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Research Article

Index of Competence in Palliative Care Among Staff Nurses in Government Hospitals

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ABSTRACT:

Palliative care is a vital component of holistic healthcare that aims to improve the quality of life of patients with life-limiting illnesses and their families through the comprehensive management of physical, psychosocial, emotional, and spiritual concerns. Nurses play a crucial role in delivering palliative care, as they maintain the most direct and continuous contact with patients and their families. However, variations in training, clinical experience, and professional exposure may influence nurses' competence in providing such care. This study determined the Index of Competence in Palliative Care (ICPC) among staff nurses working in selected government hospitals in Eastern Pangasinan, Philippines. The study employed a descriptive-correlational research design involving 109 staff nurses selected through convenience sampling. Data were collected using a researcher-developed questionnaire validated by a panel of experts. Descriptive statistics, t-test, Analysis of Variance (ANOVA), and Pearson correlation were utilized to analyze the data at the 0.05 level of significance. Findings revealed that staff nurses demonstrated a high level of competence in palliative care, with a grand overall weighted mean of 4.756, interpreted as "Very Competent." Competence was evident across key domains, including quality of life, symptom management, emotional and psychological support, spiritual and existential care, care coordination, family and caregiver support, and individualized care. Significant differences were found in selected domains when grouped by sex and monthly income, while no significant differences were observed across other profile variables. The results highlight the need for continuous professional development and structured training programs. Consequently, the CARES Program (Compassionate and Advanced Responsive Education in Palliative Care for Staff Nurses) was proposed to further enhance nurses' competencies in holistic palliative care delivery.

Keywords: *Palliative Care Competence, staff nurses, holistic nursing care, Eastern Pangasinan, training program development*

INTRODUCTION

Palliative care is a specialized healthcare approach that aims to improve the quality of life of patients with life-threatening illnesses and their families. It focuses on the prevention, assessment, and relief of suffering through the management of pain and other physical, psychosocial, emotional, and spiritual concerns. Unlike curative treatment, palliative care is not limited to the final stage of illness. Rather, it may be introduced at any point in the disease trajectory and may be provided alongside curative or life-prolonging interventions to ensure comprehensive and patient-centered care (Etafa et al., 2020). The World Health Organization defines palliative care as an approach that improves the quality of life of patients and their families' facing problems associated with life-threatening illness through early identification, impeccable assessment, and treatment of pain and other problems, whether physical, psychosocial, or spiritual (World Health Organization [WHO], 2020; Teoli et al., 2023). In modern healthcare systems, palliative care has become increasingly important because it promotes symptom control, effective communication, continuity of care, and respect for patient dignity across various healthcare settings such as hospitals, outpatient facilities, and home-based care. Its primary goal is not only to reduce pain and distress, but also to support patients and families throughout the course of illness by addressing complex and multidimensional needs.

Nurses play a central role in the delivery of palliative care because they are often the healthcare professionals with the most direct and sustained interaction with patients and their families. Their responsibilities extend beyond physical care to include symptom assessment and management, patient and family education, emotional support,

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care coordination, and advocacy for patient preferences and needs (Etafa et al., 2020). Nurses play a pivotal role in palliative care, where their competence in delivering holistic, compassionate, and evidence-based support directly impacts outcomes for patients with serious or terminal conditions. This competence encompasses knowledge, clinical skills, attitudes, judgment, and behaviors needed to manage symptoms, communicate effectively, address psychosocial and spiritual needs, collaborate interprofessionally, and provide individualized care aligned with patient values. Yet, research reveals gaps in nurses' knowledge, attitudes, and skills that can undermine care quality. Assessing this competence is thus crucial for pinpointing weaknesses and designing targeted education and training to enhance patient and family outcomes.

Palliative care systems vary significantly across countries, shaped by healthcare structures, policy frameworks, cultural values, and resources, offering valuable insights into diverse delivery models. In the United States, a dual approach combines palliative services with curative treatment and end-of-life hospice care, delivered by multidisciplinary teams of physicians, nurses, social workers, and spiritual providers to address physical, emotional, and spiritual needs; reforms like the 2010 Patient Protection and Affordable Care Act expanded access, yet disparities remain for minority groups due to historical inequities (Givler et al., 2023). Canada's national framework promotes high-quality end-of-life care through collaboration among government, institutions, nonprofits, and professionals, with a strong focus on cultural competence for Indigenous communities favoring home-based, culturally safe approaches (Health Canada, 2023; Qureshi et al., 2021; Monette, 2021). Sweden integrates palliative care seamlessly into its universal healthcare system via interdisciplinary teamwork, efficient communication, and patient-centered strategies, aided by societal openness about death that encourages active patient participation in decisions (Givler et al., 2023; Osterlind et al., 2021). Germany's model provides inpatient and outpatient services across hospitals, nursing homes, and homes, reinforced by the 2015 Hospice and Palliative Care Act for insurance coverage, with cultural emphasis on family involvement in end-of-life choices (Nassif, 2023). In contrast, India's palliative care is still developing, with urban-rural disparities despite the 2017 National Health Policy's push for primary care integration; cultural beliefs, infrastructure limits, and family reluctance to discuss terminal diagnoses often influence care (Burke et al., 2023; Salinas et al., 2022).

In the Philippines, palliative care is an emerging field with services mainly in urban healthcare institutions and hospices, though access is limited in public hospitals and rural areas, where few dedicated units exist and formal training for professionals is insufficient (So, 2024). Strengthening education, service delivery, and institutional support is essential. Filipino cultural values—strong family ties, shared decision-making, home-based caregiving as a moral duty, and religious views on suffering and death—profoundly shape end-of-life preferences, potentially limiting formal service use while emphasizing emotional support (So, 2024). Nurses thus require competence in symptom management, communication, spiritual care, family support, and culturally sensitive practices.

Assessing nurses' competence in palliative care is vital for enhancing healthcare delivery in the Philippines, amid challenges like variable training, limited resources, and cultural influences that create inconsistencies in services. As primary caregivers and coordinators, nurses' expertise directly affects support quality for patients and families with life-limiting illnesses. Such evaluations pinpoint gaps in knowledge, skills, and attitudes, informing targeted educational programs and policies to bolster palliative care. Nurses handle complex symptom management, multidisciplinary coordination, family communication, and emotional, psychological, and spiritual support during critical illness stages. Yet, literature indicates limitations in preparedness and confidence, especially in end-of-life communication, psychosocial aid, and symptom control—issues amplified in developing systems with scarce specialized training and services. In Eastern Pangasinan, government hospitals continue to provide care to a growing number of patients with chronic and life-limiting conditions. Despite the increasing demand for palliative care services, there is limited empirical evidence regarding the competence of staff nurses in delivering palliative

care in these healthcare institutions. The absence of local data creates a gap in understanding the current level of preparedness of nurses in providing holistic and compassionate end-of-life care. Addressing this gap is essential for developing appropriate training programs and strengthening institutional support mechanisms that can improve patient outcomes and enhance the quality of care.

In response to this need, the present study determined the **Index of Competence in Palliative Care among staff nurses in government hospitals in Eastern Pangasinan**. Specifically, it assessed nurses' competence across various domains and examined how selected demographic and professional characteristics influenced their level of competence. The findings of this study are expected to contribute to the development of evidence-based recommendations that may support the improvement of nursing education, staff development initiatives, and institutional policies related to palliative care. Furthermore, this study is anchored on the Philippine Nursing Core Competency Standards (PNCCS), which provide the national framework outlining the essential knowledge, skills, and attitudes required for competent nursing practice in the Philippines. By examining palliative care competence in relation to these professional standards, the study contextualized nurses' performance within established national competency frameworks and to identify areas where further professional development may be required. The conceptual framework illustrated the relationship between the nurses' profile variables and their palliative care competence, serving as the basis for a proposed training intervention.

Theoretical/ Conceptual Framework

This study is anchored on established theories that explain the development of nursing competence and the behavioral factors influencing healthcare practice. Specifically, the study draws upon Patricia Benner's Novice-to-Expert Model (1984), the Health Belief Model (HBM), and the Theory of Reasoned Action (TRA). These theoretical perspectives collectively explain how nurses' clinical experience, professional training, beliefs, and behavioral intentions influence their competence in delivering palliative care.

Patricia Benner's Novice-to-Expert Model provides the foundational theory for nursing competence, which evolves through clinical experience and reflective practice beyond mere theoretical knowledge, spanning five stages: novice, advanced beginner, competent, proficient, and expert (Niu et al., 2025). Novices rely on rules and protocols, progressing to integrate intuition, critical thinking, and holistic decision-making. In palliative care, this progression highlights experiential learning's role in managing end-of-life complexities, enabling nurses to address physical, emotional, spiritual, and familial needs with compassion, cultural sensitivity, and patient-centered focus. Structured training, simulations, and mentorship accelerate advancement from novice to expert levels (Niu et al., 2025). Ultimately, the model affirms that palliative care competence grows via hands-on experience, education, and continuous development.

The Health Belief Model (HBM), developed in the 1950s, explains health behaviors through individuals' perceptions of threats and actions' effectiveness, via six constructs: perceived susceptibility, severity, benefits, barriers, cues to action, and self-efficacy (Alyafei & Easton-Carr, 2024). In palliative care nursing, HBM illuminates how nurses' beliefs shape practices—for instance, those who perceive unmanaged pain's severity and interventions' benefits are more likely to apply effective symptom management. Barriers like opioid fears, misconceptions, or cultural taboos around death can hinder care. Thus, HBM stresses education and training to reshape beliefs, boost self-efficacy, and foster evidence-based practices. In the Philippine context, culturally tailored programs can dispel misconceptions and enhance nurses' confidence in palliative services (Alyafei & Easton-Carr, 2024).

The Theory of Reasoned Action (TRA) posits that behavior stems from behavioral intentions, driven by attitudes toward the behavior and subjective norms (perceived expectations from others) (Firouzbakht et al., 2021). In palliative care nursing, nurses' attitudes and workplace norms profoundly influence engagement in end-of-life discussions, symptom management, and family support. Positive attitudes paired with colleague and policy support promote compassionate behaviors, while negative views or institutional gaps deter

involvement (Firouzbakht et al., 2021). Fostering supportive environments and positive attitudes is thus essential to boost nurses' competence and confidence in palliative care.

Collectively, these theories provide a comprehensive explanation of how nursing competence in palliative care develops. Benner's model emphasizes the role of clinical experience and professional growth, the Health Belief Model explains the influence of beliefs and perceptions on health-related practices, and the Theory of Reasoned Action highlights the importance of attitudes and social norms in shaping professional behavior. These theoretical perspectives support the assumption that nurses' competence in palliative care is influenced by their demographic characteristics, professional experience, educational preparation, and training exposure.

The study's conceptual framework highlights the relationship between independent variables—specifically the demographic and professional characteristics of respondents—and the dependent variable, which is the Index of Competence in Palliative Care (ICPC) as seen in the second research question. This framework positions these independent variables as potential influences on nurses' competence in palliative care. The ICPC serves as a tool for evaluating holistic nursing competence in palliative care, reflecting adherence to patient-centered and interdisciplinary healthcare principles. Importantly, the ICPC is correlated with the Philippine Nursing Core Competency Standards (PNCCS) established under the Philippine Nursing Act of 2002, which delineates essential nursing competencies, including safe and quality care, effective communication, interprofessional collaboration, ethical practice, and ongoing professional development. By aligning ICPC domains with PNCCS, the study reinforces the integration of palliative care competence within national nursing practice standards. An emergent output of the research is a proposed enhancement training program designed to address gaps in nurses' knowledge, skills, and attitudes regarding palliative care, ultimately aiming to elevate the quality of services provided in government hospitals and serve as a foundation for future professional development initiatives.

Research Questions

This study aimed to determine the Index of Competence in Palliative Care (ICPC) among staff nurses working in selected government hospitals in Eastern Pangasinan during the Academic Year 2025–2026.

Specifically, this study sought to answer the following questions:

1. What is the profile of the respondent-staff nurses across the following:
   a. age;
   b. sex;
   c. religious affiliation;
   d. income;
   e. highest educational attainment;
   f. number of years as staff nurse;
   g. position; and
   h. number of relevant trainings on palliative care?
2. What is the Index of Competence in Palliative Care (ICPC) among the respondent, staff nurses in terms of the following domains:
   a. focus on quality of life;
   b. symptoms management;
   c. emotional and psychological support;
   d. spiritual and existential Support;
   e. care coordination;
   f. family and care giver support; and
   g. individualized approach?
3. Is there a significant difference in the Index of Competence in Palliative Care (ICPC) among the staff nurses across their profile variables?
4. Is there a significant relationship between the Index of Competence in Palliative Care (ICPC) among the staff nurses and their profile variables?
5. What training program could be proposed and implemented for enhancing the competences of staff nurses in palliative care?

METHODOLOGY

Research Method

This study employed the descriptive-correlational research design. This design is appropriate for studies that aim to describe existing

conditions and examine relationships among variables without manipulating the research environment. It allows the researcher to gather data from respondents in their natural setting and analyze the relationships among variables as they naturally occur. According to Ghanad (2023), descriptive research is appropriate when the objective is to describe the characteristics of a phenomenon as it naturally exists without altering any variables. In this study, the descriptive component was used to determine the current level of competence of staff nurses in palliative care across several domains. On the other hand, correlational research aims to determine the degree of relationship between two or more variables (Creswell, 2022). In this study, correlational analysis was used to examine the relationship between the nurses' profile variables and their Index of Competence in Palliative Care (ICPC). Through this approach, the study not only describes the current level of competence of staff nurses in palliative care but also determines whether significant differences and relationships exist among the variables that may provide insights for improving nursing competence in palliative care practice.

Sampling Design

The target population of this study consisted of 186 staff nurses currently working in three government hospitals in Eastern Pangasinan, Philippines. From this population, a total of 109 staff nurses participated in the study. The study employed a convenience sampling technique, wherein respondents who were available and willing to participate during the data collection period were selected. Convenience sampling was utilized due to practical considerations such as time constraints, accessibility of respondents, and the varying work schedules of hospital staff. Although convenience sampling may limit the generalizability of the findings, it is commonly used in descriptive and correlational studies conducted in real clinical settings where access to respondents may be limited. The inclusion criteria consist of registered nurses with at least six months of experience as staff nurses in areas such as the medical-surgical wards, outpatient department (OPD), intensive care unit (ICU), emergency room (ER), operating room (OR), and other specialized areas.

Data Gathering Tool and Data Gathering Procedures

The primary instrument used in this study was a researcher-developed questionnaire-checklist designed to measure the Index of Competence in Palliative Care (ICPC) among staff nurses. The instrument consisted of two parts: Part 1 focuses on the background information and profile of the respondents in terms of their age, sex, religious affiliation, highest educational attainment, area of assignment, length of experience, position, monthly income, and training or seminars attended in palliative care. Part 2 focused on the index of competence of the Staff Nurses on palliative care, across the domains of the phenomenon under study namely: a) Focus on quality of life, b) Symptoms Management, c) Emotional and Psychological Support, d) Spiritual and Existential Support, e) Care Coordination, f) Family and Care Giver Support, and g) Individualized Approach. construction. This included professors of nursing, clinical instructors, and a professor with a PhD in Research and Evaluation. The Content Validation Instrument was used by the panel of evaluators. This ensures that the items were relevant, clear, and aligned with the objectives of the study. Although pilot testing was not conducted due to time constraints, the expert validation process helped ensure the appropriateness and content validity of the research instrument.

Data collection was conducted after obtaining approval from the Committee on Oral Examination, which was endorsed by the Acting Dean of the UCU Institute of Graduate and Advanced Studies (IGAS), as well as permission from the administrators of the government hospitals included in the study. Prior to data collection, ethical clearance was obtained from the University Research Ethics Committee to ensure that the study complied with established ethical standards. The staff nurses were informed about the purpose of the study, the confidentiality of their responses, ethical considerations, and their right to withdraw from the study at any time without penalty. The questionnaire-checklist was administered either online through Google Forms or through printed copies distributed personally, depending on the availability and preference of the respondents. Respondents were given sufficient time to complete

the questionnaire. After completion, the questionnaires were immediately retrieved by the researcher for data processing.

Treatment of Data

The accomplished questionnaires were organized, collated, and tallied using Microsoft Excel. The encoded data were then transferred to the Statistical Package for the Social Sciences (SPSS) Version 21 for statistical analysis. Descriptive statistics were used to summarize the profile of the respondents and their level of competence in palliative care. Specifically, frequency counts and percentages were used to describe the demographic characteristics of the respondents.

Legend:

Literal Rating	WM Score Range	Descriptive Rating	Transmuted Rating
A	4.50-5.00	Always (A)	Very Competent (VC)
B	3.50- 4.49	Often (O)	Competent (C)
C	2.50- 3.49	Sometimes (S)	Moderately Competent (MC)
D	1.50- 2.49	Seldom (Sl)	Slightly Competent (SC)
E	1.00-1.49	Never (N)	Not Competent (NC)

The legend in this study provides a framework for interpreting weighted mean (WM) scores by linking numerical values to both descriptive ratings and corresponding levels of competence. Scores within 4.50–5.00 are interpreted as “Always” and transmuted as “Very Competent,” indicating that the competencies are consistently demonstrated by respondents, while lower ranges reflect decreasing frequency and competence, from “Often” (Competent) to “Never” (Not Competent). This dual classification allows for a clearer understanding of not only how often the competencies are practiced but also how proficient respondents perceive themselves to be. To determine whether there were significant differences in the Index of Competence in Palliative Care (ICPC) when respondents were grouped according to their profile variables, independent samples t-test and Analysis of Variance (ANOVA) were used. Furthermore, the Pearson Product-Moment Correlation Coefficient (r) was used to determine the existence and strength of the relationship between the respondents’ profile variables and their level of competence in palliative care. All statistical tests were conducted at a 0.05 level of significance

RESULTS AND DISCUSSIONS

In terms of age, the respondents were distributed across several age groups. The largest proportion of respondents (30 or 27.5%) belonged to the 36–40 years old age bracket, followed by those aged 26–30 years old with 26 respondents (23.9%). Meanwhile, only 10 respondents (9.2%) were 41 years old and above. These results suggest that the nursing workforce in the selected hospitals is composed largely of early- to mid-career nurses. Although age may reflect accumulated professional exposure, previous studies indicate that age alone does not strongly predict competence in palliative care practice (Lin et al., 2021; Rafiee et al., 2024). Instead, professional training and clinical experience are often considered more important determinants of competence. With respect to sex, the majority of respondents were female (74 or 67.9%), while 35 respondents (32.1%) were male. This finding reflects the traditional gender distribution in the nursing profession, where females typically comprise a larger proportion of the workforce. However, previous studies indicate that sex does not significantly influence competence in palliative care when nurses receive similar levels of education and clinical exposure (Kim et al., 2020).

Table 1: Frequency and percentage distribution of the staff nurses according to their profile variables.

Variable	Variable Categories	Frequency	Percentage
Age	20-25 years old	21	19.3
	26-30 years old	26	23.9
	31-35 years old	22	20.2

	36-40 years old	30	27.5
	41 years & above	10	9.2
Sex	Male	35	32.1
	Female	74	67.9
Religious Affiliation	Non-Catholics	21	19.3
	Catholics	88	80.7
Highest Educational	Bachelor of Science in Nursing (BSN)	95	87.2
	Master in Nursing (MAN)	14	12.8
Years of Service in Nursing	1-5 years	64	58.7
	6-10 years	27	24.8
	11 years or more	18	16.5
Position	Ward Staff Nurse	59	54.1
	Specialized Area (ICU, HD) Staff Nurse	35	32.1
	ER Staff Nurse	15	13.8
Income	10,000 to 20,000 Php	73	67.0
	20,000 to unified compensation and position classification for all Philippine government personnel 30,000 Php	36	33.0
Relevant In-Service Training	1-2 Trainings	89	81.7
	3 or more Trainings	20	18.3

In terms of religious affiliation, the majority of respondents (88 or 80.7%) identified as Roman Catholic, while 21 respondents (19.3%) reported belonging to other Christian denominations. Religion may influence nurses' perspectives regarding death, dying, and spiritual care. Studies suggest that nurses' spiritual beliefs can affect their attitudes toward providing spiritual and existential support to patients receiving palliative care (Boateng et al., 2025). In the Philippine context, where Christianity is the dominant religion, spirituality often plays a role in shaping healthcare providers' perspectives on illness and end-of-life care (Soriano, 2019). Regarding highest educational attainment, the majority of respondents (95 or 87.2%) were Bachelor of Science in Nursing (BSN) degree holders, while only 14 respondents (12.8%) had completed a Master's degree in Nursing (MAN). Higher educational attainment is often associated with improved clinical competence, critical thinking ability, and greater preparedness in managing complex healthcare situations, including palliative care (Hökkä et al., 2024). With respect to years of service as a staff nurse, most respondents (64 or 58.7%) had 1–5 years of professional experience, while only 18 respondents (16.5%) reported having 11 years or more of experience. This indicates that a considerable proportion of the respondents are relatively early in their professional careers. Previous research suggests that increased clinical experience may enhance nurses' confidence in managing end-of-life care situations and communicating with patients and families regarding palliative care needs (Lin et al., 2021). In terms of position, the majority of respondents (59 or 54.1%) were ward staff nurses, followed by specialized unit nurses such as those assigned to the ICU or hemodialysis unit (35 or 32.1%), while 15 respondents (13.8%) were assigned to the emergency room. Nurses working in inpatient wards may encounter palliative care situations more frequently, particularly in cases involving chronic illness or terminal conditions, which may influence their level of competence in providing end-of-life care (Lin et al., 2021). Regarding monthly income, the majority of respondents (73 or 67.0%) reported earning between ₱10,000 and ₱20,000 per month, while 36 respondents (33.0%) reported earning between ₱20,000 and ₱30,000 per month. This distribution may reflect variations in employment

status, length of service, or hospital compensation structures. Finally, in terms of relevant in-service training, most respondents (89 or 81.7%) reported attending 1–2 palliative care-related training, while 20 respondents (18.3%) reported attending three or more training sessions. This finding suggests that while some level of exposure to palliative care training exists, opportunities for advanced or continuous professional development in this area may still be limited.

Index of Competence in Palliative Care (ICPC) in the Domain of Focused on Quality of Life

Table 2 illustrates the Index of Competence in Palliative Care (ICPC) for staff nurses regarding their focus on quality of life. The data summary includes weighted means (WM) and their corresponding descriptive ratings (DR) and transmuted ratings (TR). The overall weighted mean (OWM) is 4.741, indicating a high level of competence in this aspect of palliative care. This score corresponds to a DR of "Always (A)" and a TR of "Very Competent (VC)." Among specific indicator statements, Statement No. 4, which emphasizes prioritizing patient safety during palliative care interventions, achieved the highest WM of 4.798, translating to "Always" and "Very Competent." Conversely, Statement No. 1, regarding comprehensive and timely assessments of patients with life-limiting conditions, received the lowest WM of 4.651, yet still falls within the "Always" and "Very Competent" ratings. Overall, all indicators are classified as "Very Competent," reflecting the staff nurses' consistent high competency level in palliative care. However, the lower rating for patient assessment indicates a potential area for further improvement in clinical evaluation skills. Accurate and timely assessment is a fundamental component of effective palliative care practice, as it guides appropriate interventions and patient-centered care planning. This observation is consistent with literature emphasizing the complexity of assessing life-limiting conditions, particularly among less experienced nurses (Lin et al., 2021).

Table 2: Index of Competence in Palliative Care in Domain: Focus on Quality of Life

Focus on Quality of Life (PNCCS: Safe and quality nursing care) **Indicator Statement** As a staff nurse, I…	**WM**	**DR**	**TR**
1. perform comprehensive and timely assessments of patients with life-limiting conditions.	4.651	A	VC
2. implement evidence-based interventions tailored to patient needs.	4.706	A	VC
3. monitor for clinical changes that may require urgent action.	4.771	A	VC
4. prioritize patient safety when implementing palliative care interventions.	4.798	A	VC
5. evaluate the effectiveness of nursing and medical interventions on patient outcomes.	4.780	A	VC
Total	23.706		
Overall Weighted Mean	4.741	A	VC

Index of Competence in Palliative Care (ICPC) in the Domain of Symptoms Management

Table 3 showcases the Index of Competence in Palliative Care (ICPC) for staff nurses concerning Symptom Management, revealing a high overall weighted mean (OWM = 4.811), categorized as "Always (A)" and "Very Competent (VC)." The highest-rated indicator is Statement No. 4, which emphasizes team coordination for continuity of care across shifts (WM = 4.853), reflecting effective teamwork. Conversely, Statement No. 2, regarding organizing the care environment to uphold patient dignity and comfort, has the lowest weighted mean (WM = 4.761) but still maintains a "Very Competent" rating. These findings underscore a consistent high level of competence in symptom management among staff

nurses, though the slightly lower score in care environment organization may indicate an opportunity for reinforcing best practices to further enhance patient-centered palliative care delivery.

Table 3: Index of Competence in Palliative Care in Key Aspect: Symptoms Management

Symptoms Management (PNCCS: Safe and Quality Nursing Care and Management of Resources) **Indicator Statement** As a staff nurse, I…	**WM**	**DR**	**TR**
1.ensure that essential supplies and equipment for patient comfort are available.	4.780	A	VC
2. organize the care environment to promote patient dignity and comfort.	4.761	A	VC
3. safely utilize available resources to meet patient needs.	4.816	A	VC
4. coordinate with the team to ensure continuity of care across shifts.	4.853	A	VC
5. maintain a therapeutic and safe physical environment for palliative care.	4.844	A	VC
Total	24.054		
Overall Weighted Mean	4.811	A	VC

Index of Competence in Palliative Care (ICPC) in the Domain of Emotional and Psychological Support

Among the indicators, Indicator Statement No. 1, "communicate clearly and respectfully with patients and families," obtained the highest weighted mean (WM = 4.816). This result corresponds to "Always" in descriptive rating and "Very Competent" in transmuted rating, indicating that nurses consistently demonstrate effective communication with patients and their families. On the other hand, Indicator Statement No. 3, "use communication techniques suitable for patients with declining function," obtained the lowest weighted mean (WM = 4.752). Although this indicator received the lowest rating among the items, it still falls within the "Always" descriptive rating and "Very Competent" transmuted rating. Overall, the results indicate that the staff nurses demonstrate a consistently high level of competence in providing emotional and psychological support to patients in palliative care settings, as reflected by all indicators being rated Very Competent. While all indicators fall within the same competence level, the slightly lower rating for communication with patients experiencing declining function may suggest an area where continued professional development in specialized communication techniques could further enhance patient-centered care. Effective communication is essential in palliative care because it helps address emotional distress, supports decision-making, and strengthens trust between healthcare providers, patients, and families. Studies have emphasized that communicating with patients experiencing cognitive or physical decline can be challenging and requires advanced communication skills and empathy from healthcare professionals (Back et al., 2020).

Table 4: Index of Competence in Palliative Care in Domain: Emotional and Psychological Support

Emotional and Psychological Support (PNCCS: Communication and Ethico-Moral Responsibility) **Indicator Statement** As a staff nurse, I…	**WM**	**DR**	**TR**
1. communicate clearly and respectfully with patients and families.	4.816	A	VC
2. provide psychosocial and emotional support through appropriate communication.	4.798	A	VC

3. use communication techniques suitable for patients with declining function.	4.752	A	VC
4. clarify information to avoid misunderstandings during care transitions.	4.789	A	VC
5. practice therapeutic communication tailored to culturally diverse patients.	4.771	A	VC
Total	23.927		
Overall Weighted Mean	4.785	A	VC

Index of Competence in Palliative Care (ICPC) in the Domain of Spiritual and Existential Support

Table 5 presents the Index of Competence in Palliative Care (ICPC) for staff nurses in Spiritual and Existential Support, with an overall weighted mean (OWM) of 4.633, classified as "Always (A)" and "Very Competent (VC)." This indicates a high level of expertise among nurses. The top-performing indicator, Statement No. 1 ("explain disease processes and care options in terms families can understand"), scored the highest weighted mean (WM = 4.725), also rated "Always" and "Very Competent." The lowest scores were for Statement No. 4 ("educate patients on faith-based comfort measures") and Statement No. 5 ("assess spiritual learning needs and adjust teaching strategies"), both at WM = 4.596—still within the "Always" and "Very Competent" categories. Overall, these results underscore nurses' strong capabilities in spiritual and existential support, while highlighting opportunities to strengthen structured interventions in faith-based and culturally sensitive education. This suggests that while nurses recognize the importance of spiritual care, delivering structured spiritual support may require additional training and experience. Previous studies have similarly reported that spiritual care competencies are sometimes underdeveloped in nursing education and clinical training (Dewi et al., 2025).

Table 5: Index of Competence in Palliative Care in Domain: Spiritual & Existential Support

Spiritual & Existential Support (PNCCS: Health Education and Personal &Professional Development) **Indicator Statement** As a staff nurse, I…	**WM**	**DR**	**TR**
1. explain disease processes and care options in terms families can understand.	4.725	A	VC
2. teach caregivers spiritual coping techniques, such as integrating prayer or novenas into daily care routines.	4.624	A	VC
3. provide information on existential concerns to help families explore meaning and purpose in end-of-life transitions.	4.624	A	VC
4. educate patients on faith-based comfort measures, like connecting symptoms to divine will while promoting dignity.	4.596	A	VC
5. assess spiritual learning needs and adjust teaching strategies to respect cultural beliefs about death and afterlife.	4.596	A	VC
Total	23.165		
Overall Weighted Mean	4.633	A	VC

Index of Competence in Palliative Care (ICPC) in the Domain of Care Coordination

Table 6 presents the Index of Competence in Palliative Care (ICPC) for staff nurses in Care Coordination, with an overall weighted mean (OWM) of 4.776, classified as "Always (A)" and "Very Competent (VC)." This reflects a consistently high level of expertise in coordinating palliative care services. The top indicator, Statement No. 3 ("share relevant patient information during handovers"),

achieved the highest weighted mean (WM = 4.844), also rated "Always" and "Very Competent," highlighting effective communication for care continuity. The lowest score was for Statement No. 2 ("participate actively in interdisciplinary meetings") at WM = 4.679—still within "Always" and "Very Competent" categories. These findings affirm nurses' strong care coordination skills across all indicators, though enhanced opportunities for interdisciplinary engagement could further bolster collaborative decision-making. Effective care coordination and interdisciplinary collaboration are essential components of palliative care because they ensure continuity of care and support comprehensive management of patients' physical, psychosocial, and spiritual needs. Collaborative teamwork among healthcare professionals is therefore necessary to deliver high-quality palliative care services (World Health Organization, 2020).

Table 6: Index of Competence in Palliative Care in Domain: Care Coordination

Care Coordination (PNCCS: Collaboration and Teamwork, and Quality Assurance) **Indicator Statement** As a staff nurse, I…	**WM**	**DR**	**TR**
1. coordinate with the healthcare team to align patient goals.	4.826	A	VC
2. participate actively in interdisciplinary meetings.	4.679	A	VC
3. share relevant patient information during handovers.	4.844	A	VC
4. assist colleagues in responding to urgent needs of palliative patients.	4.780	A	VC
5. foster a collaborative environment that supports safe palliative care.	4.752	A	VC
Total	23.881		
Overall Weighted Mean	4.776	A	VC

Index of Competence in Palliative Care (ICPC) in the Domain of Family and Care Giver Support

Table 7 presents the Index of Competence in Palliative Care (ICPC) for staff nurses in Family and Caregiver Support, with an overall weighted mean (OWM) of 4.763, classified as "Always (A)" and "Very Competent (VC)." This demonstrates a high level of expertise in aiding families and caregivers of palliative care patients. The top indicator, Statement No. 1 ("regularly update the family about the patient's condition, treatment options, and expected outcomes using language they can easily understand"), scored the highest weighted mean (WM = 4.835), also rated "Always" and "Very Competent," emphasizing clear communication of critical information. The lowest was Statement No. 4 ("identify signs of caregiver burnout and refer them to appropriate support services") at WM = 4.697—still within "Always" and "Very Competent" ratings. Overall, nurses exhibit consistently high competence across all indicators, underscoring their vital role in supporting family decision-making and emotional needs in life-limiting conditions. Family and caregiver support is a crucial component of palliative care, as family members often play a significant role in decision-making, caregiving responsibilities, and emotional support for patients with life-limiting conditions. Effective communication, education, and psychosocial support provided by nurses help families better understand the patient's condition and prepare for end-of-life care decisions (World Health Organization, 2020).

Table 7: Index of Competence in Palliative Care in Domain: Family & Care Giver Support

Family & Care Giver Support (PNCCS: Collaboration and Teamwork) **Indicator Statement** As a staff nurse, I…	**WM**	**DR**	**TR**
1. regularly update the family about the patient's condition, treatment options, and expected outcomes using language they can easily understand.	4.835	A	VC
2. provide reassurance and connect them with counseling, spiritual care, or support groups as needed.	4.688	A	VC
3. give practical guidance on medication administration, positioning, and safety measures at home	4.826	A	VC
4. identify signs of caregiver burnout and refer them to appropriate support services	4.697	A	VC
5. assist families in understanding advance directives, do-not-resuscitate (DNR) orders, and end-of-life care preferences	4.771	A	VC
Total	23.817		
Overall Weighted Mean	4.763	A	VC

Index of Competence in Palliative Care (ICPC) in the Domain of Individualized Approach:

Table 8 details the Index of Competence in Palliative Care (ICPC) for staff nurses in the Individualized Approach domain, showing a high overall weighted mean (OWM) of 4.780, categorized as "Always" and "Very Competent." The highest scoring indicator was Statement No. 5, focusing on building patient trust and participation, with a weighted mean of 4.816. The lowest score was for Statement No. 2, addressing the incorporation of cultural practices and personal wishes, at 4.697, yet still within the "Always" and "Very Competent" classifications. These findings underscore nurses' proficiency in personalized care delivery. Overall, the findings indicate that the staff nurses demonstrate a consistently high level of competence in applying an individualized approach to palliative care, as reflected by all indicators being rated Very Competent. However, the relatively lower rating for integrating cultural practices and personal beliefs into care planning may suggest that incorporating cultural and spiritual considerations into clinical decision-making can be a complex aspect of patient-centered care. Individualized palliative care requires healthcare providers to consider patients' values, preferences, and cultural contexts to ensure holistic and person-centered care (World Health Organization, 2020). Palliative care in the Philippines is not taught as a separate course nor subject in most Bachelor of Science in Nursing (BSN) curriculum; instead, its concepts were discussed across several subjects. Core topics such as pain and symptoms management, care planning and psychosocial support to both dying patients and their families are discussed in Medical - surgical nursing, oncology nursing, transcultural nursing, care of older adults, among others (CHED, 2017). However, a scoping review on palliative care states that palliative education in Asia - Pacific region notes that palliative care integration in the nursing programs remains inconsistent.

Table 8: Index of Competence in Palliative Care in Domain: Individualized Approach

Individualized Approach (PNCCS: Quality Nursing Care, Ethico-Moral Responsibility, Personal & Professional Growth) **Indicator Statement** As a staff nurse, I…	**WM**	**DR**	**TR**
1. use validated tools (e.g., pain scales, quality-of-life assessments) tailored to the patient's condition	4.798	A	VC
2. incorporate the patient's cultural practices, religious beliefs and personal wishes that align with the patient's life goals and dignity into the care plan	4.697	A	VC
3. adjust interventions based on the patient's unique needs, priorities, and disease trajectory.	4.780	A	VC

4. regularly reassess and modify interventions depending on changes in the patient's condition or response to treatment.	4.807	A	VC
5. build trust that empowers the patient to express needs and participate in decision-making.	4.816	A	VC
Total	23.898		
Overall Weighted Mean	4.780	A	VC

This implies that although palliative care concepts are mentioned in Filipino nursing education, it is mostly taught in a disjointed, non-systematic manner, which may lead to gaps in nurses' competency when they start working in government hospitals and other settings.

Table 9: Summary of the Index of Competence in Palliative Care (ICPC) among Staff Nurses

Key Aspects of Palliative Care	OWM	Transmute Rating
1. Focus on Quality of Life	4.741	VC
2. Symptoms Management	*4.811*	VC
3. Emotional and Psychological Support	*4.785*	VC
4. Spiritual & Existential Support	*4.633*	VC
5. Care Coordination	*4.776*	VC
6. Family & Care Giver Support	*4.763*	VC
7. Individualized Approach	*4.780*	VC
Total	***33.289***	
Grand Overall Weighted Mean (GOWM)	***4.756***	***VC (Very Competent)***

Differences in the Index of Competence in Palliative Care (ICPC) among Staff Nurses across the Variable, Age

Table 10 presents the ANOVA results showing the differences in the Index of Competence in Palliative Care (ICPC) of the staff nurses across the variable age. The table displays the computed F-values and their corresponding significance values (p-values) for each key aspect of palliative care. As shown in the table, the computed F-values and significance levels are as follows: $F = 0.964$, $p = 0.430$ for Focus on Quality of Life; $F = 1.302$, $p = 0.274$ for Symptoms Management; $F = 1.831$, $p = 0.128$ for Emotional and Psychological Support; $F = 2.451$, $p = 0.051$ for Spiritual and Existential Support; $F = 2.220$, $p = 0.072$ for Care Coordination; $F = 2.096$, $p = 0.087$ for Family and Caregiver Support; $F = 0.815$, $p = 0.519$ for Individualized Approach; and $F = 1.723$, $p = 0.150$ for the grand total.

Table 10: ANOVA Results on the Differences in the Index of Competence across the Variable, Age

Aspects of Palliative Care		Sum of Squares	df	Mean Square	F	Sig.
Focus on Quality of Life total	Between Groups	17.472	4	4.368	.964ns	.430
	Within Groups	471.134	104	4.530		
	Total	488.606	108			
Symptoms Management total	Between Groups	15.630	4	3.908	1.302ns	.274
	Within Groups	312.039	104	3.000		
	Total	327.670	108			
Emotional & Psychological Support total	Between Groups	23.384	4	5.846	1.831ns	.128
	Within Groups	332.029	104	3.193		
	Total	355.413	108			
	Between Groups	57.986	4	14.496	2.451ns	.051

Spiritual & Existential Support total	Within Groups	615.042	104	5.914		
	Total	673.028	108			
Care Coordination total	Between Groups	33.003	4	8.251	2.220ns	.072
	Within Groups	386.446	104	3.716		
	Total	419.450	108			
Family & Care Giver Support total	Between Groups	29.414	4	7.354	2.096ns	.087
	Within Groups	364.916	104	3.509		
	Total	394.330	108			
Individualized Approach total	Between Groups	10.932	4	2.733	.815ns	.519
	Within Groups	348.958	104	3.355		
	Total	359.890	108			
Grand total	Between Groups	941.900	4	235.475	1.723ns	.150
	Within Groups	14211.072	104	136.645		
	Total	15152.972	108			

*Significant at 0.05 alpha level
ns=Not significant at 0.05 alpha level

Since all the p-values are greater than the 0.05 level of significance, the results indicate that there are no statistically significant differences in the ICPC of the staff nurses across age groups for all key aspects of palliative care.Therefore, the null hypothesis stating that there are no significant differences in the Index of Competence in Palliative Care (ICPC) among the staff nurses when grouped according to age is accepted. This means that the level of competence in palliative care among the respondent staff nurses does not significantly vary across different age groups. Regardless of age, the nurses demonstrate a consistently high level of competence in all key aspects of palliative care. This finding may suggest that professional competence in palliative care is influenced more by clinical training, professional experience, and institutional practices rather than age alone. Previous studies have also emphasized that competence in palliative care depends largely on education, continuing professional development, and interdisciplinary collaboration rather than demographic characteristics such as age (World Health Organization, 2020).

Differences in the Index of Competence in Palliative Care (ICPC) among the Staff Nurses across the Variable, Sex

Table 11 reports t-test results on differences in the Index of Competence in Palliative Care (ICPC) among staff nurses grouped by sex. Key findings include: t = 0.026, p = 0.979 for Focus on Quality of Life; t = -1.182, p = 0.240 for Emotional and Psychological Support; t = -1.894, p = 0.061 for Spiritual and Existential Support; t = -1.234, p = 0.220 for Care Coordination; and t = -1.834, p = 0.069 for the Grand Total. All p-values exceed the 0.05 significance level, indicating no statistically significant differences. The null hypothesis is thus accepted, confirming that male and female nurses exhibit comparable competence across these palliative care domains.

Table 11: t-Test Results on Differences in the Index of Competence across the Variable, Sex

Key Aspects of Palliative Care	**Variable : Sex**	**N**	**Variance**	**t-test for Equality of Means**				
				Mean	**Mean Difference**	**t-value**	**df**	**Sig. (2-tailed)**
Focus on Quality of Life total	Male	35	Assumed	23.7143	.01158	.026	107	.979
	Female	74	Not assumed					
Symptoms Management total	Male	35	Assumed	23.4857	-.83861	-2.398	107	.018*
	Female	74	Not assumed					
	Male	35	Assumed	23.6286	-.43900	-1.182	107	.240

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Emotional & Psychological Support total	Female	74	Not assumed					
Spiritual & Existential Support total	Male	35	Assumed	22.5143	-.95869	-1.894	107	.061
	Female	74	Not assumed					
Care Coordination total	Male	35	Assumed	23.5429	-.49768	-1.234	107	.220
	Female	74	Not assumed					
Family & Care Giver Support total	Male	35	Assumed	23.2857	-.78185	-2.023	107	.046*
	Female	74	Not assumed					
Individualized Approach total	Male	35	Assumed	23.2857	-.90347	-2.469	107	.015*
	Female	74	Not assumed					
Grand Total	Male	35	Assumed	163.4571	-4.40772	-1.834	107	.069
	Female	74	Not assumed					

*Significant at 0.05 alpha level; ns=Not significant at 0.05 alpha level

However, the results show statistically significant differences for the aspects Symptoms Management ($t = -2.398$, $p < 0.05$), Family and Caregiver Support ($t = -2.023$, $p < 0.05$), and Individualized Approach ($t = -2.469$, $p < 0.05$). Since the computed p-values are less than the 0.05 level of significance, the null hypothesis for these aspects is rejected. This indicates that the level of competence in these specific aspects of palliative care differs significantly between male and female staff nurses. The negative t-values indicate the direction of the difference between the two groups, suggesting that the group with the higher mean score demonstrates greater competence in these aspects of palliative care. These findings suggest that demographic factors such as sex may influence certain dimensions of palliative care competence, although the overall level of competence remains high among the respondents. Competence in palliative care is influenced by professional training, experience, and collaborative practice, rather than demographic characteristics alone (World Health Organization, 2020).

Differences in the Index of Competence in Palliative Care (ICPC) among the-Staff Nurses across the Variable, Religious Affiliation

Table 12 presents the t-test results showing the differences in the Index of Competence in Palliative Care (ICPC) of the staff nurses when grouped according to the variable religious affiliation. The table displays the computed t-values and their corresponding significance values (p-values) for each key aspect of palliative care. As shown in Table 12, the computed values are $t = 0.360$, $p = 0.720$ for Focus on Quality of Life; $t = 0.814$, $p = 0.418$ for Symptoms Management; $t = 0.875$, $p = 0.384$ for Emotional and Psychological Support; $t = 0.634$, $p = 0.528$ for Spiritual and Existential Support; $t = -1.049$, $p = 0.297$ for Care Coordination; $t = -1.256$, $p = 0.212$ for Family and Caregiver Support; $t = 1.488$, $p = 0.140$ for Individualized Approach; and $t = 1.058$, $p = 0.293$ for the Grand Total. Since all the p-values are greater than the 0.05 level of significance, the results indicate that there are no statistically significant differences in the ICPC of the staff nurses across the variable religious affiliation for all key aspects of palliative care

Table 12: t-Test Results on Differences in the Index of Competence across the Variable, Sex

Key Aspects of Palliative Care	**Variable: Religious Affiliation**	**N**	**Variance**	**t-test for Equality of Means**				
				Mean	**Mean Difference**	**t-value**	**df**	**Sig. (2-tailed)**

Focus on Quality of Life total	Non-Catholic	21	Assumed	3.82571	.18669	.360	107	.720
	Catholic	88	Not assumed	23.6705				
Symptoms Management total	Non-Catholic	21	Assumed	24.3333	.34470	.814	107	.418
	Catholic	88	Not assumed	23.9886				
Emotional & Psychological Support total	Non-Catholic	21	Assumed	24.2381	.38582	.875	107	.384
	Catholic	88	Not assumed	23.8523				
Spiritual & Existential Support total	Non-Catholic	21	Assumed	23.4762	.38528	.634	107	.528
	Catholic	88	Not assumed	23.0909				
Care Coordination total	Non-Catholic	21	Assumed	24.2857	.50162	1.049	107	.297
	Catholic	88	Not assumed	23.7841				
Family & Care Giver Support total	Non-Catholic	21	Assumed	24.2857	.58117	1.256	107	.212
	Catholic	88	Not assumed	23.7045				
Individualized Approach total	Non-Catholic	21	Assumed	24.4286	.65584	1.488	107	.140
	Catholic	88	Not assumed	23.7727				
Grand Total	Non-Catholic	21	Assumed	168.9048	3.04113	1.058	107	.293
	Catholic	88	Not assumed	165.8636				

Therefore, the null hypothesis stating that there are no significant differences in the Index of Competence in Palliative Care (ICPC) among the staff nurses when grouped according to religious affiliation is accepted. This implies that regardless of the religious affiliation of the respondent staff nurses, their level of competence in palliative care remains similar across the different key aspects. The results further indicate that the respondent staff nurses consistently demonstrate a high level of competence in palliative care, as reflected in their ratings of Very Competent across all domains.This finding suggests that professional competence in palliative care is primarily influenced by clinical training, professional education, and practical experience, rather than personal demographic characteristics such as religious affiliation. In palliative care practice, healthcare providers are expected to deliver holistic and patient-centered care while respecting the diverse spiritual and cultural beliefs of patients and their families (World Health Organization, 2020).

Differences in the Index of Competence in Palliative Care (ICPC) among the Staff Nurse across the Variable, Highest Educational Attainment

Table 13 presents the t-test results showing the differences in the Index of Competence in Palliative Care (ICPC) of the staff nurses when grouped according to the variable highest educational attainment. The table displays the computed t-values and their corresponding significance levels (p-values) for each key aspect of palliative care. As shown in Table 13, the computed values are $t = -0.283$, $p = 0.778$ for Focus on Quality of Life; $t = -1.358$, $p = 0.177$ for Symptoms Management; $t = 0.783$, $p = 0.435$ for Emotional and Psychological Support; $t = 1.069$, $p = 0.288$ for Spiritual and

Existential Support; t = −0.822, p = 0.413 for Care Coordination; t = 0.213, p = 0.831 for Family and Caregiver Support; t = −0.221, p = 0.826 for Individualized Approach; and t = −0.041, p = 0.967 for the Grand Total. Since all the p-values are greater than the 0.05 level of significance, the results indicate that there are no statistically significant differences in the ICPC of the respondent staff nurses across the variable highest educational attainment for all key aspects of palliative care. Therefore, the null hypothesis stating that there are no significant differences in the Index of Competence in Palliative Care (ICPC) among the staff nurses when grouped according to highest educational attainment is accepted. This means that whether the respondent staff nurses hold a Bachelor of Science in Nursing (BSN) degree or a Master of Arts in Nursing (MAN) degree, their level of competence in palliative care remains comparable across the different key aspects. Furthermore, the demographic data presented in Table 1 indicate that the majority of the respondents are holders of a BSN degree, while only a small number possess a MAN degree. Despite this difference in educational attainment, the results show that the staff nurses demonstrate a consistently high level of competence in palliative care, as reflected by their ratings of Very Competent across all domains.This finding suggests that competence in palliative care may be influenced not only by formal academic qualifications but also by clinical experience, continuous professional development, and institutional training programs. Competence in palliative care is influenced by education, training, and professional development that enable healthcare providers to deliver holistic and patient-centered care (World Health Organization, 2020).

Table 13: t-Test Results on Differences in the Index of Competence across the Variable, Highest Educational Attainment

Key Aspects of Palliative Care	**Variable: High. Educ Attain**	**N**	**Variance**	**t-test for Equality of Means**				
				Mean	**Mean Difference**	**t-value**	**df**	**Sig. (2-tailed)**
Focus on Quality of Life total	BS Nursing	95	Assumed	23.6842	-.17293	-.283	107	.778
	MAN	14	Not assumed	23.8571				
Symptoms Management total	BS Nursing	95	Assumed	23.9684	-.67444	-1.358	107	.177
	MAN	14	Not assumed	24.6429				
Emotional & Psychological Support total	BS Nursing	95	Assumed	23.9789	.40752	.783	107	.435
	MAN	14	Not assumed	23.5714				
Spiritual & Existential Support total	BS Nursing	95	Assumed	23.2632	.76316	1.069	107	.288
	MAN	14	Not assumed	22.5000				
Care Coordination total	BS Nursing	95	Assumed	23.8211	-.46466	-.822	107	.413
	MAN	14	Not assumed	24.2857				
Family & Care Giver Support total	BS Nursing	95	Assumed	23.8316	.11729	.213	107	.831
	MAN	14	Not assumed	23.7143				
Individualized Approach total	BS Nursing	95	Assumed	24.4286	-.11579	-.221	107	.826
	MAN	14	Not assumed	23.7727				
Grand Total	BS Nursing	95	Assumed	168.9048	-.13985	-.041	107	.967

	MAN	14	Not assumed	165.86 36				

Differences in the Index of Competence in Palliative Care (ICPC) among the Staff Nurse across the Variable, Number of Years in Service as Nurse

Table 14 presents the ANOVA results showing the differences in the Index of Competence in Palliative Care (ICPC) of the staff nurses when grouped according to the variable number of years in service as nurse. The table displays the computed F-values and their corresponding significance values (p-values) for each key aspect of palliative care. As shown in Table 14, the computed values are F = 1.161, p = 0.317 for Focus on Quality of Life; F = 0.889, p = 0.414 for Symptoms Management; F = 2.119, p = 0.125 for Emotional and Psychological Support; F = 2.035, p = 0.136 for Spiritual and Existential Support; F = 0.742, p = 0.479 for Care Coordination; F = 0.382, p = 0.684 for Family and Caregiver Support; F = 1.002, p = 0.371 for Individualized Approach; and F = 1.151, p = 0.320 for the Grand Total. Since all the p-values are greater than the 0.05 level of significance, the results indicate that there are no statistically significant differences in the ICPC of the staff nurses across the variable number of years in service as nurse for all key aspects of palliative care.

Table 14: ANOVA Results on the Differences in the Index of Competence across the Variable, Number of Years in Service as Nurse

Key Aspects of Palliative Care		Sum of Squares	df	Mean Square	F	Sig.
Focus on Quality of Life total	Between Groups	10.478	2	5.239	1.161	.317
	Within Groups	478.128	106	4.511		
	Total	488.606	108			
Symptoms Management total	Between Groups	5.403	2	2.701	.889	.414
	Within Groups	322.267	106	3.040		
	Total	327.670	108			
Emotional & Psychological Support total	Between Groups	13.663	2	6.831	2.119	.125
	Within Groups	341.750	106	3.224		
	Total	355.413	108			
Spiritual & Existential Support total	Between Groups	24.890	2	12.445	2.035	.136
	Within Groups	648.137	106	6.115		
	Total	673.028	108			
Care Coordination total	Between Groups	5.792	2	2.896	.742	.479
	Within Groups	413.657	106	3.902		
	Total	419.450	108			
Family & Care Giver Support total	Between Groups	2.819	2	1.409	.382	.684
	Within Groups	391.512	106	3.694		
	Total	394.330	108			
Individualized Approach total	Between Groups	6.679	2	3.339	1.002	.371
	Within Groups	353.211	106	3.332		
	Total	359.890	108			
Grand Total	Between Groups	322.128	2	161.064	1.151	.320
	Within Groups	14830.845	106	139.914		
	Total	15152.972	108			

Therefore, the null hypothesis stating that there are no significant differences in the Index of Competence in Palliative Care (ICPC) among the staff nurses when grouped according to their number of years in service is accepted. This implies that whether the staff nurses have relatively few years or many years of professional experience, their level of competence in palliative care remains similar across

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the different key aspects. The results further indicate that the staff nurses consistently demonstrate a high level of competence in palliative care, as reflected by their Very Competent ratings across all domains. This finding suggests that competence in palliative care may be influenced by professional training, institutional practices, and continuing education, rather than the length of professional service alone. Competence in palliative care is strengthened through professional training and continuing education that enable healthcare providers to deliver holistic and patient-centered care (World Health Organization, 2020).

Differences in the Index of Competence in Palliative Care (ICPC) among the Staff Nurse across the Variable, Position

Table 15 presents the ANOVA results showing the differences in the Index of Competence in Palliative Care (ICPC) among the staff nurses when grouped according to their position in the hospital. The table shows the computed F-values and their corresponding significance values (p-values) for each key aspect of palliative care. As shown in Table 15, the computed values are F = 0.088, p = 0.916 for Focus on Quality of Life; F = 0.175, p = 0.840 for Symptoms Management; F = 0.452, p = 0.638 for Emotional and Psychological Support; F = 0.501, p = 0.608 for Spiritual and Existential Support; F = 0.756, p = 0.472 for Care Coordination; F = 0.983, p = 0.378 for Family and Caregiver Support; F = 0.483, p = 0.618 for Individualized Approach; and F = 0.334, p = 0.717 for the Grand Total. Since all the p-values are greater than the 0.05 level of significance, the results indicate that there are no statistically significant differences in the ICPC of the staff nurses across the variable position for all key aspects of palliative care.

Table 15: ANOVA Results on the Differences in the Index of Competence across the Variable, Position

Key Aspects of Palliative Care		Sum of Squares	df	Mean Square	F	Sig.
Focus on Quality of Life total	Between Groups	.809	2	.404	.088	.916
	Within Groups	487.797	106	4.602		
	Total	488.606	108			
Symptoms Management total	Between Groups	1.078	2	.539	.175	.840
	Within Groups	326.591	106	3.081		
	Total	327.670	108			
Emotional & Psychological Support total	Between Groups	3.004	2	1.502	.452	.638
	Within Groups	352.408	106	3.325		
	Total	355.413	108			
Spiritual & Existential Support total	Between Groups	6.298	2	3.149	.501	.608
	Within Groups	666.730	106	6.290		
	Total	673.028	108			
Care Coordination total	Between Groups	5.902	2	2.951	.756	.472
	Within Groups	413.548	106	3.901		
	Total	419.450	108			
Family & Care Giver Support total	Between Groups	7.178	2	3.589	.983	.378
	Within Groups	387.152	106	3.652		
	Total	394.330	108			
Individualized Approach total	Between Groups	3.253	2	1.626	.483	.618
	Within Groups	356.637	106	3.364		
	Total	359.890	108			
Grand Total	Between Groups	94.892	2	47.446	.334	.717
	Within Groups	15058.080	106	142.057		
	Total	15152.972	108			

Therefore, the null hypothesis stating that there are no significant differences in the index of competence in palliative care (ICPC) among the staff nurses when grouped according to their position is accepted. This finding suggests that regardless of whether the respondents are ward staff nurses, ICU staff nurses, or ER staff nurses, their competence in providing palliative care remains relatively similar across the different domains. Furthermore, the results indicate that staff nurses demonstrate a very competent level of palliative care practice, reflecting the integration of professional nursing competencies in delivering holistic, patient-centered, and compassionate care. The World Health

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Organization (2020) emphasizes that palliative care should be integrated across all healthcare settings and nursing roles to ensure quality of life for patients with life-limiting illnesses.

Differences in the Index of Competence in Palliative Care (ICPC) among the Staff Nurse across the Variable, Monthly Income

Table 16 details the ANOVA results concerning the Index of Competence in Palliative Care (ICPC) among staff nurses, segmented by monthly income. The computed F-values and their significance (p-values) for various aspects of palliative care reveal that, for the domains of Focus on Quality of Life (F = 2.207, p = 0.140), Symptoms Management (F = 0.219, p = 0.641), Spiritual and Existential Support (F = 2.420, p = 0.123), Care Coordination (F = 1.736, p = 0.190), Family and Caregiver Support (F = 0.619, p = 0.433), Individualized Approach (F = 1.617, p = 0.206), and the Grand Total (F = 2.066, p = 0.154), none show statistically significant differences as all p-values exceed 0.05. However, the domain of Emotional and Psychological Support shows a significant difference with F = 6.016 and p = 0.016, indicating that the ICPC varies significantly based on monthly income in this area.

Table 16: ANOVA Results on the Differences in the Index of Competence across the Variable, Monthly Income

Key Aspects of Palliative Care		Sum of Squares	df	Mean Square	F	Sig.
Focus on Quality of Life total	Between Groups	9.876	1	9.876	2.207	.140
	Within Groups	478.729	107	4.474		
	Total	488.606	108			
Symptoms Management total	Between Groups	.670	1	.670	.219	.641
	Within Groups	327.000	107	3.056		
	Total	327.670	108			
Emotional & Psychological Support total	Between Groups	18.920	1	18.920	6.016	.016*
	Within Groups	336.493	107	3.145		
	Total	355.413	108			
Spiritual & Existential Support total	Between Groups	14.886	1	14.886	2.420	.123
	Within Groups	658.141	107	6.151		
	Total	673.028	108			
Care Coordination total	Between Groups	6.696	1	6.696	1.736	.190
	Within Groups	412.753	107	3.858		
	Total	419.450	108			
Family & Care Giver Support total	Between Groups	2.268	1	2.268	.619	.433
	Within Groups	392.062	107	3.664		
	Total	394.330	108			
Individualized Approach total	Between Groups	5.359	1	5.359	1.617	.206
	Within Groups	354.531	107	3.313		
	Total	359.890	108			
Grand Total	Between Groups	286.996	1	286.996	2.066	.154
	Within Groups	14865.977	107	138.934		
	Total	15152.972	108			

*Significant at 0.05 alpha level ns=Not significant at 0.05 alpha level

Thus, the null hypothesis asserting no significant differences in ICPC among staff nurses by monthly income is partially rejected, highlighting a significant variation specifically in emotional and psychological support. This finding suggests that variations in socioeconomic factors, such as income level, may influence nurses' experiences, exposure, or access to resources that contribute to psychosocial aspects of palliative care practice. Nevertheless, the results still indicate that the staff nurses demonstrate a very competent level of palliative care practice across all domains. Palliative care emphasizes the provision of holistic support that addresses not only physical symptoms but also the emotional, psychological, and spiritual needs of patients and their families (World Health Organization, 2020).

Differences in the Index of Competence in Palliative Care (ICPC) among the Staff Nurse

across the Variable, Relevant In-Service Trainings

Table 17 presents t-test results indicating no significant differences in the Index of Competence in Palliative Care (ICPC) among staff nurses based on their in-service training. The computed t-values and p-values for various aspects of palliative care are as follows: Focus on Quality of Life ($t = -1.150$, $p = 0.253$), Symptoms Management ($t = -0.410$, $p = 0.682$), Emotional and Psychological Support ($t = -0.199$, $p = 0.842$), Spiritual and Existential Support ($t = -0.365$, $p = 0.716$), Care Coordination ($t = -0.927$, $p = 0.356$), Family and Caregiver Support ($t = -1.256$, $p = 0.212$), Individualized Approach ($t = -1.225$, $p = 0.223$), and Grand Total ($t = -0.919$, $p = 0.360$). All p-values exceed the 0.05 significance level, leading to the acceptance of the null hypothesis that asserts no significant differences in ICPC among staff nurses based on their participation in relevant in-service training. Consequently, the level of competence in palliative care remains relatively uniform across nurses who attended different numbers of training. Furthermore, the results indicate that the staff nurses demonstrate a very competent level of palliative care practice in all key aspects. This may suggest that competence in palliative care is influenced not only by formal training but also by clinical experience, institutional practices, and professional exposure in providing holistic patient care. Palliative care competence among healthcare professionals involves the integration of knowledge, skills, and compassionate care to improve the quality of life of patients and their families facing life-threatening illnesses (World Health Organization, 2020).

Table 17: t-Test Results on Differences in the Index of Competence across the Variable, Relevant In-Service Trainings

Key Aspects of Palliative Care	Variable: Relevant in-Service Trainings	N	Variance	t-test for Equality of Means				
				Mean	Mean Difference	t-value	df	Sig. (2-tailed)
Focus on Quality of Life total	1-2 Trainings	89	Assumed	23.5955	-.60449	-1.150	107	.253
	≥ 3 Trainings	20	Not assumed	24.2000				
Symptoms Management total	1-2 Training	89	Assumed	24.0225	-.17753	-.410	107	.682
	≥ 3 Trainings	20	Not assumed	24.2000				
Emotional & Psychological Support total	1-2 Training	89	Assumed	23.9101	-.08989	-.199	107	.842
	≥ 3 Trainings	20	Not assumed	24.0000				
Spiritual & Existential Support total	1-2 Training	89	Assumed	23.1236	-.22640	-.365	107	.716
	≥ 3 Trainings	20	Not assumed	23.3500				
Care Coordination total	1-2 Training	89	Assumed	23.7978	-.45225	-.927	107	.356
	≥ 3 Trainings	20	Not assumed	24.2500				
Family & Care Giver Support total	1-2 Training	89	Assumed	23.7079	-.59213	-1.256	107	.212
	≥ 3 Trainings	20	Not assumed	24.3000				
Individualized Approach total	1-2 Training	89	Assumed	23.7978	-.55225	-1.225	107	.223
	≥ 3 Trainings	20	Not assumed	24.3500				
Grand Total	1-2 Training	89	Assumed	165.9551	-2.69494	-.919	107	.360
	≥ 3 Trainings	20	Not assumed	168.6500				

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Relationships between the Index of Competence in Palliative Care (ICPC) among the Staff Nurses and the Profile Variables

Table 18 displays Pearson r correlation coefficients revealing relationships between the Index of Competence in Palliative Care (ICPC) among staff nurses and profile variables such as age, sex, and income. Notable findings include a positive correlation between sex and symptoms management (r = 0.226, p = 0.018), as well as with family and caregiver support (r = 0.192, p = 0.046) and individualized approach (r = 0.232, p = 0.015). These results imply that gender influences competence in family-centered care. Conversely, a negative correlation was noted between monthly income and emotional and psychological support (r = −0.231, p = 0.016), indicating that higher income levels may relate to enhanced competence in providing such support. Based on these findings, the null hypothesis stating that there are no significant relationships between the ICPC among the staff nurses in the domains of symptoms management, emotional and psychological support, family and caregiver support, and individualized approach and the variables sex and monthly income is rejected. However, the results also show that no significant relationships were observed between the ICPC and the other profile variables, including age, religious affiliation, highest educational attainment, years in service, position, and relevant in-service training, as all corresponding p-values were greater than the 0.05 level of significance.

These findings suggest that while certain demographic or contextual variables may influence specific domains of palliative care competence, the overall competence of the staff nurses remains consistently high across most areas of palliative care practice. Palliative care requires healthcare professionals to integrate physical, emotional, psychosocial, and spiritual support to improve the quality of life of patients and their families facing life-threatening illnesses (World Health Organization, 2020).

Table 18: Relationships between the Index of Competence in Palliative Care and the Profile Variables n=109

Key Aspects of Palliative Care	Pearson Correlation	Age	Sex	Religious Affiliat'n	Highest Educ'l Attainment	Yrs in Serv.	Position	Mo. Income	In-Serv. Trainings
Focus on Quality of Life total	r- value	.070	-.003	-.035	.027	-.009	.037	-.142	.111
	Sig. (2-tailed)	.467	.979	.720	.778	.929	.705	.140	.253
Symptoms Management total	r- value	.017	.226*	-.078	.130	.108	-.034	.045	.040
	Sig. (2-tailed)	.864	.018	.418	.177	.262	.728	.641	.682
Emotional & Psychological Support total	r- value	-.013	.114	-.084	-.076	-.009	-.087	-.231*	.019
	Sig. (2-tailed)	.891	.240	.384	.435	.924	.371	.016	.842
Spiritual & Existential Support total	r- value	.046	.180	-.061	-.103	-.070	-.096	-.149	.035
	Sig. (2-tailed)	.633	.061	.528	.288	.468	.319	.123	.716
Care Coordination total	r- value	.106	.118	-.101	.079	.083	-.086	-.126	.089
	Sig. (2-tailed)	.273	.220	.297	.413	.389	.372	.190	.356
	r- value	.173	.192*	-.121	-.021	.080	-.128	-.076	.121

Family & Care Giver Support total	Sig. (2-tailed)	.072	.046	.212	.831	.409	.184	.433	.212
Individualized Approach total	r- value	-.023	.232*	-.142	.021	.022	-.073	-.122	.118
	Sig. (2-tailed)	.812	.015	.140	.826	.817	.448	.206	.223
Grand Total	r- value	.065	.175	-.102	.004	.028	-.078	-.138	.088
	Sig. (2-tailed)	.503	.069	.293	.967	.769	.419	.154	.360

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

CONCLUSIONS

Based on the findings of the study, the following conclusions were drawn:

a. The staff nurses in the selected government hospitals represent a workforce composed largely of early- to mid-career female professionals with varying levels of exposure to palliative care training and clinical experience.

b. The staff nurses demonstrate a generally high level of competence in providing palliative care, indicating that they possess the necessary knowledge and skills to support patients with life-limiting illnesses through holistic nursing care.

c. Despite the generally high level of competence, certain areas of palliative care practice require further strengthening, particularly those related to holistic assessment, communication, spiritual care, caregiver support, and individualized care planning.

d. Selected demographic and workplace characteristics appear to influence certain aspects of palliative care competence, suggesting that contextual and professional factors may shape the development and application of these competencies in clinical practice.

e. Continuous professional development and structured educational interventions are necessary to sustain and further enhance the competence of nurses in delivering comprehensive and patient-centered palliative care.

RECOMMENDATIONS

Based on the conclusions drawn from the study, the following recommendations are proposed:

a. Since the nursing workforce in the selected government hospitals is largely composed of early- to mid-career professionals with varying exposure to palliative care training, hospital administrators and nursing service managers may provide more structured orientation and continuing education programs in palliative care to support nurses in strengthening their competencies in caring for patients with life-limiting illnesses.

b. Considering that staff nurses already demonstrate a generally high level of competence in providing palliative care, healthcare institutions may sustain and further enhance this competence by promoting continuous professional development, mentoring programs, and opportunities for advanced training related to palliative care practice.

c. In view of the areas identified for improvement—particularly holistic patient assessment, therapeutic communication, spiritual care, caregiver support, and individualized care planning—healthcare institutions may implement targeted training programs, such as the proposed palliative care competency enhancement program, to further strengthen nurses' skills in these aspects of care.

d. Since certain demographic and workplace characteristics appear to influence some aspects of palliative care competence,

hospital administrators and nursing leaders may consider workplace support mechanisms such as mentorship, collaborative practice, and equitable professional development opportunities to ensure that all nurses are able to continuously develop their competencies regardless of their background or work conditions.

e. To sustain and further enhance the competence of nurses in providing comprehensive and patient-centered palliative care, healthcare institutions may institutionalize regular in-service training programs, workshops, and interdisciplinary learning activities that focus on improving the knowledge, skills, and attitudes of nurses in palliative care practice.
f. Future researchers may conduct similar studies involving a larger sample size or different healthcare settings in order to further explore factors that may influence palliative care competence among nurses and to validate the findings of the present study.

Proposed Training Program for Enhancing the Index of Competence in Palliative Care of Staff Nurses

The findings of this study revealed that although the respondent staff nurses demonstrated a very competent level of palliative care practice, several indicators obtained comparatively lower weighted means across different domains of competence. These areas include quality-of-life assessment, symptom management, communication, spiritual care, interdisciplinary collaboration, caregiver support, and individualized patient care. To address these areas and further strengthen the competence of staff nurses, the **CARES Program (Compassionate and Advanced Responsive Education in Palliative Care for Staff Nurses)** is proposed. This training program aims to enhance the knowledge, skills, and attitudes of staff nurses in providing patient-centered, compassionate, and culturally sensitive palliative care. The program integrates lecture-discussions, workshops, simulations, and interdisciplinary collaboration activities to ensure that nurses develop practical competencies in palliative care practice.

For the domain **Focus on Quality of Life**, the training will emphasize comprehensive and timely patient assessment using appropriate palliative care tools. After the session, staff nurses are expected to demonstrate the ability to conduct holistic assessments of patients with life-limiting conditions. This will involve a three-hour lecture and clinical workshop facilitated by a palliative care physician, head nurses, and selected staff nurses. For **Symptom Management**, the program will focus on organizing the care environment to promote patient comfort, dignity, and privacy. Through simulation-based activities, nurses will be trained to create patient-centered care settings that support symptom relief and comfort measures. In the area of **Emotional and Psychological Support**, which showed a significant difference based on monthly income, the training will prioritize therapeutic communication. Nurses will engage in role-playing activities to enhance their ability to communicate effectively with patients experiencing emotional distress, fear, and anxiety. This domain is given special emphasis due to its identified variability and its critical role in holistic care. For **Spiritual and Existential Support**, nurses will be trained to assess patients' spiritual needs and integrate culturally sensitive approaches into care planning. Workshops will focus on respecting diverse beliefs about death, dying, and the afterlife, particularly within the Filipino cultural context. The **Care Coordination** component will develop nurses' ability to actively participate in interdisciplinary team discussions. Through simulated case conferences, nurses will practice collaborative decision-making and coordinated care planning involving physicians, social workers, and other healthcare professionals. In terms of **Family and Caregiver Support**, the training will enable nurses to identify signs of caregiver burnout and initiate appropriate referrals. Case analysis activities will strengthen nurses' ability to support families emotionally and connect them with available resources. Lastly, the **Individualized Approach** domain will train nurses to incorporate patients' cultural beliefs, personal values, and life goals into care planning. Workshops will focus on developing personalized care plans

that respect patient autonomy and cultural sensitivity.

The program will involve head nurses, staff nurses, and a palliative care physician as facilitators. Each session will last approximately three hours and will utilize a combination of lectures, simulations, and interactive activities. To include the total estimated budget, covering lecturer honoraria, participant snacks, and training materials.

Monitoring, Evaluation and Expected Outcomes of the Program

The effectiveness of the CARES Program will be evaluated through multiple methods to ensure both knowledge acquisition and practical application. Pre-test and post-test assessments will be conducted to measure improvement in knowledge. Skills competency will be evaluated through return demonstrations and simulation performance. Participant feedback forms will be used to assess training relevance and satisfaction. In addition, head nurses and supervisors will conduct observational evaluations in the clinical setting to determine improvements in actual nursing practice. A follow-up evaluation will be conducted after three months to assess the sustainability of the acquired competencies and their impact on patient care. Following the implementation of the CARES Program, it is expected that staff nurses will demonstrate improved competence across all domains of palliative care. This includes enhanced assessment skills, better symptom management, stronger communication abilities, and improved provision of emotional, spiritual, and family-centered care. Moreover, the program is expected to contribute to improved quality of life for patients with life-limiting illnesses, strengthened interdisciplinary collaboration, and increased support for families and caregivers. Ultimately, the integration of culturally sensitive and individualized care approaches will enhance the overall delivery of palliative care services in government hospitals in Eastern Pangasinan.

Compliance with Ethical Standards

The researchers ensured full compliance with ethical standards in the conduct of this study. Prior to data collection, approval was secured from the University Research Ethics Committee, which issued ethical clearance, and permission was likewise obtained from the administrators of the selected government hospitals. Informed consent was obtained from all staff nurses after clearly explaining the purpose of the study. Participation was strictly voluntary, and respondents were assured of their right to withdraw at any time without penalty. The anonymity and confidentiality of the respondents were rigorously maintained, and all data collected were handled in accordance with Data Privacy regulations. The well-being of the participants was safeguarded throughout the research process, with no procedures posing harm or risk. The researchers declare that there is no conflict of interest in the conduct of this study, and that plagiarism was strictly avoided through proper citation of sources. Objectivity and impartiality were upheld, ensuring that there was no bias in the interpretation of the findings, and that results were used solely for academic and research purposes. Furthermore, any use of artificial intelligence (AI) tools in the preparation of this study has been disclosed to ensure full transparency.

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