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"Spanish Palliative Care Nurses' Degree of Acceptance of a Proposal for Nursing Competencies in Palliative Care"

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Abstract

Background: In Spain, palliative care (PC) nursing is not a recognized specialization and PC nurses do not receive systematic specialized academic training in PC. To ensure the quality of PC in Spain, the Spanish Association of Palliative Care Nursing has been working since 2011 to design a model of competencies for PC nurses. **Objective:** Verify whether a sample of Spanish PC nurses accepts the proposed model of PC nursing competencies describing their work. **Methods:** Descriptive cross-sectional observational study based on an ad-hoc questionnaire about 98 proposed competencies, which participants rated for whether they belong to the purview of PC nurses and for their degree of concordance with their own practice and their degree of importance in PC nursing. Competencies receiving approval by more than 75% of participants for the three dimensions were considered to have been accepted by consensus. Mixed logistical models were developed to study the association between demographic variables and the responses. **Results:** Sixty-two out of 98 proposed competencies were accepted by more than 75% of participants. We therefore considered these competencies to have been accepted by consensus. Thirty-six proposed competencies failed to meet the threshold of 75% acceptance. For competencies that were accepted overall, participants with more than 10 years of experience in PC and participants with specialized training in PC were more likely to report that these competencies were part of the purview of PC nursing. Participants age >50 were less likely to report that competencies related to research concorded with their practice. Participants accepted the importance of all 98 proposed competencies. **Conclusion:** The variables of experience, training and age had a statistically significant relationship with the acceptance or rejection of the proposed competencies on the basis of purview and concordance. Further research is necessary to understand more fully these relationships to eventually arrive at a consensus model for the competencies of PC nurses.

Keywords

Competencies, nursing skills, palliative care, end of life

Highlights

What is already known about the topic?

- Spain does not have a regulated framework of PC competencies, and PC is not a recognized nursing specialization. Some other countries have such frameworks, which define the roles of PC nurses with respect to areas of responsibility and fields of action.
- PC nurses are vital to providing high-quality care at the end of life.
- Training, professional experience and organizational support allow nurses to develop specialized competencies.

What this paper adds?

- The importance of the proposed competencies was accepted by all participants, demonstrating a high degree of consensus.
- More than 60% of the competencies in our model reached the threshold for consensus.
- The proposed ethical and legal competencies—in which nurses are advocates, mediators, and protectors—were mostly accepted.
- The proposed competencies related to the delivery of care were the most accepted overall, especially those related to care plans.

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- The proposed competencies related to professional development were the least accepted by participants.

Implications for practice, theory, and policy

- Establishing a set of core competencies for PC nursing is a step toward achieving recognition of nurses' work in PC.
- Understanding the variables linked to the acceptance or rejection of the proposed competencies can guide future work to achieve consensus for a competencies framework in PC, thus ensuring the quality of care for patients at the end of life and their families.

Introduction

The World Health Organization estimates that, annually, 40 million people could benefit from palliative care (PC).[1] The increasing complexity of care at the end of life means that nurses need to develop competencies in PC.[2] In Spain, PC nurses do not receive specialized academic training and are not recognized as specialists. Nurses need advanced knowledge to provide satisfactory PC[3–5] demonstrating at the same time that the lack of training, support and organizational structures keep them from developing these advanced competencies.[6] PC nursing is a complex mix of practical skills and personal qualities.[7] Differences in culture, place, time, attitude and knowledge create unequal opportunities for the practice of PC.[6]

In accordance with European Association in Palliative Care (EAPC) guidelines, PC nurses should be able to demonstrate their competence in the five practice domains of the PC nurse,[8] Some countries,[9–12] such as Great Britain[13] and Ireland, have reference frameworks that define the competencies of nurses in PC.[4] In Spain, the National Strategy for PC[14] recommends PC training in undergraduate and graduate training for professionals that work in this area. However, this training is not uniform, nor is it based in a consensus model of competencies. In 2011 the Spanish Association of Palliative Care Nursing started a research group with the objective of working in consensus with PC nurses to identify competencies for PC nurses. In 2013, we published a competencies framework,[15] based on the competencies model of the International Council of Nursing.[16] We divide the competencies into three areas: ethical and legal, delivery and management of care, and professional development.

Competencies are a shared frame of references or norms that guide practice in each area of nursing.[17] In the current study, we verified whether a sample of PC nurses accepted the proposed competencies for their work and explored whether sociodemographic variables were associated with the outcomes.

Methods

Observational descriptive cross-sectional design in Spain among PC nurses in front-line care (hospital and in-home), management, training, and research. Data was collected between May and December 2015. The study population were the 237 members of the Sociedad Española de Cuidados Paliativos (SECPAL) who were PC nurses. The inclusion criteria were >5 years of professional nursing experience and having specific training in PC, according to the criteria of the European Association for Palliative Care. We contacted the nurse members of SECPAL by email to describe the study objectives, procedures, and characteristics and to provide a link to a self-administered ad-hoc survey on the Survey Monkey® platform. Survey responses were anonymous. One hundred fifty participants submitted a survey, and 70 of these submissions were complete. Incomplete submissions were disregarded. One person who submitted a survey response did not meet the inclusion criteria. Therefore, the final sample was 69.

Instruments

The competencies model was designed by nine PC nurses (from care, teaching or research) with at least 15 years of experience in PC, drawing on a range of international source documents and in consultation with other experts. (Figure 1).

The full list of competencies is shown in Tables 2–4. Once the list of competencies was established, the team designed a questionnaire to inquire whether the competencies fit into the purview of PC nurses, concorded with their PC practice and were important parts of PC (Figure 2) .We piloted the questionnaire with 20 members of Spanish Association of Palliative Care Nursing. We made changes based on their recommendations and administered the improved questionnaire, which collected sociodemographic information and participants' responses.

Variables

The categorical variables were purview, concordance, and importance for the 98 competencies, which we divided into three dimensions: ethical and legal, delivery and management of care and professional development. Participants rated each proposed competency for whether it fell under the purview of PC, for its concordance with their own practice, and for its importance (the priority the participants thought it should have in PC nursing). Purview was a binary variable (yes or no). Concordance and importance were rated on a 5-point Likert scale.

Although the appropriate level of consensus for competencies models has been extensively discussed in the literature, it continues to be an arbitrary decision.[18] We deemed 75% to be an appropriate cut-off point.[19] When at least 75% of participants marked "yes" for purview and rated the concordance and importance of a given competency as "high" or "very high," we considered the competency to have been accepted.

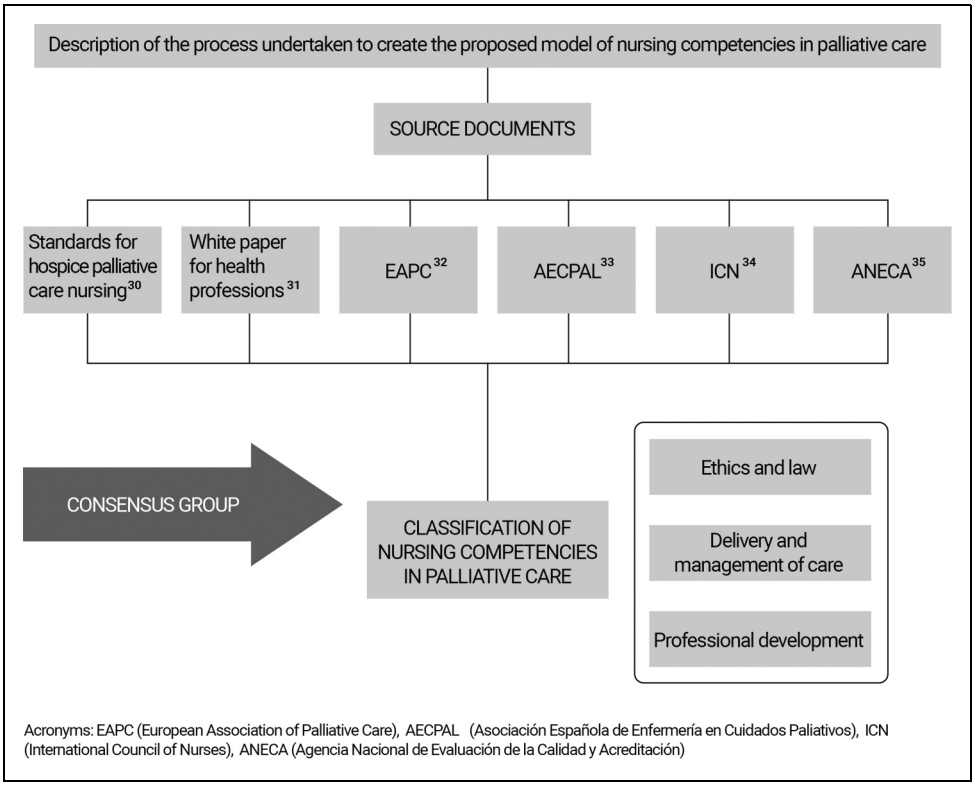

Figure 1. Description of the process undertaken to create the proposed model of nursing competencies in palliative care.

Statistical Analysis

Descriptive analysis of the variables using the SPSS version 21 statistics package and a second analysis using intraclass correlation with R version 3.5.0 for Windows. We used a mixed-effects logistic regression model to study the association between the demographic variables and the variables for purview and concordance of the 98 competencies, calculating the odds ratio (OR) for a competency to be rejected, given the different variables. Statistical significance was set to $p < 0.05$. As described below, the variable of importance was excluded from this step because all participants rated all proposed competencies as important.

Ethical Considerations

We contacted the president of SECPAL via email to request permission to contact members. When we invited SECPAL members to participate, we described the study objectives and explained that participation was voluntary and anonymous. The study was approved by the Clinical Research Ethics Committee of the Bellvitge University Hospital. Ref. Observational Study. Code/ICO/2018.

Results

84.05% of participants were women between ages 36 and 55. They were mainly front-line nurses from hospital (33.30%) and in-home (34.79%) settings, and the majority (62.90%) had more than 20 years of professional experience. 62.30% had >10 years of experience in PC and 89.85% had specific training in PC. 70.50% worked in a region of Spain that had a regional PC plan. (Table 1).

Sixty-two (63.2%) of the 98 competencies were accepted by more than 75% of participants ("yes" for purview and "high" or "very high" for concordance and importance). The 36.7% of competencies that did not meet this threshold achieved more than 50% positive responses, meaning that even these competencies were received well by participants. The importance of all proposed competencies was rated as "high" or "very high" by all participants, suggesting a good fit between the framework and the way that participants thought PC nursing should be practiced. Tables 2–4 show the acceptance or rejection of the competencies organized according to the three variables.

Ethics and law

We divided the 23 competencies into three sub-areas: responsibility, ethical and legal rules, and ethical practice. Of the 23 competencies, 15 (65.2%) were accepted and 8 (34.7%) were rejected (Table 2).

Accepted ethics and law. Competencies related to the role of nurses in responsibility, decision-making (C1.3, C1.4) and ethical dilemmas (C1.6, C1.7) were accepted. The largest group of accepted competencies was related to ethical practice,

Table 1. Population.

	n = 69 n = %
Sex	
Male	11 (15.94%)
Female	58 (84.05%)
Age	
18 to 30	1 (1.40%)
31 to 35	5 (7.29%)
36 to 40	12 (17.39%)
41 to 45	12 (17.39%)
46 to 50	18 (26.09%)
51 to 55	12 (17.39%)
56 to 60	8 (11.59%)
61 to 65	1 (1.46%)
Region of Spain	
Andalusia	5 (7.14%)
Aragon	5 (7.14%)
Asturias	0 (0.00%)
Balearic Islands	4 (5.71%)
Canary Islands	0 (0.00%)
Cantabria	1 (1.43%)
Castilla la Mancha	5 (7.14%)
Castilla y León	5 (7.14%)
Catalonia	14 (20.28%)
Ceuta and Melilla	0 (0.00%)
Valencia	7 (10.14%)
Extremadura	4 (5.71%)
Galicia	3 (4.29%)
Madrid	9 (12.9%)
Murcia	0 (0.00%)
Navarra	2 (2.86%)
Basque Country	5 (7.14%)
Palliative care regional plan in place?	
Yes	52 (75,36%)
No	17 (24.63%)
Work sphere	
Hospital PC support team	23 (33.30%)
In-home PC team	24 (34.70%)
Inpatient PC unit	14 (20.28%)
Center for training or research in PC	8 (11.59%)
Years of experience in nursing	
≤ 10	7 (10.09%)
10 to 20	19 (27.10%)
≥ 20	44 (62.90%)
Years of experience in paliative care nursing	
≤ 10	26 (37.68%)
10 to 20	34 (49.27%)
≥ 20	9 (13.04%)
Specific training in palliative care	
Specific training in PC	62 (89.85%)
Training in PC as part of other training	7 (10.14%)

including acting as an advocate for and/or a representative of the patient, a protector of diversity, individuality and rights and a mediator between the team and the family (C1.12, C1.13, C1.14, C1.15, C1.16, C1.19, C1.20, C1.21, C1.22).

Rejected ethics and law. Competencies rejected on the basis of purview were most notably related to adapting values and beliefs to provide care and support for the patient and the family; caring for the body after death; respecting privacy, confidentiality, nurse-patient privilege; and ensuring that the nurses' beliefs do not affect the patient (C1.1, C1.2, C1.17, C1.18, C1.11). The competency related to ethics in research was also rejected (C1.8). Competencies that were rejected because participants reported that they didn't concord with their own practice as PC nurses included that related to leadership and health policy (C1.5) and that related to providing support and seeking help in clinical scenarios such as assisted suicide and euthanasia (C1.23).

Demographics, ethics, and law. Having >10 years of experience in PC was significantly associated with rejecting an ethical or legal competency (Table 5). Participants with >10 years of experience in PC were significantly less likely to reject the idea that the accepted ethical and legal competencies linked to advocacy, protection, and mediation (C1.12, C1. 13, C1.16) fell under the purview of PC nurses (Table 5). The same pattern occurred for the competencies linked to respect for values, beliefs, and lifestyles (C1.1, C1.2, C1.11, C 1.18).

Delivery and Management of Care

Of the 55 competencies, 41 (74.5%) were accepted and 14 (25.5%) were rejected (Table 3). This set of competencies is divided into the eight sub-areas: essential principles, health promotion, assessment, planning, execution, assessment, therapeutic communication/interpersonal relationships, and safe environment/comprehensive care/resource management.

Accepted delivery and management of care. The most accepted competencies were those related to essential principles surrounding the care plan, including taking into account the needs and priorities of the patient and family (C 2.1, C.2.2, C 2.3, C 2.4, C2.5, C2.6, C2.7), teamwork (C 2.8), evidence-based practice (C2.9), health promotion at the end of life (C 2.11, C2.12, C.2.13, C2.15, C2.16), assessment (C 2.17, C 218, C 2. 19, C2. 20, C 2.21), and the execution of care plans (C 2.31, C2.32, C2.33). Participants also accepted, with some exceptions, the competencies related to planning (C2.23, C2.25, C2.26, C2.27, C2.28, C2.30) and those related to therapeutic communication (C2.40, C2.41, C2.42, C2.43, C2.44, C2.45), except for the competency related to providing support during grief, which was rejected as not concordant with practice (C2.46). The sub-area of assessment was less well received by participants. Only the competencies related to the use and evaluation of care plans from a multidisciplinary viewpoint oriented to the patient and family were accepted (C2.35, C2.38, C2.39). In the sub-area of comprehensive care, accepted competencies were those related to organization and resource management that considered the needs of patient, family, and team (C2.48, C2.52, C2.53).

Table 2. Ethical-Legal Competences.

ETHICAL-LEGAL COMPETENCIES					
	RESPONSIBILITY	PURVIEW	CONCORDANCE	IMPORTANCE	ACCEPTANCE
C1.1	To respect the values, lifestyles and beliefs of the person during the care process. Adapting care, accordingly, even when opposed to the nurses' own values.	✕	✓	✓	
C1.2	To give support to the family in order to respect the values and decisions of the person.	✕	✓	✓	
C1.3	To provide nursing assessment as an essential element for team decision-making in situations of conflict or ethical dilemma and in situations of discrepancy. Act consciously.	✓	✓	✓	
C1.4	To be aware of social reflections about the concepts of suffering and pain at the end of life: dignified death, limitation of therapeutic effort, rejection of treatment, palliative sedation, futile treatment, assisted suicide and euthanasia.	✓	✓	✓	
C1.5	To participate in the development of national and regional policies as well as guidelines in relation to the rights of the person at the end of life.	✓	✕	✓	
	ETHICAL AND LEGAL RULES	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
C1.6	To apply the general ethical and deontological principles of the nursing profession related to the decision-making process, care and assistance of people at the end of life.	✓	✓	✓	
C1.7	To know the legal framework and limits of professional performance in the end-of-life field.	✓	✓	✓	
C1.8	To be familiar with current regulations governing research processes and to ensure compliance, guaranteeing respect for the rights of persons who are research subjects.	✕	✓	✓	
	ETHICAL PRACTICE	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
C1.9	To participate in team decision-making that recognizes the complexity of the situation of the person with advanced disease and end of life, as well as the need for a multidisciplinary approach	✓	✓	✓	
C1.10	To recognize the vulnerability and frailty of the person in the situation of advanced disease and end of life, and consequently the need to ensure actively that their fundamental rights are respected.	✓	✓	✓	
C1.11	To avoid the influence that the nurse's own beliefs and values may have on the delivery of care.	✕	✓	✓	

(continued)

Table 2. Continued.

ETHICAL-LEGAL COMPETENCIES					
	RESPONSIBILITY	PURVIEW	CONCORDANCE	IMPORTANCE	ACCEPTANCE
C1.12	To recognize the socio-cultural diversity at the end-of life by favoring an environment in which the person and family can perform their rites and customs.	✓	✓	✓	
C1.13	To protect the person's right to decide by ensuring that they have the necessary information during the entire care process, in a manner adapted to the demand, receptivity and clinical situation using oral and/or written consent and the advance directive document.	✓	✓	✓	
C1.14	To help the person in a situation of advanced disease and at the end of life so that they can exercise their autonomy with their friends, family and care providers.	✓	✓	✓	
C1.15	To prioritize the patient's desire to be informed in cases in which family members request tight control over information.	✓	✓	✓	
C1.16	To respect the patient's right to refuse treatment or care proposed by professionals, emphasizing their right to continue being attended to, treated, and cared for.	✓	✓	✓	
C1.17	To maintain the principles of intimacy, confidentiality and dignity with the body after death.	✓	✓	✓	
C1.18	To protect confidentiality and professional secrecy by recognizing that the owner of the information is the patient and information will only be shared with prior consent in the cases established by law.	✕	✓	✓	
C1.19	To report to the team the detection of altered daily life needs, of the person and family in the process of advanced disease and end of life, so that the decision-making process is as holistic and individualized as possible.	✓	✓	✓	
C1.20	To encourage the expression of the persoṅs will, in anticipation of situations of foreseeable cognitive impairment, in which they cannot express themselves, leaving a record of their preferences in the clinical history and/or with the realization and recording of advance directives.	✓	✓	✓	
C1.21	In situations of change in therapeutic orientation and palliative sedation, to ensure implicit or explicit consent.	✓	✓	✓	
C1.22	To seek an environment that facilitates	✓	✓	✓	

(continued)

Table 2. Continued.

ETHICAL-LEGAL COMPETENCIES					
	RESPONSIBILITY	PURVIEW	CONCORDANCE	IMPORTANCE	ACCEPTANCE
	the maximum cognitive and emotional competence of the person or their representatives for decision-making and if necessary, include specialized help.				
C1.23	To accompany the person to clarify their values, motives and consequences and to obtain specialized help if deemed necessary, in the request for assisted suicide, refusal of treatment or euthanasia.	✓	×	✓	
ACCEPTED					✓
NOT ACCEPTED					×

Rejected delivery and management of care. In terms of the competencies that were rejected for lack of concordance, we find those related to leadership and participation in social and professional debate (C2.10). Participants also rejected the concordance of the management of care resources that enables the specialized treatment of cases (C2.49, C2.50, C2.54, C2.55) and the individualization of care (C2.34, C2. 36, C2.37). With respect to the competencies that were rejected for purview, we have those related to nursing language in diagnosis (C2.22), problems with collaboration (C2.24), the prevention of risk through a record of safety problems (C2.47) and the use of indicators (C2. 51).

Demographics, delivery, and management of care. The variables >10 years of experience in PC and having advanced training in PC were significant. Participants meeting these characteristics were less likely to deny that the following accepted competencies fell under the purview of PC nursing: C2.2, C2.3, C2.9, C2.12, C2.28. For C2.11, which includes planning and safety in care, and which relates to planning educational activities, participants with >10 years of experience in PC were less likely to say this competency didn't concord with their practice. The same occurs for C2.12 (promotion of wellbeing and lifestyles). For C2.28 (including the medical history in the care plan), as well as activities related to collaboration, participants with >10 years of experience in PC were less likely to deny that the competencies fell under the purview of PC nursing.

In terms of competencies related to the delivery of care that did not achieve consensus for concordance, participants with advanced training in PC were more likely to reject C2.22 (defining and prioritizing nursing diagnoses) as not concordant. Participants with >10 years of experience in PC were less likely to reject on the basis of purview C2.34 (evaluating the outcome of actions in relation to the expected objectives) and C2.37 (evaluating the outcome of actions, techniques and procedures). In contrast, participants with advanced training in PC were more likely to deny that these competencies fell under the purview of PC nursing.

Finally, participants with >10 years of experience in PC were less likely to reject the concordance of C2.54 (designing care plans to support other nurses). With respect to the competencies that were rejected because participants said they didn't fall under the purview of PC nursing, participants with >10 years of experience in PC were less likely to say that C2.24 (defining problems of collaboration with other professionals that provide care) didn't belong to the purview of PC nursing. Participants >10 years of experience in PC were less likely to reject the concordance of C2.47 (preventing situations of risk and recording safety problems).

Professional Development

The 20 proposed competencies were divided into four subareas: professional commitment, quality improvement, continuing training and teaching, and research. Of the 20 competencies, 6 (30%) were accepted and 14 (70%) were rejected for lack of concordance with the practice of participants (Table 4).

Accepted professional development. While participants reported that all proposed competencies in this area fell under the purview of PC nursing and were important, most competencies were rejected on the basis of lack of concordance. The only accepted competencies were those related to professional commitment (C3.1, C3.2, C3.5, C3.6), the application of practical knowledge (C3.13) and applying scientific evidence (C3.16), coinciding with C2.9 in the delivery and management of care.

Rejected professional development. The remaining 14 competencies were rejected as not concordant with the participants' practice, including those related to leadership and health policy (C3.3, C3.4). Participants also rejected the concordance of competencies involving leadership related to participation and the dissemination of knowledge through expert research (C3.17, C 3.18, C 3.19, C 3.20) and in improving quality (C 3.7, C3.8, C3.9, C3.10, C3.11). Finally, participants rejected the concordance of

Table 3. Provision and Management Care.

PROVISION AND MANAGEMENT CARE					
	ESSENTIAL PRINCIPLES OF CARE DELIVERY AND MANAGEMENT	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
C2.1	To establish a communication process that promotes the development of personal resources and the care capacity of the patient and their family in the process of adaptation to the end of life.	✓	✓	✓	
C2.2	To organize the care plan by identifying health problems and establishing priorities focused on the quality of daily life activities and the patient's well-being.	✓	✓	✓	
C2.3	To be aware of, adjust, manage and safely evaluate specific forms of care and treatments.	✓	✓	✓	
C2.4	To identify and to integrate the patient's main caregiver into the care process	✓	✓	✓	
C2.5	To establish a specific care plan for the needs of the family group	✓	✓	✓	
C2.6	To act as a mediator between the family and patient, facilitating their adaptation to the end-of-life process.	✓	✓	✓	
C2.7	To promote continuity of care by managing available community resources and establishing communication channels between all the participating health teams.	✓	✓	✓	
C2.8	To participate and promote teamwork as an instrument to tackle the complexity of care and attending to the patient at the end of life.	✓	✓	✓	
C2.9	To use available scientific evidence and apply results throughout the care process	✓	✓	✓	
C2.10	To participate in and promote debate about innovations and changes in care for people in the process of advanced illness and the end of life.	✓	✕	✓	
	HEALTH PROMOTION	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
C2.11	To include in the care plan the planning of health education activities according to the clinical situation, knowledge, personal resources and previous experiences.	✓	✓	✓	
C2.12	To promote lifestyles that contemplate the well-being of the patient and family while respecting their habits and customs.	✓	✓	✓	
C2.13	To adapt the environment to the changing needs of the person at the end of life using social, family, environmental and material resources.	✓	✓	✓	
C2.14	To provide knowledge and skills that help the patient to have maximum autonomy in the management of their end-of-life process.	✓	✓	✓	
C2.15	To help the person to delegate their care and attention to significant people based on progressive functional and/or cognitive deterioration at the end of life.	✓	✓	✓	
C2.16	To promote positive attitudes in society toward the end-of-life stage	✓	✓	✓	
	ASSESSMENT	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
C2.17	To evaluate systematically the clinical and emotional or social risk situation using specific criteria or indicators.	✓	✓	✓	
C2.18	To determine the degree of dependence and functional impact of health problems arising from the end-of-life process.	✓	✓	✓	

(continued)

Table 3. Continued.

PROVISION AND MANAGEMENT CARE					
	ESSENTIAL PRINCIPLES OF CARE DELIVERY AND MANAGEMENT	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
C2.19	To evaluate the degree of information and knowledge of the vital situation and life prognosis of the patient and family.	✓	✓	✓	
C2.20	To evaluate the emotional impact and the degree of coping of the patient and family with the end-of-life process by exploring their personal, social and community resources.	✓	✓	✓	
C2.21	To evaluate systematically the organizational, emotional or self-care care capacity of the care environment.	✓	✓	✓	
	PLANNING	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
C2.22	To define and prioritize nursing diagnoses with patient and family.	✓	✕	✓	
C2.23	To identify the critical situation and activate early referral to other professionals based on the limits of their professional performance.	✓	✓	✓	
C2.24	To define collaboration problems with the other professionals involved in the care process.	✕	✓	✓	
C2.25	To activate the specific protocols for end-of-life care (pain care; care for patients with delirium, in their final days, and/or in their dying moments; postmortem care; grief care) procedures and techniques (discharge, referrals, routes of administration) by individualizing them to the person and the situation.	✓	✓	✓	
C2.26	To define outcome criteria and establish the schedule of activities, according to the complexity of the situation of the person with advanced disease and end of life.	✓	✓	✓	
C2.27	To anticipate new needs of the person and their family not foreseen and typical of the changing situation.	✓	✓	✓	
C2.28	To include in the medical history the planning of nursing care and activities related to collaboration problems.	✓	✓	✓	
C2.29	To record the activation of specific techniques, protocols and procedures used, indicating the outcome criteria.	✕	✕	✓	
C2.30	To prepare the indications for care and treatments to favor self-care and/or participation of the main caregiver and to prepare the necessary written documentation	✓	✓	✓	
	EXECUTION	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
C2.31	To act according to the established plan, while adjusting the activities to the changing needs of the patient and family at the end of life.	✓	✓	✓	
C2.32	To provide the necessary information and documentation to ensure the greatest possible degree of participation by the patient and primary caregiver.	✓	✓	✓	
C2.33	To document and to record changes in their interventions.	✓	✓	✓	
	EVALUATION	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
C2.34	To assess the results of activities outlined in the care plan activities, in relation to the planned objectives.	✓	✕	✓	
C2.35	To include the patient and family in the assessment of progress and expected results.	✓	✓	✓	
C2.36	To use the results of assessments to deepen the individualization of the care plan.	✓	✕	✓	

(continued)

Table 3. Continued.

PROVISION AND MANAGEMENT CARE					
	ESSENTIAL PRINCIPLES OF CARE DELIVERY AND MANAGEMENT	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
C2.37	To evaluate the results of the delegated activities, techniques, protocols and procedures used.	✓	✕	✓	
C2.38	To collaborate in the assessment of the multidisciplinary therapeutic plan.	✓	✓	✓	
C2.39	To integrate the results of the care plan into the multidisciplinary treatment plan.	✓	✓	✓	
	THERAPEUTIC COMMUNICATION AND INTERPERSONAL RELATIONSHIPS	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
C2.40	To use the therapeutic relationship as a support in all interactions with the patient and family, taking into account the emotional fragility caused by the end-of-life situation.	✓	✓	✓	
C2.41	To respond to information needs and demands by integrating bad news as a part of the communication process with the person and family.	✓	✓	✓	
C2.42	To encourage the expression of feelings and emotions of the person and family, in the different stages of the loss and grief processes, without fear of being judged.	✓	✓	✓	
C2.43	To create an intimate therapeutic context that stimulates communication.	✓	✓	✓	
C2.44	To encourage teamwork to handle emotions of the professionals that can hinder the helping relationship.	✓	✓	✓	
C2.45	To establish objectives and communication actions with the patient that are mutually agreed upon.	✓	✓	✓	
C2.46	To accompany the family after death by detecting specific needs in the grief process.	✓	✕	✓	
	SAFE ENVIRONMENT, INTEGRAL ATTENTION AND RESOURCE MANAGEMENT	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
C2.47	To prevent risk through early detection, communication and recording of security problems to the corresponding authorities.	✕	✓	✓	
C2.48	To foster a flexible organization adapted to changing care needs.	✓	✓	✓	
C2.49	To develop criteria that allow assigning the most appropriate and capable nurse to provide care and attention, taking into account their knowledge and/or emotional response to the complexity of the situation.	✓	✕	✓	
C2.50	To establish and maintain transdisciplinary and interdisciplinary relationships for decision-making that guarantee comprehensive care.	✓	✕	✓	
C2.51	To use quality indicators and current or potential risk management adapted to the end-of-life situation.	✓	✕	✓	
C2.52	To agree to and to guarantee the level of intervention and care resources appropriate to the situation and needs of the patient and/or family and/or referring team.	✓	✓	✓	
C2.53	To provide specialized support to the demands of other professionals and teams from other healthcare levels in the care and attention of the patient and family at the end of life.	✓	✓	✓	
C2.54		✓	✕	✓	

(continued)

Table 3. Continued.

PROVISION AND MANAGEMENT CARE					
	ESSENTIAL PRINCIPLES OF CARE DELIVERY AND MANAGEMENT	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
	To design specific care plans to support nurses at other levels of care in caring for people at the end of life.				
C2.55	To establish circuits and intervention criteria between the different levels of care involved in end-of-life care.	✓	×	✓	
Marked as YES or HIGH/VERY HIGH by >75% of participants					✓
Marked as YES or HIGH/VERY HIGH by more than ≤75% of participants					×

competencies linked to training and ongoing education in leadership and the management of knowledge (C3.12, 3.14, 3.15).

Demographic professional development. Having >10 years of experience in PC and age >50 were linked significantly to these outcomes (Table 5). In particular, the accepted competency C3.16 (identifying and applying the best scientific evidence in PC) was more likely to be rejected by participants aged >50. The rejected competencies C3.17, C3.18 and C3.20 (related to research activities), were also more likely to be rejected by participants >50.

Discussion

We examined the acceptance of a proposed model of PC competencies by asking PC nurses to self-assess whether each competency fell under the purview of PC nursing and having them rate their concordance with their own practice and their importance to PC nursing. The vast majority of proposed competencies related to advocacy, mediation and protection were rated positively for all three variables. Having >10 years of experience in PC, having undergone advanced training in PC and being >50 are the only variables that had a significant relationship with whether participants said that some competencies fell under the purview of PC nursing and/or concorded with their practice. In competencies related to care plans, participants with advanced training in PC were significantly more likely to rate the competencies as not falling under the purview of PC nursing.

Competencies related to research did not reach consensus for concordance among nurses aged >50. The development of competencies can of course depend on individual factors and the work setting.[20] The fact that most participants worked as front-line nurses providing PC (either in the hospital or at home) may explain why many of them reported that management, teaching and research activities did not concord with their practice. Geographic variables can also affect the development of competencies,[21] but in our study geographic origin was not significant.

Competencies related to using continuous clinical assessment that considers the opinions and habits of patients and their families achieved maximum consensus among participants that had >10 years of PC experience in PC. In this line, Kenneth, et al.'s research among members of the Hospice and Palliative Nurses Association concluded that managing patients' symptoms, including pain, and talking to patients and families about death are core competencies.[22]

Nurses' commitment to providing care, reducing suffering and defending the rights of patients, families and communities empower them to develop leadership competencies[23] However, in our sample, competencies related to leadership and PC health policy were not accepted. In 2017, the Hospice and Palliative Nurses Association and the American Nurse Association released recommendations about the promotion of leadership of nurses to guide the development of PC.[24] In Spain, we need guidelines that make it possible to define roles, resolve problems, and empower nurses as they perform their duties.[25] In this line, Gallagher, et al. identify the need for nursing organizations to defend the interests of patients and families in countries where PC is not yet sufficiently developed.[26]

The proposed competencies related to improving quality, through research, training and teaching did not achieve sufficient consensus in terms of concordance. This could be related to the fact that most of the participants were front-line nurses, rather than in management, teaching or research. Positive organizational culture and good management and evaluation of health activities are decisive for nurses to consume and apply research.[27] If nurses conduct research and implement the results, patient care and safety can be improved.[28]

The competencies that were accepted by our participants are a starting point. They should be continuously reviewed and adjusted to the context, the individual nurse and the specific discipline.[23] Additionally, these results serve as a launch point for implementing nursing competencies in PC from the area of management or specific training, to ensure that PC is implemented adequately in this country and in other countries with similar health systems and approaches to PC.[29]

Limitations

The ad-hoc questionnaire limits the generalizability of our findings. Our model of competencies is linked to the Spanish healthcare system (which does not train, recognize or regulate PC nurses as specialists) and would have to be adapted to the academic, cultural, and legal framework of other countries if

Table 4. Development Professional.

DEVELOPMENT PROFESSIONAL					
	PROFESSIONAL COMMITMENT	PURVIEW	CONCORDANCE	IMPORTANCE	ACCEPTANCE
C3.1	To be a reference in the field of palliative care.	✓	✓	✓	
C3.2	To manage and to contribute nursing knowledge in palliative care.	✓	✓	✓	
C3.3	To know and analyze the political and/or institutional situation related to the care needs of people at the end of life.	✓	✓	✓	
C3.4	To implement the necessary changes at a professional, institutional and political level to improve care for people at the end of life.	✓	✕	✓	
C3.5	To assume ethical and legal co-responsibility in the comprehensive care of the patient at the end of life and their family throughout the care process.	✓	✕	✓	
C3.6	To contribute to the social understanding of the end of life as part of the life cycle.	✓	✓	✓	
	QUALITY IMPROVEMENT	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
C3.7	To know, develop and apply quality indicators and standards of care plans for people at the end of life.	✓	✕	✓	
C3.8	To participate in the evaluation processes and improvement of the quality of care for people at the end of life.	✓	✕	✓	
C3.9	To incorporate the criteria of effectiveness and efficiency to guarantee the best care while optimizing available resources.	✓	✕	✓	
C3.10	To generate resources to respond to specific care needs with quality criteria.	✓	✕	✓	
C3.11	To apply and disseminate the conclusions and proposals for improvement of the analysis of the results of the quality-of-care assessment.	✓	✕	✓	
	CONTINUOUS TRAINING AND TEACHING	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
C3.12	To lead the learning process for nurses in palliative care.	✓	✕	✓	
C3.13	To apply reflective learning on one's own practice as an element of continuous learning.	✓	✓	✓	
C3.14	To participate in the detection of training needs and collaborate in the development, implementation and evaluation of educational programs in palliative care for all professionals in the health field.	✓	✕	✓	
C3.15	To educate society about caring for people at the end of life.	✓	✕	✓	
	RESEARCH	**PURVIEW**	**CONCORDANCE**	**IMPORTANCE**	**ACCEPTANCE**
C3.16	To identify and apply the best scientific evidence in the practice of palliative care.	✓	✓	✓	
C3.17	To identify research priorities and establish feasible lines of research and develop research networks at the local, national and international level.	✓	✕	✓	
C3.18	To consider the ethical issues of research with human beings who are vulnerable because they are at the end of life.	✓	✕	✓	
C3.19	To acquire leadership, collaboration and promotion skills in palliative care research	✓	✕	✓	

(continued)

Table 4. Continued.

DEVELOPMENT PROFESSIONAL					
	PROFESSIONAL COMMITMENT	PURVIEW	CONCORDANCE	IMPORTANCE	ACCEPTANCE
	projects at the local, national and international levels.				
C3.20	To disseminate the results of research in palliative care.	✓	✕	✓	
ACCEPTED					✓
NOT ACCEPTED					✕

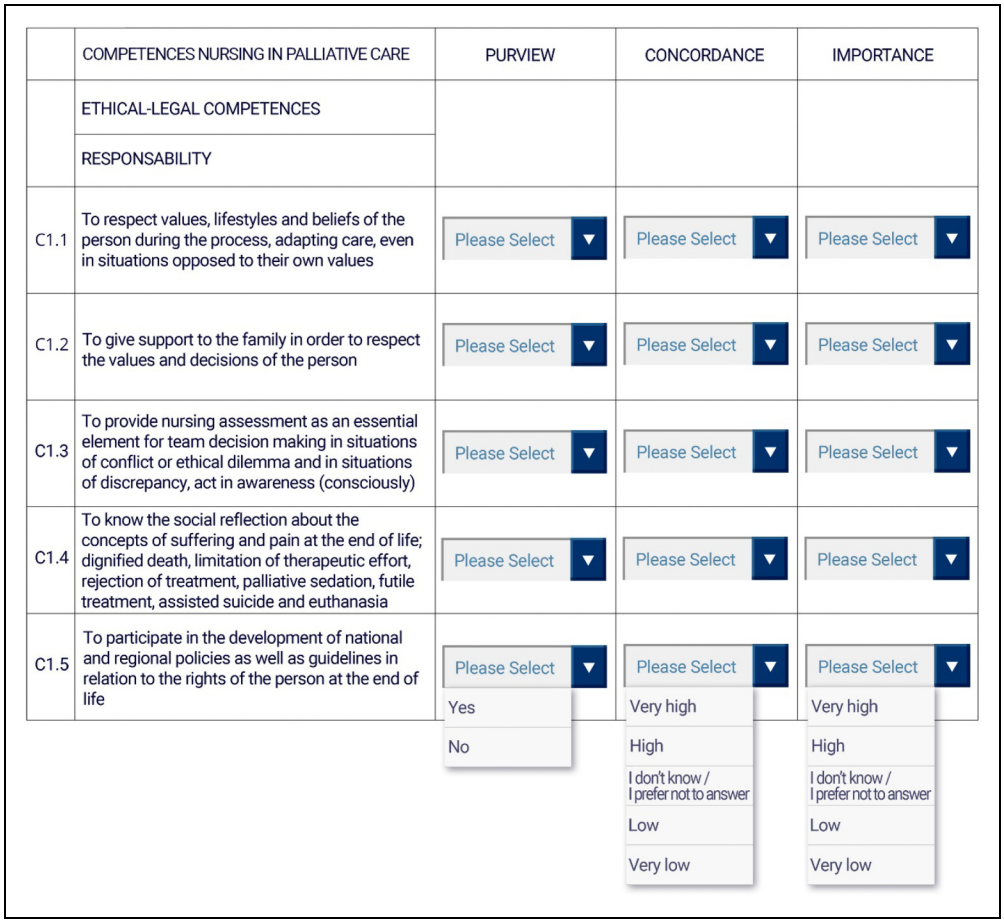

Figure 2. Sample question from the ad-hoc survey.

implemented there. Finally, the publication of our research has been delayed by the COVID-19 pandemic because several of the authors returned to front-line care as PC nurses.

Conclusions

Of the 98 competencies in PC proposed to our participants, 62 were accepted. All 98 proposed competencies were rated as important by the participants. Most of the proposed competencies related to ethics and law were accepted. However, some competencies for this dimension were rejected as not falling under the purview of PC nursing. Most of the competencies related to the delivery and management of care were identified as falling under the purview of PC nursing. It was surprising, however, that there was not consensus on incorporating into care plans the evaluation of past outcomes to adjust care to the needs of the patient and the family. The fact that the competencies related to professional development tended not to

Table 5. Odds Ratio(OR) for the Rejection of the Pertinence and Concordance of the Competencies in Relation to the Statistically Significant Variables.

Competence accepted

Competence not accepted

Statistically significant variables	COMPETENCIES	Odss Ratio (OR) PERTINENCE OR (IC 95%)	Odss Ratio (OR) CONCORDANCE OR (IC 95%)
>10 YEARS PALLIATIVE CARE WORK EXPERIENCE	C 1.1	0.04 to 0.42	
	C 1.2	0.05 to 0.54	
	C 1.8	0.09 to 0.89	
	C 1.11	0.10 to 0.92	
	C 1.12	**0.06 to 0.76**	
	C 1.13	**0.08 to 0.93**	
	C 1.16	**0.08 to 0.94**	
	C 1.18	0.04 to 0.48	
	C 2.2	**0.04 to 0.61**	
	C 2.9	**0.06 to 0.84**	
	C 2.11		**1.75 to 42.00**
	C 2.12	**0.04 to 0.73**	
	C 2.24	0.04 to 0.69	
	C 2.28	**0.03 to 0.66** **1.56 to 41.42**	
	C 2.47		1.69 to 36.15
	C 2.54		1.15 to 11 to 10
SPECIFIC TRAINING IN PALLIATIVE CARE	**C 2.3**	**1.42 to 35.18**	
	C 2.22	**1.46 to 63.53**	
>10 YEARS PALLIATIVE CARE WORK EXPERIENCE & SPECIFIC TRAINING IN PALLIATIVE CARE	C 2.34	1.41 to 35.24	
	C 2.37	1.62 to 47.16	
50 YEARS OF AGE	**C 3.16**		**0.02 to 3.33**
	C 3.17		0.03 to 0.66
	C 3.18		0.02 to 0.48
	C 3.20		0.05 to 0.83

concord with participants' practice could be related to the fact that there is not a specific line of professional development in PC nursing. A next step would be to investigate through qualitative action research whether responses to the proposed competencies can be modified through dialog, thus achieving greater consensus on the model. It is also necessary to investigate the factors that make it possible for nurses to develop their competencies in PC to meet the needs of patients at the end of life and their families. The competencies model described here and our approach to measuring its acceptance can be useful to other health systems in which palliative care has not been consolidated as a specialisation or in which the model of palliative care competencies needs to be defined or updated.

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Ethical Approval

Not applicable, because this article does not contain any studies with human or animal subjects.

Informed Consent

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Trial Registration

Not applicable, because this article does not contain any clinical trials.

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