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The quality of oncology nursing care: A cross sectional survey in three countries in Europe

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ABSTRACT

Purpose: The increase in patients diagnosed with and living with cancer calls for the provision of quality nursing care within this paradigm, one that can reflect the complex needs of the patient that cancer and its treatments induce. The study aimed to evaluate the quality of oncology nursing care, as perceived, by hospitalized cancer patients in three European countries.

Methods: This was a cross-sectional descriptive study. In-patients diagnosed with cancer were selected based on explicit inclusion and exclusion criteria. Data was collected with the Quality of Oncology Nursing Care Scale- QONCS, comprising of 34 items grouped in 5 domains. Sociodemographic data was also retrieved.

Results: The sample included 610 patients receiving care in 2 hospitals in Cyprus (n = 274), 1 hospital in Greece (n = 144) and 2 hospitals in the Czech Republic (n = 192). Statistically significant differences were found between the three countries and across all domains of the QONCS, with the exception of the spiritual and religious care (p = 0.136). Age and days of treatment produced statistically significant differences across all the domains of the QONCS, whilst gender did not produced any statistically significant differences (p ranged from (0.136–0.369).

Conclusion: This is one of the first studies that provide evidence on the Quality of Nursing Care delivered to patients diagnosed with cancer in various European countries. Discrepancies were found between the participating countries. However, the provision of spiritual and religious care by the nurses received the lowest scores across the three participating countries.

1. Introduction

Cancer has become one of the most common diseases worldwide and the second leading cause of death. The International Agency for Research on Cancer (IARC) reported 3.71 million new cases and 1.93 million deaths from cancer in Europe in 2012 (IARC, 2016). Within these figures, the 28 member states of the European Union (E.U) accounted for nearly 2.63 million new cases (54% men, 46% women) and over 1.28 million cancer deaths (OECD/EU, 2014). The projections for the next decade estimate that the number of people who will be touched by cancer will increase, which means that more people will require specialised and person-centred care throughout their cancer trajectory. Cancer and its treatment can be lengthy and demanding, and subsequently can have a profound impact on the person diagnosed with cancer. Therefore, quality cancer care becomes of paramount importance and it is something both expected and demanded by the patient (Radwin, 2000) but at the same time promised by the healthcare providers (Ferrell et al., 2013; Charalambous et al., 2014).

The quality of nursing care has received some attention in the literature but not exhaustively for patients diagnosed with and living with cancer (Radwin, 2000; Charalambous and Adamakidou, 2014; Williams, 1998). This can partly be attributed to the fact that a clear definition of quality nursing care is not available or widely

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acceptable (Charalambous et al., 2009; Izumi et al., 2010); the complexity of cancer care that needs to be reflected on the definition and the fact that the quality nursing care can be influenced by other variables such as the extent to which the patient's expectations are met by the care provider (Redman and Lynn, 2005) or patients' demographic, type and stage of cancer (Redman and Lynn, 2005; Mitchell et al., 1998; Radwin and Alster, 2002).

Two definitions however, re-framed the parameters of quality nursing care within the cancer care paradigm. Firstly, Radwin (2000) defined quality of nursing care as the patient's subjective perception of the degree of excellence of nursing care. Secondly, Charalambous et al. (Charalambous et al., 2009, 2008) developed a conceptual framework of Quality of Oncology Nursing Care which identifies six fundamental areas that comprise the quality of nursing care: being valued, being respected, being cared for by communicative and supportive nurses, being confirmed, being cared for religiously and spiritually and sense of belonging.

With the burden of cancer increasing in terms of people affected, resources spent for care - as well as the burden on family caregivers - the European Commission stressed the need for a uniformal provision of quality care across members states (Directive, 2011/24/EU, European Union, 2011). The aim is not only to achieve quality care for the patients, but most importantly, to allow and facilitate cross-border care in the member states. This will allow the mobility of patients diagnosed with cancer to seek treatment and overall care of the highest quality in a country other than their own.

The aim of this study was to evaluate the quality of cancer nursing care in Cyprus, Greece and the Czech Republic, three countries with rather distinct healthcare systems, as these are described below. The study was guided by the following research questions:

1. What is the level of Quality Nursing Care in cancer care settings in the three countries?
2. Are there any differences (i.e problematic areas) in Quality Nursing Care among the three countries in terms of the 5 domains?
3. What is the influence of the demographic and illness characteristics on Quality Nursing Care in the three countries?

1.1. Greece

The Greek Health Care System can be characterised as a mixed system: the health care branches of the various social insurance funds co-exist with the National Health System comprising elements from both the public and private sectors, and incorporate the principles of different organizational patterns. Access to the services is mainly based on citizenship as well as on occupational status. There are three primary ways from which the health care system is financed. These include the state budget, social insurance contributions and private payments. The largest share of health expenditure constitutes private expenditure, mainly in the form of out of pocket payments which is also the element contributing the most to the overall increase in health expenditure (Economou, 2010).

1.2. Czech Republic

The Czech statutory health insurance system is based on universal coverage and a basic universal benefit package provided as benefits-in-kind for all insured individuals. Unlike the Greek and Cypriot healthcare systems, universal accessibility of health care is stipulated by the legislation, particularly the law on public health insurance. The financial support of the system mainly derives through mandatory, wage-based statutory health insurance contributions administered by the health insurance funds. Other sources of financing include general taxation and out-of-pocket payments (Kinkorova and Topolcan, 2012; Alexa et al., 2015).

1.3. Cyprus

The health system consists of two parallel delivery systems: a public and a private one presenting a few similarities to the Greek one. The public system is exclusively financed by the state budget, with services being directly controlled by the Ministry of Health. The private system is financed by out-of-pocket payments and to some degree by private health insurance schemes. Other minor health care delivery sub-systems include: the Workers' Union schemes, which mostly provide primary care services, and the schemes offered by semi-state organizations. The former mostly have their own network of providers, while the latter uses private providers (Theodorou et al., 2012).

2. Methods

2.1. Sample and settings

Participants for this cross-sectional survey study were selected based on explicit inclusion and exclusion criteria. The recruitment process period was six months and was undertaken by research associates in collaboration with the nurse managers. Sample size was determined with NQuery. The power calculation required a minimum of 140 completed questionnaires to be collected from each of the three countries to allow for comparisons where $a = 0.01$ and the power is 90%. Patients were included if they met the following criteria: a histopathological diagnosis of cancer, were 18 years or older, were on active treatment and were receiving care at the hospital as inpatients. Participants should also have a score of >50 on the Karnofsky Performance Scale Index. Patients were excluded if they were receiving palliative care or they had an impaired cognitive ability.

The study group comprised of 610 patients receiving care in 2 hospitals in Cyprus (n = 274, Response Rate 65%), 1 hospital in Greece (n = 144, Response Rate 59%) and 2 hospitals in the Czech Republic (n = 192, Response Rate 68%). The study group consisted of adult patients diagnosed with various types of cancer receiving inpatient care.

2.2. Data collection

Data collection was completed in 2016 and the data was retrieved using the Quality of Oncology Nursing Care Scale – QONCS (Charalambous and Adamakidou, 2014) and a sociodemographic data questionnaire. The QONCS contained 34 items grouped into five domains as follows: Being supported and confirmed (16 items), Being cared for religiously and spiritually (6 items), Sense of belonging (5 items), Being valued (4 items) and Being respected (3 items). All questions are assessed on a 5-point Likert Scale: 1 (completely disagree), 2 (disagree), 3 (neither agree nor disagree), 4 (agree), 5 (completely agree) with higher mean scores indicating better quality nursing care. The QONCS was previously validated in both Greece and Cyprus with an overall Cronbach alpha 0.95 for the entire scale (Charalambous and Adamakidou, 2014).

The Czech version of the QONCS scale was constructed for use in the Czech Republic based on the principles of the Brislin model for instrument translation (Brislin, 1970; Jones et al., 2001). The scale was first translated by a professional translator into Czech language

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