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

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

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

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

Fax: 780-735-7302

E-mail: Palliative.Institute@covenanthealth.ca

Table of Contents

Dedication

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

Forward

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

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

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

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

Alberta Spiritual Care Practitioners’ Palliative Care Competencies Referent Group

The Alberta Spiritual Care Practitioners’ Palliative Care Competencies Referent Group below assisted in recruiting individuals participating in the production of the Alberta Spiritual Care Practitioners’ Palliative Care Competency Framework. This includes members of the Alberta Palliative Care Competencies Advisory Working Group and the Alberta Spiritual Care Practitioners’ 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 Spiritual Care Practitioners’ 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
• Alberta Kidney Care South
• Calgary Zone Palliative and End-of-Life Care Program
• Calgary Zone Palliative Home Care
• Edmonton Zone Palliative Care Program
• Edmonton Zone Palliative and End-of-Life Care and Community Programs, Continuing Care
• Provincial Palliative and End-of-Life Care, Community, Seniors, Addiction and Mental Health
• Red Deer Regional Hospital Centre
• Royal Alexandra Hospital, Edmonton
Covenant Health
• Bonnyville Health Centre
• Edmonton General Continuing Care Centre
• Professional Practice and Research
• Tertiary Palliative Care Unit, Grey Nuns Community Hospital, Edmonton
• Villa Caritas, Edmonton</td><td>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</td></tr>
</table>

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 Spiritual Care Practitioners’ 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 Spiritual Care Practitioners’ Palliative Care Competency Framework which was developed by the Alberta Spiritual Care Practitioners’ Palliative Care Competency Working Group.

Competency statements are organized according to the following two dimensions:

1. Level of expertise
2. Competency domains

---

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

Level of Expertise

According to the Alberta Palliative Care Competency Triangle (Figure 1), HCPs have varying levels of palliative care expertise depending on how frequently and closely they work with patients who have life-limiting illnesses.

The Alberta Palliative Care Competency Triangle and associated definitions are adapted from the Irish and BC palliative care frameworks. The Alberta Palliative Care Competency Triangle is divided into three health care provider (HCP) levels of expertise, represented by ALL, SOME and FEW. Each level of expertise requires a different set of competencies. They are separated by a dotted line to highlight that some HCPs may fit into more than one category. Each HCP level includes the competencies from the ones above it. For example, HCPs in the SOME category would also be expected to have the competencies outlined in the ALL level, and HCPs in the FEW level would be expected to have the competencies from the ALL and SOME levels.

Figure 1: The Alberta Palliative Care Competency Triangle

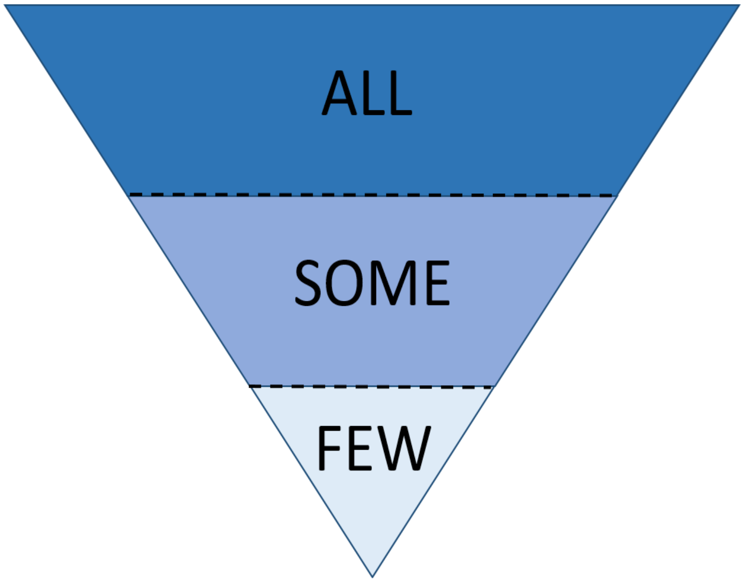


Table 1: Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions
All: HCPs in this level provide care within their scope of practice, to any person in any care setting, including those with life-limiting illnesses. They have foundational knowledge and skills in palliative care. This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

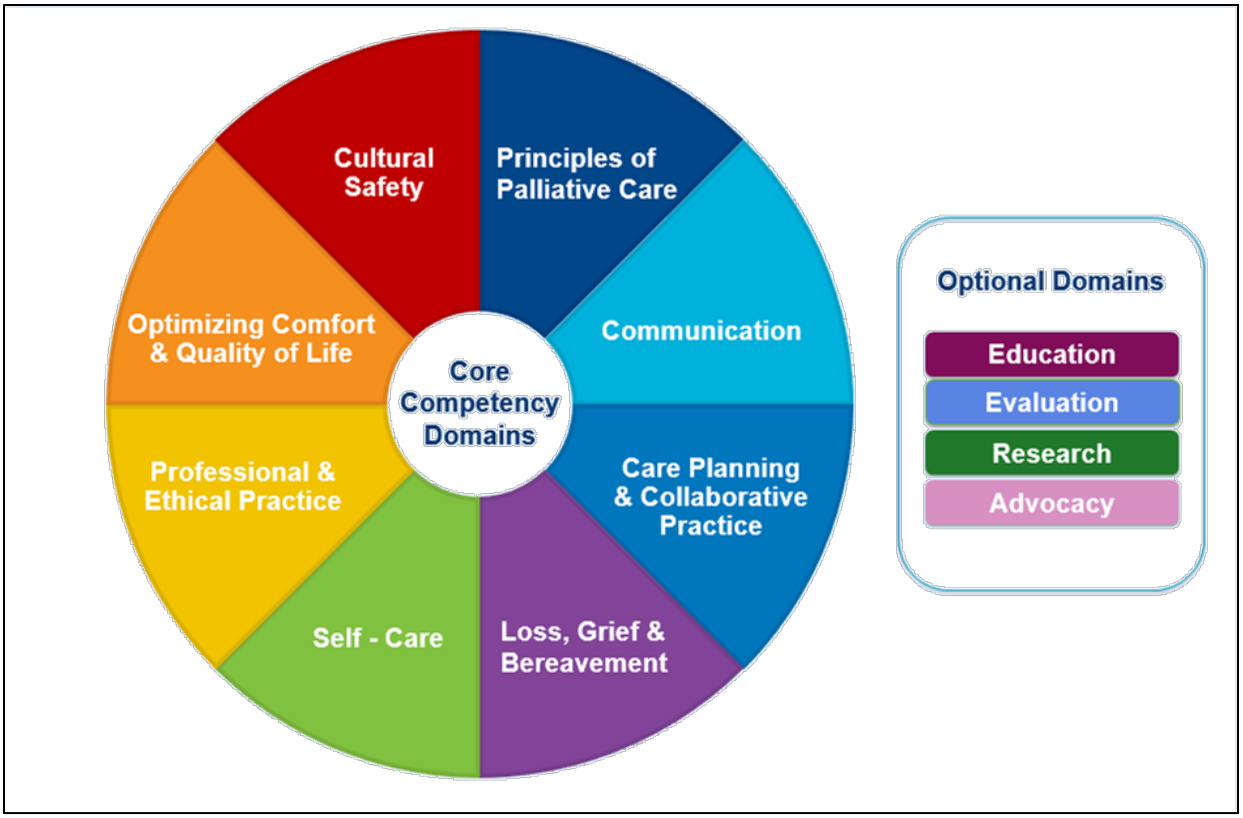
Table 1 Continued: Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions
Some: These HCPs have deeper knowledge, understanding and application of palliative and end-of-life care. HCPs in this level also provide care in any setting. They have expertise in palliative and end-of-life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

Competency Domains

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

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

Figure 2. Alberta Palliative Care Competency Domains



Domain 1: Principles of Palliative Care
Palliative care is both a philosophy and an approach to care that enables all patients with a life-limiting illness to receive integrated and coordinated care across the continuum of life. This care incorporates each patient's and family's values, preferences and goals of care, and spans the disease process from diagnosis to end-of-life, including bereavement. The following principles are foundational in providing palliative care to each patient and their family within Alberta: patient- and family-centeredness; equitable access; collaborative and integrated team service delivery; communication and information sharing; safe; ethical and quality care; sustainability and accountability; clearly defined governance and administration models; and research.

Domain 2: Communication
Communicating effectively is essential to the delivery of palliative care. Specific consideration should be given to communication as a method of establishing therapeutic relationships and patient/family participation in decision-making. Empathetic, person to person communication is foundational to palliative care. Communication is also important where circumstances are ambiguous or uncertain or when strong emotions and distress arises. Effective communication includes information technology (i.e. NetCare, Connect Care) for knowledge transfer at all levels (patient and family, service delivery and system) and the use of common tools, language and utilization of the most appropriate documentation to support seamless transitions of

each person, to convey appropriate information and to safely manage each person's and family's care needs.

Domain 3: Care Planning and Collaborative Practice

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

Domain 4: Optimizing Comfort and Quality of Life

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

Domain 5: Loss, Grief and Bereavement

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

Domain 6: Professional and Ethical Practice

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

Domain 7: Cultural Safety

Cultural safety is a process that encourages a patient to feel safe, without any fear of judgement, repercussions, discrimination (individual or systemic), or assault because of their needs and identities. It is defined and experienced by the patient. It is based on respectful engagement, and communicating respect for a patient's beliefs, behaviors, and values and ensures that the patient is a partner in decision making. It requires acknowledgement that we are all bearers of culture including the need for self-reflection about one's own attitudes, beliefs, assumptions and values. It requires recognition of the power differentials inherent in healthcare service delivery, institutional discrimination, and the need to address these inequities through education and system change. Assessing and respecting values, beliefs and traditions related to health, illness, family caregiver roles and decision-making are the first step in providing spiritually and culturally sensitive palliative care. Culturally safe care involves building trust with the patient and recognizing the role of socioeconomic conditions, history and politics in health. It requires awareness of family dynamics and the role the family plays in the cultural safety of the patient. Cultural competency is the process HCPs achieve with cultural safety being the outcome. [Health Council of Canada]

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

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

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

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

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

Alberta Spiritual Care Practitioners' Palliative Care Competencies

Domain 1: Principles of Palliative Care

All	Educational Opportunity
1. Explain the philosophy of palliative care and a palliative approach.	☐
2. Describe the meaning of the term 'life-limiting illness'.	☐
3. Demonstrate an understanding that a palliative approach starts early in the trajectory of a life-limiting illness and may be appropriate at the time of diagnosis.	☐
4. 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.	☐
5. Describe the role and function of the interprofessional team in palliative care.	☐
6. Describe the role and function of the Palliative Care Consult Team.	☐
7. Offer support and encouragement to the interprofessional team to promote well-being and self-care.	☐
8. Interpret the impact of family role change.	☐
9. Recognize that spiritual care, provided by a certified spiritual care practitioner, is an essential of holistic care for the patient with a life-limiting illness and their family.	☐
10. Understand the nature of spirituality, recognizing that everyone has a spiritual dimension and that for many people this may have a religious component.	☐
11. Recognize that the opportunity for human development (physical, emotional and spiritual) is an essential component of palliative care.	☐
12. Understand and appreciate that spiritual and emotional pain often results from a loss of meaning and unmet spiritual needs.	☐
13. Understand and respect that one's own belief system and social/cultural environment influence our professional practice and how we interact with and listen to our patients.	☐
14. Integrate spiritual and/or religious care into palliative care when appropriate.	☐
15. Apply models of palliative care that promote dignity when providing care (e.g. Dignity Conserving Care).	☐
16. Establish a spiritually engaged therapeutic connection with the patient who is experiencing spiritual distress and pain to assess needs and develop a care plan.	☐

17. Demonstrate awareness of the nature of existential suffering, where it is a normal symptom of living with a progressive illness and knowledge of impending death.	☐
18. Assist the patient with a life-limiting illness to discern their spiritual needs, creating a safe space where they can name and address them.	☐
19. Demonstrate the ability to articulate important spiritual, existential and emotional concepts for the patient and their family.	☐
20. Demonstrate foundational understanding of world faiths, philosophies, beliefs, practices, cultures and traditions regarding life, illness, dying, death and bereavement.	☐
21. Demonstrate an awareness of the impact of multiple losses when formulating relevant and realistic treatment programs.	☐
22. Understand the unique contributions of family caregiving in the practice of patient and family-centered palliative care.	☐
Some	**Educational Opportunity**
1. Be committed to ongoing spiritual, personal, clinical and professional development.	☐
2. Facilitate empathic and responsive relationships between the patient and their family and the interprofessional team.	☐
3. Demonstrate leadership that encourages colleagues to foster a caring environment that supports all staff working in sensitive situations.	☐
Few	**Educational Opportunity**
1. Be familiar with family systems practice and its importance within palliative care.	☐
2. Demonstrate an understanding of palliative care standards and best practices.	☐
3. Take a leadership role in the delivery of spiritual and/or religious care within the context of an interprofessional team approach.	☐

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 and their family.	☐
4. Recognize the potential for conflict in decision-making.	☐
5. Adapt communication and information sharing to the unique needs of the patient and their family.	☐
6. Engage in specialist support as needed to bridge communication barriers (e.g. interpreter, sign language interpreter and assistive technology).	☐
7. Provide patient and family-centered focused spiritual care that respects diversity in all its dimensions.	☐
8. Use age appropriate communication in the provision of professional spiritual care.	☐
9. Be sensitive to the significant changes in the patient's condition when moving toward end-of-life.	☐
10. Facilitate the patient and their family to consider options for spiritual care and support.	☐
11. Engage respectfully and sensitively with the patient around their beliefs, fears, hopes and uncertainties regarding death and after-life.	☐
12. Through spiritual accompaniment, help the patient to make their final journey with dignity, peace and compassion, while also providing support to their family.	☐
13. Understand and practice appropriate principles of confidentiality in relation to matters of a private and sensitive nature.	☐
14. Apply best practice in spiritual assessment and documentation to determine and communicate interprofessional plan of care.	☐
15. Respond appropriately to those who are dissatisfied with palliative care services.	☐
16. Provide culturally relevant information and resources to support the patient and their family.	☐
17. Demonstrate self-awareness of own responses to communication challenges.	☐
18. Support the interprofessional team in sharing difficult or bad news, relating to illness or death, where appropriate.	☐

Some	**Educational Opportunity**
1. Provide spiritually and culturally appropriate spiritual care support during patient and family conferences and when participating in support groups.	☐
2. Effectively communicate with the patient and their family to devise care plans for the patient's palliative care needs and communicate these plans to the team.	☐
3. 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.	☐
4. Demonstrate the ability to apply knowledge of the key physical, psychological and social principles in palliative care in order to communicate effectively with the interprofessional team.	☐
5. Assess the patient's and their family's understanding of the life-limiting illness and its trajectory.	☐
Few	**Educational Opportunity**
1. Use a variety of strategies to engage in highly skilled, compassionate, individualized and timely communication with the patient, their family and the interprofessional team.	☐
2. Demonstrate expertise as a mediator.	☐
3. Facilitate discussions between the patient, their family and the interprofessional team and recognize potential differences in decision-making in the context of palliative care.	☐
4. Understand how different styles of communication can be adapted and used to enhance communication in complex situations at end-of-life.	☐
5. Maintain ongoing communication with the patient, their family and the interprofessional team regarding the end-of-life plan of care.	☐

Notes:

Domain 3: Care Planning and Collaborative Practice	
All	**Educational Opportunity**
1. 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 interprofessional team member.	☐
2. Recognize the overall impact of a life-limiting illness on the patient and their family, providing support to address identified needs.	☐
3. Recognize that the patient may lose cognitive and functional capacity to make decisions towards end-of-life.	☐
4. Respect professional boundaries when offering and providing spiritual care to the patient, their family and when interacting with other members of the interprofessional team.	☐
5. Document appropriate referrals following spiritual assessment (e.g. referral to the patient's own faith representative if requested).	☐
6. Engage in interprofessional team meetings, highlighting and addressing spiritual issues and suggesting appropriate responses for identified spiritual needs.	☐
7. When able, provide care in the patient's preferred place, while recognizing the complexities and challenges involved for the patient and their family.	☐
8. Recognize how interprofessional practice enhances patient outcomes when caring for a patient with a life-limiting illness.	☐
9. Identify priorities and concerns in collaboration with the patient and their family, taking into account their coping strategies and perception of diagnosis.	☐
10. Recognize the collaborative relationship between the patient with a life-limiting illness, their family and the interprofessional team.	☐
11. Facilitate and advocate for patient and their family's access to needed services and resources.	☐
12. Demonstrate leadership within the interprofessional team in identifying spiritual and/or religious issues.	☐
Some	**Educational Opportunity**
1. Understand and identify appropriate times to engage in advance care planning discussions.	☐
2. Identify families in need of respite care and make appropriate referrals.	☐
3. Facilitate collaborative processes and interprofessional relationships that respect the principles of holistic care within the wider health care institutional culture.	☐

4. Be able to quantify the benefits and measurable outcomes of spiritual care interventions through reflecting on expressed patient and family satisfaction.	☐
5. Work collaboratively with the patient, their family and the interprofessional team, including attending patient and family meetings, team meetings, mediating discussions and planning for future care.	☐
6. Enable the patient and their family to make an informed decision regarding place of care.	☐
7. Collaborate within and between teams across the continuum of care to facilitate continuity in palliative care.	☐
8. Integrate patient and their family's strengths in plan of care.	☐
9. Collaborate with the interprofessional team for the holistic management of pain and other symptoms.	☐
10. Facilitate the active involvement of the patient in goal setting, decision making and informed consent to support the best possible outcomes and quality of life.	☐

Few	**Educational Opportunity**
1. Develop a plan of care for the family.	☐
2. Collaborate effectively with the patient, their family and the interprofessional team to define goals of care and to develop, implement and evaluate a plan of care.	☐
3. Facilitate conversations to support end-of-life decision making.	☐
4. Identify the patient's and their family's values, beliefs, and preferences regarding the various components of palliative care provision.	☐
5. Demonstrate knowledge of the range of palliative care services and resources.	☐
6. Identify and access services and resources specific to the patient's goals of care.	☐
7. Initiate referrals to and requests for resources, services and settings.	☐
8. Collaborate with the patient and their family to identify resources that will provide support during end-of-life care.	☐
9. Provide relevant palliative care related information and resources to the patient and their family.	☐
10. Demonstrate an understanding of advance care planning and goals of care designations, according to institutional policy and procedure.	☐
11. Demonstrate an understanding of the role of an alternate decision-maker in patient care.	☐

Notes:

Domain 4: Optimizing Comfort and Quality of Life	
All	**Educational Opportunity**
1. Recognize how a palliative approach can enhance the assessment and management of symptoms.	☐
2. Use non-pharmacological symptom management to promote comfort and quality of life.	☐
3. Provide care in a compassionate manner.	☐
4. Demonstrate awareness of one's own responses in the presence of a patient who is suffering.	☐
5. Provide care in keeping with the patient's expressed wishes and identified goals of care.	☐
6. Help the patient and their family to adapt to a transition from life prolonging treatment to a focus on palliative care.	☐
7. Recognize pathological responses to loss, referring appropriately to the Palliative Care Consult Team.	☐
8. Offer reassurance to the patient and their family that spiritual care practitioners are capable of accompanying persons of all religious traditions, as well as those who do not identify as religious, regardless of life philosophy or worldview.	☐
9. Assess the spiritual/religious needs of the patient with a life-limiting illness and share as appropriate with the interprofessional team.	☐
10. At the request of the patient or their family, liaise with the patient's parish clergy, faith group, spiritual companions/leaders and/or other community religious/spiritual and cultural resources.	☐
11. Recognize the signs of approaching death.	☐
12. Facilitate the patient's and their family's wishes for death rituals.	☐

13. Assist members of the interprofessional team to understand the nature and importance of addressing the spiritual and religious needs of the patient and how these may impact on wellbeing.	☐
14. Engage the patient and their family in discussions of the spiritual and/or existential distress that may accompany pain and illness.	☐
15. Demonstrate an understanding of the uniqueness of a good death for each patient and facilitate its achievement.	☐
16. Support the patient, their family and interprofessional teams with end-of-life decision making, including withdrawing or withholding interventions.	☐
17. Recognize the physical, psychological, social and spiritual issues that affect the patient and their family.	☐
18. Apply interprofessional approaches to optimize comfort and enhance quality of life of the patient and their family.	☐
19. Recognize the ways in which the patient can be engaged in self-management of their illness.	☐
20. Recognize a need for a change in the focus of care and treatment goals as the patient’s illness progresses.	☐
21. Use spiritual, cultural, and religious reflection in exploring and making meaning of one's situation.	☐
22. Encourage the patient and their family to share fears, concerns, hopes, dreams, creative expression, intuition and awareness of relationships, including the divine and transcendent.	☐
Some	**Educational Opportunity**
1. Demonstrate an ability to analyze and integrate appropriate knowledge and information to inform decision making in end-of-life care.	☐
2. Support the interprofessional team in their understanding and consideration of the patient's wishes when considering treatment and care options.	☐
3. Recognize common illness trajectories, including common symptoms.	☐
4. Recognize that symptoms and symptom meaning is highly subjective and should be assessed and understood from a patient-centered perspective.	☐
5. Recognize when physiological and/or psychological symptoms are limiting engagement with or effectiveness of care and engage in consultation with other professionals as needed.	☐
6. Demonstrate awareness of and support best practices for expected death, including local and organizational policies and processes.	☐

7. Facilitate expression of the patient's and their family's beliefs, values, needs and desires that shape the patient's choices and interactions.	☐
8. Provide care to ameliorate the interconnected sufferings of body, mind and spirit that accompanies the dying process.	☐
Few	**Educational Opportunity**
1. Utilize philosophical, spiritual, religious, socio-cultural and psychological perspectives on human development and life transitions to gain an understanding of the patient's and their family's source(s) of spiritual strength, hope, methods and ways of coping, needs, risks and wellness goals.	☐
2. Co-develop, with the patient and their family, a spiritual care plan that complements and is integrated with their care plan, treatment and interventions.	☐
3. Provide a variety of interventions and approaches to spiritual care related to needs assessment and co-developed interprofessional care plans.	☐
4. Assist the patient and their family in the evaluation of the role and function of spiritual or religious identity.	☐
5. Facilitate contextualized meaning-making as it relates to the sacred or religious dimensions of life.	☐
6. Enable reconciliation with the patient, their family, communities and the interprofessional team (e.g., conflict management, forgiveness, and relational growth).	☐
7. Identify potential psycho-spiritual barriers to providing pain management.	☐
8. Act as an expert resource regarding the role of discipline-specific interventions.	☐
9. Provide specialist spiritual care interventions based on continuing assessment of palliative care needs.	☐
10. Provide a relational, patient and family-centered approach to assessment and care that sensitively engages the patient and their family in their healing process.	☐
11. Assess for spiritual distress, meaningless, or hopelessness.	☐
12. Articulate the appropriate use of authority at key transitional moments in the spiritual companionship of the dying.	☐
13. Describe the causes of common non-pain symptoms at end-of-life.	☐

Notes:

Domain 5: Loss, Grief and Bereavement	
All	**Educational Opportunity**
1. Work in partnership with the patient's faith group, faith leaders and other community religious, spiritual and cultural resources to ensure that all sacramental, religious, faith based and ceremonial rituals are met in a timely and appropriate manner.	☐
2. Work in partnership with parents/guardians and family members to prepare and support children and vulnerable adults for the loss of loved ones.	☐
3. Provide appropriate spiritual care and emotional support to grieving persons of diverse cultural and religious traditions and to persons with no affiliation to a faith tradition.	☐
4. Plan and lead services suitable for specific faith traditions and also ecumenical and interfaith services.	☐
5. Demonstrate knowledge of grief and bereavement to support others from a cross-cultural perspective.	☐
6. Recognize the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief.	☐
7. Provide appropriate guidance, support and information to the patient's family, based on awareness of cultural needs and direct them to bereavement services as required.	☐
8. Accurately assess the patient's and their family's loss, grief and bereavement needs.	☐
Some	**Educational Opportunity**
1. Recognize the factors that may increase the risk for grief difficulties.	☐
2. Demonstrate cultural awareness of the nuances of pain, suffering, loss, complicated and anticipatory grief and life review.	☐
Few	**Educational Opportunity**
1. Demonstrate a comprehensive knowledge of the grieving process and reactions in order to support patients and their families throughout the illness trajectory.	☐
2. Provide multidisciplinary team debriefing and support the development of self-care strategies for colleagues working in end-of-life care.	☐
3. Identify those experiencing or at risk for complex and disenfranchised grief, talking with the affected patient or their family members, and communicate this through consultation, clinical documentation and making appropriate referrals.	☐
4. Articulate important spiritual, existential and emotional concepts for the patient and their family.	☐

5. Mentor and educate colleagues regarding the personal impact of loss, grief, and bereavement, supporting them to recognize their own loss responses and encourage engagement in activities to maintain their resilience.	☐

Notes:

Domain 6: Professional and Ethical Practice	
All	**Educational Opportunity**
1. Anticipate and address ethical and legal issues that may be encountered when caring for a patient and their family.	☐
2. Explore and respect the patient's wishes regarding their care options and preferences.	☐
3. Respect the patient’s decisions 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.	☐
4. Respond to inquiries regarding Medical Assistance in Dying (MAID) in accordance with regulatory body's relevant guidelines and standards and employer policy.	☐
5. Demonstrate maintenance of one's integrity and authenticity in practice during the process of assisting others in moral and ethical decisions.	☐
6. Participate in patient and family meetings honoring diverse ethnic, cultural, religious and faith traditions and philosophical world views.	☐
7. Recognize when beliefs, attitudes, and values limit one's own ability to be present and provide patient and family-centered care to the patient with a life-limiting illness and their family.	☐
8. Collaborate with others to ensure optimal care is provided in the circumstance when one's own beliefs, attitudes, and values limit one's ability to be present and provide patient and family-centered care to the patient with a life-limiting illness and their family.	☐

9. Respect and uphold the dignity of the person who is receiving palliative care.	☐
10. Recognize and articulate challenging areas of ethical sensitivity and awareness in palliative care.	☐
11. Engage in reflective practice to promote greater self-awareness and ability to critically evaluate one's own practice within end-of-life care.	☐
12. Utilize professional supervision to ensure best practice in end-of-life care and to meet organizational and professional requirements.	☐
13. Practice in accordance with the Code of Ethics and Professional Conduct for Spiritual Care Practitioners and Psycho-Spiritual Therapists set out by the Canadian Association for Spiritual Care/Association canadienne de soins spirituels (CASC/ACSS).	☐
14. Acknowledge the patient's right to informed consent and to self-determination with respect to declining or withdrawing treatment in the context of relevant federal, provincial or religious community guidelines on medical decision-making.	☐
15. Engage with the patient and their family experiencing loss and suffering.	☐
16. Be aware of the difference between managing a condition and providing end-of-life care.	☐
17. Advocate for plans of care that accurately reflect the patient's and their family's stated beliefs, values, culture and preferences.	☐
Some	**Educational Opportunity**
1. Communicate and advance the distinct contribution of spiritual care to palliative care.	☐
2. Participate in patient and family meetings around ethical decision-making for the patient and their family honoring diverse ethnic, cultural, religious/faith tradition and philosophical world views.	☐
3. Demonstrate leadership through advocating for on-going and continuous service development	☐
4. Describe distinctions among ethical and legal concepts, such as: the principle of double effect, palliative sedation and MAID.	☐
5. Demonstrate awareness of faith tradition directives regarding MAID, the provision, withholding and withdrawal of life-sustaining treatments.	☐
Few	**Educational Opportunity**
1. Apply a comprehensive understanding of contemporary legal, ethical and professional standards to the provision of quality palliative care.	☐

2. Facilitate discussion and resolution of ethical and legal issues in collaboration with the patient, their family and other appropriate members of the interprofessional team.	☐
3. Actively participate in and promote palliative care strategic initiatives and policy development.	☐
4. Demonstrate an understanding of the process of quality improvement in the context of palliative care.	☐
5. Articulate ethical issues regarding the use of palliative sedation therapy.	☐
6. Be informed of relevant legislation and policies, e.g. Bill C-14 Medical Assistance in Dying; 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.	☐

Notes:

Domain 7: Cultural Safety	
All	**Educational Opportunity**
1. Describe the influence of culture on key issues in palliative care.	☐
2. Understand health, wellness and serious illness from diverse perspectives.	☐
3. 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.	☐
4. Respect the patient's and their family's social, spiritual and cultural values and practices that may influence their care preference.	☐
5. Assess the unique needs and preferences of patients and their families considering social determinants of health, ethnicity, culture, gender identity, sexual orientation, language, religion, age and ability.	☐
6. Provide opportunities for patients and their families to exercise religious, cultural and spiritual rituals, customs, rites and beliefs at end-of-life.	☐

7. Respect who the patient identifies as family.	☐

Notes:

Domain 8: Self-Care	
All	**Educational Opportunity**
1. Demonstrate an understanding of the personal impact of loss, grief and bereavement.	☐
2. Identify one’s own responses to loss.	☐
3. Identify one’s own attitudes regarding death, dying and caring for a patient with a life-limiting illness and their family.	☐
4. Identify the impact of past experiences of suffering, death and dying when caring for a patient and their family.	☐
5. Attend to own emotional responses that result from caring for a patient with palliative care needs and their family.	☐
6. Recognize compassion fatigue in one’s self and colleagues.	☐
7. Practice self-care to maintain resilience, competence and compassion.	☐
8. Engage in healthy activities that help prevent compassion fatigue when caring for a patient and their family.	☐

Notes:

Domain 9: Education, Research and Evaluation	
All	**Educational Opportunity**
1. Demonstrate familiarity with research in palliative care and use this to inform practice.	☐
2. Critically evaluate outcomes against standards and guidelines.	☐
3. Participate in palliative care continuing education opportunities.	☐
4. Educate the patient and their family about palliative care and a palliative approach.	☐
5. Contribute to the evaluation of the quality of palliative care.	
Some	**Educational Opportunity**
1. Apply knowledge gained from palliative care research.	☐
Few	**Educational Opportunity**
1. Where possible, lead, facilitate, and engage in education and research.	☐
2. Contribute to the evaluation of the quality of palliative care and the effectiveness of the Palliative Care Consult Team.	☐
3. Where possible, provide the patient and/or their family with opportunities to participate in research regarding end-of-life care.	☐
4. Acts as a resource, contributing to palliative care development and delivery.	☐
5. Participate in and/or promote research and knowledge translation in spiritual care and palliative care, where possible.	☐
6. Develop, facilitate and provide palliative care related education, leadership and mentorship to members of the discipline and students.	☐
7. Where possible, identify the opportunities for and barriers to discipline-specific research unique to palliative care.	☐

Notes:

Domain 10: Advocacy	
All	**Educational Opportunity**
1. Advocate for the place of spiritual and religious care in palliative care.	☐
2. Support autonomous decision-making.	☐
Few	**Educational Opportunity**
1. Advocate for the needs, decisions and rights of the patient by recognizing potential vulnerabilities.	☐
2. Advocate for the development, maintenance and improvement of health care and social policy related to palliative care.	☐
3. Advocate for health care professionals to participate in palliative care continuing education opportunities.	☐
4. Advocate for health care professionals to have adequate resources to provide quality palliative care.	☐
5. Promote equitable and timely access to resources.	☐

Notes:

Appendix 1: Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

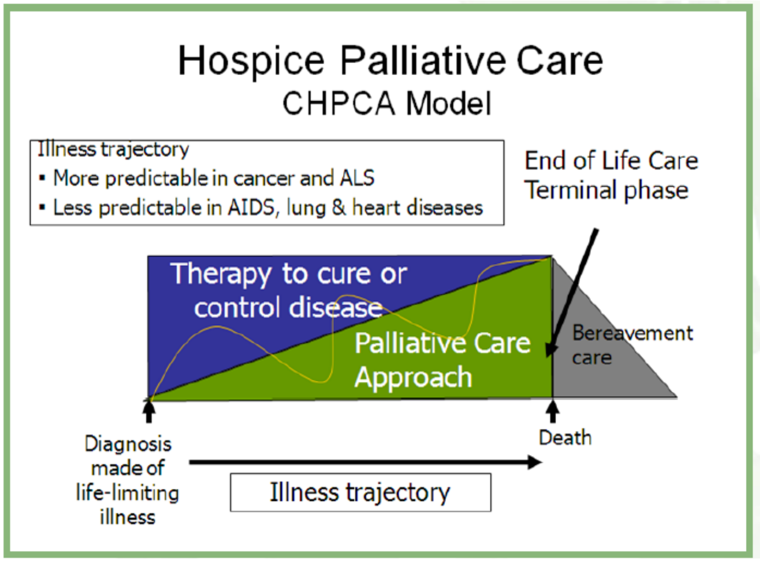
Interprofessional: interprofessional collaboration occurs when health professionals from different disciplines work together to identify needs, solve problems, make joint decisions on how best to proceed and evaluate outcomes collectively. Interprofessional collaboration supports patient-centered care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

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

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

Palliative and end-of-life care: is both a philosophy and an approach to care that enables all individuals with a life-limiting and/or life-threatening illness to receive integrated and coordinated care across the continuum. This care incorporates patient and family values, preferences and goals of care, and spans the disease process from early diagnosis to end of life, including bereavement. Palliative care aims to improve the quality of life for patients and families facing the problems associated with a life-limiting illness through the prevention and relief of suffering by means of early identification, comprehensive interdisciplinary assessments and appropriate interventions [Alberta Health Services].

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



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

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

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

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

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

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

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

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

Appendix 2: Additional Resources

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

Canadian Association for Spiritual Care. (2017). *Common qualifications and competencies for professional chaplains.* https://spiritualcare.ca/professional_practice_home/common-standards/

Canadian Association for Spiritual Care. (2019). *Competencies of CASC/ACSS certified professionals.* https://spiritualcare.ca/download/competencies-for-certified-members-spiritual-care-practitioners-and-psycho-spiritual-therapists/

Canadian Association for Spiritual Care (2019). Competencies of CASC/ASCC certified supervisor-educators. https://spiritualcare.ca/explore-spiritual-care/cascacss_competencies/

Canadian Hospice Palliative Care Association. (2013). *A model to guide hospice palliative care: Based on national principles and norms of practice.* https://www.chpca.ca/wp-content/uploads/2019/12/norms-of-practice-eng-web.pdf

Canadian Partnership Against Cancer & Health Canada. (July 2020). *The Canadian inter-disciplinary palliative care competency framework. A curriculum guide for educators and reference manual for health professionals and volunteers.* Ottawa, ON.

Covenant Health Palliative Institute. (September 2020). *Alberta palliative care competency framework technical report*. Edmonton, AB.

Murray, K. (2017, January 23). *Palliative care competencies: Once upon a time, there were competencies.* Life & Death Matters. https://www.lifeanddeathmatters.ca/upon-time-competencies/

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 Spiritual Care Practitioners’ Palliative Care Competencies Working Group.

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

Alberta Spiritual Care Practitioners’ Palliative Care Competencies Working Group

Name	Position	Location/Program/Organization
Christine Enfield, M.Div., Certified Spiritual Care Practitioner (CASC)	Program Chaplain	Edmonton/Tertiary Palliative Care Unit-Unit 43/ Grey Nuns Community Hospital/Covenant Health
Jessica Loxdale, MS Chap, BSW, BA, RSW	Spiritual Health Practitioner	Red Deer-Central Zone/Red Deer Regional Hospital Centre/Alberta Health Services
Jane Christensen, Master of Divinity, Ordained Clergy, Certified Spiritual Care Practitioner with Canadian Association of Spiritual Care	Chaplain	Edmonton/Villa Caritas site (Acute Care Geriatric Psychiatry)/Covenant Health Professional Practice and Resource Lead for Spiritual Care/Covenant Health Former Interim Manager for Spiritual Care Seniors and Long Term Care/Covenant Health
Becky Vink, MA	Spiritual Health Practitioner	Alberta Kidney Care South (SARP)/Alberta Health Services
Jaeun Joanne Macen, PhD, Certified Spiritual Care Practitioner (CASC)	Spiritual Health Consultant	Calgary Zone/Palliative Home Care/Alberta Health Services
Cheryl Krueger, Master of Divinity in Pastoral Counseling	Spiritual Health Practitioner - Specialist	Edmonton Zone/Royal Alexandra Hospital/Alberta Health Services
Arthur Peterson, M.Div., Pastoral Counselling, CASC/ACSS Certified Specialist	Spiritual Care Practitioner/Chaplain	Edmonton/Edmonton General Continuing Care Centre/Covenant Health
William Patterson	Chaplain	Bonnyville/Bonnyville Health Centre/Covenant Health