



Identifying undergraduate nurses' learning requirements and teaching strategies in dementia care education: A nominal group technique

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ARTICLE INFO

Keywords:

Dementia
Curriculum design
Nurse education research
Nursing care
Nursing students
Nominal group technique

ABSTRACT

Aim: Identify priorities and reach a consensus on student nurses' learning requirements and the best-suited teaching strategies in dementia care.

Background: Dementia has become a global health priority. Nurses are primary service providers for people with dementia, but they may fall short on professional training. Nursing curricula still lacks a clear educational framework for dementia, meaning that nurse educators must make decisions amidst uncertainty.

Design: Nominal group technique based on the conceptual framework proposed by Van de Ven and Delbecq (1972).

Methods: A structured face-to-face meeting convened in November 2021 involved nine participants who were directly involved in dementia care. The steps in the technique were (a) idea generation, (b) round-robin recording, (c) discussion, (d) voting and ranking, (e) discussion on the vote and (f) re-ranking. Participants answered two nominal questions. Consent, anonymity, feedback and iteration were guaranteed throughout the process.

Results: The nominal group prioritized theoretical understanding of dementia, communication, caregivers' needs, comprehensive assessment and ethical practice as learning requirements for nursing students. The outstanding teaching strategy discussed included various approaches to experiential learning.

Conclusions: The nominal group technique process explored learning requirement priorities for student nurses within a specific context. Participants discussed experiential learning as the best-suited teaching strategy. Findings could support nurse educators to design and deliver better dementia education.

1. Introduction

Dementia has become a global health priority due to current prevalence figures, trends in demographics and the huge burden on health-care systems (World Health Organization, 2017). Data from 2019 estimated that 55.2 million people worldwide had dementia, which would rise to 139 million by 2050. Regardless of a country's income, dementia is one of the leading causes of care dependency and disability in old age. In turn, this will cause a huge rise in dementia costs, topping US\$2.8 trillion by 2030. Furthermore, a dramatic increase in deaths caused by dementia has made it the seventh leading cause of death worldwide (World Health Organization, 2021). The need for immediate action is no longer debatable.

As primary service providers, nurses play an essential role in enhancing quality of care for people with dementia (Evrpidou et al., 2019; Hallberg et al., 2013). However, some experts have expressed their concern that nurses' professional training is insufficient for this purpose (Alushi et al., 2015; Balzer et al., 2016), which leads to inequities, indecision regarding care options and lack of continuity in care (Martin et al., 2020). Across the world, regulatory bodies for healthcare workers are trying to ensure mandatory dementia training, bearing in mind that effective dementia care services would require a competency framework across different levels of practice (Traynor et al., 2011). As important as it is to focus on the qualified workforce, training and development for future healthcare professionals is also of great concern (Alushi et al., 2015). Higher Education Institutions play a key role in

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providing dementia education at pre-registration level (Collier et al., 2015) which is essential for future practice as it could positively impact outcomes for people with dementia and their caregivers (Adewuyi et al., 2018).

The WHO Global Plan on Dementia aimed to make dementia a public health priority and highlighted the development of dementia knowledge and skills amongst healthcare professionals as an urgent action (World Health Organization, 2017). Although much has been written about the importance of preparing nursing students to care for this population, in the literature we found that nursing curricula lack a clear framework for dementia education. Even though dementia is relevant to most healthcare settings, findings indicate sparse inclusion of dementia education in undergraduate courses, lack of knowledge regarding the best approach to deliver it and unclear learning outcomes within pre-registration nursing programmes (Knifton et al., 2019; Traynor et al., 2011). As a result, health professional educators sometimes have to make decisions in uncertain situations lacking empirical evidence. In these circumstances, the aim of this study is to identify the priorities and reach a consensus on undergraduate nurses' learning requirements and the best-suited teaching strategies in dementia care.

2. Methods

2.1. Design

We took a qualitative approach based on a consensus method. Consensus group methods can be useful when determining components of a curriculum or defining competencies (Foth et al., 2016). Recent studies have used consensus methodologies to explore different aspects of nursing education, such as nursing research (Cooper et al., 2020), exchange programmes (Cunningham, 2017), meaning of dignity (Mullen et al., 2019) and medication administration (Rossler et al., 2021). We used a nominal group technique for our study, based on the conceptual framework proposed by Van de Ven and Delbecq (1972).

Nominal group technique is a consensus method used by researchers across a wide range of fields to define agreement on topics (Waggoner et al., 2016) through structured face-to-face meetings. During the nominal group technique, participants have the opportunity to meet, generate ideas and debate topics. Other reasons for choosing an nominal group technique in this study included creating a shared space where people who had been directly involved in caring for people with dementia could verbalize information and experiences first-hand, time-efficiency and promoting participant satisfaction through immediate

Table 1
Stages of the Nominal Group Technique by Van de Ven & Delbecq (1972).

Stage 1 – Silent idea generation	This stage is carried out in silence, in writing and individually.
Stage 2 – Round-robin recording of ideas	One at a time, each participant shares one of their answers from stage 1 while the facilitator records it in writing in view of all the participants (i.e. on a flip-chart). This stage ends when all participants have exhausted their individual lists. No discussion of ideas is allowed at this point.
Stage 3 – Discussion of ideas	The group discusses every idea, one at a time, to clarify, defend or dispute them, allowing for further items to be suggested during the discussion.
Stage 4 – Voting & ranking	Each participant independently chooses the items he/she considers most important and records them on a card. Participants give each item a numerical value according to its degree of importance (the most important item receives the highest value).
Stage 5 – Discussion of the vote	Once the voted items are ranked and reported to the participants, a spontaneous group discussion may emerge in which the preliminary ranking is re-clarified, defended or disputed.
Stage 6 – Re-ranking	Following the discussion on the vote, each participant gets the chance to review and change their preliminary vote from stage 4 as they see fit.

dissemination of results to the group (Harvey and Holmes, 2012) (Table 1).

The results presented in this manuscript are part of a larger investigation that aims to improve teaching and learning of dementia education for nursing students. They are preceded by a scoping review of the literature (Carriñanos-Ayala et al., 2022). Subsequent phases of the research will help develop a teaching sequence and measure its learning effectiveness.

2.2. Planning the nominal group technique

2.2.1. Identifying the nominal questions

Two of the authors (SC, JZ) proposed two separate nominal questions specifically and clearly, bearing in mind the different background of the participants (Horton, 1980; Humphrey-Murto et al., 2016; Waggoner et al., 2016). Once formulated, we asked an experienced nurse educator to review them to ensure clarity. Following her suggestions, the final nominal questions were:

1. What knowledge and skills do nursing students require to be able to care for a person with dementia?
2. What strategies can be implemented during university training so that nursing students learn how to care for a person with dementia?

2.2.2. Briefing information

While early publications do not specify that briefing information should be given to the participants prior to the nominal group technique (Horton, 1980; Van de Ven and Delbecq, 1972) some authors defend this as a valid option (Humphrey-Murto et al., 2016), although the potential for bias among participants has also been acknowledged (Humphrey-Murto et al., 2017). In this study, participants did not receive any briefing information prior to the face-to-face meeting and data collection relied solely on their expert opinion.

2.3. Participants

Given that the main topic was the essence of caring for a person with dementia and nursing education, we ensured that different nursing roles were sufficiently represented among the participants. Additionally, other health and social care professionals, a recently graduated nurse and relatives of people with dementia were also included. Although irreconcilable differences among the participants might emerge during the meeting (Humphrey-Murto et al., 2016), heterogeneous groups are likely to express more varied and creative suggestions (Waggoner et al., 2016). According to the most appropriate size and characteristics for a nominal group technique group (Humphrey-Murto et al., 2016; Waggoner et al., 2016), this study included nine people whose personal or professional experience, expertise and perceptions related directly to the topic in question.

With regards to the definition of an expert, some authors favor a broader perspective and declare that expertise in a topic is not a prerequisite for participation in a nominal group technique (Kirk et al., 2013). Other authors set a minimum of 3 years of practice experience within a field or as a clinical preceptor (Rossler et al., 2021) or even 5 years (Montejano-Lozoya et al., 2019). For the purpose of this study, we included participants with at least 5 years of expertise from any of the following two groups: 1) health/social care professionals and relatives who had cared for people with dementia and 2) nurse educators who had lectured in geriatric nursing in Higher Education. Finally, we ensured data-input from multiple references (Van de Ven and Delbecq, 1972), by including a recently graduated nurse as she would be able to provide the best insight into the nursing education she had recently received and how well it met the needs of people with dementia.

The strict inclusion criteria reduced the possible candidates for this study. For this reason, participants 2, 4, 6 and 7 had briefly been acquainted with the one researcher in this study who specializes in

Geriatric Nursing.

2.4. Organizing the nominal group technique

We set two meeting dates and contacted all the possible candidates a month before those dates, either by phone or email. Our main priority was their willingness to participate in the nominal group technique (Fink et al., 1984; Humphrey-Murto et al., 2016). After the first round of contacts, two declined to participate and the first date was agreed with all the other candidates. Two weeks before the nominal group technique date, all the participants received an email from the main researcher containing all the relevant information on the arrangements for the meeting, terms of their participation and use for the generated data, the requirement for confidentiality and institutional review board approval.

2.5. Implementation of the nominal group technique

We carried out a nominal group technique involving a 2-h meeting on November 23rd, 2021. The meeting room comfortably accommodated all nine participants, the facilitator and two observers (researchers), given the safety measures required due to COVID-19. The participants were seated in a U, with a large white board at the open end in full view. There was a folder on each seat (containing the information sheet, schedule for the day and separate sheets for each question), a pen, two unmarked envelopes (containing 5 cards in each), a stand for each participant's number, a small bottle of water and a recyclable cup. We maintained participant anonymity by identifying each work space with the word "Participant" followed by a number from 1 to 9. Before the start of the technique, the researcher who led the meeting reminded the participants about all the key aspects they had previously been informed of via email.

Each stage took place as described in Table 1. In stage one, participants had 2–3 min to answer each of the nominal questions. During the round-robin stage, the facilitator wrote all the answers on the whiteboard using the participants' exact words. Once all the answers to both questions had been listed, participants engaged in a discussion to clarify or debate all the listed items one at a time, avoiding judgment and criticism. Following this, participants took a preliminary vote using the cards in the envelopes (cards for each question were placed in separate envelopes). Participants chose five items from each list, listing the top five priority items in their opinion and wrote each item on a card. They then ranked these items by allocating numbers 1 (lowest priority) up to 5 (highest priority). Once the participants had put their votes back in the envelope, they took a break while the facilitator and observers looked at the votes, calculated a provisional group ranking and placed the votes back in the original envelopes. When the break ended, stage 5 of the technique was started, where the overall ranking was announced to the group and participants had the chance to discuss the results further. As a result of this discussion, if any participants wished to change their previous ranking, they had the chance to do so. In stage 6, the participants reviewed their items and placed their final votes in the envelopes. Once all the steps had concluded, the facilitator thanked everyone for participating in the meeting and reassured them they would receive an email with the final ranking and the chance to make further observations known to the research team or change their vote outside of the face-to-face stage of the technique. This email was sent a week after the meeting and three participants replied to it but none changed their original vote.

2.6. Data collection

We collected data from stages 2–6 of the technique (information written during the meeting on the white board, ranking on the flip chart) as well as written notes from the observers.

2.7. Data analysis

Following data collection, two authors (SC, MA) independently reviewed all the data sources. We ensured collation of discussed items and their individual scoring through an iterative process. A complete list of items emerged from stage 2. The preliminary ranking was announced after stages 3 and 4. Second-round scores were obtained after stage 6. Final-round scores were completed a week after the meeting, once participants had gathered their thoughts. Individual item scores were added up after each round, which produced a final list of items in descending rank order. This process allowed researchers to obtain the top five items which the group had agreed on.

2.8. Validity and reliability

In our study, we ensured a purposeful selection of participants to improve the chance of representativeness (Cooper et al., 2020). Similarly to other consensus groups on nursing education (Kirk et al., 2013; Rossler et al., 2021), the nominal group in our study comprised health and social care professionals from all branches (research, teaching, clinical, management) and relatives. Moreover, given the diversity of backgrounds, the facilitator prevented any one participant dominating the group (Humphrey-Murto et al., 2016) by ensuring equal participation.

In terms of consensus, ranking the top five items obtained during the discussion phase is practical and common in the literature (Cooper et al., 2020). In our study, we identified the top five items for each question by adding up the individual scores for each item. As a final consideration, Humphrey-Murto et al. (2016, 2017) highlighted that iteration and feedback are essential during the consensus process. Our study ensured these features at two different points: at the end of the meeting and a week later. Both times, participants had the chance to view the results of the consensus group in writing and assess them. Moreover, they had the chance to comment further or even change their vote as they wished.

2.9. Ethical considerations

Attendance to and participation in the meeting was acknowledged as participants' consent in this study. Besides, the Head of the Nursing School where the meeting was held had agreed in writing to the terms and data collection for this study. Participants received no incentive (economic or otherwise) before or after attending. Moreover, the facilitator preserved anonymity by not declaring any of the participants' names or backgrounds and by using unmarked envelopes during polling. Finally, participants were reminded that their participation was voluntary at the beginning of the meeting. This research is part of a larger project, which has been approved by the Institutional Review Board (M10_2021_310).

3. Results

3.1. Participants

Nine participants attended the meeting (five females and four males). Two participants were caregivers, one was a social worker, one was a geriatrician and five were nurses.

The combined areas of expertise of the seven health/social care professionals who attended included six with clinical experience in caring for people with dementia, four with a teaching background as lecturers or clinical placement mentors, two were managers in care services for people living with dementia and one had a long-term research career in geriatrics (Table 2).

Table 2
Composition and characteristics of the participants in the NGT.

Profile	Reasons for inclusion in the group	Area of expertise	Years of expertise
1 Nurse	Manager at a psychogeriatric day centre	Management	6
	Staff nurse in various nursing homes/services	Clinical	13
	Mentor for nursing students on placement in psychogeriatric day centre	Teaching	6
2 Nurse	Director of a psychogeriatric nursing home	Management	29
	Former nurse in a nursing home	Clinical	7
	Mentor for nursing students on placement in psychogeriatric units	Teaching	4
3 Nurse	Staff nurse in a nursing home	Clinical	19
	University lecturer (subject: Geriatric Nursing)	Teaching	4
4 Nurse	University lecturer (subject: Geriatric Nursing)	Teaching	5
	Mentor for nursing students on placement in nursing homes		
5 Nurse	Staff nurse in a nursing home	Clinical	1
6 Doctor	Geriatrician at a nursing home	Clinical	30
	Researcher in geriatrics	Research	32
7 Social worker	Social worker for an association for Alzheimer's and other dementias	Clinical	30
8 Relative	Caregiver for spouse who lived with dementia	Caregiver	>10
9 Relative	Caregiver for parent who lives with dementia	Caregiver	>10

3.2. Knowledge and skills that student nurses require to care for a person with dementia

The first of the nominal questions at the meeting aimed to explore what knowledge and skills nursing students should have to be able to care for a person with dementia. Out of the nineteen items discussed, participants voted for and ranked seventeen items as shown in Table 3.

The top five items ranked in descending order were, first, academic training including knowledge on types, causes, symptoms, progression of the disease and non-pharmacological approach to dementia. Secondly, communication which according to participants was a way not only to relate but also to get closer to the other person. Thirdly, early diagnosis of dementia was mentioned as an opportunity to support the family as they accepted the diagnosis as well as a chance to set up an

Table 3
Responses to the first nominal question: ranking of final responses (highest to lowest).

Items discussed	Ranking score
Academic training	33
Communication	16
Early diagnosis	15
Comprehensive assessment	14
Family as the support system	9
Ethics & rights	9
Behavioural management	7
Individuality of the person	7
Individuality of the symptoms	5
Empathy	5
Daily activities	4
Observational skills	3
Teamwork	2
Support for the family	2
Preventative measures	2
Socioeconomical consequences	1
Impact upon caregiver	1

early care plan and follow up for both the person with dementia and their family. Participants ranked comprehensive assessment in fourth place, meaning the ability to assess both people who live with dementia and their family. In fifth place, two items were scored as equally relevant: family as the support system and ethics and rights. Concerning ethics, several participants argued that it comprised topics like legal rights, self-determination and respectful behavior towards people with dementia.

3.3. Teaching strategies during university training

The second nominal question explored different strategies that could be implemented during university training for student nurses to learn how to care for a person with dementia. Among the items discussed, thirteen were voted for and ranked as shown in Table 4.

The top five items ranked were, firstly, clinical placements. Participants considered that a clinical placement in settings where people with dementia were cared for should be compulsory for all student nurses. Secondly, participants in the nominal group deemed real experiences necessary. Even if these took place outside the clinical setting, participants considered that student nurses could benefit greatly from getting together with people with dementia and/or their caregivers, that is, people who dealt with dementia first-hand on a daily basis. In third place, strategies for building teamwork were outlined, with particular emphasis on an interdisciplinary approach. In fourth place, participants thought that inviting non-profit organizations (such as associations) to the training was a suitable strategy for student nurses, so students can find out about their work and the support they provide to people with dementia and their family. Finally, distributing dementia education across the nursing curriculum was considered a relevant strategy to promote the students' learning process in dementia care.

4. Discussion

The aim of this study was to identify the priorities and reach a consensus on student nurses' learning requirements and best-suited teaching strategies in dementia care using the nominal group technique. This technique makes it possible to generate ideas, discuss and debate topics lacking consensus (Humphrey-Murto et al., 2017) and our study findings demonstrate that this methodology is useful on nursing education, since nominal group technique was effective in obtaining the necessary data to meet the proposed aim.

The results for the first nominal question reveal that our study participants agreed that student nurses require both knowledge and skills to care for a person with dementia. Recent scoping reviews have identified that the learning outcomes from educational programmes carried out with either healthcare programme undergraduates or just student nurses include dementia knowledge, attitudes, confidence, preparedness, empathy, self-confidence, self-efficacy, awareness and students'

Table 4
Responses to the second nominal question: ranking of final responses (highest to lowest).

Items discussed	Ranking score
Clinical placement	34
Real experiences	27
Teamwork	19
Collaboration with associations	13
Cross-curricular approach	11
Communication strategies	10
Students' observations (portfolio)	6
Simulation	5
Family education	3
Contact with different professionals	3
Visits to care centres	2
Meeting people with dementia (initial stage)	1
Clinical placements in primary healthcare	1

perceptions (Carriñanos-Ayala et al., 2022; Williams and Daley, 2021). However, in contrast to our findings, neither review refers to specific skills. Above all, participants in this study prioritized that student nurses' academic training should include knowledge of types of dementia, causes, symptoms, progression of the disease and non-pharmacological treatments. This finding does not surprise the authors, since Higher Education strategies in our context have been mainly theoretical (Michavila and Zamorano, 2007). Gerontological education in nearby countries also echoes this trend (Tavares et al., 2021). Although it has been suggested that lecture-based teaching helps students to understand theoretical concepts (Siew et al., 2021), some studies involving giving lectures on the abovementioned aspects of dementia (Kimzey et al., 2019, 2021; Long and Hale, 2022; Matsuda et al., 2018) have shown inconsistent results regarding knowledge acquisition. Although lecture-based learning has been prevalent in nursing education in the past and modest yet non-significant improvements in knowledge have been described for this approach on dementia education (Maharaj, 2017), it would appear that, in isolation, this is insufficient for undergraduate nurses to learn the complexity of caring for a person with dementia.

Our study also found that the second priority the nominal group agreed on was communication. Communication is paramount as it allows us to participate in society, share experiences and inform others about our needs and wishes. The neural loss that takes place with dementia, among other symptoms, leads to the progressive degradation of language, including difficulties in verbal expression, understanding, reading and writing (Banovic et al., 2018). Communication difficulties arise from the neurological damage to people living with dementia, but they could also be enhanced by the caregivers' failure to compensate for the other person's lost abilities. As a result, poor communication could affect quality of life and care (Downs and Collins, 2015). In a study by Zucca et al. (2022) 51.9 % of caregivers perceived communication conflicts with the patient as a moderate or serious problem. When it comes to nursing students, they also state that interacting with older adults with dementia is challenging (Long and White, 2019) and although several studies have addressed communication challenges within various educational programmes (Kimzey et al., 2019, 2021; Long and White, 2019; Mitchell et al., 2017; Webster and DiBartolo, 2014), none of them have measured communication skills as a learning outcome. Alushi et al. (2015) also reported similar findings. In contrast, some evidence suggests that working on nursing students' communication skills may help reduce the shock of caring for people with dementia (Hartung et al., 2020) and makes them feel more confident and less anxious about starting placements (Naughton et al., 2018). Bearing in mind that communication is central to person-centered care and high-quality dementia care (Downs and Collins, 2015), the findings from this study support that communication skills should be a core component of student nurses' training.

The following three items prioritized by the nominal group were early diagnosis, comprehensive assessment and family as the support system. Although participants discussed these items independently during the meeting, they all had the same supporting argument: caregivers' needs. We find that the combination of different health and social care professionals directly involved in caring or managing services for people with dementia and the inclusion of relatives in our nominal group produced multiple viewpoints on this one topic. Participants debated that an early (timely) diagnosis was key for family acceptance and to begin measures to support caregivers. By the time a diagnosis is made, caregivers might have been suspecting it for some time. However, the instant the dementia diagnosis is confirmed, the caregiver receives an unexpected and demanding role, usually accompanied by a huge emotional impact (Confederación Española de Alzheimer, 2017). The nominal group in our study debated that an early diagnosis was essential for professionals to support the family through all stages. It is essential that caregivers receive tailored information, especially during the early stages of dementia (Bressan et al., 2020). Conversely, Zucca et al. (2022)

reported that the most frequently (31,5 %) unmet need expressed by dementia caregivers was "counseling and emotional support". They also reported that very often the only emotional support came from other family members, which was described as counterproductive. Timely diagnosis could help to initiate long-term care pathways required throughout the entire course of the disease and until the end of life and also facilitate the response to physical, psychological, social and spiritual demands (Confederación Española de Alzheimer, 2017; World Health Organization, 2017), although unfortunately these pathways are often fragmented or absent (World Health Organization, 2017).

Our study participants agreed that a comprehensive assessment should consider both the needs of the person with dementia and the needs of the family caregivers. The progressive and debilitating nature of dementia means that caregivers face a wide range of issues requiring continuous adjustments (Bressan et al., 2020) and accurate assessment of their needs. In a cross-sectional study carried out in Germany with caregivers and community-dwelling people with mild to moderate dementia, 75.7 % of caregivers had at least one unmet need and the higher the number of unmet needs, the greater the risk of caregiver burden and healthcare costs (Zwingmann et al., 2019). In terms of specific caregivers' needs, a scoping review by Queluz et al. (2020) identified the most frequently reported domains were emotional health (58 %), formal/informal help (55 %) and information about dementia and dementia care (52 %). Therefore, some evidence supports the finding in our study since assessing the needs of those caring for people with dementia is an important step for planning health and social services (Queluz et al., 2020; Zwingmann et al., 2019). However, serious challenges surround this topic. On the one hand, it is still not fully understood how caregivers' needs change through the different stages of the disease (Bressan et al., 2020; Queluz et al., 2020) and, on the other hand, there is lack of evidence-based, specific tools to assess caregivers' needs (Queluz et al., 2020; Zucca et al., 2022).

In addition, recognizing the family as the support system for people with dementia was highly relevant for the nominal group. When people with dementia have had the chance to express their preferences, family involvement was ranked highly, in first (Denning et al., 2013) and second places (Mulqueen and Coffey, 2017). Besides, the caregiving family is the main axis around which care for the person with dementia revolves. Families sacrifice a great deal during the time they spend caring for their loved ones and their role as caregivers needs to be valued and recognized by others (Confederación Española de Alzheimer, 2017). A lot is expected of the family and healthcare professionals need to provide timely, tailored care for them as well (Bressan et al., 2020). They are involved in direct care and support of people with dementia, they are aware of their wishes and preferences and they can make an essential contribution to individualized care plans (World Health Organization, 2017). Therefore, allowing families to participate in care planning and provision alongside health and social care professionals may support the preferences of those living with dementia as well as adding to caregivers' deserved value.

Finally, the last item prioritized in the first question concerned ethical aspects of dementia care. As the cognitive symptoms of dementia become more severe, autonomy and decision-making capacity are lost (Smebye et al., 2016) leading to many ethical dilemmas, including communicating the diagnosis, disclosure of information, patient involvement in decision-making, capacity assessment, symptom and behavioral management and therapeutic lying (Chiong et al., 2021; Hughes and Common, 2015). Consequently, people living with dementia are more vulnerable to care omissions, abuse and neglect (Evripidou et al., 2019) and their human rights are often denied (World Health Organization, 2017). Chiong et al. (2021) state that advance care planning (ACP) facilitates decision-making in concordance with patient and their surrogate's, values and preferences. As a result, ACP can help to address ethical issues before they become dilemmas. While the nominal group in our study shared some personal experiences they considered to have breached the principle of beneficence, no specific

mention of ACP was raised during the discussion. This echoes the content gap in nursing education identified by Cariñanos-Ayala et al. (2022). Since ACP is crucial to preserve autonomy and reduce the burden on caregivers (Chiong et al., 2021), professionals should promote its implementation early on for every person diagnosed with dementia.

Before concluding this first section, it is worth mentioning that all the items discussed so far match four dementia nursing competencies proposed by Traynor et al. (2011), namely, understanding dementia, effective communication, ethical and person-centered care and responding to the needs of family caregivers.

In response to the second nominal question, participants discussed items related to teaching strategies, content of teaching and context of teaching. Many participants lacked expertise on teaching in Higher Education, which may explain why some of the items they discussed did not answer the question directly. The results showed a high level of agreement over experiential learning in dementia care as a suitable strategy for student nurses. Experiential learning highlights the relevance of experience for learning (Murray, 2018) and it has been found to be the most effective pedagogy to augment dementia care competence among nursing students (Adewuyi et al., 2022). In order of prioritization, the nominal group proposed clinical placement, real experiences, teamwork (ensuring interprofessional input) and collaboration with associations. However, careful consideration is required for each option. For instance, clinical placement assignment must guarantee safe and effective opportunities to interact with people in different stages of dementia (Long and Hale, 2022) and maintenance of professional behaviors and standards at the point of care (Skaalvik et al., 2010). Nursing homes should be considered as a suitable learning environment for students at different levels of their education (Gonella et al., 2019). Moreover, students need sufficient prior theory content to develop practical experience (Adewuyi et al., 2022) and to relate to the new experience to avoid increasing stigma and negative attitudes towards dementia (Jordan and Church, 2013; Mitchell et al., 2017). Although many options may fulfill the characteristics of experiential learning, nurse educators need to consider the time, resources and planning required as well as each strategy's challenges.

4.1. Limitations

First, due to the characteristics of participants in our study, it may not be possible to generalize results across different countries. Second, during the meeting, some participants may have been more prone to share their positions due to their great level of expertise, although the facilitator took every care to ensure they all had sufficient time to express their opinions and respected each other's interventions. Finally, some participants had been acquainted with one of the researchers before the beginning of this study. For this reason, bias to the results is possible, although every care was taken to reduce its impact.

5. Conclusions

This study identified the learning requirements and teaching strategies that stakeholders considered key to build student nurses' competence in dementia care. Although the cultural context of each country may differ, the complexity of caregivers' needs should not be overlooked. Besides, promoting opportunities where students can come into direct contact with people with dementia could be central to their learning. These findings may assist nursing educators to plan, design and deliver better education in dementia care for future professionals.

Funding sources

This research did not receive any specific grants from funding agencies in the public, commercial or not-for-profit sectors.

CRedit authorship contribution statement

Susana Cariñanos-Ayala: Conceptualization, Methodology, Investigation, Data curation, Writing – original draft, Visualization. **Jagoba Zarandona:** Conceptualization, Methodology, Investigation, Data curation, Writing – review & editing, Project administration. **Iván Durán-Sáenz:** Conceptualization, Methodology, Investigation, Writing – review & editing. **Marta Arrue:** Conceptualization, Methodology, Resources, Data curation, Writing – review & editing, Supervision.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.nepr.2023.103711.

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