



Covenant Health
Palliative Institute

Alberta Interprofessional Palliative Care Competency Framework

A Resource for Health Care
Providers, Educators,
Professional Regulators,
Accreditors, and Employers

Alberta Palliative Care Competencies
and Education Project
February 2023



Land Acknowledgement

The Palliative Institute and all Covenant Health facilities reside on Treaty Territories 4, 6, 7, 8 and 10, and Métis Regions 1-6 across Alberta. We acknowledge the many diverse First Nation, Inuit, and Métis Peoples whose ancestors' footsteps have marked these lands since time immemorial. We are grateful to the Elders, Knowledge Keepers and stewards of this land: past, present, and future generations. We recognize the land and its Original Peoples as an act of reconciliation and express gratitude to those whose territory we reside on or are visiting. We recognize and respect Indigenous knowledge for its expertise in teaching us ways of caring for the land, each other and providing us with a model of living well in connected and compassionate communities.



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Alberta Interprofessional Palliative Care Competency Framework

Dedication

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

The patient and their family are at the heart of every interaction and intervention in palliative care. Sharing family palliative care stories serves as an important reminder to continually improve palliative care wherever possible. We share with you the following words and experiences of Jim Mulcahy: 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 country.”



Purpose of this Document

This document presents the Alberta Interprofessional Palliative Care Competency Framework. Competency frameworks allow health care providers (HCPs) to identify the minimum skills, knowledge and attitudes required when providing palliative care. This framework supports consistent standards of interprofessional practice in palliative care within Alberta. The Alberta Interprofessional Palliative Care Competency Framework can be referred to in short as the *Alberta IPC Competency Framework* and can be used as a resource to inform and guide academic curricula, professional development, continuing education programs, accreditation and regulated professional and employer standards.

A competency is defined by Parry¹ 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.”

How to Use the Alberta Interprofessional Palliative Care Competency Framework

This framework is a necessary resource for HCPs to engage in self-assessment of their palliative care practice. The Alberta Interprofessional Palliative Care Competency Framework provides a reference and opportunity for HCPs to critically assess knowledge, skills, behaviours and attitudes toward palliative care. Competency frameworks are interconnected with practice standards and education guidance. Educators may use this document to identify skills gaps, enhance evidence-informed curricula and attain interprofessional educational objectives.

This framework will help professional regulators and health service providers develop or revise professional codes of ethics, policy and minimum standards of practice. It expands upon national and Alberta discipline-specific palliative care frameworks in its development of interprofessional domains. The competencies presented in this document are specific to palliative care in Alberta; each competency must be considered in relation to each HCP’s professional standards, scope of practice and applied in context of varied clinical practice settings in alignment with professional codes of ethics.

Competency statements in this framework are organized by areas of expertise for ease of recognition. The numbering of domains refers simply to order and does not signify levels of importance. A checkbox marked *Educational Opportunity* beside each competency statement helps to identify competencies which may require further education and training. A glossary of terms is provided in an Appendix to support standardized language.

Competency statements are organized according to the following two dimensions:

- Level of Expertise
- Competency Domains

¹ Parry, S. B. (1996). The quest for competencies. *Training* 33, 48–54, 56.



Benefits of a Standardized Provincial Framework

Establishing palliative care early in an illness trajectory is beneficial to patients and families and requires intervention in both generalist and specialist settings by interprofessional care teams²³⁴. Early access to person-centred palliative care in the right place, at the right time, improves patient, family and practitioner experiences.

To ensure all HCPs are competent in providing patients and their families with the best care possible, it is important to equip them with standardized core knowledge and technical skills related to palliative care and to cultivate compassionate attitudes. Palliative care is enhanced when delivered by collaborative interprofessional care teams, whose members possess standardized competencies to deliver consistent, high-quality care.

Health care providers are responsible for continually reevaluating their palliative care competency to identify learning gaps and, where necessary, engaging in continuing professional development education.

Alberta Interprofessional Palliative Care Competency Framework Development

Standardized provincial competencies best reflect contexts of practice when co-designed by multi-disciplinary local HCPs. In phase one of the project, the team oversaw the creation of 14 discipline-specific provincial palliative care competency frameworks⁵. Development of these frameworks involved engaging 184 HCPs, of whom 110 participated in a series of consensus-building activities across the province. It became evident across the discipline-specific competency profiles that Alberta HCPs share common competencies in both generalist and specialist contexts.

In phase two, the same 110 individuals were reengaged to establish the interprofessional palliative care competency framework from themes identified across the discipline-specific frameworks. This was achieved by organizing and aligning competency statements according to level of expertise and competency domains.

For more detailed information about the development of the Alberta Interprofessional Palliative Care Competency Framework, you're invited to review the accompanying Alberta Palliative Care Competency Framework: Technical Report.

² Cameron-Taylor, E. (2012). *The palliative approach to care: A resource guide for healthcare workers*. pp.4 M&K Publishing; London, UK.

³ Parker, S. M., Remington, R., Nannini, A., & Cifuentes, M. (2013). Patient outcomes and satisfaction with care following palliative care consultation. *Journal of Hospice & Palliative Nursing*, 15(4), 225-232. doi:10.1097/NJH.0b013e318279f4ce.

⁴ Wanniarachigie, D. (2015). More palliative care specialists is not enough. *Canadian Medical Association Journal*, 187(3): 171. doi: 10.1503/cmaj.109-4972.

⁵ Covenant Health Palliative Institute. Alberta Palliative Care Competency Framework Technical Report. Edmonton, AB: September 2020.

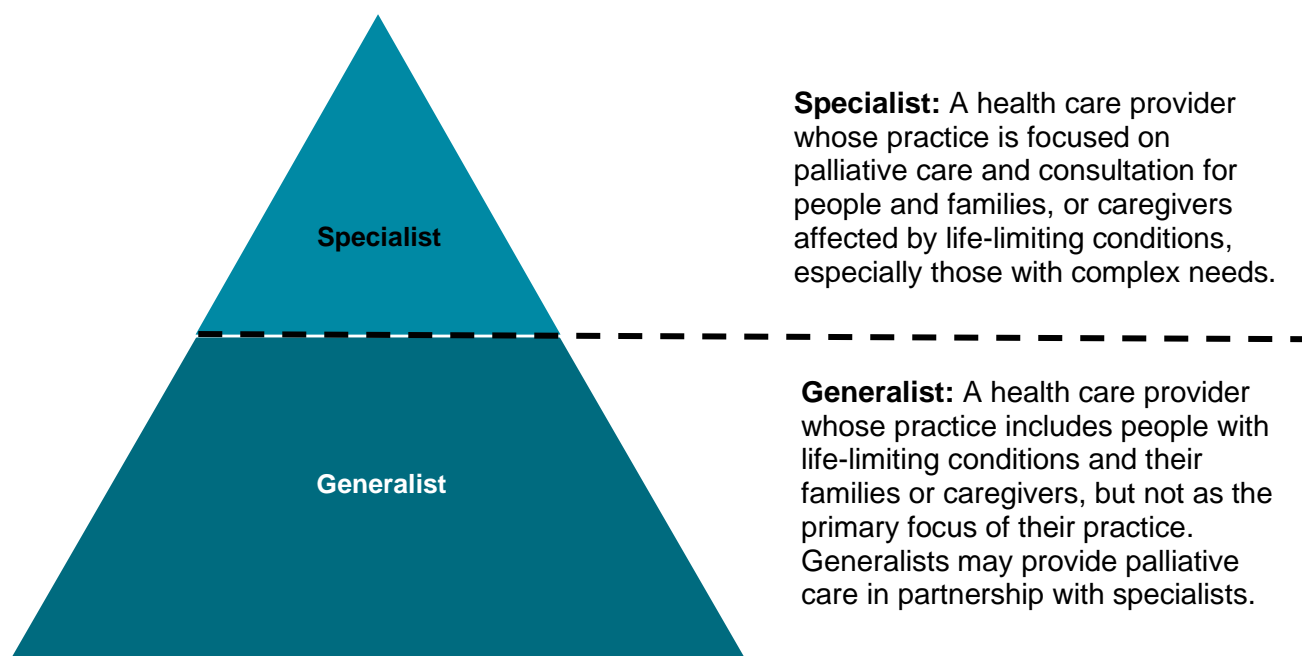


Level of Expertise

HCPs have varying levels of palliative care expertise depending on how frequently and closely they work with patients with life-limiting illnesses.

The Alberta Interprofessional Palliative Care Competency Framework levels of expertise are adapted from the Canadian Interdisciplinary Palliative Care Competency Framework⁶. The Alberta IPC Competency Framework levels of expertise are divided into two health care provider levels: generalist and specialist (Figure 1). They are separated by a dotted line to highlight that some HCPs may fit into more than one category. Additionally, HCPs in the specialist category would also be expected to possess proficiency in the competencies outlined in the generalist level.

Figure 1. The Alberta Interprofessional Palliative Care Competency Framework Triangle



Competency Domains

The competency statements are organized according to eight core competency domains and additional optional competency domains (Figure 2). The core competency domains are common to 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, levels

⁶ Canadian Partnership Against Cancer & Health Canada. The Canadian Interdisciplinary Palliative Care Competency Framework. Toronto, ON: 2021.



of expertise and context settings. Each competency domain is defined by 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.

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 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-centredness; equitable access; collaborative and integrated team service delivery; communication and information sharing; safety; ethical and quality care; sustainability and accountability; clearly defined governance and administration models; and research.

Domain 2: Communication

Effective communication is essential to the delivery of palliative care. Specific consideration should be given to communication as a method of establishing therapeutic relationships and facilitating 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 (e.g., NetCare, Connect Care) for transferring knowledge at all levels (patient and family, service delivery and system) and the use of common tools, language and appropriate documentation to convey appropriate information and safely manage each person and family's care needs.

Domain 3: Care Planning and Collaborative Practice

According to the Alberta Health Services Palliative and End-of-Life Care Alberta Provincial Framework (AHS PEOLC Provincial Framework, 2014), "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 Services⁷].

Care planning is a collaborative practice that includes addressing, coordinating and integrating patient- and family-centred 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.

⁷ [Palliative and End of Life Care Alberta Provincial Framework \(albertahealthservices.ca\)](https://www.albertahealthservices.ca)



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, which also includes effective symptom management that aligns 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, family and community needs, identifying those who may require additional bereavement support and providing information, resources and support to all.

Domain 6: Professional and Ethical Practice

According to the AHS PEOLC 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 guides all HCPs in their consideration of how best to provide ongoing care to people with life-limiting illnesses as their health care needs change.

Domain 7: Cultural Safety

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

Cultural safety is based on respectful engagement and communicating respect for a patient's beliefs, behaviours and values and ensures that the patient is a partner in decision making. It requires acknowledgement that we are all immersed in culture(s) that encompass the need for self-reflection on one's own attitudes, beliefs, assumptions and values. It requires recognition of the power differentials inherent in healthcare service delivery and institutional discrimination as well as the need to address these inequities through education and system change.

Assessing and respecting values, beliefs and traditions related to health, illness, family and community caregiver roles and decision-making are the first step in providing spiritually and culturally safer palliative care. Culturally safer 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 and community play in cultural safety for the patient. Cultural competency is the process HCPs achieve with cultural safety being the outcome [Health Council of Canada⁸].

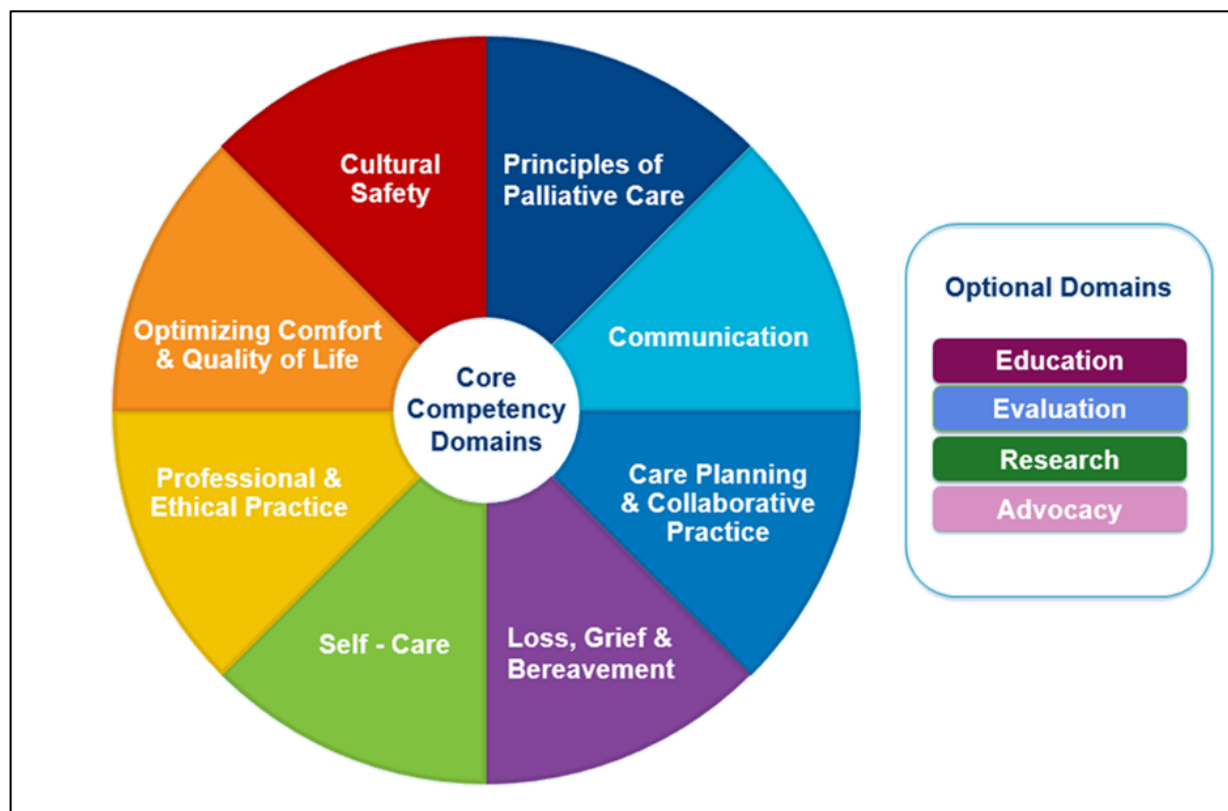
⁸ Health Council of Canada. (2012). Empathy, dignity, and respect: Creating cultural safety for Aboriginal people in urban health care. Toronto. Health Council of Canada.



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 one's own health as well as the health and function of the team.

Figure 2. Alberta Interprofessional Palliative Care Competency Framework Domains



Domain 9A: Education

Participating in palliative care continuing education, facilitating palliative care educational opportunities for HCPs, volunteers, patients, their family, community and the public.

Domain 9B: Evaluation

Palliative health care delivery should be based on the most current evidence-informed practices and available research. HCPs are encouraged to engage in leading and/or participating in the evaluation of palliative care services exploring HCPs', patients' and families' and communities' experiences.



Domain 9C: Research

The provision of quality palliative care necessitates engagement in ongoing palliative care research and the involvement of patients, families and communities in relevant research activities.

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 Interprofessional Palliative Care Competency Framework

Domain 1: Principles of Palliative Care

Generalist	<i>Educational Opportunity</i>
1. Explain the philosophy of a palliative approach to care.	<input type="checkbox"/>
2. Apply the principles of palliative care in clinical practice.	<input type="checkbox"/>
3. Identify when and why a patient may benefit from a palliative approach to care.	<input type="checkbox"/>
4. Identify the role and function of each interprofessional team member in palliative care.	<input type="checkbox"/>
5. Apply multimodal interprofessional approaches to optimize comfort and enhance the quality of life of the patient with a life-limiting illness and their family.	<input type="checkbox"/>
Specialist	<i>Educational Opportunity</i>
1. Apply palliative care standards of practice, guidelines and policies.	<input type="checkbox"/>
2. Encourage colleagues to foster a caring environment that supports each member of the interprofessional team.	<input type="checkbox"/>
3. Provide leadership in the delivery of an interprofessional team approach to palliative care.	<input type="checkbox"/>
4. Promote palliative care principles in all care settings.	<input type="checkbox"/>

Domain 2: Communication

Generalist	<i>Educational Opportunity</i>
1. Assess the patient's and family's understanding of the life-limiting illness and its trajectory.	<input type="checkbox"/>
2. Explore with the patient and family their priorities, preferences, values, beliefs, fears, and hopes regarding death and dying with respect and sensitivity.	<input type="checkbox"/>
3. Identify patients and families in need of additional communication supports (including but not limited to: interpreters, assistive technology, supportive communication, hearing aids/personal amplification devices and visual aids).	<input type="checkbox"/>
4. Adapt communication approach with the patient and their family based on their understanding of the life-limiting illness and amount/type of information they wish to receive.	<input type="checkbox"/>



5. Identify when illness progression impacts the ability or capacity of the patient to engage in meaningful discussion.	<input type="checkbox"/>
Specialist	<i>Educational Opportunity</i>
1. Engage in highly skilled, compassionate, individualized and timely communication with the patient, their family and the interprofessional team.	<input type="checkbox"/>
2. Discuss care and treatment options with the patient, their family and interprofessional team (including, but not limited to: the anticipated benefits, burdens and risks of options).	<input type="checkbox"/>
3. Explore patient and family perspectives across physical, functional, psychological, social and spiritual domains.	<input type="checkbox"/>
4. Provide support, mediation and advocacy to explore and clarify treatment goals and care planning.	<input type="checkbox"/>
5. Facilitate interprofessional team discussions, debriefings and case reviews.	<input type="checkbox"/>

Domain 3: Care Planning and Collaborative Practice	
Generalist	<i>Educational Opportunity</i>
1. Apply relevant Advance Care Planning and Goals of Care Designation policy in clinical practice.	<input type="checkbox"/>
2. Participate in Advance Care Planning (ACP) and Goals of Care Designation (GCD) discussions with the patient, family, and the interprofessional team.	<input type="checkbox"/>
3. Support the patient and their family to be actively involved in palliative care decision making and goal setting.	<input type="checkbox"/>
4. Respect the patient's autonomy and right to refuse treatment.	<input type="checkbox"/>
5. Adapt care according to the patient's and family's values, beliefs and preferences throughout the care trajectory.	<input type="checkbox"/>
6. Explain the role and function of the Palliative Care Consult Team.	<input type="checkbox"/>
7. Identify when a patient would benefit from a referral to the Palliative Care Consult Team.	<input type="checkbox"/>
Specialist	<i>Educational Opportunity</i>
1. Provide evidence-based, timely, and therapeutic interventions relevant to the patients' palliative care needs.	<input type="checkbox"/>
2. Facilitate safe and smooth transitions of care for the patient and their family.	<input type="checkbox"/>
3. Facilitate the patient and family access to the full range of palliative care services, resources and settings where they are available.	<input type="checkbox"/>



4. Mentor other health care providers to build empathetic and compassionate relationships with the patient and their family.	<input type="checkbox"/>
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Domain 4: Optimizing Comfort and Quality of Life

Generalist	<i>Educational Opportunity</i>
1. Provide palliative care that acknowledges all dimensions of personhood (physical, psychological, social, and spiritual).	<input type="checkbox"/>
2. Regularly assess the physical, psychological, social and spiritual needs of the patient with life-limiting illness and their family.	<input type="checkbox"/>
3. Recognize changes in the physical, psychological, social, and spiritual needs of each patient with a life-limiting illness and their family.	<input type="checkbox"/>
4. Provide appropriate referrals to address the patient and family's physical, functional, psychological, social and spiritual needs.	<input type="checkbox"/>
5. Identify the need for a change in focus of care and treatment goals at critical points throughout the course of a life-limiting illness.	<input type="checkbox"/>
6. Recognize common signs and symptoms that may be associated with progression of a life-limiting illness (including but not limited to: anorexia, anxiety, cachexia, constipation, delirium, depression, diarrhea, drowsiness, dyspnea, fatigue, nausea, pain, vomiting, malaise and change in overall well-being).	<input type="checkbox"/>
7. Recognize that symptoms are subjective in nature and should be assessed and understood from a patient-centered perspective.	<input type="checkbox"/>
8. Utilize pharmacological and/or non-pharmacological symptom management strategies to minimize suffering and promote comfort and quality of life.	<input type="checkbox"/>
9. Regularly reassess clinical interventions to ensure they are effective and congruent with the patient's goals and illness trajectory.	<input type="checkbox"/>
10. Recognize and respond to palliative care emergencies.	<input type="checkbox"/>
11. Adapt care to address the patient's fears, worries, concerns, anxieties and hopes.	<input type="checkbox"/>
12. Provide care in the patient's preferred location when possible.	<input type="checkbox"/>
13. Identify complexities and challenges that may impact the ability to provide quality palliative care in the patient's preferred location.	<input type="checkbox"/>
14. Provide education to the patient and their family regarding symptom management.	<input type="checkbox"/>
15. Support the patient to engage in self-management of their illness.	<input type="checkbox"/>
16. Work together with the patient and family to identify their collective strengths and effective coping strategies	<input type="checkbox"/>



17. Recognize and respond to the signs of imminent death.	<input type="checkbox"/>
18. Participate in the care and support of the imminently dying patient and their family.	<input type="checkbox"/>
19. Prepare the patient and their family for what to expect in last days and hours of life.	<input type="checkbox"/>
Specialist	<i>Educational Opportunity</i>
1. Apply advanced knowledge of the full spectrum of life-limiting illness trajectories in response to the patients and their family's complex and multidimensional care needs.	<input type="checkbox"/>
2. Apply advanced clinical knowledge and understanding of complex symptoms associated with life-limiting illness when providing care and consultation	<input type="checkbox"/>
3. Identify underlying etiology, contributing factors and treatment options related to signs and symptoms.	<input type="checkbox"/>
4. Act as a clinical resource to generalist and specialist team members to assess and care for a patient with complex symptoms and care needs.	<input type="checkbox"/>
5. Utilize palliative care screening tools to diagnose and manage complex symptoms and care needs.	<input type="checkbox"/>
6. Apply expertise to address the complex interplay of factors that impact a patients physical functioning and quality of life within the context of a life-limiting illness.	<input type="checkbox"/>
7. Provide expert guidance regarding pharmacological and non-pharmacological management of complex symptoms to promote comfort and quality of life.	<input type="checkbox"/>
8. Act as an expert resource for colleagues regarding the role of discipline-specific interventions in symptom management and optimizing quality of life.	<input type="checkbox"/>
9. Apply the ethical tenets of palliative sedation to the care of a patient with a life-limiting illness.	<input type="checkbox"/>
10. Address factors that contribute to distress within the family paradigm during life-limiting illness.	<input type="checkbox"/>
11. Address acute and chronic psychological distress in a patient with advanced disease.	<input type="checkbox"/>

Domain 5: Loss, Grief and Bereavement	
Generalist	<i>Educational Opportunity</i>
1. Describe the dimensions of grief.	<input type="checkbox"/>
2. Acknowledge diverse perspectives on loss, grief and bereavement.	<input type="checkbox"/>



3. Describe the impact of physical, psychological, spiritual, emotional and social dimensions of loss.	<input type="checkbox"/>
4. Identify the loss, grief and bereavement needs of the patient with life-limiting illness and their family.	<input type="checkbox"/>
5. Recognize the factors that may increase the risk of complicated and disenfranchised grief.	<input type="checkbox"/>
6. Provide support to the patient and family throughout the grieving process including during illness, decline, time of death and bereavement.	<input type="checkbox"/>
Specialist	<i>Educational Opportunity</i>
1. Address the needs of those at risk of, or who may be experiencing complex and/or disenfranchised grief	<input type="checkbox"/>
2. Address the physical, psychological, spiritual, emotional and social responses to loss and grief.	<input type="checkbox"/>
3. Utilize a broad range of evidence-based interventions for the patient with a life-limiting illness and their family when increased stress, vulnerability and/or complex grief are present.	<input type="checkbox"/>
4. Mentor colleagues to support their personal understandings of loss, grief, and bereavement.	<input type="checkbox"/>
5. Support bereavement follow-up with families.	<input type="checkbox"/>

Domain 6: Professional and Ethical Practice	
Generalist	<i>Educational Opportunity</i>
1. Respect and uphold the dignity of the person who is receiving palliative care.	<input type="checkbox"/>
2. Collaborate with the interprofessional team and the Palliative Care Consult Team to assess, coordinate, promote and improve the provision of palliative care.	<input type="checkbox"/>
3. Identify ethical and legal issues that may be encountered when caring for the person with life-limiting illness and their family.	<input type="checkbox"/>
4. Apply professional, legal, and ethical codes of practice related to the Personal Directives Act, advance care plans, informed consent, confidentiality and documentation.	<input type="checkbox"/>
5. Apply professional, legal and ethical codes of practice related to palliative sedation, Medical Assistance in Dying (MAID) and withdrawing and withholding life-sustaining therapies.	<input type="checkbox"/>
6. Participate in processes that mitigate and resolve conflict in palliative care.	<input type="checkbox"/>



Specialist	<i>Educational Opportunity</i>
1. Apply evidence-based practice to enhance patient safety and delivery of quality care across the continuum of palliative care.	<input type="checkbox"/>
2. Address the nature and cause(s) of potential conflict in palliative care.	<input type="checkbox"/>
3. Employ evidence-based strategies to resolve or mediate conflict.	<input type="checkbox"/>
4. Mentor and educate colleagues about professional and ethical practice in palliative care.	<input type="checkbox"/>

Domain 7: Cultural Safety	
Generalist	<i>Educational Opportunity</i>
1. Describe the influence of culture in palliative care.	<input type="checkbox"/>
2. Identify personal biases and values that may influence care.	<input type="checkbox"/>
3. Apply strategies to mitigate personal biases and values that may influence care.	<input type="checkbox"/>
4. Incorporate the patient and family's cultural preferences (beliefs, values and practices) into goal setting, decision making and care planning.	<input type="checkbox"/>
5. Respond to patient and family members' unique needs and experiences (including but not limited to: ethnicity, culture, gender, sexual orientation, language, religion, spirituality, age, ability and preferences).	<input type="checkbox"/>
6. Participate in educational opportunities about cultural safety in palliative care.	<input type="checkbox"/>
7. Provide culturally safe palliative care.	<input type="checkbox"/>
Specialist	<i>Educational Opportunity</i>
1. Educate colleagues and organizations about cultural safety in palliative care.	<input type="checkbox"/>
2. Advocate for culturally safe palliative care.	<input type="checkbox"/>
3. Assist with the development of resources, spaces, and opportunities for cultural and personal expression in palliative care.	<input type="checkbox"/>

Domain 8: Self-Care	
Generalist	<i>Educational Opportunity</i>
1. Regularly self-assess personal responses to loss, grief, and bereavement.	<input type="checkbox"/>
2. Engage in activities that support wellbeing and resilience when caring for a patient with a life-limiting illness and their family.	<input type="checkbox"/>



3. Demonstrate healthy self-care behaviors and activities that mitigate the personal impact of loss, grief and bereavement.	<input type="checkbox"/>
Specialist	<i>Educational Opportunity</i>
1. Mentor colleagues regarding the personal impact of loss, grief and bereavement.	<input type="checkbox"/>
2. Facilitate activities that support colleagues to address their own loss responses and maintain resilience (e.g., staff debriefing following a patient's death).	<input type="checkbox"/>

Domain 9: A. Education, B. Research and C. Evaluation	
Generalist	<i>Educational Opportunity</i>
1. Provide education to the patient and their family about palliative care and a palliative approach to care.	<input type="checkbox"/>
2. Maintain competency in palliative care by attending professional development opportunities that support ethical practice.	<input type="checkbox"/>
3. Support research that leads to evidence-based practice in palliative care.	<input type="checkbox"/>
4. Participate in palliative care quality improvement initiatives.	<input type="checkbox"/>
Specialist	<i>Educational Opportunity</i>
1. Critically appraise current themes and trends in palliative care research.	<input type="checkbox"/>
2. Lead palliative care quality improvement initiatives.	<input type="checkbox"/>
3. Contribute to the development and delivery of palliative care education.	<input type="checkbox"/>
4. Contribute to the development and advancement of palliative care research.	<input type="checkbox"/>

Domain 10: Advocacy	
Generalist	<i>Educational Opportunity</i>
1. Advocate for the needs and rights of patients and their families in palliative care.	<input type="checkbox"/>
2. Advocate for the patient and family to access appropriate and timely palliative care.	<input type="checkbox"/>
3. Advocate for removal of barriers to accessing palliative care.	<input type="checkbox"/>
4. Advocate for health care providers to have access to evidence-based palliative care education and resources.	<input type="checkbox"/>



Specialist	<i>Educational Opportunity</i>
1. Address misconceptions about life-limiting illness, death, bereavement and palliative care.	<input type="checkbox"/>
2. Advocate for equitable palliative care across service locations.	<input type="checkbox"/>
3. Identify opportunities for advocacy and health promotion in palliative care.	<input type="checkbox"/>
4. Advocate for the development, maintenance and improvement of health care and social policies related to palliative care.	<input type="checkbox"/>
5. Contribute to palliative care service development and delivery across all care settings.	<input type="checkbox"/>
6. Promote palliative care strategic initiatives and policy development at local, regional and national levels.	<input type="checkbox"/>



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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 and are adopted from the AHS PEOLC Alberta Provincial Framework⁹ and referenced in the technical document, Alberta Palliative Care Competency Framework Technical Report [Covenant Health¹⁰].

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].

⁹ [Palliative and End of Life Care Alberta Provincial Framework \(albertahealthservices.ca\)](https://www.albertahealthservices.ca)

¹⁰ [Alberta Palliative Care Competency Framework - Technical Report \(covenanthealth.ca\)](https://www.covenanthealth.ca)



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 the focal point of care [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 caregivers are likely to vary according to the trajectory they are following. Being aware of these trajectories may help clinicians plan care to better meet their patients’ multidimensional needs and help patients and caregivers cope with their situation. Different models of care that reflect and tackle patients’ individual experiences and needs may be necessary.

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-centred 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’s role 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].

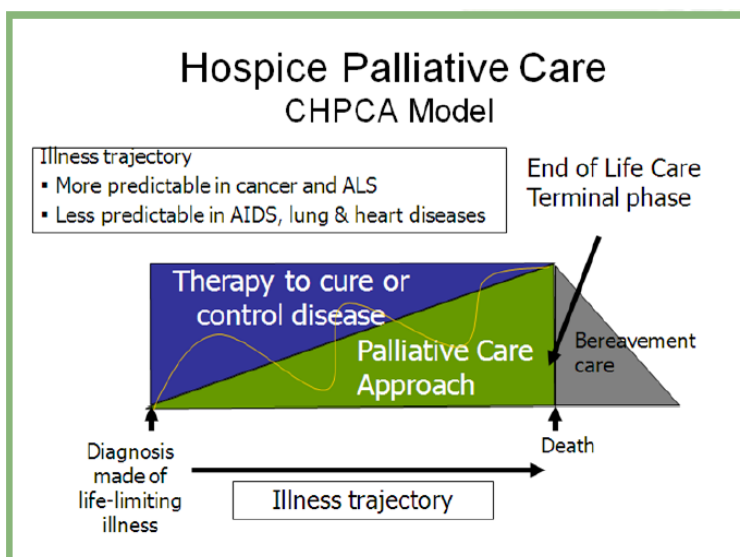
Palliative and end-of-life care: is both a philosophy and an approach to care that enables all individuals with a life-limiting and/or life-threatening illness to receive integrated and coordinated care across the continuum. This care incorporates patient and family values, preferences and goals of care, 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 cooperation and coordination 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-centred 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-centred 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 designates 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 one) has effect with respect to a personal matter only when the patient lacks capacity with respect to that matter [Alberta Health Services].

Referral: refers to when a patient is instructed by a health care professional or organization 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].



Appendix 2: 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; the Ontario Palliative Care Network Provincial Palliative Care Education Steering Committee; the Canadian Partnership Against Cancer Palliative Care Competencies Working Group, who led the development of palliative care competencies' frameworks in Ireland, Nova Scotia, British Columbia, Ontario, and Canada respectively. Their work was used to inform the Alberta Interprofessional Palliative Care Competency Framework.

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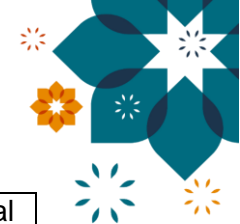
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