NURSE'S SKILLS FOR CARDIOLOGY PALLIATIVE CARE
COMPETÊNCIAS DO ENFERMEIRO PARA O CUIDADO PALIATIVO EM CARDIOLOGIA
COMPETENCIAS DEL ENFERMERO PARA EL CUIDADO PALIATIVO EN CARDIOLOGÍA

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ABSTRACT

Objective: to analyze the professional competencies of the nurse for palliative care in the Cardiology Intensive Care Unit. **Method:** a qualitative, descriptive, exploratory study based on the theoretical reference of the Central Skills in Palliative Care and carried out at the ICU of a cardiological hospital. A semi-structured interview was conducted with eight nurses. For the interpretation of the data, the content analysis and the categorization were used. **Results:** nurses from 31 to 41 years old, with more than ten years of experience in the profession and with at least one postgraduate course prevailed. The most cited competences are related to the central constituents of palliative care, family, self-knowledge, professional development and physical comfort. The less-quoted categories portray psychological, spiritual, teamwork, communication, and ethical and clinical decision-making. There were no reports of social needs. The competences that were not applied, refer to the performance in the multiprofessional team, the joint decision making and the education of the professionals and the family. **Conclusion:** citations of competence related to care prevailed. After the recent implementation of the service, the need to strengthen the multiprofessional team and the education of nursing professionals is observed. **Descriptors:** Palliative Care; Professional Competence; Critical Care; Nursing; Intensive Care Units; Cardiology.

RESUMO

Objetivo: analisar as competências profissionais do enfermeiro para o cuidado paliativo em Unidade de Terapia Intensiva Cardiológica. **Método:** estudo qualitativo, descritivo e exploratório fundamentado no referencial teórico das Competências Centrais em Cuidados Paliativos e realizado na UTI de um hospital cardiológico. Realizou-se a entrevista semiestruturada com oito enfermeiros. Para a interpretação dos dados, utilizaram-se a análise de conteúdo e a categorização. **Resultados:** prevaleceram enfermeiras de 31 a 41 anos, com mais de dez anos de experiência na profissão e com, ao menos, um curso de pós-graduação. As competências mais citadas estão relacionadas aos constituintes centrais dos cuidados paliativos, à família, ao autoconhecimento, ao desenvolvimento profissional e ao conforto físico. As categorias menos citadas retratam as necessidades psicológicas, espirituais, o trabalho em equipe, a comunicação e a tomada de decisão ética e clínica. Não houve relatos das necessidades sociais. As competências não aplicadas referem-se à atuação na equipe multiprofissional, à tomada de decisão conjunta e à educação dos profissionais e da família. **Conclusão:** prevaleceram citações de competências relacionadas à assistência. Após recente implantação do serviço, observa-se a necessidade do fortalecimento da equipe multiprofissional e da educação dos profissionais de Enfermagem. **Descritores:** Cuidados Paliativos; Competência Profissional; Cuidados Críticos; Enfermagem; Unidade de Terapia Intensiva; Cardiologia.

RESUMEN

Objetivo: analizar las competencias profesionales del enfermero para el cuidado paliativo en Unidad de Terapia Intensiva Cardiológica. **Método:** estudio cualitativo, descriptivo, exploratorio fundamentado en el referencial teórico de las Competencias Centrales en Cuidados Paliativos y realizado en la UTI de un hospital cardiológico. Se realizó la entrevista semiestructurada con ocho enfermeros. Para la interpretación de los datos, se utilizaron el análisis de contenido y la categorización. **Resultados:** prevalecieron enfermeras de 31 a 41 años, con más de diez años de experiencia en la profesión y con, al menos, un curso de postgrado. Las competencias más citadas están relacionadas a los constituyentes centrales de los cuidados paliativos, a la familia, al autoconocimiento, al desarrollo profesional y al confort físico. Las categorías menos citadas retratan las necesidades psicológicas, espirituales, el trabajo en equipo, la comunicación y la toma de decisión ética y clínica. No hubo informes de las necesidades sociales. Las competencias no aplicadas se refieren a la actuación en el equipo multiprofesional, a la toma de decisión conjunta y a la educación de los profesionales y de la familia. **Conclusión:** prevalecieron citas de competencias relacionadas a la asistencia. Después de la reciente implantación del servicio, se observa la necesidad del fortalecimiento del equipo multiprofesional y de la educación de los profesionales de Enfermería. **Descritores:** Cuidados Paliativos; Competencia Profesional; Cuidados críticos; Enfermería; Unidades de cuidados intensivos; Cardiología.

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INTRODUCTION

The global need for palliative care is increasing as a result of the increase in chronic noncommunicable diseases and the aging of populations.¹

In this scenario, cardiovascular diseases account for 39% of the 40 million people who need palliative care each year.² Despite the growing prevalence of heart failure (HF) and the high burden of symptoms that the disease when compared to patients with malignant diseases, the literature indicates that patients with heart failure are unlikely to receive palliative care, and when they receive care, they differ qualitatively and quantitatively.³⁻⁴

This is because HF presents a set of challenges to the effective implementation of palliative care. Throughout the course of HF, the patients face periods of acute exacerbation producing a non-linear and unclear trajectory. Thus, despite the various guidance tools, the unpredictability of this condition leads to prognostic uncertainty about progression, exacerbation, or death. The lack of knowledge of patients about their condition and insufficient communication among professionals are also barriers.⁴⁻⁵

International data suggest that HF patients generate a high cost of health because of the amount of resources used in the last six months of life.⁴ A survey conducted in four hospitals in New York showed that patients receiving palliative care decreased hospital costs around seven thousand dollars when compared to those who received usual care. The effectiveness of palliative care is revealed, not only in preserving the patient's dignity and quality of life, but also in the economic sphere.⁶

Working with palliative care requires dealing not only with physical needs but with the spiritual, psychological, and social domains.⁵ Skills are needed to understand death as a natural life process, to support the patient and family in the constant redefinition of realistic hopes, communicate effectively and consistently with the patient, health and family staff, including bad news, and, in fact, understand the concept of palliative care and that there is no conflict between the administration of therapies intended to prolong survival and palliative care.⁷

Nurses are frequently confronted with stressful and tragic situations such as death and mourning.⁸ In order to manage these complex situations, nurses need to use skills that imply the ability to mobilize, integrate and utilize resources, knowledge and skills in

the professional environment.⁹ Based on these reflections, the following question was raised: what are the professional competencies of the nurse to work with palliative care in a Cardiological Intensive Care Unit (ICU)?

As a theoretical contribution to this study, the Central Skills in Palliative Care were used.¹⁰ According to the referential, the term Competence can be defined as "an aggregate of related knowledge, skills and attitudes that affects an important part of a job". The author also points out that competence relates to performance in the work environment and can be improved through training and professional development.¹¹

In the referential, guidelines were identified as central constituents of palliative care, so named because they encompass competencies that should be considered during the application of these care. They reflect the underlying values for the application of palliative care principles, thus translating the thinking behind the skills required for professional practice in this area. The constituents listed are: autonomy; dignity; relationship between the professional and the patient; quality of life; position in relation to life and death; Communication; public education; multiprofessional approach and loss and mourning.¹⁰

To follow the line of central constituents, the Ten Central Competences were proposed with the objective of sharing a common language for the practice of palliative care in Europe. They are: 1. Applying the central constituents of palliative care in the proper and safer environment for patients and families; 2. Increase physical comfort during sickness trajectories; 3. Address the psychological needs of patients; 4. Address the social needs of the sick; 5. Address the spiritual needs of the sick; 6. Respond to the needs of family caregivers in relation to short, medium and long term care goals; 7. Respond to the challenges of clinical and ethical decision-making in palliative care; 8. Implement comprehensive care coordination and interdisciplinary work in all contexts where palliative care is offered; 9. Develop interpersonal and communication skills appropriate to palliative care and 10. Promote self-knowledge and continuous professional development.¹⁰

Palliative care is, in essence, collaborative. Thus, the ten competencies transcend the role and function of a specific profession and are expected of all professionals working in palliative care independent of the professional area. The identification of the ten competencies aims to guide the training

of health professionals in the development of education programs in palliative care, as well as being essential and relevant to the delivery of high quality clinical practice.¹⁰

In this context, understanding the need to disclose palliative care in diseases that threaten life beyond the limits of oncology, this study brings to the cardiovascular clinic the discussion of the necessary competencies for nurses to work in the care of the patient and his family in palliative care. Therefore, it was considered essential to evaluate the practice of caring implemented.

OBJECTIVE

- To analyze the professional competences of nurses for palliative care in Cardiology Intensive Care Unit.

MÉTHOD

This is a descriptive, exploratory, qualitative study, based on the theoretical framework of the Central Skills in Palliative Care.⁹ The study was carried out in the Clinical ICU of a public cardiological hospital, after three months of the implementation of a palliative care service, with nurses who worked in the care of patients with cardiovascular diseases.

The inclusion criterion adopted included nurses who worked at the Cardiac Clinical ICU with palliative care. Exclusion criteria included nurses on medical leave or leave in the period of data collection.

The study obeys the ethical precepts of the research and was approved by the research ethics committee under CAAE opinion nº: 62538216.8.0000.5462.

Subsequent to this approval, the data collection took place in the period from July to September of 2017 through individually recorded interviews. For the interview, a semi-structured script was created, created by the researchers, containing characterization data of the sample (age, gender, time of experience as a nurse in intensive care, performance in the institution and post-graduation) and open questions for the identification of competencies of nurses, as well as their application in daily practice.

For the interpretation of the data, the Content Analysis technique was used. The interviews were transcribed and the reading was floated, to identify the competences, based on the discourse of the nurses, followed by the codification and grouping of units into common categories. Double check was made for the exclusion of repetitions and classification of contents.

The responses were classified according to the content analysis and categorized according to the Ten Central Skills in Palliative Care, according to the adopted European theoretical framework.

RESULTS

Regarding the profile of the respondents, eight nurses from the Cardiology ICU were interviewed, all female and aged between 31 and 41 years (62.5%). As for the time of experience as a nurse, four (50%) of them had more than ten years. Regarding the time spent in the ICU, three (37.5%) had between six years to ten years and the same amount presented more than ten years. The time spent in the institution varied, for the most part, between six and ten years (62.5%). All the interviewees had at least one postgraduate course, the majority being Lato sensu in Cardiology (75%), and only one (12%) had a Stricto sensu postgraduate degree, a doctorate.

Through the reports, 46 competencies were identified. In the category of competence **Num.1 - Apply the central constituents of palliative care in the proper environment and safer for patients and families** 15 competences were mentioned. Among the reports are:

(...)provide the patient with a quiet environment, close to their loved ones. (E05)

(...)elaborating the care for the wishes of the family. (E05)

(...)the extended visit time for the patient in palliative care. (E01)

(...)sometimes adaptations need to be made(...) sometimes, there is no physical structure. (E02)

(...)have adequate staffing dimensioning. (E07)

However, in the same category, competences related to the recognition of the need of the patient and the family for an integral care, in addition to the understanding of desires, beliefs and culture.

Nine competencies were cited by nurses in relation to the competency category **Num.6 - Respond to the needs of family caregivers in relation to short, medium and long term care goals**. Most are related to clarifying doubts (...), guiding and promoting family education. The competencies of: guiding the family after death; promote comfort to the family; value their opinions; counseling and working on conflict management with family members were cited by the minority of respondents.

Regarding the competence category **Num.10 - To promote the self-knowledge and the continuous professional**

development, six competences were highlighted. Amongst them, *deepen knowledge (...), design projects and promote studies on palliative care, prepare the team to promote the comfort and well-being of the patient. However, there was no mention of the competence to exercise self-knowledge, being aware of their personal strengths, frailties and moral and spiritual beliefs.*

Within the competence category **Num.2 - To increase the physical comfort during the trajectories of disease of the patients**, five competences were cited, among them, the observation and recognition of common physical signs and symptoms at the end of life. Competences related to the prevention of possible complications and exacerbation of suffering did not appear in the interviewees' statements.

In relation to the competence category **Num.3 - Addressing the psychological needs of patients**, the nurses pointed out four competences that encompassed the concepts present in the referential as identifying psychological suffering, providing psychological support to the patient and family, providing emotional support to the patient, and alleviating suffering, fear and anxiety.

In relation to the competences cited in the category **Num.8 - Implement comprehensive care coordination and interdisciplinary work in all contexts where palliative care is offered**, the nurses reported only two competencies:

The nurse has, as main competences, to compose the multi-professional team (...). (E05)

The nurse must work together with the multi-professional team (...). (E04)

The competence to identify the responsibilities of each team member in the provision of care was not mentioned by any nurses.

In competence **Num.9 - Develop appropriate interpersonal and communication skills for palliative care**, were also cited only two skills that addressed concepts of performing secure and effective communication and empathy. The creation of strategies and the construction of a therapeutic relationship with the patients were not mentioned by the interviewees.

Already in category **Num. 5 - Meeting the spiritual needs of patients**, only one (12.5%) nurse approached about ... allowing religious visits (...). (E08) and none mentioned about integrating the spiritual and religious needs of patients and families into the care plan.

Another category addressed only by one of the interviewees was the **Num.7 Respond to the challenges of clinical and ethical decision-making in palliative care**. None of the interviewees cited action based on bioethical principles, national and international legal frameworks, and the science that the most appropriate ethical care does not always coincide with the patient's desire.

About the category **Num.4 - Meeting the social needs of patients**, none of the respondents addressed competences that encompass these needs.

During the interview, when asked how much **to the applicability of competences** cited by nurses, five (62.5%) of them answered that they were able to put the said competences into practice, but two (25%) said they did not.

The competences not applied are related to the composition and joint decision making with the multi-professional team and the education of the professionals and the family. The main reasons cited are the need to strengthen and integrate the multi-professional team, the organization of work, through the intense demand of the unit, limitations of physical structure and staffing, factors that make it difficult to meet the constant needs of family members.

DISCUSSION

Through the reports, nurses' concerns about structural adaptations to meet the patients' needs are seen in relation to the adopted framework, which considers adaptation a key issue in the successful integration of the principles of palliative care, stressing that it is the professionals who must adapt and not the patient / family to make significant changes in their life circumstances.¹⁰

The report on personnel sizing is more a necessity than a competence in itself. It should be emphasized that human resources are indispensable for the development of the skills required for palliative care, thus interfering in the effective implementation of the principles recommended for palliative care.

Among the competencies of category 1, of the central constituents, which were not mentioned by the nurses, the literature states that one of the key components of palliative care is the decision-making autonomy of the patient and family regarding invasive procedures and emergency measures such as cardiopulmonary resuscitation.⁷ The family should participate in the end-of-life process in

the healthiest way possible, be consulted about therapeutic behaviors and respected in their cultural values, thus reinforcing the competences included in category 6.¹⁰

The family should be included in care as reported in the principles of palliative care, as it feels more secure when it understands the disease process and participates in care, and it is essential that all conflicts involving care are recognized and treated appropriately and referenced to specialist assistance when necessary.¹⁰ Guidance and support at the time of mourning should be given to family members, as well as encouraging them to plan and participate in postmortem rituals to help them understand the real situation and overcome the loss of their loved one.¹²

For the professional who is involved in this type of care, it is necessary to develop the skills covered in category Num.10, which refers to self-knowledge and professional development. Deficiency in education, from the training of professionals, is one of the main obstacles to the implementation of palliative care.^{3,13} Professionals should acquire new knowledge, whenever possible, and be able to identify their competencies and limits in order to focus on their improvement.¹⁰ The quality of care is closely linked to personal skills, highlighting the need for training nurses with knowledge and skills to care for patients with life-threatening diseases.¹⁴

Among the competencies related to category Num.2 are those related to observation and recognition of signs and symptoms. HF patients present a wide variety of physical signs and symptoms such as dyspnea, chest pain, edema, fatigue, exercise intolerance, muscular cramps, pain, anorexia, nausea, constipation and incontinence.¹⁵ Thus, not only to assess and control, as quoted by nurses, but also to anticipate and reevaluate the patient's physical signs and symptoms. Anticipation and reassessment of signs and symptoms aim to prevent possible complications and exacerbations of suffering and, consequently, improve patients' quality of life.¹⁰

In addition to all signs and symptoms related to the clinical picture of HF, it is known that heart disease patients frequently present with psychiatric comorbidities such as anxiety and depression. The diagnosis of these conditions is relevant, since depression is associated with a higher mortality rate. Often, however, the prognosis is not realized because of the overlapping symptoms of HF such as weight loss and changes in sleep.¹⁶ Understanding the patient's psychological

needs and supportive interventions are extremely important, as they not only help the patient, but also the family.^{10,17}

In relation to the competences of category 8, of interdisciplinary work, it is known that in order to achieve one of the main objectives of palliative care, which is to understand and assist the needs of patients with life-threatening diseases and to comply with one of its principles, excellence is required in clinical practice associated with multi-professional teamwork.²

Multi-professional team work also adds other benefits such as work optimization, reduced mortality, and improved patient care.¹⁸ Despite this, the competence to identify and share responsibilities among staff members was not cited by nurses. In order for teamwork to become a means of continuity of care, it is necessary to delineate specific roles and responsibilities of each member towards a common goal and thus make the most effective team action.¹⁰

Communication is a fundamental competence in the finite-life process, since it allows the identification of the needs of the patients and family and is an instrument of emotional support to the patient.¹⁷ However, none of the nurses mentioned the creation of new communication strategies, nor did it explicitly the construction of a therapeutic relationship with patients and the consideration of the level of information that the family and the patient want to receive. A study involving nurses working with patients with HF in palliative care has shown that among the main barriers of communication are lack of professional time and fear of taking the patient's hopes, while a good relationship with the patient and repeated opportunities of discussion are factors that facilitate communication between the professional and the patient.¹⁹

Skills related to spirituality did not appear expressively in the interviewees' statements. Spirituality is seen as a strategy to deal with difficulties and is associated with lower rates of depression, despair and hopelessness in end-stage patients. The literature indicates that the greatest indicator of good patient care in palliative care is attention to religious aspects.²⁰ Thus, it is necessary for professionals to make spiritual needs an integral part of care and a means of providing a supportive environment.¹⁰

No professional has made a decision-making based on ethical principles. Professionals working with palliative care patients must prepare to face and make decisions in the face of ethical dilemmas. It is therefore

necessary for the professional to develop the competence to know and deal with these challenges, taking into account all existing legislation, in addition to the basic principles that involve benevolence, non-maleficence, autonomy and justice.²¹

The lack of reports regarding category 4 of social needs is of concern, since among the most common symptoms in HF patients are the loss of independence in daily living activities and isolation, both closely related to the issue. In addition, the inpatient palliative care patient has concerns about external issues and therefore professionals should assess the patient's and family's social context, provide information about benefits and rights to health and social care when needed, and to enable these patients to manage their own personal affairs where possible.⁹

This lack of reporting may result from the understanding that this is not a competence of the nurse practitioner and, rather, of the social worker, which it is. However, it is evaluated that social, psychological, spiritual and physical factors are part of the integral care and the nurse, respecting the specific competence of each professional area, frequently receives the demands and needs of the patient and family and has, as competence, which understand the social context and refer to specialized help.

Core competencies represent a guideline for professional practice. Thus, it is important that the professional is aware of the factors that may impact the consolidation of his / her professional competencies to implant and anticipate measures that guarantee the adequate provision of palliative care.⁹ In the case of a recently implemented service, the initial diagnosis of the competencies of the nurses represents a north for the consolidation of the work of the multi-professional team, the clarification of the nurse competences and the specifics of palliative care in cardiology, strengthening the development of the service.

The nurses reported difficulties in applying the skills related to decision making in a multi-professional team and the education of professionals and the family due to the intense demand for work, the limitations of the physical structure and the scarcity of human resources. The relevance of promoting an interdisciplinary team work is recognized and valued by the referential, which points out the need to strengthen this aspect so that the team can provide the necessary support to the patient and the family during the disease process.¹⁰

One of the barriers cited in the literature is the lack of information provided to patients and their relatives regarding the progression and severity of the disease. The impact of this is the lack of knowledge of the real course of the disease, which makes it difficult to discuss care goals.⁷

The education of professionals is another important point. The professionals, who work with palliative patients, should be trained, through permanent education and in-service training, to carry out actions guided by knowledge and provide quality care, in an individualized and integral way, that meet the needs of patients and of their relatives.^{10,22}

In the interviewees' speeches, the demand for work, the lack of human resources and the limitations of physical structure are closely linked to the difficulty of realizing decision-making competences and professional and family education. The management of people and the adequate physical structure become a key point for the quality of palliative patient care, since there must be a structure of beds and proper places for the development of actions that aim at the humanized care of the patient, besides from adjusting the needs of the patients' profile to the ideal quantitative of employees. In the absence of this adequate design and with a limited structure, the overload becomes a visible consequence and the professionals end up exercising multiple functions in their work day generating even an occupational stress.²²

Therefore, it is necessary to provide conditions so that the nurse can assist the patient in its entirety allowing the patient who is in their finitude to complete their life cycle with dignity.

CONCLUSION

It is evident that the nurses' competences, in their perception, are related to the competences Num.1, to apply the central constituents of palliative care in the proper and safer environment; Num.6, to recognize and support the needs of family members; Num.10, to promote the continuous professional development and the self-knowledge and Num.2, to provide physical comfort during the trajectory of the disease.

The central competences less quoted by nurses are those of Num. 3, to meet the psychological needs; Num.8, to implement an interdisciplinary team work and Num.9, to develop interpersonal and communication skills. There was only one citation from the nurses regarding the core competencies of Num. 5, meeting the spiritual needs and of

Num. 7, meeting the challenges of ethical and clinical decision making. Finally, the core competence of Num. 4, which refers to meeting social needs, was not mentioned by any nurses.

It is verified that a great part of the competences recognized by nurses during the palliative care of the cardiological patient is related to the patient and family care, thus showing the valuation of care at the bedside by the nurse, in providing a self-care integral to the patient and his / her family, as well as the patient's physical comfort during the end-of-life process.

The main difficulties in the application of skills during patient care reflect the need to strengthen the multiprofessional team, joint decision making, and the need for education of health professionals.

Thus, in order to have a holistic care of the patient in palliative care, it is necessary the delineation of the professionals' competences, as well as the joint action of the multiprofessional team with the sole objective of attending the principles of end of life care.

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