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Identification and validation of end-of-life nursing care competencies for Kenyan nurses: A modified Delphi technique

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ABSTRACT

Background: The number of patients requiring end-of-life care in acute care hospitals in Kenya continues to increase due to increases in non-communicable diseases. Despite advances in the field of palliative care (PC), its utilization is deficient in our setting, particularly at the end of life. Many patients and family members have unmet needs during the end-of-life phase. The aim of this study was to identify and validate end-of-life nursing competencies required by non-specialized nurses in Kenya. Validation of competencies for end-of-life care would help to develop relevant professional development programs in palliative care for these nurses.

Methods: A two-round modified Delphi study was conducted. A 20-member panel of specialists in end-of-life care was involved in the identification and validation of the end-of-life nursing care competencies.

Results: The results highlighted a total of eight core competencies namely: palliative nursing care; pain management; symptom management; ethical-legal issues; psychosocial, cultural and spiritual considerations; communication; loss, grief and bereavement; and death and dying. Additionally, 92 sub-competencies were identified that general nurses should possess within three domains of learning: knowledge (43 competencies), attitude (17 competencies), and practice/skills (32 competencies).

Conclusions: The study forms a basis from which the identified end-of-life competencies can be utilized for continuous professional development programs for general nurses in acute care hospitals. Such programs could enhance the capacities of the general nurses and promote the integration of end-of-life care in acute care hospitals, thus improving the outcomes in quality of life for patients and families.

Keywords: palliative care, end-of-life care, nurse competencies, Kenya

INTRODUCTION

Nurses are the frontline health care professionals who spend much time with patients (Hendricks-Ferguson et al., 2015). Therefore, it is important for them to be skilled, not only knowing their jobs but also performing well. At present, few nurses have the essential education or experience to provide optimal end-of-life nursing care (EOLNC) to patients and their families in our setting.

Nurses are present throughout the trajectory of care, from the beginning to the end of life, and play a key role in caring for patients in their final hours. Despite the frequency of deaths occurring in acute care wards, there is evidence not all nurses are comfortable in caring for individuals who are dying (Park & Oh, 2019; Sedillo et al., 2015). Therefore, educating nurses regarding end-of-life (EOL) care is critical if we are to see improvements. The End-of-Life Nursing Education Consortium (ELNEC) is a program whose primary aim is to educate nurses on EOL care to improve EOL care in the United States. Over the years, it has been introduced to other continents, including Africa; and Kenya was not left behind.

Kenya is a country in East Africa with a coastline on the Indian Ocean. It is overwhelmingly religious with a majority of its population identifying as Christians. There are many traditions and trends in Kenya's culture with no single prominent culture. Instead, the country's cultural heritage and current expressions consist of a variety of cultures that have been shaped and practised by its various communities.

In Kenya, non-communicable diseases account for about 40.8% of the deaths (WHO, 2024). These individuals could benefit from a palliative care approach. However, at present, as with other African countries, palliative care reaches only about 5% to 10% of the individuals who could benefit from it (Kimani et al., 2023; Fraser et al., 2017). Additionally, these patients often spend their last days in acute care hospitals (Malloy et al., 2017; Rhee et al., 2017) because there are insufficient hospices/palliative care facilities (Rhee et al., 2017). In this regard, general nurses who are employed in these acute care hospitals are expected to provide high-quality EOL care to persons at their final hours and do not have the opportunity of caring for patients requiring palliative care over longer periods of time.

These situations ensue within a background context of many students leaving nursing school without having acquired theoretical knowledge about palliative care/end-of-life care. The basic nursing programs at diploma and bachelors level have classroom content in palliative care integrated in the

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curriculum. This inclusion, however, does not provide clinical experience for students. Thus, students exit training without having had a structured clinical experience focused on the provision of care to patients during the final hours. This lack of structured clinical exposure during basic education can mean general nurses are inadequately prepared to provide EOL nursing care. In a previous study, findings revealed that the basic nursing education program in Kenya was inadequate in preparation of general nurses to provide end-of-life nursing care (Machira et al., 2020). Notably, at the time of that study, there were only 68 (0.14%) nurses trained in palliative care who were registered and licensed by the regulatory body in Kenya.

Although a palliative care approach can be integrated at any point in an individual's illness, this paper focuses on palliative care at the EOL. It is focused on care delivered to an individual who is nearing death. The study aimed to identify and validate competencies requisite for the provision of high-quality EOLNC by Kenyan nurses (generalists). The identification of competencies is an important initial step to provide a foundation for teaching non-specialist nurses who are critical in achieving the provision of high-quality EOLNC in Kenya. It is hoped that the identification and validation of the competencies will contribute to nurses receiving EOLNC training that is focused on the requisite EOLNC competencies. In turn, enriching their competencies through continuous professional development will empower them to provide high-quality EOL nursing care.

We sought to validate the eight ELNEC module topic domains (these were adopted as competencies in this study) as core competencies within an African setting and, specifically, Kenya; and to identify and validate sub-competencies within each of the eight core competencies for end-of-life nursing care for Kenyan nurses. The study addressed the research question: "What nurses' competencies are appropriate for end-of-life nursing care in Kenya". This paper reports on the core and sub-competencies for EOL nursing care that were identified and validated by a team of experts in palliative care nursing.

Theoretical Underpinnings

The study was guided by two theories: Parse's Theory of Human Becoming and Kolcaba's Theory of Comfort (Betül Tosun et al., 2015; Gayoso et al., 2018). Professor Rosemarie Parse's Theory of Human Becoming posits that the goal of nursing practice is to improve health without considering any problems to be solved; it is the subjective understanding of health that is to be improved, not necessarily the health condition itself. This is a critical understanding for nurses as it emphasizes the need for planning goals of care with the patient and their families. For this planning to be accomplished effectively, nurses will be required to possess a set of competencies that enable them to perform optimally.

According to Kolcaba's Theory of Comfort, nurses identify comfort needs of patients and/or family members and design and coordinate interventions to address these needs (Coelho et al., 2016). Kolcaba posits that patients are strengthened as their needs for three types of comfort (relief, ease, or transcendence renewal) are met in four contexts of human experience

(physical, psychosocial, environmental, and social; Betül Tosun et al., 2015). This is in line with the primary goal for high quality EOL care which is to promote comfort and dignity to patients and their families (Ferrell et al., 2015).

METHODS

Study design

A cross-sectional, descriptive study using a two-round modified Delphi technique (mDT) was utilized to validate the eight ELNEC competencies (ELNEC, n.d.; Ferrell et al., 2015) and to identify and validate EOLNC sub-competencies through consensus among experts. The Delphi method has been used extensively in health care research (Atkinson et al., 2015; Castro et al., 2016; Collins et al., 2017; Geng et al., 2018) to achieve consensus on a topic. The Delphi approach was selected for use in this study, as it offered the opportunity for building a consensus among the leaders in palliative care.

We modified the Delphi technique by starting with a list of statements instead of a round of open-ended questions, as is characteristic of the traditional Delphi technique (Avella, 2016). Furthermore, we omitted the sharing of summary results with the experts in each round. Instead, the information from the participants in Round 1 was incorporated into the survey tool that was administered in the second round. These modifications have been used successfully in other investigations (Joyner & Stevenson, 2017). Figure 1 shows the steps followed to identify and validate the EOLNC competencies for non-specialist palliative care nurses in Kenya.

Expert Panel Composition

The Delphi panel requires active participation by individuals who are knowledgeable and possess expertise in the study topic, to ensure validity of the results (Murphy et al., n.d.). We adapted the Fehring criteria (Quatrini Carvalho Passos Guimarães et al., 2015) to select panel experts. Registration by the Nursing Council of Kenya (NCK) was not considered an inclusion criterion because the registration is limited to nurses trained in palliative care at post-basic diploma level. As such, nurses trained in palliative care at higher levels, which is primarily undertaken outside the country, would be left out.

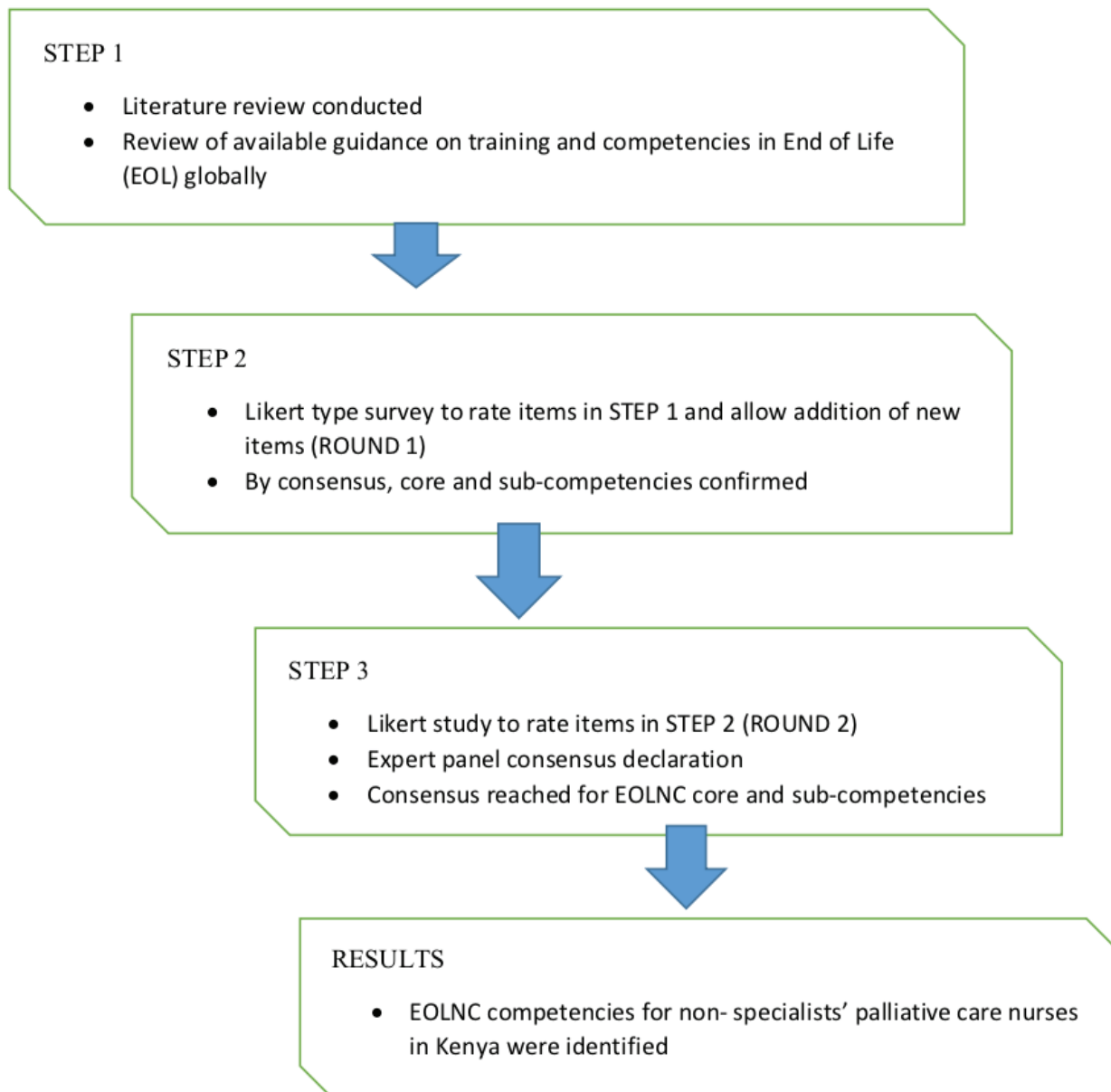
Sample size and sampling method

A register for nurses with a post-basic diploma in palliative care nursing exists within the NCK. Although Kenya has 47 counties, since the researcher was based in Nairobi County (which is a metropolitan city), purposive sampling was used to identify nurses within Nairobi County. Fifteen of the total 68 nurses registered by NCK were located in this county and included.

A register for nurses trained in palliative care nursing at degree level and above does not exist in NCK. Thus, following the purposive sampling utilized to identify the initial participants meeting the criterion, snowballing was used for subsequent recruitment of experts from this group. Five experts were identified through snowballing, making the total sample 20 experts.

Figure 1

Illustration of the Steps Followed in the Modified Delphi Process



Note. EOLNC = end-of-life nursing care.

Delphi procedure

Tool development

The Round 1 survey was designed by adopting the eight module topic domains within the ELNEC program as the core competencies (Ferrell et al., 2015) to be considered for this study. These were 1) palliative care nursing; 2) pain management; 3) symptom management; 4) ethical issues; 5) cultural and spiritual considerations; 6) communication; 7) loss, grief and bereavement; and 8) final hours. A Likert-type scale was used to rate the importance and validate these competencies as core within the Kenyan context.

Sub-competencies were defined as subsets of knowledge, skills, and attitudes contained within each core competency.

To identify these sub-categories for the survey, the following literature was used: 1) The ELNEC content (Ferrell et al., 2015), and 2) The NCK syllabi that have content in end-of-life care; specifically, the a) post-basic diploma in palliative care (Nursing Council of Kenya, 2021), and b) Bachelor of Science in Nursing (Nursing Council of Kenya, 2014). These syllabi form the basis for the professional competencies approved by the NCK. All competencies prescribed in the NCK documents were linked to a specific ELNEC core competency as sub-competencies and overlapping competencies were merged. The resulting 76 proposed sub-competencies for EOL nursing care were subsequently rated for importance using Likert scales.

The Round 1 survey consisted of three sections: a) Demographic information; b) Core competencies; and c) Sub-competencies. In this round, participants were asked to state the extent to which they agreed on the importance of each of the core and sub-competencies using a five-point Likert scale (5 = strongly agree; 4 = agree; 3 = neutral; 2 = disagree; 1 = strongly disagree). Two open-ended questions in sections two and three allowed participants to add additional items.

A pilot study was conducted with four individuals, who completed the tool and provided feedback about clarity. The feedback did not yield any significant changes to the tool. Face and content validity are claimed for the tool as it is based on the ELNEC content. Maintaining confidentiality contributed to the equivalence of the research conditions. The demographic information section was omitted in the Round 2 survey, and sections two and three included the items added from the open-ended qualitative data gathered from Round 1. The Round 2 survey was aimed at validating the revised core and sub-competencies. Participants were asked to state the extent to which they agreed on the importance of the core and sub-competencies using a five-point Likert scale (5 = strongly agree; 4 = agree; 3 = neutral; 2 = disagree; 1 = strongly disagree).

Data collection

A two-round survey was conducted with the recruited individuals. For both the Round 1 and 2 surveys, participants were asked to rate the extent to which they agreed with the list of core and sub-competencies on a five-point Likert scale.

Additionally, in Round 1, experts were asked two open-ended questions: a) list any competency(s) that is(are) missing, and b) list the competency(s) you want deleted. Responses received in Round 1 were incorporated into the Round 2 survey. These open-ended questions were repeated in the second-round survey. However, there were no responses received from the Round 2 open-ended questions. The response rates for Round 1 and 2 were 100% (20) and 85% (17) respectively.

Data were collected at two points in time. Initially, the 15 experts were contacted via telephone and all gave verbal consent for participation. A package including a cover letter, consent form, instructions, and the Round 1 survey was issued to the 20 experts (which included 5 additional individuals recruited via snowball strategy). The panel members were given two weeks to return the completed survey. A reminder was sent via text one week before the deadline with another reminder sent to those who had still not responded after the lapse of two weeks. Since the same experts continued with the second round, this follow-up strategy for non-respondents was also used in the subsequent round. The planned time between the first and second round was set at two weeks to allow for data analysis from Round 1, but also ensure a high response rate (Trevelyan & Robinson, 2015). However, the data collection, took one month, due to the participants' non-response. The two rounds were conducted over six months. All statements, both for core and sub-competencies, in Round 2 scored more than 75% agreement, indicating a consensus was reached. Therefore, the Delphi process stopped after the second round.

Data analysis

Data analysis included both qualitative and quantitative approaches. The qualitative data from the open-ended questions from Round 1 was categorized into preconceived themes (based on the literature) and deductive coding was completed. The analysis produced suggested changes, which were integrated into the survey used in Round 2.

The quantitative data from the two survey rounds were organized, coded, and converted into quantitative summary reports for analysis using the Statistical Package for Social Sciences (SPSS) version 24 database. Descriptive statistics of median (Md) and interquartile range (IQR) were calculated for all items and the overall group response and the spread of responses obtained.

To examine the percentage of overall agreement among the experts, variables were re-coded to combine *agree* and *strongly agree* into a single category. The same recoding was completed for the *strongly disagree* and *disagree*. A 75% agreement rating was considered as a relatively 'strong' definition of consensus. To calculate the spread of response, the criteria of Md and IQR recommended by Punpataracheevin (Prak & Wivatvanit, 2018) were used. The acceptable criteria for each item were Md equal to or greater than 3.50 and IQR equal to or less than 1.50. The acceptable criteria were applied in both rounds.

Ethical Considerations

Approval to conduct the study was obtained from the National Commission for Science, Technology and Innovations (NACOSTI) and Kenyatta National Hospital/University of Nairobi Ethics and Research Committee (KNH/UON-ERC). A written consent was obtained from all the participants.

RESULTS

Experts' demographics

There was equivalent representation of female and male respondents; most were between 31–40 years (40%; $n = 8$); a majority possessed a post-basic diploma qualification in palliative care (75%; $n = 15$); half represented the clinical area while the other half represented the academic setting; and none of the experts had an advance directive.

1.0 Core competencies for EOLNC

Five of the eight core competencies derived from the ELNEC program modules recorded 100% agreement, specifically, palliative nursing care; pain management; symptom management; communication; and, loss, grief and bereavement. There were variations on the level of agreement for three of the proposed core competencies, namely, ethical issues (75%); cultural & spiritual considerations (40%); and final hours (40%). Suggestions for incorporation into the core competencies included adding "legal" ($n = 10$) and "psychosocial" ($n = 160$, and rewording "death and dying" ($n = 15$). These suggestions were incorporated into the Round 2 survey. The eight core competencies had more than a 90% level of agreement (Table 1).

Table 1

Core and Sub-Competencies Derived from Participants' Suggestions in Round 1 of a 2-Round Modified Delphi Study

Core Competencies	Knowledge domain (KD)/ Attitude domain (AD)/Practice domain (PD)	
	Suggestions for inclusion in core competencies	Suggestions for inclusion in sub-competencies
Palliative Nursing Care	None	KD - <i>role of multidisciplinary team</i> (17) PD - <i>nursing process</i> (18) PD - <i>provide care in a team-based manner</i> (14)
Pain Management	None	KD - <i>principles of pain management</i> (15) PD - <i>administer the appropriate pain therapies, e.g., opioids</i> (17)
Symptom Management	None	KD - <i>complementary therapies</i> (10) PD - <i>palliative care emergencies and their interventions</i> (14)
Ethical Issues	Add the term " <i>legal</i> " (10)	KD - <i>ethical and legal management issues that impact on symptom management, e.g., will writing, patient rights, euthanasia</i> (13) PD - <i>ethical principles in end of life care</i> (10)
Cultural and Spiritual Considerations	Add the term " <i>psychosocial</i> " (16)	KD - <i>concept of sexuality</i> (15) KD - <i>effects of a terminal illness on sexuality</i> (12) KD - <i>types of informal care givers</i> (10) KD - <i>role of informal care givers in end-of-life care</i> (14) AD - <i>patient sexuality</i> (12) PD - <i>informal care giver's needs and interventions</i> (11)
Communication	None	KD - <i>breaking bad news to a patient/family</i> (18) PD - <i>communication with informal care givers</i> (13)
Loss, Grief, and Bereavement	None	KD - <i>referral mechanisms to appropriate support services</i> (10)
Final Hours	Replace the terms " <i>final hours</i> " with " <i>Death and dying</i> " (15)	KD - <i>role of a nurse during death and dying</i> (15)

Note. Words in italics are as reported by participants, while the figures in brackets represent the number of participants

2.0 Sub-competencies for EOLNC

In Round 1, a total of 76 sub-competencies were assessed. There were variations regarding the level of agreement for the listed sub-competencies ranging between 70% and 99% (Table 2). A total of 16 sub-competencies were suggested for inclusion, distributed across three domain areas. In the Knowledge Domain suggestions were made to add the role of multidisciplinary team ($n = 17$); principles of pain management ($n = 15$); complementary therapies ($n = 10$); ethical and legal management issues (e.g., writing a will, patient rights, euthanasia; $n = 13$); concept of sexuality ($n = 15$); effects of a terminal illness on sexuality ($n = 12$); types of informal care givers ($n = 10$); role of informal care givers in EOL care ($n = 14$); breaking bad news to a patient/family ($n = 18$); referral mechanisms to appropriate support services ($n = 10$); and role of nurse during death and dying (15).

In the Attitude Domain, there was one suggestion made by 12 participants regarding inclusion of patient sexuality. Lastly, seven sub-competencies were proposed for inclusion in the Practice Domain: nursing process ($n = 18$); provide care in a team-based manner ($n = 14$); administer appropriate pain therapies, e.g., opioids ($n = 17$); palliative care emergencies and their interventions ($n = 14$); ethical principles in EOL care ($n = 10$); informal care giver's needs and interventions ($n = 11$); and communication with informal care givers ($n = 13$).

In Round 2, 92 sub-competencies were listed among the three dimensions of knowledge, attitude, and practice. The original 34 knowledge competencies were increased by eight, following suggestions for additions by the Round 1 participants. The number of sub-competencies within the attitude domain increased from 16 to 17, while those in the practice domain increased from 26 to 32. Unlike in Round 1, the level of agreement in this round ranged between 90% and 100% (Table 2).

Table 2

Results for Participants' Level of Agreement on Importance of Core Competencies in Rounds 1 & 2

Core Competencies (competencies)	Round 1				Round 2			
	Agree (%)	Disagree (%)	Median	IQR	Agree (%)	Disagree (%)	Median	IQR
Palliative Nursing Care	100	0	5	0	100	0	5	0
Pain Management	100	0	5	1	100	0	5	0
Symptom Management	100	0	5	0	100	0	5	1
Ethical-*Legal Issues	75	25	3.5	1.5	90	10	4	1
*Psychosocial, Cultural, and Spiritual Considerations	40	60	2.5	2	96	4	4	1
Communication	100	0	5	1	100	0	5	0
Loss, Grief, and Bereavement	100	0	5	0	100	0	5	0
*Death and *Dying	40	60	2.5	1.9	97	3	5	1

Note. *Changes that were suggested for inclusion from the first round.

IQR = interquartile range.

DISCUSSION

This study validated the eight ELNEC module topic domains as core competencies, as well as identifying and validating common EOL nursing care competencies within those core competencies for nurses who are non-specialists in palliative care in Kenya. All eight core and 92 sub-competencies met the pre-set acceptable criteria; they had >75% agreement indicating that consensus was reached. Overall, the data from the first and the second surveys aligned. The first round validated the EOLNC core competencies and defined the sub-competencies within each core competency general nurses ought to possess, while the second round served to validate the revised core and sub-competencies.

The agreement regarding the eight ELNEC core competencies reported in this study is consistent with what Ferrell and colleagues (2015) documented in their study. It is possible that the integration of the ELNEC content in the nursing undergraduate curriculum, following the training conducted in Kenya, could have raised the awareness regarding the broad competencies' requisite for effective EOLNC. However, the findings also emphasize the universality of the care competency for palliative care.

As far as the sub-competencies are concerned, there were two suggestions for additions. One was on *knowledge on the role of the multidisciplinary team*. This is likely to have originated from one of the principles of palliative care, which advocates for a holistic approach to care provision and, thus, the need for interprofessional collaboration (Coulter et al., 2015; Ho et al., 2016; Kobewka et al., 2017). In addition, patients at EOL are likely to present with multiple symptoms requiring a multifaceted approach of management, which can result in reversal of the symptoms leading to improved quality of life (Armstrong et al., 2019).

There was a suggestion about the inclusion of the nursing process as a sub-competency. The nursing process was proposed by Yura and Walsh in 1967 as a decision-making approach that promotes critical thinking (Yura and Walsh, 1967, as cited in Stonehouse, 2017) and consists of a cyclical process of five stages (Semachew, 2018). The importance of inclusion of the nursing process sub-competency reported in this study is consistent with findings of a previous study conducted in Kenya which indicated that implementation of the nursing process led to improved quality of nursing care in hospitals (Wagoro & Rakuom, 2015).

The proposal from the experts to include a competency on administration of analgesics in the pain management core competency is likely to have been guided by recognition of the fact that reduction of suffering at EOL is critical, as suffering is associated with a 'bad death' (Burlles et al., 2016). Further, administration of analgesics, requires close monitoring, and, nurses are the healthcare professionals who spent much of the time with patients (Hendricks-Ferguson et al., 2015). This emphasizes the fact that nursing practice requires nurses to be humanly present and be personally involved in patient care, a characteristic that aligns well with Parse's Theory of Human Becoming, which emphasizes the physical presence of the nurse during care provision; and Kolcaba's Theory of Comfort that emphasizes the importance of nursing interventions that promote comfort (Betül Tosun et al., 2015; Gayoso et al., 2018; Abate et al., 2019; Hu et al., 2019).

The suggestions about sub-competencies to add into the ethical-legal issues core competency are likely to have been triggered by the need to embrace advance directives in care planning (Brännström & Jaarsma, 2015) in our setting. Advanced directives have ethical-legal implications (Bülbul et al., 2015), and in Kenya, the law is silent on this topic at the moment. Additions to the cultural and spiritual

Table 3*List of Core and Level of Agreement for Sub-Competencies for End-of-Life Nursing Care*

Core Competencies		Sub-Competencies*	% agreement in Round 1	% agreement in Round 2
Palliative Nursing Care	1.1	Knowledge		
	1.1.1	Understand the key concepts in palliative nursing care	90	90
	1.1.2	Explain the general principles of palliative nursing care	95	95
	1.1.3	Discuss approaches used in palliative care	77	90
	1.1.4	*Demonstrate an understanding of the role of multidisciplinary team		90
	1.1.5	Describe support systems available and how to access appropriate support services	76	91
	1.1.6	Awareness of triggers and reactions to stressful/distressing situations	80	90
	1.1.7	Understand referral patterns and access to specialist palliative care	87	92
	1.1.8	Demonstrate an understanding of the approaches to assessment in palliative care tools which may be utilized in the holistic assessment process	78	98
	1.2	Attitudes		
	1.2.1	Respect the roles, responsibilities and boundaries in multi-professional working	76	96
	1.2.2	Value the opinions and views of others	77	97
	1.2.3	Value the collaborative approach to working with other services across various sectors	76	96
	1.2.4	Be respectful and empathetic to patients/clients with life-limiting conditions as you provide individualized care.	80	98
	1.2.5	Be supportive and caring to the patient and his/her family	87	97
	1.2.6	Be an advocate for patients/clients and ensure appropriate and timely palliative care interventions at EOL	78	98
	1.3	Skills		
	1.3.1	Be able to apply research findings to improve EOLNC outcomes	80	90
	1.3.2	Effectively work in partnership with other specialist teams	87	96
	1.3.4	*Be able to develop a patient-care plan using the nursing process, and in a team-based manner		95
1.3.5	Be able to recognize when the person's care needs are complex and warrant referral to specialist palliative care	78	98	
Pain Management	2.1	Knowledge		
	2.1.1	Explain the importance of a holistic approach to pain assessment and management	90	90
	2.1.2	Describe the principles of pain management for patients with advanced progressive disease	98	98
	2.1.3	Identify the common physical, spiritual, and psychosocial issues that impact on pain management	80	90
	2.1.4	Describe the pharmacological and non-pharmacological aspects of pain management	98	98
	2.1.5	Describe barriers to pain management	99	99
	2.1.6	*Demonstrate an understanding of the principles of pain management		97
	2.2	Attitudes		
	2.2.1	Be respectful and sensitive to the patient's/family's subjective experience(s)	90	99

Core Competencies	Sub-Competencies*	% agreement in Round 1	% agreement in Round 2
	2.3 Skills		
	2.3.1 Utilize appropriate skills to assess, diagnose, and manage pain	76	96
	2.3.2 *Be able to administer the appropriate pain therapies, including opioids as prescribed		93
	2.3.3 Be able to monitor outcomes of both pharmacological and non-pharmacological management plans	77	97
	2.3.4 Be able to utilize principles of pain management	76	100
Symptom Management	3.1 Knowledge		
	3.1.1 Explain the importance of a holistic approach to symptom assessment and management	90	90
	3.1.2 Describe the principles of palliative symptom management for patients with advanced progressive disease	80	90
	3.1.3 Identify the common physical, spiritual, and psychosocial issues that impact on symptom management	78	91
	3.1.4 Describe the causes and presentation of palliative care emergencies	70	92
	3.1.5 Demonstrate awareness and understanding of Advanced Care Planning, and the times at which it would be appropriate	73	90
	3.1.6 Understand common chronic illness, the expected natural course and trajectories, common treatments and complications	75	97
	3.1.7 *Demonstrate an understanding of the complementary therapies		93
	3.2 Attitudes		
	3.2.1 Treat everyone with whom you come into contact with dignity, respect, humanity, and compassion	87	97
	3.2.3 Value the ethical principles involved when planning care	90	96
	3.3 Skills		
	3.3.1 Be able to assess, diagnose, and manage common symptoms at EOL associated with life-limiting conditions.	87	98
	3.3.2 Set realistic goals of care in partnership with patient/carer(s)	90	97
3.3.3 *Be able to identify palliative care emergencies and intervene appropriately		98	
3.3.4 Regularly review and evaluate care management plans and update appropriately	76	96	
3.3.5 Refer in an appropriate and timely manner to specialist palliative care team, or other disciplines as necessary	80	96	
Ethical and Legal issues	4.1 Knowledge		
	4.1.1 Understand the relevant laws and policies or regulations	74	94
	4.1.2 Discuss ethical principles and their application to EOLNC	88	96
	4.1.3 Identify and discuss issues such as informed choice, mental capacity/incapacity legislation, consent, confidentiality, and patient autonomy	70	90
	4.1.4 *Understand the ethical and legal management issues that impact on symptom management, e.g., will writing, patient rights, euthanasia		90
	4.2 Attitudes		
	4.2.1 Be professional when the patient or family requests for further or modification of treatment	80	98
	4.3 Skills		
4.3.1 Collaborate with others in the use of an ethical framework which guides decision making in the context of EOL care	90	98	

Core Competencies	Sub-Competencies*	% agreement in Round 1	% agreement in Round 2
	4.3.2 *Apply ethical principles in provision of end of life care		96
	4.3.3 Implement and monitor outcomes of ethical decisions	95	98
	4.3.4 Share and document information sensitively and while respecting confidentiality	90	100
Psychosocial, Cultural, and Spiritual Considerations	5.1 Knowledge		
	5.1.1 Understand how one's own personal beliefs and philosophy of life impact on the ways we act and interact with others	72	94
	5.1.2 Identify the spiritual and/or religious needs of patients/families/carers and describe how they may be addressed	77	97
	5.1.3 Demonstrate an understanding of cultural issues at EOL care	70	98
	5.1.4 Understand various aspects of spiritual care	70	90
	5.1.5 *Demonstrate an understanding of the concept of sexuality and how this is affected by the presence of a terminal illness		98
	5.1.6 *Understand the types of informal care givers and their role in EOL care		97
	5.2 Attitudes		
	5.2.1 Be objective and neutral to the patient and his/her family irrespective of the spiritual stance	76	96
	5.2.2 *Be non-judgmental regarding patient sexuality while providing EOL care		98
	5.2.3 Respect the opinions of the informal caregivers	80	98
	5.3 Skills		
	5.3.1 Be able to establish and respect people's wishes about their care and options/preferences	80	94
	5.3.2 Be able to provide last offices in the context of the individuals' beliefs, culture and religious practice	76	76
	5.3.3 Identify the care needs of people from different cultural and religious backgrounds	78	93
	5.3.4 *Be able to identify informal care giver's needs and intervene appropriately		98
	Communication	6.1 Knowledge	
6.1.1 Demonstrate an understanding of the components of open and sensitive communication		80	95
6.1.2 Understand the importance of using strategies that empower effective communication, e.g., active listening, plain language, appropriate tone, empathy		87	97
6.1.3 Explain the importance and impact of non-verbal and verbal communication within all aspects of care		90	95
6.1.4 *Demonstrate an understanding of the process of breaking bad news to a patient/family			96
6.1.5 Explain the concepts of counselling		85	98
6.2 Attitudes			
6.2.1 Show respect for cultural and religious diversity when communicating with the family unit		85	95
6.2.2 Value the importance of establishing a rapport with the patient/carer based on openness, honesty and trust		90	99
6.3 Skills			
6.3.1 *Be sensitive and effective in your communication to patients and informal care givers		100	

Core Competencies	Sub-Competencies*	% agreement in Round 1	% agreement in Round 2	
	6.3.2 Be flexible and modify personal communication style to facilitate communication with persons with a range of communication impairments.	96	98	
	6.3.3 Utilize counselling skills in the care of a patient/family	98	97	
	6.3.4 Communicate with family/carers as appropriate, to determine anticipated care outcomes	95	96	
Loss, Grief, and Bereavement	7.1 Knowledge			
	7.1.1 Understand that grief is a normal and appropriate response to loss which has physical, psychological, spiritual, emotional, and social aspects that affect how it is experienced	70	96	
	7.1.2 Understand the personal impact of loss, grief, and bereavement	80	98	
	7.1.3 Understand the strategies to identify the losses that persons with cognitive and sensory impairment encounter and intervene appropriately	75	95	
	7.1.4 *Demonstrate an understanding of the referral mechanisms to appropriate support services		93	
	7.2 Attitudes			
	7.2.1 Respect the individual nature of the grief response	80	90	
	7.3 Skills			
	7.3.1 Demonstrate self-awareness of personal experiences of loss, to prevent them from negatively impacting on patients/clients.	98	98	
	7.3.2 Be able to provide support in order to help the family to adapt to the bereavement and loss	80	95	
	7.3.3 Be able to engage with a person who is experiencing loss in the context of professional scope of practice and/role	98	98	
	7.3.4 Be able to identify those experiencing complicated grief and utilize resources to appropriately support them	76	90	
	Death and Dying	8.1 Knowledge		
		8.1.1 Outline the practical issues surrounding the death of a patient, for example, death certification and registration	75	96
8.1.2 Demonstrate knowledge of issues and policies relating to any legal, cultural, religious or health and safety requirements when caring for the patient's body		70	97	
8.1.3 *Understand the role of a nurse during death and dying			98	
8.2 Attitudes				
8.2.1 Value the need for dignity and respect towards the patient and others at and around the time of death		95	98	
8.3 Skills				
8.3.1 Care for the patient's body after death, respecting any wishes expressed by the family and any particular religious rites		78	90	
8.3.2 Ensure appropriate identification/verification/certification of death, and care of the patient's body throughout duration of care		87	95	
8.3.3 Be able to anticipate, recognize and respond effectively to signs and symptoms of imminent death		90	97	

Note. *Suggested revisions from Round 1 that were incorporated into Round 2
EOL = end of life; EOLNC = end-of-life nursing care.

core competency may have been triggered by the fact that the presence of a life-threatening illness impacts heavily on both the patient and the family and, as such, there is need to support patients and family caregivers in all aspects of their lives (Bijnsdorp et al., 2019; Grant, 2017; Hu et al., 2019). Experts may have suggested the inclusion of the sub-competencies (Table 2) in the communication core competency, due to the need to foster collaborative relationships during care provision and the importance of effective communication in the whole trajectory of care (Coyle et al., 2015; Nouvet et al., 2016; Ó Coimín et al., 2019; Price et al., 2017).

Finally, in the loss, grief and bereavement core competency, the proposed additions could have emanated from the understanding that the nurses who were the focus for this investigation were non-specialist palliative care nurses. As such, they may be limited in handling complicated grief, which is quite common following death (Kentish-Barnes et al., 2016). Finally, in the death and dying core competency, experts could have suggested the inclusion of this sub-competency due to the fear nurses have expressed regarding death and dying (Ferrell et al., 2015) and understanding their role would enable them to be adequately involved. Adequate involvement by nurses in EOL care is key for provision of high-quality EOL care, as it is noted that they interact with patients the most during the patient's hospital stay.

Limitations

Several limitations of this study should be considered. The study is based upon results from a small expert panel. It was also a homogeneous group with participants from urban communities. This can be a hinderance to representation of rural

communities. Also, the study expert group consisted of nurses only. PC provision is multidimensional in nature and, as such, it would have been prudent to obtain views from other members of a multidisciplinary team to enable robust representation.

Implication of Findings on Policy in Practice

The validated ELNEC competencies on which consensus was achieved can serve as a guideline for the design of end-of-life training programs in Kenya. For instance, the EOLNC common competencies highlighted in this study will enable healthcare facilities to formulate standards, as well as practice procedures, that tackle the required EOL nursing skills, knowledge, and attitude competencies for professional practice among generalist registered nurses.

CONCLUSION

The study indicated consensus was reached among Kenyan nurse experts regarding the EOLNC core and sub-competencies requisite for provision of high-quality EOLNC by generalists. The requisite competencies, identified in this study, for the provision of care for individuals at EOL and their families could be used to guide future policy making and development of EOLNC standards of practice. Nevertheless, further validation of the identified competencies is required, both as an educational resource and as a strategy for actual practice.

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