TITLE

Implementation and Evaluation of a Training Programme to Promote the Development of Professional Competences in Nursing: A Pilot Study

ABSTRACT

Background: Clinical narratives may be used as a means to improve the acquisition of clinical competences. Even though there are studies that recognize the potential value of clinical narratives to promote nursing professional development, there is no evidence that shows their value as a tool to improve nurses' competences to provide person-centred nursing care.

Purpose: To evaluate the preliminary efficacy of narratives for the development of three nursing professional competences —*respect*, *intentional presence* and *knowing the person*— for providing person-centred care.

Method: Using a pre-post quasi-experimental design, a pilot study with a total of 34 nurses enrolled in a training course of nursing specialization was conducted between September 2016 and June 2017. All the nurses received a multi-component intervention based on the Critical Reflective Inquiry model. The strategies of this programme consisted of writing three narratives, attending two masterclasses, participating in a discussion group, and participating in a face-to-face interview. The NarratUN Evaluation tool was used to assess the outcomes. Changes among nurses were analysed using the Wilcoxon signed Rank test.

Results: The difference in the means between the pre- and post-intervention scores were statistically significant for *respect* [0.59 (95% CI 0.23-0.95; p=0.001)], *intentional presence* [0.75 (95% CI 0.32-1.17; p<0.0001)] and *knowing the person* [0.62 (95% CI 0.25-0.99; p=0.001)]. The difference in the mean score for *use of the narrative and reflection* also increased significantly [0.65 (95% CI 0.32-0.98; p<0.001)].

Conclusions: The use of narratives combined with other reflective strategies (masterclass sessions and discussion groups) proved to be effective for the development of professional competences of nurses.

Keywords: Nursing, Person-Centred Care, Nurse-Patient Relationship, Reflective Practice, Professional Development, Clinical Narratives, Pilot Quasi-experimental Study.

INTRODUCTION

Reflective practice is much more than a simple linear application of theory to practice; it involves a complex process of professionals' management of situational demands, intuition, experience and knowledge (Schön, 1983). According to Schön, professionals who base their practice on reflection are able to modify tacit behaviours —generated by their repetitive experiences in practice— and provide new meanings to situations of uncertainty and uniqueness. In line with this theory, Gustafsson & Fagerberg (2004) showed reflective practice enables nurses to critically think about an idea, experience or action and to incorporate their life experiences that remain in their cognitive world, thus allowing the integration of theory, research and practice. In this way, reflective practice favours self-awareness and professional competence (Epstein & Humbdert, 2002), and the learning that results from this process is highly meaningful (Levett-Jones, 2007).

In this context, several authors propose clinical narratives as a useful tool for learning and developing professional nursing skills (Asselin, 2011; Benner, 1984; Choperena et al., 2019; Levett-Jones, 2007). According to Patricia Benner's approach (1984), a narrative can be a reconstruction/representation of a clinical experience which provides meaning to that experience. Consequently, nurses are able to fully explore the complexity of their practice, and to identify strengths and weaknesses. Furthermore, narratives allow nurses to address the practical knowledge hidden in their practice, which comes from experiential learning. Indeed, narratives can be used as tools that help nurses provide depth and analysis to the situations they face in their practice, a goal which cannot be achieved through mere intuitive verbal reflection on a clinical situation (Asselin, 2011). As stated by Gustafsson and Fagerberg (2004), the reflection linked to narratives involves not only cognitive processes but also the integration of theory, research and practice in an on-going process from which professional development may arise. Thus, the use of

narratives in the context of nursing reflective practice may lead nurses to improve and build their skills and competences and promote professional development (Cathcart & Greenspan, 2013; Levett-Jones, 2007).

A number of prescriptive models have been developed to guide and teach nurses how to reflect on practice (Gibbs, 1988; Johns, 1995; Kim, 1999; Kim et al., 2010; Koshy et al., 2017). The Critical Reflective Inquiry Model (CRI), based on the notions of action science and reflective practice, is oriented to analysing practitioners' beliefs and actions and exploring different models of knowledge-use in clinical situations, through the reflective analysis of clinical narratives (Kim, 1999). This model consists of three consecutive phases: (1) the descriptive phase —nurses develop descriptions of practical situations in the form of clinical narratives; (2) the reflective phase —the narratives are examined by experts with a reflective approach, helping the nurses to contrast the content with their previous personal beliefs, assumptions and knowledge; and (3) the critical phase —the narratives are used to correct and change ineffective practices and to introduce innovative attitudes that emerge from the narrated practice (Kim, 1999). Indeed, the CRI model offers a structured approach to reflection and a reflective guide for the professional development of nurses.

BACKGROUND AND CONTEXT

Person-Centred Care (PCC) is an approach to practice in which establishing therapeutic relationships —between health professionals, patients and others meaningful to the patients— is key to achieving good outcomes in patients (McCormack, Dewing & McCance, 2011). In this regard, developing an authentic and caring nurse-patient relationship is paramount to providing PCC (McCormack, 2003). Accordingly, it is crucial to develop a clinical nursing practice oriented to the establishment of caring and

helpful relationships focused primarily on the person (Errasti-Ibarrondo et al., 2015).

Previous research has shown that every authentic, specific and unique nurse-patient relationship is compounded by some core elements (Errasti-Ibarrondo et al., 2015; Rumeu-Casares et al., 2016; Saracíbar, 2009). In this sense, the Nursing Professional Practice Model of the Clínica Universidad de Navarra (NPPM-CUN) (Figure 1) (Rumeu-Casares et al., 2016), whose core part is the interpersonal nurse-person/family relationship, highlights that *respect, knowing the person* and *intentional presence* are three —not chronological but interrelated— essential elements of the nurse-person relationship that lead nurses to provide personal and authentic care (Rumeu-Casares et al., 2016; Saracíbar, 2009).

As seen in Figure 1, it is assumed that in the relationship there is bidirectional communication between the nurse and the person founded on their values, beliefs and expectations. In this dialogue, an essential requirement is that the nurse gets to know the person, for which it is essential that she/he conveys the unique, different and special nature of each patient. Indeed, *knowing the person* implies knowing patients in a personal way as unique human beings that are living through certain experiences related to their health condition, and orienting their actions to incorporate their personal values and goals into care delivery (Osácar, 2018; Somerville, 2009). Likewise, it is paramount to establish an open dialogue that it is not solely based on words. Hence, the nurse's *intentional presence* is vital, as this is what makes it possible for nursing care to be grounded on the knowledge the nurse has of the person's values, beliefs, convictions, needs and experiences as perceived by him/her. If the nurse's intentional presence is given, the person may feel that the relationship is authentic and thus, gain awareness of being cared for. Intentional presence can be philosophically understood as "a consciousness and awareness that are directed toward the patient, with purpose and

efficacy toward action, expectation, belief, volition, and even the unconscious" (Watson, 2002, p. 14). More practically, Monge & López (2015) acknowledged that intentional presence is the interpersonal process characterized by the transcendent unity between two people who sustain their bond in a relationship that is satisfactory for both, and in which the nurse intentionally builds a dynamic relationship with the patient, according to his/her uniqueness. Furthermore, the nurse-person relationship has to be based on mutual *respect*. When all this happens, the patient feels safe, protected and comforted, and the nurse is able to truly take care of him/her in accordance to his/her real needs and life experiences (Rumeu-Casares et al., 2016; Saracíbar, 2009). In this sense, Pérez (2013) found that through respect, nurses not only manifest their genuine interest in the person, but also avoid the violation of his/her privacy and intimacy, so a safe space in which the patient's personal life remains preserved may be created. Pérez noted that respect includes advocating for the patient, promoting decision making and helping the patient find meaning in the health process he/she is going through.

Taking into account that these three elements are central for the nurse-patient relationship, and, therefore, the provision of PCC, it is essential to guide nurses towards fostering their abilities in these elements. As mentioned above, clinical narratives can promote critical thinking and knowledge development among nurses, resulting in an improvement in their professional competences. In this sense, the aforementioned three fundamentals of the nurse-patient relationship can be expressed in the skills, attitudes and knowledge –main components of a professional competence- reflected in a clinical narrative. For this reason, the use of clinical narratives appears as an adequate and useful means to foster therapeutic nurse-patient relationships and PCC.

Nevertheless, few specific interventions have been developed to make use of the potential value of clinical narratives as an efficient way to promote and evaluate nursing

professional development (Asselin & Fain, 2013; Brubakken et al., 2011; Forneris & Peden-McAlpine, 2006). In addition, none have studied the effectiveness of clinical narratives in improving *respect*, *intentional presence* and *knowing the person* as professional competences within an overall nursing care approach that pursues PCC.

Accordingly, the hypothesis of this study is that the use of narratives improves the development of professional competences of nurses. For this hypothesis, this study focused on evaluating the preliminary efficacy of narratives for the development of *respect*, *knowing the person* and *intentional presence* as a means to provide PCC.

METHODS

Design

A pre-post quasi-experimental pilot study was designed as a preliminary trial to help estimate the treatment effect (Mujika et al., 2014) testing the hypothesis that the use of clinical narratives would have an impact on the development of professional competences in providing PCC (Clinical trial number: NCT03791411).

Study population

This study was conducted at the Clinica Universidad de Navarra (CUN), a tertiary hospital in Pamplona (northern Spain). Participants were nurses (n=35) enrolled in a mandatory training course called *Narratives and Reflective Practice*, which was part of the Nursing Specialization Programme of the CUN (https://www.cun.es/docencia/programas-especializacion-enfermeria), in the 2016-17 academic year. All nurses in the Nursing Specialization Programme were invited to participate in the study/training programme, regardless of their age or previous professional experience.

Sample size determination

Given that this was a pilot study using a pre-post quasi-experimental design with the aim of investigating preliminary efficacy, conventional sample size calculations, appropriate for a full-scale intervention, were not deemed necessary (Viechtbauer et al., 2015). Based on other training programmes for nurses, we determined a minimum of 25 participants were necessary to obtain an estimate of the intervention's effect size (Chambers, Meyer, & Peterson, 2018).

Recruitment

Recruitment took place in September 2016. One week before the intervention took place at the CUN, the principal investigator (ACA) explained the study to the nurses in a three-hour session. In this session, all the nurses were informed about the purpose and design of the study, and all of them voluntarily agreed to participate in the training programme. Once nurses agreed to participate in the study, their socio-demographic data were collected.

Baseline assessment

After recruitment, the principal investigator (ACA) asked participants to write a narrative (T1) focused on nurses' actions, thoughts and feelings (Kim, 1999) and all the circumstances involved in a meaningful encounter with a patient in a practical situation. Participants had to consider how *respect, intentional presence* and *knowing the person* had been present in the encounter (see instructions in Box 1). They had one week to write the narrative and to deliver it in paper form to the research team.

Study procedures

The study was conducted by a research team composed of seven people; six were nurses combining academic profiles, with professionals with a clinical background (including the principal investigator ACA), and the other was an expert in textual and discourse analysis (IOM). The intervention study, based on the CRI model (Kim, 1999; Kim et al., 2010), consisted of three phases. In the *descriptive phase*, nurses wrote narratives describing specific clinical situations including actions, thoughts and feelings; in the *reflective phase*, nurses were

asked to deconstruct their narratives, to gain knowledge about processes in practice, self-awareness, beliefs, and assumptions guiding practice; and the *critical phase* was focused on strategies to enhance practice with respect to the three core values of the nurse-patient relationship. The intervention was implemented from October 2016 to June 2017. Figure 2 shows the timeline of the educational strategies and the different phases of the CRI model.

Descriptive Phase:

In this phase, the narrative writing was combined with theoretical masterclasses, to train nurses to align the content of their narratives to the theoretical understanding of the narrated situations. The first three-hour training masterclass was provided by the principal investigator (ACA). This session focused on the nurse-patient relationship and the core values of *respect, intentional presence* and *knowing the person*. One week after the first session, nurses received the second three-hour masterclass. The topic of how to write and deal with the process of writing of narratives was addressed together with their usefulness for clinical practice. This session was taught by another research team member (IOM), specialist in textual analysis. After this session, participants wrote their second narrative (T2). To write this narrative, participants received the same instructions as the first time. A paper version had to be handed no more than one month later to the research team. Researchers considered that one month was time enough to collect meaningful experiences on which to base their narratives. Assessment criteria were provided to participants. All the participants had all the theoretical material from the sessions available on their Moodle platform.

Reflective Phase:

In this phase, narratives were examined by participants and researchers in small groups, in order to gain knowledge about processes in practice, self-awareness related to decision making, knowledge gaps, beliefs, and assumptions guiding practice (Kim, 1999). Indeed, six months after the first masterclass, all the participants took part in a two hour long discussion

group. For this dialogue, the nurses were asked to deconstruct their first two narratives (T1-T2) and share their experiences with the other participants and the research team. A discussion guide was designed by the research team to help participants deconstruct their narratives. Guiding questions included in the guide facilitated narrative discussion (see Box 2). At the end of the session, nurses were asked to write the third and last narrative (T3), following the same instructions as the first time. Again, a paper version had to be submitted to the research team no more than one month later.

Critical Phase:

The last phase of the intervention (nine months after the intervention began) was oriented to developing strategies to enhance practice with respect to the three core values of the nurse-patient relationship. Each participant had a 30-minute face-to-face interview with one member of the research team, to identify potential change through new learning, and how future actions would change in future similar situations. Some guiding questions with the purpose of changing practice were provided to participants to prepare for the interview (Box 3 shows all the guiding questions). Issues regarding strengths, weaknesses and improvements in nurses' practice identified in this phase were included in a reflective profile drawn up by the research team, based on the entire training process.

Evaluation process

To evaluate the narratives, an evaluation tool designed by the researchers and based on the NPPM-CUN Model —the NarratUN Evaluation Tool (NET)— was used. Narratives were evaluated in the same way at T1, T2 and T3. At the beginning of the intervention, the principal investigator (ACA) formed pairs of researchers combining academic profiles, with professionals with a clinical background. Each narrative was independently assessed by each member of the pair. After that, each pair discussed their evaluations and assigned a score to the narrative by consensus. Then, pairs shared their evaluations with the rest of the research

team in three working sessions (after T1, T2 and T3) and received feedback from the principal investigator (ACA) and the expert in discourse analysis (IOM). Researchers who did the masterclasses (ACA and IOM) were not evaluators of the narratives. All the research team members had been previously trained in different group sessions focusing on narratives, their use, and the application of NET for their evaluation.

Measuring instruments

To collect the sociodemographic data, a questionnaire was designed (Table 1). This questionnaire was developed specifically for the study, and data collection took place prior to the intervention.

To evaluate the narratives, the NET was used. The NET, which is based on the *Massachusetts General Hospital Instrument* (http://www.mghpcs.org/ipc/programs/recognition/Describing.asp), consists of a 19-item questionnaire, which is classified into four dimensions. The first three dimensions correspond to the three core competences —*respect*, *intentional presence*, and *knowing the person*, and the fourth dimension corresponds to the reflective process developed by nurses —*use of the narrative and reflection*—. This latter dimension refers to the capacity/ability of the nurse to use the narrative as a strategy to demonstrate professional growth and clinical expertise. To guide the scoring process of competence development, each item includes possible skills, knowledge or attitudes that can be expressed by nurses in the narratives. The score for each item varies from 1 to 4, where 1 is "no", 2 is "somewhat", 3 is "sufficiently", and 4 is "completely". An example of the scoring process can be seen in Box 4. Although the internal consistency of the instrument has not been studied, content validity was assessed through different procedures. This property is considered the most important because it measures whether the items are relevant, comprehensive, and comprehensible with respect to the construct of interest and target population (Prinsen et al., 2018):

- A panel of four international experts from Boston College and Massachusetts General Hospital carried out the validation (Grant & Davis, 1997). In this sense, the content validity showed that 100% of the items were congruent with the constructs to be measured (Polit & Beck, 2006).
- In addition, the research team piloted the tool in the evaluation of 10 randomly selected narratives (Polit & Yang, 2016). Each researcher evaluated the narratives independently and then scores were shared and compared with the research team.
- Finally, the acceptability and comprehensibility of scale items were studied using a focus group. Afterwards, the instrument was revised, and one item was changed. The items of the scale were shared with participants, so assessment criteria were provided.

Strategies to maintain intervention fidelity

To minimize interventionist effects, all the participants received the same training sessions at the same time. These sessions were given by two members of the research team (ACA and IOM) trained in narrative analysis. Regarding the training in narrative techniques, the research team wrote a detailed intervention manual, explaining the objectives of the different training sessions and how the dialogue group had to be conducted. This manual was reviewed by experts from the University of Navarra and Boston College.

Outcome measures

The primary outcome measures in the study were the difference in the mean scores for *respect*, *intentional presence* and *knowing the person* pre- and post-intervention. *Use of the narrative and reflection* measure was a secondary outcome pre- and post-intervention along with the differences between means at different times in the study.

Statistical analysis

Baseline data were reported as the mean [standard deviation (SD)] for continuous variables. Categorical variables were reported as frequencies and percentages (*n*, %).

Changes among nurses were analysed using the Wilcoxon signed Rank test. The Wilcoxon rank sum test was used to compare the average of the two raters' total scores among nurses.

The analyses were performed using Stata version 11.1 (StataCorp, College Station, TX, USA). Statistical significance was set at 5% (*P*-values<0.05, based on two-tailed tests).

Ethical considerations

Ethical approval was sought and granted by the University of Navarra Research Ethics Committee (reference number: 27/2016). Informed consent was obtained from all the postgraduate nurses participating in the trial.

RESULTS

Participants

Figure 3 shows a flow-chart for the study participants' evaluation. Of the 35 subjects enrolled in the trial, 34 (97.1%) completed the 9-month follow-up.

Baseline characteristics

Table 1 describes the demographic characteristics of the participants. Of the 35 participants, 100% were women, and the mean age was 23.6 years. Most had less than 4 years of clinical experience and had not previously completed another Nursing Specialization Programme.

Quantitative results

- *Respect*, *intentional presence* and *knowing the person*

  From time point 1 (T1) to time point 3 (T3), participants showed a significant increase in all measures of overall *respect*, *intentional presence*, and *knowing the person*. *Respect* increased by 0.59 (95% CI 0.23-0.95; p=0.001). The difference was 0.75 (95% CI 0.32-1.17; p<0.001) for *intentional presence* and 0.62 (95% CI 0.25-0.99;

p=0.001) for *knowing the person*. Table 2 shows the difference between means at different time points in the study.

- *Use of the narrative and reflection*

  This dimension also showed a significant increase between T1 and T3 [0.65 (95% CI 0.32-0.98 p<0.001)]. Additionally, compared to the primary outcomes, this variable also showed a significant increase between T1 and T2 [0.43 (95% CI 0.11-0.76; p=0.008)]. Table 2 shows the difference between means at the different time points in the study.

Qualitative results

Dialogue opportunities held between researchers and participants in the discussions groups and in the face-to-face interviews also supported that a significant increase in competences between T1 and T3 occurred. Indeed, most of the participants were not aware of the significance of an encounter with patients before participating in the training programme, and they primarily focused on the physical dimension as the most important aspect to address. One participant commented in the first narrative:

> "Through this patient, who had been hospitalized for several days, I was able to perceive the progression of the disease and the continuity of care. With this continuity I am referring to the care that I provided day after day: aspiration of secretions through the tracheostomy cannula, personal hygiene, intestinal rhythm (...)" (T1).

Nurses also manifested that they faced difficulties when they tried to balance and integrate what they understood as the "professional dimension", with the "personal dimension" of the nurse-patient relationship:

> "In my first contact with the patient, I tried to be warm, as I do with all patients, although in cases like these I have something in my conscience that tells me that my attitude should be more professional" (T2).

Overall, it was clear that, at the end of the programme, nurses were able to be more reflective about all those elements, and they incorporated the new knowledge into their clinical practice:

> "I warned her that I was going to instill saline solution to dilute the secretions (...). At last, we both managed to stay calm. In her case, by feeling relief, ease of breathing and overcoming the anxiety associated with that uncomfortable procedure; in my case, for understanding that trust is greater than personal fears and that we, as nurses, are capable of more than we think" (T3).

DISCUSSION

This study is the first to evaluate the preliminary efficacy of clinical narratives to improve PCC-specific competences. The results of this research supported the study hypothesis and confirmed the preliminary efficacy of using narratives in the development of professional competences. These results are similar to the results of other research in this area (Asselin & Fain, 2013; Brubakken et al., 2011; Forneris & Peden-McAlpine, 2006) that showed using narratives in a training programme can achieve a significant change in the development of professional competences.

The changes produced in the three main variables of the study —*respect, intentional presence* and *knowing the person*— can be explained through the use of narratives as a way to promote professional development in providing PCC. In other studies that used narratives as a strategy to improve competences, the authors highlight that this strategy improved reflection and, hence, critical thinking, which is essential to transform nursing practice (Chau et al., 2001; Hartrick, 2000; Peden-McAlpine et al., 2005). In this sense, the qualitative findings obtained in the discussion groups and face-to-face interviews also supported that a significant increase in competences between T1 and T3 occurred.

In addition, the use of the CRI theoretical framework to guide the design of the intervention protocol also contributed to the increase in the competences. As in other studies which have used the CRI model (Asselin & Schwartz-Barcott, 2015; Curtin et al., 2015; Curtin, Martins & Schwartz-Barcott, 2015; Halpin, 2016; Woods & Murfet, 2015), this model facilitated reflection and competence development. Although other prescriptive models have been developed to guide nurses on how to reflect on practice (Gibbs, 1988; Johns, 1995; Koshy et al., 2017), the CRI shows a difference in nursing reflective thinking about clinical practice situations. Indeed, as Asselin (2011) and Asselin & Fain (2013) highlighted, the CRI model provides a straightforward approach that incorporates a plan with different strategies to ensure that reflection has occurred during the process. Similarly, other studies emphasize its utility. For example, Halpin (2016) showed that this model provides a forum for nurses to reflect on how their practice is both defined and constrained and to consider different ways of practice; Curtin et al. (2015) stated that the CRI model is helpful in promoting in-depth description and reflection on students' underlying assumptions and values as well as identifying initial strategies for "emancipation" in specific patient care situations. In this study, the CRI model was particularly valuable in contributing to the professional competence development of participants in a very intuitive and progressive way and in capturing the core elements of the nurse-patient relationship from a PCC approach, through the individual writing of clinical narratives. In this sense, the model is not a prescriptive predetermined structure; it is a flexible approach that can be adapted to different environments with different resources. Not following the CRI model may explain why other studies (Spencer & Newell, 1999) found no statistically significant changes in subjects' reflections.

In contrast to other similar studies (Forneris & Penden-McAlpine, 2006), the present pilot study showed some significant differences not only at the end of the study (between T1 and T3) but also between T1 and T2 (*respect* and *intentional presence*). Since most of the training strategies took place during this period of time (masterclasses, discussion groups), we consider that in order to improve the critical thinking of participants, it is necessary to combine training sessions with writing narratives throughout the entire programme. This argument is reinforced by the fact that between T2 and T3, no significant results were found in any PCC competences. However, the mean differences increased for all variables —*respect, intentional presence* and *knowing the person*. In this sense, it is interesting to note that in the present study, informal counselling between researchers and participants was maintained throughout the training programme, which could have strengthened the results. Each participant had a reference researcher whit whom to discuss their concerns, doubts and feelings about the writing of the narratives and how the process was conducted. Taking this into account, we propose that in a future larger confirmatory study, the development and delivery of other face-to-face pre-established strategies should be reinforced. For example, one strategy could be to strengthen the role of tutors in assisting nurses to deconstruct their clinical experiences through the interaction between novice and expert nurses (Asselin & Fain, 2013; Koshy, 2017). Indeed, in a theoretical review conducted by Choperena et al. (2019), the strategy of establishing dialogue opportunities between participants and tutors when using narratives to enhance reflective practice was emphasized as an essential element of the critical thinking process (Forneris & Peden-McAlpine, 2006) and as a way to direct participants from theory to a deeper level of reflection in practice (Durgahee, 1997). In this study, participants had the opportunity to deconstruct their narratives with tutors in the context of small discussion groups. Posing guiding questions, working with small

groups of people, and generating a climate of trust led researchers to enhance the development of participants' competences.

With regard to the secondary outcomes, *use of the narrative and reflection* showed a significant increase between T1 and T3 and T2 and T3 but not between T1 and T2. To compensate for these findings, in a future trial, greater effort should be made from the beginning to more explicitly explain how to use narratives as a strategy to demonstrate professional growth and clinical expertise. Participants attended just one personal face-to-face interview. This interview was expected to help nurses direct their attention to the PCC competences and to correct participants for future practice. Integration of personal interviews as a way to develop competences in nursing has been widely implemented by other authors, such as Facione et al. (2008) and Levet-Jones (2007). For this reason, we think that carrying out face-to-face interviews after writing each narrative would be very useful to guide participants through the whole process and develop the competences more easily.

Another strategy for a future trial could be to reduce the time between the activities undertaken to preserve the reflective process and help maintain the sense of continuity of the programme. Indeed, in the face-to-face interviews, participants pointed out that the activities were too infrequent and that this could distract them from the main aim of the programme. In line with these thoughts, there is evidence supporting that reflection is a continuous process for professional development (Jayatilleke & Mackie, 2013). Future projects should guide nurses to consider when and how to reflect, as part of their continuous learning experience.

Implications for future educational interventions

The results of this study show that the use of narratives can be effective in improving professional competences. However, the training programme must be based on a

theoretical framework to be feasible. In our case, the use of the CRI theoretical framework to guide the design of the intervention has been proven to be effective. The CRI Model promotes practice thinking (Asselin & Fain, 2013). This can be easily incorporated into educational strategies to assist staff to enhance their professional practice and can be adapted to different environments with different resources.

On the other hand, an interesting aspect of this kind of educational intervention is the development of interspersed reflective sessions to preserve the continuous reflection process. More specifically, reflective dialogue around narratives, face-to-face interviews and informal counselling by tutors can make the difference.

Finally, as Hoffman et al. point out (2014), an essential aspect for the feasibility of the programme is the training of trainers. This training must take into account how a narrative has to be carried out and how it has to be evaluated. In addition, they must be experts in the competences that are going to be evaluated by means of the narratives.

Strengths and weaknesses

This study has the following strengths. The intervention was based on a structured reflection model (CRI) (Kim, 1999) that provides a straightforward approach to reflective practice (Asselin, 2011; Asselin & Fain, 2013). Several authors point out how the use of theory in the design of interventions improves outcomes (Ajzen, 2011). In this sense, prior to the design of the intervention, the authors of this paper, as advised by the MRC (Craig et al., 2008), identified evidence concerning all the theoretical aspects involved in the project (Choperena et al., 2019) and recognized the components of the interventions and the underlying mechanisms of influence (Choperena et al., 2019). Furthermore, the retention rate of this study was high (97.1%), which means that there was no significant risk for bias (Pardavila et al., 2018). This retention rate could be explained by the training

programme being a part of a training course, in the context of a Nursing Specialization Programme.

Nonetheless, a number of potential limitations needs to be acknowledged. Firstly, the sample size might have been too small to study the effectiveness of the intervention. However, the significant differences in the mean scores between T1 and T3 suggest that further exploration of this approach is worthwhile. Moreover, since this research was conducted as a pilot study, a small number of subjects seemed to be reasonable (Connelly, 2008). Adopting such an approach avoids spending too many resources (e.g., subjects, time and financial costs) and helps to identify an important association for a future larger confirmatory study (main trial).

Secondly, the lack of a control group might also have affected the validity of the study. Nevertheless, because it was believed that this pre-post quasi-experimental study was the best way (Polit & Hungler, 1999) to investigate the preliminary efficacy of the narratives for the development of professional competences, we were reluctant to either randomize subjects or use a control group. Additionally, non-randomized methods are common in educational research and are considered by experts not to be inferior to randomized clinical trials. In systematic reviews, the best evidence in medical education is graded on the strength of articles using several factors but not whether the study was randomized (Harden et al. 1999).

Thirdly, this approach requires considerable dedication by researchers. Therefore, this may be a limitation when implementing it in large groups. Working with small groups of nurses could facilitate a more continuous interaction between participants and researchers.

Fourthly, the NET questionnaire is still in the process of validation. However, content validation was carried out by expert panel consensus among experts from Massachusetts

General Hospital and Boston College. The NET is also theory-driven and unique in terms of content validity of the items.

Finally, narratives were not anonymized in the evaluation process, and evaluators knew which were the first, second and third narratives when scoring them. However, evaluators did not know participants before the intervention and the final score of each narrative was assigned by consensus, so this may have mitigated the possibility of introducing any bias into the scoring process.

CONCLUSIONS

The results of this pilot study suggest that the use of narratives combined with other reflective strategies (masterclass sessions and discussion groups) may be effective for the development of professional competences of nurses (*respect, intentional presence* and *knowing the person*) in a specialized training programme to provide PCC. Moreover, this pilot study supports the use of a structured reflection model (CRI) as an approach to improve nurses' reflection. Such findings should be taken into account in the design of further studies to determine the effectiveness of tailored training programmes.

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ABSTRACT

Background: Clinical narratives may be used as a means to improve the acquisition of clinical competences. Even though there are studies that recognize the potential value of clinical narratives to promote nursing professional development, there is no evidence that shows their value as a tool to improve nurses' competences to provide person-centred nursing care.

Purpose: To evaluate the preliminary efficacy of narratives for the development of three nursing professional competences —*respect*, *intentional presence* and *knowing the person*— for providing person-centred care.

Method: Using a pre-post quasi-experimental design, a pilot study with a total of 34 nurses enrolled in a training course of nursing specialization was conducted between September 2016 and June 2017. All the nurses received a multi-component intervention based on the Critical Reflective Inquiry model. The strategies of this programme consisted of writing 3 narratives, attending 2 masterclasses, participating in a discussion group, and participating in a face-to-face interview. The NarratUN Evaluation tool was used to assess the outcomes. Changes among nurses were analysed using the Wilcoxon signed Rank test.

Results: The difference in the means between the pre- and post-intervention scores were statistically significant for *respect* [0.59 (95% CI 0.23-0.95; p=0.001)], *intentional presence* [0.75 (95% CI 0.32-1.17; p<0.0001)] and *knowing the person* [0.62 (95% CI 0.25-0.99; p=0.001)]. The difference in the mean score for *use of the narrative and reflection* also increased significantly [0.65 (95% CI 0.32-0.98; p<0.001)].

Conclusions: The use of narratives combined with other reflective strategies (masterclass sessions and discussion groups) proved to be effective for the development of professional competences of nurses.

Keywords: Nursing, Person-Centred Care, Nurse-Patient Relations, Reflective Practice, Professional Development, Clinical Narratives, Pilot Quasi-experimental Study.

Title: IMPLEMENTATION AND EVALUATION OF A TRAINING PROGRAMME TO PROMOTE THE DEVELOPMENT OF PROFESSIONAL COMPETENCES IN NURSING: A PILOT STUDY

Authors details:

1. Ana Choperena[a,b]
   Job title: Assistant Professor
   Qualifications: PhD, MSc, RN
   mail: achoperena@unav.es. Phone number: 0034 948425600
   Twitter: @AnaChoperena

2. Miren Idoia Pardavila-Belio[a,b]
   Job title: Assistant Professor
   Qualifications: PhD, MSc, RN
   mail: mpardavila@unav.es. Phone number: 0034 948425600
   Twitter: @IdoiaPardavila

3. Begoña Errasti-Ibarrondo[a,b]
   Job title: Assistant Professor
   Qualifications: PhD, MSc, RN
   mail: meibarrondo@unav.es. Phone number: 0034 948425600
   Twitter: @begoerrasti

4. Cristina Oroviogoicoechea[c]
   Job title: Associate Professor
   Qualifications: PhD, MSc, RN
   mail: corovio@unav.es
   Twitter: @CristinaOrovio

5. Amparo Zaragoza-Salcedo[a,b]
   Job title: Assistant Professor
   Qualifications: PhD, MSc, RN
   mail: azaragoza@unav.es
   Twitter: @Amparo Z5

6. Rosana Goñi-Viguria[c]
   Job title: Advance Practice Nurse
   Qualifications: MSc, RN
   mail: rgviguria@unav.es

7. Sonsoles Martín-Pérez[c]
   Job title: Head Nurse
   Qualifications: MSc, RN
   mail: smartin5@unav.es

8. Teresa Llàcer[c]
Job title: Head Nurse
Qualifications: MSc, RN
mail: tllacer@unav.es

9. Virginia La Rosa [a,b]
Job title: Assistant Professor
Qualifications: PhD, MSc, RN
mail: vlarsal@unav.es

[a]Faculty of Nursing. University of Navarra.
Calle Irunlarrea, 1. Postal code: 31008. Pamplona (Spain)

[b]IdisNA, Navarra Institute for Health Research.

[c]Clínica Universidad de Navarra.
Avda. Pío XII, 36. Postal code: 31008. Pamplona (Spain).

Corresponding Author: Begoña Errasti-Ibarrondo[a,b]
Faculty of Nursing. University of Navarra.
Calle Irunlarrea, 1. Postal code: 31008. Pamplona (Spain)

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TITLE

Implementation and Evaluation of a Training Programme to Promote the Development of Professional Competences in Nursing: A Pilot Study

ABSTRACT

Background: Clinical narratives may be used as a means to improve the acquisition of clinical competences. Even though there are studies that recognize the potential value of clinical narratives to promote nursing professional development, there is no evidence that shows their value as a tool to improve nurses' competences to provide person-centred nursing care.

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INTRODUCTION

Reflective practice is much more than a simple linear application of theory to practice; it involves a complex process of professionals' management of situational demands, intuition, experience and knowledge (Schön, 1983). According to Schön, professionals who base their practice on reflection are able to modify tacit behaviours —generated by their repetitive experiences in practice— and provide new meanings to situations of uncertainty and uniqueness. In line with this theory, Gustafsson & Fagerberg (2004) showed reflective practice enables nurses to critically think about an idea, experience or action and to incorporate their life experiences that remain in their cognitive world, thus allowing the integration of theory, research and practice. In this way, reflective practice favours self-awareness and professional competence (Epstein & Humbdert, 2002), and the learning that results from this process is highly meaningful (Levett-Jones, 2007).

In this context, several authors propose clinical narratives as a useful tool for learning and developing professional nursing skills (Asselin, 2011; Benner, 1984; Choperena et al., 2019; Levett-Jones, 2007). According to Patricia Benner's approach (1984), a narrative can be a reconstruction/representation of a clinical experience which provides meaning to that experience. Consequently, nurses are able to fully explore the complexity of their practice, and to identify strengths and weaknesses. Furthermore, narratives allow nurses to address the practical knowledge hidden in their practice, which comes from experiential learning. Indeed, narratives can be used as tools that help nurses provide depth and analysis to the situations they face in their practice, a goal which cannot be achieved through mere intuitive verbal reflection on a clinical situation (Asselin, 2011). As stated by Gustafsson and Fagerberg (2004), the reflection linked to narratives involves not only cognitive processes but also the integration of theory, research and practice in an on-going process from which professional development may arise. Thus, the use of

narratives in the context of nursing reflective practice may lead nurses to improve and build their skills and competences and promote professional development (Cathcart & Greenspan, 2013; Levett-Jones, 2007).

A number of prescriptive models have been developed to guide and teach nurses how to reflect on practice (Gibbs, 1988; Johns, 1995; Kim, 1999; Kim et al., 2010; Koshy et al., 2017). The Critical Reflective Inquiry Model (CRI), based on the notions of action science and reflective practice, is oriented to analysing practitioners' beliefs and actions and exploring different models of knowledge-use in clinical situations, through the reflective analysis of clinical narratives (Kim, 1999). This model consists of three consecutive phases: (1) the descriptive phase —nurses develop descriptions of practical situations in the form of clinical narratives; (2) the reflective phase —the narratives are examined by experts with a reflective approach, helping the nurses to contrast the content with their previous personal beliefs, assumptions and knowledge; and (3) the critical phase —the narratives are used to correct and change ineffective practices and to introduce innovative attitudes that emerge from the narrated practice (Kim, 1999). Indeed, the CRI model offers a structured approach to reflection and a reflective guide for the professional development of nurses.

BACKGROUND AND CONTEXT

Person-Centred Care (PCC) is an approach to practice in which establishing therapeutic relationships —between health professionals, patients and others meaningful to the patients— is key to achieving good outcomes in patients (McCormack, Dewing & McCance, 2011). In this regard, developing an authentic and caring nurse-patient relationship is paramount to providing PCC (McCormack, 2003). Accordingly, it is crucial to develop a clinical nursing practice oriented to the establishment of caring and

helpful relationships focused primarily on the person (Errasti-Ibarrondo et al., 2015).

Previous research has shown that every authentic, specific and unique nurse-patient relationship is compounded by some core elements (Errasti-Ibarrondo et al., 2015; Rumeu-Casares et al., 2016; Saracíbar, 2009). In this sense, the Nursing Professional Practice Model of the Clínica Universidad de Navarra (NPPM-CUN) (Figure 1) (Rumeu-Casares et al., 2016), whose core part is the interpersonal nurse-person/family relationship, highlights that *respect, knowing the person* and *intentional presence* are three —not chronological but interrelated— essential elements of the nurse-person relationship that lead nurses to provide personal and authentic care (Rumeu-Casares et al., 2016; Saracíbar, 2009).

As seen in Figure 1, it is assumed that in the relationship there is bidirectional communication between the nurse and the person founded on their values, beliefs and expectations. In this dialogue, an essential requirement is that the nurse gets to know the person, for which it is essential that she/he conveys the unique, different and special nature of each patient. Indeed, *knowing the person* implies knowing patients in a personal way as unique human beings that are living through certain experiences related to their health condition, and orienting their actions to incorporate their personal values and goals into care delivery (Osácar, 2018; Somerville, 2009). Likewise, it is paramount to establish an open dialogue that it is not solely based on words. Hence, the nurse's *intentional presence* is vital, as this is what makes it possible for nursing care to be grounded on the knowledge the nurse has of the person's values, beliefs, convictions, needs and experiences as perceived by him/her. If the nurse's intentional presence is given, the person may feel that the relationship is authentic and thus, gain awareness of being cared for. Intentional presence can be philosophically understood as "a consciousness and awareness that are directed toward the patient, with purpose and

efficacy toward action, expectation, belief, volition, and even the unconscious" (Watson, 2002, p. 14). More practically, Monge & López (2015) acknowledged that intentional presence is the interpersonal process characterized by the transcendent unity between two people who sustain their bond in a relationship that is satisfactory for both, and in which the nurse intentionally builds a dynamic relationship with the patient, according to his/her uniqueness. Furthermore, the nurse-person relationship has to be based on mutual *respect*. When all this happens, the patient feels safe, protected and comforted, and the nurse is able to truly take care of him/her in accordance to his/her real needs and life experiences (Rumeu-Casares et al., 2016; Saracíbar, 2009). In this sense, Pérez (2013) found that through respect, nurses not only manifest their genuine interest in the person, but also avoid the violation of his/her privacy and intimacy, so a safe space in which the patient's personal life remains preserved may be created. Pérez noted that respect includes advocating for the patient, promoting decision making and helping the patient find meaning in the health process he/she is going through.

Taking into account that these three elements are central for the nurse-patient relationship, and, therefore, the provision of PCC, it is essential to guide nurses towards fostering their abilities in these elements. As mentioned above, clinical narratives can promote critical thinking and knowledge development among nurses, resulting in an improvement in their professional competences. In this sense, the aforementioned three fundamentals of the nurse-patient relationship can be expressed in the skills, attitudes and knowledge –main components of a professional competence- reflected in a clinical narrative. For this reason, the use of clinical narratives appears as an adequate and useful means to foster therapeutic nurse-patient relationships and PCC.

Nevertheless, few specific interventions have been developed to make use of the potential value of clinical narratives as an efficient way to promote and evaluate nursing

professional development (Asselin & Fain, 2013; Brubakken et al., 2011; Forneris & Peden-McAlpine, 2006). In addition, none have studied the effectiveness of clinical narratives in improving *respect*, *intentional presence* and *knowing the person* as professional competences within an overall nursing care approach that pursues PCC.

Accordingly, the hypothesis of this study is that the use of narratives improves the development of professional competences of nurses. For this hypothesis, this study focused on evaluating the preliminary efficacy of narratives for the development of *respect*, *knowing the person* and *intentional presence* as a means to provide PCC.

METHODS

Design

A pre-post quasi-experimental pilot study was designed as a preliminary trial to help estimate the treatment effect (Mujika et al., 2014) testing the hypothesis that the use of clinical narratives would have an impact on the development of professional competences in providing PCC (Clinical trial number: NCT03791411).

Study population

This study was conducted at the Clinica Universidad de Navarra (CUN), a tertiary hospital in Pamplona (northern Spain). Participants were nurses (n=35) enrolled in a mandatory training course called *Narratives and Reflective Practice*, which was part of the Nursing Specialization Programme of the CUN (https://www.cun.es/docencia/programas-especializacion-enfermeria), in the 2016-17 academic year. All nurses in the Nursing Specialization Programme were invited to participate in the study/training programme, regardless of their age or previous professional experience.

Sample size determination

Given that this was a pilot study using a pre-post quasi-experimental design with the aim of investigating preliminary efficacy, conventional sample size calculations, appropriate for a full-scale intervention, were not deemed necessary (Viechtbauer et al., 2015). Based on other training programmes for nurses, we determined a minimum of 25 participants were necessary to obtain an estimate of the intervention's effect size (Chambers, Meyer, & Peterson, 2018).

Recruitment

Recruitment took place in September 2016. One week before the intervention took place at the CUN, the principal investigator (ACA) explained the study to the nurses in a three-hour session. In this session, all the nurses were informed about the purpose and design of the study, and all of them voluntarily agreed to participate in the training programme. Once nurses agreed to participate in the study, their socio-demographic data were collected.

Baseline assessment

After recruitment, the principal investigator (ACA) asked participants to write a narrative (T1) focused on nurses' actions, thoughts and feelings (Kim, 1999) and all the circumstances involved in a meaningful encounter with a patient in a practical situation. Participants had to consider how *respect, intentional presence* and *knowing the person* had been present in the encounter (see instructions in Box 1). They had one week to write the narrative and to deliver it in paper form to the research team.

Study procedures

The study was conducted by a research team composed of seven people; six were nurses combining academic profiles, with professionals with a clinical background (including the principal investigator ACA), and the other was an expert in textual and discourse analysis (IOM). The intervention study, based on the CRI model (Kim, 1999; Kim et al., 2010), consisted of three phases. In the *descriptive phase*, nurses wrote narratives describing specific clinical situations including actions, thoughts and feelings; in the *reflective phase*, nurses were

asked to deconstruct their narratives, to gain knowledge about processes in practice, self-awareness, beliefs, and assumptions guiding practice; and the *critical phase* was focused on strategies to enhance practice with respect to the three core values of the nurse-patient relationship. The intervention was implemented from October 2016 to June 2017. Figure 2 shows the timeline of the educational strategies and the different phases of the CRI model.

Descriptive Phase:

In this phase, the narrative writing was combined with theoretical masterclasses, to train nurses to align the content of their narratives to the theoretical understanding of the narrated situations. The first three-hour training masterclass was provided by the principal investigator (ACA). This session focused on the nurse-patient relationship and the core values of *respect, intentional presence* and *knowing the person*. One week after the first session, nurses received the second three-hour masterclass. The topic of how to write and deal with the process of writing of narratives was addressed together with their usefulness for clinical practice. This session was taught by another research team member (IOM), specialist in textual analysis. After this session, participants wrote their second narrative (T2). To write this narrative, participants received the same instructions as the first time. A paper version had to be handed no more than one month later to the research team. Researchers considered that one month was time enough to collect meaningful experiences on which to base their narratives. Assessment criteria were provided to participants. All the participants had all the theoretical material from the sessions available on their Moodle platform.

Reflective Phase:

In this phase, narratives were examined by participants and researchers in small groups, in order to gain knowledge about processes in practice, self-awareness related to decision making, knowledge gaps, beliefs, and assumptions guiding practice (Kim, 1999). Indeed, six months after the first masterclass, all the participants took part in a two hour long discussion

group. For this dialogue, the nurses were asked to deconstruct their first two narratives (T1-T2) and share their experiences with the other participants and the research team. A discussion guide was designed by the research team to help participants deconstruct their narratives. Guiding questions included in the guide facilitated narrative discussion (see Box 2). At the end of the session, nurses were asked to write the third and last narrative (T3), following the same instructions as the first time. Again, a paper version had to be submitted to the research team no more than one month later.

Critical Phase:

The last phase of the intervention (nine months after the intervention began) was oriented to developing strategies to enhance practice with respect to the three core values of the nurse-patient relationship. Each participant had a 30-minute face-to-face interview with one member of the research team, to identify potential change through new learning, and how future actions would change in future similar situations. Some guiding questions with the purpose of changing practice were provided to participants to prepare for the interview (Box 3 shows all the guiding questions). Issues regarding strengths, weaknesses and improvements in nurses' practice identified in this phase were included in a reflective profile drawn up by the research team, based on the entire training process.

Evaluation process

To evaluate the narratives, an evaluation tool designed by the researchers and based on the NPPM-CUN Model —the NarratUN Evaluation Tool (NET)— was used. Narratives were evaluated in the same way at T1, T2 and T3. At the beginning of the intervention, the principal investigator (ACA) formed pairs of researchers combining academic profiles, with professionals with a clinical background. Each narrative was independently assessed by each member of the pair. After that, each pair discussed their evaluations and assigned a score to the narrative by consensus. Then, pairs shared their evaluations with the rest of the research

team in three working sessions (after T1, T2 and T3) and received feedback from the principal investigator (ACA) and the expert in discourse analysis (IOM). Researchers who did the masterclasses (ACA and IOM) were not evaluators of the narratives. All the research team members had been previously trained in different group sessions focusing on narratives, their use, and the application of NET for their evaluation.

Measuring instruments

To collect the sociodemographic data, a questionnaire was designed (Table 1). This questionnaire was developed specifically for the study, and data collection took place prior to the intervention.

To evaluate the narratives, the NET was used. The NET, which is based on the *Massachusetts General Hospital Instrument* (http://www.mghpcs.org/ipc/programs/recognition/Describing.asp), consists of a 19-item questionnaire, which is classified into four dimensions. The first three dimensions correspond to the three core competences —*respect*, *intentional presence*, and *knowing the person*, and the fourth dimension corresponds to the reflective process developed by nurses —*use of the narrative and reflection*—. This latter dimension refers to the capacity/ability of the nurse to use the narrative as a strategy to demonstrate professional growth and clinical expertise. To guide the scoring process of competence development, each item includes possible skills, knowledge or attitudes that can be expressed by nurses in the narratives. The score for each item varies from 1 to 4, where 1 is "no", 2 is "somewhat", 3 is "sufficiently", and 4 is "completely". An example of the scoring process can be seen in Box 4. Although the internal consistency of the instrument has not been studied, content validity was assessed through different procedures. This property is considered the most important because it measures whether the items are relevant, comprehensive, and comprehensible with respect to the construct of interest and target population (Prinsen et al., 2018):

- A panel of four international experts from Boston College and Massachusetts General Hospital carried out the validation (Grant & Davis, 1997). In this sense, the content validity showed that 100% of the items were congruent with the constructs to be measured (Polit & Beck, 2006).
- In addition, the research team piloted the tool in the evaluation of 10 randomly selected narratives (Polit & Yang, 2016). Each researcher evaluated the narratives independently and then scores were shared and compared with the research team.
- Finally, the acceptability and comprehensibility of scale items were studied using a focus group. Afterwards, the instrument was revised, and one item was changed. The items of the scale were shared with participants, so assessment criteria were provided.

Strategies to maintain intervention fidelity

To minimize interventionist effects, all the participants received the same training sessions at the same time. These sessions were given by two members of the research team (ACA and IOM) trained in narrative analysis. Regarding the training in narrative techniques, the research team wrote a detailed intervention manual, explaining the objectives of the different training sessions and how the dialogue group had to be conducted. This manual was reviewed by experts from the University of Navarra and Boston College.

Outcome measures

The primary outcome measures in the study were the difference in the mean scores for *respect*, *intentional presence* and *knowing the person* pre- and post-intervention. *Use of the narrative and reflection* measure was a secondary outcome pre- and post-intervention along with the differences between means at different times in the study.

Statistical analysis

Baseline data were reported as the mean [standard deviation (SD)] for continuous variables. Categorical variables were reported as frequencies and percentages (*n*, %).

Changes among nurses were analysed using the Wilcoxon signed Rank test. The Wilcoxon rank sum test was used to compare the average of the two raters' total scores among nurses.

The analyses were performed using Stata version 11.1 (StataCorp, College Station, TX, USA). Statistical significance was set at 5% (*P*-values<0.05, based on two-tailed tests).

Ethical considerations

Ethical approval was sought and granted by the University of Navarra Research Ethics Committee (reference number: 27/2016). Informed consent was obtained from all the postgraduate nurses participating in the trial.

RESULTS

Participants

Figure 3 shows a flow-chart for the study participants' evaluation. Of the 35 subjects enrolled in the trial, 34 (97.1%) completed the 9-month follow-up.

Baseline characteristics

Table 1 describes the demographic characteristics of the participants. Of the 35 participants, 100% were women, and the mean age was 23.6 years. Most had less than 4 years of clinical experience and had not previously completed another Nursing Specialization Programme.

Quantitative results

- *Respect*, *intentional presence* and *knowing the person*

  From time point 1 (T1) to time point 3 (T3), participants showed a significant increase in all measures of overall *respect*, *intentional presence*, and *knowing the person*. *Respect* increased by 0.59 (95% CI 0.23-0.95; p=0.001). The difference was 0.75 (95% CI 0.32-1.17; p<0.001) for *intentional presence* and 0.62 (95% CI 0.25-0.99;

p=0.001) for *knowing the person*. Table 2 shows the difference between means at different time points in the study.

- *Use of the narrative and reflection*

  This dimension also showed a significant increase between T1 and T3 [0.65 (95% CI 0.32-0.98 p<0.001)]. Additionally, compared to the primary outcomes, this variable also showed a significant increase between T1 and T2 [0.43 (95% CI 0.11-0.76; p=0.008)]. Table 2 shows the difference between means at the different time points in the study.

Qualitative results

Dialogue opportunities held between researchers and participants in the discussions groups and in the face-to-face interviews also supported that a significant increase in competences between T1 and T3 occurred. Indeed, most of the participants were not aware of the significance of an encounter with patients before participating in the training programme, and they primarily focused on the physical dimension as the most important aspect to address. One participant commented in the first narrative:

> "Through this patient, who had been hospitalized for several days, I was able to perceive the progression of the disease and the continuity of care. With this continuity I am referring to the care that I provided day after day: aspiration of secretions through the tracheostomy cannula, personal hygiene, intestinal rhythm (...)" (T1).

Nurses also manifested that they faced difficulties when they tried to balance and integrate what they understood as the "professional dimension", with the "personal dimension" of the nurse-patient relationship:

> "In my first contact with the patient, I tried to be warm, as I do with all patients, although in cases like these I have something in my conscience that tells me that my attitude should be more professional" (T2).

Overall, it was clear that, at the end of the programme, nurses were able to be more reflective about all those elements, and they incorporated the new knowledge into their clinical practice:

> "I warned her that I was going to instill saline solution to dilute the secretions (...). At last, we both managed to stay calm. In her case, by feeling relief, ease of breathing and overcoming the anxiety associated with that uncomfortable procedure; in my case, for understanding that trust is greater than personal fears and that we, as nurses, are capable of more than we think" (T3).

DISCUSSION

This study is the first to evaluate the preliminary efficacy of clinical narratives to improve PCC-specific competences. The results of this research supported the study hypothesis and confirmed the preliminary efficacy of using narratives in the development of professional competences. These results are similar to the results of other research in this area (Asselin & Fain, 2013; Brubakken et al., 2011; Forneris & Peden-McAlpine, 2006) that showed using narratives in a training programme can achieve a significant change in the development of professional competences.

The changes produced in the three main variables of the study —*respect, intentional presence* and *knowing the person*— can be explained through the use of narratives as a way to promote professional development in providing PCC. In other studies that used narratives as a strategy to improve competences, the authors highlight that this strategy improved reflection and, hence, critical thinking, which is essential to transform nursing practice (Chau et al., 2001; Hartrick, 2000; Peden-McAlpine et al., 2005). In this sense, the qualitative findings obtained in the discussion groups and face-to-face interviews also supported that a significant increase in competences between T1 and T3 occurred.

In addition, the use of the CRI theoretical framework to guide the design of the intervention protocol also contributed to the increase in the competences. As in other studies which have used the CRI model (Asselin & Schwartz-Barcott, 2015; Curtin et al., 2015; Curtin, Martins & Schwartz-Barcott, 2015; Halpin, 2016; Woods & Murfet, 2015), this model facilitated reflection and competence development. Although other prescriptive models have been developed to guide nurses on how to reflect on practice (Gibbs, 1988; Johns, 1995; Koshy et al., 2017), the CRI shows a difference in nursing reflective thinking about clinical practice situations. Indeed, as Asselin (2011) and Asselin & Fain (2013) highlighted, the CRI model provides a straightforward approach that incorporates a plan with different strategies to ensure that reflection has occurred during the process. Similarly, other studies emphasize its utility. For example, Halpin (2016) showed that this model provides a forum for nurses to reflect on how their practice is both defined and constrained and to consider different ways of practice; Curtin et al. (2015) stated that the CRI model is helpful in promoting in-depth description and reflection on students' underlying assumptions and values as well as identifying initial strategies for "emancipation" in specific patient care situations. In this study, the CRI model was particularly valuable in contributing to the professional competence development of participants in a very intuitive and progressive way and in capturing the core elements of the nurse-patient relationship from a PCC approach, through the individual writing of clinical narratives. In this sense, the model is not a prescriptive predetermined structure; it is a flexible approach that can be adapted to different environments with different resources. Not following the CRI model may explain why other studies (Spencer & Newell, 1999) found no statistically significant changes in subjects' reflections.

In contrast to other similar studies (Forneris & Penden-McAlpine, 2006), the present pilot study showed some significant differences not only at the end of the study (between T1 and T3) but also between T1 and T2 (*respect* and *intentional presence*). Since most of the training strategies took place during this period of time (masterclasses, discussion groups), we consider that in order to improve the critical thinking of participants, it is necessary to combine training sessions with writing narratives throughout the entire programme. This argument is reinforced by the fact that between T2 and T3, no significant results were found in any PCC competences. However, the mean differences increased for all variables —*respect, intentional presence* and *knowing the person*. In this sense, it is interesting to note that in the present study, informal counselling between researchers and participants was maintained throughout the training programme, which could have strengthened the results. Each participant had a reference researcher whit whom to discuss their concerns, doubts and feelings about the writing of the narratives and how the process was conducted. Taking this into account, we propose that in a future larger confirmatory study, the development and delivery of other face-to-face pre-established strategies should be reinforced. For example, one strategy could be to strengthen the role of tutors in assisting nurses to deconstruct their clinical experiences through the interaction between novice and expert nurses (Asselin & Fain, 2013; Koshy, 2017). Indeed, in a theoretical review conducted by Choperena et al. (2019), the strategy of establishing dialogue opportunities between participants and tutors when using narratives to enhance reflective practice was emphasized as an essential element of the critical thinking process (Forneris & Peden-McAlpine, 2006) and as a way to direct participants from theory to a deeper level of reflection in practice (Durgahee, 1997). In this study, participants had the opportunity to deconstruct their narratives with tutors in the context of small discussion groups. Posing guiding questions, working with small

groups of people, and generating a climate of trust led researchers to enhance the development of participants' competences.

With regard to the secondary outcomes, *use of the narrative and reflection* showed a significant increase between T1 and T3 and T2 and T3 but not between T1 and T2. To compensate for these findings, in a future trial, greater effort should be made from the beginning to more explicitly explain how to use narratives as a strategy to demonstrate professional growth and clinical expertise. Participants attended just one personal face-to-face interview. This interview was expected to help nurses direct their attention to the PCC competences and to correct participants for future practice. Integration of personal interviews as a way to develop competences in nursing has been widely implemented by other authors, such as Facione et al. (2008) and Levet-Jones (2007). For this reason, we think that carrying out face-to-face interviews after writing each narrative would be very useful to guide participants through the whole process and develop the competences more easily.

Another strategy for a future trial could be to reduce the time between the activities undertaken to preserve the reflective process and help maintain the sense of continuity of the programme. Indeed, in the face-to-face interviews, participants pointed out that the activities were too infrequent and that this could distract them from the main aim of the programme. In line with these thoughts, there is evidence supporting that reflection is a continuous process for professional development (Jayatilleke & Mackie, 2013). Future projects should guide nurses to consider when and how to reflect, as part of their continuous learning experience.

Implications for future educational interventions

The results of this study show that the use of narratives can be effective in improving professional competences. However, the training programme must be based on a

theoretical framework to be feasible. In our case, the use of the CRI theoretical framework to guide the design of the intervention has been proven to be effective. The CRI Model promotes practice thinking (Asselin & Fain, 2013). This can be easily incorporated into educational strategies to assist staff to enhance their professional practice and can be adapted to different environments with different resources.

On the other hand, an interesting aspect of this kind of educational intervention is the development of interspersed reflective sessions to preserve the continuous reflection process. More specifically, reflective dialogue around narratives, face-to-face interviews and informal counselling by tutors can make the difference.

Finally, as Hoffman et al. point out (2014), an essential aspect for the feasibility of the programme is the training of trainers. This training must take into account how a narrative has to be carried out and how it has to be evaluated. In addition, they must be experts in the competences that are going to be evaluated by means of the narratives.

Strengths and weaknesses

This study has the following strengths. The intervention was based on a structured reflection model (CRI) (Kim, 1999) that provides a straightforward approach to reflective practice (Asselin, 2011; Asselin & Fain, 2013). Several authors point out how the use of theory in the design of interventions improves outcomes (Ajzen, 2011). In this sense, prior to the design of the intervention, the authors of this paper, as advised by the MRC (Craig et al., 2008), identified evidence concerning all the theoretical aspects involved in the project (Choperena et al., 2019) and recognized the components of the interventions and the underlying mechanisms of influence (Choperena et al., 2019). Furthermore, the retention rate of this study was high (97.1%), which means that there was no significant risk for bias (Pardavila et al., 2018). This retention rate could be explained by the training

programme being a part of a training course, in the context of a Nursing Specialization Programme.

Nonetheless, a number of potential limitations needs to be acknowledged. Firstly, the sample size might have been too small to study the effectiveness of the intervention. However, the significant differences in the mean scores between T1 and T3 suggest that further exploration of this approach is worthwhile. Moreover, since this research was conducted as a pilot study, a small number of subjects seemed to be reasonable (Connelly, 2008). Adopting such an approach avoids spending too many resources (e.g., subjects, time and financial costs) and helps to identify an important association for a future larger confirmatory study (main trial).

Secondly, the lack of a control group might also have affected the validity of the study. Nevertheless, because it was believed that this pre-post quasi-experimental study was the best way (Polit & Hungler, 1999) to investigate the preliminary efficacy of the narratives for the development of professional competences, we were reluctant to either randomize subjects or use a control group. Additionally, non-randomized methods are common in educational research and are considered by experts not to be inferior to randomized clinical trials. In systematic reviews, the best evidence in medical education is graded on the strength of articles using several factors but not whether the study was randomized (Harden et al. 1999).

Thirdly, this approach requires considerable dedication by researchers. Therefore, this may be a limitation when implementing it in large groups. Working with small groups of nurses could facilitate a more continuous interaction between participants and researchers.

Fourthly, the NET questionnaire is still in the process of validation. However, content validation was carried out by expert panel consensus among experts from Massachusetts

General Hospital and Boston College. The NET is also theory-driven and unique in terms of content validity of the items.

Finally, narratives were not anonymized in the evaluation process, and evaluators knew which were the first, second and third narratives when scoring them. However, evaluators did not know participants before the intervention and the final score of each narrative was assigned by consensus, so this may have mitigated the possibility of introducing any bias into the scoring process.

CONCLUSIONS

The results of this pilot study suggest that the use of narratives combined with other reflective strategies (masterclass sessions and discussion groups) may be effective for the development of professional competences of nurses (*respect, intentional presence* and *knowing the person*) in a specialized training programme to provide PCC. Moreover, this pilot study supports the use of a structured reflection model (CRI) as an approach to improve nurses' reflection. Such findings should be taken into account in the design of further studies to determine the effectiveness of tailored training programmes.

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Figure 1. Nursing Professional Practice Model of the Clínica Universidad de Navarra (NPPM-CUN)

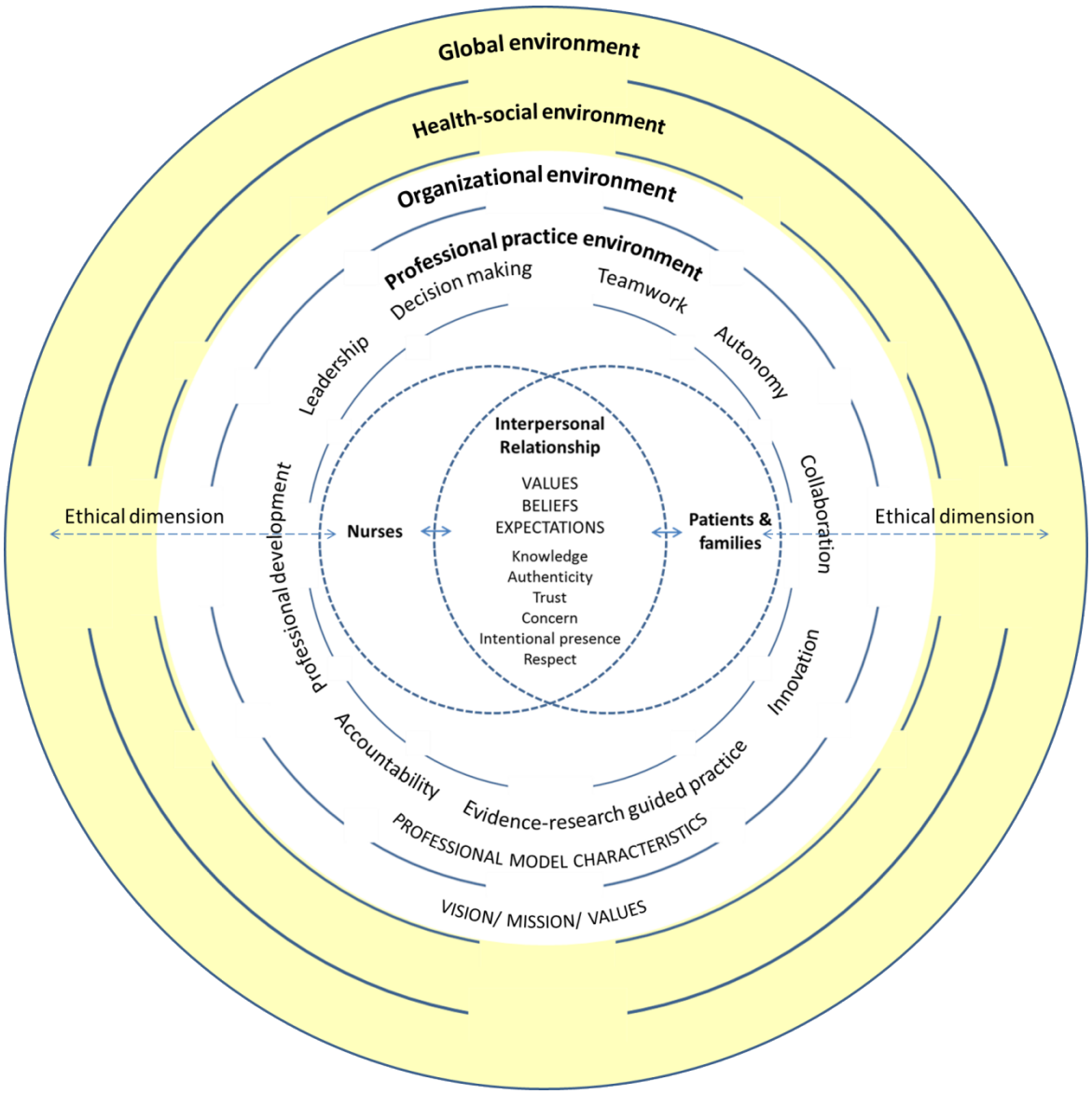


Figure 2.

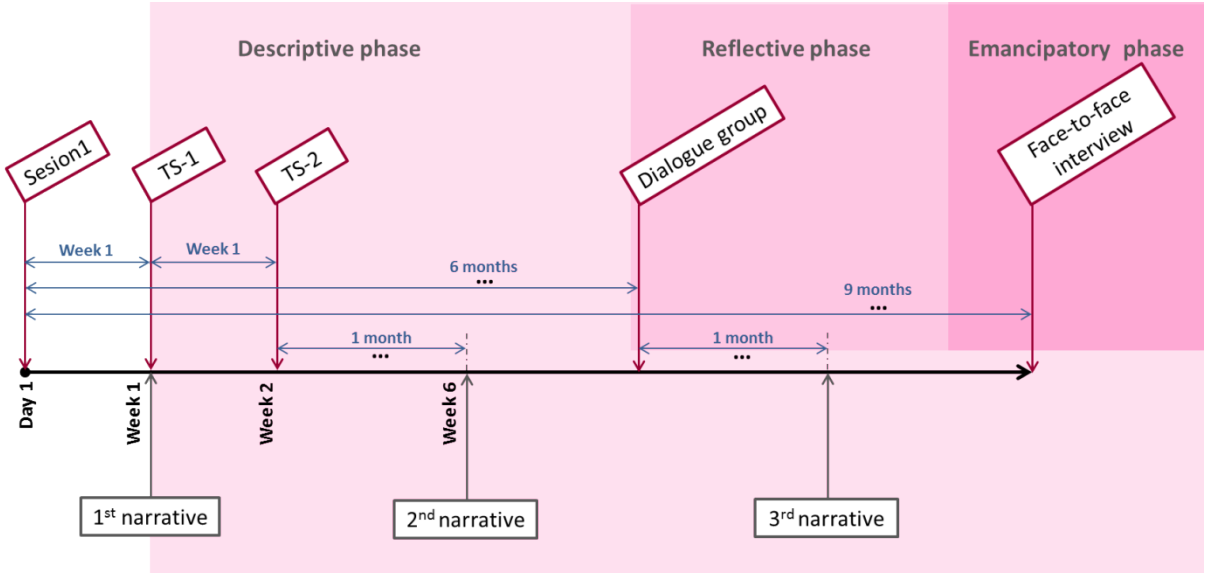
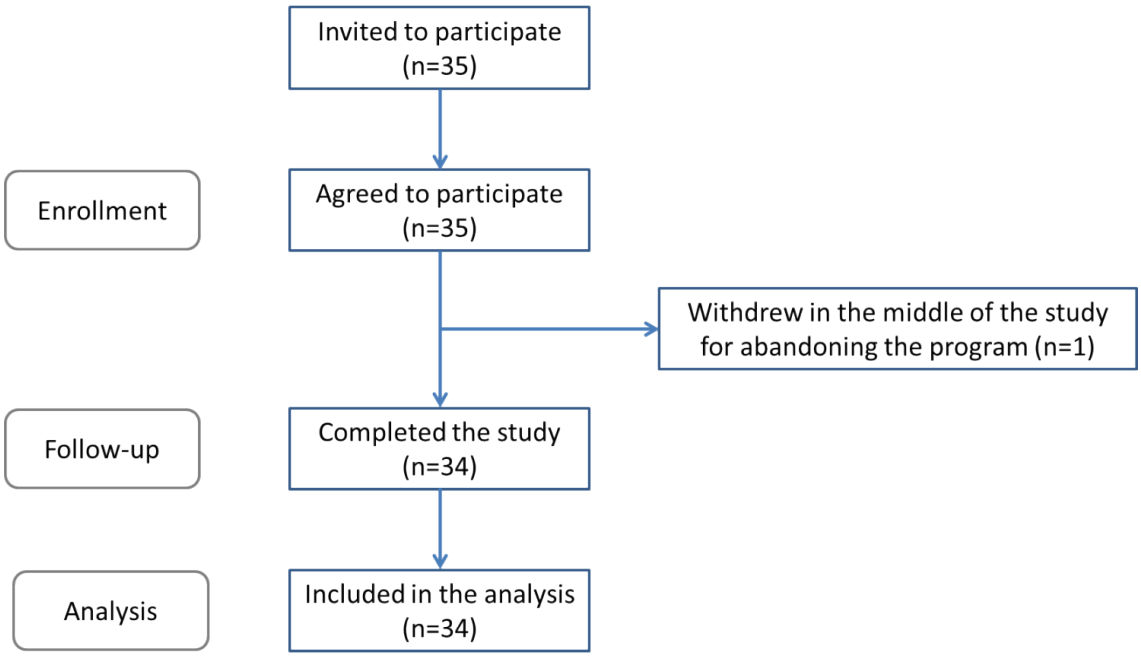

Descriptive phase
Reflective phase
Emancipatory phase
Sesion1
TS-1
TS-2
Dialogue group
Face-to-face interview
Week 1
Week 1
6 months
9 months
1 month
1 month
Day 1
Week 1
Week 2
Week 6
1st narrative
2nd narrative
3rd narrative

Figure 3. Flow-chart of participants throughout the trial



Box1. Instructions about how to write the narratives

- A narrative based on a significant case of your clinical practice.
- Description of actions, thoughts, feelings, circumstances.
- Look at the past in terms of feelings, not just actions.
- Deeply descriptive.
- Structure: Introduction, development, results.
- Theme: competencies of respect, intentional presence and knowing the person.
- A clinical experience with a patient or family that illustrates how your intervention made a difference in patient outcomes.
- A clinical experience that was particularly demanding.
- A clinical event or situation that you think captures the essence of your discipline.
- A clinical situation that you commonly confront in your practice and that gave you new insight into your role as a professional clinician.
- Information about yourself including your name, title, unit, and length of time in practice.
- Information that allows the reader to put the situation in context such as a description of where the event took place, the time of day and shift on which it occurred, a description of special conditions on the unit, and details about the patient's background.
- A detailed description about what happened.

Box 2. Discussion guide

Aims	**Questions related to the reflective process**	**Questions related to competences development**
- To reflect and analyze in groups the content of the narratives in a climate of trust. - To generate a shared dialogue that broadens perspectives. - To explore practical issues embedded in the text. - To look for common interests between participants. - To identify strengths and limits. - To define learning objectives and strategies to achieve them.	- Do I use the narrative as a strategy to demonstrate professional growth and clinical expertise? - Do I develop a narrative that communicates my lived experience with a patient? - Do I describe feelings and meaning associated with the patient encounter? - Do I provide data that accurately supports insights and decisions? - Do I describe my relation and interaction with other involved agents (patient, family of patient, members of the medical team, etc.), and how they influenced/impacted care? - Do I include explicit reflections on aspects that were more demanding?	- Do I recognize the individual uniqueness of the patient and its dimensions, as sex, culture, spirituality, etc. and how they influence her/his experience? - Do I demonstrate a behavior that reflects attentive and warm care: caring presence, touch, intention…? - Do I create a safe space for patient intimacy? - Do I respect the patient's image with other people (medical team, family, etc.)? - Do I advocate for the patient? - Do I promote patient decision making related to care? - Do I help the patient to find meaning to the process that he/she is going through? - Do I show authentic commitment with the patient? - Do I communicate to patient accordingly to her/his uniqueness? - Do I establish an open dynamic relationship with the patient? - Do I acquire personal knowledge of the patient? - Do I seek ways to incorporate patient's meaning and goals into care delivery? - Do I handle the novelty of the encounters with the patient and am I aware of the uniqueness of each patient experience?

Box 3. Guiding questions for the face-to-face interviews

- Were my actions in that situation the best or most appropriate? Why? Would I act now in another way?
- Did I develop respect, intentional presence and knowing the person in an adequate way? How did I reflect these aspects in the narratives? Currently, would I act otherwise? Would I manifest it in the narrative in another way?
- Should I rethink the concept I have about the three attributes?
- What have I learned through narratives?
- What have I learned through the training programme?
- How can I improve my practice in the future?

Box 4. Narrative excerpt examples in the evaluation of one item of the *respect* competence

Competence	**Item**	**Scores**	**Examples of narrative excerpts**
Respect	**Item 1** The nurse recognizes the individual uniqueness of the patient and its dimensions, sex, culture, spirituality, etc., and how they influence her/his experience	**1. NO** The nurse does not accomplish /achieve this component	*When I saw the patient in a critical situation, this made me see the importance of performing excellent care, as if it was performed to me* (PD. T1).
		2. SOMEWHAT a) The nurse senses the individual uniqueness of the patient **or** b) The nurse identifies and comprehends the individual uniqueness of the patient in a limited way	*I am with the medication cart. I find an older man, about seventy years old, who comes out of the elevator. Suddenly I remember about him. Yesterday I was talking to him. He is the husband of ninety-two's* (CA. T1).
		3. SUFFICIENTLY a) The nurse identifies the individual uniqueness of the patient and recognizes how its dimensions influence her/his experience **or** b) The nurse incorporates a limited number of individual dimensions of the patient into care	*I was approached by my patient's mother. She looked so helpless, so lost (...). She broke into tears. At that moment I was absolutely blocked, not knowing what to say (...). She told me that she was leaving her son's life in God. I made it easy for her to talk to the priest* (MF. T2).
		4. COMPLETELY a) The nurse identifies the individual uniqueness of the patient and fully incorporates its implication into patient care **or** b) Crucial aspects of nurse care are adapted to the individual dimensions of the patient **or** c) The nurse bases the nature of patient care on the individual uniqueness of the patient, who she/he understands and respects	*I know the bathroom helped the patient to feel comfortable, and I think about how it would be when someone is in a strange place and with so many unknown people around (...). My communication with her was continuous. It was very beautiful to be the patient's eyes and explain her who entered and left the room, explain each procedure, and hold her hand until she fell asleep* (AG. T3).

Table 1. Baseline characteristics of participants

	(n=35)
Demographic characteristics	
Age, mean (SD)	23,6 (2,2)
Sex, n (%)	
Female	35 (100.0)
Area of specialty in nursing, n (%)	
Cardiology	5 (14.3)
Operating nurse	9 (25.7)
Intensive care	9 (25.7)
Surgical hospitalization	5 (14.3)
Oncology	4 (11.5)
Psychiatry	3 (8.5)
Years of nursing experience, n (%)	
0-4	31 (91.2%)
5-9	3 (8.8%)
≥10	
Educational background, n (%)	
Degree	35 (100%)
Master	1 (2.9%)
PhD	0
Other specialty course	n=3 (8.8%)
Other postgraduate	1 (2.9%)

SD: Standard Deviation

Table 2. Differences in the level of nurses' competences through time (N=35)

Competences	Level of competence Mean (SD)			Differences in the level of competence between time of study Wilcoxon signed-rank test z (IC 95%; *p* value)		
	T1	T2	T3	T1-2	T2-3	T1-3
Respect	2.25 (0.80)	2.66 (0.74)	2.84 (0.62)	0.40 (0.01-0.79; 0.040)	0.18 (-0.15-0.53; 0.280)	0.59 (0.23-0.95; 0.001)
Intentional presence	2.19 (0.89)	2.66 (0.86)	2.94 (0.80)	0.46 (0.02-0.90; 0.037)	0.28 (-0.13-0.69; 0.182)	0.75 (0.32-1.17; 0.000)
Knowing the person	2.31 (0.78)	2.66 (0.78)	2. 94 (0.71)	0.34 (-0.04-0.73; 0.084)	0.28 (-0.09-0.65; 0.140)	0.62 (0.25-0.99; 0.001)
Use of the narrative and reflection	2.34 (0.70)	2.56 (0.66)	3.00 (0.62)	0.21 (-0.12-0.56; 0.206)	0.43 (0.11-0.76; 0.008)	0.65 (0.32-0.98; 0.000)

CRediT author statement:

Ana Choperena: Conceptualization, Investigation, Writing-Original Draft, Supervision, Project Administration, Funding acquisition

Miren Idoia Pardavila-Belio: Methodology, Writing - Review & Editing

Begoña Errasti-Ibarrondo: Writing-Original Draft, Visualization

Cristina Oroviogoicoechea: Formal Analysis, Investigation, Writing - Review & Editing

Amparo Zaragoza-Salcedo: Investigation, Writing - Review & Editing

Rosana Goñi-Viguria: Investigation, Writing - Review & Editing

Sonsoles Martín-Pérez: Investigation, Writing - Review & Editing

Teresa Llacer: Investigation, Writing - Review & Editing

Virginia La Rosa-Salas: Formal Analysis, Writing-Original Draft

Universidad de Navarra

INSTRUMENT 1

NarratUN

First and last names: _____ **Specialty:** _____

Narrative title: _____ **Number:** _____

COMPETENCE 1. RESPECT

The corresponding points will be given when the narrative meets one or more of the proposed criteria.

Components	No (1)	Somewhat (2)	Sufficiently (3)	Completely (4)	Points/Comments
1. The nurse recognizes the individual uniqueness of the patient and its dimensions, as sex, culture, spirituality, etc…and how they influence her/his experience.	The nurse does not accomplish /achieve this component.	a) The nurse senses the individual uniqueness of the patient. b) The nurse identifies and comprehends the individual uniqueness of the patient in a limited way.	a) The nurse identifies the individual uniqueness of the patient, and recognizes hoy its dimensions influence her/his experience. b) The nurse incorporates a limited number of individual dimensions of the patient into care.	a) The nurse identifies the individual uniqueness of the patient and fully incorporates its implication into patient care. b) Crucial aspects of nurse care are adapted to the individual dimensions of the patient. c) The nurse bases the nature of patient care on the individual uniqueness of the patient, who she/he understands and respects.	
2. The nurse demonstrates a behavior that reflects attentive and warm care: caring presence, touch, intention…	---	a) The nurse satisfies the basic aspects of courtesy to the patient.	a) The nurse cultivates a kind and attentive relationship with the patient. b) The nurse displays a behavior that reflects attentiveness going beyond mere courtesy.	a) The nurse attempts to promote a pleasant and kind relationship with the patient. b) The nurse actively involves himself/herself in a kind and delicate relationship with the patient.	

3. The nurse creates a safe space for patient intimacy.	---	a) The nurse shows basic behaviors for preserving patient intimacy. b) The nurse is capable of preserving patient intimacy in a limited number of situations.	a) The nurse detects and respects aspects of patient intimacy that go beyond what is considered to be basic care. b) The nurse recognizes situations in which patient intimacy is at stake.	a) The nurse creates a safe space in which fully integrates the patient's need for intimacy. b) The nurse is capable of correctly responding to patient demands of intimacy in any situation. c) The nurse is capable of anticipating and handling situations in which patient intimacy comes into play.	
4. The nurse respects the patient's image with other people (medical team, family, etc.).	---	a) The nurse complies with the basic aspects of confidentiality and upholds professional secrecy.	a) The nurse speaks respectfully of the patient to other people. b) The nurse detects situations in which it is important to show respect to the patient.	a) The nurse encourages other people to show respect to the patient. b) The nurse is capable of handling the information and judgments regarding a patient in diverse situations and places.	.
5. The nurse advocates for the patient.	---	a) The nurse asks herself/himself what is good for the patient. b) Although the nurse thinks she/he has recognized what is good for the patient, she/he is unable to clearly define it.	a) The nurse identifies what is good for the patient. b) The nurse advocates for the patient.	a) The nurse bases her actions on what she/he has correctly recognized as being good for the patient. b) The nurse advocates for the patient in all her/his actions/decisions.	

6. The nurse promotes patient decision making related to care.	---	a) The nurse informs the patient regarding the care that will be given to him/her. b) The nurse explains to the patient why each type of care is being given.	a) The nurse solicits patient opinions regarding the care given to them. b) The nurse is receptive to the reactions and opinions of the patient.	a) The nurse involves the patient in his/her own care. b) The nurse incorporates the decisions and opinions of the patient into his/her care.	
7. The nurse helps the patient to find meaning to the process that he/she is going through.	---	a) The nurse questions what each patient's experience means to him/her. b) The nurse places importance on the fact that the patient has found meaning in his/her experience.	a) The nurse recognizes what each patient's experience means to him/her. b) The nurse requests information from the patient as to what meaning he/she gives to his/her experience.	a) The nurse establishes an active dialogue with the patient regarding the meaning that the patient has given to his/her experience. b) The nurse attempts to deal explicitly with the patient about what his/her experience has meant to him/her.	
Holistic Evaluation					

COMPETENCE 2. INTENTIONAL PRESENCE

The corresponding points will be given when the narrative meets one or more of the proposed criteria.

Components	No (1)	Somewhat (2)	Sufficiently (3)	Completely (4)	Points/Comments
1. The nurse shows authentic commitment with the patient.	The nurse does not accomplish /achieve	a) The nurse addresses patient needs that arise. b) The nurse takes care of the patient and some of his/her needs.	a) The nurse gives full attention to the needs of the patient. b) The nurse takes the initiative of covering some of the patient's needs.	a) The nurse is always available to help the patient. b) The nurse does not limit his/her interest in or attention toward the patient, always showing a self-giving attitude.	
2. The nurse communicates to patient accordingly to her/his uniqueness.	---	a) The nurse communicates adequately with the patient regarding practical and instrumental aspects of his/her care.	a) The nurse establishes individualized and personal communication with the patient. b) When meeting with a patient, the nurse does not limit himself/herself to basic or instrumental communication.	a) The nurse actively looks for the opportunity to establish tailored and integral communication with the patient. b) The nurse facilitates encounters and opportunities for integral communication with the patient accordingly to her/his uniqueness.	
3. The nurse establishes an open dynamic relationship with the patient.	---	a) The nurse encourages and promotes a caring environment when dealing with a patient, trying to form a close	a) The nurse creates a trusting environment with the patient, at both personal and professional level.	a) The nurse successfully develops a full interpersonal relationship with the patient.	

		relationship between nurse and patient. b) The nurse does not act with preconceived ideas when caring for the patient.	b) The nurse shows understanding and empathy towards the patient.	b) The nurse is fully willing and able to establish an authentic dynamic relationship with the patient.	
Holistic evaluation					

COMPETENCE 3. KNOWING THE PERSON

The corresponding points will be given when the narrative meets one or more of the proposed criteria.

Components	No (1)	Somewhat (2)	Sufficiently (3)	Completely (4)	Points/Comments
1. The nurse acquires personal knowledge of the patient.	The nurse does not accomplish /achieve	a) The nurse somewhat knows the patient he/she is caring for, focusing the care just on one or two dimensions of the individual. b) The nurse only handles and evaluates data regarding the clinical situation of the patient under his/her care.	a) The nurse broadens her/his knowledge to nonclinical dimensions of the patient under her/his care. b) The nurse has data related to several dimensions of the patient under his/her care, but does not handle them integrally.	a) The nurse has full and integrated knowledge of the patient under her/his care. b) The nurse gets to know personal aspects of the patient: interests, motivations, values, etc.	
2. The nurse seeks ways to incorporate patient's meaning and goals into care delivery.	---	a) The nurse recognizes patient's meaning and goals, but, in practice, is unable to integrate them into care.	a) The nurse integrates some individual dimensions that go beyond the clinical aspects of her/his care for the patient. b) The nurse is capable of sensing the implications that patient's meaning and goals has on her/his care. c) On occasion, the nurse acts in accordance with the implications of the patient's meaning and goals.	a) The nurse fully incorporates patient's meaning and goals into her/his care. b) The nurse is capable of always acting in line with patient's meaning and goals.	

3. The nurse handles the novelty of the encounters with the patient and is aware of the uniqueness of each patient experience.	---	a) The nurse recognizes singular aspects of the encounters with the patient. b) The nurse acts in line with the singular aspects of each patient experience. c) The nurse is attentive so as to detect the novel aspects of each encounter, but is unable to clearly identify them.	a) On occasion, the nurse adapts herself/himself to the novel aspects that each encounter with the patient presents. b) The nurse responds to some new aspects of the encounters with the patient, but is limited to a certain degree.	a) The nurse is capable of adequately responding to the novel aspects of each encounter with the patient and is aware of the uniqueness of each patient experience. b) The nurse knows how to act in each encounter with the patient.	
Holistic evaluation					

INSTRUMENT 2: HANDLING THE NARRATIVE AND REFLEXIVITY

The corresponding points will be given when the narrative meets one or more of the proposed criteria.

Components	No (1)	Somewhat (2)	Sufficiently (3)	Completely (4)	Points/Comments
1. The nurse uses the narrative as a strategy to demonstrate professional growth and clinical expertise.	The nurse does not accomplish /achieve	The nurse is only capable of using the narrative for: (a) reflecting on her/his practice in a very general manner; (c) reflecting on challenges of limited significance.	(a) The nurse is capable of using the narrative to reflect upon her/his practice, but dealing with all of these things is very general. (b) The narrative reflects the existing demands and raises questions of a certain degree of relevance with regard to the nurse's practice.	(a) The nurse is capable of using the narrative in order to reflect deeply upon her/his practice and demonstrate professional growth and clinical expertise. (b) The case reflects existing demands or very important questions regarding the nurse's practice.	
2. The nurse develops a narrative that communicates her/his lived experience with patient.	---	(a) There is a sufficient level of detail in the narrative, but the facts/thoughts/emotions should be more clearly organized. (b) The narrative is coherent and organized but some or even quite a few facts/thoughts/emotions are only generally described or do not appear when necessary.	(a) The case is well understood because the relevant facts/thoughts/emotions are clearly included and organized in the narrative. (b) The narrative dedicates too much space to less relevant details. (c) The narrative does not dedicate enough space to the more important details.	(a) The case is thoroughly known because all the relevant facts/thoughts/emotions are presented in detail and are organized, and theological relations (for example, cause-consequence relations) are clearly explained. (b) The narrative dedicates a space that is proportional to the corresponding importance of the facts/thoughts/emotions.	

3. Through the narrative, the nurse is able to describe feelings and meaning associated with the patient encounter	---	(a) The narrative contains few descriptions regarding feelings and meaning. (b) The narrative contains various references to feelings and meaning, but they are very general and/or described with frequently used adjectives such as: *sad*, *happy*, etc.	(a) The narrative contains numerous references regarding feelings and meaning, which are described with a diverse repertoire of words and expressions, some of which are frequently used terms (*sad*, *happy*, etc.) and others which are more precise (*disappointed*, *intrigued*, *thrilled*, *intimidated*, *restless*, *surpassed*, etc.). (b) The narrative contains very few references to feelings and meaning, but those that are mentioned describe in great detail what the nurse experienced.	(a) The narrative contains many references to feelings and meaning, and these are described with a very extensive repertoire: a combination of general and specific adjectives; nuances in terms of intensity, characteristics and the effects of emotions, etc. (b) The narrative contains many references to feelings and meaning. They are described in detail (see point *a*) and are very precisely related to the facts and events narrated (for example, what event triggers emotion, etc.).	
4. The nurse provides data that accurately supports insights and decisions.	---	(a) The narrative contains very few descriptions regarding insights and decisions. (b) The narrative mentions some insights and decisions but they are very general and do not allow a detailed reconstruction of what the nurse was thinking at different times.	(a) The narrative frequently mentions insights and decisions, and these are described in a comprehensible manner. (b) The narrative relates some events with insights and decisions that led the nurse to act.	(a) The narrative contains abundant descriptions of insights and decisions, and they are described in detail. (b) The majority of the events narrated are related expressing the insights and decisions of the nurse.	

5. Within the narrative, the nurse describes her/his relation and interaction with other involved agents (patient, family of patient, members of the medical team, etc.), and how they influenced/impacted care.	---	The narrative refers to some interactions with other agents but these interactions: (a) are described in a short summary or in a very general manner (for example, *I spoke with the family*; *I asked the patient how he was feeling,* etc.); (b) are not sufficient for reconstructing the relation and/or the conversations maintained with the agents.	(a)The narrative describes significant details of numerous interactions maintained with other agents. (b) The narrative provides enough information in terms of the conversations maintained between the nurse and other agents so as to give the reader a close idea of the interactions that have taken place.	(a) The narrative describes numerous interactions that are very important within the experience that has been lived. (b) The narrative includes descriptions of numerous interactions that are addressed in detail and how they influenced/impacted care.	
6. In the narrative, the nurse includes explicit reflections on aspects of the case or on the experience lived that were more demanding for her/his and her/his personal response.	---	(a) The narrative contains some reflections regarding nursing practice, but they are very general and/or the nurse could have made these same reflections before writing the narrative. (b) The reflections included in the narrative do not make reference to the more demanding aspects of the case, and her/his response to them.	(a) The narrative contains reflections on the demands of the case and their repercussions on the nurse's practices, but some of them could have been developed more. (b) Although there are a sufficient number of explicit reflections, there are relevant aspects of the case that have been left out.	(a) The narrative includes profound reflections regarding the demands of the case, the diverse aspects of nurse practice and/ her/his response to them. (b) The nurse knows how to take full advantage of the case: this allows the nurse to reflect on her/his nursing practices and professional growth.	

Holistic Evaluation					