

Alberta Speech-Language Pathologists' and Audiologists' Palliative Care Competency Framework

Version 1.0 (September 2020)

A Resource Manual for Health Care Professionals



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

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Dedication

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

Forward

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

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

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

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

Alberta Speech-Language Pathologists' and Audiologists' Palliative Care Competencies Referent Group

The Alberta Speech-Pathologists' and Audiologists' Palliative Care Competencies Referent Group below assisted in recruiting individuals participating in the production of the Alberta Speech-Pathologists' and Audiologists' Palliative Care Competency Framework. This includes members of the Alberta Palliative Care Competencies Advisory Working Group and the Alberta Speech-Pathologists' and Audiologists' 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 Speech-Language Pathologists' and Audiologists' Palliative Care Competencies Referent Group	
Health Care Organizations	Educational Institutions
<ul style="list-style-type: none"> • Alberta Health Emergency Medical Services <p><u>Alberta Health Services</u></p> <ul style="list-style-type: none"> • Calgary Zone Consult and Treat Team Integrated Home Care • Calgary Zone Integrated Supportive and Facility Living Program • Calgary Zone Palliative and End-of-Life Care Program • Camrose-Central Zone Early Supported Discharge • Cold Lake-North Zone • Edmonton Zone Consulting Services in Continuing Care, Facility and Supportive Living • Edmonton Zone Palliative Care Program • Edmonton Zone Palliative and End-of-Life Care and Community Programs, Continuing Care • Foothills Medical Centre, Calgary • Grande Prairie-North Zone Public Health and Home Care • Lethbridge-South Zone • Northern Lights Regional Health Centre, Fort McMurray • Provincial Palliative and End-of-Life Care, Community, Seniors, Addiction and Mental Health • Red Deer-Central Zone Allied Health Supportive Living Team • Richmond Road Diagnostic and Treatment Centre, Calgary <p><u>Covenant Health</u></p> <ul style="list-style-type: none"> • Grey Nuns Community Hospital, Edmonton • Professional Practice and Research • Tertiary Palliative Care Unit, Grey Nuns Hospital, Edmonton 	<p><u>University of Alberta</u></p> <ul style="list-style-type: none"> • Department of Communication Sciences and Disorders • Faculty of Nursing • Faculty of Medicine and Dentistry <p><u>University of Calgary</u></p> <ul style="list-style-type: none"> • Department of Family Medicine • Department of Oncology
	Professional Regulatory Bodies and Associations
	<ul style="list-style-type: none"> • Alberta College of Speech-Language Pathologists and Audiologists • College of Licensed Practical Nurses of Alberta

Alberta Palliative Care Competency Framework

A competency is defined by Parry¹ 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 Speech-Pathologists’ and Audiologists’ 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 Speech-Pathologists’ and Audiologists’ Palliative Care Competency Framework which was developed by the Alberta Speech-Pathologists’ and Audiologists’ Palliative Care Competencies Working Group.

Competency statements are organized according to the following two dimensions:

1. Level of expertise
2. Competency domains

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

Level of Expertise

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

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

Figure 1: The Alberta Palliative Care Competency Triangle

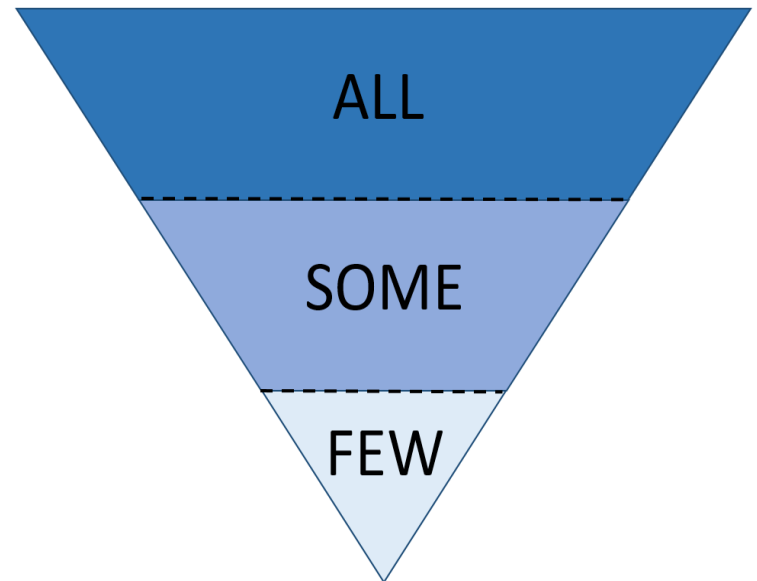


Table 1: Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions

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

Table 1 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.

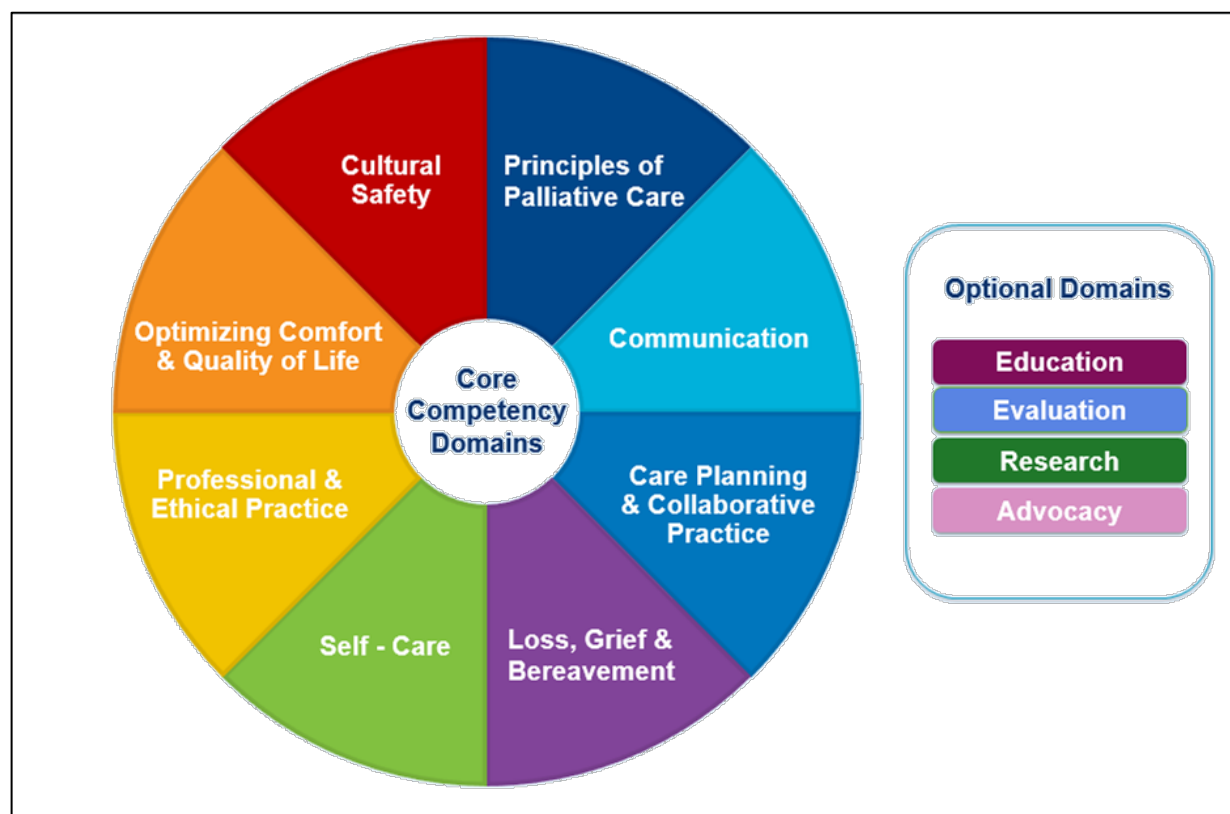
Few: This level of HCPs are palliative care experts who provide care for patients and their families, including those with the most complex palliative care needs. They provide a focused level of service for patients and families who require specialized, frequent and skilled assessments and interventions 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 Speech-Language Pathologists' and Audiologists' Palliative Care Competencies

Domain 1: Principles of Palliative Care	
All	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Explain the philosophy of palliative care.	<input type="checkbox"/>
2. Identify that a palliative approach starts early in the trajectory of a progressive life-limiting illness and may be appropriate at the time of diagnosis.	<input type="checkbox"/>
3. Describe the meaning of the term 'life-limiting illness'.	<input type="checkbox"/>
4. Apply palliative care standards, guidelines and policies.	<input type="checkbox"/>
5. 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.	<input type="checkbox"/>
6. Conserve patient dignity by facilitating expression of needs, hopes, feelings and concerns when planning palliative care.	<input type="checkbox"/>
7. Recognize the impact of family role change for the patient and their family due to the life-limiting illness.	<input type="checkbox"/>
8. Respond appropriately to those who are dissatisfied with palliative care services.	<input type="checkbox"/>
9. Describe the role and function of the Palliative Care Consult Team, including volunteers.	<input type="checkbox"/>
10. Describe the role and function of the interprofessional team in palliative care.	<input type="checkbox"/>
Some	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Apply an in-depth knowledge of the full spectrum of trajectories of life-limiting illnesses in the context of your current clinical practice.	<input type="checkbox"/>
Few	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Apply an advanced knowledge of the full spectrum of trajectories of life-limiting illnesses when responding to complex and multidimensional care needs, within the context of your current clinical practice.	<input type="checkbox"/>

Notes:

Domain 2: Communication	
All	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Describe the essential role that communication plays in palliative care.	<input type="checkbox"/>
2. Teach communication skills, strategies and tools to the interprofessional team.	<input type="checkbox"/>
3. Recognize the multidimensional communication challenges that arise when caring for a patient with a life-limiting illness.	<input type="checkbox"/>
4. 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) throughout the trajectory of a life-limiting illness.	<input type="checkbox"/>
5. Support each patient to make informed decisions regarding the depth of information about diagnosis, prognosis and disease progression they wish to receive and share with their family.	<input type="checkbox"/>
6. Recognize the potential for conflict in palliative care decision-making.	<input type="checkbox"/>
7. Acknowledge personal responses to communication challenges while remaining engaged in meaningful contact with the patient and their family.	<input type="checkbox"/>
Additional Competencies for Speech-Language Pathologists:	
8. Participate in processes that mitigate conflict in palliative care decision-making.	<input type="checkbox"/>
9. Communicate functional status regarding communication and disorders of feeding, eating, drinking and swallowing and likely progression in an accurate and compassionate manner, accounting for the patient's needs and wishes and possible changes in function throughout the trajectory of a life-limiting illness.	<input type="checkbox"/>

10. Act as a mediator by providing education to and advocating for the patient regarding initiating, withdrawing and withholding artificial hydration and nutrition.	<input type="checkbox"/>
Additional Competencies for Audiologists:	
11. Communicate functional status regarding hearing and communication in an accurate and compassionate manner, accounting for the patient's needs and wishes and possible changes in function.	<input type="checkbox"/>
12. Act as a mediator by advocating for the patient regarding the introduction and use of assistive listening device technology.	<input type="checkbox"/>
13. Act as an expert to support and teach aural rehabilitation skills to the interprofessional team within the context of palliative care.	<input type="checkbox"/>
Some	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	<input type="checkbox"/>
1. Enlist the skills of the interprofessional team and/or colleagues to enhance and support communication with the patient with a life-limiting illness and their family.	<input type="checkbox"/>
Additional Competencies for Speech-Language Pathologists:	
2. Facilitate assessment of decision-making capacity of the patient with communication or cognitive-communication impairment within the context of a life-limiting illness.	<input type="checkbox"/>
Few	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	<input type="checkbox"/>
1. Apply strategies to engage in highly skilled, compassionate, individualized, and timely communication with each patient with a life-limiting illness, their family and the interprofessional.	<input type="checkbox"/>
Additional Competencies for Speech-Language Pathologists:	
2. Act as a mediator by advocating for the patient to access appropriate and timely palliative care.	<input type="checkbox"/>

Notes:

Domain 3: Care Planning and Collaborative Practice	
All	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Explain that communication regarding palliative care is an on-going collaborative process.	<input type="checkbox"/>
2. Demonstrate flexibility in relation to care planning, acknowledging that a patient's priorities can alter as their illness progresses.	<input type="checkbox"/>
3. Communicate with the patient and their family about their understanding of the life-limiting illness and its trajectory.	<input type="checkbox"/>
4. Recognize the overall impact of a life-limiting illness on the patient, including their mental health and coping mechanisms.	<input type="checkbox"/>
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.	<input type="checkbox"/>
6. Support the patient to adapt to changing clinical presentation and functional communication ability throughout the trajectory of their life-limiting illness.	<input type="checkbox"/>
7. Provide support to help the patient adapt to the changes in their condition.	<input type="checkbox"/>
8. Describe the collaborative relationship between the palliative care patient, their family and the interprofessional team.	<input type="checkbox"/>
9. Collaborate with the interprofessional team to manage the symptoms of a life-limiting illness.	<input type="checkbox"/>
10. Identify priorities and concerns in collaboration with the patient and their family, taking into account the patient's coping strategies, perception and understanding of their life-limiting illness.	<input type="checkbox"/>
11. Facilitate the patient and their family toward active involvement in decision-making and goal setting to support best outcomes and quality of life.	<input type="checkbox"/>
12. Recognize that family conversations may involve children and that different communication approaches may be required when discussing palliative care and the life-limiting illness.	<input type="checkbox"/>
13. Provide culturally relevant information and palliative care resources to support the patient and their family.	<input type="checkbox"/>
14. Collaborate within the interprofessional team and with other stakeholders to manage positive working relationships that will support the wellbeing of the patient and promote patient-centered palliative care planning.	<input type="checkbox"/>

15. Consult with appropriate interprofessional team members to facilitate optimal palliative care therapy outcomes for the patient and their family.	<input type="checkbox"/>
16. Utilize the strengths of the interprofessional team to facilitate optimal palliative care therapy outcomes for the patient and their family.	<input type="checkbox"/>
Additional Competencies for Speech-Language Pathologists:	
17. Understand that there are appropriate times to engage in Advance Care Planning (ACP) discussions throughout the trajectory of a life-limiting illness.	<input type="checkbox"/>
18. Invite the patient, their family, and the interprofessional team to participate in discussions regarding the care plan within the context of the life-limiting illness.	<input type="checkbox"/>
19. Facilitate the involvement of the patient, their family and the interprofessional team in discussions regarding the care plan throughout the trajectory of the life-limiting illness.	<input type="checkbox"/>
20. Facilitate informed decision-making by the patient with a life-limiting illness regarding place of care, while identifying risks in a supportive manner.	<input type="checkbox"/>
21. When able, provide care in the patient's preferred place, while recognizing the complexities and challenges involved for the patient and their family.	<input type="checkbox"/>
22. Facilitate safe, smooth and seamless transition of care between care settings for the patient with a life-limiting illness with complex communication, cognitive-communication and feeding, eating, drinking and swallowing needs.	<input type="checkbox"/>
23. Access expertise of the interprofessional team in the pharmacological, behavioral, and environmental management of secretions, dyspnea and anxiety which may impact safe and pleasurable engagement in eating, drinking, swallowing and communication.	<input type="checkbox"/>
24. Provide expertise on the role of SLP in symptom management and optimizing quality of life.	<input type="checkbox"/>
25. Provide expertise to the health care team where communication or swallowing impacts symptoms e.g. when swallowing prohibits ability to manage oral medications.	<input type="checkbox"/>
Some	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Anticipate factors that may affect the patient's cognition and functional capacity to make decisions towards the end-of-life, including health status changes.	<input type="checkbox"/>
2. Collaborate with the interprofessional team to ensure that consent and information regarding care decisions is accessible to the patient's level of communication and cognition.	<input type="checkbox"/>

3. Collaborate with the patient and their family to formulate individualized goal based treatment programs that are patient-centered and responsive to the changing needs of the patient throughout the trajectory of their life-limiting illness.	<input type="checkbox"/>
Additional Competencies for Audiologists:	
4. Understand that there are appropriate times to engage in ACP discussions throughout the trajectory of a life-limiting illness.	<input type="checkbox"/>
Few	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Act as an expert clinical resource, as required, to generalist and other specialist providers of palliative care, role modelling advanced clinical skills when assessing and managing a patient with a complex life-limiting illness.	<input type="checkbox"/>

Notes:

Domain 4: Optimizing Comfort and Quality of Life	
All	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Recognize common trajectories of life-limiting illnesses, including common symptoms' presentation.	<input type="checkbox"/>
2. Apply interprofessional approaches to optimize comfort and enhance the quality of life of the patient and their family.	<input type="checkbox"/>
3. Explain how a palliative approach can enhance the assessment and management of symptoms.	<input type="checkbox"/>
4. Apply the principles of symptom management within the context of palliative care.	<input type="checkbox"/>
5. Provide palliative care in a compassionate manner.	<input type="checkbox"/>

6. Recognize that symptoms, symptom meaning and how a patient experiences symptoms are highly subjective and can change throughout the course of a life-limiting illness.	<input type="checkbox"/>
7. Recognize the physical, psychological, social and spiritual issues that affect the patient and their family throughout the trajectory of a life-limiting illness.	<input type="checkbox"/>
8. Use non-pharmacological symptom management to promote comfort and quality of life for the patient with a life-limiting illness.	<input type="checkbox"/>
9. Use compensatory and rehabilitation approaches to alleviate symptoms, improve quality of life, and optimize effective and safe participation in activities for a patient with a life-limiting illness.	<input type="checkbox"/>
10. Recognize the ways in which a patient can be engaged in self-management of his/her life-limiting illness.	<input type="checkbox"/>
11. Encourage continued participation in functional communication activities throughout the trajectory of a life-limiting illness.	<input type="checkbox"/>
12. Facilitate the patient's identification of personally significant functional communication activities and empower participation through supportive conversation and total communication approaches that can adapt to changes in patient's condition.	<input type="checkbox"/>
13. Provide recommendations for devices and modifications that promote communicative autonomy and are adaptable to the trajectory of a patient's life-limiting illness.	<input type="checkbox"/>
14. Assist the interprofessional team in maximizing communicative access to promote patient autonomy for the patient with a life-limiting illness.	<input type="checkbox"/>
15. Identify the psychosocial impact of diminishing communication providing modifications to facilitate social participation.	<input type="checkbox"/>
16. Provide care in keeping with the patient's expressed wishes and identified goals of care.	<input type="checkbox"/>
17. Make decisions regarding the appropriateness of interventions for each patient living with a life-limiting illness, taking into consideration the patient's expressed wishes and identified goals of care.	<input type="checkbox"/>
18. 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.	<input type="checkbox"/>
19. Identify the patient who would benefit from Emergency Medical Services Palliative and End of Life Care Assess, Treat and Refer (EMS PEOLC ATR) Program.	<input type="checkbox"/>
20. Support the patient's and family's wishes and death rituals.	<input type="checkbox"/>

21. Explore one's own responses to being in the presence of a palliative care patient who is suffering.	<input type="checkbox"/>
Additional Competencies for Speech-Language Pathologists:	
22. Assess caregivers' skills and need for training and support to assist with safe swallowing techniques and communication strategies.	<input type="checkbox"/>
23. Assess the benefits, burdens and risks of Speech-Language Pathology (SLP) interventions.	<input type="checkbox"/>
24. Manage decisions regarding withdrawing or postponing SLP interventions.	<input type="checkbox"/>
25. Identify the psychosocial impact of diminishing communication and swallow function providing modifications to facilitate social participation.	<input type="checkbox"/>
26. Apply expert knowledge of the impact of symptoms such as pain, dyspnea, nausea, anxiety and depression that affect swallowing function and communication performance, along with the strategies required to manage them.	<input type="checkbox"/>
27. Identify the patient's values and goals to understand what a good death means to the patient, particularly as it pertains to communication/swallowing.	<input type="checkbox"/>
28. Provide expertise on the role of SLP in symptom management and optimizing quality of life.	<input type="checkbox"/>
Additional Competencies for Audiologists:	
29. Assess the caregivers' skills and need for training and support, to assist with assistive listening device technology and communication access strategies in the context of palliative care.	<input type="checkbox"/>
30. Assess the benefits, burdens and risks of audiological interventions in the context of palliative care.	<input type="checkbox"/>
31. Manage decisions regarding withdrawing or postponing audiological interventions, while recognizing when to re-initiate interventions in the context of palliative care.	<input type="checkbox"/>
32. Assess the patient for assistive listening device technology and other communication access supports.	<input type="checkbox"/>
33. Provide expertise on the role of Audiologists in symptom management and optimizing quality of life in the context of palliative care.	<input type="checkbox"/>
Some	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Anticipate the needs of the patient who has been diagnosed with a life-limiting illness based on known disease trajectories.	<input type="checkbox"/>

2. Support the patient with a life-limiting illness and their family to adapt to a transition from life-prolonging treatment to a focus on palliative care.	<input type="checkbox"/>
3. Demonstrate increased awareness of the impact of multiple loss (e.g. communicative autonomy, ability to eat/drink, loss of hearing), when formulating relevant and realistic treatment programs appropriate to the needs of the patient with a life-limiting illness.	<input type="checkbox"/>
4. Access interprofessional expertise and non-pharmacological interventions to support the management of symptoms of a life-limiting illness including fatigue, dyspnea, secretion management, anxiety that can impact safe and/or pleasurable engagement in communication activities, social participation and quality of life.	<input type="checkbox"/>
5. Explain the causes of common non-pain symptoms at end-of-life.	<input type="checkbox"/>
6. Support the patient, family, Alternate Decision Maker (ADM) and health care teams with end-of-life decision-making, including withdrawing or withholding interventions.	<input type="checkbox"/>
Additional Competencies for Speech-Language Pathologists:	
7. Refer the patient to appropriate specialty program for assistive/alternative communication technology.	<input type="checkbox"/>
8. Recognize the need to seek expertise in seating and other equipment which may promote autonomy in communication and enhance safety and independence in eating, drinking and swallowing in the patient with a life-limiting illness within the hospital, facility and/or home environment.	<input type="checkbox"/>
Few	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Apply advanced knowledge of the patient's clinical presentation and illness trajectory, responding in a proactive and in a timely manner to identified needs.	<input type="checkbox"/>
2. Utilize compensatory and palliative care rehabilitation approaches to alleviate symptoms and optimize effective, pleasurable and safe participation in activities.	<input type="checkbox"/>
3. Apply advanced clinical knowledge and understanding of complex symptoms associated with progressive disease in order to comprehensively identify current and prospective clinical issues in palliative care.	<input type="checkbox"/>
4. Recognize professional boundaries, clinical and personal limitations when caring for patient with a life-limiting illness and refer to other colleagues appropriately in a timely manner.	<input type="checkbox"/>
5. Facilitate the patient's and family's perception of a good death.	<input type="checkbox"/>

Notes:

Domain 5: Loss, Grief and Bereavement	
All	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Recognize the range of individual physical, psychological, spiritual, emotional and social responses to loss and grief.	<input type="checkbox"/>
2. Describe the dimensions of grief.	<input type="checkbox"/>
3. Support the family by providing them with guidance, information and direction to grief and bereavement services, as required and based on awareness of culture and needs.	<input type="checkbox"/>
4. Address pathological responses to loss, referring appropriately to the Palliative Care Consult Team.	<input type="checkbox"/>
Some	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Appreciate the nature of disenfranchised grief in patients and families and appropriate methods of addressing this grief.	<input type="checkbox"/>
2. Describe diverse perspectives on loss, grief, bereavement and mourning, to support others from a cross-cultural perspective.	<input type="checkbox"/>
Few	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Respond to complex grief reactions and processes using one's own skills and/or referral to appropriate disciplines or agencies.	<input type="checkbox"/>

Notes:

Domain 6: Professional and Ethical Practice	
All	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Respect the patient's wishes regarding their care options and preferences regarding their life-limiting illness.	<input type="checkbox"/>
2. Respond to inquiries regarding MAID in accordance with the regulatory body's relevant guidelines and standards and/or employer's policy.	<input type="checkbox"/>
3. Explain the difference between managing a condition and providing end-of-life care.	<input type="checkbox"/>
4. Recognize when beliefs, attitudes and values limit one's ability to be present and provide patient-centered care.	<input type="checkbox"/>
5. 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-centered palliative care.	<input type="checkbox"/>
6. Anticipate ethical and legal issues that may be encountered when caring for a patient with a life-limiting illness.	<input type="checkbox"/>
7. Address or refer to appropriate members of the interprofessional team if ethical and legal issues are encountered when caring for a patient with a life-limiting illness.	<input type="checkbox"/>
8. 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.	<input type="checkbox"/>
Additional Competencies for Speech-Language Pathologists:	
9. Use recognized ethical, legal and professional frameworks to guide SLP interventions in end-of-life care decision making related to initiating, withdrawing and withholding artificial hydration and/or nutrition, as a result of severe oropharyngeal dysphagia.	<input type="checkbox"/>
Some	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Provide and participate in professional supervision and peer review processes to monitor personal and professional responses to clinical situations in palliative care.	<input type="checkbox"/>
Few	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	

1. Promote strategic initiatives and policy development for palliative care services at local, regional and national levels.	<input type="checkbox"/>
2. Apply an advanced understanding of contemporary legal, ethical and professional standards to the provision of quality palliative care services.	<input type="checkbox"/>
3. Develop clinical governance and quality assurance programs that are specific to palliative care.	<input type="checkbox"/>
4. Act as an expert resource contributing to palliative care service development and delivery across all clinical settings including primary, acute, tertiary and residential care.	<input type="checkbox"/>
5. Participate in processes of clinical governance and quality assurance to maintain and improve clinical practice in palliative care.	<input type="checkbox"/>

Notes:

Domain 7: Cultural Safety	
All	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Describe the influence of culture on key issues in palliative care.	<input type="checkbox"/>
2. Respect the patient's and family's social, spiritual and cultural values and practices that may influence their palliative care preferences.	<input type="checkbox"/>
3. Validate cultural preferences and values by identifying ways to accommodate them into goal setting, decision-making and palliative care planning.	<input type="checkbox"/>
4. Accommodate the patient's and family's social, spiritual and cultural values and practices related to palliative care.	<input type="checkbox"/>
5. Respect who the patient identifies as family throughout their illness trajectory.	<input type="checkbox"/>
6. Identify personal biases and values that may influence your ability to provide palliative care.	<input type="checkbox"/>
7. Identify mechanisms to overcome personal biases to ensure they do not impact palliative care and treatment.	<input type="checkbox"/>

Notes:

Domain 8: Self-Care	
All	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Explore one's own attitudes regarding death, dying and caring for patients requiring palliative care.	<input type="checkbox"/>
2. Identify the impact of past experiences of suffering, death and dying when providing palliative care.	<input type="checkbox"/>
3. Attend to own emotional responses that result from caring for patients with palliative care needs.	<input type="checkbox"/>
4. Engage in activities that support well-being and resilience.	<input type="checkbox"/>
5. Recognize the personal impact of loss, grief and bereavement.	<input type="checkbox"/>
6. Recognize own responses to loss.	<input type="checkbox"/>
7. Recognize compassion fatigue in one's self and in colleagues.	<input type="checkbox"/>
8. Engage in healthy activities that help prevent compassion fatigue.	<input type="checkbox"/>
9. Support colleagues who are experiencing compassion fatigue.	<input type="checkbox"/>

Notes:

Domain 9: Education, Research and Evaluation	
All	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Participate in palliative care continuing education opportunities.	<input type="checkbox"/>
2. Contribute to the monitoring and evaluation of quality of palliative care.	<input type="checkbox"/>
3. Participate in palliative care continuing education opportunities.	<input type="checkbox"/>
Additional Competencies for Speech-Language Pathologists:	
4. Educate the patient, their family, and interprofessional team on the role of the SLP in palliative care.	<input type="checkbox"/>
Additional Competencies for Audiologists:	
5. Educate the patient, their family and the interprofessional team on the role of the Audiologist in palliative care.	<input type="checkbox"/>
Some	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Educate patients and families about palliative care and a palliative approach.	<input type="checkbox"/>
2. Apply knowledge gained from palliative care research to improve clinical care provided within palliative care settings.	<input type="checkbox"/>
3. Engage in research that will lead to evidence based clinical practices in palliative care.	<input type="checkbox"/>
Few	Educational Opportunity
Speech-Language Pathologists' and Audiologists' Shared Competencies:	
1. Where possible, provide the family with information about opportunities to participate in palliative caregiving research.	<input type="checkbox"/>
2. Facilitate and provide palliative care related education, leadership and mentorship to members of the discipline and students.	<input type="checkbox"/>
3. Where possible, identify the opportunities for and barriers to discipline-specific research unique to palliative care.	<input type="checkbox"/>
4. Develop palliative care related education for members of the discipline and for students.	<input type="checkbox"/>

Notes:

Domain 10: Advocacy

All	Educational Opportunity
Speech Language Pathologists' and Audiologists' Shared Competencies:	
1. Advocate for health care providers to have adequate resources to provide palliative care.	<input type="checkbox"/>
2. Advocate for the patient to access appropriate and timely palliative care.	<input type="checkbox"/>
Competencies for Speech-Language Pathologists:	
3. Advocate for SLP services and/or involvement in palliative care where SLP is not yet acknowledged as part of the health care team and the benefit of SLP is not well understood.	<input type="checkbox"/>
Competencies for Audiologists:	
4. Advocate for Audiology services or involvement where Audiology is not yet acknowledged as part of the health care team, and/or the benefit of Audiology is not well understood.	<input type="checkbox"/>
Some	Educational Opportunity
Speech Language Pathologists' and Audiologists' Shared Competencies:	
1. Advocate for the development, maintenance, and improvement of health care and social policies related to palliative care.	<input type="checkbox"/>

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.

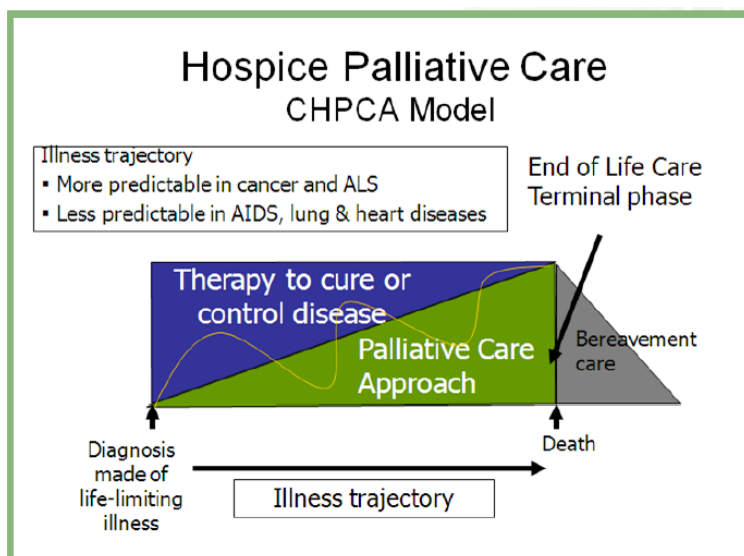
Life-limiting illness. Describes illness where it is expected that death will be a direct consequence of the specified illness. The term "person living with a life-limiting illness" also incorporates the concept that people that are actively living with such illnesses, often for long periods of time, 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 Alliance of Audiology and Speech-Language Pathology Regulators. (2018). *National speech-language pathology competency profile*. <https://www.acslpa.ca/wp-content/uploads/2019/05/National-Speech-Language-Pathology-Competency-Profile-ACSLPA-nov-2018.pdf>
- Canadian Alliance of Audiology and Speech-Language Pathology Regulators. (2018). *National audiology competency profile*. <https://www.acslpa.ca/wp-content/uploads/2019/05/National-Audiology-Competency-Profile-ACSLPA-nov2018.pdf>
- 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 interdisciplinary 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.

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