nations, Inuit, Métis and urban Indigenous people**
- **Supports planning for expected deaths, particularly when caring for First Nations, Inuit, Métis and urban Indigenous in the community**
  - E.g. Comprehensive discharge planning, family caregivers are identified and educated on what to expect at time of passing and who to call for grief counselling and crisis management
- Outlines the dying process
- Identifies and discusses signs and symptoms that may occur during the last days and hours

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### Loss, Grief and Bereavement

- Demonstrates knowledge of diverse perspectives on grief, loss, bereavement and mourning to support others from a cross-cultural perspective

- **Recognizes the impact of colonization, historical loss and trauma when caring for First Nations, Inuit, Métis and urban Indigenous people**
- E.g. Spirituality/Religion and– colonization
- E.g., Palliative care can only be truly defined by the individual experiencing life limiting conditions and their families. It will be different for everyone
- Understands the dimensions of grief and recognizes the factors that may increase the risk of complicated grief
  - **Understands cumulative grief which can be particularly significant in First Nations and Inuit communities**
  - E.g., More focus on the competency of aftercare. This is a huge gap and people tend to leave FN communities quickly after a death. There is little offered in terms of debriefing or opportunities for traditional healing activities.
  - E.g. Among some FNs communities, offices will close to pay respect to the deceased and the family. This process reflects the traditional culture and values.
- Provides appropriate support and information based on an awareness of individuals culture and needs
  - E.g. First Nations, Inuit, Métis and urban Indigenous resources (traditional and non-traditional) might be needed to support people and communities in teaching their children and those with special needs about the death

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## Professional and Ethical Practice

\*No additions

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### Self-Care

- **Demonstrates understanding of the concept of good “helping relationships” when working with First Nations, Inuit, Métis and urban Indigenous people**
  - E.g. Acknowledging emotions, setting boundaries (dual relationships can especially be an issue for First Nations, Inuit, Métis and urban Indigenous community palliative care), finding common ground
- **Demonstrates understanding of the concept of companioning particularly when working with First Nations, Inuit, Métis and urban Indigenous people**
  - E.g. Life-giving, hope-filled model, seeking reconciliation not “recovery”
- Identify strategies for self-care
- **Participates in community-driven debriefs when working with First Nations, Inuit, Métis and urban Indigenous people**
  - E.g. Checking in to help health and social care staff during and after someone passes away (community-driven process)
- Examines some of the stressors and rewards of working in palliative care
- Explores the ideas of “burnout”
- Recognizes the importance of self-care in our personal and professional lives
- Examines personal and professional experiences of grief and bereavement

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### Advocacy

- Provides an overview of the Ontario hierarchy and the role of substitute decision makers
- **Recognizes and mitigates potential barriers and limitations to supporting transitions between specialty care and primary care particularly in First Nations, Inuit, Métis and urban Indigenous communities**

- E.g. Recognizes there are few existing or planned hospices within reasonable proximity to many First Nations, Inuit, Métis and urban Indigenous communities, especially in the northern region. There may also be no formal relationships between the existing local hospices and First Nations, Inuit, Métis and urban Indigenous communities

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### Education

- ***Participates in First Nations, Inuit, Métis and urban Indigenous cultural competency training opportunities***
  - E.g. Including the reading of materials such as the Charter of Relationship Principles for Nishnawbe Aski Nation Territory, the Truth and Reconciliation Commission, etc. <https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/charter-nan.html>

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### Evaluation

- Leads or participates in the evaluation of palliative care services and patient and family experiences.

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### Research

- Leads or participates in palliative care research, keeping abreast of palliative care research and inviting patients and families to participate in relevant research projects.

## APPENDIX C: GLOSSARY OF TERMS

**Advance Care Planning (ACP):** In Ontario, advance care planning is an iterative process that involves the mentally capable patient:

*Identifying their future Substitute Decision Maker* by either

- Confirming their satisfaction with their default/automatic Substitute Decision Maker in the Substitute Decision Maker hierarchy list in the Health Care Consent Act; OR
- Choosing someone else to act as Substitute Decision Maker by preparing a Power of Attorney for Personal Care (a formal written document).

*Sharing their wishes, values, and beliefs* through conversations with the SDM and others that clarify their wishes, values and beliefs, and more generally, how they would like to be cared for in the event of incapacity to give or refuse consent. Rather than being a single event, advance care planning is ongoing and dynamic, with the potential for personal preferences to change over time as health status changes. It may be initiated at any point in the health care process, and may involve individuals who are currently healthy<sup>7</sup>.

**CanMEDS:** An educational framework that describes the abilities physicians require to effectively meet the health care needs of the people they serve. It is the basis for the educational and practice standards of the Royal College of Physicians and Surgeons of Canada, for more information visit:  
<http://canmeds.royalcollege.ca/en/framework/27>.

**Caregiver:** A caregiver is an unpaid person who provides care and support in a nonprofessional capacity, such as a family member, a friend, or anyone else identified by the person with a progressive, life-limiting illness. Other terms commonly used to describe this role include care partner, informal caregiver, family caregiver, carer, or primary caregiver<sup>2</sup>.

**Care Teams:** Describes the involvement of multiple interdisciplinary care teams in a patient's care, may include the Specialist Palliative Care Team in addition to Primary Care or an Acute Care Team.

**Children and Family Services Act:** Legislation that protects children who are living in situations of abuse or neglect<sup>28</sup>. For further information visit:  
<https://novascotia.ca/coms/families/changestoCFSA/index.html>

**Competencies:** Competencies refer to the range of knowledge, personal attributes, and skills that enable the behaviours needed to effectively perform a role within an organization<sup>4</sup>.

**Cultural Humility:** A process of self-reflection to understand personal and systemic conditioned biases, and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a life-long learner when it comes to understanding another's experience. Cultural humility enables cultural safety<sup>18</sup>.

**Cultural Safety:** Predicated on understanding the power differentials inherent in health service delivery and redressing these inequities through educational processes. Addressing inequities, through the lens of cultural safety, enables health professionals to:

- Improve health care access for clients or individuals, aggregates and populations
- Acknowledge that we are all bearers of culture

- Expose the social, political and historical contexts of health care
- Enable practitioners to consider difficult concepts, such as racism, discrimination and prejudice
- Understand that cultural safety is determined by those to whom health professionals provide care
- Understand the limitations of “culture” in terms of having people access and safely move through health care systems and encounters with care providers
- Challenge unequal power relations<sup>19</sup>.

**Dignity conserving approach:** This type of care encompasses a broad range of interventions, based on an understanding of the many sources of distress that may infringe on a patient's sense of dignity. What defines dignity for each patient and his or her family is unique and should be considered by clinicians to provide the most comprehensive, empathic care possible<sup>29</sup>.

**Double Effect:** The principle of double effect is a rule of conduct frequently used to determine when a person may lawfully and ethically perform an action from which two effects will follow, one bad and the other good<sup>30,31</sup>.

**Duty of Care:** A common law duty to take reasonable care to avoid causing harm to others<sup>32</sup>.

**End-of-Life Care:** End-of-life care refers to care for people in decline who are expected to die in the foreseeable (near) future. It constitutes active care aimed at helping patients and families to prepare for death, ensure comfort, and to make care decisions that are consistent with the patient's prognosis and goals of care<sup>7</sup>.

**Family:** Family consists of those closest to a person in terms of knowledge, care, and affection, and may include biological family (i.e. parents, grandparents, and siblings), family through marriage, or family of choice and friends. The person with the progressive, life-limiting illness defines their family and who will be involved in their care<sup>2</sup>.

**Goals of Care Discussion:** A discussion between a patient (or his/her Substitute Decision Maker if the patient lacks capacity) and healthcare provider(s) addresses the patient's goals for his or her care in the context of healthcare consent and decision-making in advanced illness. The purpose of these discussions is to outline the patient's values, beliefs, wishes, perception of quality of life and what he or she characterizes as meaningful and important. Other elements include the patient's understanding of current health conditions, prognosis, and likely course of events if his or her goals of care are applied to potential treatment decisions. The goals of care discussion provides the foundation for decision-making and will often include the development of (and obtaining informed consent to) a plan of treatment<sup>7</sup>.

**Hospice:** The term “hospice” is used to describe a variety of specific services and supports, and care settings. Residential hospices create a home-like environment for patients who are at the end of their lives and need access to 24-hour care. In contrast, visiting hospices offer care through out-patient facilities or by travelling to a patient's home. Finally, virtual hospices offer online resources to members of the public on palliative care, advance care planning and other issues relevant to the last stages of life<sup>7</sup>.

**Hospice Level Care:** The care provided in the last weeks of life for those who cannot or do not wish to die at home. Hospice, in relation to acute palliative care, is for those who are relatively

stable but require monitoring and interventions that are unavailable in their home setting, for a variety of reasons.

**Interdisciplinary Care Team:** Interdisciplinary care team or interdisciplinary team refers to all individuals who are involved in providing care (including regulated professionals, such as registered nurses, nurse practitioners, pharmacists, physicians, physiotherapists, psychologists, occupational therapists, social workers, and speech-language pathologists and unregulated professions, such as personal support workers, behavioural support workers, and administrative staff).

**Interprofessional:** Interprofessional describes the relationship between various disciplines as they purposely interact to work and learn together to achieve a common goal. For example, if a client has trouble swallowing, nurse, speech language pathologists and dietitians need to work together as a team to figure out what is wrong and how to help the client<sup>33</sup>.

**Interprofessional Practice:** The process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients/clients/ families and communities to enable optimal health outcomes. Elements of collaboration include respect, trust, shared decision making and partnerships<sup>34</sup>.

**Life-Limiting Condition:** Denotes a medical condition for which there is no cure and from which a person is expected to die prematurely<sup>35</sup>.

**Medical Assistance in Dying (MAID):**

- a. The administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; OR
- b. The prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.

Medical assistance in dying is an insured service under the Ontario Health Insurance Plan (OHIP) and drugs required for medical assistance in dying are available at no cost to the individual.

Healthcare providers, including physicians, nurses and pharmacists, should refer to their regulatory colleges for more information and guidance on medical assistance in dying<sup>36</sup>.

For patient eligibility requirements, please refer to section 241.2(1) of Bill C-14.

**Nurse Practitioner (NP):** The CNA defines an NP as a registered nurse with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice. NPs practice in primary and acute care settings<sup>37</sup>. For further information see <https://cna-aiic.ca>

**Palliative Approach:** A palliative approach to care focuses on meeting a person's and his/her family's full range of needs – physical, psychosocial and spiritual – at all stages of a chronic progressive illness. It reinforces the person's autonomy and right to be actively involved in his or her own care – and strives to give individuals and families a greater sense of control. It sees palliative care as less of a discrete service offered to dying persons when treatment is no longer effective and more of an approach to care that can enhance their quality of life throughout the

course of their illness or the process of aging. The term ‘palliative care approach’ is also used to refer to palliative care delivered at a generalist level of competency by family physicians, primary care NPs, oncologist, internists, etc. as opposed to specialist level palliative care provided by palliative care specialists<sup>7</sup>.

**Palliative Care:** The Ontario Palliative Care Network (OPCN) endorses the definition provided by Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action. This document states: Hospice palliative care is a philosophy of care that aims to relieve suffering and improve the quality of living and dying. It strives to help individuals and families to:

- Address physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears;
- Prepare for and manage end-of-life choices and the dying process;
- Cope with loss and grief;
- Treat all active issues;
- Prevent new issues from occurring; and
- Promote opportunities for meaningful and valuable experiences, and personal and spiritual growth<sup>7</sup>.

**Palliative Care Support:** Palliative care support consists of health advice, resources, treatment, and other assistance provided by the health care team to meet a person’s palliative care needs. Support should be culturally relevant and it can come in many forms, including a telephone call with a registered nurse; a number to call when pain or other symptoms are not well managed; or a home visit from a primary care or palliative care provider<sup>2</sup>.

**Palliative Sedation:** Based on the Canadian Consensus Framework, palliative sedation is defined as:

- a. The use of (a) pharmacological agent(s) to reduce consciousness;
- b. Reserved for treatment of intolerable and refractory physical symptoms (rarely for existential distress); and
- c. Only considered in a patient who has been diagnosed with an advanced progressive illness.

Continuous palliative sedation therapy (CPST) is the use of ongoing sedation continued until the patient’s death. There remains concern over the misuse or abuse of sedation in general and continuous palliative sedation therapy in particular. Typically, continuous palliative sedation therapy is intended for the last days or weeks of life. Palliative sedation is distinct from sedation caused as an unintended side-effect of medications that are given to relieve other symptoms (e.g. opioids administered for analgesia). Palliative sedation is also distinct from sedation given to relieve anxiety or agitation, when the intended effect is to make the patient calm and relaxed (but not necessarily unconscious)<sup>7</sup>. There has been some research exploring the practice and documentation of continuing palliative sedation therapy:

<http://www.currentoncology.com/index.php/oncology/article/view/1773/1486>

**Power of Attorney for Personal Care:** Power of Attorney for Personal Care is a legal document in which one person gives another person the authority to make personal care decisions on his or her behalf if he/she becomes incapable. In the document, the person is referred to as an attorney for personal care (this person is the Substitute Decision Maker). This is distinct from assigning Continuing Power of Attorney for Property, which gives the authority to make financial decisions on behalf of an incapable person<sup>7</sup>.

**Practice Focused in Palliative Care:** Health professionals and volunteers who specialize in palliative care or have a practice focused in palliative care may be members of a Specialist Palliative Care Team or practice in settings where the vast majority patients require palliative care.

**Primary Care:** Primary care is the first point of contact between a patient and the health care system and includes illness prevention, health promotion, diagnosis, treatment, and rehabilitation and counselling<sup>38</sup>.

**Professional Association:** A professional association acts in the interest of its members, who are usually also members of a professional college. Membership in an association is generally voluntary.

**Professional College:** A professional college is the regulatory body for a profession and has as its primary goal the responsibility to protect the public. Membership in a professional college is mandatory in order to practice in a particular jurisdiction.

**Profession-specific:** Unique to a particular health profession.

**Settings of Care:** The setting of care is the place where palliative care is provided. Care settings may include the person's home, a hospice residence or in-patient palliative care unit, a long-term care home, a correctional facility, or for a person who is homeless or vulnerably housed, a shelter or the street<sup>2</sup>.

**Specialist Palliative Care Team:** The Specialist Palliative Care Team (also called the Specialist Palliative Care Consult Team or Palliative Care Specialty Team) is a specially trained team of doctors, nurse practitioners, nurses, social workers and other health care professionals who work collaboratively with a patient's Interdisciplinary Care Team to provide an extra layer of support for people with life-limiting conditions. The Specialist Palliative Care Team focuses on providing relief from symptoms and improving quality of life for both the patient and the family. Consultation with the Specialist Palliative Care Team is appropriate at any age and at any stage of a life-limiting condition and can be provided along with curative-intent treatment<sup>39</sup>.

**Specialize in Palliative Care:** Health professionals and volunteers who specialize in palliative care or have a practice focused in palliative care may be members of a Specialist Palliative Care Team or practice in settings where the vast majority patients require palliative care.

**Substitute Decision Maker (SDM):** A Substitute Decision Maker is a person who makes care and treatment decisions on another person's behalf if and when that person becomes incapable of making these decisions. Decisions would be based on the incapable person's prior capable wishes, or, if these are not known, or not applicable, the decision should be consistent with known values and beliefs and in the best interest of that person. The Health Care Consent Act provides a hierarchy that lists who the automatic Substitute Decision Maker(s) would be if a patient did not have capacity to provide consent for a plan of treatment. If a patient is not satisfied with the automatic Substitute Decision Maker provided in the list, the patient must prepare a Power of Attorney for Personal Care<sup>7</sup>. For more terms, please see the Lexicon developed by The Way Forward: <http://www.hpcintegration.ca/resources/lexicon.aspx>

**The Ontario Mental Health Act:** The Mental Health Act sets out the powers and obligations of psychiatric facilities in Ontario. It governs the admission process, the different categories of patient admission, as well as directives around assessment, care and treatment.

The Act also outlines the powers of police officers and Justices of the Peace to make orders for an individual, who meets certain criteria, to undergo psychiatric examination by a physician. Patient rights are also referred to, including procedural details such as rights of appeal to the Consent and Capacity Board<sup>40</sup>.

**Total Pain:** The suffering that encompasses all of a person's physical, psychological, social, spiritual and practical struggles<sup>41</sup>.

## APPENDIX D: EXPLANATION OF ABBREVIATIONS

### Abbreviation Definition

|        |  |
|--------|--|
| ACP    | Advance Care Planning                                    |
| CADD   | Continuous Ambulatory Delivery Device                    |
| CAM    | Complementary and Alternative Medicine                   |
| CARF   | Commission on Accreditation of Rehabilitation Facilities |
| CASC   | Canadian Association of Spiritual Care                   |
| CHPCA  | Canadian Hospice Palliative Care Association             |
| CAN    | Canadian Nurses Association                              |
| DIC    | Disseminated Intravascular Coagulation                   |
| DNR    | Do Not Resuscitate                                       |
| ED     | Emergency Department                                     |
| EG     | Example(s)   |
| ETC    | Etcetera   |
| GOC    | Goals of Care  |
| GI     | Gastrointestinal   |
| HCC    | Health Care Consent                                      |
| HCCA   | Health Care Consent Act                                  |
| HEIA   | Health Equity Impact Assessment                          |
| IE     | That Is  |
| IV     | Intravenously  |
| LTC    | Long-Term Care   |
| LVAD   | Left Ventricular Assist Device                           |
| RPN    | Registered Practical Nurse                               |
| MAiD   | Medical Assistance in Dying                              |
| NP     | Nurse Practitioner                                       |
| NSAIDs | Nonsteroidal Anti-Inflammatory Drugs                     |
| NSHA   | Nova Scotia Health Authority                             |
| OIN    | Opioid Induced Neurotoxicity                             |
| OPCN   | Ontario Palliative Care Network                          |
| PICC   | Peripherally Inserted Central Catheters                  |
| PST    | Palliative Sedation Therapy                              |
| PSW    | Personal Support Worker                                  |
| RN     | Registered Nurse   |
| ROM    | Range of Motion  |
| RPN    | Registered Practical Nurse                               |
| SCC    | Spinal Cord Compression                                  |
| SDM    | Substitute Decision Maker                                |
| SIADH  | Syndrome of Inappropriate Antidiuretic Hormone           |
| SLP    | Speech Language Pathology/Pathologist                    |
| SVCO   | Superior Vena Cava Obstruction                           |
| TBD    | To Be Determined   |
| VP     | Ventricular Peritoneal                                   |

## REFERENCES

- <sup>1</sup> Ontario Palliative Care Network. Action Plan 1: 2017 – 2020 [Internet]. Toronto (ON): The Network; 2017 [cited 2018 November 2]. Available from: <https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/OPCNAActionPlan1.pdf>.
- <sup>2</sup> Health Quality Ontario. Quality Standards. Palliative Care: Care for Adults with a Progressive, Life-Limiting Illness [Internet]. Toronto (ON): Queen's Printer for Ontario; 2018 [cited 2018 November 2]. Available from: <http://www.hqontario.ca/portals/0/documents/evidence/quality-standards/qs-palliative-care-clinical-guide-en.pdf>.
- <sup>3</sup> Ontario Palliative Care Network (2018). Palliative Care Health Services Delivery Framework: Recommendations for a Model of Care to Improve Palliative Care in Ontario, Focus Area 1: Adults Receiving Care in Community Settings. (In-Print).
- <sup>4</sup> Lucia AD, Lepsinger R. The Art and Science of Competency Models: Pinpointing Critical Success Factors in Organizations. San Francisco: Jossey-Bass/Pfeiffer; 1999.
- <sup>5</sup> Palliative Care Competence Framework Steering Group. Palliative Care Competence Framework [Internet]. Dublin, Ireland: Health Service Executive; 2014 [cited 2018 November 2]. Available from: <http://aiihpc.org/wp-content/uploads/2015/02/Palliative-Care-Competence-Framework.pdf>.
- <sup>6</sup> Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action [Internet]. Queen's Printer of Ontario; 2013 [cited 2018 November 2]. Available from: [http://health.gov.on.ca/en/public/programs/ltc/docs/palliative%20care\\_report.pdf](http://health.gov.on.ca/en/public/programs/ltc/docs/palliative%20care_report.pdf).
- <sup>7</sup> Ontario Palliative Care Network. Key Palliative Care Concepts and Terms [Internet]. Toronto (ON): The Network; 2017 [update 2017; cited 2018 November 2]. Available from: [https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/KEY\\_PALLIATIVE\\_CARE\\_CONCEPTS\\_AND\\_TERMS.pdf](https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/KEY_PALLIATIVE_CARE_CONCEPTS_AND_TERMS.pdf).
- <sup>8</sup> McCallum M, Carver J, Dupere D, Ganong S, Henderson D, Jewers H, McKim A, McNeil-Campbell L, Richardson H, Simpson J, and Tschupruk C. The Palliative Care Capacity Building Working Group. The Nova Scotia Palliative Care Competency Framework: A Reference Guide for Health Professionals and Volunteers [Internet]. Halifax, Nova Scotia: Nova Scotia Health Authority; 2017 [cited 2018 November 2]. Available from: [https://library.nshealth.ca/ld.php?content\\_id=34202519](https://library.nshealth.ca/ld.php?content_id=34202519).
- <sup>9</sup> Canadian Palliative Care Nursing Standards Committee. Canadian Hospice Palliative Care Nursing Standards of Practice. Canadian Hospice Palliative Care Association [Internet]. Ottawa (ON); 2014 [cited 2018 November 2]. Available from: <http://www.chpca.net/professionals/nurses.aspx>.
- <sup>10</sup> The Canadian Nurses Association (CNA), the Canadian Hospice Palliative Care Association (CHPCA) and the Canadian Hospice Palliative Care Nurses Group (CHPC-NG). Joint Position Statement – The palliative approach to care and the role of the nurse [Internet]. Ottawa (ON); 2015 [cited 2018 November 2]. Available from: <https://www.cna->

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[aiic.ca/~media/cna/page-content/pdf-en/the-palliative-approach-to-care-and-the-role-of-the-nurse\\_e.pdf](http://aiic.ca/~media/cna/page-content/pdf-en/the-palliative-approach-to-care-and-the-role-of-the-nurse_e.pdf).

- 11 Canadian Hospice Palliative Care Association. Paediatric Hospice Palliative Care: Guiding Principles and Norms of Practice [Internet]. Ottawa (ON); 2006 [cited 2018 November 2]. Available from: <http://www.chpca.net>.
- 12 Cooper D, Barnes P, Horst G, Sinclair S, and Associates. How Spiritual Care Practitioners Provide Care In Canadian Hospice Palliative Care Settings: Recommended Advanced Practice Guidelines and Commentary. Ottawa (ON): The Spiritual Advisors Interest Group, Canadian Hospice Palliative Care Association; 2013.
- 13 Accreditation Canada. Hospice, Palliative, End of Life Services Standards, version 11, For Surveys Starting After: January 01, 2017. Ottawa (ON); 2016.
- 14 Canadian Hospice Palliative Care Association. The Pan-Canadian Gold Standard for Palliative Home Care: Towards Equitable Access to High Quality Hospice Palliative and End-of-Life Care at Home. Ottawa (ON); 2006.
- 15 Bosma H, Johnston M, Cadell S, Wainwright W, Abernathy N, Feron A, Kelley ML, Nelson F. Canadian Social Work Competencies for Hospice Palliative Care: A Framework to Guide Education and Practice at the Generalist and Specialist Levels. Canadian Hospice Palliative Care Association [Internet]. 2008 [cited 2018 November 5]. Available from: [http://www.acsp.net/media/7868/Social\\_Work\\_Competencies\\_July\\_2009.pdf](http://www.acsp.net/media/7868/Social_Work_Competencies_July_2009.pdf).
- 16 A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice Canadian Hospice Palliative Care Association revised and Condensed edition: 2013. Canadian Hospice Palliative Care Association [Internet]. Ottawa (ON); 2013 [cited 2018 November 5]. Available from: <http://www.chpca.net/media/319547/norms-of-practice-eng-web.pdf>.
- 17 Cultural Competence & Cultural Safety in First Nations, Inuit, Métis and Urban Indigenous Nursing Education an Integrated Review of the Literature. Aboriginal Nurses Association of Canada, Canadian Association of Schools of Nursing and the Canadian Nurses Association. Ottawa (ON); 2009.
- 18 FNHA's Policy Statement on Cultural Safety and Humility. First Nations Health Authority [Internet]. [cited 2018 November 5]. Available from: <http://www.fnha.ca/documents/fnha-policy-statement-cultural-safety-and-humility.pdf>.
- 19 Breiddal SM. Self-Care in Palliative Care: A Way of Being. *Illness, Crisis & Loss* [Internet]. 2012 Jan 20 [cited 2018 Nov 15] (1):5-17. Available from: <https://doi.org/10.2190%2FILL.20.1.b>.
- 20 Practice Standard: Professional Standards, Revised 2002. College of Nurses of Ontario [Internet]. Toronto (ON); 2018 [cited 2019 February 15]. Available from: [https://www.cno.org/globalassets/docs/prac/41006\\_profstds.pdf](https://www.cno.org/globalassets/docs/prac/41006_profstds.pdf).
- 21 Practice Standard: Professional Standards, Revised 2002. College of Nurses of Ontario [Internet]. Toronto (ON); 2018, pg. 3 [cited 2019 February 15]. Available from: [https://www.cno.org/globalassets/docs/prac/41006\\_profstds.pdf](https://www.cno.org/globalassets/docs/prac/41006_profstds.pdf).

- 
- <sup>22</sup> Advanced Nursing Practice: A National Framework. Canadian Nurses Association [Internet]. Ottawa (ON); 2008, pg. 13 [cited 2019 February 15]. Available from: [https://www.cna-aiic.ca/~media/cna/page-content/pdf-en/anp\\_national\\_framework\\_e.pdf](https://www.cna-aiic.ca/~media/cna/page-content/pdf-en/anp_national_framework_e.pdf).
- <sup>23</sup> End-of-Life Care during the Last Days and Hours. Registered Nurses' Association of Ontario [Internet]. Toronto (ON); 2011 [cited 2019 February 15]. Available from: <https://rnao.ca/bpg/guidelines/endoflife-care-during-last-days-and-hours>.
- <sup>24</sup> A Palliative Approach to Care in the Last 12 Months of Life. Registered Nurses' Association of Ontario [Internet]. Toronto; 2019 forthcoming [cited 2019 February 15].
- <sup>25</sup> Professional Competencies for Canadian Pharmacists at Entry to Practice. National Association of Pharmacy Regulatory Authorities. [Internet]. 2014 [cited 2019 February 19]. Available from: <https://napra.ca/pharmacists/professional-competencies-canadian-pharmacists-entry-practice-2014>.
- <sup>26</sup> Medical Assistance in Dying. Guidance to Pharmacists and Pharmacy Technicians. Ontario College of Pharmacists [Internet]. 2018 [cited 2019 February 19]. Available from: <http://www.ocpinfo.com/regulations-standards/policies-guidelines/assisted-death/>.
- <sup>27</sup> Frank, JR. The CanMEDS Physician Competency Framework. Better standards. Better physicians. Better care. Royal College of Physicians and Surgeons of Canada and Associated Medical Services Inc. Second Printing; Ottawa (ON); 2005.
- <sup>28</sup> An Act Respecting Services to Children and their Families, the Protection of Children and Adoption. Authority of the Speaker of the House of Assembly. Halifax; 1990, c. 5. Available from: <http://nslegislature.ca/legc/statutes/children%20and%20family%20services.pdf>.
- <sup>29</sup> Chochinov HM. Dignity-Conserving Care – A New Model for Palliative Care Helping the Patient Feel Valued. JAMA. 2002; 287(17): 2253-2261.
- <sup>30</sup> Saunders C. The Symptomatic Treatment of Incurable Malignant Disease. Prescribers' Journal. 1964; 4(4): 68-73.
- <sup>31</sup> Ethical Framework of Palliative Sedation: The Principle of Double Effect. Stanford School of Medicine [Internet]. Stanford University; 2016 [cited 2018 November 5]. Available from: <https://palliative.stanford.edu>.
- <sup>32</sup> Duty of Care Definition. Collins English Dictionary [Internet]. 2017 [cited 2018 November 5]. Available from: <https://www.collinsdictionary.com/dictionary/english/>.
- <sup>33</sup> Education. University of Toronto [Internet]. 2008 [cited 2018 November 5]. Available from: <http://www.sicq.net/departments/education/faq.aspx>.
- <sup>34</sup> Competencies Working Group, Canadian Interprofessional Health Collaborative. A National Interprofessional Competency Framework [Internet]. Her Majesty the Queen in Right of Canada. Vancouver (B.C); 2010 [cited 2018 November 5]. Available from: [https://www.cihc.ca/files/CIHC\\_IPCompetencies\\_Feb1210.pdf](https://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf).
-

- 
- <sup>35</sup> Life-Limiting Illness Definition. Oxford Dictionary [Internet]. 2017 [cited 2018 November 5]. Available from <https://en.oxforddictionaries.com>.
- <sup>36</sup> Bill C-14. Parliament of Canada [Internet]. 2016 [cited 2018 November 5]. Available from: <http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&DocId=8384014>.
- <sup>37</sup> The Nurse Practitioner Position Statement. Canadian Nurses Association [Internet]. Ottawa (ON); 2009 [cited 2018 November 5]. Available from: [https://www.cna-aiic.ca/-/media/nurseone/files/en/ps\\_nurse\\_practitioner\\_e.pdf](https://www.cna-aiic.ca/-/media/nurseone/files/en/ps_nurse_practitioner_e.pdf).
- <sup>38</sup> Primary Care Payment Models in Ontario. Ministry of Health and Long-Term Care [Internet]. 2017 [cited 2018 November 5]. Available from: <http://www.health.gov.on.ca/en/pro/programs/pcpm/>.
- <sup>39</sup> Canadian Society for Palliative Care Physicians. Palliative Care Lexicon. Ottawa (ON); 2017.
- <sup>40</sup> Mental Health and Addictions Legislation. Canadian Mental Health Association [Internet]. 2018 [cited 2018 November 5]. Available from: <https://ontario.cmha.ca/provincial-policy/criminal-justice/mental-health-and-addictions-legislation/>.
- <sup>41</sup> Saunders C. The Symptomatic Treatment of Incurable Malignant Disease. Prescribers' Journal. 1964; 4(4): 68-73.