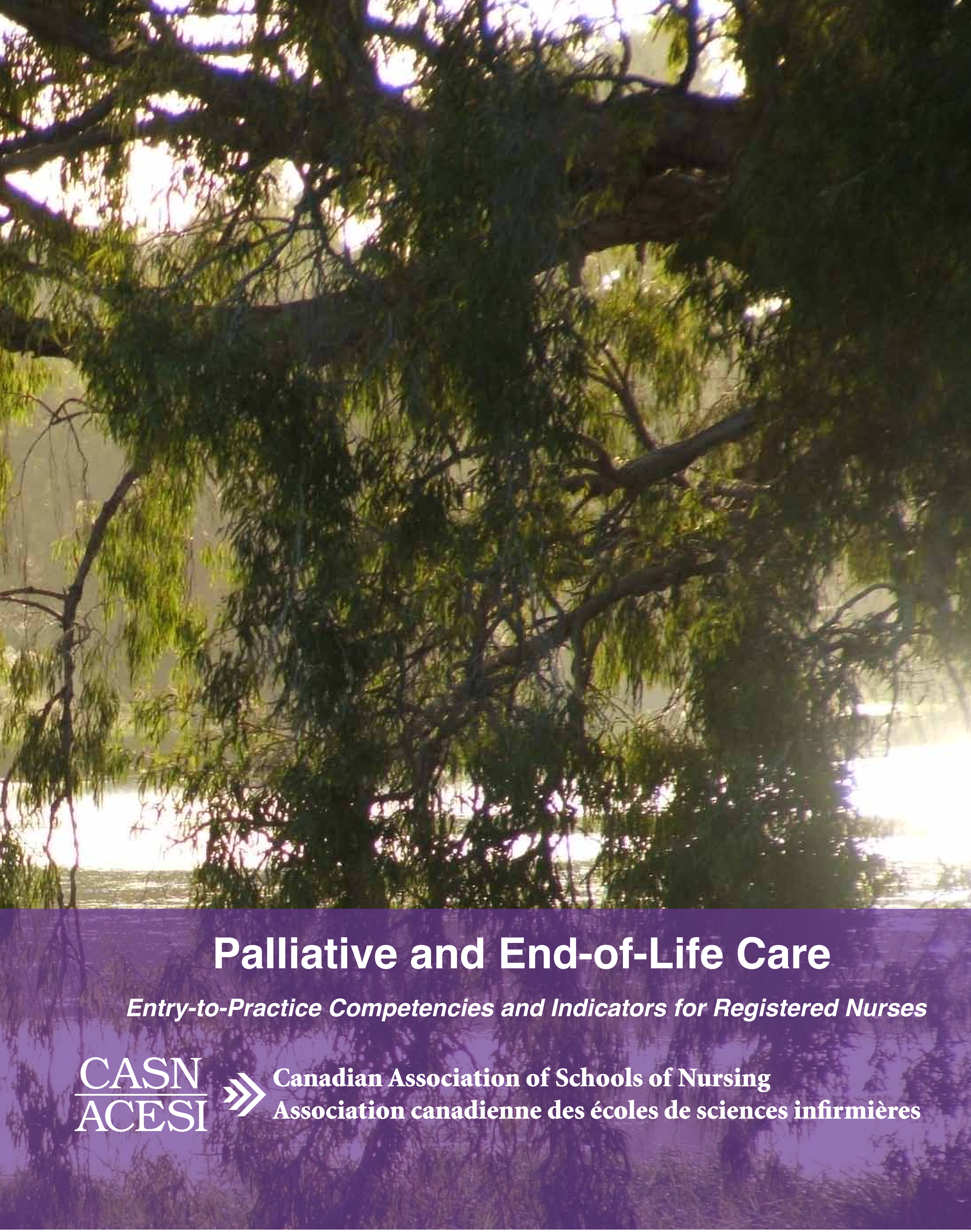

Palliative and End-of-Life Care

Entry-to-Practice Competencies and Indicators for Registered Nurses

CASN
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Canadian Association of Schools of Nursing
Association canadienne des écoles de sciences infirmières

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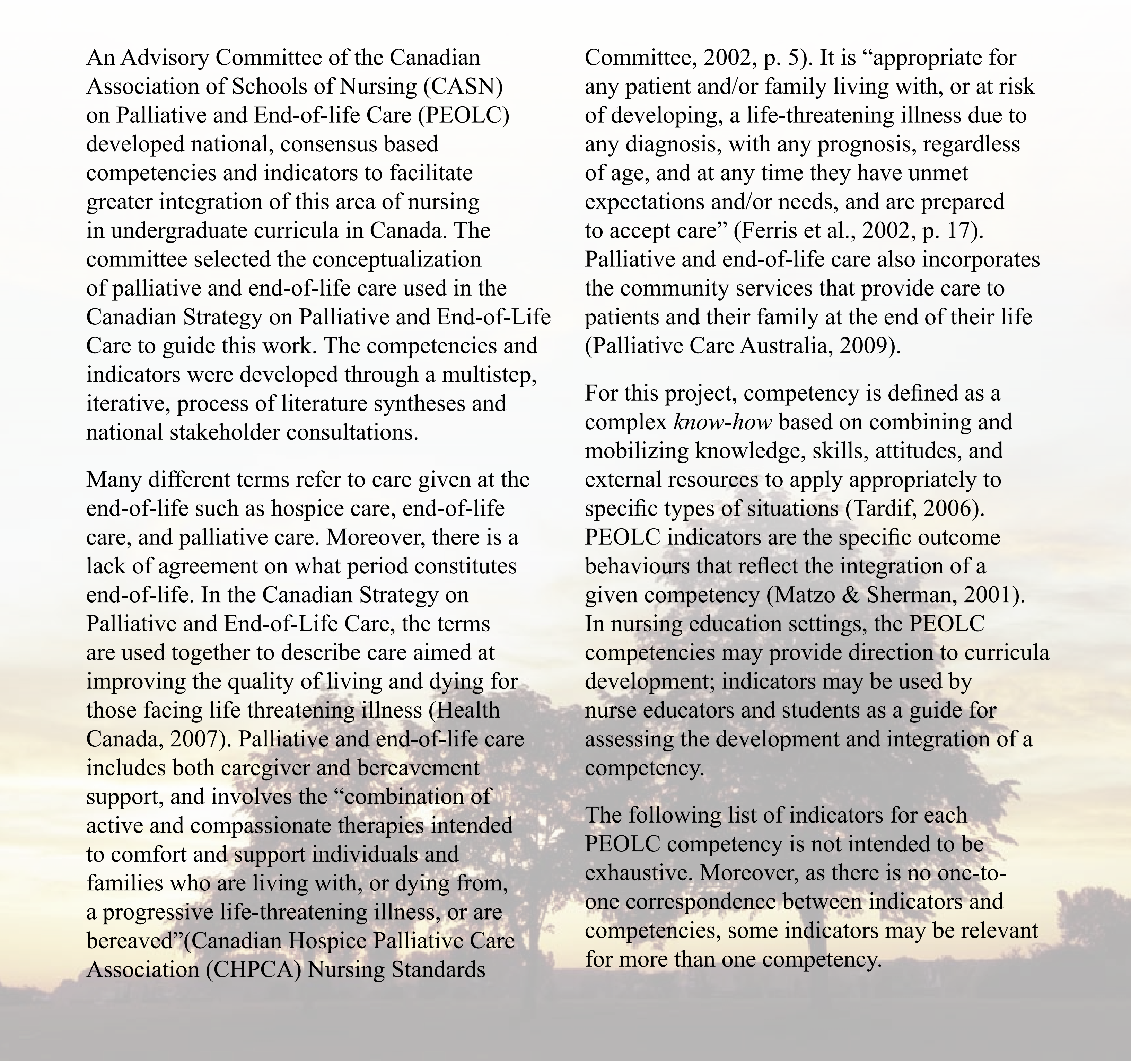
Palliative and End-of-Life Care Advisory Committee

Brenda Jacono (Chair), MScN, RN	School of Professional Studies, Department of Nursing, Cape Breton University
Cynthia Baker, PhD, RN	Canadian Association of Schools of Nursing - Executive Director
Darcee R. Bidgood, MSN, RN, CHPCN(C)	Canadian Hospice Palliative Care Nurses Group
Maryse Bouvette, BScN, MEd, RN, CON(C), CHPCN(C)	Palliative Care Program, Bruyère Continuing Care
Beryl Cable-Williams, BScN, MN, PhD, RN	Trent/Fleming School of Nursing, Trent University
Florence Flynn, MSW, RSW	Canadian Association of Social Workers Health Interest Committee
Heather Jewers, MN, CHPCN(C)	School of Nursing, St. Francis Xavier University
Evelyn Kennedy, PhD(c), RN	Canadian Association of Schools of Nursing - Board of Directors
Mireille Lavoie, PhD, RN	Faculté des sciences infirmières, Université Laval, Centre de recherche du CHUQ – Hôtel-Dieu de Québec
S. Lawrence Librach, MD, CCFP, FCFP	Association of Faculties of Medicine of Canada, Head, Division of Palliative Care, Dept. of Family & Community Medicine, and Sun Life Financial Chair in Bioethics and Director Joint Centre for Bioethics, University of Toronto
Mitzi G. Mitchell, BScN, BA, MHSc, MN, DNSc, PhD(c), RN, GNC(C)	Faculty of Health, School of Nursing, York University
Holly R. L. Richardson, BScN, MA, PhD(c), RN	School of Nursing, Dalhousie University
Christine Rieck Buckley, MScA, RN	Canadian Nurses Association
Sharon Specht, BA, BSN, RN, CHPCN(C)	Canadian Hospice Palliative Care Nurses Group
Mary Strain, BScN Student	Canadian Nursing Students' Association
Lynne E. Young, PhD, RN	School of Nursing, University of Victoria

Palliative and End-of-Life Care Competencies and Indicators Working Group

Lynne E. Young (Chair), PhD, RN	School of Nursing, University of Victoria
Darcee R. Bidgood, MSN, RN, CHPCN(C)	Canadian Hospice Palliative Care Nurses Group
Maryse Bouvette, BScN, MEd, RN, CON(C), CHPCN(C)	Palliative Care Program, Bruyère Continuing Care
Brenda Jacono, MScN, RN	School of Professional Studies, Department of Nursing, Cape Breton University
Heather Jewers, MN, CHPCN(C)	School of Nursing, St. Francis Xavier University
Christine Rieck Buckley, MScA, RN	Canadian Nurses Association

Preamble



An Advisory Committee of the Canadian Association of Schools of Nursing (CASN) on Palliative and End-of-life Care (PEOLC) developed national, consensus based competencies and indicators to facilitate greater integration of this area of nursing in undergraduate curricula in Canada. The committee selected the conceptualization of palliative and end-of-life care used in the Canadian Strategy on Palliative and End-of-Life Care to guide this work. The competencies and indicators were developed through a multistep, iterative, process of literature syntheses and national stakeholder consultations.

Many different terms refer to care given at the end-of-life such as hospice care, end-of-life care, and palliative care. Moreover, there is a lack of agreement on what period constitutes end-of-life. In the Canadian Strategy on Palliative and End-of-Life Care, the terms are used together to describe care aimed at improving the quality of living and dying for those facing life threatening illness (Health Canada, 2007). Palliative and end-of-life care includes both caregiver and bereavement support, and involves the “combination of active and compassionate therapies intended to comfort and support individuals and families who are living with, or dying from, a progressive life-threatening illness, or are bereaved”(Canadian Hospice Palliative Care Association (CHPCA) Nursing Standards Committee, 2002, p. 5). It is “appropriate for any patient and/or family living with, or at risk of developing, a life-threatening illness due to any diagnosis, with any prognosis, regardless of age, and at any time they have unmet expectations and/or needs, and are prepared to accept care” (Ferris et al., 2002, p. 17). Palliative and end-of-life care also incorporates the community services that provide care to patients and their family at the end of their life (Palliative Care Australia, 2009).

For this project, competency is defined as a complex *know-how* based on combining and mobilizing knowledge, skills, attitudes, and external resources to apply appropriately to specific types of situations (Tardif, 2006). PEOLC indicators are the specific outcome behaviours that reflect the integration of a given competency (Matzo & Sherman, 2001). In nursing education settings, the PEOLC competencies may provide direction to curricula development; indicators may be used by nurse educators and students as a guide for assessing the development and integration of a competency.

The following list of indicators for each PEOLC competency is not intended to be exhaustive. Moreover, as there is no one-to-one correspondence between indicators and competencies, some indicators may be relevant for more than one competency.

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Competencies and Indicators

1. Uses requisite relational skills to support decision making and negotiate modes of palliative and end-of-life care on an ongoing basis.

1.1. Discusses the benefits and burdens of the usual palliative and end-of-life (PEOL) treatment options to assist the patient and family members in meeting their goals of care, and documents the information provided.

1.2. Provides information and assurance to the patient and family members regarding comfort measures during the last days/hours of living, and documents the information provided.

1.3. Communicates respectfully, empathetically and compassionately with the PEOL patient and family members.

1.4. Conserves patient and family dignity by facilitating expression of their feelings, needs, hopes, joys, and concerns in planning for palliative and end-of life care.

1.5. Invites, facilitates, negotiates and respects the involvement of the patient and family members and other team members in discussions about the plan of palliative and end-of-life care.

1.6. Provides the opportunity for the patient approaching end-of-life to conduct a life review.

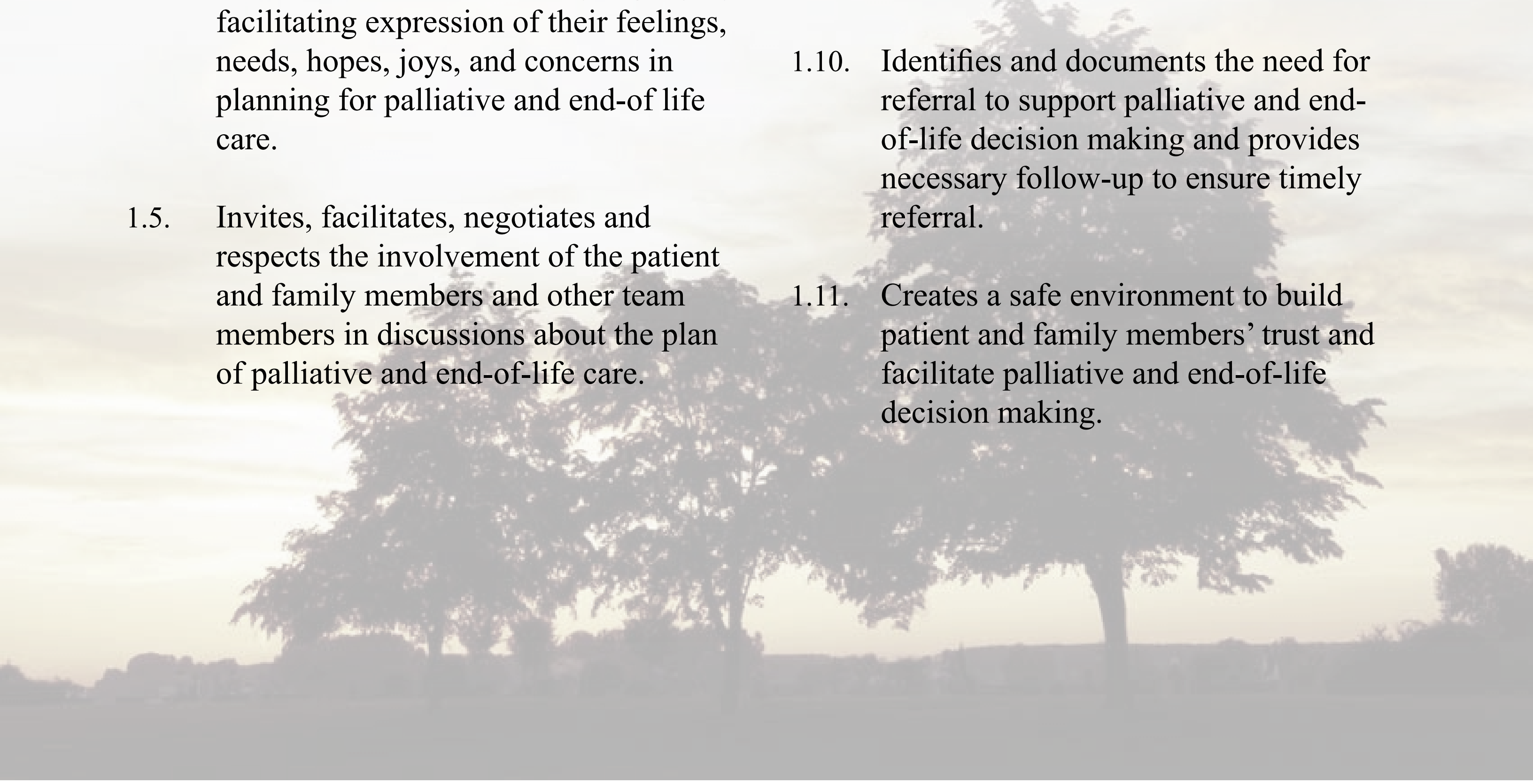
1.7. Reviews, and clarifies the patient and family members’ understanding of palliative and end-of-life care information presented by other care providers, and documents this.

1.8. Facilitates conversations that support end-of-life decision making such as health care directives, living wills and tending to personal affairs.

1.9. Communicates and documents decisions made by the patient and family members regarding their goals for palliative and end-of-life care.

1.10. Identifies and documents the need for referral to support palliative and end-of-life decision making and provides necessary follow-up to ensure timely referral.

1.11. Creates a safe environment to build patient and family members’ trust and facilitate palliative and end-of-life decision making.



2. Demonstrates knowledge of grief and bereavement to support others from a cross-cultural perspective.

2.1. Accurately assesses and documents the patient’s and family members’ needs related to loss, grief and bereavement.

2.2. Identifies individuals experiencing, or at high risk for experiencing, a complicated and/or disenfranchised grief reaction, and discusses, documents and makes appropriate referrals.

2.3. Uses insights gained from personal experiences of loss, bereavement and grief to provide supportive care to others.

2.4. Identifies situations when personal beliefs, attitudes and values result in limitations in the ability to be present for the patient and family members experiencing loss, grief, and/or bereavement.

2.5. Demonstrates understanding of grief theories and their application to PEOLC.

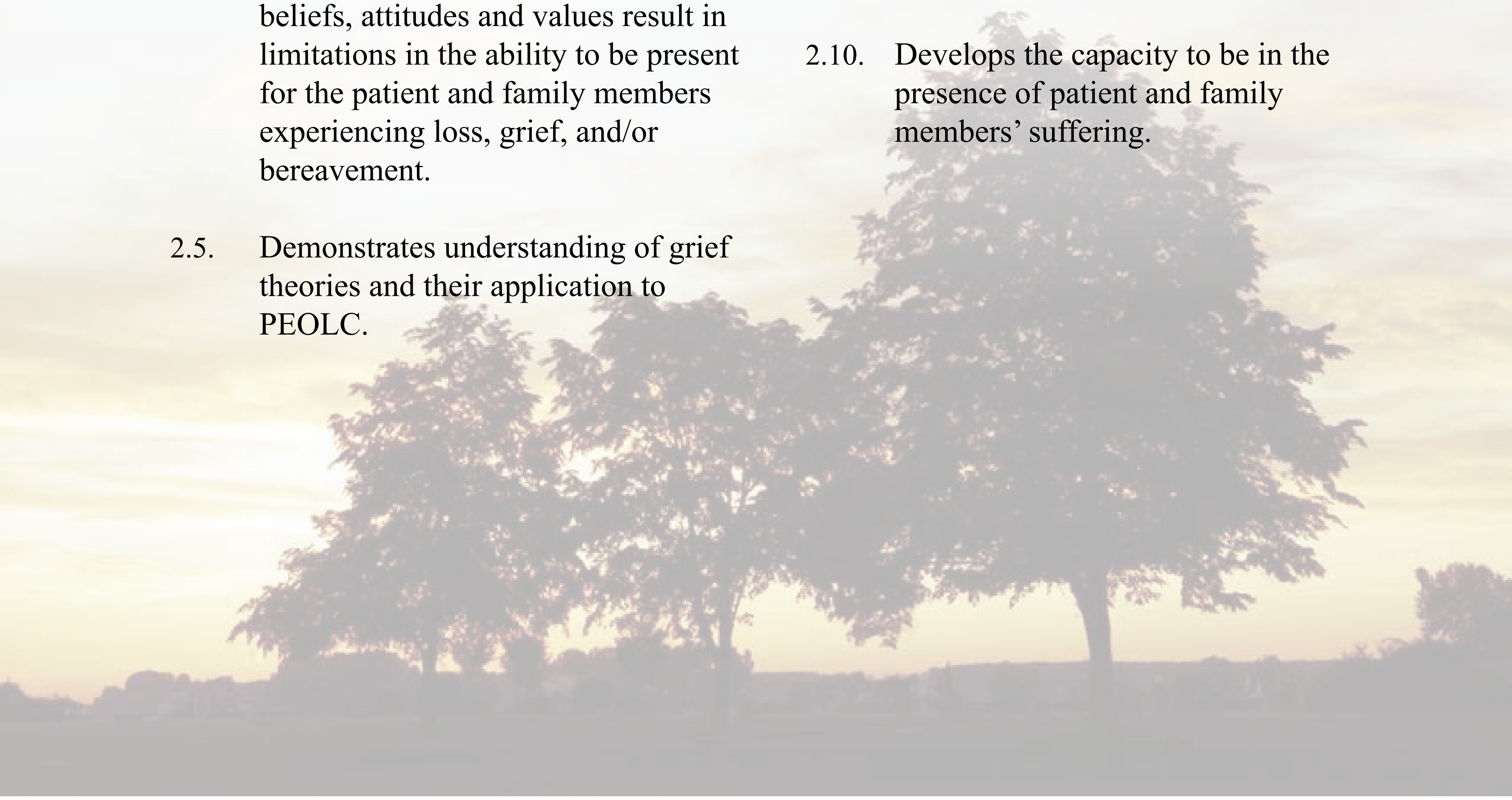
2.6. Demonstrates understanding of the common, normal manifestations of grief (emotional, physical, cognitive, behavioural).

2.7. Demonstrates understanding of individual, social, cultural, and spiritual variables that affect grief.

2.8. Provides guidance, support, and referrals to bereaved family members and documents such practice actions.

2.9. Listens, affirms, and responds empathetically and compassionately to the patient and family members working through the tasks of grief and bereavement.

2.10. Develops the capacity to be in the presence of patient and family members’ suffering.



3. **Demonstrates knowledge and skill in holistic, family-centered nursing care of persons at end-of-life who are experiencing pain and other symptoms.**

3.1. Identifies gaps in knowledge, skills, and abilities as a first step in acquiring new knowledge, skills, and abilities for PEOLC.

3.2. Demonstrates understanding of the concept of ‘total pain’ when caring for PEOL patients and their family members, total pain being inclusive of physical, emotional, spiritual, practical, psychological, and social elements.

3.3. Applies principles of pain and other symptom management when caring for PEOL patients.

3.4. Utilizes best practice assessment tools for baseline and ongoing assessment of pain, including word descriptors, body maps, precipitating and alleviating factors, and documents pain assessments.

3.5. Utilizes and documents evidence-informed pharmacological approaches to alleviate pain, including intended effects, doses and routes of medication, and common side-effects.

3.6. Utilizes and documents evidence-informed non-pharmacological approaches to pain, including any potential adverse effects.

3.7. Assesses and documents common non-pain symptoms at end-of-life.

3.8. Understands causes of common non-pain symptoms at end-of-life.

3.9. Implements and documents evidence-informed pharmacological and non-pharmacological approaches for non-pain symptoms at end-of-life.

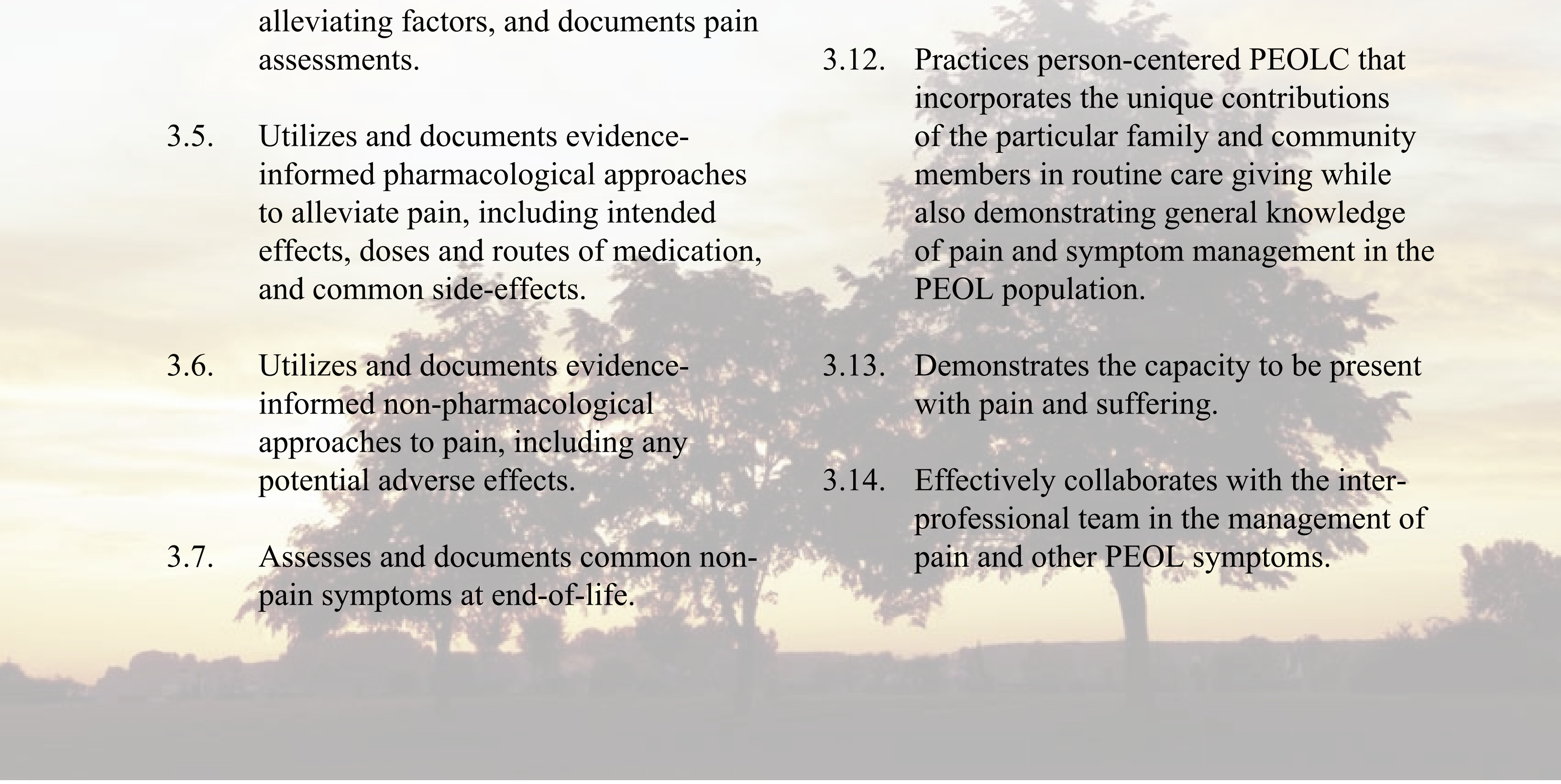
3.10. Discusses, teaches, assists PEOL patient and family members in managing pain and other symptoms including the recognition of areas requiring further assessment, and documents this.

3.11. Evaluates and documents all outcomes of pain and symptom management interventions throughout the course of the patient’s illness experience against a baseline assessment using comparative evaluations.

3.12. Practices person-centered PEOLC that incorporates the unique contributions of the particular family and community members in routine care giving while also demonstrating general knowledge of pain and symptom management in the PEOL population.

3.13. Demonstrates the capacity to be present with pain and suffering.

3.14. Effectively collaborates with the inter-professional team in the management of pain and other PEOL symptoms.



4. Recognizes and responds to the unique end-of-life needs of various populations, such as elders, children, multicultural populations, those with cognitive impairment, language barriers, those in rural and remote areas, those with chronic diseases, mental illness and addictions, and marginalized populations.

4.1. Recognizes and responds to the unique needs or backgrounds of patients of varying ethnicities, nationalities, cultures, genders, ages and abilities that may affect their experience of palliative and end-of-life care.

4.2. Identifies who the family is for the PEOL patient, and responds to family members' unique needs and experiences.

4.3. Adapts communication, assessment and information sharing to the unique needs of the PEOL patient and family members to facilitate informed decision-making, and consults with/refers to appropriate supports such as translated documents and interpreters.

4.4. Considers and incorporates the determinants of health when formulating a plan of care for PEOL patients and families with unique needs.

5. **Applies ethical knowledge skillfully when caring for persons at end-of-life and their families while attending to one's own responses such as moral distress and dilemmas, and successes with end-of life decision making.**

5.1. Identifies and addresses ethical issues in palliative and end-of-life care using ethical principles, and documents this.

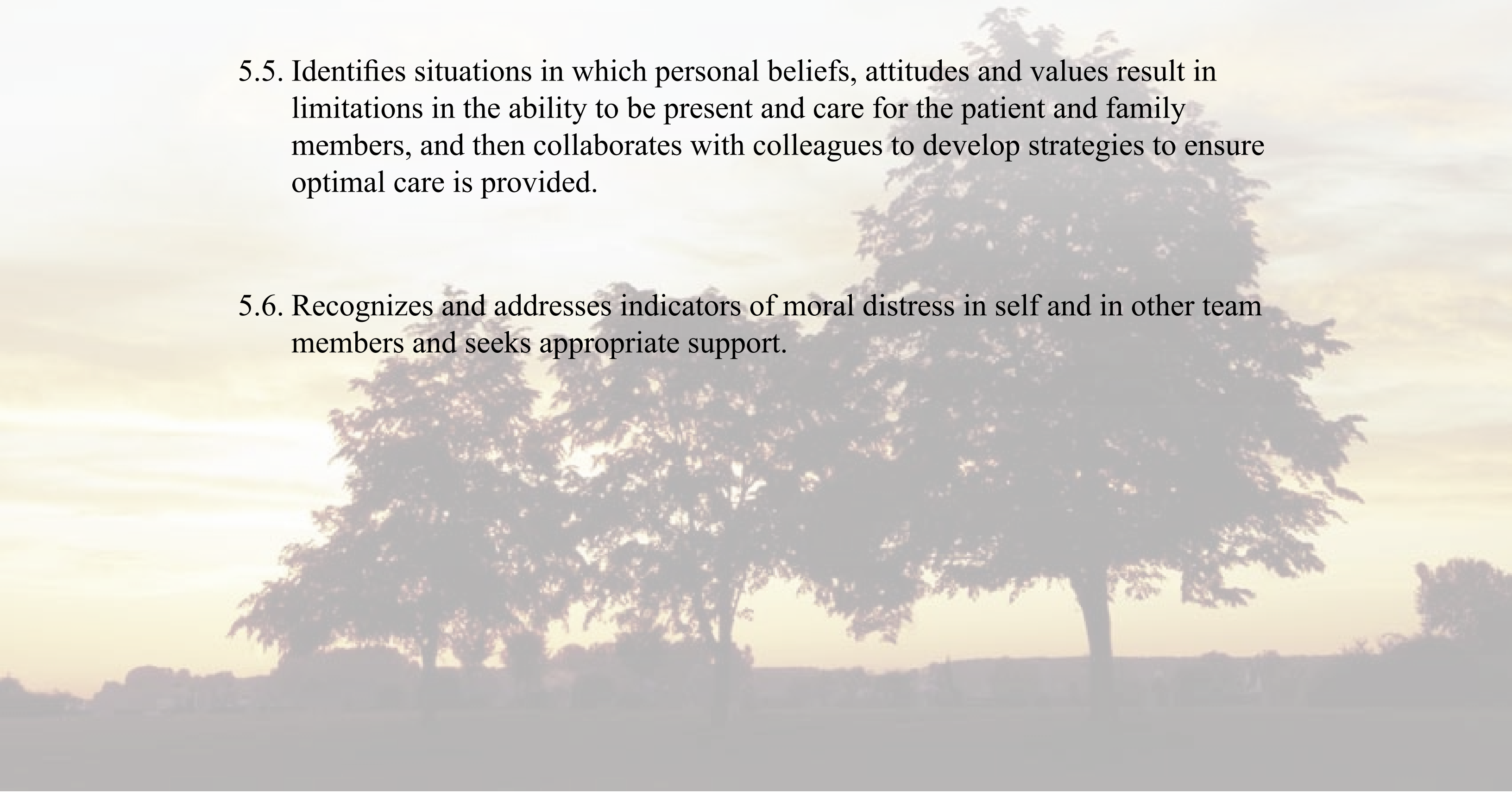
5.2. Provides the patient and family members with accurate and complete information to make informed decisions about treatment choices, and documents this.

5.3. Inquires about the patient's and family members' preferences regarding the extent to which they wish to be informed about the patient's condition and the treatment options, respects their wishes for information where ethically appropriate, and documents this.

5.4. Understands the distinctions among the following concepts: principle of double effect, palliative sedation, euthanasia, and physician assisted suicide.

5.5. Identifies situations in which personal beliefs, attitudes and values result in limitations in the ability to be present and care for the patient and family members, and then collaborates with colleagues to develop strategies to ensure optimal care is provided.

5.6. Recognizes and addresses indicators of moral distress in self and in other team members and seeks appropriate support.



6. **Demonstrates the ability to attend to psychosocial and practical issues such as planning for death at home and after death care relevant to the person and the family members.**

6.1. Identifies and provides verbal and written information about dying at home and after death care that the patient and family members' request, and documents the information provided.

6.2. Conducts and documents an assessment which includes emotional, psychological, social, spiritual and practical strengths and needs of the PEOL patient and family members.

6.3. Identifies and documents the PEOL patient's and family members' values, beliefs, and preferences regarding the various components of palliative and end-of-life care provision.

6.4. Demonstrates openness and sensitivity to social, spiritual and cultural values and practices that may influence palliative and end-of-life care preferences of the PEOL patient and family.

7. Identifies the full range and continuum of palliative and end-of-life care services, resources and the settings in which they are available, such as home care.

7.1. Demonstrates knowledge of the full range of PEOLC services, resources, and settings.

7.2. With compassionate empathy, initiates regular conversations with patient and family members about their goals of care.

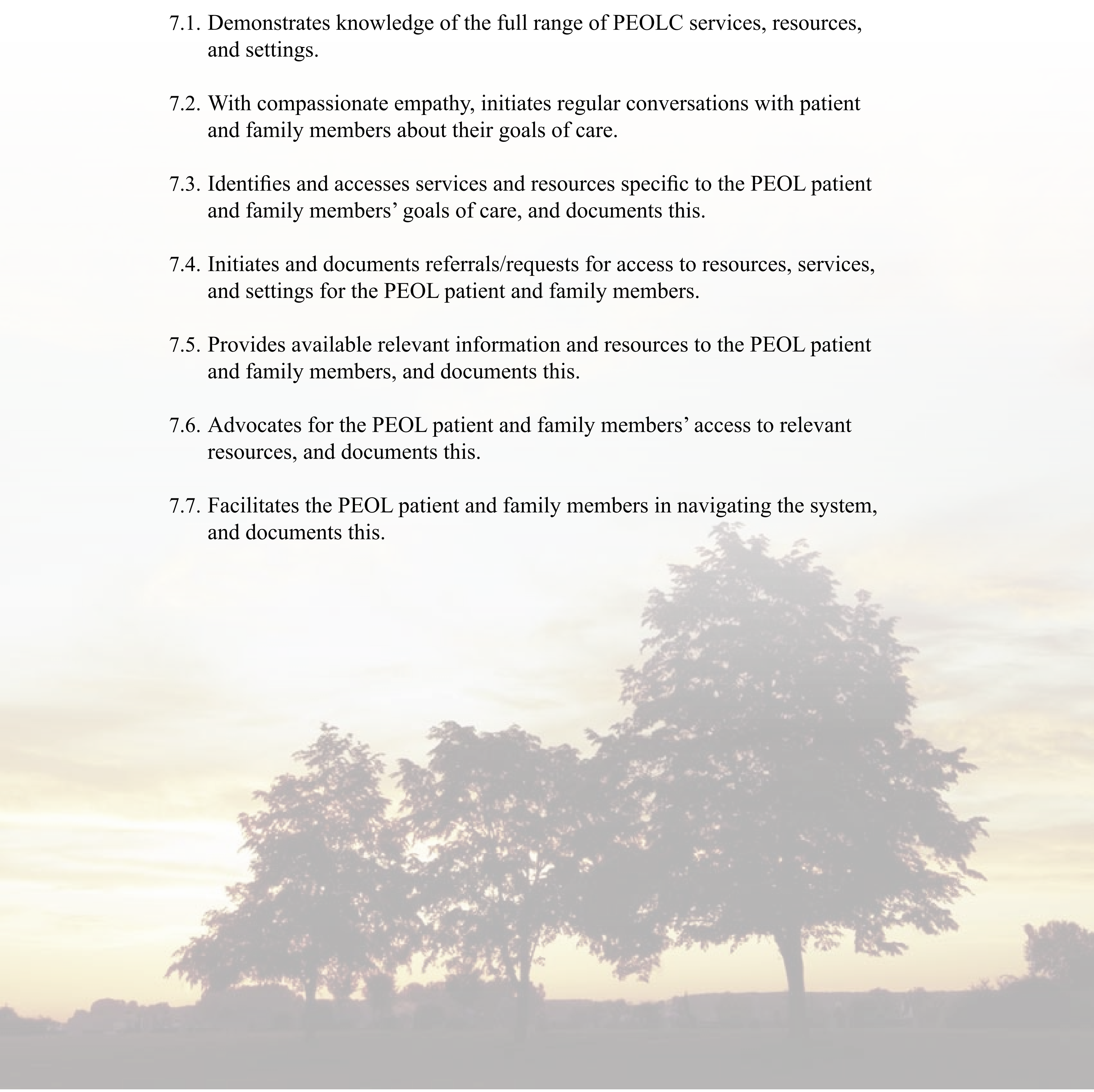
7.3. Identifies and accesses services and resources specific to the PEOL patient and family members' goals of care, and documents this.

7.4. Initiates and documents referrals/requests for access to resources, services, and settings for the PEOL patient and family members.

7.5. Provides available relevant information and resources to the PEOL patient and family members, and documents this.

7.6. Advocates for the PEOL patient and family members' access to relevant resources, and documents this.

7.7. Facilitates the PEOL patient and family members in navigating the system, and documents this.



8. **Educates and mentors patients and family members on care needs, identifying the need for respite for family members, and safely and appropriately delegating care to other caregivers and care providers.**

8.1. Facilitates the PEOL patient and family members' participation in care planning.

8.2. Identifies, documents, and integrates the strengths of the PEOL patient and family members in the plan of care.

8.3. Assists PEOL family members in the performance of caregiving roles.

8.4. Provides family members with opportunities and information to participate in research about family caregiving at the end-of-life.

8.5. Identifies, verifies, and advocates for perceived and real needs of the PEOL patient and family members, and documents this.

8.6. Engages in family and team conferences regarding the PEOL patient.

8.7. Develops a separate plan of care for the PEOL family members.

8.8. Assists the family members in acquiring respite care as needed, and documents this.

9. **Demonstrates the ability to collaborate effectively to address the patient and family members' priorities within an integrated inter-professional team, including non-professional health care providers, and the patient himself or herself.**

9.1. Demonstrates knowledge of the role of the nurse and other team members in PEOLC.

9.2. Communicates respectfully with the interprofessional team using effective communication skills including conflict management.

9.3. Builds on collaborative relationships with patient and family members, and members of the inter-professional palliative care team in determining patient's goals and plans of care.

9.4. Reflects on the need for different inter-professional team approaches in different situations.

9.5. Respects and considers the opinion, knowledge, and skills of others in a shared decision-making process regarding the priorities of care for the PEOL patient.

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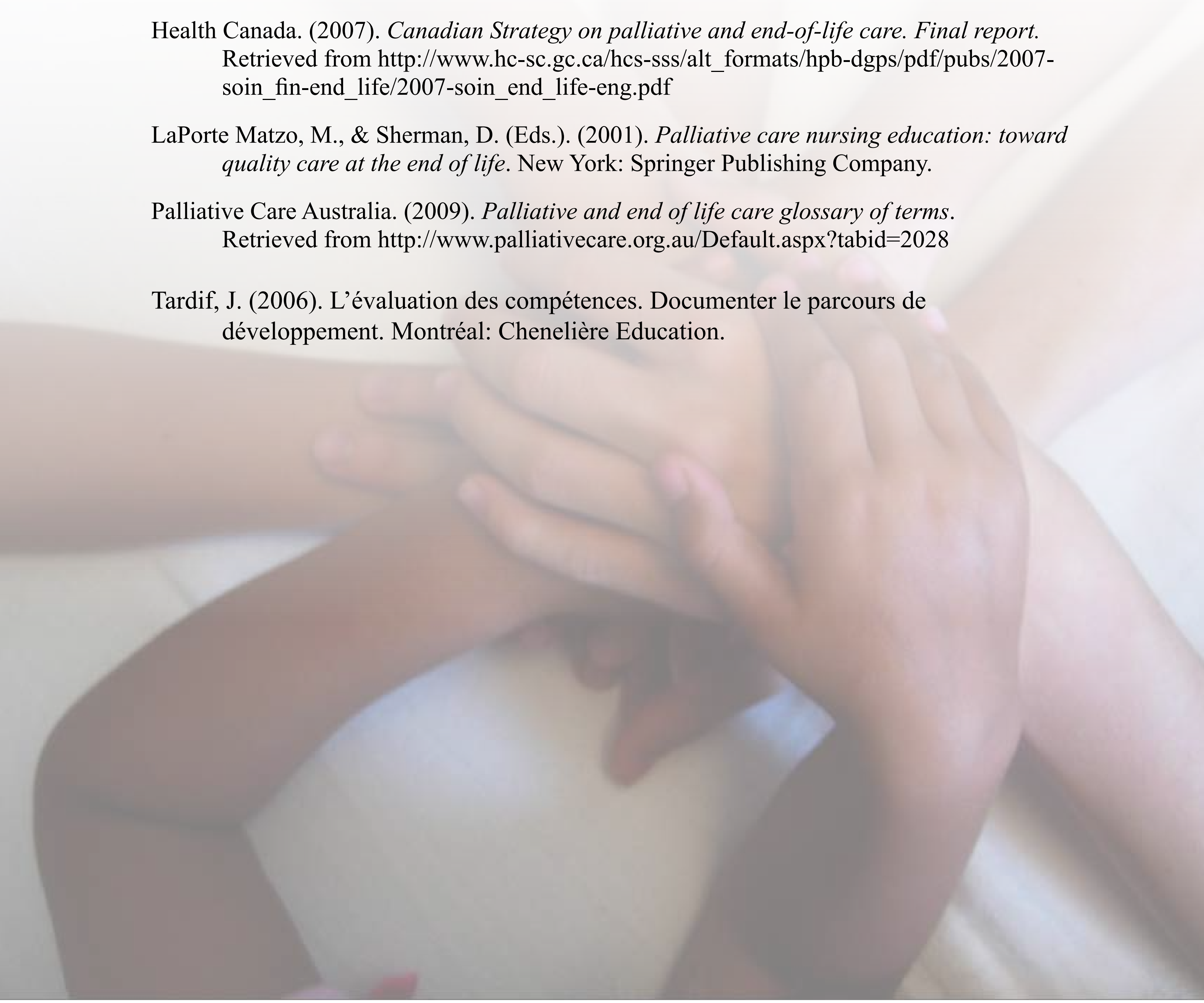

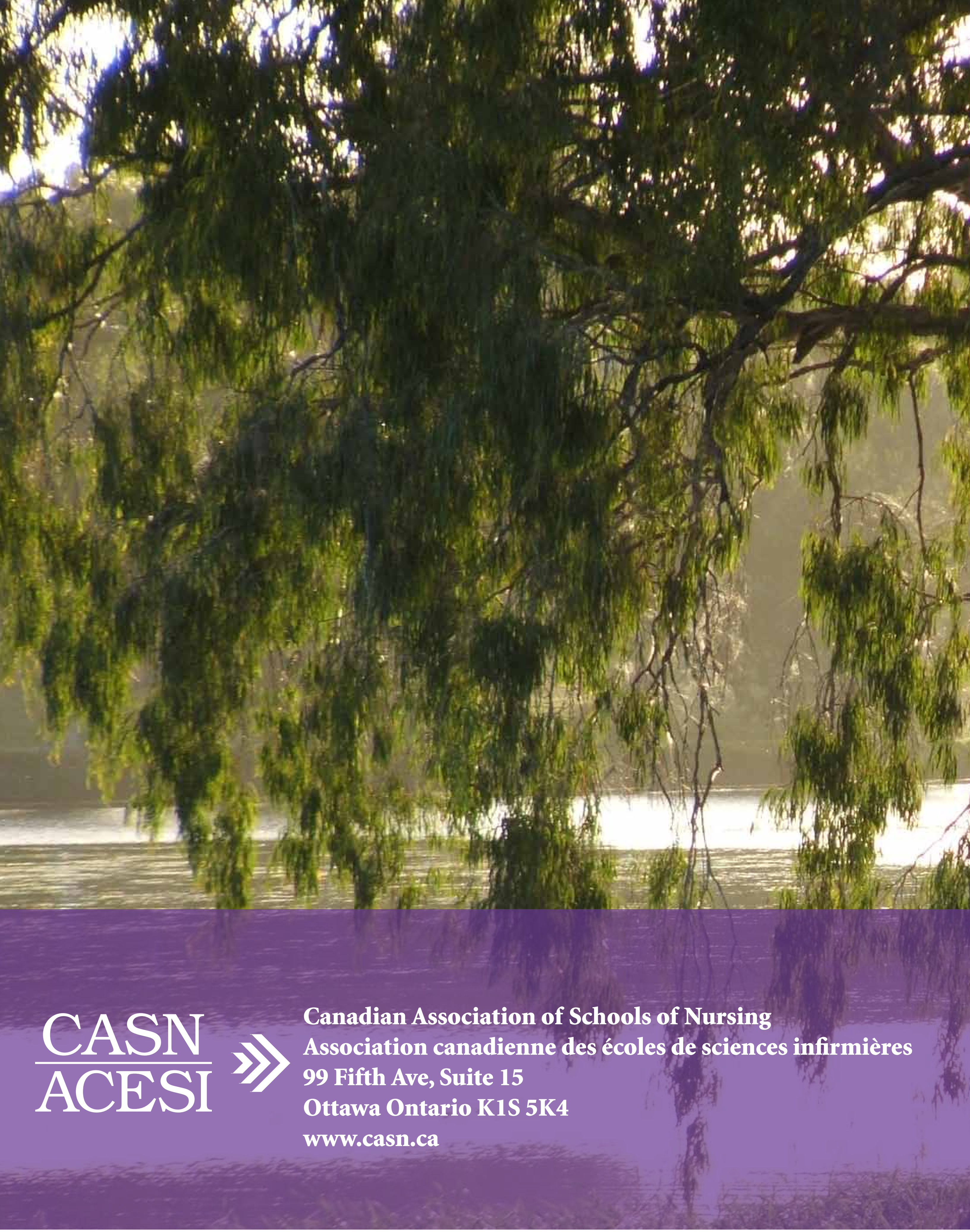

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Association canadienne des écoles de sciences infirmières
99 Fifth Ave, Suite 15
Ottawa Ontario K1S 5K4
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