


# Nurses' required end-of-life care competence in health centres inpatient ward – a qualitative descriptive study

Elina Haavisto RN, PhD (Professor)<sup>1</sup>, Anu Soikkeli-Jalonen RN, MA, MHSc (Research Assistant)<sup>2</sup> ,  
Mia Tonteri RN, MHSc<sup>2</sup> and Maija Hupli RN, PhD (University Lecturer)<sup>2</sup>

<sup>1</sup>Department of Nursing Science, Satakunta Central Hospital, University of Turku, Pori, Finland and <sup>2</sup>Department of Nursing Science, University of Turku, Pori, Finland

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## Nurses' required end-of-life care competence in health centres inpatient ward – a qualitative descriptive study

**Background:** Studies of nurses' required competence in EOL care in health centres are rare. It is important to produce information about experienced nurses' perceptions of the competence they consider important in their practical work.

**Aim:** The aim of this study was to describe nurses' required competence in EOL care in health centre inpatient wards as experienced by nurses.

**Method:** A descriptive qualitative study using four semi-structured group interviews (20 nurses) and inductive descriptive content analysis.

**Results:** Five categories describing nurses' required competence in EOL care in a health centre inpatient ward

were identified: (1) ethics and courage in action, (2) support for the patient, (3) support for the family, (4) care planning and (5) physical care. Factors promoting nurses' competence in EOL care comprised two categories: (1) professional development in EOL care and (2) an organisation that supports EOL care.

**Conclusions:** End-of-life care in health centre inpatient wards requires wide and complex competence from nurses. Nurses' experiences of required competence are associated with holistic care of the patient, encountering the family and multiprofessional cooperation. Nurses' competence in EOL care could be enhanced with post-graduate education, and educational planning should be given more attention in the future.

**Keywords:** end-of-life care, nurse, competence, inpatient, health centre, qualitative study.

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## Introduction

End-of-life (EOL) care is symptomatic treatment in a situation where there is no longer any possibility for curative treatment. EOL care is sometimes used as a synonym for palliative and hospice care (1). In this study, EOL care refers to the last period of palliative care provided in the dying phase, that is, the final weeks or days of a patient's life.

The WHO has estimated that every year, over 20 million people need palliative care (2), and the number will grow in the future as populations age, especially in developed countries (1,2).

The expenses for care at the end-of-life phase are remarkable (3), but utilising palliative care services is perceived to be cost-effective, reducing the overall costs

of care (2). Several studies have highlighted the quality of EOL care, emphasising patient-centred and holistic care (4,5). In the developed world, most patients die in hospitals (6), but not all dying patients receive evidence-based care (7). The competence of healthcare professionals has a significant impact on the provided EOL care (8), and the competence of nurses is especially necessary for proper and quality care (9-11). In every healthcare unit, the ability to deliver EOL care is expected to be part of nurses' competence (12).

Overall, health centres do not have validated instruments to assess palliative care competence, and there is little research on the competence needed at health centres. EOL competence areas are mostly defined for specialist palliative care, and studies about nurses' EOL competences in primary care settings are rare (9,13). Therefore, it is relevant to study the required competence by using a qualitative approach. EOL care competence research is important not only for healthcare professionals (14) but also for education and government policy. It is important to produce information about the

### Correspondence to:

Anu Soikkeli-Jalonen, RN, MA, MHSc, Department of Nursing Science, FI-20014, University of Turku, Pori, Finland.  
E-mail: apoik@utu.fi

competence perceived as important in the practical work by nurses and also to find out whether there are some aspects of competence that nurses feel they lack. The results can be utilised to develop and improve the quality of EOL care and provide an opportunity to make recommendations for nursing education on basic and specialised levels.

## Background

Nurse competence is a combination of knowledge, skills, attitudes and values (15,16). In order to promote the development of EOL care competence, the framework of core competence areas in EOL care has been defined to include understanding the structure and process of care and ethical and legal aspects, as well as meeting and responding to patients' and family members' needs in physical, psychological, social, spiritual, and cultural care and decision-making (17). In addition, competence requires skills relating to cooperation and multiprofessionalism, in addition to continuous professional development. Some competence areas have been recognised to be essential when assessing nurses' knowledge, skills and educational needs (18,19).

It has been recognised that some healthcare professionals experience uncertainty in their ability to deliver EOL care, and the need for further training has been identified (20,21). To deliver high-quality care, healthcare professionals must understand the principles of EOL care and be able to put them into practice. Competence in symptomatic treatment, such as fundamental care and pain management, is considered to be an essential part of EOL care (22,23). It has been observed that physical needs of the patients are usually prioritised, and emotional support and spiritual needs of the dying patient are rarely provided (22,24). In addition, nurses' competence in cultural and religious care is often considered to be poor (25). Nurses need the competence to recognise impending death and keep the family informed about the situation and medical facts related to EOL care (19,23) and advocate for the dying patient (26-28). In the case of EOL care, the role of the nurse is to ensure that the needs of the patient and their family are taken into account (25) and stand for the patient in decision-making (26). Nurses also need the competence to provide mental and emotional support for the patient and family (23,26,29), addressing their practical needs and allowing the patient's family to participate in the patient's care, and being present for the patient and listening (26,29). In addition, nurses need the competence to cooperate and organise care by disseminating information and coordinating patient care, arranging meetings and consulting with other professionals (18,19). Nurses' competence to support the communication and continuity of care between the patient, their family and the physician is important (25,26). Within the organisation, nurses must

have the competence to make sure that the care instructions are clear to all nurses, especially inexperienced ones (30). Nurses also need the ability to help patients and their families to participate in decision-making (23).

There are some studies that discuss factors contributing to nurses' EOL care competencies. The experience of caring for terminally ill and dying patients (31,32), working in units with terminally ill patients and caring for EOL patients regularly all promote nurses' competence in EOL care (33,34). Besides these factors, a general professional experience in nursing and years of experience enhances competence in palliative care (34,35). Education is also an important element that has an impact on competence. Nurses with higher educational levels (13,36) or who have received postgraduate palliative care education are more competent in EOL care (9,21). Guidance from a colleague has been considered important for developing competence (37). Observing the work of expert nurses (37) and having the possibility to discuss issues with experienced nurses improve the quality of EOL care. EOL care instructions (38) also improve nurses' competence.

## Aim

The aim of this study was to describe nurses' required competence in EOL care in a health centre inpatient ward, from the nurses' own perspective.

The research questions were as follows:

- 1 What kind of EOL care competence is required of nurses in health centres' inpatient wards?
- 2 What factors promote nurses' EOL care competence?

## Method

### *Study design*

The study was conducted with a descriptive qualitative design using semi-structured group interviews and inductive descriptive content analysis (39). The study was intended to describe experiences of required nursing care competence that nurses reported needing to meet in their profession (40).

### *Sample/Participants*

The participants were 20 Registered Nurses in four different health centres in Southern Finland. Nurses met the inclusion criteria if they were Registered Nurses with experience in EOL care working in health centre inpatient wards that had beds for EOL care. However, nurses working in long-term care units were excluded because it is estimated that over half of patients in long-term care units are diagnosed with cognitive decline and dementia (41,42). Cognitive decline and dementia make the

prognosis of patients' disease and approaching death challenging and bring special elements to EOL care (43). A purposive sampling method was used when recruiting the participants to find nurses with experience in EOL care and similar educational backgrounds (44). Purposive sampling also allows informants who have the best knowledge (45) and personal experience on the topic to be interviewed.

#### Collection of the data

The data were collected using a semi-structured group interview method (45). The group interview method was used because group interviews have the benefit of producing more multidimensional data and facilitating the generation of ideas from participants. Four group interviews (four to six participants) were conducted in autumn 2016. The duration of the group interviews ranged from 73 to 90 minutes. The interviews consisted of four themes, drawn from prior literature (11-12,17,46), concerning nurses' required competence in EOL care: (1) care of the patient, (2) interaction with the patient's family, (3) multiprofessional cooperation and (4) factors promoting EOL care competence. The group interview method was utilised to obtain a multidimensional description of the phenomenon by giving participants a socially interactive situation where they could share their perceptions and generate information (44). The data collection continued until saturation of data was achieved after the fourth group interview.

#### Data analysis

The data were analysed with descriptive inductive content analysis (45). To get an overall view of the data, the interviews were read through multiple times after transcription. The data were then examined to find units of analysis, and sentences that were related to the research questions of competencies in EOL care were chosen as the unit of analysis. These sentences were then simplified into more easily analysable expressions. The simplified expressions were coded; after coding, similar codes were classified into sub-categories. The classification was continued by combining sub-categories with similar content into categories.

## Results

#### The study participants

In total, 20 nurses working in health centre inpatient wards participated in the study. The age of the participants was 28–59 years ( $n = 43$ ). The longest work experience in EOL care was 36 years and the shortest 1.5 years ( $n = 12.6$ ). None of the participants had completed

specialised education in palliative or EOL care. Less than half had attended specialising courses in palliative or EOL care during the last year.

#### EOL care competence required of nurses

Five categories describing nurses' required competence in EOL care were identified: (1) ethics and courage in action, (2) support for the patient, (3) support for the family, (4) care planning and (5) physical care (Table 1).

#### Ethics and courage in action

Ethics and courage in action consist of two sub-categories (Table 1). *Ethics in action* refers to the competence to identify the uniqueness of each caring event to respect and treat the patient with dignity. In addition, after the patient has died, nurses need competence in delivering individual treatment of the deceased with respect. Ethical action is also about acting as patients' advocate by defending patients' interests in EOL care and the ability to defend the patient in challenging encounters. If a physician wants additional examinations for the patient, it is the responsibility of the nurse to discuss the meaning of good EOL care, call into question the necessity of the examination and remind others that the procedure might cause suffering for the patient.

End-of-life care requires competence to have *courage in action* from the nurse to discuss death-related issues and act relentlessly. Nurses should act with courage, be on the patients' side and act vigorously, promoting the patients' best interests. Nurses have to be able to remain steadfast in getting physicians to understand patients' situations when giving or changing instructions for treatment.

**Table 1** EOL care competence required of nurses.

Categories	Sub-categories
Ethics and courage in action	Ethics in action Courage in action
Support for the patient	Providing comfortable environment Psychological support Spiritual support
Support for the family	Preparing family to EOL care of the patient Guidance in patient care Supporting the family after the patient's death
Care planning	Coordinating the care Keeping the care plan updated Documentation of care
Physical care	Symptom management Fundamental care

C5: You have to be on the patient's side against the doctor, no matter how hard the doctor tries to do some new examinations; it's quite tough sometimes to argue with the doctor about what kind of care is decent for the patient.

### Support for the patient

Three sub-categories are included in this category (Table 1). The required competence in *providing a comfortable environment* refers to taking into consideration the patients' needs within the possibilities provided by the health centre ward. Nurses also strive to create a safe and comfortable atmosphere by telling patients and their families that a nurse is available whenever needed.

Within the required competence of *psychological support*, the participants described that they need competence to alleviate anxiety, restlessness and fear, mainly with medication, but also by discussing concerns with the patient. Discussions are also a way to promote well-being by creating a peaceful moment, listening and being present. Genuine presence and listening are practical ways to support the patient and the family. Nurses need to focus on the current situation and listen carefully to the patient and observe gestures and expressions instead of just performing caring procedures. However, medication was seen by participants as an easiest way to treat patients' anxiety because nurses rarely have enough time to stay with patients to alleviate the psychological symptoms with discussions.

C3: Yes, fear and anxiety are quite challenging. Of course, medication is one thing, but it's so limited that you could be there and discuss with a patient ... when there are so few nurses and so many patients, it's sometimes difficult, but it is still a thing to strive for, the discussion.

*Spiritual support* refers to the competence to identify and support patients' spirituality, but the nurses described that spiritual issues were not the first to be taken into consideration when treating patients. Multiculturalism brings challenges of encountering different religions, where the nurses felt they needed knowledge. It is important to know when to implement or avoid religious symbols depending on each patient's religious beliefs.

### Support for the family

The required competence in support for the family comprises three sub-categories (Table 1). *Preparing family for EOL care of the patient* refers to the competence to prepare the family for EOL care through continuous discussion about the purpose and content of the care. Nurses have

to have the competence to recognise approaching death and understand that the family's impact on the patient's well-being. Nurse must be able to prepare and support the family to accept the patient's coming death while taking into account the individual circumstances of the family when talking about death. Nurses need competence to work in challenging situations when the family does not agree with the essentiality of EOL care.

*Guidance in patient care* means that nurses need to have competence to advice the family on practices concerning patient care. Patients and their families often have negative preconceptions about strong pain medications, presuming them to be addictive, and nurses need the competence to motivate the patient and family to use proper medication. In addition, nurses have to know how to give concrete advice and guidance on post-mortem arrangements to the deceased's family. The competence required for guidance with fears concerning patients' nutrition and hydration was highly emphasised. Nurses must have competence to repeatedly discuss nutrition and hydration in EOL care and alleviate family members' anxiety because fear of death arises when patients are not eating or drinking.

Additionally, nurses are required to have competence to *support the family after the patient's death*. Death needs to be discussed using direct and genuine expressions, avoiding euphemisms and implicit language. The participants described that facing a family member after the patient's death requires sensitivity and ability to be genuine in the situation. Family is offered the opportunity to say goodbye in a peaceful setting and take part in dressing the deceased.

D2: There is often problems with communication, even though there have been many conversations during the week with relatives – that the patient is in terminal care now and what that means, still very often family members don't understand that [the meaning of EOL care], they get anxious about [the] patient not being hydrated and that he or she will be dehydrated and all that kind of stuff.

### Care planning

The required competence in care planning includes three sub-categories (Table 1). Nurses are required to have competence in *coordinating care*. They have to know how to keep the EOL care team up to date on patient care issues so everyone is aware of the patient's care and how to coordinate the multiprofessional collaboration if the patient or family need, for example, support from the social worker. The nurse has to have competence to be the one promoting communication between the patient, family and the physician, conveying the wishes of the patient's family to the physician.

The nurses also described the need for the competence to *keep the care plan updated*. Nurse need to know how to identify the patient's current needs and wishes by discussing them with the patient or the family and respecting them in the care planning. Keeping the care plan updated also requires competence to communicate the patient's condition and plan the care together with the physician. The nurse has to know how to make sure that the physician understands the patient's actual condition because the physician is not always aware of it, as they see patients less often than the nurse does. Discussion about the need for EOL care is often initiated by nurses when they notice that a patient's condition is deteriorating. Together with the physician, they consider the care policy and the transition to EOL care.

The required competence in *the documentation of care planning* means that the nurse is responsible for ensuring that the care plan is valid and that the essential aspects of care are documented. Valid and versatile documentation was seen by participants as an important factor in care planning, improving the continuity and safety of patient care when the nurse sees what the patient's needs and goals were in past and what should be taken into consideration at the present time.

D2: To get the terminal EOL care started. You often have to tell the doctor that it might be time for EOL care, that the patient begins to look bad or something. Very often you have to discuss that it is time to initiate EOL care.

### Physical care

The required competence in the physical care category includes two sub-categories (Table 1). Nurses need to have competence in *symptom management*, aiming at a balanced situation where the patient has no disturbing physical symptoms. Nurses need to monitor and evaluate patients' symptoms and well-being repeatedly. In the interviews, pain management was seen as far above and beyond other symptomatic treatments in importance. Nurses must have the practical knowledge to choose the pain management method appropriate for the patient's situation. Successful pain management requires nurses to have the competence to evaluate pain, assess the effects and suitability of medication and take into account the patient's assessment of pain. In addition, nurses also have to be aware of nonpharmacological pain management methods. The nurse has to be able to ensure the correct medication and be prepared to make changes to medication based on guidelines given by the physician. The nurse has to actively seek medical advice from a physician and make sure that the physician has updated the patient's medication instructions.

D2: ... [The] nurse needs to check the response to the medication that is used to treat the pain, whether it is poor medication for that patient, whether some other (medication) would be better.

The required competence in *fundamental care* is a necessity for high-quality care to support patients' well-being. The competence in caring for a bedridden patient, knowing posture care and planning treatment procedures carefully to minimise pain was considered critical by participants. When a patient is bedridden, oral care is increased to keep the patient's mouth moist and odourless and nurses need to assist the patient with eating and drinking.

### Factors promoting nurses' competence in EOL care

Factors promoting nurses' competence in EOL care consist of two categories: (1) professional development in EOL care and (2) an organisation that supports EOL care (Table 2).

#### Professional development in EOL care

Professional development in EOL care includes three sub-categories (Table 2). *Obtaining information* includes further education, referring to information on the principles of EOL care and provision of concrete tools for nursing, and independent learning, meaning that the nurse is interested in nursing care, wants to focus on it and actively seeks information about EOL care. Information is retrieved from nursing literature, educational events and databases.

*Work experience in EOL care* develops interpersonal skills and understanding of nonverbal communication. These experiences also help to identify changes in the patients' condition and recognise impending death. Such experience also makes it easier for nurses to face anxiety. The professional knowledge gained through work experience help nurses cope with EOL care and manage their feelings during the care. Nursing is facilitated by relying

**Table 2** Factors promoting nurses' competence in EOL care.

Categories	Sub-categories
Professional development in EOL care	Obtaining information Work experience in EOL care Personal connection with EOL care
Organisation that supports EOL care	Support from the work community Multiprofessional cooperation Optimal work assignment planning

on professional expertise and putting personal feelings in the background in care situations.

A3: Every care experience enhances the skills. Next time, I will remember this thing and I will do it differently. And even though there are awful matters, you can always learn something, and it brings something good along.

*Personal connection with EOL care* refers to nurses' own experience of caring for a family member. These personal experiences help nurses to appreciate the experience of the patient's family and the importance of successful symptomatic care and help them to act positively during the care process.

#### *An organisation that supports EOL care*

Three sub-categories comprise the category of professional development (Table 2). *Support from the work community* refers to a common understanding of the nature of care. The nurses reported that they look for support from the organisation's management and also hope for discussions with physicians about treatment options. Collegial support is important in practical EOL care situations. Other nurses help with care procedures for the dying patient or take more responsibility for caring for other patients, which enable spending more time with the dying patient. In emotionally difficult care situations, discussions and support from a colleague are important.

*Multiprofessional cooperation* with other professionals is another factor promoting competence. Working with an experienced doctor increases nurses' competence – for example, discussing what was successful and what should have been done differently in a patient's care. The nurses appreciated getting acquainted with other organisations to find viewpoints for developing their own organisation and sharing experiences with nurses working in other organisations. More experienced nurses provide a model for work and give advice and guidance. New nurses are given introductions to how the department operates. In addition, some health centres receive guidance and support from a specialist nurse, such as a pain nurse. According to participants, without cooperation, carrying out EOL care is challenging and can cause suffering to patients.

Promoting competence requires *optimal work assignment planning* within the organisation. In an ideal situation, work assignments are organised in a way that gives more time to care for the dying patient. Successful shift planning provides an opportunity to focus on the care of the dying, and other nurses take care of the less critically ill patients.

D2: Yes, it is assessed with colleagues that how they see, for example, the effectiveness of pain management or if there is something else to pay attention

to. Just as you read those care documents, there might be things that you haven't paid attention to and someone else is, it's kind of like a dialogue (with a colleague).

## Discussion

The aim of this study was to describe nurses' required competence in EOL care in health centre inpatient wards, as described by nurses. Earlier studies have shown that there is a disparity in the level of nurses' EOL care competence (13,21). In this study, the required competences described by nurses included varying aspects of holistic care in the care of EOL patients.

Ethical questions cannot be avoided in EOL care (12,17). In this study, patient advocacy was emphasised when considering nurses' ethical competence in EOL care, in agreement with previous studies (26,27). Moreover, the need for having courage in caring for an EOL care patient came forth in the interviews. It also appears that nurses have a crucial role in promoting patients' rights to adequate and appropriate care. Ensuring these rights requires nurses to have the courage to defend their opinions among the care team about what benefits the patient most. Courage, a factor which arose in the current study, was not mentioned in previous studies, although it can be seen as a part of patient advocacy.

Supporting patients and their families is an essential aspect of EOL care. In this study, the nurses described the competence required for this skill, but the support was mainly conducted via physical means and organising the environment rather than offering mental or spiritual support. According to previous studies, nurses need competence to support patients and family, especially mentally and emotionally (23,26,29) by being present and listening (26,29). It was noticed in this study, as well as previous ones, that the requirement for patient psychological support is recognised, but nurses lack the competence and resources to offer support other than in a physical fashion. In the treatment of psychological symptoms, medication was emphasised rather than presence, listening and discussion (22,23). In addition to the competence requirements in emotional and mental support, the requirements relating to cultural competence got very little attention in these interviews. Cultural competence was mentioned only as part of multiculturalism and was related to religion. Spirituality was the only context where nurses stated the need for competence in addressing different cultures. However, cultural care is defined as one of the core competence areas of palliative and EOL care (12,17) and is important when assessing the competence level and educational needs of nurses (18,19). This increases the challenge for quality care in organisations, as nurses have little experience and knowledge of how to consider different cultures.

Care planning was an area that was emphasised in this study. Nurses experienced that it was the nurse who was responsible for care planning and should have the competence to observe the patient's condition and current needs, and it was the nurse whose task it was to facilitate multiprofessional cooperation. The element of care planning was only briefly mentioned in earlier studies (30), and care planning has not been defined to be an independent competence area (12,17). It is possible that care planning is considered to be a part of all care in general, and it has not been seen as a factor that has importance on its own. This phenomenon may go unrecognised because care planning had not been focused on in earlier studies due to bias in data analysis. However, care planning is essential element of nursing care because it is the only way to ensure the stable content, quality and continuity of care, and it has a major role in the nursing profession.

In this study, the factors contributing to nurses' EOL care competence were professional development and organisational support. Nurses' competence in EOL care was described as especially enhanced by experience and education, as supported by previous studies (9,13,36). Postgraduate palliative and EOL care education are extremely valuable for improving nurses' competence and are related to better competence in performing EOL care. Support from the work community, particularly from colleagues and physicians, was seen as important from the perspective of nursing care competence. Organisations that have common understanding of the principles and practices of EOL care and work assignment planning were seen as promoting nurses' competence. If the nurses had more time to care for the EOL patient, they had more opportunity to be competent in care.

## Conclusions

Nurses' experiences of required EOL competences in health centre inpatient wards are associated with holistic care of the patient, encountering the family and multiprofessional cooperation. Performing EOL care requires comprehensive competence in EOL care, and competence areas were mainly identified in earlier research. Care planning is a competence area that has not previously been specified but could be a potential aspect of future competence research. The factors contributing to nurses' EOL care competencies were related to professional development and organisational support of EOL care. Palliative and EOL education should be given more attention when examining quality of care, and it should be a standard part of training for nurses who provide EOL care. The possibility for cooperation with other professionals is also vital for development of competence.

## Limitations

Although it was possible to define nurses' required competences in the health centre inpatient ward setting, there are limitations to be considered when interpreting the results. First, the sample size was relatively small, and study participants were Registered Nurses from a single hospital district in Finland. This may be considered in the transferability of the results, taking into account cultural and local perspectives, and may limit the international applicability of the results. Many of the participants knew each other, which may have affected the way in which the participants expressed their thoughts. Secondly, the data collection was conducted by a single researcher, and it is possible that some information may have gone unnoticed during the interviews. However, the themes were developed by the entire research group based on previous literature. To ensure data adequacy, data were collected until saturation (44). In descriptive qualitative research, content analysis seeks to describe the phenomenon, although the process of analysis always, to some extent, involves interpretation (45).

## Conflicts of interest

The authors report no conflicts of interest in connection with this article.

## Author contributions

M.T., E.H. and M.H. conceptualised and designed the study. M.T. collected the data. M.T., E.H., M.H. and A.S.-J. analysed the data. A.S.-J., E.H. and M.H. wrote the manuscript. All authors contributed to the revision of the manuscript and approved the final version.

## Ethical approval

The standards of the Declaration of Helsinki were followed during this study (47). Permission for the research was granted by all participating organisations. According to Finnish law, a separate statement from a research ethics committee was not required because the study did not intervene in the integrity of the participants (48). Participation in the study was voluntary, participants were informed by a related research bulletin, and informed consent was sought from participants. No personnel register was formed in the study (49). The anonymity of interviewees was protected in this study so that the interviewees cannot be identified through examples of the original verbiage used.

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