

Alberta Occupational Therapists' Palliative Care Competency Framework

Version 1.0 (September 2020)

A Resource Manual for Health Care Professionals



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

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Dedication

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

Forward

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

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

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

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

Alberta Occupational Therapists' Palliative Care Competencies Referent Group

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

Alberta Occupational Therapists' Palliative Care Competencies Referent Group	
Health Care Organizations	Educational Institutions
<ul style="list-style-type: none"> • Alberta Health Emergency Medical Services <p><u>Alberta Health Services</u></p> <ul style="list-style-type: none"> • Calgary Zone Palliative and End-of-Life Care Program • Calgary Zone Palliative Home Care • Cold Lake-North Zone • Cross Cancer Institute, Edmonton • Edmonton Zone Palliative Care Program • Edmonton Zone Palliative and End-of-Life Care and Community Programs, Continuing Care • Edmonton Zone Urban Palliative Home Care • Innisfail Health Care Centre • Lethbridge-South Zone Palliative Care Team and Community OT Team • Provincial Palliative and End-of-Life Care, Community, Seniors, Addiction and Mental Health • Royal Alexandra Hospital, Edmonton • St. Albert-Edmonton Zone, North Home Care <p><u>Covenant Health</u></p> <ul style="list-style-type: none"> • Professional Practice and Research • St. Joseph's Auxiliary Hospital, Edmonton • Tertiary Palliative Care Unit, Grey Nuns Hospital, Edmonton 	<p><u>University of Alberta</u></p> <ul style="list-style-type: none"> • Department of Occupational Therapy, Calgary satellite • Department of Occupational Therapy, Edmonton • Enable Health, Calgary satellite • Faculty of Nursing • Faculty of Medicine and Dentistry <p><u>University of Calgary</u></p> <ul style="list-style-type: none"> • Department of Family Medicine • Department of Oncology <p>Professional Regulatory Bodies and Associations</p> <ul style="list-style-type: none"> • College of Licensed Practical Nurses of Alberta

Alberta Palliative Care Competency Framework

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.” 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 Occupational Therapists’ 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 Occupational Therapists’ Palliative Care Competency Framework which was developed by the Alberta Occupational Therapists’ Palliative Care Competencies Working Group.

Competency statements are organized according to the following two dimensions:

1. Level of expertise
2. Competency domains

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

Level of Expertise

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

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

Figure 1: The Alberta Palliative Care Competency Triangle

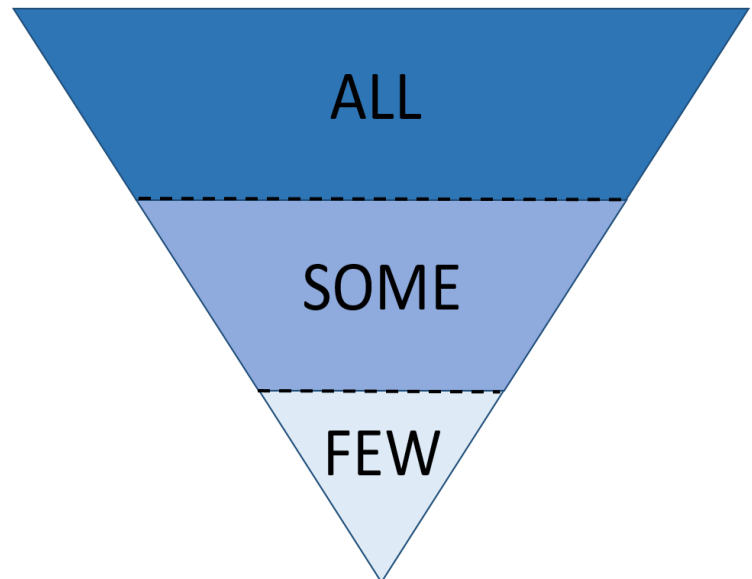


Table 1. Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions

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

Table 1 Continued. Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions

Some: These HCPs have deeper knowledge, understanding and application of palliative and end-of-life care. HCPs in this level also provide care in any setting. They have expertise in palliative and end-of-life care, in managing pain and other symptoms and in providing psychosocial and spiritual support. They ensure that adequate assessment and management of symptoms, psychological distress, practical and financial issues and spiritual needs are incorporated into comprehensive care for patients and families. They provide enhanced care for more complex needs and consult with specialized palliative care services as required. They are a resource for colleagues within their local environment and may support patients and families who are not directly assigned to their care.

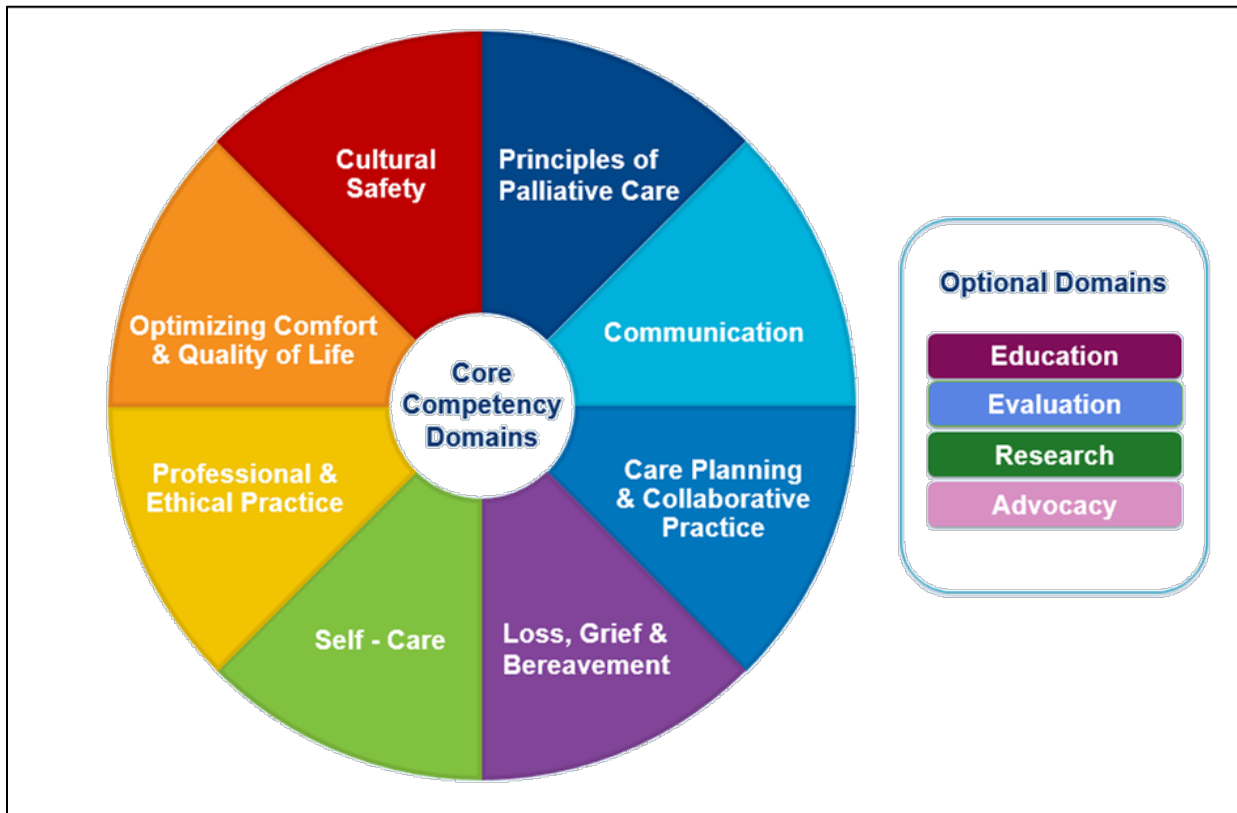
Few: This level of HCPs are palliative care experts who provide care for patients and their families, including those with the most complex palliative care needs. They provide a focused level of service for patients and families who require specialized, frequent and skilled assessments and interventions in palliative and end-of-life care. They may act as a resource and support to any HCP (including those working in hospices and palliative home care) and provide formal and informal expert palliative and end-of-life care consultation. These palliative care experts provide leadership mentoring, and education in palliative and end-of-life care. This level also includes, but is not limited to, experts who conduct research and develop advocacy strategies that advance approaches to palliative care and contribute to quality improvement on a system level.

Competency Domains

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

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

Figure 2. Alberta Palliative Care Competency Domains



Domain 1: Principles of Palliative Care

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

Domain 2: Communication

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

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

Domain 3: Care Planning and Collaborative Practice

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

Domain 4: Optimizing Comfort and Quality of Life

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

Domain 5: Loss, Grief and Bereavement

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

Domain 6: Professional and Ethical Practice

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

Domain 7: Cultural Safety

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

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

Domain 8: Self-Care

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

Domain 9A: Education

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

Domain 9B: Evaluation

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

Domain 9C: Research

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

Domain 10: Advocacy

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

Alberta Occupational Therapists' Palliative Care Competencies

Domain 1: Principles of Palliative Care	
All	Educational Opportunity
1. Demonstrate an understanding of the philosophy of palliative care.	<input type="checkbox"/>
2. Demonstrate an understanding that a palliative approach to care starts early in the trajectory of a progressive life-limiting illness.	<input type="checkbox"/>
3. Conserve patient dignity by facilitating expression of needs, hopes, feelings and concerns when planning palliative care.	<input type="checkbox"/>
4. Practice patient and family-centered palliative care that incorporates dignity and the unique contributions of the family in routine care giving.	<input type="checkbox"/>
5. Offer a support system to help the patient live as actively as possible, with optimal quality of life, until death.	<input type="checkbox"/>
6. Understand, recognize, and address responses to loss of occupational roles and functional independence which may impact on the behavior and decision-making of a patient with a life-limiting illness and their family, referring to specialist palliative care when appropriate.	<input type="checkbox"/>
7. Understand the impact that psychological responses, social stressors, and spiritual dimension of loss (including the impact of multiple losses) may have on behavior, coping, and decision making of a patient with a life-limiting illness and their family and take this into account when planning care.	<input type="checkbox"/>
8. Demonstrate an understanding of the role and function of the interprofessional team in palliative care.	<input type="checkbox"/>
9. Demonstrate an understanding of the role and function of the Palliative care Consult Team including volunteers and refer appropriately.	<input type="checkbox"/>
Some	Educational Opportunity
1. Demonstrate an understanding of palliative care standards, norms of practice and best practices.	<input type="checkbox"/>
2. Utilize enhanced competence developed through experience in palliative care to provide applicable, holistic, ethical and quality palliative care.	<input type="checkbox"/>
3. Demonstrate in-depth understanding of the trajectories of life-limiting illnesses in the context of current clinical practice.	<input type="checkbox"/>
4. Understand and respond to the psychosocial and mental health needs of the patient and their family.	<input type="checkbox"/>

Few	Educational Opportunity
1. In your area of practice, demonstrate advanced knowledge and understanding of the trajectories of life-limiting illnesses when responding to complex and multidimensional care needs.	<input type="checkbox"/>

Notes:

Domain 2: Communication	
All	Educational Opportunity
1. Demonstrate an understanding that communication regarding palliative care is an essential and on-going collaborative process.	<input type="checkbox"/>
2. Maintain ongoing communication with each patient, family and the interprofessional team regarding the care plan.	<input type="checkbox"/>
3. Recognize the complexity of palliative care decision-making and how to contribute to its management.	<input type="checkbox"/>
4. Assess the patient's current understanding of their health, roles and functional status, identifying their occupational performance in the context of the patient's life-limiting illness.	<input type="checkbox"/>
5. Recognize that family conversations may involve children and individuals with different communication needs, and varying approaches may be required.	<input type="checkbox"/>
6. Demonstrate awareness of specialist support in relation to communication (e.g. interpreters, sign language interpreters and assistive technology).	<input type="checkbox"/>
7. Demonstrate self-awareness of responses to communication challenges and remain engaged in meaningful contact with the patient and their family.	<input type="checkbox"/>
8. Demonstrate expertise in the assessment of cognitive and functional ability in order to enable the patient to communicate their needs and engage with others.	<input type="checkbox"/>
9. Identify and assist the patient to acquire assistive technology and modify assistive technology as required.	<input type="checkbox"/>

10. Use therapeutic use of self and understand the role that occupational therapists have in providing basic counselling skills to the palliative care patient and their family.	<input type="checkbox"/>
Some	Educational Opportunity
1. Demonstrate enhanced understanding of the multidimensional communication challenges that arise when working with a patient with a life-limiting illness, responding with sensitivity and compassion to their needs and the needs of their family.	<input type="checkbox"/>
2. Use and modify effective communication strategies to support the changing needs and wishes of a patient with a life-limiting illness and their family, including enhanced psychosocial screening.	<input type="checkbox"/>
3. Facilitate informed decision-making, and communicate current occupational performance status and likely progression in an accurate and compassionate manner, taking account of the patient's needs and wishes.	<input type="checkbox"/>
4. Communicate the benefits, burdens, and risks of occupational therapy interventions with the patient, their family and the interprofessional team and make decisions regarding the appropriateness of interventions.	<input type="checkbox"/>
5. Demonstrate appropriate communication skills while providing psychosocial occupational therapy assessments and interventions, including counseling.	<input type="checkbox"/>
Few	Educational Opportunity
1. Use a variety of strategies to engage in highly skilled, compassionate, individualized, and timely communication with the patient with a life-limiting illness, their family and the interprofessional team.	<input type="checkbox"/>
2. Demonstrate expertise as a mediator and advocate for each patient to have access to appropriate and timely palliative care.	<input type="checkbox"/>
3. Understand and navigate the complexities in communication regarding end-of-life options, such as Medical Assistance in Dying (MAID).	<input type="checkbox"/>
4. Demonstrate self-awareness of one's own responses to communication challenges.	<input type="checkbox"/>
5. Act as an expert that supports and facilitates interprofessional teaching of occupational therapy in palliative care.	<input type="checkbox"/>

Notes:

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 an appreciation of the appropriate time(s) to engage in discussions regarding occupational therapy goals and preferences for care.	<input type="checkbox"/>
2. Recognize that a patient with a life-limiting illness may lose the ability to make decisions towards the end-of-life, and their ability to make decisions may fluctuate. 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.	<input type="checkbox"/>
3. Understand the collaborative relationship between the patient, family and the interprofessional team in palliative care.	<input type="checkbox"/>
4. Effectively collaborate with the interprofessional team to manage palliative care symptoms and functional changes, including attending family meetings/case conferences.	<input type="checkbox"/>
5. Recognize the overall impact of a life-limiting illness on a patient and their family, including their mental health and coping mechanisms and provide support to address identified needs, or make appropriate referrals, including referral to the Palliative Care Consult Team for the management of complex needs.	<input type="checkbox"/>
6. Facilitate the patient and their family towards active involvement in decision-making and goal setting to support patient identified outcomes and quality of life.	<input type="checkbox"/>
7. Assist the family in caregiving; identify caregiver burden; and support the acquisition of respite care.	<input type="checkbox"/>
8. Contribute to decision making with the patient, family, Alternate Decision Maker (ADM) and care teams about withdrawing or withholding interventions, while recognizing when to reinstate interventions.	<input type="checkbox"/>
9. Facilitate discharge planning, recognizing palliative care complexities and the challenges the patient and their family may encounter.	<input type="checkbox"/>
10. Provide relevant information and resources to the patient and family and facilitate access to palliative care services, and initiate referrals as appropriate and in collaboration with the interprofessional team.	<input type="checkbox"/>
Some	Educational Opportunity
1. Collaborate with the patient and their family to develop individualized goal based treatment programs that are realistic, meaningful and responsive to the changing needs of the patient with a life-limiting illness.	<input type="checkbox"/>
2. Demonstrate flexibility in relation to care planning, acknowledging that the patient's priorities can alter with a change in their condition and disease advancement.	<input type="checkbox"/>

3. Facilitate the patient to make an informed decision regarding place of care, while identifying potential and actual functional and environmental risks.	<input type="checkbox"/>
4. Understand various palliative care interventions and treatment options based on the patient's care needs, and evaluate the effect on the patient's occupational performance (e.g. radiation therapy, chemotherapy, nerve blocks, vertebroplasties).	<input type="checkbox"/>
Few	Educational Opportunity
1. Demonstrate an advanced level of clinical expertise in palliative care services in supporting the patient to adapt to changing presentation and functional abilities.	<input type="checkbox"/>
2. Develop a holistic, patient and family-centered plan that acknowledges, addresses and responds to the psychosocial impact of diminishing function and roles in occupational performance.	<input type="checkbox"/>
3. Demonstrate an advanced level of clinical occupational therapy expertise to support the patient to adapt to changing clinical presentation.	<input type="checkbox"/>
4. Be able to act as an expert clinical resource, as required, to generalist and other specialist providers of palliative care, role modelling advanced clinical skills when assessing and managing a patient with a complex life-limiting illness.	<input type="checkbox"/>

Notes:

Domain 4: Optimizing Comfort and Quality of Life	
All	Educational Opportunity
1. Demonstrate an understanding of how a palliative approach can enhance the assessment and management of symptoms and how symptoms affect function.	<input type="checkbox"/>
2. Recognize the importance and benefit of interprofessional approaches in optimizing comfort and enhancing the quality of life of the patient.	<input type="checkbox"/>
3. Recognize common trajectories of life-limiting illnesses, including common symptoms.	<input type="checkbox"/>

4. In collaboration with the patient, family and the interprofessional team, make decisions regarding the appropriateness of interventions, taking into consideration the patient's or Alternate Decision Maker's (ADM's) preferences.	<input type="checkbox"/>
5. Provide appropriate assessment and intervention for the management of a palliative care patient's cognitive and perceptual disorders.	<input type="checkbox"/>
6. Demonstrate an understanding of the significance of anticipating and responding to the needs of each patient in a proactive and timely manner.	<input type="checkbox"/>
7. Recognize potentially reversible causes of functional deterioration in occupational performance areas of self-care, productivity and leisure, employing a palliative care rehabilitation approach that is appropriate to promote optimal independence and safety.	<input type="checkbox"/>
8. Evaluate non-complex interventions as they pertain to the patient's quality of life and propose options and alternatives to achieve the patient's goals.	<input type="checkbox"/>
9. Apply the principles of pain and symptom management as it relates to occupational performance.	<input type="checkbox"/>
10. Demonstrate an understanding of the concept of 'total pain'.	<input type="checkbox"/>
11. Demonstrate an understanding of the causes of common non-pain symptoms related to palliative care (e.g. shortness of breath, fatigue) and report to other interprofessional team members, as appropriate.	<input type="checkbox"/>
12. Use non-pharmacological symptom management strategies to promote comfort and quality of life.	<input type="checkbox"/>
13. Identify patients who would benefit from the Emergency Medical Services Palliative and End of Life Care Assess Treat and Refer (EMS PEOLC ATR) program and refer as appropriate.	<input type="checkbox"/>
14. Assist each patient to adapt to changes from a mental health perspective to enhance or support the patient's occupational engagement.	<input type="checkbox"/>
15. Support each patient with a life-limiting illness to adapt to on-going changes in occupational performance and roles.	<input type="checkbox"/>
16. Formulate treatment plans that address the loss and grief of a patient with a life-limiting illness to enable them to continue engaging in meaningful occupations.	<input type="checkbox"/>
17. Discuss the benefits and burdens of palliative care treatment options to assist the patient in meeting their goals of care and clinical needs.	<input type="checkbox"/>
18. Apply and use adaptive or compensatory strategies and/or environmental modifications that will enhance and support the safety, occupational performance and functional independence of the patient, including interventions, supports and strategies that address the mental, emotional and psychological adaptations that arise with end of life experiences.	<input type="checkbox"/>

19. Demonstrate knowledge and competence in equipment prescription and provision to enable the functional independence and/or facilitate the care and comfort needs of the patient with a life-limiting illness within the hospital and/or home environment.	<input type="checkbox"/>
20. Demonstrate expertise in enabling each patient to identify the meaningful occupations in which they want to engage and adapting these activities to support continued engagement, and promote quality of life, while understanding the reality that a decline in function is expected and activities can be modified and graded as that happens.	<input type="checkbox"/>
21. Assess for and address cognitive limitations associated with disease progression and/or effects of treatment (e.g. “brain fog”).	<input type="checkbox"/>
22. Initiate comprehensive seating assessments as indicated.	<input type="checkbox"/>
23. Prescribe specialized surfaces for the palliative care patient with pressure care needs to provide comfort and enable engagement in occupational performance.	<input type="checkbox"/>
24. Provide education and practical strategies to the patient and family about the management of symptoms.	<input type="checkbox"/>
25. Effectively and sensitively educate caregivers in the skills required to assist the patient with personal care and transfers, at current level of function and with anticipated decline.	<input type="checkbox"/>
26. Demonstrate an awareness of the impact of family role changes when formulating relevant and realistic care plans.	<input type="checkbox"/>
27. Provide a compassionate presence and attend to a patient’s suffering.	<input type="checkbox"/>
28. Anticipate, recognize and respond to the signs of imminent death.	<input type="checkbox"/>
29. Support the patient’s and family’s wishes and death rituals.	<input type="checkbox"/>
30. Demonstrate awareness of the Care of the Imminently Dying Pathway.	<input type="checkbox"/>
31. Anticipate positioning and other comfort needs and respond efficiently.	<input type="checkbox"/>
32. Maintain a patient and family centered perspective until the time of the patient’s death.	<input type="checkbox"/>
Some	Educational Opportunity
1. Recognize a need for change in the focus of care and treatment goals at critical decision points in the course of a life-limiting illness and manage occupational therapy related needs accordingly, including increased use of and comfort with interventions, supports and strategies that address the changing emotional, psychological and spiritual needs of the patient and their family	<input type="checkbox"/>
2. Help the patient with a life-limiting illness and their family to adapt to a transition from life prolonging/sustaining treatment to a focus on palliative care.	<input type="checkbox"/>

3. Demonstrate an understanding of the causes of complex non-pain symptoms (e.g. delirium, existential distress, spinal cord compression), as well as emergencies that may arise in palliative care (e.g. spinal cord compression, opioid neurotoxicity, delirium, deep venous thrombosis, pulmonary embolism) and report to other team members as appropriate.	□
4. Utilize non-pharmacological interventions to manage common palliative care symptoms, including but not limited to fatigue, dyspnea, anxiety and pain, which can have an impact on functional engagement in occupational performance activities and quality of life.	□
5. Provide education, advice, and practical strategies for energy conservation, activity analysis, pacing, and prioritization to support the management of fatigue and dyspnea symptoms.	□
6. Provide education, advice, and practical strategies for managing anxiety and pain including education in relaxation techniques for symptom reduction.	□
7. Provide appropriate assessment and intervention for the management of cognitive and perceptual disorders associated with a primary or secondary brain disease caused by a life-limiting illness.	□
8. Demonstrate an awareness and acceptance of each patient's and their family's perception of dying well and support their wishes.	□
Few	Educational Opportunity
1. Act as an expert resource to the interprofessional team on the role of occupational therapy and rehabilitation in symptom management and optimizing quality of life.	□
2. Recommend energy conserving interventions for the patient with advanced illness.	□
3. Demonstrate expert knowledge of the impact of common symptoms (e.g. fatigue, dyspnea, lymphedema, anxiety, and pain) on occupational performance.	□
4. Utilize non-pharmacological and palliative care rehabilitation approaches to alleviate and manage complex distressing symptoms and promote optimal function.	□

Notes:

Domain 5: Loss, Grief and Bereavement	
All	Educational Opportunity
1. Understand that grief is a natural experience resulting from a loss, including (but not limited to) the loss of function, roles, health, relationships and also death.	<input type="checkbox"/>
2. Understand and address anticipatory grief, and the effect of this on the patient's occupation/roles and physical, cognitive, mental, emotional and spiritual health.	<input type="checkbox"/>
3. Recognize and address the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief and consequences of not addressing loss and grief.	<input type="checkbox"/>
4. Provide guidance, support, and information to the family and make referrals to grief and bereavement services, as required.	<input type="checkbox"/>
5. Understand the impact that an unexpected death has on the family and health care providers.	<input type="checkbox"/>
Some	Educational Opportunity
1. Understand the nature of disenfranchised grief in patients and families and address this grief.	<input type="checkbox"/>
2. Recognize and address internal and external factors that may affect and or complicate a patient's grief experience.	<input type="checkbox"/>
3. Understand and address developmental factors affecting the grief experience for children and teens.	<input type="checkbox"/>
4. Demonstrate knowledge of grief and bereavement to support others from a cross-cultural perspective.	<input type="checkbox"/>
Few	Educational Opportunity
1. Demonstrate advanced knowledge of the grieving experience.	<input type="checkbox"/>
2. Support the patient and their family throughout the illness trajectory and after death.	<input type="checkbox"/>
3. Respond to the patient's and family's expressions of grief and loss reactions and refer to appropriate disciplines or agencies.	<input type="checkbox"/>
4. Mentor and educate colleagues to understand the personal impact of loss, grief and bereavement.	<input type="checkbox"/>
5. Support colleagues to recognize their own loss responses and encourage them to engage in activities to maintain their resilience.	<input type="checkbox"/>

Notes:

Domain 6: Professional and Ethical Practice	
All	Educational Opportunity
1. Demonstrate an understanding of the difference between managing a life-limiting illness and providing end-of-life care.	<input type="checkbox"/>
2. Accept, respect, and advocate for the patient's wishes regarding their care preferences (e.g. initiating, not initiating, withholding and withdrawing dialysis, hydration, nutrition support, resuscitation and other relevant treatment options at end of life).	<input type="checkbox"/>
3. Identify situations where personal beliefs, attitudes and values limit one's ability to be present and provide patient care collaborating with others to ensure optimal care is provided.	<input type="checkbox"/>
4. Understand distinctions among ethical and legal concepts.	<input type="checkbox"/>
5. Understand the role of the clinical ethicist and refer as needed.	<input type="checkbox"/>
6. Gain knowledge, as required, of relevant legislation and policies (e.g. Bill C-14 (MAID), Children and Family Services Act, Adult Protection Act, Personal Directives Act).	<input type="checkbox"/>
7. Be aware of and act according to the code of ethics and professional conduct of one's applicable regulatory body (e.g. Alberta College of Occupational Therapists).	<input type="checkbox"/>
Some	Educational Opportunity
1. Provide and participate in professional supervision and peer review processes to monitor personal and professional responses to clinical situations.	<input type="checkbox"/>
2. Anticipate and address ethical and legal issues that may be encountered when caring for a patient with a life-limiting illness.	<input type="checkbox"/>
3. Respond to inquiries regarding MAID in accordance with the regulatory body's relevant guidelines and standards and/or employer policy.	<input type="checkbox"/>
Few	Educational Opportunity
1. Apply an advanced understanding of contemporary legal, ethical and professional standards in the provision of quality palliative care services.	<input type="checkbox"/>
2. Act as an expert resource to other occupational therapists as they navigate ethical issues related to palliative care in their own practice and setting.	<input type="checkbox"/>
3. Contribute to discussions towards the resolution of ethical and legal issues in conjunction with the patient, their family and the care team.	<input type="checkbox"/>

Notes:

Domain 7: Cultural Safety	
All	Educational Opportunity
1. Build relationships by listening without judgement and being open to learning 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:

Domain 8: Caring for Self as an Occupational Therapist	
All	Educational Opportunity
1. Demonstrate an understanding of the personal impact of caring for patients with life-limiting illnesses and of death, dying, moral distress and ethical dilemmas.	<input type="checkbox"/>
2. Engage in activities that support well-being and resilience.	<input type="checkbox"/>
3. Recognize compassion fatigue in self and colleagues; intervene and refer appropriately.	<input type="checkbox"/>
4. Understand the needs of Therapy Assistants and encourage them to care for themselves as part of the care team.	<input type="checkbox"/>
5. Demonstrate awareness of employee assistant programs. (e.g. counselling, ethics, crisis, debriefing)	<input type="checkbox"/>
6. Recognize when debriefing and collegial support would be helpful.	<input type="checkbox"/>
7. Understand that less frequent contact with patients with life-limiting illness may predispose clinicians to more vulnerability and greater need for support.	<input type="checkbox"/>

Domain 9: Education, Research and Evaluation	
All	Educational Opportunity
1. Provide education to the patient with a life-limiting illness, their family and the interprofessional team in the context of your role and at an appropriate level.	<input type="checkbox"/>
2. Participate in the monitoring and evaluation of the quality of palliative care and Occupational Therapy.	<input type="checkbox"/>
3. Undertake additional professional development relevant to the needs of patients with life-limiting illnesses.	<input type="checkbox"/>
4. Participate in continuing education specific to rehab in palliative care.	<input type="checkbox"/>
5. Identify and utilize research that would lead to evidence-based practice in palliative care.	<input type="checkbox"/>
Some	Educational Opportunity
1. Participate in processes of clinical governance and quality assurance to maintain and improve clinical practice.	<input type="checkbox"/>
2. Undertake 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"/>
Few	Educational Opportunity
1. Advocate for and contribute to the advancement of continuing education specific to occupational therapy in palliative care.	<input type="checkbox"/>
2. Participate in research projects in line with palliative care service needs, collaborating with all relevant stakeholders in respect of research issues.	<input type="checkbox"/>
3. Act as an expert resource providing and advising on undergraduate and postgraduate education in the domain of occupational therapy practice in palliative care.	<input type="checkbox"/>
4. Actively influence and promote palliative care strategic initiatives and policy development.	<input type="checkbox"/>
5. Lead and develop clinical governance and quality assurance programs that are specific to palliative care.	<input type="checkbox"/>
6. Design research projects in line with palliative care service needs, collaborating with all relevant stakeholders in respect of research issues.	<input type="checkbox"/>
7. Apply knowledge gained from palliative care research.	<input type="checkbox"/>
8. When possible, provide the family with opportunities to participate in palliative and end-of-life caregiving research.	<input type="checkbox"/>
9. Contribute to the evaluation of the quality of palliative care and the effectiveness of the Palliative Care Consult Team.	<input type="checkbox"/>

10. Where possible, identify the opportunities for and barriers to discipline-specific research unique to palliative care.	<input type="checkbox"/>
11. Develop, facilitate and provide education, leadership, mentorship and professional support for colleagues and generalist providers and students of occupational therapy and palliative care.	<input type="checkbox"/>

Notes:

Domain 10: Advocacy	
All	Educational Opportunity
1. Advocate for access to comfort products; specialty services; environmental aids and modifications; home care services; volunteer programs; and applicable services within the community.	<input type="checkbox"/>
2. Advocate for palliative care support.	<input type="checkbox"/>
3. Advocate for caregiver supports that promote self-care.	<input type="checkbox"/>
4. Advocate for appropriate funding from organizations.	<input type="checkbox"/>
Some	Educational Opportunity
1. Advocate for the patient's and their family's needs, decisions and rights by recognizing potential vulnerabilities with regards to palliative care.	<input type="checkbox"/>
Few	Educational Opportunity
1. Advocate for health care providers to participate in palliative care continuing education opportunities.	<input type="checkbox"/>
2. Advocate for the need for resources required to adequately provide palliative care (e.g. education, funding, self-care, staffing and specialty equipment).	<input type="checkbox"/>
3. Advocate for the development, maintenance and improvement of health care and social policy related to palliative care.	<input type="checkbox"/>

4. Actively influence and promote strategic initiatives and policy development for palliative care and palliative care occupational therapy services at local, regional and national levels.	<input type="checkbox"/>
5. 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:

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.

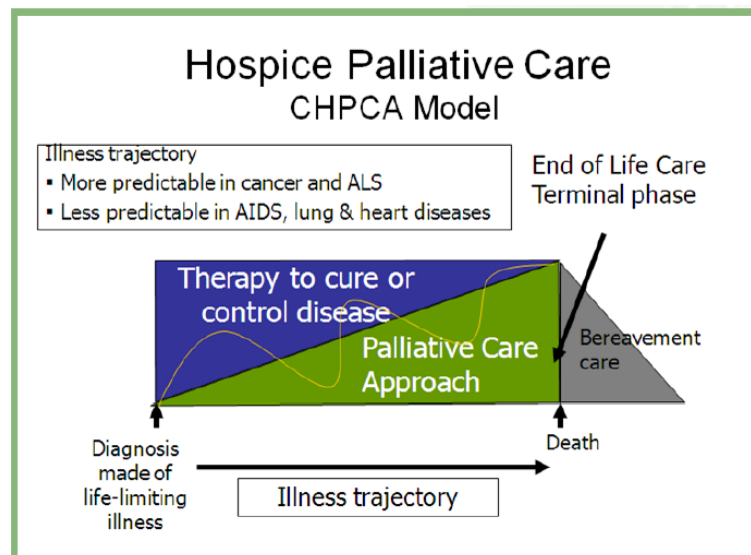
Life-limiting illness. Describes illness where it is expected that death will be a direct consequence of the specified illness. The term "person living with a life-limiting illness" also incorporates the concept that people that are actively living with such illnesses, often for long periods of time,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

- Association of Canadian Occupational Therapy Regulatory Organizations. (2011). *Essential competencies of practice for occupational therapists. (3rd Ed.)*. https://acotroacore.org/sites/default/files/uploads/ACOTRO_EC_3rd_ed.pdf
- Canadian Association of Occupational Therapists. (2012). *Profile of practice of occupational therapists in Canada*. <https://www.caot.a/document/3653/2012otprofile.pdf>
- Canadian Association of Occupational Therapists. (2017). *CAOT position statement: Occupational therapy and end-of-life care*. https://www.caot.ca/document/6130/PS_EndofLife.pdf
- 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.
- Glover Takahashi, S., Beggs, C., & Herold, J. (2011). *Essential competencies of practice for occupational therapists in Canada (Third Edition) – Methodology supplement*. https://www.acotro-acore.org/sites/default/files/uploads/pdfs/methodology_supplement_to_the_essential_competencies_of_practice_for_occupational_therapists_in_canada.pdf
- 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/>

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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