BC Centre for Palliative Care

Revision Dec. 2024

# BC Centre for Palliative Care
# Inter-professional Palliative Competency Framework
# **-revised**

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This Framework was adapted from the Palliative Care Competence Framework1, with the permission of Ireland Health Service Executive and The Nova Scotia Palliative Care Competency Framework,2 with the permission of the Nova Scotia Health Authority.

Competency statements within the Health Care Assistant-specific competencies with quotation marks are directly quoted from the BC Provincial HCA (Health Care Assistant) Curriculum Guide.[3]

Social Worker / Counsellor-Specific competencies were informed by the Canadian Social Work Competencies for Hospice Palliative Care: A Framework to Guide Education and Practice at the Generalist and Specialist Levels.[4]

Physician and Nurse Practitioner – specific competencies were adapted with permission from The Canadian Society of Palliative Care Physicians. Educating Future Physicians in Palliative and End of Life Care (EFPEC): Palliative Care Competencies for Undergraduate Medical Students in Canada.[5] The language was adapted to apply to practicing physicians rather than medical students, modified slightly for a B.C. context and categorized into domains. At the request of B.C. physicians, the competencies for Generalist-ALL practice include the relevant CanMEDS roles, in brackets after each domain.[6] The physician-specific competencies are also line with the scope of practice for B.C. Nurse Practitioners.[7] Nurse Practitioners have reviewed these competencies and have determined them to be applicable to their practice in addition to the discipline-specific competencies for nurses.

In November of 2024, this document was updated with permission. The names of the domains were adapted to align with The Canadian Interdisciplinary Palliative Care Competency Framework,[17] and the B.C. content has been re-organized into Domains 1-11. Domain 12, Virtual Care, was not included in the original B.C. document so competency statements have been adopted from the Canadian Framework. All modified and new language is identified by **bold** text and an asterisk *. The competency statements within the other domains are unchanged from 2019 and will be adapted in the future.

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## Introduction

This palliative competency framework, originally created in 2019, has now been revised to align with the language of the Canadian Interdisciplinary Palliative Care Competency Framework,[17](Canadian Framework), while maintaining the components specific to the B.C. context. The framework will continue to be foundational to the development of educational resources, professional development pathways and service delivery models. We recognize the valuable contributions of the Pall Ed Advisory Council to this revision (see Appendix A for a list of members).

## Background

The Pall Ed Advisory Council (the Council), facilitated by the BC Centre for Palliative Care (BCCPC) is comprised of educators and leaders from each B.C. health authority and several province-wide organizations. The Council directs activities to support health care providers (HCPs) to deliver high-quality palliative care in all regions of B.C. Previously known as Pall Ed BC: Community of Practice for Palliative Care Education, the Council oversaw the Competency Framework Committee which created the initial BCCPC Inter-professional Palliative Competency Framework in 2019.[18] For a list of contributors to the 2019 framework, see Appendix B.

The 2019 framework informed several Council and BCCPC activities including a review of educational resources,[19] development of a provincial education framework[20] and education action plan,[21] creation of eight online modules; Strengthen Your Core! Palliative Competencies[22] and accompanying ECHO program; Flex your Core! The Palliative workout.[23]

The initial BC Framework included some of the formal HCPs who care for people with life-limiting conditions. Disciplines included: Physicians and Nurse Practitioners, Nurses (Nurse Practitioners, Licensed Practical Nurses, Registered Psychiatric Nurses and Registered Nurses), Psychosocial care providers (Social Workers and Counsellors) and Health Care Assistants (HCAs). These disciplines (referred to throughout this document as “initial disciplines”) were chosen because they are the most common HCPs working with people with life-limiting conditions across the most settings. Other disciplines are also vital to team- based care and will be included in the future as resources allow.

In 2021, the B.C. Hospice Volunteer Competency Framework[24] was created through collaboration with BCCPC, the Provincial Hospice Working Group and representatives from many B.C. hospice associations. Since that framework was informed by the Canadian Framework, it will not be revised at this time.

The competencies were created to span across settings and populations; recognizing that each local context would determine the ideal HCP composition and relevant competencies for their population and setting.

## Definitions

**Palliative care:** According to the World Health Organization, "Palliative care … improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual." [15]

**Palliative approach to care (PAC):**[16] The adoption of palliative care principles and adaptation of palliative knowledge and expertise to chronic life-limiting conditions. PAC may be incorporated into care by HCPs in a variety of care settings. A palliative approach is characterized by:

- Upstream identification of people with life-limiting conditions and their families, and addressing their needs based on the knowledge of the life-limiting nature of their specific condition or conditions.
- Adaptation of palliative knowledge and expertise to specific patient populations and contexts.
- Integration of PAC into systems and models of care that do not specialize in palliative care.

**People:** Throughout this document, "people" and "person" refer to the recipient of care, the one who has a life-limiting condition; this includes terms such as "patient", "client" or "resident".

**Life-limiting condition:** Any condition or illness which is progressive and could cause the death of the person; this includes "serious illness", "life-threatening illness", "terminal illness", and other similar terms.

**Competency:** The performance of critical work functions using related knowledge, skills and abilities.[9, 10]

**Health Care Assistants:** This term includes many roles such as Community Support Worker, Health Care Aide, Nurses' Aide, Home Support Worker, Long Term Care Aide, etc. The Canadian Framework uses the term "Personal Support Worker" [17]

## Approach

Following the release of the Canadian Framework, the Council recognized the benefits of aligning the language and structure of this B.C. Framework and BCCPC education materials. However, two elements specific to the B.C. context were identified as essential to retain:

- Core competencies,[25] which are fundamental and shared by all the initial disciplines at a basic level.
- The Enhanced (SOME) category in the discipline-specific competencies. HCPs in this category may provide care in any setting but focus their practice more on people with

life-limiting conditions. They provide enhanced care for more complex needs and consult with specialists as required. They are a resource for colleagues within their local environment and may support people who are not directly assigned to their care.

The overarching goal is to fully adopt the Canadian Framework, supplemented with additional content related to Core competencies and the Enhanced category for each initial discipline. To achieve this, the Council implemented a phased approach:

1. **Initial Alignment**:
    - The names of the competency domains were adapted, and the B.C. content was reorganized into Domains 1–11, retaining the original 2019 competency statements within each domain.
    - A new Domain 12: Virtual Care was incorporated, adopting competency statements directly from the Canadian Framework, as this domain was not included in the original B.C. Framework.
2. **Educational Material Updates**:
    - As of January 2024, all newly developed educational materials by BCCPC are based on the revised B.C. Framework.
    - Pre-existing BCCPC materials will be gradually updated to align with the nomenclature of this revised framework.
3. **Integration Phase**:
    - Starting in 2025, the Canadian Framework content will be adopted for the discipline-specific competencies. A working group will develop statements for the Enhanced (SOME) category and integrate them into the framework. The group will also consider if the Core competencies need to be updated at that time.

This strategic and phased approach ensures that the revised B.C. Framework remains contextually relevant while benefiting from the consistency and comprehensiveness of the Canadian Framework.

## Competency framework structure

The framework has four components which will be described: competency triangle; competency domains; core competencies; and discipline-specific competencies.

## Competency triangle (Health care provider categories)

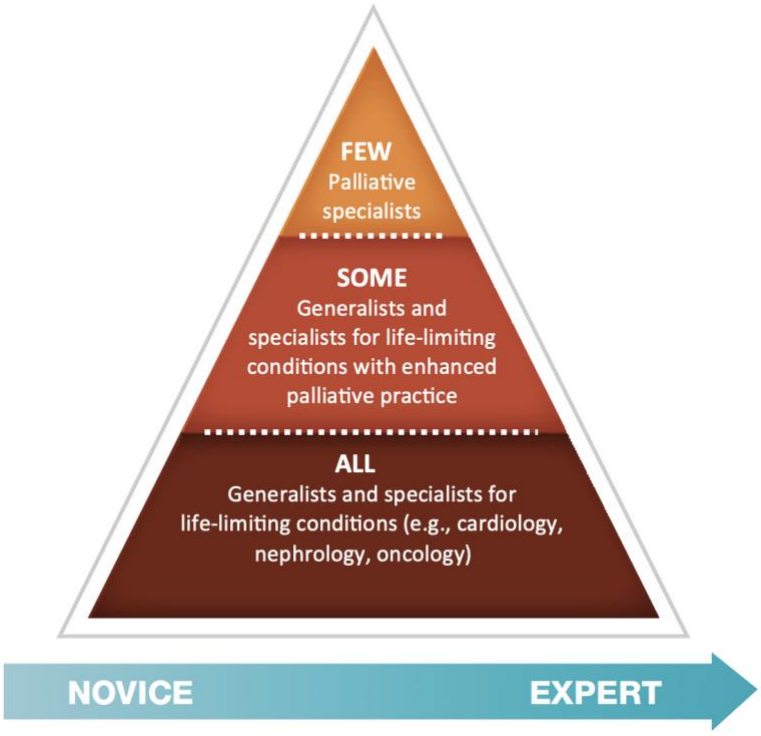


Figure 1 – Competency triangle

The competency triangle is the foundational structure of the framework (Figure 1). It is divided horizontally into three HCP categories of specialization represented by FEW, SOME and ALL. The triangle image and HCP categories were adapted from the Irish framework[1] to represent the relative numbers of HCPs required to meet the needs of the population.

Each HCP category includes the competencies from the ones below it in the diagram (e.g., HCPs in the SOME category may have competencies in both the SOME and ALL categories). Through continuing education and experience, HCPs should aim to move from novice to expert within a category (i.e., horizontal progression), whereas changing categories (i.e., vertical progression) is not necessarily the goal. For example, a HCP working on a medical ward could move from novice to expert in providing a palliative approach and remain in the ALL category.

B.C. health authorities and organizations may review the competencies and descriptions for each category and determine the requisite staffing mix to meet the needs of the people they care for. This framework does not identify specific care settings or roles for the categories. Rather, the following general descriptions guided the categorization:

**Generalist (ALL):** These HCPs provide direct care for any person, including those with life-limiting conditions, in any care setting. They use evidence-based guidelines and consultation with HCPs with enhanced or specialized palliative practice to provide care for people with basic needs. HCPs in the ALL category are a resource for people and their families, contributing regularly to inter-professional collaboration.

**Enhanced Practice (SOME):** HCPs in this category also provide care in any setting but these workers focus their practice more on people with life-limiting conditions. They provide enhanced care for more complex needs and consult with specialists as required. They are a resource for

colleagues within their local environment and may support people who are not directly assigned to their care.

**Specialist (FEW):** This category of HCPs provides direct palliative care for people with the most complex needs. They are a resource for HCPs along with people inside and outside of their local setting. They may also contribute to quality improvement on a system level.

## Description of competency domains


The competency domain names were adapted to align with the Canadian palliative care competencies.[17] The domains include core competencies and discipline-specific competencies in each category of Generalist (ALL), Enhanced Practice (SOME) and Specialist (FEW) in the triangle; the twelve domains together form a pie shape (Figure 2). Every HCP is responsible for both the core competencies and the competencies specific to their discipline and category.

**Figure 2 – The 12 competency domains**

The descriptions and icons are directly copied from the Canadian Competencies.[17] Used with permission.

**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 health care. Through self-reflection and consideration of the concepts of racism, discrimination, and prejudice, healthcare 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 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 caregivers 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 caregivers' 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 caregivers, 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 caregivers' care needs that are unique to the last days and hours of a person's life.

**7. Loss, grief, and bereavement**

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

**8. Self-care**
Self-care is paramount for healthcare 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 caregivers' values, needs, and wishes, while the healthcare provider maintains professional and personal integrity. This domain guides decision-making as life-limiting illnesses progress and healthcare 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 caregivers' 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 health care 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.

## Core competencies[25]

Core competencies are categorized within each domain and are shared by the initial disciplines. They are made explicit to emphasize the commonalities amongst the disciplines and to inform development of inter-professional educational materials. Each HCP is responsible for competencies according to their role, experience and education, as determined by their regulating body, the law, and agency policies. These competencies were created by analyzing discipline-specific national documents available at that time, to find shared competency expectations.[4, 5, 13-14] Then, clinical consultants for each discipline validated the statements.

## Discipline-specific competencies[26]

Each discipline has competencies which are unique to their profession. These were determined by reviewing provincial and national standards, [4, 5, 13-14] as well as the two original source documents.[1, 2] Clinical consultants for each discipline as well as the Committee and Pall Ed BC provided input, review and final approval.

## Conclusion

This revised competency framework builds on the foundational BC Framework and aligns with the Canadian Interdisciplinary Palliative Care Competency Framework to reflect both national standards and the unique needs of the province. Ideally, it will serve to enhance both pan-Canadian and intra-provincial collaboration towards the shared goal of equitable access to high-quality palliative care.

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