Alberta Health Services

Covenant Health Palliative Institute

Alberta Palliative Care Competency Framework

Technical Report

September 2020

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 Palliative Care Competencies Referent Group

The Alberta Palliative Care Competencies Referent Group below assisted in recruiting individuals participating in the production of the Palliative Care Competency Framework. This includes members of the Alberta Palliative Care Competencies Advisory Working Group and the Alberta Palliative Care Competencies Working Groups (see detailed acknowledgements in Appendix 6). 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 Palliative Care Competencies Referent Groups

Health Care Organizations	Professional Regulatory Bodies and Associations	Educational Institutions
• Bethany Care Society • Capital Care Norwood • Carewest • CBI Home Health • Foothill Country Hospice Society • Hospice Calgary • Life & Death Matters <u>Alberta Health</u> • Emergency Medical Services Policy, Standards & Reporting • Health Care Aide Competencies and Curriculum <u>Alberta Health Services</u> • Alberta Clinician Professional Practice Council • Allied Health Professional Practice and Education • Cancer Care Alberta • Diagnostic Imaging Services • EMS Mobile Integrated Healthcare • Health Professions Strategy and Practice	• Alberta Association for Spiritual Care and Chaplain and Provisional Supervisor • Alberta College of Medical Diagnostic and Therapeutic Technologists • Alberta College of Occupational Therapists • Alberta College of Paramedics • Alberta College of Pharmacy • Alberta College of Social Workers • Alberta College of Speech-Language Pathologists and Audiologists • Alberta Pastoral Care Association • Alberta Pharmacists' Association • Canadian Society of Palliative Care Physicians • College and Association of Registered Nurses of Alberta • College of Registered Psychiatric Nurses of Alberta • College and Association of Respiratory Therapists of Alberta • College of Alberta Psychologists	• Bow Valley College • Northern Lakes College <u>Athabasca University</u> • Faculty of Health Disciplines <u>MacEwan University</u> • Centre for Professional Nursing Education • Faculty of Health and Community Studies • Faculty of Nursing • School of Social Work <u>NorQuest College</u> • Faculty of Health and Community Studies <u>Northern Alberta Institute of Technology</u> • Medical Radiologic Technology Program • Respiratory Program <u>Southern Alberta Institute of Technology</u> • Diagnostic Imaging Programs • Life Sciences • Respiratory Therapy Program

Alberta Palliative Care Competencies Referent Groups		
Health Care Organizations	**Professional Regulatory Bodies and Associations**	**Educational Institutions**
• Palliative and End-of-Life Innovations Steering Committee • Palliative Care Zone Directors/Leads • Professional Practice <u>Covenant Care</u> • Dulcina Hospice <u>Covenant Health</u> • Professional Practice and Research • Senior Leadership Team	• College of Dietitians of Alberta • College of Licensed Practical Nurses of Alberta • Physiotherapy Alberta College + Association • Psychologists' Association of Alberta	• School of Health and Public Safety <u>University of Alberta</u> • Department of Communication Sciences and Disorders • Department of Occupational Therapy (Calgary and Edmonton Divisions) • Department of Physical Therapy • Enable Health, Calgary • Faculty of Agricultural Life and Environmental Sciences • Faculty of Medicine and Dentistry • Faculty of Nursing • Faculty of Pharmacy and Pharmaceutical Sciences • Faculty of Rehabilitation Medicine • Radiation Therapy Program <u>University of Calgary</u> • Department of Family Medicine • Department of Oncology • Department of Psychology • Faculty of Nursing • Faculty of Social Work

Executive Summary

Introduction: Establishing palliative care early in an illness trajectory is beneficial to the patient and their family and requires services to be delivered in both generalist and specialist settings by multidisciplinary care teams. According to a 2016 Ipsos poll, Canadians feel health care providers (HCPs) should receive certification for additional training specialized in palliative care (86%) and that mandatory annual training for palliative care HCPs should be implemented (82%). However, evidence suggests most HCPs feel they have received limited education and are not adequately trained to provide palliative care. Competencies lead to better patient outcomes, as such, it is important to ensure all HCPs possess foundational competencies in palliative care.

Purpose: The purpose of this report is to provide a description of the evidence-based process that was used to leverage palliative care competencies formulated external to the province and adapt them to the Alberta context. In the fall of 2018, the Covenant Health Palliative Institute, under the direction of the Alberta Health Services (AHS) Provincial Palliative and End-of-Life Innovations Steering Committee, brought palliative care experts together and drafted a protocol to begin the process of developing Alberta mulitdisciplinary palliative care competencies.

Approach: We approached palliative care competencies development using a learner-centered educational paradigm to promote transformative learning and enhance knowledge translation in palliative care. The most prominent learner-centered pedagogies used in health care education are constructivism, social constructionism and humanism. These pedagogies were integrated into palliative care competencies development in Alberta.

Method: The Alberta Palliative Care Competency Framework was developed in four steps. We: (1) conducted a comprehensive review of the literature (2) established a steering committee and formulate a network of HCP specific working groups (3) established a competency framework structure and (4) developed Alberta health care provider (HCP) specific palliative care competencies using evidence-based consensus development.

Results: The literature searches yielded 209 final documents, all of which were used to inform initial drafts of HCP specific palliative care competencies. We established a project steering committee, an advisory working group and 15 HCP specific palliative care competencies working groups. We established an Alberta palliative care competencies structure that organized palliative care competencies into 10 domains and three levels of palliative care expertise. We used the Consensus Oriented Decision-Making Model and a modified Delphi method to formulate palliative care competencies

for the 15 HCP specific working groups, representing 24 HCP groups including volunteers.

Discussion: We applied a comprehensive and evidence-based approach to palliative care competency development in Alberta. The strengths of this project are evident in the competency characteristics as well as their representativeness, transferability and scope. Key learnings were apparent at various points in the palliative care competencies development process, such as, the challenge of categorizing competency statements in one of three levels of expertise and the emergence and validation of interprofessional competencies. As with any study, some limitations in the Alberta palliative care competencies process were noted.

Conclusion: A robust and skilled health care workforce is essential to the future sustainability of palliative care delivery. Having Alberta specific palliative care competencies allows HCPs to identify the skills, knowledge and attitudes required when providing palliative care. Additionally, the Alberta palliative care competencies can be used as a resource to inform and guide academic curricula, professional development, professional regulatory bodies, continuing education programs and employers.

Introduction

Establishing palliative care early in an illness trajectory is beneficial to patients and families and requires services to be delivered in both generalist and specialist settings by interprofessional care teams (Parker et al., 2013; Wanniarachigue, 2015; Cameron-Taylor, 2012). According to a 2016 Ipsos poll, Canadians feel HCPs should receive certification for additional training specialized in palliative care (86%) and that mandatory annual training for palliative care HCPs should be implemented (82%) (Roulston, 2016). However, evidence suggests most HCPs feel they have received limited education and are not adequately trained to provide palliative care (Aslakson, 2014). Health Canada (2018) states it is important to ensure all HCPs possess foundational competencies in palliative care. Substantial progress identifying palliative care competencies has been made in Ireland and several provinces across Canada: Nova Scotia, British Columbia and Ontario. Accordingly, under the direction of the AHS Provincial Palliative and End-of-Life Innovations Steering Committee, the Covenant Health Palliative Institute built on the work of other provinces to inform and create various HCP palliative care competencies for Alberta.

Purpose of this Document

This document describes the process used to develop Alberta based HCP specific palliative care competencies. The work of Ireland, Nova Scotia, Ontario and British Columbia was adapted to the Alberta context by conducting a series of systematic reviews and by utilizing a rigorous evidence-based consensus development process. Having province specific palliative care competencies allows HCPs to identify the skills, knowledge and attitudes required when providing palliative care in Alberta. Additionally, the Alberta Palliative Care Framework can be used as a resource to inform and guide academic curricula, professional development, professional regulatory bodies, continuing education programs and employers.

Scope of this Document

This document is intended to be used as a reference by HCPs, subject to the rules and regulations of their respective professional standards, competencies and code of ethics. Each HCP should consider these palliative care competencies within the context of their respective professional standards, competencies and code of ethics.

Glossary of Terms

Palliative care is a philosophy and approach to care that aims to improve the quality of a life of patients with a life-limiting illness and their families. For the purpose of this project, we adopt Alberta Health Services' (AHS) Palliative and End-of-Life Care Alberta Provincial Framework definition of palliative and end-of-life care (AHS, 2014). The Canadian Hospice Palliative Care Association's definition of a palliative approach was utilized (Canadian Hospice Palliative Care Association, 2013). Throughout the document several terms are used which may not be familiar to all readers. To ensure a common understanding of the terminology, a glossary of terms is included in Appendix 2, including palliative and end-of-life care and a palliative approach.

Understanding Competencies

A competency is defined by Parry (1996) 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".

Approach

Health care education is inundated with content heavy knowledge that saturates the cognitive learning domain (Dieklemann, 2002). Although the retention of this knowledge is an essential component of competent and safe patient and family care, on its own, it is not the comprehensive learning experience that HCPs require to become truly educated and well-developed professionals (Bevis & Watson, 1989). Accordingly, educational programs have shifted their learning paradigms away from a focus on behaviorism and content retention to an emphasis on learning-centeredness (Schumacher, 2017). The intent of this paradigm shift is to promote transformational learning and knowledge translation (Schumacher, 2017). Transformational learning is a process by which learners transform existing, taken for-granted frames of reference (beliefs, meanings, perspectives, habits of mind, mind sets) to make them more inclusive, discriminating, open, emotionally capable of change, and reflective so that they may generate beliefs and action based on evidence (Mezirow 2000). The premise of knowledge translation is to bridge that gap between theory and practice (Bjork et al., 2013).

We approached palliative care competency development in Alberta using a learner-centered educational paradigm to promote transformative learning and enhance knowledge translation in palliative care. The most prominent learner-centered

pedagogies used in health care education are constructivism, social constructionism, and humanism. What follows is a discussion on how these learning theories were integrated into palliative care competency development in Alberta.

Constructivism and Competency Based Learning

Competency based education frameworks are becoming a standard for most health care disciplines and serve various functions, such as, defining the characteristics of a competent workforce and assessing expertise (Schumacher, 2017; Batt, 2019). Aligning with a constructivist perspective, competency-based learning considers the incremental nature of knowledge attainment from clinical experience and formal education. It facilitates the development of clinical knowledge and career growth in health care (Connolly, 2012). This competency-based approach can provide a balance between individual and collective skills development in health care and contribute to the development of an entire organization or program (Brahimi, 2011). Additionally, competency in health care is the foundation for quality patient care and outcomes (Carney & Bistline, 2008 as cited in Franklin et al. 2015). A number of palliative care competencies' profiles and tools have been developed in numerous jurisdictions and among various health care disciplines (Appendix 4). The Alberta Palliative Care Competencies are grounded in the constructivist competency-based learning approach. Additionally, to enhance the measurability of the palliative care competencies we utilized Bloom's Taxonomy (Bloom et al., 1956; Krathwohl et al., 2009; Krathwohl et al., 1973; Simpson, 1966). Although Bloom's Taxonomy is traditionally a pedagogical application of behaviorism (Brahimi, 2011), we integrated this framework into a learner-centered competency development process by engaging learners and end-users in negotiating and determining their own palliative care competencies.

Consensus Decision Making

We engaged numerous learners and end-users in consensus decision-making to determine Alberta HCP specific palliative care competencies. Consensus decision-making is based on the social constructionists' and constructivists' principle that individuals learn best when they are involved in the development and pursuit of their own learning objectives and competencies (Noddings, 2015). Consensus decision making is a process used by groups seeking to generate widespread levels of participation and agreement, where learners are proactive beings who construct their own knowledge through dialogue and relational processes. (Hartnett, 2011; Brahimi, 2011; Gergen, 2009). The purpose of this approach is to learn from one another and enable shared decision-making (Phillips, 2014, Vol.2, pp. 719). Consensus decision-making is an alternative to "top-down" decision-making, which occurs when leaders of a group make decisions in a way that does not include the participation of all end-users and subject matter experts (SMEs) who have a thorough knowledge of the role under examination and are close enough to the job to be able to provide current and accurate

input (Langins & Borgermans, 2015). Consensus decision-making enhances transferability, representativeness and knowledge translation of final content by engaging individuals with diverse perspectives, experiences and knowledge (Langins & Borgermans, 2015). Using consensus decision-making, we developed palliative care competencies that holistically addressed each learning domain and promoted critical reflection by health care providers providing direct care, professional practice leaders, academia, regulatory bodies and professional associations.

Learning Domains and Critical Reflection

While traditional behaviorist learning paradigms tend to focus only on cognitive learning, Sipos, Battisti, and Grim (2008) emphasize that transformative learning is most effective when there is a balance between: cognitive learning, which involves integrated theoretical learning; affective learning, which encompasses the transference of values and personal meaning into behavior; and psychomotor learning, which translates theoretical knowing into action. The affective domain is very present in the activities of health care but is often unrecognized in comparison to the cognitive and psychomotor learning domains (Lejonqvist et al., 2016). For instance, researchers have found that patients and families place a high value on therapeutic relationships and compassion as elements of quality of care (Sinclair et al., 2017). In essence, who you are with a patient is just as important as what you do to or for a patient. This holistic perspective is foundational to a palliative approach which is grounded in patient and family-centered care (AHS, 2014). Aligning with humanistic pedagogy, the Alberta Palliative Care Competencies address cognitive, affective, and psychomotor learning domains. Additionally, the competencies promote transformational learning through critical reflection.

The Alberta Palliative Care Competencies are structured in the form of a competency self-assessment tool. A competency self-assessment tool is intended to encourage each HCP to reflect on their palliative care practice and identify areas of strength and areas they may wish to include in their personal development plan. (American College of Healthcare Executives, 2018, p. 1). Based on humanistic principles of self-awareness, emotional intelligence and intuitive knowledge, reflective practice is a transformational learning approach that fosters personal and professional development through critical reflection (Howatson-Jones, 2016). Critical reflection has been likened to critical thinking, with a greater emphasis on the affective learning domain (Sherwood & Horton-Deutch, 2012). Critical reflection leads an individual through an examination of personal innate assumptions, values and perspectives (Johns & Freshwater, 2005). The benefits of reflective practice in health care are well documented and include enhanced individual effectiveness, enhanced problem-solving skills and ultimately enhanced patient care delivery (Howatson-Jones, 2016).

Methods

In fall 2018, under the direction of the AHS Provincial Palliative and End-of-Life Innovations Steering Committee, the Covenant Health Palliative Institute began the process of developing Alberta palliative care competencies.

The following are the four steps used in the competency development process:

1. Conduct comprehensive literature reviews
2. Establish a steering committee and formulate a network of working groups
3. Establishing a competency framework structure
4. Develop Alberta based HCP specific palliative care competencies

1. Conduct Comprehensive Literature Reviews

A rapid review of existing palliative care competencies was conducted and used to inform draft HCP specific palliative care competencies for each HCP group.

Search Strategy

The search strategy was developed, and peer reviewed by two experienced librarians. Searches were conducted in three key bibliographic databases (MEDLINE, CINAHL and PsycInfo) for publications on the topic of palliative competencies for each health care professional group and health care volunteers. The database searches were supplemented by performing keyword searches in Google Scholar and Google and by conducting a targeted search of select Canadian and selected international health care professional association websites to identify grey literature. Search limiters included: adult population, English language, Canada and United States, all health care settings (e.g. acute care, continuing care, hospice, home care), and publication year 2015 to 2019. A summary table of the literature review search strategy is presented in Appendix 5, along with a detailed example of a MEDLINE search strategy. Search strategies for other key databases are available from the corresponding author upon request.

Inclusion Criteria: adult population, English language, Canada and United States, all health care settings (e.g. acute care, continuing care, hospice, home care) and publication year 2015 to 2019.

Exclusion criteria: non-healthcare settings, inaccessible full text, not peer-reviewed, conference proceedings, opinion articles, editorials, commentaries.

2. Establish a Steering Committee and Formulate a Network of Working Groups

To advise the competency development structure and process a steering committee was collaborated with and established working groups as follows (Figure 1):

The AHS Provincial Palliative and End-of-Life Innovations Steering Committee (AHS PPAL EOL ISC) served as the Steering Committee for this project.

The Alberta Palliative Care Competencies Advisory Working Group (Advisory Working Group) consists of palliative care experts from across the province and advises the Covenant Health Palliative Institute (PI) Palliative Care Competencies Working Group (PI Working Group) on direction and approach of the project.

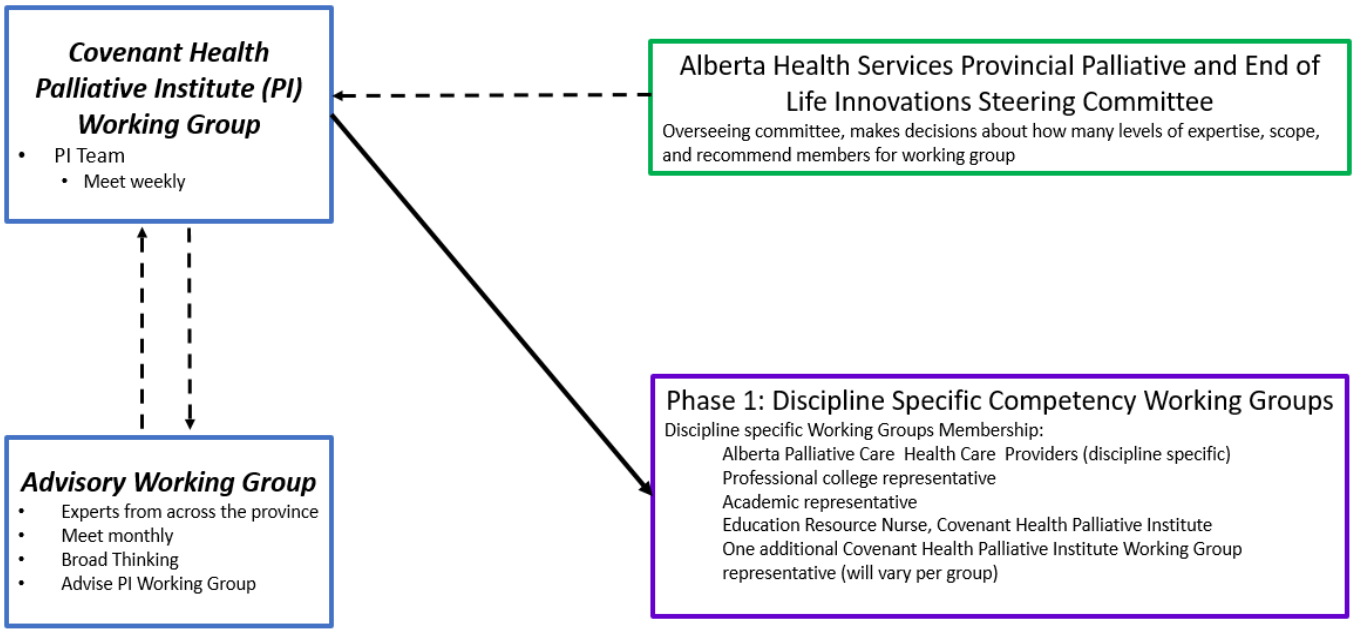
Covenant Health Palliative Institute Palliative Care Competencies Working Group wrote project protocols, managed ethics submission, coordinated the project on a day-to-day basis and was accountable to the Advisory Working Group and the AHS PPAL EOL ISC.

The HCP palliative care competencies specific working groups with the support of the PI Working Group, were responsible for the review, revision and development of HCP specific palliative care competencies. Each working group had the opportunity to have membership representation from front line providers, each provincial health care zone, educational institutes and provincial regulatory bodies. To obtain this representation, key stakeholders from across the province were contacted including: discipline specific professional regulatory bodies, AHS Provincial Professional Practice Council (discipline specific), AHS Alberta Clinician Professional Practice Council, Covenant Health Professional Practice, and various Alberta educational institutes within the discipline specific programs (Appendix 2).

The responsibility of each HCP specific palliative care competencies working group was to:

- Review a HCP specific competencies' draft and related literature (both provided by the PI Working Group)
- Provide HCP specific feedback
- Review internal and external feedback of the competencies and provide edits and/or comments and/or recommendations and;
- Oversee the finalization of their HCP specific palliative care competencies.
- Establish a Competency Framework Structure

Figure 1: Alberta Palliative Competencies Project Working Group Structure



3. Establish a Competency Framework Structure

In consultation with the Advisory Working Group and the AHS PPAL EOL ISC, a competency structure framework was established to organize and describe the Alberta palliative care competencies.

Competency statements are organized according to the following two dimensions:

3.1. Level of expertise

3.2. Competency domains

3.1. 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

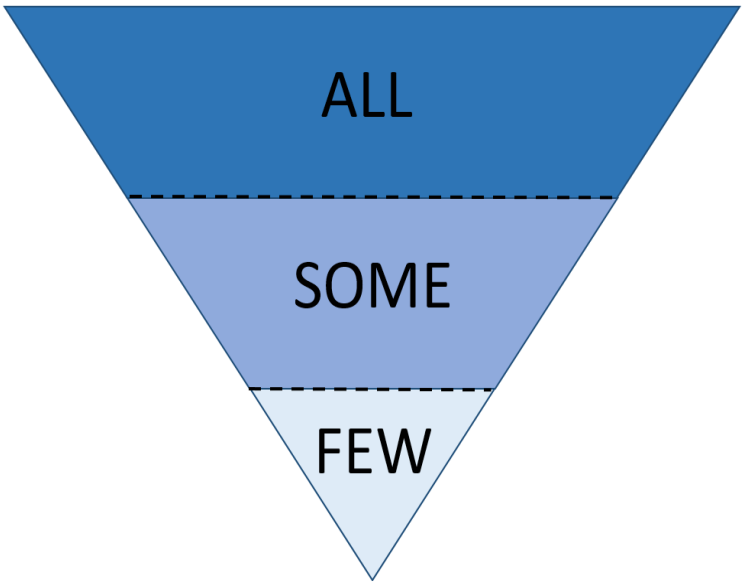


Table 1: Alberta Palliative Care Competency Triangle: Levels of Expertise Definitions
All: HCPs in this level provide care within their scope of practice, to any person in any care setting, including those with life-limiting illnesses. They have foundational knowledge and skills in palliative care. This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

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

3.2. 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.

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.

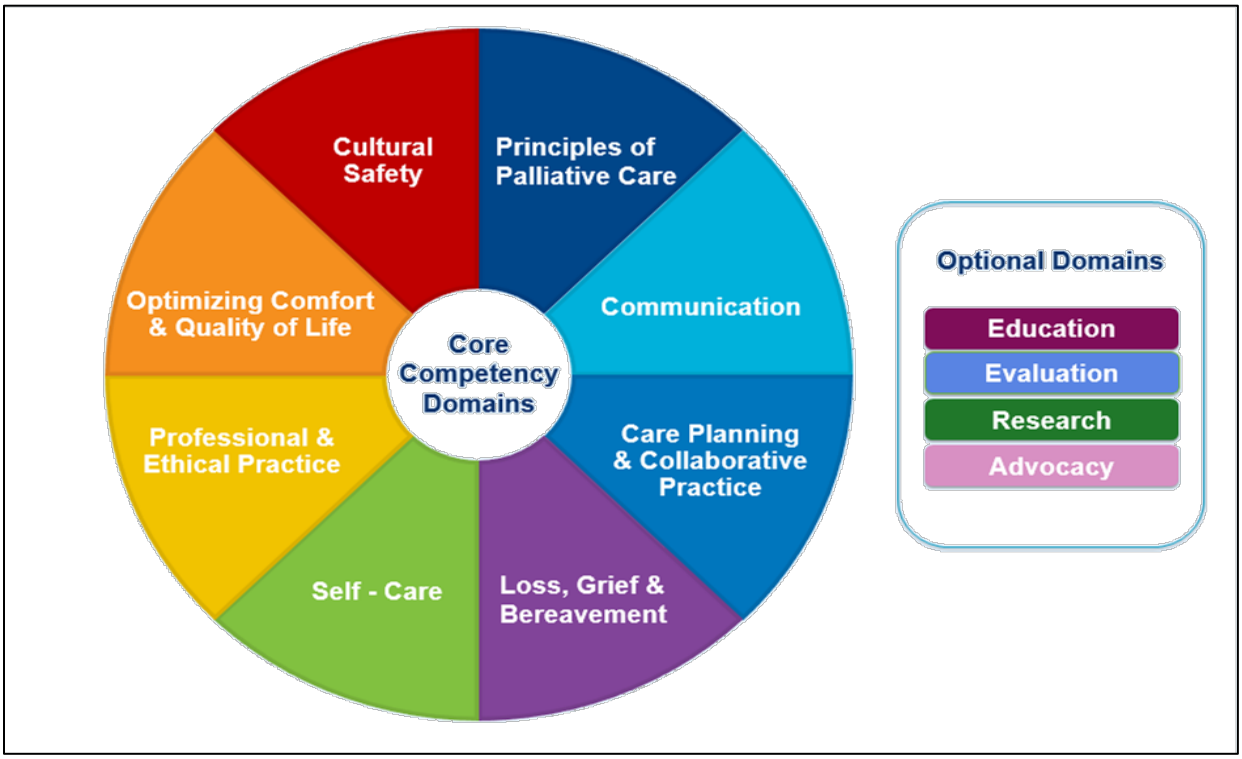
Domain 9A: Education
Participating in palliative care continuing education, facilitating palliative care educational opportunities for HCPs, volunteers, each patient, their family and the public.

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.

Figure 2. Alberta Palliative Care Competency Domains



4. Develop Alberta HCP Specific Palliative Care Competencies

We used an evidence-based consensus development approach to competency development in Alberta. The type of consensus development approach best suited to a particular guideline development depends on several factors including the geographical scope of the expertise required (national, regional or global); the focus and subject matter of the guideline under development; the population that will be affected by the recommendations; the users of the guideline; the quality of the available evidence; and the time and resource constraints involved (Langins & Borgermans, 2015). A consensus development approach can take on two methods: the implicit approach which utilizes

informal qualitative methods (e.g. group discussion), or the explicit approach involving statistical methods to form consensus (e.g. Delphi) (Kea, 2015). We used the Consensus Oriented Decision-Making Model (implicit approach) and the modified Delphi method (explicit approach) to form consensus. Competency statements gathered from key documents (Nova Scotia, Ontario, British Columbia and Irish palliative care competency frameworks) were compiled into draft competency profiles for each HCP group and working group members were asked for their feedback.

The Consensus Oriented Decision-Making Model is a model of consensus building that incorporates the principles of collaboration, inclusion, empathy and open-mindedness (Hartnett, 2011). The goal of this model is to facilitate collaborative decision making through group discussion. The Consensus Oriented Decision-Making model was piloted with the first six HCP specific working groups (Paramedics, Physiotherapists, Occupational Therapists and Respiratory Therapists). Working group meetings were held monthly. During these meetings, working group members engaged in discussion to collaboratively adapt and revise the draft HCP specific palliative care competencies to meet the Alberta context. However, this consensus building process was found to be incredibly time consuming and several working group members expressed concerns over not being able to contribute their input during discussions. The World Health Organization (2015) recommends using hybrid approaches that draw upon the advantages of various methods, accordingly, to build consensus for the remaining nine working groups (Pharmacists, Dietitians, Nurses, Advanced Practice Nurses, Social Workers, Speech-Language Pathologists and Audiologists, Medical Radiation and Imaging Technologists, Psychologists and Spiritual Care Practitioners) we adopted a modified Delphi method with elements of the Consensus Oriented Decision-Making model to form consensus[1].

The modified Delphi method is recommended for use in health care as an effective means of determining consensus for particular clinical topics (Eubank et al., 2016). It is particularly useful whenever the judgments of experts are needed but time, distance and other factors make it difficult for the group to convene in person (Langins & Borgermans, 2015). This method is an iterative process that uses a systematic progression of rounds of surveys to elicit expert opinions and reach group consensus on a specific topic (Wiek, Withycombe, & Redman, 2011). Several questions have been addressed using the Delphi method, including educational questions surrounding curricular design and the identification of core principles, and guidelines (Grunspan, 2018). We adapted the Delphi method to evaluate and validate draft HCP specific

[1] The Alberta Volunteers' Palliative Care Competencies Working Group preferred to and agreed to use informal group discussions to formulate their competencies.

palliative care competencies then conducted three rounds of iterative surveys in which working group members were asked to rank each competency statement in terms of relevance to their profession and provide written feedback. The surveys were created in REDCap, a secure web application for building and managing online surveys and databases. The surveys were circulated by email and accompanied by a clear explanation of the objectives of the survey and specific instructions for member participation. Descriptive statistics were used to analyze quantitative data and thematic analysis was used to analyze qualitative data. There were two in person/virtual meetings during which working group members came together to engage in discussion (using the Consensus-Oriented Decision Making Model). The first meeting was at the beginning of the process which served as an introductory meeting intended to inform working group members of the project background and process. The second meeting occurred after the Delphi 3 analysis, which resulted in a final draft document. The purpose of the final meeting was to discuss the document as a whole and determine if any further revisions were required. After this meeting, the final document was sent to the working group members for one final opportunity to provide written feedback.

Ethics

Ethical approval was obtained from the University of Alberta Health and Ethics Research Board (Pro00089536), the Covenant Health Research Board and the Alberta Health Services Research Office.

Results

The Alberta Palliative Competencies project results are presented as follow:

1. Literature reviews
2. HCP Specific Palliative Care Competencies Working Groups
3. Developing HCP Specific Palliative Care Competencies

1. Literature Reviews

Overall, our search strategy yielded a total of 1543 citations (Tables 2-4). There were 232 duplicates that were removed, leaving 1311 citations for title/abstract screening using the inclusion and exclusion criteria. A total of 209 publications were identified for use in developing palliative care competencies for each HCP group.

Table 2. Alberta Palliative Care Competencies Literature Reviews: Databases Searched

HCP Group	Med-line	CIN-AHL	Psyc-INFO	Nursing & Allied Health	Health Source: Nursing/ Academic	OT-seeker	PEDro	Records identified through database searching	Number of duplicates removed
Registered Nurses	97	87	43	0	0	0	0	227	60
Occupational Therapists	0	0	0	0	0	0	0	0	0
Paramedics/ Emergency Medical Services	0	1	0	0	0	0	0	1	0
Physiotherapists	0	0	0	0	0	0	0	0	0
Licensed Practical Nurses	0	1	0	0	0	0	0	1	0
Registered Psychiatric Nurses	0	0	0	0	0	0	0	0	0
Health Care Assistants/Aides	0	0	0	0	0	0	0	0	0
Respiratory Therapists	1	1	0	0	0	0	0	2	1
Pharmacists	30	30	9	0	0	N/A	N/A	69	0
Dietitians	16	25	0	0	0	N/A	N/A	41	0
Advanced Practice Nurses	115	16	53	0	0	N/A	N/A	184	0
Medical Radiation and Imaging Technologists	7	5	0	0	0	N/A	N/A	12	0
Speech Language Pathologists	33	3	112	0	0	N/A	N/A	148	0
Social Workers	19	36	6	0	0			61	0
Volunteers	2	7	0	0	0	N/A	N/A	9	0
Spiritual Care Practitioners/ Chaplains	2	5	0	0	2	0	0	9	0
Psychologists	10	13	149	0	0	N/A	N/A	172	0

Table 3. Alberta Palliative Care Competencies Literature Reviews: Grey Literature Searches

HCP Group	Google Scholar	Google Advanced	Best Medical Search Engine	Additional records identified through other sources	Total records identified through database searching	Number of duplicates removed	Records screened out by librarian
Registered Nurses	23	14	0	0	264	60	100
Occupational Therapists	2	2	0	0	4	0	0
Paramedics/ Emergency Medical Services	3	0	0	0	4	0	0
Physiotherapists	1	2	1	0	4	0	0
Licensed Practical Nurses	1	1	0	0	3	0	0
Registered Psychiatric Nurses	0	0	0	0	0	0	0
Health Care Assistants/Aides	0	0	0	0	0	0	0
Respiratory Therapists	3	0	0	0	5	0	1
Pharmacists	16	N/A	N/A	3	88	11	13
Dietitians	7	N/A	N/A	0	48	2	16
Advanced Practice Nurses	6	N/A	N/A	2	192	32	44
Medical Radiation and Imaging Technologists	3	N/A	N/A	0	15	0	0
Speech Language Pathologists	8	N/A	N/A	0	156	10	106
Social Workers	30	8	N/A	2	101	37	23
Volunteers	21	11	N/A	0	41	22	4
Spiritual Care Practitioners/ Chaplains	2	1	2	0	14	0	2
Psychologists	12	N/A	N/A	0	184	7	91

Table 4. Alberta Palliative Care Competencies Literature Reviews: Final Literature Screening

HCP Group	Records remaining for investigator to screen	Records excluded after abstract review	Full text articles assessed for eligibility	Full text articles excluded with reason	Additional records	Total documents included
Registered Nurses	104	97	7	0	1	**8**
Occupational Therapists	4	2	2	0	3	**5**
Paramedics/ Emergency Medical Services	4	2	3	0	2	**4**
Physiotherapists	4	2	2	0	2	**4**
Licensed Practical Nurses	3	0	3	0	1	**4**
Registered Psychiatric Nurses	0	0	3	0	0	**0**
Health Care Assistants/Aides	0	0	0	0	5	**5**
Respiratory Therapists	4	1	3	0	2	**5**
Pharmacists	116	105	3	0	0	**11**
Dietitians	30	26	3	0	0	**4**
Advanced Practice Nurses	116	101	3	0	6	**21**
Medical Radiation and Imaging Technologists	15	7	3	0	5	**13**
Speech Language Pathologists	40	34	6	0	0	**6**
Social Workers	41	21	3	0	0	**20**
Volunteers	15	11	3	0	0	**4**
Spiritual Care Practitioners/ Chaplains	12	2	0	0	0	**10**
Psychologists	86	81	5	0	0	**5**
					Total	**209**

2. HCP Specific Palliative Care Competency Working Groups

This project involved 15 HCP specific palliative care competencies working groups, encompassing 24 HCP groups, including volunteers (Table 5). Working group membership included HCPs representatives from across the province. Working group numbers varied between seven and 20 members and involved a total of 185 participants (Table 5).

Table 5. Alberta Palliative Care Competencies Project: Health Care Provider Specific Working Groups

Group	Started	Completed
Emergency Medical Responders (EMRs)/Paramedics, Physiotherapists (PTs), Occupational Therapists (OTs)	November 2018	May 2019
Nurses (Registered Nurses (RN), Registered Psychiatric Nurses (RPN), and Licenced Practical Nurses (LPN)), Health Care Aides (HCAs), Respiratory Therapists (RTs)	January 2019	July 2019
Pharmacists, Dietitians, Advanced Practice Nurses (APN) (Clinical Nurse Specialists (CNS), Nurse Practitioners (NP)), Speech-Language Pathologists (SLPs) and Audiologists, Medical Radiation and Imaging Technologists (MRITs), Psychologists	September 2019	January 2020
Social Workers (SWs), Spiritual Care Practitioners (SCPs), Volunteers	January 2020	July 2020

Note: Medicine palliative care competencies for palliative care residents have been established by the College of Family Physicians Canada and The Royal College of Physicians and Surgeons of Canada. Furthermore, competencies for undergraduate medical education and for post-graduate education have been, or are in the process of being established, by the Canadian Society of Palliative Care Physicians (Educating Future Physicians in Palliative and End-of-Life Care (EFPPEC)) and Palliative Approach to Care Education (PACE) working groups respectively.

Table 6. Alberta HCP Palliative Care Competencies Project: Working Group Representation

HCP Group	North	Edmonton	Central	Calgary	South	Regulatory/ Association	Educational	Covenant	Alberta Health	Provincial AHS	Other	Total
PTs	1	1	1	2	1	1	1	1	-	-	-	10
OTs	1	4	1	2	1	-	3	2	-	-	-	14
EMRs/Paramedics	1	-	-	1	1	1	1	NA	1	1	-	7
RTs	2	2	2	3	3	1	3	1	-	-		17
Nurses	1	2	3	2	3	3	4	2	-	1	-	20
HCAs	3	1	1	1	1	NA	4	1	-	1	4	17
Pharmacists	2	1	1	-	1	2	1	1	-	-	-	9
Dietitians	1	1	1	1	1	1	2	2	-	1		11
Psychologists	1	1	-	1	1	2	2	2	-	-		10
SLPs and Audiologists	3	1	2	4	2	2	2	1	-	1	-	18
MRITs	1	2	1	-	-	1	3	1	-	-	-	9
APNs	1	1	1	2	-	1	2	2	-	1		11
SWs	1	4	2	2	1	1	2	3	-	1	-	17
SCPs	1	1	1	1	-	1	-	3	-	-	-	8
Volunteers	-	-	-	3	-	-	-	4	-	-	-	7
										Total		**185**

Table Legend

HCP: Health care provider
PTs: Physiotherapists
OTs: Occupational Therapists
EMRs: Emergency Medical Responders
HCAs: Health Care Aides
SLPs: Speech Language Pathologists
MRITs: Medical Radiation and Imaging Technologists
APNs: Advanced Practice Nurses
SWs: Social Workers
SCPs: Spiritual Care Practitioners

3. Developing HCP Specific Competencies

The Consensus Oriented Decision-Making Model was used to build consensus with the PTs, OTs, Paramedics and RTs. An average of six one-hour meetings was required to reach consensus for each group. Revisions that occurred during the meeting were captured as tracked changes on the draft competency document which was presented on the Skype for Business screen so that all attendees could view the revisions as they were made. The goal was to discuss the draft competencies under each domain and revise the competencies through discussion. At the end of each domain discussion, there was a group vote to either accept the changes or to modify the domain further. We

used a majority threshold of 75% to determine consensus for each vote, meaning that if 75% of the group voted to accept the domain revisions, we would move on to discuss the next domain (Table 7).

Table 7. Alberta Palliative Care Competencies Project: Consensus Oriented Decision-Making Votes to Accept each Domain*

	Domain									
HCP Group	**POP**	**Com**	**OCQL**	**CPCP**	**LGB**	**PEP**	**CS**	**SC**	**EER**	**Ad**
PTs	8/9	9/9	7/7	7/7	7/7	6/7	6/6	6/6	6/6	6/7
OTs	10/11	9/9	8/9	8/8	8/8	9/10	9/10	6/6	6/6	6/6
Paramedics	6/7	6/7	5/5	5/5	4/5	5/5	5/5	5/5	5/5	Deferred to written feedback
RTs	8/8	7/7	7/7	5/5	5/5	6/6	6/6	7/7	6/7	7/7
Volunteers	Facilitated Group Discussions									

Table Legend

HCP: Health care provider
PTs: Physiotherapist
OTs: Occupational Therapists
RTs: Respiratory Therapists
POP: Principles of Palliative Care
Com: Communication
OCQL: Optimizing Comfort and Quality of Life
CPCP: Care Planning and Collaborative Practice
LGB: Loss, Grief, and Bereavement
PEP: Principles of Ethical Practice
CS: Cultural Safety
SC: Self-Care
EER: Education, Evaluation, and Research
Ad: Advocacy
*A majority threshold of 75% was used to determine consensus for each vote

For the remaining HCP palliative care competencies' working groups, we employed a combination of the Consensus-Oriented Decision Making Model and a modified Delphi method. A draft document of HCP specific palliative care competencies' statements was developed and rounds of iterative surveys were conducted in which working group members were asked to provide feedback on the competencies. We conducted three rounds of Delphi surveys for each HCP working group with increasing specificity, in order to achieve a pre-determined percentage of consensus. A total of 30 Delphi surveys were conducted (Table 7) for the remaining 10 HCP working groups.

Table 8. Alberta Palliative Care Competencies Project: Delphi Survey Response Rates

HCP Group	Delphi 1		Delphi 2		Delphi 3	
	Invites	Reponses # (%)	Invites	Responses # (%)	Invites	Responses # (%)
Nurses	21	19 (90.4)	21	17(80.9)	21	16(76.1)
HCAs	16	14(87.5)	15*	9(60)	15*	10(66.6)
Psychologists	9	8(88.8)	9	7(77.7)	9	7(77.7)
Pharmacists	9	9(100)	9	8(88.8)	9	6(66.6)
APNs	11	7(63.6)	11	6(54.5)	11	4 (36.3)
MRIT s	9	9(100)	9	8(88.8)	9	6(66.6)
Dietitians	11	11(100)	11	9(81.8)	11	9(81.8)
SLP and Audiologists	17	17(100)	17	15(88.2)	13	12(92.3)
SWs	17	15(88.2)	17	15(88.2)	17	13(76.5)
SCPs	8	6(75)	8	8(100)	7*	7(100)

* 1 member of the working group retired

Table Legend

HCP: Health care provider
PTs: Physiotherapists
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EMRs: Emergency Medical Responders
HCAs: Health Care Aides
SLPs: Speech Language Pathologists
MRITs: Medical Radiation and Imaging Technologists
APNs: Advanced Practice Nurses
SWs: Social Workers
SCPs: Spiritual Care Practitioners

Delphi Survey 1: Initial Feedback (Table 9)

The goal of Delphi survey 1 was to solicit respondents' ratings of the content of each competency statement in terms of relevance to their profession. A questionnaire with compiled competencies was sent out to working group members. Participants were asked to rate each competency on a 5-point Likert scale indicating the degree of importance of including that competency. The following scale was utilized: extremely relevant (5), relevant (4), somewhat relevant (3), not relevant (2) and not specific to

palliative care (1). Competencies were ranked for inclusion based on the aggregated Likert scales as follows:

1. If greater than or equal to 75% of participants rated 1-2 / 5, the competency indicator was not included
2. If greater than or equal to 75% of participants rated 3/ 5, the competency indicator was considered a Group B statement
3. If greater than or equal to 75% of participants rated 4-5/5, the competency indicator was considered a Group A statement

Group A and B competencies were included in the next round of Delphi surveys for further evaluation. Participants were also given the opportunity to provide comments and suggest additional competencies that may not have been included when developing the initial list of statements.

Table 9. Alberta Palliative Care Competencies Project: Delphi Survey 1 Results

HCP Group	Statements reviewed	Group A Statements	Group B Statements	Statements Removed	Statements added
Nurses	162	162	0	0	15
HCAs	93	79	14	0	9
Pharmacists	204	125	79	0	0
Dietitians	184	139	46	0	3
Psychologists	212	195	17	0	1
SLPS and Audiologists	167	51	114	2	0
MRITs	116	8	108	0	1
APNs	103	101	2	0	15
SWs	243	213	32	0	8
SCPs	232	197	34	0	1

Table Legend

HCPs: Health care providers
PTs: Physiotherapists
OTs: Occupational Therapists
EMRs: Emergency Medical Responders
HCAs: Health Care Aides
SLPs: Speech Language Pathologists
MRITs: Medical Radiation and Imaging Technologists
APNs: Advanced Practice Nurses
SWs: Social Workers
SCPs: Spiritual Care Practitioners

Delphi Survey 2: Two Components (Table 10)

Delphi survey 2 addressed two components of the draft palliative care competencies: competency statement language revisions and level of expertise. Competency statements were divided into Group A and Group B statements. For Group A statements respondents were asked to vote to:

1. Accept competency indicator with no revisions, or
2. Revise indicator with free text section to record revision recommendations and

3. Indicate under which level of expertise (All, Some, Few) the indicator belongs

For Group B Statements respondents were asked to:

1. Accept competency indicator (with opportunity to provide language revisions) and
2. Indicate under which level of expertise (All, Some, Few) the indicator belongs, or
3. Do not include in the palliative care competencies

For Group A statements, competency statements were accepted with no revisions if greater than or equal to 75% of participants indicated to accept with no revisions. Group A competency statements were accepted with collated recommended revisions for domains in which less than 75% of participants voted to accept the domain with no revisions. For Group B statements, competency statements were removed from the competencies if greater than or equal to 60% of the participants voted to reject the statement in the palliative care competencies. Level of expertise was determined with a 60% majority threshold. If statements did not meet the required majority thresholds for this Delphi round, they were deferred to Delphi Round 3 for further clarification.

Table 10. Alberta Palliative Care Competencies Project: Delphi Survey 2 Results

		Statement Revisions			Level of Expertise		
HCP Group	**Statements reviewed**	**Statements accepted with no revision**	**Statements accepted with revision**	**Statements that required further vote**	**Statements moved to a different level of expertise**	**Statements that required further clarification**	**Statements removed**
Nurses	177	174	1	2	15	30	0
HCAs	101	83	11	7	13	33	1
Pharmacists	204	167	24	14	20	65	13
Dietitians	187	147	8	20	9	38	11
Psychologists	213	203	7	4	8	39	0
SLPs and Audiologists	165	77	18	55	1	69	15
MRITs	117	87	19	9	12	40	2
APNs	118	103	15	0	8	69	0
SCPs	233	181	45	9	20	86	8
SWs	251	235	14	2	13	121	0

Table Legend

HCPs: Health care providers
PTs: Physiotherapists
OTs: Occupational Therapists
EMRs: Emergency Medical Responders
HCAs: Health Care Aides
SLPs: Speech Language Pathologists
MRITs: Medical Radiation and Imaging Technologists
APNs: Advanced Practice Nurses
SWs: Social Workers
SCPs: Spiritual Care Practitioners

Note: After Delphi 2, the Audiologists deferred their consensus process to group meetings and discussions due to the small number of participants being only four people which made it difficult to reach the required majority thresholds.

Delphi Survey 3: Final Thoughts (Table 11)

The final Delphi survey was sent out with revised competencies organized under each respective domain and level of expertise. Participants were asked to review the domains as a whole and provide their feedback. Regarding each competency domain, respondents were asked to:

1. Accept domain with no revisions
2. Accept domain with revisions (with a free text section to record revision recommendations)

For the competency statements from Delphi 2 that required a re-vote regarding inclusion or exclusion, respondents were asked to:

1. Accept statement (with opportunity to provide language revisions) and
2. Indicate in which level of expertise the competency statement belongs, or
3. Do not include statement in the palliative care competencies

For the competency statements from Delphi 2 that required a re-vote regarding level of expertise, respondents were asked to vote on which level of expertise each competency statement belonged. Domains were accepted with no revisions if greater than or equal to 75% of participants indicated to accept the domain with no revisions. Domains were accepted with collated recommended revisions for domains in which less than 75% of participants voted to accept the domain with no revisions. Statements that required voting regarding inclusion and exclusion were removed from the competencies if greater than or equal to 60% of the participants voted to reject the statement in the palliative care competencies. All revision recommendations were made to these statements if they remained in the competencies. For statements that required further clarification regarding the level of expertise, majority vote was used to determine which level of expertise it would belong.

Table 11. Alberta Palliative Care Competencies Project: Delphi Survey 3 Results

HCP Group	State-ments reviewed	Domains accepted with no revision	Domains accepted with revision	Statements accepted with no revision	State-ments with revision	Statements moved to a different level of expertise	State-ments removed	Statements requiring clarification
Nurses	177	24	6	2	0	23	0	1
HCAs	100	22	0	3	4	16	3	1
Pharmacists	191	23	0	8	6	17	6	19

Table 11. Continued Alberta Palliative Care Competencies Project: Delphi Survey 3 Results

HCP Group	State-ments reviewed	Domains accepted with no revision	Domains accepted with revision	Statements accepted with no revision	State-ments with revision	Statements moved to a different level of expertise	State-ments removed	Statements requiring clarification
Dietitians	176	21	0	3	12	15	5	4
Psychologists	213	25	0	1	2	24	0	2
SLPs and Audiologists	150		0	38	17	17	0	7
MRITs	115	15	1	0	5	17	7	10
APNs	118	8	2	0	0	20	0	27
SCPs	225	21	0	221	4	22	0	17
SWs	251	28	0	249	2	36	0	13

Table Legend

HCPs: Health care providers
PTs: Physiotherapists
OTs: Occupational Therapists
EMRs: Emergency Medical Responders
HCAs: Health Care Aides
SLPs: Speech Language Pathologists
MRITs: Medical Radiation and Imaging Technologists
APNs: Advanced Practice Nurses
SWs: Social Workers
SCPs: Spiritual Care Practitioners

After the Delphi 3 results were compiled, the final draft Word document version of the Alberta HCP specific palliative care competencies was sent out to the working group members for final feedback which was provided during a final meeting and/or through written feedback.

Table 12. Alberta Palliative Care Competencies Project: Summary of Consensus Building Process

	Delphi Process						Iterative revisions (discussion and written feedback)	
HCP Group	**Starting Competency statements**	**Statements removed**	**Statements added**	**Statement revisions**	**Domain revisions**	**Statements moved to different level of expertise**		**Final number of state-ments**
Nurses	162	0	55	1	7	38		229
HCAs	93	3	9	15	0	29		100
Pharmacists	204	19	0	30	0	37		174
Dietitians	184	16	3	20	0	24		170
Psychologists	212	0	1	9	0	32		206
MRITs	116	9	1	24	1	29		104
APN	103	0	15	15	2	28		88
SLP	167	17	0	35	0	18		149
SWs	243	0	8	16	0	49		228
SCPs	232	8	1	49	0	42		209

Table 12 Continued. Alberta Palliative Care Competencies Project: Summary of Consensus Building Process

Table Legend:	
HCPs: Health care providers	SLPs: Speech Language Pathologists
PTs: Physiotherapists	MRITs: Medical Radiation and Imaging Technologists
OTs: Occupational Therapists	APNs: Advanced Practice Nurses
EMRs: Emergency Medical Responders	SWs: Social Workers
HCAs: Health Care Aides	SCPs: Spiritual Care Practitioners

Discussion

We applied a comprehensive and evidence-based approach to palliative care competencies development in Alberta. The strengths of this project are evident in the competency statement characteristics, as well as their representativeness, transferability, and scope. Additionally, the consensus process validated that there are indeed interprofessional palliative care competencies that resonate with each HCP group. Key learnings were apparent at various points in the palliative care competencies' development process. For instance, it became evident that categorizing competency statements according to three levels of expertise can be challenging. Some limitations in the Alberta palliative care competencies process are also apparent.

Competency Statement Characteristics

The palliative care competency statements are measurable and innovative. Six key features are important to highlight in our understanding of effective HCP competencies: they take time to acquire: they can inform recruitment, evaluation and training; they can be assessed; they must be flexible; they go beyond clinical-technical skills; and they describe and distinguish HCPs. Table 13 shows how the Alberta palliative competencies align with these features.

Table 13. Competency Features

Competency Feature	Explanation
Competencies take time to acquire	Competencies are complex. Over time, professionals have the opportunity to move from being novice in their competencies to experts in their competencies. With practice experience, and through ethical reasoning, self-reflection, and mentoring, HCPs may progress across the levels of competency (Benner, 1984; Benner & Tanner, 2009). The palliative care competencies are organized into the All, Some, Few model of expertise, however, HCPs should aim to move from novice to expert in whichever category they identify themselves.

Table 13 Continued. Competency Features

Competency Feature	Explanation
Competencies inform recruitment, evaluation and training	Competencies serve to inform standards by which performance of HCPs can be assessed. Whether or not regulated, it is important that competencies are made explicit. The HCP can then be made aware that, upon entry into the exercising of the profession they are agreeing to the mastery of these competencies in order to be deemed competent. In the clinical setting, these core competencies can inform job descriptions, recruitment criteria, clinically-based training programs, monitoring and evaluation, performance reviews and promotion to leadership roles. The palliative care competencies can be used as a resource to inform and guide academic curricula, professional development, professional regulatory bodies, continuing education programs and employers.
Competencies can be assessed	Despite their complex nature, assessments of competencies are possible and available. Assessments should focus on improving the competency rather than on penalizing the lack of achievement of a certain level of competence. Literature looking at assessing familiarity with competencies in initial education settings and the literature on adult education provide valuable insights on how to conduct these assessments. The palliative care competencies provide opportunity for each HCP to engage in self-assessment.
Competencies must be flexible	Just as it is important to standardize competencies, it is important to recognize flexibility. Defining competencies is important for having standards and scopes of practice but an unclear definition may compromise outcomes. A strict definition may limit innovation and change in practice as needed. Competencies need to be improved based on the changing nature of patient and population needs. The palliative care competencies address the care needs of patients and their families throughout the entire trajectory of a life-limiting illness from diagnosis, to end-of-life and into bereavement
Competencies go beyond clinical-technical skills	Competencies are not limited to clinical-technical skills, such as assessment, diagnostic procedures and clinical interventions. Rather several competencies are known as relational skills, such as communication, collaboration, self-awareness, reflection, role clarity and working in teams. Defining these competencies guide the choice of tools to strengthen them. The competency communication, for instance, can focus on tools that help HCPs to maintain professionalism, being sensitive to cultural, political, domestic, and economic circumstances and viewpoints, among others. The palliative care competencies address cognitive, affective, and psychomotor skills.

Table 13 Continued. Competency Features

Competency Feature	Explanation
Competencies describe and distinguish health care providers	Competencies serve to distinguish the HCPs from other groups of professionals (e.g. competencies of HCPs are different from those of engineers), but also to distinguish professional groups within a profession (e.g. competencies of nurses are different from those of pharmacists). There are, however, competencies that can unify and facilitate collaboration of HCPs. The palliative care competencies describe HCP specific competencies. However, there are several overlapping competencies that may represent interprofessional palliative care competencies

Note: Adapted from Langins & Bergermans, 2015, p. 4.

Each palliative care competency statement is defined using a short action statement describing what a HCP must be able to perform to provide quality palliative care to patients and their families. These verbs provide measurable guidance as to the required level of performance in providing palliative care. The competency statements are innovative in that they measure “what is” and “what will be needed in the future” or “what should be” (Campion, 2001). For instance, several of the competency statements require HCPs to develop palliative care competencies beyond that of which they are currently trained. In essence, the competencies statements are future-oriented, describing the ideal state of palliative care education and training in Alberta. One potential limitation of the palliative care competencies is the extensive number of statements and the extent of detail covered in each statement. This is perhaps one of the most difficult issues in developing competency profiles, as there can be tension between a desire for detail on the one hand and a desire for simplicity on the other (Campion, 2011). While detail is helpful for developing stronger skills and the potential for evaluation, simplicity is better for getting end-users to actually use the competencies (Campion, 2011). This is a fine balance that we attempted to maintain and navigate throughout the competencies’ development process.

Representativeness and Scope

Alberta, Nova Scotia, Ontario and British Columbia have established multidisciplinary provincial palliative care competencies which are built upon each other’s work, as well as the work of other organizations and jurisdictions (Table 14). Nova Scotia and Ontario developed draft competency profiles and sent them to key stakeholders to elicit feedback, validation, and endorsement (NSHA, 2017; OPCN, 2019), whereas British Columbia used a combination of informal and modified Delphi feedback to inform their

provincial palliative care competencies (BC Center for Palliative Care, 2018). Building on these processes, we formulated palliative care competencies in Alberta using a rigorous consensus development process. To date, the Alberta palliative care competencies' process is the largest and most rigorous process known used to formulate palliative care competencies in Canada. The representativeness, transferability and scope of the Alberta palliative care competencies is extensive because we formed and engaged 15 HCP specific palliative care competencies' working groups, representing 24 HCP groups, in a measurable consensus building process. Each group had the opportunity to have subject matter experts and end-user membership representation from front line providers, as well as representatives from each provincial health care zone, educational institutes, and provincial regulatory bodies. Additionally, the process involved experts with diverse perspectives, experiences, and knowledge representing various levels of palliative care experience and expertise.

Table 14. Comparison of Provincial Palliative Care Competency Frameworks: HCP Groups

Discipline	Ireland	Nova Scotia	Ontario	British Columbia	Alberta
Physicians	✓	✓	✓	✓*	X
Nurses	✓ *	✓ *	✓*	✓	✓ *
Midwifery	✓	X	X	X	X
Health Care Aides	✓	✓	✓	✓	✓
Social Workers	✓	✓	✓	✓	✓
Occupational Therapists	✓	✓	✓	X	✓
Physiotherapists	✓	✓	✓	X	✓
Speech Language Therapists	✓	✓	✓	X	✓
Audiologists	X	X	X	X	✓
Dietitians	✓	✓	✓	X	✓
Pharmacists	✓	✓	✓	X	✓
Psychologists	✓	✓	✓	X	✓
Spiritual Care Practitioners	✓	✓	✓	X	✓
Volunteers	X	✓ *	✓	X	✓
Medical Imaging and Radiation Technologists	X	✓ *	✓	X	✓*
EMTs and Paramedics	X	✓	✓	X	✓
Respiratory Therapists	X	✓	✓	X	✓

* Denotes that the discipline is broken down into smaller groups within the discipline

Interprofessional Competencies

It is well known that interprofessional collaborative practice is essential for improvement in patient, family and community health outcomes in all health care contexts including palliative care (Canadian Interprofessional Health Collaborative, 2011). Due to the interdisciplinary nature of palliative care service delivery, there is consistency in the shared competencies across professions (NSHA, 2017), which can help to establish a common knowledge and skills base that will promote and enable interprofessional collaboration (OPCN, 2019). In this context, Nova Scotia, Ontario and British Columbia identified interprofessional or shared competencies at the onset of their competency development. However, in Alberta, we took a different approach to exploring interprofessional competencies. In order to ensure that the interprofessional competencies identified by the other provinces resonated with all Alberta HCPs, we incorporated them into the draft competencies for each HCP group and sought working group feedback and validation for each statement. Interestingly, several of the interprofessional competencies that were identified by the other provinces were removed from some HCP specific competency profiles or moved from the “All” group level of expertise to the “Some” or “Few” group level of expertise. This was particularly true for competency statements related to communication, care planning and collaborative practice. There are, however, several competency statements that were accepted and validated by all of the HCP specific working groups. These competencies can potentially be identified in future work as Alberta interprofessional palliative care competencies.

Levels of Expertise

The benefits of early integration of palliative care in a person’s illness trajectory are well documented (Parker, Remington, Nannini, & Cifuentes, 2013). Cameron-Taylor (2012) asserts that the majority of palliative care services can and should be provided in generalist settings, with intermittent consultation from palliative care experts when patients develop complex needs. All HCPs should therefore be able to provide appropriate palliative care, and therefore need to be trained to provide the highest possible standards of care in order to meet the needs of patients and families (Gamondi, 2013). WHO (2014) asserts that palliative care education is required at three levels: basic palliative care training for all health professionals; intermediate training for those who routinely care for patients with life threatening illnesses; and specialist palliative care training for those who manage the more complex symptom and care needs of palliative care patients. However, other variations in levels of educational training regarding palliative care expertise, frequency of caring for patients with a life-limiting illness and area of specialization have been described (Table 15). For instance, the Nova Scotia and Ontario palliative care competency frameworks use a simplified

two-level model of palliative care expertise, whereas, Ireland and BC distinguished three levels of palliative care expertise. Defining levels of proficiency is an important aspect of competency modelling and the number of levels should depend on the number of levels perceived by the end users of the information (Campion, 2011). Accordingly, at the onset of this project, in consultation with our steering committee, advisory group and HCP specific palliative care competencies' working groups we determined that three levels of palliative care expertise best represented the Alberta context. However, as competency development progressed, working group members reported that they struggled to determine in which level of expertise each competency statement belonged. This struggle was reflected both through group discussion and low Delphi consensus. For instance, several of the groups determined that the "Some" level of expertise was not applicable to each domain and one group determined that the Few level of expertise did apply to their profession. Additionally, in Delphi round 2 a total of 590 statements (including all HCP groups) did not reach the 60% majority threshold to determine level of expertise, thus required a revote in Delphi round 3. This lack of consensus repeated in Delphi 3, as such, the final determination for the majority of these statements was based off of majority vote. The three levels of expertise were a consistent topic of discussion, debate, and incongruity within the working groups, suggesting that two levels of expertise ("All" and "Few") would have been a better model to represent Alberta HCPs.

Table 15. Levels of Palliative Care Expertise Comparison

Levels of Expertise	Document
Two Levels	• Nova Scotia Palliative Care Competency Framework Ontario Palliative Care Competency Framework A Framework for Generalist and Specialist Palliative and End of Life Care Competency (Northern Ireland Cancer Network, 2008) • The Principles and Practice of Palliative Care Nursing and Palliative Care Competencies for Canadian Nurses (Jacono et al., 2009) • Core Competencies for Spiritual Health Care Practitioners (Manitoba's Spiritual Health Care Partners, 2017) • Competencies for Advanced Certification for Hospice Palliative Care (National Association of Catholic Bishops, 2015)
Three Levels	• Palliative Care Competency Framework 2014: Ireland • Recommended Core Education Standards for Care and Support for the Dying Person in the Last Days and Hours of Life (NHS, 2014) • The Macmillan Allied Health Professions Competence Framework for those Working with People affected by Cancer (Macmillan Cancer support, UK, 2017) • Core competencies in palliative care: an EAPC White Paper on palliative care education – part 1 and 2 (Gamondi, Larkin, & Payne, 2013)

Table 15. Levels of Palliative Care Expertise Comparison

Levels of Expertise	Document
Three Levels	• A Strategy and Educational Framework for Nurses Caring for People with Cancer in Ireland (Hanan,.Laffoy, & Wynne, 2012) • A Competence Framework for Nurses Caring for Patient Living with and Beyond Cancer (Macmillan Cancer Support, 2014) • Palliative Care Nurse Practitioner Candidate Clinical Competencies (Quinn, Glaetzer, & Hudson, 2011) • Common core competences and principles for health and social care workers working with adults at the end of life – To support the National End of Life Strategy 2009 (National End of Life Care Programme, 2009) • Social Care (Adults, England) Knowledge set for end of life care (revised edition, 2010), Skills for Care (part of the sector skills council – (Skills for care, 2010)
Four Levels	• National Professional Development Framework for Cancer Nursing in New Zealand (Ministry of Health, 2009) • A National Professional Development Framework for Palliative Care Nursing in Aotearoa New Zealand (Palliative Care Nurses New Zealand, 2014) • Competencies in Nursing: A Framework for Nurses Working in Specialists Palliative Care (Royal College of Nursing, 2002) • Spiritual & religious Care Competencies for Specialist Palliative Care (Mitchells, 2003)

Limitations

As with the majority of studies, the design and structure of this study is subject to limitations. Because we used purposive sampling to recruit working group participants, there is the potential that our participant sample does not reflect the general population or appropriate population concerned. Additionally, given that there are thousands of Alberta HCPs working in various professions in Alberta, it is possible that our sample size is too small to generalize to the larger population of HCPs. We attempted to mitigate the aforementioned limitations by ensuring broad participant representation as well as allowing adequate time for each participant to provide feedback. However, there may be opportunities to validate the palliative care competencies to the broader Alberta HCP populations to ensure their representativeness.

Conclusion and Future Opportunities

The completion of the Alberta palliative care competencies opens the door to explore palliative care competencies in Alberta at greater depth. For instance, although the Alberta palliative care competencies address cultural safety, these competencies are

generalized. As such, recognizing the unique health perspective of our Alberta First Nations, Inuit, and Metis People, future work should explore HCP palliative care competencies from the Indigenous perspective giving voice to Indigenous Peoples and honor and respect the collective knowledge that Indigenous Peoples and communities have to share with us. Additionally, although we are confident with the transferability and representativeness of the palliative care competencies, there is opportunity to further affirm and refine them by obtaining formal validation from each provincial regulatory body. Additionally, due to the interprofessional nature of palliative care, it is evident that there are shared competencies that are applicable to all health care providers (Gamondi, 2013). These interprofessional competencies should be identified and described. Moreover, while comprehensive, the Alberta palliative care competencies' project did not include all HCPs. Although not an exhaustive list, future work could explore palliative care competencies from the perspective of music therapists, art therapists, massage therapists, laboratory technologists, midwives, recreation therapists and alternative health therapists. Finally, although there are palliative care educational opportunities available across Alberta for both generalist and specialist palliative care HCPs, the education varies since there is no set provincial standard for palliative care education. As such, there is opportunity to examine the current state of palliative care education available to Alberta HCPs and map these opportunities to the palliative care competencies. Mapping of current educational palliative care opportunities will support HCPs to effectively choose amongst palliative educational opportunities based on their professional and personal learning needs and enable us to identify any existing gaps.

A robust and skilled health care workforce is essential to the future sustainability of palliative care delivery. Having Alberta specific palliative care competencies allows HCPs to identify the skills, knowledge and attitudes required when providing palliative care. Additionally, the Alberta palliative care competencies can be used as a resource to inform and guide academic curricula, professional development, professional regulatory bodies, continuing education programs and employers.

Appendix 1: Steering Committee and Working Group Members

Provincial Palliative and End-of-Life Innovations Steering Committee		
Name	**Position**	**Location/Program/Organization**
Dr. Francois Belanger	Vice President Quality & Chief Medical Officer	Sponsors – Ex Officio
Deb Gordon	Chief Health Operations Officer, Northern Alberta	Sponsors – Ex Officio
Linda Howitt-Taylor	Patient and Family Advisor	Patients and Family Representatives
Andrew Kennedy	Senior Consultant, Strategic Coordinator, Primary Care	Primary Care Representatives
Barbara O'Neill	Senior Provincial Director, Cancer and Critical Care SCN	AHS Palliative Clinical Leadership
Dr. James Silvius	Senior Medical Director, Provincial Seniors Health and Continuing Care	AHS Palliative Clinical Leadership
Vacant	Director, Home Care and Specialty Clinical Programs, Community, Seniors and Addictions & Mental Health	AHS Palliative Clinical Leadership
Bev Berg	Director, PEOLC, Calgary Zone	AHS Palliative Clinical Leadership
Karen Butel	Manager, Pediatrics, Calgary Zone	AHS Palliative Clinical Leadership
Dr. Charlie Chen	Medical Director, Palliative/End of Life Care, Calgary Zone	AHS Palliative Clinical Leadership
Dr. Peter Davis	Physician, Surgery SCN	AHS Palliative Clinical Leadership
Dr. Ingrid DeKock	Section Chief, Palliative Care Program, Edmonton Zone	AHS Palliative Clinical Leadership
Tiffany Fassnidge	Director, Clinical Policy Development	AHS Palliative Clinical Leadership
Dr. Josh Foley	Palliative Medical Director	AHS Palliative Clinical Leadership
Karen Fritz	Director - Integrated Home Care, South Zone, Seniors Health	AHS Palliative Clinical Leadership
Dr. Naomi Goloff	Physician, Pediatrics	AHS Palliative Clinical Leadership
Janice Hagel	Manager, Palliative / Hospice Care, Calgary Zone	AHS Palliative Clinical Leadership

Provincial Palliative and End-of-Life Innovations Steering Committee		
Name	**Position**	**Location/Program/Organization**
Natalie Houseman	Patient Care Manager, Pediatric Oncology, Hematology and Palliative Care	AHS Palliative Clinical Leadership
Aurora Leang	Lead, Seniors Health, Community, Seniors and Addiction & Mental Health, PEOLC	AHS Palliative Clinical Leadership
Tracy Lee	Lead, Indigenous Health, North Zone	AHS Palliative Clinical Leadership
Dana Malloy	Clinical Policy Consultant	AHS Palliative Clinical Leadership
Dr. Debbie McAllister	Section Chief, Palliative Medicine, Department of Pediatrics. Medical Director, (CHaPS)	AHS Palliative Clinical Leadership
Dr. Maureen McCall	Medical Director, Palliative Care, Central Zone	AHS Palliative Clinical Leadership
Jennifer Olson	Manager of Zone Continuing Care Programs, Central Zone	AHS Palliative Clinical Leadership
Michelle Peterson Fraser	Director, Seniors Health, Community, Seniors and Addiction & Mental Health, PEOLC	AHS Palliative Clinical Leadership
Michelle Podmore	Director Palliative/End of Life Care and Community Programs, Edmonton Zone	AHS Palliative Clinical Leadership
Tracy Reberger	Acute Care Manager, Central Zone	AHS Palliative Clinical Leadership
Dr. Cara Robertson	Palliative Medical Director, North Zone	AHS Palliative Clinical Leadership
Mary Sabbe	Central Zone Practice Lead, Palliative Care	AHS Palliative Clinical Leadership
Dr. Jessica Simon	Division Head, Palliative Medicine	AHS Palliative Clinical Leadership
Dr. Dionne Walsh	Palliative Medical Director	AHS Palliative Clinical Leadership
Dr. Eric Wasylenko	Medical Advisor, HQCA - Clinical Ethics	AHS Palliative Clinical Leadership
Donna Rose	Project Manager, Person-Centred Care Integration, Provincial Practices, CancerCare Alberta	AHS Palliative Clinical Leadership
Dr. Sharon Watanabe	CancerCare Alberta	AHS Palliative Clinical Leadership

Provincial Palliative and End-of-Life Innovations Steering Committee		
Name	**Position**	**Location/Program/Organization**
Dr. Bev Wilson	Physician, Pediatrics	AHS Palliative Clinical Leadership
Vacant	Lead, Seniors Health, Community, Seniors and Addiction & Mental Health, PEOLC	AHS Palliative Clinical Leadership
Terri Woytkiw	Lead, North Zone	AHS Palliative Clinical Leadership
Cheryl Cameron	EMS Specialist, Alberta Health	Ministries – Alberta Health
Becky Donelon	Manager, EMS Policy, Standards and Reporting (interim for Cheryl Cameron)	Ministries – Alberta Health
Carmen Grabusic	Director, Program Policy and Quality Improvement, Program Policy and Quality Improvement Unit, Alberta Health	Ministries – Alberta Health
Scott Fullmer	Manager Health Evidence and Policy Unit	Ministries – Alberta Health
Wafa Nuradin	Alberta Health	Ministries – Alberta Health
Kate Wagontall	HTA	Ministries – Alberta Health
Carleen Brenneis	Director	Palliative Institute, Covenant Health
Dr. Konrad Fassbender	Assistant Professor, Division of Palliative Care Medicine, Department of Oncology, University of Alberta, Scientific Director,	Palliative Institute, Covenant Health
Karen Macmillian	Senior Operating Officer Acute Services	Covenant Health
Sharon Baxter	Executive Director	Canadian Hospice Palliative Care Association
Leanne Clarke		Canadian Hospice Palliative Care Association
Nicole Liboiron	Home and Community Care Regional Coordinator	First Nations and Inuit Health-Alberta Region
Kristi Puchbauer	Executive Director	Alberta Hospice Palliative Care Association
Brenda Rehaluk	Director of Health	Bearspaw Nation, Eden Valley

Provincial Palliative and End-of-Life Innovations Steering Committee		
Name	**Position**	**Location/Program/Organization**
Pam Tailfeathers Buffalo	Home and Community Care Manager	First Nations and Inuit Health-Alberta Region
Cherie Willier	Nurse in charge	Sucker Creek First Nation
David O'Brien	Senior Program Officer, Seniors Health, Community, Seniors and Addiction & Mental Health	Alberta Health Services
Tracy Wasylak	Senior Program Officer, Strategic Clinical Networks	Alberta Health Services

Covenant Health Palliative Institute Palliative Care Competencies Working Group		
Name	**Position**	**Location/Program/Organization**
Carleen Brenneis, RN, MHSA	Director	Edmonton/Palliative Institute/Covenant Health
Konrad Fassbender, PhD	Scientific Director	Edmonton/Palliative Institute/Covenant Health
Lorelei Sawchuk, MN, NP, CHPCN(C)	Education Lead and Nurse Practitioner	Edmonton/Palliative Institute/Covenant Health
Lisa Vaughn, RN, MN	Education Resource Nurse	Edmonton/Palliative Institute/Covenant Health

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

Alberta Occupational Therapists' Palliative Care Competencies Working Group		
Name	**Position**	**Location/Program/Organization**
Jennifer St. Pierre, BScOT	Occupational Therapist	St. Albert-Edmonton Zone/North Home Care/Alberta Health Services
Stacey Bilou, BScOT	Occupational Therapist	Edmonton Zone/Urban Palliative Home Care/Alberta Health Services
Deanna Makortoff, BScOT	Occupational Therapist	Innisfail-Central Zone/Innisfail Health Care Centre/Alberta Health Services
Sandy Ayre, BscOT	Occupational Therapist	Edmonton/Tertiary Palliative Care Unit, Grey Nuns Community Hospital/Covenant Health
Kerry Spavor, BscOT	Occupational Therapist	Calgary Zone/Palliative Home Care/Alberta Health Services
Rachel Kitchen, BscOT	Occupational Therapist	Calgary Zone/Palliative Home Care/Alberta Health Services
Susan Mulholland, MScRehab, BScOT	Calgary Coordinator	Calgary/Department of Occupational Therapy, Faculty of Rehabilitation Medicine/Calgary Satellite-University of Alberta
Julie Brose, BScOT(Hons), MIPH, MA	PhD Candidate Occupational Therapist	Calgary/University of Alberta - Calgary Satellite/Enable Health, Calgary
Amy Driga, BScOT	Occupational Therapist	Edmonton Zone/Cross Cancer Institute/Alberta Health Services
Ashley Thomson, MScOT	Occupational Therapist	Lethbridge-South Zone/Palliative Care Team and Community OT Team,
Lili Liu, OT, PhD	Professor and Chair	Department of Occupational Therapy/Faculty of Rehabilitation Medicine/University of Alberta
Cherie Henderson, BScOT, MScRS	Professional Practice Lead-Occupational Therapy	Edmonton Zone/Royal Alexandra Hospital/Alberta Health Services
Haeyoung Kim, MScOT	Occupational Therapist	Edmonton/St. Joseph's Auxiliary Hospital/Covenant Health
Todd Farrell, BScOT	Occupational Therapy Clinical Lead	Cold Lake-North Zone/Alberta Health Services

Alberta Physiotherapists' Palliative Care Competencies Working Group		
Name	**Position**	**Location/Program/Organization**
Jason Daoust, MScPT, BSc	Professional Practice Lead- Physiotherapy	North Zone/Alberta Health Services
Donna Davies, PT, BScPT, MScPT	Professional Practice Lead-Physical Therapy, Adult Services	Ponoka-Central Zone/Alberta Health Services
Cara Page, PT	Physiotherapist	Calgary Zone/Palliative Home Care/Alberta Health Services
Margot Sondermann, BScPT, MEd	Palliative Consultant for End Stage Lung Disease	Calgary Zone/Palliative Care Consult Service/Alberta Health Services
Leanne Loranger, PT, MHM	Manager, Policy and Practice	Physiotherapy Alberta College + Association
William Tung, PT	Professional Practice Leader-Physiotherapy	Edmonton Zone/Royal Alexandra Hospital/Alberta Health Services
Mark Hall, PT, PhD	Associate Teaching Professor, Associate Chair and Director MScPT program	Edmonton/Department of Physical Therapy, University of Alberta
Alyssa Sherwin, PT	Physiotherapist	Edmonton/Tertiary Palliative Care Unit, Grey Nuns Community Hospital/Covenant Health
Alex Grant, PT, CLT	Physiotherapist	Lethbridge-South Zone/Community Oncology/Alberta Health Services
Kimberley Barrett, PT	Physiotherapist	Edmonton Zone/Glenrose Rehabilitation Hospital/Alberta Health Services

Alberta Emergency Medical Services' and Paramedics' Palliative Care Competencies Working Group		
Name	Position	Location/Program/Organization
Cheryl Cameron, M.Ed., ACP	Manager, EMS Policy, Standards, and Reporting	Emergency Health Services/Alberta Health
Tyne Lunn, CP	Community Paramedic	North Zone/EMS Mobile Integrated Healthcare (MIH)/Alberta Health Services
Becky Donelon, EdD, MADL, ACP	Chair, Allied Health Programs	Slave Lake/Northern Lakes College
Tim A. Ford, ACP	Registrar	Alberta College of Paramedics
Suzanne Maynard, ACP, BHSc	Manager Learning and Development, EMS	South Zone/Alberta Health Services
Ian MacEwan, ACP, B.Comn	Senior Quality Assurance Strategist Provincial Lead	EMS Palliative and End-of-Life Care Assess Treat Refer Program/Alberta Health Services
Claire Ruzsvanszki, CP, RN	EMS Mobile Integrated Healthcare (MIH) Team Lead	Calgary Zone/Alberta Health Services

Alberta Nurses' (Registered Nurses (RN), Registered Psychiatric Nurses (RPN), Licensed Practical Nurses LPN)) Palliative Care Competencies Working Group		
Name	**Position**	**Location/Program/Organization**
Michelle Stone, MN, NP	Professional Practice Lead Advanced Practice Nursing	Covenant Health
Glenda Tarnowski, MA, LPN, CHE	Director of Professional Practice	College of Licensed Practical Nurses of Alberta
Harrison Applin, PhD, RN	Director, Nursing Professional Practice	Health Professions Strategy and Practice (HPSP)/ Alberta Health Services
Lorelei Sawchuk, MN, NP, CHPCN(C)	Education Lead and Nurse Practitioner	Edmonton/Palliative Institute/Covenant Health
Laura Garrett-Gabay, BScN, RN, CHPCN(C)	Clinical Educator	Red Deer-Central Zone/Palliative Care, Oncology Unit, Red Deer Regional Hospital/Alberta Health Services
Elizabeth Taylor, RPN, GHSA	Director of Regulatory Services	College of Registered Psychiatric Nurses of Alberta
Ann Ranson Ratusz, RN, PhD	Associate Professor	Edmonton/Faculty of Nursing/MacEwan University
Gail Couch, MN, RN	Assistant Professor	Edmonton/Center for Professional Nursing Education/MacEwan University
Pam Mangold, MN, RN	Policy and Practice Consultant	College and Association of Registered Nurses of Alberta
Angela L. Ferguson, PhD, RN	Clinical Nurse Specialist, Palliative and End-of-Life Care	Calgary/Faculty of Nursing/University of Calgary Representative
Mary DeLong, RN, MSN	Nursing Instructor	Calgary/School of Health and Wellness/Bow Valley College
Brenda Brigley, MN, RN, GNC(C)	Site Manager	Coronation-Central Zone/Coronation Health Care Centre, Acute Care and Home Care/Alberta Health Services
Rebecca Watt, LPN	Licensed Practical Nurse	Lacombe-Central Zone/Lacombe Hospital Acute Care/Alberta Health Services
Gary Frank, BA, BEd, RN	Palliative Care Resource Nurse	Edmonton Zone/Royal Alexandra Hospital/Alberta Health Services
Myrtle Heinie Mallari, LPN	Licensed Practical Nurse	Edmonton/Palliative Care Unit, Capital Care Norwood/Capital Care
Brandi Campbell, RN BScN	Clinical Nurse Educator	North Zone/Palliative Care Team/Alberta Health Services
Chris de Haan, LPN	Licensed Practical Nurse	Calgary Zone/Palliative Home Care/Alberta Health Services
Marie Webb, MSc, CHPCN(C)	Clinical Nurse Specialist	Okotoks-Calgary Zone/Palliative Care Consult Team-Rural/Alberta Health Services
Darlene Larsen, RN	Registered Nurse, Acute Care	Medicine Hat-South Zone/Alberta Health Services
Angelina Hannam, LPN	Licensed Practical Nurse	Medicine Hat-South Zone/Home Care/Alberta Health Services

Alberta Advanced Practice Nurses' Palliative Care Competencies Working Group		
Name	**Position/Location**	**Location/Program/Organization**
Marlee MacDonald, BN MN,NP	Nurse Practitioner	Central Zone/Palliative Care Team/Alberta Health Services
Sandra VanHecke, MN, NP	Senior Practice Lead – Advanced Practice Nursing	North Zone/Health Professions Strategy and Practice/Alberta Health Services
Lorelei Sawchuk, MN, NP	Education Lead and Nurse Practitioner	Edmonton/Palliative Institute/Covenant Health
Sarah Kosowan, MN, NP	CCU and Outpatient Heart Function Clinic	Edmonton/Misericordia Community Hospital/Covenant Health
Amy Regnier, MN, NP	Nurse Practitioner	Bonnyville-North Zone/Alberta Health Services
Tara Hos, MN, CNS	Clinical Nurse Specialist	Calgary Zone/Palliative Care Consult Service/Alberta Health Services
Lauren Hutchison, MN, CNS	Clinical Nurse Specialist	Calgary Zone/Palliative Care Consult Service/Alberta Health Services
Marcie Smigorowsky, NP, PhD, CCN(C)	NP Policy and Practice Consultant	College and Association of Registered Nurses of Alberta
Donna McLean, NP, PhD, CCN(C)	Nurse Practitioner	Edmonton Zone/Devon, AHI, MCH GH – Nursing/Alberta Health Services
Karen Cook, PhD, RN	Assistant Professor	Faculty of Health Disciplines, Athabasca University
Shelley Raffin Bouchal, PhD, RN	Associate Professor	Calgary/Faculty of Nursing/University of Calgary

Alberta Health Care Aides' Palliative Care Competencies Working Group		
Name	**Position**	**Location/Program/Organization**
Katherine Murray, RN, BSN, MA, CHPCN(C), FT	Hospice Palliative Care Nurse, Educator and Author	Life & Death Matters, Victoria, BC
Barbara Roemer, RN	Professional Practice Leader Nursing-Seniors	Covenant Health
Amandeep Sahota, RN	Clinical Educator and Palliative Program Lead	Bethany Care Society
Brenda Slobozian, RN, MN	Quality Practice Leader-Palliative Care	Bethany Care Society
Lenora Carriere, RSW, BAHSA	Senior Program Lead, Provincial Health Care Aide Program, Associate Chief Nursing Office, Health Professions Strategy and Practice	Alberta Health Services
Gail Thauberger, RN, MEd	Coordinator, HCA, RTA and NM Programs	Calgary/School of Health and Wellness/Bow Valley College
Jodi Wilson, CPHR	Regional Manager People and Culture/Regional Privacy Officer	Calgary/CBI Home Health
Katie Knott, HCA	Health Care Aide	Mayerthorpe-North Zone/Long Term Care/Alberta Health Services
Robert James Jimenez, HCA	Health Care Aide	Acute Care, Grand Prairie, North Zone, Alberta Health Services
Jennifer Kohn, HCA	Health Care Aide	Home Care, Grand Prairie, North Zone, Alberta Health Services
Debbie Hall, HCA	Health Care Aide	Home Care, Medicine Hat, South Zone, Alberta Health Services
Adeene Schultz, HCA	Health Care Aide	Bentley Care Center, Bentley, Central Zone, Alberta Health Services
Sandra Cook Wright, RN, MHS, CHPCN(C)	Educator, Pain and Palliative Consultant	Calgary/Sarcee Hospice Educator, Pain and Palliative Consultant/Carewest
Mary DeLong, RN, MSN	Nursing Instructor	School of Health and Wellness, Bow Valley College
Cheryl Brindza, HCA	Health Care Aide	Edmonton/Edmonton General Continuing Care Centre, Mel Miller Hospice/Covenant Health
Tammy Crush, RN, BN	HCA Instructor	Edmonton/Instructor, HCA/ Faculty of Health and Community Studies/NorQuest College
Karen Van Niejenhuis, RN	HCA Instructor	Edmonton/Instructor, HCA/ Faculty of Health and Community Studies/NorQuest College

Alberta Respiratory Therapists' Palliative Care Competencies Working Group		
Name	**Position**	**Location/Program/Organization**
Cara Thomas, RRT, CRE	Manager of Respiratory Health and Outpatient Cardiology	Lethbridge-South Zone/Chinook Regional Hospital, Alberta Health Services
Bryan Buell, RRT, BGS, CTAJ	Registrar-Executive, Complaints Director	College and Association of Respiratory Therapists of Alberta
Jennifer Stefura, MAL, BSc, RRT	Supervisor	Calgary/Life Sciences, School of Health and Public Safety/Southern Alberta Institute of Technology
Erin Choquette, RRT	Instructor, Respiratory Therapy Program	Calgary/Southern Alberta Institute of Technology
Sam Magus, RRT	Instructor	Edmonton/Respiratory Therapy Program/Northern Alberta Institute of Technology
Doug Kremp, RRT	Clinical Lead Respiratory	Onoway-North Zone/Alberta Health Services
Darla Van Spengen, RRT, CRE	Team Lead-Respiratory Therapy Services	Edmonton Zone/Allied Health, Community Health Services/Alberta Health Services
Kelly Jorgensen, RRT, CRE	Respiratory Therapist	Red Deer-Central Zone/Allied Health Supportive Living Team/Alberta Health Services
Craig Hollingshead, RRT	Critical Care Clinical Lead	Red Deer-Central Zone/Red Deer Regional Hospital/Alberta Health Services
Catherine Johansen, RRT	Manager, Cardio-Respiratory Services	Medicine Hat-South Zone/Medicine Hat Regional Hospital/Alberta Health Services
Chris Simpson, RRT III BHSc	Respiratory Lead	Grand Prairie-North Zone/Queen Elizabeth II Hospital/Alberta Health Services
Patricia Williams, RRT	Respiratory Therapist	Fort Macleod, Milk River-South Zone, Alberta Health Services
Suzanne Boyd, BA, RRT	Education Consultant II-Respiratory Services	Calgary Zone/Peter Lougheed Centre/Alberta Health Services
Heather Mughal, BHSc RRT, CRE	Respiratory Therapist Clinical Practice Lead, Quality, Practice and Education	Calgary Zone/Integrated Supportive and Facility Living/Alberta Health Services
Ellen Su, RRT, CRE	Respiratory Therapist	Calgary Zone/Palliative Home Care Team/Alberta Health Services
Linda J Sheen, RRT	Respiratory Therapy Team Lead	Edmonton/Grey Nuns Community Hospital/ Covenant Health
Sue Reap, RRT, BFA, BEd	Respiratory Therapist	Edmonton Zone/Urban Palliative Home Care Team/Alberta Health Services

Alberta Dietitians' Palliative Care Competencies Working Group		
Name	**Position**	**Location/Program/Organization**
Kim Johnson, RD	Dietitian	Edmonton Zone/Cross Cancer Institute/Alberta Health Services
Ed Walker, RD	Dietitian	Calgary Zone/Foothills Hospital/Alberta Health Services
Terelyn Bloor, RD	Dietitian	Edmonton/Grey Nuns Community Hospital/Covenant Health
Shannon Mackenzie, MEd, RD	Director, Professional Practice	College of Dietitians of Alberta
Carla Prado, PhD, RD	Associate Professor and Campus Alberta Innovates Chair in Nutrition, Food and Health	Edmonton/Faculty of Agricultural, Life and Environmental Sciences/University of Alberta
Heidi Bates, MSc, RD	Director, Integrated Dietetic Internship	Edmonton/Faculty of Agricultural, Life and Environmental Sciences/University of Alberta
Erin Bowers, RD	Clinical Dietitian	Red Deer-Central Zone/Home Care/Alberta Health Services
Mikala Wilson, RD	Dietitian	Grande Prairie-North Zone/Queen Elizabeth II Hospital/Alberta Health Services
Chelsea Corbett, RD II	Provincial Practice Lead	Provincial Strategy, Standards & practice/Alberta Health Services
Christin Barber, RD	Program Manager, Corporate Clinical Nutrition	Covenant Health
Melanie Hildebrandt, RD	Dietitian	Medicine Hat-South Zone/Margery E. Yuill Cancer Centre and Bow Island/Alberta Health Services

Alberta Speech-Language Pathologists' and Audiologists' Palliative Care Competencies Working Group		
Name	**Position**	**Location/Program/Organization**
Linda Nelson-Filek, MS, R.SLP, CCC-SLP	Speech-Language Pathologist	Grande Prairie-North Zone/Public Health & Home Care/Alberta Health Services
Sara Girardin M.S. R. SLP, S-LP (C)	Speech-Language Pathologist	Red Deer-Central Zone/Allied Health Supportive Living Team/Alberta Health Services
Alyssa Rose, R.SLP, S-LP (C)	Speech-Language Pathologist	Camrose-Central Zone/Early Supported Discharge/Alberta Health Services
Vanna Thiel, M.Sc., R.SLP, CCC-SLP	Speech Language Pathologist	Cold Lake-North Zone/Alberta Health Services
Heather Stamler, MSLP, R.SLP, S-LP(C)	Team Lead	Edmonton/Grey Nuns Community Hospital/Covenant Health
Sandy Nickel, M.SLP, R.SLP	Director of Professional Practice	Alberta College of Speech-Language Pathologists and Audiologists
Cheryl Blair, M.Sc., R. Aud	Audiology Practice Advisor	Alberta College of Speech-Language Pathologists and Audiologists
Lesley Wihnan, MA, R.SLP	Speech-Language Pathologist	Lethbridge and Area-South Zone/Alberta Health Services
Stuart Cleary, PhD, R.SLP, CCC-SLP	Associate Teaching Professor	Edmonton/Rehabilitation Medicine, Communication Sciences and Disorders/University of Alberta
Briana Strachan, M.S., R.SLP, CCC-SLP	Speech-Language Pathologist	Edmonton Zone/Consulting Services in Continuing Care, Facility and Supportive Living/Alberta Health Services
Holly Smith, M.A., R-SLP, SLP(C)	Speech-Language Pathologist	Calgary Zone/Foothills Medical Centre/Alberta Health Services
Jayninn Yue, MHSc, R.SLP, SLP(C)	Speech Language Pathologist	Calgary Zone/Integrated Supportive and Facility Living Program/Alberta Health Services
Robyn Wells, MSc. R.SLP(C),	PhD Neuroscience Student	University of Calgary
Bridget McLeod, E, R.SLP	Speech Language Pathologist	Calgary Zone/Consult and Treat Team, Integrated Home Care/Alberta Health Services
James Brophy, R. Aud	Speech Language Pathologist	Fort McMurray-North Zone/Northern Lights Regional Health Centre/Alberta Health Services
Tanis Howarth, M.Sc., R.Aud, Aud(C)	Director Provincial Audiology, Health Professions Strategy and Practice	Alberta Health Services
Charlene M. Watson, B.Sc, M.Ed, R. Aud	Clinical Audiologist/Professional Practice Lead, Audiology	Calgary Zone/Richmond Road Diagnostic and Treatment Centre/Alberta Health Services
Beverly Ortega, R. Aud	Audiologist	Lethbridge-South Zone/Alberta Health Services

Alberta Pharmacists' Palliative Care Competencies Working Group		
Name	**Position**	**Location/Program/Organization**
Heather Derrick, BSc Pharm	Clinical Practice Leader	Red Deer-Central Zone/Red Deer Regional Hospital Pharmacy/Alberta Health Services
Tara Leslie, BSP, BCOP	Clinical Assistant Professor	Edmonton/Faculty of Pharmacy and Pharmaceutical Sciences/University of Alberta
Serena Rix, BSc (Pharm)Hons, Pharm D.	Pharmacist	Edmonton/Tertiary Palliative Care Unit, Grey Nuns Community Hospital/Covenant Health
Catherine Biggs, BSc Pharm CPgPain CDE	Clinical Practice Leader	Edmonton Zone/Royal Alexandra Hospital/Alberta Health Services
Cathy Hearn, BSP	Pharmacist	Whitecourt-North Zone/Whitecourt Healthcare Centre/Alberta Health Services
Denise Wilson, BSc Pharm	Pharmacist	Grande Prairie-North Zone/Queen Elizabeth II Hospital/Alberta Health Services
Vincent Ha, BSc. Pharm, ACPR	Pharmacist	Department of Symptom Control and Edmonton Zone/Palliative Care, Cross Cancer Institute/Alberta Health Services, (Regulatory body representative)
Matt Tachuk, BSc Pharm, RPh	Director, Pharmacy Practice	Alberta Pharmacists' Association
Angela Gee, BSc Pharm	Acting Clinical Practice Leader, Pharmacy, and Pharmacist	Lethbridge, South Zone/Chinook Regional Hospital/Alberta Health Services Lethbridge/St. Michael's Palliative Care Unit/Covenant Health

Alberta Psychologists' Palliative Care Competencies' Working Group		
Name	**Position**	**Location/Program/Organization**
Tracy Sutton, MSc, R.Psych	Manager	Calgary Zone/Advance Care Planning and Goals of Care and Grief Support Program, Palliative/End of Life Care/Alberta Health Services
Cheryl Nekolaichuk, PhD, R. Psych	Registered Psychologist and Professor	Edmonton/Palliative Institute/Covenant Health Edmonton/Faculty of Medicine & Dentistry, Department of Oncology, Palliative Care Medicine/University of Alberta
Arlin Pachet, PhD	Clinical Neuropsychologist	Psychologists' Association of Alberta
Candace Konnert, PhD	Professor and Director of Training	Calgary/Clinical Psychology Program, Department of Psychology/University of Calgary
Richard Spelliscy, PhD, R. Psych	Registrar and Chief Executive Officer	College of Alberta Psychologists
Kay Wilson, PhD, R. Psych	Registered Psychologist	Edmonton/Misericordia Community Hospital/Covenant Health
Ceinwen Cumming, PhD, R. Psych	Registered Psychologist	Edmonton Zone/Psychosocial and Spiritual Resources, Cross Cancer Institute/ Cancer Care/ Alberta Health Services
Jill Turner, R. Psych	Supportive Care Lead	North Zone/North Cancer Control Alberta/Alberta Health Services
Laura Labelle, PhD	Psychologist and Supportive Care Lead	South Zone/South Cancer Control Alberta/Alberta Health Services
Karen Cook, PhD, RN	Assistant Professor	Faculty of Health Disciplines/Athabasca University

Alberta Medical Radiation and Imaging Technologists' Palliative Care Competencies Working Group		
Name	**Position/**	**Location/Program/Organization**
Alefiyah Gulamhusein, BSc, MRT(NM), CTIC	Director of Education and Competence	Alberta College of Medical Diagnostic and Therapeutic Technologists
Kelly Sampson, MRT(T), BSc (Hons)	Radiation Therapist	Red Deer-Central Zone/Central Alberta Cancer Center/Alberta Health Services
Susan Fawcett, MRT(T), BSc(Hons), MA	Director	Edmonton/Radiation Therapy Program, Department of Oncology, Faculty of Medicine and Dentistry/University of Alberta
Jennifer Brown MEd, MRT(R)	Academic Chair	Calgary/Diagnostic Imaging Programs and Allied Health Practicum Coordinator, School of Health and Public Safety/Southern Alberta Institute of Technology
Laura-Ann Aube, MRT(R), CTIC	Academic Chair	Edmonton/Medical Radiologic Technology Program/Northern Alberta Institute of Technology
Fiona Mitchell, MRT(T), MA, EdD, FCAMRT	Senior Practice Leader Radiation Therapy	Edmonton Zone/Community Oncology/Alberta Health Services
Gillian Graham, MRT(T), CMD, MA (L), CHE	CCA Clinical Educator-Radiation Therapy	Edmonton Zone/Tom Baker Cancer Centre/ Alberta Health Services
Winter Spence, BSc, MRT(T), MHSc	Senior Consultant	North Zone/North Cancer Control Alberta/Alberta Health Services
Twyla Fortier, MRT(R)	Manager Diagnostic Imaging-Radiology, CT, Interventional, Nuclear Medicine and Nursing	Edmonton/Covenant Health

Alberta Social Workers' Palliative Care Competencies Working Group		
Name	**Position**	**Location/Program/Organization**
Andrea Oiffer, MSW, RSW	Professional Practice Leader-Social Work	Covenant Health
Hongmei Tong, PhD, MSW, RSW	Assistant Professor	Edmonton/School of Social Work/ Faculty of Health and Community Studies/MacEwan University
Meg Hagerty, BA, BSW, RSW	Palliative Social Worker	Edmonton/Mel Miller Hospice/Edmonton General Continuing Care Center/Covenant Health
Julie Provencher, RPN, RSW	Registered Social Worker	Vermilion-Central Zone/Allied Health/Alberta Health Services
Andre Tinio, BA, BSW, RSW	Social Worker-Membership Activities	Alberta College of Social Workers
Tracy Paterson, BA, BSW,	Registered Social Worker	Edmonton Zone/Neurosciences/Kaye Edmonton Clinic/Alberta Health Services
Patrick Ulrich, BA adv, MSW, RSW	Social Worker	Vermilion-Central Zone/Alberta Health Services
Melissa Wilde MSW RSW	Social Worker	South Zone/South West Palliative Care Team/Alberta Health Services
Debra Samek MSW, RCSW	Practice Director-Provincial Social Work	Allied Health Profession Practice & Education Health Professions Strategy & Practice/Alberta Health Services
Bonnie Stewart, BSW, RSW	Social worker	Calgary Zone/Palliative Home Care/Alberta Health Services
Patricia Samson, PhD, RSW	Assistant Professor	Faculty of Social Work/Central and Northern Region/University of Calgary
Kirsten Harding, MSW, RSW	Social Worker	Edmonton Zone/Neurosciences Clinics/Kaye Edmonton Clinic/Alberta Health Services
Janelle Kruger, BSW, RSW	Social Worker	Red Water-North Zone/Complex Care and Palliative Care Team/Red Water Health Center/Alberta Health Services
Garth Goertz, MSW, RSW	Social Worker	Calgary Zone/Intensive Palliative Care Unit-Unit 47/Foothills Medical Centre/Alberta Health Services
Laura Cunliffe, BSW, RSW	Social Worker	Edmonton Zone/Mechanical Circulatory Support (MCS)/Mazankowski Alberta Heart Institute/ University of Alberta Hospital
Lindsay Ames, RSW	Medical Social Worker	Grand Prairie-North Zone/General Systems E. Garner King Critical Care Unit-3C3/3C4 & Firefighters Burn Treatment Unit-3C2/Queen Elizabeth II Hospital/Alberta Health Services
Kim Crowe, BSW, RSW	Social Worker	Edmonton/Tertiary Palliative Care Unit-Unit 43/Grey Nuns Community Hospital/Covenant Health

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

Alberta Volunteers' Palliative Care Competencies Working Group		
Name	**Position**	**Location/Program/Organization**
Kelli Luber, BA, MA	Hospice Volunteer	Edmonton/ Edmonton General Continuing Care Center/Covenant Health
Teresa Lucier, CVM	Manager	Edmonton/Volunteer Services /Grey Nuns Community Hospital/Covenant Health
Christina James	Hospice Volunteer	Calgary/Dulcina Hospice/Covenant Care
Theresa M. Bellows	Volunteer Coordinator	Calgary/Dulcina Hospice/Covenant Care
Lisa Shirley, RN, BScN	Unit Manager	Edmonton/Mel Miller Hospice/Edmonton General Continuing Care Center/Covenant Health
Bonnie Palmer	Coordinator of Volunteer Services	Okotoks/Foothills Country Hospice/Foothills Country Hospice Society
Shelley Blair	Palliative Care Volunteer	Edmonton/Grey Nuns Community Hospital/Covenant Health

Appendix 2: Glossary of Terms

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, 2016).

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, 2019).

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, 2016).

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" (Parry, S.B., 1996).

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, 2019).

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, 2016).

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, 2016).

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, 2018).

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, 2019).

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, 2016).

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, 2018).

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 (Murray et al., 2005).

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 (McDonald, C., & McCallin, A., 2010).

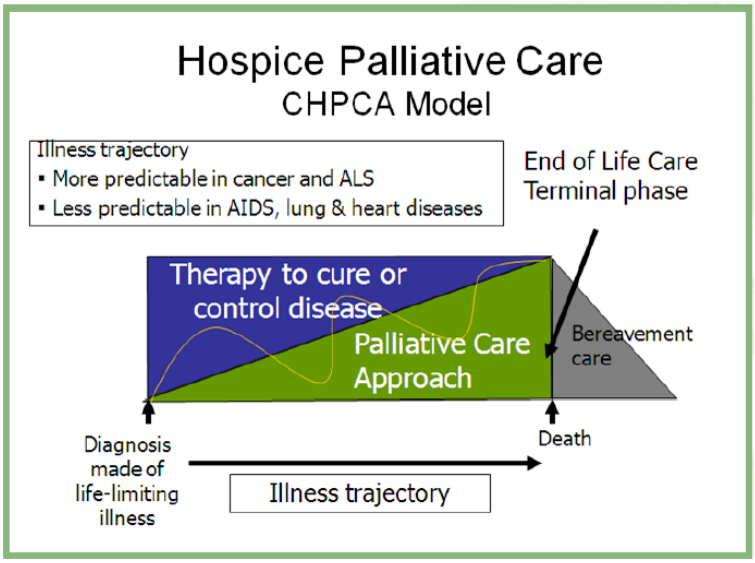
Imminently dying: Any patient who, according to the most responsible health practitioner's clinical assessment, is within the last hours to days of life (Alberta Health Services, 2018).

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, 2018).

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, 2014).

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, 2013; Shadd, J. D eta al. 2013).

Patient: an adult who receives or has requested health care or services. This term is inclusive of residents, clients and outpatients (Alberta Health Services, 2019).

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, 2019).

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, 2016).

Principle of double effect (Catholic Health Alliance of Canada, 2012): 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, 2019).

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, 2016).

Appendix 3: Literature Search Strategy

Databases	**Search Limiters**
Ovid MEDLINE and In-Process & Other Non-Index Citations Ovid APA PsycInfo Ebsco CINAHL	Adult population 2015 - present Canada and US English Health care settings

Search Terms

Concept	**Database subject headings**			**Keyword terms**
	MeSH (Medline)	**PsycINFO**	**CINAHL**	
Palliative Care	Palliative care Terminal care Hospice care	Palliative care Terminally ill patients Hospice	Palliative care Terminal care Hospice care	palliative end-of-life terminal hospice
AND				
Competencies	exp Professional competence Competency-based education	exp Professional competence	Professional competence+	competency* curriculum certification specialist* discipline* qualification* requirement* residency standard
AND				
Canada OR United States	North America exp United States exp Canada			United States Canada North America each Canadian province and territory name each US state name
AND				
Each health care professional group				
Physical Therapists	Physical therapists	Physical therapists Physical therapy	Physical therapists	physiotherap* physical therap*

	Physical therapy modalities Physical therapy specialty			
Occupational Therapists	Occupational therapists Occupational therapy	Occupational therapists Occupational therapy		occupational therap*
Nurses	exp Nurses exp Nursing Licensed practical nurses Nursing, practical	exp Nurses exp Nursing	Nurses+ Specialties, nursing+	nurse* nursing
Advanced Practice Nurses	Advanced practice nursing Nurse practitioners Nurse clinicians		Advanced practice nurses Clinical nurse Specialists Nurse anesthetists Nurse practitioners Gerontologic nurse practitioners Family nurse practitioners Adult nurse practitioners Physician assistants Advanced nursing practice Anesthesia nursing	nurse practitioner* advanced practice nurs* nurse clinician* physician assistant* clinical nurse specialist*
Health Care Aides	exp Allied health personnel		Nursing assistants Home health aides	healthcare aid* healthcare assistant* health care aid* health care assistant* nursing assistant*
Dietitians	Nutritionists		Dietitians	dietician* dietitian*

				nutritionist*
Pharmacists	Pharmacists	Pharmacists	Pharmacists Pharmacy technicians Students, pharmacy	pharmacist*
Psychologists		exp Psychologists Psychotherapists Psychoanalysts	Psychologists	psychologist* psychoanalyst* psychotherapist*
Speech Language Pathologists			Speech-language pathologists	speech language pathologist* speech therapist* speech correctionist* speech teacher*
Medical Radiation Technologists			Radiation therapy technologists Nuclear medicine technicians Radiologic technologists	medical radiation technologist* medical imaging technologist*
Emergency Medical Technicians	Emergency medical technicians Emergency medical services Allied health personnel	Emergency services Paramedical sciences Allied health personnel	Emergency medical technicians Emergency medical services	paramedic* emergency medical technicians
Respiratory Therapists	Respiratory therapy		Respiratory therapists	respiratory therapist*
Social Workers	Social workers exp Social work	exp Social workers	Social workers	social work*
Chaplains	Chaplaincy service, hospital Pastoral care	Chaplains Pastoral counseling	Chaplains Chaplaincy service, hospital	chaplain*
Volunteers	exp Volunteers	exp Volunteers	Volunteer workers	volunteer*

Example of Ovid MEDLINE Search Strategy

1. exp Professional Competence/

2. exp Physicians/ or Students, Medical/ or “Internship and Residency”

3. Palliative Care/ or Terminal Care/ or Hospice Care/

4. 1 and 2 and 3

5. ((palliative or end-of-life or terminal or hospice) adj3 (strategy or competenc* or curriculum or certification or specialist* or discipline* or qualification* or job requirement* or residency or standard*)).ti,ab.

6. (physician* or resident* or intern* or geriatrician* or general practitioner* or specialist*).ti,ab.

7. 5 and 6

8. 4 or 7

9. exp United States/ or exp Canada/ or North America/

10. (canada or canadian or "british columbia" or alberta or saskatchewan or manitoba or ontario or quebec or "new brunswick" or "nova scotia" or "prince edward island" or newfoundland or labrador or nwt or "northwest territories" or yukon or nunavut).af.

11. ("united states" or usa or american or alabama or alaska or arizona or arkansas or california or colorado or connecticut or delaware or florida or georgia or hawaii or idaho or illinois or indiana or iowa or kansas or kentucky or louisiana or maine or maryland or massachusetts or michigan or minnesota or mississippi or missouri or montana or nebraska or nevada or "new hampshire" or "new jersey" or "new mexico" or "new york" or "north carolina" or "north dakota" or ohio or oklahoma or oregon or pennsylvania or "rhode island" or "south carolina" or "south dakota" or tennessee or texas or utah or vermont or virginia or washington or "west virginia" or wisconsin or wyoming).af.

12. 9 or 10 or 11

13. 8 and 12

14. limit 13 to (english language and yr="2015 -Current")

Appendix 4: Palliative Care Competency Frameworks and/or Guidelines

Interdisciplinary

1. The Canadian Interdisciplinary Pallitaive Care Competency Framework. A cirriculum Guide for Educators and Reference Manual for Health Professionals and Volunteers (Canadian Partnership Against Cancer & Health Canada, July 2020)
2. A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice (2013)
3. The Nova Scotia Palliative Care Competency Framework (Nova Scotia Health Authority, 2017)
4. The Ontario Palliative Care Competency Framework (Ontario Palliative Care Network, 2019)
5. Palliative Care Competency Framework 2014: Ireland (Palliative Care Competency Steering Group, 2014)
6. A Framework for Generalist and Specialist Palliative and End of Life Care Competency (Northern Ireland Cancer Network, 2008)
7. Palliative and End of Life Care Competency Assessment Tool (Northern Ireland Practice and Education Council, 2016)
8. Recommended Core Education Standards for Care and Support for the Dying Person in the Last Days and Hours of Life (NHS, 2014)
9. The Macmillan Allied Health Professions Competence Framework for Those Working with People Affected by Cancer (Macmillan Cancer support, UK, 2017)
10. Core Competencies in Palliative Care: An EAPC White Paper on Palliative Care Education – Part 1 and 2 (Gamondi, Larkin, & Payne, 2013)
11. Transforming the System: Palliative Care Competencies in Undergraduate Education (International Association for Hospice and Palliative Care, 2015)
12. Developing a Palliative Care Competence Framework for Health and Social Care Professionals: The Experience in the Republic of Ireland (Connolly, Ryan, & Charnley, 2016)
13. Inter-professional Palliative Competency Framework (BC Center for Pallitaive Care, 2018)
14. Physician & NP Competencies (BC Center for Palliative Care, 2019)
15. Inter-professional Palliative Competency Framework: Social Workers/Counsellors (BC Center for Palliative Care, 2019)

Dietitians

16. Competencies for dysphagia assessment and management in dietetic practice (Alliance of Canadian Dietetic Regulatory Bodies, January 2019)
17. Canadian dietetic registration examination (CDRE) preparation guide (Alliance of Canadian Dietetic Regulatory Bodies, May 2020)

18. The professional practice handbook for dietitians in Alberta (College of Dietitians of Alberta, 2014)
19. Standards of practice (College of Dietitians of Alberta, 2018)

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