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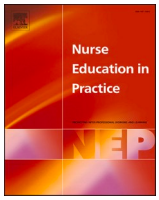

The relationship competencies guiding tool: A development, content validation and implementation study☆

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ABSTRACT

Aim: The aims of this paper are (1) to present the results of the development, content validation and implementation study of the *Relationship Competencies Guiding Tool*; (2) to provide examples of how each item in the tool is reflected in clinical narratives written by nurses and justify the corresponding scores after the evaluation; (3) to present how the language and content of the narratives are interpreted with the tool and to describe an exemplar; and (4) to present barriers to and facilitators of the application of the tool.

Background: From a person-centered care approach, the fostering of authentic relationships with patients is key to achieving therapeutic benefits. Therefore, it is essential to help nurses establish meaningful relationships with patients and help them acquire these abilities. Clinical narratives can be used as a way to promote reflective practice and professional competency development among nurses. A tool to evaluate the knowledge, skills, attitudes and values necessary for developing authentic encounters with patients through clinical narratives was developed, validated and implemented.

Design: An instrument-development study comprised of three steps: (1) conceptualization; (2) item generation and content validity; and (3) implementation of the tool and linguistic evaluation.

Methods: This study was conducted in three major steps. Step one entailed conceptualization. Step two included the generation of items and content validation. In step three, the tool was used to independently evaluate 25 narratives. One of these narratives was also linguistically analysed to provide a comprehensive view of the interpretative strategies deployed by evaluators.

Results: The *Relationship Competencies Guiding Tool* was developed, validated and implemented. It could help nurses work on nursing relationship-based professional competencies, guided the evaluators in the process of assigning scores to the corresponding items and helped the researchers identify certain barriers and facilitators before and during the narrative evaluation process.

Conclusions: The tool has been shown to be clear, relevant and conceptually and linguistically suitable for evaluating clinical narratives. The *Relationship Competencies Guiding Tool* could be applied to interpret how nurses reflect professional competencies in a clinical narrative as a preliminary step in the construction of a measurement tool.

Tweetable abstract: From a person-centered relationship-based care approach, clinical narratives can be used to promote professional competencies between nurses. The *Relationship Competencies Guiding Tool* may help evaluate the knowledge, skills, attitudes and values necessary for developing authentic encounters with persons/families, as reflected by nurses' clinical narratives.

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1. Introduction

Person-centered care is a framework that centers the patient in the provision of care (McCance et al., 2011) and considers the fostering of authentic relationships as key for achieving therapeutic benefits (McCormack et al., 2011; McCance et al., 2011). The relationship between the nurse and the person being cared for has become so important in recent decades that it has emerged as the central focus of the nursing discipline, becoming the essence of nursing practice (McCormack et al., 2021).

Because establishing interpersonal relationships between nurses and persons/families provides the basis for improved care and health-related results (Errasti-Ibarrondo et al., 2015), it is essential to help nurses establish such relationships with patients (Choperena et al., 2020). The *Nursing Professional Practice Model* of the Clinica Universidad de Navarra (NPPM-CUN) (Rumeu-Casares et al., 2017) highlights the competencies of *respect*, *knowing the person* and *intentional presence* as three essential elements of the nurse-person/family interpersonal relationship that help nurses provide personal and authentic care (Choperena et al., 2020; Errasti-Ibarrondo et al., 2015; Olano-Lizarraga et al., 2020; Rumeu-Casares et al., 2017). Putting these competencies into practice may help both the patient and the nurse better understand the health experience and determine what is significant and relevant to them.

Given the importance of developing interpersonal competency, scholars have suggested that nurses may need assistance in the form of educational interventions to improve in this area (Asselin and Fain, 2016; Choperena et al., 2020; Fitzpatrick, 2021). Some studies have proposed clinical narratives as a way of learning and developing professional interpersonal skills (Asselin and Fain, 2016; Asselin, 2011; Choperena et al., 2020, 2019; Kristoffersen, 2021; Levett-Jones, 2007). However, nursing interventions based on the use of clinical narratives to promote professional competency development are limited (Asselin and Fain, 2016; Bolg et al., 2020; Kim et al., 2017). Furthermore, a preliminary review of the literature did not find any satisfactory tool for exploring nurses' relationship competency development through written texts.

2. Background

The *Nursing Professional Practice Model* (NPPM-CUN) has identified that *respect*, *knowing the person* and *intentional presence* are fundamental values that define the nurse-person/family relationship. In this interaction, a two-way communication is established based on the values, beliefs and expectations of both parties (Rumeu-Casares et al., 2017). *Respect* is defined as nurses' manifestation of their genuine interest in the other person and the need to avoid violation of their privacy and intimacy to create a safe space where the patient's personal life remains preserved (Pérez, 2012). The concept includes advocating for the patient, promoting decision making and helping the patient find meaning in his/her health process (Choperena et al., 2020). *Knowing the person* implies knowing patients as unique human beings who are living through certain experiences related to their health condition and orienting themselves as professionals to incorporate their personal values and goals into care delivery (Choperena et al., 2020; Osacar, 2018; Somerville, 2009). *Intentional presence* is defined as the interpersonal process characterized by the transcendent unity between two people who sustain their bond in a relationship that is satisfactory for both and where the nurse intentionally builds a dynamic relationship with the patient according to his/her uniqueness (Monge, 2017; Choperena et al., 2020).

Due to all the above aspects, the essence of nursing practice lies in the relationship that the nurse establishes with the person/family and how this relationship expresses the values about the nature of both. This practice requires specific knowledge development and encourages nurses to assume the professional responsibilities that lie at the core of their discipline (Rumeu-Casares et al., 2017).

Professional competency development is the basis for acting effectively in practice. Although competency development has traditionally been an essential element in the delivery of nursing care, there is still confusion in the reference literature about its definition and how it should be evaluated and implemented (Prendi et al., 2022). Concerning clinical narratives, a preliminary review of the literature revealed that there is no extant tool for interpreting how nurses reflect professional competencies through written texts. Although two instruments to evaluate narratives have been developed, one focuses on assessing reflection (Asselin and Fain, 2016) and the instrument developed by Kim et al. (2017) predicts attitudinal and behavioral changes through a cultural approach. Therefore, from a relationship-based care approach, it was deemed necessary to develop a tool that could accurately help identify interpersonal competency development for nurses using clinical narratives.

3. Methods

3.1. Aims

The first objective of this paper is to present the results of the development, content validation and implementation of the *Relationship Competencies Guiding Tool* (RCGT). The second objective is to provide examples of how each of the items of the tool is reflected in clinical narratives and justify the corresponding scores after the evaluation. The third objective is to present how the language and content of the narratives are interpreted with this tool and to describe an exemplar. Finally, the fourth objective is to present barriers to and facilitators of the application of the tool.

3.2. Methodology

An instrument-development study comprised of three steps was conducted. Step one entailed conceptualization. Step two included the generation of items and content validation. In step three, the tool was used independently by two researchers to evaluate 25 narratives to identify the competencies required to establish an authentic nurse-person/family relationship and to detect barriers to and facilitators of its application. One of the narratives was also linguistically analysed to provide a comprehensive view of the interpretative strategies deployed by both evaluators, which comprised the identification of explicit and implicit content in the text.

3.2.1. Step one: conceptualization

The initial step when developing a new scale is to build an operational definition of the concept to be measured (Polit and Yang, 2016). For this study, the conceptual framework of the guide was based on the *Nursing Professional Practice Model* of the Clinica Universidad de Navarra (NPPM-CUN), developed by experts (Rumeu-Casares et al., 2017; Saracíbar-Rázquin, 2009; Olano-Lizarraga et al., 2020) and the concept of competency. According to Hand (2006), professional competencies can be understood as the knowledge, skills, attitudes and values that someone is performing. Thus, *respect*, *intentional presence* and *knowing the person* (the core elements of the NPPM-CUN) were defined in terms of competency. For *respect*, knowledge is described as the recognition of the individual uniqueness of the patient, such as sex, culture, spirituality and how these attributes influence her/his experience; skills lie in demonstrating behavior that reflects attentive and warm care through a caring presence, touch and intention; attitudes are reflected when the nurse creates a safe space for patient intimacy, respects the patient's image with other people (medical team, family, etc.), advocates for the patient and promotes patient decision making related to care; and values are described as helping the patient find meaning in the process that he/she is undergoing (Choperena et al., 2020; Pérez, 2012). For *knowing the person*, competencies are described in the form of the acquisition of personal knowledge of the patient, the incorporation of the patient's

meaning and goals into care provision, the capacity to handle novel encounters with the patient and the awareness of the uniqueness of each patient's experience (Choperena et al., 2020; Osacar, 2018; Somerville, 2009). Finally, for *intentional presence*, knowledge, skills, attitudes and values are developed when the nurse shows authentic commitment to the patient, communicates to the patient according to his/her uniqueness and establishes an open, dynamic relationship with the patient (Monge, 2017; Choperena et al., 2020).

3.2.2. Step two: item generation and content validation

This phase consisted of constructing an item bank that was built on the operational definition (Pueyo-Garrigues et al., 2021). In addition, the RCGT structure was based on the Massachusetts General Hospital Instrument (http://www.mghpcs.org/ipc/programs/recognition/Describing.asp). Thus, the first version of the RCGT consisted of a 9-item questionnaire. This version was created by a research team composed of eight international experts from the University of Navarra and Boston College (Grant and Davis, 1997). All members of the team had academic or professional expertize in the use of clinical narratives; four of them worked in the academic field and four worked in different clinical practice settings (intensive care unit and outpatient services). The age range of team members was 40–60 years. The tool was translated into English by the same experts who developed it.

Once the tool had been developed, its relevance, pertinence and the clarity of the dimensions and subdimensions were assessed by a panel of six experts (five nurses and one expert in psychology). For the analysis of relevance and clarity, a 4-point evaluation rubric was used (Polit et al., 2007) and a dichotomous scale (Yes/No) and free space for written suggestions for additional modifications were employed for consistency. The relevance and clarity criteria were estimated through a content validity index (CVI) at the scale level (S-CVI/Ave - content validity index, mean calculation method; acceptable limit > 0.90) and for each item (I-CVI; acceptable cut-off > 0.78) (Polit and Beck, 2017) with the modified kappa concordance index (k * ; acceptable cut-off > 0.60; Polit et al., 2007). Items that did not meet the minimum standards and did not reach a percentage of total agreement with respect to concordance were modified.

3.2.3. Step three: implementation of the tool and linguistic evaluation

The implementation study was conducted with a convenience sample of 25 nurses. To ensure that the sample was as representative as possible, nurses from a wide range of clinical departments/services participated in the study, such as general hospital wards, intensive care units, outpatient services and other departments (perioperative, elder care, haemodialysis and emergency). The nurses who agreed to participate received specific training on clinical narratives in a three-hour theoretical master class by two experts. The nurses were trained in the theoretical understanding of the nurse-person/family relationship from an NPPM-CUN approach and how to write clinical narratives. After this, all the nurses were asked to write a narrative about their clinical practice. The researchers were responsible for giving instructions, answering queries, ensuring privacy and no coercion and collecting the narratives. Finally, two other researchers of the team (evaluators) independently evaluated the narratives with the RCGT. The scores assigned to each item were supported by the evaluators with textual evidence (quotations from the narratives). One of the evaluators, who worked in an academic field, was unfamiliar with the tool and the other, who worked in a clinical field, had experience in the use of the tool. Both were familiar with the NPPM-CUN Model. Another researcher on the team with a background in linguistics and discourse analysis conducted an in-depth

Table 1
Examples of linguistic evidence used to support individual scores.

Narrative number 63				
Item	Score evaluator 1	Evidence in the narrative	Score evaluator 2	Evidence in the narrative
Item 2 – The nurse seeks ways to communicate according to the patient's individual uniqueness.	4 – The nurse actively seeks to establish personalized and comprehensive communication with the patient.	During admission, we had many conversations, but I would like to comment on one that marked me the most. First, I went upstairs to see you; you asked your mother to leave the room. "I am really scared" you told me, "I'm dying, right?". I got a lump in my throat. We stared at each other, our eyes filled with tears, and we could only hug each other. (.) "Are you afraid of death?" you asked me. I had been talking about it for a long time. I said that "death is something I respect, fear? No, because I know what comes next, perhaps selfishness for not wanting to leave what I have here, but fear as such, no." We continued talking (…).	4 – The nurse actively seeks to establish personalized and comprehensive communication with the patient.	During admission, we had many conversations. First I went up to see you. I (we were) talking a lot about the subject. we kept talking; I was very afraid.
Item 5 – The nurse respects the aspects of patient confidentiality in any circumstance.	1 – Nothing	In the narrative, the nurse reveals personal information of the patient and her family, but she does not mention that she shares them with someone not related with the patient's care. This is implied in what I point out.	1 – Nothing	My score is 1. However, I have doubts, as at no place does the nurse tell that this conversation is transmitted to the patient's mother afterwards. It could be even assumed that the conversation was treated with the highest confidentiality.
Item 8 – The nurse successfully cares for the patient.	4 – The nurse completely integrates what's best for the patient, beyond the protocols.	I tried to reassure her. I told her that we would always and at all times be aware of her and that we would not let her suffer. Now, I am concerned about his inner suffering. I called Dr. González and told him how our patient was doing. We both went upstairs; I sat on the floor, next to his chair again, Dr. González in his chair, now Carlos, her husband, was also in the room. We explained in a lot of detail how everything was going to happen.	4 – The nurse completely integrates what's best for the patient, beyond the protocols.	We were writing a letter to her son. I promised him that I would write him one for when he is older, telling him what his mother was like, how she fought until the end and how she would be watching over him from heaven.

qualitative analysis of one of the narratives (number 63) concerning the linguistic and textual evidence provided by both evaluators to support their ratings (see Table 1).

3.3. Ethical considerations

This research was approved by the Research Ethics Committee of University of Navarra (2020.002). All participants were asked to complete the instrument after obtaining written informed consent. They were fully informed of the study purpose, their right to withdraw from the study at any time and the codification process for the study.

4. Results

4.1. Development

The *Relationship Competencies Guiding Tool* was developed by the research team. The tool is based on a conceptual framework developed by experts and the concept of competency defined by Hand (2006). The first version of the tool emerged from consensus among and acceptance by all the experts.

4.2. Content validation

The I-CVIs of all items in the RCGT ranged from 0.57 to 1.00, with only one item (item 5 'The nurse respects the *aspects of patient confidentiality* in any circumstance') having an I-CVI less than 0.78. Therefore, I-CVI scores were above the minimum acceptable standard (0.78) (Polit et al., 2007). The S-CVI/Ave indices for relevance and clarity were above the minimum acceptable standard of 0.90. A kappa statistic was also calculated (Wynd et al., 2003). The k * statistic calculation confirmed that the degree of agreement between experts regarding relevance and clarity was good (>0.74) for most items. Item 5 had a k * value for clarity that was considered only fair (between 0.40 and 0.59) (Polit et al., 2007), but the experts gave it the highest score for relevance. Therefore, following suggestions from the experts, the research team decided to modify the wording from 'The nurse is concerned about treating the patient's image with respect in front of third parties (medical team, family, etc.)' to 'The nurse respects *aspects of patient confidentiality* in any circumstance'.

4.3. Implementation study

4.3.1. Sociodemographic characteristics

Table 2 provides the demographic and work-related characteristics of the sample. All of the participants were female. The mean age was 39.26 years (SD 10.03) and the participants had worked in nursing for a mean of 16.13 years (SD 9.94). Most of them were nurse assistants (87 %) with no previous training in narratives (93 %).

Table 2
Participants` demographic characteristics (N = 23).

Variable	Mean (SD)
Age	39.26 (10.03)
Years of professional experience	16.13 (9.94)
Variable	***n* (%)**
Gender	
Female	23 (100)
Spanish mother language	23 (100)
Yes	
Highest level of education in nursing	
Graduate	16 (69.6)
Master degree	7 (30.4)
Previous experience	23 (100)
Yes	
Professional role	
Nurse assistant	20 (87.0)
Nurse manager	2 (8.7)
Clinical nurse specialist	1 (4.4)
Workplace	11 (47.8)
Medical inpatient service	
Medical-surgical inpatient service	1 (4.4)
Emergency and Critical care unit	8 (34.8)
Outpatient service	3 (13.0)
Training in narratives	
No	21 (91.3)

4.3.2. Scores

In Table 3 we provide selected quotes from the 25 clinical narratives to show how each item of the tool was recognized in the texts. The use of the RCGT helped evaluators identify the competencies of *respect*, *knowing the person* and *intentional presence* in the nurses' clinical narratives and guided in the process of assigning scores to the corresponding items.

4.3.3. Barriers and facilitators before and during the evaluation

The use of the tool helped evaluators identify some barriers and facilitators before and during the narrative evaluation process. The main barriers were related to the writing of narratives and evaluator training. The principal facilitators were related to the evaluator's own experience, the handling of the tool and/or the experience of notetaking during the evaluation (Fig. 1).

The analysis conducted by the researcher expert in linguistics and discourse analysis showed that a full spectrum of heuristic dimensions, ranging from explicit to implicit evidence and from concrete textual hints to overall interpretations, should be considered when working with clinical narratives. The examples described also suggest that although the use of the RCGT was always supported by textual evidence, the final assignment of scores allowed for a certain degree of flexibility among evaluators. This analysis also allowed the identification of three common interpretative strategies deployed by the evaluators:

(1) Some of the items and their ratings were easily supported with linguistic evidence. For example, both evaluators used the same passages of the narrative to support the highest score given to item 2, which evaluates how the nurse communicates with the patient (see Table 1). The selected passages explicitly report several conversations that were crucial in the nurse-person/family relationship. They narrate how the nurse actively sought to open new spaces to interact with the patient (e.g., the doctor—nurse-person/family conversation promoted by the nurse) and "keep permanent attention" on him/her.
(2) An overall assessment of the entire narrative and its explicit and implicit content was the basis for certain scores. This was the case for item 8, for which the evaluators used different quotations to support the same high score (4–The nurse completely integrates what has been identified as *best* for the patient, *beyond the protocols*). Indeed, although the nurse did not explicitly reflect his/her own choices, the passage described a series of decisions and actions (facilitating a crucial doctor—patient conversation or helping the patient cope with his/her fears and emotions) that were decisive for the patient's wellbeing and went beyond mere practical protocols.
(3) Both evaluators reported difficulties in assigning scores to item 5 (how the nurse managed confidentiality). The topic was not mentioned or addressed directly in the narrative; therefore, they assigned the lowest score (1–Does not show anything) to this item. This score did not necessarily indicate that the nurse did not respect confidentiality in his/her practice but rather that the text itself did not offer information on this topic.

5. Discussion

In this study, we present the development, content validation and

Table 3
Items, quotes and their corresponding scores.

Items	Nothing (1)	Something (2)	Sufficiently (3)	Completely (4)
1. The nurse recognizes the *individual uniqueness* of the patient (sex, culture, spirituality.) and how these influence the patient's experience.	—	A patient who had attempted suicide by shooting himself directly in the abdomen with his hunting gun. Difficult to treat patient: "his fame preceded him."	Her admission to the floor was not due to a serious situation nor was such a significant deterioration expected by any of the professionals who attended her. I spent a lot of time with her in the first days of admission: an endearing "grandmother", one of those who touch your heart.	This family, who I really care about, consists of 6 people, 4 adopted children each from a different country and the parents (…). The member of the family that I have looked after and followed the most has been Jon, the youngest of all, who is already 18 years old. Talking with Jon is talking about the ongoing struggle he has along with his parents to integrate, to be accepted, to continue schooling, to have friends, to learn basic social norms…
2. The nurse seeks ways to *communicate* according to the patient's individual uniqueness.	—	I spent a lot of time with her, in the first few days. an endearing grandmother, one of those who touch your heart. Sometimes, when the shifts allowed me, I would visit her again.	After making him comfortable so he could stay 4 h in the same position, he said "Thank you very much, you are like my mother." Covering him and making him comfortable was something I did without thinking.	The impossibility of communicating verbally (…) forced me to develop other nonverbal skills for expressing my support, my dedication and my affection and respect. My attitude at that time was to use nonverbal language, that is, the look, a hug, "accompanying" so that the family would feel my intentional presence.
3. The nurse demonstrates *care* in dealing with the patient.	—	She tried to comfort her daughters. trying to give support and help, she can only cry.	That day, because of a question of yours, I saw that he had time, and I invited him to come in for a visit.	I entered the room determined to provide the best care regardless of the response. I greeted the patient trying to maintain a cordial but professional tone. I concentrated on the task, explaining to José what I was going to do.
4. The nurse preserves the patient's *privacy*.	—	(.) that every day as I passed her, I could look into her eyes and whisper "how are you?"	I extended my hand and told her that if she was nervous, she could say "yes" to me and that if she was feeling bad she could squeeze my hand. (…) With a little patience and time, I was able to get it [to communicate with her] (…) by looking at the expression on her face; I could tell that I had helped her.	I left the whole family alone so that they could express their feelings and fears and resolve pending issues.
5. The nurse respects the *aspects of patient confidentiality* in any circumstance.	—	In the story of the narrative, reveals the name of the patient, diagnosis and situation that could help identify them. .	The patient is the mother of a former colleague of the unit (nurse) who is currently working in another unit of our institution. Also, her daughter is a friend of the supervisor of this unit. [The cardio resident] is a bit reluctant to the favor I've asked, justified by saying she's the grandmother of a friend of his (…).	There are also countless emails that both his mother and he have written to me and that I have answered, always sharing the information with the rest of the team [psychiatrists, assistants, social worker, etc.].
6. The nurse encourages the patient be involved in making *decisions* about his or her care.	—	I got to know their food preferences, their beliefs in how the disease should be managed and how they were living their moment. We are like "their defenders"; we watch over their care, and I believe that this allows us to know them very well.	In the operating room, especially when the patient is awake during the procedure, we like to play the music that they like; it relaxes them or distracts them during those endless minutes that it can take. Therefore, I asked what music she liked, and when he told me, the first thing I put on was the happy birthday song.	Midmorning is approaching; the patient is better, so we offer wash to them. Once that sensitive information was conveyed, we entered the room so that I, the morning nurse, would introduce the afternoon nurse (in this unit they have a divider inside the patient's room, so that the patient can be involved and be aware of his or her situation).
7. The nurse shows a *genuine commitment* to patient care.	—	(.) I could only explain where to go and informed him that I would call him in a few days to take note of what happened (.).	The nurse *is ahead* in meeting some of the patient's needs but is not fully available.	One of the days that I went in and the patient was calm, I offered his wife to go down to have something to drink in the cafeteria or go for a walk. I promised her that I would stay in her place while she was gone. I insisted as much as I could without trying to force her but didn't succeed. She thanked me, but that was all; she continued by her husband's side. Fifteen minutes later, she rang the bell (.) without changing her sweet expression, she told me that her husband had died. (.) She told me "I have taken care of him and you have taken care of us both. Thank you." Sometimes caring can be just to be, to be silent, to accompany and to respect the times and the silence.
8. The nurse *successfully cares for* the patient.	—	Knowing that I was relieving him. he was a very grateful person.	. concern and fear that she was feeling. I could only explain to her where to go and… I would call her in a few days. (I could have done something more.).	I ask her what she would like, she answered "something fresh", (.) I sit by her side of the bed and hold her hand; I say "You feel a bit better, right? Would

(*continued on next page*)

Table 3 (*continued*)

Items	Nothing (1)	Something (2)	Sufficiently (3)	Completely (4)
				you like a frozen yogurt?", to which the patient responds, "How good you are. Yes, I will try that shake". Midmorning is approaching, the patient is better so we offer to clean her (…). We take the opportunity to tell the daughter to go to breakfast, enjoy a quiet cup of coffee, and that we'll take care of her in the meantime. When she got back, the patient tells her daughter that "they have left me like a queen".
9. The nurse encourages the patient to find *meaning* in their health process.	—	Then, she said "thank you and sorry", to which I could not answer, and then she said, "I have a 4-year-old boy". At that moment, I understood that her problem was not the pain, nor her terminal situation, but that she only cared about her son. I stayed with her holding her hand tight and told her that she was very brave and that everything would be fine.	That phone conversation that I caught in a hallway stuck in my soul too, that damn needle, since the tears that fell and that I only heard told me the concern and fears that she was feeling. (.). She told me in detail about her experience in the mutual aid hospital where she got the needle (.) her fear and discomfort because physically the treatment was causing her to vomit and be nauseous (…).	During admission, we had many conversations, but I would like to comment on one that marked me the most. First, I went upstairs to see you, you asked your mother to leave the room, "I am really scared" you told me "I'm dying, right?". I got a lump in my throat. We stared at each other, our eyes filled with tears, and we could only hug each other. (.) "Are you afraid of death?" you asked me. I had been talking about it for a long time. I said that "death is something I respect, fear? No, because I know what comes next, perhaps selfishness for not wanting to leave what I have here, but fear as such, no." We continued talking.

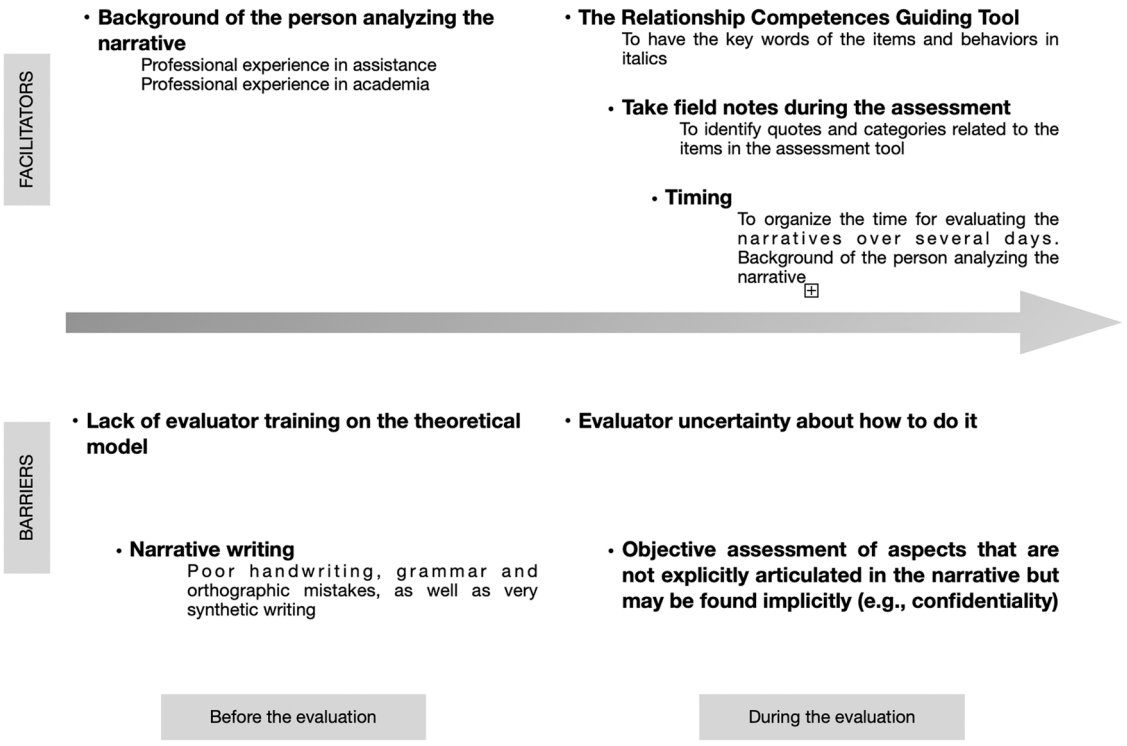

Fig. 1. Barriers and facilitators before and during the evaluation.

implementation study of the *RCGT*. This tool may help evaluate the knowledge, skills, attitudes and values necessary for developing authentic interpersonal encounters reflected by nurses through clinical narratives from an NPPM approach. Addressing clinical narratives through specific content instruments that preserve a consistent, cohesive, organized, sufficient structure and appropriate language is essential (Oliveira et al., 2018).

Previous studies have described the development of other validated instruments that partially interpret narratives: one assesses reflection (Asselin and Fain, 2016) and the other measures elements of storytelling that are predicted to affect attitudinal and behavioral changes through a cultural approach (Kim et al., 2017). Compared with these preceding studies, this tool has helped identify how nurses reflect interpersonal knowledge, skills, attitudes and values in clinical narratives. Furthermore, the results of this work have broadened the elements that comprise the narrative evaluation process. Consequently, this study has

focused on the holistic development of nursing professional competencies.

The good content validity of the RCGT has been confirmed for two characteristics: relevance and clarity. The most common method for measuring content validity is calculating the item-level CVI (I-CVI). However, an alternative way to measure content validity is the scale-level CVI (S-CVI), which can be calculated with the S-CVI/UA or S-CVI/Ave (Rodrigues et al., 2017; Pueyo-Garrigues et al., 2021). The two approaches can lead to different values, making it difficult to draw proper conclusions about content validity (Polit and Beck, 2006) because the I-CVI measures the content validity of individual items and the S-CVI reflects the content validity of the overall scale. Most papers report the I-CVI or the S-CVI, but not both. This paper considered both because the S-CVI is an average score that can be skewed by outliers (Rodrigues et al., 2017). More specifically, in this study, the I-CVIs of all items in the RCGT ranged from 0.57 to 1.00, with only one item (item 5) having an I-CVI less than 0.78. Therefore, I-CVI scores were above the minimum acceptable standard (0.78); an I-CVI of 0.78 or higher is considered excellent (Polit et al., 2007). This result supports the conclusion that individual items in the RCGT were important and relevant in measuring the nurse-person/family relationship in the narrative. The minimum acceptable S-CVI is considered to be any value between 0.80 and 0.90 (Polit et al., 2007; Yamada et al., 2010). In this study, the S-CVI/Ave indices for relevance and clarity were above the minimum acceptable standard of 0.90. However, because this index does not consider the possibility of inflated values, a kappa statistic was also calculated (Wynd et al., 2003). The k * statistic calculation confirmed that the degree of agreement between experts regarding relevance and clarity was good (>0.74) for most items. This result confirmed that the RCGT reflects the conceptual domain of interest that it is intended to measure.

Item 5 had a k * value for clarity that was considered only fair (Polit et al., 2007), but the experts gave it the highest score for relevance. Therefore, the wording from 'The nurse is concerned about treating the patient's image with respect in front of third parties (medical team, family, etc.)' to 'The nurse respects *aspects of patient confidentiality* in any circumstance' was modified to improve the clarity of the item and retain it in the tool. Overall, lack of clarity, misinterpretation and ambiguity were the primary reasons for this modification (Rodrigues et al., 2017).

This study has shed light on various elements that conform to the narrative evaluation process to facilitate the development of strategies to overcome barriers and enhance facilitators. Before implementing the tool, it was considered essential to train both the nurses and the evaluators so that they could make the best use of the guide (Choperena et al., 2020). Integrating the writing of clinical narratives into educational training programs that contain reflective activities promotes nursing professionals' contemplation of their nursing practices and cultivates growth (Choperena et al., 2020; Yang et al., 2018). In this vein, reading personal narratives helped evaluators remember similar experiences, which is why this study has highlighted the possible influence of the evaluator's background when evaluating narratives (Gerrig, 2018). The examples of how each of the items of the tool was identified in the clinical narratives, together with their corresponding scores, may also help in this regard.

Considering these elements and some previously mentioned issues, such as the intuitive nature of some components of the evaluation process, this study has proposed how to approach the analysis of clinical narratives using the RCGT. Narratives should be evaluated by evaluator pairs, preferably with different backgrounds to bring richness and rigor to the evaluation process and evaluation should integrate the full spectrum of heuristic dimensions, from explicit to implicit evidence and from specific textual clues to global interpretations of narrative material (Chase, 2005). Although implicit competencies are not named explicitly in the text, the evaluation process may also guide in their identification, as exemplified by the linguistic analysis of narrative 63 (item 5). Indeed, when reflecting on their overall performance, evaluators reported that in some instances, item evaluation was conducted based on implicit—not explicit—information in the narrative; other times, it was difficult for them to find a single or concrete passage representing one item, so general ideas of the entire narrative were used to assign scores. As the literature has suggested, although evaluators generally limit themselves to the story and the perspective of the narrator, they may also move beyond the narrative frame and address evaluations towards the person writing the narrative in an evolving communicative context (Hollis, 2021; Özyürek and Trabasso, 1997).

Finally, this study has reinforced the incipient trend towards the use of clinical narratives as a way to promote nurses' professional development (Choperena et al., 2020, 2019; Asselin, 2011; Levett-Jones, 2007). This study not only has provided a guide for interpreting how nurses reflect professional competencies in written texts but also has explained how to use this tool in practice. In this work, clinical narratives promoted reflection on action in the context of the relationship established with persons/families (Byermoen, 2021; Schön, 2011). This type of reflection enables professional competency evaluation through the analysis of the knowledge, skills, attitudes and values that drive clinical encounters with patients, ultimately promoting nurses' continuing professional nursing development (Vázquez-Calatayud et al., 2021).

5.1. Limitations and strengths

A few potential limitations need to be acknowledged. First, the content validation indices were not re-evaluated in a second round of expert consultation due to the limited time frame (Pueyo-Garrigues et al., 2021). However, in the first round, experts were asked to provide suggestions regarding the items and those that were unclear were changed based on these suggestions. Moreover, after the changes, the experts were able to revisit the items. Second, the generalizability of the data may be limited by the use of convenience sampling and the small sample size (Polit and Beck, 2017). However, the purpose of this study is not to generalize but to deepen the understanding of the most important aspects of the implementation of this tool (Powell et al., 2015). To accomplish this goal, a representative sample of nurses working in a variety of care units demanding high-quality nursing care was selected. Finally, the fact that the sample was entirely female, as there were no men working in these services, may have influenced the results. It is recommended that further studies explore the usefulness of the tool in narratives written by men.

This study also has several strengths. First, we enrolled one expert from a discipline other than nursing to ascertain the content validity of the scale (expert in psychology); involving other professionals (e.g., an expert in linguistics) in the study enriched the potential for valuable insights when defining the conceptualization process by encompassing the views of professional experts in the interpretation of texts and the power of language. Second, the tool is based on a solid nursing model of the nurse-person/family relationship that has emerged from research (Rumeu-Casares et al., 2017; Saracíbar, 2009). Finally, the brevity of this guide (9 items) makes its application in clinical practice feasible.

5.2. Implications for research, clinical practice and education

This tool has potential implications for research, clinical practice and education. Researchers can use this tool to obtain important insights into their nursing population of interest. The information that this tool may provide would increase understanding of the current situation of nurses' learning needs and guide further implementation of training programs to promote relationship-based care from a person-centered care approach. The standardized implementation of this tool in clinical settings may be considered an appropriate way to promote a culture of relationship-based care. This tool may also be useful for nursing managers who support continuing education programs in clinical and higher education settings.

6. Conclusions

The tool has been shown to be clear, relevant and conceptually and linguistically suitable for evaluating clinical narratives. The *Relationship Competencies Guiding Tool* could be applied to interpret how nurses reflect professional competencies in a clinical narrative as a preliminary step in the construction of a measurement tool. Larger studies that test this tool in diverse populations and contexts are needed. Ultimately, professional development interventions based on the use of clinical narratives could be expanded.

CRediT authorship contribution statement

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.nepr.2023.103562.

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