Alberta Health Services

Covenant Health
Palliative Institute

Alberta Dietitians'
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."

Publication date: September 2020

How to cite this document

Covenant Health Palliative Institute. *Alberta Dietitians' Palliative Care Competency Framework: A Resource Manual for Health Care Professionals.* Edmonton, AB: September 2020.

Authors: Lisa Vaughn, RN, MN; Lorelei Sawchuk, MN, NP, CHPCN(C); Carleen Brenneis, RN, MHSA; and Konrad Fassbender, PhD

To obtain additional information, please contact the Covenant Health Palliative Institute.

Address: Covenant Health Palliative Institute, c/o Grey Nuns Community Hospital, Rm 416, St. Marguerite Health Services Centre, 1090 Youville Drive West, Edmonton, AB T6L 0A3

Fax: 780-735-7302

E-mail: Palliative.Institute@covenanthealth.ca

Table of Contents

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 Dietitians' Palliative Care Competencies Referent Group

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

Health Care Organizations	**Educational Institutions**
• Alberta Health Emergency Medical Services • Capital Care Norwood Palliative Care Unit, Edmonton <u>Alberta Health Services</u> • Calgary Zone Palliative and End-of-Life Care Program • Central Zone Palliative Care Team • Coronation Health Care Centre, Acute Care and Home Care • Edmonton Zone Palliative and End-of-Life Care and Community Programs • Edmonton Zone Palliative Care Program • Health Professions Strategy and Practice • Lacombe Hospital Acute Care • Medicine Hat Home Care • Medicine Hat Regional Hospital • North Zone Palliative Care Team • Okotoks-Calgary Zone Palliative Care Consult Team - Rural • Palliative and End-of-Life Innovations Steering Committee • Palliative Care Zone Directors/Leads • Professional Practice • Provincial Palliative and End-of-Life Care, Community, Seniors, Addiction and Mental Health • Red Deer Hospital Palliative Care Oncology Unit • Royal Alexandra Hospital Palliative Care Program, Edmonton <u>Covenant Health</u> • Bonnyville Health Centre • Misericordia Community Hospital, Edmonton • Professional Practice and Research • Tertiary Palliative Care Unit, Grey Nuns Community Hospital, Edmonton	• Athabasca University Faculty of Health Disciplines • Bow Valley College School of Health and Wellness <u>MacEwan University</u> • Faculty of Nursing • Centre for Professional Nursing Education <u>University of Alberta</u> • Faculty of Nursing • Faculty of Medicine and Dentistry <u>University of Calgary</u> • Department of Family Medicine • Department of Oncology • Faculty of Nursing
	Professional Regulatory Bodies and Associations
	• College of Licensed Practical Nurses of Alberta • College and Association of Registered Nurses of Alberta • College of Registered Psychiatric Nurses of Alberta

Alberta Palliative Care Competency Framework

A competency is defined by Parry[1] 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 Dietitians’ 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 Dietitians’ Palliative Care Competency Framework which was developed by the Alberta Dietitians’ 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

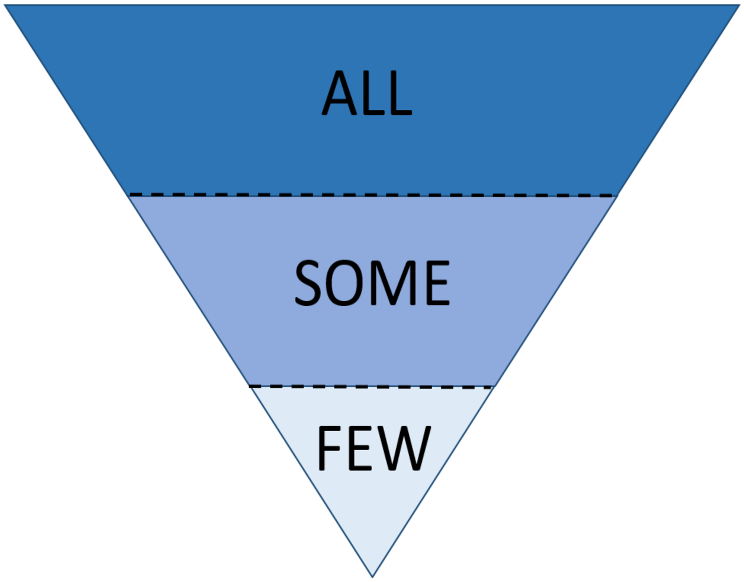


Table 1. Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions
All: HCPs in this level provide care within their scope of practice, to any person in any care setting, including those with life-limiting illnesses. They have foundational knowledge and skills in palliative care. This 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.

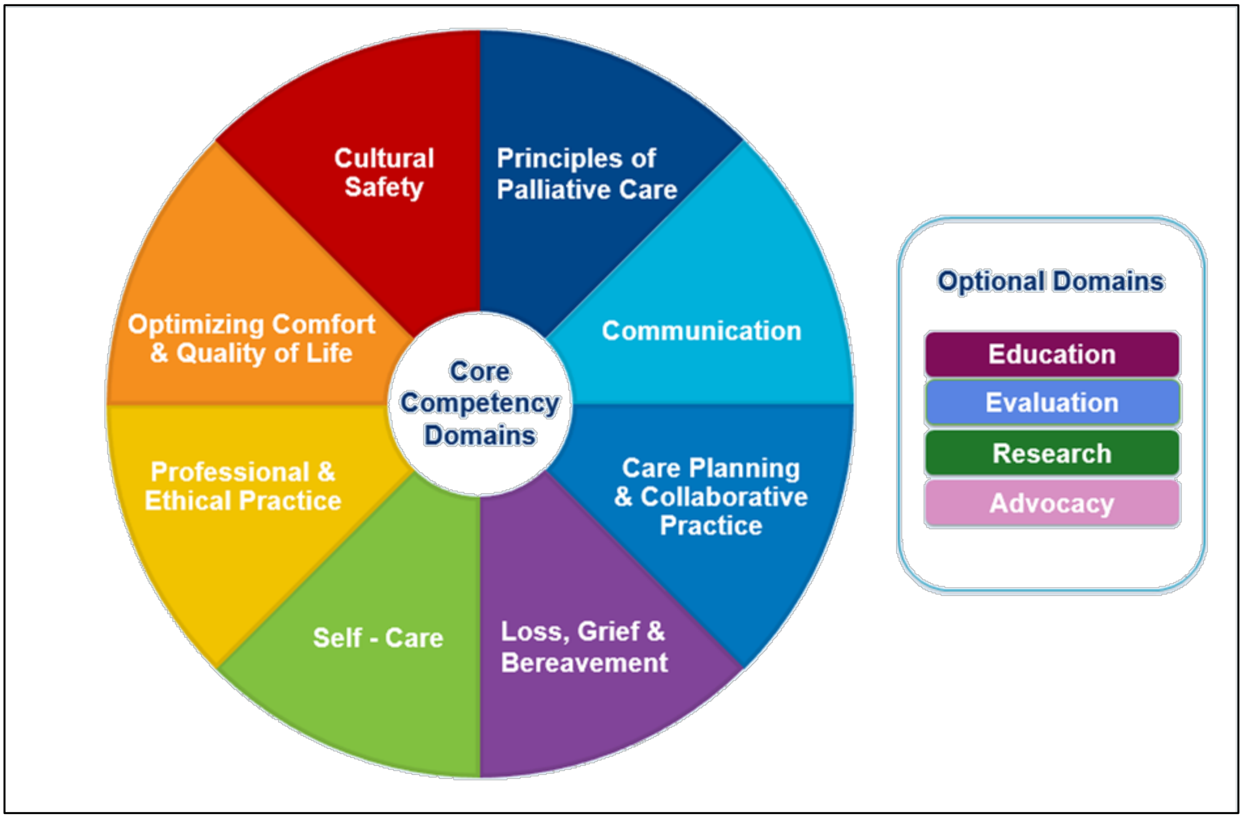
Table 1. Continued Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions
Some: These HCPs have deeper knowledge, understanding and application of palliative and end-of-life care. HCPs in this level also provide care in any setting. They have expertise in palliative and end-of-life 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 Dietitians' Palliative Care Competencies

Domain 1: Principles of Palliative Care	
All	**Educational Opportunity**
1. Explain the philosophy of palliative care.	☐
2. Describe the meaning of the term 'life-limiting illness'.	☐
3. Identify that a palliative approach to care can start early in the trajectory of a progressive life-limiting illness and may be appropriate at the time of diagnosis.	☐
4. Conserve patient dignity by facilitating expression of needs, hopes, feelings and concerns when planning palliative care.	☐
5. Apply the principles of palliative care that affirm life by supporting the patient to live as actively as possible until death with optimal quality of life.	☐
6. Practice patient-centered palliative care that incorporates the unique contributions of the family in caregiving.	☐
7. Describe the role and function of the interprofessional team in palliative care.	☐
Some	**Educational Opportunity**
1. Describe the full spectrum of trajectories of life-limiting illnesses in the context of your current clinical practice.	☐
2. Facilitate empathic and responsive relationships between the patient experiencing a life-limiting illness and the interprofessional team.	☐
3. Demonstrate understanding of palliative care standards, guidelines and policies in your health care zone.	☐
Few	**Educational Opportunity**
1. Describe the full spectrum of trajectories of life-limiting illnesses and their impact on nutritional management for the patient with complex and multidimensional care needs.	☐
2. Practice leadership that encourages colleagues to foster a caring environment that supports all health care providers working in sensitive situations.	☐
3. Apply models of palliative care that promote dignity when providing care (e.g. Dignity Conserving Care).	☐

Notes:

Domain 2: Communication	
All	**Educational Opportunity**
1. Describe the essential role that communication plays in palliative care.	☐
2. Explain that communication regarding palliative care is an on-going collaborative process.	☐
3. Recognize the potential for conflict in palliative care decision-making.	☐
4. Invite the patient, family, and the interprofessional team to participate in discussions regarding the nutrition care plan.	☐
5. Adapt the communication approach with the patient and their family based on their understanding of the life-limiting illness.	☐
6. Recognize that family conversations may involve children and different communication approaches may be required.	☐
7. Provide culturally relevant information and resources to support the patient and their family.	☐
Some	**Educational Opportunity**
1. Adapt communication and information sharing to the unique needs of the patient and their family by engaging specialist support as needed to bridge communication barriers (e.g. interpreter, sign language interpreter and assistive technology).	☐
2. Enlist the skills of the interprofessional team to enhance and support communication with the patient with a life-limiting illness and their family.	☐
3. Assess the patient's and family's understanding of the life-limiting illness and its trajectory.	☐
4. Support each patient regarding the depth of information about diagnosis, prognosis and disease progression they wish to receive and share with their family.	☐
5. Facilitate conversations to support decision-making.	☐
6. Maintain ongoing communication with the patient, their family and the interprofessional team regarding the plan of care.	☐
7. Participate in processes that mitigate conflict in palliative care decision-making.	☐
Few	**Educational Opportunity**
1. Apply strategies to engage in highly skilled, compassionate, individualized and timely communication with each patient, their family and the interprofessional team.	☐

2. Demonstrate expertise as a mediator by advocating for the patient to access appropriate and timely palliative care.	☐
3. Acknowledge personal responses to communication challenges while remaining engaged in meaningful contact with the patient and their family.	☐

Notes:

Domain 3: Care Planning and Collaborative Practice	
All	**Educational Opportunity**
1. Describe the collaborative relationship between the patient, their family and the interprofessional team.	☐
2. Identify how interprofessional practice enhances patient outcomes.	☐
3. Contribute to the effectiveness of the interprofessional care team.	☐
4. Collaborate with the patient and the interprofessional team to manage symptoms.	☐
5. Recognize that care planning and decision-making may involve the family and the larger community.	☐
6. Support the patient to express their wishes and/or identify goals of care by referring them to the most appropriate member of the interprofessional team.	☐
7. Refer the patient and their family to the appropriate member of the interprofessional team if the patient needs further information or clarification regarding Advance Care Planning (ACP) and Goals of Care Designations (GCDs).	☐
8. Identify priorities and concerns in collaboration with the patient and their family, taking into account their coping strategies and perception of diagnosis.	☐
9. Identify that there are appropriate times to engage in ACP discussions.	☐
10. Explain the role of an ADM in decision making regarding a patient's care and in the patient's nutrition care plan.	☐

11. Facilitate discussions with the patient with a life-limiting illness and their family to determine their preferences for nutrition support and oral feeding when indicated.	☐
12. Recognize the overall impact of a life-limiting illness on the patient, including their mental health and coping mechanisms.	☐
13. Provide support to the patient to address identified needs.	☐
14. Apply an advanced level of discipline-specific clinical expertise in supporting the patient and their family to adapt to the changing clinical presentation.	☐
15. Support the discharge planning process to facilitate smooth transitions.	☐
16. Recognize clinical limitations and professional boundaries.	☐
17. Where clinical limitations and professional boundaries exist, refer to other most appropriate member of the interprofessional team in a timely manner.	☐
Some	**Educational Opportunity**
1. Collaborate within the interprofessional team and with other stakeholders to manage positive working relationships that will support the well-being of the patient and promote patient-centered care planning.	☐
2. Collaborate within and between teams across the continuum of care to facilitate continuity in palliative care.	☐
3. Use shared scopes of practice to optimize care.	☐
4. Demonstrate flexibility in relation to care planning, acknowledging that a patient's priorities can alter as their condition changes.	☐
5. Develop therapeutic relationships with the patient, their family and the interprofessional team.	☐
6. Anticipate factors/conditions that may affect the patient's cognition and functional capacity to make decisions as their illness progresses.	☐
7. Support and facilitate informed decision-making by the patient regarding place of care.	☐
8. Facilitate the patient and their family toward active involvement in decision-making and goal setting to support best outcomes and quality of life.	☐
9. Participate in patient and/or family, and team conferences.	☐
10. Participate in conversations with the patient, their family and the interprofessional team to define goals of care.	☐
11. Participate in conversations with the patient, their family and the interprofessional team to implement and evaluate a plan of care.	☐
12. Recognize the complexities and challenges involved for the patient and their family related to discharge planning.	☐

Few	**Educational Opportunity**
1. Act as an expert resource to the interprofessional team on the role of food and nutrition related interventions in symptom management and optimizing quality of life.	☐
2. Apply an advanced level of clinical expertise in facilitating safe, smooth and seamless transitions of care for the patient and their family.	☐
3. Identify the patient’s and family’s values, beliefs and preferences regarding the various components of palliative care provision.	☐
4. Create a holistic, patient-centered plan that acknowledges the psychosocial impact of changing nutritional requirements and food and nutrition intake.	☐
5. Involve the patient and their family to identify resources that will provide support during end-of-life care.	☐
6. Identify the full range and continuum of palliative care services, resources, and the settings in which they are available.	☐
7. Identify services and resources specific to the patient’s goals of care.	☐
8. Facilitate access to services and resources specific to the patient’s goals of care.	☐
9. Initiate referrals to resources, services, and settings specific to the patient’s goals of care.	☐
10. Delegate aspects of care to the family, where indicated.	☐
11. Integrate patient strengths in the plan of care.	☐
12. Support the family to access respite care.	☐

Notes:

Domain 4: Optimizing Comfort and Quality of Life

All	**Educational Opportunity**
1. Apply interprofessional approaches to optimize comfort and enhance quality of life of the patient and their family.	☐
2. Explain the collaborative relationship between the patient, their family and community in supporting symptom management.	☐
3. Recognize common trajectories of life-limiting illnesses, including common symptoms.	☐
4. Explain how a palliative approach can enhance the assessment and management of symptoms.	☐
5. Anticipate the needs of the patient who has been diagnosed with a life-limiting illness based on known disease trajectories.	☐
6. Explain the causes of common non-pain symptoms in palliative care.	☐
7. Recognize that symptoms and symptom meaning are highly subjective.	☐
8. Recognize the physical, psychological, social and spiritual issues that affect the patient and their family.	☐
9. Provide care in keeping with the patient's expressed wishes and identified goals of care.	☐
10. Make decisions regarding the appropriateness of interventions for each patient living with a life-limiting illness, while taking into consideration the patient's expressed wishes and identified goals of care.	☐
11. Recognize potentially reversible causes of food and nutrition issues (i.e. symptoms related to food and/or nutrition intolerance).	☐
12. Employ appropriate food and nutrition support strategies for the palliative care patient with potentially reversible causes of food and/or nutrition related issues.	☐
13. Provide individualized food and nutrition counselling to the patient with palliative care needs.	☐
14. Provide education to address patient and family concerns related to food and nutrition, including information on practical strategies that can be employed.	☐
15. Recognize the need for a change in the focus of care and treatment goals at critical decision points in the course of a life-limiting illness.	☐
16. Provide care in a compassionate manner.	☐
17. Recognize the signs of imminent death.	☐
18. Support the patient's and family's wishes and death rituals.	☐

19. Explore one’s own responses to being in the presence of a patient who is suffering.	☐
Some	**Educational Opportunity**
1. Apply the principles of symptom management.	☐
2. Use non-pharmacological symptom management to promote comfort and quality of life.	☐
3. Assess the benefits, burdens and risks of clinical interventions for palliative care patients.	☐
4. Discuss the benefits, burdens, and risks of clinical interventions with palliative care patients.	☐
5. Assess the patient’s and their family’s skills and need for food and nutrition related education and supports taking into consideration the social determinants of health, as well as their ethnicity, culture, gender, language, religion, age, ability and preferences.	☐
6. Provide education to the patient and their family in relation to management of nutrition support, including information on practical strategies that can be employed.	☐
7. Provide education to the patient and their family regarding management of symptoms, including: anorexia, cachexia, dysphagia, nausea, vomiting, constipation, diarrhea and taste changes, management of nutrition support and refusal to eat or drink.	☐
8. Engage in dysphagia assessment and management according to the Alliance of Canadian Dietetic Regulatory Bodies’ 2019 Competencies for Dysphagia Assessment and Management in Dietetic Practice.	☐
9. Interpret the impact of family role change when formulating relevant and realistic nutrition care plans in collaboration with the patient with a life-limiting illness.	☐
10. Recognize the ways in which the patient can be engaged in self-management of their condition.	☐
11. Contribute to decision-making about withdrawing or withholding interventions as part of the interprofessional team with the patient and their family, whilst recognizing when to re-engage if appropriate.	☐
12. Support the patient, family, Alternate Decision Maker (ADM) and the interprofessional team with end-of-life decision making, including withdrawing or withholding nutrition interventions.	☐
13. When able, provide care in the patient’s preferred place, while recognizing the complexities and challenges involved for the patient and their family.	☐

Few	**Educational Opportunity**
1. Apply a comprehensive understanding of the clinical presentation and disease trajectories of life-limiting illnesses when responding to complex and multidimensional care needs, in order to comprehensively identify current and prospective clinical issues in palliative care.	☐
2. Facilitate the patient's and family's perception of a good death.	☐

Notes:

Domain 5: Loss, Grief and Bereavement	
All	**Educational Opportunity**
1. Describe diverse perspectives on loss, grief, bereavement, and mourning, acknowledging that culture influences the experience of a life-limiting illness.	☐
2. Recognize the range of individual physical, psychological, spiritual, emotional, social and cultural responses to loss and grief.	☐
Some	**Educational Opportunity**
1. Recognize the factors that may increase the risk of complicated grief.	☐
2. Demonstrate understanding of the dimensions of grief.	☐
Few	**Educational Opportunity**
1. Apply comprehensive knowledge of the grieving process and reactions in order to support the patient and their family throughout the disease trajectory.	☐
2. Address pathological responses to loss, referring appropriately to the Palliative Care Consult Team.	☐
3. Support the family with guidance and information on bereavement services that is culturally sensitive and family-specific.	☐

Notes:

Domain 6: Professional and Ethical Practice	
All	**Educational Opportunity**
1. Explore the patient's wishes regarding their care options and preferences.	☐
2. Respect the patient's wishes regarding their care options and preferences.	☐
3. Respect the patient's decisions regarding initiating, not initiating, withholding and withdrawing dialysis, hydration, nutrition support, resuscitation and other life-prolonging/life-sustaining interventions.	☐
4. Participate in the discussion and management of ethical and legal issues regarding nutrition support with the patient, their family and the interprofessional team.	☐
5. Demonstrate understanding of the ethical issues that may be encountered when caring for a patient with a life-limiting illness.	☐
6. Identify ethical and legal issues that may arise regarding oral feeding and enteral and parenteral nutrition support.	☐
7. Identify the profession's regulatory standards and/or guidelines relevant to palliative and end-of-life care identify the profession's regulatory standards and/or guidelines relevant to palliative and end of life care.	☐
8. Respond to inquiries regarding MAID in accordance with regulatory body's relevant guidelines and standards and/or employer policy (e.g. College of Dietitians of Alberta Position Statement: Medical Assistance in Dying for Registered Dietitians in Alberta).	☐
9. Explain the difference between managing a condition and providing palliative care.	☐
10. Recognize when beliefs, attitudes and values limit one's ability to be present and provide patient-centered care.	☐
11. Collaborate with others to ensure optimal care is provided in the circumstance when one's beliefs, attitudes and values limit one's ability to be present and provide patient-centered care.	☐
12. Engage with people experiencing loss and suffering.	☐

Some	**Educational Opportunity**
1. Participate in processes of clinical governance and quality assurance to maintain and improve clinical practice.	☐
2. Describe ethical concepts, such as: the principle of double effect, palliative sedation and Medical Assistance in Dying (MAID).	☐
3. Identify relevant legislation and policies, e.g. Bill C-14 Medical Assistance in Dying (MAID); Child, Youth and Family Enhancement Act; Protection for Persons in Care Act; Adult Guardianship and Trusteeship Act; and the Personal Directives Act.	☐
Few	**Educational Opportunity**
1. Apply a comprehensive understanding of contemporary legal, ethical, and professional standards to the provision of quality palliative care.	☐
2. Facilitate discussion and resolution of ethical and legal issues in conjunction with the patient, their family and the interprofessional team.	☐
3. Manage legal issues that may be encountered when caring for a patient with a life-limiting illness.	☐
4. Act as an expert resource contributing to palliative care development and delivery.	☐

Notes:

Domain 7: Cultural Safety

All	**Educational Opportunity**
1. Describe the influence of culture on key issues in palliative care.	☐
2. Incorporate cultural preferences and values into goal setting, decision-making and care planning.	☐
3. Assess the food and nutrition palliative care needs unique to each patient and their family, considering the social determinants of health, ethnicity, culture, gender, sexual orientation, language, religion, age, ability and their preferences.	☐

4. Respect the patient's and family's social, spiritual and cultural values and practices that may influence their care preference.	☐
5. Accommodate the patient's and family's social, spiritual and cultural values and practices.	☐
6. Recognize who the patient identifies as family, and respond to the family members' unique needs and experiences.	☐
7. Respect who the patient identifies as family.	☐
8. Identify personal biases and values that may influence care.	☐
9. Identify mechanisms to overcome personal biases to ensure they do not impact care and treatment.	☐

Notes:

Domain 8: Self-Care	
All	**Educational Opportunity**
1. Describe the personal impact of loss, grief and bereavement.	☐
2. Identify own responses to loss.	☐
3. Explore own attitudes regarding death, dying and caring for patients requiring palliative care.	☐
4. Identify the impact of past experiences of suffering, death and dying when providing palliative care.	☐
5. Attend to own emotional responses that result from caring for a patient with palliative care needs.	☐
6. Recognize compassion fatigue in one's self and colleagues.	☐
7. Engage in healthy activities that help prevent compassion fatigue.	☐
8. Support colleagues who are experiencing compassion fatigue.	☐
9. Engage in activities that support well-being and resilience.	☐

Notes:

Domain 9: Education, Research and Evaluation	
All	**Educational Opportunity**
1. Participate in palliative care continuing education opportunities.	☐
2. Apply knowledge gained from palliative care research.	☐
Some	**Educational Opportunity**
1. Undertake additional education relevant to the needs of patients with life-limiting illnesses to further knowledge and enhance application in practice.	☐
2. Engage in research that will lead to evidence based clinical practice.	☐
Few	**Educational Opportunity**
1. Educate the patient, and their family about palliative care and a palliative approach.	☐
2. Where possible, facilitate palliative care research.	☐
3. Critically evaluate outcomes against standards and guidelines.	☐
4. Develop palliative care related education for members of the discipline and students.	☐
5. Facilitate and provide palliative care related education, leadership, and mentorship to members of the discipline and students.	☐
6. Where possible, identify the opportunities for and barriers to discipline-specific research unique to palliative care.	☐
7. Contribute to the monitoring and evaluation of the quality of palliative care services.	☐
8. Where possible, provide the family with opportunities to participate in palliative caregiving research.	☐

Notes:

Domain 10: Advocacy	
All	**Educational Opportunity**
1. Provide equitable and timely access to nutrition related palliative care resources.	☐
Few	**Educational Opportunity**
1. Advocate for the development, maintenance and improvement of health care and social policies related to palliative care.	☐
2. Advocate for health care providers to participate in palliative care continuing education opportunities.	☐
3. Advocate for health care providers to have adequate resources to provide palliative care.	☐
4. Advocate for the needs, decisions~~,~~ and rights of the patient by recognizing potential vulnerabilities.	☐
5. Mitigate potential barriers and limitations to transitions between specialty and primary care.	☐
6. Influence strategic palliative care initiatives and policy development.	☐
7. Actively promote palliative care strategic initiatives and policy development.	☐

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.

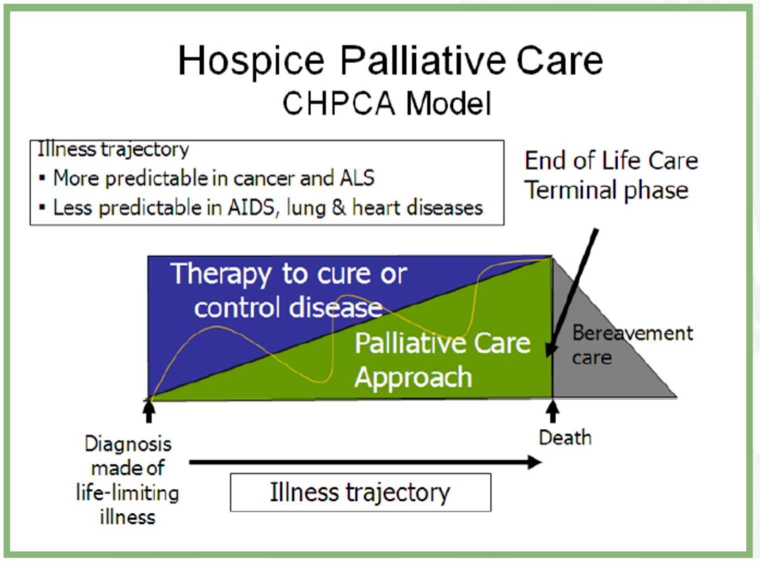
Interprofessional: interprofessional collaboration occurs when health professionals from different disciplines work together to identify needs, solve problems, make joint decisions on how best to proceed and evaluate outcomes collectively. Interprofessional collaboration supports patient-centered care 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.

Alliance of Canadian Dietetic Regulatory Bodies. (January 2019). *Competencies for dysphagia assessment and management in dietetic practice.* https://www.collegeofdietitians.ab.ca/wp-content/uploads/2019/03/CDA-Dysphagia-Competencies-EN-January-2019.pdf

Alliance of Canadian Dietetic Regulatory Bodies. (May 2020). *Canadian dietetic registration examination (CDRE) preparation guide.* https://www.collegeofdietitians.ab.ca/wp-content/uploads/2020/03/Current-CDRE-Prep-Guide-May-2020.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.

College of Dietitians of Alberta. (2014). *The professional practice handbook for dietitians in Alberta.* https://www.collegeofdietitians.ab.ca/wp-content/uploads/2017/01/Professional-Practice-Handbook-for-Dietitians-in-Alberta-2014.pdf

College of Dietitians of Alberta. (2018). *Standards of practice.* https://www.collegeofdietitians.ab.ca/wp-content/uploads/2019/09/CDA-Standards-of-Practice-October-2018-revised.pdf

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/

Partnership for Dietetic Education and Practice. (August 2020). *Integrated competencies for dietetic education and practice (ICDEP).* https://www.pdep.ca/library/PDEP-*Policies/INTEGRATED-COMPETENCIES-FOR-DIETETIC-EDUCATION-AND.aspx*

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.

We thank Cheryl Tschupruk, Kathleen Yue, Susan Blacker, Tara Walton, Deborah Dudgeon and Julie Lachance for their ongoing consultation, guidance and advice throughout this project.

We appreciate the Canadian Partnership Against Cancer Palliative Care Competencies Working Group for their ongoing consultation.

We acknowledge the Covenant Health Foundation for their financial support of the Alberta Palliative Care Competencies’ Project

We are grateful to Covenant Health Library Services whose staff conducted numerous and thorough literature reviews.

Last but not least, 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 Advisory Working Group, and all the members of the Alberta Dietitians’ Palliative Care Competencies Working Group.

Alberta Palliative Care Competencies Advisory Working Group

Name	**Position**	**Location/Program/Organization**
Michelle Peterson Fraser, RN, BN	Director	Provincial Palliative and End-of-Life Care, Community, Seniors, Addiction and Mental Health/Alberta Health Services
Christy Raymond, RN, PhD	Assistant Professor	Edmonton/Faculty of Nursing/University of Alberta
Sandy Ayre, BScOT	Occupational Therapist	Edmonton/Tertiary Palliative Care Unit, Grey Nuns Community Hospital/Covenant Health
Sarah Burton MacLeod, MD, CCFP(PC)	Residency Program Director Enhanced Skills in Palliative Care and Palliative Care Physician Consultant	Edmonton/Faculty of Medicine and Dentistry/University of Alberta Edmonton Zone/Palliative Care Program/Alberta Health Services
Jacqueline Hui, MD, MHPE, CCFP (PC), FCFP, DTMH	Assessment Director, Enhanced Skills Palliative Care Residency Program Director, and Clinical Assistant Professor; and Consulting Physician	Calgary/Department of Family Medicine Residency Program Family Medicine, Departments of Oncology & Family Medicine/Cumming School of Medicine/University of Calgary Calgary Zone/Palliative and End-of-Life Care Program/Alberta Health Services
Charlotte Pooler, RN, PhD	Clinician Scientist	Edmonton Zone/Palliative and End-of-Life Care and Community Programs, Continuing Care/Alberta Health Services
Jeanne Weis MN, BN, RN, CHPCA (C)	Executive Officer	College of Licensed Practical Nurses of Alberta
Cheryl Cameron, M.Ed., ACP	Manager, EMS Policy, Standards and Reporting	Emergency Health Services/Alberta Health
Roberta Parkes, RN	Professional Practice Lead	Nursing, Professional Practice and Research/Covenant Health

Alberta Dietitians’ Palliative Care Competencies Working Group

Name	Position	Location/Program/Organization
Kim Johnson, RD	Dietitian	Edmonton Zone/Cross Cancer Institute/Alberta Health Services
Ed Walker, RD	Dietitian	Calgary Zone/Foothills Hospital/Alberta Health Services
Terelyn Bloor, RD	Dietitian	Edmonton/Grey Nuns Community Hospital/Covenant Health
Shannon Mackenzie, MEd, RD	Director, Professional Practice	College of Dietitians of Alberta
Carla Prado, PhD, RD	Associate Professor and Campus Alberta Innovates Chair in Nutrition, Food and Health	Edmonton/Faculty of Agricultural, Life and Environmental Sciences/University of Alberta
Heidi Bates, MSc, RD	Director, Integrated Dietetic Internship	Edmonton/Faculty of Agricultural, Life and Environmental Sciences/University of Alberta
Erin Bowers, RD	Clinical Dietitian	Red Deer-Central Zone/Home Care/Alberta Health Services
Mikala Wilson, RD	Dietitian	Grande Prairie-North Zone/Queen Elizabeth II Hospital/Alberta Health Services
Chelsea Corbett, RD II	Provincial Practice Lead	Provincial Strategy, Standards & practice/Alberta Health Services
Christin Barber, RD	Program Manager, Corporate Clinical Nutrition	Covenant Health
Melanie Hildebrandt, RD	Dietitian	Medicine Hat-South Zone/Margery E. Yuill Cancer Centre and Bow Island/Alberta Health Services