

# Alberta Volunteers' Palliative Care Competency Framework

Version 1.0 (September 2020)

A Resource Manual for Volunteers



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

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## Dedication

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

## Forward

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

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

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

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

## Alberta Volunteers' Palliative Care Competencies Referent Group

The Alberta Volunteers' Palliative Care Competencies Referent Group below assisted in recruiting individuals participating in the production of the Alberta Volunteers' Palliative Care Competency Framework. This includes members of the Alberta Palliative Care Competencies Advisory Working Group and the Alberta Volunteers' 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 Volunteers' Palliative Care Competencies Referent Group	
Health Care Organizations	Educational Institutions
<ul style="list-style-type: none"> <li>• Alberta Health Emergency Medical Services</li> <li>• Dulcina Hospice, Covenant Care, Calgary</li> <li>• Foothills Country Hospice, Foothills Country Hospice Society, Okotoks</li> </ul> <p><u>Alberta Health Services</u></p> <ul style="list-style-type: none"> <li>• Calgary Zone Palliative and End-of-Life Care Program</li> <li>• Edmonton Zone Palliative Care Program</li> <li>• Edmonton Zone Palliative and End-of-Life Care and Community Programs, Continuing Care</li> <li>• Provincial Palliative and End-of-Life Care, Community, Seniors, Addiction and Mental Health</li> </ul> <p><u>Covenant Health</u></p> <ul style="list-style-type: none"> <li>• Edmonton General Continuing Care Centre</li> <li>• Grey Nuns Community Hospital, Edmonton</li> <li>• Mel Miller Hospice, Edmonton General Continuing Care Centre, Edmonton</li> <li>• Professional Practice and Research</li> <li>• Tertiary Palliative Care Unit, Grey Nuns Hospital, Edmonton</li> <li>• Volunteer Services, Grey Nuns Community Hospital, Edmonton</li> </ul>	<p><u>University of Alberta</u></p> <ul style="list-style-type: none"> <li>• Faculty of Nursing</li> <li>• Faculty of Medicine and Dentistry</li> </ul> <p><u>University of Calgary</u></p> <ul style="list-style-type: none"> <li>• Faculty of Medicine</li> <li>• Department of Oncology</li> </ul>
	Professional Regulatory Bodies and Associations
	<ul style="list-style-type: none"> <li>• College of Licensed Practical Nurses of Alberta</li> </ul>



# Alberta Palliative Care Competency Framework

A competency is defined by Parry<sup>1</sup> as a “cluster of related knowledge, skills and attitudes that affects a major part of one’s job (a role or responsibility), that correlates with performance on the job, that can be measured against well-accepted standards, and that can be improved via training and development.” A Competency Framework is a compilation of competency statements.

## How to Use the Alberta Palliative Care Competency Framework

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

## Purpose of this Document

Competencies allow HCPs to identify the skills, knowledge and attitudes required when providing palliative care. The Alberta Volunteers’ 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 Volunteers’ Palliative Care Competency Framework which was developed by the Alberta Volunteers’ Working Group.

Competency statements are organized according to the following two dimensions:

1. Level of expertise
2. Competency domains

## Level of Expertise

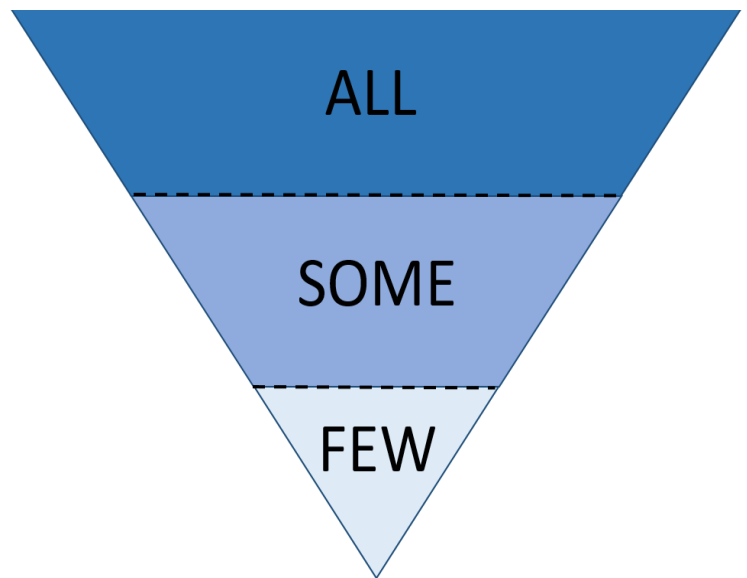
According to the Alberta Palliative Care Competency Triangle (Figure 1), HCPs have varying levels of palliative care expertise depending on how frequently and closely they work with patients who have life-limiting illnesses.

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<sup>1</sup> Parry, S. B. (1996). The quest for competencies. *Training* 33, 48–54.  
Alberta Volunteers’ Palliative Care Competency Framework  
(September 2020)

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.

**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.

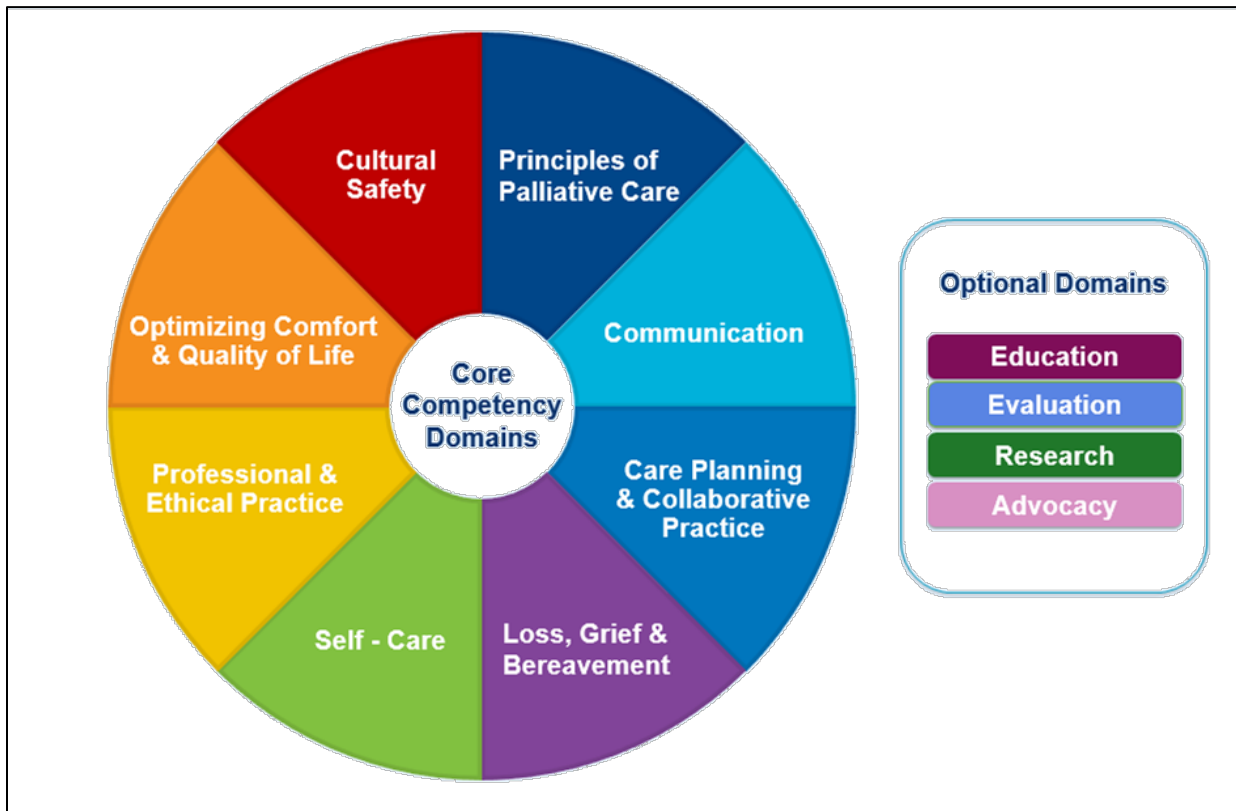
## Competency Domains

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 Volunteers' Palliative Care Competencies

### Domain 1: Principles of Palliative Care

#### The Palliative Care Volunteer Will Be Able To:

#### Educational Opportunity

1. Describe the philosophy of palliative care and a palliative approach.	<input type="checkbox"/>
2. Describe the meaning of the term 'life-limiting illness'.	<input type="checkbox"/>
3. Recognize the continuum of palliative care and different models of palliative care.	<input type="checkbox"/>
4. Describe the role of the health care team and Collaborative Care <sup>2</sup> in palliative care.	<input type="checkbox"/>
5. Describe the key components of volunteer support (presence, listening, respect for others, boundaries).	<input type="checkbox"/>
6. Describe the palliative care standards and policies which guide palliative care volunteers.	<input type="checkbox"/>
7. Demonstrate an understanding of the volunteer's responsibility to their organization and palliative care services.	<input type="checkbox"/>
8. Recognize the most common needs of the patient who is living with a progressive, life-limiting illness, as well as their family and friends.	<input type="checkbox"/>
9. Demonstrate awareness of one's own responses in the presence of a person who is suffering.	<input type="checkbox"/>
10. Recognize who the patient considers family and include family in care.	<input type="checkbox"/>

#### Notes:

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<sup>2</sup> "Collaborative Care in healthcare occurs when multiple health providers from different professions provide comprehensive services by working with people, their families, care providers, and communities to deliver the highest quality of care across settings. Practice includes both clinical and non-clinical health-related work, such as diagnosis, treatment, surveillance, health communications, management, and support services."

<b>Domain 2: Communication</b>	
<b>The Palliative Care Volunteer Will Be Able To:</b>	<b>Educational Opportunity</b>
1. Identify that communication regarding palliative care is an on-going collaborative process.	<input type="checkbox"/>
2. Identify and utilize sensitive and effective communication skills when listening and responding to the patient, their family and members of the health care team.	<input type="checkbox"/>
3. Identify and address barriers to effective communication.	<input type="checkbox"/>
4. Identify the role and importance of experienced translators for individuals with language barriers.	<input type="checkbox"/>
5. Identify communication needs of the patient and their family and utilize and adapt supports as needed for effective communication (e.g. interpreters, assistive technology).	<input type="checkbox"/>
6. Recognize that family conversations may involve children and different communication approaches may be required.	<input type="checkbox"/>
7. Identify the value and variety of appropriate uses of silence.	<input type="checkbox"/>
8. Use active listening tools such as silence and acknowledgment to provide sensitive emotional support to the patient and their family.	<input type="checkbox"/>
9. Communicate health changes and concerns of the patient and their family to the health care team.	<input type="checkbox"/>

**Notes:**

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**Domain 3: Care Planning and Collaborative Practice**
**The Palliative Care Volunteer Will Be Able To:**
**Educational  
Opportunity**

1. Assist in planning and organizing special events for patients and their families.	<input type="checkbox"/>
2. Demonstrate an awareness of Advance Care Planning (e.g. goals of care designations, personal directive and green sleeves).	<input type="checkbox"/>
3. Understand the role an Alternate Decision Maker (ADM) plays in decision making regarding a patient's care.	<input type="checkbox"/>
4. Understand the collaborative relationship between the patient, their family and the health care team.	<input type="checkbox"/>
5. Effectively collaborate with the health care team.	<input type="checkbox"/>
6. Demonstrate awareness of the function and importance of a care plan for each patient in palliative care.	<input type="checkbox"/>
7. Contribute to care planning by offering observations of the patient and their family to the health care team.	<input type="checkbox"/>
8. Understand the roles, responsibilities and limits of the volunteer as per the organization's policies.	<input type="checkbox"/>

**Notes:**


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**Domain 4: Optimizing Comfort and Quality of Life**
**The Palliative Care Volunteer Will Be Able To:**
**Educational  
Opportunity**

1. Demonstrate basic knowledge of the most common conditions experienced in end-of-life care and their interventions; inclusive of, but not limited to, delirium/dementia, COPD, etc.	<input type="checkbox"/>
2. Identify and adhere to the scope of the volunteer role in providing spiritual support to the patient and their family.	<input type="checkbox"/>

3. Demonstrate appreciation of the boundaries regarding identifying and reporting pain and other symptoms and providing comfort care.	<input type="checkbox"/>
4. Demonstrate awareness of Complementary and Alternative Medicine (CAM) and their impact on health and well-being.	<input type="checkbox"/>
5. Provide support and presence to the patient and their family facing a life-limiting illness in a compassionate and sensitive way.	<input type="checkbox"/>
6. Assist the health care team with supporting the patient's needs as per the organization's policies.	<input type="checkbox"/>
7. Recognize when a patient is experiencing pain or discomfort and alert the health care team.	<input type="checkbox"/>
8. Provide holistic patient-centered care that maintains dignity, well-being and self-image.	<input type="checkbox"/>
9. Provide simple comfort measures within the scope of the volunteer role (including but not limited to: mouth care, better positioning, use of a fan or reduction in environmental stimuli).	<input type="checkbox"/>
10. Recognize ways that volunteers can assist the patient and their family to cope with emotional and psychosocial issues.	<input type="checkbox"/>
11. Recognize and respect that everyone has spiritual, cultural and religious beliefs.	<input type="checkbox"/>
12. Recognize and respect that some people may or may not have religious elements to their spirituality.	<input type="checkbox"/>
13. Identify when to refer the patient and their family to social work, spiritual care, or local clergy.	<input type="checkbox"/>
14. Identify the volunteer role at the time of approaching death, based on patient and family wishes and organizational policy.	<input type="checkbox"/>
15. Recognize and respond appropriately to the signs of imminent death.	<input type="checkbox"/>
16. Support the patient's and family's wishes regarding death rituals.	<input type="checkbox"/>
17. Recognize one's own emotional and psychosocial issues related to the volunteer role and the experience of supporting a patient and their family with illness, death, dying and loss.	<input type="checkbox"/>

**Notes:**

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<b>Domain 5: Loss, Grief and Bereavement</b>	
<b>The Palliative Care Volunteer Will Be Able To:</b>	<b>Educational Opportunity</b>
1. Understand the role of the volunteer in supporting individuals who are dying and/or the bereaved.	<input type="checkbox"/>
2. Demonstrate respect for diversity and support the patient and their family in an open and non-judgmental environment.	<input type="checkbox"/>
3. Demonstrate awareness of the losses that a patient and their family may experience during the course of life-limiting illness and the dying process.	<input type="checkbox"/>
4. Describe grief as an expected reaction to loss that is experienced uniquely by everyone.	<input type="checkbox"/>
5. Recognize common grief reactions in the patient and their family, which may occur from time of diagnosis through bereavement.	<input type="checkbox"/>
6. Demonstrate understanding of the diversity and complexity of grief experiences and how they relate to the grieving process.	<input type="checkbox"/>
7. Demonstrate awareness of individual differences in the way people grieve and cope with bereavement.	<input type="checkbox"/>
8. Demonstrate awareness of cultural differences in the way people grieve and cope with bereavement.	<input type="checkbox"/>
9. Demonstrate an understanding of what either supports or creates barriers for a grieving person as they adjust to significant loss, change, and bereavement.	<input type="checkbox"/>
10. Recognize when a person may require grief and bereavement services and engage the health care team to support the person as needed.	<input type="checkbox"/>
11. Identify the common fears associated with death and dying, and understand various ways of responding to those fears.	<input type="checkbox"/>
12. Demonstrate understanding of supportive communication compared to non-supportive communication.	<input type="checkbox"/>

**Notes:**

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<b>Domain 6: Professional and Ethical Practice</b>	
<b>The Palliative Care Volunteer Will Be Able To:</b>	<b>Educational Opportunity</b>
1. Demonstrate understanding of the importance of maintaining privacy and confidentiality.	<input type="checkbox"/>
2. Maintain privacy and confidentiality and report concerns to the most appropriate health care team member.	<input type="checkbox"/>
3. Demonstrate awareness of personal attitudes and feelings regarding death and dying.	<input type="checkbox"/>
4. Identify the palliative care volunteer's rights and responsibilities.	<input type="checkbox"/>
5. Identify the volunteer role boundaries, their purpose and strategies for maintaining them.	<input type="checkbox"/>
6. Practice within the scope of the volunteer role.	<input type="checkbox"/>
7. Effectively communicate the role of the volunteer and one's limits and boundaries.	<input type="checkbox"/>
8. Promote incorporation of the patient's and family's wishes, values and beliefs into all care provision.	<input type="checkbox"/>
9. Respond to those who are dissatisfied with palliative care services by referring to the most appropriate member of the health care team.	<input type="checkbox"/>
10. Describe ethical issues related to palliative care and the volunteer role in navigating those issues.	<input type="checkbox"/>
11. Demonstrate knowledge of relevant legislation and applicable organizational policies (e.g. Bill C-14 (MAID)).	<input type="checkbox"/>

**Notes:**

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<b>Domain 7: Cultural Safety</b>	
<b>The Palliative Care Volunteer Will Be Able To:</b>	<b>Educational Opportunity</b>
1. Demonstrate awareness of organizational mission statements and values.	<input type="checkbox"/>
2. Demonstrate awareness that diversity is the range of human characteristics that live in all of us and make us unique, including race, religious beliefs, colour, gender, gender identity, gender expression, physical disability, mental disability, age, ancestry, place of origin, marital status, source of income, family status, sexual orientation, education or diversity of perspective.	<input type="checkbox"/>
3. Demonstrate awareness that inclusion is deliberately creating an environment that welcomes and sustains diversity. This includes inviting perspectives and experiences, continuously being open to learning about differences and embracing those learnings.	<input type="checkbox"/>
4. Recognize the impact of a life-limiting illness on familial roles.	<input type="checkbox"/>
5. Describe the influence of culture on key issues in palliative care.	<input type="checkbox"/>
6. Recognize the influence that personal culture, gender identity, beliefs and values may have on the volunteer in their role.	<input type="checkbox"/>
7. Practice self-reflection to identify and address personal and systemic biases.	<input type="checkbox"/>
8. Demonstrate a respectful attitude towards cultural and spiritual differences in family practices surrounding illness and the end-of-life.	<input type="checkbox"/>
9. Demonstrate openness and sensitivity to social, spiritual and cultural values and practices that may influence individual and family preferences and accommodate these.	<input type="checkbox"/>
10. Help support a safe, respectful and culturally inclusive environment.	<input type="checkbox"/>

**Notes:**

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<b>Domain 8: Self-Care</b>	
<b>The Palliative Care Volunteer Will Be Able To:</b>	<b>Educational Opportunity</b>
1. Demonstrate awareness of the supports available from the organization and the health care team.	<input type="checkbox"/>
2. Practice self-care strategies.	<input type="checkbox"/>
3. Describe the concept of compassion fatigue, its manifestations and ways to help prevent it.	<input type="checkbox"/>
4. Participate in team self-care activities (e.g. debriefing sessions).	<input type="checkbox"/>
5. Demonstrate self-awareness of own response to illness, death and dying.	<input type="checkbox"/>
6. Identify ways volunteers can manage and cope with the impact of dying and death.	<input type="checkbox"/>
7. Identify the impact past experiences have on suffering, death and dying when caring for a patient with a life-limiting illness and their family.	<input type="checkbox"/>

**Notes:**

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<b>Domain 9: Education, Research and Evaluation</b>	
<b>The Palliative Care Volunteer Will Be Able To:</b>	<b>Educational Opportunity</b>
1. Contribute to the formal and informal evaluation of the quality of palliative care and the effectiveness of the palliative care system (e.g. focus groups, surveys).	<input type="checkbox"/>
2. Participate in continuing education related to palliative care.	<input type="checkbox"/>
3. Promote community understanding of palliative care.	<input type="checkbox"/>
4. Acts as a mentor to volunteers new to palliative care.	<input type="checkbox"/>
5. Contribute to quality improvement programs and initiatives.	<input type="checkbox"/>
6. Participate in research activities such as data collection.	<input type="checkbox"/>

**Notes:**

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<b>Domain 10: Advocacy</b>	
<b>The Palliative Care Volunteer Will Be Able To:</b>	<b>Educational Opportunity</b>
1. Advocate for the patient's and their family's values and beliefs.	<input type="checkbox"/>
2. Advocate for a culturally safe work and care environment.	<input type="checkbox"/>

**Notes:**

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## Appendix 1: Glossary of Terms

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

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

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

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

**Competency:** a "cluster of related knowledge, skills and attitudes that affects a major part of one's job (a role or responsibility), that correlates with performance on the job, that can be measured against well-accepted standards, and that can be improved via training and development".

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

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

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

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

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

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

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

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

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

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

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

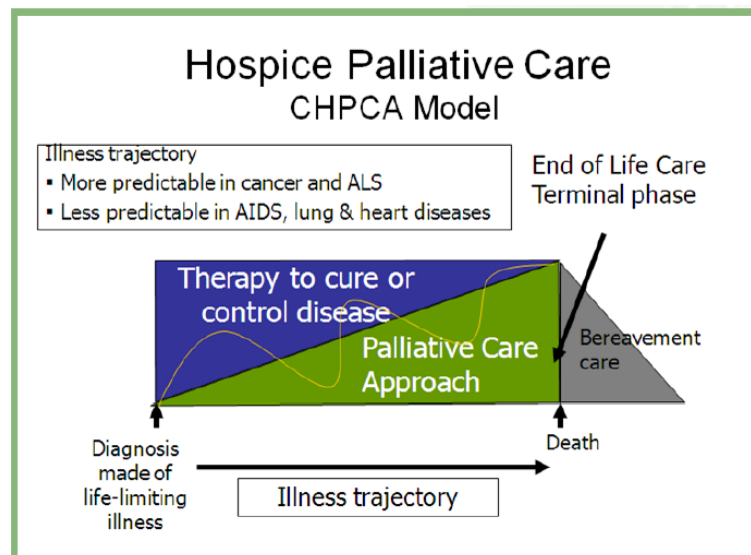
**Life-limiting illness.** Describes illness where it is expected that death will be a direct consequence of the specified illness. The term "person living with a life-limiting illness" also incorporates the concept that people that are actively living with such illnesses, often for long periods of time,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

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

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

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

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



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

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

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



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

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

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

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

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

## Appendix 2: Additional Resources

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

- Canadian Hospice Palliative Care Association. (2012). *Hospice palliative care volunteers: A training program*. Canadian Hospice Palliative Care Association.
- Canadian Hospice Palliative Care Association. (2013). *A model to guide hospice palliative care: Based on national principles and norms of practice*. <https://www.chpca.ca/wp-content/uploads/2019/12/norms-of-practice-eng-web.pdf>
- Canadian Partnership Against Cancer & Health Canada. (July 2020). *The Canadian inter-disciplinary palliative care competency framework. A curriculum guide for educators and reference manual for health professionals and volunteers*. Ottawa, ON.
- Covenant Health Palliative Institute. (September 2020). *Alberta palliative care competency framework technical report*. Edmonton, AB.
- Murray, K. (2017, January 23). *Palliative care competencies: Once upon a time, there were competencies*. Life & Death Matters. <https://www.lifeanddeathmatters.ca/upon-time-competencies/>

## 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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