# Education Blueprint

## Palliative Care Education for Long Term Care Homes

### Quality Palliative Care in Long Term Care Alliance (QPC-LTC)

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# Introduction

Under the Long-Term Care Homes Act effective in Ontario on July 1, 2010 it is stipulated that all staff providing direct care to residents must receive training and re-training in the area of palliative care. Although the act requires direct staff to have palliative care education upon orientation and each year, the act does not specify how, when, or what tools should be used to provide this education. The act also does not stipulate specifically what content should be included in palliative care education for long term care (LTC) home staff or how education should be tracked and recorded.

The Model for Quality Palliative Care in Long-Term Care suggests that a palliative care educational plan for staff is a key structural component of a good palliative care program. This toolkit aims to assist in strengthening the current and future capacity of LTC home staff to provide quality palliative care through education and training and to provide long term care homes with an adaptable blueprint so they can customize palliative care education to meet their needs.

# Overview of the Education Blueprint Toolkit

This toolkit for planning palliative care education has been designed with a focus on the competencies needed for providing quality palliative care in long term care. The thirteen competency areas are generic competencies needed by long term care home staff as a whole in order to effectively deliver quality palliative care to residents and their family members. Competencies for this toolkit are based on a synthesis of existing competencies for palliative care and include information from the following sources:

- Canadian Social Work Competencies for Hospice Palliative Care: A Framework to Guide Education and Practice at the Generalist and Specialist Levels (2008).
- Canadian Association of Schools of Nursing (CASN). Palliative and End-of-Life Care: Entry-to Practice Competencies and Indicators for Registered Nurses (2011).
- Canadian Hospice Palliative Care Association (CHPCA). Hospice Palliative Care Nursing Certification Examination: List of Assumptions and Competencies (2008).
- Educating Future Physicians in Palliative and End-of-Life Care (EFPPEC). Undergraduate Medical Education Curriculum & Competencies in Palliative and End-of-Life Care for Postgraduate Family Medicine Education (2004).
- Marie Curie Cancer Care. Spiritual and Religious Care Competencies for Specialist Palliative Care (2003).
- Quality Palliative Care in Long Term Care Alliance (QPC-LTC). Personal Support Worker Competencies (2012).

This tool emphasizes the importance of the interprofessional team in the LTC setting and identifies disciplines that could potentially be members of a palliative care resource team. Also included are essential considerations and steps to take when developing and implementing a palliative care education plan for staff in LTC. Some key considerations include: assessment, planning, implementation, and evaluation of education and training activities.

Suggested resource options for delivering applicable palliative care education and checklists for tracking education activities are also provided. This toolkit is purposefully not prescriptive, allowing for each long term care home to customize its own unique palliative care education plan.

## How to use the framework:

**Key aspects of this tool include:**

- **Potential Members of the Interprofessional Palliative Care Resource Team**
- **Considerations for Providing Palliative Care Education in LTC**
- **Checklist for Providing Palliative Care Education in LTC**
- **Palliative Care Competency Areas for LTC**
- **Competency-based Assessment Tool for LTC Staff**
- **Suggested Palliative Care Education Resources**
- **Education Plan Blueprint**
- **Tracking Sheets**

With this toolkit, long term care homes can use a 'competency-based' method for developing their palliative care education plan, focusing on specific areas of practice or needed skills. Learning needs can be determined by completing the palliative care competency assessment checklist. Once identified, these learning needs will provide a basis for developing a relevant and targeted palliative care education plan.

The chart of suggested resources and examples of different options for providing palliative care education provided is meant to be used as a guide for LTC homes when planning educational opportunities and training for staff. However, the suggested resources are not exhaustive. Since there are innumerable tools for delivering palliative care education as well as consistently emerging new tools, this framework does not aim to prescribe preferred methods or curricula, but rather to provide LTC homes with the basis for developing a unique, adaptable blueprint to customize their own education plans.

This toolkit also includes sample templates and examples of how to develop a palliative care education plan for staff, inclusive of education upon orientation and annual continuing education and training. Sample tracking sheets are also provided so that LTC home management staff can easily document and identify who has participated in palliative care education, and what type and/or level of education was provided.

# How to use the framework (continued):

**Suggested Steps for Utilizing this Framework:**

1) Consider the potential members of an interprofessional Palliative Care Resource Team. Which disciplines are represented in your home? Who in your home could contribute to the Palliative Care Resource Team? (See pages 6-7)

2) Reflect on specific considerations that need to be taken into account before providing palliative care education for staff in LTC. Consider the key steps of assessment, planning, implementation, and evaluation prior to any education initiative as well as the principles of adult learning. (See pages 8-10)

3) Review the Palliative Care Competency Areas for Long-Term Care. (See pages 11-26)

4) Complete the Competency-based Assessment Tool (Appendix A)

   ⇒ Once the audit tool has been completed and learning needs identified, LTC homes can develop an education plan based on applicable resources to address those needs.

5) Education Resources Chart (Appendix B)

   ⇒ Review the education resources chart for suggestions and ideas for addressing staffs' identified learning needs. Seek out other applicable and/or locally relevant resources.

6) Palliative Care Education Plan Blueprint (Appendix C)

   ⇒ Create an education plan for orientation activities and the year based on identified learning needs and the resources available. Refer to the samples in Appendix C as a guide and/or utilize the template provided.

7) Implement education and training activities in accordance with the plan and track all education in which staff participates. Use forms (see Appendix D for examples) for reporting/tracking staff participation in various types of education so that a report can easily be generated.

# Potential Members of the Resource Team in LTC:

Effective quality palliative care is best provided by an interprofessional team who are both knowledgeable and skilled in all aspects of the caring process related to their discipline of practice (CHPCA, 2005). This framework is intended to have applicability to all disciplines in long term care.

Shown below are the potential members of an interprofessional palliative care resource team in the long term care home setting. A palliative care resource team is not a clinical team. The team provides leadership and education to other staff and is responsible for developing and implementing quality improvement initiatives for palliative care in the home. A palliative care resource team should be interprofessional in nature and should include staff from all departments. The roles of each staff member will be different within the palliative care team based on the staff's expertise and the role of the department he or she is representing. The following are generic tasks that the palliative care resource team will complete. If any of the services are required any member of the Resource Team can be approached. If the team member cannot provide such support or information, he or she can locate another team member.

- Mentoring other Staff / Families
- Providing Emotional Support for Staff/ Families/ Residents
- Provide Information regarding  Training / Tools for Other Staff Members
- Clarification After a Hospital Transfer
- Educating / Providing Information to Residents and Families
- Provide Input into Guidelines / Policies and Procedures
- Advertise Palliative Approach and End-of-Life Care Services to Residents and Families

In the chart below, interprofessional team members are broken down into streams related to the focus and level of care each discipline provides. While there are similarities across disciplines related to certain palliative care competencies required for long term care, each discipline has a unique role, focus, or necessary skill/knowledge level related to each competency and thus also have differing educational needs.

| The Interprofessional Team | | | |
|---|---|---|---|
| **Nursing Staff:**<br><br>Physicians<br>Nursing (RN,RPN)<br>Personal Support Workers | **Allied Staff:**<br><br>Social Workers<br>Spiritual Care<br>Occupational Therapists<br>Physical Therapists<br>Pharmacists<br>Psychologists<br>Speech Pathologists<br>Life Enrichment Aids | **Support Staff:**<br><br>Housekeeping<br>Maintenance<br>Dietary Aids | **Palliative Care Volunteers:**<br><br>Volunteers |

# Palliative Care Education Planning and Delivery:

**Specific Considerations for Providing Palliative Care Education in Long Term Care:**

**Orientation Considerations:**

- Before assuming their job responsibilities, direct care staff and volunteers must receive palliative care training.
- Orientation for new staff in long term care at a minimum should include education and training in the first competency area outlined in this toolkit, the Palliative Care Philosophy.
- Suggested topics include:
  - ⇒ Introduction to Palliative Care; and
  - ⇒ Introduction to the Palliative Care Program and Services offered in the LTC home.

**Suggestions for Continuing Education and Training:**

- Direct care staff and volunteers must receive annual retraining on palliative/end-of-life care.
- When creating an education plan and budget, consider things like time, space, materials, expertise and finances needed.
- To ensure adherence to the Act, consider establishing an organizational policy that staff must take palliative care education each year and establish a minimum requirement of sessions/hours staff need to complete.
- Provide ongoing organizational support and advocacy for continuing education initiatives.
- Advertise palliative care education within the LTC home.
- Look for potential partnerships for providing palliative care education:
  - ⇒ **Educational Partners**—Collaborate with college and university partners with common goals for success of learners
  - ⇒ **Clinical Agencies**—Consider a clinical partner where learners are provided with the opportunity for mentorship
  - ⇒ **Community Collaboration**—Work with existing community resources and seek community stakeholder support
  - ⇒ **Interprofessional Collaboration**—Provide education opportunities inclusive of all long term care home staff; encourage staff to become palliative care champions.

# Checklist—Providing Palliative Care Education in LTC

The following checklist has been adapted from the Registered Nurses' Association of Ontario (2005) Educator's Resource: Integration of Best Practice Guidelines.

**Prior to an educational event the following areas should be considered:**

**Assessment:**

- ☐ Topic/competency area identified
- ☐ Identify target learners and learning needs
- ☐ Assess the environment (e.g. appropriate timing/readiness)
- ☐ Determine resources required

**Planning:**

- ☐ Goals, objectives and key deliverables of education identified
- ☐ Appropriate strategies/tools for delivering education chosen
- ☐ Evaluation plan determined
- ☐ Logistics of the event arranged
- ☐ Sufficient staff coverage ensured
- ☐ Communication, advertisement and registration strategy
- ☐ Event scheduled
- ☐ Participant availability determined - be sure to provide/seek educational opportunities at different times to accommodate shift work

# Checklist—Providing Palliative Care Education

**Implementation:**

☐ Consideration of Goodlad's Principles of Adult Learning:

It is suggested that any plan for delivering continuing education, and the education provided, be based on the principles of adult learning.

**Adults prefer learning situations which:**

⇒ Are practical and problem-centered

⇒ Promote their positive self esteem

⇒ Integrate new ideas with existing knowledge

⇒ Show respect for the individual learner

⇒ Capitalize on their experience

⇒ Allow choice and self-direction

☐ Troubleshoot/anticipate any problems

☐ Deliver learning event

**Evaluation:**

☐ Implement evaluation plan

☐ Analyze and communicate evaluation results to appropriate stake holders

☐ Incorporate findings into planning the next educational initiative

**Note:** most educational tools/programs are designed with their own evaluation methods. If not, consider the importance of evaluating the effectiveness of educational initiatives offered within the LTC home. For example: Is the learning being implemented into practice?

**According to Benner's (2001) model, learners have reached a level of competency when they:**

⇒ Are aware of all the relevant aspects of a situation

⇒ Can see actions as at least partly in terms of long-term goals

⇒ Are conscious of deliberate planning

⇒ Can set priorities

⇒ Are developing critical thinking skills

## Developing Palliative Care Competencies for LTC

"Competencies" refer to the skills, knowledge, abilities, and personal attributes that are necessary for successful work performance. Competencies go beyond a mere job description to try and capture the abilities needed to perform that job. Competencies can also be converted to learning objectives.

This educational toolkit is based on literature pertaining to established competencies for palliative care, primarily, those developed by the Canadian Association of Schools of Nursing (2011). While competencies specific to the provision of palliative care have been developed for physicians, nurses, personal support workers, social workers and spiritual advisors, the majority of these competencies lack a specific focus on the unique context of practice in long term care homes. QPC-LTC project findings and the CHPCA's Square of Care Model were used to fill gaps in palliative care competency areas deemed necessary for practice in a long term care setting.

The competencies in this framework represent a comprehensive synthesis of developed competencies for the overall interprofessional team providing palliative care in LTC. Therefore, each competency or emerging topic area will not be applicable to all disciplines. Each member of the interprofessional team should work within the competencies according to his or her own scope of practice.

## Palliative Care Competency Areas for LTC

1. Palliative Care Philosophy
2. Communication and Information-sharing with Residents and Families
3. Assessment and Documentation
4. Care planning and Decision-making
5. Resident-Centred Care Delivery (psychosocial/spiritual needs)
6. Pain and Symptom Management
7. End-of-Life Care/Death management
8. Loss, Grief and Bereavement Support
9. Research and Evaluation
10. Ethical and Legal issues
11. Advocacy
12. Interprofessional, Collaborative Practice
13. Professional Development/Mentorship (Self- care, Awareness, and Reflection)

# 1. Palliative Care Philosophy

***Possesses knowledge of the philosophy of palliative care and the palliative approach to care as it applies to the long term care home setting.***

- ⇒ Demonstrates knowledge of the history of the palliative care movement and its implications on the long term care setting.
- ⇒ Demonstrates knowledge of the values and principles of palliative care.
- ⇒ Demonstrates an understanding of the palliative care philosophy and approach to care.
- ⇒ Ability to differentiate between palliative and end-of-life care.
- ⇒ Demonstrates knowledge of the full range of palliative and end-of-life care services and resources available in the long term care home setting.
- ⇒ Understands the role and scope of practice of each member of the interprofessional team.

## 2. Communication and Information-Sharing with Residents & Families

***Communicates with, and provides information effectively, to residents and family members.***

- ⇒ Understands the importance and impact of non-verbal and verbal communication.
- ⇒ Ability to communicate and provide information about the palliative care approach and philosophy.
- ⇒ Shares information about palliative and end-of-life care services and resources available in the long term care home as applicable.
- ⇒ Communicates respectfully, empathetically and compassionately to facilitate discussion and understanding about issues related to: diagnosis, prognosis, goals of care, decision-making, treatment options, dying and death, loss, grief and bereavement.
- ⇒ Communicates information, including bad news, effectively.
- ⇒ Provides accurate and comprehensive information to make informed decisions about treatment choices.
- ⇒ Adapts communication and information sharing to the unique needs of residents and family members to enable informed decision-making, and consults with/refers to appropriate supports such as translated documents and interpreters when necessary.
- ⇒ Engages in, or leads, family and team conferences regarding the resident and participates effectively.
- ⇒ An ability to recognize and respond appropriately to emotional issues and conflict in residents and families.
- ⇒ Asks about preferences, such as the extent to which they wish to be informed about the resident's condition and treatment options, respects their wishes for information where ethically appropriate and documents this.
- ⇒ Reviews and clarifies understandings of palliative and end-of-life care information provided, and documents this.

## 3. Assessment and Documentation

***Demonstrates the ability to conduct and document comprehensive assessments on an ongoing basis to inform decision-making and facilitate care planning and delivery.***

**A. Assessment:**

- ⇒ Recognizes that holistic assessment includes consideration of physical, emotional, psychological, social, spiritual, and practical strengths and needs of residents and their family members.
- ⇒ Knowledge of assessment tools and strategies relevant to medical, psychosocial, and spiritual dimensions of palliative and end-of-life experiences of residents and families.
- ⇒ Ability and willingness to ask difficult questions and discuss sensitive topics such as advance care planning and issues or questions around grief and bereavement.
- ⇒ Recognition that assessment is an ongoing process reflective only of the current reality of the resident/family.
- ⇒ Ability to identify changing issues, needs, and goals of care during courses of illness, dying, death and bereavement.
- ⇒ Recognizes and communicates promptly with appropriate interprofessional team members, including family, about changes in resident's status.

**B. Documentation:**

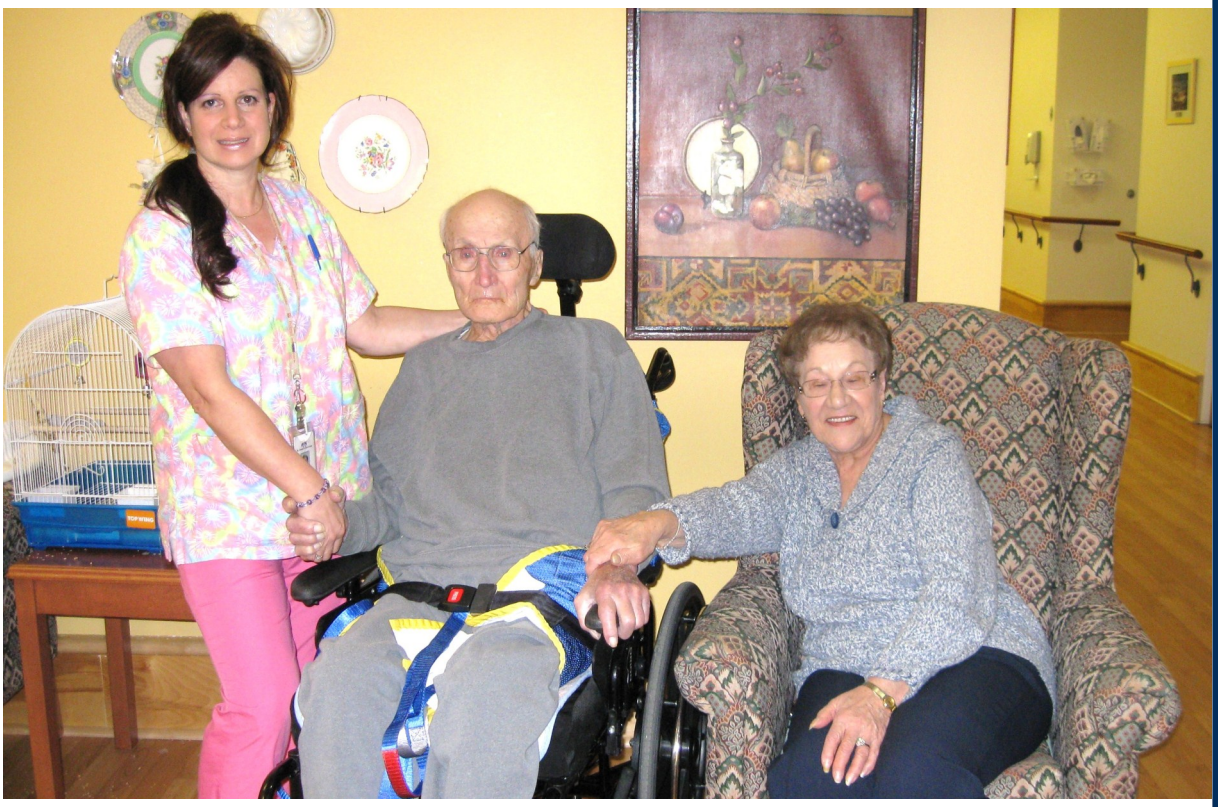
- ⇒ Demonstrates appropriate documentation of spiritual assessments/perceived spiritual needs.
- ⇒ Ability to meet professional standards in verbal/written reports and documentation of the ongoing assessment process.

# 4. Care Planning and Decision-Making

***Develops an individualized care plan in collaboration with the resident, family and interprofessional team to meet the needs of the resident and family.***

**A. Creating the conditions - building a trusting relationship:**

- ⇒ Welcomes, facilitates, and respects the involvement of the resident, family members, and other team members in discussions about the plan of palliative and end-of-life care.
- ⇒ Initiates regular care planning conversations with residents and their family members.
- ⇒ Identifies and documents the resident's and family members' values, beliefs, and preferences concerning the various aspects of palliative and end of-life care provision.
- ⇒ Preserves resident and family dignity by helping them to express their feelings, needs, hopes, and concerns in planning for palliative and end-of life care.
- ⇒ Helps to create a safe environment and build the resident's and family members' trust to facilitate palliative and end of life decision-making.
- ⇒ Knowledge of the factors that influence the care planning process along the course of illness, dying, death and bereavement.



**B. Advance Care Planning:**

- ⇒ Knowledgeable in the parameters (e.g. capacity, competence) of informed decision-making and information sharing.
- ⇒ Discusses the benefits and burdens of palliative and end-of-life care options to assist the resident and family members in meeting their goals of care, and documents the information provided.
- ⇒ Facilitates conversations that support end-of-life decision making such as advance care plans, directives, living wills and tending to personal affairs.
- ⇒ Identifies, documents, and integrates the strengths of the resident and family members in the plan of care.
- ⇒ Communicates and documents decisions made by the resident and family members regarding their goals for palliative and end-of-life care.
- ⇒ Ability to plan for continuity of care as needs change throughout the course of a life-limiting illness.
- ⇒ Identifies and documents when a referral is needed to support palliative and end of-life decision making and provides necessary follow-up.

## 5. Resident-Centred Care Delivery (Psychosocial/ Spiritual Needs)

***Provides resident-centred care delivery by addressing the psychosocial and spiritual needs of the resident and family.***

- ⇒ Recognizes and responds to the unique end-of-life needs of various populations, such as elders, multicultural populations, those with cognitive impairment, language barriers, those with chronic diseases, mental illness and marginalized populations.
- ⇒ Recognizes and responds to the unique needs or backgrounds of residents of varying ethnicities, nationalities, cultures and abilities that may affect their experience of palliative and end-of-life care.
- ⇒ Identifies who "the family" is for the resident, and responds to family members' unique needs and experiences when sharing information and arriving at decisions.
- ⇒ Ability to build and maintain therapeutic relationships until end-of-life and bereavement.
- ⇒ Demonstrates openness and sensitivity to social, spiritual/ religious and cultural values and practices that may influence palliative and end-of-life care preferences of the resident and family.
- ⇒ An ability to use active listening skills to recognize unmet spiritual and religious needs.
- ⇒ Demonstrate a wide range of skills to recognize, assess, and address the complex spiritual and religious needs of residents/ families.
- ⇒ Ability to develop and provide a plan for spiritual care based on spiritual or religious need.
- ⇒ Commitment to resident and family-centred care that acknowledges what is meaningful to individual residents and families.
- ⇒ Provides the opportunity for the resident approaching end-of-life to conduct a life review.
- ⇒ Recognition of one's own limitations/bias to manage difficult issues, referring on to appropriate members of the interprofessional team.

# 6. Pain and Symptom Management

***Demonstrates knowledge and skill in providing holistic pain and symptom management for residents receiving palliative or end-of-life care.***

**A. Screening/Assessment:**

- ⇒ Demonstrates understanding of the concept of 'total pain' when caring for residents and their family members, which is inclusive of physical, emotional, spiritual, practical, psychological, and social elements.
- ⇒ Utilizes best practice assessment tools for baseline and ongoing assessment of pain, including word descriptors, body maps, precipitating and alleviating factors, and documents pain assessments.
- ⇒ Demonstrates knowledge of the stepped approach to pain assessment based on the type and severity of the pain.
- ⇒ Demonstrates knowledge of special considerations of pain and symptom assessment and management for older adults with life-limiting illnesses and special needs (e.g. impaired cognition, communication).
- ⇒ Understands causes of common non-pain symptoms at end-of-life.

**B. Addressing and Documenting Pain and Symptom Issues:**

- ⇒ Demonstrates knowledge of medication commonly used for pain and symptom management.
- ⇒ Applies principles of pain and other symptom management when caring for residents receiving palliative or end-of-life care.
- ⇒ Utilizes and documents evidence informed pharmacological approaches to alleviate pain, including intended effects, doses and routes of administration, and common side effects.
- ⇒ Utilizes and documents evidence based non-pharmacological approaches to pain, including any potential adverse effects.
- ⇒ Discusses, teaches, and assists the resident and family members in managing pain and other symptoms.
- ⇒ Implements and documents evidence informed pharmacological and non-pharmacological approaches for non-pain symptoms at end-of-life.
- ⇒ Effectively collaborates with the interprofessional team to manage pain and other palliative/end-of-life symptoms.

**C. Evaluation:**

- ⇒ Evaluates and documents all outcomes of pain and symptom management interventions throughout the course of the resident's illness experience against a baseline assessment using comparative evaluations.
- ⇒ Knowledge of components and processes of clinical assessment, including evaluation of interventions in relation to medical and psychosocial outcomes.
- ⇒ Evaluates, reassesses and revises pain/symptom management goals and plan of care.
- ⇒ Responds to potential side effects of medication, interactions, and complications.

# 7. End-of-Life Care & Death Management

***Anticipates, recognizes, and responds to the signs and symptoms of imminent death and continues care provision after death.***

**A. End-of-life care:**

- ⇒ Assists the resident at end-of-life and family to: a) cope emotionally b) maintain a desired level of control, c) communicate their preferences and needs, d) contact significant others, e) contact appropriate resources and support, f) interact meaningfully in the resident's last days.
- ⇒ Assists the resident with life closure (e.g. completing business, closing relationships, saying goodbye)
- ⇒ Provides comfort to the resident through touch, presence, sound/ silence, positioning and softened light.
- ⇒ Provides information and assurance to the resident and family members regarding comfort measures during the last days/hours of living.
- ⇒ Assists in the education of residents and family members about end-of-life care issues and pain and symptom management.
- ⇒ Knowledge of cognitive (decreased awareness, increased drowsiness, restlessness) and physical changes (profound weakness, respiratory changes, skin colouration, difficulty swallowing, decreased urinary output) associated with imminent death.
- ⇒ Teaches family members the signs of imminent death (cognitive/ physical).
- ⇒ Ability to describe and implement a supportive approach to suffering.
- ⇒ Assists the resident and family to prepare for the time of death (e.g. providing resources regarding funeral arrangements, organ, tissue donation, developing a list of people to contact at time of death).
- ⇒ Communicates promptly with appropriate staff about changes in the residents' status.

**B. Death Management:**

- ⇒ Assesses and respects the family's need for privacy and closure at the time of death, offering presence as appropriate.
- ⇒ Facilitates arrangements for pronouncement of death and certification of death, where appropriate.
- ⇒ Facilitates opportunities for staff and residents to say good-bye.
- ⇒ Provides care of the body for transportation.

## 8. Loss, Grief and Bereavement Support

***Demonstrates knowledge of grief and bereavement and related skills in order to support others.***

- ⇒ Demonstrates knowledge of loss, grief and bereavement.
- ⇒ Demonstrates understanding of grief theories and their application to palliative and end-of-life care.
- ⇒ Demonstrates understanding of the common, normal manifestations of grief (emotional, physical, cognitive, behavioural/social, and spiritual).
- ⇒ Demonstrates understanding of individual, social, cultural, and spiritual variables that affect grief.
- ⇒ Identifies situations when personal beliefs, attitudes and values result in limitations in the ability to be present for the resident and family members experiencing loss, grief, and/or bereavement.
- ⇒ Supports the family's wishes and death rituals (e.g. religious, cultural, spiritual).
- ⇒ Uses insights gained from personal experiences of loss, bereavement and grief to provide support to others.
- ⇒ Listens, affirms, and responds compassionately to residents and family members working through grief and bereavement.
- ⇒ Accurately assesses and documents the resident's and family members' needs related to loss, grief and bereavement.
- ⇒ Identifies individuals experiencing, or at high risk for experiencing, a complicated and/or disenfranchised grief reaction, and discusses, documents and makes appropriate referrals.
- ⇒ Provides guidance, support, and referrals to bereaved family members and documents this.
- ⇒ Develops the capacity to be in the presence of suffering.

## 9. Research and Evaluation

***Participates in research and evaluation activities, and applies knowledge gained from research in palliative care and related areas.***

- ⇒ Participates in the development, monitoring and evaluation of the quality of palliative care programs and services.
- ⇒ When possible, participates in research activities appropriate to one's position/discipline.
- ⇒ Provides family members with opportunities and information to participate in research about family caregiving at the end-of-life.
- ⇒ Integrates current knowledge in approaches to palliative/end-of-life care practice (e.g. research-based standards, clinical guidelines, outcome measures).

## 10. Ethical and Legal Issues

***Applies ethical knowledge skillfully when caring for residents receiving palliative or end-of-life care and their families.***

- ⇒ Collaborates with the resident, family, full term Substitute Decision Maker, and the interprofessional team to recognize and address ethical issues related to palliative and end-of-life care.

- ⇒ Understands the importance of confidentiality and when to disclose and document information.

- ⇒ Provides guidance to the resident/family in identifying and addressing relevant legal issues (e.g. advance/health-care directives, guardianship and trusteeship, power of attorney, proxy/ substitute decision-maker).

- ⇒ Supports informed decisions that the resident, family, full term Substitute Decision Maker, and interprofessional team have made.

- ⇒ Uses an ethical process for addressing challenging issues and controversial clinical situations (e.g. palliative sedation, hydration, feeding, ventilation, withdrawing/withholding life-sustaining treatment, advance directives, full term Do Not Resuscitate orders).

# 11. Advocacy

***Advocates for the needs, decisions, and rights of residents and families in palliative and end-of-life care; advocates to address clinical and policy issues.***

**A. Resident/Family Advocacy:**

- ⇒ Provides a voice at times when residents cannot speak for themselves, acting on the resident's behalf, to ask for things the resident would ask for themselves if able.
- ⇒ Advocates for the resident and family members' timely access to relevant resources, and documents this.
- ⇒ Identifies, verifies, and advocates for perceived and real needs of the resident and family members, and documents this.
- ⇒ Commitment to, and promotion of, resident autonomy, self-determination, dignity, confidentiality, privacy and informed choice.

**B. Organization/Professional Advocacy:**

- ⇒ Knowledge of health care and social systems and how they act as both resources and barriers.
- ⇒ Ability to identify and address gaps in service.
- ⇒ Advocates for the development, maintenance and improvement of health care and social policy related to palliative care in the long term care setting.
- ⇒ Advocates for health care professionals to have continuing education and adequate resources to provide quality palliative care.
- ⇒ Advocates for institutional acknowledgement and support of staff grief and bereavement related to the loss of residents.

## 12. Interprofessional & Collaborative Practice

***Demonstrates the ability to collaborate effectively within an integrated interprofessional team, including non-professional health care providers, family members, and the resident himself or herself.***

- ⇒ Recognizes that effective palliative care is best provided by an interprofessional team.
- ⇒ Demonstrates knowledge of own role and the role of other team members in providing palliative and end-of-life care, and areas where roles may overlap.
- ⇒ Builds on collaborative relationships with residents and family members, and members of the interprofessional palliative care team in determining resident's goals and plan of care.
- ⇒ Respects and considers the opinion, knowledge, and skills of others in a shared decision-making process regarding the priorities of care for the resident.
- ⇒ Possesses knowledge of the issues related to confidentiality within team practice.
- ⇒ Communicates respectfully with the interprofessional team using effective communication skills including conflict management.
- ⇒ Reflects on the need for different interprofessional team approaches in different situations.
- ⇒ Recognizes when to refer on to other members of the interprofessional team and clearly articulates reason for referral.
- ⇒ Contributes as an effective member of the interprofessional team.

## 13. Professional Development/Mentorship (Self-Care, Awareness, and Reflection)

***Commitment to professional development, the mentoring and support of other team members, and recognition of the importance of self-care, awareness, and reflection.***

**A. Self- care, awareness, and reflection:**

⇒ Self-assesses one's own attitudes and beliefs about death and dying and caring for people at the end-of-life.

⇒ Recognizes how personal attitudes, values, and beliefs related to spirituality, religion, culture and ethnicity may influence care provision.

⇒ Demonstrates self-awareness of the unique stressors in providing palliative/end-of-life care for residents and family members and utilizes self-care and coping strategies to promote personal wellbeing.

⇒ Recognizes and takes appropriate measures to cope with multiple and cumulative losses and grief reactions (e.g. peer support, debriefing, physical/social activities).

**B. Professional Development:**

⇒ Identifies gaps in knowledge, skills, and abilities as a first step in acquiring new knowledge, skills, and abilities for palliative and end -of-life care.

⇒ Participates in ongoing educational activities, including in-house training, supervision opportunities, and applies new knowledge to practice.

⇒ Stays up-to-date on developments in one's profession.

⇒ Advertises palliative care education opportunities and resources within the long term care home.

**C. Mentorship/Support:**

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

⇒ Act as a resource for knowledge, support, mentorship, training and education for other health care professionals, families, students, and volunteers when applicable/appropriate.

## Next Steps: Developing Your LTC Home's Palliative Care Education Plan

1. **Complete the Competency Assessment Checklist (Appendix A) to identify staff learning needs.**
2. **Refer to the Education Resources Chart (Appendix B) for ideas; select appropriate education options to meet identified learning needs.**
3. **Develop a Palliative Care Education Plan (Appendix C) for orientation and continuing education:**

   i) Write staff departments/disciplines in chart

   ii) Decide upon and list education activities for staff orientation

   iii) Decide upon and list education activities for continuing palliative care education on an annual basis; consider education opportunities at both the basic and advanced level

   iv) Select target dates for education delivery

   v) Implement planned education and training activities

4. **Track staff members' palliative care education activities: (Appendix D)**

   i) List employee name

   ii) List employee discipline/department

   iii) Record in Legend what each type of education involves (e.g. Orientation – what does it cover/include?)

   iv) List other types of education offered and also include a fuller description in the legend

   v) Have a column to record the total number of palliative care education hours each staff member participated in throughout the year

# Sample Educational Audit Form

**Quality Palliative Care in Long-Term Care: Competency Assessment Checklist**

This checklist has been developed to assess the competency level of staff in specific areas for palliative care. This checklist can be used in conjunction with the "Education Blueprint" tool to assist LTC homes to identify staff learning needs and monitor progress toward staff competency in providing quality palliative care in long-term care facilities.

| | PALLIATIVE CARE COMPETENCY & DESCRIPTION | KNOWLEDGE/SKILL LEVEL<br>None (N) Some (S)<br>Proficient (P) Expert (E) |
|---|---|---|
| 1. | **Palliative Care Philosophy:**<br>*Possesses knowledge of the philosophy of palliative care and the palliative approach to care as it applies to the long term care home setting.* | |
| 1.1 | Demonstrates knowledge of the history of the palliative care movement and its implications on the long term care setting. | ☐ N ☐ S ☐ P ☐ E |
| 1.2 | Demonstrates knowledge of the values and principles of palliative care. | ☐ N ☐ S ☐ P ☐ E |
| 1.3 | Demonstrates an understanding of the palliative care philosophy and approach to care. | ☐ N ☐ S ☐ P ☐ E |
| 1.4 | Ability to differentiate between palliative and end-of-life care. | ☐ N ☐ S ☐ P ☐ E |
| 1.5 | Demonstrates knowledge of the full range of palliative and end-of-life care services and resources available in the long term care home setting. | ☐ N ☐ S ☐ P ☐ E |
| 1.6 | Understands the role and scope of practice of each member of the interprofessional team. | ☐ N ☐ S ☐ P ☐ E |
| 2. | **Communication & Information-Sharing with Residents & Families**<br>*Communicates with, and provides information effectively, to residents and family members.* | |
| 2.1 | Understands the importance and impact of non-verbal and verbal communication. | ☐ N ☐ S ☐ P ☐ E |
| 2.2 | Ability to communicate and provide information about the palliative care approach and philosophy. | ☐ N ☐ S ☐ P ☐ E |
| 2.3 | Shares information about palliative and end-of-life care services and resources available in the long term care home as applicable. | ☐ N ☐ S ☐ P ☐ E |
| 2.4 | Communicates respectfully, empathetically and compassionately to facilitate discussion and understanding about issues related to: diagnosis, prognosis, goals of care, decision-making, treatment options, dying and death, loss, grief and bereavement. | ☐ N ☐ S ☐ P ☐ E |
| 2.5 | Communicates information, including bad news, effectively. | ☐ N ☐ S ☐ P ☐ E |
| 2.6 | Provides accurate and comprehensive information to make informed decisions about treatment choices. | ☐ N ☐ S ☐ P ☐ E |
| 2.7 | Adapts communication and information sharing to the unique needs of residents and family members to enable informed decision-making, and consults with/refers to appropriate supports such as translated documents and interpreters when necessary. | ☐ N ☐ S ☐ P ☐ E |
| 2.8 | Engages in, or leads, family and team conferences regarding the resident and participates effectively. | ☐ N ☐ S ☐ P ☐ E |
| 2.9 | An ability to recognize and respond appropriately to emotional issues and conflict in residents and families. | ☐ N ☐ S ☐ P ☐ E |
| 2.10 | Asks about preferences, such as the extent to which they wish to be informed about the resident's condition and treatment options, respects their wishes for information where ethically appropriate and documents this. | ☐ N ☐ S ☐ P ☐ E |
| 2.11 | Reviews and clarifies understandings of palliative and end-of-life care information provided, and documents this. | ☐ N ☐ S ☐ P ☐ E |
| 3. | **Assessment & Documentation**<br>*Demonstrates the ability to conduct and document comprehensive assessments on an ongoing basis to inform decision-making and facilitate care planning and delivery.* | |
| A. | **Assessment:** | |
| 3.1 | Recognizes that holistic assessment includes consideration of physical, emotional, psychological, social, spiritual, and practical strengths and needs of residents and their family members. | ☐ N ☐ S ☐ P ☐ E |
| 3.2 | Knowledge of assessment tools and strategies relevant to medical, psychosocial, and spiritual dimensions of palliative and end-of-life experiences of residents and families. | ☐ N ☐ S ☐ P ☐ E |
| 3.3 | Ability and willingness to ask difficult questions and discuss sensitive topics such as advance care planning and issues or questions around grief and bereavement. | ☐ N ☐ S ☐ P ☐ E |
| 3.4 | Recognition that assessment is an ongoing process, reflective only of the current reality of the resident/family. | ☐ N ☐ S ☐ P ☐ E |
| 3.5 | Ability to identify changing issues, needs, and goals of care during courses of illness, dying, death and bereavement. | ☐ N ☐ S ☐ P ☐ E |
| 3.6 | Recognizes and communicates promptly with appropriate interprofessional team members, including family, about changes in resident's status. | ☐ N ☐ S ☐ P ☐ E |
| B. | **Documentation:** | |
| 3.7 | Demonstrates appropriate documentation of spiritual assessments/perceived spiritual needs. | ☐ N ☐ S ☐ P ☐ E |
| 3.8 | Ability to meet professional standards in verbal/written reports and documentation of the ongoing assessment process. | ☐ N ☐ S ☐ P ☐ E |

| | PALLIATIVE CARE COMPETENCY & DESCRIPTION | KNOWLEDGE/SKILL LEVEL<br>None (N) Some (S)<br>Proficient (P) Expert (E) |
|---|---|---|
| 4. | **Care Planning and Decision-Making**<br>***Develops an individualized care plan in collaboration with the resident, family and interprofessional team to meet the needs of the resident and family.*** | |
| A. | **Creating the conditions - building a trusting relationship:** | |
| 4.1 | Welcomes, facilitates, and respects the involvement of the resident, family members, and other team members in discussions about the plan of palliative and end-of-life care. | ☐ N ☐ S ☐ P ☐ E |
| 4.2 | Initiates regular and ongoing care planning conversations with residents and their family members. | ☐ N ☐ S ☐ P ☐ E |
| 4.3 | Identifies and documents the resident's and family members' values, beliefs, and preferences concerning the various aspects of palliative and end of-life care provision. | ☐ N ☐ S ☐ P ☐ E |
| 4.4 | Preserves resident and family dignity by helping them to express their feelings, needs, hopes, and concerns in planning for palliative and end-of life care. | ☐ N ☐ S ☐ P ☐ E |
| 4.5 | Helps to create a safe environment and build the resident's and family members' trust to facilitate palliative and end of life decision-making. | ☐ N ☐ S ☐ P ☐ E |
| 4.6 | Knowledge of the factors that influence the care planning process along the course of illness, dying, death and bereavement. | ☐ N ☐ S ☐ P ☐ E |
| B. | **Advance Care Planning:** | |
| 4.7 | Knowledgeable in the parameters (e.g. capacity, competence) of informed decision-making and information sharing. | ☐ N ☐ S ☐ P ☐ E |
| 4.8 | Discusses the benefits and burdens of palliative and end-of-life care options to assist the resident and family members in meeting their goals of care, and documents the information provided. | ☐ N ☐ S ☐ P ☐ E |
| 4.9 | Facilitates conversations that support end-of-life decision making such as advance care plans, directives, living wills and tending to personal affairs. | ☐ N ☐ S ☐ P ☐ E |
| 4.10 | Identifies, documents, and integrates the strengths of the resident and family members in the plan of care. | ☐ N ☐ S ☐ P ☐ E |
| 4.11 | Communicates and documents decisions made by the resident and family members regarding their goals for palliative and end-of-life care. | ☐ N ☐ S ☐ P ☐ E |
| 4.12 | Ability to plan for continuity of care as needs change throughout the course of a life-limiting illness. | ☐ N ☐ S ☐ P ☐ E |
| 4.13 | Identifies and documents when a referral is needed to support palliative and end of-life decision making and provides necessary follow-up. | ☐ N ☐ S ☐ P ☐ E |
| 6. | **Resident-Centred Care Delivery (Psychosocial/Spiritual Needs)**<br>***Provides resident-centred care delivery by addressing the psychosocial and spiritual needs of the resident and family.*** | |
| 5.1 | Recognizes and responds to the unique end-of-life needs of various populations, such as elders, multicultural populations, those with cognitive impairment, language barriers, those with chronic diseases, mental illness and marginalized populations. | ☐ N ☐ S ☐ P ☐ E |
| 5.2 | Recognizes and responds to the unique needs or backgrounds of residents of varying ethnicities, nationalities, cultures and abilities that may affect their experience of palliative and end-of-life care. | ☐ N ☐ S ☐ P ☐ E |
| 5.3 | Identifies who "the family" is for the resident, and responds to family members' unique needs and experiences when sharing information and arriving at decisions. | ☐ N ☐ S ☐ P ☐ E |
| 5.4 | Ability to build and maintain therapeutic relationships until end-of-life and bereavement. | ☐ N ☐ S ☐ P ☐ E |
| 5.5 | Demonstrates openness and sensitivity to social, spiritual/religious and cultural values and practices that may influence palliative and end-of-life care preferences of the resident and family. | ☐ N ☐ S ☐ P ☐ E |
| 5.6 | An ability to use active listening skills to recognize unmet spiritual and religious needs. | ☐ N ☐ S ☐ P ☐ E |
| 5.7 | Demonstrate a wide range of skills to recognize, assess, and address the complex spiritual and religious needs of residents/families. | ☐ N ☐ S ☐ P ☐ E |
| 5.8 | Ability to develop and provide a plan for spiritual care based on spiritual or religious need. | ☐ N ☐ S ☐ P ☐ E |
| 5.9 | Commitment to resident and family-centred care that acknowledges what is meaningful to individual residents and families. | ☐ N ☐ S ☐ P ☐ E |
| 5.10 | Provides the opportunity for the resident approaching end-of-life to conduct a life review. | ☐ N ☐ S ☐ P ☐ E |
| 5.11 | Recognition of one's own limitations/bias to manage difficult issues, referring on to appropriate members of the interprofessional team. | ☐ N ☐ S ☐ P ☐ E |
| 8. | **Pain and Symptom Management**<br>***Demonstrates knowledge and skill in providing holistic pain and symptom management for residents receiving palliative or end-of-life care.*** | |
| A. | **Screening/Assessment:** | |
| 8.1 | Demonstrates understanding of the concept of 'total pain' when caring for residents and their family members, which is inclusive of physical, emotional, spiritual, practical, psychological, and social elements. | ☐ N ☐ S ☐ P ☐ E |
| 8.2 | Utilizes best practice assessment tools for baseline and ongoing assessment of pain, including word descriptors, body maps, precipitating and alleviating factors, and documents pain assessments. | ☐ N ☐ S ☐ P ☐ E |

| | PALLIATIVE CARE COMPETENCY & DESCRIPTION | KNOWLEDGE/SKILL LEVEL<br>None (N) Some (S)<br>Proficient (P) Expert (E) |
|---|---|---|
| 6.3 | Demonstrates knowledge of the stepped approach to pain assessment based on the type and severity of the pain. | ☐ N ☐ S ☐ P ☐ E |
| 6.4 | Demonstrates knowledge of special considerations of pain and symptom assessment and management for older adults with life-limiting illnesses and special needs (e.g. impaired cognition, communication). | ☐ N ☐ S ☐ P ☐ E |
| 6.5 | Understands causes of common non-pain symptoms at end-of-life. | ☐ N ☐ S ☐ P ☐ E |
| 6.6 | Assesses common non-pain symptoms at end-of-life. | ☐ N ☐ S ☐ P ☐ E |
| B. | Addressing and Documenting Pain and Symptom Issues: | |
| 6.7 | Demonstrates knowledge of medication commonly used for pain and symptom management. | ☐ N ☐ S ☐ P ☐ E |
| 6.8 | Applies principles of pain and other symptom management when caring for residents receiving palliative or end-of-life care. | ☐ N ☐ S ☐ P ☐ E |
| 6.9 | Utilizes and documents evidence based pharmacological approaches to alleviate pain, including intended effects, doses and routes of administration, and common side effects. | ☐ N ☐ S ☐ P ☐ E |
| 6.10 | Utilizes and documents evidence informed non-pharmacological approaches to pain, including any potential adverse effects. | ☐ N ☐ S ☐ P ☐ E |
| 6.11 | Discusses, teaches, and assists the resident and family members in managing pain and other symptoms. | ☐ N ☐ S ☐ P ☐ E |
| 6.12 | Implements and documents evidence informed pharmacological and non-pharmacological approaches for non-pain symptoms at end-of-life. | ☐ N ☐ S ☐ K ☐ E |
| 6.13 | Effectively collaborates with the interprofessional team to manage pain and other palliative/end-of-life symptoms. | ☐ N ☐ S ☐ P ☐ E |
| C. | Evaluation: | |
| 6.14 | Evaluates and documents all outcomes of pain and symptom management interventions throughout the course of the resident's illness experience against a baseline assessment using comparative evaluations. | ☐ N ☐ S ☐ P ☐ E |
| 6.15 | Knowledge of components and processes of clinical assessment, including evaluation of interventions in relation to medical and psychosocial outcomes. | ☐ N ☐ S ☐ P ☐ E |
| 6.16 | Evaluates, reassesses and revises pain/symptom management goals and plan of care. | ☐ N ☐ S ☐ P ☐ E |
| 6.17 | Responds to potential side effects of medication, interactions, and complications. | ☐ N ☐ S ☐ P ☐ E |
| 7. | **End-of-Life Care & Death Management**<br>***Anticipates, recognizes, and responds to the signs and symptoms of imminent death and continues care provision after death.*** | |
| A. | End-of-life care: | |
| 7.1 | Assists the resident at end-of-life and family to: a) cope emotionally, b) maintain a desired level of control, c) communicate their preferences and needs, d) contact significant others, e) contact appropriate resources and support, f) interact meaningfully in the resident's last days. | ☐ N ☐ S ☐ P ☐ E |
| 7.2 | Assists the resident with life closure (e.g. completing business, closing relationships, saying goodbye). | ☐ N ☐ S ☐ P ☐ E |
| 7.3 | Provides comfort to the resident through touch, presence, sound/silence, positioning and softened light. | ☐ N ☐ S ☐ P ☐ E |
| 7.4 | Provides information and assurance to the resident and family members regarding comfort measures during the last days/hours of living. | ☐ N ☐ S ☐ P ☐ E |
| 7.5 | Assists in the education of residents and family members about end-of-life care issues and pain and symptom management. | ☐ N ☐ S ☐ P ☐ E |
| 7.6 | Knowledge of cognitive (decreased awareness, increased drowsiness, restlessness) and physical changes (profound weakness, respiratory changes, skin colouration, difficulty swallowing, decreased urinary output) associated with imminent death. | ☐ N ☐ S ☐ P ☐ E |
| 7.7 | Teaches family members the signs of imminent death (cognitive/physical). | ☐ N ☐ S ☐ P ☐ E |
| 7.8 | Ability to describe and implement a supportive approach to suffering. | ☐ N ☐ S ☐ P ☐ E |
| 7.9 | Assists the resident and family to prepare for the time of death (e.g. providing resources regarding funeral arrangements, organ, tissue donation, developing a list of people to contact at time of death). | ☐ N ☐ S ☐ P ☐ E |
| 7.10 | Communicates promptly with appropriate staff about changes in the residents' status. | ☐ N ☐ S ☐ P ☐ E |
| B. | Death Management: | |
| 7.11 | Assesses and respects the family's need for privacy and closure at the time of death, offering presence as appropriate. | ☐ N ☐ S ☐ P ☐ E |
| 7.12 | Facilitates arrangements for pronouncement of death and certification of death, where appropriate. | ☐ N ☐ S ☐ P ☐ E |
| 7.13 | Facilitates opportunities for staff and residents to say good-bye. | ☐ N ☐ S ☐ P ☐ E |
| 7.14 | Provides care of the body for transportation. | ☐ N ☐ S ☐ P ☐ E |
| 8. | **Loss, Grief and Bereavement Support**<br>***Demonstrates knowledge of grief and bereavement and related skills in order to support others.*** | |
| 8.1 | Demonstrates knowledge of loss, grief and bereavement. | ☐ N ☐ S ☐ P ☐ E |

| | PALLIATIVE CARE COMPETENCY & DESCRIPTION | KNOWLEDGE/SKILL LEVEL<br>None (N) Some (S)<br>Proficient (P) Expert (E) |
|---|---|---|
| 8.2 | Demonstrates understanding of grief theories and their application to palliative and end-of-life care. | ☐ N ☐ S ☐ P ☐ E |
| 8.3 | Demonstrates understanding of the common, normal manifestations of grief (emotional, physical, cognitive, behavioural/social, and spiritual). | ☐ N ☐ S ☐ P ☐ E |
| 8.4 | Demonstrates understanding of individual, social, cultural, and spiritual variables that affect grief. | ☐ N ☐ S ☐ P ☐ E |
| 8.5 | Identifies situations when personal beliefs, attitudes and values result in limitations in the ability to be present for the resident and family members experiencing loss, grief, and/or bereavement. | ☐ N ☐ S ☐ P ☐ E |
| 8.6 | Supports the family's wishes and death rituals (e.g. religious, cultural, spiritual). | ☐ N ☐ S ☐ P ☐ E |
| 8.7 | Uses insights gained from personal experiences of loss, bereavement and grief to provide support to others. | ☐ N ☐ S ☐ P ☐ E |
| 8.8 | Listens, affirms, and responds compassionately to residents and family members working through grief and bereavement. | ☐ N ☐ S ☐ P ☐ E |
| 8.9 | Accurately assesses and documents the resident's and family members' needs related to loss, grief and bereavement. | ☐ N ☐ S ☐ P ☐ E |
| 8.10 | Identifies individuals experiencing, or at high risk for experiencing, a complicated and/or disenfranchised grief reaction, and discusses, documents and makes appropriate referrals. | ☐ N ☐ S ☐ P ☐ E |
| 8.11 | Provides guidance, support, and referrals to bereaved family members and documents this. | ☐ N ☐ S ☐ P ☐ E |
| 8.12 | Develops the capacity to be in the presence of suffering. | ☐ N ☐ S ☐ P ☐ E |
| 9. | **Research & Evaluation**<br>***Participates in research and evaluation activities, and applies knowledge gained from research in palliative care and related areas.*** | |
| 9.1 | Participates in the development, monitoring and evaluation of the quality of palliative care programs and services. | ☐ N ☐ S ☐ P ☐ E |
| 9.2 | When possible, participates in research activities appropriate to one's position/discipline. | ☐ N ☐ S ☐ P ☐ E |
| 9.3 | Provides family members with opportunities and information to participate in research about family caregiving at the end-of-life. | ☐ N ☐ S ☐ P ☐ E |
| 9.4 | Integrates current knowledge in approaches to palliative/end-of-life care practice (e.g. research-based standards, clinical guidelines, outcome measures). | ☐ N ☐ S ☐ P ☐ E |
| 10. | **Ethical and Legal Issues**<br>***Applies ethical knowledge skillfully when caring for residents receiving palliative or end-of-life care and their families.*** | |
| 10.1 | Collaborates with the resident, family, full term Substitute Decision Maker, and the interprofessional team to recognize and address ethical issues related to palliative and end-of-life care. | ☐ N ☐ S ☐ P ☐ E |
| 10.2 | Understands the importance of confidentiality and when to disclose and document information. | ☐ N ☐ S ☐ P ☐ E |
| 10.3 | Provides guidance to the resident/family in identifying and addressing relevant legal issues (e.g. advance/health-care directives, guardianship and trusteeship, power of attorney, proxy/substitute decision-maker). | ☐ N ☐ S ☐ P ☐ E |
| 10.4 | Supports informed decisions that the resident, family, full term Substitute Decision Maker, and interprofessional team have made. | ☐ N ☐ S ☐ P ☐ E |
| 10.5 | Uses an ethical process for addressing challenging issues and controversial clinical situations (e.g. palliative sedation, hydration, feeding, ventilation, withdrawing/withholding life-sustaining treatment, advance directives, full term Do Not Resuscitate orders). | ☐ N ☐ S ☐ P ☐ E |
| 11. | **Advocacy**<br>***Advocates for the needs, decisions, and rights of residents and families in palliative and end-of-life care; advocates to address clinical and policy issues.*** | |
| A. | Resident/Family Advocacy: | |
| 11.1 | Provides a voice at times when residents cannot speak for themselves, acting on the resident's behalf, to ask for things the resident would ask for themselves if able. | ☐ N ☐ S ☐ P ☐ E |
| 11.2 | Advocates for the resident and family members' timely access to relevant resources, and documents this. | ☐ N ☐ S ☐ P ☐ E |
| 11.3 | Identifies, verifies, and advocates for perceived and real needs of the resident and family members, and documents this. | ☐ N ☐ S ☐ P ☐ E |
| 11.4 | Commitment to, and promotion of, resident autonomy, self-determination, dignity, confidentiality, privacy and informed choice. | ☐ N ☐ S ☐ P ☐ E |
| B. | Organization/Professional Advocacy: | |
| 11.5 | Knowledge of health care and social systems and how they act as both resources and barriers. | ☐ N ☐ S ☐ P ☐ E |
| 11.6 | Ability to identify and address gaps in service. | ☐ N ☐ S ☐ P ☐ E |
| 11.7 | Advocates for the development, maintenance and improvement of health care and social policy related to palliative care in the long term care setting. | ☐ N ☐ S ☐ P ☐ E |
| 11.8 | Advocates for health care professionals to have continuing education and adequate resources to provide quality palliative care. | ☐ N ☐ S ☐ P ☐ E |

| PALLIATIVE CARE COMPETENCY & DESCRIPTION | KNOWLEDGE/SKILL LEVEL<br>None (N) Some (S)<br>Proficient (P) Expert (E) |
|---|---|
| 11.9 Advocates for institutional acknowledgement and support of staff grief and bereavement related to the loss of residents. | ☐ N ☐ S ☐ P ☐ E |
| 12. Interprofessional & Collaborative Practice<br>*Demonstrates the ability to collaborate effectively within an integrated interprofessional team, including non-professional health care providers, family members and the resident himself or herself.* | |
| 12.1 Recognizes that effective palliative care is best provided by an interprofessional team. | ☐ N ☐ S ☐ P ☐ E |
| 12.2 Demonstrates knowledge of own role and the role of other team members in providing palliative and end-of-life care, and areas where roles may overlap. | ☐ N ☐ S ☐ P ☐ E |
| 12.3 Builds on collaborative relationships with residents and family members, and members of the interprofessional palliative care team in determining resident's goals and plan of care. | ☐ N ☐ S ☐ P ☐ E |
| 12.4 Respects and considers the opinion, knowledge, and skills of others in a shared decision-making process regarding the priorities of care for the resident. | ☐ N ☐ S ☐ P ☐ E |
| 12.5 Possesses knowledge of the issues related to confidentiality within team practice. | ☐ N ☐ S ☐ P ☐ E |
| 12.6 Communicates respectfully with the interprofessional team using effective communication skills including conflict management. | ☐ N ☐ S ☐ P ☐ E |
| 12.7 Reflects on the need for different interprofessional team approaches in different situations. | ☐ N ☐ S ☐ P ☐ E |
| 12.8 Recognizes when to refer on to other members of the interprofessional team and clearly articulates reason for referral. | ☐ N ☐ S ☐ P ☐ E |
| 12.9 Contributes as an effective member of the interprofessional team. | ☐ N ☐ S ☐ P ☐ E |
| 13. Professional Development/Mentorship (Self-Care, Awareness, and Reflection)<br>*Commitment to professional development, the mentoring and support of other team members, and recognition of the importance of self-care, awareness, and reflection.* | |
| A. Self- care, awareness, and reflection:<br>13.1 Self-assesses one's own attitudes and beliefs about death and dying and caring for people at the end-of-life. | ☐ N ☐ S ☐ P ☐ E |
| 13.2 Recognizes how personal attitudes, values, and beliefs related to spirituality, religion, culture and ethnicity may influence care provision. | ☐ N ☐ S ☐ P ☐ E |
| 13.3 Demonstrates self-awareness of the unique stressors in providing palliative/end-of-life care for residents and family members and utilizes self-care and coping strategies to promote personal wellbeing. | ☐ N ☐ S ☐ P ☐ E |
| 13.4 Recognizes and takes appropriate measures to cope with multiple and cumulative losses and grief reactions (e.g. peer support, debriefing, physical/social activities). | ☐ N ☐ S ☐ P ☐ E |
| B. Professional Development:<br>13.5 Identifies gaps in knowledge, skills, and abilities as a first step in acquiring new knowledge, skills, and abilities for palliative and end-of-life care. | ☐ N ☐ S ☐ P ☐ E |
| 13.6 Participates in ongoing educational activities, including in-house training, supervision opportunities, and applies new knowledge to practice. | ☐ N ☐ S ☐ P ☐ E |
| 13.7 Stays up-to-date on developments in one's profession. | ☐ N ☐ S ☐ P ☐ E |
| 13.8 Advertises palliative care education opportunities and resources within the long term care home. | ☐ N ☐ S ☐ P ☐ E |
| C. Mentorship/Support:<br>13.9 Recognizes and addresses indicators of moral distress in self and in other team members and seeks appropriate support. | ☐ N ☐ S ☐ P ☐ E |
| 13.10 Act as a resource for knowledge, support, mentorship, training and education for other health care professionals, families, students, and volunteers when applicable/appropriate. | ☐ N ☐ S ☐ P ☐ E |

# Sample Education Tracking Form

**Sample Staff Tracking Sheet – Annual Palliative Care Education**

| Staff Name | Discipline | Orientation | PCFLW | LEAP | In-Svc (S) | Soc His | PSNO Conf | Total Hours |
|---|---|---|---|---|---|---|---|---|
| Jane Doe | RN | ✓ | ✓ | ✓ | ✓ | ✓ | | 31 |
| David Brown | PSW | ✓ | ✓ | | ✓ | ✓ | ✓ | 25 |
| John Doe | PSW | ✓ | ✓ | | | | ✓ | 17 |
| Shelia Jones | RPN | ✓ | ✓ | ✓ | | | | 29 |
| Janet Smith | Dietary | ✓ | | | | | | 1 |
| Jessica Johnson | Social Work | ✓ | ✓ | | | | | 16 |
| Sarah Stewart | LEA | ✓ | ✓ | | | ✓ | | 17 |
| Lisa Heron | Maintenance | ✓ | | | | | | 1 |
| Bob Sims | Physician | ✓ | | ✓ | | | | 14 |
| Beth Forbes | Spiritual Care | ✓ | ✓ | | | | | 16 |
| Jim Kern | Pharmacist | ✓ | | ✓ | | | | 14 |
| Sally Hart | Dietary | ✓ | | | | | | 1 |
| Jack Trent | PSW | ✓ | | | ✓ | ✓ | | 3 |
| Jen Stern | PSW | ✓ | ✓ | | | | ✓ | 22 |
| Sasha Holt | PSW | ✓ | | | ✓ | ✓ | | 3 |
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**Legend:**
Orientation – Introduction to Palliative Care, Palliative Care Program/Services in the LTC home
PCFLW- Palliative Care for Frontline Workers
LEAP- Learning Essential Approaches to Palliative and End of Life Care
In-Svc (S) – In-Service on Spirituality
Soc His – Social History Training
PSNO Conf – Personal Support Network of Ontario Conference
Total Hour – Total Hours of Palliative Care Education for the Year

# Sample Education Plan

**Sample Palliative Care Education Plan**

| DISCIPLINE/ DEPARTMENT | ORIENTATION (MONTHLY) | YEARLY | | | |
|---|---|---|---|---|---|
| | | BASIC | | ADVANCED | |
| | | EDUCATION OFFERED | TARGET DATE | EDUCATION OFFERED | TARGET DATE |
| Physician | -Introduction to PC and PC Program/Services | | | -Learning Essential Approaches to Palliative and End of Life Care (LEAP) | Oct 21/12 |
| RN/RPN | -Introduction to PC and PC Program/Services | -In-Service on Spirituality<br>-Social History Training | Feb 12/12<br>Jul 15/12 | -Learning Essential Approaches to Palliative and End of Life Care (LEAP) | Oct 21/12 |
| PSW | -Introduction to PC and PC Program/Services | -Palliative Care for Frontline Workers (PCFLW)<br>-In-Service on Spirituality<br>-Social History Training | Mar/Apr/12<br>Feb 12/12<br>Jul 15/12 | -Personal Support Network of Ontario (PSNO) Conference | Oct 15/12 |
| Social Work | -Introduction to PC and PC Program/Services | -Palliative Care for Frontline Workers (PCFLW) | Mar/Apr/12 | | |
| Spiritual Care | -Introduction to PC and PC Program/Services | -Palliative Care for Frontline Workers (PCFLW) | Mar/Apr/12 | | |
| Occupational/ Physical Therapist | -Introduction to PC and PC Program/Services | | | | |
| Pharmacist | -Introduction to PC and PC Program/Services | | | -Learning Essential Approaches to Palliative and End of Life Care (LEAP) | Oct 21/12 |
| Psychologist | -Introduction to PC and PC Program/Services | | | | |
| Speech Pathologist | -Introduction to PC and PC Program/Services | | | | |
| Life Enrichment Aid | -Introduction to PC and PC Program/Services | -Palliative Care for Frontline Workers (PCFLW)<br>-Social History Training | Mar/Apr/12<br>Jul 15/12 | | |
| Housekeeping | -Introduction to PC and PC Program/Services | | | | |
| Maintenance | -Introduction to PC and PC Program/Services | | | | |
| Dietary Aid | -Introduction to PC and PC Program/Services | | | | |
| Volunteers | -Introduction to PC and PC Program/Services | -Hospice Northwest Volunteer Training | Feb/Apr/Jun/ Sept/Nov/12 | | |

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## Key Partners

Lakehead University | McMaster University | Halton Region | St. Joseph's Care Group

## Funders

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