



**BC Centre for
Palliative Care**
Palliative
Competency
Framework

Finalized 09-01-2021

**Hospice
Volunteers**



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BC Centre for Palliative Care Team

- Project Sponsor: Dr. Eman Hassan, MD, MPH, Executive Director, BC Centre for Palliative Care
- Project Director: Kathleen Yue, RN, MN, CHPCNG (C), Director, Strategic Initiatives BC Centre for Palliative Care
- Project Manager: Tina Lowery, MA, CPHR, CVA, BC Centre for Palliative Care
- Community Engagement: Melody Jobse, BC Centre for Palliative Care

Steering Committee (PHWG)

The committee comprises four members from the Provincial Hospice Working Group, a collective of leading hospice and palliative care organizations in BC

- Pablita Thomas, Executive Director, BC Hospice Palliative Care Association
- Gretchen Hartley, MSW, Executive Director, Cowichan Hospice and President Vancouver Island Federation of Hospices
- Kevin Harter, CEO, Victoria Hospice
- Susan Gabe, Sovereign Order of St. John of Jerusalem

Hospice Focus group (in alphabetical order)

- Leslie Beare, RN, Board, Chair New Denver Hospice Society
- Thérèse Bouchard, Director of Client Services, Pacific Rim Hospice Society
- Chris Bradly BSC, MSc, PhD, Volunteer Vigil Sitter and Advance Care Planning Program Coordinator, Saltspring Hospice Society
- Nicole Carothers, MACP, Program Director, Sea to Sky Hospice Society
- Camilla Rosnes-Cockburn, Program Assistant Comox Valley Hospice Society
- Jennifer Dufour, Coordinator, Volunteer Resources Richmond Hospice, Rotary Hospice House
- Kristine Gagnon, BA (Hons), Interim Director, Volunteer Services, Victoria Hospice
- Sue Graham, Volunteer Coordinator, Inlet Centre Hospice – Port Moody
- Theresa Hamilton, B.Sc., Certificate in Death Midwifery, Executive Director Volunteer Coordinator, Revelstoke Hospice Society
- Jacqueline Harris, Master of Counselling, Coordinator of Volunteers, Mission Hospice Society
- Tricia Keith, Coordinator of Volunteers, Peace Arch Hospice Society
- Cookie Langenfeld, Executive Director, Shuswap Hospice Society
- Maureen McKay, Coordinator, Palliative Support Services, Ridge Meadows Hospice Society
- Suzannah Meir, Business Management, Dale Carnegie, Executive Director, Quesnel & District Hospice & Palliative Care Association
- Michele Neider, M.Ed, Executive Director, Hospice Society of Columbia Valley
- Fernande Ouellette Palliate Program Coordinator, Langley Hospice Society
- Gail Potter BScN, MDiv, MN, CGN(C) Greater Trail Hospice Society, Board Member, Spiritual Care Chaplain and Volunteer Trainer
- Tina Schoen, Volunteer Programs Coordinator, Cowichan Hospice

Background

The need for provincial competency standards for palliative care and palliative approach provision has been identified by the BC Centre for Palliative Care (BCCPC) and the Community of Practice for Palliative Care Education (Pall Ed).

In 2019, BCCPC developed the Inter-professional Palliative Care Competency Framework to identify ideal competencies for health-care providers (HCPs) caring for people* with life-limiting conditions in British Columbia. The resulting inter-professional competency framework and discipline-specific competencies were established for physicians and nurse practitioners, nurses, social workers, counsellors, and health care assistants.

The case for hospice volunteer competencies

At the same time, the need for establishing core competencies for hospice volunteers was identified as a priority by the Provincial Hospice Working Group (PHWG), a collective of leading hospice and palliative care organizations in BC. In their 2020 [Path Forward](#) report, the PHWG included the need for establishing core competencies for hospice volunteers in their recommended 10 steps to improve access to high quality, fully integrated, and sustained hospice care for all British Columbians. The report is the result of a year-long project including a current state assessment of hospice care in BC followed by a stakeholder roundtable discussion and extensive consultation with BC hospice organizations, palliative care experts and researchers, and key stakeholders in the health systems and community.

*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”.

The current state assessment of hospice care in BC that was conducted as part of the PHWG project identified insights specifically related to hospice volunteers as part of the hospice workforce:

- The volunteer-to-staff ratio in the BC hospice workforce is 10:1
- On average, the BC hospice workforce supports over 10,000 people monthly
- The BC hospice workforce supports patients, families, and caregivers in a variety of settings including the patient's home, hospital palliative care units, hospices, long-term care homes, and assisted living facilities
- There is a lack of provincial standards for hospice care
- There is a lack of cultural competencies
- There is limited access to standardized education, training and resources
- There are inconsistent volunteer engagement strategies

In 2021, the BCCPC in collaboration with the PHWG and a focus group of hospice organization representatives built on relevant work done in BC and beyond to develop this competency framework for hospice volunteers affiliated with community-based hospice organizations

Approach and Method

The development of this framework was guided by the PHWG whose members served as the steering committee for the project. To ensure widespread awareness and engagement in creating the competencies, hospice society representatives from across BC were invited to an information session on April 7, 2021 to learn about the project. From this province-wide group of representatives, a focus group of was formed.

With representatives from large, small, urban, and rural Hospice societies the mandate of the focus group was to identify and adapt the core competencies for volunteers included in the Canadian Interdisciplinary Palliative Care Competency Framework for volunteers as they relate to the British Columbian context. Four focus group meetings were hosted by the BCCPC each week from April 13th to May 4th. An additional meeting was held on May 11th to discuss indicators or other information beyond what was included in the national competencies, and to consider their inclusion in the British Columbia document.

The final competencies document combines the information gathered from the focus group members with the Centre’s previous work in developing competencies for other disciplines. As a result, the volunteer competency framework reflects the needs of hospices in BC and aligns seamlessly with competencies developed for other members of the hospice workforce.

Who can use this document?

This resource outlines the core competencies for hospice volunteers specifically recruited, screened, and trained by **community-based hospice organizations to** support people with life limiting illness, their families, caregivers, and communities.

These volunteers may work in a variety of settings, including hospice, hospital palliative units, and long-term care facilities.

We recognize that other groups or individuals with an interest in improving access to, and quality of, hospice care in community settings may find this competency framework of value. These may include:

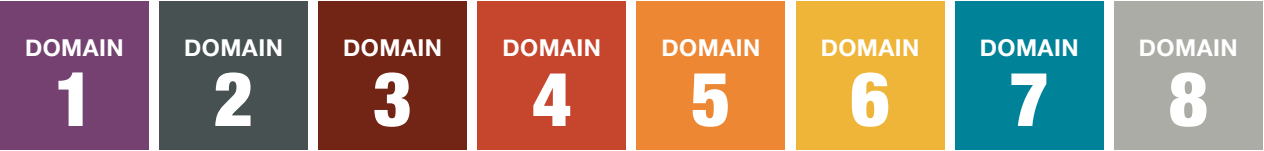
- 1. Hospice administrators, staff and volunteers
- 2. Associations and regional federations for hospice organizations
- 3. Educators
- 4. Policy makers
- 5. Health care teams

Competency Framework

What is a Competency?

The definition of a “competency” has been a matter of some debate.^{1,2} The use of the word for this document, as with the [BCCPC](#) Health-care Providers (HCPs) Competencies that have been created so far, tends towards the behavioural instead of the attributional definition. We define a competency as the performance of critical work functions using related knowledge, skills and abilities.³

The framework was developed to identify ideal competencies for health-care providers (HCPs) caring for people with life-limiting conditions. The competency domains include standards specific to each category; the eight domains together form a pie shape



General Overview of each Domain

Domain 1: Principles of palliative care and palliative approach

The palliative approach aims to improve the quality of life of all people who have life-limiting conditions and their families by applying the principles of palliative care in all settings in a manner that is proactive and context dependent. The palliative approach is applicable for people of any age and may come into play at any point from diagnosis through to bereavement.



Domain 2: Cultural safety and humility

Palliative care that is currently provided within the healthcare system often does not address priorities that are important to First Nations, Inuit, or Métis. As a result, the provision of culturally safe palliative care for First Nations, Inuit, and Métis is complex.

This Domain’s focus is on incorporating the uniqueness of each person, family and community into care planning through authentic listening. They use this domain to practice “relationship-based care” by adopting a humble, self-reflective clinical practice, and positioning themselves as a respectful and curious partner when providing care.^{4, 5} While Cultural Safety and Humility is often imbedded into other domains, since it is an expectation of all care provision, it was decided to also keep it separate domain to highlight its importance.

Domain 3: Communication

Communicating effectively is essential to the delivery of palliative care where circumstances can be uncertain and strong emotions and distress can arise. Specific consideration should be given to communication as a method of establishing therapeutic relationships and person/family participation in decision-making. This domain addresses communication with people and families, whereas Domain 5 addresses communication between the care team.

Domain 4: Comfort and quality of life

Supporting and optimizing comfort and quality of life as defined by the person and family includes addressing their emotional, psychological, social and spiritual needs as well as their physical needs. This is an ongoing process which aims to prevent, assess and relieve suffering in a timely and proactive manner, and includes effective pain and symptom management.

Domain 5: Care planning and collaborative practice

Care planning is a collaborative practice that includes addressing, coordinating, and integrating person- centered and family-centered care needs. It is enabled by inter-disciplinary and cross-sector care planning and communication that involves assessing need and planning for likely changes that occur within the context of a deteriorating disease trajectory.

Domain 6: Loss, grief and bereavement

The palliative approach seeks to assist in providing support to people, families and communities, when possible, throughout the illness trajectory as they experience loss, grief and bereavement. Identifying needs and providing information and resources to those who may develop issues in their grieving is part of palliative care.

Domain 7: Professional and ethical practice

This Domain’s focus is on respecting and incorporating the values, needs and wishes of the person and their family into care planning while maintaining professional, personal and ethical integrity. It guides all to consider how best to provide continuing care to people with life-limiting conditions as their health-care needs change.

Domain 8: Self-care

The palliative care approach includes ongoing self-reflection for all regarding the impact of caring for people with life-limiting conditions by using strategies to promote the health of oneself and the team.

COMPETENCIES AND INDICATORS BY DOMAIN

DOMAIN 1: PRINCIPLES OF PALLIATIVE CARE AND PALLIATIVE APPROACH	
Hospice volunteers, as members of the health care teams, are expected to demonstrate the competencies only as appropriate for their scope of practice, organizational policies, and specific role descriptions.	
COMPETENCY	INDICATORS
Understanding the philosophy of palliative care and the palliative approach to care	Describes key elements of hospice palliative care and palliative approach.
	Demonstrates understanding of the community-specific protocols and practices of caring for members of underserved populations who are living with a life-limiting illness so they can live fully throughout their care.
	Demonstrates understanding community-specific protocols of caring for First Nations, Inuit, and Métis who are living with a life-limiting illness so they can live fully throughout their care.
	Can describe the key components of volunteer support (such as presence, listening, use of silence, respect for other, and other's pace of understanding of situation.)
	Demonstrates an understanding and can assist organization with community education initiatives about palliative care.
Understanding the multidisciplinary team	Describes the role and function of the multidisciplinary care team, its members, and the role of volunteers in the team.
Includes and incorporates the uniqueness of each persons designated family and/or caregiver(s) in all aspects of care	Supports and acknowledges who the person considers to be and not to be family and includes the designated family and/or caregiver(s) in the person's care.
	Supports and acknowledges the importance of the role of designated family, caregiver(s), and community, especially for members of underserved populations throughout their palliative care.
	Supports and acknowledges the importance of the role of family and Community for First Nations, Inuit, and Métis throughout their palliative care.
	Recognizes and supports the impact of a life-limiting condition on familial roles.
Honoring people holistically	Describes people as holistic beings i.e., with physical, emotional, mental, social, and spiritual aspects to be cared for.

DOMAIN 2: CULTURAL SAFETY AND HUMILITY

Hospice volunteers, as members of the health care teams, are expected to demonstrate the competencies only as appropriate for their scope of practice, organizational policies, and specific role descriptions.

COMPETENCY	INDICATORS
Supporting cultural practices	Demonstrates understanding that cultural practices and beliefs influence how palliative and end-of-life care is provided and received, in particular for members of underserved populations.
	Demonstrates understanding that First Nations, Inuit, and Métis cultural practices and beliefs influence how palliative and end-of-life care is provided and received.
	Helps to create a safe, respectful, culturally inclusive and gender sensitive environment that is free of racism, sexism and discrimination.
Recognizing and respecting the diversity of people, families and caregivers, and communities	Demonstrates a respectful attitude towards the identities, and cultural and spiritual differences in family and/or caregiver practices surrounding illness and the end-of-life.
Engaging in self-reflection	Practices self-reflection to identify and address personal and systemic biases.

DOMAIN 3: COMMUNICATION

Hospice volunteers, as members of the health care teams, are expected to demonstrate the competencies only as appropriate for their scope of practice, organizational policies, and specific role descriptions.

COMPETENCY	INDICATORS
Seek to understand, recognize and respect that each person and family and caregiver has a unique perspective	Uses active listing, mirrors language, and adapts communication and shares information according to the unique needs of the person and their designated family and/or caregiver(s).
Listening and providing emotional support	Uses active listing, mirroring, silence and nonverbal communication to provide sensitive emotional support to the person and their designated family or caregiver(s).
	Provides emotional support within the scope of role to the person and family throughout the trajectory from diagnosis to bereavement
Adapting communication for developmental or age-appropriate conversations	Follows the current principles and best practices for communicating about dying, death, loss and grief.
	Uses a variety of strategies to engage in ongoing compassionate, individualized and timely communication with the person and their families.

DOMAIN 3: COMMUNICATION (CONT'D)

Hospice volunteers, as members of the health care teams, are expected to demonstrate the competencies only as appropriate for their scope of practice, organizational policies, and specific role descriptions.

COMPETENCY	INDICATORS
Identify people who would be suitable for and benefit from a virtual palliative approach to care	Demonstrates ability to communicate clearly with people and their families and/or caregivers, offering observations about the person and sharing information with multidisciplinary team.
	Adapt a variety of information and communication techniques to deliver a person-centered palliative approach to care virtually.
	Recognizes and shares with multidisciplinary team equity challenges to accessing and receiving virtual care including geography, finances, disabilities, language, availability of, and familiarity with technology.
Using appropriate supports to communicate effectively	Identifies barriers and utilizes supports as needed for effective communication (e.g., interpreters, assistive technology).
	Demonstrates understanding that designated family, caregiver(s) and community members may have a role in the care team, in particular for members of underserviced populations.
	Demonstrates understanding that First Nations, Inuit, and Métis family, caregiver(s), and community members may have a role in the care team.
Communicating collaboratively	Communicates health changes and concerns of the person and their designated family and/or caregiver(s) to the appropriate care team member(s).

DOMAIN 4: OPTIMIZING COMFORT AND QUALITY OF LIFE

Hospice volunteers, as members of the health care teams, are expected to demonstrate the competencies only as appropriate for their scope of practice, organizational policies, and specific role descriptions.

COMPETENCY	INDICATORS
Maintaining dignity	Provides care that maintains dignity, well-being, and the self-image of the person.
	Incorporates quality of life, as defined by the person, as a key focus of care.
Recognizing changes in health status	Observes the person’s functioning and indicators of distress, and promptly communicates changes to the health care team and/or coordinator of volunteers.
	Demonstrates a basic awareness of the most common conditions and the type of care people receive at end-of-life.
Caring for people holistically	Provides a holistic approach to care that acknowledges the physical, emotional, mental, social, cultural, and spiritual aspects to care.
	Provides simple comfort measures according to volunteer policies and scope of role as defined by organizational policies and/or collective agreement.
	Recognizes when a person is experiencing pain or discomfort and encourages person to inform health professionals and/or informs team with persons permission.
	Demonstrates respect for the role of the designated family and/or caregiver(s) for members of underserved populations throughout their palliative care.
	Demonstrates respect the role of family and community for First Nations, Inuit, and Métis throughout their palliative care.
	Demonstrates understanding that complementary and alternative medicine (CAM) can play an important role in palliative care, especially for members of underserved populations.
	Demonstrates awareness that not all family or caregivers may be in agreement with treatment choices and may need to share their concerns with the multidisciplinary team.
	Recognizes that traditional medicine can play an important role in palliative care for First Nations, Inuit, Métis and other cultures.
Offering presence	Offers a compassionate, empathic presence in response to the needs of the person and their designated family and/or caregiver(s).

DOMAIN 5: CARE PLANNING AND COLLABORATIVE PRACTICE

Hospice volunteers, as members of the health care teams, are expected to demonstrate the competencies only as appropriate for their scope of practice, organizational policies, and specific role descriptions.

COMPETENCY	INDICATORS
Understanding multidisciplinary collaboration	Demonstrates understanding of the importance of care plans, personal preference, and advance care plans, which may change through the life-limiting illness, and shares any request to change these by the person with the multidisciplinary team.
	Demonstrates understanding that designated family, caregiver(s), and community members, may have a role in the care team, in particular for members of underserved populations.
	Demonstrates understanding and cultural humility that First Nations, Inuit, and Métis family and community members may have a role in the care team.
	Understands and adheres to the scope of role, responsibilities, and limitations of the volunteer as per the organization’s policies.
	Assists medical, professional, hospice staff, and coordinator of volunteers with supporting the person’s needs as per the organization’s policies.

DOMAIN 6: LOSS, GRIEF AND BEREAVEMENT	
Hospice volunteers, as members of the health care teams, are expected to demonstrate the competencies only as appropriate for their scope of practice, organizational policies, and specific role descriptions.	
COMPETENCY	INDICATORS
Supporting diverse responses to loss	Understands grief as an expected reaction to loss that is experienced and expressed uniquely by each person.
	Acknowledges that the experience of trauma and of negative experiences on a person, including members of underserved populations, can shape the expressions of grief, bereavement, and mourning.
	Acknowledges the impact that historical and ongoing systemic trauma, racism and loss have on First Nations, Inuit, and Métis experiences and expressions of grief, bereavement, and mourning.
	Recognizes common stages and types of grief reactions in people and their families and/or caregivers, which may occur from the time of diagnosis through bereavement.
Offering support services	Understands the scope of the volunteer role in supporting people who are dying and who are bereaved.
Anticipating changes as death nears	Knows and recognize the expected changes as the person nears death sharing observations with the multidisciplinary team.
Respecting death rituals	Knows and respects the responsibilities and scope of volunteer's role and responsibilities during last hours and following death and fulfills them as appropriate with respect for the person and their designated family and/or caregiver(s).
Involving and supporting designated family and/or caregiver(s)	Demonstrates support for the designated family and/or caregiver's wishes and death rituals unless they contradict the person's own stated wishes.
	Demonstrates support for the persons, families and community-specific protocols and practices surrounding death, loss, and grief.
	Demonstrates openness to incorporating protocols and practices when caring for members of underserved populations.
	Demonstrates support for family and community-specific protocols and practices surrounding death, loss, and grief when caring for First Nations, Inuit, and Métis.

DOMAIN 7: PROFESSIONAL AND ETHICAL PRACTICE	
Hospice volunteers, as members of the health care teams, are expected to demonstrate the competencies only as appropriate for their scope of practice, organizational policies, and specific role descriptions.	
COMPETENCY	INDICATORS
Understanding legislation and policy	Demonstrates understanding of the importance of maintaining privacy and confidentiality and abides by organizational policies and procedures.
Addressing ethical issues	Anticipates and recognizes common ethical issues that may arise (e.g., issues associated with the progression of the illness, treatment choices, or differing designated family and/or caregiver(s) opinions.)
	Demonstrates an awareness of ethical issues and where to direct concerns.
Supports the inclusion of the person’s and their designated family and/or caregiver’s beliefs and values	Supports and promotes the incorporation of the person’s and their designated family and/or caregiver(s) wishes, values, and beliefs into the provision of all care.
Maintaining boundaries	Demonstrate understanding of the volunteer boundaries, their purpose, and strategies for establishing and maintaining boundaries with people and their designated families or caregivers.
Accessing continuing education	Participates in continuing education related to palliative care and according to their organization and role specific requirements.
	Participates in cultural safety and humility training opportunities, especially any that are specific to underserved populations and where available, that are regionally specific.
	Participates in First Nations, Inuit, and Métis cultural safety and humility training opportunities. Where available, participate in regionally specific training.
Educating and supporting learners	Acts as a mentor for other new volunteers in understanding what palliative care means and entails.
Contributing to quality improvement	Participates in quality improvement initiatives.
Collecting data	Participates in research activities, such as data collection, as directed by staff or care team.

DOMAIN 7: PROFESSIONAL AND ETHICAL PRACTICE (CONT'D)

Hospice volunteers, as members of the health care teams, are expected to demonstrate the competencies only as appropriate for their scope of practice, organizational policies, and specific role descriptions.

COMPETENCY	INDICATORS
Proponent for the person, family and/or caregiver(s), and societal rights	Supports the incorporation of the person’s and their designated family and/ or caregiver’s values and beliefs into care planning.
	Assists organization with community education initiatives about palliative care.
Facilitating person and family safety	Applies infectious disease protocols during visits per agency mandate.
	Reports any lapse in protocols to Coordinator of Volunteers, designate, or appropriated member of the multidisciplinary team.
	Acknowledges client/family emotional response to infection threats (e.g. fear, anxiety, etc.)

DOMAIN 8: SELF CARE

Hospice volunteers, as members of the health care teams, are expected to demonstrate the competencies only as appropriate for their scope of practice, organizational policies, and specific role descriptions.

COMPETENCY	INDICATORS
Understanding compassion fatigue	Describes the concept and can identify signs of compassion fatigue, its manifestations, and ways to help prevent it. Seeks help and resources as needed, practicing healthy strategies to help develop resilience.
	Works to provide healthy self-care strategies for the caregiver(s).
Supporting healthy behaviours for self and team	Regularly engages in health enhancing behaviors to help prevent compassion fatigue.
	Asks organization for support and resources when help is needed.
Demonstrating self-awareness	Explores own attitudes and beliefs regarding death, dying, grief and caring for people with life-limiting conditions. Attends to own responses.

Appendix A Definitions

Advance Care Planning (ACP)

An Advance Care Plan is a record of an individual’s values, beliefs, wishes and instructions about their future health and personal care, for use when unable to make decisions.

An ACP can be written down, audio/video recorded or spoken. It may also include written legal documents such as an Advance Directive and Representation Agreement.⁶

CAM

The philosophy of integrative medicine and refers to a diverse group of therapies and products that are not part of standard medical care. Complementary therapies are practiced in conjunction with standard care, while alternative therapies are practiced alone or in place of standard care.

The range of treatments currently considered by most to be CAM can include acupuncture, art therapy, ayurvedic medicine, homeopathy, massage therapy, meditation, music therapy, naturopathy, osteopathy, reiki, traditional Chinese medicine, and yoga.⁷

Caregiver or Carer

Family or other significant people (as identified by the care recipient) who provide unpaid care and assistance to individuals living with a life limiting illness.

Competency

For the purposes of the Canadian competency framework, “competency” is defined as follows: A competency is a cluster of related knowledge, skills and attitudes that affects a major part of one’s job (a role or responsibility), that correlates with performance on the job, that can be measured against well-accepted standards, and that can be improved via training and development.

Cultural Safety and Humility

Cultural Safety is an outcome based on respectful engagement that recognizes and strives to address imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.

Cultural Humility is a process of self-reflection to understand personal and systemic biases, and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another’s experience.⁸

Designated Family

In recognition of the diversity of Canadians and their families, we have added the term “designated” in front of “family” to infer that family is whomever the person receiving palliative care identifies to be in or not in this role for them, regardless of biological relationship. This may be especially important to consider for members of underserved populations.⁹

Hospice care

Hospice care refers to services provided by staff and volunteers of community-based, not-for-profit organizations with mandates for supporting individuals with life-limiting illnesses and their caregivers and bereaved.

Hospice Care Volunteers

Hospice Palliative care volunteers are those volunteers specifically recruited, screened, and trained by community-based not for profit Hospice organizations. These volunteers may work in a variety of settings, including but not limited to, in Community settings, Hospital Palliative units, Hospices, and Long-Term Care.

Interdisciplinary / Multidisciplinary team

Caregivers with different training and skills who work together to develop a team and implement a person’s plan of care. Membership varies depending on the services required to address the person’s and family’s identified issues, expectations, needs and opportunities. An interdisciplinary team typically includes one or more physicians, nurses, social workers, psychologists, spiritual advisors, pharmacists, personal support workers, and volunteers. Other disciplines may be part of the team if resources permit.¹⁰

Life limiting condition

Any condition or illness which is progressive and could cause the death of a person; this includes terms such as “serious illness”, “life threatening illness”, “terminal illness” and other similar terms.¹¹

Mirroring

Mirroring is a communication tool that replicates the physical and verbal behaviors of another to establish rapport and empathy during a conversation. Mirroring confirms understanding and acceptance of the persons situation or circumstances. For example, if the person says “when I have passed” the listener mirrors and uses the same phrase.

Palliative care

According to the World Health Organization, “Palliate approach to 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.”¹²

Palliative approach to care (PAC)

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 health care providers 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 care¹³

Underserviced populations

Underserviced populations refers to individuals who identify with belonging to these populations: perinatal, infants, children, adolescents, and young adults; the elderly; First Nations, Inuit, and Métis; racial or ethnic minorities; members of minority language communities; members of the LGBTQ2 community; immigrants and refugees; persons who have illnesses other than cancer; those who live in rural, remote, and northern communities, or are socioeconomically disadvantaged, homeless, incarcerated, engage in sex work, or have mental or cognitive impairments. Please note that this is not an exhaustive list and it can be expanded upon.¹⁴

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*People affected by serious illness have
the best quality of life, supported by care
that reflects their goals and wishes.*