CPCNA | Canadian Palliative Care Nursing Association
ACSIP | Association Canadienne des Soins Infirmiers Palliatifs

STANDARDS OF PRACTICE

January 2020

ACKNOWLEDGMENTS

This work is dedicated to the individuals and families who have inspired us to continuously improve palliative care nursing.

The CPCNA Standards were adapted from the Canadian Palliative Care Nurses Group Standards, 2019 edition.

Members of the 2021 Standards development committee are:

Mahoganie Hines RN, BScN, CHPCN(C)
Julia Johnston RN-EC, MN, CHPCN(C)
Janice Nesbitt RN, BScN, MN CHPCN(C)
Jeanne Weis RN, LPN, MN, CHPCN(C)

CPCNA Standards, inaugural edition were accepted by the CPCNA Board of Directors January, 2021.

In-kind support for this project was provided by the following:
College of Licensed Practical Nurses of Alberta, AB
Hospice Niagara, ON
Winnipeg Regional Health Authority, MB

CITATION

The Canadian Palliative Care Nursing Association Standards of Practice are relevant to nurses who work with people with palliative care needs, and their family in any setting. The recommended citation is:

Canadian Palliative Care Nursing Standards Committee. (2021). *Canadian palliative care nursing standards of practice.* Canadian Palliative Care Nursing Association.

TABLE OF CONTENTS – to be completed after content approved.

Canadian Palliative Care Nursing Association Vision, Mission and Purpose

VISION

The Vision of the Association is to:

- Live well;
- Die well;
- Nurse well.

MISSION

The mission of the Association is to:

- Cultivate a community of nurses who care for people affected by serious and life limiting illness.
- Inspire knowledgeable and compassionate nursing practice.
- Establish the highest national standards of palliative and end of life care.

PURPOSE

The purpose of the Association is to promote public health by:

1. Promoting equitable access for all Canadians to palliative care by strengthening the competence and confidence of nurses specialized in palliative care;
2. Providing information to support public awareness and understanding of palliative care and advance care planning;
3. Educating the public and allied health professional, community, and government groups about the practice of palliative care nursing;
4. Maintaining adherence to the Canadian Nurses Association (C.N.A) code of ethics and the values of a palliative approach, and educating the public, industry, and government on the same;
5. Defining, evaluating, and revising core clinical competencies for palliative care nurses;
6. Developing a national standard of practice for palliative care nursing maintaining relevancy by reviewing and updating every five years;
7. Promoting palliative care education for all nurses and the integration of a palliative approach supporting eligibility for Canadian Nurses Association certification; and
8. Supporting research in the field of palliative care.

FOREWORD

The Canadian Palliative Care Nursing Association (CPCNA) *Standards* (here-after referred to as the *Standards*) have been developed to define professional expectations for nurses whose practices involves the health and welfare of people with palliative care needs, and their family. The Standards support nurses in their roles as clinicians, consultants, educators, administrators, researchers and educators to deliver and promote high quality palliative care nursing.
The Standards also inform people with palliative care needs and the public of what to expect from nurses.

The *Standards* are numbered but not ranked. All standards in this document are of equal importance and are interrelated.

The *Standards* apply to all nurses who specialize in the provision of palliative care, regardless of their role, setting or job description. The CPCNA recognizes that all nurses who work with people and families require skills and competencies in palliative care nursing so encourages all nurses who work with people with palliative care needs and their family to use these standards to guide their practice, practice environment supports and policies.

It may be helpful to be familiar with the most current Canadian Nurses' Association (CNA) Hospice Palliative Care Nursing Certification *Exam Specialty Competencies* available on the CNA website at https://cna-aiic.ca

The CPCNA Executive is responsible to ensure routine standards review and revision at least every 5 years. The process is completed through the development of an ad hoc CPCNA Standards sub-committee with committee membership consisting of CPCNA Board members and Association members in good standing. The CPCNA strives to include sub-committee members from diverse regions across Canada and include clinical, administrative, research, and education sectors. The CPCNA Board of Directors is responsible for final approval of the standards and executing their distribution.

Maintaining Competency

The Canadian Nurses Association recognizes PC nurses as specialists in palliative care and confers the designation CHPCN(C). The CNA offers certification credentialing as part of its national certification program. Certification credentials demonstrate to patients, employers, the public, and professional licensing bodies, that the certified nurse is qualified, competent and current in a nursing specialty. Certified nurses have met the rigorous requirements to achieve this expert credential. CNA certification must be renewed every five years and confirms proficiency in the nursing specialty (CNA, 2013).

The CPCNA encourages nurses practicing in specialties other than palliative care, who work with people with life limiting illnesses and/or older adults to consider dual certification in their specialty and palliative care nursing.

DEFINITION OF PALLIATIVE CARE

The World Health Organization defines palliative care as an approach improving the quality of life of people and their families facing 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 (World Health Organization, 2014).

Palliative care:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as part of the normal process of living
- neither hastens nor prolongs death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the person’s illness and throughout their own bereavement
- enhances quality of life, and may also positively influence the course of illness
- is offered early in the course of the illness, in conjunction with other therapies intended to prolong life, and includes investigations to better understand and manage distressing clinical complications (World Health Organization, 2014).

ASSUMPTIONS AND VALUES

Listed below are assumptions and values about person, environment, health, and nursing, which underpin Palliative Care nursing practice. As in all areas of nursing, the *CNA Code of Ethics for Registered Nurses* (2017) provides a foundation for Palliative Care nursing.

Person

“You matter because you are you and you matter to the last moment of your life. We will do all we can to help you, not only to die peacefully but to live until you die” (Saunders, 1976).

- The unit of care is the person living-dying with life-limiting illness and the person’s family.
- The family is defined by the person.
- Each person is unique and has intrinsic value.
- The person and family have the right to be informed and to participate in decisions and care to the degree that they wish.
- The person has the right to receive individualized care that aligns with changing personal meanings and hopes.
- The person refers to those who are at any stage across the lifespan, of any population, in any setting.

Environment

- To the extent possible, care is:
    - provided in the setting chosen by the person and family o available at primary, secondary and tertiary levels
    - accessible in any setting: community, acute, long-term care, hospice or complex care setting in urban, rural and remote areas.
- Care resources may vary widely and are provided through the collaborative practice of members of an interprofessional team to meet the holistic needs of the person and the family living with chronic or life-limiting illness.
- Care spans the continuum from diagnosis until death of the person and includes the family bereavement period.

Health

- Health is a dynamic and continuous process in which a person aspires to well-being and quality of life.
- Each person defines his/her quality of life.
- Living-dying is a natural process.
- Health includes experiences of living-dying, loss, grief and suffering. These experiences may provide opportunities for personal growth.
- Health promotion, in the setting of life-limiting illness, relates to quality of life.

Nursing

- Nurses advocate for and support persons in their experience of living-dying.
- Nurses provide comprehensive, coordinated, compassionate and holistic care.
- Palliative Care nursing practice attends to pain and other symptom relief; and, psychosocial, grief and bereavement support.
- Palliative Care nursing includes all areas of practice: clinical, education, administration, research and advocacy.

CANADIAN PALLIATIVE CARE NURSING ASSOCIATION STANDARDS

The palliative nurse maintains and conducts practice in a manner that is congruent with the Canadian Nurses Association *Code of Ethics* and relevant provincial or territorial standards. The following *Standards* pertain to specialized palliative (PC) nursing.

1. Person and Family-Focused Care

The Palliative Care nurse focuses on the quality of the experience of the person who is living with and dying from a life-limiting illness, as well as the experience of the family.

The Palliative Care nurse practices with respect for the personal meanings, specific needs, and hopes of the person throughout the illness trajectory and his/her family.

The Palliative Care nurse is mindful of and sensitive to the ways that their own communication influences the experiences of – and shapes their relationships with – persons and families.

2. Comfort

The Palliative Care nurse utilizes a knowledge-based, systematic, holistic and evolving approach to addressing symptoms and issues specific to the living-dying experience.

3. **Coordination and Navigation**

The Palliative Care nurse coordinates care throughout the illness and transitions trajectory. Transitions may occur over a short period of time (sudden death) or may be a longer process (exacerbations of chronic illness or recurrences of disease). The HPC nurse coordinates and supports the person and his/her family during transitions, the dying process, and grief and bereavement processes.

The Palliative Care nurse assists persons and families to access and navigate the health-care system.

4. **Quality and Safety**

The Palliative Care nurse practices in accordance with legislation, policies, and accepted guidelines and tools in fulfilling responsibilities, including but not limited to: assessment, care planning (including advance care planning), documentation, information sharing, decision-making, pain and symptom relief, pronouncement of death, after death care, and grief and bereavement support.

5. **Leadership**

The Palliative Care nurse advocates for and promotes high quality and safe palliative care.

The Palliative Care nurse advances Palliative Care nursing through the generation, critical analysis, and application, and dissemination of knowledge and research.

The Palliative Care nurse is an essential team member of the interprofessional team and establishes collegial partnerships and contributes to the professional development of students, peers, colleagues and others through consultation, education, leadership, and mentorship.

The Palliative Care nurse communicates and advances the distinct contribution of nursing to the care of people and family members.

The Palliative Care nurse advocates for the skillful integration of a palliative approach in all settings where persons live and die with chronic and life-limiting conditions.

The Palliative Care nurse recognizes and responds to the ‘double vulnerability’ of many Canadians, i.e., the ways that persons are vulnerable not only because they are ill or dying, but also because of structural conditions that interfere with their access to the social determinants of health.

6. Personal and Professional Growth

The Palliative Care nurse recognizes the privileges and challenges of working with persons who are living-dying and their families.

The Palliative Care nurse understands his/her own personal experience in response to suffering and death.

The Palliative Care nurse recognizes his/her personal needs and practices self-care while experiencing multiple losses during the care of persons who are dying and their families.

7. End-of-life care options

The Palliative Care nurse understands and practices within the law regarding the different options available to Canadians for end-of-life care. These options include, but are not limited to, the withdrawal and withholding of unwanted treatment, palliative sedation, and medical assistance in dying (MAiD).

Regardless of what options are chosen by the patient and family, the Palliative Care nurse:

- Engages with persons who are living-dying and their families to understand their wishes and to support alleviation of all types of suffering.
- Recognizes that they have an ongoing responsibility to provide palliative care to persons who are also pursing MAiD, when such care is desired by the person and their family.
- Ensures that they do not impose their own beliefs onto the person and family.
- Understands the regulatory requirements and legalities of MAiD in their jurisdiction of practice.

GLOSSARY

These definitions are to assist nurses in understanding the context of the CPCNA Nursing standards.

Accountability: Nurses are accountable for their actions and answerable for their practice. As members of a self-regulating profession, nurses practice according to the values and responsibilities in the *Code of Ethics for Registered Nurses* and in keeping with the professional standards, laws and regulations supporting ethical practice (*CNA Code of Ethics for Registered Nurses*, 2017).

Advance care planning: Advance care planning is a process of reflection and communication about values and wishes, letting others know a person's future health care personal care preferences in the even that they become incapable of consenting to or refusing treatment or other care. (Speak Up Canada, 2021)

Advocacy-based care: Described as a guiding principle of HPC, it is understood that "regular interaction with legislators, regulators, policy makers, health care funders, other hospice palliative care providers, professional societies and associations, and the public increases awareness of hospice palliative care activities and the resources required to support them" (CHPCA, 2013a, p. 8).

Autonomy: Each person is considered to be an "autonomous and unique individual. Care is guided by quality of life as defined by the individual. Care is only provided when the person and family are prepared to accept it" (CHPCA, 2013a, p. 7).

Bereavement: Bereavement is not only the loss of a significant person but also the period of transition for the bereaved individual following that person's death (Stroebe & Schut, 1999). Bereavement is a broad term that encompasses the entire experience of family members and friends in the anticipation, death, and subsequent adjustment to living following the death of a loved one (Christ, Bonanno, Malkinson & Rubin, 2003).

Competencies: These are significant job-related knowledge, skills, abilities, attitudes, and judgment required for competent performance by members of the profession. More detailed than standards and written in behavioral terms, competencies are suitable for examination purposes (ASI, 2009).

Evidence-informed and knowledge-based: A guiding principle of HPC is that "[t]he development, dissemination, and integration of new knowledge improves the quality of hospice palliative care. All activities are based on the best available evidence. Ongoing education of all persons, families, caregivers, staff and stakeholders is integral to providing and advancing quality hospice palliative care" (CHPCA, 2013a, p. 8).

Family: These references those who are most closely affiliated to and knowledgeable about the person, with regard to care needs and preferences. Family is designated by the person, and may include the relations through biology, acquisition, or choice **(**CHPCA, 2002).

Grief: This term describes diverse reactions, such as psychological, physical and social reactions, to the loss of a significant person are characterized by both suffering and growth (Stroebe, Hansson, Stroebe, & Schut, 2001). It is not unusual to experience grief responses many months and, even, longer after the death (Pereira, 2013). Grief is qualified in various ways including but not limited to: uncomplicated, anticipatory, acute, chronic, and complicated.

Holistic: Holistic care can be understood in various ways. According to Palliative Care Australia (2005), holistic "is a whole made up of interdependent parts…[sometimes] referred to the mind/body connection; mind/body/spirit, or physical/mental/emotional/spiritual aspects" of a person (p. 25).

Holistic nursing: Holistic nursing is a practice that "draws on nursing knowledge, theories, expertise and intuition to guide nurses in becoming therapeutic partners with people in their care. This practice recognizes the totality of the human-being, the interconnectedness of body, mind, emotion, spirit, social/cultural, relationship, context and environment" (American Holistic Nurses Association, 2014).

Living-Dying: The term *living-dying* can be used to honour the belief that persons are simultaneously living and dying. It is also described as a dynamic, constantly changing journey of living while dying/dying while living (McWilliam, 2008).

Pain: McCaffery (1968) expanded the conceptualization of pain beyond associations with tissue damage by positing that pain "is whatever the experiencing person says it is, existing whenever the experiencing person says it does" (p. 95).

Palliative Approach: This refers to care that focuses on meeting a person's and family's full range of physical, psychosocial and spiritual needs at all stages of a life-limiting illness, not just at the end of life. It reinforces the person's autonomy and right to be actively involved in his or her own care and strives to give individuals and families a greater sense of control (CHPCA, 2013b).

Person/family centered care: Person- and family-centered care (PFCC) is defined as care that is "respectful of and responsive to individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions" (IPFCC, 2021).

"The person is engaged in and directs his or her care, including deciding how family members will be involved. When care is provided, the person and family (as determined by the person) are treated as a unit. All aspects of care are provided in a manner that is sensitive to the person's and family's personal, cultural, and religious values, beliefs and practices, their developmental state and preparedness to deal with the dying process" (CHPCA, 2013, p. 8).

Place of care: Settings for hospice palliative care may include the person's home, an acute, chronic, rehabilitative or long-term care facility, retirement home, a hospice or palliative care unit, a jail or prison, the street, or any location where care is provided.

Quality of life: This refers to well-being as defined by the person living with advanced illness. It relates to experiences that are meaningful to the individual (CHPCA, 2002). Quality of living and dying is the goal of hospice palliative care.

Self-actualization: The CHPCA norms of practice refer to self-actualization as a value driving hospice palliative care. Specifically, "dying is a part of living, and both living and dying provide opportunities for personal growth and self-actualization" (CHPCA, 2013a, p. 7).

Spirituality: An existential construct inclusive of all the ways in which a person makes meaning and organizes sense of self around a personal set of beliefs, values and relationships. This is sometimes understood in terms of transcendence or inspiration. Involvement in a community of faith and practice may be a part of an individual's spirituality (CHPCA, 2002).

Standards: Defined as broad in scope, reflecting all aspects of the profession, standards can be used as a guideline for practice and can be understood by general members of the public who may not have a complete knowledge of HPC nursing in Canada (ASI, 2009).

Team-based/circle of care: A guiding principle of HPC is that "care is most effectively delivered by an interprofessional team of health care providers who are both knowledgeable and skilled in all aspects of care within their discipline of practice. The professional team comes together with family members, friends and other caregivers to form a circle of care around the person and family" (CHPCA, 2013a, p. 8).

References and Resources

American Holistic Nurses‟ Association. (2014). *What is holistic nursing?* Retrieved from www. ahna.org/About-Us/What-is-Holistic-Nursing

Assessment Strategies, Inc. (2009). *Standards and competencies.* Ottawa, ON.

Canadian Hospice Palliative Care Association, Nursing Standards Committee. (2002). *Hospice palliative care nursing standards of practice.* Retrieved from www. http://www.chpca.net/professionals/norms.aspx

Canadian Hospice Palliative Care Association. (2006). Pediatric hospice palliative care: Guiding principles and norms of practice. Retrieved from http://www.chpca.net/media/7841/Pediatric_Norms_of_Practice_March_31_2006_Englis h.pdf

Canadian Hospice Palliative Care Association. (2006). *The pan-Canadian gold standards for palliative home care: Towards equitable access to high quality hospice palliative and end-of-life care at home.* Ottawa, ON.

Canadian Hospice Palliative Care Association. (2007). *Hospice palliative care in Canada: A brief to the Special Senate Committee on Aging.*

Canadian Hospice Palliative Care Association. (2009). *What is hospice palliative care?* Retrieved from www.chpca.net/general_information.html

Canadian Hospice Palliative Care Association. (2013a). *A model to guide hospice palliative care.* A revision of Ferris F, Balfour H, et al. A model to guide hospice palliative care, 2002. Ottawa, ON: Author. Retrieved from http://www.chpca.net/media/319547/norms-ofpractice-eng-web.pdf

Canadian Hospice Palliative Care Association. A Model to Guide Hospice Palliative Care. Ottawa, ON: Canadian Hospice Palliative Care Association, 2013.

Canadian Hospice Palliative Care Association, Quality End of Life Care Coalition of Canada, & Government of Canada. (2013b). The way forward national framework: A roadmap for the integrated palliative approach to care *Draft for stakeholder feedback*. Ottawa: Saint Vincent Hospital.

Canadian Hospice Palliative Care Association. (2014). About advance care planning. *Speak up campaign* Retrieved from http://www.advancecareplanning.ca/about-advance-careplanning.aspx

Canadian Hospice Palliative Care Nursing Standards Committee. (2009). *Hospice palliative care nursing standards of practice.* Retrieved from www.chpca.net/resource_doc_library/Hospice_Palliative_Care_Nursing_Standards_of Practice.PDF

Canadian Nurses Association. (2004). *Achieving excellence in professional practice: A guide to preceptorship and mentoring.* Ottawa, ON.

Canadian Nurses Association. (2008). *Code of ethics for registered nurses.* Ottawa, ON.

Canadian Palliative Care Association. (1995). *Palliative care: Towards a consensus in standardized principles of practice.* Ottawa, ON.

Christ, G., Bonanno, G., Malkinson, R. & Rubin, S. (2003). *Bereavement experiences after the death of a child.* New York, NY: Cambridge University Press, 213-243.

Institute for Patient- and Family-Centered Care (2021). *What is patient- and family-centered health care?* Retrieved from http://www.ipfcc.org/about/pfcc.html.

McCaffery, M. (1968). *Nursing practice theories related to cognition, bodily pain, and man environment interactions*. Los Angeles, CA: UCLA Press.

McWilliam, C. L., Ward-Griffin, C., Oudshoorn, A., & Krestick, E. (2008). Living while dying/dying while living: Older clients‟ sociocultural experience of home-based palliative care. *Journal of Hospice and Palliative Nursing, 10*(6), 338-349.

Oberle, K., & Davies, B. (1992). Support and caring: Exploring the concepts, *Oncology Nursing Forum, 19*(5), 763-767.

Ong, C., & Forbes, D. (2005). Embracing Cicely Saunders's concept of total pain. *British Medical Journal, 331*, 576-577.

Palliative Care Australia. (2005). *Standards for providing quality palliative care for all Australians*. Deakin West, A.C.T.: Author.

Pereira, J. (2013). *The Pallium palliative pocketbook: A peer-reviewed, referenced resource* (1rs ed., 3rd printing). The Pallium Project: Edmonton, AB.

Reimer-Kirkham, S. et al. (2016). Death is a Social Justice Issue: perspectives on equity-informed palliative care. *Advances in Nursing Science, 39* (4), 293-307.

Saunders, C. (1976). Care of the dying. 1. The problem of euthanasia. *Nursing Times, 72,* 1003-1005.

Speak Up Canada (2021). Definition of advance care planning. Retrieved from https://www.advancecareplanning.ca/resource/advance-care-planning-terms/

Stroebe, M. S., Hansson, R. O., Stroebe, W., & Schut, H. (2001). Concepts and issues in contemporary research on bereavement. In M. S. Stroebe, R. O. Hansson, W. Stroebe & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and caring* (pp. 671-703). Washington, D.C.: American Psychological Association.

Stroebe, M. S., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies, 23*, 197-224.

Tuckman, B. W. (2001). Developmental sequence in small groups. *Group Facilitation*, (3), 66.

Victoria Hospice Society. (2001). *Palliative Performance Scale.PPSv2*. Victoria, BC. Retrieved from http://palliative.info/resource_material/PPSv2.pdf

World Health Organization. (2014). WHO definition of palliative care. Retrieved from http://www.who.int/cancer/palliative/definition/en/