Palliative nursing competencies required for different levels of palliative care provision: a qualitative analysis of healthcare professionals' perspectives.

Short title: Nursing competencies in different levels

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Keywords: Competences, Education, Nursing, Palliative care, professional competence, Qualitative research

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ABSTRACT

Background: Nurses must possess adequate competencies to provide high-quality palliative care. Earlier statements have described certain competencies that are relevant for palliative care, yet only limited empirical research has focused on the perspective of healthcare professionals to clarify which competencies are required for different levels of palliative care provision.

Objective: The aim was to describe the required palliative nursing competencies of registered nurses aligned to different levels of palliative care provision, from the perspectives of multi-professional groups.

Design: A qualitative study design.

Setting/Subjects: A purposive sample of professionals, working in different levels of palliative care across various settings in Finland, was used to gain information about the aim of the study (*n=222*).

Measurements: Content analysis was applied to describe the competencies of registered nurses.

Results: Competencies relevant to basic palliative care were categorized under 17 main categories, which included a total of 75 subcategories. 'Competence in managing the most common symptoms' was the main category which contained the largest number of reduced expressions (f=75). An analysis of specialist palliative care data yielded 10 main categories, including 49 subcategories, with 'Competence in maintaining expertise and taking care of own well-being at work' containing the most reduced expressions.

Conclusion: The study provided new knowledge; more specifically, competencies related to encounters and maintaining hope were described as palliative care nursing competences. The results can be used to ensure that palliative nursing education focuses on the competences that are necessary in practice.

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Introduction

Nurses are the largest professional group in healthcare, representing approximately 59% of all healthcare professionals[1] and the largest professional group involved in palliative care provision over a wide range of contexts.[2,3] Palliative care is evolving rapidly due to increasing global demand, based mainly on population aging and the growing prevalence of non-communicable diseases.[4]

The European Union assembly considers access to palliative care as a human right.[5] There are certain recommendations to develop palliative care and fully integrate it into the healthcare system.[5,6] Nevertheless, it has been stated that palliative care has not reached an appropriate quality standard within Europe[5] and that its provision requires adequate competence from the healthcare professionals involved.[6]

The World Health Organization defines palliative care as an approach to relieve and prevent suffering and improve the quality of life of patients and families burdened by life-threatening illness. It is an approach that addresses the physical, psychological, social and spiritual needs of the patient and their family.[7] Following levels can be identified in the provision of palliative care: (1) the palliative care approach, which is provided in settings that do not

provide specialist palliative care, such as primary care, nursing homes and hospital wards; and (2) specialist palliative care settings, where the main focus is to provide palliative care by specialized professionals.[8] The levels can also be defined as primary palliative care, whereby care is provided by non-specialists, and specialty palliative care, whereby care is provided by palliative care specialists.[9] Thus, various forms and levels of education must exist, and reflect the competencies required to work in the distinct levels of palliative care.[6]

When providing quality palliative care, nurses are the professional group spending the most time with the patient and their closest ones. In this way, nurses coordinate care, ensure the continuity and quality of care, and support the patient and their family.[10,11] In the context of nursing, competence covers a diverse set of knowledge, skills, values and attitudes that enable the nurse to care for their patient.[12, 13] Appropriate palliative care nursing competencies are described as an antecedent, an ability that will enable nurses to deliver high-quality palliative care[14].

The different levels of palliative care provision in Finland are defined in the current national recommendation[15]. The specialist level of palliative care is provided by hospital wards, hospices and palliative home-care units. The main focus in these units is on palliative care and, as such, the healthcare professionals working in this level of care should have specialized palliative care education[15]. In Finland, basic palliative care is provided across various care settings, including nursing homes and hospital wards. This level of care provides basic palliative care by non-specialist healthcare professionals and the undergraduate education should provide adequate competencies to provide the care.[15] In this study, the expression ‘specialist level competencies’ refers to the competencies needed to provide palliative care in specialized contexts by specialized nurses, whereas the expression ‘basic level competencies’

refers to the competencies that all non-specialized nurses providing basic palliative care should possess.

Nurses' palliative care education varies considerably in Finland.[15] Sufficient education has been identified as a critical factor in the integration of palliative care into the healthcare system.[16] When developing the education, there is a need to define the competencies aligned to the different levels. Previous research has rarely defined the palliative care nursing competencies that correspond to a distinct level of palliative care. Hence, there is a knowledge gap concerning which competencies nurses should possess to successfully work in different levels of palliative care.[17, 18]

METHODS

This study aimed to describe the required palliative nursing competencies of registered nurses aligned to different levels of palliative care provision, from the perspectives of multi-professional groups. To present a comprehensive summary of the phenomenon of interest, a descriptive qualitative study design was applied[19].

Data collection and sample

A purposive sample of professionals, working in different levels of palliative care across various settings, was invited to provide information in workshops about competencies relevant to different levels of palliative care. The workshops were organized in different parts of Finland. Before the recruitment began, the Ethical Committee of North Ostrobothnia's Hospital District was asked whether ethical approval would be required. The Ethical Committee stated that formal approval was not required because the study did not intervene with the professionals' integrity. Participating organizations were informed of the data

collection and they agreed with it. The sample (n=222) included representatives from a range of healthcare and patient organizations (Table 1).

(Table 1 here please)

Managers from each of the organizations were asked to propose the most appropriate representatives for the aim of the study. Individuals recommended by the managers were sent an invitation letter that included information on the purpose of the study, why the study was being conducted and those responsible for it.

Teachers from universities of applied sciences (UASs) participating in a national EduPal-project, whose aim is to develop palliative care education, organized the workshops. The workshops took place either at the UASs or the workplaces of the workshop members. In some cases, a basic level group and a specialist level group were invited to the same workshop; in these instances, the workshops covered more than one working group (WG). In total, data were collected from 36 WGs in 21 workshops. The workshops were moderated by teachers of the UASs and, in two workshops, the research team members (H-L.M. & J.T.L) acted as the moderator. However, no participant-moderator relationships were formed before the start of the study. No persons other than the participants and moderators were present in the workshops.

A questionnaire was used to collect the data. The moderators started the workshops by presenting the study and the project, and by going through the instructions for the workshop activities. The participants were informed that their participation was voluntary and that the collected data would be treated anonymously. All the participants provided their informed

consent. The questionnaire was developed specifically for this study. It consisted of 10 open-ended questions covering competencies relevant to the field of palliative care, along with other aspects of palliative care development. The questionnaire had been pre-tested on one WG before data collection. The results of the pre-test indicated that no changes to the questionnaire were required; hence, the pre-test data could be included in the actual research data.

The participants discussed their views and documented their answers. In most cases, the answers were documented on paper, while a small portion of the WGs used computers to document their answers. The moderators did not participate in the discussions but were available for the purpose of clarifying any questions. Moreover, they observed the discussions and made field notes. The workshops lasted from two to four hours. This paper reports the findings from the data concerning the following questions:

1. What are the required palliative care nursing competencies of every registered nurse at the basic level?
2. What are the required palliative care nursing competencies of a specialized registered nurse at the specialist level?

Data analysis

Data collected from the workshops were transcribed verbatim. Qualitative content analysis was used in the analysis, with only the manifest content being analyzed. The unit of analysis was set as either a word, phrase, sentence or many sentences, i.e., anything constituting a unit of meaning. In the reduction phase, meaningful expressions related to the study questions were coded. Codes were then grouped based on similarities in content. In the abstraction phase, subcategories and main categories were created and named based on their contents.[20]

(Table 2) Two researchers (M.H. and H-L.M.) independently coded all the material. They compared the identified codes and, when differences were found, discussed the issue together to find a consensus. The first author (M.H.) created the categorization, which was then critically checked by two other research team members (H-L.M. and J.T.L.). The researchers made the final decisions regarding the analysis together as a team.[20] The analysis was performed manually. The number of codes was counted so that the frequencies (f) of codes for each category could be presented. Basic level data yielded 651 codes and specialist level data yielded 465 codes. Data saturation was achieved in both cases, which meant that no further data collection was necessary.[21] In reporting the findings, citations from the original data have been presented in italics.

(Table 2 here please)

An inductive approach, i.e., categories emerging from the data, was applied in the analysis of the basic level data.[20] (Table 3) The analysis of specialist level data applied a combination of deductive and inductive approaches. (Table 4) More specifically, the analysis began in the first part with a deductive approach, followed by an inductive approach in the second part.

The first part of the specialist level data analysis applied a deductive approach. This means that the researcher operationalized a structured or unconstrained matrix of analysis based on previous knowledge, e.g., a theory or model.[20,22] This approach was chosen because many WGs expressed that specialist nurses should possess the same competencies as nurses working at the basic level, along with additional competencies. Hence, the categories representing basic level competencies were used as a structured matrix for the analysis of the specialist level data. In this part of the analysis, only data corresponding to the basic level

main categories of the framework were coded. Secondly, codes that included new information that was unique to the specialist level were included in the analysis. They were abstracted inductively into new subcategories which belonged to the main categories that had been identified from the basic level data analysis.

The second part of the specialist level data analysis applied an inductive approach. This part of the analysis concentrated on the codes which were so unique to the specialist level that they did not fit into the structured matrix. As such, this part of the data analysis produced new main categories and subcategories.

The frequencies (f) of the codes constituting each category were counted to show the noteworthiness of the category in relation to the entirety. These frequencies are reported in association with the reporting of the categories.

FINDINGS

Nursing competencies required for basic level palliative care

The content analysis identified 17 main categories, including a total of 75 subcategories related to nursing competencies required for basic level palliative care. (Table 3). Of these main categories ‘Competence in managing the most common symptoms’ was the category which included the largest number of codes (f = 75). The subcategory with the most codes (f=30) was ‘Assessing the patient’s symptoms and defining the need for treatment’.

“Comprehensive monitoring of the client's symptoms (pain, shortness of breath, mood, nutrition, physical functioning, etc.). Using ESAS in the evaluation” (WG 31)

"Observes the patient's symptoms: physical, mental and social. Gives medicine based on the symptom, not by the clock… manages non-pharmacological treatment" (WG 6)

'Competence in supporting the patient and her/his closest ones' was another main category that included an extensive set of codes (f = 74). The subcategory which was constituted from the largest number of codes was 'Identification of the need for, and implementation of, psychosocial support' (f=20)

"adequate ability to… support the patient with incurable illness and her/his closest ones." (WG 30)

"supporting and calming down the patient/client and relatives." (WG 18)

"The nurse should be able to give the patient a feeling of positive ... end of life (creating hope even if she/he is sick and dying)." (WG 21)

(Table 3 here please)

Nursing competencies required for specialist level palliative care

The first part of specialist level data, i.e., the data corresponding to the basic level main categories and the new subcategories unique for the specialist level, are shown in Table 4. Of the subcategories unique for the specialist level, most codes fell under the 'Participation as an expert in advanced care planning and setting goals of care' (f=4) and 'Addressing existential suffering' (f=4).

"Understanding advanced situations when setting the goals of care/participating in the care discussion as an expert." (WG 26)

"Recognizing the existential needs and support patients in difficult situations" (WG 28)

The second part of the content analysis of the specialist level data identified 10 main categories, which included a total of 37 subcategories (Table 4). The main category which included the largest number of codes was 'Competence in maintaining expertise and taking care of own well-being at work' (f=34).

"Updating knowledge with the help of education." (WG 8)

"Reflection and identification of own resources and understanding their value." (WG 26)

Another main category with a large number of codes (f=26) was 'Advanced symptom management in nursing care of patients in palliative care'.

"Autonomous management of symptom care … (Performing tasks related to other professions by task transfer)." (WG 26)

"management of specialist level symptom treatments." (WG 16)

(Table 4 here please)

DISCUSSION

This study aimed toward describing the required palliative nursing competencies of registered nurses aligned to different levels of palliative care provision, from the perspectives of multi-professional groups. The results of the presented research highlight the competencies nurses need to possess when working on basic or specialist palliative care level**.**

Nursing competencies aligned to basic level palliative care

Both similarities and differences were found when comparing the results of this study with previous competence statements and literature. For example, competence in symptom

management was the most emphasized main competence category. Symptom management has also been highlighted in earlier nursing competence research and statements[17,23-27] and in an interprofessional competence framework.[9]

'Competence in supporting the patient and her/his closest ones' and 'Competence in encountering the patient and her/his closest ones' were also often discussed in the WGs. Supporting the patient and family is a competence which has also been mentioned in earlier nursing competence reports.[23-24, 26] The main category 'Competence in supporting the patient and closest ones' included the subcategory of 'Maintenance of hope'. This means that nurses providing palliative care should have the competence to maintain hope among their patients and their closest ones. This area of competence has not been mentioned in earlier statements of nursing competence, even though maintaining hope has been shown to be important for patients throughout all phases of cancer care.[28]

The professionals considered encounters with the patient as an important aspect of palliative care nursing, with this main category described as respectful encountering, seeing the patient as a person and the encounter as a unique situation. Nurses should be present to patients and their family. The aspect of encounters with patients was described as being similar to the caring encounter concept,[29] yet it had not been widely mentioned earlier in conjunction with palliative nursing competencies.[23-27]

Many professionals from the WGs mentioned an unhesitant, or bold, attitude when providing palliative care. This need for courage was associated with the implementation of care, encounters, being present, breaking bad news and when bringing along one's own expertise. This finding may reflect the need to develop and refine palliative care education, as it is

already stated that palliative care professionals need to improve their competencies [30]. Nevertheless, courage in action was identified as a nursing competency in a recent study.[10] Moreover, a study reported that developing competence through education can increase courage among nurses. [31]

Competencies aligned to specialist palliative care

The content analysis identified certain competencies that were unique and specifically related to specialist palliative care. Nurses working at the specialist level of palliative care were perceived as professionals who coordinate the care of the patient and link the care between different levels and settings of palliative care. The results described nurses involved in specialist palliative care as being quite autonomous, due to their multiple roles in palliative care, a finding that has support from earlier research.[17]

Research and development of palliative care was identified as a competence area for specialized nurses, as also in earlier literature.[23-27] Earlier literature has emphasized that participating in policy making is an aspect for specialist nurses.[18,23,25,26,32] However, we did not identify competencies related to policy making from the specialist level data. This may reflect the fact that the role of specialist nurses is still at a stage of early development in Finland and/or that there can be limited opportunities for nurses to participate in policy making.

At both levels of palliative care, there were subcategories representing a small number of reduced expressions. Still, they are, nevertheless, important since they present the diverse competencies that nurses must possess to work in palliative care.

Strengths and limitations of the study

The trustworthiness of the study was ensured by choosing a research method that was suitable for the purpose of the study, as well as pretesting the questionnaire on a sample of participants.[19] Moreover, the study sample was large and represented diverse settings and levels of care. All the university hospital catchment areas in Finland were covered. Therefore, it can be considered that the data represents the whole phenomenon of interest quite well.

The response rate could not be calculated since the working group nurses were suggested by managers at the participating organizations. The workshops were organized only once, and thus, there was no opportunity to ask the participants any further questions. An additional limitation was that the transcripts were not sent to the participants for correction and/or comments. Moreover, the results were not sent to the participants, and thus, they had no possibility to provide feedback.

Conclusions

Information from the data showed that nurses working in palliative care need to possess a wide range of competencies. Basic level and specialist level palliative care were found to differ in terms of the competencies required. The study provided new knowledge, as it reported encounters and the maintenance of hope as palliative care nursing competencies. Future avenues of research could aim to confirm the competencies identified in this study (especially encounters and the maintenance of hope) and reflect on how cultural differences affect nursing competencies in palliative care. Curricula should always be developed to reflect the competencies nurses will need in practice. The information presented in the current paper can be utilized in critical assessments of how undergraduate and post-graduate education prepares nurses for a career in palliative care.

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Table 1. Professionals participating in data collection workshops

Participating professionals	**Number of professionals**
Specialist level, professionals	
Registered nurses	69
Licensed practical nurses	10
Physicians	16
Basic level, professionals	
Registered nurses	63
Licensed practical nurses	25
Physicians	12
Other professionals	
Experts from third sector organizations	7
Elderly care professionals	1
Social workers	3
Physiotherapists	3
Nursing managers	9
Spiritual care professionals	4
Total	**222**

Table 2. An example of the coding procedure how the subcategory ‘Multi-culturality in the implementation of palliative nursing (f=5)’ was produced inductively.

Examples of the original data	Examples of codes (reduced expressions)	Subcategory
WG3 Can take into account cultural differences (Sámi people)	WG3 Can take into account cultural differences (Sámi)	
WG22 Competence in cultural nursing	WG22 The competence in cultural nursing	
WG23 the nurse notices different cultures and their needs at the end of life	WG23 different cultures and their needs in the end of life	(73.) Multi-culturality in the implementation of palliative nursing (f=5)
WG23 for example, the customs of Romani people	WG23 the own customs of Romani culture	
WG28 Multicultural competence and sensitivity	WG28 Multicultural competence and sensitivity	

f, number of codes included in the subcategory.
WG, working group

Table 3. Nursing competencies required for basic palliative care level with the number of codes included in the main categories and subcategories (f).

Main category	Subcategory
(1.) Competence in managing the most common symptoms (f=75)	(1.) Assessing the patient's symptoms and defining the need for treatment (f=30) (2.) Mastering of pharmacological and non-pharmacological methods of symptom management (f=17) (3.) Implementation of symptom relieving care (f=10) (4.) Assessing physical symptoms and defining the need for treatment (f=7) (5.) Basics of symptom management (f=7) (6.) Assessing psychosocial symptoms and defining the need for treatment (f=4)
(2.) Competence in supporting the patient and her/his closest ones (f=74)	(7.) Identification of the need for, and implementation of, psychosocial support (f=20) (8.) Supporting the closest ones in palliative care (f=14) (9.) Maintenance of hope (f=10) (10.) Provision of psychological support (f=10) (11.) Coordination of spiritual support (f=7) (12.) Involving the closest ones in care (f=6) (13.) Supporting the patient in palliative care (f=4) (14.) Utilization of multi-professional support (f=3)
(3.) Competence in basics of holistic palliative care (f=68)	(15.) Understanding concepts and guidelines of palliative care (f=15) (16.) Basic nursing care as a part of palliative nursing (f=13) (17.) Palliative care of different patient groups (f=12) (18.) Assessment of the need for palliative care (f=11)

	(19.) Holistic palliative nursing (f=9)
	(20.) Addressing oral, skin, position and mobility issues in palliative care (f=6)
	(21.) Nutrition as a part of palliative nursing (f=2)
(4.) Competence in encountering the patient and her/his closest one (f=64)	(22.) Encounters with persons during palliative nursing (f=40)
	(23.) Presence as a part of palliative nursing (f=13)
	(24.) Genuine and respectful encounter (f=11)
(5.) Competence of pain management and nursing care of patients in pain (f=51)	(25.) Assessment of pain (f=15)
	(26.) Pharmacological methods of pain management (f=15)
	(27.) Implementation of pain management and nursing care of patients in pain (f=9)
	(28.) Non-pharmacological methods of pain management (f=7)
	(29.) Basics of pain management (f=5)
(6.) Competence in social interactions in palliative care (f=45)	(30.) Social interactions as a part of palliative nursing (f=17)
	(31.) Sensitivity and empathy in social interaction (f=16)
	(32.) Verbal communication (f=9)
	(33.) Breaking bad news (f=3)
(7.) Competence in pharmacological treatment (f=39)	(34.) Implementation of pharmacological treatment in palliative care (f=19)
	(35.) Basics of pharmacological treatment (f=9)
	(36.) Assessing and anticipating the need for pharmacological treatment and evaluation of its effectiveness in palliative care (f=8)
	(37.) Knowledge and skills required for verification of medical competence (f=3)

(8.) Competence in education and consulting (f=38)	(38.) Education of the patient and the closest one (f=18) (39.) Consultation skills (f=8) (40.) Identification of the need for a consultation (f=6) (41.) Guidance of the working community (f=3) (42.) Perception of a student (f=2) (43.) Provision of consultative support for the members of the working community (f=1)
(9.) Competence in setting goals of care and advanced care planning (f=31)	(44.) Documentation as a part of palliative nursing (f=12) (45.) Adherence to goals of care (f=6) (46.) Implementation of advanced care plans (f=6) (47.) Applying collaboration when drafting care plans (f=4) (48.) Concepts of setting goals of care (f=3)
(10.) Competence in multi-professional collaboration (f=30)	(49.) Multi-professional collaboration in implementation of palliative care (f=18) (50.) Collaboration between the nurse and physician (f=8) (51.) The nurse works as a liaison person between the patient and the physician (f=4)
(11.) Competence in coordination of palliative care (f=29)	(52.) Coordination of palliative nursing and end-of-life care (f=19) (53.) Integration of the third sector with patient care (f=7) (54.) Network collaboration (f=3)
(12.) Unhesitant attitude in palliative care (f=27)	(55.) Unhesitant attitude in implementation of care (f=11) (56.) Unhesitant attitude in encounters and presence (f=8) (57.) Unhesitant attitude in breaking the bad news (f=6)

	(58.) Unhesitant attitude in bringing along one's own expertise (f=2)
(13.) Competence in care of an end-of-life patient and her/his closest ones (f=25)	(59.) Caring for a dying patient (f=8) (60.) Identification of approaching death (f=7) (61.) Giving up unnecessary nursing practices (f=5) (62.) Caring after death (f=5)
(14.) Competence in strengthening one's own competence and self - awareness (f=19)	(63.) Development of one's own competencies (f=11) (64.) Compassion toward oneself in palliative care (f=5) (65.) Identification of one's own emotions (f=3)
(15.) Ethical and juridical competence (f=18)	(66.) Patient's autonomy (f=5) (67.) Ethical aspects of palliative nursing (f=4) (68.) Professionality (f=4) (69.) Advocacy in promoting the patient's matters (f=3) (70.) Patient's rights (f=1) (71.) Truthfulness (f=1)
(16.) Cultural competence (f=10)	(72.) Knowledge of different cultures (f=5) (73.) Multi-culturality in the implementation of palliative nursing (f=5)
(17.) Competence in existential questions (f=8)	(74.) Encountering death (f=5) (75.) Helping in existential suffering (f=3)

f, number of codes included in the category

Table 4. Competencies required for specialist palliative care level with the number of codes included in each category (f). Categories identified from the basic level data are marked with *Italics*; Categories identified from the specialist level data are presented in Bold.

Findings of the first part of the specialist level analysis	
Main category	**Subcategory**
(4.) Competence in encountering the patient and her/his closest one (f=64[a])	*Three subcategories on the basic level (see Table 3)*
	(76.) Encounters with children (f=3[c])
(f=70[b] from both basic and specialist level data)	**(77.) Confidence in constructive encounters (f=2[c])**
	(78.) Patient-based encounters (f=1[c])
(7.) Competence in pharmacological treatment (f=39[a])	*Four subcategories on the basic level (see Table 3)*
(f=42[b] from both basic and specialist level data)	**(79.) Extensive expertise in pharmacological treatment (f=3[c])**
(9.) Competence in setting goals of care and advanced care planning (f=31[a])	*Five subcategories on the basic level (see Table 3)*
	(80.) Advanced expertise in setting of care goals (f=1[c])
(f=36[b] from both basic and specialist level data)	**(81.) Participation as an expert in advanced care planning and setting goals of care (f=4[c])**
(13.) Competence in care of an end-of-life patient and her/his closest ones (f=25[a])	*Four subcategories on the basic level (see Table 3)*
	(82.) Addressing patient's convictions at the end of life and after death (f=2[c])

(f=31[b] from both basic and specialist level data)	**(83.) Supporting the closest ones after the patient's death (f=3[c])**
	(84.) Assessment of unnecessary nursing practices (f=1[c])
(15.) Ethical and juridical competence (f=18[a])	*Six subcategories on the basic level (see Table 3)*
***(f=21[b] from both generalist and specialist level data*)**	**(85.) Assessment of ethical issues and discussing them with the patient (f=3[c])**
(17.) Competence in existential questions (f=8[a])	*Two subcategories on the basic level (see Table 3)*
(*f=13[b] from both basic and specialist level data*)	**(86.) Advanced expertise in dealing with death (f=1[c])**
	(87.) Addressing existential suffering (f=4[c])

Findings of the second part of the specialist level analysis

Main category	**Subcategory**
(18.) Competence in maintaining expertise and taking care of own well-being at work (f=34[d])	**(88.) Active self-development (f=5[c])**
	(89.) Postgraduate education (f=6[c])
	(90.) Strong clinical know-how (f=4[c])
	(91.) Autonomous decision-making and expertise (f=10[c])
	(92.) Critical thinking and reflection (f=2[c])
	(93.) Recognition of one's own limits and acceptance of support (f=7[c])
(19.) Advanced symptom management in nursing care of patients in palliative care (f=26[d])	**(94.) Extensive know-how in symptom management (f=4[c])**
	(95.) Assessment and management of advanced symptoms (f=4[c])

	(96.) Palliative sedation and the issues related to it (f=6[c])
	(97.) Special techniques for the management of symptoms (f=6[c])
	(98.) Autonomous management of symptoms (f=1[c])
	(99.) Acute situations in palliative care (f=5[c])
(20.) Teaching, development and research competence in palliative care (f=20[d])	**(100.) Educating about palliative care (f=12[c])**
	(101.) Development of palliative care (f=6[c])
	(102.) Researching phenomena linked to palliative care (f=2[c])
(21.) Extensive competence in palliative nursing care of special groups (f=20[d])	**(103.) Palliative care for different special groups (f=10[c])**
	(104.) Palliative care for children and adolescents (f=7[c])
	(105.) Palliative care for mentally retarded persons (f=2[c])
	(106.) Palliative care for lonely persons (f=1[c])
(22.) Competence in advanced support to patient in palliative care, and her/his closest ones (f=19[d])	**(107.) Assessment of the need for social support in patients and their closest ones, along with the provision of support (f=6[c])**
	(108.) Provision of support for grief work (f=5[c])
	(109.) Advanced psychosocial support (f=3[c])
	(110.) Specialized support for families with children (f=5[c])

(23.) Extensive competence in coordination of palliative care (f=19[d])	**(111.) Collaboration with the third sector (f=1[c])** **(112.) Coordination of the patient's care chain and ensuring the continuity of patient's care (f=10[c])** **(113.) Coordination of large networks and management of the collaboration of networks (f=6[c])** **(114.) End-of-life care at home (f=1[c])** **(115.) Effects of the care environment on the patient (f=1[c])**
(24.) Advanced competence in patient education and consultations (f=12[d])	**(116.) Advanced patient education in different situations (f=3[c])** **(117.) Strong competence in consultations (f=3[c])** **(118.) Consultative support for different palliative care provision levels and health care settings (f=6[c])**
(25.) Advanced competence in pain management and pain management nursing (f=11[d])	**(119.) Extensive expertise in pain management (f=3[c])** **(120.) Management of special techniques in pain management (f=8[c])**
(26.) Special competence in palliative care (f=8[d])	**(121.) Extensive expertise in palliative care as a part of nurse's work (f=4[c])** **(122.) Assessment and anticipation of the patient's needs in special situations and anticipation of them in palliative nursing (f=4[c])**

(27.) Competence in demanding social interactions (f=7[d])	**(123.) Management of demanding social interaction situations (f=6[c])**
	(124.) Breaking bad news with an active approach (f=1[c])

f, number of codes

[a] Codes included in the basic level main category

[b] Codes included in the main categories from both basic and specialist level data

[c] Codes included in each subcategory unique to specialist level

[d] Codes included in each main category unique to specialist level