Alberta Psychologists'

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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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 Psychologists' Palliative Care Competencies Referent Group

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

<table>
<tr><th colspan="2">Alberta Psychologists' Palliative Care Competencies Referent Group</th></tr>
<tr><th>Health Care Organizations</th><th>Educational Institutions</th></tr>
<tr><td>
Alberta Health Emergency Medical Services
<u>Alberta Health Services</u>

Calgary Zone Palliative and End-of-Life Care Program
Calgary Zone Advance Care Planning and Goals of Care and Grief Support Program, Palliative and End-of-Life Care
Cross Cancer Institute, Edmonton
Edmonton Zone Palliative Care Program
Edmonton Zone Palliative and End-of-Life Care and Community Programs, Continuing Care
North Cancer Control Alberta
Provincial Palliative and End-of-Life Care, Community, Seniors, Addiction and Mental Health
South Cancer Control Alberta

<u>Covenant Health</u>

Misericordia Community Hospital, Edmonton
Professional Practice and Research
Tertiary Palliative Care Unit, Grey Nuns Hospital, Edmonton

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<u>Athabasca University</u>
Faculty of Health Disciplines

<u>University of Alberta</u>

Faculty of Nursing
Faculty of Medicine and Dentistry
Department of Oncology, Palliative Care Medicine

<u>University of Calgary</u>

Department of Psychology
Department of Family Medicine
Department of Oncology

Professional Regulatory Bodies and Associations

College of Alberta Psychologists
College of Licensed Practical Nurses of Alberta
Psychologists' Association of Alberta

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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 Psychologists' 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 Psychologists' Palliative Care Competency Framework which was developed by the Alberta Psychologists' 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

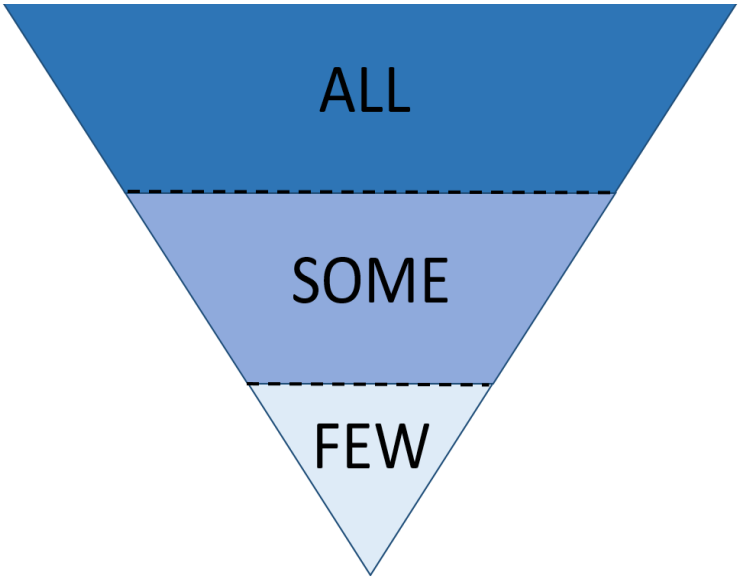


Table 1: Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions
All: HCPs in this level provide care within their scope of practice, to any person in any care setting, including those with life-limiting illnesses. They have foundational knowledge, and skills in palliative care.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

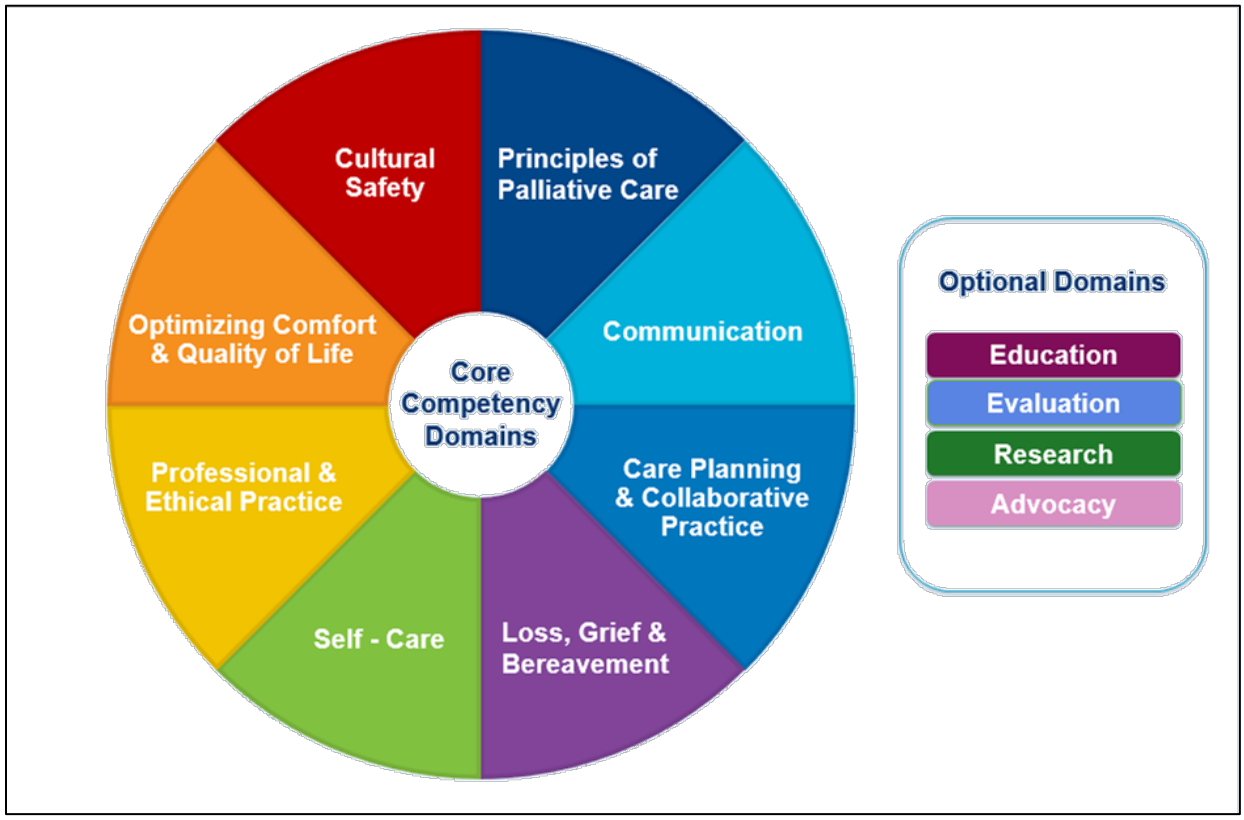
Table 1: Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions
Some: These HCPs have deeper knowledge, understanding and application of palliative and end-of-life care. HCPs in this level also provide care in any setting. They have expertise in palliative and end-of-life care,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

Covenant Health Palliative Institute

Alberta Psychologists' Palliative Care Competencies

Domain 1: Principles of Palliative Care

All	**Educational Opportunity**
1. Explain the philosophy of palliative care.	☐
2. Describe the meaning of the term 'life-limiting illness'.	☐
3. Maintain patient dignity by facilitating expression of needs, hopes, feelings and concerns when planning palliative care.	☐
4. Describe the role and function of the interprofessional team in palliative care.	☐
5. Describe the role and function of the Palliative Care Consult Team, including volunteers.	☐
6. Explain that a palliative approach starts early in the trajectory of a progressive life-limiting illness, and may be appropriate at the time of diagnosis.	☐
7. 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.	☐
8. Apply models of palliative care that promote dignity when providing care (e.g. Dignity Conserving Care).	☐
9. Explain the psychological aspects of a life-limiting illness and potential mental health needs.	☐
10. Integrate a self-reflective process within clinical practice regarding the existential issues that impact the patient with a life-limiting illness, their family and health care providers themselves.	☐
11. Assess the impact of family role change for the patient with a life-limiting illness and their family members.	☐
Some	**Educational Opportunity**
1. Apply the scientist-practitioner framework to inform clinical practice and research regarding the mental health needs of the patient with a life-limiting illness.	☐
2. Maintain a thorough knowledge of psychological theories of death, dying and living with a life-limiting illness.	☐
3. Maintain a thorough understanding of specific psychological issues pertaining to the clinical practice of palliative care, such as the impact of integrating palliative care with active treatment and the significance of transition periods.	☐
4. Critically evaluate the effectiveness of psychological intervention for a patient with a life-limiting illness and modify or refer on for more specialist support, as appropriate.	☐
5. Engage in general assessment of the patient with a life limiting illness.	☐
6. Engage in formal assessment of the patient with a complex life-limiting illness.	☐
7. Engage in psychological formulation and intervention with the patient with a life-limiting illness.	☐

8. Describe the relevant national policy, practice and legislation pertaining to palliative care.	☐
9. Take part in evaluation of psychological services in palliative care.	☐
Few	**Educational Opportunity**
1. Describe the historical development and role of psychology in palliative care nationally and internationally and the challenges associated with the adoption of a holistic model of care within dynamic health care systems.	☐
2. Engage in psychological assessment of the patient with life-limiting illness and their family who present with complex and multiple clinical conditions.	☐
3. Engage in psychological formulation and intervention with the patient with life-limiting illness and their family who present with complex and multiple clinical conditions.	☐
4. Consult on various psychological protective functions such as death denial and death anxiety, as appropriate to palliative care.	☐
5. Provide a broad range of evidence-based therapeutic interventions (e.g. Cognitive Behavioral Therapy (CBT), Meaning Centered Therapy) to patients and their families.	☐

Notes:

Domain 2: Communication

All	**Educational Opportunity**
1. Describe the essential role that communication plays in palliative care.	☐
2. Explain that communication regarding palliative care is an on-going collaborative process.	☐
3. Recognize the communication challenges that arise when caring for a patient with a life-limiting illness.	☐
4. Assess the patient's and family's understanding of the life-limiting illness and its trajectory.	☐

5. Support each patient with a life-limiting illness to make informed decisions regarding the depth of information about diagnosis, prognosis, and disease progression they wish to receive and share with their family.	☐
6. Adapt a communication approach with the patient and family based on their understanding of the life-limiting illness and care planning.	☐
7. Explain the role and importance of experienced translators for the patient with life-limiting illnesses who has a language barrier.	☐
8. Recognize the potential for conflict in palliative care decision-making.	☐
9. Participate in processes that mitigate conflict in palliative care decision-making.	☐
10. Respond to those who are dissatisfied with palliative care services.	☐
Some	**Educational Opportunity**
1. Support parents/guardians/families in sharing difficult or bad news relating to illness or death by facilitating direct supportive communication.	☐
2. Adapt communication and information sharing to the unique needs of the patient with a life-limiting illness and their family, by engaging specialist support as needed to bridge communication barriers (e.g. interpreters, sign language interpreters and assistive technology).	☐
3. Describe the different levels of communication (such as verbal and non-verbal; conscious and unconscious) of patients with a life-limiting illness.	☐
4. Utilize theoretical knowledge of evidence-based models of psychotherapeutic intervention and outcome measures appropriate for the communication needs of each patient with a life-limiting illness and their family.	☐
5. Facilitate effective communication among the patient with a life-limiting illness, their family, and the interprofessional team.	☐
6. Facilitate discussions regarding Advance Care Planning, capacity and contemporary end-of-life issues with each patient, their family, and the interprofessional team.	☐
7. Communicate clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences; including professional colleagues, patients with life-limiting illnesses, and their families.	☐
Few	**Educational Opportunity**
1. Engage in leadership in communication, such as facilitating team communication, staff support, debriefing and case reviews in palliative care.	☐
2. Apply broader aspects of psychological theory as it applies to the patient with a life-limiting illness, including but not limited to: the unconscious, the intra-psychic and other non-verbal communication.	☐
3. Describe the impact of palliative medications, physical pain, organic changes, or cognitive impairment on the patient with a life-limiting illness and their family.	☐
4. Provide training and support to enable health care providers working in palliative care to communicate with patients with life-limiting illnesses and their families in a sensitive and effective manner.	☐

5. Provide training for members of the interprofessional team regarding the normal and complicated adjustment and systemic processes for the patient with a life-limiting illness and their family.	☐

Notes:

Domain 3: Care Planning and Collaborative Practice

All	**Educational Opportunity**
1. Explain the Advance Care Planning and Goals of Care Designations policy and procedure.	☐
2. Identify that there are appropriate times to engage in Advance Care Planning discussions.	☐
3. Explain how an Alternate Decision Maker (ADM) is selected	☐
4. Explain the role of an ADM in decision-making regarding a patient's care.	☐
5. Identify how interprofessional practice enhances patient outcomes when caring for a patient with a life-limiting illness.	☐
6. Explain the collaborative relationship between the patient with a life-limiting illness, their family and the interprofessional team.	☐
7. Recognize that psychological assessment and treatment of a patient with a life-limiting illness takes place in the context of the interprofessional care team.	☐
8. Work collaboratively with the interprofessional team to ensure a realistic care plan so that services do not place an undue burden on the patient with a life-limiting illness.	☐
9. Collaborate with the interprofessional team to manage pain and symptoms.	☐
10. Support the patient with a life-limiting illness to express their wishes and/or identify goals of care by referring them to the most appropriate member of the interprofessional team.	☐
11. Communicate to each patient with a life-limiting illness and their family the limits of confidentiality and the need for a joint patient record and team communication about care planning.	☐
12. Evaluate communication with the patient with a life-limiting illness and their family to ensure the care plan meets the patient's identified needs.	☐
13. Recognize the overall impact of a life-limiting illness on the patient, including their mental health and coping mechanisms.	☐
14. Anticipate factors that may affect cognition and functional capacity of a patient with a life-limiting illness, to make decisions, including health status changes towards end-of-life.	☐

15. Provide supports to help the patient with a life-limiting illness to adapt to the changes in their condition.	☐
16. Identify priorities and concerns in collaboration with the patient with a life-limiting illness and their family, taking into account their coping strategies and perception of diagnosis.	☐
17. Demonstrate flexibility in relation to care planning, acknowledging that a patient's priorities can shift as their life-limiting illness progresses.	☐
18. Facilitate and support informed decision-making by the patient with a life-limiting illness regarding place of care, while identifying risks.	☐
19. When able, provide care in the patient's preferred place of care, while recognizing the complexities and challenges involved for the patient with a life-limiting illness and their family.	☐
20. Support wishes and death rituals of the patient with a life-limiting illness and their family.	☐
21. Recognize the signs of imminent death.	☐
22. Respond to the signs of imminent death by supporting the patient, their families and the interprofessional team.	☐
23. Support planning for expected deaths.	☐
24. Assist each patient with a life-limiting illness and their family to inform themselves and appropriately use self-help resources and support groups.	☐
25. Engage in self-reflection of one's own existential issues, as well as those of the patient with a life-limiting illness and their family, considering the impact of such issues on counter-transference and self-care.	☐
Some	**Educational Opportunity**
1. Explain the relationship between physical conditions and treatment of mental health presentations in palliative care.	☐
2. Describe best practices for expected death, including local and organizational policies and processes.	☐
3. Recognize that psychological care planning of a patient with a life-limiting illness takes place in a dynamic field of changing health and care, where care plans have to regularly be revised and reformulated.	☐
4. Refer the patient with a life-limiting illness and their family members to other mental health professionals for issues outside the scope of practice (such as family therapy).	☐
Few	**Educational Opportunity**
1. Conduct psychological formulation and re-formulation of care planning in the context of changing health status of the patient with a life-limiting illness.	☐
2. Provide opportunities for the family of a patient with a life-limiting illness and the extended community to gather and be together.	☐
3. Anticipate the signs of imminent death.	☐
4. Mentor other health care professionals with regards to building empathic, responsive relationships, and maintaining physical and emotional presence with each patient and their family.	☐

5. Apply international best practice guidelines on end-of life care.	☐
6. Educate other health care professionals on the application of the international best practice guidelines on palliative care.	☐

Notes:

Domain 4: Optimizing Comfort and Quality of Life

All	**Educational Opportunity**
1. Explain how a palliative approach can enhance the assessment and management of symptoms.	☐
2. Apply interprofessional approaches to optimize comfort and enhance quality of life of the patient with a life-limiting illness and their family.	☐
3. Recognize common trajectories of life-limiting illnesses, including common symptoms.	☐
4. Recognize how disease progression and associated medical treatments can adversely affect quality of life by virtue of their potential impact on the patients' and family's emotional well-being, interpersonal relationships, material well-being, personal development, physical well-being, self-determination, social inclusion and human rights.	☐
5. Explain the factors underpinning psychosocial adjustment to a life-limiting illness.	☐
6. Anticipate the needs of the patient who has been diagnosed with a life-limiting illness based on known disease trajectories.	☐
7. Explain the concept of 'total pain'.	☐
8. Apply the principles of symptom management when caring for a patient with a life-limiting illness.	☐
9. Recognize that symptoms and symptom meaning are highly subjective.	☐
10. 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.	☐
11. Assess the benefits, burdens, and risks of psychological interventions for the patient with a life-limiting illness.	☐
12. Discuss the benefits, burdens, and risks of psychological interventions with the patient with a life-limiting illness and their family.	☐
13. Make decisions regarding the appropriateness of psychological interventions for each patient living with a life-limiting illness, while taking into consideration the patient's expressed wishes and identified goals of care.	☐

14. Support the patient, family, Alternate Decision Maker (ADM), and the interprofessional team with end-of-life decision making, including withdrawing or withholding interventions.	☐
15. Educate the patient with a life-limiting illness and their family about quality of life decisions and the psychological implications of decisions.	☐
16. Identify patients who would benefit from Emergency Medical Services Palliative and End- of-Life Care Assess, Treat and Refer (ATR) Program.	☐
17. Provide care in a compassionate manner when caring for a patient with a life-limiting illness and their family.	☐
18. Recognize the physical, psychological, social, and spiritual issues that affect the patient with a life-limiting illness and their family.	☐
19. Facilitate the patients' and family's perception of a good death.	☐
20. Explore one's own responses to being in the presence of a patient who is suffering.	☐
Some	**Educational Opportunity**
1. Explain the causes of common symptoms other than pain at end-of-life.	☐
2. Support the patient with a life-limiting illness to psychologically process the implications and impact of moving from life prolonging care to palliative care.	☐
3. Conduct standardized assessment of the psychological adjustment of a patient with a life-limiting illness.	☐
4. Develop psychological formulations based on assessment findings when caring for a patient with a life-limiting illness.	☐
5. Communicate psychological formulations, as appropriate, to relevant stakeholders, in order to shape and support the care plan of the patient with a life-limiting illness.	☐
6. Provide evidence-based psychotherapeutic interventions to the patient with a life-limiting illness and their family.	☐
7. Educate the patient, their family, and health care professionals about the psychological aspects of pain, fatigue, anxiety and other presentations associated with the experience of a life-limiting illness.	☐
Few	**Educational Opportunity**
1. Apply advanced clinical knowledge of complex mental health presentations of the patient with a life-limiting illness through assessment, diagnosis and treatment.	☐
2. Provide specialist evidence-based psychotherapeutic interventions based on on-going psychological assessment of the patient with a life-limiting illness.	☐
3. Support the interprofessional team in the management of a patient with a life-limiting illness who presents with organic brain damage, toxicity, dual mental health diagnosis or personality disorders, which may affect their engagement with services.	☐
4. Provide consultation to the interprofessional team when considering the care and treatment options for a patient with a life-limiting illness, with due regard to the patient's wishes and how their psychological state may influence this.	☐
5. Provide consultation and direct support to the family with complex dynamics and to the interprofessional team that cares for them.	☐

6. Support the interprofessional team as appropriate, such as debriefing, supervision, case management in palliative care.	☐

Notes:

Domain 5: Loss, Grief and Bereavement

All	**Educational Opportunity**
1. Describe diverse perspectives on loss, grief, bereavement and mourning, to support others from a cross-cultural perspective.	☐
2. Describe contemporary theories and models of loss and grief.	☐
3. Recognize the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief.	☐
4. Describe the dimensions of grief.	☐
5. Recognize the factors that may increase the risk of complicated grief.	☐
6. Address pathological responses to loss, referring appropriately to the Specialist Palliative Care Consult Team, or other interdisciplinary care team members as appropriate.	☐
7. Support the family of the patient with a life-limiting illness by providing them with guidance, information, and direction to bereavement services, as required, and based on awareness of culture and needs.	☐
8. Describe the needs of children of various developmental stages in dealing with grief and loss of a parent or sibling.	☐
9. Explain the psychological impact of death and dying on individuals with increased stress vulnerability.	☐
10. Assess loss, grief, and bereavement needs of the patient with a life-limiting illness and their family.	☐
11. Identify the patient with a life-limiting illness who is at risk for complicated grief.	☐
12. Respond to complex grief reactions and processes and refer to specialty supports, when needed.	☐

13. Encourage colleagues to engage in activities to maintain their resilience on an on-going basis.	☐
14. Demonstrate good self-care practice and include an emphasis on work impact on self when giving and receiving supervision.	☐
15. Support colleagues regarding the personal impact of loss, grief and bereavement, including role modelling, informal and formal mentoring.	☐
Some	**Educational Opportunity**
1. Apply contemporary, evidence-based models of bereavement supports and counselling across a broad range of patients, adjusting for differences in cognitive level and learning style; and demonstrating sensitivity to ethnicity, culture, gender, sexual orientation, language, religion, age and ability.	☐
2. Communicate therapeutically with the patient with a life-limiting illness, and their family, by noting normal and pathological loss responses and attending to individual styles of coping and grieving.	☐
3. Provide bereavement intervention to family if required.	☐
4. Maintain knowledge of current of literature in the area of grief, loss and bereavement.	☐
5. Disseminate literature in the area of grief, loss, and bereavement to colleagues, patients and families, as appropriate.	☐
Few	**Educational Opportunity**
1. Apply an in-depth understanding of the grief and loss literature to the care of a patient with a life-limiting illness and their family.	☐
2. Provide consultation and training updates for mental health professionals.	☐
3. Provide expert input to the interprofessional team regarding the complex and dynamic nature of responses to loss and other complex psychological aspects related to a life-limiting illness.	☐
4. Apply validated assessment tools to diagnose and differentiate between ego-syntonic sadness and mental health issues, such as, anxiety, depression and post-traumatic stress disorder, when caring for a patient with a life-limiting illness.	☐
5. Utilize a broad range of evidence-based therapeutic interventions for the patient with a life-limiting illness and their family who present with increased stress vulnerability and/or complex grief responses.	☐
6. Utilize recognized and validated tools to diagnose Post Traumatic Stress Disorder and other pathological grief responses in the patient with a life-limiting illness and their family.	☐
7. Assess the efficacy of grief and loss interventions for the patient with a life-limiting illness and adjust accordingly.	☐
8. Provide consultation with regard to the normal and complicated adjustment to loss and systemic processes of grief.	☐
9. Lead strategies and evidence-based practices that enhance well-being of patients with a life-limiting illness and their families to help them cope with grief and loss.	☐

Notes:

Domain 6: Professional and Ethical Practice

All	Educational Opportunity
1. Anticipate ethical and legal issues that may be encountered when caring for a patient with a life-limiting illness.	☐
2. Address ethical and legal issues that may be encountered when caring for a patient with a life-limiting illness.	☐
3. Explore the wishes of a patient with a life-limiting illness, regarding their care options and preferences.	☐
4. Respect the wishes of a patient with a life-limiting illness, regarding their care options and preferences.	☐
5. Respect the decisions of a patient with a life-limiting illness, regarding initiating, not initiating, withholding and withdrawing life-prolonging/sustaining interventions such as, dialysis, hydration, nutrition support, resuscitation and other life-prolonging/life-sustaining interventions.	☐
6. Describe distinctions among ethical and legal concepts, such as: the principle of double effect, palliative sedation and Medical Assistance in Dying (MAID).	☐
7. Identify relevant legislation and policies, e.g. Bill C14 Medical Assistance in Dying (MAID), Bill 84 (Medical Assistance in Dying Statute Law Amendment Act, 2017) , Child, Youth and Family Enhancement Act, Protection for Persons in Care Act, Adult Guardianship and Trusteeship Act and the Personal Directives Act.	☐
8. Assess inquiries regarding MAID in accordance with regulatory body's relevant guidelines and standards and employer policy.	☐
9. Engage with the patient and family experiencing loss and suffering.	☐
10. Explain the difference between managing a condition and providing end-of-life care.	☐
11. Recognize when personal beliefs, attitudes, and values limit one's ability to be present and provide patient-centered care to the patient with a life-limiting illness and their family.	☐

12. Collaborate with others to ensure optimal care is provided when one's beliefs, attitudes and values limit one's ability to be present and provide patient-centered care to the patient with a life-limiting illness and their family.	☐
Some	**Educational Opportunity**
1. Participate in professional supervision and peer review processes to monitor personal and professional responses to clinical situations and to ensure best practice in providing care to patients with life-limiting illnesses and their families.	☐
2. In conjunction with the interprofessional team, the patient, and their family, participate in discussions and resolution of ethical and legal issues that may arise in relation to factors which impact the patients with a life-limiting illness.	☐
3. Use recognized, ethical, legal and professional frameworks to guide end-of-life decision making.	☐
4. Facilitate discussion and resolution of ethical issues that may arise in palliative care.	☐
Few	**Educational Opportunity**
1. Be committed to advancing the role of psychology in palliative care through the application of knowledge and generation and dissemination of research.	☐
2. Demonstrate skills in bridging the biomedical and social sciences research paradigm by leading multidisciplinary research projects and publications in palliative care.	☐
3. Apply an advanced understanding of contemporary legal, ethical and professional standards in the provision of quality palliative care.	☐

Notes:

Domain 7: Cultural Safety

All	**Educational Opportunity**
1. Describe the influence of culture on key issues in palliative care.	☐
2. Validate cultural preferences and values by identifying ways to accommodate them into goal setting, decision making and care planning when caring for a patient with a life-limiting illness and their family.	☐

3. Respect the patient's and family's social, spiritual, and cultural values and practices that may influence their care preference in palliative care.	☐
4. Assess the unique needs and preferences of the patient with a life-limiting illness and their family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age and ability.	☐
5. Respect who the patient with a life-limiting illness identifies as family.	☐
6. Respond to family members' unique needs and experiences.	☐
7. Identify personal, cultural biases and values that may influence the care of a patient with a life-limiting illness and their family.	☐
8. Identify mechanisms to overcome personal biases to ensure they do not impact care and treatment of a patient with a life-limiting illness.	☐
Some	**Educational Opportunity**
1. Demonstrate cultural safety in academic or applied practice, for example, maintain a critical understanding of the dominant discourses in palliative care.	☐

Notes:

Domain 8: Self-Care

All	**Educational Opportunity**
1. Identify personal responses to loss.	☐
2. Identify personal attitudes regarding death, dying and caring for a patient with a life-limiting illness.	☐
3. Identify the impact of past experiences of suffering, death and dying when caring for a patient with a life-limiting illness.	☐
4. Attend to own emotional responses that result from caring for a patient with palliative care needs.	☐
5. Recognize compassion fatigue in self and colleagues.	☐
6. Engage in healthy activities that help prevent compassion fatigue when caring for a patient with a life-limiting illness and their family.	☐

7. Support colleagues who are experiencing compassion fatigue when caring for a patient with a life-limiting illness and their family.	☐
8. Engage in activities that support well-being and resilience when caring for a patient with a life-limiting illness and their family.	☐

Notes:

Domain 9: Education, Research and Evaluation

All	**Educational Opportunity**
1. Participate in palliative care continuing education opportunities.	☐
2. Educate the patient with a life-limiting illness and their family about palliative care and the palliative approach.	☐
3. Critically evaluate palliative care outcomes against standards and guidelines.	☐
4. Contribute to the evaluation of the quality of palliative care and the effectiveness of the palliative care system.	☐
Some	**Educational Opportunity**
1. Critically appraise research evidence relevant to practice as it pertains to living with a life-limiting illness.	☐
2. Contribute to the education of health care providers and the general public about the psychology of death and dying (such as promoting a bio-psycho-social understanding of death).	☐
Few	**Educational Opportunity**
1. Contribute to teaching curricula on loss, grief and bereavement across a range of disciplines, including undergraduate and graduate programs.	☐
2. Engage in research pertaining to palliative care within the context of the local work environment.	☐
3. Be involved as team members, or leaders, in the design and conduct of staff support and training programs in issues pertaining to life-limiting illness.	☐

4. Engage in research that adds to the body of literature on psychology, loss, grief and bereavement and disseminate research findings.	☐
5. Facilitate research addressing issues pertaining to palliative care.	☐
6. Provide leadership in the development and delivery of palliative care policy at local and national levels.	☐
7. Engage in continuous professional training pertaining to the evolving field of palliative care.	☐
8. Provide leadership in the psychology of palliative care by contributing to the knowledge base of society (e.g. talks, conferences, and media).	☐
9. Engage in leadership in palliative care education as it pertains to psychology, including undergraduate and graduate programs.	☐

Notes:

Domain 10: Advocacy

All	**Educational Opportunity**
1. Advocate for the development, maintenance and improvement of health care and social policies related to palliative care.	☐
2. Advocate for health care providers to have adequate resources to provide palliative care.	☐
3. Advocate for the needs, decisions and rights of the patient with a life-limiting illness and their family by recognizing potential vulnerabilities.	☐
4. Support autonomous decision-making for the patient with a life-limiting illness and their family.	☐
5. Promote equitable and timely access to palliative care resources, with particular emphasis on the often unmet mental health needs of patients with a life-limiting illness.	☐
6. Advocate for health care professionals to participate in palliative care continuing education opportunities.	☐
Some	**Educational Opportunity**
1. Promote access to psychological therapies for patients with a life-limiting illnesses.	☐

2. Raise awareness of a psychological perspective on death and dying and mental health needs of patients with life-limiting illness at all levels including but not limited to: among people with a life-limiting illness, their family, the interprofessional team and work organizations.	☐
Few	**Educational Opportunity**
1. Promote the provision of comprehensive palliative care services at local, regional and national levels, and across all clinical settings including primary, acute and tertiary care.	☐
2. Advocate for on-going and continuous service development and delivery with particular emphasis on the often unmet mental health needs of patients with a life-limiting illness.	☐

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.

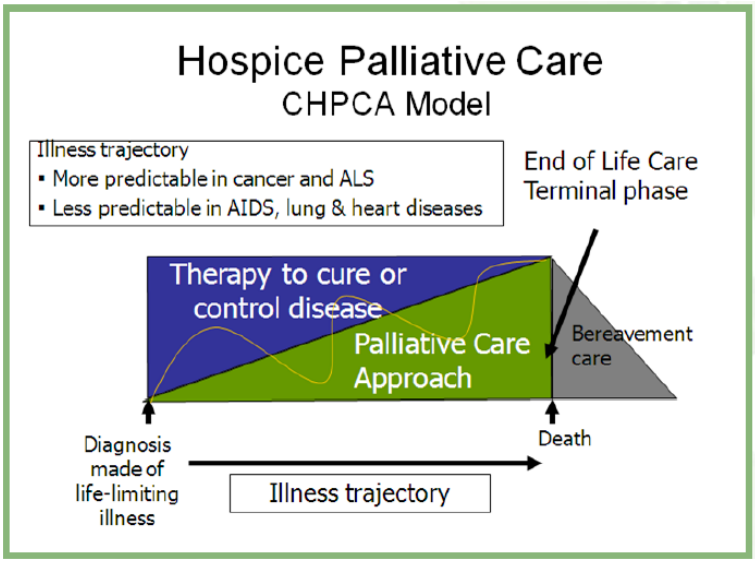
Imminently dying: Any patient who, according to the most responsible health practitioner's clinical assessment, is within the last hours to days of life.

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.

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Appendix 3: Acknowledgements

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