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OBSERVATIONAL STUDY

# Core competencies in palliative care among oncology nurses: an observational study

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## Findings:

*This study highlights the importance of the nurses' experiential component in palliative care, which represents a strongly influential element directly correlated to the provided performances.*

## ABSTRACT

**BACKGROUND:** Palliative care requires a collaborative approach from a multidisciplinary team, incorporating nurses with ethical, clinical, communicative-relational, psychosocial, and teamwork skills. However, many professionals feel unprepared to face end-of-life challenges, highlighting a lack of skills, especially regarding psychosocial and spiritual aspects.

**AIM:** The purpose of this study is to explore nurses' self-perception of competencies in palliative care.

**METHODS:** A single-center descriptive observational study was conducted among palliative and non-palliative care nurses at the Fondazione IRCCS Istituto Nazionale dei Tumori in Milan (INT), using the short Italian version of the Professional Competence Scale (PCSQ). The Kruskal-Wallis test was used along with multivariate ANOVA for statistical analysis.

**RESULTS:** 122 nurses participated (response rate: 52%), predominantly women (78%), aged 25-34 (50%), with a degree (46%) and over 10 years of experience (41%). The majority had no experience (71%) in palliative care, while 16% were currently working in this field. Statistical analysis revealed no significant correlations between educational level and responses. The Kruskal-Wallis test showed that experience in palliative care significantly influenced self-assessment scores, such as in activating non-pharmacological management strategies (p=0.004).

**CONCLUSIONS:** Nurses perceive high competence in ethical and clinical decision-making in palliative care, influenced more by experience than by training. Addressing patients' subjective needs and using non-pharmacological interventions remain a challenge for nurses not working in palliative care settings.

KEYWORDS: *Palliative care, Professional competence, Nursing care, Self-assessment, Nurses*

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STUDIO OSSERVAZIONALE

# Le competenze fondamentali nell'ambito delle cure palliative fra gli infermieri di area oncologica: uno studio osservazionale

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## Riscontri:

*Questo studio evidenzia l'importanza della componente esperienziale nella formazione degli infermieri nelle cure palliative, un elemento fortemente influente, direttamente correlato alle prestazioni fornite.*

## ABSTRACT

**BACKGROUND:** Le cure palliative richiedono un approccio collaborativo di un team multidisciplinare, che integra infermieri dotati di competenze etiche, cliniche, comunicativo-relazionali, psicosociali e di lavoro di squadra. Tuttavia, molti professionisti si sentono impreparati ad affrontare le sfide del fine vita, sottolineando la mancanza di abilità soprattutto riguardo aspetti psicosociali e spirituali.

**OBIETTIVO:** Lo scopo di questo studio è esplorare l'auto-percezione delle competenze degli infermieri sulle cure palliative.

**METODI:** È stato condotto uno studio descrittivo osservazionale monocentrico tra gli infermieri di cure palliative e non della Fondazione IRCCS Istituto Nazionale dei Tumori a Milano (INT), utilizzando la versione breve italiana del questionario sulla competenza professionale (PCSQ). Il test di Kruskal-Wallis è stato impiegato insieme all'ANOVA a più vie per l'analisi statistica.

**RISULTATI:** 122 infermieri hanno partecipato (tasso di risposta: 52%), prevalentemente donne (78%), tra 25-34 anni (50%), con una laurea (46%) e oltre 10 anni di esperienza (41%). La maggior parte non aveva esperienza (71%) in cure palliative, mentre il 16% lavorava attualmente in questo campo. L'analisi statistica non ha rivelato correlazioni significative tra il titolo di studio e le risposte. Il Test di Kruskal-Wallis ha mostrato che l'esperienza in cure palliative ha influenzato significativamente i punteggi di autovalutazione come nell'attivare strategie di gestione non farmacologiche (p=0.004).

**CONCLUSIONI:** Gli infermieri percepiscono un'elevata competenza nella presa di decisioni etiche e cliniche in cure palliative, influenzate più dall'esperienza che dalla formazione. Affrontare i bisogni soggettivi dei pazienti e usare interventi non farmacologici rimane una sfida per gli infermieri che non lavorano nei setting di cure palliative.

KEYWORDS: *Cure Palliative, Competenza professionale, Assistenza infermieristica, Autovalutazione, Infermieri*

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## BACKGROUND

Palliative care (PC) represents specialized assistance directed towards individuals afflicted by an advanced illness with the goal of alleviating the symptoms and suffering caused by the disease itself, aiming to meliorate the quality of life for both patients and their caregivers.(1) This type of care embodies a holistic approach that encompasses the various dimensions of the individual, including the mental, physical, spiritual, social, and economic aspects.(2)

Since palliative care involves many dimensions of care, a multidisciplinary approach is needed, necessitating the collaboration of diverse and specialized team members, including nurses.(3–5) To provide excellent care, healthcare practitioners need a deep understanding of end of life care principles, which they must apply in practice. Nurse competence encompasses knowledge, skills, attitudes, and values. In palliative care, nurses coordinate, maintain, and guarantee care quality while offering support to patients and their families.(6,7) Nurses make up the largest number of healthcare professionals involved in the delivery of palliative care, and in order to provide personalized care, it is necessary to have appropriate training.(8–10)

Based on a descriptive study conducted by Pereira S.M. et al., which examined the current status of undergraduate and postgraduate nursing education across Europe, it becomes evident that in 14 out of 25 countries surveyed (including Italy), palliative care was not designated as a compulsory education in undergraduate nursing programs. Furthermore, in approximately half of these countries, there were no postgraduate palliative care education opportunities available for nurses.(8)

Hospice and palliative care education has indeed played a significant role in enhancing knowledge about these care but nursing students found to have a poor knowledge of palliative care.(11) When they receive hospice education, it results in a more positive overall attitude toward death, including reduced death anxiety.(11,12)

The "Guide for the Development of Palliative Nurse Education in Europe" by the European Association for Palliative Care (EAPC), presented a comprehensive framework consisting of three tiers of palliative care nursing education: the basic educational level (level A); the advanced level (level B) and the specialist level (level C) that correspond to various aspects of learning process and professional standards expected in practice, aiming to achieve various levels of competence.(8,13)

Core competences in palliative care are knowledge, key skills, personal qualities, attributes and behaviours that an individual must have in order to perform a job effectively and divided them into five areas: ethical, clinical, communicative-relational, psychosocial, and teamwork.(14)

In 2013, the European Association for Palliative Care (EAPC) released a white paper defining ten core competencies for palliative care professionals

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globally.(15) Concurrently, the Italian Society of Palliative Care (SICP) developed a Nursing Core Curriculum in Palliative Care (CCICP) with 26 competencies.(16,17) The assessment of nurses' competencies can be carried out using questionnaires, which, however, are lacking in the specific context of palliative care.(18)

Enhancing this curriculum, in 2015, the SICP introduced the Professional-competence short questionnaire (PCSQ), developed by Prandi, Biagioli, and Fida, as a self-assessment tool for nurses, based on these competencies. This initiative reflects a significant step towards standardizing and improving palliative care training and self-evaluation.(19)

Even with heightened awareness and a greater understanding of palliative care, there persists a uncertainty regarding the interpretation of palliative care and its practical application among health care professionals.(19–24). Nevertheless, literature has identified that numerous nurses do not feel sufficiently prepared to deliver end-of-life care, experiencing a sense of unreadiness, lack of support, and confidence and skill deficits for fulfilling this role,(24–26) especially regarding the psychosocial and spiritual aspects of end-of-life care.(27) This is particularly evident among nurses working in non-specialist palliative care settings.(28) However, further studies are needed both to explore the level of self-competence perceived by nurses with respect to the provision of palliative care and as a starting point for embarking on a broader process of assessing professionals and, thus, learning about and addressing their educational, professional and interpersonal needs. (29)

In fact, in the most recent scientific literature, the knowledge and attitudes regarding end-of-life care, especially among nurses who do not work in palliative care settings, are still relatively unexplored. (28)

**Aim:** The aim of this study is to explore the perceived self-competence by nurses on palliative care.

## METHODS

### Study design

The chosen study design to achieve the research aim is that of a single-center observational descriptive study, following the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) checklist.(30)

### Setting

The study was conducted at the Fondazione IRCCS Istituto Nazionale dei Tumori of Milan (INT), an Italian oncology center known for its high-quality public healthcare services and commitment to research, preclinical and clinical activities, screening, differential diagnosis, and cancer treatments.

### Sampling

The sample was selected through a convenience sampling method, targeting all nurses employed at INT.

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### Recruitment

The inclusion criteria encompass nurses with and without experience in palliative care, engaged in the Clinical Departments of Surgical Oncology, Oncology and Hematology, including direct care providers and coordinators. Exclusion criteria apply to nurses in Diagnostic Pathology, Research, Administrative Management, operating rooms.

### Instrument

Data collection was carried out through the italian version of the questionnaire "The Professional-competence short questionnaire (PCSQ)"(31) (Supplementary Material). The questionnaire, consisting of 24 items, explores the five areas of competence in palliative care: ethical, clinical, communicative-relational, psychosocial, and teamwork. For each of the items of every area of the questionnaire, respondents are asked to make a self-judgment about how competent they feel they are for each activity described on a scale numbered from 0 ("not at all competent") to 10 ("completely competent").

### Data analysis

Data were extracted from the questionnaires and analyzed using Microsoft Excel software and the R studio program through R software (version 4.2.2).(32) Descriptive statistical analysis was carried out through graphs and summary statistics. Next, the Kruskal Wallis test was used to compare the variables Question (categorical variable) and Answer (numerical variable). Confidence intervals were set at 95% with a p value <0.05. Then, through multi-way ANOVA, it was tested whether, by joint estimation, the selected groups possessed statistical effect.

### Data collection

Prior authorization for the study was obtained from the IRCCS Istituto Nazionale dei Tumori's Health Professions Management. An email was then sent to nursing coordinators and their teams in the relevant departments, inviting participation in the study. Data collection was conducted via a web-survey from February 8 to March 3, 2023, using the RedCap web application, supported by the Institute's ICT and Corporate Information Systems staff. The survey included a socio-demographic data form before the questionnaire to ensure complete data collection.

### Ethical considerations

All of the participants provided written consent after being informed orally and in writing about the study purpose, that it was voluntary and their right to withdraw. They were informed that the data would be processed in aggregate form and used in accordance with the current legislation on the protection of sensitive data and the privacy regulations set forth in Legislative Decree No. 101/2018 and EU Regulation No. 2016/679, laying down provisions for the protection of individuals with regard to the processing of personal data, ensuring the anonymity of participants. In addition, that data would be treated

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confidentially, and grades in placement would not be affected.

## RESULTS

The total number of nurses invited to participate in the study was 233, of whom 122 (52%) participated. Among them, after excluding reports that were incomplete, there were 115 questionnaires deemed valid for the study.

The sociodemographic characteristics of the participating nurses are shown in *Table 1*.

The sample consisted mainly of women (78%) and nurses in the 25-34 age group (50%). The majority of respondents have a bachelor's degree (46%) and over 10 years of experience (41%). Seventy-one percent have no experience in Palliative Care, 16% currently work in this field, and 13% have past experience. Among those with Palliative Care experience, 79% have basic training, while 21% hold a first-level university master's degree in "Palliative Care and Pain".

*Table 2* summarizes the descriptive statistics of individual items in the questionnaire.

The values of the medians for individual items range from a minimum value of 6 (for items: 2, 3, 4, 5, 6, 17), to a maximum value of 8 (in the case of items 9, 10, 11, 15, 20). As for the variances, the values range from $s^2$ = 2,76 (item 20) to 7.44 (item 9).

| CHARACTERISTICS | N | (%) | MEAN TOTAL SCORE |
|---|---|---|---|
| **Age** | | | |
| <25 years old | 6 | 5% | 5,4 |
| 25-34 years old | 58 | 50% | 6,6 |
| 35-44 years old | 19 | 17% | 7,5 |
| 45-54 years old | 15 | 13% | 6,2 |
| >54 years old | 17 | 15% | 7 |
| **GENDER** | | | |
| Female | 90 | 78% | 6,5 |
| Male | 24 | 21% | 7,2 |
| Other | 1 | 1% | 7 |
| **DEPARTMENT** | | | |
| Medical | 63 | 55% | 7 |
| Surgical | 52 | 45% | 6,4 |
| **NURSING EXPERIENCE** | | | |
| <6 months-2 years | 16 | 14% | 6,3 |
| 3-5 years | 25 | 22% | 6,8 |
| 6-10 years | 27 | 23% | 6,8 |
| >10 years | 47 | 41% | 6,7 |
| **EXPERIENCE IN THE WARD** | | | |
| <6 months-2 years | 38 | 33% | 6,6 |
| 3-5 years | 26 | 23% | 6,6 |
| 6-10 years | 17 | 15% | 6,9 |
| >10 years | 34 | 29% | 6,7 |
| **EXPERIENCE IN PALLIATIVE CARE** | | | |
| Yes, actual experience | 18 | 16% | 7,6 |
| Yes, previous experience | 15 | 13% | 7 |
| No | 82 | 71% | 6,4 |
| **IF YOU HAVE EXPERIENCE IN PALLIATIVE CARE, WITH WHAT TRAINING?** | | | |
| Basic training | 26 | 79% | 7,1 |
| Master's degree in Palliative Care and Pain Therapy | 7 | 21% | 8,2 |
| **EDUCATIONAL QUALIFICATION** | | | |
| Regional Diploma | 18 | 16% | 6,8 |
| University Diploma | 1 | 1% | 9,7 |
| Bachelor's Degree | 53 | 46% | 6,7 |
| First Level Master's Degree | 37 | 32% | 6,5 |
| Master's Degree | 6 | 5% | 6,9 |
| Second Level Master's Degree | 0 | 0% | 0 |

*Table 1: Characteristics of participants*

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| Items | Means | Median | ±ds (s) | Variance | IC min means | IC max means |
|---|---|---|---|---|---|---|
| **1**. Identify adequate interventions for different sorts of pain | 7,12 | 7 | 1,8 | 3,25 | 6,74 | 7,5 |
| **2**. Use non-pharmacological strategies for pain control in a team. | 5,8 | 6 | 2,26 | 5,11 | 5,32 | 6,28 |
| **3**. Team management of the care process and the required medications for palliative sedation. | 6,17 | 6 | 2,48 | 6,14 | 5,64 | 6,69 |
| **4**. Use tailored, appropriate and effective interventions for the collaborative management of the main problems of the person cared in Palliative Care. | 6,08 | 6 | 2,14 | 4,56 | 5,63 | 6,53 |
| **5**. Use tailored, appropriate and effective team interventions to manage responses to disease, symptoms, treatment, death and mourning. | 5,83 | 6 | 2,23 | 4,95 | 5,35 | 6,3 |
| **6**. Activate non-pharmacological strategies for the management of the person cared for. | 5,85 | 6 | 2,13 | 4,55 | 5,4 | 6,3 |
| **7**. Identify the clinical conditions that require the following therapies: antibiotic therapy, transfusions of blood derivatives, dialysis, artificial nutrition, hydration, paracentesis and thoracentesis and manage them in teams | 7,19 | 7 | 1,74 | 3,03 | 6.82 | 7,56 |
| **8**. Use clinical-organisational tools for the best managing of the last days/hours of life of the cared for person and his/her family. | 6,18 | 7 | 2,17 | 4,73 | 5,72 | 6,64 |
| **9**. Prepare the body, respecting the dignity and will of the person in the framework of current regulations and provisions. | 6,74 | 8 | 2,73 | 7,44 | 6,16 | 7,32 |
| **10**. Apply the principles for the safeguard of the dignity and empowerment of each person. | 7,58 | 8 | 1,92 | 3,68 | 7,18 | 7,99 |
| **11**. Foster the expression of needs. | 7,57 | 8 | 1,87 | 3,49 | 7,17 | 7,96 |
| **12**. Evaluate the totality of needs, both expressed and not, catching the deeper meanings of narratives about health/disease experiences. | 7,03 | 7 | 1,95 | 3,8 | 6,61 | 7,44 |
| **13**. Use tailored care responses, valuing one's own abilities and those of each person involved in the care plan. | 6,91 | 7 | 2,01 | 4,05 | 6,49 | 7,34 |
| **14**. Manage, individually and in teams, emotional states that impinge on effective communication. | 6,77 | 7 | 2,11 | 4,46 | 6,33 | 7,22 |
| **15**. Adapt communication to the culture; values; knowledge levels; emotions; preferences and clinical and cognitive conditions of the patient, his/her family and scenario of care. | 7,14 | 8 | 2,03 | 4,12 | 6,71 | 7,57 |
| **16**. Use all interventions and tools that enable effective communication, in accordance with the patient's degree of disability. | 6,97 | 7 | 2,01 | 4,04 | 6,55 | 7,4 |
| **17**. Respond appropriately, in a team and in all the services of the Palliative Care Network, to the cultural, ethnic, generational, gender and reaction differences to illness, the process of dying, death and mourning. | 5,99 | 6 | 2,24 | 5,03 | 5,52 | 6,47 |
| **18**. Safeguard, in the team and in all the Network services, the assisted person's rights. | 6,97 | 7 | 2,05 | 4,19 | 6,53 | 7,4 |
| **19**. Safeguard the patient's will, taking into account the complexity of decisions in Palliative Care. | 7,08 | 7 | 2,04 | 4,18 | 6,65 | 7,51 |
| **20**. Apply the ethical and deontological principles of care. | 7,65 | 8 | 1,66 | 2,76 | 7,3 | 8 |
| **21**. Implement Palliative Care regulations. | 6,32 | 7 | 2,33 | 5,45 | 5,83 | 6,82 |
| **22**. Apply the philosophy and founding values of Nursing and Palliative Care | 6,35 | 7 | 2,26 | 5,12 | 5,87 | 6,83 |
| **23**. Address ethical/moral issues in Palliative Care decisions. | 6,26 | 7 | 2,36 | 5,58 | 5,76 | 6,76 |
| **24**. Address clinical situations requiring an arduous decision-making about the appropriateness of some treatments in Palliative Care | 6,32 | 7 | 2,49 | 6,19 | 5,79 | 6,85 |

*Table 2: Descriptive statistics of questionnaire responses*

Subsequently, the correlations between each numerical variable (i.e. the data collected for each item) and the categorical variables (referring to the socio-demographic characteristics) were analysed using the Kruskal Wallis Test. From the entire analysis, we report the questionnaire questions from which certain correlations emerge, considering p-

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values <0.05 to be valid. In particular, *Table 3* summarises the relationship of the items (expressed in numerical values from 1 to 24) with the categorical variables: Age, Gender, Department, Nursing experience, Experience in the ward, If you have experience in Palliative Care, with what training?, Educational qualification.

| | p-value | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Items** | **Age** | **Gender** | **Department** | **Nursing experience** | **Experience in the ward** | **Experience in palliative care** | **If you have experience in palliative care, with what training?** | **Educational qualification** |
| **1** | 0.539 | 0.454 | 0.866 | 0.907 | 0.883 | 0.299 | 0.334 | 0.157 |
| **2** | 0.111 | 0.141 | 0.078 | 0.828 | 0.621 | 0.082 | 0.077 | 0.567 |
| **3** | 0.187 | 0.236 | **0.014** | 0.505 | 0.259 | **0.003** | **0.002** | 0.074 |
| **4** | 0.203 | 0.27 | **0.030** | 0.280 | 0.728 | **0.000** | **0.000** | 0.228 |
| **5** | 0.078 | 0.226 | **0.011** | 0.477 | 0.542 | **0.000** | **0.000** | 0.247 |
| **6** | 0.232 | 0.565 | 0.190 | 0.616 | 0.886 | **0.004** | **0.002** | 0.766 |
| **7** | 0.475 | 0.215 | 0.924 | 0.523 | 0.704 | 0.905 | 0.389 | 0.384 |
| **8** | 0.211 | 0.519 | 0.083 | 0.363 | 0.997 | **0.014** | **0.008** | 0.181 |
| **9** | **0.015** | 0.877 | **0.002** | 0.403 | 0.759 | **0.001** | **0.013** | 0.285 |
| **10** | 0.372 | 0.308 | 0.131 | 0.931 | 0.970 | 0.091 | 0.411 | 0.173 |
| **11** | 0.188 | 0.11 | 0.227 | 0.938 | 0.968 | 0.600 | 0.192 | 0.253 |
| **12** | 0.128 | 0.300 | 0.137 | 0.966 | 0.851 | 0.140 | **0.039** | 0.389 |
| **13** | 0.215 | 0.097 | 0.072 | 0.831 | 0.803 | 0.067 | **0.019** | 0.469 |
| **14** | 0.191 | **0.007** | 0.637 | 0.988 | 0.941 | 0.570 | 0.075 | 0.532 |
| **15** | 0.087 | 0.119 | 0.495 | 0.915 | 0.825 | 0.858 | 0.156 | 0.324 |
| **16** | **0.023** | 0.219 | 0.265 | 0.844 | 0.836 | 0.332 | 0.096 | 0.451 |
| **17** | **0.025** | 0.421 | 0.337 | 0.73 | 0.437 | **0.048** | **0.019** | 0.295 |
| **18** | 0.232 | 0.250 | 0.541 | 0.900 | 0.862 | **0.047** | 0.070 | 0.304 |
| **19** | 0.072 | 0.338 | 0.108 | 0.959 | 0.998 | 0.082 | 0.090 | 0.404 |
| **20** | 0.145 | 0.411 | 0.268 | 0.833 | 0.898 | 0.433 | 0.505 | 0.231 |
| **21** | 0.0898 | 0.133 | 0.063 | 0.819 | 0.572 | **0.006** | **0.005** | 0.427 |
| **22** | 0.088 | 0.233 | 0.336 | 0.810 | 0.431 | **0.049** | **0.026** | 0.514 |
| **23** | 0.109 | 0.152 | 0.084 | 0.811 | 0.307 | 0.073 | 0.068 | 0.510 |
| **24** | 0.095 | **0.044** | 0.072 | 0.871 | 0.746 | 0.064 | 0.053 | 0.5811 |

*Table 3: Kruskal Wallis Test for all variables*

The gathered data indicates that there is no significant evidence of correlation among variables for responses to items 1, 2, 7, 10, 11, 15, 19, 20, 23. Within the chosen sample, there are no notable correlations with educational qualification. However, statistical significance is observed in connection with work experience in Palliative Care and relevant training, as well as age, department, and, in two instances, gender. Hence, these results suggest that experience and training in Palliative Care are likely the primary prerequisites, among the identified categories, exerting a more substantial impact on the probed

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competence values. Conversely, there seems to be no alignment with educational background in a general sense.

In order to summarise this data, a Kruskal Wallis Test was again performed by analysing a global variable, obtained by averaging all the questions, in order to obtain a final self-assessment score of one's palliative care skills.

Taking into consideration the results obtained and in view of the dependence of the category inherent to the experience in palliative care with the relevant training, we wanted to test its statistical effect by means of the multiple-way ANOVA test. From the joint test it emerges that the second category, relating to education, has no statistical effect without the first, therefore, of the two variables, in order to estimate the mean of the responses, only the correlation between experience in palliative care with nursing skills is to be considered statistically valid (p = 0.013), as reported in *Table 4*.

| Group (Categorical Variable) | P-value Kruskal Wallis | p-value Two-way ANOVA |
|---|---|---|
| **1:** Age | **0.028** | |
| **2:** Gender | 0.135 | |
| **3:** Department | 0.072 | |
| **4:** Nursing experience | 0.831 | |
| **5:** Experience in the ward | 0.827 | |
| **6:** Experience in palliative care | **0.013** | **0.014** |
| **7:** If you have experience in Palliative Care, with what training? | **0.008** | 0.173 |
| **8:** Educational qualification | 0.390 | |

*Table 4: Kruskal Wallis Test for mean response and two-way Anova for mean response (experience in palliative care and related training)*

To assess the reliability of the questionnaire in relation to the sampling taken for the study, the Cronbach's Alpha was calculated, which presented a value of 0.98.

## DISCUSSION

This study explored the self-assessment of palliative and non-palliative care nurses within an Italian cancer center on the palliative care competencies they possessed, as described by the SICP Nursing Core Curriculum in Palliative Care, offering a broad overview of general nursing preparation. In fact, in the most recent scientific literature, the area of knowledge and attitudes related to end-of-life care by nurses who do not specialize in this area is still relatively unexplored. (28)

The results of this study reported that seventy-one percent of the participants in this study's sample having no work experience in the specific context of palliative care, and only about 6% have obtained a first-level Master's degree in "Palliative Care and Pain Therapy". For the participating nurses, educational qualification does not appear to be a correlating factor for the competencies investigated, as instead has been shown in the literature.(20) On the contrary, they present rather equidistributed values among the various levels of education and with average fluctuations in scores among the different items tending to be homogeneous. (20)

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It is evident that professional experience plays an impactful role with regard to skills in the management of palliative sedation, the use of personalised and appropriate interventions, the activation of non-pharmacological strategies the use of clinical-organisational tools in the last days of the person assisted, the preparation of the body, the relationship with cultural, generational and reaction to illness diversity, the protection of the assisted person's rights and the application of palliative care legislation, its philosophy and values.

Analyzing specific competencies, it is observed that nurses in the Medicine department rate themselves higher than their colleagues in the Surgery departments. This data is particularly relevant and can be justified by the fact that Palliative Care has its roots in the medical field, where the required care extends throughout the entire clinical course of the condition and its progression, unlike the surgical context. This approach aligns more closely with the care management expected of operational nurses in palliative settings. The data indicates that nurses in specialized oncology settings, regardless of their training level, feel more confident and skilled in caring for patients with chronic-advanced diseases and their families, showing heightened sensitivity and understanding of disease progression and approaching end-of-life situations. The findings emphasize that in oncology, where end-of-life care is frequent, practical experience outweighs formal training in shaping professionals approaches. While basic training covers some aspects of palliative care, the key to developing palliative skills lies in hands-on work experience. Training remains important for foundational knowledge, but in oncology, practical experience, influenced by the professionals' age, seems to be the primary determinant of palliative expertise.

Participating nurses self-assess positively in terms of their skills in effective communication with the assisted individual and their family, garnering medium to high scores. Through the Kruskal-Wallis Test, emerged a correlation between the age of nurses and the communication strategies employed in relation to the level of disability of the assisted person ($p = 0.023$) and between gender and emotional management in relationships, indicating that men rate themselves as more competent compared to women ($p = 0.007$).

Despite the challenging and delicate nature of end-of-life care, overall, the nurses in this study self-assess with a median score ranging between 7 and 8 out of a total of 10. This applies to items related to the application of ethical, moral, and philosophical principles in care, adherence to legislation, and the handling of clinical situations involving difficult decisions regarding the appropriateness of treatments.

The results indicate that nurses not specialized in palliative care within oncology demonstrate strong self-assessed competencies, with higher scores in aspects requiring more scientific and organizational

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preparation. Furthermore, challenges arise in meeting the subjective needs of patients and in using non-pharmacological interventions, highlighting the need for greater focus on these aspects in training and professional development programs.

This study may serve to make nurses more aware of their competencies and the need to enhance their training, especially on certain aspects of end-of-life care; the compilation of a questionnaire like that used in this study, can make nurses reflect on their own competences.

**Limitations**

This study has several limitations. The study was conducted in the Northern Italy, therefore, results from our study may not be representative of other regions in Italy. It is a single-center study, therefore the sampling is confined to a single hospital, and the data obtained are not generalizable to all nursing staff. In addition, the hospital in which the study was carried out is single-specialty i.e. oncology and the results are representative only of the circumscribed oncology setting. As for the sample, the percentage of participants who joined the study is not particularly high.

## CONCLUSIONS

The current study aimed at the self-assessment of nurses' competencies at the IRCCS National Cancer Institute in the field of Palliative Care. In this context, it is essential that the nursing staff feel prepared, trained, and competent in caring for this type of patient. Participants in this study evaluated their competencies in the entire range of Palliative Care with overall medium-high scores. Specifically, they believe they possess good competence in the ability to care for the person at the end of life and their family, with sensitivity and overall attention, safeguarding the rights of the involved individuals and their respective beliefs and values, through the application of ethical and deontological principles of care. Furthermore, this study highlights the importance of the nurses' experiential component in palliative care, which represents a strongly influential element directly correlated to the provided performances. Future studies are necessary to gain a broader overview of how nurses evaluate their competencies in the context of palliative care, expanding to other geographical areas of Italy.

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**Declaration of Competing Interest**

The authors declare that there are no conflicts of interest.

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# APPENDIX

## Appendix n.1: Professional-Competence Short Questionnaire (PCSQ)

| Not competent | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Fully competent |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1**. Identify adequate interventions for different sorts of pain | | | | | | | | | | | | |
| **2**. Use non-pharmacological strategies for pain control in a team. | | | | | | | | | | | | |
| **3**. Team management of the care process and the required medications for palliative sedation. | | | | | | | | | | | | |
| **4**. Use tailored, appropriate and effective interventions for the collaborative management of the main problems of the person cared in Palliative Care. | | | | | | | | | | | | |
| **5**. Use tailored, appropriate and effective team interventions to manage responses to disease, symptoms, treatment, death and mourning. | | | | | | | | | | | | |
| **6**. Activate non-pharmacological strategies for the management of the person cared for. | | | | | | | | | | | | |
| **7**. Identify the clinical conditions that require the following therapies: antibiotic therapy, transfusions of blood derivatives, dialysis, artificial nutrition,hydration, paracentesis and thoracentesis and manage them in teams. | | | | | | | | | | | | |
| **8**. Use clinical-organisational tools for the best managing of the last days/hours of life of the cared for person and his/her family. | | | | | | | | | | | | |
| **9**. Prepare the body, respecting the dignity and will of the person in the framework of current regulations and provisions. | | | | | | | | | | | | |
| **10**. Apply the principles for the safeguard of the dignity and empowerment of each person. | | | | | | | | | | | | |
| **11**. Foster the expression of needs. | | | | | | | | | | | | |
| **12**. Evaluate the totality of needs, both expressed and not, catching the deeper meanings of narratives about health/disease experiences. | | | | | | | | | | | | |
| **13**. Use tailored care responses, valuing one's own abilities and those of each person involved in the care plan. | | | | | | | | | | | | |
| **14**. Manage, individually and in teams, emotional states that impinge on effective communication. | | | | | | | | | | | | |
| **15**. Adapt communication to the culture; values; knowledge levels; emotions; preferences and clinical and cognitive conditions of the patient, his/her family and scenario of care. | | | | | | | | | | | | |
| **16**. Use all interventions and tools that enable effective communication, in accordance with the patient's degree of disability. | | | | | | | | | | | | |
| **17**. Respond appropriately, in a team and in all the services of the Palliative Care Network, to the cultural, ethnic, generational, gender and reaction differences to illness, the process of dying, death and mourning. | | | | | | | | | | | | |
| **18**. Safeguard, in the team and in all the Network services, the assisted person's rights. | | | | | | | | | | | | |
| **19**. Safeguard the patient's will, taking into account the complexity of decisions in Palliative Care. | | | | | | | | | | | | |
| **20**. Apply the ethical and deontological principles of care. | | | | | | | | | | | | |
| **21**. Implement Palliative Care regulations. | | | | | | | | | | | | |
| **22**. Apply the philosophy and founding values of Nursing and Palliative Care | | | | | | | | | | | | |
| **23**. Address ethical/moral issues in Palliative Care decisions. | | | | | | | | | | | | |
| **24.** Address clinical situations requiring an arduous decision-making about | | | | | | | | | | | | |

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