Covenant Health Palliative Institute

# Alberta Interprofessional Palliative Care Competency Framework

## Technical Report

Alberta Palliative Care Competencies and Education Project
February 2023

# Land Acknowledgement

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

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# Alberta Interprofessional Palliative Care Competency Framework: Technical Report

## Dedication

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

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

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

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

## Introduction

Establishing palliative care early in an illness trajectory is beneficial to patients and families and requires services to be delivered in both generalist and specialist settings by interprofessional care teams (Parker et al., 2013; Wanniarachigue, 2015; Cameron-Taylor, 2012). According to a 2016 Ipsos poll, Canadians feel health care providers (HCPs) should receive additional training specialized in palliative care (86%) and that mandatory annual training for palliative care HCPs should be implemented (82%) (Roulston, 2016).

To ensure all HCPs have the competency required to provide patients and their families with the best possible care, it is important to equip them with core knowledge and skills in palliative care as well as to foster compassionate attitudes. In phase 1 of the Alberta Palliative Care Competencies and Education project, we facilitated the creation of 14 Alberta-specific palliative care competency frameworks that represent 24 HCP groups (Covenant Health Palliative Institute, 2020). It is evident across these competency profiles that Alberta HCPs share common competencies both in generalist and specialist contexts.

In March 2021, the Palliative Institute received Alberta Health funding to proceed with phase 2 of the project. The goal of phase 2 is to provide standardized interprofessional competency-based palliative care educational opportunities for health care providers in Alberta (for generalists and specialists) to help prepare them to provide high-quality palliative care. The first objective of phase 2 was to identify Alberta-based interprofessional palliative care (IPC) competencies that can be used to inform development of standardized generalist and specialist interprofessional competency-based palliative care education programs.

## Purpose of this Document

This document describes the process by which the Alberta Interprofessional Palliative Care Competency Framework (AB IPC Competency Framework) was developed. A competency is defined by Parry (1996) 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.” Having province-specific palliative care competencies allows HCPs to identify the skills, knowledge and attitudes required when providing palliative care in Alberta. Additionally, the Alberta IPCs can be used as a resource to inform and guide academic curricula, professional development, continuing education programs, accreditation and regulated professional and employer standards.

## Scope of this Document

This document is intended to be used as a reference by HCPs, subject to the rules and regulations of their respective professional standards, competencies and codes of ethics. Each HCP should consider these palliative care competencies within the context of their respective professional standards, competencies, scope of practice, clinical practice setting and codes of ethics.

## Glossary of Terms

Palliative care is both a philosophy and an approach to care that aims to improve the quality of life of patients with a life-limiting illness and their families. For this project, we adopted Alberta Health Services' (AHS) Palliative and End-of-Life Care Alberta Provincial Framework definition of palliative and end-of-life care (AHS, 2014) as well as the Canadian Hospice Palliative Care Association's definition of a palliative approach (Canadian Hospice Palliative Care Association, 2013). Throughout the document, several terms are used which may not be familiar to all readers. To ensure common understanding of the terminology, a glossary of terms is included in Appendix 2.

## Methods

Three main steps were used in the Alberta Interprofessional Palliative Care Competency Framework development process:

1. Recruit interdisciplinary HCP participants
2. Establish a competency framework structure
3. Develop Alberta interprofessional palliative care competencies

### 1. Recruit Interdisciplinary HCP Participants

We sent emails to all 184 HCPs who participated in phase one of this project, inviting them to participate in phase two. We also invited the Alberta Palliative Care Competency and Education Advisory Committee members, the Alberta Health Services and Covenant Health professional practice teams and the Provincial Palliative and End of Life Innovations Steering Committee (PPAL EOL ISC). A total of 110 HCPs agreed to participate.

### 2. Establish a Competency Framework Structure

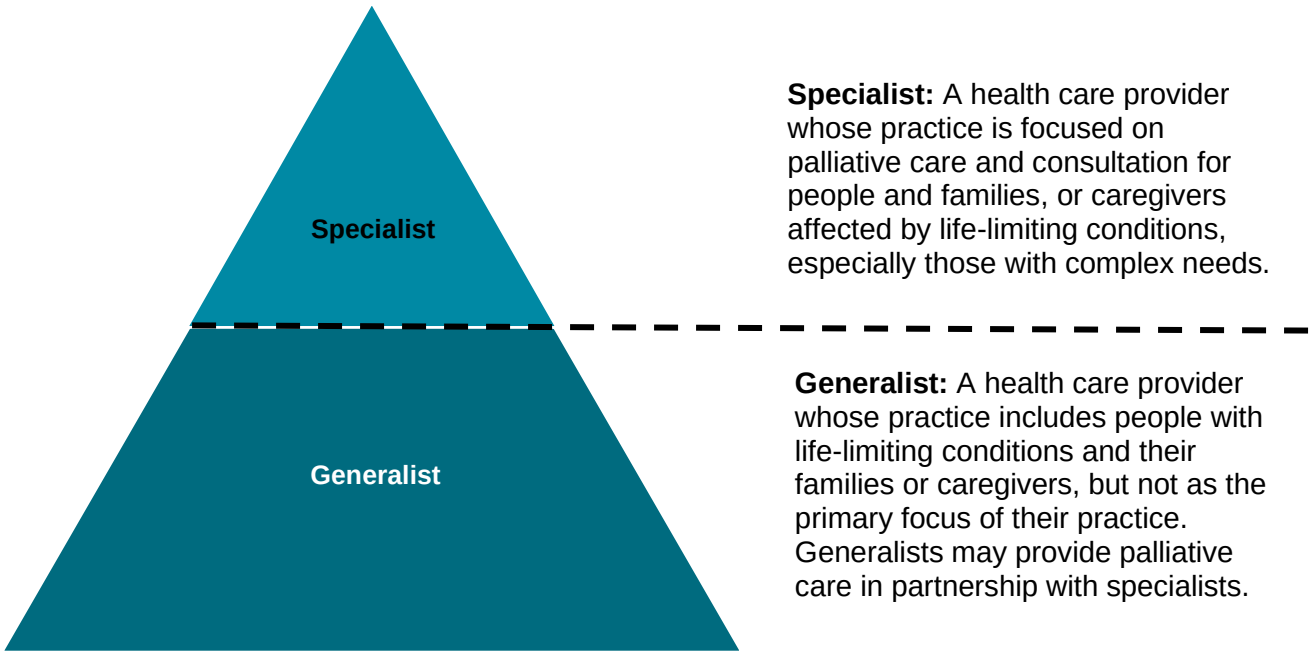
A competency structure framework was established to organize and describe the Alberta IPC Competency Framework. The structure is based on the phase one Alberta Palliative Care Competency Framework (Covenant Health, 2020) and the Canadian Interdisciplinary Palliative Care Competency Framework (Canadian Partnership Against Cancer, 2021).

Competency statements are organized according to the following two dimensions: level of expertise and competency domains.

## 2.1. Level of Expertise

HCPs have varying levels of palliative care expertise depending on how frequently and closely they work with patients with life-limiting illnesses. The Alberta IPC Competency Framework levels of expertise are adapted from the Canadian Interdisciplinary Palliative Care Competency Framework (Canadian Partnership Against Cancer, 2021). The levels of expertise are divided into two health care provider levels: generalist and specialist (Figure 1). They are separated by a dotted line to highlight that some HCPs may fit into more than one category. Additionally, HCPs in the specialist category would also be expected to possess proficiency in the competencies outlined in the generalist level.

**Figure 1.** The Alberta Interprofessional Palliative Care Competency Framework Triangle




## 2.2. Competency Domains

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

## Domain 1: Principles of Palliative Care

Palliative care is both a philosophy and an approach to care that enables all patients with a life-limiting illness to receive integrated and coordinated care across the continuum of life. This care incorporates each patient and family's values, preferences and goals of care and spans the disease process from diagnosis to end of life, including bereavement. The following principles are foundational in providing palliative care to each patient and their family within Alberta: patient- and family-centredness; equitable access; collaborative and integrated team service delivery; communication and information sharing; 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 arise. Effective communication includes information technology (e.g., 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 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 Alberta Health Services Palliative and End-of-Life Care Alberta Provincial Framework (AHS PEOLC Provincial Framework, 2014), "In order to meet the individual needs of each person and their family, comprehensive interprofessional teams with varying skills and knowledge are required to safely and effectively care for Albertans who are palliative or are at the end of life" (Alberta Health Service).

Care planning is a collaborative practice that includes addressing, coordinating and integrating patient- and family-centred care needs. It is enabled by interprofessional, cross-sector care planning and communication that involves comprehensive needs assessment, promoting and preserving choice and planning for likely changes that occur with the context of a deteriorating illness trajectory. Care planning ensures that multiple disciplines and agencies can be accessed and referred to as required in a timely manner. Each patient and their family should be supported in care planning to the extent that they are able and wish to be involved.

## Domain 4: Optimizing Comfort and Quality of Life

Supporting and optimizing comfort and quality of life as defined by the patient and family includes comprehensively assessing and addressing their emotional, psychological, social and spiritual needs as well as their physical needs. This is an ongoing process which aims to prevent, assess, acknowledge and relieve suffering in a timely and proactive manner, which also includes effective symptom management that 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, family and community needs, identifying those who may require additional bereavement support and providing information, resources and support to all.

## Domain 6: Professional and Ethical Practice

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

## Domain 7: Cultural Safety

Cultural safety is a concept that encourages a patient to feel safe, without fear of judgement, repercussions, discrimination (individual or systemic) or assault because of their needs and intersectional identities. It is defined and experienced by the patient. It is based on respectful engagement and communicating respect for a patient’s beliefs, behaviours and values and ensures that the patient is a partner in decision making.

Cultural safety requires that we acknowledge that we are all immersed in culture(s) and that we reflect on our 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 and community caregiver roles and decision making are the first steps in providing spiritually and culturally safer palliative care.

Providing culturally safer care involves building trust with the patient and recognizing the role of socioeconomic conditions, history and politics in health. It requires awareness of family dynamics and the role the family and community play in cultural safety for the patient. Cultural competency is the process HCPs achieve, with cultural safety being the outcome (Health Council of Canada, 2012).

## Domain 8: Self-Care

Self-care covers a spectrum of knowledge, skills, attitudes and aspects of self-awareness. It requires all HCPs to engage in ongoing self-reflection regarding appropriate professional boundaries and the personal impact of caring for patients with life-limiting illnesses and their families. Self-care requires the use of holistic wellness strategies that promote one’s own health

as well as that of teams as a whole.

## Domain 9A: Education

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

## Domain 9B: Evaluation

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

## Domain 9C: Research

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

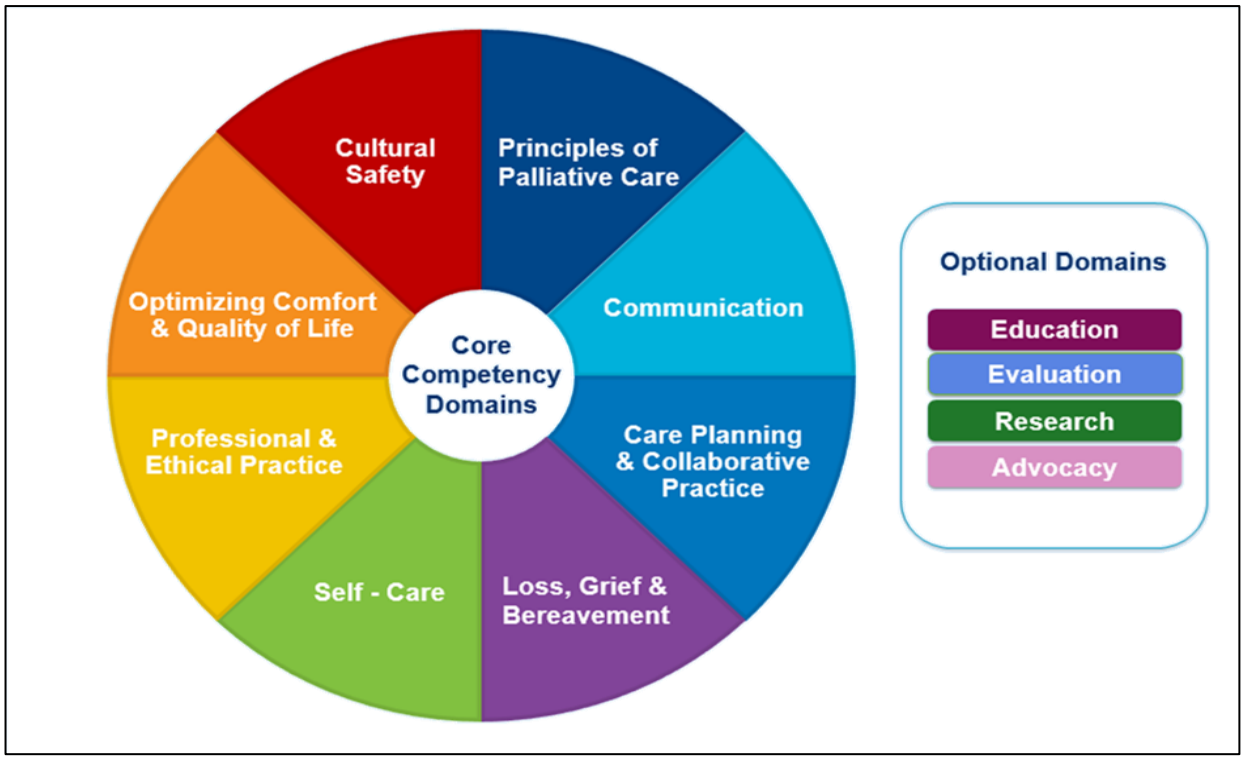
## Domain 10: Advocacy

The provision of quality palliative care necessitates advocating for access to and funding for palliative care services and associated educational initiatives, as well as policy development and the addressing of the social determinants of health to improve patient outcomes.

## 3. Develop Alberta Interprofessional Palliative Care Competencies

The project team conducted two rounds of group concept mapping and a final validation survey to develop Alberta Interprofessional Palliative Care Competency Framework. Group concept mapping is a community-based research method that integrates qualitative group processes (e.g., brainstorming and pile sorting) with multi-variable statistical analyses to create visual maps of topics of interest. (Aarons et al., 2016; Abdul-Quader & Collins, 2011). The method can be used to develop theoretical frameworks, action planning, need assessments and evaluation, and has been reported to have good validity and reliability (Kane & Trochim, 2009).

**Figure 2.** Alberta Interprofessional Palliative Care Competency Framework Domains




Concept mapping typically requires participants to brainstorm a large set of statements relevant to the topic of interest, individually sort these statements into piles of similar ones, rate each statement on one or more dimensions and interpret the maps that result from the data analyses (Kane & Rosas, 2017). In our process, we deferred the brainstorming phase because competency statements had already been developed in phase one of this project. The phase one competency statements were inputted into Group Wisdom (a group concept mapping software platform) as the brainstorming phase and participants were asked to sort them into themes (or piles). Additionally, we deferred the rating phase of this exercise because our goal was not to identify comparative levels of perceived importance among the competency statements. A validation survey was used to elicit final feedback and validation of the competency statements.

## Data Collection

Data collection occurred between September and November 2021. We used group concept mapping to identify common competency themes across all 14 of the discipline-specific palliative care competency profiles developed in phase one. Data collection encompassed several steps. The Alberta Palliative Care Competency Framework (Covenant Health, 2020) features an inverted triangle indicating levels of HCP expertise: *all*, *some* and *few*. Each of these three levels of expertise requires a different set of competencies.

First, all competency statements from the phase one competency profiles were collated by competency domain and level of expertise. Competency statements originally coded during phase one in the *all* level of expertise were grouped into the generalist category, and statements originally coded in the *some* and *few* levels of expertise were grouped into the specialist category. The generalist and specialist levels of expertise replaced the *all*, *some* and *few* categories in the Alberta IPC Competency Framework. Competency statements from key national physician profiles[1] were added to the collated lists.

Second, two reviewers independently filtered statement domains for repetition. Each reviewer coded statements as unique, redundant or repetitive. Statements that were coded as redundant or repetitive by both reviewers were removed from the competency list. Reviewers discussed statements that did not have initial consensus and collaboratively determine whether to exclude or include them.

Third, participants were asked to sort the statements into themes. Competency statements were inputted into Group Wisdom by domain and level of expertise, resulting in 20 categories of statements. Participants were randomly assigned to sort two categories of statements, one category in round one of the group concept mapping activity and one category in round two. Three members of the project team collaboratively translated the cluster themes that arose from this process into competency statements. Lastly, these competency statements were sent out to all participants for validation in the form of a survey.

[1] Postgraduate Competencies for Palliative Care A Guidance Document (Canadian Society of Palliative Care Physicians, 2019), Educating Future Physicians in Palliative and End-of-Life Care Competencies (Canadian Society of Palliative Care Physicians 2018), Objectives Of Training in The Subspecialty of Adult Palliative Medicine (Royal College of Physicians and Surgeons of Canada, 2016), Red Book: College of Family Physicians: Palliative Care: Priority Topics for the Assessment of Competence: Enhanced Skills Key Features

# Results

110 HCPs agreed to participate in the project. A total of 93 (0.85) HCPs completed at least one of the activities in this project. Participants included HCPs from across the province (Table 1.)

| **Table 1. Alberta IPC Development: HCP Representation** | |
|---|---|
| **HCP Group** | **Number of Participants** |
| Physiotherapists | 3 |
| Occupational Therapists | 8 |
| Emergency Medical Responders/Paramedics | 3 |
| Respiratory Therapists | 3 |
| Nurses (Registered Nurses, Registered Psychiatric Nurses, Licensed Practical Nurses, Clinical Nurse Specialists, Nurse Practitioners) | 27 |
| Health Care Aides | 0 |
| Pharmacists | 5 |
| Dietitians | 8 |
| Psychologists | 2 |
| Speech Language Pathologists | 5 |
| Medical Radiation Imaging Technologists | 5 |
| Social Workers | 8 |
| Spiritual Care Practitioners | 7 |
| Audiologists | 3 |
| Physicians | 6 |
| | **Total:** 93 |

## Group Concept Mapping

During the group concept mapping activities, ten categories of competency statements were sorted in round one and ten categories were sorted in round two (Tables 2 and 3). Each category had 11 to 13 people randomly assigned to it for sorting. Participations rates were higher in round one (85/110) than in round two (62/110). A total of 91 out of 110 (0.83) participants completed at least one of the group concept mapping activities. The number of final themes and their accompanying competency statements from each category were based on a collaborative qualitative analysis conducted by three members of the project team. Final cluster numbers (themes) for each category ranged between three and 12 clusters (Tables 2 and 3). Stress values for each category ranged between 0.1338 and 0.3509 (Tables 2 and 3)[2].

| **Table 2. Group Concept Mapping Activity 1** | | | |
|---|---|---|---|
| **Domain-Level of Expertise** | **Completion Rate** | **Number of Clusters** | **Stress Value** |

[2] Stress Value: The better the fit of a map to the similarity matrix the lower the value, best to have <0.35

| | | | |
|---|---|---|---|
| Principles of Palliative Care-Generalist | 6/11 (0.55) | 5 | 0.3156 |
| Principles of Palliative Care-Specialist | 11/11 (1.0) | 5 | 0.3030 |
| Loss, Grief, and Bereavement-Generalist | 7/12 (0.58) | 5 | 0.3424 |
| Loss, Grief, and Bereavement-Specialist | 8/10 (0.8) | 4 | 0.2885 |
| Communication-Generalist | 10/11 (0.9) | 8 | 0.3284 |
| Self-Care-Specialist | 10/11 (0.9) | 3 | |
| Education, Evaluation, Research-Generalist | 8/11 (0.72) | 4 | 0.1672 |
| Cultural Safety-Generalist | 8/11 (0.73) | 4 | 0.1338 |
| Cultural Safety-Specialist | 8/11 (0.73) | 3 | 0.2184 |
| Advocacy-Generalist | 9/12 (0.75) | 5 | 0.2316 |
| | **Total Response Rate:** 85/110 (0.77) | | |

**Table 3. Group Concept Mapping Activity 2**

| Domain-Level of Expertise | Completion Rate | Number of Clusters | Stress Value |
|---|---|---|---|
| Advocacy-Specialist | 5/11 (0.45) | 8 | 0.2899 |
| Communication-Specialist | 6/11 (0.55) | 7 | 0.3044 |
| Education, Evaluation, Research-Specialist | 4/12 (0.33) | 3 | 0.195 |
| Professional and Ethical Practice-Generalist | 7/12 (0.58) | 3 | 0.2207 |
| Professional and Ethical Practice-Specialist | 5/11 (0.45) | 4 | 0.2936 |
| Self-Care-Generalist | 8/10 (0.8) | 3 | 0.1876 |
| Care Planning and Collaborative Practice-Specialist | 5/11 (0.45) | 8 | 0.2734 |
| Care Planning and Collaborative Practice-Generalist | 8/10 (0.8) | 8 | 0.3509 |
| Optimizing Comfort and Quality of Life-Generalist | 7/11 (0.64) | 12 | 0.3301 |
| Optimizing Comfort and Quality of Life -Specialist | 7/11 (0.64) | 8 | 0.3236 |
| | **Total Response Rate:** 62/110 (0.56)[3] | | |

[3] One person from activity 1 declined to participate this round due to health issues

## Validation

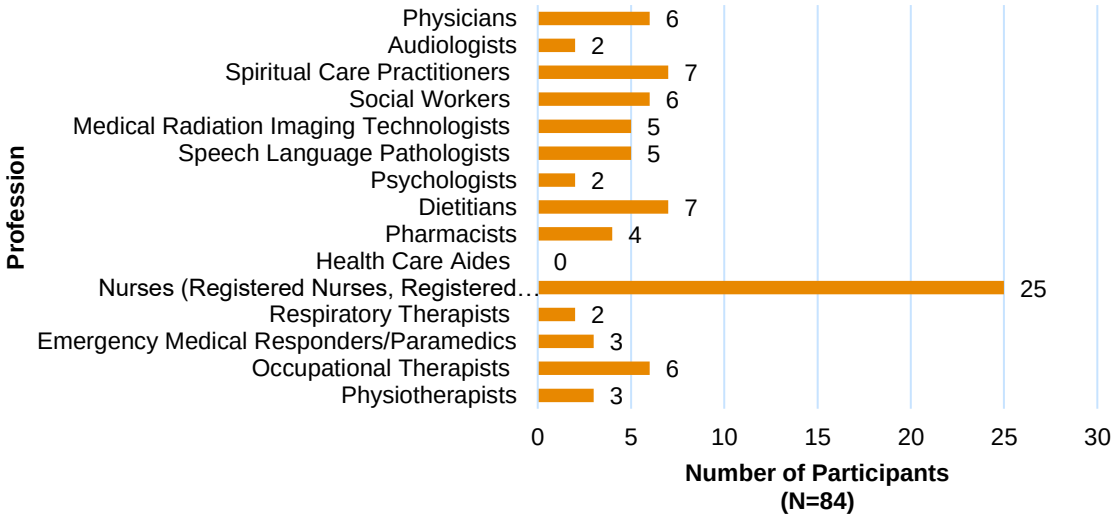
Competency statements that arose from the group concept mapping exercise were compiled into a draft competency list and sent to participants for final validation in the form of a survey. 84 HCPs representing varying professions and levels of palliative care expertise participated in the survey. (Table 4 and Figure 2). For each competency statement, participants were asked to vote: 1.) include statement in the Alberta Interprofessional Palliative Care Competencies or, 2.) Do not include statement in the Alberta Interprofessional Palliative Care Competencies.

Participants were provided an opportunity to revise a competency statement if they voted to keep it. Competency statements were accepted if >75% of participants voted to accept it. Based on the 75% threshold criteria, none of the draft competency statements were voted out. Competencies statements were revised based on qualitative collation of the revision suggestions provided.

**Table 4. Alberta IPC Validation Survey Response Rate**

| Level of Expertise | Number of Participants |
|---|---|
| Generalist | 52/84 (0.62) |
| Specialist | 32/84 (0.38) |
| Total participants | 84/110 (0.76) |

**Figure 2. Alberta IPC Validation Survey: HCP Representation**



## Discussion

Interprofessional collaborative practice is essential for improvement in patient, family and community health outcomes in all health care contexts, including palliative care (Canadian Interprofessional Health Collaborative, 2011). Due to the interdisciplinary nature of palliative care service delivery, there is consistency in the shared competencies across professions (Nova Scotia Health Authority, 2017), which can help to establish a common knowledge and skills base that will promote and enable interprofessional collaboration (Ontario Palliative Care Network, 2019). We applied a comprehensive and evidence-based approach to IPC competency development in Alberta. The strengths of this project are evident in the competency statement characteristics, as well as their representativeness and scope.

The palliative care competency statements are measurable and innovative. Each competency is articulated by an action statement describing what HCPs must be able to demonstrate to provide quality palliative care. These statements provide measurable guidance as to the required level of performance in providing palliative care. The competency statements are innovative in that they measure “what is” and “what will be needed in the future” or “what should be” (Campion, 2001). For instance, several of the competency statements require HCPs to develop palliative care competencies beyond those for which they currently have training. In essence, the competencies statements are future-oriented, describing the ideal state of palliative care education and training in Alberta.

The Alberta Interprofessional Palliative Care Competency Framework expands upon the Canadian Interdisciplinary Palliative Care Competency Framework (Canadian Partnership Against Cancer, 2021). The national framework represents five HCP groups (nurses, physicians, social workers, personal support workers and volunteers) and outlines competencies for generalists HCPs, while the Alberta IPC Competency Framework identifies competencies for HCP groups working in both generalist and specialist settings. Additionally, the selected project method and approach has been effective in facilitating stakeholder input into health care initiatives (Aarons et al., 2009).

To date, the Alberta IPC Competency Framework development process is the largest and most rigorous process used to formulate interprofessional palliative care competencies in Canada. The representativeness, transferability and scope of the Alberta IPC Competency Framework is extensive because we used a participatory action process that engaged 93 HCPs from varying professions and contexts. Additionally, the process involved experts with diverse perspectives, experiences and knowledge representing various levels of palliative care experience and expertise.

Key learnings were apparent at various points in the palliative care competencies’ development process. For instance, it became evident that identifying shared competencies that are broad enough to represent multiple health care provider groups can be challenging. Accordingly, the IPC Competency Framework is best used in conjunction with the HCP-specific palliative care competency profiles. Additionally, while the IPC Competency Framework can be used as a guide for HCPs in palliative care, they need to be considered in relation to each HCP’s role and scope of practice, as this can vary across professions and contexts. Furthermore, applying the IPC competencies in practice would be complimented by an in-depth understanding and application of the national interprofessional competency framework (CIHC, 2012).

## Limitations

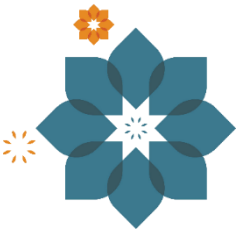
Some limitations of the current study should be noted. First, because we used purpose-driven sampling to recruit working group participants, there is the potential that our participant sample does not reflect the general population or appropriate population groups. Notably, we did not recruit or engage patients, families, caregivers or the public, nor did we strategize targeted outreach to engage participants from structurally excluded groups, such as Indigenous Peoples.

Second, given that there are thousands of Alberta HCPs working in various professions in Alberta, it is possible that our sample size is too small to represent the larger population of HCPs. We attempted to mitigate the limitations by ensuring broad participant representation as well as allowing adequate time for each participant to provide feedback. However, although we had participants who lead health care aide (HCA) curriculum and competency development programs, we were not able to recruit HCA participants. As such, there may be opportunities to validate the palliative care competencies to the broader Alberta HCP populations and members of the public to ensure their representativeness and comprehensiveness.

The IPC Competency Framework development process occurred during the peak of the fourth wave of the COVID pandemic, which may have hindered participation rates and the quality and quantity of feedback provided. Lastly, while comprehensive, the Alberta IPC Competency Framework development project did not include all HCP disciplines. Future work could explore palliative care competencies from the perspective of music therapists, art therapists, massage therapists, laboratory technologists, midwives, recreation therapists and alternative health therapists, among others.

## Conclusion

A robust and skilled health care workforce is essential to the future sustainability of palliative care delivery. Having Alberta-specific palliative care competencies allows HCPs to identify the skills, knowledge and attitudes required to optimize palliative care. Additionally, the Alberta Interprofessional Competency Framework can be used to inform standardized interprofessional competency-based palliative care educational opportunities for health care practitioners to help prepare them to provide high-quality palliative care. Further, the Alberta IPC Competency Framework can be used as a resource to inform and guide academic curricula, professional development, continuing education programs, accreditation and regulated professional and employer standards.





**Publication Date:** February 2023



**Cite as follows:** Covenant Health Palliative Institute (2023). Alberta Interprofessional Palliative Care Competency Framework: Technical Report.

**Disclaimer:** Funding for this project was provided, in whole or in part, by the Government of Alberta. The views and opinions expressed in this document are those of the authors and do not necessarily reflect the official policy or position of the Alberta government.

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# Appendix 1: Glossary of Terms

Please note that the organizational authorities are acknowledged for selected terms. Definitions were adapted from academic sources and are adopted from the AHS PEOLC Alberta Provincial Framework and 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 a specific 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, regulated health professionals, unregulated care providers and/or other caregivers, including the client's family. Within the team the client remains central [Alberta Health].

**Illness trajectory:** three typical illness trajectories have been described for patients with progressive chronic illness: cancer, organ failure and the frail elderly or dementia trajectory. Physical, social, psychological and spiritual needs of patients and their caregivers are likely to vary according to the trajectory they are following. Being aware of these trajectories may help clinicians plan care to meet their patients' needs better and help patients and caregivers 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-centred care and takes place through teamwork. Team interactions, wider organizational issues and environmental structures such as safety, quality, efficiency and effectiveness issues influence this model of care. These broader contextual influences affect practice where there are tensions between the ideals of interprofessional collaboration and the realities of practice. This is evident when patient and family involvement in interprofessional collaboration is considered.

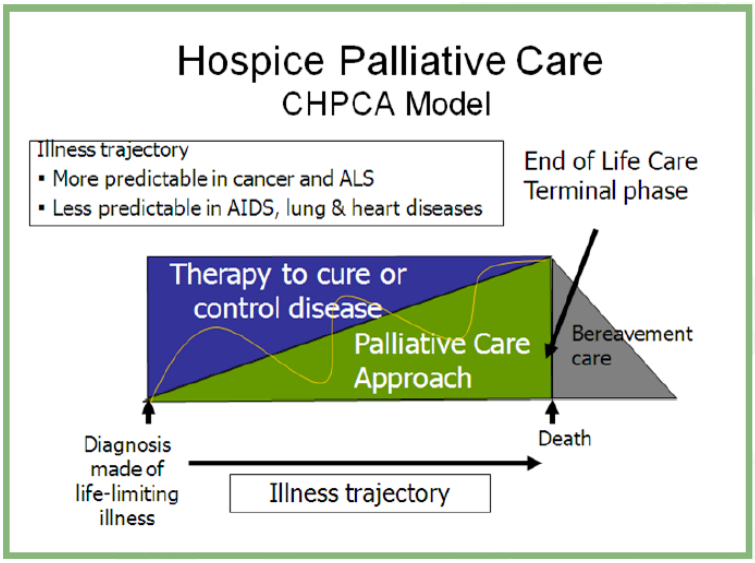
**Imminently dying:** any patient who, according to the most responsible health practitioner's clinical assessment, is within the last hours to days of life.

**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 a 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 assessment and appropriate interventions [Alberta Health Services].

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

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




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

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

**Personal directive:** a written document in accordance with the requirements of the Personal Directives Act (Alberta), in which an adult designates an agent(s) or provides instruction regarding his/her personal decisions, including the provision, refusal and/or withdrawal of consent to treatments/procedures. A personal directive (or part of one) has effect with respect to a personal matter only when the patient lacks capacity with respect to that matter [Alberta Health Services].

**Referral:** refers to when a patient is instructed by a health care professional or organization to obtain additional services from another organization or provider. These may include change of service, changes in level of care, and/or transfer between units [Alberta Health Services].

# Appendix 2: Acknowledgements

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

We thank Cheryl Tschupruk, Kathleen Yue, Susan Blacker, Tara Walton, Deborah Dudgeon, and Lorelei Sawchuk for their ongoing consultation, guidance, and advice throughout this project. Tyne M. Lunn for review, content contribution and writing and Benjamin Freeland for language and technical editing.

We acknowledge Alberta Health for their financial support of the Alberta Palliative Care Competencies and Education Project.

The development of these competencies would not have been possible without the support of the members of the Alberta Health Services Provincial Palliative and End-of-Life Innovations Steering Committee, the Alberta Palliative Care Competencies and Education Advisory Committee and all multidisciplinary HCPs who participated in the development of the Alberta Interprofessional Palliative Care Competency Framework project.

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# Appendix 4: References


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