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 None (N) Some (S) Proficient (P) Expert (E)
1. <u>Palliative Care Philosophy:</u> ***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. <u>Communication & Information-Sharing with Residents & Families</u> ***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. <u>Assessment & Documentation</u> ***Demonstrates the ability to conduct and document comprehensive assessments on an ongoing basis to inform decision-making and facilitate care planning and delivery.***	
A. <u>Assessment:</u> 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

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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
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: 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
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.***	
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
6. Pain and Symptom Management	

PALLIATIVE CARE COMPETENCY & DESCRIPTION	KNOWLEDGE/SKILL LEVEL None (N) Some (S) Proficient (P) Expert (E)
Demonstrates knowledge and skill in providing holistic pain and symptom management for residents receiving palliative or end-of-life care.	
A. **Screening/Assessment:**	
6.1 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
6.2 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
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** ***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

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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 ***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
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 ***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 ***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 ***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

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11.4 Commitment to, and promotion of, resident autonomy, self-determination, dignity, confidentiality, privacy and informed choice.	☐ N ☐ S ☐ P ☐ E
B. <u>Organization/Professional Advocacy:</u> 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
11.9 Advocates for institutional acknowledgement and support of staff grief and bereavement related to the loss of residents.	☐ N ☐ S ☐ P ☐ E
12. <u>Interprofessional & Collaborative Practice</u> ***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. <u>Professional Development/Mentorship (Self-Care, Awareness, and Reflection)</u> ***Commitment to professional development, the mentoring and support of other team members, and recognition of the importance of self-care, awareness, and reflection.***	
A. <u>Self- care, awareness, and reflection:</u> 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. <u>Professional Development:</u> 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. <u>Mentorship/Support:</u> 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