Alberta Health Services

Covenant Health
Palliative Institute

Alberta Social Workers'
Palliative Care Competency Framework

Version 1.0 (September 2020)

A Resource 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 Social Workers’ 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 Social Workers’ Palliative Care Competencies Referent Group

The Alberta Social Workers’ Palliative Care Competencies Referent Group below assisted in recruiting individuals participating in the production of the Alberta Social Workers’ Palliative Care Competency Framework. This includes members of the Alberta Palliative Care Competencies Advisory Working Group and the Alberta Social Workers’ Palliative Care Competencies Working Group (see detailed acknowledgements in Appendix 3). Inclusion does not necessarily reflect official endorsement at the organizational level. Details of the broad and intensive consensus process can be found in a companion technical document, the Alberta Palliative Care Competency Framework Technical Report [Covenant Health]. Errors and omissions are attributed solely to the Covenant Health Palliative Institute.

Alberta Social Workers’ Palliative Care Competencies Referent Group	
Health Care Organizations	**Educational Institutions**
• Alberta Health Emergency Medical Services <u>Alberta Health Services</u> • Allied Health Profession Practice and Education Health Professions Strategy and Practice • Calgary Zone Palliative and End-of-Life Care Program • Calgary Zone Palliative Home Care • Edmonton Zone Palliative and End-of-Life Care and Community Programs, Continuing Care • Edmonton Zone Palliative Care Program • General Systems E. Garner King Critical Care Unit and Firefighters Burn Treatment Unit, Queen Elizabeth II Hospital, Grande Prairie • Intensive Palliative Care Unit, Foothills Medical Centre, Calgary • Mechanical Circulatory Support, Mazankowski Alberta Heart Institute, University of Alberta Hospital, Edmonton • Neurosciences Clinic, Kaye Edmonton Clinic • North Zone Complex Care and Palliative Care Team, Redwater • Provincial Palliative and End-of-Life Care, Community, Seniors, Addiction and Mental Health • South Zone/South West Palliative Care Team • Vermillion-Central Zone, Allied Health <u>Covenant Health</u> • Mel Miller Hospice, Edmonton General Continuing Care Centre, Edmonton • Professional Practice and Research • Tertiary Palliative Care Unit, Grey Nuns Community Hospital, Edmonton	<u>University of Alberta</u> • Faculty of Nursing • Faculty of Medicine and Dentistry <u>MacEwan University</u> • School of Social Work • Faculty of Health and Community Studies <u>University of Calgary</u> • Department of Family Medicine • Department of Oncology • Faculty of Nursing • Faculty of Social Work-Central and Northern Region
	Professional Regulatory Bodies and Associations
	• Alberta College of Social Workers • College of Licensed Practical Nurses of Alberta

Alberta Palliative Care Competency Framework

A competency is defined by Parry[1] as a “cluster of related knowledge, skills and attitudes that affects a major part of one’s job (a role or responsibility), that correlates with performance on the job, that can be measured against well-accepted standards, and that can be improved via training and development.” A Competency Framework is a compilation of competency statements.

How to Use the Alberta Palliative Care Competency Framework

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

Purpose of this Document

Competencies allow HCPs to identify the skills, knowledge and attitudes required when providing palliative care. The Alberta Social Workers’ 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 Social Workers’ Palliative Care Competency Framework which was developed by the Alberta Social Workers’ Palliative Care Competency Working Group.

Competency statements are organized according to the following two dimensions:

1. Level of expertise
2. Competency domains

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.

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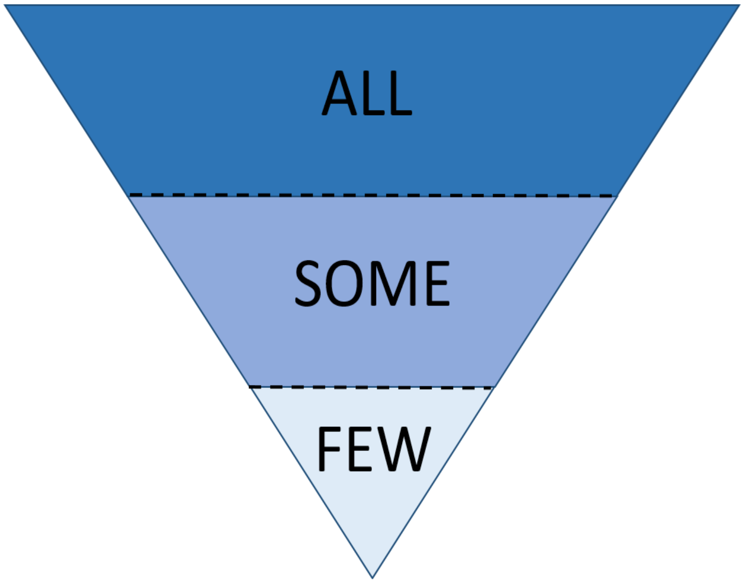
[1] Parry, S. B. (1996).The quest for competencies. Training 33, 48–54.

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.
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.

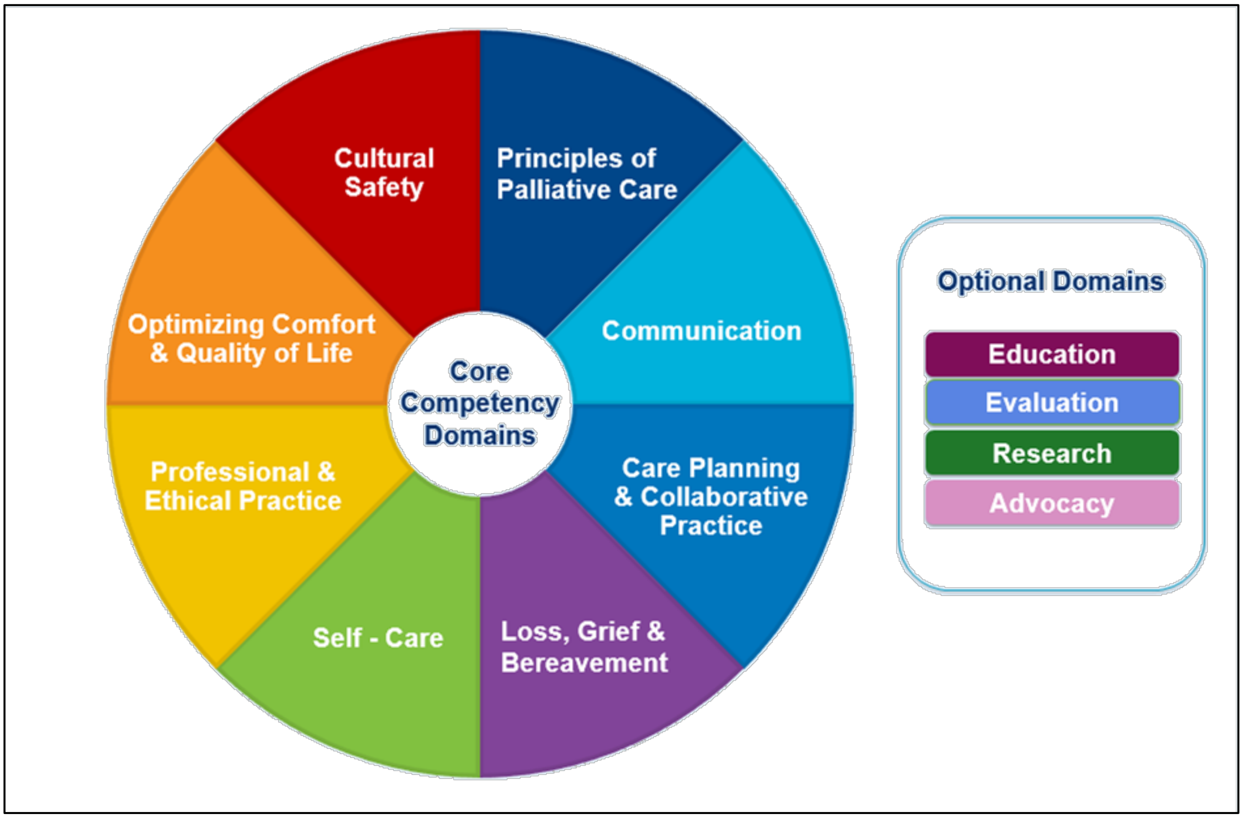
Few: This level of HCPs are palliative care experts who provide care for patients and their families, including those with the most complex palliative care needs. They provide a focused level of service for patients and families who require specialized, frequent and skilled assessments and interventions 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 Social Workers' 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. Utilize a holistic approach to care in the context of a life-limiting illness and declining health.	☐
6. Foster a caring environment that supports all interprofessional team members.	☐
7. Conserve patient dignity by facilitating expression of needs, hopes, feelings and concerns when planning palliative care.	☐
8. Describe the role and function of the Palliative Care Consult Team.	☐
9. Ask the patient who they consider family and include family in care.	☐
Some	**Educational Opportunity**
1. Adapt and apply palliative care principles to specific care settings and specialty populations of care.	☐
2. Apply psychosocial models of palliative care and bereavement.	☐
3. Use assessment tools and clinical knowledge to support the interprofessional team to identify a patient who could benefit from a palliative approach early in their care journey.	☐
4. Demonstrate an understanding of palliative care standards, norms of practice and best practices.	☐
Few	**Educational Opportunity**
1. Promote the adaptation of palliative care principles in all care settings through capacity building of other care providers and community partners, as appropriate for the role.	☐

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 can arise when caring for a patient with a life-limiting illness and their family.	☐
4. Seek to understand the unique perspective of each patient and their family.	☐
5. Support each patient with a life-limiting illness to make informed decisions regarding the depth of information about diagnosis, prognosis and disease progression they wish to receive and share with their family.	☐
6. Adapt communication and information sharing to the unique needs of the patient and their family and engage specialist support as needed to bridge communication barriers (e.g. interpreter, sign language interpreter, and assistive technology).	☐
7. Recognize the potential for conflict in decision-making.	☐
8. Respond appropriately to those who are dissatisfied with palliative care services.	☐
9. Support the patient and their family to adjust to the patient's life-limiting illness and to understand its potential impact on their welfare, mental health and well-being.	☐
10. Identify how disease progression may impact on the capacity of the patient to engage in meaningful discussions.	☐
11. Facilitate the interprofessional team and the patient and their family's conversations to ensure clear and consistent information is given.	☐
12. 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.	☐
13. Adapt communication when children are involved.	☐
14. Support the patient and their family to communicate with each other about difficult topics.	☐
15. Assess the patient's and family's understanding of the life-limiting illness and its trajectory, in collaboration with the interprofessional team.	☐
16. Consider timing, readiness, and pace of sharing information.	☐
17. Identify how fatigue, weakness, and imminent death may impact communication and help the patient, their family and interprofessional team interpret other forms of communication (e.g., symbolic communication, gestures, and facial expressions).	☐
18. Provide support, education, and patient advocacy when a patient's goals are not supported by their family or if plan of care is contrary to the patient's goals.	☐
19. Debrief with colleagues if communication causes an emotional impact on oneself.	☐
Some	**Educational Opportunity**
1. Mediate conflicts in goal setting and decision-making.	☐

2. Facilitate consensus building in care planning with the patient, their family and the interprofessional team.	☐
3. Support the patient and their family to identify and report discomfort and challenges.	☐
4. Address discrepancies between the patient's, their family's and the interprofessional team's perception of the life-limiting illness, comfort and quality of life.	☐
5. Initiate conversations about palliative care with the patient and their family.	☐
6. Provide support, mediation, and advocacy in exploring and clarifying treatment goals and care planning.	☐
Few	**Educational Opportunity**
1. Facilitate difficult conversations with families and members of the interprofessional team.	☐
2. Mentor others to facilitate and support difficult conversations.	☐

Notes:

Domain 3: Care Planning and Collaborative Practice	
All	**Educational Opportunity**
1. Explain the Advance Care Planning and Goals of Care Designation policy and procedure.	☐
2. Identify that there are appropriate times to engage in advance care planning discussions.	☐
3. Explain how an Alternate Decision Maker (ADM) is selected.	☐
4. Explain the role of an ADM in decision-making regarding a patient's care.	☐
5. Support the patient with a life-limiting illness to express their wishes and/or identify goals of care by referring them to the most appropriate member of the interprofessional team.	☐

6. Anticipate factors (including health status changes) that may affect the patient's cognition and functional capacity to make decisions including health status changes towards end-of-life.	☐
7. Explain the collaborative relationship between the patient with a life-limiting illness, their family and the interprofessional team.	☐
8. Identify how interprofessional practice enhances patient outcomes when caring for a patient with a life-limiting illness.	☐
9. Facilitate collaborative interprofessional team members' relationships.	☐
10. Work collaboratively with the interprofessional team to ensure a realistic care plan so that services do not place an undue burden on the patient with a life-limiting illness and/or their family.	☐
11. Collaborate with the interprofessional team to manage pain and other symptoms.	☐
12. Participate in team, patient and family meetings to plan care that addresses psychosocial issues.	☐
13. Regularly review and adjust care delivery according to changing needs throughout the course of a life-limiting illness, into bereavement.	☐
14. Promote bio-psychosocial perspective as integral to health and well-being, delivery of care, goals and decision-making.	☐
15. Describe the impact of social, psychological, and spiritual dimensions of loss and demonstrate when planning care.	☐
16. Recognize the overall impact of a life-limiting illness on the patient and their family providing support to address identified needs.	☐
17. When able, provide care in the patient's preferred place, while recognizing the complexities and challenges involved for the patient and their family.	☐
18. Explore possible internal and external pressures related to caregiving.	☐
19. Where possible, facilitate application to provincial, federal, and private personal benefit applications which are available for palliative care patients and their families.	☐
20. Demonstrate awareness of psychosocial and financial benefits available to the palliative care patient and their family, where they apply to the patient population being served.	☐
Some	**Educational Opportunity**
1. Provide the psychosocial perspective to other members of the interprofessional team.	☐
2. Recognize and address changing capacity for and interest in decision-making.	☐
3. Assess capacity of the family to provide care, adapting care plans as necessary.	☐
4. Adapt care plans to address the social determinants of heath.	☐
5. Demonstrate awareness of differences between interprofessional team members, disciplines, and systems, and an appreciation of the perspective, knowledge and skills of other disciplines' contributions to palliative care, as well as the team as a whole.	☐

6. Facilitate safe, smooth, and seamless transitions of care.	☐
7. Help to identify the patient’s ADM and provide information about needed documentation.	☐
8. Demonstrate awareness of the community context and available resources, providing information, referral and coordination as needed.	☐
Few	**Educational Opportunity**
1. Support the navigation of the full range and continuum of palliative care services, resources and the settings in which they are available.	☐
2. Address system issues related to transitions across care settings.	☐
3. Discuss the benefits and burdens of palliative care treatment options with the patient, their family and the interprofessional team.	☐
4. Address complexity in decision-making with declining health (e.g., disagreement between family members, no ADM).	☐
5. Lead interprofessional team and family meetings to plan care that addresses complex psychosocial issues.	☐
6. Facilitate resolution of interprofessional team conflict to ensure collaborative practice in partnership with organizational leadership, if within one’s role.	☐
7. Provide leadership in case reviews and debriefings related to the care of an imminently dying patient and their family.	☐
8. Challenge the interprofessional team, health care organizations, and public attitudes regarding psychosocial needs of people with a life-limiting illnesses and their families.	☐

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. Identify that psychological assessment and treatment of a patient with a life-limiting illness takes place in the context of the interprofessional care team.	☐
3. Recognize and support the ways in which the patient can be engaged in self-management of their illness.	☐
4. Support the patient and their family to focus on their strengths and effective coping strategies.	☐
5. Recognize and support the ways in which family can be involved in the patient's care.	☐
6. Address the impact of family role change throughout the patient's illness.	☐
7. Provide care in keeping with the patient's expressed wishes and identified goals of care.	☐
8. Provide care that acknowledges all the dimensions of personhood (physical, emotional, social, spiritual and sexual).	☐
9. Offer a compassionate, empathic presence in response to the needs of the patient and their family.	☐
10. Apply a dignity-conserving approach to care.	☐
11. Recognize common trajectories of life-limiting illnesses, including common symptoms.	☐
12. Recognize that symptoms and symptom meaning is highly subjective and should be assessed and understood from a patient-centered perspective.	☐
13. Describe the causes of common non-pain symptoms at end-of-life.	☐
14. Observe the patient's functioning and indicators of distress.	☐
15. Acknowledge and adapt care, where appropriate, to address the patient's fears and anxieties related to past trauma.	☐
16. Anticipate the psychosocial needs of the patient who has been diagnosed with a life-limiting illness based on known disease trajectories.	☐
17. Assess for anxiety, depression and existential distress in collaboration with the interprofessional team.	☐
18. Provide or refer the patient and their family for psychosocial interventions such as legacy work, life review and purposeful conversations about suffering and meaning.	☐
19. Provide information and referrals for the patient and their family regarding practical, economic, and financial needs.	☐
20. Offer information about emotional, spiritual and practical support services to the family, involving the interprofessional team, as needed.	☐
21. 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.	☐
22. Support the patient and their family to adjust to declining health.	☐
23. Respect the patient's self-determination to die as they like and facilitate the achievement of this within the scope of applicable law.	☐
24. Assist the patient and their family to prepare for expected death.	☐
25. Facilitate the patient's and family's wishes for death rituals.	☐

26. Provide emotional support for the family during and following the patient's last moment.	☐
27. Provide opportunities for family and the extended community to gather and be together.	☐
28. Recognize the signs and expected changes (physical and psychosocial) as the patient approaches death.	☐
Some	**Educational Opportunity**
1. Differentiate between circumstantial and chronic anxiety and depression in people with a life-limiting illness.	☐
2. Describe the concept of 'total pain'.	☐
3. Provide psychosocial perspective on 'total pain' to the inter-professional team.	☐
4. Apply the principles of pain and symptom management.	☐
5. Provide non-pharmacological interventions for symptom management to promote comfort and quality of life, as appropriate to scope and as directed (e.g. relaxation techniques to reduce anxiety related to shortness of breath).	☐
6. Apply diverse psychosocial interventions relevant to various and changing care needs including legacy work, life review and purposeful conversations about suffering and meaning.	☐
7. Educate, and work with the patient, their family and the interprofessional team regarding the interplay of spiritual, emotional, social, cognitive and physical aspects of the patient's past experiences on their current quality of life.	☐
8. Address and explore changing family dynamics and factors that contribute to distress within families during a life-limiting illness.	☐
9. Support opportunities for the patient's and their family's personal and spiritual growth while living with a life-limiting illness, declining health and into bereavement.	☐
10. Demonstrate an understanding of the Palliative Coverage Program and facilitate patients' enrollment.	☐
11. Provide the patient and their family counselling through a variety of social work and counselling frameworks and approaches.	☐
Few	**Educational Opportunity**
1. Apply comprehensive knowledge and understanding of the clinical presentation and disease trajectories of life-limiting illnesses when responding to complex and multidimensional care needs, in order to comprehensively identify current and prospective clinical issues in palliative care.	☐
2. Demonstrate knowledge of assessment tools and strategies relevant to medical, psychosocial and spiritual dimensions of palliative care.	☐
3. Act as an expert resource regarding the role of discipline-specific interventions in symptom management and optimizing quality of life.	☐

Notes:

Domain 5: Loss, Grief and Bereavement	
All	**Educational Opportunity**
1. Identify the dimensions of grief and recognize the factors that may increase the risk of complicated grief.	☐
2. Identify those at risk of experiencing pathological or complicated responses to loss and intervene or refer appropriately.	☐
3. Recognize the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief.	☐
4. Describe stressors and conflicts often faced with a life-limiting illness and into bereavement, supporting the patient, their family and interprofessional team to address these.	☐
5. Support the expression of grief reactions in the patient and their family, which may occur from time of diagnosis and into bereavement.	☐
6. Provide information on and/or referral to support and bereavement services within the organization and community to support long-term grief and bereavement.	☐
Some	**Educational Opportunity**
1. Conduct a bereavement risk assessment, differentiating between normal and complicated and prolonged grief.	☐
2. Educate the family and interprofessional team regarding possible range of expressions and experiences of grief to help normalize these.	☐
3. Assist the patient and their family to expect, recognize and express grief.	☐
4. Address anticipatory and cumulative grief.	☐
5. Provide emotional support for grief /bereavement within practice scope and role.	☐
6. Explore possible strategies for coping with loss with the patient, their family and the interprofessional team.	☐

7. Demonstrate knowledge of the distinctive characteristics of parental, sibling and grandparent bereavement.	☐
8. Support the needs of children at varying developmental stages in dealing with grief, in partnership with the family.	☐
Few	**Educational Opportunity**
1. Demonstrate a comprehensive knowledge of current approaches to loss, grief and bereavement.	☐
2. Assess complex grief reactions and situations, such as multiple loss, traumatic loss and pre-existing vulnerabilities including mental illness and addiction, abuse and neglect.	☐
3. Contribute to research and practice in grief, loss and bereavement.	☐
4. Provide the patient and their family with bereavement counselling and psychosocial education through evidence-based frameworks, if within role and expertise.	☐

Notes:

Domain 6: Professional and Ethical Practice	
All	**Educational Opportunity**
1. Facilitate discussion and management of ethical and legal issues in conjunction with the patient, their family and the interprofessional team.	☐
2. Identify relevant legislation and policies, e.g. Bill C-14 Medical Assistance in Dying (MAID); Child, Youth and Family Enhancement Act; Protection for Persons in Care Act; Adult Guardianship and Trusteeship Act; and the Personal Directives Act.	☐
3. Respond to inquiries regarding MAID in accordance with regulatory body's relevant guidelines and standards and employer policy.	☐
4. Anticipate and address ethical and legal issues that may be encountered when caring for a patient with a life-limiting illness and their family.	☐
5. Respect the patient's wishes regarding their care options and preferences.	☐

6. 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.	☐
7. Explain the difference between managing a condition and providing end-of-life care.	☐
8. Recognize clinical limitations and professional boundaries and refer to other colleagues appropriately and in a timely manner.	☐
9. Recognize when 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.	☐
10. Collaborate with others to ensure optimal care is provided in the circumstance when one's 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.	☐
11. Practice self-reflection to identify and mitigate the potential for transference and counter-transference.	☐
12. Apply the Alberta College of Social Workers' Standards of Practice when caring for a patient with a life-limiting illness and their family.	☐
13. Apply the Canadian Association of Social Workers' Code of Ethics when caring for a patient with a life-limiting illness and their family.	☐
Some	**Educational Opportunity**
1. Demonstrate awareness of the contextual nature of ethical issues and support colleagues in ethical reflection and decision-making.	☐
2. Apply social work models, community development initiatives and capacity building approaches to palliative care.	☐
3. Describe distinctions among ethical and legal concepts, such as: the principle of double effect, palliative sedation and MAID.	☐
4. Demonstrate the ability to support the interprofessional team in their efforts to be self-reflective, with a particular focus on understanding risks for compassion fatigue.	☐
5. Educate the interprofessional team about maintaining healthy boundaries, if within role.	☐
Few	**Educational Opportunity**
1. Apply a comprehensive understanding of contemporary legal, ethical and professional standards to the provision of quality palliative care.	☐
2. Facilitate interprofessional team reflection to identify group values and ethical practices, and the impact of these on patients, their families and the interprofessional team.	☐

Notes:

Domain 7: Cultural Safety	
All	**Educational Opportunity**
1. Describe the influence of culture on key issues in palliative care.	☐
2. Explore the patient’s and their family’s cultural, religious, and spiritual needs, beliefs, and preferences and incorporate these into goal setting, decision-making and care planning.	☐
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. Partner with the patient and their family to provide opportunity for cultural, religious, or personal practices.	☐
5. Respect the patient’s and family’s social, spiritual and cultural values and practices that may influence their care preference.	☐
6. Assess the unique needs and preferences of the patient with a life-limiting illness and their family, considering the social determinants of health, as well as their ethnicity, culture, gender, sexual orientation, language, religion, age and ability.	☐
7. Respond to family members’ unique needs and experiences.	☐
8. Identify personal cultural biases and values that may influence the care of a patient with a life-limiting illness and their family.	☐
9. Identify mechanisms to overcome personal biases to ensure they do not impact care and treatment of a patient with a life-limiting illness and their family.	☐
10. Practice self-reflection to identify and address personal and systemic biases.	☐
Some	**Educational Opportunity**
1. Address spirituality, religion, hope and meaning-making in a way that is congruent with the patient's and their family's beliefs, values and goals of care.	☐
2. Advocate for changes in policy to facilitate incorporation of culture into care.	☐
3. Demonstrate knowledge of different cultural needs regarding access and utilization of palliative care and bereavement services.	☐
4. Demonstrate understanding of the barriers for marginalized and vulnerable groups at end-of-life and in bereavement.	☐
Few	**Educational Opportunity**
1. Advocate for incorporation of the patient’s and family’s cultural traditions, beliefs, expectations and preferences into decision making, care planning and service delivery models.	☐
2. Facilitate expression and inclusion of the patient’s and family’s values, beliefs and wishes during declining health and bereavement.	☐

Notes:

Domain 8: Self-Care	
All	**Educational Opportunity**
1. Identify one's own responses to loss, grief and bereavement.	☐
2. Demonstrate awareness of one's own responses in the presence of a person who is suffering.	☐
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 with a life-limiting illness 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 self and colleagues.	☐
7. Engage in healthy activities that help prevent compassion fatigue when caring for a patient with a life-limiting illness and their family.	☐
8. Support colleagues who are experiencing compassion fatigue related to when caring for a patient with a life-limiting illness and their family, where appropriate.	☐
9. Engage in activities that support well-being and resilience when caring for a patient with a life-limiting illness and their family.	☐
10. Recognize the importance of self-care when caring for a patient with a life-limiting illness and their family.	☐
11. Identify and address personal issues and barriers to effective practice.	☐
Some	
1. Engage with members of the interprofessional team and organization to promote personal and professional well-being.	☐
2. Educate others about the positive and negative personal impact of working with loss, grief, and bereavement.	☐
3. Explore multiple perspectives with the interprofessional team.	☐

4. Support the team to engage in reflective behaviors about the personal impact of working with a dying patient and their family.	☐
Few	
1. Mentor and educate colleagues regarding the personal impact of loss, grief, and bereavement, encouraging self-awareness and activities that maintain their resilience.	☐

Notes:

Domain 9: Education, Research and Evaluation	
All	**Educational Opportunity**
1. Participate in continuing education related to palliative care.	☐
2. Educate patients and families on palliative care and a palliative approach.	☐
3. Participate in quality improvement initiatives.	☐
Some	**Educational Opportunity**
1. Participate in research activities related to palliative care.	☐
2. Educate others about the social determinants of health and their impact on the patient's and their family's experience of palliative care.	☐
3. Applies knowledge gained from palliative care research.	☐
4. Provide education on a palliative approach to interprofessional colleagues and learners.	☐
5. Act as a mentor for others new to palliative care.	☐
6. Educate others regarding psychosocial palliative care.	☐
Few	**Educational Opportunity**
1. Where possible, lead and facilitate palliative care 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 family with opportunities to participate in palliative care research.	☐
4. Demonstrate the ability to plan, implement and evaluate palliative care services.	☐
5. Act as an expert resource contributing to palliative care development and delivery.	☐
6. Demonstrate the ability to bring a psychosocial perspective to the development and implementation of both social work and the interprofessional education and, where possible research initiatives.	☐
7. Where possible, identify the opportunities for and barriers to palliative care research.	☐

Notes:

Domain 10: Advocacy	
All	**Educational Opportunity**
1. Demonstrate awareness of the potential impact of social determinants of health on the person's and their family's experience of palliative care.	☐
2. Describe the intersection of the social determinants of health and barriers to access services and identify strategies for advocacy.	☐
3. Engage in advocacy through the lens of social determinants of health.	☐
4. Identify organizational issues that affect the delivery of palliative care.	☐
5. Identify barriers to accessing palliative care.	☐
6. Facilitate and advocate for a compassionate societal response to illness, death and bereavement.	☐
7. Identify society, community, family and individual definitions and attitudes about illness, death and bereavement.	☐
8. Advocate for the patient's and their family's perspective when defining quality of life and identifying goals of care.	☐
9. Address the socio-economic impact of a life-limiting illness on the patient and their family, facilitating access to services as needed.	☐
10. Advocate for the role of the social worker/counsellor in responding to complex situations.	☐
Some	**Educational Opportunity**
1. Identify and address barriers that impact access to and usage of palliative care programs and services.	☐

2. Describe micro and macro factors that promote or constrain palliative care.	☐
3. Address misconceptions about illness, death, bereavement and palliative care.	☐
Few	**Educational Opportunity**
1. Take leadership in policy, program development and delivery of psychosocial palliative care as appropriate for role.	☐
2. Identify points of influence in the health system that could advance palliative care issues.	☐
3. Advocate for equity in reducing barriers to accessing palliative care related to determinants of health.	☐
4. Participate as a member of organizations which advocate for equitable, accessible, safe and quality palliative care.	☐
5. Describe how changes in legislation could affect individuals with palliative care needs.	☐
6. Describe how changes in funding and structure of the health system could affect delivery of palliative care.	☐
7. Contribute to the creation of policies and procedures to address the social determinants of health on an organizational level.	☐
8. Actively influence and promote palliative care strategic initiatives and policy development.	☐
9. Advocate for palliative care at a system and community level.	☐
10. Participate in community awareness and engagement activities to build understanding, capacity and inclusion.	☐

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.

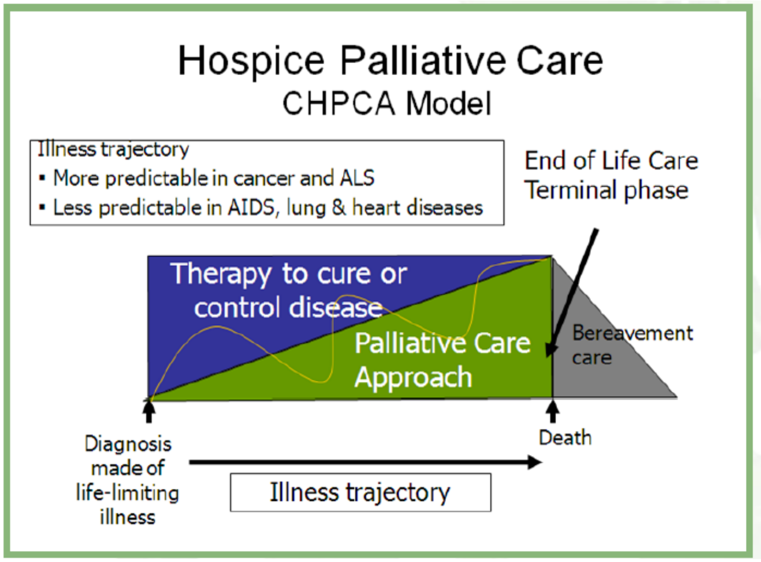
Interprofessional: interprofessional collaboration occurs when health professionals from different disciplines work together to identify needs, solve problems, make joint decisions on how best to proceed and evaluate outcomes collectively. Interprofessional collaboration supports patient-centered care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

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