




## REVIEW

## Key competences of outpatient nurses, as perceived by patients attending nurse-led clinics – An integrative review

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## Abstract

**Aim:** The aim of this review was to identify key competences of outpatient nurses, as perceived by patients attending nurse-led clinics.

**Background:** The increased demand for nurses to manage treatment and care in hospital outpatient clinics requires a better understanding of nurses' competences important to outpatients.

**Design:** An integrative review using Whittemore and Knafl's five-stage model.

**Methods:** Relevant studies were located by systematically searching PubMed, CINAHL and Scopus. A group of three researchers assessed the studies found and the quality of the included studies using the CASP tool. Data were extracted and analysed by thematic analyses. The current study was evaluated using PRISMA checklist.

**Results:** Nine studies met the inclusion criteria. Three key competences emerged: *providing access, sharing knowledge and establishing relationships*. The key competences were supported by ten sub-themes that were characterised by nurses' actions and qualities, derived from the included studies.

**Conclusions:** The identified key competences reflected a holistic approach that encompasses knowledge, skills and attitudes, indicating outpatient nurses being able to manage different ways of involving patients, which may lead to the consideration of outpatient consultations as a kind of negotiation, based on a respectful dialogue.

**Relevance to clinical practice:** The findings are usable when optimising the performance and quality of the health workforce, including outpatient nurses, as recommended by WHO (World Health Organization, Global strategy on human resources for health: Workforce 2030, 2016). Furthermore, the identified knowledge emphasises the need for clinical skills training and academic education, specially targeted outpatient nurses, in order to enable the nurses to become experts in specific practice settings.

## KEYWORDS

ambulatory, care needs, communication, competence, nursing, patient experiences, patient-centred care, review

## 1 | INTRODUCTION

Worldwide, more people are living longer, and many suffer from chronic diseases, leading to an increased need for outpatient services. Furthermore, the need to perform complex treatments in outpatient settings and years of rationalisation, resulting in less availability of hospital beds, make it essential for health professionals to be competent to provide quality outpatient services (Durrani, 2016). According to the World Health Organization (WHO), all over the world, the expected lack of doctors and nurses represents a major future challenge. One of WHO's strategies includes optimising the performance and quality of the health workforce, including people-centred health services that patients may benefit from (World Health Organization, 2016).

To meet the increased need for people-centred health services, the number of nurse-led clinics has increased (Farrell et al., 2017). Within community-based nurse-led clinics, nurse-led consultations have a positive impact on patient outcomes and satisfaction, resulting in patients experiencing coordination of care, decision support, problem-solving and patient activation (Massimi et al., 2017). Furthermore, a Cochrane review, conducted by Laurant et al., showed how patients experience trained nurses to provide care that is equal in quality to that provided by primary care doctors. In addition, Laurant et al. (2018) found that in some areas, nurses achieve higher levels of patient satisfaction compared to primary care doctors, when responsible for first contact and ongoing care for patients in family and general practices. The higher levels of satisfaction were found within the areas of patients' experiences of communication and attitude, relationship to provider, information, access to care and empathy (Laurant et al., 2018).

This points to the fact that the increased number of nurse-led clinics may be one strategy to optimise the performance of the health workforce as suggested by WHO (World Health Organization, 2016).

Nurse-led clinics are not new; they have existed within general practices for many years. A characteristic is that nurses perform independent consultations for well-defined patient categories, for example patients with cardiovascular diseases, cancers, chronic respiratory diseases or diabetes (Massimi et al., 2017; Wong & Chung, 2006). In hospitals, a wide range of nurse-led clinics is presented, ranging from clinics treating physical conditions to supportive clinics focusing on more existential needs. A focused ethnographic study of nurses' roles in nurse-led chemotherapy clinics identified four levels of nurse-led clinics based on the nurses' autonomy and the scope of their clinical practice and great disparities in the tasks of nurses at the different levels were found. Based on those findings, it was recommended to explore needed competences across each level as well as the level of the nurses' education (Farrell et al., 2017).

Morrison and Symes (2011) have studied expert nurses' competences in varying contexts. They define experts as nurses having the ability to use professional knowledge available, including comfort measures and caring interventions that complement the technical skill of managing equipment and procedures. They found

### What does this paper contribute to the wider global clinical community?

- Discusses three key nursing competences important to patients attending outpatient clinics.
- Highlights the importance of including the patient perspective when assessing nurses' competences.
- Adds enriched insight into the need for clinical skills training as well as academic education

that regardless of nursing specialism, employment settings and countries, it appears that nurses possess competences that may be difficult to define or articulate (Morrison & Symes, 2011). This may be one of the reasons why nurse competences within a nurse-led clinic, and regardless whether the nurse is an expert or not, may be difficult to describe. However, a main challenge seems to be that, apparently, there is no common understanding of the concept 'nurse competences' (Axley, 2008; Caruso et al., 2016; Scott Tilley, 2008). Furthermore, it may be challenging to distinguish between the concepts 'competence' and 'competency'. According to Khan and Ramachandran (2012), the definitions of competence and competency are not very clear in the literature, and the authors argue that competency is a skill and competence is the attribute of a person as well as a point on the spectrum of improving performance (Khan & Ramachandran, 2012). In this context, we are inspired by the 'Integrated Model of Nursing Competence' (Caruso et al., 2016). The model is based on a synthesis and concept analysis from a literature review that included 14 review papers published between 2005 and 2014. The model highlights the complexity of nurses' competences, by identifying two perspectives. One perspective describes what the nurses are capable of (competences). The other perspective describes how the competences are operationalised and experienced in a certain context (performance). Common to the two perspectives are that both perspectives rely on nurses' personal characteristics and professional training, together with their daily tasks and the organisational environment (Caruso et al., 2016).

If competences are seen from the two perspectives identified by Caruso et al. (2016), it seems relevant not only to describe competences, as seen from the professional perspective, but also to approach the subject from the patient perspective. This approach is supported by Coulter (2012), who highlights the importance of including patients' experiences in the assessment of competences, as this contributes to nuancing and informing nursing practice about patients' preferences and expectations for care and treatment (Coulter, 2012). Furthermore, Berglund et al. (2015) find patients' experiences in outpatient clinics to be essential indicators of value and quality in the assessment of treatment and care and thus also an important indicator in the assessment of nurses' competences (Berglund et al., 2015). Therefore, the aim of the current review was to identify key competences of outpatient nurses, as perceived by patients attending nurse-led clinics.

## 2 | METHODS

### 2.1 | Design

The study was an integrative review that allowed inclusion of research with diverse methodologies. This was expected to contribute to a more complete understanding of the patient perspective on nurses' competences in nurse-led outpatient clinics. The structure of the integrative review was inspired by Whittemore and Knafl's methodology, as it offers a structured way of conducting reviews. The methodology consists of five stages, which are used in the current review – respectively, problem identification (introduction section), literature search, data evaluation, data analysis and presentation (result section) (Whittemore & Knafl, 2005). Preferred Reporting Items of Systematic reviews and Meta-Analyses (PRISMA) was used to optimise the reporting quality of the current review (Moher et al., 2009). The PRISMA checklist is presented in Table S1.

### 2.2 | Literature search

Whittemore and Knafl (2005) suggest to broaden and diversify the sampling framework (Whittemore & Knafl, 2005). Therefore, a comprehensive and iterative search was applied to the subject. The research team, consisting of the authors, searched the topic on websites and in references and talked to nurses from nurse-led outpatient clinics about their competences and how their clinics were composed and defined.

The keywords were derived from core concepts of the research question, – respectively, 'competences', 'nurse-led clinics' and 'patient perspective', and partially found during the broad iterative search and through individual and shared reflection in the research team. The key words were then converted into search terms. The search terms used for each individual database are presented in Table S2. The search terms were modified and combined using Boolean operators. The extensive and structured search was performed in CINAHL, PubMed and Scopus with the aim of finding different types of studies in line with the aim of conducting an integrative review. No search limits were used.

Inspired by Whittemore and Knafl (2005), the qualitative search-tool SPIDER (Sample, Phenomenon of Interest, Design, Evaluation and Research type) was used, in order to define the inclusion criteria (Cooke et al., 2012). The use of SPIDER resulted in five inclusion criteria:

- Sample: patients' perceptions of nurse-led outpatient clinic.
- Phenomenon of interest: nurses' competences.
- Design: questionnaires, interviews, focus groups and patient narratives.
- Evaluation: patient perspectives, such as vision, experience and satisfaction.
- Research type: qualitative and quantitative studies.

Studies that did not meet these criteria were excluded.

### 2.3 | Search outcome

The search process identified 1,200 potentially relevant papers. The research team reviewed the studies found and conducted screening and assessment for eligibility based on the inclusion criteria.

Possibly relevant papers were screened, based on title, abstract and overall results. To ensure that all relevant papers were included, two of the researchers reviewed all the excluded studies and thus verified that relevant studies had not been excluded. If they found relevant papers among those excluded, these were re-read and discussed in the research team. One paper was included after the validation process. The review process yielded nine papers, all of which met the inclusion criteria and underwent evaluation and analysis. The search process and audit trail are illustrated in Figure 1, using the PRISMA Flow Diagram, which depicts the flow of information through the different phases of the process, for example the number of records identified, included and excluded and the reasons for exclusions (Moher et al., 2009). An overview and summary of the nine included papers/studies is presented in Table 1.

### 2.4 | Data evaluation

As recommended by Whittemore and Knafl (2005), the quality of the included studies was evaluated by using a specific tool, in order to decide whether to include the studies or not. In this review, the Critical Appraisal Skills Program (CASP) was chosen (Critical Appraisal Skills Programme, 2018). A schema was developed to create an overview of the included studies, structured by the relevant CASP questions. The assessment of the included studies is provided in Table S3 and S4. After the quality appraisal, there was full agreement within the research team to include all nine studies.

### 2.5 | Data abstraction and analysis

The integrative review method developed by Whittemore and Knafl (2005) offers an analysis approach that allows for the combination of diverse methodologies. Completely unexpected, there were only qualitative studies included in the current review. Therefore, the recommended analysis approach had to be modified, why we decided to divide the analysis into a two-step process. In the *first step*, the original key findings from the studies were identified, abstracted and displayed. The data displayed served as a starting point for analysing at the second step. The data extracted were the patients' descriptions of the nurses' actions and qualities. The *second step* was undertaken using a thematic analysis method (TA) inspired by Braun and Clarke (Braun & Clarke, 2006). TA is an accessible and theoretical flexible method of qualitative analysis that gave the researchers a method for systematically identifying, organising and offering insight into patterns of meaning (themes) across the extracted descriptions of the nurses' actions and qualities extracted in step one. Two members

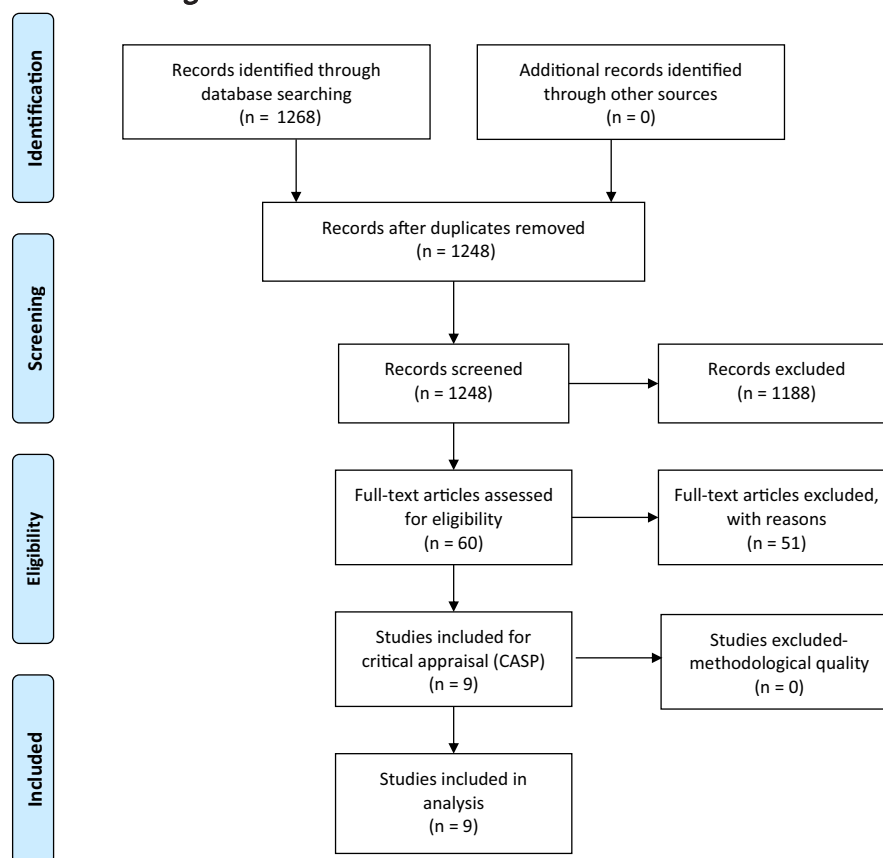


FIGURE 1 Flow chart – Search results. Adapted from Moher et al. (2009) [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]

of the research team individually looked for patterns of meaning. After this, they met to compare and discuss the initial coding until consensus was reached. Together, the whole research team sorted the various codes into potential themes, including considering how the themes were linked together. The themes were reviewed in order to check the themes in relation to the entire data set. Based on this, the final main themes were defined and named. During the analysis process, the ten sub-themes were merged into three main themes.

### 3 | RESULTS

#### 3.1 | Included studies

The nine included studies were from Sweden (6), Australia (2) and Canada (1). All included studies were based on a qualitative research approach, using interviews for data collection. Most of the studies had as their primary aim to examine the patient perspective on the nurses' role in nurse-led consultations.

The focus was on patients' *experience* (Bala et al., 2012; Jakimowicz et al., 2015; Larsson et al., 2012; Sjo & Bergsten, 2018), *satisfaction* (Koinberg et al., 2002; Stahlke et al., 2017), *empowerment* (Arvidsson et al., 2006) and *perceptions* (Larsson et al., 2007; Wand et al., 2011), of the meeting with nurses in various nurse-led

outpatient clinics. Common to the clinics were that the nurses conducted independent consultations and worked in teams with other professionals. Characteristics of the included studies are listed in Table 1.

All the included studies found nurses' competences to be an important theme (Arvidsson et al., 2006; Bala et al., 2012; Koinberg et al., 2002; Larsson et al., 2007, 2012; Sjo & Bergsten, 2018; Stahlke et al., 2017; Wand et al., 2011). The included review by Jakimowicz et al. (2015) synthesised themes focusing on nurses' actions and competences (Jakimowicz et al., 2015).

#### 3.2 | Themes

Three main themes found were *providing access*, *sharing knowledge* and *establishing relationships*, illustrated in Table 2. The main themes emerged from the identified sub-themes.

#### 3.3 | Providing access

The key theme *providing access* included nurses' support to the patients regarding their getting access to the right treatment and care. The nurses' support was divided into three sub-themes: *being available*, *being a gatekeeper* and *being a lifeline* (Table 2).

TABLE 1 Included studies

Author(s) (year) and location	Aim	Methodology and data collection	Sample size	Setting type of clinic	Findings – themes/categories
Sjo and Bergsten (2018) Sweden	To add a deeper understanding of participants 'experience of meeting with a nurse every 6 weeks over a 12-month period	Qualitative and Phenomenographic approach Interviews	14	Meeting with a nurse in a rheumatology clinic at a hospital	<b>Three categories with sub-categories</b> 1. Encountering competence Increased knowledge about the disease and treatment Support from other healthcare professionals Experiencing participation 2. A sustainable relationship Enhanced sense of security Easy access 3. Making a personal journey Increased self knowledge Learnt how to take care of myself
Stahlke et al. (2017) Canada	To add what is known about patient satisfaction with nurse practitioner (NP) care, from perspectives of breast cancer patients who were followed by an NP	Qualitative Interpretive description Interviews	9	Outpatient clinic within a large cancer centre	<b>Four themes</b> Initial Reactions NP and Oncologist Role Tensions and understandings Value-Added Aspects of NP Care Satisfaction
Jakimowicz, S., Stirling, C. & Duddle, M. (2015) Australia	To systematically review the qualitative evidence on factors that affect the experience of patients attending nurse-led clinics and compare with key elements of person-centred care	Studies that have a qualitative approach	11	Nurse-led clinics in hospital, general practice and primary care	<b>Three synthesis statements with categories</b> 1. Establishing a therapeutic relationship 2. Thoughtful and effective communication 3. Clinical skills and collaborating
Larsson et al. (2012) Sweden	To describe patients' experiences of a nurse-led rheumatology clinic for those undergoing biological therapy	Qualitative Inductive approach Exploratory Interviews	20	Nurse-led clinic in a rheumatology clinic	<b>Three themes with sub-themes</b> 1. Experience and security Patients experienced competence Patients experienced accessibility 2. Experiencing familiarity Patients experienced confirmation Patients experienced sensitivity 3. Experiencing participation Patients experienced exchange of information Patients experienced involvement
Bala et al. (2012) Sweden	To describe how people with RA experience the care provided by Swedish nurse-led rheumatology outpatient clinics	Qualitative Descriptive explorative design Interviews	18	Nurse-led rheumatology outpatient clinic	<b>Three categories with nine sub-categories</b> 1. Social environment Warm encounter Familial atmosphere Pleasant premises 2. Professional approach Empathy Knowledge and skill Support 3. Value-adding measures Security Accessibility Continuity

(Continues)

TABLE 1 (Continued)

Author(s) (year) and location	Aim	Methodology and data collection	Sample size	Setting type of clinic	Findings – themes/categories
Wand et al. (2011) Australia	To examine participants' perceptions of a feasibility, acceptability, and efficacy of an ED based MHNP outpatient service	Mix-method design Survey and Realist telephone interview Thematic analysis	23		<b>Two themes with eight sub-themes</b> 1. Therapeutic dimensions of the service Listened to and Understood A focus on solutions, not problems Selected therapeutic approach did not suit all client needs Health information and education The 'nurse' in nurse practitioner 2. Practical and timely access to follow up Responsive access to care Continuity of care The need for an extended service
Larsson et al. (2007) Sweden	To describe how head and neck cancer patients with eating problems conceived the significance of a supportive nursing care clinic before, during and after completion of radiotherapy	Interview (8 patients twice)	12	A supportive nursing care clinic	<b>One main category with three descriptive categories</b> 1. A source of safety and security Knowledge and practical advice Coordination and control Commitment and concern
Arvidsson et al. (2006) Sweden	To describe a nurse-led rheumatology clinic's impact on empowering patients with RA	Qualitative Descriptive Phenomenographic approach Interview 30–90 min	16	Nurse-led rheumatology clinic treating DMARDs	<b>Three categories with eight conceptions</b> 1. Teaching Gaining insight Receiving information 2. Regular view Receiving security Realising regularity Achieving accessibility 3. Attention Getting a holistic assessment Receiving coordinated care Getting sufficient time
Koinberg et al. (2002) Sweden	To describe breast cancer patients' satisfaction with a spontaneous system of checkup visits to a specialist nurse	Qualitative Descriptive Phenomenographic approach Interview Half-structured questions	19	Spontaneous check-ups after breast cancer surgery	<b>5 Categories</b> The need for accessibility The need for information The need for trust The need for confirmation The need for self-care

### 3.3.1 | Being available

Easy access to a nurse seems to be important when patients need to speak with someone about their concerns. It is even perceived as a fundamental prerequisite if the experience at a nurse-led clinic is to be satisfactory (Arvidsson et al., 2006; Bala et al., 2012; Koinberg et al., 2002; Sjo & Bergsten, 2018; Wand et al., 2011).

Having the opportunity to call the clinic and to get quick feedback was important to the patients, as was having the opportunity to make an appointment, if needed (Bala et al., 2012; Larsson et al., 2012; Sjo & Bergsten, 2018). Patients used words such as: efficient,

prompt and flexible, when they spoke about the nurse-led clinics (Wand et al., 2011). In some studies, patients had a more negative experience of access to the clinics. In those studies, they described lack of regularity, structure, that some of the telephone calls were not in-depth and that long waiting times were exhausting (Bala et al., 2012; Wand et al., 2011). In general, time and resources impact patients' experiences of easy access to clinics (Bala et al., 2012; Larsson et al., 2012; Sjo & Bergsten, 2018; Wand et al., 2011). Being available influences the patients' experience of the nurses, as they felt a kind of safety and security when it was easy to get in touch with the nurse/clinic (Larsson et al., 2007).

**TABLE 2** Thematic analysis that identifies the nurse's competences in themes and sub-themes based on nurses' actions as and qualities perceived by patients

Theme	Sub-Theme	Nurses' actions	Nurses' qualities
Providing access	Being accessible	No concrete actions from the nurse it is more the fact that she must <i>be available</i>	
	Being a gatekeeper	Coordinate care Understand individual needs Referring Access individual needs Work with other team members Act like skilled advocates Cooperate in a friendly manner	Being responsible
	Being a lifeline	Offer a sense of stability and confidence Monitor the need for existential care Talk to patients Answer questions Take concerns seriously	Being calm Being able to communicate
Sharing knowledge	Providing specialist knowledge	Give information Learn patients Make patients understand Answer questions about disease or treatment Mediate knowledge Seek medical attention if in doubt	Possess up-to date knowledge Known limitations Communicate knowledge
	Giving practical advice	Verbalise patient-related issues Discuss patient-related issues Give practical advice in concrete situations Guide	Being experienced Being able to communicate
	Using knowledge from patients	Exchange information Share experiences Provide relevant knowledge Invite patients to participate Involve patients Take active interest Listen to life situation Make room for patients to be active	Being able to communicate
Establishing relationships	Creating continuity	Know patient's history and background	Being able to communicate
	Building relationships	Create a familiarity atmosphere Use body language/facial expressions/quiet speech Listen Speak on an equal footing Treat patients with respect Read the patient	Possess intuition Being sympathetic Being empathic Being sensitive Being attentive Have an instinctive understanding
		Supporting patient's life	Being 'more hands on' Being able to communicate
	Providing emotional support	Understand the individual need for emotional support Supporting relatives	Being sensitive Being attentive

### 3.3.2 | Being a gatekeeper

The studies showed that nurses were able to understand and assess patients' individual needs for referral to other members of the interdisciplinary team (Arvidsson et al., 2006; Bala et al., 2012). The fact that nurses were able to work with other interdisciplinary team

members, acting as skilled advocates, cooperating in a friendly manner and being responsible, meant a lot to patients (Bala et al., 2012; Sjo & Bergsten, 2018). Patients found that nurses within nurse-led were coordinators of care, and they found it easier and more convenient to turn to the nurses to make arrangements, rather than doing it themselves (Larsson et al., 2007). This highlights the understanding that nurses have a role as gatekeeper, in coordinating



patients' appointments. Another aspect of being a gatekeeper was the patients' expectations of nurses' cooperation with doctors. Some patients seemed to be unaware of the nurses' independent role and professional competences at their first visit to the clinic, but, over time, they were pleased to be assigned to the nurse-led clinic (Stahlke et al., 2017). When the patient perceived to be a competent gatekeeper, patients felt secure and comfortable. On the other hand, patients felt surprised by meeting a nurse instead of a doctor, as well as uncertain and confused when they did not understand the professional role of the nurse (Stahlke et al., 2017).

### 3.3.3 | Being a lifeline

Nurses were considered and mentioned as a lifeline for patients when they offered a sense of stability and confidence, especially if something unexpected happened (Larsson et al., 2007; Stahlke et al., 2017). The need for stability also included a need for confirmation, for example nurses being aware of patients need of existential support and helped those without a social network to manage difficult life situations (Koinberg et al., 2002). The actions performed by the nurses involved talking to the patients and answering their questions, as well as taking the patients' concerns seriously (Larsson et al., 2007, 2012). The nurse as a lifeline gave patients a feeling of reassurance. It helped them to feel comfortable and be able to heal and return home with a renewed strength (Stahlke et al., 2017). The reassurance also contributed to patients feeling confident and secure, and it diminished anxiety (Larsson et al., 2007; Stahlke et al., 2017).

## 3.4 | Sharing knowledge

The key theme *sharing knowledge* covers knowledge given and received with the intention of adapting it to the individual patient. It meant a lot to patients and consisted of three sub-themes: providing specialist knowledge, using knowledge from patients and giving practical advice. The sub-themes described the composite and directional knowledge shared between patient and nurse. For the nurse to provide specialist knowledge and give practical advice, it was essential to gain knowledge from the patients. Nurses employed several actions and possessed personal qualities that made it possible to share knowledge with the patient. The themes are presented in Table 2.

### 3.4.1 | Providing specialist knowledge

The fact that nurses possessed up-to-date knowledge about diseases, diagnosis and treatment seemed to be important to patients (Arvidsson et al., 2006; Bala et al., 2012; Jakimowicz et al., 2015; Sjo & Bergsten, 2018; Stahlke et al., 2017). Patients' experienced how nurses gave information and taught the patients about their disease

and helped them understand certain things, e.g., the importance of nutrition (Arvidsson et al., 2006; Koinberg et al., 2002; Larsson et al., 2007; Sjo & Bergsten, 2018). Also when patients felt that they could pose questions and afterwards get answers it was experienced, as an important aspects of being in the nurse-led clinic (Sjo & Bergsten, 2018). In one of the studies, it was described that the nurse served as a mediator of knowledge and was seen as a primary source of knowledge in nutrition (Larsson et al., 2007).

The patients also described how important it was for them that the nurse sought the doctor if in doubt, thus being aware of his/her own limitations (Larsson et al., 2012).

When patients experienced that nurses provided specialist knowledge, it gave them a feeling of security, trust, reassurance and a sense of being in control (Arvidsson et al., 2006; Bala et al., 2012; Jakimowicz et al., 2015; Larsson et al., 2012; Sjo & Bergsten, 2018).

### 3.4.2 | Using knowledge from patients

Using knowledge and information from patients was based on several activities performed by the nurses in the clinic. Larsson et al. (2012) found that, when nurses exchanged information and shared experiences, thus providing relevant knowledge and information, it encouraged the patients to participate in decision-making (Larsson et al., 2012). In addition, when nurses took an active interest in the patient's life situation and listened, it resulted in patients participating and being involved in their own care (Larsson et al., 2012). The nurses' way of communicating with the patients was more of a two-way dialogue, making room for the patients to be more active and reflect on their own situation (Jakimowicz et al., 2015; Larsson et al., 2012; Sjo & Bergsten, 2018). When the nurses made use of patients' knowledge, it was found that it influenced the patients' experience of their participation in making decisions. Patients experienced being a resource in care and a co-actor, and it invited them to be active in their own care, which contributed to positive outcomes for them (Larsson et al., 2012).

### 3.4.3 | Giving practical advice

Nurses giving practical advice are closely related to the two previous sub-themes. One study described how theoretical and specialist knowledge combined with practical advice made the nurses proficient teachers, who managed to verbalise and discuss patient-related issues (Bala et al., 2012). The fact that the nurse was experienced seemed to be an important factor when giving practical advice in the specific and complex situation in which the patients often found themselves (Koinberg et al., 2002; Larsson et al., 2007). When patients were guided and given practical advice, it made them feel more in control, calm and secure (Bala et al., 2012; Larsson et al., 2007). Practical advice also contributed to a reduction of fear and anxiety (Jakimowicz et al., 2015), and it motivated patients to follow practical strategies and apply them to daily life (Wand et al., 2011).



### 3.5 | Establishing relationships

The key theme *establishing relationships* consisted of the sub-themes: *creating continuity*, *building relationships*, *supporting patient's life* and *providing emotional care*. It represents an important theme within the included studies, because a good relationship with the nurse is crucial for the patient's experience of satisfaction. According to the included studies, nurses managed to create continuity and build relationships in addition to supporting the patient's life and emotions (Arvidsson et al., 2006; Bala et al., 2012; Larsson et al., 2012). Several factors influenced the establishment of a good relationship between nurse and patient, which is unfolded in the sub-themes presented below (Table 2).

#### 3.5.1 | Creating continuity

Larsson et al. (2007) showed that continuity helped facilitate a trustful relationship between nurses and patients, when patients needed care during a long hospital stay (Larsson et al., 2007). Meeting with the same nurse created this continuity, and it was a very important aspect of establishing a relationship (Arvidsson et al., 2006; Bala et al., 2012; Koinberg et al., 2002; Sjo & Bergsten, 2018). The reason why patients found continuity valuable was that the established relationship, with the same nurse, made patients open up, be authentic and expose their vulnerabilities, worries and concerns, without losing pride or dignity (Jakimowicz et al., 2015; Larsson et al., 2007). Patients found continuity satisfying also because the nurse knew their history and background, so they did not have to repeat it (Larsson et al., 2007). An important part of continuity of care was how the relationship with the nurse worked, as it was found equally important to patients to be able to switch to another nurse if needed, for example if the personal 'chemistry' was not right (Arvidsson et al., 2006; Bala et al., 2012). The continuity contributed to feelings of trust, control, comfort and security, and patients felt supported and satisfied with the care provided in the nurse-led clinics (Bala et al., 2012; Larsson et al., 2007; Sjo & Bergsten, 2018).

#### 3.5.2 | Building relationships

The fact that nurses are able to establish a relationship with the patients is closely related to the previous sub-theme of continuity, as continuity is a prerequisite for being able to create a close relationship. Patients described experiencing a familiarity when they met the nurse; they described the atmosphere created by the nurse as calm, warm and friendly (Arvidsson et al., 2006; Bala et al., 2012; Larsson et al., 2012).

The nurse created this atmosphere using body language/facial expressions, quiet speech, listening and talking on an equal footing with the patient (Bala et al., 2012; Larsson et al., 2012). Personal chemistry and treating patients with respect were also found to be important when creating relationships (Arvidsson et al., 2006).

Another aspect of creating a good relationship, as experienced by the patients, was the nurse possessing interpersonal skills (Jakimowicz et al., 2015). These skills included intuition, an instinctive understanding, being able to read the patient, being sympathetic, empathetic, sensitive and attentive (Bala et al., 2012; Larsson et al., 2012). Having this relationship with the nurse increased patients' feelings of trust, hope, optimism, reliance and security; and it made them feel seen, heard, and believed (Arvidsson et al., 2006; Bala et al., 2012; Larsson et al., 2012; Wand et al., 2011). One of the things that could prevent a good relationship with the nurse was if she did not answer patients' questions. If this happened, the patients did not feel a commitment from the nurse (Bala et al., 2012).

#### 3.5.3 | Supporting patient's life

Nurses supporting patients' lives was described as being 'more hands on' and nurses being able to 'look at the bigger picture' and as 'knowing the entire person' (Arvidsson et al., 2006; Stahlke et al., 2017). This holistic approach related to the nurses' way of listening to and interviewing the patient and was based on how the nurse included the issues that were important to the patient (Arvidsson et al., 2006; Stahlke et al., 2017). Patients described how the nurses developed care plans that fitted their lives and that private issues, such as job and family life were acknowledged and accommodated in the care provided (Stahlke et al., 2017). Nurses having a holistic approach meant that the patients gained a better insight into how their illness or treatment could be connected to other aspects of their lives. This helped them to cope with everyday life outside the hospital (Sjo & Bergsten, 2018). Patients also described that the nurses' actions led them to adapt and adjust activities. When the fact that activities related to the disease could fit into everyday life was recognised, it gave patients a desired opportunity to determine which activities they could perform. This realisation resulted in a sense of comfort and support (Arvidsson et al., 2006; Sjo & Bergsten, 2018).

#### 3.5.4 | Providing emotional support

Emotional support seemed to be an important aspect of establishing relationships, especially when patients were feeling hopeless and experienced situations that were unbearable or out of control – such as transitions (Bala et al., 2012; Larsson et al., 2007).

Patients stated that the need for emotional support depended on whether they were able to get support from their relatives (Larsson et al., 2007). Stahlke et al. (2017) expressed the fact that the patients had various needs for support. Some patients indicated that support was not needed, because they got it elsewhere or because they believed they were strong enough to cope on their own. Most importantly, patients stated that they were aware of the fact that nurses must be able to understand patients' needs for support, if they were to tailor care to the individual (Stahlke et al., 2017). Patients also stated that the nurses supporting their relatives were considered

important, because if relatives' stress and anxiety were reduced it removed pressure from the patients (Larsson et al., 2007). Providing emotional support promoted patients' well-being, optimism and hope for the future (Larsson et al., 2007).

## 4 | DISCUSSION

The aim of this study was to identify key competences of outpatient nurses as perceived by patients attending nurse-led clinics. The identification of three key competences: *providing access*, *sharing knowledge* and *establishing relationships*, places emphasis on competences understood as individual abilities derived from a combination of attributes and tasks to be performed within particular situations (Caruso et al., 2016; McCormack & McCance, 2016). According to McCormack and McCance (2016), who view competence in the context of person-centredness, competence is more than simply undertaking a task or demonstrating a desired behaviour. Competence reflects a holistic approach that encompasses knowledge, skills and attitudes. The findings from this study support this approach to competence, which is illustrated in Table 2 by highlighting the different aspects of outpatient nurses' competences, derived from the included studies. A challenge, however, may be the influence of workplace culture, as culture shapes the values shared by teams in the workplace and this applies to the competences that are considered the most important within a team (McCormack & McCance, 2016). In order not only to practice competences important to the workplace values but also important to the patients and their relatives, it seems necessary to identify nurse competences from a professional as well as a patient perspective, which emphasises the aim of the current review.

The key competences *providing access* and *sharing knowledge* indicate a need for the nurses to be able to manage different ways of involving patients – respectively, inviting patients to use the professional knowledge accessible at the hospital or nurse-led outpatient clinic and to draw on the knowledge and experiences that are important to the patients in their everyday lives. A similar patient involvement perspective was found in a study conducted by Thomsen et al. (2017). The study showed how patient involvement in an outpatient clinic may be understood as a 'two-way movement', characterised by the fact that, first, active patient involvement invites patients and relatives to participate in everything that relates to 'the clinical practice', for example tests, treatment and other measures offered at the hospital (Thomsen et al., 2017). Along with this, patient involvement also opens the way for health professionals to participate in 'the non-clinical practice' – that is '*the lives, life circumstances and lifeworld of the patients*' (Cribb, 2011). Understanding patient involvement as a two-way movement may lead one to consider nurse-led outpatient consultations as a kind of negotiation, where, through a respectful dialogue, an opportunity is created to include knowledge and perspectives from both patients and nurses (Jacobsen et al., 2015). The nurse contributes with her/his professional knowledge and

the patient with her/his knowledge about the physical, emotional and social consequences of the illness.

The third key competence *establishing relationships* between healthcare professionals and patients highlights the importance of nurses in outpatient nurse-led clinics being able to use and develop skills such as listening, reading the patient and using body language (Table 2). In this review, it was found that, if patients did not experience *establishing relationships*, it could result in a feeling of losing trust, control, comfort, security and difficulty showing their vulnerability. In a review, focusing on the elements of patient-centred care (PCC), a similar competence was identified (Kitson et al., 2013). The review, based on 60 papers, identified three core elements respectively, patient participation and involvement, the relationship between the patient and the healthcare professional and the context in which the care is delivered. As identified in the current study, Kitson et al. (2013) also highlight how the relationship between patient and healthcare professional includes not only open communication about knowledge, but also personal qualities, such as being polite, and being respectful, sensitive and welcoming (Kitson et al., 2013). McCormack and McCance (2006, 2016) support those findings in their description of PCC theory, in which establishing a therapeutic nurse/patient relationship appears to be crucial, to ensure and identify patients' holistic needs and to enhance their involvement in decision-making. The fact that our findings seem to be linked to PCC adds strength to our results. At the same time, it becomes important to focus on the context in which the established relationship develops, given that context is considered a crucial element in PCC theory (Kitson et al., 2013; McCormack & McCance, 2006, 2016).

Common to the three key competences found in this study was the identification of not only the nurses' individual actions but also context-anchored variables, such as continuity and having easy access to the nurse. The context-anchored variables seemed to have an impact on how the nurses were able to act in specific situations. According to Caruso et al. (2016), competences have to be seen from two perspectives – respectively, *what* the nurses are capable of (competences), and *how* the competences are operationalised and experienced in a certain context (performance), as the nurses' competences are influenced by a set of variables that originate in the organisational environment (Caruso et al., 2016). The recommended focus on *how* competences are experienced in a certain context support the research approach taken in review. It is, however, crucial to be aware that the patient perspective does not necessarily identify all competences important to practice nursing. Aspects as medical-technical competence and competence related to patient safety may not identify as especially important, which it might be from a professional perspective. This indicates that being a professionally competent outpatient nurse is a complex task and it requires continuously learning and development, in order to acquire medical-technical as well as caring skills that enable the nurses to become more expert in a specific practice (McCormack & McCance, 2016). Whether in the specific situation it is most appropriate with local skills training or it is necessary with, for example academic education may be regarded

as a matter of managerial assessment. Nevertheless, a study identified great disparities between clinics run by chemotherapy nurses and those run by advanced nurse practitioners (ANPs). This included the number of patients seen within each clinic, operational aspects and clinical decision-making abilities (Farrell et al., 2017). Based on that, and knowing that nurse-led clinics add value to the overall patient treatment and care, it seems important to highlight outpatient nurses' need for clinical skills training as well as academic education (de Thurah et al., 2017).

In analysing qualitative data found in the included studies, there was a risk of misinterpreting what patients in fact experienced, which could have influenced our findings. Using the thematic analysis, the same risk emerged because our goal was to move beyond the semantic level and onto the latent level, to identify and explain the underlying ideas of nurses' competences, based on patients' experiences (Braun & Clarke, 2006). To minimise the risk of misinterpreting findings from qualitative data and in conducting thematic analysis, throughout the process consensus was reached among all authors regarding inclusion, assessment and analysis of the findings.

It may seem as a limitation that we only included PubMed, CINAHL and Scopus. The three databases cover a broad perspective of research, professional literature and not scientifically reports, for example diaries as recommended by Whittemore and Knafl (2005). However, only the search in PubMed and CINAHL returned.

The studies included in the review covered an eclectic group of outpatient nurse-led clinics, ranging from rheumatology clinics treating physical conditions to supportive clinics focusing on more existential needs. This diversity may have affected the findings of the study. However, we found several comparable competences among the nurses across the clinics, countries and cultures, which may allow transferability of the results to other contexts (Kitto et al., 2008).

It could seem to be a limitation that the literature search in this integrative review returned only qualitative studies. The reason for this may be that the search terms represented the patient perspective rather than patients' satisfaction, as patient perspective often reflects experiences or observations. In hindsight, we could therefore have chosen methodologies other than the integrative review – for instance a systematic review focusing on qualitative studies (Ludvigsen et al., 2016). On the other hand, using the integrative review approach made it possible to explore the research field from a broad perspective, in order to validate the literature search.

## 5 | CONCLUSION

Based on nine identified studies and using a thematic strategy for the analysis, the findings pointed to three key competences that nurses must possess seen from a patients' perspective *providing access*, *sharing knowledge* and *establishing relationships*. The key competences were supported by ten sub-themes characterised by nurses' actions and qualities, derived from the included

studies. The discussion highlighted how nurse competences in this review reflected a holistic approach that encompasses knowledge, skills and attitudes. Furthermore, it became clear, how an interaction between the competences *providing accessibility* and *sharing knowledge* indicating the nurses being able to manage different ways of involving patients, may lead to the consideration of outpatient consultations as a kind of negotiation, based on a respectful dialogue. Discussing the competence *establishing relationships* made it clear, how the relationship between patient and healthcare professional included not only open communication about knowledge, but also personal qualities, such as being polite, respectful and sensitive. This to ensure and identify patients' holistic needs and to enhance their involvement in decision-making. In addition, it seemed crucial to be aware that the patient perspective does not necessarily identify all competences important to practice nursing. Aspects as medical-technical competence and competence related to patient safety may not be identified as important. In addition, the necessity of offering outpatient nurses clinical skills training as well as academic education was highlighted.

## 6 | RELEVANCE TO CLINICAL PRACTICE

From a clinical perspective, the findings highlight several nurse competences that from a patient perspective seem important to be aware of, when establishing or develop nurse-led outpatient clinics. This is important knowledge, in order to optimising the performance and quality of the health workforce, including outpatient nurses, as recommended by WHO (World Health Organization, 2016). Furthermore, the identified knowledge emphasises the need for clinical skills training and academic education, specially targeted outpatient nurses, in order to enable the nurses to become more expert in a specific practice.

The discussion of the finding highlighted how context-anchored variables seem to have an impact on how the nurses were able to use their competences in specific situations (Caruso et al., 2016; McCormack & McCance, 2016). This approach to understand competences indicates the need for not only focusing on nurses' and other health professionals' competences, when to enhance the quality of treatment and care in nurse-led outpatient clinics. It also seems necessary to be aware of conditions in the specific clinic that may be changed in order to support the performance of the nurses. Therefore, training and education are not enough. It is at least as important with managerial attention and action.

## CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

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## SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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