CANADIAN HOSPICE PALLIATIVE CARE
NURSING STANDARDS OF
PRACTICE

This work is dedicated to those individuals and families who have inspired us to improve hospice palliative care nursing practice.

CHPC Nursing Standards Sub-Committee

2014
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FOREWORD

The Canadian Hospice Palliative Care Nursing Standards (hereafter referred to as the Standards) have been developed to support the project of Canadian Nurses’ Association specialty certification in hospice palliative care nursing. Consistent with Canadian Registered Nurses’ scope of practice, the Standards articulate what the public can expect from HPC certified nurses in any practice setting in Canada. Refer to the glossary for definitions that differentiate standards and competencies. The 2014 Standards are best read in conjunction with the most current Canadian Nurses’ Association (CNA) Hospice Palliative Care Nursing Certification Exam Blueprint and Specialty Competencies available on the CNA website.

Relevant to nurses with a specialty focus of hospice palliative care in any Canadian practice settings, the Standards inform:

• provision of HPC nursing care;
• professional and public education for and about HPC nursing; and
• quality improvement, scholarly, and advocacy activities in HPC broadly and HPC nursing specifically.

The Standards are integral to the CNA Hospice Palliative Care nursing certification process. Standards are broad statements that inform the development of more specific HPC nursing competencies, indicators, and certification exam questions.

As mandated by the CNA certification program, the Canadian Hospice Palliative Care Nurses Group (CHPC NG) conducts an ongoing 5-year cycle of the Standards review and revision process. The ongoing review and revision of the Standards is maintained to reflect:

• current evidence-informed and knowledge-based HPC nursing practices;
• the full scope of the practice of Registered Nurses in the provision of HPC in Canada’s diverse healthcare milieu;
• public expectations and needs with respect to HPC; and,
• HPC-related health and legislative policy.

The CHPC NG executive delegates the responsibility for conducting standards review and revision to the HPC Standards of Nursing Practice Sub-committee. Sub-committee membership for the 2014 round of review and revision included CHPC NG members from diverse regions and settings across Canada. Members represented clinical, administrative, research, and education sectors (see Acknowledgments for 2014 Standards Sub-committee membership). Reporting to the CHPC NG executive, Sub-committee activities included consultation with CHPC NG membership and other stakeholders to inform the review process.

2014 Standards Revision Process

The 2014 Standards revision process included analyzing feedback about the 2009 Standards from Canadian nurses with an interest or expertise in HPC. Feedback was received in 89
responses to a SurveyMonkey® questionnaire distributed to Canadian nurses via the CHPC NG list serve. Four separate submissions of the 2009 Standards document were received with specific recommendations and comments made by individuals or groups. Feedback was also submitted by HPC nurse specialists who participated in a focus group that was facilitated by a member of the Standards Sub-Committee. Future efforts will be made to refine the methodology of Standards revision. Feedback from CHPC Nurses Group members and stakeholders indicated relatively minor revisions were necessary in 2014. These revisions were made. Given the affiliation of the CHPC NG with the Canadian Hospice Palliative Care Association (CHPCA), the Standards were also aligned with the newly revised Canadian Hospice Palliative Care Association Model to Guide Hospice Palliative Care (CHPCA, 2013). A key emerging trend in HPC, the ‘palliative approach’, integral to the revised and streamlined standards is also an important focus in the 2014 edition of the Standards.

In addition to responding to feedback from the CHPC NG executive and membership, the 2014 Sub-Committee members sought to honour the original work of the 2004 and 2009 Sub-Committees. This included building on previous versions of the Standards, striving to broadly represent HPC specialty nursing practice, holding discussions with HPC nurses about evolving understandings and standards of their practice, and aligning nursing standards with CHPCA standards and norms of practice.

**History of CHPC Nursing Standards**

A chronicle of the CHPC Nursing Standards and competencies is given below:

- **2002**: First publication of the CHPC Nursing Standards.
  - *Supportive Care Model* (Oberle & Davies, 1992) chosen as a framework.
  - Specific competencies as well as general standards were included (detailed competencies had been developed in Canadian HPC nursing at that time).
- **2003**: HPC nursing established as a CNA specialty through the advocacy of CHPC NG members.
- **2004**: First administration of the CNA HPC nursing certification exam.
- **2009**: First revision of the Standards.
  - Extensive consultation with HPC nurses throughout Canada identified that while nurses indicated that the *Supportive Care Model* (Oberle & Davies, 1992) could continue to be a resource for HPC nursing, the majority of nurses indicated that HPC Nursing Standards should be aligned with the Ferris et al. (2002) *Canadian Hospice Palliative Care Association (CHPCA) Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice*.
  - While members of the 2009 CHPC Nursing Standards Sub-Committee identified the importance of building on the original Standards, they also strove to broadly represent HPC nursing practice. In addition, Sub-Committee members set the vision that future revisions involve dialogue with nurses to reflect evolving understandings and standards of nursing practices.
2014: Second revision of the CHPC Nursing Standards for Practice.

- Feedback from CHPC NG members and stakeholders indicated relatively minor revisions were necessary.
- Revision process honoured the vision and approach set by the 2009 Subcommittee: build on original standards; strive to broadly represent HPC nursing practice; dialogue with nurses to reflect evolving understandings and standards of HPC nursing practice; and, align nursing standards with CHPCA standards and norms of practice.
- The Standards were aligned with the newly revised Canadian Hospice Palliative Care Association Model to Guide Hospice Palliative Care (CHPCA, 2013).
- A key emerging trend in HPC, the ‘palliative approach’, named and integrated in the revised and streamlined standards was also integrated in the 2014 Standards.

**HOSPICE PALLIATIVE CARE NURSING IN CANADA**

The philosophy and delivery of care at St. Christopher's Hospice in England in the 1960s inspired Canadian pioneers who developed the first formal Canadian hospice palliative care services. The first facilities were opened at St. Boniface Hospital, Winnipeg, Manitoba, in November 1974, and shortly thereafter at the Royal Victoria Hospital, Montreal, Quebec, in January 1975. In these settings, care delivery was designed to be inter-professional and included representatives of nursing. Since that time the HPC movement has grown to have as well as advocate for some form of HPC services in various cities and communities in all Canadian provinces and territories.

HPC nurses are committed to providing quality hospice palliative care to the “whole person” and family. The HPC nurse draws on an extensive, specialized body of knowledge to attend to the physical, emotional, psychosocial, cultural, and spiritual concerns of each person. HPC nurses practice in collaboration with caregivers, volunteers and professional providers. The contributions of nurses and nursing continue to be integral to the HPC movement.

Nurses engage in processes of specialization and certification as ways to improve the quality of care provision. The ongoing recognition and desire to establish a formal specialization for HPC nursing in Canada was brought to the fore during the first meeting of the Canadian Hospice Palliative Care Association (CHPCA) Nurses Interest Group, held in Winnipeg, Manitoba, in 1993. The main purpose of this meeting was to network and advance HPC nursing in Canada. Two major goals set by the group were to establish Canadian HPC Nursing Standards and to have HPC nursing recognized as a specialty area of practice by the Canadian Nurses Association (CNA). These goals were achieved in 2002. Eventually, the Nurses Interest Group was titled: The Canadian Hospice Palliative Care Nurses Group (CHPC NG). The overwhelming original and ongoing response to write the CNA exam and renew certification attests to the dedication of HPC nurses to advance their practice. In 2008, the CHPC NG became an Associate Member of CNA.

The CHPC NG continues to be an active member of CHPCA, which has a large nursing membership and supports an electronic list serve for networking and discussions related to achieving standards of practice. The CHPC Nurses Group has an elected national executive
board that hosts an annual general meeting for paid members and stakeholders at the CHPCA conference.

Nurses are integral members of HPC teams. They often serve as the primary professional contact and liaison with the person and family and among other team members. HPC nurses complete comprehensive assessments, interventions, and evaluations; establish mutually agreed upon goals of care; monitor the person’s health and disease progression; and attend to complex multidimensional palliative care needs. HPC nurses often coordinate services across the continuum of care and collaborate with various inter-professional and volunteer team members (adapted from CHPCA Pan Canadian Gold Standards, 2006). HPC nurses will continue to play a critical role in advocating for better access to services and the promotion of clinical excellence, to improve the quality of living-dying for those with life-limiting illness.

Nursing care of people who are living with and dying from a life-limiting illness, along with equal supportive care of their families is undertaken by nurses in all settings with varying levels of expertise. HPC nurses strongly support that comprehensive hospice palliative care should be available in all settings, including but not limited to private homes, prisons, group homes, rehabilitation centres, on the street and in specialized facilities such as mental health facilities, cancer centres, schools, workplaces, and day hospice programs (adapted from HPC Nursing Standards of Practice, CHPCA 2002).
DEFINITION OF HOSPICE PALLIATIVE CARE


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).

For ease of reference, included here are several definitions and descriptions developed by the CHPCA (2013a) and relevant to HPC nursing practice in Canada. Note also the references to “the palliative approach” and paediatric palliative care at the end of this section.

Hospice palliative care aims to relieve suffering and improve the quality of living and dying.

Hospice palliative care strives to help individuals and families:
• address physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears
• prepare for and manage self-determined life closure and the dying process
• cope with loss and grief during the illness and bereavement experience.

Hospice palliative care aims to:
• treat all active issues
• prevent new issues from occurring
• promote opportunities for meaningful and valuable experiences, personal and spiritual growth, and self-actualization.

Hospice palliative care is appropriate for any person and/or family living with or at risk of developing a life-threatening illness due to any diagnosis, with any prognosis, regardless of age, and at any time they have unmet expectations and/or needs, and are prepared to accept care.
Hospice palliative care may complement and enhance disease-modifying therapy or it may become the total focus of care.

Hospice palliative care engages individuals and their families in planning for the care they want at different stages in their illness based on their own goals and values and on a clear understanding of their prognosis and treatment options (advance care planning). When people have access to palliative care services, they report fewer symptoms, better quality of life, and greater satisfaction with their care. The health care system reports more appropriate referrals, better use of hospice care, fewer emergency room visits and hospitalizations, and less use of ineffective intensive interventions in the last days of life. (CHPCA, 2013a, p. 6)

Hospice palliative 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. Providers are typically trained by schools or organizations governed by educational standards and are accountable to standards of professional conduct set by licensing bodies and/or professional associations. (CHPCA, 2013, p. 7)

Foundational concepts on which hospice palliative care is based:

There are three foundational concepts articulated in *A Model to Guide Hospice Palliative Care.*

- **Effective communication** – fundamental to the process of providing care, the team-based approach to person and family-centred care and the efficient function of a hospice palliative care organization. When combined with informed and skilled decision-making, effective communication leads to better care delivery decisions, less conflict, a more effective plan of care, greater person/family/caregiver satisfaction with the therapeutic relationship, fewer caregiver errors, less stress and fewer burnout/retention problems.
- **Effective group function** – involves a process of group formation and function that includes forming and then move through storming and norming until the group begins performing their tasks effectively together. Each participant plays a role in the circle of care. Whenever the composition of the circle of care changes, the group must re-establish itself by again moving through the stages until it is performing effectively. To be effective, all groups need skilled leadership to facilitate their activities and promote effective group dynamics. (Tuckman, 2001)
- **Ability to facilitate change** – the interprofessional team must be skilled at maximizing openness and adaptability in the attitudes, knowledge, skills and behaviours of everyone involved in the circle of care. They must also have specific skills to assist individuals and families through the transitions they experience during illness and bereavement. All aspects of organizational development and function, education, research and advocacy are also based on the effective use of change strategies. (CHPCA, 2013a, p.9)
The Role of Hospice Palliative Care throughout the Illness Trajectory

While HPC grew out of and includes care for people at the end of life, HPC is increasingly understood as appropriate for any person and/or family living with or at risk of developing a life-threatening illness due to any diagnosis, with any prognosis, regardless of age, and at any time they have unmet expectations and/or needs, and are prepared to accept care. The following figure (CHPCA, 2013, p.7) illustrates the typical shift in focus of care over time, and how hospice palliative care plays an increasingly significant role as the person moves through the illness trajectory.

**Palliative Care Approach:**
The palliative care approach (CHPCA, 2013b) has been proposed to emphasize that hospice palliative care can be appropriately integrated throughout the illness trajectory and bereavement experience to address suffering and quality of life, and to facilitate the participation of persons and family members in healthcare and choices for care. HPC nurses work collaboratively with persons, family members, and other healthcare providers to integrate HPC services and the palliative care approach into a comprehensive care plan throughout the life trajectory, including times of acute, chronic, and advanced life-threatening illness.

The principles of HPC and a palliative care approach are applicable in the nursing care of people of any age and population. Notably, the document entitled *Paediatric Hospice Palliative Care: Guiding Principles and Norms of Practice* (2006) specifies that, “paediatric hospice palliative care is based on the same principles as adult hospice palliative care but also recognizes the unique needs of families faced with a child’s illness and death” (p. 7).
VISION

All persons and their families living with and dying from life-limiting illness will have access to nurses who provide knowledgeable and compassionate care to lessen the burden of suffering and improve the quality of living and dying.

MISSION

Hospice Palliative Care (HPC) nurses bring specialized knowledge, skills, and attitudes to the delivery of comprehensive, coordinated, and compassionate care for people living with or at risk of developing a life-limiting illness and their families throughout the illness trajectory and bereavement experience, and in the setting of their choice. Through a commitment to public and professional education, mentorship, leadership, research, and advocacy, HPC nurses strive to support the highest possible quality of life for the person and their family throughout the illness continuum, dying process, and bereavement experience.

PURPOSE

The purpose of Canadian HPC Nursing Standards is to:

• define the standard of care that can be expected by all persons receiving care from nurses who specialize in HPC;
• provide a framework for the development of performance evaluation criteria;
• serve as a foundation for the development of certification in HPC nursing;
• guide the ongoing development of related HPC nursing competencies;
• inform specialty HPC nursing education throughout the nurse’s career; and,
• promote HPC nursing practice as a specialty.

ASSUMPTIONS AND VALUES

Listed below are assumptions and values about person, environment, health, and nursing, which underpin HPC nursing practice. As in all areas of nursing, the CNA Code of Ethics for Registered Nurses (2008) provides a foundation for HPC 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:
  o provided in the setting chosen by the person and family
  o available at primary, secondary and tertiary levels
  o 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.
• HPC nursing practice attends to pain and other symptom relief; and, psychosocial, grief and bereavement support.
• HPC nursing includes all areas of practice: clinical, education, administration, research and advocacy.
The hospice palliative nurse maintains and conducts practice in a manner that is congruent with the Canadian Nurses Association Code of Ethics; relevant provincial or territorial standards; and Canadian Hospice Palliative Care Association guiding values and principles. The following Standards pertain to specialized hospice palliative (HPC) nursing.

1. **Person and Family-Focused Care**

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

2. **Comfort**

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

4. **Quality and Safety**

   The HPC nurse works 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 HPC nurse advocates for and promotes high quality and safe palliative care.

   The HPC nurse advances HPC nursing through the generation, critical analysis, and application, and dissemination of knowledge and research.
The HPC 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 HPC nurse communicates and advances the distinct contribution of nursing to the care of people and family members.

6. **Personal and Professional Growth**

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

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

The HPC 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.
GLOSSARY

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

**Accountability:** Registered Nurses are accountable for their actions and answerable for their practice. As members of a self-regulating profession, Registered Nurses practise 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*, 2008).

**Advance care planning:** This is a process whereby people reflect on their values and wishes and communicate future health and personal care preferences in the event of incapacitation (CHPCA, 2014).

**Advocacy-based care:** Described as a guiding principle of HPC, it is understood that “[r]egular 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).

**Collaborative:** “Each community’s needs for hospice palliative care are assessed and addressed through collaborative efforts/partnerships among organizations and services in the community” (CHPCA, 2013, p. 8).

**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).

**Continuum of care/Illness trajectory:** This refers to the entire period of time throughout the illness and including the bereavement experience (CHPCA, 2002).

**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:** This 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).

**Interprofessional team:** A team of caregivers who work together to develop and implement a plan of care. Membership varies depending on the services required to address the identified expectations and needs (CHPCA, 2002).

**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 centred:** “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).
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