Alberta Nurses'

Palliative Care Competency Framework

Registered Nurses (RN), Registered Psychiatric Nurses (RPN), Licenced Practical Nurses (LPN), Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP)

Version 1.0 (September 2020)

A Resource Manual for Health Care Professionals

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

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Dedication

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

Forward

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

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

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

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

Alberta Nurses’ Palliative Care Competencies Referent Group

The Alberta Nurses’ Palliative Care Competencies Referent Group below assisted in recruiting individuals participating in the production of the Alberta Nurses’ Palliative Care Competency Framework. This includes members of the Alberta Palliative Care Competencies Advisory Working Group; Alberta Nurses’ (Registered Nurses (RN), Registered Psychiatric Nurses (RPN), Licensed Practical Nurses LPN)) Palliative Care Competencies Working Group; and the Alberta Advanced Practice Nurses’ 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 Nurses’ Palliative Care Competencies Referent Group

Health Care Organizations	Educational Institutions
• Alberta Health Emergency Medical Services • Capital Care Norwood Palliative Care Unit, Edmonton Alberta Health Services • 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 Covenant Health • Bonnyville Health Centre_Professional Practice and Research • Misericordia Community Hospital, Edmonton • Tertiary Palliative Care Unit, Grey Nuns Community Hospital, Edmonton	• Athabasca University Faculty of Health Disciplines • Bow Valley College School of Health and Wellness MacEwan University • Centre for Professional Nursing Education • Faculty of Nursing University of Alberta • Faculty of Nursing • Faculty of Medicine and Dentistry University of Calgary • Department of Family Medicine • Department of Oncology • Faculty of Nursing
	Professional Regulatory Bodies and Associations
	• College and Association of Registered Nurses of Alberta • College of Licensed Practical 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 Nurses' 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 Nurses' Palliative Care Competency Framework which was developed by the Alberta Nurses' (Registered Nurses (RN), Registered Psychiatric Nurses (RPN), Licensed Practical Nurses LPN)) Palliative Care Competencies Working Group; and the Alberta Advanced Practice Nurses' Palliative Care Competencies Working Group.

Competency statements are organized according to the following two dimensions:

1. Level of expertise
2. Competency domains

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[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

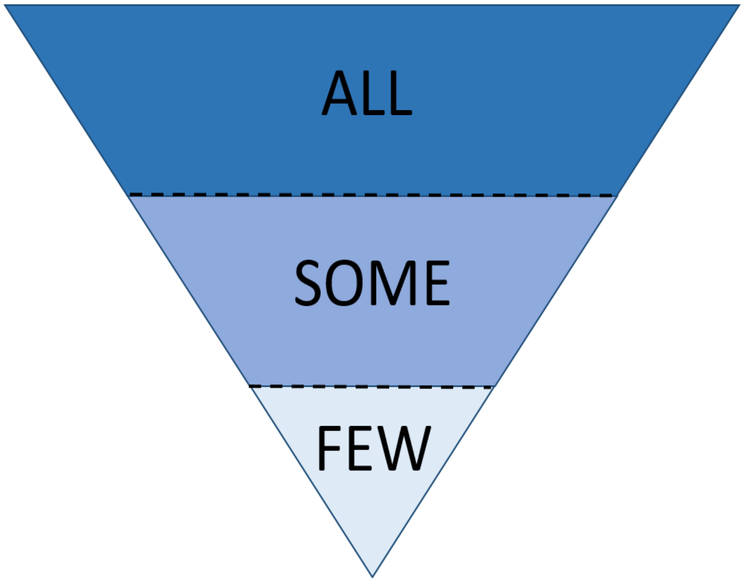


Table 1: Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions
All: HCPs in this level provide care within their scope of practice, to any person in any care setting, including those with life-limiting illnesses. They have foundational knowledge and skills in palliative care. This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

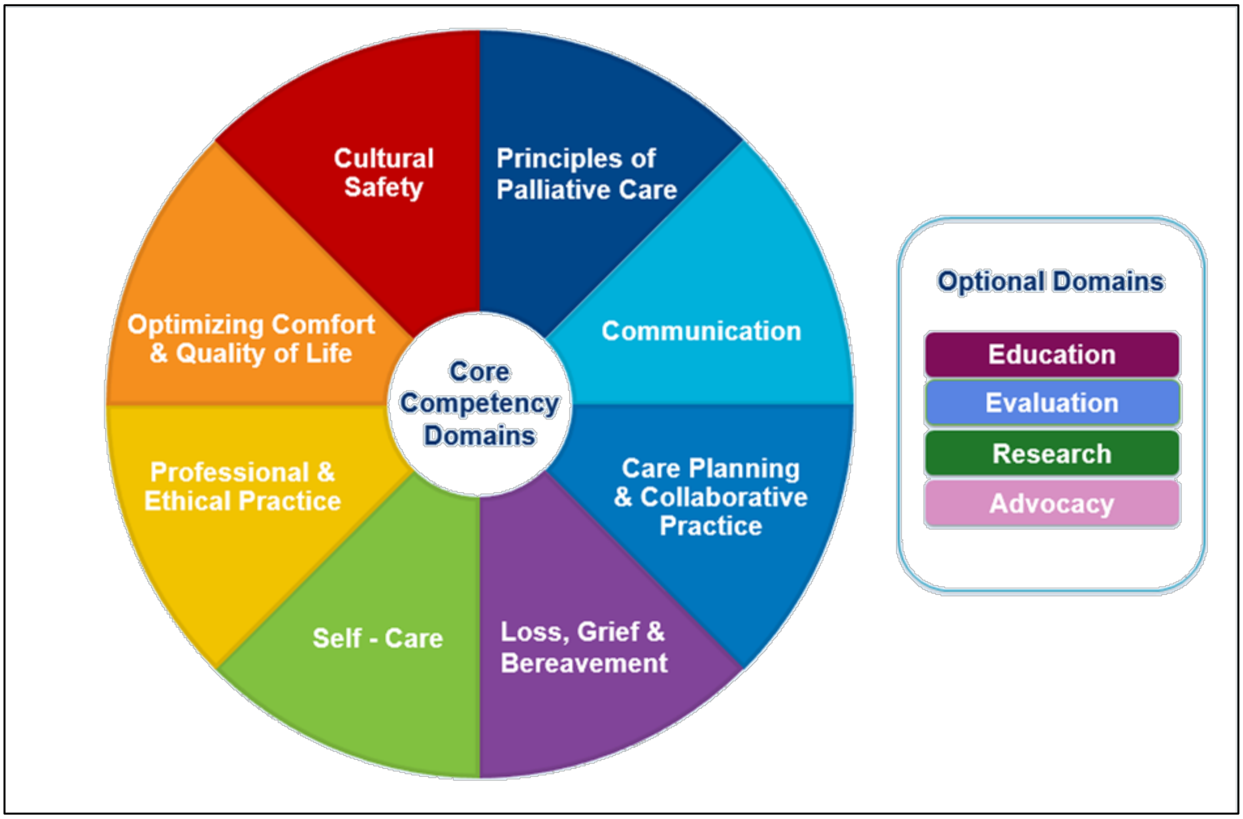
Table 1 Continued: Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions
Some: These HCPs have deeper knowledge, understanding and application of palliative and end-of-life care. HCPs in this level also provide care in any setting. They have expertise in palliative and end-of-life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

Domain 1: Principles of Palliative Care	
All	**Educational Opportunity**
1. Demonstrate an understanding of the philosophy of palliative care including a palliative approach.	☐
2. Demonstrate an understanding that a palliative approach starts early in the illness trajectory of a progressive life-limiting illness.	☐
3. Identify the patient who would benefit from a palliative approach early in their illness trajectory.	☐
4. Identify and support the patient with a progressive life-limiting illness and their family beginning at time of the palliative care diagnosis.	☐
5. Provide a holistic interprofessional team approach that is patient- and family-centered and in alignment with the patient’s and family’s priorities, values and choices in the provision of care.	☐
6. Conserve patient dignity by facilitating expression of needs, hopes, feelings and concerns in providing and planning palliative care.	☐
7. Facilitate empathic and responsive relationships between the patient experiencing a life-limiting illness, their family and the interprofessional team.	☐
8. Describe common illness trajectories related to life-limiting illnesses.	☐
9. Recognize that the patient and their family may experience varying emotions related to the diagnosis and progression of the patient’s life-limiting illness.	☐
10. Explore own responses in the presence of a patient who is suffering.	☐
Additional Competencies Shared by the CNS and NP:	
11. Identify the various phases of palliative care from the time of diagnosis of a life-limiting illness to the end-of-life.	☐
12. Recognize the role of primary and acute care in the provision of palliative care across a variety of settings.	☐
13. Address beliefs and attitudes of society and health care providers that may prohibit access to palliative care.	☐
14. Address misperceptions that patients, families and health care providers may have of palliative care.	☐
15. Explore the impact of a life-limiting illness on the different facets of a patient’s life and the lives of their family.	☐
16. Address barriers to the provision of palliative care.	☐
17. Describe diverse societal perspectives on dying and death.	☐
18. Identify the beliefs and attitudes of society and health care providers towards palliative care.	☐

Few	**Educational Opportunity**
1. Contribute to the development of practice support tools to assist in the identification of patients who may benefit from a palliative approach.	☐

Notes:

Domain 2: Communication	
All	**Educational Opportunity**
1. Demonstrate an understanding of the essential role communication plays in palliative care.	☐
2. Demonstrate an understanding that communication regarding palliative care is an on-going collaborative process.	☐
3. Introduce the patient and their family to the concept of palliative care as the main focus of care or combined with other disease modifying treatments.	☐
4. Nurture hope in a way that is congruent with the trajectory of the life-limiting illness and the patient's goals of care.	☐
5. Explore the patient's and family's understanding of the patient's life-limiting illness and its trajectory.	☐
6. Review and clarify the patient's and family's understanding of palliative care information presented by other members of the interprofessional team.	☐
7. Effectively communicate with the patient and their family to devise a care plan for the patient's palliative care needs and communicate the plan to the interprofessional team.	☐
8. Describe the importance of life legacy work in palliative care and support the patient to explore related therapeutic activities, when identified as an appropriate intervention.	☐
9. Use a variety of strategies to engage in ongoing compassionate, individualized and timely communication with the patient and their family.	☐
10. Use developmentally and cognitively appropriate communication approaches during conversations with the patient and their family.	☐
11. Assess the need for specialist communication supports (e.g. interpreter, sign language interpreter and assistive technology).	☐

12. Identify the patient's and family's information needs and preferences regarding diagnosis, prognosis and disease progression.	☐
13. Determine and support decisions regarding the extent to which the patient desires to be involved in their own care.	☐
14. Demonstrate an understanding of the multidimensional communication challenges that may arise when caring for a patient with a life-limiting illness.	☐
15. Identify potential barriers that may affect communication of clinical information and the patient’s changing health status to the patient with a life-limiting illness and their family.	☐
16. Provide the patient and their family with time to discuss their fears and concerns.	☐
17. Discuss the patient’s Advance Care Planning (ACP) and Goals of Care Designation (GCD) preferences with the patient, family, and the interprofessional team.	☐
18. Demonstrate empathy for the patient and their family who are not accepting of the prognosis.	☐
19. Respond to concerns regarding “starving or dehydrating” at end-of-life.	☐
20. Discuss organ, tissue and body donation.	☐
21. Demonstrate self-awareness of one’s own responses to communication challenges and remain engaged in meaningful contact with the patient and their family.	☐
Additional Competencies Shared by the CNS and NP:	
22. Describe approaches to effectively and compassionately communicate sensitive information about the patient’s illness to the patient and their family, including clinical updates and changing status.	☐
23. Lead patient and family meetings.	☐
24. Respond to a patient’s and family’s questions regarding expected time of death.	☐
25. Periodically review goals of care, particularly when changes occur in the disease status and functional level.	☐
26. Assess prognosis and trajectory of a life-limiting illness on an ongoing basis.	☐
27. Discuss prognosis and trajectory of a life-limiting illness on an ongoing basis.	☐
28. Present the patient with care and treatment options with their anticipated benefits, burdens and risks, considering the patient’s goals of care.	☐
29. Inform the patient and family of progression of illness and associated complications.	☐
30. Distinguish between withholding and withdrawing treatment versus ‘withdrawal of care’ understanding that withdrawal of care is unethical and should never occur.	☐
31. Address unrealistic expectations regarding prognosis and treatment options.	☐
Additional Competencies for the NP:	
32. Establish a GCD Order.	☐
Some	**Educational Opportunity**
1. Describe the role of patient/family meetings with the patient and their family.	☐
2. Facilitate the opportunity for the patient to conduct a therapeutic life review.	☐
3. Respond to and explore any family requests not to share information with the patient regarding diagnosis, prognosis and other information.	☐

4. Explore expectations regarding prognosis and treatment options with the patient, their family and interprofessional team.	☐
5. Support the patient and their family who are transitioning from life prolonging/sustaining interventions to a palliative approach.	☐
6. Discuss preferred setting of care and death with the patient and their family.	☐
7. Recognize the potential for conflict in palliative care decision-making and explore approaches to enhance communication toward an effective resolution.	☐
Additional Competencies Shared by the CNS and NP:	
8. Demonstrate an ability to effectively and compassionately communicate clinical information and updates on the patient's changing status with the patient and their family.	☐
9. Discuss issues of truth-telling for the patient with a life-limiting illness, including the influence of cultural issues.	☐
10. Discuss withholding and withdrawing treatments to ensure that treatment decisions are informed and align with identified goals of care.	☐
11. Demonstrate competence using the Palliative Performance Scale (PPS) as a way to communicate with the interprofessional team the patient's status, based on five observable parameters: degree of ambulation; ability to do activities and extent of disease; ability to do self-care; food and fluid intake; and level of consciousness.	☐
Few	**Educational Opportunity**
1. Discuss care and treatment options with the patient, their family and interprofessional team, along with the anticipated benefits, burdens, and risks of those options, while considering the patient's goals of care.	☐
Additional Competencies for the CNS and NP:	
2. Facilitate ongoing discussions regarding goals of care, end-of-life decision-making and informed consent.	☐

Notes:

Domain 3: Care Planning and Collaborative Practice	
All	**Educational Opportunity**
1. Demonstrate an understanding of the ACP and GCD Policy and Procedure and the Personal Directives Act, and support the patient’s wishes and/or revisions of their ACP/GCD.	☐
2. Participate in ACP discussions and document discussions on the ACP/GCD Tracking Record form.	☐
3. Participate in patient/family care meetings.	☐
4. Facilitate, encourage and respect the involvement of the patient and their family in discussions regarding the care plan.	☐
5. In collaboration with the interprofessional team, identify the strengths and needs of the patient and their family when defining goals of care; and when developing, implementing and evaluating a care plan.	☐
6. When developing and modifying the care plan, collaborate with the patient, their family, and other members of the interprofessional team to access information and resources to address physical, practical, psychological, social, emotional, cultural and spiritual needs.	☐
7. Contribute to the overall functioning and well-being of the interprofessional team.	☐
8. Collaborate with other health care providers to support efficient transitions of care between institutions, settings, services, and teams.	☐
9. Facilitate patient and family access to needed services and resources.	☐
10. Ensure that interprofessional team members are up to date with current and accurate patient and family information.	☐
11. Provide relevant information and resources to the patient and their family.	☐
12. Identify the components of a holistic interprofessional patient record.	☐
13. Discuss the importance of routine, interprofessional monitoring of the treatment care plan for the patient with a life-limiting illness and their family.	☐
14. Describe the key roles of other health care professionals in caring for a patient and their family.	☐
15. Incorporate the veteran's military service and related potential benefits into palliative care planning, if applicable (e.g. through the Department of Veteran’s Affairs).	☐
16. Assess and consider preferred language, health literacy, health literacy and financial literacy and barriers.	☐
Additional Competencies Shared by the CNS and NP:	
17. Identify the need for Home Care and Palliative Care Nurses to have rapid access to Primary Care Physicians, NPs and Specialists.	☐
18. Demonstrate awareness that the care and decision-making provided by physicians, NPs, and other interprofessional team members may be influenced by their ongoing experiences of loss, both personal and professional.	☐

19. Demonstrate appropriate referral, consultation and communication with the interprofessional team involved in caring for the patient with a life-limiting illness and their family.	☐
20. Promote the role the advance practice nurse has in caring for a palliative care patient and their family.	☐
21. Assist in the development and discussion of goals of care, including discussing and developing a Personal Directive with the patient with a life-limiting illness and their family.	☐
22. Develop a patient-centered, holistic symptom management plan.	☐
Additional Competencies for the NP:	
23. Establish a communication system plan to address urgent situations encountered by Home Care and Palliative Care nurses.	☐
24. Provide or arrange for after-hours coverage of the patient.	☐
Some	**Educational Opportunity**
1. Coordinate care and facilitate referrals to appropriate interprofessional team members and other support services including referral to the Palliative Care Consult Team, if required.	☐
2. When able, plan for care in the patient's preferred setting, while recognizing the complexities and challenges that may be involved for the patient and their family.	☐
Few	**Educational Opportunity**
1. Lead patient/ family meetings.	☐
2. Act as an expert resource regarding the role of discipline specific interventions in symptom management and optimizing quality of life.	☐
3. Support members of the interprofessional team and provide information and resources to address the patient's and family's physical, practical, psychological, social, emotional, cultural and spiritual care needs.	☐
Additional Competencies for the CNS and NP:	
4. Initiate referrals to address and manage psychological, social, spiritual and cultural needs issues.	☐
5. Provide consultation support to the Palliative Care Consult Team and other members of the interprofessional team.	☐
6. Apply knowledge, including interpretation of screening tools, to the diagnosis and management of depression, anxiety, distress, delirium and quality of life issues.	☐

Notes:

Domain 4: Optimizing Comfort and Quality of Life	
All	**Educational Opportunity**
1. Integrate “quality of life”, as defined by the patient, as a key outcome of care.	☐
2. Demonstrate understanding of how a palliative approach can enhance the assessment and management of symptoms.	☐
3. Participate in evidence-based holistic interprofessional symptom management.	☐
4. Understand common symptoms, including but not limited to: ☐ Anorexia ☐ Anxiety ☐ Appetite ☐ Cachexia ☐ Constipation ☐ Delirium ☐ Depression ☐ Diarrhea ☐ Drowsiness ☐ Dyspnea ☐ Fatigue ☐ Nausea ☐ Pain ☐ Vomiting ☐ Well-being	☐
5. Demonstrate knowledge of the pathophysiology of common symptoms.	☐
6. Regularly screen for symptoms and needs.	☐
7. Apply techniques for symptom assessment on an ongoing basis.	☐
8. Use standardized instruments and tools to regularly screen and assess symptoms and needs.	☐
9. Discuss, teach, and assist the patient and their family with the management of symptoms.	☐
10. Use investigations appropriately, considering the risks and benefits related to the patient’s comfort, quality of life, goals of care and trajectory of the life-limiting illness.	☐
11. Evaluate symptom management outcomes against baseline assessment.	☐
12. Recognize that symptoms and symptom meaning is subjective and should be assessed and understood from a patient and family-centered care perspective.	☐
13. Use non-pharmacological symptom management strategies to promote comfort and quality of life.	☐
14. Recognize conditions that constitute emergencies.	☐
15. Identify priorities and concerns in collaboration with the patient and their family, taking into account their coping strategies and perception(s) of diagnosis.	☐
16. 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.	☐
17. Recognize and promote ways in which the patient can be engaged in autonomy and self-management of their condition.	☐
18. Support the patient, family, Alternate Decision Maker (ADM), and health care teams with palliative and end-of-life care decision making, including withdrawing or withholding life prolonging and/or sustaining interventions.	☐
19. Identify patients who would benefit from Emergency Medical Services Palliative and End of Life Care Assess, Treat and Refer (EMS PEOLC ATR) Program.	☐

Additional Competencies Shared by the CNS and NP:	
20. Demonstrate a patient and family-centered and interprofessional approach to assessing symptoms in patients with an advanced progressive illness.	☐
21. Describe the role of the patient, their family and interprofessional care team in monitoring treatment plans.	☐
22. Offer support to patients in their end-of-life journey and make recommendations for family members to access community or professional support after the death.	☐
23. Perform ongoing care needs and symptom management assessments throughout the trajectory of a life-limiting illness.	☐
24. Assess symptoms effectively by conducting a thorough history, appropriate physical exam and relevant investigations.	☐
25. Ensure treatment plans are consistent with the patient's goals of care, Advance Care Plan (ACP), Personal Directive and the trajectory of the life-limiting illness.	☐
26. Periodically review clinical interventions, including medications, to ensure congruence with goals of care and the illness trajectory.	☐
27. Discuss appropriate/relevant investigations of symptoms.	☐
28. Recognize "total pain", where physical, psychological, social, emotional and spiritual concerns each contribute to the pain experience.	☐
29. Ensure that the World Health Organization approach to the management of pain is incorporated into patient care.	☐
30. Monitor the efficacy of treatment plans for symptoms.	☐
31. Apply a comprehensive understanding and use of non-pharmacological interventions.	☐
32. Recognize the risks of Post-Traumatic Stress Disorder (PTSD) and its impact on patients and family members at end-of-life.	☐
33. Use non-pharmacologic interventions as first line therapy for treating neuropsychiatric symptoms knowing pharmacologic interventions have limited efficacy in treatment of dementia and neuropsychiatric symptoms.	☐
34. Address comfort and support needs for the veteran and their family during the palliative care journey.	☐
Additional Competencies for the NP:	
35. Manage common symptoms in advanced illness, including but not limited to: pain, fatigue, cachexia, anorexia, constipation, dyspnea, nausea, vomiting, delirium, anxiety and depression**.**	☐
36. Identify opportunities to modify the symptom management strategy according to effectiveness, side-effects, patient preferences and the stage of illness.	☐
37. Manage conditions that constitute emergencies in palliative care patients.	☐
Pain Management	
38. Discuss routes of opioid administration.	☐
39. Recognize "total pain", where physical, psychological, social, emotional and spiritual concerns each contribute to the pain experience.	☐
40. Distinguish pain classifications as they relate to effective pain management.	☐

41. Address patient and family fears, concerns and/or myths about opioids.	☐
42. Recognize that opioid dosing is not equivalent between different formulations of opioids.	☐
43. Describe safe storage and disposal of opioids.	☐
44. Demonstrate understanding of the potential barriers to providing pain management.	☐
45. Describe common side effects of opioids and an approach to their management that includes anticipation and prevention of side effects.	☐
46. Explain the concepts of tolerance, physical dependence and addiction as they relate to the use of opioids in palliative care.	☐
Additional Competencies Shared by the CNS and NP:	
47. Describe responsible prescribing of opioids.	☐
48. Identify potential risk factors for opioid use disorder, including topics such as abuse, addiction and/or diversion.	☐
49. Describe the use of adjunct medications in symptom management.	☐
50. Describe how pharmacokinetics and pharmacodynamics impact the choice of opioids, including patient specific considerations such as age, weight, frailty, prior exposure and renal and hepatic function.	☐
Additional Competencies for the NP:	
51. Propose opioid therapies, including effective prescribing, titration, breakthrough dosing and prevention of side-effects based on best practice and available evidence.	☐
52. Describe an appropriate prescription for an opioid naïve patient including breakthrough dosing.	☐
53. Identify strategies to manage opioid-induced neurotoxicity versus overdose.	☐
54. Describe appropriate approaches to opioid titration for the patient with palliative care needs.	☐
Assess and Manage Gastrointestinal Events	
55. Assess the patient for symptoms of partial or complete bowel obstruction.	☐
56. Explore the patient's and their family's concerns regarding appetite and weight loss.	☐
57. Explore the patient's and their family's concerns related to common gastrointestinal symptoms associated with a life-limiting illness.	☐
Assess and Manage Bleeding and Thrombo-Embolic Events	
58. Ensure the care plan includes interventions to manage a major hemorrhage, if the patient is at risk.	☐
Assess and Address Psychosocial, Spiritual and Existential Needs	
59. Describe the psychosocial and spiritual issues that a patient with a life-limiting illness and their family may experience.	☐
60. Conduct an assessment of the patient's and family's emotional, psychological, social, spiritual and practical strengths and needs, to address and support them as they advance on the palliative care continuum.	☐

61. Participate in care planning to address psychosocial and spiritual issues in collaboration with other disciplines.	☐
62. Use strategies that promote personal and spiritual growth through living with a life-limiting illness.	☐
63. Assess and manage depression and anxiety.	☐
Additional Competencies Shared by the CNS and NP:	
64. Develop and propose a care plan to address psychosocial and spiritual issues in collaboration with the interprofessional team.	☐
65. Describe the incidence and how to screen and diagnosis depression and other mood disturbances in a patient with palliative care needs.	☐
66. Describe the features of dignity conserving care.	☐
Complementary Alternative Medicine	
67. Respect the patient’s decision to use Complementary Alternative Medicine (CAM).	☐
68. Encourage the patient to share CAM use with the interprofessional team to assess compatibility and safety.	☐
69. Reinforce the importance of accurate information and open communication regarding CAM when communicating with the patient, their family and the interprofessional team.	☐
Palliative Sedation	
70. For care involving palliative sedation, use a standardized tool to assess and monitor a patient’s level of sedation.	☐
Additional Competencies for the CNS and NP:	
71. Identify the patient who could benefit from palliative sedation for the management of refractory symptoms at end-of-life.	☐
72. Ensure all criteria are met prior to initiating palliative sedation.	☐
73. Collaborate with the Palliative Care Consult Team to assist with the provision of palliative sedation.	☐
74. Develop a palliative sedation treatment plan consistent with the patient’s goals of care and trajectory of the life-limiting illness.	☐
75. Assess the patient’s response to palliative sedation.	☐
Additional Competencies for NP:	
76. Utilize the Alberta Health Services Provincial Clinical Knowledge Topic, Palliative Sedation, Adult – All Locations, when initiating and prescribing palliative sedation.	☐
Last Hours to Days of Life	
77. Educate the family on what to expect at end-of-life, including the signs of imminent death and associated comfort measures.	☐
78. Explore the range of options regarding care location considering the patient’s wishes.	☐

79. Manage the care needs of the dying patient, including communicating with and supporting their family members.	☐
80. Anticipate, identify and respond to the signs of imminent death.	☐
81. List common medications used for control of symptoms at end-of-life.	☐
Additional Competencies for the NP:	
82. Identify situations when the medical examiner must be contacted.	☐
83. Describe the steps needed to pronounce death.	☐
Some	**Educational Opportunity**
1. Identify and address psychosocial, spiritual, and existential needs.	☐
2. Act as resource for the interprofessional team regarding symptom management and optimizing quality of life.	☐
3. Demonstrate enhanced knowledge and skill in holistic assessment and management of symptoms.	☐
4. Demonstrate a patient and family-centered and interprofessional approach to assessing symptoms in a patient with an advanced progressive illness.	☐
5. Describe the role of the patient, their family and interprofessional care team in monitoring treatment plans.	☐
6. Demonstrate a comprehensive knowledge of common symptom management medications, potential side effects, interactions, and/or complications (e.g. opioid neurotoxicity).	☐
7. Demonstrate an enhanced understanding of the principles of safe practice of administration and adjustment of opioids including resources such as equianalgesic conversion tables.	☐
8. Identify the indications for opioid rotation.	☐
9. Demonstrate an in-depth understanding of non-pharmacological interventions.	☐
10. Where possible and appropriate, identify underlying etiology, contributing factors, and reversible measures related to signs and symptoms.	☐
11. Manage difficult to control symptoms and refer to appropriate health care professionals, as needed.	☐
12. Support others to distinguish between difficult to manage symptoms and refractory symptoms.	☐
13. Assess and discuss the benefits, burdens, and risks of clinical interventions with the patient and their family.	☐
14. Explain anorexia-cachexia syndrome and the risks and benefits related to various treatment options, while considering the patient's illness trajectory.	☐
15. Identify reversible versus non-reversible causes of fatigue.	☐
16. Describe the benefits and limitations of artificial hydration and nutrition.	☐

17. Address upper and lower airway secretions and coughing, and refer to the appropriate health care professional as needed.	☐
18. Identify, assess, and manage palliative care emergencies and refer to the appropriate health care professional as needed.	☐
19. Implement an enhanced care plan related to palliative care emergencies that is consistent with the goals of care and trajectory of the life-limiting illness.	☐
20. Support others to anticipate and identify emergencies at the end-of-life.	☐
21. Assess and recognize the patient for whom palliative sedation may be appropriate.	☐
22. Describe the ethical considerations regarding palliative sedation.	☐
23. Ensure the ethical tenets of palliative sedation are applied to patient care.	☐
24. Identify indications for palliative sedation.	☐
25. Explore and address any concerns related to the patient's sexual health.	☐
26. Offer support to the patient in their palliative care journey and make recommendations for family members to access community or professional supports.	☐
27. Recognize the risks of PTSD and its impact on the patient and their family members at the end-of-life.	☐
28. Address the comfort and support needs for the veteran and their family during the palliative care journey and provide recommendations for community or professional support for the family.	☐
29. Describe the use of adjunct medications in symptom management.	☐
30. Assess the patient’s response to palliative sedation.	☐
31. Complete a palliative care assessment.	☐
32. Describe the prevalence and impact of common symptoms patients with a life-limiting illness may experience (refer to symptoms listed in Optimizing Comfort and Quality of Life: All).	☐
33. Describe potential issues in the identification and treatment of symptoms across the spectrum of developmental, cognitive and physical abilities.	☐
34. Understand the multiple forms of cognitive impairment in order to optimize symptom management.	☐
35. Attend to multi-dimensional sources of suffering.	☐
36. Describe the elements of suffering a palliative care patient and their family may experience.	☐
37. Describe a supportive approach to addressing multi-dimensional sources of suffering in the patient and their family.	☐
Additional Competencies Shared by the CNS and NP:	
38. Integrate palliative care with survivorship care related to recurrent disease and long term disease management.	☐

39. Utilize adjuvant modalities and medications for pain management.	☐
Few	**Educational Opportunity**
1. Apply comprehensive knowledge and understanding of the clinical presentation and disease trajectories of life-limiting illnesses when responding to complex and multidimensional care needs.	☐
2. Draw from advanced education, knowledge and skills in palliative care to deliver holistic patient-centered care.	☐
3. Use research and evaluation methods to determine evidence of best practice as a rationale for symptom assessment and care interventions.	☐
4. Recognize the potential impact of CAM for symptom management.	☐
5. Demonstrate in-depth understanding of pharmacological use and physiological effects of adjuvant medications in managing symptoms.	☐
6. Utilize risk assessment tools, interviewing and observation to help identify patients with substance use disorders and to recommend supportive and management strategies.	☐
7. Manage reversible versus non-reversible causes of appetite loss.	☐
8. Identify the patient who could benefit from artificial hydration and/or and nutrition and those who would not.	☐
9. Recommend evidence-based interventions for the patient with advanced disease who is experiencing fatigue.	☐
Additional Competencies Shared by the CNS and NP:	
10. Describe the role of treatment options in the management of symptoms.	☐
11. Monitor analgesic response, activities of daily living, adverse events and atypical behaviors especially with patients known to have substance use disorders.	☐

Notes:

Domain 5: Loss, Grief and Bereavement	
All	**Educational Opportunity**
1. Demonstrate knowledge of grief and bereavement to support the patient with a life-limiting illness and their family, from a cross-cultural perspective.	☐
2. Demonstrate a basic understanding of the needs of family and friends, including children at various developmental stages, in dealing with grief and loss.	☐
3. Recognize the range of individual physical, psychological, spiritual, emotional, cultural, religious and social responses to loss and grief and that grief responses are unique to each person.	☐
4. Recognize the types and manifestations of grief.	☐
5. Assess the patient's and family's loss, grief and bereavement needs.	☐
6. Assist the family in understanding the concepts of loss and the processes of grief and bereavement, considering developmental stages and referring to members of the interprofessional team and specialists, within scope of practice.	☐
7. Provide guidance, support and information to the patient and their family and refer to grief and bereavement services, as required.	☐
8. Identify, manage and support the patient and their family throughout the continuum of loss, grief, and bereavement referring to the interprofessional team that may include the Palliative Care Consult Team.	☐
9. Refers the patient and their family to appropriate resources.	☐
Some	**Educational Opportunity**
1. Demonstrate an enhanced knowledge of loss, grief and bereavement.	☐
2. Demonstrate knowledge of models of grief and bereavement.	☐
3. Demonstrate an enhanced understanding of the needs of family and friends, including children at various developmental stages, experiencing grief, loss and bereavement.	☐
4. Recognize the differences between depression and grief and refer the patient and/or family to the interprofessional team and specialists, as needed.	☐
5. Identify persons at risk for complicated grief.	☐
6. Describe the impact of developmental stage and cognitive functioning on the understanding of dying, death and manifestations of grief.	☐
7. Proactively respond to complex grief reactions and processes and refer to specialty supports, when needed.	☐
8. Assist the family in understanding the concepts of loss, grief and bereavement, considering developmental stages, and refer as needed.	☐
9. Support the patient and their family experiencing pathological responses to grief, referring to other resources (e.g. grief support groups, psychology, counselors), as needed.	☐

Additional Competencies for the CNS and NP:	
10. Describe the features of anticipatory grief, normal grief and atypical grief as defined by current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria, including risk factors for atypical grief.	☐
Few	**Educational Opportunity**
1. Demonstrate a specialized understanding of the needs of family and friends, including children at various developmental stages, in dealing with grief and loss.	☐

Notes:

Domain 6: Professional and Ethical Practice	
All	**Educational Opportunity**
1. Anticipate and address ethical and legal issues that may be encountered when caring for a patient with a life-limiting illness and their family.	☐
2. Identify situations where personal beliefs, attitudes and values limit one's ability to be present and provide patient care.	☐
3. Respect the patient's decision regarding initiating, not initiating, withholding and withdrawing life-sustaining treatment (e.g. dialysis, resuscitation, hydration and nutrition support).	☐
4. Demonstrate knowledge and understanding of professional, legal, moral and ethical codes of practice related to the Personal Directives Act, advance care plans, palliative sedation, Medical Assistance in Dying (MAID) and withdrawing and withholding of life-sustaining therapies.	☐
5. Respond to inquiries regarding MAID in accordance with scope of practice, relevant guidelines, standards and policies of their professional regulatory body and organization.	☐
6. Apply palliative care standards, guidelines, principles and policies to care.	☐
7. Demonstrate leadership that fosters and enhances caring environments.	☐

Additional Competencies for the CNS and NP:	
8. Address palliative care decision making and planning using a bioethical and legal framework.	☐
Some	**Educational Opportunity**
1. Mentor and educate colleagues about professional and ethical practice in palliative care.	☐
2. Demonstrate leadership by applying a palliative approach.	☐
3. Ensure the family and the interprofessional team understand when and how to safely remove medications from the patient’s home.	☐
4. Facilitate patient enrollment in palliative care benefits.	☐
Few	**Educational Opportunity**
1. Facilitate discussion and resolution of complicated ethical and legal issues in conjunction with the patient, their family and interprofessional team.	☐
2. Apply evidence based research to develop and update professional and ethical practice guidelines, policies and processes related to palliative care.	☐

Notes:

Domain 7: Cultural Safety	
All	**Educational Opportunity**
1. Describe the influence of culture on key issues in palliative care.	☐
2. Demonstrate a willingness to learn cultural beliefs and customs related to palliative care.	☐
3. Assess and address the unique needs of each patient with a life-limiting illness, along with the family's needs, by considering ethnicity, culture, race, spirituality, religion, gender, sexual orientation, language, religion, age, ability and preferences.	☐
4. Demonstrate respect and sensitivity to social, spiritual, and cultural values and practices that may influence preferences of the patient and their family.	☐
5. Explore the patient's and family's cultural and religious needs, beliefs and preferences as they relate to palliative care.	☐
6. Recognize and respect who the patient identifies as family.	☐
7. Provide opportunities for the patient and their family to participate in cultural and/or religious practices, referring to other members of the interprofessional team, as required.	☐
Some	**Educational Opportunity**
1. Mentor and educate colleagues about cultural safety and cultural humility in palliative care.	☐

Notes:

Domain 8: Self-Care	
All	**Educational Opportunity**
1. Explore one's own attitudes and beliefs regarding death, dying and caring for a patient with a life-limiting illness and their family and attend to one's own responses.	☐
2. Demonstrate an awareness of ways to manage and cope with the impact of a patient's diagnosis, dying, and death.	☐
3. Engage in self-care activities.	☐
4. Identify the impact of past experiences of suffering, death and dying when caring for a patient with a life-limiting illness and their family.	☐
5. Contribute to and foster a team environment of caring and support by recognizing compassion fatigue in oneself and colleagues, and engaging in health activities including accessing counselling services, self-care, work-life balance and other supportive services, when needed.	☐
Some	**Educational Opportunity**
1. Mentor and educate colleagues regarding the personal impact of loss, grief and bereavement, supporting them to recognize their own loss responses and encouraging engagement in activities to maintain their resilience on an on-going basis (e.g. staff debriefing following a patient's death).	☐

Notes:

Domain 9: Education, Research and Evaluation	
All	**Educational Opportunity**
1. Participate in palliative care continuing education opportunities.	☐
2. Educate the patient, their family, and the interprofessional team regarding palliative care and a palliative approach.	☐
3. Advocate for educational needs and equitable access to palliative care education opportunities.	☐
4. Apply knowledge from palliative care research.	☐
5. Where possible and appropriate, provide patients, families and members of the interprofessional team with opportunities to participate in research.	☐
Additional Competencies for the CNS and NP:	
6. Support the development of education related to palliative care competencies for health care providers and nursing students.	☐
Some	**Educational Opportunity**
1. Identify the potential opportunities for and barriers to research unique to palliative care.	☐
2. Promote awareness of palliative care by providing education on the philosophy, values, principles, practices and competencies of palliative care.	☐
3. Advocate for health care providers to participate in palliative care continuing education opportunities.	☐
4. Demonstrate supportive leadership by mentoring health care providers with less experience, knowledge and skills in palliative care.	☐
Additional Competencies for the CNS and NP:	
5. Lead educational workshops related to palliative care competencies for health care providers and nursing students.	☐
Few	**Educational Opportunity**
1. Develop, facilitate, and provide palliative care related education, leadership and mentorship to members of the nursing discipline and students.	☐
2. Lead, facilitate, and engage in quality improvement, evaluation and research in palliative care.	☐
3. Contribute to the development and advancement of palliative care research, evaluation, education, standards, guiding principles and policies.	☐
4. Advocate for health care providers to have access to adequate resources to provide palliative care.	☐
5. Advocate for health care providers to participate in palliative care continuing education opportunities.	☐
6. Advocate for the development, maintenance and improvement of health care and social policy related to palliative care.	☐

Notes:

Domain 10: Advocacy	
All	**Educational Opportunity**
1. Act as an advocate and mediator for the patient and their family in accessing appropriate and timely palliative care.	☐
2. Respond to the needs of vulnerable and marginalized populations.	☐
Additional Competencies for the CNS and NP:	
3. Identify vulnerable and marginalized populations.	☐
4. Participate in organizations which advocate for equitable, accessible, safe and quality palliative care.	☐
Some	**Educational Opportunity**
1. Advocate for health care providers to have equitable access to adequate resources to provide palliative care.	☐
2. Promote ACP/GCD conversations, documentation and education.	☐
3. Identify vulnerable and marginalized populations.	☐
4. Participate as a member of organizations which advocate for equitable, accessible, safe and quality palliative care.	☐
Additional Competencies for the CNS and NP:	
5. Identify barriers to providing palliative care for vulnerable or marginalized populations.	☐
6. Identify organizational issues that affect the delivery of palliative care.	☐
7. Describe how changes in legislation could affect patients with palliative care needs and their families.	☐
8. Describe the moral, ethical and professional issues inherent in health care advocacy related to palliative care.	☐

Few	**Educational Opportunity**
1. Actively influence and promote palliative care strategic initiatives and policy development.	☐
2. Advocate for the development, maintenance and improvement of health care, social policy and education related to palliative care.	☐
3. Describe how legislation, funding and structure of the health care system could affect the delivery of palliative care.	☐
4. Contribute to identifying current and prospective issues in palliative care at a system level.	☐
5. Identify barriers to providing palliative care for vulnerable or marginalized populations.	☐
6. Identify organizational issues that affect the delivery of palliative care.	☐
7. Describe how changes in legislation, changes in funding and structure of the health care system could affect changes in palliative care delivery and impact patients with palliative care needs and their families.	☐
8. Describe the moral, ethical and professional issues inherent in health care advocacy related to palliative care.	☐
9. Describe the role of the Canadian Hospice Palliative Care Association in advocating for patients with life-limiting illnesses and their families.	☐
Additional Competencies for the CNS and NP:	
10. Contribute to efforts to ensure equity, including, but not limited to: barriers to accessing palliative care services and resources; availability of primary care, interprofessional teams and specialized services; delayed or lack of identification of patients who would benefit from palliative care; lack of availability of community-based resources; geographic inequities; poverty; and the cost of dying at home.	☐
11. Identify points of influence in the health care system that could advance palliative care issues.	☐

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.

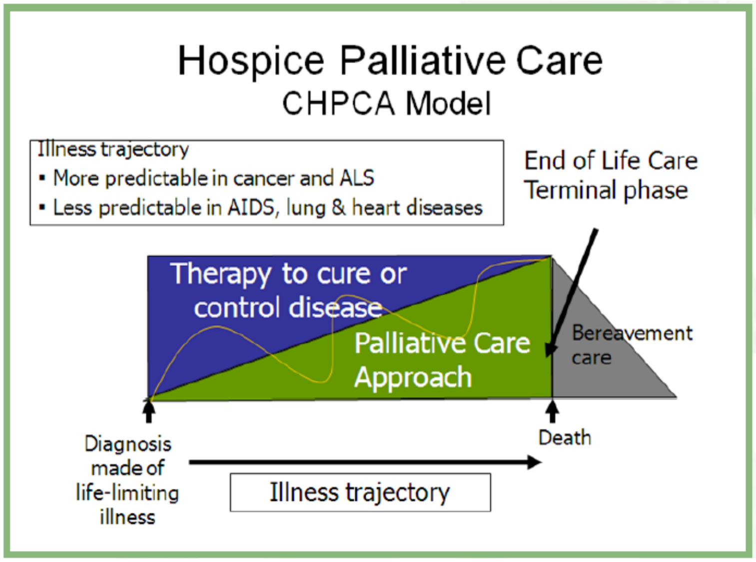
Interprofessional: interprofessional collaboration occurs when health professionals from different disciplines work together to identify needs, solve problems, make joint decisions on how best to proceed and evaluate outcomes collectively. Interprofessional collaboration supports patient-centered care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

Canadian Association of Schools of Nursing. (2011). *Palliative and end-of-life care: Entry-to-practice competencies and indicators for registered nurses*. https://casn.ca/wp-content/uploads/2014/12/PEOLCCompetenciesandIndicatorsEn.pdf

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Appendix 3: Acknowledgements

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