

Alberta Emergency Medical Responders' and Paramedics' Palliative Care Competency Framework

Version 1.0 (September 2020)

A Resource Manual for Health Care Professionals



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

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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

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Dedication

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

Forward

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

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

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

“It is the lived acknowledgement and therapeutic significance of an authentic, personal, compassionate relationship between the caregiver and the patient. A relationship of trust, commitment, and tenderness. It is a gift, a blessing given by the caregiver to the patient. The gift of community, the gift of consolation, meaning, and companionship. A gift which ennoble 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 ennoble 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 Emergency Medical Responders' and Paramedics' Palliative Care Competencies' Referent Group

The Alberta Emergency Medical Responders' and Paramedics' Palliative Care Competencies' Referent Group below assisted in recruiting individuals participating in the production of the Alberta Emergency Medical Responder' and Paramedics' Palliative Care Competency Framework. This includes members of the Alberta Palliative Care Competencies Advisory Working Group and the Alberta Emergency Medical Responders' and Paramedics' 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 Emergency Medical Responders' and Paramedics' Palliative Care Competencies Referent Group	
Health Care Organizations	Educational Institutions
<ul style="list-style-type: none"> • Alberta Health Emergency Medical Services <p><u>Alberta Health Services</u></p> <ul style="list-style-type: none"> • Calgary Zone Palliative and End-of-Life Care Program • Calgary Zone EMS Mobile Integrated Healthcare • Edmonton Zone Palliative Care Program • Edmonton Zone Palliative and End-of-Life Care and Community Programs, Continuing Care • EMS Palliative and End-of-Life Care Assess Treat Refer Program • North Zone EMS Mobile Integrated Healthcare • Provincial Palliative and End-of-Life Care, Community, Seniors, Addiction and Mental Health • South Zone, Learning and Development, EMS <p><u>Covenant Health</u></p> <ul style="list-style-type: none"> • Professional Practice and Research • Tertiary Palliative Care Unit, Grey Nuns Community Hospital, Edmonton 	<p><u>University of Alberta</u></p> <ul style="list-style-type: none"> • Faculty of Nursing • Faculty of Medicine and Dentistry <p><u>University of Calgary</u></p> <ul style="list-style-type: none"> • Department of Family Medicine • Department of Oncology • Northern Lakes College, Slave Lake <p>Professional Regulatory Bodies and Associations</p> <ul style="list-style-type: none"> • College of Licensed Practical Nurses of Alberta

Alberta Palliative Care Competency Framework

A competency is defined by Parry¹ as a “cluster of related knowledge, skills and attitudes that affects a major part of one’s job (a role or responsibility), that correlates with performance on the job, that can be measured against well-accepted standards, and that can be improved via training and development.” A Competency Framework is a compilation of competency statements.

How to Use the Alberta Palliative Care Competency Framework

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

Purpose of this Document

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

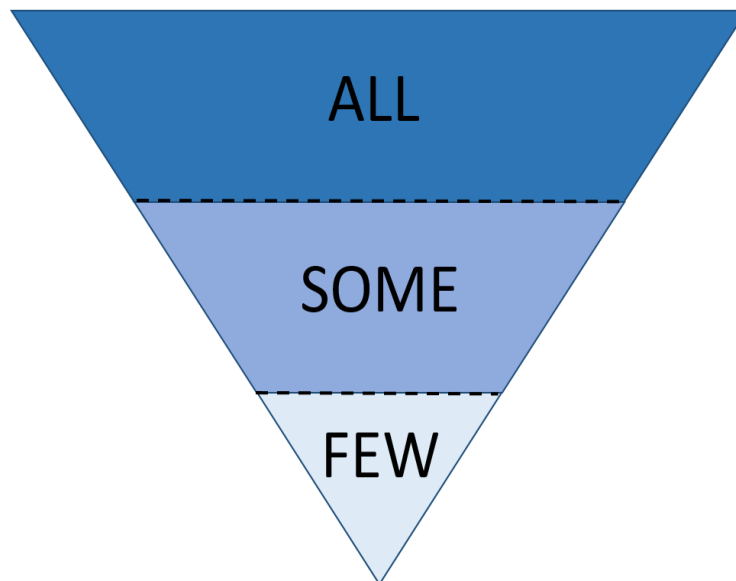


Table 1: Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions

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.

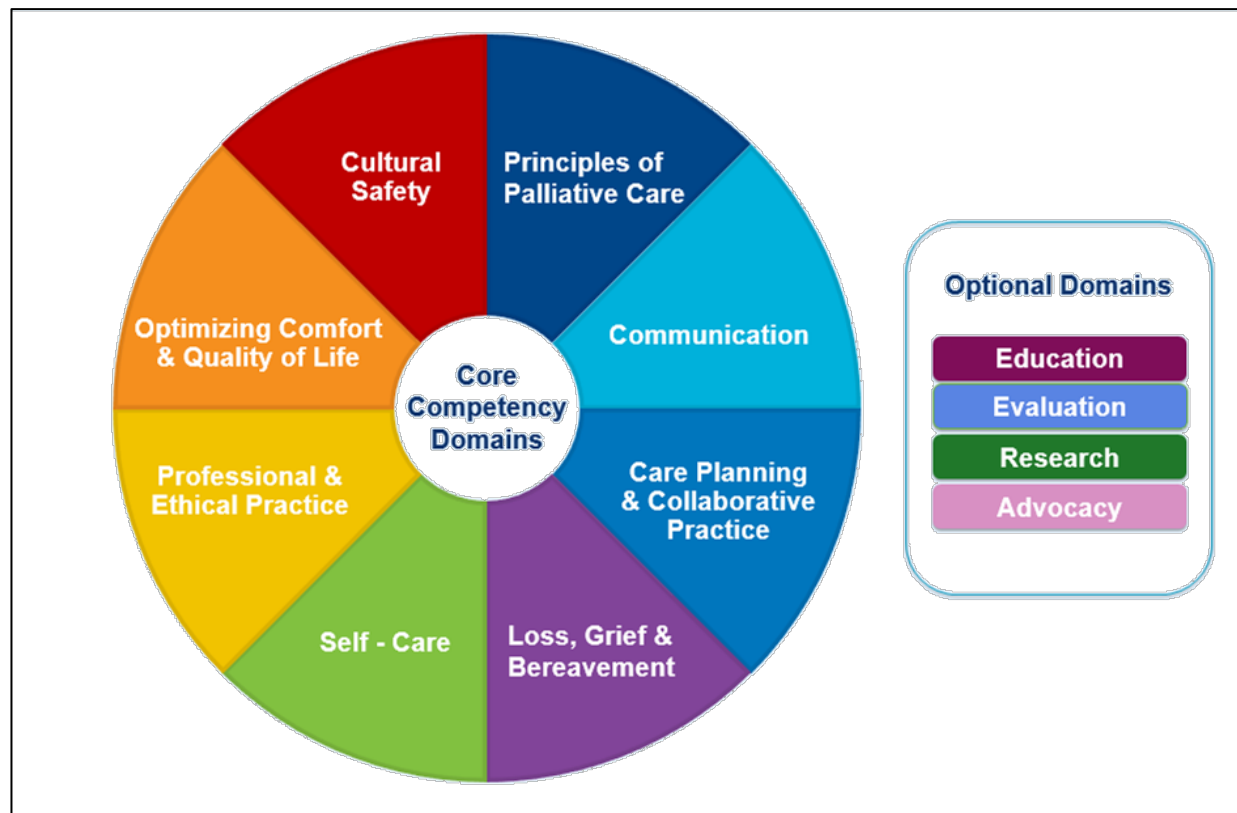
Few: This level of HCPs are palliative care experts who provide care for patients and their families, including those with the most complex palliative care needs. They provide a focused level of service for patients and families who require specialized, frequent and skilled assessments and interventions 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 Emergency Medical Responders' and Paramedics' Palliative Care Competencies

Domain 1: Principles of Palliative Care	
All	Educational Opportunity
1. Explain the philosophy of palliative care.	<input type="checkbox"/>
2. Practice emotional literacy.	<input type="checkbox"/>
3. Identify and name emotions, relaying empathy and compassion to the patient and their family.	<input type="checkbox"/>
4. Identify that a palliative approach starts early in the trajectory of a progressive life-limiting illness.	<input type="checkbox"/>
5. Identify the patient who may benefit from a palliative approach.	<input type="checkbox"/>
6. Explain the practitioner's role in palliative care.	<input type="checkbox"/>
7. Describe the influence that the social determinants of health can have on a patient's palliative care journey.	<input type="checkbox"/>
8. Describe the practitioner's critical role in providing support for palliative care patients.	<input type="checkbox"/>
9. Provide a compassionate presence.	<input type="checkbox"/>
10. Attend to the patient's suffering.	<input type="checkbox"/>
11. Explore own responses in the presence of a patient who is suffering.	<input type="checkbox"/>
12. Engage in self-reflection regarding personal attitudes and feelings regarding death and dying.	<input type="checkbox"/>
Some	Educational Opportunity
1. 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.	<input type="checkbox"/>
2. Identify disease processes that contribute to a life-limiting illness.	<input type="checkbox"/>
3. Describe the common presentations associated with a patient receiving palliative care.	<input type="checkbox"/>
4. Integrate the approach, assessment, and treatment of a patient who wishes to stay at home.	<input type="checkbox"/>
5. Describe the Emergency Medical Services Palliative and End-of-Life Care Assess, Treat and Refer (EMS PEOLC ATR) Program.	<input type="checkbox"/>
6. Identify patients who would benefit from the EMS PEOLC ATR Program.	<input type="checkbox"/>

Notes:

Domain 2: Communication	
All	Educational Opportunity
1. Guided by patient and family wishes, discuss a palliative approach to care with the patient and their family.	<input type="checkbox"/>
2. Explain the characteristics of effective communication.	<input type="checkbox"/>
3. Utilize evidence based communication strategies while listening and responding to the patient and their family.	<input type="checkbox"/>
4. Respond to inquiries regarding Medical Assistance in Dying (MAID) in accordance with regulatory expectations and/or employer policies and procedures.	<input type="checkbox"/>
Some	Educational Opportunity
1. Describe the communication challenges that may arise in the context of engaging in goals of care conversations with a palliative care patient.	<input type="checkbox"/>
2. Identify strategies to navigate the complexities in communication regarding end-of-life options, such as MAID.	<input type="checkbox"/>
3. Where the patient lacks capacity, identify the most appropriate designate to engage in clinical decision making (i.e. Alternate Decision Maker (ADM)).	<input type="checkbox"/>
4. Use appropriate strategies to maintain hope in advanced life-limiting illnesses.	<input type="checkbox"/>
5. Recognize that family conversations may involve children and different communication approaches may be required.	<input type="checkbox"/>
6. Adapt communication strategies to support varied cultural/spiritual/religious values.	<input type="checkbox"/>
7. Explain the Goals of Care Designations to the patient and their family.	<input type="checkbox"/>
8. Discuss the patient's wishes related to Advance Care Planning and Goals of Care Designations with the patient, and their family and consult with the interprofessional team.	<input type="checkbox"/>
9. Provide the patient and family with information regarding expected death at home.	<input type="checkbox"/>
10. Respond to those who are dissatisfied with palliative care services.	<input type="checkbox"/>
11. Utilize communication strategies and techniques to navigate difficult conversations with the patient and their family.	<input type="checkbox"/>
12. Support the family in the moments before and after the patient's death.	<input type="checkbox"/>

Notes:

Domain 3: Care Planning and Collaborative Practice	
All	Educational Opportunity
1. Adapt care based on the patient's existing Goals of Care Designation Order, general wishes for care, history and presentation.	<input type="checkbox"/>
2. Describe the role of the ADM.	<input type="checkbox"/>
3. Describe the role of the ADM in decision making regarding a patient's care.	<input type="checkbox"/>
4. Inquire about spiritual, cultural and religious considerations related to palliative care decisions.	<input type="checkbox"/>
5. Identify community-based palliative care resources for the patient and their family.	<input type="checkbox"/>
6. Facilitate patient and family access to community-based palliative care resources.	<input type="checkbox"/>
7. Build relationships with the patient and their family.	<input type="checkbox"/>
8. Foster trust with the patient and their family.	<input type="checkbox"/>
Some	Educational Opportunity
1. Recognize the factors that influence decision-making and the care plan of a patient with a life-limiting illness.	<input type="checkbox"/>
2. Explain the Advance Care Planning and Goals of Care Designation Policy and Personal Directives Act.	<input type="checkbox"/>
3. Consider the benefits, burdens and risks of clinical interventions.	<input type="checkbox"/>
4. Make decisions regarding the appropriateness of interventions for each patient living with a life-limiting illness, taking into consideration the patient's Goals of Care Designation and Personal Directive.	<input type="checkbox"/>
5. Develop a care plan that is consistent with the goals of care, trajectory of the life-limiting illness and the patient's wishes and circumstances.	<input type="checkbox"/>
6. Assist in making appropriate clinical decisions related to palliative care.	<input type="checkbox"/>
7. Verify that home death plans are in place to avoid 911 calls and/or involvement of the medical examiner.	<input type="checkbox"/>
8. Analyze how age, gender, history and health status relate to the patient's presentation.	<input type="checkbox"/>
9. Infer a differential diagnosis.	<input type="checkbox"/>
10. Identify pathologies where transport to an emergency department or acute care facility may be warranted (e.g. spinal cord compression).	<input type="checkbox"/>
11. Identify palliative care resources available to paramedics to enhance knowledge and practice.	<input type="checkbox"/>
12. Complete holistic a patient and family assessment, including addressing psychosocial-spiritual, emotional and medical needs.	<input type="checkbox"/>

Notes:

Domain 4: Optimizing Comfort and Quality of Life	
All	Educational Opportunity
1. Recognize when a patient is experiencing pain or discomfort and alert the most appropriate health care professionals.	<input type="checkbox"/>
2. Describe of the concept of 'total pain'.	<input type="checkbox"/>
3. Identify non-pharmacological interventions for symptom management.	<input type="checkbox"/>
Some	Educational Opportunity
1. Describe the anticipated changes in patient presentation in the last months, weeks and days of life and hours before death.	<input type="checkbox"/>
2. Recognize common palliative care symptoms and care needs which include, but are not limited to: pain, dyspnea, psychological distress, hydration, nutrition, nausea, vomiting and delirium.	<input type="checkbox"/>
3. Provide appropriate interventions for the patient, within scope of practice and based on established protocols or practice guidelines.	<input type="checkbox"/>
4. In consultation with the online physician, develop an appropriate symptom management plan, including pharmacological and non-pharmacological interventions.	<input type="checkbox"/>
5. When applicable, educate and assist the family to deliver appropriate treatments within symptom management care plan.	<input type="checkbox"/>
Pain	Educational Opportunity
6. Recognize common opioid related side effects.	<input type="checkbox"/>
7. Provide appropriate analgesia for the patient, within scope of practice and based on established protocols or practice guidelines.	<input type="checkbox"/>
8. Utilize pharmacological and non-pharmacological measures to manage pain.	<input type="checkbox"/>
Dyspnea	Educational Opportunity
9. Recognize the subjectivity of dyspnea.	<input type="checkbox"/>
10. Identify possible underlying causes of dyspnea.	<input type="checkbox"/>
11. Provide pharmacological and non-pharmacological interventions for dyspnea.	<input type="checkbox"/>
Psychological Distress	Educational Opportunity
12. Appreciate the challenges of recognizing acute and chronic psychological distress in a patient with advanced disease.	<input type="checkbox"/>
13. Focus on dignity while supporting the patient and family wishes for care.	<input type="checkbox"/>
Gastro-Intestinal Symptoms, Hydration, and Nutrition	Educational Opportunity
14. Identify the patient who may benefit from artificial hydration.	<input type="checkbox"/>
15. Identify possible underlying causes of nausea and vomiting.	<input type="checkbox"/>
16. Assist with and/or support the family to do the patient's oral care.	<input type="checkbox"/>

17. Utilize pharmacological and non-pharmacological measures to manage nausea and vomiting.	<input type="checkbox"/>
Delirium	Educational Opportunity
18. Recognize delirium.	<input type="checkbox"/>
19. Identify and address possible underlying causes of delirium.	
20. Differentiate between delirium and dementia.	<input type="checkbox"/>
21. Utilize pharmacological and non-pharmacological measures to manage delirium.	<input type="checkbox"/>
Last Days and Hours	Educational Opportunity
22. Inquire about spiritual, cultural and religious wishes surrounding last days and hours.	<input type="checkbox"/>
23. Prepare the patient and their family for what to expect in last days and hours.	<input type="checkbox"/>
24. Prepare the patient and their family for potential physiological signs of approaching death.	<input type="checkbox"/>
25. Recognize refractory symptoms.	<input type="checkbox"/>
26. In consultation with online physician, the patient's most responsible physician and primary care team develops an appropriate symptom management plan.	<input type="checkbox"/>
27. Provide comfort measures.	<input type="checkbox"/>
28. Identify the signs of approaching death.	<input type="checkbox"/>
29. Notify appropriate members of the interprofessional team regarding the patient's imminent death.	<input type="checkbox"/>
30. Prepare the patient and their family with steps to take following an expected death in the home.	<input type="checkbox"/>

Notes:

Domain 5: Loss, Grief and Bereavement	
All	Educational Opportunity
1. Identify potential losses that a patient and their family may experience during the course of a life-limiting illness and the dying process.	<input type="checkbox"/>
2. Engage in self-reflection regarding personal responses to one's own grief experiences.	<input type="checkbox"/>

Some	Educational Opportunity
1. Recognize the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief.	<input type="checkbox"/>
2. Assess the patient's and family's loss, grief and bereavement needs.	<input type="checkbox"/>
3. Provide guidance, support, and information to the family and make referral to bereavement services, as required.	<input type="checkbox"/>
4. Identify that health care providers can experience grief related to patient and family care.	<input type="checkbox"/>

Notes:

Domain 6: Professional and Ethical Practice	
All	Educational Opportunity
1. Explore personal beliefs and values that may influence a patient's care.	<input type="checkbox"/>
2. Establish boundaries so as to not infringe or influence the patient's and family's decisions.	<input type="checkbox"/>
3. Respect the patient and their family's rights to informed, evidence based options for life-supporting and life-ending health care.	<input type="checkbox"/>
4. Engage with the patient who is experiencing loss and suffering.	<input type="checkbox"/>
5. Gain knowledge as required of relevant legislation and policies, e.g. Bill C-14, MAID, Children and Family Services Act, Adult Protection Act, Personal Directives Act, Advance Care Planning and Goals of Care Designation Policy and Procedure.	<input type="checkbox"/>
Some	Educational Opportunity
1. Identify that the paramedic work environment may present unique challenges when providing support to a patient with a life-limiting illness.	<input type="checkbox"/>
2. Address ethical and legal issues that may be encountered when caring for a patient with a life-limiting illness.	<input type="checkbox"/>

Notes:

Domain 7: Cultural Safety	
All	Educational Opportunity
1. Respect diverse spiritual, cultural and/or religious beliefs.	<input type="checkbox"/>
2. Recognize that some people may or may not have religious elements to their spirituality.	<input type="checkbox"/>
3. Maintain a respectful attitude to diversity.	<input type="checkbox"/>
4. Support the patient by cultivating an open and non-judgmental environment.	<input type="checkbox"/>
Some	Educational Opportunity
1. Identify the influence of religion, culture, and/or beliefs on key issues in palliative care.	<input type="checkbox"/>
2. Assess the end-of-life needs unique to each patient and family, considering ethnicity, culture, gender, sexual orientation, language, religion, age, ability and preferences.	<input type="checkbox"/>
3. Provide opportunities for the patient and their family to exercise religious, cultural and spiritual rituals, customs, rites and beliefs at end-of-life.	<input type="checkbox"/>

Notes:

Domain 8: Self-Care	
All	Educational Opportunity
1. Practice self-care strategies.	<input type="checkbox"/>
2. Identify one's own psychological distress and poor coping related to participating in the care of a patient with a life-limiting illness.	<input type="checkbox"/>
3. Recognize the potential challenge of transitioning from one's work role to home life on a daily basis.	<input type="checkbox"/>
4. Engage in activities that support one's mental health and coping.	<input type="checkbox"/>
Some	Educational Opportunity
1. Explore own attitudes regarding death, dying and caring for a patient with a life-limiting illness.	<input type="checkbox"/>
2. Recognize the impact of past experiences of suffering, death and dying when providing palliative care.	<input type="checkbox"/>
3. Attend to own emotional responses that result from caring for palliative care patients.	<input type="checkbox"/>
4. Recognize compassion fatigue in self and colleagues.	<input type="checkbox"/>
5. Engage in healthy activities that help prevent compassion fatigue, support one's mental health and coping and promote personal and professional growth.	<input type="checkbox"/>
6. Identify the emotional and spiritual supports available to practitioners.	<input type="checkbox"/>

Domain 9: Education, Research and Evaluation	
All	Educational Opportunity
1. Participate in palliative care continuing education opportunities.	<input type="checkbox"/>
Some	Educational Opportunity
1. Educate the patient and their family about palliative care and a palliative approach.	<input type="checkbox"/>
2. Contribute to the monitoring and evaluation of the quality of palliative care provided by paramedics.	<input type="checkbox"/>
3. Apply knowledge gained from palliative care research.	<input type="checkbox"/>
Few	Educational Opportunity
1. Where possible, lead and facilitate palliative care education and research.	<input type="checkbox"/>
2. Where possible, engage in palliative care education and research.	<input type="checkbox"/>
3. Critically evaluate outcomes against standards and guidelines.	<input type="checkbox"/>
4. Contribute to the evaluation of the quality of palliative care and the effectiveness of the EMS PEOLC ATR program and other programs that support a palliative care patient.	<input type="checkbox"/>
5. Act as an expert in the pre-hospital context, contributing to palliative care system development and service delivery.	<input type="checkbox"/>

Notes:

Domain 10: Advocacy	
All	Educational Opportunity
1. Advocate for the needs, decisions and rights of the patients and their families.	<input type="checkbox"/>
2. Support autonomous decision-making.	<input type="checkbox"/>
Some	Educational Opportunity
1. Promote equitable and timely access to palliative care resources.	<input type="checkbox"/>
Few	Educational Opportunity
1. Advocate for the development, maintenance and improvement of healthcare and social policy related to palliative care.	<input type="checkbox"/>

2. Advocate for paramedics to participate in palliative care continuing education opportunities.	<input type="checkbox"/>
3. Advocate for paramedics to have adequate resources to provide palliative care.	<input type="checkbox"/>
4. Promote advance care planning.	<input type="checkbox"/>
5. Identify organizational issues that affect the delivery of palliative care.	<input type="checkbox"/>
6. Identify points of influence in the health care system that could advance palliative care issues.	<input type="checkbox"/>

Notes:

Appendix 1: Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

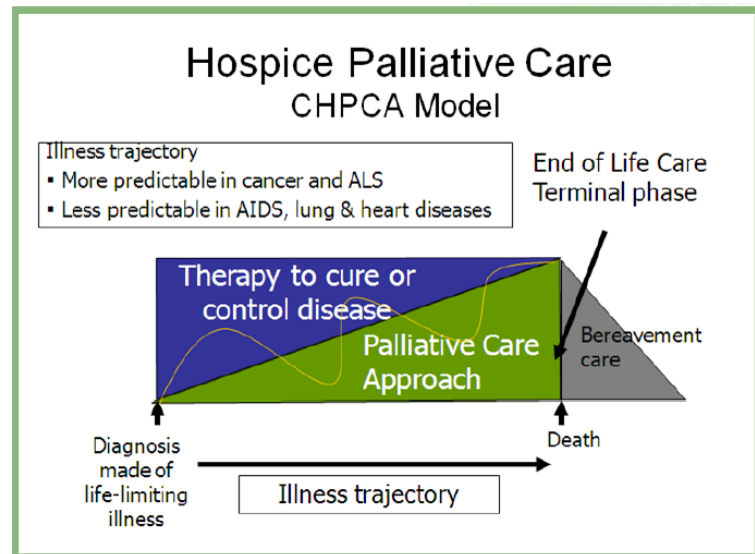
Life-limiting illness. Describes illness where it is expected that death will be a direct consequence of the specified illness. The term "person living with a life-limiting illness" also incorporates the concept that people that are actively living with such illnesses, often for long periods of time,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

Palliative and end-of-life care: is both a philosophy and an approach to care that enables all individuals with a life-limiting and/or life-threatening illness to receive integrated and coordinated care across the continuum. This care incorporates patient and family values, preferences and goals of care, and spans the disease process from early diagnosis to end of life, including bereavement. Palliative care aims to improve the quality of life for patients and families facing the problems associated with a life-limiting illness through the prevention and

relief of suffering by means of early identification, comprehensive interdisciplinary assessments and appropriate interventions [Alberta Health Services].

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

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



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

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

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

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

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

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

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

Appendix 2: Additional Resources

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

- Alberta College of Paramedics. (March 2019). *Standards of practice*.
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- Paramedic Association of Canada. (October 2011). *National occupational competency profile for paramedics*. <http://abparamedics.com/wp-content/uploads/2017/08/2011-10-31-Approved-NOCP-English-Master-003.pdf>

Appendix 3: Acknowledgements

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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 Emergency Medical Services' and Paramedics' Palliative Care Competencies Working Group

Name	Position	Location/Program/Organization
Cheryl Cameron, M.Ed., ACP	Manager, EMS Policy, Standards, and Reporting	Emergency Health Services/Alberta Health
Tyne Lunn, CP	Community Paramedic	North Zone/EMS Mobile Integrated Healthcare (MIH)/Alberta Health Services
Becky Donelon, EdD, MADL, ACP	Chair, Allied Health Programs	Slave Lake/Northern Lakes College
Tim A. Ford, ACP	Registrar	Alberta College of Paramedics
Suzanne Maynard, ACP, BHSc	Manager Learning and Development, EMS	South Zone/Alberta Health Services
Ian MacEwan, ACP, B.Comn	Senior Quality Assurance Strategist Provincial Lead	EMS Palliative and End-of-Life Care Assess Treat Refer Program/Alberta Health Services
Claire Ruzsvanszki, CP, RN	EMS Mobile Integrated Healthcare (MIH) Team Lead	Calgary Zone/Alberta Health Services