Acta Paulista de Enfermagem

REFERÊNCIA

SOUSA, Janaina Meirelles; ALVES, Elioenai Dornelles. Nursing competencies for palliative care in home care. **Acta Paulista de Enfermagem**, São Paulo, v. 28, n. 3, p. 264-269, maio/jun. 2015. Disponível em: <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-21002015000300264&lng=en&nrm=iso>. Acesso em: 16 abr. 2018. doi: http://dx.doi.org/10.1590/1982-0194201500044.

Nursing competencies for palliative care in home care

Competências do enfermeiro para o cuidado paliativo na atenção domiciliar

Janaina Meirelles Sousa[1]
Elioenai Dornelles Alves[1]

Keywords
Professional competence; Primary care nursing; Nursing research; Palliative care; Home care services

Descritores
Competência profissional; Enfermagem de atenção primária; Pesquisa em enfermagem; Cuidados paliativos; Serviços de assistência domiciliar

Submitted
October 18, 2014

Accepted
December 15, 2014

Abstract

Objective: To identify the competencies of nurses for palliative care in home care.
Methods: An exploratory study using the Delphi method to identify the consensus of nurses working in home care regarding 43 competencies listed in a questionnaire, with the inclusion of a five-point Likert scale.
Results: In the sample of 20 nurses, there was consensus about 18 general competencies and 25 specific competencies, with agreement above 75%, and Cronbach's alpha coefficient of 0.7 for all the listed competencies. The favorable consensus about the proposed competencies indicates the recognition of palliative care as a nursing care practice in home care.
Conclusion: The list of competencies presented internal reliability and provides assertive statements about the work of nurses in palliative care in home care.

Resumo

Objetivo: Identificar competências do enfermeiro para o cuidado paliativo na atenção domiciliar.
Métodos: Estudo exploratório que utilizou o método *Delphi* para identificar o consenso de enfermeiros que atuam na atenção domiciliar para com 43 competências elencadas em um questionário, com inclusão de escala de *Likert* de cinco pontos.
Resultados: Na amostra de 20 enfermeiros, houve consenso para 18 competências gerais e 25 específicas com percentuais acima de 75% de concordância, e coeficiente alfa de *Cronbach* de 0,7 para todas as competências elencadas. O consenso favorável às competências propostas indica o reconhecimento do cuidado paliativo como prática assistencial de enfermagem na atenção domiciliar.
Conclusão: O elenco de competências apresentou confiabilidade interna e fornece afirmações assertivas sobre a atuação do enfermeiro em cuidado paliativo na atenção domiciliar.

Corresponding author
Janaina Meirelles Sousa
Campus Universitário Centro Metropolitano 1, Conjunto A, Ceilândia, DF, Brazil. Zip Code: 72220-900
sjana@unb.br

DOI
http://dx.doi.org/10.1590/1982-0194201500044

[1]Universidade de Brasília, Brasília, DF, Brazil.
Conflicts of interest: no conflicts of interest to declare.

Introduction

Quality care at the end of life depends on an aligned interdisciplinary health team with strong interpersonal skills, clinical knowledge, technical competencies and respect for individuals.[1] Palliative care as care modality required of health professionals who work in home care, together with the increased morbidity and mortality from chronic degenerative diseases worldwide inflates the need for multidisciplinary care to patients facing life-threatening diseases. In this context, the World Health Organization proposes concepts and guidelines for this type of care, with an approach that allows the best quality of life for patients and their families, through the identification, evaluation and treatment of problems of physical, psychosocial and spiritual order.[2-4]

In the multidisciplinary team of palliative care, the nursing professionals are on the front line to provide care, comfort and counseling for families and patients. In this interaction, the successful implementation of care arises from the patient-nursing relationship and from their interest and willingness to exercise such care at the end of life.[1,5]

Dealing with the death and dying in the daily routine of nurses, associated with clinical inexperience and lack of adequate training and emotional support, are seen as obstacles to the quality of care provided to patients at end of their lives, and ultimately, influence the expression of these professionals' competence.[6]

Professional competence consists on knowing how to appropriately mobilize and combine a group of personal and environmental resources when managing a complex situation. Building competencies favors the formation of resource mobilization schemes, enabling that subjects apply them in their daily activities, in accordance with projects to which they attribute meaning and sense.[7]

The operationalization of competencies results from the quality of the interface between people and the work situation, where professionalism and competence emerge from knowing, wanting and being able to act. Thus, mapping the competence adds economic and social value to individuals and organizations, to the extent that it contributes to the achievement of organizational objectives and expresses the social recognition of the ability of people. It is noteworthy that the competencies required from a professional permeate the competence desired in an individual and the role system established between the social actors.[8]

Competence is revealed in knowing how to act responsibly, which is recognized by others in a dynamic that implies knowing how to mobilize, integrate and transfer resources, knowledge and competencies in a particular professional context. The objective of this study was to identify the competencies of nurses for palliative care in home care.

Methods

This is a descriptive, exploratory study with quantitative approach. At the first moment of the study, the researcher elaborated a list of competencies based on national and international literature of scientific articles, palliative care manuals and specific books on the subject. At the second moment, the list of competencies was analyzed by a jury of three Brazilian nurses with experience in palliative care and currently engaged in health care programs in palliative care. After the jury review, the suggestions were examined in the light of scientific literature. Then, the researcher revised the list of competencies, resulting in 43 competencies that were presented to nurses at the third moment of the study in order to reach a consensus.

The parameters of the Delphi method were used to define the study location and the participating nurses. Such method is a structured procedure for collection and synthesis of knowledge of a group of professionals who are engaged with the area where the study is being developed, because of their experience and/or their technical

expertise regarding a certain phenomenon. This process occurs through a series of questionnaires, together with an organized opinion feedback, which is repeated in subsequent rounds until reaching the predetermined consensus or until reducing the level of disagreement to the level of saturation.[9]

The population consisted of nurses linked to the Multidisciplinary Teams of Home Care (EMAD – Equipes Multiprofissionais de Atenção Domiciliar) of the Health Department of Distrito Federal (SES-DF), in the data collection period. The inclusion criteria were nurses linked to a Multidisciplinary Team of Home Care who accepted to participate in the study by signing the Informed Consent Form. The data collection period was in the months of March and June 2014.

The sample consisted of 20 nurses who answered a sociodemographic questionnaire that included a list of general and specific competencies, plus a Likert scale, where participants would choose a 'Likert item' to reach a level of agreement. The items were graded as follows: strongly disagree (1), partially disagree (2), neutral (3), partially agree (4), strongly agree (5). There was an open question in the questionnaire, where participants could add the competencies they considered relevant to the consensus, and which had not been included in the proposed questionnaire.

The first round of the Delphi method happened in personal meetings with the nurses scheduled by telephone. In that occasion, the researcher explained about the study and requested their participation. After the first round of data collection and statistical treatment of information, this was confronted with the consensus level stipulated as 70%.

The analysis of the first round results revealed that the second round would not be necessary, because 100% of the competencies had reached consensus, and the situations exposed in the open question were not considered relevant for building new competencies, since they referred to widespread personal positions on the nurses' role in the conduction of palliative care in home care.

Data were expressed as simple and percentage frequency. Considering the set of general and specific competencies, was applied the Cronbach's alpha for the statistical reliability analysis of the competencies list.

The development of the study met national and international standards of ethics in research involving human beings.

Results

The sample of 20 nurses was composed of 95% female, 5% male. The mean age was 38.5 years and the standard deviation was 8.99. Among the sample, 65% had majored in nursing less than 10 years before the survey, 25% had graduated between 11-20 years before and 10% had between 21-30 years since graduation. The majority of nurses (90%) had attended lato sensu post-graduation courses, while 10% had not; 65% mentioned to have participated in courses addressing the theme of palliative care and 35% denied such participation.

In percentage, the time of professional experience in Home Care Regional Centers was distributed as follows: 40% had between 1 month and 2 years of experience, 40% had 3-5 years, 5% had over six years and 15% did not report their experience time. Among professionals, 25% had another employment engagement and 75% worked in a single place.

Of the 43 competencies presented for the nurses' judgment, 18 general competencies and 25 specific competencies obtained a favorable consensus, with percentage above 75%. Tables 1 and 2 show the Cronbach's alpha coefficient above 0.7 for all the listed competencies.

The results showed consensus in the level of total agreement for 17 of the general competencies and an only competency ('observe dynamic changes in the demographics of the population') has reached consensus with partial level of agreement. The specific competencies have obtained full consensus in the level of total agreement.

Table 1. General competencies

General competencies	Alpha Cronbach's	Frequency (%) Level of agreement				
		5*	4*	3*	2*	1*
Assess the impact of traditional, complementary and technological therapies focused on patient outcomes.	0.7265	17(85)	1(5)	2(10)	-	-
Integrate the multidisciplinary team in the planning and evaluation of health actions to patients at the end of life.	0.7288	20(100)	-	-	-	-
Consolidate patients and their families as the care focus of the multidisciplinary team.	0.7288	20(100)	-	-	-	-
Observe dynamic changes in the demographics of the population.	0.7673	1(5)	15(75)	3(15)	-	1(15)
Refer patients and families to participate in the processes of chronic illness and grieving.	0.7079	17(85)	3(15)	-	-	-
Express effectively with the community and the health team about issues of end of life.	0.7079	17(85)	3(15)	-	-	-
Identify the impending death and employ appropriate care to patients and their families.	0.7221	19(95)	1(5)	-	-	-
Identify the barriers and facilitating actions for patients and caregivers in the effective use of resources at home.	0.7288	20(100)	-	-	-	-
Interpret the own attitudes, feelings, values and expectations about death and cultural and spiritual diversity existing in the beliefs and customs represented in the community.	0.7207	18(90)	2(10)	-	-	-
Operate in the evaluation, management and control of signs and symptoms (dyspnea, fatigue, anorexia, nausea and vomiting, constipation, mental confusion, pain), common at the end of life.	0.7402	18(90)	2(10)	-	-	-
Operate in the organization, analysis and improvement of health care at home.	0.7288	20(100)	-	-	-	-
Employ, through the multidisciplinary team, guidance to families on funeral rituals, social rights and responsibilities with papers and documents on the situation of death.	0.7235	15(75)	5(25)	-	-	-
Guide patients and family members about the disease process of patients at the end of life.	0.7288	20(100)	-	-	-	-
Elaborate the care plan based on the objectives, preferences and choices of patients and their families.	0.7128	17(85)	3(15)	-	-	-
Provide patient care in the afterlife respectfully.	0.7221	19(95)	1(5)	-	-	-
Elaborate the care plan considering the physical, psychological, social and spiritual dimensions, aimed at improving quality of life.	0.7288	20(100)	-	-	-	-
Elaborate the care plan in order to avoid gaps that lead patients to feel abandoned during clinical evolution.	0.7288	20(100)	-	-	-	-
Value the views and wishes of patients and their families during the care at the end of life.	0.7229	16(80)	4(20)	-	-	-

Table 2. Specific competencies

Specific competencies	Alpha Cronbach's	Frequency (%) Level of agreement				
		5*	4*	3*	2*	1*
Integrate the multidisciplinary team in the assessment and management of the complex psychosocial and spiritual needs of patients and their families.	0.7251	18(90)	2(10)	--	--	--
Integrate the multidisciplinary team when giving 'bad news' to family and patients in situations at the end of life.	0.7236	18(90)	2(10)	--	--	--
Integrate the multidisciplinary team in the decision making process with the family, in face of ethical situations involving care and supportive treatment to patients at the end of life.	0.7278	19(95)	1(5)	--	--	--
Employ communication effectively with patients, families and caregivers about issues of the end of life.	0.7162	18(90)	2(10)	--	--	--
Employ an intervention plan in mourning with the multidisciplinary team, for the caregivers and families in patients' after-death.	0.7131	18(90)	2(10)	--	--	--
Employ evaluation data of signs and symptoms presented by patients and families in the management of symptoms, using the integrative and complementary health practices.	0.7137	16(80)	4(20)	--	--	--
Employ the ethical principles of palliative care in decision making on complex issues of the end of life, recognizing the influence of personal values, professional code of ethics and patient preferences.	0.7361	17(85)	3(15)	--	--	--
Provide emotional support to the family, caregivers and health professionals in the mourning situation	0.7221	19(95)	1(5)	--	--	--
Establish emotional support to patients, families, caregivers, community and the health team to deal with the suffering during the care at the end of life.	0.7105	16(80)	4(20)	--	--	--
Establish with patients and caregivers a physical activity plan to encourage mobility at home	0.7272	15(75)	4(20)	--	1(5)	--
Establish and execute a shared plan of home care with caregivers at risk of distress or overload	0.7189	17(85)	3(15)	--	--	--
Establish research projects in palliative care	0.7445	16(80)	3(15)	--	1(5)	--
Carry out the systematization of nursing care to patients at the end of life	0.7272	19(95)	--	1(5)	--	--
Provide comfort care for the death at home as a component of nursing care	0.7251	17(85)	3(15)	--	--	--
Provide education for families and caregivers for the evaluation and treatment of signs and symptoms at home (dyspnea, fatigue, anorexia, nausea and vomiting, constipation, mental confusion, pain), common at the end of life.	0.7206	19(95)	1(5)	--	--	--
Provide education for patients, families and caregivers about safety, prevention of falls, body care, medication use, dressings, care for probes, posture and active-passive exercises.	0.7131	18(90)	2(10)	--	--	--
Define with patients and family members, the goals of palliative care in the short, medium and long term	0.7005	16(80)	4(20)	--	--	--
Provide access to the multidisciplinary team for the family members and caregivers in mourning.	0.7263	18(90)	1(5)	--	1(5)	--
Write the methods of education in palliative care for patients and families	0.7143	17(85)	3(15)v	--	--	--
Write an intervention plan with the staff for family claudication.	0.7159	17(85)	3(15)	--	--	--
Respond as a consultant in the analysis of complex ethical situations involving care and supportive treatment to patients at the end of life.	0.7062	15(75)	5(25)	--	--	--
Respond for the quality of nursing care provided to patients at the end of life.	0.7320	17(85)	3(15)	--	--	--
Follow the legal guidelines on informed consent and advance directives when making decisions in situations at the end of life.	0.7250	19(95)	1(5)	--	--	--
Follow standardized tools to assess signs and symptoms of patients in palliative care.	0.7174	15(75)	5(25)	--	--	--
Add the language of diet, as well as routines and rituals of patients and families to the care plan.	0.7279	17(85)	2(10)	1(5)	--	--

Discussion

The limits of the study results are the number of participants, defined by the Delphi method, restricting the sample to nurses in the Multidisciplinary Teams of Home Care of Distrito Federal.

The results provide subsidies for the institutions when formulating the competencies expected of nursing professionals in home care. They also point out limits of this activity in the interdisciplinary context of home care. Moreover, such results contribute as a starting point for building competencies in palliative care nursing, and reinforce the need for specific training to ensure the proper implementation of palliative care on the national scenario.

In order to perform an activity with competence, professionals builds their own operating scheme by organizing their professional conduct. In this route, rules are followed and serve to say where one should go, indicating that every path is unique due to the possibility of solving a problem competently in various ways.[8]

In solving a problem, individuals implement what they have learned to organize throughout their professional experience, and in the possibility of repeated situations, they should not act the same way, but may respond similarly. Therefore, there is the risk of a single behavioral profile, in which professionals may be restricted to a care position that prevents the singularity, the unexpected, or the surprises contained in the events. Competence is revealed in knowing how to act here and now, beyond the prescribed, when faced with familiar events but of unexpected expression.[8]

In the context of palliative care, home care is essential to ensure continuity of the care process and provide answers to the multiple socio-sanitary needs of patients facing life-threatening diseases, particularly in countries with limited health resources and reduced access to institutional care. The challenge in this treatment modality is to avoid the care fragmentation through organizational and integration practices of health and social services.[10]

In the study, the unanimous consensus in six general competencies (Table 1) shows the concordance among nurses in relation to the palliative approach of interdisciplinary work, focusing on the needs of patients and family, in search of better quality of life. It is worth mentioning the challenge of teamwork, which is sharing a philosophy of common care and goals.[11]

The Cronbach's alpha coefficient measures the magnitude with which items of an instrument are correlated. It revealed that the list of competencies presented reliability in the sample where it was applied. The general and specific competencies about which the studied nurses reached a consensus corroborate the findings in the literature. They reflect the autonomy, dignity, communication and relationship between patients and health care professionals, as well as the multidisciplinary approach, quality of life, position in relation to life and death, loss and grief, and public education as central elements for the assistance in palliative care.[12-14]

The majority of nurses reached consensus in the level of partial agreement regarding the general competency identified as 'observe dynamic changes in the demographics of the population'. This may indicate that information about the approach of territoriality is incipient as knowledge and practice to be shared in the multidisciplinarity. This knowledge contributes to the production of health care, as well as for the formation of networks of care, to the extent that it recognizes and utilizes the social equipment in care flows. The disease that limits life has impact on interpersonal relationships of patients and families, and noticing when and how making referrals to specialized help, favors the access to additional resources in order that patients and family members are able to maintain a good quality of life at the end of life.[4,11,12]

The affirmations found in the competencies were recognized as knowledge and practices of nurses in palliative care. The consensus on specific competencies in the level of total agreement, points to confidence in the palliative potential of nurses because they claim to be able to anticipate and re-

spond to the palliative care needs, understand their own limitations and the need to seek help for complex actions.[4]

The low percentage indicated by nurses in the level of partial agreement and disagreement on some specific competencies (table 2), may indicate the need to acquire more knowledge on palliative care to maintain and develop their own professional competencies. Most nurses claimed to have participated in courses addressing the theme of palliative care, and the literature indicates that all health professionals should increasingly acquire education on the principles and practices of palliative care, going beyond the initial formation and reaching a level of expertise, especially those whose work is focused on providing palliative care.[13]

The originality of this research encourages new studies in this context, expecting that the academic community refutes or expands the reflection of the presented results, contributing to the consolidation of palliative care as a discipline and specialty in nursing.

Conclusion

The favorable consensus obtained in the proposed competencies indicates the recognition of palliative care as a nursing care practice in home care, and provides assertive statements about the competencies of palliative care nurses in home care.

Collaborations

Sousa JM participated in the project design, collection and interpretation of data, article writing and final approval of the version to be published. Alves ED contributed in the project design, relevant critical review of the intellectual content and final approval of the version to be published.

References

1. Mutto EM, Errázquin A, Rabhansl MM, Villar MJ. Nursing education: the experience, attitudes, and impact of caring for dying patients by undergraduate Argentinian nursing students. J Palliat Med. 2010; 13(12):1445-50.
2. Worldwide Palliative Care Alliance. Global atlas of palliative care at the end of life [Internet]. 2014 [cited 2014 Jun 20]. Available from: http://www.who.int/cancer/publications/palliative-care-atlas/en.
3. Porto AR, Thofehrn MB, Amestoy SC, Gonzáles RIC, Oliveira NA. The essence of interdisciplinary practice in palliative care delivery to cancer patients. Invest Educ Enferm. 2012; 30(2):231-9.
4. Slåtten K, Hatlevik O, Fagerström L. Validation of a new instrument for self-assessment of nurses' core competencies in palliative care. Nurs Res Pract. 2014:61549.
5. Kirby E, Broom A, Good P. The role and significance of nurses in managing transitions to palliative care: a qualitative study. BMJ Open. 2014; 4(9):e006026.
6. Powazki R, Walsh D, Cothren B, Rybicki L, Thomas S, Morgan G, et al. The Care of the Actively Dying in an Academic Medical Center: A Survey of Registered Nurses' Professional Capability and Comfort. Am J Hosp Palliat Care. 2013; 31(6):619-627.
7. Le Boterf G. [Évaluer les compétences: quels jugements? quels critères? quelles instances?]. Educ Permanente. 1998; 135:143-5. French.
8. Le Boterf G. [Apprendre à agir et à interagir en professionnel compétent et responsible]. Educ Permanente. 2011; 188(3):97-112. French.
9. Sinha IP, Smyth RL, Williamson PR. Using the Delphi technique to determine which outcomes to measure in clinical trials: recommendations for the future based on a systematic review of existing studies. PLoS Med. 2011; 8 (1):e1000393.
10. Nevado DC, Barbarro AA, Lozano MA. [Continuidad de cuidados, innovación y redefinición de papeles profesionales en la atención a pacientes crónicos y terminales. Informe SESPAS 2012]. Gac Sanit. 2012; 26(Supl):63-8. Spanish.
11. Vissers KC, Brand MW, Jacobs J, Groot M, Veldhoven C, Verhagen C, et al. Palliative medicine update: a multidisciplinary approach. Pain Practice. 2013; 13(7):576-88.
12. Docherty SL, Thaxton C, Allison C, Barfield RC, Tamburro RF. The nursing dimension of providing palliative care to children and adolescents with cancer. Clin Med Insights Pediatr. 2012; 6:75-88.
13. Gamondi G, Larkin P, Payne S. Core competencies in palliative care: an EAPC White Paper on palliative care education - part 1. Eur J Palliat Care. 2013; 20(2):86-91.
14. Gamondi G, Larkin P, Payne S. Core competencies in palliative care: an EAPC White Paper on palliative care education - part 2. Eur J Palliat Care. 2013; 20(3):140-5.