THE CANADIAN INTERDISCIPLINARY PALLIATIVE CARE COMPETENCY FRAMEWORK

A curriculum guide for educators and reference manual for disciplines providing palliative care.

CANADIAN PARTNERSHIP AGAINST CANCER
PARTENARIAT CANADIEN CONTRE LE CANCER

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Acknowledgements

The Canadian Partnership Against Cancer (the Partnership) was created in 2007 by the Government of Canada. Since then, our primary mandate has been to move Canada's cancer control strategy into action and help it succeed through coordinated, system-level change across the full cancer care continuum. To do this, the Partnership works closely with national, and provincial and territorial partners.

Developing this Framework would not have been possible without the participation and dedicated efforts of the members of the Palliative and End-of-life Care National Network (PEOLCNN). The Partnership and Health Canada would like to acknowledge the significant contributions of the PEOLCNN and the numerous expert advisors and leaders, educators, clinicians, patients and family members, policy makers, researchers, health service planners, and cancer control organizations that have helped shape this Framework. The Partnership and Health Canada would especially like to acknowledge the invaluable contributions also made by the BC Centre for Palliative Care, the Canadian Society of Palliative Care Physicians, and Pallium Canada.

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SECTION 1

Introduction

Canadians want and need high-quality palliative care

One measure of a society's commitment to its most vulnerable citizens is how the society helps people through the difficult consequences of life-limiting illnesses. High-quality palliative care provides the physical, psychosocial, and spiritual support people and their families or caregivers need as they navigate some of the most challenging events of their lives. Palliative care helps people live more fully, and more comfortably – even through the stages of advanced disease.

Yet, although the number of Canadians suffering from life-limiting illnesses continues to increase, most do not receive any palliative, hospice, or end-of-life care. According to available data in a 2018 report called *Access to Palliative Care in Canada*, 75 per cent of Canadians want to die at home, but only 15 per cent were able to do so supported by home palliative care.[1] This report also found that 89 per cent of Canadians could benefit from palliative care in their last year of life. But, at present, our health system does not have sufficient numbers of people with the skills, knowledge, and attitudes required to provide people and their families or caregivers with palliative care whenever and wherever they need it.

An Ipsos survey conducted in 2016 on behalf of the Palliative Care Matters initiative showed that Canadians support high-quality palliative care for all people, regardless of where they live. Eighty-six per cent of respondents said our public health system should cover the costs of palliative care as people need it – whether in hospitals, hospices, or in the home. Respondents also said they want strong national leadership for palliative care in Canada, and that the providers caring for people should have the required skills and knowledge to deliver high-quality palliative care.[2] However, in a 2014 survey of primary care physicians and nurses,[3] although there was strong support for the value of palliative care, most respondents did not feel comfortable or prepared to provide it.

In 2017, federal legislation set in motion the development of a national palliative care framework. Bill C-277 called for better access to palliative and end-of-life services in community and home settings, including hospitals, long-term care facilities and residential hospices. It also called on the federal government to work with the provinces and territories, as well as palliative care experts, to develop a structure that will guide and support the implementation of high-quality palliative care services.

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[1] Canadian Institute for Health Information. *Access to Palliative Care in Canada*. Ottawa, ON: CIHI; 2018.

[2] Palliative Care Matters. *News Release - Ipsos Survey Report: Canadians Strongly Support Access to High Quality Palliative Care*. 2016.

[3] Canadian Hospice Palliative Care Association. *The way forward - moving towards an integrated palliative approach to care: Survey of GP/FPs and nurses in primary care, Final report*. 2014.

In response to the legislation, and after extensive consultation with provinces and territories, experts, and stakeholders (including people with lived experience) across Canada, Health Canada developed the *Framework on Palliative Care in Canada* (2018)[4] and the Action Plan on Palliative Care (2019)[5].

The latter calls for the development of a pan-Canadian, interdisciplinary palliative care competency framework that documents essential skills, knowledge, and abilities for health care workers.

Building on a foundation of provincial research

Health Canada worked closely with the Canadian Partnership Against Cancer (the Partnership) to create the *Canadian Interdisciplinary Palliative Care Competency Framework*.

This framework leverages and owes a strong debt of gratitude to the work several provinces have done to establish palliative care competency frameworks for their jurisdictions. They include Quebec, Nova Scotia, British Columbia, Ontario, and Alberta. In addition, the framework is built on discipline-specific competencies for medicine, nursing, social work, personal support work, and volunteering. Health Canada, the Partnership, and their partners synthesized the provincial and discipline-specific work and assembled a comprehensive set of interdisciplinary competencies common to all provinces and territories across five disciplines – both for those who specialize in palliative care, and for those who wish to integrate its principles into another discipline.

While the aim was to create a national standard and interdisciplinary set of competencies, educators and administrators using this document may need to make adaptations if roles and responsibilities are different within their province or territory.

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[4] Health Canada. *Framework on palliative care in Canada*. Ottawa, ON: Health Canada; 2018.

[5] Health Canada. *Action Plan on Palliative Care: Building on the Framework on Palliative Care in Canada*. Ottawa, ON: Health Canada; 2019.

75% of Canadians want to **die at home** but **only 15%** were able to do so **supported** by home **palliative care**

Underserviced populations

Specially referenced in the *Canadian Strategy for Cancer Control* (2019), underserviced populations are more likely to experience difficulty in obtaining necessary healthcare in Canada. They may receive less or a lower standard of care, and they may experience differential treatment by health care providers. Consequentially, members of underserviced populations often report receiving treatment that does not meet their needs, or less satisfaction with healthcare than the general population.[6] The inequities they report experiencing are further intensified by the historical and personal traumas they may have experienced, as well as ongoing systemic injustices. The cumulative result for members of underserviced populations may be that they experience poorer health outcomes compared to other Canadians, including receiving limited or no palliative care.

The term *underserviced populations* is used in this framework to refer to individuals who identify with belonging to any of these populations: perinatal, infants, children, adolescents, and young adults; the elderly; First Nations, Inuit, and Métis; racial or ethnic minorities; members of minority language communities; members of the LGBTQ2 community; immigrants and refugees; persons who have illnesses other than cancer; those who live in rural, remote, and northern communities, or are socioeconomically disadvantaged, houseless, incarcerated, engage in sex work, or have mental or cognitive impairments. Please note that this is not an exhaustive list and it can be expanded upon.

In recognition of the diversity of Canadians and their families, we have added the term “designated” in front of “family” to infer that family is whomever the person receiving palliative care identifies to be in this role for them, regardless of biological relationship. This may be especially important to consider for members of underserviced populations.

First Nations, Inuit, and Métis-specific palliative care competencies

There are many factors that amplify the challenges First Nations, Inuit, and Métis experience when it comes to access to and experience of palliative and end-of-life care, including the historical impacts of colonization, intergenerational trauma, and ongoing systemic racism. Further, palliative care that is currently provided within the healthcare system often does not address priorities that are important to First Nations, Inuit, or Métis. As a result, the provision of culturally safe palliative care for First Nations, Inuit, and Métis is complex.

The inclusion of competencies specific to First Nations, Inuit, and Métis in this framework reflects Canada’s commitment to reconciliation, the momentum of cultural safety, and the partnerships that have been built across the country. To fully address racism and prejudice will require broader societal efforts, however, their impact on care can be mitigated through comprehensive education and training. The *Canadian Strategy for Cancer Control* (2019) calls for all cancer care providers to receive education and training on community realities and First Nations-, Inuit- and Métis-defined cultural safety to understand and to provide culturally appropriate palliative care that respects the values of Indigenous peoples.

Palliative care services are often limited or not available on reserve or in remote or isolated communities, requiring people to travel great distances to seek care that is not always culturally safe or inclusive of community protocols and practices. A lack of pain and symptom management close to home, as well as challenges in navigating the healthcare system, can further affect the provision of palliative care services. To address these gaps and to ensure equitable, high-quality palliative care, the distinct needs, beliefs, and

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[6] Canadian Partnership Against Cancer. *2019-2029 Canadian Strategy for Cancer Control*. Toronto, ON: 2019.

values of each community must be considered when developing a palliative care plan. For these reasons, this framework requires competencies specific to the care of First Nations, Inuit, and Métis.

While broader competencies addressing care to First Nations, Inuit, and Métis are included in this framework, further engagement with First Nations, Inuit, and Métis governments, organizations, and communities is needed to identify gaps and opportunities in service delivery, and inform the development of the core competencies all palliative care providers should demonstrate when working with and caring for First Nations, Inuit, and Métis.

What this document seeks to achieve, and how to use it

This document establishes a minimum national standard for palliative care in Canada, and it seeks to direct consistent implementation and measurement of palliative care competencies in practice. It serves as a guiding document for jurisdictions that lack an explicit set of palliative care competencies, and also as high-level guidance for provinces that have built their own competency frameworks. We have written it with several readers in mind:

Individuals, managers and human resources personnel will use it to fill skills gaps and guide hiring practices.

Educators will use it to identify minimum standards for palliative care competencies, weave the development of essential skills into existing curricula, or build new curricula to teach the competencies.

National accreditation and regulatory agencies will use it as a guide for establishing minimum national standards in palliative care.

Competency tables and professional domains

The bulk of this document comprises a set of tables (section 2) that provide detailed information about the skills health care providers and volunteers must have to meet a minimum national standard for palliative care competency.

The tables are organized under five disciplines – nurses, physicians, social workers, personal support workers*, and volunteers – and further divided under 12 professional domains. We provide a definition of each professional domain on page 8.

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* Please note that across Canada, in different provinces and territories, and in different settings, personal support workers may be identified as continuing care assistants, health care assistants, nursing assistants, and by other similar titles. We have used the title of personal support workers here for simplicity; however, we are referring to all titles that refer to this discipline.

Skills self-assessments

In Appendix 1, we have tailored a set of skills self-assessment tools for the five health care provider disciplines. In addition, the competencies are divided into generalist and specialist levels for nursing and social work.

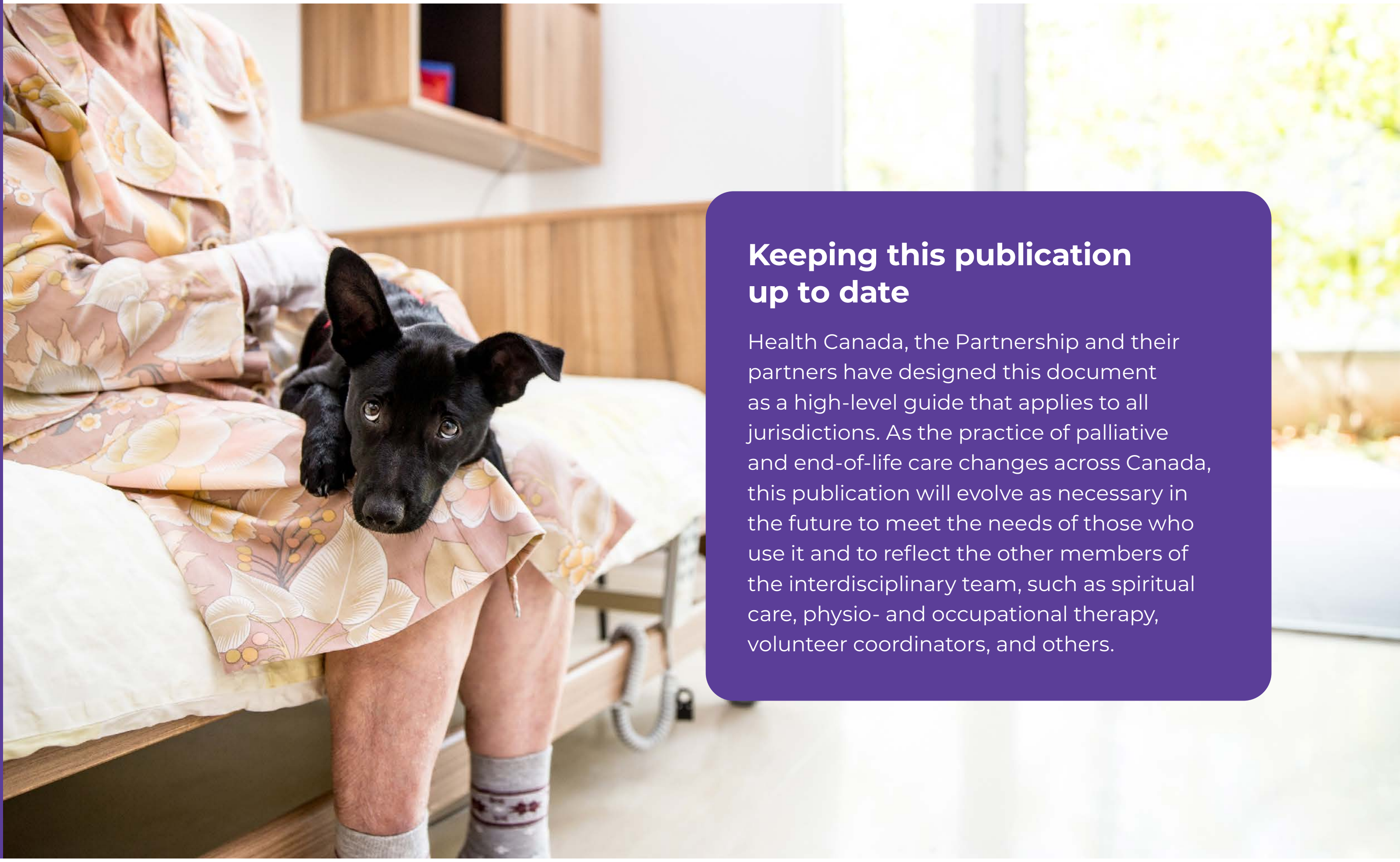
These tools provide the health care practitioner with a snapshot of their own competencies at a given point in their career. The self-assessments provide managers with tools to gauge the levels of palliative care competencies within a team. The results of the self-assessments can guide professionals and managers as they customize continuing education plans to build skills and improve the delivery of palliative care.

Education resources

Appendix 2, our education section, provides links to organizations that provide or curate up-to-date educational resources in palliative care. Professionals and organizations will use these resources as one tool for tailoring learning plans and improving the practice of palliative care.

Glossary of terms

A glossary of terms is provided in Appendix 3 to clarify the meaning of particular terminology used in the competency tables and to expand upon the competencies and associated skills.



Keeping this publication up to date

Health Canada, the Partnership and their partners have designed this document as a high-level guide that applies to all jurisdictions. As the practice of palliative and end-of-life care changes across Canada, this publication will evolve as necessary in the future to meet the needs of those who use it and to reflect the other members of the interdisciplinary team, such as spiritual care, physio- and occupational therapy, volunteer coordinators, and others.

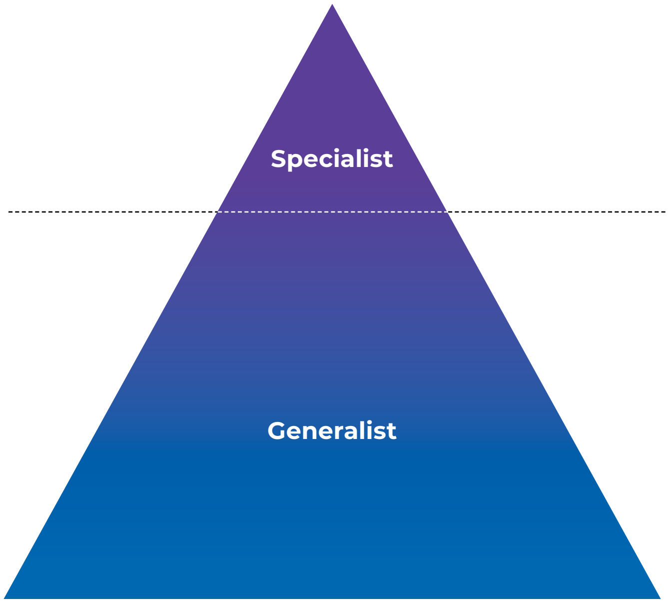
A competency framework for two levels of care

After extensive consultations with our partners and stakeholders, we have tailored the Canadian competency framework for two levels of care: the generalist and the specialist. We recognize that some health care providers will move between the two levels of care, depending on their specific expertise.

If you are using this document in conjunction with a provincial palliative care competency framework, you may notice that some provinces include a middle level, called "Enhanced practice." This represents health care providers who have enhanced knowledge and expertise in palliative care, and may provide local consultation, but do not have a specialized practice. Competencies for these enhanced groups are likely included in some of the specialist and generalist competencies in this document. This Canadian framework does not include the middle level because of the wide classification variations we found between and within provinces.

For the purposes of the Canadian competency framework, we define "competency" as follows:

> *A competency is a cluster of related knowledge, skills and attitudes that affects a major part of one's job (a role or responsibility), that correlates with performance on the job, that can be measured against well-accepted standards, and that can be improved via training and development.*
>
> —Parry, 1996[7]



Specialist: A health care provider whose practice is focused on palliative care and consultation for people and families or caregivers affected by life-limiting conditions, especially those with complex needs.

Generalist: A health care provider whose practice includes people with life-limiting conditions and their families or caregivers, but not as the primary focus of their practice.

Generalists provide palliative care in partnership with specialists in three models:

1. maintaining primary responsibility with specialist consultation
2. sharing care with specialists
3. transferring the patient to specialists

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[7] Parry, S. B. *The quest for competencies*. Training. 1996;33(7):48–54.

Twelve domains of competency

The Canadian Interdisciplinary Palliative Care Competency Framework is organized under 12 domains of practice. These domains were adapted from several existing palliative care competency frameworks, and we are grateful for the permission to reuse them in this synthesis.

1. Principles of a palliative approach to care

Palliative care aims to improve the quality of life of people with life-limiting conditions and their designated families or caregivers. This person-centred care ideally begins at diagnosis, continues into bereavement, and is for people of any age.

2. Cultural safety and humility

This domain is built on a foundation of seeking to understand and address power differentials and inequities in the social, political, and historical context of healthcare. Through self-reflection and consideration of the concepts of racism, discrimination, and prejudice, health care providers can practice relationship-based care.

3. Communication

Communication is essential in care of those affected by life-limiting illness. The person, their designated family or caregivers, and team may experience uncertainty and strong emotions. Effective communication helps to establish therapeutic relationships, ensures that people, and designated families and caregivers understand and participate in decision-making, enables interdisciplinary teamwork, and facilitates smooth transitions between care settings. Communication may be verbal or written, and may include the use of technology.

4. Optimizing comfort and quality of life

Optimizing comfort and quality of life as defined by the person and their designated family or caregiver(s) by addressing their holistic needs. This is an ongoing, dynamic, and proactive process, aimed at relieving and preventing suffering. The process includes effective symptom management in alignment with the person's and their designated family or caregiver's goals of care.

5. Care planning and collaborative practice

Care planning and collaboration enables integrated, coordinated, person-centred care that optimizes comfort and quality of life. Collaboration involves the person and their designated family or caregiver(s), interdisciplinary team, and often multiple agencies or sectors. Care planning includes assessing current needs, planning for future illness deterioration, and possible transitions between care settings.

6. Last days and hours

Particular care should be paid to addressing the person's and their designated family or caregiver's care needs that are unique to the last days and hours of a person's life.

7. Loss, grief, and bereavement

People, and designated families and caregivers, may experience loss and grief from the time of diagnosis, during the illness, into bereavement, and after death. Health care providers assess needs, identify issues, and provide information and support.

8. Self-care

Self-care is paramount for health care providers. It encompasses a spectrum of knowledge, skills, and attitudes, including self-awareness and reflection, maintaining professional boundaries, and practising holistic wellness strategies for the individual provider and the team.

9. Professional and ethical practice

Ethical care is focused on the person's and their designated family or caregiver's values, needs, and wishes, while the health care provider maintains professional and personal integrity. This domain guides decision-making as life-limiting illnesses progress and health care needs change.

10. Education, evaluation, quality improvement, and research

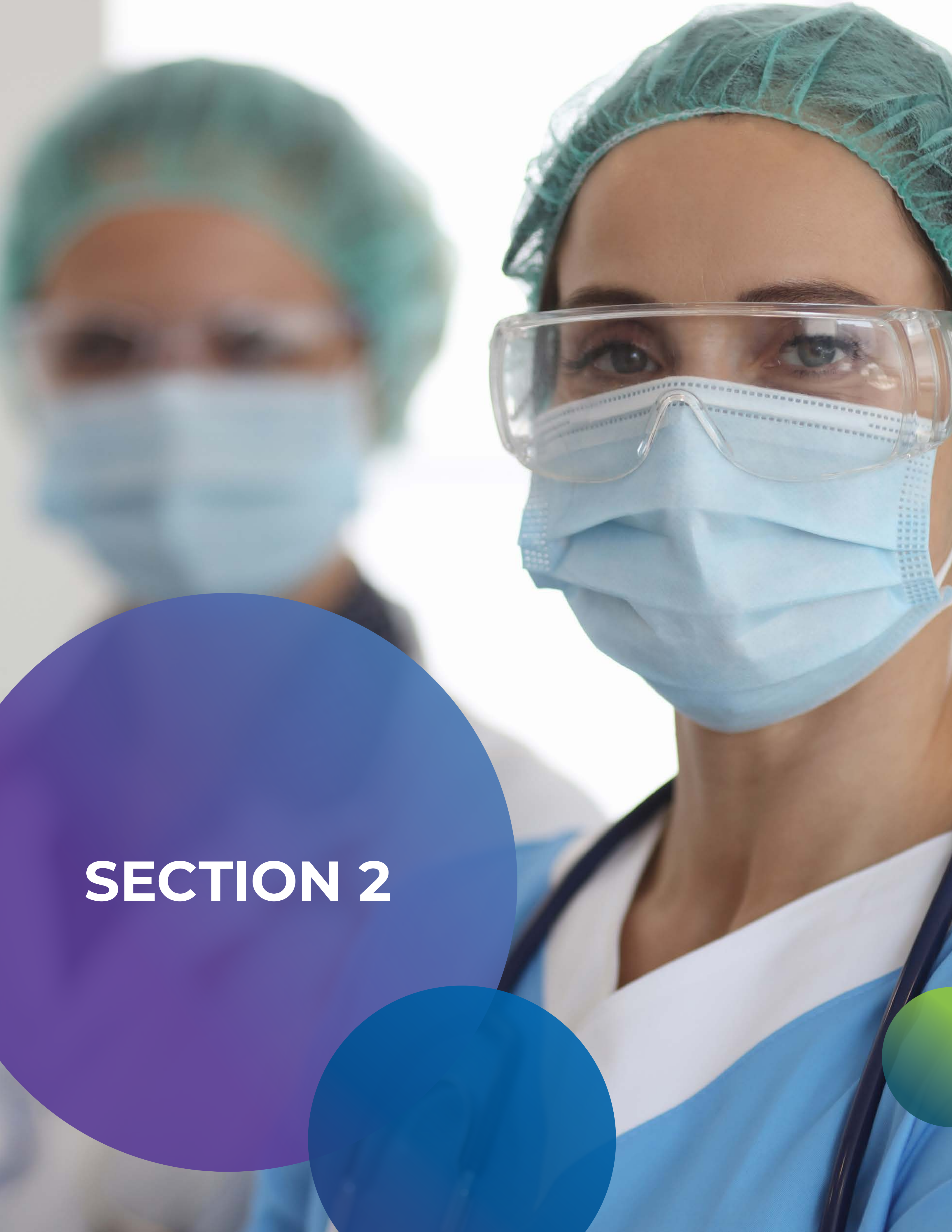
Palliative care education, as well as consistent evaluation and research, are important for all parties. Care providers participate in palliative care continuing education initiatives, and lead or participate in the evaluation of palliative care services, including the person's and their designated family or caregiver's experiences. In doing so, they contribute to ongoing quality improvement. They promote, contribute to, or lead research, keeping abreast of current evidence, and invite potential participants to research studies.

11. Advocacy

Individuals advocate for funding and access to palliative care services and associated educational opportunities, contribute to policy development, and address the social determinants of health.

12. Virtual care

Virtual care is the application of technologies to expand the provision of healthcare beyond traditional in-person encounters and healthcare settings. It can include synchronous and asynchronous communication, remote monitoring, messaging, phone, video visits, e-consults, and other modalities. Virtual care is meant to complement rather than replace in-person care.



SECTION 2

Competencies for five disciplines under each domain

This section describes the palliative care competencies specific to each of five disciplines: nurses, generalist physicians, social workers, personal support workers,* and volunteers. We have formatted the competencies into tables that describe the overarching competency and the specific skills associated with the discipline in question for the generalist practitioner – and for the specialist practitioner where applicable.

We have organized the competencies under our 12 domains of practice. Practitioners are expected to demonstrate the competencies only as appropriate for their professional scope of practice, jurisdictional and organizational policies, and specific job and role descriptions.

Please note that specialists are also expected to have all the skills of the generalist.

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* Also known as continuing care assistants, health care assistants, nursing assistants, and by other similar titles.

Palliative care helps people **live more fully, and more comfortably** – even through the stages of advanced disease.

Nurses

This discipline includes registered nurses, registered psychiatric nurses, licensed practical nurses, registered practical nurses, clinical nurse specialists, and nurse practitioners. Nurse practitioners may also share many competencies with physicians. Please see the physician-specific competencies to consider how they may apply in your jurisdiction and scope of practice.

1. Principles of a palliative approach to care

Competency	Generalist	Specialist
Understanding the core philosophy of palliative care and the palliative approach to care	Understand the philosophy of palliative care and the palliative approach to care, which starts early in the trajectory of a life-limiting condition.	Provide leadership and contribute to the development of palliative care education, standards, and policies.
	Understand how the palliative approach can enhance the assessment and management of symptoms.	
	Understand and contribute to the development of the relevant palliative care education, standards, guidelines, and policies.	
	Seek to understand and incorporate community-specific practices and protocols of caring for members of underserviced populations who are living with a life-limiting illness so that they can live fully throughout their care.	
	Seek to understand community-specific protocols of caring for First Nations, Inuit, and Métis who are living with a life-limiting illness so they can live fully throughout their care.	
Identifying people who would benefit from a palliative approach	Able to describe the meaning of the term “life-limiting condition”. Understand and respond to complex and multidimensional care needs.	Apply knowledge of life-limiting conditions to respond to complex and multidimensional care needs, and comprehensively identify current and prospective issues in palliative care at the system level.
	Identify and initiate, early in the illness trajectory, people who would benefit from a palliative approach.	

1. Principles of a palliative approach to care

Competency	Generalist	Specialist
Understanding the interdisciplinary team	Understand the role and function of the interdisciplinary care team to foster a caring environment in palliative care. Understand the role of primary and acute care, and the function of specialist palliative care teams, designated family and caregivers, and volunteers. Know when to reach out and utilize specialist resources.	Demonstrate leadership that encourages colleagues to foster a caring environment that supports all team members working in sensitive situations.
Addressing barriers to care	Identify and understand barriers, and how they affect access and care, with particular attention to members of underserviced populations.	Identify and address perceptions, beliefs, and attitudes towards palliative care – that the person, their designated family or caregiver(s), and colleagues have – that undermine access to high-quality palliative care.
	Recognize, identify, and understand specific barriers experienced by First Nations, Inuit, and Métis that may affect access and care.	
Including designated family or caregiver(s) in the unit of care	Ask the person who they consider family, and include the designated family or caregiver(s) in the person's care.	
	Respond to the designated family or caregiver's unique needs and experiences.	
	Respect the importance of the role of designated family or caregiver(s), and community, for members of underserviced populations throughout their palliative care.	
	Respect the importance of the role of designated family or caregiver(s), and community, for First Nations, Inuit, and Métis, throughout their palliative care.	
Seeing people holistically	Provide a holistic interdisciplinary team approach that is person- and family- centered, and that aligns with the person's and designated family or caregiver's priorities, values, and choices in the provision of care.	Lead conversations and planning when there is a greater complexity in the care needs and/or family dynamics.

2. Cultural safety and humility

Competency	Generalist	Specialist
Engaging in self-reflection	Practice self-reflection to identify and address personal and systemic biases.	
Supporting cultural practices	Acknowledge the influence of culture and lived experiences on a person's attitudes towards health, wellness, serious illness, and death. Demonstrate openness to incorporating these attitudes into the care of members of underserviced populations.	Engage with underserviced populations to create and facilitate partnerships that influence and address the care needs of these populations. Identify and collaborate with system partners to advocate and implement changes to better serve underserviced populations.
	Understand that First Nations, Inuit, and Métis cultural practices and beliefs influence how palliative care is provided. Demonstrate openness to incorporating First Nations, Inuit, and Métis community-specific protocols and practices into provision of palliative care.	
	Demonstrate openness and sensitivity to social, spiritual, and cultural values and practices that may influence the person's and their designated family or caregiver's preferences.	
Recognizing and respecting the diversity of people, designated families or caregivers, and communities	Assess the diverse needs and preferences of the person and their designated family or caregiver(s). In doing so, consider the social determinants of health, as well as ethnicity, culture, gender, sexual orientation, language, religion, and economic circumstance. Incorporate these determinants into goal setting, decision-making, and care planning.	
	Demonstrate understanding and provide accommodation to the social, spiritual, and cultural values and practices that may influence care provided to the person and their designated family or caregiver(s).	

2. Cultural safety and humility

Competency	Generalist	Specialist
CONT'D	Recognize that concepts such as wellness and illness may be defined differently by people, and in particular by members of underserviced populations. Collaborate with people, designated family or caregiver(s), and communities to ensure a shared understanding of terminology, while also respecting and supporting cultural protocols and practices that promote comfort and quality of life.	
	Recognize that concepts such as wellness and illness may be defined differently by First Nations, Inuit, and Métis. Collaborate with people, designated family or caregiver(s), and communities to ensure a shared understanding of terminology, while also respecting and supporting cultural protocols and practices that promote comfort and quality of life.	

3. Communication

Competency	Generalist	Specialist
Promoting ongoing collaborative communication	Understand that communication regarding palliative and end-of-life care is an ongoing collaborative process.	Demonstrate leadership and facilitate communication in situations in which the generalist team requires support.
	Understand that for members of underserviced populations, designated family or caregiver(s), and community members may have a role in the care team. Acknowledge and respect that responsibility for communication with the health care provider may be designated to a family member or caregiver, and incorporate those wishes in the provision of care.	
	Understand that First Nations, Inuit, and Métis family and community members may have a role in the care team. Acknowledge and respect that responsibility for communication with the health care provider may be designated to a family member or caregiver, and incorporate those wishes in the provision of care.	
Listening and providing emotional support	Provide emotional support to the person and designated family or caregiver(s) from diagnosis to bereavement. Use a variety of strategies to engage in highly skilled, compassionate, individualized, and timely communication with people, families, caregivers, and members of their care teams.	Role model, coach, and mentor team to build capacity in abilities surrounding difficult/complex conversations with patient and designated family or caregiver(s).
Adapting communication for children	Recognize that designated family or caregiver conversations may involve toddlers, children, and adolescents, and that may require different communication approaches. Have an understanding of developmental stages and appropriate communication skills to match their needs.	
Using appropriate supports to communicate effectively	Assess the need and provide specialist support (e.g. interpreters, sign language interpreters, and assistive technology) to bridge communication barriers.	

3. Communication

Competency	Generalist	Specialist
Delivering difficult news and managing essential conversations	Introduce people and their designated family or caregiver(s) to the concept and benefits of palliative care. Share difficult news in a compassionate and supportive manner and provide a safe space for them to process their emotions.	Provide support, mentorship, and role modelling for generalists in developing these skills.
	Support people so they can make informed decisions about the types of information they wish to receive about their diagnosis, prognosis, and disease progression, and how best to share that news with their designated families.	Identify the person's and designated family or caregiver's information needs and preferences before providing information and discussing diagnosis and prognosis. Regularly ask whether information is meeting the person's and designated family or caregiver's needs.
	Review and clarify the person's and designated family or caregiver's understanding of palliative care information that has been presented by other health care providers. Discuss care preferences, including the pros and cons of life-sustaining treatments (e.g. CPR, admissions to ICU, antibiotics).	
	Explore people's and designated family or caregiver's questions about the dying process and what to expect.	

4. Optimizing comfort and quality of life

Competency	Generalist	Specialist
Promoting self-management/care	Recognize and educate people and designated family or caregiver(s) about how they can engage in self-management of their condition, while acknowledging the barriers and limitations that may make self-management/care difficult.	
Maintaining dignity	Conserve and promote dignity of the person by facilitating expression of needs, hopes, feelings, and concerns in planning palliative care.	

4. Optimizing comfort and quality of life

Competency	Generalist	Specialist
Caring for people holistically	Understand the concept of "total pain" and the multiple factors that may impact on the person and their designated family or caregiver(s).	Acknowledge the cumulative losses inherent in the experience of a life-limiting condition and its effects on the person and their designated family or caregiver(s).
Involving the designated family or caregiver(s) in care	Recognize and anticipate the impact of the role changes designated families experience as a result of a person's illness when formulating relevant and realistic care plans.	
	Respect the role of the designated family or caregiver(s), and community, especially when caring for members of underserviced populations throughout their palliative care.	
	Respect the role of the designated family or caregiver(s), and community, for First Nations, Inuit, and Métis, throughout their palliative care.	
Screening, assessing, and managing pain and other symptoms and psychosocial concerns	Regularly screen for symptoms and needs, using validated, standardized instruments, such as the Edmonton Symptom Assessment System (ESAS).	
	Demonstrate an understanding of the use of non-pharmacological interventions for pain and symptom management, support the person's decision to use complementary and alternative medicine (CAM), and address requests for information. Be aware of the credible resources available within their community regarding CAM. Understand professional responsibilities regarding CAM practices and interventions.	
	Implement evidence-informed pharmacological and non-pharmacological approaches for pain and symptom management at end-of-life.	
	Recognize that complementary and alternative medicine (CAM) can play an important role in palliative care, especially when caring for members of underserviced populations. Collaborate with the person and their designated family or caregiver(s) to incorporate these into the care plan.	

4. Optimizing comfort and quality of life

Competency	Generalist	Specialist
CONT'D	Recognize that traditional medicine can play an important role in palliative care for First Nations, Inuit, and Métis. Collaborate with the person and their designated family or caregiver(s) to incorporate traditional medicine into the care plan.	
	Collaborate with the care team to manage pain and symptoms effectively based on the person's identified goals of care.	Manage more complex conditions and provide consultation, advice, and mentorship to generalist level nurses.
	Administer medicine or other treatments appropriate for the types and severity of the person's pain, side effects, drug interactions, complications, and condition.	
	Demonstrate a comprehensive knowledge of common medications, and respond to potential side effects, interactions, or complications.	
	Describe the indications for opioid rotation.	
Understanding the severity of the person's pain, other symptoms, and condition	Incorporate knowledge of pain classification, the pathophysiology of pain and other symptoms in management of symptoms.	Incorporate evidence-based off label use of medications, as appropriate, for management of symptoms.

5. Care planning and collaborative practice

Competency	Generalist	Specialist
Understanding interdisciplinary collaboration, transitions, and roles	Collaborate with the interdisciplinary team, person, and designated family or caregiver(s) to ensure care plans are consistent with goals of care, preferences, and advance care plans, which may change throughout the life-limiting condition.	Assist with coordinating care and making referrals to interdisciplinary team members and/or organizations – e.g. visiting volunteers.
	Identify and support navigation of the full range and continuum of palliative care services, resources, and settings in which such services are available. Recognize and coordinate smooth transitions between institutions.	

5. Care planning and collaborative practice

Competency	Generalist	Specialist
Modifying care plans as needed	Evaluate communication with the person and their designated family or caregiver(s) to ensure that their care plan meets the person's identified needs.	
	Engage with First Nations, Inuit, and Métis community leaders and/or Elders, when appropriate or if requested, to co-create a high-quality approach to palliative care for the person and their designated family or caregiver(s).	
	Evaluate interventions within the care plan, discuss with the interdisciplinary team and propose appropriate alternatives, if necessary.	
	Recognize common symptoms of common trajectories of life-limiting conditions, and anticipate the needs of the person who has a particular disease.	
	Routinely assess Palliative Performance Scale (PPS) to determine changing functional status.	
Making informed decisions	Understand the importance of determining the person's capacity before having conversations with them regarding advance care planning (ACP), goals of care, and healthcare consent. Understand how a substitute decision maker (SDM) is determined, and the role the SDM plays in making healthcare decisions if the person does not have capacity. Know and apply laws applicable to specific jurisdiction.	
	Facilitate informed decision-making and consent by the person (or, if incapable, their SDM) regarding place of care, while identifying risks in a supportive manner.	
	Support the person, their designated family or caregiver(s), and SDM in decision-making, including withholding or withdrawing an intervention.	

5. Care planning and collaborative practice

Competency	Generalist	Specialist
CONT'D	When able, provide care in the person's preferred place while recognizing the complexities and challenges involved for people, designated families, and caregivers.	Provide palliative care and support capacity building in all settings where people reside. This includes the home, long-term care facilities, and acute care settings, such as community hospitals and emergency departments in rural and remote settings, hospices, group/supportive housing, shelters, jail/prison, etc.
Understanding advance care planning	Understand advance care planning (ACP) and help people set their goals and preferences for care if they wish to prepare or revise an ACP.	
	Provide care and implement treatment plans in keeping with the person's expressed wishes and/or goals of care.	

6. Last days and hours

Competency	Generalist	Specialist
Anticipating changes as death nears	Assist the person and their designated family or caregiver(s) to prepare for the time of death, and provide information about expected changes and comfort measures during the last days and hours of life.	Anticipate possible complications and advocate for appropriate medications/treatments or interventions to be available.
	Identify people who are in the terminal phase, and recognize and respond to signs of imminent death.	
Supporting death rituals	Provide care of the body immediately following death as per the person and designated family or caregiver's preferences and rituals, and the organization's policies and procedures.	
	Support designated family and community-specific protocols and practices surrounding death, loss, and grief, in particular when caring for members of underserviced populations.	
	Support designated family and community-specific protocols and practices surrounding death, loss, and grief when caring for First Nations, Inuit, and Métis.	

6. Last days and hours

Competency	Generalist	Specialist
Involving and supporting the designated family or caregiver(s)	Facilitate discussions with appropriate professionals if an autopsy is requested or required.	
	Help the designated family or caregiver(s) do the following: • cope with emotional responses, • maintain a desired level of control, • share preferences and needs, • discuss place of death, • access resources, • communicate meaningfully, • process emotions associated with anticipatory grief.	
	Facilitate discussions with appropriate professionals if the person or their designated family or caregiver(s) request organ or tissue donation.	

7. Loss, grief, and bereavement

Competency	Generalist	Specialist
Supporting diverse responses to loss	Recognize the range of individual physical, psychological, spiritual, emotional, cultural, and social responses to loss and grief.	
	Demonstrate an understanding of the needs of children at various developmental stages in dealing with grief and loss.	
	Accurately assess and manage people's and their designated families' or caregivers' loss, grief, and bereavement needs.	
Recognizing complicated grief	Acknowledge the impact of personal traumas and negative experiences, in particular for members of underserviced populations, and how these can shape the expressions of grief, bereavement, and mourning. Practice trauma-informed principles and care.	Engage with the designated family or caregiver(s), and community, to identify community-specific protocols and practices that support the experience and expressions of grief.

7. Loss, grief, and bereavement

Competency	Generalist	Specialist
CONT'D	Acknowledge the impact that historical and ongoing systemic trauma and loss have on First Nations, Inuit, and Métis experiences and expressions of grief, bereavement, and mourning. Practice trauma-informed principles and care.	Engage with the designated family or caregiver(s), and community, to identify First Nations, Inuit, and Métis community-specific protocols and practices that support the experience and expression of grief.
Using support services	Provide guidance, support, and information to designated families, caregivers, and others (based on awareness of cultures and needs), and make referrals to bereavement services as required.	

8. Self-care

Competency	Generalist	Specialist
Promoting self-awareness	Explore own attitudes and beliefs regarding death, dying, and caring for people who require palliative care.	
	Demonstrate an awareness of the effects of past experiences of suffering, death, and dying when caring for people with life-limiting conditions.	
	Understand and attend to own emotional responses that result from caring for people with life-limiting conditions.	
Promoting healthy behaviors for self and team	Demonstrate an awareness of ways to manage and cope with the impact of death and with people dying.	
	Demonstrate an awareness of the emotional and spiritual supports available for self and team.	
	Identify colleagues who may be suffering and provide support.	Support colleagues to identify factors contributing to stress in caring for people who require a palliative approach to care and their designated families or caregivers. Support colleagues to develop a plan to cope with stress.

8. Self-care

Competency	Generalist	Specialist
Preventing compassion fatigue	Recognize compassion fatigue in self and colleagues; intervene and refer appropriately.	Identify issues in the system that contribute to compassion fatigue and advocate for change.
	Engage in healthy activities that help prevent compassion fatigue.	

9. Professional and ethical practice

Competency	Generalist	Specialist
Addressing ethical issues	Anticipate and address ethical and legal issues that may be encountered when caring for people with life-limiting conditions.	
	Facilitate discussion and management of ethical and legal issues in conjunction with the person, their designated family or caregiver(s), their care team, and institutional ethics review boards (or equivalent), where they exist.	
	Identify situations where beliefs, attitudes, and values limit one's ability to be present and provide care to people and their designated families or caregivers. Collaborate with others to ensure optimal care is provided.	
	Understand distinctions among ethical and legal concepts, such as: the principle of double effect, palliative sedation, and medical assistance in dying (MAiD).	
	Access resources to guide ethically complex situations and implement possible resolutions.	
Advocating for inclusion of the person's and their designated family or caregiver's beliefs and values	Establish and respect peoples' wishes, options, and preferences regarding their care, and respect their decisions.	

9. Professional and ethical practice

Competency	Generalist	Specialist
Understanding legislation and policy	Demonstrate knowledge of relevant legislation/ policies – e.g. medical assistance in dying (MAiD), *Children and Family Services Act, Adult Protection Act*, and *Personal Directives Act*, and any other legislation related to field of practice.	Apply a comprehensive understanding of and contribute to the development and refinement of legal, ethical, and professional standards to the provision of quality palliative care.
Understanding MAiD	Respond to inquiries regarding MAiD in accordance with the appropriate regulatory body's guidelines and standards.	

10. Education, evaluation, quality improvement, and research

Competency	Generalist	Specialist
Accessing continuing education	Participate in palliative care continuing education opportunities.	
	Participate in cultural safety training opportunities, especially any that are specific to underserviced populations. Where available, participate in regionally specific training.	
	Participate in First Nations, Inuit, and Métis cultural safety training opportunities. Where available, participate in regionally specific training.	
Educating and supporting learners	Educate people, families, caregivers and interdisciplinary teams regarding palliative care and the palliative approach.	Develop, facilitate, and provide palliative care-related education, leadership, and mentorship to generalists and students preparing to be specialists.
		Promote public awareness and education regarding end-of-life issues, beliefs, and attitudes about palliative care.
Contributing to quality improvement	Contribute to the monitoring and evaluation of the quality of palliative care, and critically evaluate outcomes against standards and guidelines.	Contribute to the evaluation of the quality of palliative care and the effectiveness of the specialist palliative care consult team.

10. Education, evaluation, quality improvement, and research

Competency	Generalist	Specialist
Evaluating person outcomes	Routinely incorporate standardized measures recognizing the importance of person-reported outcomes (PROs).	Contribute to the development, implementation, and evaluation of PROs based on evidence-informed standards and guidelines, and advocate for the importance of PROs in all aspects of palliative care policy and practice.
Promoting knowledge generation, translation, and synthesis	Apply knowledge gained from palliative care research to all activities in delivering a palliative approach to care.	Lead, facilitate, and engage in research in palliative care, and act as an expert resource contributing to palliative care development and delivery.
	Where possible and appropriate, encourage people and designated families or caregivers to participate in research opportunities.	Identify the opportunities for, and barriers to, discipline-specific and interdisciplinary research unique to palliative care.

11. Advocacy

Competency	Generalist	Specialist
Advocating for the person, designated family or caregiver(s), and societal rights	Advocate for the incorporation of people’s and designated families’ or caregivers’ values and beliefs into the care plan.	
	Advocate that the needs, decisions, and rights of underserviced populations, including First Nations, Inuit, and Métis, be incorporated into care planning.	
		Actively influence and promote palliative care strategic initiatives and policy development.
		Advocate for health professionals to be supported in participating in palliative care continuing education opportunities, and to have access to adequate resources to provide palliative care.
		Describe how changes in legislation and/or funding, and the structure of the healthcare system, could affect delivery of palliative care to people. Actively engage generalist and others in these processes.
Acting as an advocate	Advocate for equitable, accessible, safe, high-quality palliative care, and timely access to resources for palliative care.	Participate in and lead as a member of organizations that advocate for equitable, accessible, safe, and high-quality palliative care.
	Advocate for culturally safe practices that are free of racism and discrimination.	Provide advocacy and leadership, and contribute to policy and program development at a systems level to ensure culturally safe care.

12. Virtual care

Competency	Generalist	Specialist
Identifying people who would be suitable for and benefit from virtual care	Identify people who would be suitable to be assessed by virtual care modalities and where it would optimize symptom and psychosocial supports.	
	Recognize equity challenges to virtual care including geography, finances, disabilities, language, and familiarity with technology.	
Adapting care to a virtual modality	Deliver virtual care as per standards of Accreditation Canada, provincial standards of practice, and workplace regulations and guidelines.	
	Adapt a variety of information and communication techniques to deliver person-centred care.	
	Utilize various tools to deliver care virtually.	
	Develop clear processes for patient follow-up and hand-over to other professionals.	
	Develop clear processes for involvement of the interdisciplinary team.	
Delivering care virtually	Communicate effectively and clearly with people and their designated families or caregivers, and elicit signs and symptoms remotely.	

Generalist Physicians

Here we provide generalist competencies in palliative care for physicians. To avoid duplication or conflicts with physician colleges in Canada, we have not set out the specialist competencies for physicians practicing as consultants in palliative medicine.

For information about competencies for specialist physicians, please contact the College of Family Physicians of Canada about their Certificates of Added Competency, and the Royal College of Physicians and Surgeons of Canada about their Palliative Medicine Subspecialty.

1. Principles of a palliative approach to care

Competency	Generalist
Provide a palliative approach to care	Describe the benefits of and provide an early holistic palliative approach to care that addresses physical, psychosocial, spiritual, and practical concerns.
	Recognize common trajectories, natural histories of functional decline, and transition points to trigger early initiation of a palliative approach to care.
	Understand community-specific protocols and practices, including the role of complementary and alternative medicine (CAM), when caring for members of underserviced populations who are living with a life-limiting illness so they can live fully throughout their care.
	Understand community-specific protocols, including the role of traditional medicine, when caring for First Nations, Inuit, and Métis who are living with a life-limiting illness so they can live fully throughout their care.
Address barriers to palliative care	Identify and address misperceptions, beliefs, and attitudes towards palliative care – that the person, their designated family or caregiver(s), and colleagues have – that undermine access to high-quality palliative care.

2. Cultural safety and humility

Competency	Generalist
Create an environment of cultural safety	Demonstrate cultural safety and describe how diversity impacts decision making to provide person- and family-centered care.
	Recognize the values, biases, or perspectives of people, physicians, or other health care professionals that may have an impact on the quality of care and modify the approach to the person and their designated family or caregiver(s) accordingly.
	Recognize that concepts such as wellness and illness may be defined differently by members of underserviced populations.
	Recognize that concepts such as wellness and illness may be defined differently by First Nations, Inuit, and Métis.
	Demonstrate sensitivity to spiritual, religious, and cultural considerations relative to palliative care, including rituals and approaches to end-of-life care.
	Embed First Nations, Inuit, and Métis community protocols and cultural practices, including traditional medicine, surrounding palliative and end-of-life care when providing care.

3. Communication

Competency	Generalist
Communicate effectively with patients, designated families, and other informal caregivers	Communicate honestly and compassionately about life-threatening illness and prognosis from time of diagnosis throughout the illness trajectory: • Elicit understanding from the patient and their designated family or caregiver(s) of their illness and prognosis for information sharing. • Demonstrate the ability to discuss an individualized estimation of survival and disease trajectory.
	Understand that for members of underserviced populations, designated family or caregiver(s) and community may have a role in the care team. Acknowledge and respect that responsibility for communication with the health care provider may be assigned to a designated family member or caregiver(s), and incorporate these wishes in the provision of care.
	Understand that First Nations, Inuit, and Métis family and community members may have a role in the care team. Acknowledge and respect that responsibility for communication with the health care provider may be designated to a designated family member or caregiver(s), and incorporate these wishes in the provision of care.

3. Communication

Competency	Generalist
CONT'D	Communicate with the person and their designated family or caregiver(s) in order to determine, record, and implement a care plan aligned with the person's values and goals of care.
	Adapt communication approaches as required when designated family and caregiver conversations involve children.
	Demonstrate the ability to educate patients and families or caregivers receiving a palliative approach to care about matters related to advancing disease.
	Communicate with health care providers, including the primary care team, about the natural history of the illness, what to monitor, when to refer, prognostication, and suggestions around "community-based action plans".
	Facilitate meetings between the person and their designated family or caregiver(s).

4. Optimizing comfort and quality of life

Competency	Generalist
Assess and manage pain in a palliative context	Conduct a thorough pain history and perform an appropriate physical exam for someone presenting with pain.
	Demonstrate a person- and family-centered and interdisciplinary approach to assessing pain in patients with life-threatening illness.
	Describe and recognize 'total pain' where physical, psychological, social, emotional, and spiritual concerns each contribute to the pain experience.
	Describe and use standardized tools for pain assessment.
	Choose appropriate/relevant investigations of pain.
	Choose an appropriate analgesia regimen, including non-pharmacological and pharmacological elements.
Use opioids effectively to manage pain and other symptoms in a palliative context	Write an opioid prescription for an opioid-naïve patient, including breakthrough dosing: • Manage common routes of opioid administration and their effect on bioavailability and dosing frequency. • Manage relevant pharmacokinetic and pharmacodynamic properties.
	Demonstrate appropriate opioid titration.
	Manage common side effects of opioids and anticipate and prevent side effects such as nausea and constipation.

	4. Optimizing comfort and quality of life
Competency	**Generalist**
CONT'D	Address patient and designated family or caregiver(s) concerns or misconceptions about opioids.
	Explain the concepts of tolerance, physical dependence, and addiction as they relate to the use of opioids.
	Identify potential risk factors for opioid misuse, abuse, addiction and/or diversion, and describe approaches for managing these issues.
	Recognize opioid-induced neurotoxicity (OIN) and distinguish OIN from opioid overdose.
Use adjuvant modalities and medications for pain management in a palliative context	Use adjuvant analgesics appropriately, including but not limited to corticosteroids, non-steroidal anti-inflammatory drugs, and neuropathic agents.
	Recognize the potential role of adjuvant modalities, including but not limited to chemotherapy, radiation therapy, surgery, and interventional analgesia, in the management of pain and other symptoms, and refer when appropriate.
Assess and manage common symptoms, including but not limited to constipation, nausea, vomiting, dyspnea, delirium, and insomnia	Conduct a thorough history and perform an appropriate physical exam for a patient presenting with common symptoms.
	Demonstrate a person- and family-centered and interdisciplinary approach to assessing symptoms in people with life-threatening illness.
	Describe and use Edmonton Symptom Assessment System (ESAS) and other validated tools as appropriate to regularly screen for symptoms in the patient population.
	Choose appropriate/relevant investigations for identified symptoms.
	Initiate appropriate first-line therapy to manage identified symptoms including non-pharmacological interventions.
Address psychosocial and spiritual issues that people with life-threatening illness and their designated families or caregivers encounter	Identify, assess, and plan for the psychosocial and spiritual needs that people and their designated families or caregivers encounter across the illness trajectory.
	Recognize the level of demand and stress on families and caregivers and identify risk factors for burnout.
	Demonstrate the ability to screen, diagnose, and initiate treatment for patients experiencing depression and/or anxiety.
	Identify patients and families or caregivers who have complex psychosocial needs, who would benefit from referral to expert resources.
	Describe the relationship between psychosocial, spiritual, and cultural issues with respect to total suffering and total pain.

4. Optimizing comfort and quality of life

Competency	Generalist
Assess and describe appropriately the elements of suffering for people receiving a palliative approach to care and their designated families or caregivers	Integrate diverse societal perspectives on dying and death.
	Identify and describe issues contributing to suffering in people requiring a palliative approach to care and their designated families or caregivers.
Provide a supportive approach to suffering	Demonstrate a supportive approach to address multidimensional sources of suffering in people with palliative care needs and their designated families or caregiver(s).
Participate in providing care for the child requiring a palliative approach to care and their designated family or caregiver(s), ***if provision of pediatric care is applicable to scope of practice***	Describe the similarities and differences in providing palliative care to children and adults, including the impact of grief and loss on the designated family or caregiver(s).
	Identify the challenges (societal, professional, and personal) which arise when caring for a child with palliative care needs and their designated family or caregiver(s).
	Describe the interdisciplinary approach to care which benefits the child and designated family or caregiver(s) when life-limiting illness is present.

5. Care planning and collaborative practice

Competency	Generalist
Establish advance care plans with patients and their designated family or caregiver(s) in accordance with provincial/territorial regulations and terminology	Demonstrate respect for differing family structures, roles, and cultural issues with sharing information and arriving at decisions, including plans of care.
	Engage with First Nations, Inuit, and Métis community leaders and/or Elders, when appropriate or if requested, to develop a high-quality approach to palliative care for the person and their designated family or caregiver(s).
Demonstrate the use of advance care planning	Demonstrate an effective approach to advance care planning.
Develop and propose a care plan in collaboration with other disciplines	Collaborate in the development of an interdisciplinary care plan to meet the psychosocial and spiritual needs of people facing life-threatening illness and their designated families or caregivers. Aim to provide palliative care in the person's preferred location, whenever possible.

5. Care planning and collaborative practice

Competency	Generalist
CONT'D	Actively involve primary care providers and other community-based supports in the psychosocial and spiritual support of people facing life-threatening illness and their designated families or caregivers.
	Recognize that complementary and alternative medicine (CAM) can play an important role in palliative care, in particular for members of underserviced populations. Collaborate with the person and their designated family or caregiver(s) to incorporate community-specific practices into the care plan.
	Recognize that traditional medicine can play an important role in the palliative care of First Nations, Inuit, and Métis. Collaborate with the person and their designated family or caregiver(s) to incorporate community-specific practices into the care plan.
Collaborate as members of an interdisciplinary team	Work effectively with interdisciplinary colleagues to provide a palliative approach to care throughout the illness trajectory.
	Refer patients with complex needs requiring specialized palliative care expertise, including but not limited to: reasons for consultation, pertinent investigations, pain management, medication list, and opioid toxicity.
	Ensure the continuity of a palliative approach to care across different settings by collaborating with the most responsible clinician.
	Demonstrate the ability to collaborate with other disciplines regarding which serious illness conversations have occurred and share the person's and their designated family's or caregiver's responses.

6. Last days and hours

Competency	Generalist
Participate in the care of the dying patient and their designated family or caregiver(s) in uncomplicated cases	Identify signs of approaching death.
	Describe common signs of the natural dying process.
	Prepare and educate the person and their designated family or caregiver(s) when death approaches.
	Prescribe medications for symptom control in the dying phase.
	Pronounce a patient's death and complete a death certificate. Identify circumstances that may warrant the involvement of a coroner/medical examiner.

6. Last days and hours

Competency	Generalist
CONT'D	Facilitate discussions with appropriate professionals if an autopsy is requested or required. Facilitate discussions with appropriate professionals if the patient or their designated family or caregiver(s) request organ or tissue donation.
	Integrate pre- and post-death rituals and practices at end-of-life, in accordance with the patient's or designated family or caregiver(s) wishes.
	Integrate community-specific protocols and practices surrounding end-of-life, when caring for First Nations, Inuit, and Métis.

7. Loss, grief, and bereavement

Competency	Generalist
Address grief and bereavement in people with life-threatening illness and their designated families or caregivers	Accurately assess and manage loss, grief, and bereavement needs.
	Identify risk factors for complicated grief.
	Demonstrate an understanding of the needs of children at various developmental stages in dealing with grief and loss.
	Describe an approach to provide or refer to supportive care any persons experiencing anticipatory grief and/or bereavement.
	Support designated family and caregiver(s), and community-specific protocols and practices surrounding death, loss, and grief when caring for members of underserviced populations.
	Support designated family and community-specific protocols and practices surrounding death, loss, and grief when caring for First Nations, Inuit, and Métis.
	Acknowledge the impact of personal traumas and negative experiences on members of underserviced populations, and how these can shape their expressions of grief, bereavement, and mourning. Practice trauma-informed principles and care.
	Acknowledge the impact that historical and ongoing systemic trauma and loss have on First Nations, Inuit, and Métis experiences and expressions of grief, bereavement, and mourning. Practice trauma-informed principles and care.

8. Self-care

Competency	Generalist
Demonstrate self-reflection and self-care in working with people requiring a palliative approach to care and their designated families or caregivers	Identify common factors contributing to personal and professional stress in caring for people who require a palliative approach to care and their designated families or caregivers.
	Develop a plan to cope with personal and professional stress that may arise in caring for people who require a palliative approach to care and their designated families or caregivers. Offer support to colleagues.
	Engage in healthy activities that help prevent compassion fatigue in oneself and colleagues.
	Exhibit self-reflective capacity in analyzing one's own values, beliefs, and reactions when faced with dying and death.
	Demonstrate awareness when personal reactions may impact the ability to provide a palliative approach to care and seek help to mitigate.

9. Professional and ethical practice

Competency	Generalist
Actively engage in advance care planning, goals of care discussions, and decision-making with people who would benefit from a palliative approach to care, using bioethical and legal frameworks	Discuss the common ethical issues that arise throughout the illness trajectory such as decision-making, withdrawing or withholding therapy, and resuscitation orders.
	Distinguish between Medical Assistance in Dying (MAiD), continuous palliative sedation therapy (CPST) for refractory symptoms at the very end-of-life, and withholding or withdrawing therapy, in accordance with provincial/territorial/federal regulations and terminology.
	Demonstrate the ability to respond to patients and their designated families or caregivers when discussing MAiD, CPST, and withholding or withdrawing therapy.
	Compassionately explore and address suffering with the patient and their designated family or caregiver(s) when discussing MAiD, CPST, and withholding or withdrawing therapy.
	Involve specialist palliative care services when appropriate.

10. Education, evaluation, quality improvement, and research

Competency	Generalist
Access continuing education in palliative approach to care	Participate in continuing education opportunities for maintenance of competency in palliative approach to care.
	Participate in cultural safety training opportunities, especially any that are specific to underserviced populations. Where available, participate in regionally specific training.
	Participate in First Nations, Inuit, and Métis cultural safety training opportunities. Where available, participate in regionally specific training.
	Keep up-to-date on current evidence base for provision of palliative approaches to care.
Contributing to quality improvement	Participate in cultural safety training opportunities with the intention of improving the quality of palliative care, in particular for underserviced populations, including for First Nations, Inuit, and Métis.
	Contribute to the evaluation of the quality of palliative care and the effectiveness of the palliative care system, as related to own practice.
	Evaluate continuously for gaps in the provision of care toward people seeking palliative care and their designated family or caregiver(s).
Promote knowledge generation, translation, and synthesis	Participate, as appropriate, in research activities on improving palliative care delivery.
	Keep up to date on current and emerging research in palliative care delivery.

11. Advocacy

Competency	Generalist
Identify determinants of health and address barriers impacting palliative care provision	Identify, and where possible, address barriers for availability and accessibility of palliative care, including but not limited to: geography, stigma associated with receiving palliative care, lack of recognition of people who would benefit, availability of community resources, and availability of specialized palliative care services.
	Identify and work in partnership with allies among underserviced populations to address the inequities in their access to palliative care.
	Identify, and where possible, address barriers for availability and accessibility of palliative care specific to First Nations, Inuit, and Métis.
	Identify opportunities to advocate for improving the health and well-being of persons with palliative care needs.
	Advocate for culturally safe practices that are free of racism and discrimination.

12. Virtual care

Competency	Generalist
Identify people who would be suitable for and benefit from virtual palliative approach to care	Identify people who would be suitable to be assessed by virtual care modalities in the palliative care context.
	Recognize equity challenges to accessing and receiving virtual care including geography, finances, disabilities, language, availability of, and familiarity with technology.
Adapt care to a virtual modality where suitable	Deliver virtual care as per standards of Accreditation Canada.
	Adapt a variety of information and communication techniques to deliver a person-centered palliative approach to care virtually.
	Utilize assessment tools for remote monitoring of palliative care symptoms, including Edmonton Symptom Assessment System (ESAS) tools, to deliver care virtually.

Social Workers

Social workers play an important role in the delivery of palliative care. Most social work practitioners, regardless of care setting, will encounter people and families or caregivers facing progressive life-limiting illness, dying, death, or bereavement. Each domain will be enacted by individual health care providers as appropriate for their role, scope of practice, and expertise. Frontline social workers in all settings require generalist-level palliative care competencies. Specialist-level palliative care social workers require more training and experience.

1. Principles of a palliative approach to care

Competency	Generalist	Specialist
Understanding the philosophy of palliative care and a palliative approach	Understand the philosophy of palliative care and a palliative approach.	Contribute to the integration of a palliative approach to care into social work education, policy, and practice.
	Apply the principles of palliative care, such as offering a support system to help people live as actively as possible until death with optimal quality of life, and helping families and caregivers cope.	
	Understand community-specific protocols of caring for members of underserviced populations who are living with a life-limiting illness so they can live fully throughout their care.	
	Understand community-specific protocols of caring for First Nations, Inuit, and Métis who are living with a life-limiting illness so they can live fully throughout their care.	
Identifying people who would benefit from a palliative approach	Define and recognize “life-limiting conditions" and understand the different illness trajectories.	
	Communicate to people and families or caregivers the continuum of care, disease trajectory, and optimal time to refer to palliative care.	
	Use appropriate evidence-informed tools, from diagnosis of a life-limiting illness throughout the illness trajectory, to help the interdisciplinary care team identify people who could benefit from a palliative approach (e.g. psychosocial concerns, screening for distress).	Act as an expert resource to the interdisciplinary care team and social work colleagues, regarding identification of people who would benefit from a palliative approach.

1. Principles of a palliative approach to care

Competency	Generalist	Specialist
Understanding the interdisciplinary team	Understand the role of the interdisciplinary team in palliative care and involve other team members and specialists as appropriate.	Foster a caring environment that supports all care team members. Act as a specialist on the interdisciplinary team, representing psychosocial aspects of care.
Including designated family or caregiver(s) in the unit of care	Ask the person who they consider family, and include the designated family or caregiver(s) in the person's care, if the person wishes.	Describe the impact of dying, death, and bereavement on the person, their designated family or caregiver(s), and health care providers. Describe the designated family or caregiver's roles and dynamics (e.g. a sociogram), and how they wish to be involved in the person's care.
	Respect the importance of the role of designated family or caregiver(s) and community throughout a person's care, especially for members of the underserviced populations.	Serve as a conduit of communication and information between the designated family or caregiver(s) and the care team.
	Respect the importance of the role of designated family and community for First Nations, Inuit, and Métis throughout their palliative care.	
Seeing people holistically	Acknowledge the physical, emotional, mental, social, and spiritual aspects to care.	Actively address the non-physical aspects of a person's needs and concerns.
Addressing barriers to care	Identify and address barriers to accessing care.	Describe and address micro and macro factors that promote or constrain palliative care.
	Address barriers to accessing services and plans for continuity of care.	
Ensuring a thorough awareness of resources	Is aware of the community context and available resources, and can provide information, referral, and coordination as needed for the person and their designated family or caregiver(s).	Help the person, their designated family or caregiver(s), and the care team navigate to appropriate and available resources.

2. Cultural safety and humility

Competency	Generalist	Specialist
Recognizing and respecting the diversity of people, families or caregivers, and communities	Assess the unique needs and preferences of the person and their designated family or caregiver(s). In doing so, consider social determinants of health, ethnicity, culture, gender, sexual orientation, language, religion, age, and ability.	Advocate for the person's unique needs and preferences to be respected.
	Demonstrate understanding of the influence of culture and lived experiences on key issues in palliative and end-of-life care. Demonstrate sensitivity to cultural considerations of members of underserviced populations, relative to palliative care and end-of-life needs.	
	Understand that distinct beliefs, cultural practices, and lived experiences of First Nations, Inuit, and Métis influence how palliative and end-of-life care is provided. Incorporate community-specific protocols and practices into the palliative care of First Nations, Inuit, and Métis.	
Engaging in self-reflection	Practice self-reflection to identify and address personal and systemic biases.	
Supporting cultural practices	Partner with people and families or caregivers to provide opportunities for cultural, religious, or personal practices.	
	Explore people's and their designated family or caregiver's cultural, religious, and spiritual needs, beliefs, and preferences, and incorporate these into goal setting, decision-making, and care planning.	

3. Communication

Competency	Generalist	Specialist
Recognizing and respecting that each person and designated family or caregiver(s) has a unique perspective.	Ask and seek to understand the unique perspective of each person and their designated family or caregiver(s).	
Listening and providing emotional support	Listen and provide emotional support to the person and their designated family or caregiver(s) as they adjust to their life-limiting condition. Understand the potential impact on the person's and designated family or caregiver's welfare, mental health, and well-being.	Consider timing, readiness, and pace of sharing information.
Adapting communication for children	Adapt communication when children are involved according to age, developmental level, comprehension, and mode of communication (e.g. play therapy).	Refer to child-life specialists, as needed.
	Support people and families or caregivers, including children, as they communicate with each other about difficult topics.	
Using appropriate supports to communicate effectively	Utilize supports as needed for effective communication and according to the person and their designated family or caregiver's health literacy (e.g. interpreters, assistive technology).	Recommend referrals to speech-language therapists and occupational therapists, where warranted.
	Acknowledge that designated family or caregiver(s) and community members may have a role in the care team, especially for members of underserviced populations. Respect that responsibility for communication with the health care provider may be designated to those members and incorporate these wishes in the provision of care.	
	Understand that First Nations, Inuit, and Métis family and community members may have a role in the care team. Acknowledge and respect that responsibility for communication with the health care provider may be designated to a family member and incorporate these wishes in the provision of care.	

3. Communication

Competency	Generalist	Specialist
Communicating collaboratively	Communicate health changes and concerns among the person and their designated family or caregiver(s) and the care team.	
Delivering difficult news and managing essential conversations	Recognize the potential for conflict in decision-making and work towards consensus-building among the person, their designated family or caregiver(s), and care team.	Describe common stressors and sources of conflict, and support the person, their designated family or caregiver(s), and care team to address these. Organize meetings and lead mediation in conflict situations within the designated family or caregiver(s) and /or care team.
	Assess and reassess the person's and their designated family or caregiver's understanding of the life-limiting condition(s) and health status, and provide information as needed.	

4. Optimizing comfort and quality of life

Competency	Generalist	Specialist
Maintaining dignity	Provide care that maintains dignity, well-being, and self-image by facilitating expression of needs, hopes, feelings, and concerns when planning palliative care.	Apply a dignity-conserving approach to care.
Recognizing changes in health status	Observe the person's functioning and indicators of distress, and promptly communicate changes to the health care team.	Support the person and their designated family or caregiver(s) as they adjust to declining health.
Promoting self-management/care	Support the person and their designated family or caregiver(s) to care for themselves as much as possible by encouraging the person and their designated family or caregiver(s) to focus on their strengths and effective coping strategies while acknowledging the barriers and limitations that may make self-management/care difficult.	
Caring for people holistically	Evaluate and provide a holistic approach to care that acknowledges the physical, emotional, mental, social, and spiritual aspects to care.	

4. Optimizing comfort and quality of life

Competency	Generalist	Specialist
CONT'D	Identify how disease progression may affect the capacity of the person to engage in meaningful discussions.	
	Address the socio-economic impact of a life-limiting condition on the person and their designated family or caregiver(s), facilitating access to services as needed.	
	Provide information and referral, when needed, for the person's and their designated family or caregiver's practical, financial, and legal needs.	
	Assess and recognize the sexual and intimacy needs of the person and their designated family or caregiver(s).	
Accompanying and offering presence	Offer a compassionate, empathic presence in response to the needs of the person and their designated family or caregiver(s).	
Involving the designated family or caregiver(s) in care	Involve the designated family or caregiver(s) in care, as desired and appropriate, while addressing the impact of designated family or caregiver's role change throughout the illness.	Mobilize and negotiate family or caregiving systems in complex relationships.
	Respect the role of designated family or caregivers and community throughout the person's care, particularly for members of underserviced populations.	
	Respect the role of designated family and community for First Nations, Inuit, and Métis, throughout their care.	
Screening, assessing, and managing symptoms and concerns	Assess for and address anxiety, depression, and existential distress in collaboration with the care team.	Provide people and their designated family or caregiver(s) counselling through a variety of social work and counselling frameworks and approaches.
	Provide information and options on interventions in collaboration with the care team for symptom management as appropriate and as directed (e.g. relaxation techniques to reduce anxiety related to shortness of breath or existential concerns).	
	Provide or refer the person and their designated family or caregiver(s) for psychosocial interventions such as legacy work, life review, and purposeful conversations about suffering and meaning.	Act as an expert resource regarding the role of discipline-specific interventions.

4. Optimizing comfort and quality of life

Competency	Generalist	Specialist
CONT'D	Recognize that complementary and alternative medicine (CAM) can play an important role in palliative care, especially for members of underserviced populations. Collaborate with the person and their designated family or caregiver(s) to incorporate community-specific practices into the care plan.	
	Recognize that traditional medicine can play an important role in palliative care for First Nations, Inuit, and Métis. Collaborate with the person and family to incorporate community-specific practices into the care plan.	

5. Care planning and collaborative practice

Competency	Generalist	Specialist
Understanding interdisciplinary collaboration, transitions, and roles	Conduct a psychosocial assessment of the person and their designated family or caregiver(s) and, with their consent, share these findings to contribute to interdisciplinary care planning.	
	Lead or participate in family meetings with the person, their designated family or caregiver(s), and care team. Help the person and their designated family or caregiver(s) understand the roles of each member of the care team, and how to communicate effectively with them.	
	Engage with First Nations, Inuit, and Métis community leaders and /or Elders, when appropriate or if requested, to co-create a high-quality approach to palliative care for the person and their designated family or caregiver(s).	
	Understand that members of underserviced populations may have designated family or caregiver(s) and community members who have a role in the care team.	
	Understand that First Nations, Inuit, and Métis family and community members may have a role in the care team.	
	Prepare the person and their designated family or caregiver(s) for transitions of care settings.	

	5. Care planning and collaborative practice	
Competency	**Generalist**	**Specialist**
Assessing and providing assistance with ADL's and IADL's	Identify care needs, safety components, and resources required to address activities of daily living (ADLs) and instrumental activities of daily living (IADLs), such as establishing a case manager, reassessing care, and respite needs for caregivers, etc.	
Acting as an advocate	Advocate for incorporation of the person's and designated family or caregiver's preferences, values, and beliefs into care planning.	
Promoting advance care planning (ACP)	Ask the person and their designated family or caregiver(s) if they have discussed care wishes and identified a substitute decision-maker (SDM), facilitate these discussions in families, and share that information with the care team. Provide information and links to resources regarding advance care planning and goals of care.	
	Explore with the person and their designated family or caregiver(s) that legal documents are in order (will, living will) and that prearrangements are done.	
Supporting informed decision-making	Support the person, their designated family or caregiver(s), SDM, and care team to make decisions regarding treatments, location, and type of care.	Discuss the benefits and considerations of palliative treatment options with the person, their designated family or caregiver(s), and care team.
	Understand the impact that psychological responses, social stressors, and spiritual dimensions of loss have on the mental health and decision-making of the person, and take these into account when planning care.	
	Encourage, support, and facilitate discussions regarding ethical issues and how they impact decision-making and well-being. Share findings with the care team.	

6. Last days and hours

Competency	Generalist	Specialist
Supporting death rituals	Facilitate the person's and designated family or caregiver's wishes for death rituals.	
	Support designated family or caregiver(s) and community-specific protocols and practices surrounding death, loss, and grief when caring for members of underserviced populations.	
	Support designated family or caregiver(s) and community-specific protocols and practices surrounding death, loss, and grief when caring for First Nations, Inuit, and Métis.	
Anticipating changes as death nears	Understand and recognize expected signs and symptoms as a person nears death. Provide support to designated family or caregiver(s).	
Involving and supporting the designated family or caregiver(s)	Provide or offer information about emotional, spiritual, and practical support services to the designated family or caregiver(s). Involve the interdisciplinary care team as needed.	
	Assist the person and their designated family or caregiver(s) to prepare for expected death.	
	Provide emotional support for the designated family or caregiver(s) throughout the illness trajectory, during and following the person's last moments.	

7. Loss, grief, and bereavement

Competency	Generalist	Specialist
Recognizing complicated grief	Identify and support those at risk for or experiencing pathological or complicated responses to loss and grief, and intervene or refer appropriately.	Proactively address complicated grief reactions.
Supporting diverse responses to loss	Recognize and support the expression of grief reactions in people and their designated families or caregivers, which may occur from the time of diagnosis until bereavement.	

7. Loss, grief, and bereavement

Competency	Generalist	Specialist
CONT'D	Describe grief and a variety of psychological responses to illness and death as an expected reaction to loss that is experienced uniquely by everyone.	
	Describe and support, in partnership with the designated family or caregiver(s), the needs of children at varying developmental stages in dealing with grief.	
	Acknowledge the impact of personal traumas and negative experiences on members of underserviced populations, and how these can shape the expressions of grief, bereavement, and mourning. Practice trauma-informed principles and care.	
	Engage with the designated family or caregiver(s) and community to identify community-specific protocols and practices that support the experience and expressions of grief.	
	Acknowledge the impact that historical and ongoing systemic trauma and loss have on First Nations, Inuit, and Métis experiences and expressions of grief, bereavement, and mourning.	
	Engage with the designated family or caregiver(s) and community to identify First Nations, Inuit, and Métis community-specific protocols and practices that support the experiences and expressions of grief.	
Facilitating the use of support services	Provide information on support and bereavement services within the organization and community.	Facilitate bereavement follow-up with the designated family or caregiver(s), following the person's death.

8. Self-care

Competency	Generalist	Specialist
Demonstrating self-awareness	Demonstrate self-awareness of own response to illness, death, and dying.	
Addressing compassion fatigue	Recognize and address compassion fatigue in self and team.	
Supporting healthy behaviors for self and team	Support the team to engage in reflective behaviors about the personal impact of working with dying people and their designated families or caregivers.	Mentor and educate interdisciplinary team regarding the personal impact of loss, grief, and bereavement, and encourage self-awareness and activities that maintain colleagues' resilience.
	Regularly engage in healthy behaviours (such as self-care) to help prevent compassion fatigue.	

9. Professional and ethical practice

Competency	Generalist	Specialist
Understanding legislation and policy	Demonstrate knowledge of current legislation and policies relevant to palliative care.	Apply comprehensive understanding of legal, ethical, and professional standards to the provision of quality palliative care.
Understanding MAiD	Respond to inquiries regarding MAiD in accordance with the appropriate legislation and regulatory body's guidelines and standards.	
Addressing ethical issues	Describe and respond to ethical issues and dilemmas that may arise (e.g. issues associated with impaired swallowing, artificial feeding, differing family or caregiver opinions).	Facilitate discussion and resolution of ethical and legal issues with people, their designated families or caregivers, and the care team.
	Collaborate with colleagues, the person and their designated family or caregiver(s) in ethical decision-making.	

9. Professional and ethical practice

Competency	Generalist	Specialist
Advocating for inclusion of the person’s and their designated family or caregiver’s beliefs and values	Promote incorporation of the person’s and their designated family or caregiver’s wishes, values, and beliefs into the provision of all care.	
	Respect and advocate for people’s decisions about their care, including declining life-sustaining treatments.	
Maintaining boundaries	Maintain professional boundaries with people and families or caregivers.	
	Practice self-reflection to identify and mitigate the potential for transference and counter-transference.	

10. Education, evaluation, quality improvement, and research

Competency	Generalist	Specialist
Educating and supporting learners	Educate staff, people, and families or caregivers on a psychosocial palliative approach.	Create courseware and educational resources for social workers caring for people receiving palliative care and their designated families or caregivers, particularly for those who wish to specialize in palliative care.
	Act as a mentor for others new to palliative care.	Provide practicums for social work students specializing in palliative care.
Accessing continuing education	Participate in continuing education related to palliative care. This could include seminars, clinical training, and supervision.	Bring a psychosocial perspective to the development of discipline-specific and interdisciplinary education.
	Participate in cultural safety training opportunities, especially any that are specific to underserviced populations. Where available, participate in regionally specific training.	
	Participate in First Nations, Inuit, and Métis cultural safety training opportunities. Where available, participate in regionally specific training.	

10. Education, evaluation, quality improvement, and research

Competency	Generalist	Specialist
Contributing to quality improvement	Participate in quality-improvement initiatives to improve professional practice in your organization.	Design and lead quality improvement initiatives.
Evaluating person outcomes	Evaluate the person's outcomes against standards and guidelines.	Contribute to the design, testing, and integration of standards and guidelines appropriate to the scope of social work for people receiving palliative care and their designated families or caregivers.
Collecting data	Participate in research activities such as data collection.	Lead or co-lead research initiatives to assess clinical practice, and identify gaps to improve psychosocial care of people and their designated families or caregivers.
Promoting knowledge generation, translation, and synthesis	Generate and disseminate new knowledge related to social work.	
	Keep up to date on current and emerging research.	

11. Advocacy

Competency	Generalist	Specialist
Advocating for the person, designated family or caregiver(s), and societal rights	Advocate for the rights of the person and their designated family or caregiver(s) for autonomy, self-determination, and privacy.	Advocate in favour of equity for all people, in all healthcare settings, to reduce barriers to accessing palliative care.
	Advocate for incorporation of the person's and designated family or caregiver's values and beliefs into care planning.	
Acting as an advocate	Advocate for the incorporation of people's and designated family or caregiver's values and beliefs into the care plan.	Describe and address barriers for marginalized and vulnerable groups at the end-of-life and in bereavement.
	Advocate for culturally safe practices that are free of racism and discrimination.	

12. Virtual care

Competency	Generalist	Specialist
Identifying people who would be suitable for and benefit from virtual care	Able to identify people who would be suitable to be assessed by virtual care modalities.	
	Recognize equity challenges to virtual care including geography, finances, disabilities, language, and familiarity with technology.	
Adapting care to a virtual modality	Deliver virtual care as per standards of Accreditation Canada.	
	Able to adapt a variety of information and communication techniques to deliver person-centred care.	
	Able to utilize various tools to deliver care virtually.	
	Develop clear processes for follow-up of the person in care and their hand-over to other professionals.	
	Develop clear processes for involvement of the interdisciplinary team.	
Delivering care virtually	Able to clearly communicate with people and their designated families or caregivers and elicit signs and symptoms remotely.	

Personal Support Workers

Personal support workers are frontline health care workers who provide direct care to people in a variety of settings. They will often encounter people facing progressive life-limiting illness, dying, death, or bereavement and their designated families or caregivers, and therefore, require generalist-level palliative care competencies.

Across Canada, in different provinces and territories, and in different settings, personal support workers may be identified as continuing care assistants, health care assistants, nursing assistants, and by other similar titles. We have used the title of personal support workers here for simplicity; however, we are referring to all the titles that apply within this discipline.

1. Principles of a palliative approach to care

Competency	Generalist
Understanding the core philosophy of palliative care and the palliative approach to care	Understand the principles and practices of palliative care and a palliative approach.
	Understand community-specific protocols, in particular when caring for members of underserviced populations who are living with a life-limiting illness so they can live fully throughout their care.
	Understand community-specific protocols of caring for First Nations, Inuit, and Métis who are living with a life-limiting illness so they can live fully throughout their care.
Identifying people who would benefit from a palliative approach	Collaborate with the care team and use evidence-based tools to identify people who could benefit from a palliative approach.
Understanding the interdisciplinary team	Understand the role of the interdisciplinary team in providing palliative care, as well as the roles of each team member.
Including designated family or caregiver(s) in the unit of care	Acknowledge who the person considers to be family, and include the designated family or caregiver(s) in the person's care, if the person wishes.
	Respect the importance of the role of designated family or caregivers and community for members of underserviced populations throughout their palliative care.
	Respect the importance of the role of designated family and community for First Nations, Inuit, and Métis, throughout their palliative care.

1. Principles of a Palliative Approach to Care

Competency	Generalist
Seeing people holistically	Acknowledge the physical, emotional, mental, social, and spiritual aspects to care.

2. Cultural safety and humility

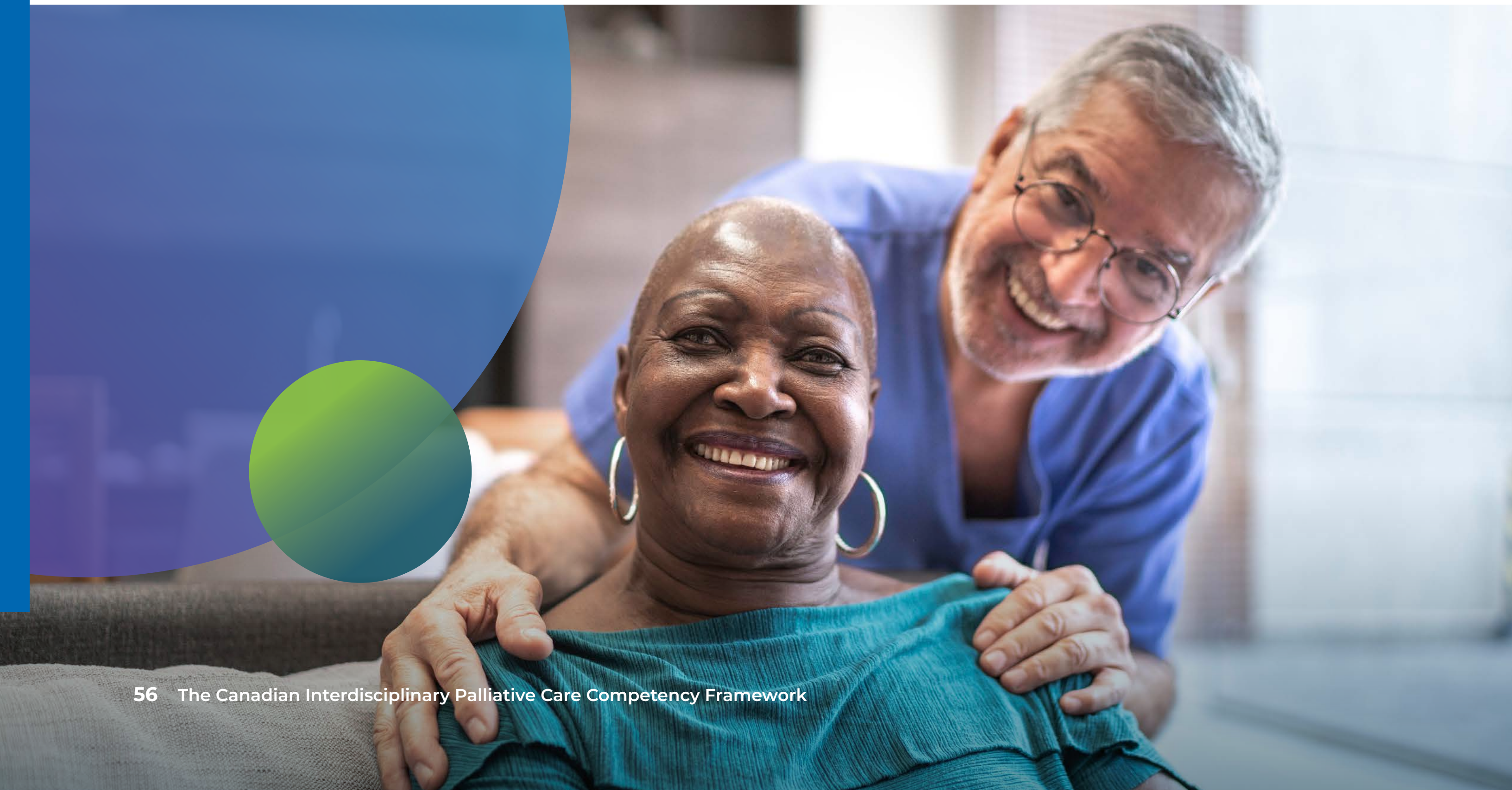
Competency	Generalist
Supporting cultural practices	Understand the influence of culture and lived experiences on a person's attitudes towards health, wellness, serious illness, and death. Incorporate these attitudes into the care of members of underserviced populations.
	Understand that First Nations, Inuit, and Métis cultural practices and beliefs influence how palliative and end-of-life care is provided. Incorporate First Nations, Inuit, and Métis community-specific protocols and practices into provision of palliative care.
	Provide culturally safe care.
	Partner with people and their designated families and caregivers to provide opportunities for cultural, religious, or personal practices.
Engaging in self-reflection	Practice self-reflection to identify and address personal biases.
Acting as an advocate	Advocate for the incorporation of people's and their designated family or caregivers' values and beliefs into the care plan.
	Advocate for culturally safe practices that are free of racism and discrimination.

3. Communication

Competency	Generalist
Recognizing and respecting that each person and their designated family or caregiver(s) has a unique perspective	Ask and seek to understand the unique perspective of each person and their designated family or caregiver(s).

3. Communication

Competency	Generalist
Listening and providing emotional support	Listen and provide emotional support to the person and their designated family or caregiver(s).
	Develop and maintain supportive and therapeutic relationships, by connecting, communicating, and establishing professional boundaries.
Adapting communication for children	Adapt communication when children are involved.
Using appropriate supports to communicate effectively	Utilize supports as needed for effective communication (e.g. interpreters, assistive technology).
	Understand that for members of underserviced populations, designated family and community members may have a role in the care team. Acknowledge and respect that responsibility for communication with the health care provider may be designated to a family member or caregiver(s), and incorporate these wishes in the provision of care.
	Understand that First Nations, Inuit, and Métis family and community members may have a role in the care team. Acknowledge and respect that responsibility for communication with the health care provider may be designated to a family member or caregiver(s), and incorporate these wishes in the provision of care.
Communicating collaboratively	Communicate health changes and concerns of the person and their designated family or caregiver(s) with the rest of the health care team.



4. Optimizing comfort and quality of life

Competency	Generalist
Maintaining dignity	Provide care that maintains the dignity, well-being, and self-image of the person.
Recognizing changes in health status	Observe the person's functioning and indicators of distress, and promptly communicate changes to the health care team.
	Have a basic knowledge of the effects of the most common diseases and their treatments, and the care people receive at end-of-life.
Promoting self-management/care	Support the person to care for themselves as much as possible while acknowledging the barriers and limitations that may make self-management/care difficult.
Caring for people holistically	Provide a holistic approach to care that acknowledges the physical, emotional, mental, social, and spiritual aspects to care.
Offering presence	Offer a compassionate, empathic presence in response to the needs of the person and their designated family or caregiver(s).
Involving the designated family or caregiver(s) in care	Respect the role of and involve the designated family or caregiver(s) in care as desired and appropriate.
	Respect the role of designated family and community for First Nations, Inuit, and Métis, throughout their palliative care.
Screening, assessing, and managing pain and other symptoms and psychosocial concerns	Provide comfort measures as appropriate and prescribed in the care plan (e.g. positioning, using a fan, timing of activities).
	Recognize that complementary or alternative medicine (CAM) can play an important role in palliative care, especially for members of underserviced populations.
	Recognize that traditional medicine can play an important role in palliative care for First Nations, Inuit, and Métis.

5. Care planning and collaborative practice

Competency	Generalist
Understanding interdisciplinary collaboration, transitions, and roles	Contribute to interdisciplinary care planning by offering observations to the health care team of challenges the person and their designated family or caregiver(s) may be experiencing, or any opportunities to provide support, using standardized tools, recording, and reporting.
	Understand that for members of underserviced populations, designated family or caregiver(s) and community members may have a role in the care team.

5. Care planning and collaborative practice

Competency	Generalist
CONT'D	Understand that First Nations, Inuit, and Métis family and community members may have a role in the care team.
Acting as an advocate	Advocate for incorporation of the person’s and their designated family or caregiver’s values and beliefs into care planning.
Promoting advance care planning	Respect the person’s and their designated family or caregiver’s preferences for care.

6. Last days and hours

Competency	Generalist
Anticipating changes as death nears	Understand and recognize expected changes as a person nears death.
	Provide care and comfort measures to support the person and their designated family or caregiver(s) through physical changes in the last days and hours.
Facilitating death rituals	Provide care of the body immediately following death as per the person and designated family or caregiver's preferences and rituals, and the organization’s policies/procedures.
Involving and supporting designated family or caregiver(s)	Respect the designated family or caregiver’s needs and preferences for supports and bring them to the attention of the health care team if they are beyond the scope of the PSW. Involve the interdisciplinary care team as needed.
	Support the designated family or caregiver(s) and community-specific protocols and practices surrounding death, loss, and grief when caring for members of underserviced communities.
	Support designated family and community-specific protocols and practices surrounding death, loss, and grief when caring for First Nations, Inuit, and Métis.

7. Loss, grief, and bereavement

Competency	Generalist
Supporting individual responses to loss	Recognize grief reactions in people and their designated families or caregivers, which may occur from the time of diagnosis until bereavement.
	Understand grief as a natural, adaptive, expected response to loss that is experienced uniquely by each person.

7. Loss, grief, and bereavement

Competency	Generalist
CONT'D	Acknowledge the impact that trauma and loss have on the experiences and expressions of grief, bereavement, and mourning for members of underserviced communities.
	Acknowledge the impact that historical and ongoing systemic trauma and loss have on First Nations, Inuit, and Métis experiences and expressions of grief, bereavement, and mourning.
Facilitating the use of support services	Provide information on support services within the organization and community.

8. Self-care

Competency	Generalist
Supporting healthy behaviours for self and team	Develop a self-care plan and regularly engage in healthy behaviours to help prevent compassion fatigue.
Addressing compassion fatigue	Recognize and address compassion fatigue in self.
Demonstrating self-awareness	Demonstrate self-awareness of own response to illness, death, and dying.

9. Professional and ethical practice

Competency	Generalist
Understanding MAiD	Share a request for hastened death with the care team and respond as per organization policy.
Addressing ethical issues	Understand ethical issues that may arise (e.g. issues associated with the progression of the illness, treatment choices, or differing designated family or caregiver(s) opinions), and bring them to the attention of the health care team if they are beyond the scope of the PSW.
Advocating for inclusion of the person's and their designated family or caregiver's beliefs and values	Promote incorporation of the person's and their designated family or caregiver's wishes, values, and beliefs into the provision of all care.
Maintaining boundaries	Maintain professional boundaries with people and families.

10. Education, evaluation, quality improvement, and research

Competency	Generalist
Accessing continuing education	Participate in continuing education related to palliative care.
	Participate in cultural safety training opportunities, especially any that are specific to underserviced populations. Where available, participate in regionally specific training.
	Participate in First Nations, Inuit, and Métis cultural safety training opportunities. Where available, participate in regionally specific training.
Educating and supporting learners	Act as a mentor for others new to palliative care.
Contributing to quality improvement	Participate in quality-improvement initiatives.
Collecting data	Participate in research activities such as data collection.

11. Advocacy

Competency	Generalist
Advocating for the person, designated family or caregiver(s), and societal rights	Advocate for incorporation of the person’s and their designated family or caregiver’s values and beliefs into care planning.

Volunteers

Volunteers are an integral part of the palliative care team. They enhance the quality of life of the person in many ways as they provide compassionate support to people and their designated families and caregivers.

1. Principles of a palliative approach to care

Competency	Generalist
Understanding the core philosophy of palliative care and the palliative approach to care	Understand the philosophy of palliative care and a palliative approach.
	Understand community-specific protocols and practices of caring for members of underserviced populations who are living with a life-limiting illness so they can live fully throughout their care.
	Understand community-specific protocols of caring for First Nations, Inuit, and Métis who are living with a life-limiting illness so they can live fully throughout their care.
	Understand the key components of volunteer support (presence, listening, respect for other and other's pace, acknowledgement).
Understanding the interdisciplinary team	Understand the role of the interdisciplinary palliative care team, its members, and the role of the volunteer in the team.
Including designated family or caregiver(s) in the unit of care	Respect who the person considers family and include the designated family or caregiver(s) in the person's care.
	Respect the importance of the role of designated family or caregiver(s), and community, for members of underserviced populations throughout their palliative care.
	Respect the importance of the role of designated family and community for First Nations, Inuit, and Métis throughout their palliative care.
	Recognize the impact of a life-limiting condition on familial roles.
Seeing people holistically	Acknowledge the physical, emotional, mental, social, and spiritual aspects to care.

2. Cultural safety and humility

Competency	Generalist
Supporting cultural practices	Understand that cultural practices influence how palliative and end-of-life care is provided, in particular for members of underserviced populations.
	Understand that First Nations, Inuit, and Métis cultural practices and beliefs influence how palliative and end-of-life care is provided.
	Help support a safe, respectful, and culturally inclusive environment that is free of racism and discrimination.
Recognizing and respecting the diversity of people, families and caregivers, and communities	Demonstrate a respectful attitude towards the identities, and cultural and spiritual differences in family or caregiver practices surrounding illness and the end-of-life.
Engaging in self-reflection	Practice self-reflection to identify and address personal and systemic biases.

3. Communication

Competency	Generalist
Recognizing and respecting that each person and designated family or caregiver has a unique perspective	Adapt communication and information sharing to the unique needs of the person and their designated family or caregiver(s).
Listening and providing emotional support	Use active listening and silence, and provide sensitive emotional support to the person and their designated family or caregiver(s).
Adapting communication for children	Adapt communication when children are involved.
Using appropriate supports to communicate effectively	Utilize supports as needed for effective communication (e.g. interpreters, assistive technology).
	Understand that designated family or caregiver(s) and community members may have a role in the care team, in particular for members of underserviced populations.
	Understand that First Nations, Inuit, and Métis family and community members may have a role in the care team.

3. Communication

COMPETENCY	GENERALIST
Communicating collaboratively	Communicate health changes and concerns of the person and their designated family or caregiver(s) to the rest of the care team.

4. Optimizing comfort and quality of life

Competency	Generalist
Maintaining dignity	Provide care that maintains dignity, well-being, and self-image.
Recognizing changes in health status	Observe the person’s functioning and indicators of distress, and promptly communicate changes to the health care team.
	Has a basic knowledge of the effects of the most common diseases and their treatments, and the type of care people receive at end-of-life.
Caring for people holistically	Provide a holistic approach to care that acknowledges the physical, emotional, mental, social, and spiritual aspects to care.
	Provide simple comfort measures according to volunteer policies, such as mouth care, better positioning, use of a fan, or reduction in environmental stimuli. Adhere to proper body mechanics in practical assistance of the person as per organizational policies.
CONT'D	Recognize when a person is experiencing pain or discomfort and alert health professionals.
	Respect the role of the designated family or caregiver(s) and community for members of underserviced populations throughout their palliative care.
	Respect the role of designated family and community for First Nations, Inuit, and Métis throughout their palliative care.
	Recognize that complementary and alternative medicine (CAM) can play an important role in palliative care, especially for members of underserviced populations.
	Recognize that traditional medicine can play an important role in palliative care for First Nations, Inuit, and Métis.
Offering presence	Offer a compassionate, empathic presence in response to the needs of the person and their designated family or caregiver(s).

5. Care planning and collaborative practice

Competency	Generalist
Understanding interdisciplinary collaboration	Contribute to interdisciplinary care planning by offering observations to the health care team of challenges the person and their designated family or caregiver(s) may be experiencing, or any opportunities to provide support.
	Understand that designated family or caregiver(s), and community members, may have a role in the care team, in particular for members of underserviced populations.
	Understand that First Nations, Inuit, and Métis family and community members may have a role in the care team.
	Understand the roles, responsibilities, and limits of the volunteer as per the organization's policies.
	Assist professional staff with supporting the person's needs as per the organization's policies.

6. Last days and hours

Competency	Generalist
Respecting death rituals	Know the responsibilities of volunteers during last hours and following death, and fulfill them with respect for the person and their designated family or caregiver(s).
Anticipating changes as death nears	Know and recognize the expected changes as the person nears death.
Involving and supporting designated family or caregiver(s)	Support the designated family or caregiver's wishes and death rituals.
	Support family and community-specific protocols and practices surrounding death, loss, and grief. Demonstrate openness to incorporating protocols and practices when caring for members of underserviced populations.
	Support designated family and community-specific protocols and practices surrounding death, loss, and grief when caring for First Nations, Inuit, and Métis.

7. Loss, grief, and bereavement

Competency	Generalist
Supporting diverse responses to loss	Understand grief as an expected reaction to loss that is experienced and expressed uniquely by everyone.
	Acknowledge the impact of personal traumas and negative experiences on members of underserviced populations, and how these can shape the expressions of grief, bereavement, and mourning.
	Acknowledge the impact that historical and ongoing systemic trauma and loss have on First Nations, Inuit, and Métis experiences and expressions of grief, bereavement, and mourning.
	Recognize common expressions of and reactions to grief in people and their designated families or caregivers, which may occur from the time of diagnosis until bereavement.
Offering support services	Understand the role of the volunteer in supporting people who are dying, and the bereaved.

8. Self-care

Competency	Generalist
Understanding compassion fatigue	Understand the concept of compassion fatigue, its manifestations, and ways to help prevent it.
Supporting healthy behaviours for self and team	Regularly engage in healthy behaviours to help prevent compassion fatigue. Ask organization for support and resources when help is needed.
Demonstrating self-awareness	Demonstrate self-awareness of own response to illness, death, and dying.

9. Professional and ethical practice

Competency	Generalist
Understanding legislation and policy	Demonstrate understanding of the importance of maintaining privacy and confidentiality.

9. Professional and ethical practice

Competency	Generalist
Addressing ethical issues	Understand ethical issues that may arise (e.g. issues associated with the progression of the illness, treatment choices, or differing designated family or caregiver(s) opinions).
Advocating for inclusion of the person's and their designated family or caregiver's beliefs and values	Promote incorporation of the person's and their designated family or caregiver's wishes, values, and beliefs into the provision of all care.
Maintaining boundaries	Demonstrate understanding of the volunteer boundaries, their purpose, and some strategies for maintaining boundaries with people and their designated families or caregivers.

10. Education, evaluation, quality improvement, and research

Competency	Generalist
Accessing continuing education	Participate in continuing education related to palliative care.
	Participate in cultural safety training opportunities, especially any that are specific to underserviced populations. Where available, participate in regionally specific training.
	Participate in First Nations, Inuit, and Métis cultural safety training opportunities. Where available, participate in regionally specific training.
Educating and supporting learners	Act as a mentor for others new to palliative care.
Contributing to quality improvement	Participate in quality improvement initiatives.
Collecting data	Participate in research activities such as data collection.

11. Advocacy

Competency	Generalist
Advocating for the person, designated family or caregiver(s), and societal rights	Advocate for incorporation of the person's and their designated family or caregiver's values and beliefs into care planning.
	Assist organization with community education initiatives about palliative care.

SECTION 3

Conclusion

Canadians want and deserve highly skilled providers able to address their palliative care needs – whenever and wherever those skills are required, be it in hospital, hospice, or in the home. At present, all too many Canadians are not getting access to high-quality palliative care.[8]

Developing competency across Canada is a long-term exercise that requires deep and sustained commitments from all parties who contribute to a highly skilled workforce. The good news is that the will exists to build palliative care capacity and competency across the country. As one indication, some provincial jurisdictions have made significant progress developing their own competency frameworks, and more provinces and territories are coming on board every year.

The Canadian Partnership Against Cancer and Health Canada, working with an extensive network of palliative care experts and stakeholders, have developed the Canadian Interdisciplinary Palliative Care Competency Framework as one show of our commitment to create a uniform standard of high-quality palliative care across Canada. We expect this document to guide all stakeholders in the development of a highly skilled workforce, including the provinces and territories that have not yet developed jurisdictional frameworks.

The competencies in this document are by no means the end of our palliative care journey. Instead, they will serve as the foundation on which our national professional organizations, and universities and colleges can build comprehensive palliative care programs for the professional communities they serve. They will also serve as the foundation for employment and quality improvement standards.

Our intention is to update this document periodically, adding to the competencies, educational resources, and number of disciplines over time, and as our pan-Canadian strategy continues to take shape.

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[8] Canadian Institute for Health Information. *Access to Palliative Care in Canada. Ottawa,* ON: CIHI; 2018.

Next Steps

To ensure equitable, high-quality palliative care for Indigenous peoples in Canada, engagement with First Nations, Inuit, and Métis governments, organizations, and communities is needed to identify gaps and opportunities in service delivery and to inform the development of Peoples-specific and self-determined palliative care competencies that all providers should demonstrate when working with and caring for Indigenous peoples, and their designated families and caregivers.

This engagement process will be informed by a working group of members from the *First Nations, Inuit and Métis Cancer Strategy Development and Practice Change Implementation Initiative*, as well as various other Indigenous partners across Canada, who are working on palliative care. The working group will identify next steps towards alignment of First Nations, Inuit, and Metis competencies and this competency framework, including determining the approach to identify competencies. Alignment of First Nations, Inuit, and Métis competencies and this competency framework is intended to occur during a future implementation phase.

the will exists **to build palliative care** capacity and competency **across the country**

Appendix 1: Discipline-specific self-assessment tools

This checklist helps individuals, supervisors, and other providers and volunteers assess specific competencies under 12 domains of palliative care. It will help identify your or your staff's learning needs and monitor progress toward providing high-quality palliative care in multiple settings. We invite you to use this checklist in conjunction with our education resources in Appendix 2.

Our process is adapted from Benner's novice-to-expert framework (1984)[9]. For each competency statement, rate your current practice by checking the appropriate box as follows:

- **Novice (N)** – may be experienced in psychosocial care but new to palliative care. Needs regular support.
- **Advanced beginner (B)** – can practice independently using some psychosocial skills specific to palliative care but still needs support.
- **Competent (C)**– mostly independent, occasionally seeks out support.
- **Proficient (P)** – autonomous practice, seeks out leadership opportunities.
- **Expert (E)** – highly proficient, is regularly sought out by others.

Please note that competencies related to caring for First Nations, Inuit, and Métis are included in this self-assessment tool to identify learning needs and monitor progress towards providing high-quality palliative care to First Nations, Inuit, and Métis. It is important to consider when caring for underserviced populations, including First Nations, Inuit, and Métis, that cultural safety is not a skill to master but rather a life-long learning process that leads to providing a higher quality of care.

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[9] Benner, P. *From novice to expert: Excellence and power in clinical nursing*. Menlo Park, CA: Addison-Wesley. 1984.

Self-assessment for Nurses

- **Novice (N)** – may be experienced in psychosocial care but new to palliative care. Needs regular support.
- **Advanced beginner (B)** – can practice independently using some psychosocial skills specific to palliative care but still needs support.
- **Competent (C)** – mostly independent, occasionally seeks out support.
- **Proficient (P)** – autonomous practice, seeks out leadership opportunities.
- **Expert (E)** – highly proficient, is regularly sought out by others.

	Palliative care competencies and descriptions	Knowledge/skill level
1	**Principles of a palliative approach to care**	
1.1	**Understanding the core philosophy of palliative care and the palliative approach to care**	
1.1.1	A. Generalist Understand the philosophy of palliative care and the palliative approach to care, which starts early in the trajectory of a life-limiting condition.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Provide leadership and contribute to the development of palliative care education, standards, and policies.	○ N ○ B ○ C ○ P ○ E
1.1.2	Understand how the palliative approach can enhance the assessment and management of symptoms.	○ N ○ B ○ C ○ P ○ E
1.1.3	Understand and contribute to the development of the relevant palliative care education, standards, guidelines, and policies.	○ N ○ B ○ C ○ P ○ E
1.1.4	Seek to understand and incorporate community-specific practices and protocols of caring for members of underserviced populations who are living with a life-limiting illness so that they can live fully throughout their care.	○ N ○ B ○ C ○ P ○ E
1.1.5	Seek to understand community-specific protocols of caring for First Nations, Inuit, and Métis who are living with a life-limiting illness so they can live fully throughout their care.	○ N ○ B ○ C ○ P ○ E
1.2	**Identifying people who would benefit from a palliative approach**	
1.2.1	A. Generalist Able to describe the meaning of the term "life-limiting condition". Understand and respond to complex and multidimensional care needs.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Apply knowledge of life-limiting conditions to respond to complex and multidimensional care needs, and comprehensively identify current and prospective issues in palliative care at the system level.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
1.2.2	Identify and initiate, early in the illness trajectory, people who would benefit from a palliative approach.	○ N ○ B ○ C ○ P ○ E
1.3	**Understanding the interdisciplinary team**	
1.3.1	A. Generalist Understand the role and function of the interdisciplinary care team to foster a caring environment in palliative care. Understand the role of primary and acute care, and the function of specialist palliative care teams, designated family and caregivers, and volunteers. Know when to reach out and utilize specialist resources.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Demonstrate leadership that encourages colleagues to foster a caring environment that supports all team members working in sensitive situations.	○ N ○ B ○ C ○ P ○ E
1.4	**Addressing barriers to care**	
1.4.1	A. Generalist Identify and understand barriers, and how they affect access and care, with particular attention to members of underserviced populations.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Identify and address perceptions, beliefs, and attitudes towards palliative care – that the person, their designated family or caregiver(s), and colleagues have – that undermine access to high-quality palliative care.	○ N ○ B ○ C ○ P ○ E
1.4.2	Recognize, identify, and understand specific barriers experienced by First Nations, Inuit, and Métis that may affect access and care.	○ N ○ B ○ C ○ P ○ E
1.5	**Including designated family or caregiver(s) in the unit of care**	
1.5.1	Ask the person who they consider family and include the designated family or caregiver(s) in the person's care.	○ N ○ B ○ C ○ P ○ E
1.5.2	Respond to the designated family or caregiver's unique needs and experiences.	○ N ○ B ○ C ○ P ○ E
1.5.3	Respect the importance of the role of designated family or caregiver(s), and community, for members of underserviced populations throughout their palliative care.	○ N ○ B ○ C ○ P ○ E
1.5.4	Respect the importance of the role of designated family or caregiver(s), and community, for First Nations, Inuit, and Métis, throughout their palliative care.	○ N ○ B ○ C ○ P ○ E
1.6	**Seeing people holistically**	
1.6.1	A. Generalist Provide a holistic interdisciplinary team approach that is person- and family- centered, and that aligns with the person's and designated family or caregiver's priorities, values, and choices in the provision of care.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
	B. Specialist Lead conversations and planning when there is a greater complexity in the care needs and/or family dynamics.	○ N ○ B ○ C ○ P ○ E
TOTAL	**1 Principles of a palliative approach to care**	
		N B C P E

2 Cultural safety and humility

2.1	**Engaging in self-reflection**	
2.1.1	Practice self-reflection to identify and address personal and systemic biases.	○ N ○ B ○ C ○ P ○ E
2.2	**Supporting cultural practices**	
2.2.1	A. Generalist Acknowledge the influence of culture and lived experiences on a person's attitudes towards health, wellness, serious illness, and death. Demonstrate openness to incorporating these attitudes into the care of members of underserviced populations.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Engage with underserviced populations to create and facilitate partnerships that influence and address the care needs of these populations. Identify and collaborate with system partners to advocate and implement changes to better serve underserviced populations.	○ N ○ B ○ C ○ P ○ E
2.2.2	Understand that First Nations, Inuit, and Métis cultural practices and beliefs influence how palliative care is provided. Demonstrate openness to incorporating First Nations, Inuit, and Métis community-specific protocols and practices into provision of palliative care.	○ N ○ B ○ C ○ P ○ E
2.2.3	Demonstrate openness and sensitivity to social, spiritual, and cultural values and practices that may influence the person's and their designated family or caregiver's preferences.	○ N ○ B ○ C ○ P ○ E
2.3	**Recognizing and respecting the diversity of people, designated families or caregivers, and communities**	
2.3.1	Assess the diverse needs and preferences of the person and their designated family or caregiver(s). In doing so, consider the social determinants of health, as well as ethnicity, culture, gender, sexual orientation, language, religion, and economic circumstance. Incorporate these determinants into goal setting, decision-making, and care planning.	○ N ○ B ○ C ○ P ○ E
2.3.2	Demonstrate understanding and provide accommodation to the social, spiritual, and cultural values and practices that may influence care provided to the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
2.3.3	Recognize that concepts such as wellness and illness may be defined differently by people, and in particular by members of underserviced populations. Collaborate with people, designated family or caregiver(s), and communities to ensure a shared understanding of terminology, while also respecting and supporting cultural protocols and practices that promote comfort and quality of life.	○ N ○ B ○ C ○ P ○ E
2.3.4	Recognize that concepts such as wellness and illness may be defined differently by First Nations, Inuit, and Métis. Collaborate with people, designated family or caregiver(s), and communities to ensure a shared understanding of terminology, while also respecting and supporting cultural protocols and practices that promote comfort and quality of life.	○ N ○ B ○ C ○ P ○ E
TOTAL	**2 Cultural safety and humility**	
		N B C P E

3 Communication

3.1	**Promoting ongoing collaborative communication**	
3.1.1	A. Generalist Understand that communication regarding palliative and end-of-life care is an ongoing collaborative process.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Demonstrate leadership and facilitate communication in situations in which the generalist team requires support.	○ N ○ B ○ C ○ P ○ E
3.1.2	Understand that for members of underserviced populations, designated family or caregiver(s), and community members may have a role in the care team. Acknowledge and respect that responsibility for communication with the health care provider may be designated to a family member or caregiver, and incorporate those wishes in the provision of care.	○ N ○ B ○ C ○ P ○ E
3.1.3	Understand that First Nations, Inuit, and Métis designated family and community members may have a role in the care team. Acknowledge and respect that responsibility for communication with the health care provider may be designated to a family member or caregiver, and incorporate those wishes in the provision of care.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
3.2	**Listening and providing emotional support**	
3.2.1	A. Generalist Provide emotional support to the person and designated family or caregiver(s) from diagnosis to bereavement. Use a variety of strategies to engage in highly skilled, compassionate, individualized, and timely communication with people, designated families, caregivers, and members of their care teams.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Role model, coach, and mentor team to build capacity in abilities surrounding difficult/complex conversations with patient and designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
3.3	**Adapting communication for children**	
3.3.1	Recognize that designated family or caregiver conversations may involve toddlers, children, and adolescents, and that may require different communication approaches. Have an understanding of developmental stages and appropriate communication skills to match their needs.	○ N ○ B ○ C ○ P ○ E
3.4	**Using appropriate supports to communicate effectively**	
3.4.1	Assess the need and provide specialist support (e.g. interpreters, sign language interpreters, and assistive technology) to bridge communication barriers.	○ N ○ B ○ C ○ P ○ E
3.5	**Delivering difficult news and managing essential conversations**	
3.5.1	A. Generalist Introduce people and their designated family or caregiver(s) to the concept and benefits of palliative care. Share difficult news in a compassionate and supportive manner and provide a safe space for them to process their emotions.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Provide support, mentorship, and role modelling for generalists in developing these skills.	○ N ○ B ○ C ○ P ○ E
3.5.2	A. Generalist Support people so they can make informed decisions about the types of information they wish to receive about their diagnosis, prognosis, and disease progression, and how best to share that news with their designated families.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Identify the person's and designated family or caregiver's information needs and preferences before providing information and discussing diagnosis and prognosis. Regularly ask whether information is meeting the person's and designated family or caregiver's needs.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
3.5.3	Review and clarify the person's and designated family or caregiver's understanding of palliative care information that has been presented by other health care providers. Discuss care preferences, including the pros and cons of life-sustaining treatments (e.g. CPR, admissions to ICU, antibiotics).	○ N ○ B ○ C ○ P ○ E
3.5.4	Explore people's and designated family or caregiver's questions about the dying process and what to expect.	○ N ○ B ○ C ○ P ○ E
TOTAL	**3 Communication**	
		N B C P E

4 Optimizing comfort and quality of life

4.1	**Promoting self-management/care**	
4.1.1	Recognize and educate people and designated family or caregiver(s) about how they can engage in self-management of their condition, while acknowledging the barriers and limitations that may make self-management/care difficult.	○ N ○ B ○ C ○ P ○ E
4.2	**Maintaining dignity**	
4.2.1	Conserve and promote dignity of the person by facilitating expression of needs, hopes, feelings, and concerns in planning palliative care.	○ N ○ B ○ C ○ P ○ E
4.3	**Caring for people holistically**	
4.3.1	A. Generalist Understand the concept of "total pain" and the multiple factors that may impact on the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
	B. Specialist Acknowledge the cumulative losses inherent in the experience of a life-limiting condition and its effects on the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
4.4	**Involving the designated family or caregiver(s) in care**	
4.4.1	Recognize and anticipate the impact of the role changes designated families experience as a result of a person's illness when formulating relevant and realistic care plans.	○ N ○ B ○ C ○ P ○ E
4.4.2	Respect the role of the designated family or caregiver(s), and community, especially when caring for members of underserviced populations throughout their palliative care.	○ N ○ B ○ C ○ P ○ E
4.4.3	Respect the role of the designated family or caregiver(s), and community, for First Nations, Inuit, and Métis, throughout their palliative care.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
4.5	**Screening, assessing, and managing pain and other symptoms and psychosocial concerns**	
4.5.1	Regularly screen for symptoms and needs, using validated, standardized instruments, such as the Edmonton Symptom Assessment System (ESAS).	○ N ○ B ○ C ○ P ○ E
4.5.2	Demonstrate an understanding of the use of non-pharmacological interventions for pain and symptom management, support the person's decision to use complementary and alternative medicine (CAM), and address requests for information. Be aware of the credible resources available within their community regarding CAM. Understand professional responsibilities regarding CAM practices and interventions.	○ N ○ B ○ C ○ P ○ E
4.5.3	Implement evidence-informed pharmacological and non-pharmacological approaches for pain and symptom management at end-of-life.	○ N ○ B ○ C ○ P ○ E
4.5.4	Recognize that complementary and alternative medicine (CAM) can play an important role in palliative care, especially when caring for members of underserviced populations. Collaborate with the person and their designated family or caregiver(s) to incorporate these into the care plan.	○ N ○ B ○ C ○ P ○ E
4.5.5	Recognize that traditional medicine can play an important role in palliative care for First Nations, Inuit, and Métis. Collaborate with the person and their designated family or caregiver(s) to incorporate traditional medicine into the care plan.	○ N ○ B ○ C ○ P ○ E
4.5.6	A. Generalist Collaborate with the care team to manage pain and symptoms effectively based on the person's identified goals of care.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Manage more complex conditions and provide consultation, advice, and mentorship to generalist level nurses.	○ N ○ B ○ C ○ P ○ E
4.5.7	Administer medicine or other treatments appropriate for the types and severity of the person's pain, side effects, drug interactions, complications, and condition.	○ N ○ B ○ C ○ P ○ E
4.5.8	Demonstrate a comprehensive knowledge of common medications, and respond to potential side effects, interactions, or complications.	○ N ○ B ○ C ○ P ○ E
4.5.9	Describe the indications for opioid rotation.	○ N ○ B ○ C ○ P ○ E
4.6	**Understanding the severity of the person's pain, other symptoms, and condition**	
4.6.1	A. Generalist Incorporate knowledge of pain classification, the pathophysiology of pain and other symptoms in management of symptoms.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
	B. Specialist Incorporate evidence-based off label use of medications, as appropriate, for management of symptoms.	○ N ○ B ○ C ○ P ○ E
TOTAL	**4 Optimizing comfort and quality of life**	
		N B C P E

5 Care planning and collaborative practice

5.1	**Understanding interdisciplinary collaboration, transitions, and roles**	
5.1.1	A. Generalist Collaborate with the interdisciplinary team, person, and designated family or caregiver(s) to ensure care plans are consistent with goals of care, preferences, and advance care plans, which may change throughout the life-limiting condition.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Assist with coordinating care and making referrals to interdisciplinary team members and/or organizations – e.g., visiting volunteers.	○ N ○ B ○ C ○ P ○ E
5.1.2	Identify and support navigation of the full range and continuum of palliative care services, resources, and settings in which such services are available. Recognize and coordinate smooth transitions between institutions.	○ N ○ B ○ C ○ P ○ E
5.2	**Modifying care plans as needed**	
5.2.1	Evaluate communication with the person and their designated family or caregiver(s) to ensure that their care plan meets the person's identified needs.	○ N ○ B ○ C ○ P ○ E
5.2.2	Engage with First Nations, Inuit, and Métis community leaders and/or Elders, when appropriate or if requested, to co-create a high-quality approach to palliative care for the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
5.2.3	Evaluate interventions within the care plan, discuss with the interdisciplinary team and propose appropriate alternatives, if necessary.	○ N ○ B ○ C ○ P ○ E
5.2.4	Recognize common symptoms of common trajectories of life-limiting conditions, and anticipate the needs of the person who has a particular disease.	○ N ○ B ○ C ○ P ○ E
5.2.5	Routinely assess Palliative Performance Scale (PPS) to determine changing functional status.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
5.3	**Making informed decisions**	
5.3.1	Understand the importance of determining the person's capacity before having conversations with them regarding advance care planning (ACP), goals of care, and healthcare consent. Understand how a substitute decision maker (SDM) is determined, and the role the SDM plays in making healthcare decisions if the person does not have capacity. Know and apply laws applicable to specific jurisdiction.	○ N ○ B ○ C ○ P ○ E
5.3.2	Facilitate informed decision-making and consent by the person (or, if incapable, their SDM) regarding place of care, while identifying risks in a supportive manner.	○ N ○ B ○ C ○ P ○ E
5.3.3	Support the person, their designated family or caregiver(s), and SDM in decision-making, including withholding or withdrawing an intervention.	○ N ○ B ○ C ○ P ○ E
5.3.4	A. Generalist When able, provide care in the person's preferred place while recognizing the complexities and challenges involved for people, designated families, and caregivers.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Provide palliative care and support capacity building in all settings where people reside. This includes the home, long-term care facilities, and acute care settings, such as community hospitals and emergency departments in rural and remote settings, hospices, group/supportive housing, shelters, jail/prison, etc.	○ N ○ B ○ C ○ P ○ E
5.4	**Understanding advance care planning**	
5.4.1	Understand advance care planning (ACP) and help people set their goals and preferences for care if they wish to prepare or revise an ACP.	○ N ○ B ○ C ○ P ○ E
5.4.2	Provide care and implement treatment plans in keeping with the person's expressed wishes and/or goals of care.	○ N ○ B ○ C ○ P ○ E
TOTAL	**5 Care planning and collaborative practice**	
		N B C P E

6 Last days and hours

6.1	**Anticipating changes as death nears**	
6.1.1	A. Generalist Assist the person and their designated family or caregiver(s) to prepare for the time of death, and provides information about expected changes and comfort measures during the last days and hours of life.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	**Knowledge/skill level**
	B. Specialist Anticipate possible complications and advocate for appropriate medications/treatments or interventions to be available.	○ N ○ B ○ C ○ P ○ E
6.1.2	Identify people who are in the terminal phase, and recognize and respond to signs of imminent death.	○ N ○ B ○ C ○ P ○ E
6.2	**Supporting death rituals**	
6.2.1	Provide care of the body immediately following death as per the person and designated family or caregiver's preferences and rituals, and the organization's policies and procedures.	○ N ○ B ○ C ○ P ○ E
6.2.2	Support designated family and community-specific protocols and practices surrounding death, loss, and grief, in particular when caring for members of underserviced populations.	○ N ○ B ○ C ○ P ○ E
6.2.3	Support designated family and community-specific protocols and practices surrounding death, loss, and grief when caring for First Nations, Inuit, and Métis.	○ N ○ B ○ C ○ P ○ E
6.3	**Involving and supporting the designated family or caregiver(s)**	
6.3.1	Facilitate discussions with appropriate professionals if an autopsy is requested or required.	○ N ○ B ○ C ○ P ○ E
6.3.2	Help the designated family or caregiver(s) do the following: • cope with emotional responses, • maintain a desired level of control, • share preferences and needs, • discuss place of death, • access resources, • communicate meaningfully, • process emotions associated with anticipatory grief.	○ N ○ B ○ C ○ P ○ E
6.3.3	Facilitate discussions with appropriate professionals if the person or their designated family or caregiver(s) request organ or tissue donation.	○ N ○ B ○ C ○ P ○ E
TOTAL	**6 Last days and hours**	
		N B C P E

7 Loss, grief, and bereavement

7.1	**Supporting diverse responses to loss**	
7.1.1	Recognize the range of individual physical, psychological, spiritual, emotional, cultural, and social responses to loss and grief.	○ N ○ B ○ C ○ P ○ E
7.1.2	Demonstrate an understanding of the needs of children at various developmental stages in dealing with grief and loss.	○ N ○ B ○ C ○ P ○ E
7.1.3	Accurately assess and manage people's and their designated families' or caregivers' loss, grief, and bereavement needs.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
7.2	**Recognizing complicated grief**	
7.2.1	A. Generalist Acknowledge the impact of personal traumas and negative experiences, in particular for members of underserviced populations, and how these can shape the expressions of grief, bereavement, and mourning. Practice trauma-informed principles and care.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Engage with the designated family or caregiver(s), and community, to identify community-specific protocols and practices that support the experience and expressions of grief.	○ N ○ B ○ C ○ P ○ E
7.2.2	A. Generalist Acknowledge the impact that historical and ongoing systemic trauma and loss have on First Nations, Inuit, and Métis experiences and expressions of grief, bereavement, and mourning. Practice trauma-informed principles and care.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Engage with the designated family or caregiver(s), and community, to identify First Nations, Inuit, and Métis community-specific protocols and practices that support the experience and expression of grief.	○ N ○ B ○ C ○ P ○ E
7.3	**Using support services**	
7.3.1	Provide guidance, support, and information to families, caregivers, and others (based on awareness of cultures and needs), and make referrals to bereavement services as required.	○ N ○ B ○ C ○ P ○ E
TOTAL	**7 Loss, grief and bereavement**	
		N B C P E

8 Self-care

8.1	**Promoting self-awareness**	
8.1.1	Explore own attitudes and beliefs regarding death, dying, and caring for people who require palliative care.	○ N ○ B ○ C ○ P ○ E
8.1.2	Demonstrate an awareness of the effects of past experiences of suffering, death, and dying when caring for people with life-limiting conditions.	○ N ○ B ○ C ○ P ○ E
8.1.3	Understand and attend to own emotional responses that result from caring for people with life-limiting conditions.	○ N ○ B ○ C ○ P ○ E
8.2	**Promoting healthy behaviors for self and team**	
8.2.1	Demonstrate an awareness of ways to manage and cope with the impact of death and with people dying.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
8.2.2	Demonstrate an awareness of the emotional and spiritual supports available for self and team.	○ N ○ B ○ C ○ P ○ E
8.2.3	A. Generalist Identify colleagues who may be suffering and provide support.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Support colleagues to identify factors contributing to stress in caring for people who require a palliative approach to care and their designated families or caregivers. Support colleagues to develop a plan to cope with stress.	○ N ○ B ○ C ○ P ○ E
8.3	**Preventing compassion fatigue**	
8.3.1	A. Generalist Recognize compassion fatigue in self and colleagues; intervene and refer appropriately.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Identify issues in the system that contribute to compassion fatigue and advocate for change.	○ N ○ B ○ C ○ P ○ E
8.3.2	Engage in healthy activities that help prevent compassion fatigue.	○ N ○ B ○ C ○ P ○ E
TOTAL	**8 Self-care**	
		N B C P E

9 Professional and ethical practice

9.1	**Addressing ethical issues**	
9.1.1	Anticipate and address ethical and legal issues that may be encountered when caring for people with life-limiting conditions.	○ N ○ B ○ C ○ P ○ E
9.1.2	Facilitate discussion and management of ethical and legal issues in conjunction with the person, their designated family or caregiver(s), their care team, and institutional ethics review boards (or equivalent), where they exist.	○ N ○ B ○ C ○ P ○ E
9.1.3	Identify situations where beliefs, attitudes, and values limit one's ability to be present and provide care to people and their designated families or caregivers. Collaborate with others to ensure optimal care is provided.	○ N ○ B ○ C ○ P ○ E
9.1.4	Understand distinctions among ethical and legal concepts, such as: the principle of double effect, palliative sedation, and medical assistance in dying (MAiD).	○ N ○ B ○ C ○ P ○ E
9.1.5	Access resources to guide ethically complex situations and implement possible resolutions.	○ N ○ B ○ C ○ P ○ E
9.2	**Advocating for inclusion of the person's and their designated family or caregiver's beliefs and values**	
9.2.1	Establish and respect peoples' wishes, options, and preferences regarding their care, and respect their decisions.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
9.3	**Understanding legislation and policy**	
9.3.1	A. Generalist Demonstrate knowledge of relevant legislation/policies – e.g. medical assistance in dying (MAiD), *Children and Family Services Act*, *Adult Protection Act*, and *Personal Directives Act*, and any other legislation related to field of practice.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Apply a comprehensive understanding of and contribute to the development and refinement of legal, ethical, and professional standards to the provision of quality palliative care.	○ N ○ B ○ C ○ P ○ E
9.4	**Understanding MAiD**	
9.4.1	Respond to inquiries regarding MAiD in accordance with the appropriate regulatory body's guidelines and standards.	○ N ○ B ○ C ○ P ○ E
TOTAL	**9 Professional and ethical practice**	
		N B C P E

10 Education, evaluation, quality improvement, and research

10.1	**Accessing continuing education**	
10.1.1	Participate in palliative care continuing education opportunities.	○ N ○ B ○ C ○ P ○ E
10.1.2	Participate in cultural safety training opportunities, especially any that are specific to underserviced populations. Where available, participate in regionally specific training.	○ N ○ B ○ C ○ P ○ E
10.1.3	Participate in First Nations, Inuit, and Métis cultural safety training opportunities. Where available, participate in regionally specific training.	○ N ○ B ○ C ○ P ○ E
10.2	**Educating and supporting learners**	
10.2.1	A. Generalist Educate people, families, caregivers and interdisciplinary teams regarding palliative care and the palliative approach.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Develop, facilitate, and provide palliative care-related education, leadership, and mentorship to generalists and students preparing to be specialists.	○ N ○ B ○ C ○ P ○ E
	C. Specialist Promote public awareness and education regarding end-of-life issues, beliefs, and attitudes about palliative care.	○ N ○ B ○ C ○ P ○ E
10.3	**Contributing to quality improvement**	
10.3.1	A. Generalist Contribute to the monitoring and evaluation of the quality of palliative care, and critically evaluate outcomes against standards and guidelines.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
	B. Specialist Contribute to the evaluation of the quality of palliative care and the effectiveness of the specialist palliative care consult team.	○ N ○ B ○ C ○ P ○ E
10.4	**Evaluating person outcomes**	
10.4.1	A. Generalist Routinely incorporate standardized measures recognizing the importance of person-reported outcomes (PROs).	○ N ○ B ○ C ○ P ○ E
	B. Specialist Contribute to the development, implementation, and evaluation of PROs based on evidence-informed standards and guidelines, and advocate for the importance of PROs in all aspects of palliative care policy and practice.	○ N ○ B ○ C ○ P ○ E
10.5	**Promoting Knowledge generation, translation, and synthesis**	
10.5.1	A. Generalist Apply knowledge gained from palliative care research to all activities in delivering a palliative approach to care.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Lead, facilitate, and engage in research in palliative care, and act as an expert resource contributing to palliative care development and delivery.	○ N ○ B ○ C ○ P ○ E
10.5.2	A. Generalist Where possible and appropriate, encourage people and designated families or caregivers to participate in research opportunities.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Identify the opportunities for, and barriers to, discipline-specific and interdisciplinary research unique to palliative care.	○ N ○ B ○ C ○ P ○ E
TOTAL	**10 Education, evaluation, quality improvement, & research**	
		N B C P E

11 Advocacy

11.1	**Advocating for the person, designated family or caregiver(s), and societal rights**	
11.1.1	Advocate for the incorporation of people's and designated families' or caregivers' values and beliefs into the care plan.	○ N ○ B ○ C ○ P ○ E
11.1.2	A. Generalist Advocate that the needs, decisions, and rights of underserviced populations, including First Nations, Inuit, and Métis, be incorporated into care planning.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Actively influence and promote palliative care strategic initiatives and policy development.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
	C. Specialist Advocate for health professionals to be supported in participating in palliative care continuing education opportunities, and to have access to adequate resources to provide palliative care.	○ N ○ B ○ C ○ P ○ E
	D. Specialist Describe how changes in legislation and/or funding, and the structure of the healthcare system, could affect delivery of palliative care to people. Actively engage generalist and others in these processes.	○ N ○ B ○ C ○ P ○ E
11.2	**Acting as an advocate**	
11.2.1	A. Generalist Advocate for equitable, accessible, safe, high-quality palliative care, and timely access to resources for palliative care.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Participate in and lead as a member of organizations that advocate for equitable, accessible, safe, and high-quality palliative care.	○ N ○ B ○ C ○ P ○ E
11.2.2	A. Generalist Advocate for culturally safe practices that are free of racism and discrimination.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Provide advocacy and leadership, and contribute to policy and program development at a systems level to ensure culturally safe care.	○ N ○ B ○ C ○ P ○ E
TOTAL	**11 Advocacy**	
		N B C P E

12 Virtual care

12.1	**Identifying people who would be suitable for and benefit from virtual care**	
12.1.1	Identify people who would be suitable to be assessed by virtual care modalities and where it would optimize symptom and psychosocial supports.	○ N ○ B ○ C ○ P ○ E
12.1.2	Recognize equity challenges to virtual care including geography, finances, disabilities, language, and familiarity with technology.	○ N ○ B ○ C ○ P ○ E
12.2	**Adapting care to a virtual modality**	
12.2.1	Deliver virtual care as per standards of Accreditation Canada, provincial standards of practice, and workplace regulations and guidelines.	○ N ○ B ○ C ○ P ○ E
12.2.2	Adapt a variety of information and communication techniques to deliver person-centred care.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
12.2.3	Utilize various tools to deliver care virtually.	○ N ○ B ○ C ○ P ○ E
12.2.4	Develop clear processes for patient follow-up and hand-over to other professionals.	○ N ○ B ○ C ○ P ○ E
12.2.5	Develop clear processes for involvement of the interdisciplinary team	○ N ○ B ○ C ○ P ○ E
12.3	**Delivering care virtually**	
12.3.1	Communicate effectively and clearly with people and their designated families or caregivers, and elicit signs and symptoms remotely.	○ N ○ B ○ C ○ P ○ E
TOTAL	**12 Virtual care**	
		N B C P E

Totals	
	N B C P E

Self-assessment for Generalist Physicians

- **Novice (N)** – may be experienced in psychosocial care but new to palliative care. Needs regular support.
- **Advanced beginner (B)** – can practice independently using some psychosocial skills specific to palliative care but still needs support.
- **Competent (C)** – mostly independent, occasionally seeks out support.
- **Proficient (P)** – autonomous practice, seeks out leadership opportunities.
- **Expert (E)** – highly proficient, is regularly sought out by others.

	Palliative care competencies and descriptions	Knowledge/skill level
1	**Principles of a palliative approach to care**	
1.1	**Provide a palliative approach to care**	
1.1.1	Describe the benefits of and provide an early holistic palliative approach to care that addresses physical, psychosocial, spiritual, and practical concerns.	○ N ○ B ○ C ○ P ○ E
1.1.2	Recognize common trajectories, natural histories of functional decline, and transition points to trigger early initiation of a palliative approach to care.	○ N ○ B ○ C ○ P ○ E
1.1.3	Understand community-specific protocols and practices, including the role of complementary and alternative medicine (CAM), when caring for members of underserviced populations who are living with a life-limiting illness so they can live fully throughout their care.	○ N ○ B ○ C ○ P ○ E
1.1.4	Understand community-specific protocols, including the role of traditional medicine, when caring for First Nations, Inuit, and Métis who are living with a life-limiting illness so they can live fully throughout their care.	○ N ○ B ○ C ○ P ○ E
1.2	**Address barriers to palliative care**	
1.2.1	Identify and address misperceptions, beliefs, and attitudes towards palliative care – that the person, their designated family or caregiver(s), and colleagues have – that undermine access to high-quality palliative care.	○ N ○ B ○ C ○ P ○ E
TOTAL	**1 Principles of a palliative approach to care**	
		N B C P E

Palliative care competencies and descriptions		Knowledge/skill level
2	**Cultural safety and humility**	
2.1	**Create an environment of cultural safety**	
2.1.1	Demonstrate cultural safety and describe how diversity impacts decision making to provide person- and family-centered care.	○ N ○ B ○ C ○ P ○ E
2.1.2	Recognize the values, biases, or perspectives of people, physicians, or other health care professionals that may have an impact on the quality of care and modify the approach to the person and their designated family or caregiver(s) accordingly.	○ N ○ B ○ C ○ P ○ E
2.1.3	Recognize that concepts such as wellness and illness may be defined differently by members of underserviced populations.	○ N ○ B ○ C ○ P ○ E
2.1.4	Recognize that concepts such as wellness and illness may be defined differently by First Nations, Inuit, and Métis.	○ N ○ B ○ C ○ P ○ E
2.1.5	Demonstrate sensitivity to spiritual, religious, and cultural considerations relative to palliative care, including rituals and approaches to end-of-life care.	○ N ○ B ○ C ○ P ○ E
2.1.6	Embed First Nations, Inuit, and Métis community protocols and cultural practices, including traditional medicine, surrounding palliative and end-of-life care when providing care.	○ N ○ B ○ C ○ P ○ E
TOTAL	**2 Cultural safety and humility**	
		N B C P E

3 Communication

3.1	**Communicate effectively with patients, families, and other informal caregivers**	
3.1.1	Communicate honestly and compassionately about life-threatening illness and prognosis from time of diagnosis throughout the illness trajectory: • Elicit understanding from the patient and their designated family or caregiver(s) of their illness and prognosis for information sharing. • Demonstrate the ability to discuss an individualized estimation of survival and disease trajectory.	○ N ○ B ○ C ○ P ○ E
3.1.2	Understand that for members of underserviced populations, designated family or caregiver(s) and community may have a role in the care team. Acknowledge and respect that responsibility for communication with the health care provider may be assigned to a family member or caregiver(s), and incorporate these wishes in the provision of care.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
3.1.3	Understand that First Nations, Inuit, and Métis designated family and community members may have a role in the care team. Acknowledge and respect that responsibility for communication with the health care provider may be designated to a family member or caregiver(s), and incorporate these wishes in the provision of care.	○ N ○ B ○ C ○ P ○ E
3.1.4	Communicate with the person and their designated family or caregiver(s) in order to determine, record, and implement a care plan aligned with the person's values and goals of care.	○ N ○ B ○ C ○ P ○ E
3.1.5	Adapt communication approaches as required when designated family and caregiver conversations involve children.	○ N ○ B ○ C ○ P ○ E
3.1.6	Demonstrate the ability to educate patients and designated families or caregivers receiving a palliative approach to care about matters related to advancing disease.	○ N ○ B ○ C ○ P ○ E
3.1.7	Communicate with health care providers, including the primary care team, about the natural history of the illness, what to monitor, when to refer, prognostication, and suggestions around "community-based action plans".	○ N ○ B ○ C ○ P ○ E
3.1.8	Facilitate meetings between the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
TOTAL	**3 Communication**	
		N B C P E

4 Optimizing comfort and quality of life

4.1 Assess and manage pain in a palliative context

4.1.1	Conduct a thorough pain history and perform an appropriate physical exam for someone presenting with pain.	○ N ○ B ○ C ○ P ○ E
4.1.2	Demonstrate a person- and family-centered and interdisciplinary approach to assessing pain in patients with life-threatening illness.	○ N ○ B ○ C ○ P ○ E
4.1.3	Describe and recognize 'total pain' where physical, psychological, social, emotional, and spiritual concerns each contribute to the pain experience.	○ N ○ B ○ C ○ P ○ E
4.1.4	Describe and use standardized tools for pain assessment.	○ N ○ B ○ C ○ P ○ E
4.1.5	Choose appropriate/relevant investigations of pain.	○ N ○ B ○ C ○ P ○ E
4.1.6	Choose an appropriate analgesia regimen, including non-pharmacological and pharmacological elements.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
4.2	**Use opioids effectively to manage pain and other symptoms in a palliative context**	
4.2.1	Write an opioid prescription for an opioid-naïve patient, including breakthrough dosing: • Manage common routes of opioid administration and their effect on bioavailability and dosing frequency. • Manage relevant pharmacokinetic and pharmacodynamic properties.	○ N ○ B ○ C ○ P ○ E
4.2.2	Demonstrate appropriate opioid titration.	○ N ○ B ○ C ○ P ○ E
4.2.3	Manage common side effects of opioids and anticipate and prevent side effects such as nausea and constipation.	○ N ○ B ○ C ○ P ○ E
4.2.4	Address patient and designated family or caregiver(s) concerns or misconceptions about opioids.	○ N ○ B ○ C ○ P ○ E
4.2.5	Explain the concepts of tolerance, physical dependence, and addiction as they relate to the use of opioids.	○ N ○ B ○ C ○ P ○ E
4.2.6	Identify potential risk factors for opioid misuse, abuse, addiction and/or diversion, and describe approaches for managing these issues.	○ N ○ B ○ C ○ P ○ E
4.2.7	Recognize opioid-induced neurotoxicity (OIN) and distinguish OIN from opioid overdose.	○ N ○ B ○ C ○ P ○ E
4.3	**Use adjuvant modalities and medications for pain management in a palliative context**	
4.3.1	Use adjuvant analgesics appropriately, including but not limited to corticosteroids, non-steroidal anti-inflammatory drugs, and neuropathic agents.	○ N ○ B ○ C ○ P ○ E
4.3.2	Recognize the potential role of adjuvant modalities, including but not limited to chemotherapy, radiation therapy, surgery, and interventional analgesia, in the management of pain and other symptoms, and refer when appropriate.	○ N ○ B ○ C ○ P ○ E
4.4	**Assess and manage common symptoms, including but not limited to constipation, nausea, vomiting, dyspnea, delirium, and insomnia**	
4.4.1	Conduct a thorough history and perform an appropriate physical exam for a patient presenting with common symptoms.	○ N ○ B ○ C ○ P ○ E
4.4.2	Demonstrate a person- and family-centered and interdisciplinary approach to assessing symptoms in people with life-threatening illness	○ N ○ B ○ C ○ P ○ E
4.4.3	Describe and use Edmonton Symptom Assessment System (ESAS) and other validated tools as appropriate to regularly screen for symptoms in the patient population.	○ N ○ B ○ C ○ P ○ E
4.4.4	Choose appropriate/relevant investigations for identified symptoms.	○ N ○ B ○ C ○ P ○ E
4.4.5	Initiate appropriate first-line therapy to manage identified symptoms including non-pharmacological interventions.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
4.5	**Address psychosocial and spiritual issues that people with life-threatening illness and their designated families or caregivers encounter**	
4.5.1	Identify, assess, and plan for the psychosocial and spiritual needs that people and their designated families or caregivers encounter across the illness trajectory.	○ N ○ B ○ C ○ P ○ E
4.5.2	Recognize the level of demand and stress on families and caregivers and identify risk factors for burnout.	○ N ○ B ○ C ○ P ○ E
4.5.3	Demonstrate the ability to screen, diagnose, and initiate treatment for patients experiencing depression and/or anxiety.	○ N ○ B ○ C ○ P ○ E
4.5.4	Identify patients and families or caregivers who have complex psychosocial needs, who would benefit from referral to expert resources.	○ N ○ B ○ C ○ P ○ E
4.5.5	Describe the relationship between psychosocial, spiritual, and cultural issues with respect to total suffering and total pain.	○ N ○ B ○ C ○ P ○ E
4.6	**Assess and describe appropriately the elements of suffering for people receiving a palliative approach to care and their designated families or caregivers**	
4.6.1	Integrate diverse societal perspectives on dying and death.	○ N ○ B ○ C ○ P ○ E
4.6.2	Identify and describe issues contributing to suffering in people requiring a palliative approach to care and their designated families or caregivers.	○ N ○ B ○ C ○ P ○ E
4.7	**Provide a supportive approach to suffering**	
4.7.1	Demonstrate a supportive approach to address multidimensional sources of suffering in people with palliative care needs and their designated families or caregiver(s).	○ N ○ B ○ C ○ P ○ E
4.8	**Participate in providing care for the child requiring a palliative approach to care and their designated family or caregiver(s), *if provision of pediatric care is applicable to scope of practice***	
4.8.1	Describe the similarities and differences in providing palliative care to children and adults, including the impact of grief and loss on the designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
4.8.2	Identify the challenges (societal, professional, and personal) which arise when caring for a child with palliative care needs and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
4.8.3	Describe the interdisciplinary approach to care which benefits the child and designated family or caregiver(s) when life-limiting illness is present.	○ N ○ B ○ C ○ P ○ E
TOTAL	**4 Optimizing comfort and quality of life**	
		N B C P E

	Palliative care competencies and descriptions	Knowledge/skill level
5	**Care planning and collaborative practice**	
5.1	**Establish advance care plans with patients and their designated family or caregiver(s) in accordance with provincial/territorial regulations and terminology**	
5.1.1	Demonstrate respect for differing designated family structures, roles, and cultural issues with sharing information and arriving at decisions, including plans of care.	○ N ○ B ○ C ○ P ○ E
5.1.2	Engage with First Nations, Inuit, and Métis community leaders and/or Elders, when appropriate or if requested, to develop a high-quality approach to palliative care for the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
5.2	**Demonstrate the use of advance care planning**	
5.2.1	Demonstrate an effective approach to advance care planning.	○ N ○ B ○ C ○ P ○ E
5.3	**Develop and propose a care plan in collaboration with other disciplines**	
5.3.1	Collaborate in the development of an interdisciplinary care plan to meet the psychosocial and spiritual needs of people facing life-threatening illness and their designated families or caregivers. Aim to provide palliative care in the person's preferred location, whenever possible.	○ N ○ B ○ C ○ P ○ E
5.3.2	Actively involve primary care providers and other community-based supports in the psychosocial and spiritual support of people facing life-threatening illness and their designated families or caregivers.	○ N ○ B ○ C ○ P ○ E
5.3.3	Recognize that complementary and alternative medicine (CAM) can play an important role in palliative care, in particular for members of underserviced populations. Collaborate with the person and their designated family or caregiver(s) to incorporate community-specific practices into the care plan.	○ N ○ B ○ C ○ P ○ E
5.3.4	Recognize that traditional medicine can play an important role in the palliative care of First Nations, Inuit, and Métis. Collaborate with the person and their designated family or caregiver(s) to incorporate community-specific practices into the care plan.	○ N ○ B ○ C ○ P ○ E
5.4	**Collaborate as members of an interdisciplinary team**	
5.4.1	Work effectively with interdisciplinary colleagues to provide a palliative approach to care throughout the illness trajectory.	○ N ○ B ○ C ○ P ○ E
5.4.2	Refer patients with complex needs requiring specialized palliative care expertise, including but not limited to: reasons for consultation, pertinent investigations, pain management, medication list, and opioid toxicity.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
5.4.3	Ensure the continuity of a palliative approach to care across different settings by collaborating with the most responsible clinician.	○ N ○ B ○ C ○ P ○ E
5.4.4	Demonstrate the ability to collaborate with other disciplines regarding which serious illness conversations have occurred and share the person's and their designated family's or caregiver's responses.	○ N ○ B ○ C ○ P ○ E
TOTAL	**5 Care planning and collaborative practice**	
		N B C P E

6 Last days and hours

6.1	Participate in the care of the dying patient and their designated family or caregiver(s) in uncomplicated cases	
6.1.1	Identify signs of approaching death	○ N ○ B ○ C ○ P ○ E
6.1.2	Describe common signs of the natural dying process.	○ N ○ B ○ C ○ P ○ E
6.1.3	Prepare and educate the person and their designated family or caregiver(s) when death approaches.	○ N ○ B ○ C ○ P ○ E
6.1.4	Prescribe medications for symptom control in the dying phase.	○ N ○ B ○ C ○ P ○ E
6.1.5	Pronounce a patient's death and complete a death certificate. Identify circumstances that may warrant the involvement of a coroner/medical examiner.	○ N ○ B ○ C ○ P ○ E
6.1.6	Facilitate discussions with appropriate professionals if an autopsy is requested or required. Facilitate discussions with appropriate professionals if the patient or their designated family or caregiver(s) request organ or tissue donation.	○ N ○ B ○ C ○ P ○ E
6.1.7	Integrate pre- and post-death rituals and practices at end-of-life, in accordance with the patient's or designated family or caregiver(s) wishes.	○ N ○ B ○ C ○ P ○ E
6.1.8	Integrate community-specific protocols and practices surrounding end-of-life, when caring for First Nations, Inuit, and Métis.	○ N ○ B ○ C ○ P ○ E
TOTAL	**6 Last days and hours**	
		N B C P E

Palliative care competencies and descriptions		Knowledge/skill level

7 Loss, grief, and bereavement

7.1	**Address grief and bereavement in people with life-threatening illness and their designated families or caregivers**	
7.1.1	Accurately assess and manage loss, grief, and bereavement needs.	○ N ○ B ○ C ○ P ○ E
7.1.2	Identify risk factors for complicated grief.	○ N ○ B ○ C ○ P ○ E
7.1.3	Demonstrate an understanding of the needs of children at various developmental stages in dealing with grief and loss.	○ N ○ B ○ C ○ P ○ E
7.1.4	Describe an approach to provide or refer to supportive care any persons experiencing anticipatory grief and/or bereavement.	○ N ○ B ○ C ○ P ○ E
7.1.5	Support designated family and caregiver(s), and community-specific protocols and practices surrounding death, loss, and grief when caring for members of underserviced populations.	○ N ○ B ○ C ○ P ○ E
7.1.6	Support designated family and community-specific protocols and practices surrounding death, loss and grief when caring for First Nations, Inuit, and Métis.	○ N ○ B ○ C ○ P ○ E
7.1.7	Acknowledge the impact of personal traumas and negative experiences on members of underserviced populations, and how these can shape their expressions of grief, bereavement, and mourning. Practice trauma-informed principles and care.	○ N ○ B ○ C ○ P ○ E
7.1.8	Acknowledge the impact that historical and ongoing systemic trauma and loss have on First Nations, Inuit, and Métis experiences and expressions of grief, bereavement, and mourning. Practice trauma-informed principles and care.	○ N ○ B ○ C ○ P ○ E
TOTAL	**7 Loss, grief and bereavement**	
		N B C P E

8 Self-care

8.1	**Demonstrate self-reflection and self-care in working with people requiring a palliative approach to care and their designated families or caregivers**	
8.1.1	Identify common factors contributing to personal and professional stress in caring for people who require a palliative approach to care and their designated families or caregivers.	○ N ○ B ○ C ○ P ○ E
8.1.2	Develop a plan to cope with personal and professional stress that may arise in caring for people who require a palliative approach to care and their designated families or caregivers. Offer support to colleagues.	○ N ○ B ○ C ○ P ○ E
8.1.3	Engage in healthy activities that help prevent compassion fatigue in oneself and colleagues.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
8.1.4	Exhibit self-reflective capacity in analyzing one's own values, beliefs, and reactions when faced with dying and death.	○ N ○ B ○ C ○ P ○ E
8.1.5	Demonstrate awareness when personal reactions may impact the ability to provide a palliative approach to care and seek help to mitigate.	○ N ○ B ○ C ○ P ○ E
TOTAL	**8 Self-care**	
		N B C P E

9 Professional and ethical practice

9.1	**Actively engage in advance care planning, goals of care discussions, and decision-making with people who would benefit from a palliative approach to care, using bioethical and legal frameworks**	
9.1.1	Discuss the common ethical issues that arise throughout the illness trajectory such as decision-making, withdrawing or withholding therapy, and resuscitation orders.	○ N ○ B ○ C ○ P ○ E
9.1.2	Distinguish between Medical Assistance in Dying (MAiD), continuous palliative sedation therapy (CPST) for refractory symptoms at the very end-of-life, and withholding or withdrawing therapy, in accordance with provincial/territorial/federal regulations and terminology.	○ N ○ B ○ C ○ P ○ E
9.1.3	Demonstrate the ability to respond to patients and their designated families or caregivers when discussing MAiD, CPST, and withholding or withdrawing therapy.	○ N ○ B ○ C ○ P ○ E
9.1.4	Compassionately explore and address suffering with the patient and their designated family or caregiver(s) when discussing MAiD, CPST, and withholding or withdrawing therapy.	○ N ○ B ○ C ○ P ○ E
9.1.5	Involve specialist palliative care services when appropriate.	○ N ○ B ○ C ○ P ○ E
TOTAL	**9 Professional and ethical practice**	
		N B C P E

10 Education, evaluation, quality improvement, and research

10.1	**Access continuing education in palliative approach to care**	
10.1.1	Participate in continuing education opportunities for maintenance of competency in palliative approach to care.	○ N ○ B ○ C ○ P ○ E
10.1.2	Participate in cultural safety training opportunities, especially any that are specific to underserviced populations. Where available, participate in regionally specific training.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	**Knowledge/skill level**
10.1.3	Participate in First Nations, Inuit, and Métis cultural safety training opportunities. Where available, participate in regionally specific training.	○ N ○ B ○ C ○ P ○ E
10.1.4	Keep up to date on current evidence base for provision of palliative approaches to care.	○ N ○ B ○ C ○ P ○ E
10.2	**Contribute to quality improvement**	
10.2.1	Participate in cultural safety training opportunities with the intention of improving the quality of palliative care, in particular for underserviced populations, including for First Nations, Inuit, and Métis.	○ N ○ B ○ C ○ P ○ E
10.2.2	Contribute to the evaluation of the quality of palliative care and the effectiveness of the palliative care system, as related to own practice.	○ N ○ B ○ C ○ P ○ E
10.2.3	Evaluate continuously for gaps in the provision of care toward people seeking palliative care and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
10.3	**Promote knowledge generation, translation, and synthesis**	
10.3.1	Participate, as appropriate, in research activities on improving palliative care delivery.	○ N ○ B ○ C ○ P ○ E
10.3.2	Keep up to date on current and emerging research in palliative care delivery.	○ N ○ B ○ C ○ P ○ E
TOTAL	**10 Education, evaluation, quality improvement, & research**	
		N B C P E

11 Advocacy

11.1	**Identify determinants of health and address barriers impacting palliative care provision**	
11.1.1	Identify, and where possible, address barriers for availability and accessibility of palliative care, including but not limited to: geography, stigma associated with receiving palliative care, lack of recognition of people who would benefit, availability of community resources, and availability of specialized palliative care services.	○ N ○ B ○ C ○ P ○ E
11.1.2	Identify and work in partnership with allies among underserviced populations to address the inequities in their access to palliative care.	○ N ○ B ○ C ○ P ○ E
11.1.3	Identify, and where possible, address barriers for availability and accessibility of palliative care specific to First Nations, Inuit, and Métis.	○ N ○ B ○ C ○ P ○ E
11.1.4	Identify opportunities to advocate for improving the health and well-being of persons with palliative care needs.	○ N ○ B ○ C ○ P ○ E
11.1.5	Advocate for culturally safe practices that are free of racism and discrimination.	○ N ○ B ○ C ○ P ○ E
TOTAL	**11 Advocacy**	
		N B C P E

	Palliative care competencies and descriptions	Knowledge/skill level
	12 Virtual care	
12.1	**Identify people who would be suitable for and benefit from virtual palliative approach to care**	
12.1.1	Identify people who would be suitable to be assessed by virtual care modalities in the palliative care context.	○ N ○ B ○ C ○ P ○ E
12.1.2	Recognize equity challenges to accessing and receiving virtual care including geography, finances, disabilities, language, availability of, and familiarity with technology.	○ N ○ B ○ C ○ P ○ E
12.2	**Adapt care to a virtual modality**	
12.2.1	Deliver virtual care as per standards of Accreditation Canada.	○ N ○ B ○ C ○ P ○ E
12.2.2	Adapt a variety of information and communication techniques to deliver a person-centered palliative approach to care virtually.	○ N ○ B ○ C ○ P ○ E
12.2.3	Utilize assessment tools for remote monitoring of palliative care symptoms, including Edmonton Symptom Assessment System (ESAS) tools, to deliver care virtually.	○ N ○ B ○ C ○ P ○ E
TOTAL	**12 Virtual care**	
		N B C P E

Totals	
	N B C P E

Self-assessment for Social Workers

- **Novice (N)** – may be experienced in psychosocial care but new to palliative care. Needs regular support.
- **Advanced beginner (B)** – can practice independently using some psychosocial skills specific to palliative care but still needs support.
- **Competent (C)** – mostly independent, occasionally seeks out support.
- **Proficient (P)** – autonomous practice, seeks out leadership opportunities.
- **Expert (E)** – highly proficient, is regularly sought out by others.

	Palliative care competencies and descriptions	Knowledge/skill level
1	**Principles of a palliative approach to care**	
1.1	**Understanding the philosophy of palliative care and a palliative approach**	
1.1.1	A. Generalist Understand the philosophy of palliative care and a palliative approach.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Contribute to the integration of a palliative approach to care into social work education, policy, and practice.	○ N ○ B ○ C ○ P ○ E
1.1.2	Apply the principles of palliative care, such as offering a support system to help people live as actively as possible until death with optimal quality of life, and designated helping families and caregivers cope.	○ N ○ B ○ C ○ P ○ E
1.1.3	Understand community-specific protocols of caring for members of underserviced populations who are living with a life-limiting illness so they can live fully throughout their care.	○ N ○ B ○ C ○ P ○ E
1.1.4	Understand community-specific protocols of caring for First Nations, Inuit, and Métis who are living with a life-limiting illness so they can live fully throughout their care.	○ N ○ B ○ C ○ P ○ E
1.2	**Identifying people who would benefit from a palliative approach**	
1.2.1	Define and recognize "life-limiting conditions" and understand the different illness trajectories.	○ N ○ B ○ C ○ P ○ E
1.2.2	Communicate to people and families or caregivers the continuum of care, disease trajectory, and optimal time to refer to palliative care.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
1.2.3	A. Generalist Use appropriate evidence-informed tools, from diagnosis of a life-limiting illness throughout the illness trajectory, to help the interdisciplinary care team identify people who could benefit from a palliative approach (e.g., psychosocial concerns, screening for distress).	○ N ○ B ○ C ○ P ○ E
	B. Specialist Act as an expert resource to the interdisciplinary care team and social work colleagues, regarding identification of people who would benefit from a palliative approach.	○ N ○ B ○ C ○ P ○ E
1.3	**Understanding the interdisciplinary team**	
1.3.1	A. Generalist Understand the role of the interdisciplinary team in palliative care and involve other team members and specialists as appropriate.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Foster a caring environment that supports all care team members. Act as a specialist on the interdisciplinary team, representing psychosocial aspects of care.	○ N ○ B ○ C ○ P ○ E
1.4	**Including designated family or caregiver(s) in the unit of care**	
1.4.1	A. Generalist Ask the person who they consider family, and include the designated family or caregiver(s) in the person's care, if the person wishes.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Describe the impact of dying, death, and bereavement on the person, their designated family or caregiver(s), and health care providers. Describe the designated designated family or caregiver's roles and dynamics (e.g., a sociogram), and how they wish to be involved in the person's care.	○ N ○ B ○ C ○ P ○ E
1.4.2	A. Generalist Respect the importance of the role of family or caregiver(s) and community throughout a person's care, especially for members of the underserviced populations.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Serve as a conduit of communication and information between the designated family or caregiver(s) and the care team.	○ N ○ B ○ C ○ P ○ E
1.4.3	Respect the importance of the role of designated family and community for First Nations, Inuit, and Métis throughout their palliative care.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
1.5	**Seeing people holistically**	
1.5.1	A. Generalist Acknowledge the physical, emotional, mental, social, and spiritual aspects to care.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Actively address the non-physical aspects of a person's needs and concerns.	○ N ○ B ○ C ○ P ○ E
1.6	**Addressing barriers to care**	
1.6.1	A. Generalist Identify and address barriers to accessing care.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Describe and address micro and macro factors that promote or constrain palliative care.	○ N ○ B ○ C ○ P ○ E
1.6.2	Address barriers to accessing services and plans for continuity of care.	○ N ○ B ○ C ○ P ○ E
1.7	**Ensuring a thorough awareness of resources**	
1.7.1	A. Generalist Is aware of the community context and available resources, and can provide information, referral, and coordination as needed for the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
	B. Specialist Help the person, their designated family or caregiver(s), and the care team navigate to appropriate and available resources.	○ N ○ B ○ C ○ P ○ E
Total	**1 Principles of a palliative approach to care**	
		N B C P E

2 Cultural safety and humility

2.1	**Recognizing and respecting the diversity of people, families or caregivers, and communities**	
2.1.1	A. Generalist Assess the unique needs and preferences of the person and their designated family or caregiver(s). In doing so, consider social determinants of health, ethnicity, culture, gender, sexual orientation, language, religion, age, and ability.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Advocate for the person's unique needs and preferences to be respected	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
2.1.2	Demonstrate understanding of the influence of culture and lived experiences on key issues in palliative and end-of-life care. Demonstrate sensitivity to cultural considerations of members of underserviced populations, relative to palliative care and end-of-life needs.	○ N ○ B ○ C ○ P ○ E
2.1.3	Understand that distinct beliefs, cultural practices, and lived experiences of First Nations, Inuit, and Métis influence how palliative and end-of-life care is provided. Incorporate community-specific protocols and practices into the palliative care of First Nations, Inuit, and Métis.	○ N ○ B ○ C ○ P ○ E
2.2	**Engaging in self-reflection**	
2.2.1	Practice self-reflection to identify and address personal and systemic biases.	○ N ○ B ○ C ○ P ○ E
2.3	**Supporting cultural practices**	
2.3.1	Partner with people and families or caregivers to provide opportunities for cultural, religious, or personal practices.	○ N ○ B ○ C ○ P ○ E
2.3.2	Explore people's and their designated family or caregiver's cultural, religious, and spiritual needs, beliefs, and preferences, and incorporate these into goal setting, decision-making, and care planning.	○ N ○ B ○ C ○ P ○ E
Total	**2 Cultural safety and humility**	
		N B C P E

3 Communication

3.1	**Recognizing and respecting that each person and designated family or caregiver(s) has a unique perspective.**	
3.1.1	Ask and seek to understand the unique perspective of each person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
3.2	**Listening and providing emotional support**	
3.2.1	A. Generalist Listen and provide emotional support to the person and their designated family or caregiver(s) as they adjust to their life-limiting condition. Understand the potential impact on the person's and designated family or caregiver's welfare, mental health, and well-being.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Consider timing, readiness, and pace of sharing information.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
3.3	**Adapting communication for children**	
3.3.1	A. Generalist Adapt communication when children are involved according to age, developmental level, comprehension, and mode of communication (e.g. play therapy).	○ N ○ B ○ C ○ P ○ E
	B. Specialist Refer to child-life specialists, as needed.	○ N ○ B ○ C ○ P ○ E
3.3.2	Support people and families or caregivers, including children, as they communicate with each other about difficult topics.	○ N ○ B ○ C ○ P ○ E
3.4	**Using appropriate supports to communicate effectively**	
3.4.1	A. Generalist Utilize supports as needed for effective communication and according to the person and their designated family or caregiver's health literacy (e.g. interpreters, assistive technology).	○ N ○ B ○ C ○ P ○ E
	B. Specialist Recommend referrals to speech-language therapists and occupational therapists, where warranted.	○ N ○ B ○ C ○ P ○ E
3.4.2	Acknowledge that designated family or caregiver(s) and community members may have a role in the care team, especially for members of underserviced populations. Respect that responsibility for communication with the health care provider may be designated to those members and incorporate these wishes in the provision of care.	○ N ○ B ○ C ○ P ○ E
3.4.3	Understand that First Nations, Inuit, and Métis designated family and community members may have a role in the care team. Acknowledge and respect that responsibility for communication with the health care provider may be designated to a family member and incorporate these wishes in the provision of care.	○ N ○ B ○ C ○ P ○ E
3.5	**Communicating collaboratively**	
3.5.1	Communicate health changes and concerns among the person and their designated family or caregiver(s) and the care team.	○ N ○ B ○ C ○ P ○ E
3.6	**Delivering difficult news and managing essential conversations**	
3.6.1	A. Generalist Recognize the potential for conflict in decision-making and work towards consensus-building among the person, their designated family or caregiver(s), and care team.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Describe common stressors and sources of conflict, and support the person, their designated family or caregiver(s), and care team to address these. Organize meetings and lead mediation in conflict situations within the designated family or caregiver(s) and /or care team.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
3.6.2	Assess and reassess the person's and their designated family or caregiver's understanding of the life-limiting condition(s) and health status, and provide information as needed.	○ N ○ B ○ C ○ P ○ E
Total	**3 Communication**	
		N B C P E

4 Optimizing comfort and quality of life

4.1	**Maintaining dignity**	
4.1.1	A. Generalist Provide care that maintains dignity, well-being, and self-image by facilitating expression of needs, hopes, feelings, and concerns when planning palliative care.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Apply a dignity-conserving approach to care.	○ N ○ B ○ C ○ P ○ E
4.2	**Recognizing changes in health status**	
4.2.1	A. Generalist Observe the person's functioning and indicators of distress, and promptly communicate changes to the health care team.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Support the person and their designated family or caregiver(s) as they adjust to declining health.	○ N ○ B ○ C ○ P ○ E
4.3	**Promoting self-management/care**	
4.3.1	Support the person and their designated family or caregiver(s) to care for themselves as much as possible by encouraging the person and their designated family or caregiver(s) to focus on their strengths and effective coping strategies while acknowledging the barriers and limitations that may make self-management/care difficult.	○ N ○ B ○ C ○ P ○ E
4.4	**Caring for people holistically**	
4.4.1	Evaluate and provide a holistic approach to care that acknowledges the physical, emotional, mental, social, and spiritual aspects to care.	○ N ○ B ○ C ○ P ○ E
4.4.2	Identify how disease progression may affect the capacity of the person to engage in meaningful discussions.	○ N ○ B ○ C ○ P ○ E
4.4.3	Address the socio-economic impact of a life-limiting condition on the person and their designated family or caregiver(s), facilitating access to services as needed.	○ N ○ B ○ C ○ P ○ E
4.4.4	Provide information and referral, when needed, for the person's and their designated family or caregiver's practical, financial, and legal needs.	○ N ○ B ○ C ○ P ○ E
4.4.5	Assess and recognize the sexual and intimacy needs of the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
4.5	**Accompanying and offering presence**	
4.5.1	Offer a compassionate, empathic presence in response to the needs of the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
4.6	**Involving designated family or caregiver(s) in care**	
4.6.1	A. Generalist Involve the designated family or caregiver(s) in care, as desired and appropriate, while addressing the impact of designated family or caregiver's role change throughout the illness.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Mobilize and negotiate family or caregiving systems in complex relationships.	○ N ○ B ○ C ○ P ○ E
4.6.2	Respect the role of designated family or caregivers and community throughout the person's care, particularly for members of underserviced populations.	○ N ○ B ○ C ○ P ○ E
4.6.3	Respect the role of designated family and community for First Nations, Inuit, and Métis, throughout their care.	○ N ○ B ○ C ○ P ○ E
4.7	**Screening, assessing, and managing symptoms and concerns**	
4.7.1	A. Generalist Assess for and address anxiety, depression, and existential distress in collaboration with the care team.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Provide people and their designated family or caregiver(s) counselling through a variety of social work and counselling frameworks and approaches.	○ N ○ B ○ C ○ P ○ E
4.7.2	Provide information and options on interventions in collaboration with the care team for symptom management as appropriate and as directed (e.g. relaxation techniques to reduce anxiety related to shortness of breath or existential concerns).	○ N ○ B ○ C ○ P ○ E
4.7.3	A. Generalist Provide or refer the person and their designated family or caregiver(s) for psychosocial interventions such as legacy work, life review, and purposeful conversations about suffering and meaning.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Act as an expert resource regarding the role of discipline-specific interventions.	○ N ○ B ○ C ○ P ○ E
4.7.4	Recognize that complementary and alternative medicine (CAM) can play an important role in palliative care, especially for members of underserviced populations. Collaborate with the person and their designated family or caregiver(s) to incorporate community-specific practices into the care plan.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
4.7.5	Recognize that traditional medicine can play an important role in palliative care for First Nations, Inuit, and Métis. Collaborate with the person and designated family to incorporate community-specific practices into the care plan.	○ N ○ B ○ C ○ P ○ E
Total	**4 Optimizing comfort and quality of life**	
		N B C P E

5 Care planning and collaborative practice

5.1	**Understanding interdisciplinary collaboration, transitions, and roles**	
5.1.1	Conduct a psychosocial assessment of the person and their designated family or caregiver(s) and, with their consent, share these findings to contribute to interdisciplinary care planning.	○ N ○ B ○ C ○ P ○ E
5.1.2	Lead or participate in family meetings with the person, their designated family or caregiver(s), and care team. Help the person and their designated family or caregiver(s) understand the roles of each member of the care team, and how to communicate effectively with them.	○ N ○ B ○ C ○ P ○ E
5.1.3	Engage with First Nations, Inuit, and Métis community leaders and /or Elders, when appropriate or if requested, to co-create a high-quality approach to palliative care for the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
5.1.4	Understand that members of underserviced populations may have designated family or caregiver(s) and community members who have a role in the care team.	○ N ○ B ○ C ○ P ○ E
5.1.5	Understand that First Nations, Inuit, and Métis family and community members may have a role in the care team.	○ N ○ B ○ C ○ P ○ E
5.1.6	Prepare the person and their designated family or caregiver(s) for transitions of care settings.	○ N ○ B ○ C ○ P ○ E
5.2	**Assess and provide assistance with ADL's and IADLI's**	
5.2.1	Identify care needs, safety components, and resources required to address activities of daily living (ADLs) and instrumental activities of daily living (IADLs), such as establishing a case manager, reassessing care, and respite needs for caregivers, etc.	○ N ○ B ○ C ○ P ○ E
5.3	**Acting as an advocate**	
5.3.1	Advocate for incorporation of the person’s and designated family or caregiver’s preferences, values, and beliefs into care planning.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
5.4	**Promoting advance care planning (ACP)**	
5.4.1	Ask the person and their designated family or caregiver(s) if they have discussed care wishes and identified a substitute decision-maker (SDM), facilitate these discussions in families, and share that information with the care team. Provide information and links to resources regarding advance care planning and goals of care.	○ N ○ B ○ C ○ P ○ E
5.4.2	Explore with the person and their designated family or caregiver(s) that legal documents are in order (will, living will) and that prearrangements are done.	○ N ○ B ○ C ○ P ○ E
5.5	**Supporting informed decision-making**	
5.5.1	A. Generalist Support the person, their designated family or caregiver(s), SDM, and care team to make decisions regarding treatments, location, and type of care.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Discuss the benefits and considerations of palliative treatment options with the person, their designated family or caregiver(s), and care team.	○ N ○ B ○ C ○ P ○ E
5.5.2	Understand the impact that psychological responses, social stressors, and spiritual dimensions of loss have on the mental health and decision-making of the person, and take these into account when planning care.	○ N ○ B ○ C ○ P ○ E
5.5.3	Encourage, support, and facilitate discussions regarding ethical issues and how they impact decision-making and well-being. Share findings with the care team.	○ N ○ B ○ C ○ P ○ E
Total	**5 Care planning and collaborative practice**	
		N B C P E

6 Last days and hours

6.1	**Supporting death rituals**	
6.1.1	Facilitate the person's and designated family or caregiver's wishes for death rituals.	○ N ○ B ○ C ○ P ○ E
6.1.2	Support designated family or caregiver(s) and community-specific protocols and practices surrounding death, loss, and grief when caring for members of underserviced populations.	○ N ○ B ○ C ○ P ○ E
6.1.3	Support designated family or caregiver(s) and community-specific protocols and practices surrounding death, loss, and grief when caring for First Nations, Inuit, and Métis.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
6.2	**Anticipating changes as death nears**	
6.2.1	Understand and recognize expected signs and symptoms as a person nears death. Provide support to designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
6.3	**Involving and supporting designated family or caregiver(s)**	
6.3.1	Provide or offer information about emotional, spiritual, and practical support services to the designated family or caregiver(s). Involve the interdisciplinary care team as needed.	○ N ○ B ○ C ○ P ○ E
6.3.2	Assist the person and their designated family or caregiver(s) to prepare for expected death.	○ N ○ B ○ C ○ P ○ E
6.3.3	Provide emotional support for the designated family or caregiver(s) throughout the illness trajectory, during and following the person's last moments.	○ N ○ B ○ C ○ P ○ E
Total	**6 Last days and hours**	
		N B C P E

7 Loss, grief, and bereavement

7.1	**Recognizing complicated grief**	
7.1.1	A. Generalist Identify and support those at risk for or experiencing pathological or complicated responses to loss and grief, and intervene or refer appropriately.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Proactively address complicated grief reactions.	○ N ○ B ○ C ○ P ○ E
7.2	**Supporting diverse responses to loss**	
7.2.1	Recognize and support the expression of grief reactions in people and their designated families or caregivers, which may occur from the time of diagnosis until bereavement.	○ N ○ B ○ C ○ P ○ E
7.2.2	Describe grief and a variety of psychological responses to illness and death as an expected reaction to loss that is experienced uniquely by everyone.	○ N ○ B ○ C ○ P ○ E
7.2.3	Describe and support, in partnership with the designated family or caregiver(s), the needs of children at varying developmental stages in dealing with grief.	○ N ○ B ○ C ○ P ○ E
7.2.4	Acknowledge the impact of personal traumas and negative experiences on members of underserviced populations, and how these can shape the expressions of grief, bereavement, and mourning. Practice trauma-informed principles and care.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
7.2.5	Engage with the designated family or caregiver(s) and community to identify community-specific protocols and practices that support the experience and expressions of grief.	○N ○B ○C ○P ○E
7.2.6	Acknowledge the impact that historical and ongoing systemic trauma and loss have on First Nations, Inuit, and Métis experiences and expressions of grief, bereavement, and mourning.	○N ○B ○C ○P ○E
7.2.7	Engage with the designated family or caregiver(s) and community to identify First Nations, Inuit, and Métis community-specific protocols and practices that support the experiences and expressions of grief.	○N ○B ○C ○P ○E
7.3	**Facilitating the use of support services**	
7.3.1	A. Generalist Provide information on support and bereavement services within the organization and community.	○N ○B ○C ○P ○E
	B. Specialist Facilitate bereavement follow-up with the designated family or caregiver(s), following the person's death.	○N ○B ○C ○P ○E
Total	**7 Loss, grief and bereavement**	
		N B C P E

8 Self-care

8.1	**Demonstrating self-awareness**	
8.1.1	Demonstrate self-awareness of own response to illness, death, and dying.	○N ○B ○C ○P ○E
8.2	**Addressing compassion fatigue**	
8.2.1	Recognize and address compassion fatigue in self and team.	○N ○B ○C ○P ○E
8.3	**Supporting healthy behaviors for self and team**	
8.3.1	A. Generalist Support the team to engage in reflective behaviors about the personal impact of working with dying people and their designated families or caregivers.	○N ○B ○C ○P ○E
	B. Specialist Mentor and educate interdisciplinary team regarding the personal impact of loss, grief, and bereavement, and encourage self-awareness and activities that maintain colleagues' resilience.	○N ○B ○C ○P ○E
8.3.2	Regularly engage in healthy behaviors (such as self-care) to help prevent compassion fatigue.	○N ○B ○C ○P ○E
Total	**8 Self-care**	
		N B C P E

	Palliative care competencies and descriptions	Knowledge/skill level
9	**Professional and ethical practice**	
9.1	**Understanding legislation and policy**	
9.1.1	A. Generalist Demonstrate knowledge of current legislation and policies relevant to palliative care.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Apply comprehensive understanding of legal, ethical, and professional standards to the provision of quality palliative care.	○ N ○ B ○ C ○ P ○ E
9.2	**Understanding MAiD**	
9.2.1	Respond to inquiries regarding MAiD in accordance with the appropriate legislation and regulatory body's guidelines and standards.	○ N ○ B ○ C ○ P ○ E
9.3	**Addressing ethical issues**	
9.3.1	A. Generalist Describe and respond to ethical issues and dilemmas that may arise (e.g., issues associated with impaired swallowing, artificial feeding, differing family or caregiver opinions).	○ N ○ B ○ C ○ P ○ E
	B. Specialist Facilitate discussion and resolution of ethical and legal issues with people, their designated families or caregivers, and the care team.	○ N ○ B ○ C ○ P ○ E
9.3.2	Collaborate with colleagues, the person and their designated family or caregiver(s) in ethical decision-making.	○ N ○ B ○ C ○ P ○ E
9.4	**Advocating for inclusion of the person's and their designated family or caregiver's beliefs and values**	
9.4.1	Promote incorporation of the person's and their designated family or caregiver's wishes, values, and beliefs into the provision of all care.	○ N ○ B ○ C ○ P ○ E
9.4.2	Respect and advocate for people's decisions about their care, including declining life-sustaining treatments.	○ N ○ B ○ C ○ P ○ E
9.5	**Maintaining boundaries**	
9.5.1	Maintain professional boundaries with people and families or caregivers.	○ N ○ B ○ C ○ P ○ E
9.5.2	Practice self-reflection to identify and mitigate the potential for transference and counter-transference.	○ N ○ B ○ C ○ P ○ E
Total	**9 Professional and ethical practice**	
		N B C P E

	Palliative care competencies and descriptions	Knowledge/skill level
10	**Education, evaluation, quality improvement, and research**	
10.1	**Educating and supporting learners**	
10.1.1	A. Generalist Educate staff, people, and families or caregivers on a psychosocial palliative approach.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Create courseware and educational resources for social workers caring for people receiving palliative care and their designated families or caregivers, particularly for those who wish to specialize in palliative care.	○ N ○ B ○ C ○ P ○ E
10.1.2	A. Generalist Act as a mentor for others new to palliative care.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Provide practicums for social work students specializing in palliative care.	○ N ○ B ○ C ○ P ○ E
10.2	**Accessing continuing education**	
10.2.1	A. Generalist Participate in continuing education related to palliative care. This could include seminars, clinical training, and supervision.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Bring a psychosocial perspective to the development of discipline-specific and interdisciplinary education.	○ N ○ B ○ C ○ P ○ E
10.2.2	Participate in cultural safety training opportunities, especially any that are specific to underserviced populations. Where available, participate in regionally specific training.	○ N ○ B ○ C ○ P ○ E
10.2.3	Participate in First Nations, Inuit, and Métis cultural safety training opportunities. Where available, participate in regionally specific training.	○ N ○ B ○ C ○ P ○ E
10.3	**Contributing to quality improvement**	
10.3.1	A. Generalist Participate in quality-improvement initiatives to improve professional practice in your organization.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Design and lead quality improvement initiatives.	○ N ○ B ○ C ○ P ○ E
10.4	**Evaluating person outcomes**	
10.4.1	A. Generalist Evaluate the person's outcomes against standards and guidelines.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
	B. Specialist Contribute to the design, testing, and integration of standards and guidelines appropriate to the scope of social work for people receiving palliative care and their designated families or caregivers.	○ N ○ B ○ C ○ P ○ E
10.5	**Collecting data**	
10.5.1	**A. Generalist** Participate in research activities such as data collection.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Lead or co-lead research initiatives to assess clinical practice, and identify gaps to improve psychosocial care of people and their designated families or caregivers.	○ N ○ B ○ C ○ P ○ E
10.6	**Promoting knowledge generation, translation, and synthesis**	
10.6.1	Generate and disseminate new knowledge related to social work.	○ N ○ B ○ C ○ P ○ E
10.6.2	Keep up to date on current and emerging research.	○ N ○ B ○ C ○ P ○ E
Total	**10 Education, evaluation, quality improvement, & research**	
		N B C P E

11 Advocacy

11.1	**Advocating for the person, designated family or caregiver(s), and societal rights**	
11.1.1	**A. Generalist** Advocate for the rights of the person and their designated family or caregiver(s) for autonomy, self-determination, and privacy.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Advocate in favour of equity for all people, in all healthcare settings, to reduce barriers to accessing palliative care.	○ N ○ B ○ C ○ P ○ E
11.1.2	Advocate for incorporation of the person's and designated family or caregiver's values and beliefs into care planning.	○ N ○ B ○ C ○ P ○ E
11.2	**Acting as an advocate**	
11.2.1	**A. Generalist** Advocate for the incorporation of people's and designated family or caregiver's values and beliefs into the care plan.	○ N ○ B ○ C ○ P ○ E
	B. Specialist Describe and address barriers for marginalized and vulnerable groups at the end-of-life and in bereavement.	○ N ○ B ○ C ○ P ○ E
11.2.2	Advocate for culturally safe practices that are free of racism and discrimination.	○ N ○ B ○ C ○ P ○ E
Total	**11 Advocacy**	
		N B C P E

	Palliative care competencies and descriptions	Knowledge/skill level				
	12 Virtual care					
12.1	**Identifying people who would be suitable for and benefit from virtual care**					
12.1.1	Able to identify people who would be suitable to be assessed by virtual care modalities.	○ N	○ B	○ C	○ P	○ E
12.1.2	Recognize equity challenges to virtual care including geography, finances, disabilities, language, and familiarity with technology.	○ N	○ B	○ C	○ P	○ E
12.2	**Adapting care to a virtual modality**					
12.2.1	Deliver virtual care as per standards of Accreditation Canada.	○ N	○ B	○ C	○ P	○ E
12.2.2	Able to adapt a variety of information and communication techniques to deliver person-centred care.	○ N	○ B	○ C	○ P	○ E
12.2.3	Able to utilize various tools to deliver care virtually.	○ N	○ B	○ C	○ P	○ E
12.2.4	Develop clear processes for follow-up of the person in care and their hand-over to other professionals.	○ N	○ B	○ C	○ P	○ E
12.2.5	Develop clear processes for involvement of the interdisciplinary team.	○ N	○ B	○ C	○ P	○ E
12.3	**Delivering care virtually**					
12.3.1	Able to clearly communicate with people and designated their families or caregivers and elicit signs and symptoms remotely.	○ N	○ B	○ C	○ P	○ E
Total	**12 Virtual care**					
		N	B	C	P	E

Totals					
	N	B	C	P	E

Self-assessment for Personal Support Workers

- **Novice (N)** – may be experienced in psychosocial care but new to palliative care. Needs regular support.
- **Advanced beginner (B)** – can practice independently using some psychosocial skills specific to palliative care but still needs support.
- **Competent (C)** – mostly independent, occasionally seeks out support.
- **Proficient (P)** – autonomous practice, seeks out leadership opportunities.
- **Expert (E)** – highly proficient, is regularly sought out by others.

	Palliative care competencies and descriptions	Knowledge/skill level
1	**Principles of a palliative approach to care**	
1.1	**Understanding the core philosophy of Palliative Care and the palliative approach to care**	
1.1.1	Understand the principles and practices of palliative care and a palliative approach.	○ N ○ B ○ C ○ P ○ E
1.1.2	Understand community-specific protocols, in particular when caring for members of underserviced populations who are living with a life-limiting illness so they can live fully throughout their care.	○ N ○ B ○ C ○ P ○ E
1.1.3	Understand community-specific protocols of caring for First Nations, Inuit, and Métis who are living with a life-limiting illness so they can live fully throughout their care.	○ N ○ B ○ C ○ P ○ E
1.2	**Identifying people who would benefit from a palliative approach**	
1.2.1	Collaborate with the care team and use evidence-based tools to identify people who could benefit from a palliative approach.	○ N ○ B ○ C ○ P ○ E
1.3	**Understanding the interdisciplinary team**	
1.3.1	Understand the role of the interdisciplinary team in providing palliative care, as well as the roles of each team member.	○ N ○ B ○ C ○ P ○ E
1.4	**Including designated family or caregiver(s) in the unit of care**	
1.4.1	Acknowledge who the person considers to be family, and include the designated family or caregiver(s) in the person's care, if the person wishes	○ N ○ B ○ C ○ P ○ E
1.4.2	Respect the importance of the role of designated family or caregivers and community for members of underserviced populations throughout their palliative care.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
1.4.3	Respect the importance of the role of designated family and community for First Nations, Inuit, and Métis, throughout their palliative care.	○ N ○ B ○ C ○ P ○ E
1.5	**Seeing people holistically**	
1.5.1	Acknowledge the physical, emotional, mental, social, and spiritual aspects to care.	○ N ○ B ○ C ○ P ○ E
TOTAL	**1 Principles of a palliative approach to care**	
		N B C P E

2 Cultural safety and humility

2.1	**Supporting cultural practices**	
2.1.1	Understand the influence of culture and lived experiences on a person's attitudes towards health, wellness, serious illness, and death. Incorporate these attitudes into the care of members of underserviced populations.	○ N ○ B ○ C ○ P ○ E
2.1.2	Understand that First Nations, Inuit, and Métis cultural practices and beliefs influence how palliative and end-of-life care is provided. Incorporate First Nations, Inuit, and Métis community-specific protocols and practices into provision of palliative care.	○ N ○ B ○ C ○ P ○ E
2.1.3	Provide culturally safe care.	○ N ○ B ○ C ○ P ○ E
2.1.4	Partner with people and their designated families and caregivers to provide opportunities for cultural, religious, or personal practices.	○ N ○ B ○ C ○ P ○ E
2.2	**Engaging in self-reflection**	
2.2.1	Practice self-reflection to identify and address personal biases.	○ N ○ B ○ C ○ P ○ E
2.3	**Acting as an advocate**	
2.3.1	Advocate for the incorporation of people's and their designated family or caregivers' values and beliefs into the care plan.	○ N ○ B ○ C ○ P ○ E
2.3.2	Advocate for culturally safe practices that are free of racism and discrimination.	○ N ○ B ○ C ○ P ○ E
TOTAL	**2 Cultural safety and humility**	
		N B C P E

	Palliative care competencies and descriptions	Knowledge/skill level
3	**Communication**	
3.1	**Recognizing and respecting that each person and their designated family or caregiver(s) has a unique perspective**	
3.1.1	Ask and seek to understand the unique perspective of each person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
3.2	**Listening and providing emotional support**	
3.2.1	Listen and provide emotional support to the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
3.2.2	Develop and maintain supportive and therapeutic relationships, by connecting, communicating, and establishing professional boundaries.	○ N ○ B ○ C ○ P ○ E
3.3	**Adapting communication for children**	
3.3.1	Adapt communication when children are involved.	○ N ○ B ○ C ○ P ○ E
3.4	**Using appropriate supports to communicate effectively**	
3.4.1	Utilize supports as needed for effective communication (e.g. interpreters, assistive technology).	○ N ○ B ○ C ○ P ○ E
3.4.2	Understand that for members of underserviced populations, designated family and community members may have a role in the care team. Acknowledge and respect that responsibility for communication with the health care provider may be designated to a family member or caregiver(s), and incorporate these wishes in the provision of care.	○ N ○ B ○ C ○ P ○ E
3.4.3	Understand that First Nations, Inuit, and Métis designated family and community members may have a role in the care team. Acknowledge and respect that responsibility for communication with the health care provider may be designated to a family member or caregiver(s), and incorporate these wishes in the provision of care.	○ N ○ B ○ C ○ P ○ E
3.5	**Communicating collaboratively**	
3.5.1	Communicate health changes and concerns of the person and their designated family or caregiver(s) with the rest of the health care team.	○ N ○ B ○ C ○ P ○ E
TOTAL	**3 Communication**	N B C P E

	Palliative care competencies and descriptions	Knowledge/skill level
4	**Optimizing comfort and quality of life**	
4.1	**Maintaining dignity**	
4.1.1	Provide care that maintains the dignity, well-being, and self-image of the person.	○ N ○ B ○ C ○ P ○ E
4.2	**Recognizing changes in health status**	
4.2.1	Observe the person's functioning and indicators of distress, and promptly communicate changes to the health care team.	○ N ○ B ○ C ○ P ○ E
4.2.2	Have a basic knowledge of the effects of the most common diseases and their treatments, and the care people receive at end-of-life.	○ N ○ B ○ C ○ P ○ E
4.3	**Promoting self-management/care**	
4.3.1	Support the person to care for themselves as much as possible while acknowledging the barriers and limitations that may make self-management/care difficult.	○ N ○ B ○ C ○ P ○ E
4.4	**Caring for people holistically**	
4.4.1	Provide a holistic approach to care that acknowledges the physical, emotional, mental, social, and spiritual aspects to care.	○ N ○ B ○ C ○ P ○ E
4.5	**Offering presence**	
4.5.1	Offer a compassionate, empathic presence in response to the needs of the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
4.6	**Involving the designated family or caregiver(s) in care**	
4.6.1	Respect the role of and involve the designated family or caregiver(s) in care as desired and appropriate.	○ N ○ B ○ C ○ P ○ E
4.6.2	Respect the role of designated family and community for First Nations, Inuit, and Métis, throughout their palliative care.	○ N ○ B ○ C ○ P ○ E
4.7	**Screening, assessing, and managing pain and other symptoms and psychosocial concerns**	
4.7.1	Provide comfort measures as appropriate and prescribed in the care plan (e.g. positioning, using a fan, timing of activities).	○ N ○ B ○ C ○ P ○ E
4.7.2	Recognize that complementary or alternative medicine (CAM) can play an important role in palliative care, especially for members of underserviced populations.	○ N ○ B ○ C ○ P ○ E
4.7.3	Recognize that traditional medicine can play an important role in palliative care for First Nations, Inuit, and Métis.	○ N ○ B ○ C ○ P ○ E
TOTAL	**4 Optimizing comfort and quality of life**	
		N B C P E

5 Care planning and collaborative practice

	Palliative care competencies and descriptions	Knowledge/skill level
5.1	**Understanding interdisciplinary collaboration, transitions, and roles**	
5.1.1	Contribute to interdisciplinary care planning by offering observations to the health care team of challenges the person and their designated family or caregiver(s) may be experiencing, or any opportunities to provide support, using standardized tools, recording, and reporting.	○ N ○ B ○ C ○ P ○ E
5.1.2	Understand that for members of underserviced populations, designated family or caregiver(s) and community members may have a role in the care team.	○ N ○ B ○ C ○ P ○ E
5.1.3	Understand that First Nations, Inuit, and Métis family and community members may have a role in the care team.	○ N ○ B ○ C ○ P ○ E
5.2	**Acting as an advocate**	
5.2.1	Advocate for incorporation of the person's and their designated family or caregiver's values and beliefs into care planning.	○ N ○ B ○ C ○ P ○ E
5.3	**Promoting advance care planning**	
5.3.1	Respect the person's and their designated family or caregiver's preferences for care.	○ N ○ B ○ C ○ P ○ E
TOTAL	**5 Care planning and collaborative practice**	
		N B C P E

6 Last days and hours

6.1	**Anticipating changes as death nears**	
6.1.1	Understand and recognize expected changes as a person nears death.	○ N ○ B ○ C ○ P ○ E
6.1.2	Provide care and comfort measures to support the person and their designated family or caregiver(s) through physical changes in the last days and hours.	○ N ○ B ○ C ○ P ○ E
6.2	**Facilitating death rituals**	
6.2.1	Provide care of the body immediately following death as per the person and designated family or caregiver's preferences and rituals, and the organization's policies/procedures.	○ N ○ B ○ C ○ P ○ E
6.3	**Involving and supporting designated family or caregiver(s)**	
6.3.1	Respect the designated family or caregiver's needs and preferences for supports and bring them to the attention of the health care team if they are beyond the scope of the PSW. Involve the interdisciplinary care team as needed.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level				
6.3.2	Support the designated family or caregiver(s) and community-specific protocols and practices surrounding death, loss, and grief when caring for members of underserviced communities.	○ N	○ B	○ C	○ P	○ E
6.3.3	Support designated family and community-specific protocols and practices surrounding death, loss, and grief when caring for First Nations, Inuit, and Métis.	○ N	○ B	○ C	○ P	○ E
TOTAL	**6 Last days and hours**					
		N	B	C	P	E

7 Loss, grief, and bereavement

7.1	**Supporting individual responses to loss**					
7.1.1	Recognize grief reactions in people and their designated families or caregivers, which may occur from the time of diagnosis until bereavement.	○ N	○ B	○ C	○ P	○ E
7.1.2	Understand grief as a natural, adaptive, expected response to loss that is experienced uniquely by each person.	○ N	○ B	○ C	○ P	○ E
7.1.3	Acknowledge the impact that trauma and loss have on the experiences and expressions of grief, bereavement, and mourning for members of underserviced communities.	○ N	○ B	○ C	○ P	○ E
7.1.4	Acknowledge the impact that historical and ongoing systemic trauma and loss have on First Nations, Inuit, and Métis experiences and expressions of grief, bereavement, and mourning.	○ N	○ B	○ C	○ P	○ E
7.2	**Facilitating the use of support services**					
7.2.1	Provide information on support services within the organization and community.	○ N	○ B	○ C	○ P	○ E
TOTAL	**7 Loss, grief and bereavement**					
		N	B	C	P	E

8 Self-care

8.1	**Supporting healthy behaviours for self and team**					
8.1.1	Develop a self-care plan and regularly engage in healthy behaviours to help prevent compassion fatigue.	○ N	○ B	○ C	○ P	○ E
8.2	**Addressing compassion fatigue**					
8.2.1	Recognize and address compassion fatigue in self.	○ N	○ B	○ C	○ P	○ E

	Palliative care competencies and descriptions	Knowledge/skill level
8.3	**Demonstrating self-awareness**	
8.3.1	Demonstrate self-awareness of own response to illness, death, and dying.	○ N ○ B ○ C ○ P ○ E
TOTAL	**8 Self-care**	
		N B C P E

9 Professional and ethical practice

9.1	**Understanding MAiD**	
9.1.1	Share a request for hastened death with the care team and respond as per organization policy.	○ N ○ B ○ C ○ P ○ E
9.2	**Addressing ethical issues**	
9.2.1	Understand ethical issues that may arise (e.g. issues associated with the progression of the illness, treatment choices, or differing designated family or caregiver(s) opinions), and bring them to the attention of the health care team if they are beyond the scope of the PSW.	○ N ○ B ○ C ○ P ○ E
9.3	**Advocating for inclusion of the person’s and their designated family or caregiver’s beliefs and values**	
9.3.1	Promote incorporation of the person’s and their designated family or caregiver’s wishes, values, and beliefs into the provision of all care.	○ N ○ B ○ C ○ P ○ E
9.4	**Maintaining boundaries**	
9.4.1	Maintain professional boundaries with people and designated families.	○ N ○ B ○ C ○ P ○ E
TOTAL	**9 Professional and ethical practice**	
		N B C P E

10 Education, evaluation, quality improvement, and research

10.1	**Accessing continuing education**	
10.1.1	Participate in continuing education related to palliative care.	○ N ○ B ○ C ○ P ○ E
10.1.2	Participate in cultural safety training opportunities, especially any that are specific to underserviced populations. Where available, participate in regionally specific training.	○ N ○ B ○ C ○ P ○ E
10.1.3	Participate in First Nations, Inuit, and Métis cultural safety training opportunities. Where available, participate in regionally specific training.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
10.2	**Educating and supporting learners**	
10.2.1	Act as a mentor for others new to palliative care.	○ N ○ B ○ C ○ P ○ E
10.3	**Contributing to quality improvement**	
10.3.1	Participate in quality-improvement initiatives.	○ N ○ B ○ C ○ P ○ E
10.4	**Collecting data**	
10.4.1	Participate in research activities such as data collection.	○ N ○ B ○ C ○ P ○ E
TOTAL	**10 Education, evaluation, quality improvement, & research**	
		N B C P E

11 Advocacy

11.1	**Advocating for the person, designated family or caregiver(s), and societal rights**	
11.1.1	Advocate for incorporation of the person's and their designated family or caregiver's values and beliefs into care planning.	○ N ○ B ○ C ○ P ○ E
TOTAL	**11 Advocacy**	
		N B C P E

Totals	
	N B C P E

Self-assessment for Volunteers

- **Novice (N)** – may be experienced in psychosocial care but new to palliative care. Needs regular support.
- **Advanced beginner (B)** – can practice independently using some psychosocial skills specific to palliative care but still needs support.
- **Competent (C)** – mostly independent, occasionally seeks out support.
- **Proficient (P)** – autonomous practice, seeks out leadership opportunities.
- **Expert (E)** – highly proficient, is regularly sought out by others.

	Palliative care competencies and descriptions	Knowledge/skill level
1	**Principles of a palliative approach to care**	
1.1	**Understanding the core philosophy of Palliative Care and the palliative approach to care**	
1.1.1	Understand the philosophy of palliative care and a palliative approach.	○ N ○ B ○ C ○ P ○ E
1.1.2	Understand community-specific protocols and practices of caring for members of underserviced populations who are living with a life-limiting illness so they can live fully throughout their care.	○ N ○ B ○ C ○ P ○ E
1.1.3	Understand community-specific protocols of caring for First Nations, Inuit, and Métis who are living with a life-limiting illness so they can live fully throughout their care.	○ N ○ B ○ C ○ P ○ E
1.1.4	Understand the key components of volunteer support (presence, listening, respect for other and other's pace, acknowledgement).	○ N ○ B ○ C ○ P ○ E
1.2	**Understanding the interdisciplinary team**	
1.2.1	Understand the role of the interdisciplinary palliative care team, its members, and the role of the volunteer in the team.	○ N ○ B ○ C ○ P ○ E
1.3	**Including designated family or caregiver(s) in the unit of care**	
1.3.1	Respect who the person considers family and include the designated family or caregiver(s) in the person's care.	○ N ○ B ○ C ○ P ○ E
1.3.2	Respect the importance of the role of designated family or caregiver(s), and community, for members of underserviced populations throughout their palliative care.	○ N ○ B ○ C ○ P ○ E
1.3.3	Respect the importance of the role of designated family and community for First Nations, Inuit, and Métis throughout their palliative care.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
1.3.4	Recognize the impact of a life-limiting condition on designated familial roles.	○ N ○ B ○ C ○ P ○ E
1.4	**Seeing people holistically**	
1.4.1	Acknowledge the physical, emotional, mental, social, and spiritual aspects to care.	○ N ○ B ○ C ○ P ○ E
TOTAL	**1 Principles of a Palliative Approach to Care**	
		N B C P E

2 Cultural safety and humility

2.1	**Supporting cultural practices**	
2.1.1	Understand that cultural practices influence how palliative and end-of-life care is provided, in particular for members of underserviced populations.	○ N ○ B ○ C ○ P ○ E
2.1.2	Understand that First Nations, Inuit, and Métis cultural practices and beliefs influence how palliative and end-of-life care is provided.	○ N ○ B ○ C ○ P ○ E
2.1.3	Help support a safe, respectful, and culturally inclusive environment that is free of racism and discrimination.	○ N ○ B ○ C ○ P ○ E
2.2	**Recognizing and respecting the diversity of people, families and caregivers, and communities**	
2.2.1	Demonstrate a respectful attitude towards the identities, and cultural and spiritual differences in family or caregiver practices surrounding illness and the end-of-life.	○ N ○ B ○ C ○ P ○ E
2.3	**Engaging in self-reflection**	
2.3.1	Practice self-reflection to identify and address personal and systemic biases.	○ N ○ B ○ C ○ P ○ E
TOTAL	**2 Cultural safety and humility**	
		N B C P E

3 Communication

3.1	**Recognizing and respecting that each person and designated family or caregiver has a unique perspective**	
3.1.1	Adapt communication and information sharing to the unique needs of the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
3.2	**Listening and providing emotional support**	
3.2.1	Use active listening and silence, and provide sensitive emotional support to the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
3.3	**Adapting communication for children**	
3.3.1	Adapt communication when children are involved.	○ N ○ B ○ C ○ P ○ E
3.4	**Using appropriate supports to communicate effectively**	
3.4.1	Utilize supports as needed for effective communication (e.g. interpreters, assistive technology).	○ N ○ B ○ C ○ P ○ E
3.4.2	Understand that designated family or caregiver(s) and community members may have a role in the care team, in particular for members of underserviced populations.	○ N ○ B ○ C ○ P ○ E
3.4.3	Understand that First Nations, Inuit, and Métis designated family and community members may have a role in the care team.	○ N ○ B ○ C ○ P ○ E
3.5	**Communicating collaboratively**	
3.5.1	Communicate health changes and concerns of the person and their designated family or caregiver(s) to the rest of the care team.	○ N ○ B ○ C ○ P ○ E
TOTAL	**3 Communication**	
		N B C P E

4 Optimizing comfort and quality of life

4.1	**Maintaining dignity**	
4.1.1	Provide care that maintains dignity, well-being, and self-image.	○ N ○ B ○ C ○ P ○ E
4.2	**Recognizing changes in health status**	
4.2.1	Observe the person's functioning and indicators of distress, and promptly communicate changes to the health care team.	○ N ○ B ○ C ○ P ○ E
4.2.2	Has a basic knowledge of the effects of the most common diseases and their treatments, and the type of care people receive at end-of-life.	○ N ○ B ○ C ○ P ○ E
4.3	**Caring for people holistically**	
4.3.1	Provide a holistic approach to care that acknowledges the physical, emotional, mental, social, and spiritual aspects to care.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
4.3.2	Provide simple comfort measures according to volunteer policies, such as mouth care, better positioning, use of a fan, or reduction in environmental stimuli. Adhere to proper body mechanics in practical assistance of the person as per organizational policies.	○ N ○ B ○ C ○ P ○ E
4.3.3	Recognize when a person is experiencing pain or discomfort and alert health professionals.	○ N ○ B ○ C ○ P ○ E
4.3.4	Respect the role of the designated family or caregiver(s) and community for members of underserviced populations throughout their palliative care.	○ N ○ B ○ C ○ P ○ E
4.3.5	Respect the role of designated family and community for First Nations, Inuit, and Métis throughout their palliative care.	○ N ○ B ○ C ○ P ○ E
4.3.6	Recognize that complementary and alternative medicine (CAM) can play an important role in palliative care, especially for members of underserviced populations.	○ N ○ B ○ C ○ P ○ E
4.3.7	Recognize that traditional medicine can play an important role in palliative care for First Nations, Inuit, and Métis.	○ N ○ B ○ C ○ P ○ E
4.4	**Offering presence**	
4.4.1	Offer a compassionate, empathic presence in response to the needs of the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
TOTAL	**4 Optimizing comfort and quality of life**	
		N B C P E

5 Care planning and collaborative practice

5.1	**Understanding interdisciplinary collaboration**	
5.1.1	Contribute to interdisciplinary care planning by offering observations to the health care team of challenges the person and their designated family or caregiver(s) may be experiencing, or any opportunities to provide support.	○ N ○ B ○ C ○ P ○ E
5.1.2	Understand that designated family or caregiver(s), and community members, may have a role in the care team, in particular for members of underserviced populations.	○ N ○ B ○ C ○ P ○ E
5.1.3	Understand that First Nations, Inuit, and Métis family and community members may have a role in the care team.	○ N ○ B ○ C ○ P ○ E
5.1.4	Understand the roles, responsibilities, and limits of the volunteer as per the organization's policies.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
5.1.5	Assist professional staff with supporting the person's needs as per the organization's policies.	○ N ○ B ○ C ○ P ○ E
TOTAL	**5 Care planning and collaborative practice**	
		N B C P E

6 Last days and hours

6.1	**Respecting death rituals**	
6.1.1	Know the responsibilities of volunteers during last hours and following death, and fulfill them with respect for the person and their designated family or caregiver(s).	○ N ○ B ○ C ○ P ○ E
6.2	**Anticipating changes as death nears**	
6.2.1	Know and recognize the expected changes as the person nears death.	○ N ○ B ○ C ○ P ○ E
6.3	**Involving and supporting designated family or caregiver(s)**	
6.3.1	Support the designated family or caregiver's wishes and death rituals.	○ N ○ B ○ C ○ P ○ E
6.3.2	Support family and community-specific protocols and practices surrounding death, loss, and grief. Demonstrate openness to incorporating protocols and practices when caring for members of underserviced populations.	○ N ○ B ○ C ○ P ○ E
6.3.3	Support designated family and community-specific protocols and practices surrounding death, loss, and grief when caring for First Nations, Inuit, and Métis.	○ N ○ B ○ C ○ P ○ E
TOTAL	**6 Last days and hours**	
		N B C P E

7 Loss, grief, and bereavement

7.1	**Supporting diverse responses to loss**	
7.1.1	Understand grief as an expected reaction to loss that is experienced and expressed uniquely by everyone.	○ N ○ B ○ C ○ P ○ E
7.1.2	Acknowledge the impact of personal traumas and negative experiences on members of underserviced populations, and how these can shape the expressions of grief, bereavement, and mourning.	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	Knowledge/skill level
7.1.3	Acknowledge the impact that historical and ongoing systemic trauma and loss have on First Nations, Inuit, and Métis experiences and expressions of grief, bereavement, and mourning.	○ N ○ B ○ C ○ P ○ E
7.1.4	Recognize common expressions of and reactions to grief in people and their families or caregivers, which may occur from the time of diagnosis until bereavement.	○ N ○ B ○ C ○ P ○ E
7.2	**Offering support services**	
7.2.1	Understand the role of the volunteer in supporting people who are dying, and the bereaved.	○ N ○ B ○ C ○ P ○ E
TOTAL	**7 Loss, grief and bereavement**	
		N B C P E

8 Self-care

8.1	**Understanding compassion fatigue**	
8.1.1	Understand the concept of compassion fatigue, its manifestations, and ways to help prevent it.	○ N ○ B ○ C ○ P ○ E
8.2	**Supporting healthy behaviours for self and team**	
8.2.1	Regularly engage in healthy behaviours to help prevent compassion fatigue. Ask organization for support and resources when help is needed.	○ N ○ B ○ C ○ P ○ E
8.3	**Demonstrating self-awareness**	
8.3.1	Demonstrate self-awareness of own response to illness, death, and dying.	○ N ○ B ○ C ○ P ○ E
TOTAL	**8 Self-care**	
		N B C P E

9 Professional and ethical practice

9.1	**Understanding legislation and policy**	
9.1.1	Demonstrate understanding of the importance of maintaining privacy and confidentiality.	○ N ○ B ○ C ○ P ○ E
9.2	**Addressing ethical issues**	
9.2.1	Understand ethical issues that may arise (e.g., issues associated with the progression of the illness, treatment choices, or differing designated family or caregiver(s) opinions).	○ N ○ B ○ C ○ P ○ E

	Palliative care competencies and descriptions	**Knowledge/skill level**
9.3	**Advocating for inclusion of the person’s and their designated family or caregiver’s beliefs and values**	
9.3.1	Promote incorporation of the person’s and their designated family or caregiver’s wishes, values, and beliefs into the provision of all care.	○ N ○ B ○ C ○ P ○ E
9.4	**Maintaining boundaries**	
9.4.1	Demonstrate understanding of the volunteer boundaries, their purpose, and some strategies for maintaining boundaries with people and their designated families or caregivers.	○ N ○ B ○ C ○ P ○ E
TOTAL	**9 Professional and ethical practice**	
		N B C P E

10 Education, evaluation, quality improvement, and research

10.1	**Accessing continuing education**	
10.1.1	Participate in continuing education related to palliative care.	○ N ○ B ○ C ○ P ○ E
10.1.2	Participate in cultural safety training opportunities, especially any that are specific to underserviced populations. Where available, participate in regionally specific training..	○ N ○ B ○ C ○ P ○ E
10.1.3	Participate in First Nations, Inuit, and Métis cultural safety training opportunities. Where available, participate in regionally specific training.	○ N ○ B ○ C ○ P ○ E
10.2	**Educating and supporting learners**	
10.2.1	Act as a mentor for others new to palliative care.	○ N ○ B ○ C ○ P ○ E
10.3	**Contributing to quality improvement**	
10.3.1	Participate in quality improvement initiatives.	○ N ○ B ○ C ○ P ○ E
10.4	**Collecting data**	
10.4.1	Participate in research activities such as data collection.	○ N ○ B ○ C ○ P ○ E
TOTAL	**10 Education, evaluation, quality improvement, & research**	
		N B C P E

	Palliative care competencies and descriptions	Knowledge/skill level
	11 Advocacy	
11.1	**Advocating for the person, designated family or caregiver(s), and societal rights**	
11.1.1	Advocate for incorporation of the person's and their designated family or caregiver's values and beliefs into care planning.	○ N ○ B ○ C ○ P ○ E
11.1.2	Assist organization with community education initiatives about palliative care.	○ N ○ B ○ C ○ P ○ E
TOTAL	**11 Advocacy**	
		N B C P E

Totals	
	N B C P E

Appendix 2: Palliative care education resources

The following links provide access to a wide range of education tools and resources for professionals seeking skills and competencies in palliative care.

Because educational opportunities are continually evolving, we have provided links to organizations rather than specific courses. Our intention is for health care professionals and managers to use this resource to pinpoint the specific educational opportunities they need once they have identified their learning requirements using the skills self-assessments in Appendix 1.

BC Centre for Palliative Care

The BC Centre for Palliative Care works with partners in the health system and community to accelerate best practices and promising innovations in palliative care and supports.

Canadian Hospice Palliative Care Association

The CHPCA is the national voice for hospice palliative care in Canada. Its work includes public policy, public education, and awareness.

Canadian Virtual Hospice

Canadian Virtual Hospice is a rich resource for information and support about palliative and end-of-life care, loss, and grief – including information about educational opportunities for health care professionals.

De Souza Institute

De Souza Institute provides online courses, such as the Interprofessional Education in Palliative and End-of-Life Care Oncology (iEPEC-O) course, to health care professionals looking to enhance their expertise and provide the best possible cancer and palliative care. An array of courses gives health care professionals advanced knowledge and expertise to handle every situation, including managing a reaction to chemotherapy medication, managing anxiety and fears, and managing pain and other symptoms.

Living My Culture

Living My Culture honours the culture, spirituality, and traditions of people from various cultures by sharing their stories and wisdom about living with serious illness, end-of-life, and grief to support others.

Life and Death Matters

Life and Death Matters is an organization with a mission to develop and deliver resources to increase the capacity of individuals to provide excellent care for the dying and the bereaved. This resource includes textbooks aimed at specific disciplines, such as nurses and PSWs.

Near North Palliative Care Network

The Near North Palliative Care Network is a registered charity that provides one-stop palliative care, bereavement and grief, and end-of-life volunteer-based free services and training in Northern Ontario.

Pallium Canada

Pallium is a national, non-profit organization focused on building professional and community capacity to help improve the quality and accessibility of palliative care in Canada. Pallium runs practical, evidence-based courses at various levels for professionals looking to learn essential skills and competencies of the palliative care approach and for those looking to enhance their practice. Pallium's Learning Essential Approaches to Palliative Care (LEAP) courses are an example of such courses that provide training and tools across multiple health care settings and specialty areas.

Paramedics and Palliative Care: Bringing Vital Services to Canadians

The Canadian Partnership Against Cancer and the Canadian Foundation for Healthcare Improvement are jointly supporting seven initiatives across the country that establish an innovative model of palliative care provided by paramedics in homes without requiring patients to be transported to hospital. This practice enables paramedics to treat-in-place, support patient wishes to remain at home, and provide a communication path for continuity of care.

Saint Elizabeth Health Career College

SE Health is a community of collaborators who inspire how people live and age well at home, today and in the future. The organization delivers online training and certificates in hospice and palliative care.

Victoria Hospice

Victoria Hospice provides end-of-life care focused on palliative treatment, as well as palliative care courses online and in the classroom for beginner to advanced professionals.

Appendix 3: Glossary of terms

This glossary aims to provide definitions and context for the specific terminology that we have used in the competency tables. It is meant to provide clarity and expand upon the expectations of the competencies and associated skills.

ACTIVITIES OF DAILY LIVING (ADLS) describe the fundamental self-care skills and tasks that a person performs independently on a day to day basis to care for themselves, such as eating, bathing, and getting dressed.

ADVANCE CARE PLANNING (ACP) is the process of thinking and talking about the kind of health and personal care that a person would want if they are not able to speak for themselves.

It involves: planning for a time when the person cannot make their own healthcare decisions; thinking about personal values, beliefs, and goals of care and discussing these with significant others, and health care and legal professionals; identifying a substitute decision maker; and recording personal wishes.

COMPETENCY is a "cluster of related knowledge, skills, and attitudes that affects a major part of one's job (a role or responsibility), that correlates with performance on the job, that can be measured against well-accepted standards, and that can be improved via training and development."[10]

COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) stems from the philosophy of integrative medicine and refers to a diverse group of therapies and products that are not part of standard medical care. Complementary therapies are practiced in conjunction with standard care, while alternative therapies are practiced alone or in place of standard care.

The range of treatments currently considered by most to be CAM can include acupuncture, art therapy, ayurvedic medicine, homeopathy, massage therapy, meditation, music therapy, naturopathy, osteopathy, reiki, traditional Chinese medicine, and yoga.

DESIGNATED FAMILY refers to whomever the patient identifies to be in this role for them.

EDMONTON SYMPTOM ASSESSMENT SYSTEM (ESAS) is a brief, comprehensive, and practical symptom assessment questionnaire that entails minimum patient burden. The ESAS questionnaire is used to rate the intensity of nine common symptoms experienced by cancer patients, including pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, well-being, and shortness of breath.

END-OF-LIFE CARE aims to reduce or relieve emotional, physical, psychological, social, and spiritual suffering to improve the quality of life until death. Although it begins in the final stage of dying, it continues beyond death into supporting family bereavement and caring of the body.

GENERALIST health care providers may have in their practice people and families or caregivers with life-limiting conditions, who are not the primary focus of their practice.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS) are the activities that a person performs on a day to day basis to care for themselves and their home. These activities require more complex planning and thinking than activities of daily living, such as grocery shopping and cooking, cleaning around the home, and managing personal finances.

MEDICAL ASSISTANCE IN DYING (MAiD) is a medical procedure that involves the intentional administration of medications by a doctor or nurse practitioner to end the life of an eligible person suffering intolerably from a grievous and irremediable medical condition, at the request of that person. Federal law (Bill C-14) governs who is eligible for MAiD and how MAID is to be provided.

OPIOID-INDUCED NEUROTOXICITY (OIN) is a group of adverse central nervous symptoms, from mild confusion or drowsiness to hallucinations, delirium, agitation, and seizures, that are caused by opioids.

PALLIATIVE APPROACH TO CARE applies palliative care principles to the care of people facing chronic, life-limiting conditions throughout the illness trajectory, not only at the end of life.

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[10] Parry, S. B. *The quest for competencies.* Training. 1996;33(7):48–54.

PALLIATIVE CARE is an approach that aims to reduce suffering and improve the quality of life for people who are living with life-limiting illness through the provision of:

- Pain and symptom management;
- Psychological, social, emotional, spiritual, and practical support; and
- Support for caregivers during the illness and after the death of the person they are caring for.[11]

PERSON-CENTERED CARE is an approach to care that puts the person receiving care in the center of the decisions that involve them, including the planning, developing, and monitoring of the delivery of care. The person can therefore ensure that the care they receive is meeting their needs.

In this approach, the person is seen as the expert, and the person partners with the health care team to get the best outcomes based on information and treatment choices shared by the care providers.

PERSONAL SUPPORT WORKERS are frontline health care workers who provide direct care to people in a variety of settings. Across Canada, in different provinces and territories, and in different settings, personal support workers may be identified as continuing care assistants, health care assistants, nursing assistants, and by other similar titles.

PALLIATIVE PERFORMANCE SCALE (PPS) is a valid, reliable, functional assessment tool that provides a framework for measuring progressive decline in performance status of palliative patients. Performance decline is measured in 10% decrements from 100% (healthy) to 0% (death) on an 11-point scale that is based on five observable parameters: ambulation, activity level, food/fluid intake, level of consciousness, and self-care.

SPECIALIST health care providers focus their practice on palliative care and consultation for people and families or caregivers affected by life-limiting conditions, especially those with complex needs.

SUBSTITUTE DECISION MAKER (SDM) is someone a person chooses (in advance) to legally make healthcare decisions on behalf of that person when they lacks the capacity to make the decision for themselves, including decisions regarding treatment, admission into a long term care home, and personal assistance services.

TRADITIONAL MEDICINE is the "sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness."[12]

Traditional medicines are not healing and medicinal practices that were used in the past, as the name "traditional" implies. Rather, these are holistic healing practices used by contemporary healers and Elders to manage and maintain health and wellness. Traditional medicine in First Nations, Inuit, and Métis communities does not have a set definition as it means different things to different communities. It is important to recognize each community has its own practices and beliefs.[13,14]

UNDERSERVICED refers to the higher likelihood that persons belonging to a certain group may find it more difficult to obtain needed care, receive less or a lower standard of care, experience different treatment by health-care providers, receive treatment that does not meet their needs, or be less satisfied with health-care services than the general population.

UNDERSERVICED POPULATIONS is used in this document to refer to (but is not limited to): perinatal, infants, children, adolescents, and young adults; the elderly; First Nations, Inuit, and Métis; racial or ethnic minorities; members of minority language communities; members of the LGBTQ2 community; immigrants and refugees; persons who have illnesses other than cancer; those who live in rural, remote, and northern communities, or are socioeconomically disadvantaged, houseless, incarcerated, engage in sex work, or have mental or cognitive impairments.

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[11] Health Canada. *Framework on palliative care in Canada.* Ottawa, ON: Health Canada; 2018.

[12] World Health Organization (WHO). *Traditional, Complementary and Integrative Medicine.* 2008.

[13] SE First Nations, Inuit and Métis Program. NAHO Publications and Resources: *Traditional Medicine – Fact Sheet.* National Aboriginal Health Organization (NAHO). 2012.

[14] Hill, D. M. *TRADITIONAL MEDICINE IN CONTEMPORARY CONTEXTS: Protecting and Respecting Indigenous Knowledge and Medicine.* National Aboriginal Health Organization (NAHO). 2003.

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