

Exam Blueprint and Specialty Competencies

Introduction – Blueprint for the Hospice Palliative Care Nursing Certification Exam

The primary function of the blueprint for the CNA Hospice Palliative Care Nursing Certification Exam is to describe how the exam is to be developed. Specifically, this blueprint provides explicit instructions and guidelines on how the competencies are to be expressed within the exam in order for accurate decisions to be made on the candidates' competence in hospice palliative care nursing.

The blueprint has two major components: (1) the content area to be measured and (2) the explicit guidelines on how this content is to be measured. The content area consists of the list of competencies (i.e., the competencies expected of fully competent practising hospice palliative care nurses with at least two years of experience), and the guidelines are expressed as structural and contextual variables. The blueprint also includes a summary chart that summarizes the exam guidelines.

Description of Domain

The CNA Hospice Palliative Care Nursing Certification Exam is a criterion-referenced exam.¹ A fundamental component of a criterion-referenced approach to testing is the comprehensive description of the content area being measured. In the case of the Hospice Palliative Care Nursing Certification Exam, the content consists of the competencies of a fully competent practising hospice palliative care nurse with at least two years of experience.

This section describes the competencies, how they have been grouped and how they are to be sampled for creating an exam.

Developing the List of Competencies

The final list of competencies was updated and approved by the Hospice Palliative Care Nursing Certification Exam Committee.

¹ Criterion-referenced exam: An exam that measures a candidate's command of a specified content or skills domain or list of instructional objectives. Scores are interpreted in comparison to a predetermined performance standard or as a mastery of defined domain (e.g., percentage correct and mastery scores), independently of the results obtained by other candidates (Brown, 1983).

Assumptions

In developing the set of competencies for hospice palliative care nurses, the following assumptions, based on current national standards for nursing practice, were made:

Principles and Philosophy

- Hospice palliative care includes the person with any life-limiting conditions and their family.
- Hospice palliative care spans the continuum of care from diagnosis to death, including bereavement.
- Integration of a palliative approach to care begins early in the trajectory of the life-limiting condition.
- Hospice palliative care supports the person to live fully until death.
- Hospice palliative care focuses on optimizing quality of life and quality of dying.
- Wellness is possible in the presence of a life-limiting condition.
- Hospice palliative care neither prolongs nor hastens death.
- Death is a part of the lifespan.

Person and Family

- The unit of care is the person living with a life-limiting condition and the person's family.
- The family is defined by the person.
- The person has intrinsic value as an autonomous and unique individual.
- The person defines what culturally safe means to them and how their cultural location, beliefs and values are or were considered.
- The person and family are situated within the context of their culture and community.
- The person's dignity is respected.
- Each person and family defines their own quality of life.
- The person and the family include individuals from all groups, regardless of age (e.g., antenatal, pediatric, adult, geriatric), gender identity, culture, geographical location, language, spirituality, sexual orientation, diagnosis, prognosis and cognitive capacity.
- Each person and family experiences unique challenges and has distinct support needs (e.g., physical, psychosocial, spiritual and practical).
- Substance use disorders often co-occur alongside a range of acute and chronic physical and mental health conditions.
- The person may use substances for multiple reasons including, but not limited to, managing health conditions (e.g., pain), increasing pleasure and coping with stressful life circumstances (e.g., grief and loss).
- The person has the right to be informed of all care options to address their suffering.

- The person and family have varying desires regarding levels of participation in all aspects of care.
- A substitute decision-maker/health-care proxy may be appointed by the person or by provincial/territorial legislation.
- The person, family and/or substitute decision-maker/health-care proxy have the right to be informed and make decisions about all aspects of care.

Nursing

- Hospice palliative care nurses integrate the philosophy, norms and standards of hospice palliative care into their practice.
- Hospice palliative care nurses create a safe space for patients to self-identify who they are, what their needs are, and how those needs are to be addressed.
- Hospice palliative care nurses have a responsibility to advocate for a person's right to quality of life.
- Hospice palliative care nurses advocate for the development and the delivery of palliative care resources.
- Hospice palliative care nurses incorporate anticipatory planning into their care of the person and family.
- Hospice palliative care nurses provide comprehensive, coordinated and compassionate care within the context of a therapeutic relationship.
- Hospice palliative care nurses engage in self-care in order to maintain resilience, well-being and compassion.
- Hospice palliative care nurses demonstrate humility (humbly acknowledging oneself as a learner when attempting to understand another's experience) in interaction with all people.
- Hospice palliative care nurses engage in the assessment and care planning of persons to address physical, spiritual and psychosocial suffering that has contributed to a request for information about MAID and/or a request for MAID.
- Hospice palliative care nurses are self-aware of their personal beliefs and values and how these affect their responses to requests for information about MAID and requests for MAID.

Environment and Context of Care

- A hospice palliative approach is accessible in all settings of care.
- Hospice palliative care is provided, when possible, in the setting desired by the person and family.
- Hospice palliative care must ensure that quality and safety are maintained wherever care is provided.
- Hospice palliative care is best provided through the collaborative practice of an interdisciplinary team and volunteers.
- Hospice palliative care promotes the development of compassionate communities.

- Hospice palliative care ensures continuity of care during transitions.
- Hospice palliative care nurses are aware of the social and environmental determinants of health specific to Indigenous peoples and of the physical, social, economic, cultural, relational and systemic barriers to health and accessibility before, during and after encounters with the person.

Competency Categories

The competencies are classified under an eight-category scheme commonly used to organize hospice palliative care nursing.

Some of the competencies lend themselves to one or more of the categories; therefore, these eight categories should be viewed simply as an organizing framework. Also, it should be recognized that the competency statements vary in scope, with some representing global behaviours and others more discrete and specific nursing behaviours.

Competency Sampling

Using the grouping and the guideline that the Hospice Palliative Care Nursing Certification Exam will consist of approximately 165 questions, the categories have been given the following weights in the total examination.

Table 1: Competency Sampling

Categories	Approximate weights in the total examination
Person and Family-Centered Care	10-15%
Pain Assessment and Management	15-20%
Symptom Assessment and Management	20-25%
Care in the Final Days	10-15%
Loss, Grief and Bereavement	7.5-12.5%
Collaborative Practice	5-10%
Education, Professional Development and Advocacy	5-10%
Ethics and Legal Issues	7.5-12.5%

Technical Specifications

In addition to the specifications related to the competencies, other variables are considered during the development of the Hospice Palliative Care Nursing Certification Exam. This section presents the guidelines for two types of variables: structural and contextual.

Structural Variables: Structural variables include those characteristics that determine the general appearance and design of the exam. They define the length of the exam, the format and presentation of the exam questions (e.g., multiple-choice format) and special functions of exam questions (e.g., case-based or independent questions).

Contextual Variables: Contextual variables specify the nursing contexts in which the exam questions will be set (e.g., client culture, client health situation and health-care environment).

Structural Variables

Exam Length: The exam consists of approximately 165 multiple-choice questions.

Question Presentation: The multiple-choice questions are presented in one of two formats: case-based or independent. Case-based questions are a set of approximately four questions associated with a brief health-care scenario (i.e., a description of the client's health-care situation). Independent questions stand alone. In the Hospice Palliative Care Nursing Certification Exam, 60 to 70 per cent of the questions are presented as independent questions and 30 to 40 per cent are presented within cases.

Taxonomy for Questions: To ensure that competencies are measured at different levels of cognitive ability, each question on the Hospice Palliative Care Nursing Certification Exam is aimed at one of three levels: knowledge/comprehension, application and critical thinking.²

1. Knowledge/Comprehension

This level combines the ability to recall previously learned material and to understand its meaning. It includes such mental abilities as knowing and understanding definitions, facts and principles and interpreting data (e.g., knowing the effects of certain drugs or interpreting data appearing on a client's record).

2. Application

This level refers to the ability to apply knowledge and learning to new or practical situation. It includes applying rules, methods, principles and theories in providing care to clients (e.g., applying nursing principles to the care of clients).

3. Critical Thinking

The third level of the taxonomy deals with higher-level thinking processes. It includes the abilities to judge the relevance of data, to deal with abstraction and to solve problems (e.g., identifying priorities of care or evaluating the effectiveness of interventions). The hospice palliative care nurse with at least two years of experience should be able to identify cause-and-effect relationships, distinguish between relevant and irrelevant data, formulate valid conclusions and make judgments concerning the needs of clients.

² These levels are adapted from the taxonomy of cognitive abilities developed in Bloom (1956).

The following table presents the distribution of questions for each level of cognitive ability.

Table 2: Distribution of Questions for Each Level of Cognitive Ability

Cognitive Ability Level	Percentage of questions on Hospice Palliative Care Nursing Certification Exam
Knowledge/Comprehension	10-20%
Application	55-65%
Critical Thinking	20-30%

Contextual Variables

Client Culture: Questions are included that measure awareness, sensitivity and respect for different cultural values, beliefs and practices, without introducing stereotypes.

Client Health Situation: In the development of the Hospice Palliative Care Nursing Certification Exam, the client is viewed holistically. The client health situations presented also reflect a cross-section of health situations encountered by hospice palliative care nurses.

Health-Care Environment: Hospice palliative care nursing is practised in the primary, secondary and tertiary levels in community, acute, chronic and long-term/continuing care settings. However, hospice palliative care nursing can also be practised in other settings. Therefore, for the purposes of the Hospice Palliative Care Nursing Certification Exam, the health-care environment is specified only where it is required for clarity or in order to provide guidance to the examinee.

Conclusions

The blueprint for the Hospice Palliative Care Nursing Certification Exam is the product of a collaborative effort between CNA, YAS and a number of hospice palliative care nurses across Canada. Their work has resulted in a compilation of the competencies required of practising hospice palliative care nurses and has helped determine how those competencies will be measured on the Hospice Palliative Care Nursing Certification Exam. A summary of these guidelines can be found in the summary chart *Hospice Palliative Care Nursing Certification Exam Development Guidelines*.

Hospice palliative care nursing practice will continue to evolve. As this occurs, the blueprint may require revision so that it accurately reflects current practices. CNA will ensure that such revision takes place in a timely manner and will communicate any changes in updated editions of this document.

Summary Chart

Hospice Palliative Care Nursing Certification Exam Development Guidelines

STRUCTURAL VARIABLES	
Examination Length and Format	Approximately 165 objective questions
Question Presentation	60-70% independent questions 30-40% case-based questions
The Cognitive Domain	Knowledge/Comprehension 10-20% of the questions Application 55-65% of the questions Critical Thinking 20-30% of the questions
Competency Categories	Person and Family-Centered Care 10-15% of the questions Pain Assessment and Management 15-20% of the questions Symptom Assessment and Management 20-25% of the questions Care in the Final Days 10-15% of the questions Loss, Grief, Bereavement and Psychosocial Considerations 7.5-12.5% of the questions Collaborative Practice 5-10% of the questions Education, Professional Development and Advocacy 5-10% of the questions Ethics and Legal Issues 7.5-12.5% of the questions
CONTEXTUAL VARIABLES	
Culture	Questions are included that measure awareness, sensitivity, and respect for different cultural values, beliefs, and practices and vulnerable populations.
Health Situation	In the development of the Hospice Palliative Care Nursing Certification Exam, the client is viewed holistically. The health situations reflect a cross-section of diseases within the continuum of advanced life-limiting illness and address physical, psychosocial and spiritual aspects of care which includes the person, family and care provider.
Health-Care Environment	It is recognized that Hospice Palliative Care nursing is practiced in a variety of settings. In this exam, the health-care environment is specified only where it is required for clarity or in order to provide guidance to the examinee.

The Hospice Palliative Care Nursing Exam List of Competencies

1. Person and Family-Centred Care

The hospice palliative care nurse:

- 1.1 Assists the person and family in exploring their responses to the diagnosis and experience of living with a life-limiting condition.
- 1.2 Recognizes the multiple losses experienced in the presence of a life-limiting condition and its impact on the person and family (e.g., anticipatory grief, loss of independence, financial losses, physical changes such as loss of hair).
- 1.3 Determines the interconnection between the life-limiting condition and:
 - 1.3a cultural practices (e.g., values, beliefs, traditions);
 - 1.3b spiritual practices (e.g., religion, faith, meaning);
 - 1.3c family and/or community dynamics (e.g., structure, roles, responsibilities, stressors, composition); and
 - 1.3d life experiences of the person and family.
- 1.4 Supports the person and family to identify effective strategies to cope with the life-limiting condition and the dying experience.
- 1.5 Uses effective communication skills (e.g., presence, empathy, reflective listening) to explore understanding of and facilitate discussion with the person and family regarding:
 - 1.5a diagnosis;
 - 1.5b prognosis;
 - 1.5c change in health status (e.g., serious illness conversation);
 - 1.5d goals of care;
 - 1.5e decision-making;
 - 1.5f advance care planning (e.g., engaging in ongoing discussion);
 - 1.5g benefits and burdens of treatments, procedures and investigations;
 - 1.5h location of care/death (e.g., planning for expected home death);
 - 1.5i organ/tissue/body donation and autopsy;
 - 1.5j dying and death; and
 - 1.5k loss, grief and bereavement.
- 1.6 Assists the person and family to determine components that contribute to their quality of life through exploration of beliefs and values about living and dying.
- 1.7 Supports the person and family in making informed choices that are consistent with their values and beliefs.
- 1.8 Recognizes the uncertainty and vulnerability experienced by the person and family.

- 1.9 Assists the person and family to explore and address sensitive issues related to:
 - 1.9a intimacy;
 - 1.9b sexuality;
 - 1.9c body image;
 - 1.9d gender identity;
 - 1.9e self-concept and self-esteem; and
 - 1.9f abuse/neglect (e.g., physical, verbal, emotional, financial).
- 1.10 Assists the person to maximize functional capacity and independence as the life-limiting condition advances.
- 1.11 Uses functional assessment tools to assist in care planning (e.g., palliative performance scale (PPS)).
- 1.12 Supports the person to maintain their autonomy as the life-limiting condition advances.
- 1.13 Assesses for burdens and stressors associated with the informal caregiver role.
- 1.14 Provides support to address needs identified by the informal caregiver.
- 1.15 Promotes personal and spiritual growth throughout the experience of living with a life-limiting condition (e.g., life review/legacy, reconciliation strategies, dignity therapy).

2. Pain Assessment and Management

The hospice palliative care nurse:

- 2.1 Demonstrates knowledge of the physiology of pain in regards to:
 - 2.1a transduction;
 - 2.1b transmission;
 - 2.1c modulation; and
 - 2.1d perception.
- 2.2 Distinguishes the following classifications/types of pain and their implication in effective pain management:
 - 2.2a acute;
 - 2.2b chronic;
 - 2.2c malignant;
 - 2.2d non-malignant;
 - 2.2e neuropathic/sympathetic (e.g., phantom, allodynia, hyperalgesia);
 - 2.2f nociceptive (e.g., somatic, visceral);
 - 2.2g incident;
 - 2.2h breakthrough; and
 - 2.2i referred.
- 2.3 Describes the concept of total pain.
- 2.4 Adapts pain assessment and management approaches for unique or vulnerable population (e.g., children, older adults, cognitively impaired, developmentally delayed, communication impairments, language barriers, cultural considerations).
- 2.5 Advocates for appropriate pain control interventions for the person who use substances.
- 2.6 Selects appropriate validated assessment tools for initial and ongoing pain assessment.
- 2.7 Completes a comprehensive pain assessment.
- 2.8 Identifies the possible causes or sources of pain.
- 2.9 Demonstrates knowledge of the pain management principles (e.g., World Health Organization's Pain Ladder).
- 2.10 Integrates ongoing pain assessment and management principles into the delivery of care.

- 2.11 Addresses potential issues related to pain management:
 - 2.11a myths and misconceptions regarding opioids (e.g., addiction, tolerance, withdrawal);
 - 2.11b the person and family (e.g., education regarding pain medication usage, disclosure of complementary and alternative therapies, literacy, finances);
 - 2.11c prescriber (e.g., apprehension to prescribe, lack of knowledge); and
 - 2.11d health system (e.g., accessibility of medications).
- 2.12 Recognizes potential issues related to opioid safety (e.g., multiple prescribers, risk of diversion, improper storage, unsafe disposal).
- 2.13 Collaborates with the person, family and interdisciplinary team to develop a pain management plan.
- 2.14 Evaluates the effectiveness of pain interventions.
- 2.15 Revises the pain management plan as required.
- 2.16 Uses medication administration techniques or routes appropriate to the situation (e.g., types and severity of pain, condition of the person, access to and availability of resources).
- 2.17 Manages potential side effects, interactions or complications of medications commonly used for pain management:
 - 2.17a constipation;
 - 2.17b opioid-induced neurotoxicity (e.g., myoclonus, delirium, hyperalgesia);
 - 2.17c pruritus/urticaria;
 - 2.17d nausea/vomiting;
 - 2.17e respiratory depression; and
 - 2.17f sedation.
- 2.18 Describes the indications and principles for opioid rotation.
- 2.19 Demonstrates knowledge of opioid dosing, titration, breakthrough dose calculations and equianalgesic conversions.
- 2.20 Explains the role of adjuvant medications in pain management (e.g., non-steroidal anti-inflammatory drugs, corticosteroids, anticonvulsants, antidepressants, antipsychotics, chemotherapy, immunotherapy).
- 2.21 Explains the role of non-pharmacological interventions in pain management (e.g., radiation therapy, surgery, rehabilitation therapies, massage).
- 2.22 Recognizes the use and potential impact of complementary and alternative therapies for pain management (e.g., traditional, homeopathic, imagery).

- 2.23 Supports the right of the person and family to seek complementary and alternative therapies for pain management.

3. Symptom Assessment and Management

The hospice palliative care nurse:

- 3.1 Completes a comprehensive symptom assessment.
- 3.2 Incorporates appropriate, validated screening and assessment tools in initial and ongoing symptom assessment (e.g., Edmonton Symptom Assessment System-revised (ESAS-r)).
- 3.3 Routinely screens all persons for substance use to identify problematic use and opportunities to provide intervention (e.g., harm reduction, education, treatment).
- 3.4 Identifies the possible causes of the symptoms in life-limiting condition.
- 3.5 Manages common and expected symptoms, including:
- 3.5a neurological:
 - i) aphasia, dysphasia;
 - ii) extrapyramidal symptoms;
 - iii) lethargy, sedation, somnolence;
 - iv) changes in level of consciousness;
 - v) paresthesia, neuropathies;
 - vi) seizure;
 - vii) paralysis; and
 - viii) changes in reflex responses.
 - 3.5b cognitive changes:
 - i) agitation, restlessness;
 - ii) confusion;
 - iii) delusions, hallucinations, paranoia;
 - iv) delirium; and
 - v) dementia.
 - 3.5c cardiovascular:
 - i) angina;
 - ii) deep vein thrombosis (DVT);
 - iii) dysrhythmia;
 - iv) edema;
 - v) syncope, dizziness; and
 - vi) hypotension, hypertension.
 - 3.5d respiratory:
 - i) apnea;
 - ii) congestion, excess secretions;
 - iii) cough;

- iv) dyspnea, shortness of breath;
 - v) hemoptysis; and
 - vi) pleural effusion.
- 3.5e gastrointestinal:
- i) bowel incontinence;
 - ii) bowel obstruction;
 - iii) abdominal spasms, cramps, colic pain;
 - iv) constipation;
 - v) diarrhea;
 - vi) dysphagia;
 - vii) jaundice;
 - viii) nausea, vomiting; and
 - ix) gastrointestinal bleeding.
- 3.5f nutritional and metabolic:
- i) anorexia;
 - ii) cachexia;
 - iii) weight loss;
 - iv) dehydration; and
 - v) electrolyte imbalance.
- 3.5g genitourinary:
- i) bladder spasms;
 - ii) urinary incontinence;
 - iii) urinary retention;
 - iv) hematuria; and
 - v) renal colic.
- 3.5h immune system:
- i) allergic response, anaphylaxis;
 - ii) infection (e.g., pneumonia, urinary tract infection, wounds, shingles);
 - iii) myelosuppression (e.g., anemia, neutropenia, thrombocytopenia); and
 - iv) pyrexia.
- 3.5i musculoskeletal:
- i) pathological fractures;
 - ii) muscle spasms, rigidity;
 - iii) muscle weakness, wasting, atrophy;
 - iv) myopathy;
 - v) decreased range of motion/contractures; and
 - vi) risk of falls.
- 3.5j skin and mucous membranes:
- i) candidiasis;
 - ii) mucositis;

- iii) pruritus;
- iv) rashes;
- v) wounds (e.g., fungating, malignant, pressure ulcer, bleeding);
- vi) xerostomia;
- vii) sialorrhea; and
- viii) vaginal dryness.

- 3.5k other physical symptoms:
- i) ascites;
 - ii) fatigue, asthenia;
 - iii) hiccups;
 - iv) lymphedema;
 - v) anasarca;
 - vi) sleep pattern changes (e.g., dream disturbances, insomnia); and
 - vii) changes in sexual function (e.g., erectile dysfunction)

- 3.5l psychosocial and spiritual:
- i) anxiety;
 - ii) existential distress;
 - iii) depression;
 - iv) diminished sense of well-being;
 - v) social isolation, relationship strain; and
 - vi) suicidal, homicidal ideation.

3.6 Manages the manifestations of the following urgent or emergent situations:

- 3.6a acute bowel obstruction;
- 3.6b cardiac tamponade;
- 3.6c delirium;
- 3.6d severe electrolyte imbalance (e.g., hypercalcemia, hyperkalemia);
- 3.6e fractures;
- 3.6f severe hemorrhage;
- 3.6g pain crisis;
- 3.6h pulmonary embolism;
- 3.6i severe or intractable seizures;
- 3.6j severe respiratory distress (e.g., airway obstruction);
- 3.6k opioid-induced neurotoxicity;
- 3.6l sepsis;
- 3.6m spinal cord compression; and
- 3.6n superior vena cava syndrome.

3.7 Manages reversible causes of symptoms while taking into consideration the person's goals of care.

3.8 Updates symptom management goals and plan of care with the person and family as indicated.

3.9 Uses medication administration techniques or routes appropriate to the situation (e.g., the types and severity of symptoms, condition of the person, access to and availability of resources).

- 3.10 Demonstrates understanding of the pharmacology of medication used in managing symptoms (e.g., steroids, anticholinergics, prokinetics, neuroleptics, antidepressants, antipsychotics, chemotherapy, immunotherapy).
- 3.11 Responds to potential side effects, interactions or complications of medications commonly used for symptom management.
- 3.12 Considers interactions between prescribed medications and substances.
- 3.13 Demonstrates understanding of the non-pharmacological approaches used in managing symptoms (e.g., radiation therapy, surgery, rehabilitation therapies, complementary therapies).
- 3.14 Adapts symptom assessment and management approaches for unique or vulnerable populations (e.g., children, older adults, cognitively impaired, developmentally delayed, communication impairments, language barriers, cultural considerations).
- 3.15 Understands that symptoms have culture-specific meanings and patients from diverse backgrounds will describe their symptoms differently, have different ideas of what might have caused them, have different acceptance of them, and have different views on what kind of treatment they would seek for them.
- 3.16 Adapts symptom assessment and management approaches for specific life-limiting conditions (e.g., chronic obstructive pulmonary disease (COPD), amyotrophic lateral sclerosis (ALS), congestive heart failure (CHF), dementia, cancer).
- 3.17 Recognizes the use and potential impact of complementary and alternative therapies for symptom management (e.g., traditional, homeopathic).
- 3.18 Supports the right of the person and family to seek complementary and alternative therapies for symptom management.

4. Care in the Final Days

The hospice palliative care nurse:

- 4.1 Recognizes the signs of imminent death:
 - 4.1a cognitive changes (e.g., decreased level of consciousness, restlessness, delirium, visions);
 - 4.1b physical changes (e.g., respiratory changes, skin discolouration, decreased urinary output);
and
 - 4.1c psychosocial changes (e.g., social withdrawal, decreased communication).
- 4.2 Demonstrates knowledge of pain and symptom assessment/management strategies unique to the final days of life.
- 4.3 Educates family on the signs of imminent death.
- 4.4 Assists family during the dying process or after the death has occurred to:
 - 4.4a cope with their emotional responses (e.g., uncertainty, fear, anger, guilt, remorse, relief);
 - 4.4b contact the appropriate resources and support (e.g., significant others, spiritual advisor, health professionals, funeral services);
 - 4.4c participate in comfort measures if desired (e.g., mouth care, repositioning); and
 - 4.4d revisit the practical considerations (e.g., documentations, tissue donation, the will, autopsy).
- 4.5 Supports the family's needs (e.g., privacy, rituals, cultural considerations), offering presence as appropriate.
- 4.6 Facilitates arrangements for pronouncement of death, care and transportation of the body, and certification of death in accordance with policy or legislation.

5. Loss, Grief and Bereavement and Psychosocial Considerations

The hospice palliative care nurse:

- 5.1 Demonstrates knowledge of models of grief, bereavement and the concept of loss (e.g., Worden's Tasks of Mourning, the Kübler-Ross Five-Stage Model, Bowlby's Attachment and Loss).
- 5.2 Supports the person and family in their unique way of grieving considering developmental stages, cultural values, etc. (e.g., understanding the concept of loss and the process of grief).
- 5.3 Recognizes types of grief:
 - 5.3a anticipatory;
 - 5.3b complicated;
 - 5.3c disenfranchised;
 - 5.3d uncomplicated; and
 - 5.3e unresolved.
- 5.4 Recognizes the manifestations of grief:
 - 5.4a behavioural/social;
 - 5.4b cognitive;
 - 5.4c emotional;
 - 5.4d physical; and
 - 5.4e spiritual.
- 5.5 Recognizes the differences between depression and grief.
- 5.6 Identifies persons at risk for complicated grief.
- 5.7 Supports the psychosocial and spiritual needs of the person and family (e.g., anger, guilt, hope, meaning/purpose of life and illness, forgiveness, suffering).
- 5.8 Facilitates the person's and family's access to psychosocial and bereavement services (e.g., referral to support groups).

6. Collaborative Practice

The hospice palliative care nurse:

- 6.1 Collaborates with the person, family and the interdisciplinary team to define goals of care and to develop, implement and evaluate a plan of care.
- 6.2 Collaborates with other care providers (e.g., primary health-care provider, community health nurse) to ensure seamless transitions between different care settings and services.
- 6.3 Facilitates referrals to appropriate interdisciplinary team members and other support services.
- 6.4 Acts as an expert resource for family conferences (e.g., participates, organizes, leads, documents).
- 6.5 Assists the person, family and caregiver(s) to access appropriate information and regional or national resources to address their health needs (e.g., Canadian Virtual Hospice, Canadian Hospice Palliative Care Association).
- 6.6 Contributes to the overall functioning and well-being of the interdisciplinary team by:
 - 6.6a recognizing stressors unique to hospice palliative care;
 - 6.6b taking appropriate measures to cope (e.g., debriefing, physical or social activities, peer support); and
 - 6.6c providing mentorship and being a role model to foster resilience.

7. Education, Professional Development and Advocacy

The hospice palliative care nurse:

- 7.1 Promotes awareness by providing education on the philosophy, values, principles and practices of hospice palliative care (e.g., to the public, students, volunteers, care providers).
- 7.2 Identifies the potential opportunities for and barriers to research unique to hospice palliative care (e.g., vulnerable populations, participant attrition, sample size).
- 7.3 Advocates for the person and family by:
 - 7.3a navigating system challenges (e.g., accessing the compassionate care benefit);
 - 7.3b addressing caregiving challenges (e.g., burden, burnout);
 - 7.3c identifying the needs of underserved populations (e.g., homeless, prison inmates, rural/remote communities); and
 - 7.3d promoting equitable and timely access to appropriate resources (e.g., support for the preferred place of care).
- 7.4 Advocates for the development and improvement of health care and social policy related to hospice palliative care at the appropriate level (e.g., health-care/educational institutions, government).

- 7.5 Contributes to a culture of learning through formal and informal education to enhance the provision of high quality palliative care (e.g., mentorship).
- 7.6 Engages in hospice palliative care learning opportunities (e.g., literature review, online courses, conferences, webinars).

8. Ethics and Legal Issues

The hospice palliative care nurse:

- 8.1 Recognizes how one's personal values and beliefs may influence the provision of hospice palliative care.
- 8.2 Collaborates with the person, family, substitute decision-maker/health-care proxy and the interdisciplinary team to address the potential ethical issues related to hospice palliative care, such as:
 - 8.2a withdrawing/withholding life-sustaining treatment (e.g., dialysis, nutrition/hydration, ventilation, transfusion, internal defibrillators);
 - 8.2b resuscitation/code status (e.g., allowing natural death);
 - 8.2c conflicting goals of care;
 - 8.2d medical assistance in dying (MAID);
 - 8.2e balancing benefits/burdens of diagnostics and interventions (e.g., concept of futility);
 - 8.2f sedation for palliative purposes;
 - 8.2g principle of double effect;
 - 8.2h resource allocation; and
 - 8.2i cultural considerations regarding information sharing/disclosure.
- 8.3 Demonstrates an understanding of ethical principles and how they apply to hospice palliative care, including:
 - 8.3a beneficence;
 - 8.3b non-maleficence;
 - 8.3c autonomy; and
 - 8.3d justice.
- 8.4 Addresses complex ethical situations by:
 - 8.4a using an ethical framework (e.g., grid, decision-making process); and
 - 8.4b engaging ethics services.
- 8.5 Responds to a request for MAID by:
 - 8.5a practising according to their code of ethics, in keeping with the laws, regulations, professional standards and guidelines for MAID in the jurisdiction where they practise;
 - 8.5b engaging in reflective practice on their own personal values and beliefs regarding MAID;
 - 8.5c understanding that when there is conscientious objection to MAID, care unrelated to the activities associated with MAID must continue to be provided;

- 8.5d engaging the person in dialogue to better understand the nature and meaning of their request for MAID; and
 - 8.5e collaborating with the interdisciplinary team to explore available treatment options, acceptable to the person, for physical, psychosocial and spiritual symptom.
- 8.6 Educates the person and family regarding relevant potential legal issues (e.g., advance care plans, health-care directives, guardianship and trusteeship, power of attorney, substitute decision-maker/health-care proxy).