Alberta Pharmacists'

Palliative Care Competency Framework

Version 1.0 (September 2020)

A Resource Manual for Health Care Professionals

Covenant Health is proud to continue our mission to seek out and respond to the needs in the vulnerable population of palliative care. Following two decades of establishing an international reputation, Covenant Health launched the Palliative Institute in October 2012 with a strategic plan to "be leaders in robust palliative and end-of-life care and advocate for it to be an essential part of the health system."

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Dedication

We dedicate this document to patients living with a life-limiting illness, their families and friends and the dedicated health care providers caring for them.

Forward

The patient and their family are at the heart of every interaction and every intervention in palliative care. We dedicate this document to patients living with a life-limiting illness, their families and friends and the dedicated health care providers (HCPs) caring for them.

Sharing family palliative care stories serves as an important reminder to continually improve palliative care whenever possible. We share with you the following words and experiences of Jim Mulcahy, patient, caregiver, husband, father, and grandfather.

“Joan Halifax, a Buddhist teacher, and a servant of the sick and dying, suggests that the practice of palliative care requires a strong back and a soft front. The strong back being the technical competencies, the skills, and knowledge crucial to minimizing the suffering, and maximizing the quality of life of those living through a life-ending illness,” Mulcahy says “The soft front being the authentic, resonate heart of the caregiver. In the end, it is the reality of personal relationships which saves everything.”

“It is the lived acknowledgement and therapeutic significance of an authentic, personal, compassionate relationship between the caregiver and the patient. A relationship of trust, commitment, and tenderness. It is a gift, a blessing given by the caregiver to the patient. The gift of community, the gift of consolation, meaning, and companionship. A gift which ennobles the caregiver and the patient in equal measure. I am going to repeat that because it is so important. I get so sick and tired of people talking about the professions in terms that they deny the possibility that it just might be an act of nobility to dedicate your life to caring for people. My wife is not a health care consumer, she is a person and she has a name. She is not just a pathology. And people who care for her genuinely, in my estimation, are noble. It is a gift that ennobles the caregiver, as well as the patient, in equal measure. A gift given until we are no more. It is the ancient, archetypal expression of human solidarity that one should care for another. It is the measure of what is best in us as people and as a county.”

Alberta Pharmacists' Palliative Care Competencies Referent Group

The Alberta Pharmacists' Palliative Care Competencies Referent Group below assisted in recruiting individuals participating in the production of the Alberta Pharmacists' Palliative Care Competency Framework. This includes members of the Alberta Palliative Care Competencies' Advisory Working Group and the Alberta Pharmacists' Palliative Care Competencies Working Group; (see detailed acknowledgements in Appendix 3). Inclusion does not necessarily reflect official endorsement at the organizational level. Details of the broad and intensive consensus process can be found in a companion technical document, the Alberta Palliative Care Competency Framework Technical Report [Covenant Health]. Errors and omissions are attributed solely to the Covenant Health Palliative Institute.

<table>
<tr><th colspan="2">Alberta Pharmacists'
Palliative Care Competencies Referent Group</th></tr>
<tr><th>Health Care Organizations</th><th>Educational Institutions</th></tr>
<tr><td>

- Alberta Health Emergency Medical Services

<u>Alberta Health Services</u>

- Calgary Zone Palliative and End-of-Life Care Program
- Chinook Regional Hospital, Lethbridge
- Cross Cancer Institute, Edmonton
- Edmonton Zone Palliative Care Program
- Edmonton Zone Palliative and End-of-Life Care and Community Programs, Continuing Care
- Provincial Palliative and End-of-Life Care, Community, Seniors, Addiction and Mental Health
- Queen Elizabeth II Hospital, Grande Praire
- Red Deer Regional Hospital
- Royal Alexandra Hospital, Edmonton
- Whitecourt Healthcare Centre

<u>Covenant Health</u>

- Professional Practice and Research
- St. Michael's Palliative Care Unit, Lethbridge
- Tertiary Palliative Care Unit, Grey Nuns Hospital, Edmonton

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<u>University of Alberta</u>

- Faculty of Nursing
- Faculty of Medicine and Dentistry
- Faculty of Pharmacy and Pharmaceutical Sciences

<u>University of Calgary</u>

- Faculty of Medicine
- Department of Oncology

Professional Regulatory Bodies and Associations

- Alberta College of Pharmacy
- Alberta Pharmacists' Association
- College of Licensed Practical Nurses of Alberta

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Alberta Palliative Care Competency Framework

A competency is defined by Parry[1] as 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." A Competency Framework is a compilation of competency statements.

How to Use the Alberta Palliative Care Competency Framework

This document provides a reference and opportunity to engage in self-assessment of your own knowledge, skills, behaviors and attitudes toward palliative care. Competency statements are organized by areas of expertise for ease of recognition (competency numbers are for reference only). A checkbox marked 'Educational Opportunity' beside each competency helps to identify competencies which may require further education and training. Space is provided at the end of each domain for additional notes, including questions or missing competencies you may wish to communicate to the report authors. A glossary of terms is provided in an Appendix.

Purpose of this Document

Competencies allow HCPs to identify the skills, knowledge and attitudes required when providing palliative care. The Alberta Pharmacists' Palliative Care Competency Framework can be used as a resource to inform and guide academic curricula, professional development, professional regulatory bodies, continuing education programs and employers. This document presents the Alberta Pharmacists' Palliative Care Competency Framework which was developed by the Alberta Pharmacists' Palliative Care Competencies Working Group.

Competency statements are organized according to the following two dimensions:

1. Level of expertise
2. Competency domains

[1] Parry, S. B. (1996).The quest for competencies. Training 33, 48–54.

Level of Expertise

According to the Alberta Palliative Care Competency Triangle (Figure 1), HCPs have varying levels of palliative care expertise depending on how frequently and closely they work with patients who have life-limiting illnesses.

The Alberta Palliative Care Competency Triangle and associated definitions are adapted from the Irish and BC palliative care frameworks. The Alberta Palliative Care Competency Triangle is divided into three health care provider (HCP) levels of expertise, represented by ALL, SOME and FEW. Each level of expertise requires a different set of competencies. They are separated by a dotted line to highlight that some HCPs may fit into more than one category. Each HCP level includes the competencies from the ones above it. For example, HCPs in the SOME category would also be expected to have the competencies outlined in the ALL level, and HCPs in the FEW level would be expected to have the competencies from the ALL and SOME levels.

Figure 1: The Alberta Palliative Care Competency Triangle

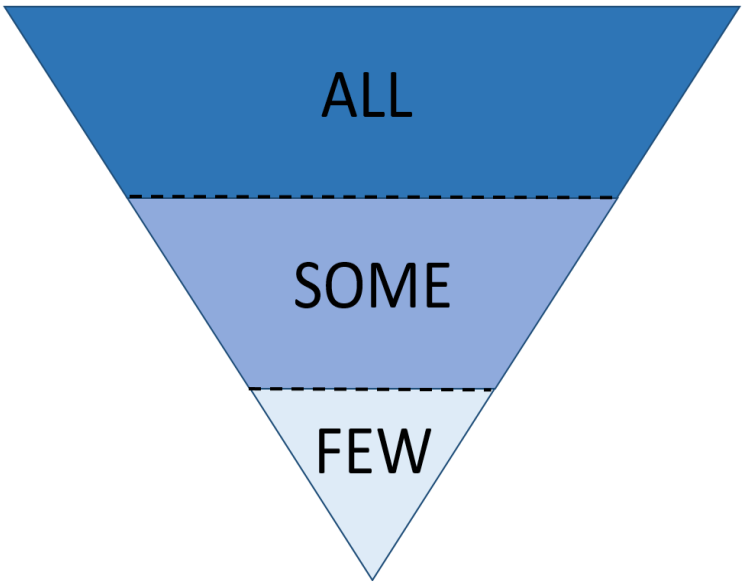


Table 1: Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions
All: HCPs in this level provide care within their scope of practice, to any person in any care setting, including those with life-limiting illnesses. They have foundational knowledge, and skills in palliative care. This category includes interprofessional health care teams that provide direct and ongoing palliative care for patients and their families by addressing their physical, emotional, social, practical, cultural and spiritual needs and respecting their personal autonomy with dignity and compassion. These HCPs may provide clinical management and care co-ordination, including assessments, interventions, referrals and triage using a palliative approach, within their scope of practice. They use evidence-based guidelines and may consult with specialized palliative care services as required, to support palliative care patients and their families. The competencies identified in this level are required for any HCP at entry to practice, point of registration and in relation to their current role.

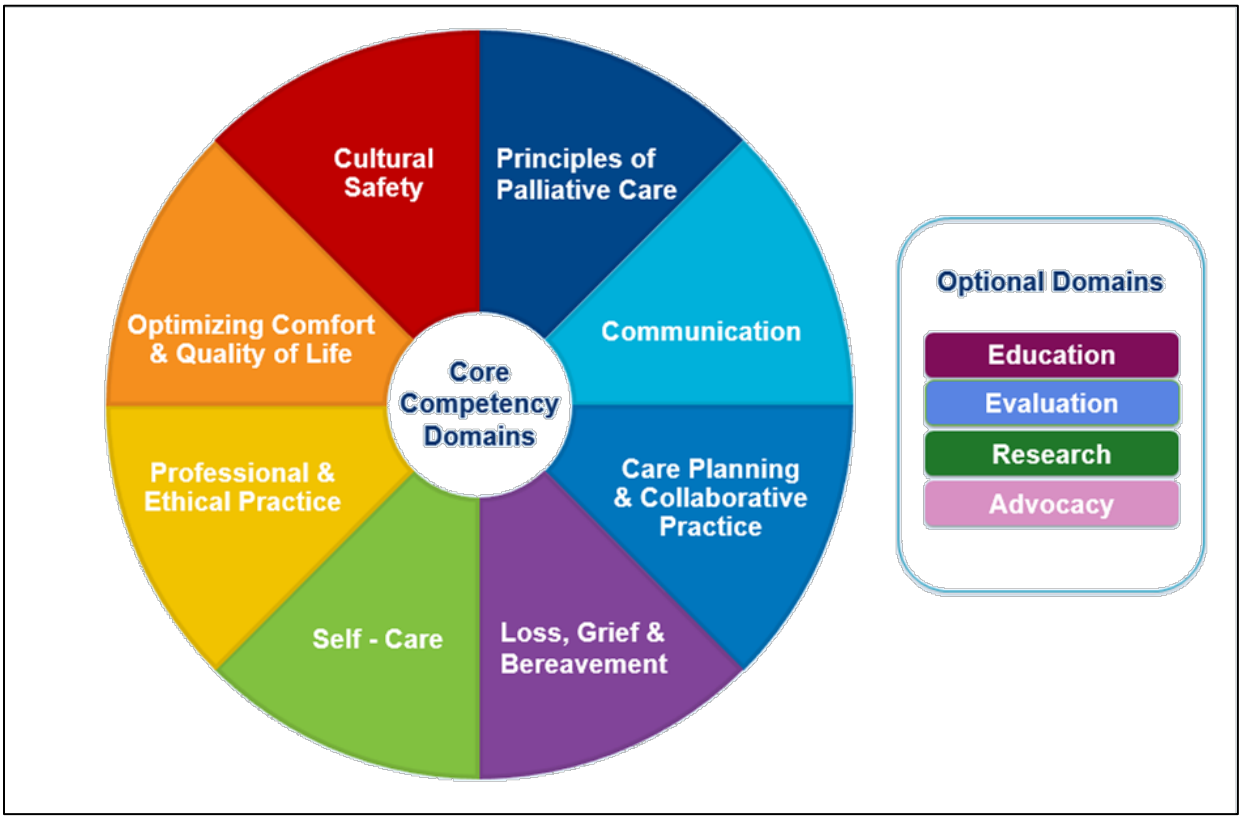
Table 1 Continued: Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions
Some: These HCPs have deeper knowledge, understanding and application of palliative and end-of-life care. HCPs in this level also provide care in any setting. They have expertise in palliative and end-of-life care, in managing pain and other symptoms and in providing psychosocial and spiritual support. They ensure that adequate assessment and management of symptoms, psychological distress, practical and financial issues and spiritual needs are incorporated into comprehensive care for patients and families. They provide enhanced care for more complex needs and consult with specialized palliative care services as required. They are a resource for colleagues within their local environment and may support patients and families who are not directly assigned to their care.
Few: This level of HCPs are palliative care experts who provide care for patients and their families, including those with the most complex palliative care needs. They provide a focused level of service for patients and families who require specialized, frequent and skilled assessments and interventions in palliative and end-of-life care. They may act as a resource and support to any HCP (including those working in hospices and palliative home care) and provide formal and informal expert palliative and end-of-life care consultation. These palliative care experts provide leadership, mentoring and education in palliative and end-of-life care. This level also includes, but is not limited to, experts who conduct research and develop advocacy strategies that advance approaches to palliative care and contribute to quality improvement on a system level.

Competency Domains

The competency statements are organized according to eight core competency domains and four optional competency domains (Figure 2). The core competencies domains are common for each HCP group and represent the primary level of understanding required to provide palliative care.

The optional competency domains may apply only to certain HCP groups and levels of expertise. Each working group collaboratively decided which optional domains to include. Each competency domain is defined with a domain statement. The domain statement remains the same irrespective of the level at which or the setting where palliative care is provided. Each domain has a set of competency statements. These statements outline the competencies required by HCPs in the context of their role and at the level of expertise with which they work.

Figure 2. Alberta Palliative Care Competency Domains



Domain 1: Principles of Palliative Care
Palliative care is both a philosophy and an approach to care that enables all patients with a life-limiting illness to receive integrated and coordinated care across the continuum of life. This care incorporates each patient's and family's values, preferences and goals of care, and spans the disease process from diagnosis to end-of-life, including bereavement. The following principles are foundational in providing palliative care to each patient and their family within Alberta: patient- and family-centeredness; equitable access; collaborative and integrated team service delivery; communication and information sharing; safe; ethical and quality care; sustainability and accountability; clearly defined governance and administration models; and research.

Domain 2: Communication
Communicating effectively is essential to the delivery of palliative care. Specific consideration should be given to communication as a method of establishing therapeutic relationships and patient/family participation in decision-making. Empathetic, person to person communication is foundational to palliative care. Communication is also important where circumstances are ambiguous or uncertain or when strong emotions and distress arises. Effective communication includes information technology (i.e. NetCare, Connect Care) for knowledge transfer at all levels (patient and family, service delivery and system) and the use of common tools, language and utilization of the most appropriate documentation to support seamless transitions of

each person, to convey appropriate information and to safely manage each person's and family's care needs.

Domain 3: Care Planning and Collaborative Practice
According to the *AHS Palliative and end-of-life care Alberta provincial framework,* "In order to meet the individual needs of each person and their family, comprehensive interprofessional teams with varying skills and knowledge are required to safely and effectively care for Albertans who are palliative or are at the end of life." [Alberta Health Services] Care planning is a collaborative practice that includes addressing, coordinating and integrating patient-centered care and family-centered care needs. It is enabled by interprofessional, cross-sector care planning, and communication that involves comprehensive needs assessment, promoting and preserving choice, and planning for likely changes that occur with the context of a deteriorating illness trajectory. Care planning ensures that multiple disciplines and agencies can be accessed and referred to as required in a timely manner. Each patient and their family should be supported in care planning to the extent that they are able and wish to be involved.

Domain 4: Optimizing Comfort and Quality of Life
Supporting and optimizing comfort and quality of life as defined by the patient and family includes comprehensively assessing and addressing their emotional, psychological, social and spiritual needs as well as their physical needs. This is an ongoing process which aims to prevent, assess, acknowledge and relieve suffering in a timely and proactive manner, as well as includes effective symptom management that is in alignment with the patient's goals of care.

Domain 5: Loss, Grief and Bereavement
A palliative approach assists HCPs in providing support to patients, families and communities, when possible, throughout the illness trajectory as they experience loss, grief and bereavement. This includes identifying patient and family needs, identifying those who may require additional bereavement support, and providing information and resources and support to all.

Domain 6: Professional and Ethical Practice
According to the *AHS Palliative and end-of-life care Alberta provincial framework*, "Comprehensive assessments by adequately skilled professionals and providers are at the heart of quality and ethical care delivery. The provision of care that is appropriate to all domains, including physical, psychological, social and spiritual requires knowledge and tools related to assessment in these areas." [Alberta Health Services] HCPs focus on respecting and incorporating the values, needs and wishes of the patient and their family into care planning while maintaining professional, personal and ethical integrity. Professional and ethical integrity guide all HCPs to consider how best to provide ongoing care to people with life-limiting illnesses as their healthcare needs change.

Domain 7: Cultural Safety
Cultural safety is a process that encourages a patient to feel safe, without any fear of judgement, repercussions, discrimination (individual or systemic), or assault because of their needs and identities. It is defined and experienced by the patient. It is based on

respectful engagement, and communicating respect for a patient's beliefs, behaviors, and values and ensures that the patient is a partner in decision making. It requires acknowledgement that we are all bearers of culture including the need for self-reflection about one's own attitudes, beliefs, assumptions and values. It requires recognition of the power differentials inherent in healthcare service delivery, institutional discrimination, and the need to address these inequities through education and system change. Assessing and respecting values, beliefs and traditions related to health, illness, family caregiver roles and decision-making are the first step in providing spiritually and culturally sensitive palliative care. Culturally safe care involves building trust with the patient and recognizing the role of socioeconomic conditions, history and politics in health. It requires awareness of family dynamics and the role the family plays in the cultural safety of the patient. Cultural competency is the process HCPs achieve with cultural safety being the outcome. [Health Council of Canada]

Domain 8: Self-Care
Self-care includes a spectrum of knowledge, skills, attitudes and self-awareness. It requires all HCPs to engage in ongoing self-reflection regarding appropriate professional boundaries and the personal impact of caring for patients with life-limiting illnesses and their families. Self-care requires the use of holistic wellness strategies that promote the health of oneself as well as the health and function of the team.

Domain 9A: Education
Participating in palliative care continuing education, facilitating palliative care educational opportunities for HCPs, volunteers, each patient, their family and the public.

Domain 9B: Evaluation
Based on evidence informed practice and available research, leading and/or participating in the evaluation of palliative care services and HCPs, patients' and families' experiences.

Domain 9C: Research
Promoting, participating in, and/or leading palliative care research; keeping abreast of palliative care research and inviting patients and their families to participate in relevant research projects.

Domain 10: Advocacy
Advocating for access to and funding for palliative care services and associated educational initiatives; policy development; and addressing the social determinants of health to improve patient outcomes.

Alberta Pharmacists' Palliative Care Competencies

Domain 1: Principles of Palliative Care	
All	**Educational Opportunity**
1. Explain the philosophy of palliative care.	☐
2. Explain that a palliative approach to care starts early in the trajectory of a progressive life-limiting illness, and may be appropriate at the time of diagnosis.	☐
3. Describe the meaning of the term 'life-limiting illness'.	☐
4. Maximize patient dignity by facilitating expression of needs, hopes, feelings and concerns when planning palliative care.	☐
5. Describe the role and function of the interprofessional team in palliative care.	☐
6. Apply the principles of palliative care that affirm life by supporting the patient to live as actively as possible until death, with optimal quality of life.	☐
7. Integrate the principles of palliative care into pharmacy practice.	☐
8. Recognize the role of the family may change as the patient's illness progresses and this may impact both the patient and their family.	☐
9. Integrate the patient's physical, psychological and social needs into the provision of pharmaceutical care and pharmacy practice.	☐
10. Practice patient-centered palliative care that incorporates the unique contributions of the family in care-giving.	☐
11. Engage in empathic and responsive relationships with the patient experiencing a life-limiting illness and their family.	☐
12. Foster a collegiate relationship with the interprofessional team.	☐
Some	**Educational Opportunity**
1. Describe a broad spectrum of life-limiting illnesses and their associated symptoms and treatments.	☐
2. Describe the role and function of the Palliative Care Consult Team, including volunteers.	☐
3. Apply palliative care standards, guidelines, norms of practice and policies into pharmacy practice.	☐
4. Apply models of palliative care that promote dignity when providing care (e.g. Dignity Conserving Care).	☐

Few	Educational Opportunity
1. Practice leadership that encourages colleagues to foster a caring environment that supports all members of the health care team working in sensitive situations.	☐
2. Identify specialist resources when providing information regarding medications used in palliative care.	☐
3. Assess the palliative care medication information needs of the interprofessional team.	☐

Notes:

Domain 2: Communication	
All	**Educational Opportunity**
1. Recognize that communication regarding palliative care is an on-going collaborative process.	☐
2. Recognize the potential for conflict in palliative care decision-making.	☐
3. Assess the patient's and family's understanding of the life-limiting illness and its trajectory.	☐
4. Adapt communication approach with the patient and family based on their understanding of the life-limiting illness.	☐
5. Adapt communication and information sharing to the unique needs of the patient and their family.	☐
6. Utilize experienced translators for the patient with language barriers.	☐
7. Maintain ongoing communication with the patient, family and the interprofessional team regarding plan of care.	☐
8. Communicate the patient's medication management needs to the interprofessional team.	☐
9. Discuss the care plan with the patient, their family and the interprofessional team.	☐

10. Communicate recommendations regarding appropriate use of palliative care medicines to the interprofessional team.	☐
11. Provide direction to the family and interprofessional team regarding the safe removal of medications from the patient's home.	☐
Some	**Educational Opportunity**
1. Apply strategies to engage in compassionate, individualized, and timely communication with each patient, their family and members of the interprofessional team.	☐
2. Support each patient to make informed decisions regarding the depth of information they wish to receive and share with their family regarding their diagnosis, prognosis and disease progression.	☐
3. Discuss the benefits and burdens of palliative pharmaceutical care options to assist the patient in meeting their goals of care.	☐
4. Recognize the multidimensional communication challenges that arise when caring for a patient with a life-limiting illness.	☐
5. Recognize the importance of offering culturally relevant palliative care information and resources to support the patient and their family.	☐
6. Provide appropriate response to those who are dissatisfied with palliative care services.	☐
7. Participate in processes that mitigate conflict in palliative care decision-making.	☐
Few	**Educational Opportunity**
1. Demonstrate expertise as a mediator by advocating for the patient to access appropriate and timely palliative care.	☐
2. Apply comprehensive knowledge of the clinical presentation and illness trajectories of life-limiting illnesses when responding to complex and multidimensional care needs, in order to comprehensively identify current and prospective clinical issues in palliative care.	☐

Notes:

Domain 3: Care Planning and Collaborative Practice	
All	**Educational Opportunity**
1. Support the patient to identify goals of care by referring them to the most appropriate member of the interprofessional team.	☐
2. Recognize the collaborative relationship between the patient, their family and the interprofessional team.	☐
3. Identify how an interprofessional team approach to care enhances patient outcomes.	☐
4. Provide support to the patient with a life-limiting illness to address identified needs.	☐
5. Facilitate the active involvement of the patient in goal setting, decision making and informed consent to support the best possible outcomes and quality of life.	☐
6. Interpret the patient's Goals of Care Designation (GCD) Order.	☐
7. Recognize that a patient's cognitive and functional capacity to make decisions may change as their disease progresses towards the end-of-life.	☐
8. Assess factors that may affect the patient's cognition and functional capacity to make decisions including health status changes towards the end-of-life.	☐
9. Understand the role of an ADM in decision making regarding a patient's care.	☐
10. Recognize that care planning and decision-making may involve the family and the larger community.	☐
11. Collaborate with the interprofessional team to manage symptoms.	☐
12. Conduct a structured, critical, and comprehensive medication review to optimize medication management and minimize the number of medication related problems.	☐
13. Recognize when alternate routes for medications are required (e.g. as death approaches and/or when the patient loses the ability to take medications orally).	☐
14. Explain methods to minimize the risk of harm to the patient related to medication safety risks that can arise with the use of medicines in palliative care.	☐
15. Provide alternate routes for medications when the patient is no longer able to take medications orally.	☐
16. Recognize the overall impact of a life-limiting illness on the patient, including their mental health and coping mechanisms.	☐
17. Advise the interprofessional team regarding special authorization medications and medications requiring alternate routes of administration.	☐
18. Demonstrate flexibility in relation to care planning, acknowledging that a patient's priorities can shift as their condition changes.	☐
19. Recognize clinical limitations and professional boundaries referring to another appropriate member of the interprofessional team in a timely manner member when required.	☐

Some	**Educational Opportunity**
1. Anticipate complex medication related issues that may develop over the illness trajectory by planning accordingly.	☐
2. Provide supports to help the patient to adapt to the changes in their condition.	☐
3. Collaborate with the patient and their family to identify priorities and concerns, considering their coping strategies and perception of diagnosis.	☐
4. Involve the patient and their family to identify resources that will provide support during end-of-life care.	☐
5. Identify the patient's and their family's values, beliefs and preferences regarding the various components of palliative care provision.	☐
6. Participate in patient/family and team conferences related to the pharmaceutical care plan or when significant medication related challenges occur.	☐
7. Participate in conversations with the patient, their family and interprofessional team to develop, implement, and evaluate a care plan in line with the patient's goals of care.	☐
8. Identify services and resources specific to the patient's goals of care.	☐
9. Collaborate with the patient, their family and the interprofessional team to design, implement, and monitor a pharmaceutical plan for symptom control throughout the disease trajectory including at the end-of-life.	☐
Few	**Educational Opportunity**
1. Identify the full range and continuum of palliative care services, resources and the settings in which they are available.	☐
2. Facilitate conversations to support end-of-life decision-making.	☐
3. Facilitate informed decision-making by the patient regarding place of care, while identifying risks in a supportive manner.	☐
4. Collaborate within and between health care teams across the continuum of care to facilitate continuity in palliative care.	☐
5. Initiate referrals to resources, services and settings specific to the patient's goals of care.	☐

Notes:

Domain 4: Optimizing Comfort and Quality of Life	
All	**Educational Opportunity**
1. Explain how a palliative approach can enhance the assessment and management of symptoms.	☐
2. Recognize common trajectories of life-limiting illnesses, including common symptoms.	☐
3. Explain the concept of 'total pain'.	☐
4. Explain the causes of common non-pain symptoms at end-of-life.	☐
5. Apply the principles of symptom management.	☐
6. Recognize that symptoms and symptom meaning are highly subjective.	☐
7. Apply an interprofessional approach to optimize patient and family comfort and enhance quality of life.	☐
8. Provide care in a compassionate manner.	☐
9. Recognize the physical, psychological, social and spiritual issues that affect the patient and their family.	☐
10. Identify the potential limitations to achieving adequate pain management and the patient's personal pain goals.	☐
11. Assess the benefits, burdens, and risks of clinical interventions for the patient with a life-limiting illness.	☐
12. Assess the appropriateness of interventions for each patient living with a life-limiting illness, while taking into consideration the patient's expressed wishes and identified goals of care.	☐
13. Discuss the benefits, burdens and risks of clinical interventions with the patient with a life-limiting illness and their family.	☐
14. Provide education to the patient and their family regarding the management of symptoms, including information on practical strategies that can be employed.	☐
15. Address any concerns that the patient and their family may have regarding medications being used to treat symptoms at end-of-life.	☐
16. Recognize the ways in which the patient can be engaged in self-management of their illness.	☐
17. Provide care in keeping with the patient's expressed wishes and identified goals of care.	☐
18. Support the patient with a life-limiting illness and their family to adapt to a transition from life prolonging treatment to a focus on symptom management and quality of life.	☐
19. Describe treatment choices for palliative care symptoms and the associated pharmaceutical care issues.	☐

20. Utilize clinically appropriate pharmacological treatment options for symptoms for the patient with a life-limiting illness.	☐
21. Recommend and utilize non-pharmacological pain and symptom management strategies to promote comfort and quality of life.	☐
22. Interpret information regarding medicines used in palliative care.	☐
23. Provide expert advice on compatibility and stability of medications being prescribed and administered.	☐
24. Promote the safe use of medicines in palliative care by encouraging the reporting of errors; improving medication use processes; and developing and implementing medication safety strategies for high risk medications.	☐
25. Support the patient, family, Alternate Decision Maker (ADM) and the interprofessional team with end-of-life decision-making, including withdrawing or withholding interventions.	☐
26. Recognize emergencies that may arise in palliative care.	☐
27. Address emergencies that may arise in palliative care.	☐
28. Recognize and respond to the signs of imminent death.	☐
29. Describe the Palliative Coverage Program.	☐
Some	**Educational Opportunity**
1. Utilize clinically appropriate pharmacological treatments for the management of complex and non-complex symptoms in palliative care.	☐
2. Provide expert advice on compatibility and stability when using multiple drugs being administered subcutaneously (SC) or intravenously (IV).	☐
3. Anticipate the needs of the patient with a life-limiting illness based on known disease trajectories.	☐
4. Identify the need for a change in the focus of care and treatment goals at critical decision points in the course of a life-limiting illness.	☐
5. Support the patient's and family's wishes and end-of-life beliefs and customs.	☐
6. Identify patients who would benefit from the Emergency Medical Services Palliative and End of Life Care Assess, Treat and Refer (EMS PEOLC ATR) Program.	☐
7. Facilitate patient enrollment in the Palliative Coverage Program.	☐
8. Support planning for the patient's eventual death.	☐
Few	**Educational Opportunity**
1. Act as an expert resource regarding the role of discipline-specific interventions in symptom management and optimizing quality of life.	☐

2. Provide expert guidance regarding the pharmacological management of complex symptom control strategies.	☐
3. Apply an advanced level of discipline-specific clinical expertise in supporting the patient to adapt to the changing clinical presentation.	☐
4. Apply an advanced level of clinical expertise in facilitating safe, smooth and seamless transitions of care for the patient and their family.	☐
5. Provide comprehensive expertise in medicine management issues that the palliative care patient may experience.	☐
6. Provide expert pharmaceutical care for the patient with complex symptoms.	☐

Notes:

Domain 5: Loss, Grief and Bereavement	
All	**Educational Opportunity**
1. Recognize the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief.	☐
Some	**Educational Opportunity**
1. Recognize the factors that may increase the risk of complicated grief.	☐
2. Describe pathological responses to loss.	☐
3. Address the patient's and/or family's pathological responses to loss, referring appropriately to the Palliative Care Consult Team.	☐
4. Support the family by providing them with guidance, information and direction to bereavement services as required and based on awareness of culture and needs.	☐
Few	**Educational Opportunity**
1. Apply comprehensive knowledge of the grieving process and reactions in order to support the patient and their family throughout the disease trajectory.	☐

2. Describe diverse perspectives on loss, grief, bereavement and mourning, to support others from a cross-cultural perspective.	☐

Notes:

Domain 6: Professional and Ethical Practice	
All	**Educational Opportunity**
1. Anticipate and address ethical and legal issues that may be encountered when caring for a patient with a life-limiting illness.	☐
2. Explore and respect the patient's wishes regarding their care options and preferences.	☐
3. Respect the patient's decisions regarding initiating, not initiating, withholding and withdrawing dialysis, hydration, nutrition support, resuscitation and other life-prolonging/life-sustaining interventions.	☐
4. Describe distinctions among ethical and legal concepts, such as: the principle of double effect, palliative sedation and Medical Assistance in Dying (MAID).	☐
5. Respond to inquiries regarding MAID within the regulatory framework.	☐
6. Explain the difference between managing a condition and providing end-of-life care.	☐
7. Recognize when beliefs, attitudes and values limit one's ability to be present and provide patient-centered care.	☐
8. Collaborate with others to ensure optimal care is provided in the circumstance when one's beliefs, attitudes, and values limit one's ability to provide patient-centered care.	☐
9. Work in partnership with peers, the interprofessional team and the Palliative Care Consult Team to assess, coordinate, promote and improve medication safety.	☐
Some	**Educational Opportunity**
1. Participate in professional supervision and peer review processes to monitor personal and professional responses to clinical situations.	☐

2. In conjunction with the interprofessional team, the patient and their family, participate in discussions and resolution of ethical and legal issues that may arise in relation to factors which impact the patient with a life-limiting illness.	☐
Few	**Educational Opportunity**
1. Apply a comprehensive understanding of contemporary legal, ethical and professional standards to the provision of quality palliative care.	☐
2. Influence processes and behaviors that determine how medicines are used in palliative care.	☐
3. Communicate the distinct contributions of the palliative care pharmacy.	☐
4. Contribute to the advancement of the distinct contributions of the palliative care pharmacy.	☐

Notes:

Domain 7: Cultural Safety	
All	**Educational Opportunity**
1. Assess the patient's and family's social, spiritual and cultural values and practices that may influence their care preference.	☐
2. Support the patient's and family's social, spiritual and cultural values and practices.	☐
3. Assess the unique needs and preferences of the patient and their family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age and ability.	☐
4. Identify and respect who the patient identifies as family.	☐
5. Identify personal biases and values that may influence care.	☐
6. Identify mechanisms to overcome personal biases to ensure they do not impact care and treatment.	☐

Some	Educational Opportunity
1. Describe the influence of culture on key issues in palliative care.	☐

Notes:

Domain 8: Self-Care	
All	**Educational Opportunity**
1. Describe the personal impact of loss, grief and bereavement.	☐
2. Identify own responses to loss.	☐
3. Explore own attitudes regarding death, dying and caring for a patient requiring palliative care.	☐
4. Identify the impact of past experiences of suffering, death and dying when providing palliative care.	☐
5. Attend to own emotional responses that result from caring for a patient with palliative care needs.	☐
6. Recognize compassion fatigue in self and colleagues.	☐
7. Engage in healthy activities that help support well-being, resilience and prevent compassion fatigue.	☐
8. Support colleagues who are experiencing compassion fatigue.	☐

Notes:

Domain 9: Education, Research and Evaluation	
All	**Educational Opportunity**
1. Promote and participate in palliative care continuing education opportunities.	☐
2. Educate the patient and their family about palliative care and a palliative approach.	☐
3. Work with pharmacy colleagues and other health care providers to assess, co-ordinate, promote and improve medication safety in the context of palliative care.	☐
4. Support the provision of evidence-based practice in a variety of care settings.	☐
Some	**Educational Opportunity**
1. Describe the process of quality improvement in the context of palliative care.	☐
2. Contribute to the effectiveness of the interprofessional team.	☐
Few	**Educational Opportunity**
1. Exhibit leadership in the delivery of palliative care education in your local health care network.	☐
2. Apply knowledge gained from palliative care research.	☐
3. Provide the family with opportunities to participate in research regarding end-of-life care giving, when possible.	☐
4. Where possible, facilitate palliative care education and research.	☐
5. Contribute to the evaluation of the quality of palliative care and the effectiveness of the interdisciplinary care team.	☐
6. Develop palliative care related education for members of the discipline and students.	☐
7. Facilitate and provide palliative care related education, leadership and mentorship to members of the discipline and students.	☐
8. Where possible, identify the opportunities for and barriers to discipline-specific research unique to palliative care.	☐

Notes:

Domain 10: Advocacy	
All	**Educational Opportunity**
1. Support autonomous decision-making.	☐
Some	**Educational Opportunity**
1. Advocate for health care providers to participate in palliative care continuing education opportunities.	☐
Few	**Educational Opportunity**
1. Demonstrate leadership in the identification, development and delivery of pharmacy related palliative care policy.	☐
2. Advocate for the needs, decisions and rights of the patient by recognizing potential vulnerabilities.	☐
3. Advocate for the development, maintenance and improvement of health care and social policies related to palliative care.	☐
4. Advocate for health care providers to have adequate medication related resources to help provide palliative care.	☐
5. Actively influence palliative care strategic initiatives and policy development.	☐
6. Promote equitable and timely access to resources.	☐

Notes:

Appendix 1: Glossary of Terms

Please note that the organizational authorities are acknowledged for selected terms. Definitions were adapted from academic sources for the remainder and are referenced in the technical document, Alberta Palliative Care Competency Framework Technical Report [Covenant Health].

Advance care planning: a process which encourages people to reflect and think about their values regarding clinically indicated future health care choices; explore medical information that is relevant to their health concerns; communicate wishes and values to their loved ones, their alternate decision-maker and their health care team; and record those choices [Alberta Health Services].

Agent: the person(s) named in a Personal Directive who can make decisions on personal matters according to the wishes expressed by the patient [Alberta Health Services].

Alternate decision maker: a person who is authorized to make decisions with or on behalf of the patient. These may include: a minor's legal representative, a guardian, a 'nearest relative' in accordance with the Mental Health Act, an agent in accordance with a personal directive, a co-decision-maker, a specific decision-maker or a person designated in accordance with the Human Tissue and Organ Donation Act [Alberta Health Services].

Competency: 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".

Family(-ies): one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers [Alberta Health Services].

Goals of care: the intended purposes of health care interventions and support, as recognized by a patient and/or alternate decision-maker [Alberta Health Services].

Goals of care designation: one of a set of short-hand instructions by which health care providers describe and communicate general care intentions, specific clinically indicated health interventions, transfer decisions, and locations of care for a patient as established after consultation between the most responsible health practitioner and patient or alternate decision maker [Alberta Health Services].

Goals of care designation order: the documented order for the goals of care designation as written by the most responsible health practitioner (or designate) [Alberta Health Services].

Green sleeve: A folder containing a patient's GCD Order, along with an Advance Care Planning (ACP)/GCD Tracking Record, for the patient to own and produce at relevant health care encounters [Alberta Health Services].

Health care provider: any person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of a health care organization [Alberta Health Services].

Health care professional: an individual who is a member of a regulated health discipline, as defined by the Health Disciplines Act (Alberta) or the Health Professions Act (Alberta), and who practices within scope and role [Alberta Health Services].

Health care team: Individuals who work together to provide health, personal, and supportive care to clients. The team may consist of, but is not limited to, different configurations of the client, regulated health professionals, unregulated care providers and/or other caregivers including the client's family. Within the team the client remains its center and client-directed care its focus [Alberta Health].

Illness trajectory: Three typical illness trajectories have been described for patients with progressive chronic illness: cancer, organ failure, and the frail elderly or dementia trajectory. Physical, social, psychological, and spiritual needs of patients and their care givers are likely to vary according to the trajectory they are following. Being aware of these trajectories may help clinicians plan care to meet their patients' multidimensional needs better, and help patients and care givers cope with their situation. Different models of care may be necessary that reflect and tackle patients' different experiences and needs.

Interprofessional: interprofessional collaboration occurs when health professionals from different disciplines work together to identify needs, solve problems, make joint decisions on how best to proceed and evaluate outcomes collectively. Interprofessional collaboration supports patient-centered care and takes place through teamwork. Team interactions, wider organizational issues and environmental structures such as safety, quality, efficiency and effectiveness issues influence this model of care. These broader contextual influences affect practice where there are tensions between the ideals of interprofessional collaboration and the realities of practice. This is evident when the patient and family position in interprofessional collaboration is considered.

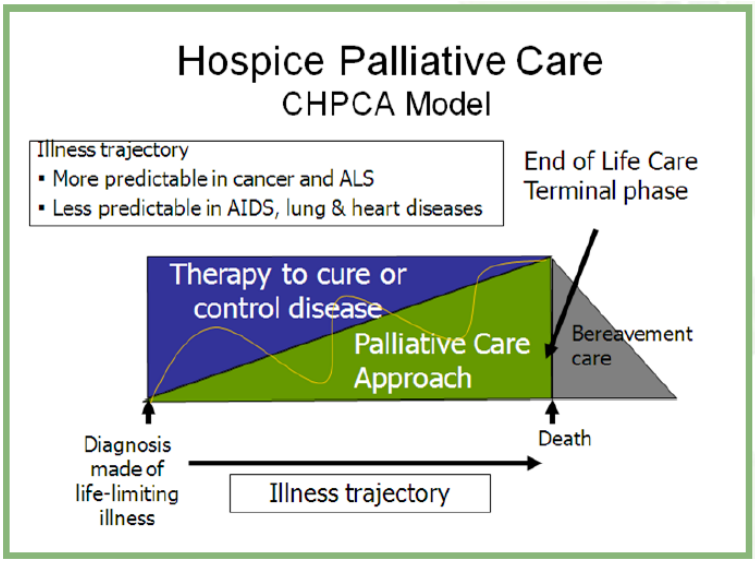
Imminently dying: Any patient who, according to the most responsible health practitioner's clinical assessment, is within the last hours to days of life.

Life-limiting illness. Describes illness where it is expected that death will be a direct consequence of the specified illness. The term "person living with a life-limiting illness" also incorporates the concept that people that are actively living with such illnesses, often for long periods of time, are not imminently dying. Therefore, it affects health and quality of life, and can lead to death [Health Canada].

Palliative and end-of-life care: is both a philosophy and an approach to care that enables all individuals with a life-limiting and/or life-threatening illness to receive

integrated and coordinated care across the continuum. This care incorporates patient and family values, preferences and goals of care, and spans the disease process from early diagnosis to end of life, including bereavement. Palliative care aims to improve the quality of life for patients and families facing the problems associated with a life-limiting illness through the prevention and relief of suffering by means of early identification, comprehensive interdisciplinary assessments and appropriate interventions [Alberta Health Services].

Palliative approach: Access to a palliative approach in primary care requires that, in every primary care setting, (outpatient offices, home care organizations, Long Term Care facilities), providers of every discipline (family physicians, nurses, nurse practitioners, pharmacists, health care aides, paramedics, social workers) possess and implement the basic palliative care knowledge, skills, and attitudes pertinent to their discipline.



This requires not just education, but also an infrastructure, a policy environment and a culture of care delivery that facilitates a palliative approach in primary care. A palliative approach in primary care also requires appropriate support from palliative care providers for patients with complex needs. High-quality palliative care, like high-quality maternity care or mental health care depends on co-operation and co-ordination between primary care and consultant palliative care teams [Canadian Hospice Palliative Care Association].

Patient: an adult who receives or has requested health care or services. This term is inclusive of residents, clients and outpatients [Alberta Health Services].

Patient-and family-centered care: care provided working in partnership with patients and families by encouraging active participation of patients and families in all aspects of care, as integral members of the patient's care and support team, and as partners in planning and improving facilities and services. Patient- and family-centered care applies to patients of all ages and to all areas of health care [Alberta Health Services].

Personal directive: a written document in accordance with the requirements of the Personal Directives Act (Alberta), in which an adult names an agent(s) or provides instruction regarding his/her personal decisions, including the provision, refusal and/or withdrawal of consent to treatments/procedures. A Personal Directive (or part of) has

effect with respect to a personal matter only when the maker lacks capacity with respect to that matter [Alberta Health Services].

Principle of double effect [Catholic Health Alliance of Canada]**:** Some human actions have both a beneficial and a harmful result, e.g., some pain treatment for a terminally ill person might carry a possibility of shortening life, even though it is given to relieve pain and is not intended to kill the person. Five conditions are cited for trying to decide if such actions would be morally/ethically permissible:

1. The action of the person must be 'good' or at least neutral in itself.
2. There are two anticipated outcomes for the action of the person, one intended and good, the other an unintended but foreseen bad/wrong/harmful.
3. The bad effect is not the means to the good effect.
4. There must be a proportionate reason to accept the bad effect.
5. There must be no less-negative alternative.

Referral: means direction from another health care professional or organization to provide service for a patient; or direction to the patient, or on behalf of the patient, to obtain additional services from another organization or provider. These may include change of service, changes in level of care, and/or transfer between units [Alberta Health Services].

Total pain: Total pain is a term that is often used to refer to the phenomenon, where the pain experience has a combination of physical, social, psychological, and spiritual (or existential) sources [Pallium Canada].

Appendix 2: Additional Resources

The following references acknowledge competency statements issued by the respective professional and national organizations.

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Appendix 3: Acknowledgements

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