

KEYWORDS PALLIATIVE CARE | SKILLS | EVIDENCE BASE

Palliative care 2: exploring the skills that nurses need to deliver high-quality care

This article looks at the skills and competencies that nurses need to provide high-quality palliative and end-of-life care in different healthcare settings

AUTHOR Robert Becker, MSc, RMN, DipN, FETC, Cert Ed (FE), RGN, is Macmillan senior lecturer in palliative care, Faculty of Health, Staffordshire University and Severn Hospice, Shropshire.

ABSTRACT Becker, R. (2009) Palliative care 2: exploring the skills that nurses need to deliver high-quality care. *Nursing Times*; 105: 14, 18–20

The second in this three-part series on palliative care outlines the skills nurses need to deliver effective care. Part 1 examined definitions of palliative care nursing, its core aims and values, and recent policies on end-of-life care. This article explores the evidence base to support the diverse range of knowledge, attitudes and skills needed to provide nursing care for people at the end of life.

INTRODUCTION

The following extract illustrates some of the challenges nurses face in palliative care.

“Will I ever be cured?” It is at times like this that we are faced with two simple choices. We can either “go”, make our excuses and change the subject, or “grow”, stay with the person and explore things further.

‘On this occasion, I chose to stay. He asked again if I knew whether he would be cured, but this time the intonation was different. It was as if he already knew the answer. I replied by saying to him that I knew very few details of his illness, but I would be happy to tell him what I knew if that was what he wanted. He replied very positively, both verbally and with a nod of his head’ (Becker, 1999).

Many nurses will have found themselves in situations like this and been left wondering whether they acted correctly, said the right things and behaved with sufficient sensitivity. Later, they may have told a colleague, manager or supervisor what happened, searching for some affirmation that the skills used were

PRACTICE POINTS

- Palliative nursing is a combination of evidence-based science, highly developed interpersonal skills, the therapeutic use of self and the ability to use all three together.
- Ensuring nurses obtain support for themselves in an ongoing professional relationship with a trusted confidante is a key part of developing the reflective maturity necessary for palliative care nursing.
- The essential comfort measures delivered by nurses at the bedside close to the end of life are of vital importance and are the embodiment of quality nursing practice.

appropriate and wondering whether they could have done things any better. The reply will depend very much on experience and knowledge of the person consulted and may range from the indifferent – ‘Well, it sounds OK to me’ – through to a more counselling-oriented comment such as: ‘How do you feel now that you have had a chance to take stock?’

These comments highlight the difficulty in determining whether nurses’ competence to manage such delicate situations is sufficiently evidence based, or simply a combination of spontaneous, intuitive responses based around life experience. Good practice at the bedside in such situations is a combination of both (Schön, 1987; Benner, 1984).

A close analysis of this encounter will illicit a whole range of skills used to facilitate the conversation. It is important to examine how these skills have been described in the literature to date. This provides a useful insight into the true nature of the diversity and essence of palliative nursing as it is delivered in practice.

THE EVOLUTION OF COMPETENCE

Learning is a complex issue and there are a number of ways to describe how nurses attain competence. For simplicity, an adapted version

of Bloom’s (1956) taxonomy can be used, alongside a variation of Benner’s (1984) ‘novice to expert’ thesis. The work of Schön (1987) must also be considered, mainly because she recognised it was the ‘artistry’ of practice that helped to differentiate between a competent and an expert practitioner. As the anecdote introducing this article illustrates, such artistry needs to be acknowledged.

This relates closely to Carper’s (1978) four patterns of knowing, which she suggested should be present in each nursing act: empirical knowledge; aesthetic knowledge; personal knowledge; and ethical knowledge.

Carper’s work emphasised the influence of nurses’ values, beliefs and life experience in their work and has stood the test of time. Elements of these four patterns can be seen in the code of conduct (NMC, 2008).

A driving force towards developing competency assessment in cancer and palliative nursing over the past decade has been the publication of key documents.

The RCN (2002) published its own core competency framework for nurses working in specialist palliative care. This was the first time such a venture had been attempted and was useful in helping to clarify and define the role of nurses working beyond the hospice environment.

The national core competency framework (NHS Executive, 2004) attempted to pull together a uniform framework of standards for cancer nursing across four levels of practitioner and a wide range of skills. Many competency statements in this document were directly transferable to the palliative setting.

The premise of both these documents is that competencies can best be assessed through observing behaviour, backed up by a plethora of written and verbal evidence. However, higher education institutions find themselves with a proliferation of accredited courses for qualified staff at all levels that may be qualitatively excellent, but tend to concentrate

BOX 1. CORE NURSING SKILLS FOR PALLIATIVE CARE

DAVIES AND OBERLE (1990)

- Valuing: global and particular
- Connecting: making, sustaining and breaking the connection

- Empowering: facilitating, encouraging, defusing, mending, giving information

- Doing for: taking charge, controlling pain, making arrangements, lending a hand

- Finding meaning: focusing on

living, acknowledging death

- Preserving own integrity: looking inward, valuing self, acknowledging own reaction

DEGNER ET AL (1991)

- Responding during the death scene

- Providing comfort

- Responding to anger

- Enhancing personal growth

- Responding to colleagues

● Enhancing quality of life

● Responding to the family

HESLIN AND BRAMWELL (1989)

- Family care: expression of emotion, enabling conflict resolution, teaching communication strategies

- Personhood: as applied to both patients and nurses

- Symptom control

- Life closure: totality of death

on competency assessment via demonstrable critical thinking ability. Here lies the problem: how does nursing develop an acceptable model of competency assessment that embodies the best of both approaches?

To answer this, we need to look further back. Only a few authors have attempted to define the skills and competencies used by nurses when caring for dying people (Taylor et al, 1997; Degner et al, 1991; Davies and Oberle, 1990; Heslin and Bramwell, 1989) (see Box 1).

These authors' work has helped others to develop working tools and frameworks to guide practice (De Vlieger et al, 2004; Becker, 2000) (Box 2).

WHAT IS COMPETENCY?

There are numerous definitions of competency. This article focuses on the RCN's (2002) definition that refers to specialist palliative nursing. Competence can be defined as: 'The skills, knowledge, experience, attributes and behaviours required by an individual in order to perform the job effectively' (RCN, 2002).

Therefore, in order to work it relies on the formulation of agreed competency statements that are then identified at different levels of practice.

At pre-registration level, it is well established that clinical staff's role is to conduct practice-based assessments of competence. The issue of grading competency to practise in pre-registration programmes is straightforward. In most instances, the assessor simply needs to make a judgement, indicating yes or no against a given statement. At post-registration level, assessing clinical skills is more complex and is predominantly based around self-judgement validated by educators and only occasionally by practitioners. This assessment

usually takes the form of the following:

- Reflective essays, diaries and journals linked to competencies;
- Portfolio development, sometimes incorporating competencies;
- Critical incident analysis.

No form of clinical assessment involving competencies can be said to be wholly objective. This may never be achieved because of the holistic nature of care delivery and the many variables that influence assessment at any one time.

COMPETENCY IN PALLIATIVE NURSING

Many areas in Boxes 1 and 2 contribute to a competent practitioner's expertise and it is important to consider the elements that stand out as vital to palliative nursing.

To illustrate this, I have used the framework developed from my own research (Becker, 2000) to devise a self-assessment competency tool for such nursing skills. While not definitive, it has been extensively evaluated for its efficacy and goes some way to represent the core elements of nurses' roles.

Communication skills

A highly developed range of sensitive and facilitative communication skills is to be expected in nursing, and is not confined to a palliative setting.

What makes palliative nursing skills stand out are: the further ability to field and respond to sometimes profound or rhetorical questions about life and death; to know when to say nothing, because that is the most appropriate response; to use therapeutic comforting touch with confidence; to challenge colleagues who may wish to deny patients information; and, perhaps to discuss the imminent death of a relative with families. It is this combination of communication skills that makes palliative nursing what it is.

Psychosocial skills

An ability to work with families, anticipating their needs, putting them in touch with services and supporting them is important, and also not confined to palliative nursing.

The psychosocial element of care is often the part that is delegated to social workers, who may well have better knowledge of and access to the support available but, like so many members of the healthcare team, their

involvement is transient.

It is nurses who will be there at the most difficult moments, helping patients plan their care, offering strategies, giving ongoing psychological support and coordinating the other team members for patients' benefit. It is the trust and confidence built through nurses' ongoing relationships with patients and the therapeutic use of 'self' that is at the core of the psychosocial approach in palliative nursing.

Teamwork skills

Working closely with other members of the multidisciplinary team is a vital part of good practice in many areas of nursing.

The palliative care team is not today confined to a hospice environment. It can be found in acute and community settings and in public and private care. The growth of the nursing role within teams has been dramatic and continues to represent a much-admired model of working (Cox and James, 2004).

BOX 2. COMPETENCY TOOLS FOR PRACTICE AND FRAMEWORKS FOR EDUCATION

BECKER (2000)

Core categories

- Communication skills
- Psychosocial skills
- Team skills
- Physical care skills
- Life closure skills
- Intrapersonal skills

DE VLIEGER ET AL (2004)

Core categories

Patient

- Nursing observation – comfort measures
- Symptom management
- Pain management
- The terminal phase and death

Family

- Communication issues
- The impact of serious illness

Bereavement

General

- Teamwork
- Self-awareness – ethical issues

Practice in depth

Physical care skills

This is about the knowledge and skills to deliver active, hands-on care in any setting throughout a long period of illness. It is not confined to the last few days of life, but is more focused during this time. In palliative care, such care embraces a range of skills, but focuses on the nature of acute and chronic pain. Accurate and holistically oriented pain assessment using a range of tools is essential, as is the ability to use such tools when patients may not be able to respond to questions.

It is about nurses' observational skills and the intuitive ability to recognise signs with patients who consistently under-report pain (Farrer, 2007). It is not only advising doctors of the prescription and dosage to manage pain but also about the advocacy role nurses have for patients at a time of extreme vulnerability. It is these aspects that make palliative nursing skills so important to patient care.

Life closure skills

This area is concerned with nursing behaviours and skills that are crucial to patients' and families' dignity when life is close to an end and thereafter. Caring for the patient's body and immediate surroundings is probably the most common area of activity in any nurse's daily life. It is also the area that is most taken for granted in health care. Preserving dignity has become central to government policy for older people (Department of Health, 2006).

REFERENCES

- Becker, R.** (2000) Competency assessment in palliative nursing. *European Journal of Palliative Care*; 7: 3, 88–91.
- Becker, R.** (1999) Teaching communication skills across cultural boundaries. *British Journal of Nursing*; 8: 14, 938–942.
- Becker, R., Gamlin, R.** (2004) *Fundamental Aspects of Palliative Care Nursing*. Salisbury: Quay Books.
- Benner, P.** (1984) *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. California: Addison-Wesley.
- Bloom, B.S.** (1956) *Taxonomy of Educational Objectives*. Boston, MA: Allyn and Bacon.
- Carper, B.** (1978) Fundamental patterns of knowing in nursing. *Advances in Nursing Science*; 1: 1, 13–23.
- Cox, K., James, V.** (2004) Professional boundaries in palliative care. In: Payne, S. et al (eds) *Palliative Care Nursing: Principles and Evidence for Practice*. Maidenhead: Open University Press.
- Davies, B., Oberle, K.** (1990) Dimensions of the supportive role of the nurse in palliative care. *Oncology Nursing Forum*; 17: 1, 87–94.

The DH (2001) launched Essence of Care to help practitioners take a much more patient-focused and structured approach. The DH (2003) set benchmarks for standards in essential care and a toolkit for clinical areas to evaluate how they met these standards. To complement these, the National Council for Palliative Care (2006) examined care priorities at the end of life.

These reinforce the importance of this area of care, which is often referred to as 'basic' care. This implies that it involves unskilled tasks of low importance. Nothing could be further from the truth – the essential comfort measures that embody such care are vital to the well-being of patients and those at the bedside.

Such care has been described as sacred work, in which the carer enters into the patient's intimate space and touches parts of the body that are usually private (Wolf, 1989). This is a highly privileged position that demands respect, a high degree of skill and sensitivity to individual need that is so essential when caring for dying patients.

Intrapersonal skills

One area that is seen as a key component in palliative care skills is the maturity to address the challenging intrapersonal issues intrinsic in caring for dying people and their families.

Nurses need to recognise and attempt to understand personal reactions that occur as a natural consequence of working with dying

and bereaved people, and to be able to reflect on how this affects care given. This is perhaps the most challenging of all competency areas and plays a significant part in the professional growth of those who choose to work in this field (Becker and Gamlin, 2004).

To be truly successful in using the palliative approach, nurses need to nurture a level of human contact and relationship that goes beyond the norm and, as such, can potentially make nurses feel emotionally vulnerable. Such reflective maturity is the domain of experience and learning, but is not confined to specialist nursing and is within reach of all nurses.

CONCLUSION

The full range of knowledge, skills and behaviours needed for nurses to demonstrate the palliative approach is much broader and deeper than may be realised at first.

Competency attained and used regularly in caring for dying people will carry through a nurse's whole career, simply because people die of many causes in many environments.

To have the opportunity to be at the bedside of someone throughout the final months, weeks and moments of their life is a privilege and honour for any carer. For nurses it is both the underpinning and overarching ethos of our profession. ●

● Part 3, to be published next week, explores using the palliative approach in practice.

- De Vlieger, M. et al** (2004) *A Guide for the Development of Palliative Nurse Education in Europe. Palliative Nurse Education: Report of the EAPC Task Force*. Milan: European Association of Palliative Care. tinyurl.com/palliativeeducation
- Degner, L.F. et al** (1991) Critical nursing behaviours in care for the dying. *Cancer Nursing*; 14: 5, 246–253.
- Department of Health** (2006) *Dignity in Care*. tinyurl.com/dignityincare
- Department of Health** (2003) *Essence of Care: Patient-focused Benchmarks for Clinical Governance*. London: DH. tinyurl.com/essenceofcare
- Department of Health** (2001) *The Essence of Care: Patient-focused Benchmarking for Health Care Practitioners*. London: DH. tinyurl.com/essenceofcare
- Farrer, K.** (2007) Pain Control. In: Kinghorn, S., Gaines, S. (eds) *Palliative Nursing: Improving End-of-life Care*. Edinburgh: Baillière Tindall.
- Heslin, K., Bramwell, L.** (1989) The supportive role of the staff nurse in the hospital palliative care situation. *Journal of Palliative Care*; 5: 20–26.

- National Council for Palliative Care** (2006) *Changing Gear: Guidelines for Managing the Last Days of Life in Adults*. London: NCFPC. tinyurl.com/lastdaysoflife
- NHS Executive** (2004) *National Core Competency Framework for Cancer Nursing: Delivering Effective Patient Care. NHS and KSF Mapped Version*. tinyurl.com/cancercompetencies
- NMC** (2008) *Standards of Conduct, Performance and Ethics for Nurses and Midwives*. London: NMC. tinyurl.com/nmc-code
- RCN** (2002) *A Framework for Nurses Working in Specialist Palliative Care: Competencies Project*. London: RCN. tinyurl.com/RCN-palliativecare
- Schön, D.** (1987) *Educating the Reflective Practitioner*. San Francisco: Jossey-Bass.
- Taylor, B. et al** (1997) Palliative nurses' perceptions of the nature and effects of their work. *International Journal of Palliative Nursing*; 3: 5, 253–258.
- Wolf, Z.R.** (1989) Uncovering the hidden work of nursing. *Nursing & Health Care*; 10: 8, 462–467.