Alberta Health Services

Covenant Health
Palliative Institute

Alberta Respiratory Therapists’
Palliative Care Competency Framework

Version 1.0 (September 2020)

A Resource Manual for Health Care Professionals

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

Publication date: September 2020

How to cite this document: Covenant Health Palliative Institute. *Alberta Respiratory Therapists’ Palliative Care Competency Framework: A Resource Manual for Health Care Professionals.* Edmonton, AB: September 2020.

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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 Respiratory Therapists' Palliative Care Competencies Referent Group

The Alberta Respiratory Therapists' Palliative Care Competencies Referent Group below assisted in recruiting individuals participating in the production of the Alberta Respiratory Therapists' Palliative Care Competency Framework. This includes members of the Alberta Palliative Care Competencies Advisory Working Group and the Alberta Respiratory Therapists' 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 Respiratory Therapists' Palliative Care Competencies Referent Group</th></tr>
<tr><th>Health Care Organizations</th><th>Educational Institutions</th></tr>
<tr><td rowspan="3">• Alberta Health Emergency Medical Services
Alberta Health Services
• Calgary Zone Integrated Supportive and Facility Living
• Calgary Zone Palliative and End-of-Life Care Program
• Calgary Zone Palliative Home Care
• Chinook Regional Hospital, Lethbridge
• Edmonton Zone Allied Health Community Health Services
• Edmonton Zone Palliative and End-of-Life Care and Community Programs, Continuing Care
• Edmonton Zone Palliative Care Program
• Edmonton Zone Urban Palliative Home Care Team
• Fort Macleod, Milk River/South Zone
• Medicine Hat Regional Hospital
• North Zone, Onoway
• Peter Lougheed Centre, Calgary
• Provincial Palliative and End-of-Life Care, Community, Seniors, Addiction and Mental Health
• Queen Elizabeth II Regional Hospital, Grande Prairie
• Red Deer Regional Hospital Centre
• Red Deer-Central Zone, Allied Health Supportive Living Team
Covenant Health
• Grey Nuns Community Hospital, Edmonton
• Professional Practice and Research
• Tertiary Palliative Care Unit, Grey Nuns Community Hospital, Edmonton</td><td>Northern Alberta Institute of Technology
• Respiratory Therapy Program
Southern Alberta Institute of Technology
• Life Sciences, School of Health and Public Safety
University of Alberta
• Faculty of Nursing
• Faculty of Medicine and Dentistry
University of Calgary
• Department of Family Medicine
• Department of Oncology</td></tr>
<tr><th>Professional Regulatory Bodies and Associations</th></tr>
<tr><td>• College of Licensed Practical Nurses of Alberta
• College and Association of Respiratory Therapists of Alberta</td></tr>
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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 Competencies

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. Alberta Respiratory Therapists' 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 Respiratory Therapists' Palliative Care Competency Framework which was developed by the Alberta Respiratory Therapists' Palliative Care Working Group.

Competency statements are organized according to the following two dimensions:

1. Level of expertise
2. Competency domains

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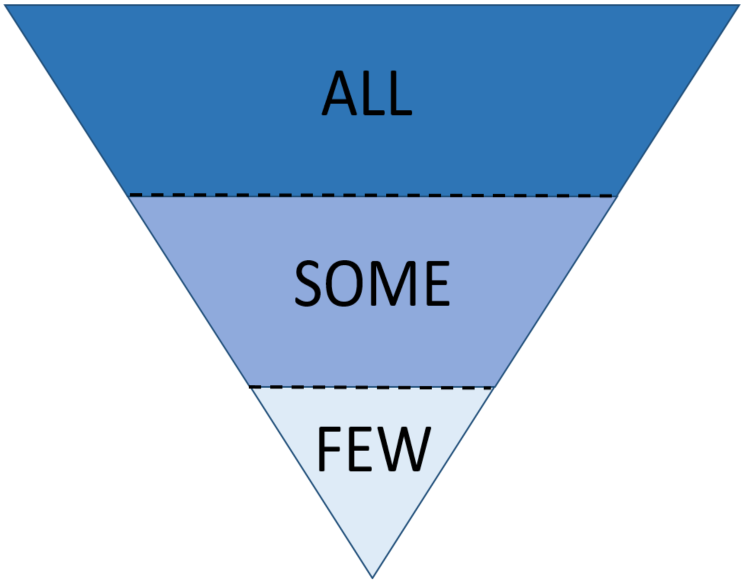
[1] Parry, S. B. (1996).The quest for competencies. Training 33, 48–54.

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.

Figure 1: The Alberta Palliative Care Competency Triangle



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.

Table 1: Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions
All: HCPs in this level provide care within their scope of practice, to any person in any care setting, including those with life-limiting illnesses. They have foundational knowledge and skills in palliative care. This category includes interprofessional health care teams that provide direct and ongoing palliative care for patients and their families by addressing their physical, emotional, social, practical, cultural and spiritual needs and respecting their personal autonomy with dignity and compassion. These HCPs may provide clinical management and care co-ordination, including assessments, interventions, referrals and triage using a palliative approach, within their scope of practice. They use evidence-based guidelines and may consult with specialized palliative care services as required, to support palliative care patients and their families. The competencies identified in this level are required for any HCP at entry to practice, point of registration and in relation to their current role.

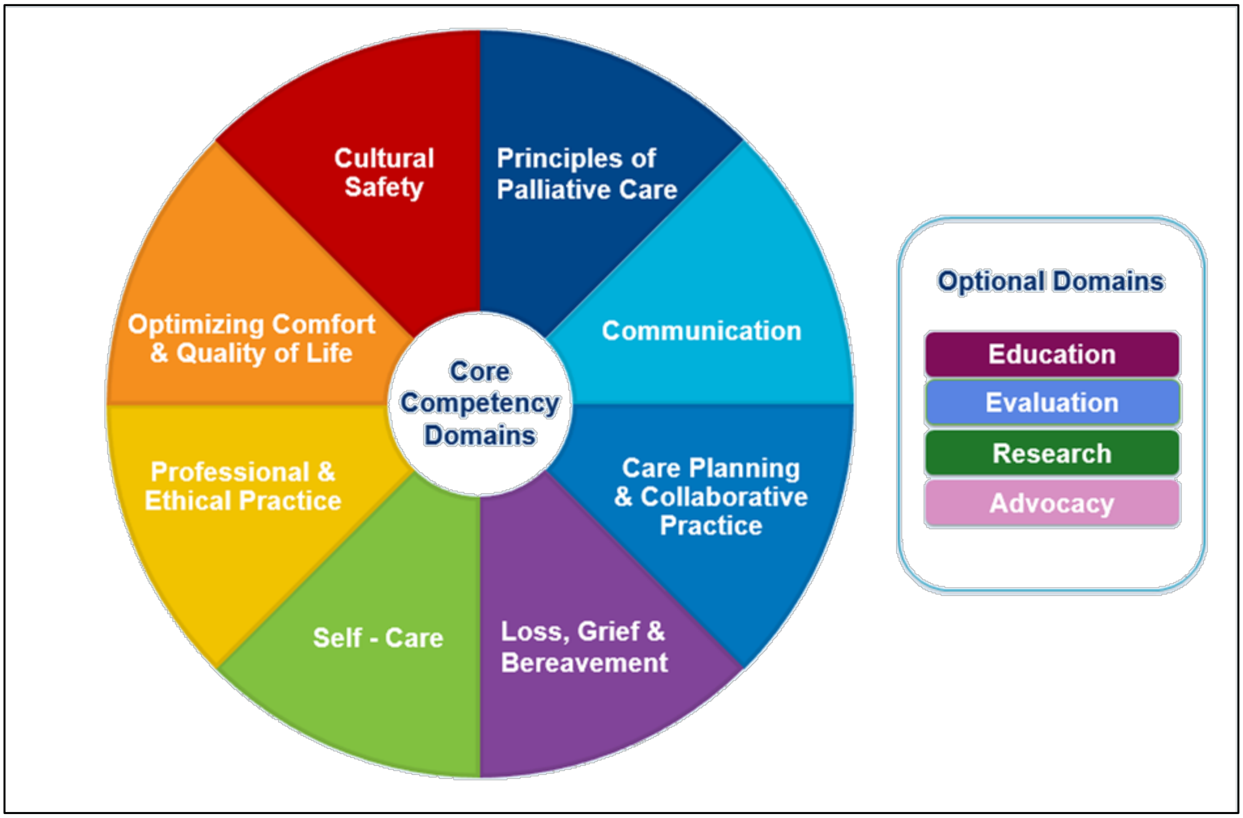
Table 1 Continued: Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions
Some: These HCPs have deeper knowledge, understanding and application of palliative and end-of-life care. HCPs in this level also provide care in any setting. They have expertise in palliative and end-of-life care, in managing pain and other symptoms and in providing psychosocial and spiritual support. They ensure that adequate assessment and management of symptoms, psychological distress, practical and financial issues, and spiritual needs are incorporated into comprehensive care for patients and families. They provide enhanced care for more complex needs and consult with specialized palliative care services as required. They are a resource for colleagues within their local environment and may support patients and families who are not directly assigned to their care.
Few: This level of HCPs are palliative care experts who provide care for patients and their families, including those with the most complex palliative care needs. They provide a focused level of service for patients and families who require specialized, frequent and skilled assessments and interventions in palliative and end-of-life care. They may act as a resource and support to any HCP (including those working in hospices and palliative home care) and provide formal and informal expert palliative and end-of-life care consultation. These palliative care experts provide leadership, mentoring and education in palliative and end-of-life care. This level also includes, but is not limited to, experts who conduct research and develop advocacy strategies that advance approaches to palliative care and contribute to quality improvement on a system level.

Competency Domains

The competency statements are organized according to eight core competency domains and four optional competency domains (Figure 2). The core competencies domains are common for each HCP group and represent the primary level of understanding required to provide palliative care.

The optional competency domains may apply only to certain HCP groups and levels of expertise. Each working group collaboratively decided which optional domains to include. Each competency domain is defined with a domain statement. The domain statement remains the same irrespective of the level at which or the setting where palliative care is provided. Each domain has a set of competency statements. These statements outline the competencies required by HCPs in the context of their role and at the level of expertise with which they work.

Figure 2. Alberta Palliative Care Competency Domains



Domain 1: Principles of Palliative Care

Palliative care is both a philosophy and an approach to care that enables all patients with a life-limiting illness to receive integrated and coordinated care across the continuum of life. This care incorporates each patient's and family's values, preferences and goals of care and spans the disease process from diagnosis to end-of-life, including bereavement. The following principles are foundational in providing palliative care to each patient and their family within Alberta: patient- and family-centeredness; equitable access; collaborative and integrated team service delivery; communication and information sharing; safe; ethical and quality care; sustainability and accountability; clearly defined governance and administration models; and research.

Domain 2: Communication

Communicating effectively is essential to the delivery of palliative care. Specific consideration should be given to communication as a method of establishing therapeutic relationships and patient/family participation in decision-making. Empathetic, person to person communication is foundational to palliative care. Communication is also important where circumstances are ambiguous or uncertain or when strong emotions and distress arises. Effective communication includes information technology (i.e. NetCare, Connect Care) for knowledge transfer at all levels (patient and family, service delivery and system) and the use of common tools, language and utilization of the most appropriate documentation to support seamless transitions of each person, to convey appropriate information and to safely manage each person's and family's care needs.

Domain 3: Care Planning and Collaborative Practice
According to the *AHS Palliative and end-of-life care Alberta provincial framework,* "In order to meet the individual needs of each person and their family, comprehensive interprofessional teams with varying skills and knowledge are required to safely and effectively care for Albertans who are palliative or are at the end of life." [Alberta Health Services] Care planning is a collaborative practice that includes addressing, coordinating and integrating patient-centered care and family-centered care needs. It is enabled by interprofessional, cross-sector care planning and communication that involves comprehensive needs assessment, promoting and preserving choice and planning for likely changes that occur with the context of a deteriorating illness trajectory. Care planning ensures that multiple disciplines and agencies can be accessed and referred to as required in a timely manner. Each patient and their family should be supported in care planning to the extent that they are able and wish to be involved.

Domain 4: Optimizing Comfort and Quality of Life
Supporting and optimizing comfort and quality of life as defined by the patient and family includes comprehensively assessing and addressing their emotional, psychological, social and spiritual needs as well as their physical needs. This is an ongoing process which aims to prevent, assess, acknowledge and relieve suffering in a timely and proactive manner, as well as includes effective symptom management that is in alignment with the patient's goals of care.

Domain 5: Loss, Grief and Bereavement
A palliative approach assists HCPs in providing support to patients, families and communities, when possible, throughout the illness trajectory as they experience loss, grief and bereavement. This includes identifying patient and family needs, identifying those who may require additional bereavement support, and providing information and resources and support to all.

Domain 6: Professional and Ethical Practice
According to the *AHS Palliative and end-of-life care Alberta provincial framework*, "Comprehensive assessments by adequately skilled professionals and providers are at the heart of quality and ethical care delivery. The provision of care that is appropriate to all domains, including physical, psychological, social and spiritual requires knowledge and tools related to assessment in these areas." [Alberta Health Services] HCPs focus on respecting and incorporating the values, needs and wishes of the patient and their family into care planning while maintaining professional, personal and ethical integrity. Professional and ethical integrity guide all HCPs to consider how best to provide ongoing care to people with life-limiting illnesses as their healthcare needs change.

Domain 7: Cultural Safety
Cultural safety is a process that encourages a patient to feel safe, without any fear of judgement, repercussions, discrimination (individual or systemic), or assault because of

their needs and identities. It is defined and experienced by the patient. It is based on respectful engagement and communicating respect for a patient's beliefs, behaviors, and values and ensures that the patient is a partner in decision making. It requires acknowledgement that we are all bearers of culture including the need for self-reflection about one's own attitudes, beliefs, assumptions and values. It requires recognition of the power differentials inherent in healthcare service delivery, institutional discrimination and the need to address these inequities through education and system change. Assessing and respecting values, beliefs and traditions related to health, illness, family caregiver roles and decision-making are the first step in providing spiritually and culturally sensitive palliative care. Culturally safe care involves building trust with the patient and recognizing the role of socioeconomic conditions, history and politics in health. It requires awareness of family dynamics and the role the family plays in the cultural safety of the patient. Cultural competency is the process HCPs achieve with cultural safety being the outcome. [Health Council of Canada]

Domain 8: Self-Care
Self-care includes a spectrum of knowledge, skills, attitudes and self-awareness. It requires all HCPs to engage in ongoing self-reflection regarding appropriate professional boundaries and the personal impact of caring for patients with life-limiting illnesses and their families. Self-care requires the use of holistic wellness strategies that promote the health of oneself as well as the health and function of the team.

Domain 9A: Education
Participating in palliative care continuing education, facilitating palliative care educational opportunities for HCPs, volunteers, each patient, their family and the public.

Domain 9B: Evaluation
Based on evidence informed practice and available research, leading and/or participating in the evaluation of palliative care services and HCPs, patients' and families' experiences.

Domain 9C: Research
Promoting, participating in, and/or leading palliative care research; keeping abreast of palliative care research and inviting patients and their families to participate in relevant research projects.

Domain 10: Advocacy
Advocating for access to and funding for palliative care services and associated educational initiatives; policy development; and addressing the social determinants of health to improve patient outcomes.

Alberta Respiratory Therapists' Palliative Care Competencies

Domain 1: Principles of Palliative Care	
All	**Educational Opportunity**
1. Explain the philosophy of palliative care.	☐
2. Describe palliative care standards, norms of practice and best practices.	☐
3. Describe the role of Respiratory Therapy in palliative care.	☐
4. Apply models of palliative care that promote dignity (e.g. Dignity Conserving Care).	☐
5. Apply the principles of palliative care that affirm life by supporting the patient live as actively as possible until death, with optimal quality of life.	☐
6. Identify that a palliative approach starts early in the trajectory of a life-limiting illness, including, but not limited to: severe chronic lung disease, cardiac disease, neuromuscular diseases and cancer.	☐
7. Describe the meaning of the term 'life-limiting illness'.	☐
8. Offer support to help each patient live as actively as possible, with optimal quality of life, until death.	☐
9. Describe the role and function of the interprofessional team in palliative care.	☐
10. Describe the role and function of the Palliative Care Consult Team, including volunteers and refer appropriately.	☐
11. Participate in empathic and responsive relationships with each patient experiencing a life-limiting illness, their family and the interprofessional team.	☐
12. Foster a caring environment that supports all staff working in sensitive situations.	☐
Some	**Educational Opportunity**
1. Apply palliative care standards, norms of practice, and best practices.	☐
2. Conserve patient dignity by facilitating expression of needs, hopes, feelings and concerns when planning palliative care.	☐
3. Facilitate ongoing empathic and responsive relationships between the patient with a life-limiting illness, their family and the interprofessional team.	☐
4. Practice patient-centered palliative care that incorporates the unique contributions of the family in routine caregiving.	☐
5. Apply leadership that encourages colleagues to foster a caring environment which supports all staff working in sensitive situations.	☐

Notes:

Domain 2: Communication	
All	**Educational Opportunity**
1. Describe of the essential role communication plays in palliative care.	☐
2. Identify that communication regarding palliative care is an on-going collaborative process.	☐
3. Identify the multidimensional communication challenges that arise when caring for a patient with a life-limiting illness.	☐
4. Explore the patient’s and family’s understanding of the life-limiting illness.	☐
5. Recognize the potential for conflict in palliative care decision-making.	☐
6. Support each patient to make informed decisions regarding the depth of information about diagnosis, prognosis and disease progression he/she wishes to receive.	☐
7. Engage in compassionate, individualized and timely communication with each patient, their family and the interprofessional team.	☐
8. Explore own responses to communication challenges.	☐
9. Utilize specialist support in relation to communication (e.g. interpreters, sign language interpreters, and assistive technology).	☐
10. Respond to those who are dissatisfied with palliative care services.	☐
11. Participate in advance care planning discussions.	☐
Some	**Educational Opportunity**
1. Initiate discussions on goals of care designations.	☐
2. Document discussions on the Advance Care Planning/Goals of Care Designation Tracking Record form.	☐
3. Address the multidimensional communication challenges that arise when caring for a patient with a life-limiting illness and their family.	☐

4. Assist with resolving conflict in palliative care decision-making.	☐
5. Collaborate with each patient and their family to devise care plans to meet the patient’s palliative care needs.	☐
6. Demonstrate expertise as a mediator by advocating for the patient and their family to access appropriate and timely palliative care.	☐
7. Maintain ongoing communication with the patient, their family and the interprofessional team regarding the end-of-life care plan.	☐
Few	**Educational Opportunity**
1. Utilize strategies to engage in highly skilled, compassionate, individualized and timely communication with each patient, their family and the interprofessional team.	☐

Notes:

Domain 3: Care Planning and Collaborative Practice	
All	**Educational Opportunity**
1. Describe the collaborative relationship between the patient, their family and the interprofessional team.	☐
2. Collaborate with the interprofessional team to manage symptoms and enhance patient outcomes and quality of life.	☐
3. Collaborate with the interprofessional team, the patient and their family to define goals of care.	☐
4. Collaborate with the interprofessional team, the patient and their family to implement and evaluate a plan of care.	☐
5. Recognize the overall impact that a life-limiting illness has on the patient and their family and provide support to address identified needs.	☐
6. Provide support to help the patient and their family adapt to changes in their condition.	☐

7. Identify priorities and concerns in collaboration with the patient and their family, taking into account their coping strategies and perceptions of the patient’s diagnosis.	☐
8. Demonstrate an understanding of the Advance Care Planning and Goals of Care Designation policy and procedure.	☐
9. Explain how an Alternate Decision Maker (ADM) is selected and the role they play in decision making regarding a patient’s care.	☐
10. Make decisions regarding the appropriateness of interventions for each patient living with a life-limiting illness, taking into consideration the patient’s Personal Directive and the patient’s or ADM’s preferences.	☐
11. Facilitate the active involvement of each patient and their family in decision making and goal setting to support best outcomes and quality of life.	☐
12. Demonstrate flexibility in relation to care planning, acknowledging that a patient’s priorities can alter as their condition changes.	☐
13. Facilitate informed decision-making regarding place of care, while identifying risks.	☐
14. Provide care in the patient’s preferred place of care when able, while recognizing the complexities and challenges involved for each patient and their family.	☐
15. Recognize that patients may lose cognitive and functional capacity to make decisions towards end-of-life.	☐
16. Recognize that a patient’s ability to make decisions may fluctuate towards the end-of-life.	☐
17. Collaborate with the patient and their family to identify resources that will provide support during end-of-life care.	☐
18. Facilitate conversations to support end-of-life decision making.	☐
19. Identify the patient’s and family’s values, beliefs and preferences regarding the various components of palliative care provision.	☐
20. Collaborate within and between teams across the continuum of care to facilitate continuity in palliative care.	☐
21. Recognize clinical limitations and professional boundaries.	☐
22. Where clinical limitations and professional boundaries exist refer to another appropriate member of the interprofessional team in a timely manner.	☐
23. Identify the impact of family role change when formulating relevant and realistic care plans.	☐
Some	**Educational Opportunity**
1. Contribute to discussion around decision making with the patient, their family, the ADM and the interprofessional team about withdrawing or withholding interventions, while recognizing when to reinitiate interventions.	☐

Few	Educational Opportunity
1. Apply an advanced level of discipline-specific clinical expertise in supporting the patient and their family to adapt to the changing clinical presentation.	☐
2. Apply an advanced level of clinical expertise and sensitivity in facilitating safe, smooth and seamless transitions of care for each patient and their family.	☐
3. Support the interprofessional team caring for the palliative care patient and their family.	☐

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. Explain the significance of anticipating and responding to the needs of the patient and their family in a proactive, timely manner.	☐
3. Explain the concept of ‘total pain’.	☐
4. Recognize the benefits of interprofessional approaches in optimizing comfort and enhancing the quality of life of the patient.	☐
5. Help each patient with a life-limiting illness and their family adapt to a transition from life prolonging treatment to a focus on palliative care.	☐
6. 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.	☐
7. Identify the uniqueness of a good death for each patient and their family.	☐
8. Identify the benefits and burdens of palliative care treatment options.	☐
9. Identify evidence informed pharmacological and non-pharmacological approaches for symptom management at end-of-life.	☐
10. Use non-pharmacological symptom management to promote comfort and quality of life.	☐

11. Recognize the significance of the physical, psychological, social and spiritual issues that may precipitate concerns for the patient and their family.	☐
12. Recognize common trajectories of life-limiting illnesses, including common symptoms.	☐
13. Explore own responses in the presence of a patient who is suffering.	☐
14. Attend to the patient's and family's suffering.	☐
15. Provide care in keeping with the patient's goals of care and/or advance care plan.	☐
16. Consider the benefits, burdens and risks of clinical respiratory interventions related to palliative care.	☐
17. Act as a resource regarding the role of discipline-specific interventions in symptom management and optimizing quality of life.	☐
18. Assess dyspnea on the basis of patient self-reporting, as well as clinical signs, lung function tests and/or oxygen saturation based on the patient's goals of care and disease trajectory.	☐
19. Use non-pharmacological interventions to reduce dyspnea prior to pharmacological interventions (e.g. oxygen for hypoxia related dyspnea).	☐
20. Manage all respiratory symptoms for comfort at end-of-life as per care plan.	☐
21. Provide education to the patient and their family regarding respiratory changes at end-of-life.	☐
22. Formulate a respiratory care plan for the palliative care patient, taking into account the patient's goals and expectations.	☐
23. Administer cardio-pulmonary diagnostic tests for the palliative care patient in keeping with their goals and care plan.	☐
24. When in keeping with the patient's goals of care or the ADM's wishes, perform invasive procedures and/or diagnostic testing for palliative care patients where indicated.	☐
25. When in keeping with the patient's goals of care or the ADM's wishes, implement or withdraw treatment with mechanical devices.	☐
Some	**Educational Opportunity**
1. Apply the principles of symptom management.	☐
2. Provide education to the patient and their family regarding the management of symptoms, including practical strategies.	☐
3. Discuss the benefits and burdens of palliative care treatment options to assist the patient in meeting their goals of care.	☐
4. Implement evidence informed non-pharmacological and pharmacological approaches for symptom management at end-of-life.	☐

5. Identify patients who would benefit from the Emergency Medical Services Palliative and End-of-Life Care Assess, Treat and Refer (EMS PEOLC ATR) program and refer as appropriate.	☐
6. Address the physical, psychological, social and spiritual issues that may precipitate concerns for the patient and their family and refer as appropriate.	☐
Few	**Educational Opportunity**
1. Apply advanced symptom management.	☐
2. Apply comprehensive knowledge and understanding of the clinical presentation and disease trajectories of life-limiting illnesses when responding to complex and multidimensional care needs, in order to comprehensively identify current and prospective clinical issues in palliative care.	☐
3. Act as an expert resource regarding the role of discipline-specific interventions in symptom management and optimizing quality of life.	☐

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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. Recognize the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief.	☐
3. Recognize the factors that may increase the risk for complicated grief.	☐
4. Recognize a variety of psychological responses to a diagnosis of a life-limiting illness.	☐
5. Identify networks and supports across a range of family needs into bereavement and refer as appropriate.	☐
6. Identify those experiencing or at risk for complicated and disenfranchised grief and discuss, document and refer as appropriate.	☐

7. Recognize pathological responses to loss and refer to the most appropriate health care professional(s) as needed.	☐

Notes:

Domain 6: Professional and Ethical Practice	
All	**Educational Opportunity**
1. Engage with the patient and their family experiencing loss and suffering.	☐
2. Address ethical and legal issues that may be encountered when caring for a patient with a life-limiting illness and their family.	☐
3. Respect each patient's and family's wishes regarding their care options and preferences.	☐
4. Respect the patient's and their family's decision regarding initiating, not initiating, withholding and withdrawing life sustaining/prolonging interventions (e.g. dialysis, hydration, nutrition support, resuscitation, and non-invasive ventilation).	☐
5. Explain the difference between managing a condition and providing end-of-life care.	☐
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 strategies to navigate the complexities in communication regarding end of life options such as MAID.	☐
8. Respond to inquiries regarding MAID in accordance with regulatory expectations and/or employer policies and procedures.	☐
9. Describe the ethical issues related to invasive and non-invasive ventilation and oxygen therapy.	☐
Some	**Educational Opportunity**
1. Apply a comprehensive understanding of contemporary legal, ethical and professional standards to the provision of quality palliative care.	☐

2. Facilitate discussion and resolution of ethical and legal issues in conjunction with each patient, their family and their care team.	☐

Notes:

Domain 7: Cultural Safety	
All	**Educational Opportunity**
1. Describe the influence of culture on key issues in palliative care.	☐
2. Respect the patient's and family's social, spiritual and cultural values and practices that may influence their care preference.	☐
3. Assess the end-of-life needs unique to each patient and their family, considering ethnicity, culture, gender, sexual orientation, language, religion, age, ability and preferences.	☐
4. Validate cultural preferences and values by identifying ways to accommodate them into goal setting, decision making and care planning.	☐
5. Respect who the patient identifies as family.	☐
6. Respond to the family members' unique needs and experiences, where appropriate.	☐
7. Access resources related to the patient's and family's cultural needs and preferences.	☐
Few	**Educational Opportunity**
1. Identify various preferences related to end-of-life care, which may include, but is not limited to cultural, religious and spiritual preferences.	☐

Notes:

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

Notes:

Domain 9: Education, Research and Evaluation	
All	**Educational Opportunity**
1. Participate in palliative care continuing education opportunities.	☐
2. Reflect on outcomes based on standards and guidelines.	☐
3. Contribute to the evaluation of the quality of palliative care	☐
4. Educate patients and families about palliative care and a palliative approach.	☐
Some	**Educational Opportunity**
1. Act as an expert resource contributing to palliative care development and delivery.	☐
2. Critically evaluate outcomes against standards and guidelines.	☐
Few	**Educational Opportunity**
1. Lead and develop education initiatives in palliative care.	☐
2. Lead and develop research in palliative care.	☐

Domain 10: Advocacy	
All	**Educational Opportunity**
1. Advocate for the patient’s and their family’s needs, decisions and rights by recognizing potential vulnerabilities.	☐
2. Support autonomous decision-making.	☐
3. Advocate for Health Care Providers (HCPs) to participate in palliative care continuing education opportunities.	☐
4. Advocate for HCPs to have adequate resources to provide quality palliative care.	☐
5. Advocate for the patient and their family to access appropriate and timely palliative care.	☐
Some	**Educational Opportunity**
1. Advocate for the development, maintenance and improvement of health care and social policy related to palliative care.	☐
Few	**Educational Opportunity**
1. Influence and promote strategic initiatives and policy development for palliative care and palliative care respiratory therapy services at local, regional and national levels.	☐
2. Act as an expert resource contributing to palliative care service development and delivery across all clinical settings including primary, acute, tertiary and residential care.	☐

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.

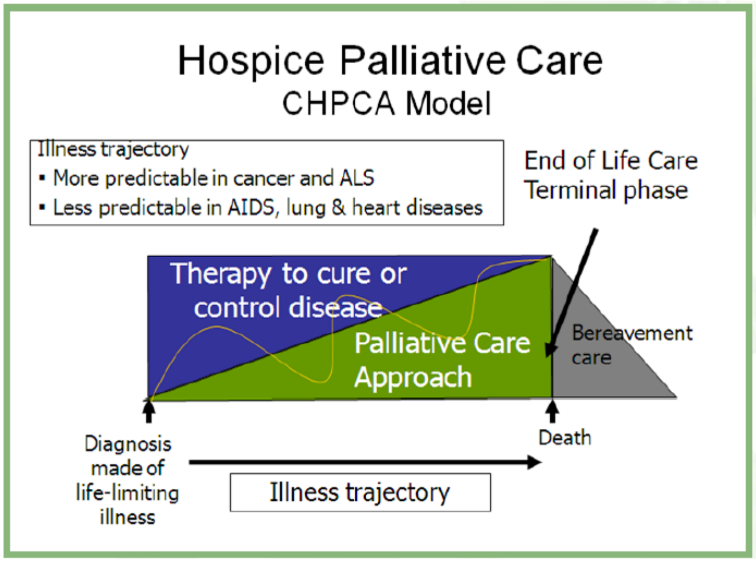
Imminently dying: Any patient who, according to the most responsible health practitioner's clinical assessment, is within the last hours to days of life.

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

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

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

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

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

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

Last but not least, the development of these competencies would not have been possible without the support of the members of the Alberta Health Services Provincial Palliative and End-of-Life Innovations Steering Committee, the Alberta Palliative Care Competencies Advisory Working Group and all the members of the Alberta Respiratory Therapists’ Palliative Care Competencies Working Group.

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