Self-assessment for Nurses

Name_____ Date_____

Title/Role _____Organization/Location_____

- **Novice (N)** – may be experienced in psychosocial care but new to palliative care. Needs regular support.
- **Advanced beginner (B)** – can practice independently using some psychosocial skills specific to palliative care but still needs support.
- **Competent (C)** – mostly independent, occasionally seeks out support.
- **Proficient (P)** – autonomous practice, seeks out leadership opportunities.
- **Expert (E)** – highly proficient, is regularly sought out by others.

5 Care planning and collaborative practice

5.1 Understanding interdisciplinary collaboration, transitions, and roles

5.1.1	A. Generalist Collaborate with the interdisciplinary team, person, and designated family or caregiver(s) to ensure care plans are consistent with goals of care, preferences, and advance care plans, which may change throughout the life-limiting condition.	◯ N ◯ B ◯ C ◯ P ◯ E
	B. Specialist Assist with coordinating care and making referrals to interdisciplinary team members and/or organizations – e.g., visiting volunteers.	◯ N ◯ B ◯ C ◯ P ◯ E
5.1.2	Identify and support navigation of the full range and continuum of palliative care services, resources, and settings in which such services are available. Recognize and coordinate smooth transitions between institutions.	◯ N ◯ B ◯ C ◯ P ◯ E

5.2 Modifying care plans as needed

5.2.1	Evaluate communication with the person and their designated family or caregiver(s) to ensure that their care plan meets the person's identified needs.	◯ N ◯ B ◯ C ◯ P ◯ E
5.2.2	Engage with First Nations, Inuit, and Métis community leaders and/or Elders, when appropriate or if requested, to co-create a high-quality approach to palliative care for the person and their designated family or caregiver(s).	◯ N ◯ B ◯ C ◯ P ◯ E
5.2.3	Evaluate interventions within the care plan, discuss with the interdisciplinary team and propose appropriate alternatives, if necessary.	◯ N ◯ B ◯ C ◯ P ◯ E
5.2.4	Recognize common symptoms of common trajectories of life-limiting conditions, and anticipate the needs of the person who has a particular disease.	◯ N ◯ B ◯ C ◯ P ◯ E
5.2.5	Routinely assess Palliative Performance Scale (PPS) to determine changing functional status.	◯ N ◯ B ◯ C ◯ P ◯ E

	Palliative care competencies and descriptions	Knowledge/skill level
5.3	**Making informed decisions**	
5.3.1	Understand the importance of determining the person's capacity before having conversations with them regarding advance care planning (ACP), goals of care, and healthcare consent. Understand how a substitute decision maker (SDM) is determined, and the role the SDM plays in making healthcare decisions if the person does not have capacity. Know and apply laws applicable to specific jurisdiction.	◯ N ◯ B ◯ C ◯ P ◯ E
5.3.2	Facilitate informed decision-making and consent by the person (or, if incapable, their SDM) regarding place of care, while identifying risks in a supportive manner.	◯ N ◯ B ◯ C ◯ P ◯ E
5.3.3	Support the person, their designated family or caregiver(s), and SDM in decision-making, including withholding or withdrawing an intervention.	◯ N ◯ B ◯ C ◯ P ◯ E
5.3.4	A. Generalist When able, provide care in the person's preferred place while recognizing the complexities and challenges involved for people, designated families, and caregivers.	◯ N ◯ B ◯ C ◯ P ◯ E
	B. Specialist Provide palliative care and support capacity building in all settings where people reside. This includes the home, long-term care facilities, and acute care settings, such as community hospitals and emergency departments in rural and remote settings, hospices, group/supportive housing, shelters, jail/prison, etc.	◯ N ◯ B ◯ C ◯ P ◯ E
5.4	**Understanding advance care planning**	
5.4.1	Understand advance care planning (ACP) and help people set their goals and preferences for care if they wish to prepare or revise an ACP.	◯ N ◯ B ◯ C ◯ P ◯ E
5.4.2	Provide care and implement treatment plans in keeping with the person's expressed wishes and/or goals of care.	◯ N ◯ B ◯ C ◯ P ◯ E
TOTAL	**5 Care planning and collaborative practice**	
		N B C P E