

## Introduction

The Ontario Palliative Care Network's Provincial Education Steering Committee is developing a recommendation document that outlines palliative care competencies for health care providers delivering palliative care. Recognizing the comprehensive process the Nova Scotia Health Authority (NSHA) implemented to develop their recent Palliative Care Competency Framework (2017), the Steering Committee elected to leverage their document and validation process to adapt their work to the Ontario context. This document provides important background information about their development process, along with key information about how the document is structured.

## Establishing Palliative Care Competencies for Nova Scotia

The 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>1</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>2</sup>.

The Irish Framework uses a three level model to represent various discipline's palliative care competencies, the "all, some, few" model<sup>1</sup>. A similar model is used by the Institute for Palliative Medicine, the "basic, advanced and expert" levels of competencies<sup>3</sup>.

To simplify the framework, the NNSA WG elected to represent the competencies in two levels.

**Figure 1** illustrates the levels of palliative care competencies. The first level includes the shared and discipline-specific palliative care competencies for health professionals and who care for people with life-limiting conditions and their families. The second level outlines the shared and discipline-specific competencies for health professionals and volunteers who specialize or have a practice focused in palliative care<sup>a</sup>. 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**



<sup>a</sup> 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 Consult Team, practice in a Palliative Care Unit or Hospice, or practice in settings where the vast majority of patients require palliative care.

Professional associations and colleges have established discipline-specific core competencies for their members, which are required in order to be licensed to practice. Discipline-specific core competencies that do not relate to palliative care are not included in the document.

In addition to the discipline-specific core competencies outlined by the professional colleges/associations, the practice of those caring for patients with life-limiting conditions should be guided by the shared and discipline-specific palliative care competencies outlined in the framework.

Please note, the shared competencies should be considered within the discipline-specific scope of practice. For example, while all disciplines play a role in optimizing comfort and quality of life, the discipline-specific functions related to optimizing comfort and quality of life vary amongst disciplines.

In addition to the shared and discipline-specific palliative care competencies, the practice of health professionals and volunteers who specialize in, or have a practice focused on, palliative care should be guided by the shared and discipline-specific palliative care specialty competencies outlined in the document. As noted above, the shared competencies should be considered within the discipline-specific scope of practice.

**Important**

Throughout the document the **discipline-specific** competencies are highlighted by a shaded background like this one. Refer to example below

**Example:**

Shaded  
backgrounds  
highlight the  
discipline- specific  
competencies

#### Additional Competencies for Pharmacists with a Practice Focused in Palliative Care

##### Principles of Palliative Care

- Applies the Dignity Conserving Care approach 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 in routine care giving
- Demonstrates an understanding of palliative care standards, guidelines and policies
- Demonstrates an in-depth knowledge of the use of specialist resources providing information regarding medicines used in palliative care
- Demonstrates leadership in the identification, development and delivery of pharmacy related palliative care policy
- Identifies and actively responds to complex medication information needs of health professionals

##### Communication

- Uses a variety of strategies to engage in highly skilled, compassionate, individualized and timely communication with patients, their families, caregivers and members of their care teams
- Maintains ongoing communication with the patient, family and care teams regarding end-of-life plan of care
- Demonstrates expertise as a mediator and advocate for the patient to access appropriate and timely palliative care
- Demonstrates awareness of one's own responses to communication challenges and remains engaged in meaningful contact with patients, family and caregivers
- 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 pharmaceutical options to assist the patient in meeting their goals of care
- Communicates patients' medication management needs to other health professionals
- Demonstrates expertise as a mediator and advocate for the patient in issues and decision making regarding pharmaceutical care
- Teaches communication skills regarding pharmaceutical care to members of the discipline and the Interprofessional Team

## Nova Scotia Competency Framework Development Process

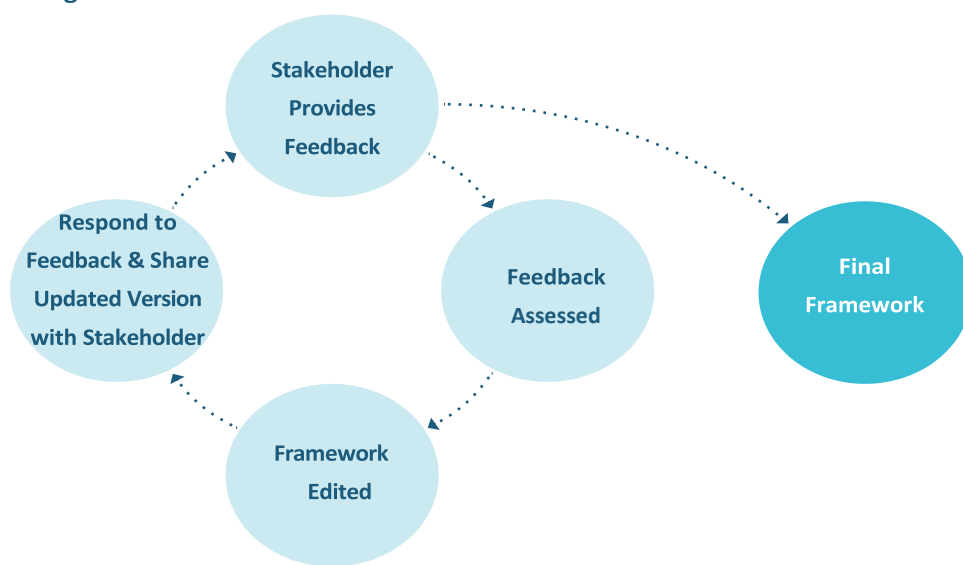
The Irish Framework was adapted to the Nova Scotia context and in a number of cases additional competencies were added. In addition, terminology specific to the Irish practice context was altered to reflect the Canadian health care system. The palliative care competencies established by national, provincial and, in some cases, American professional associations and colleges were also incorporated. The NSHA WG reviewed the competencies in detail and 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 discipline practicing in any setting, so references to documenting palliative interventions were removed, unless emphasis was warranted.

In order to represent all of the disciplines involved in palliative care in Nova Scotia, the NSHA WG expanded upon the Irish Framework to include competencies for a number of additional professions. The NSHA WG elected not to include every discipline that could be involved with the care of patients with life-limiting conditions. For many of these disciplines, palliative care competencies are reflected in their discipline-specific core competencies. Disciplines not named in the document are expected to understand and apply the principles of palliative care in their practice. Members of all disciplines will be invited to attend palliative care education programs.

The competencies outlined in the document are aligned with Accreditation Canada's Standards for Hospice, Palliative Care and End-of-Life Services, as well as documents from the Canadian Hospice Palliative Care Association<sup>4,5,6,7,8,9</sup>. The competencies outlined in the document are also aligned with Accreditation Canada's Community, Critical Care, Cancer Care and Emergency Care Standards.

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 2 illustrates the review process.

**Figure 2. Review Process**



## Ontario's Framework Development Process

We are engaging in a similar process in Ontario. At this point, we have edited the framework and we are currently seeking validation for the competencies from their respective professional colleges/associations. The feedback received will inform the final draft competency framework document. The document will be sent back to the same professional colleges/associations for endorsement.

## Competency Domains

For the most part, the Framework uses the six competency domains defined in the Irish Framework<sup>1</sup>. 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>1</sup>

### ***Communication:***

Effective communication is essential to the application of the palliative approach. 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 interprofessional teamwork.<sup>1</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>1</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, 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>1</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. Most people manage their loss by combining their own resources with support from family and friends. However, some people are at risk for developing complications or difficulties with grief. Professionals using the palliative approach have an important role to play in supporting bereaved people by providing information and support and by identifying those who require therapy or counselling.<sup>1</sup>

### ***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>1</sup>

To reflect the values of the NSHA seven domains were added:

### ***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.

### ***Cultural Safety:***

Cultural safety is predicted 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>10</sup>.

### ***Education:***

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

### ***Evaluation:***

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

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

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

### ***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.

### ***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>11</sup>.

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.

## References:

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- <sup>4</sup> Canadian Palliative Care Nursing Standards Committee. (2014). Canadian hospice palliative care nursing standards of practice. Retrieved from <http://www.chpca.net/professionals/nurses.aspx>.
- <sup>5</sup> The Canadian Nurses Association (CNA), the Canadian Hospice Palliative Care Association (CHPCA) and the Canadian Hospice Palliative Care Nurses Group (CHPC-NG). (2015). Joint Position Statement – The palliative approach to care and the role of the nurse. Ottawa: Authors.
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- <sup>7</sup> Cooper, D., Barnes, P., Horst, G., Sinclair, S. and Associates. (2013). How Spiritual Care Practitioners Provide Care In Canadian Hospice Palliative Care Settings: Recommended Advanced Practice Guidelines and Commentary. Ottawa: The Spiritual Advisors Interest Group, Canadian Hospice Palliative Care Association.
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- <sup>10</sup> Aboriginal Nurses Association of Canada, Canadian Association of Schools of Nursing and the Canadian Nurses Association. (2009). Cultural Competence & Cultural Safety in First Nations, Inuit and Métis Nursing Education an Integrated Review of the Literature. Ottawa: Aboriginal Nurses Association of Canada.
- <sup>11</sup> Breiddal SMF. (2012) Self-care in palliative care: A way of being. *Illness, Crisis & Loss*, 20: 5-17.