

# Alberta Physiotherapists' Palliative Care Competency Framework

Version 1.0 (September 2020)

A Resource Manual for Health Care Professionals



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**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 Physiotherapists' Palliative Care Competencies Referent Group

The Alberta Physiotherapists' Palliative Care Competencies Referent Group below assisted in recruiting individuals participating in the production of the Alberta Physiotherapists' Palliative Care Competency Framework. This includes members of the Alberta Palliative Care Competencies Advisory Working Group and the Alberta Physiotherapists' 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.

<b>Alberta Physiotherapists' Palliative Care Competencies Referent Group</b>	
<b>Health Care Organizations</b>	<b>Educational Institutions</b>
<ul style="list-style-type: none"> <li>• Alberta Health Emergency Medical Services</li> </ul> <p><u>Alberta Health Services</u></p> <ul style="list-style-type: none"> <li>• Calgary Zone Palliative Care Consult Service</li> <li>• Calgary Zone Palliative and End-of-Life Care Program</li> <li>• Calgary Zone Palliative Home Care</li> <li>• Edmonton Zone Palliative Care Program</li> <li>• Edmonton Zone Palliative and End-of-Life Care and Community Programs, Continuing Care</li> <li>• Glenrose Rehabilitation Hospital, Edmonton</li> <li>• Lethbridge-South Zone Community Oncology</li> <li>• North Zone</li> <li>• Ponoka-Central Zone</li> <li>• Provincial Palliative and End-of-Life Care, Community, Seniors, Addiction and Mental Health</li> <li>• Royal Alexandra Hospital, Edmonton</li> </ul> <p><u>Covenant Health</u></p> <ul style="list-style-type: none"> <li>• Professional Practice and Research</li> <li>• Tertiary Palliative Care Unit, Grey Nuns Community Hospital, Edmonton</li> </ul>	<p><u>University of Alberta</u></p> <ul style="list-style-type: none"> <li>• Faculty of Nursing</li> <li>• Faculty of Medicine and Dentistry</li> <li>• Department of Physical Therapy</li> </ul> <p><u>University of Calgary</u></p> <ul style="list-style-type: none"> <li>• Department of Family Medicine</li> <li>• Department of Oncology</li> </ul>
	<b>Professional Regulatory Bodies and Associations</b>
	<ul style="list-style-type: none"> <li>• College of Licensed Practical Nurses of Alberta</li> <li>• Physiotherapy Alberta College + Association</li> </ul>

# Alberta Palliative Care Competency Framework

A competency is defined by Parry<sup>1</sup> 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 Physiotherapists’ 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 Physiotherapists’ Palliative Care Competency Framework which was developed by the Alberta Physiotherapists’ Palliative Care Competencies Working Group.

Competency statements are organized according to the following two dimensions:

1. Level of expertise
2. Competency domains

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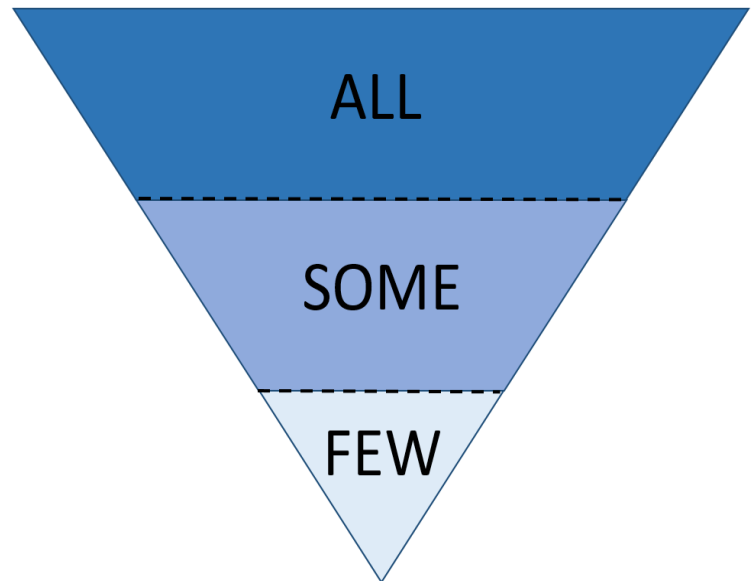
<sup>1</sup> Parry, S. B. (1996). The quest for competencies. *Training* 33, 48–54.

## 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 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.

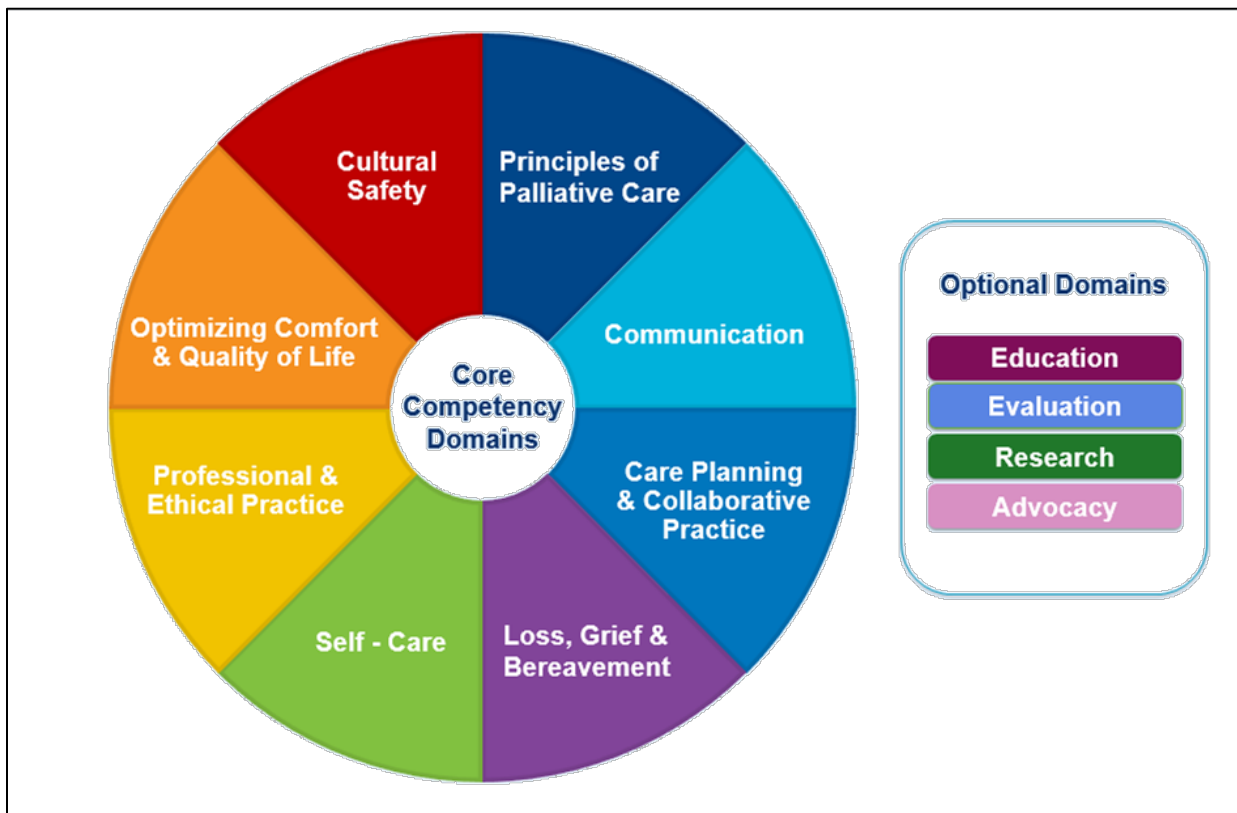
## Competency Domains

The competency statements are organized according to eight core competency domains and four optional competency domains (Figure 2). The core competency 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 Physiotherapists' Palliative Care Competencies

Domain 1: Principles of Palliative Care	
<b>All</b>	<b>Educational Opportunity</b>
1. Understand and recognize common trajectories of life-limiting illnesses, including common symptoms.	<input type="checkbox"/>
2. Understand the impact that psychological responses to loss related to role, functional independence, and social stressors have on the behavior and decision-making of the patient and their family and take this into account when planning care.	<input type="checkbox"/>
3. Understand and recognize pathological responses to loss of role and functional independence, which may impact behavior and decision-making of the patient and their family, referring to the Palliative Care Consult Team when appropriate.	<input type="checkbox"/>
4. Demonstrate awareness of own responses in the presence of the patient and family who are suffering.	<input type="checkbox"/>
5. Provide a compassionate presence and attend to each patient's suffering.	<input type="checkbox"/>
6. Provide education to the patient with a life-limiting illness, their family and other members of the interprofessional team, within the context of your role.	<input type="checkbox"/>
7. Recognize the potential role of palliative care services in supporting staff and other agencies to provide a palliative approach to the patient with a life-limiting illness, and refer when appropriate.	<input type="checkbox"/>
<b>Some</b>	<b>Educational Opportunity</b>
1. Demonstrate in-depth understanding of the full spectrum of trajectories of life-limiting illnesses in the context of your current clinical practice.	<input type="checkbox"/>
<b>Few</b>	<b>Educational Opportunity</b>
1. Demonstrate leadership that encourages colleagues to foster a caring environment that provides support to all health care providers who work in challenging situations with a patient with a life-limiting illness and their family.	<input type="checkbox"/>
2. Apply models of palliative care that promote dignity when providing care (e.g. Dignity Conserving Care).	<input type="checkbox"/>
3. Facilitate empathic and responsive relationships between each patient who is experiencing a life-limiting illness and the interprofessional team.	<input type="checkbox"/>
4. Demonstrate an understanding of palliative care standards, norms of practice and best practices.	<input type="checkbox"/>

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| 5. Demonstrate an advanced knowledge and understanding of the full spectrum of trajectories of life-limiting illnesses when responding to complex and multidimensional care needs. | <input type="checkbox"/> |
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## Domain 2: Communication

<b>All</b>	<b>Educational Opportunity</b>
1. Assess the patient's and family's current understanding of his/her health, role and functional status in the context of the patient's life-limiting illness.	<input type="checkbox"/>
2. Support the patient to make informed decisions regarding the depth of information about diagnosis, prognosis and disease progression they wish to receive and share with their family.	<input type="checkbox"/>
3. Engage, facilitate, and respect the involvement of the patient, family and the interprofessional team in discussions regarding the plan of care.	<input type="checkbox"/>
4. Demonstrate an understanding of the multidimensional communication challenges that arise when working with a patient with a life-limiting illness, responding with sensitivity and compassion to the needs of each patient and their family.	<input type="checkbox"/>
<b>Some</b>	<b>Educational Opportunity</b>
1. Utilize advanced communication strategies to support the changing needs and wishes of the patient with a life-limiting illness and their family.	<input type="checkbox"/>
<b>Few</b>	<b>Educational Opportunity</b>
1. Use a variety of strategies to engage in highly skilled, compassionate, individualized and timely communication with each patient, their family and the interprofessional team.	<input type="checkbox"/>

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| 2. Demonstrate self-awareness of one's own responses to communication challenges and remain engaged in meaningful contact with the patient and their family, even in the most complex, intense and changing circumstances. | □ |
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### Domain 3: Care Planning and Collaborative Practice

All	Educational Opportunity
1. Demonstrate awareness and understanding of the Advance Care Planning (ACP) and Goals of Care Designation (GCD) Policy and Procedure and the Personal Directives Act.	□
2. Recognize that the patient with a life-limiting illness may lose capacity to make decisions towards end-of-life. In such circumstances decisions must be made in the best interest of the person in alignment with the ACP and GCD Policy and the Personal Directives Act.	□
3. Understand how an ADM is selected and the role they play in decision-making regarding the patient's care.	□
4. In collaboration with the patient and their family, make decisions regarding interventions, and providing care, taking into consideration the patient's GCD Order, Personal Directive, and/or the patient's preferences or ADM's preferences, as appropriate.	□
5. Demonstrate the ability to manage decisions about withdrawing or withholding interventions, while recognizing when to re-engage in discussion.	□
6. Provide supports to help the patient adapt to the changes in their condition.	□

7. Recognize the overall impact of a life-limiting illness on the patient and family including their mental health and coping mechanisms and provide support to address identified needs.	<input type="checkbox"/>
8. Demonstrate an awareness of the impact of family role changes when formulating relevant and realistic care plans.	<input type="checkbox"/>
9. Provide education and collaborate with the patient, family, ADM and care teams when making decisions about withdrawing or withholding interventions, or reinitiating interventions.	<input type="checkbox"/>
10. Understand the importance of referral to the Palliative Care Consult Team for the management of the patient's palliative care needs.	<input type="checkbox"/>
11. Demonstrate flexibility in relation to care planning, acknowledging that a patient's priorities can alter as their condition fluctuates and disease advances.	<input type="checkbox"/>
12. Create a holistic, patient-centered plan that acknowledges the psychosocial impact of diminishing function and set realistic patient-centered goals.	<input type="checkbox"/>
13. Collaborate within and between teams across the continuum of care to facilitate continuity in palliative care.	<input type="checkbox"/>
<b>Some</b>	<b>Educational Opportunity</b>
1. Demonstrate an understanding of ACP and an appreciation of the appropriate time(s) to engage in discussions regarding end of life goals and preferences for care.	<input type="checkbox"/>
2. In a supportive manner, assist the patient to make an informed decision regarding place of care while identifying potential and actual risks and keep the team informed.	<input type="checkbox"/>
3. Identify the patient's and family's values, beliefs and preferences regarding the various components of palliative care provision.	<input type="checkbox"/>
<b>Few</b>	<b>Educational Opportunity</b>
1. Demonstrate an advanced level of clinical expertise and sensitivity in facilitating safe, smooth and seamless transitions of care for the patient and their family with complex care planning needs.	<input type="checkbox"/>
2. Demonstrate an advanced level of clinical expertise in supporting the patient and their family to adapt to changing clinical presentation and functional levels.	<input type="checkbox"/>
3. Collaborate with the patient and their family to identify resources that will provide support during palliative care.	<input type="checkbox"/>
4. Facilitate conversations to support end-of-life decision making.	<input type="checkbox"/>
5. Identify the full range and continuum of palliative care services, resources and the settings in which they are available.	<input type="checkbox"/>

6. Provide relevant information and resources to the patient and their family.	<input type="checkbox"/>
7. Identify and accesses services and resources specific to the patient's goals of care.	<input type="checkbox"/>
8. Initiate referrals to and requests for resources, services and settings.	<input type="checkbox"/>
9. Facilitate access to services and resources that the patient and their family require.	<input type="checkbox"/>
10. Act as a clinical resource, as required, to generalist and other specialist palliative care team members, modelling advanced clinical skills when assessing and managing a patient with complex life-limiting illnesses.	<input type="checkbox"/>
11. Demonstrate advanced understanding of the roles of the wider interprofessional team members, showing leadership through building partnerships and utilize the strengths of the team to facilitate optimal palliative care therapy outcomes for the patient and their family.	<input type="checkbox"/>
12. Critically evaluate outcomes of interventions against established standards and guidelines to further develop own practice and that of professional colleagues in specialist palliative care.	<input type="checkbox"/>

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### Domain 4: Optimizing Comfort and Quality of Life

All	Educational Opportunity
1. Use non-pharmacological symptom management strategies to promote comfort and quality of life.	<input type="checkbox"/>
2. Monitor the need for a change in the focus of care and treatment goals at critical decision points along the course of a life-limiting limiting illness (i.e. change in the patient's condition and/or at the request of the patient and/or Alternate Decision Maker (ADM)).	<input type="checkbox"/>
3. Understand how a palliative approach can enhance the assessment and management of symptoms.	<input type="checkbox"/>



4. Understand and accept alternative means of symptom management for a patient with a life-limiting illness (e.g. spiritual approach, prayers, music, pet therapy, indigenous rituals).	<input type="checkbox"/>
5. Understand the causes of common non-pain symptoms in palliative care and provide an intervention or mitigation plan accordingly.	<input type="checkbox"/>
6. Understand the concept of 'total pain'.	<input type="checkbox"/>
7. Help the patient with a life-limiting illness and their family to adapt to a transition from life prolonging treatment to a focus on sustaining quality of life.	<input type="checkbox"/>
8. Demonstrate an awareness and acceptance of the patient's and their family's perception of dying well.	<input type="checkbox"/>
9. Demonstrate an understanding of the significance of the physical, psychological, social and spiritual issues that affect the patient and their family.	<input type="checkbox"/>
10. Identify each patient's values and wishes for care and provide care in keeping with these goals of care, Goals of Care Designation (GCD) Order, and/or Personal Directive.	<input type="checkbox"/>
11. Consider the benefits, burdens and risks of physiotherapy interventions and facilitate the decision-making process regarding the appropriateness of these for each patient living with a life-limiting illness.	<input type="checkbox"/>
12. Recommend energy-sparing interventions for the patient with advanced disease who is experiencing fatigue.	<input type="checkbox"/>
13. Understand the complexity of palliative care conditions which may require additional attention and interprofessional collaborative management of symptoms, functional changes, psychological impact and self-care.	<input type="checkbox"/>
14. Teach the family how to help with patient care (e.g. positioning, transfers), while supporting them to adopt self-care strategies.	<input type="checkbox"/>
15. In the context of current scope of practice, be able to recognize frank presentation of palliative care emergencies and take appropriate action (e.g. spinal cord compression).	<input type="checkbox"/>
<b>Some</b>	<b>Educational Opportunity</b>
1. In the context of current scope of practice, be able to recognize the subtle presentation of palliative care emergencies and take appropriate action (e.g. spinal cord compression).	<input type="checkbox"/>
2. Demonstrate an awareness and acceptance of each patient's and their family's perception of dying well and support its achievement.	<input type="checkbox"/>
3. Anticipate, recognize, and respond to the signs of imminent death.	<input type="checkbox"/>
4. Support the patient's and family's wishes and death rituals.	<input type="checkbox"/>

<b>Few</b>	<b>Educational Opportunity</b>
1. Apply comprehensive knowledge and understanding of the clinical presentation and disease trajectories of life-limiting illnesses when responding to complex and multidimensional care needs, to comprehensively identify current and prospective clinical issues in palliative care.	<input type="checkbox"/>
2. Act as an expert resource regarding the role of discipline-specific interventions in symptom management and optimizing quality of life.	<input type="checkbox"/>
3. Demonstrate advanced knowledge to alleviate and manage distressing symptoms while maximizing the patient's ability to function.	<input type="checkbox"/>
4. Demonstrate advanced expertise in the management of symptoms, functional changes and interventions.	<input type="checkbox"/>
5. Ensure emphasis of palliative care treatment is on performance and symptom management and is based on the patient's needs and wishes.	<input type="checkbox"/>
6. Demonstrate advanced expertise regarding the complex interplay of factors that impact physical function and quality of life within the context of a life-limiting illness.	<input type="checkbox"/>
7. Demonstrate advanced knowledge of the benefits and burdens of palliative care treatment options to assist the patient in meeting their goals of care.	<input type="checkbox"/>

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<b>Domain 5: Loss, Grief and Bereavement</b>	
<b>All</b>	<b>Educational Opportunity</b>
1. Demonstrate sensitivity and engagement with the different stages of grief and loss, including loss of functional independence, utilizing this awareness to inform care planning and treatment interventions.	<input type="checkbox"/>
2. Recognize the factors that may increase the risk for grief difficulties.	<input type="checkbox"/>
3. Provide guidance, support and information to each family.	<input type="checkbox"/>

<b>Some</b>	<b>Educational Opportunity</b>
1. Appreciate the nature of disenfranchised grief in the patient and their family, and refer as appropriate.	<input type="checkbox"/>
2. Recognize the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief.	<input type="checkbox"/>
3. Have knowledge of theories of loss and grief and know when to refer to other palliative care professionals for complex case issues.	<input type="checkbox"/>
<b>Few</b>	<b>Educational Opportunity</b>
1. Proactively respond to complex grief reactions and processes using own skills and/or refer to appropriate disciplines or agencies.	<input type="checkbox"/>
2. Mentor and educate colleagues to understand the personal impact of loss, grief and bereavement, supporting them to recognize their own loss responses and encouraging engagement in activities to maintain their resilience on an on-going basis.	<input type="checkbox"/>
3. Demonstrate advanced knowledge of the grieving process and reactions to actively support the patient and their family throughout the patient's disease trajectory.	<input type="checkbox"/>
4. Demonstrate advanced knowledge of the nature of disenfranchised grief in each patient and their family and use appropriate methods of addressing this grief.	<input type="checkbox"/>

**Notes:**

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### Domain 6: Professional and Ethical Practice

<b>All</b>	<b>Educational Opportunity</b>
1. Understand the difference between managing a condition and providing end-of-life care.	<input type="checkbox"/>
2. Engage appropriately with each patient and family experiencing loss and suffering.	<input type="checkbox"/>

3. Anticipate and address ethical and legal issues that may be encountered when caring for a patient with a life-limiting illness.	<input type="checkbox"/>
4. Demonstrate an awareness of and respect for the patient's decisions regarding initiating/not initiating treatment, and/or withholding and withdrawing dialysis, hydration, nutrition support and resuscitation.	<input type="checkbox"/>
5. Identify situations where personal beliefs, attitudes and values limit one's ability to be present and provide care; collaborating with others to ensure optimal care is provided.	<input type="checkbox"/>
6. Understand distinctions among ethical and legal concepts, such as: the principle of double effect, palliative sedation and Medical Assistance in Dying (MAID).	<input type="checkbox"/>
7. Understand and navigate the complexities in communication regarding end-of-life care options, such as MAID.	<input type="checkbox"/>
8. Respond to inquiries regarding MAID in accordance with regulatory expectations and/or employer policies and procedures.	<input type="checkbox"/>
<b>Some</b>	<b>Educational Opportunity</b>
1. Participate in processes of clinical governance and quality assurance to maintain and improve clinical practice in palliative care.	<input type="checkbox"/>
<b>Few</b>	<b>Educational Opportunity</b>
1. Apply a comprehensive understanding of contemporary legal, ethical and professional standards to the provision of quality palliative care.	<input type="checkbox"/>
2. Facilitate discussion and resolution of ethical and legal issues in conjunction with the patient, their family, and the interprofessional team.	<input type="checkbox"/>
3. Actively influence and promote palliative care strategic initiatives and policy development.	<input type="checkbox"/>
4. Lead and develop clinical governance and quality assurance programs that are specific to palliative care.	<input type="checkbox"/>
5. Actively influence and promote strategic initiatives and policy development for palliative care services at local, regional and national levels.	<input type="checkbox"/>
6. Act as an expert resource contributing to palliative care service development and delivery across all clinical settings including primary, acute, tertiary and residential care.	<input type="checkbox"/>

**Notes:**

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## Domain 7: Cultural Safety

All	Educational Opportunity
1. Build relationships by listening without judgement and being open to learning from others about cultural and spiritual beliefs and practices about death and dying.	<input type="checkbox"/>
2. Practice self-reflection to understand personal and systemic biases related to death and dying.	<input type="checkbox"/>
3. Advocate for culturally safe practices that are free of racism and discrimination related to palliative care.	<input type="checkbox"/>

**Notes:**

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## Domain 8: Self-Care

All	Educational Opportunity
1. Demonstrate an understanding of the personal impact of loss, grief and bereavement.	<input type="checkbox"/>
2. Recognize one's own responses to loss and engage in activities that support well-being and resilience.	<input type="checkbox"/>
3. Explore one's own attitudes regarding death, dying, and caring for patients with life-limiting illnesses and their families.	<input type="checkbox"/>
4. Demonstrate an awareness of the impact of past experiences of suffering, death and dying when providing palliative care.	<input type="checkbox"/>
5. Understand and attend to one's own emotional responses that result from caring for patients with life-limiting illnesses and their families.	<input type="checkbox"/>
6. Recognize compassion fatigue in oneself and colleagues; intervene and refer appropriately.	<input type="checkbox"/>

**Notes:**

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<b>Domain 9: Education, Research and Evaluation</b>	
<b>All</b>	<b>Educational Opportunity</b>
1. Contribute to the evaluation of the quality of palliative care.	<input type="checkbox"/>
2. Participate in palliative care continuing education opportunities.	<input type="checkbox"/>
3. Educate the patient and their family about palliative care and a palliative approach.	<input type="checkbox"/>
4. Apply knowledge gained from palliative care research.	<input type="checkbox"/>
<b>Some</b>	<b>Educational Opportunity</b>
1. Contribute to research relevant to the needs of patients with life-limiting illnesses to further knowledge and enhance application in practice.	<input type="checkbox"/>
2. Identify and apply research that will lead to effective clinical practice in palliative care.	<input type="checkbox"/>
3. Facilitate and provide education, leadership, mentorship and professional support for colleagues and generalist providers of palliative care.	
<b>Few</b>	<b>Educational Opportunity</b>
1. Contribute to the evaluation of the quality of palliative care and the effectiveness of the Palliative Care Consult Team.	<input type="checkbox"/>
2. Where possible, provide the family with opportunities to participate in research regarding palliative caregiving.	<input type="checkbox"/>
3. Where possible, identify opportunities for and barriers to discipline-specific research unique to palliative care.	<input type="checkbox"/>
4. Act as an expert resource contributing to palliative care development and delivery.	<input type="checkbox"/>
5. Engage in study and continuously develop a knowledge base at an advanced level to improve the quality and standard of therapy outcomes and service delivery in palliative care.	<input type="checkbox"/>

6. Develop, facilitate, and disseminate palliative care education for other health care providers, patients and families. (Including within educational facilities).	<input type="checkbox"/>
7. Design and engage in research projects in line with palliative care service needs, collaborating with all relevant stakeholders in respect of research issues.	<input type="checkbox"/>
8. Act as an expert resource providing and advising on undergraduate and postgraduate education in the domain of physiotherapy practice in palliative care.	<input type="checkbox"/>

**Notes:**

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**Domain 10: Advocacy**

**Few**

**Educational  
Opportunity**

1. Advocate for the development, maintenance, and improvement of health care and social policy related to palliative care.	<input type="checkbox"/>
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**Notes:**

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## 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.

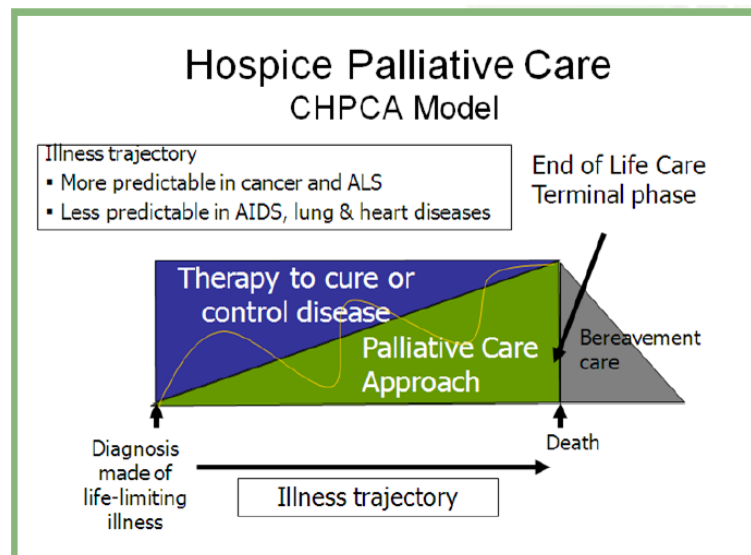
**Life-limiting illness.** Describes illness where it is expected that death will be a direct consequence of the specified illness. The term "person living with a life-limiting illness" also incorporates the concept that people that are actively living with such illnesses, often for long periods of time, 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.

- Canadian Hospice Palliative Care Association. (2013). *A model to guide hospice palliative care: Based on national principles and norms of practice*. <https://www.chpca.ca/wp-content/uploads/2019/12/norms-of-practice-eng-web.pdf>
- Canadian Partnership Against Cancer & Health Canada. (July 2020). *The Canadian inter-disciplinary palliative care competency framework. A curriculum guide for educators and reference manual for health professionals and volunteers*. Ottawa, ON.
- Covenant Health Palliative Institute. (September 2020). *Alberta palliative care competency framework technical report*. Edmonton, AB.
- Murray, K. (2017, January 23). *Palliative care competencies: Once upon a time, there were competencies*. Life & Death Matters. <https://www.lifeanddeathmatters.ca/upon-time-competencies/>
- National Physiotherapy Advisory Group. (2017). *Competency profile for Physiotherapists in Canada*. <https://peacaepc.ca/pdfs/Resources/Competency%20Profiles/Competency%20Profile%20for%20PTs%202017%20EN.pdf>

## Appendix 3: Acknowledgements

We acknowledge Ireland's Palliative Care Competence Framework Steering Group; Nova Scotia Health Authority's (NSHA's) Palliative Care Capacity Building and Practice Change Working Group; the BC Center for Palliative Care Competency Framework Committee; and the Ontario Palliative Care Network Provincial Palliative Care Education Steering Committee who led the development of palliative care competencies' frameworks in Ireland, Nova Scotia, British Columbia, and Ontario respectively. Their work was used to create the palliative care competencies for various disciplines in Alberta.

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