



HEALTH CARE PROFESSIONALS' PERCEPTIONS OF PALLIATIVE CARE QUALITY IN A COMBINED ACUTE ONCOLOGY-PALLIATIVE CARE UNIT

Improvements are Needed Regarding Information, Participation, Continuity and Existential Needs

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Background

The number of persons with life-threatening illnesses who need palliative care (PC) is expected to increase as people are living longer, due to advances in medical treatment and technology. There are major shortcomings in PC and regional differences in accessibility, quality, symptom relief, involvement and support for close relatives. Evaluation of quality of care (QoC) is important to guide improvements and the use of healthcare professionals' (HCP) perspective means that fragile patients and their close relatives are not burdened.

Aim

To investigate perceptions of HCPs working in a combined oncology-palliative care unit and specialists palliative home care teams, regarding quality of the care received by the patients (perceived reality-PR) (given care) and how important care was to patients (subjective importance - SI). A further aim was to describe differences between PR and SI.

Method

Cross-sectional study, descriptive and analytical design. Data collection, February 2018 with the four dimensional questionnaire Quality from the Patient's Perspective Palliative Care (QPP-PC) among HCP in a combined oncology-palliative care unit (total survey) in Sweden. Response rate of 53 % (n=41). In this study, high scores (≥ 3.50) and low scores (<3.00). The study was approved by the Research Ethic committee at Karlstad University (DNR no. C2018/131).

Table 1. Participants' characteristics (n=41).

Age,		Work experiences health care (year)	
Mean (SD)	44.3 (14.4)	Median	21.5
Median (year)	50	Range	1-46
Range	22-65	Mean (SD)	20.3 (15.4)
Sex, n (%)		<1 year	0
Men	8 (19.5)	1-5	13
Women	33 (80.5)	>5	28
Profession, n (%)		Work experiences palliative care (year)	
Assistant nurses	6 (15)	Median	6
Registered nurses	28 (68)	Range year	<1-30
Physician	7 (17)	Mean (SD)	8.0 (7.8)
Academic degree, n (%)		<1 year	n (%)
Candidate	26 (63)	1-5	17 (41.5)
Master	4 (10)	>5	20 (48.2)
No academic degree	8 (20)		
No answer	3 (7)		
Employed, n (%)			
Full time (100)	32 (78)		
Part time (40-96)	9 (22)		

Results

HCP scored statistically significant higher regarding SI compared to PR (p <.001) in all four dimension; medical-technical competence, physical-technical conditions, identity-oriented approach and sociocultural atmosphere.

Information (p<.001), participation (p< .001), continuity (p<.001), planning and cooperation (p<.001) together with exhaustion (p<.001) and spiritual/existential needs (p<.001) were factors respondents scored lowest values in PR compared to SI. SI scores were all high except for exhaustion and continuity. Cronbach's α-values, moderate to high.

Table 2. HCPs' perceptions of care quality regarding given care (PR) and how important (SI) each aspect of care was to the patients by dimension and factors, and significant differences between PR and SI.

Dimensions & factors	Perceived Reality Mean (SD)	Subjective Importance Mean (SD)	n	p-value
Medical-technical competence	3.00(.53)	3.58 (.36)	37	<.001
Symptom relief	3.10 (.52)	3.68 (.30)	39	<.001
Exhaustion	2.62 (.75)	3.19 (.77)	37	.002
Physical-technical conditions	3.04 (.58)	3.67 (.35)	36	<.001
Access to help, food and equipment	3.04 (.58)	3.67 (.35)	36	<.001
Identity-oriented approach	3.07 (.50)	3.73 (.28)	31	<.001
Information	2.78 (.57)	3.66 (.34)	39	<.001
Honesty	3.21 (.62)	3.80 (.39)	32	<.001
Respect and empathy	3.34 (.51)	3.78 (.30)	32	<.001
Participation	2.84 (.70)	3.56 (.49)	38	<.001
Socio-cultural atmosphere	2.94 (.49)	3.59 (.39)	30	<.001
Meaningfulness	3.30 (.62)	3.68 (.46)	33	.001
Spiritual and existential	2.73 (.64)	3.55 (.62)	33	<.001
Patients relatives and friends	3.26 (.60)	3.67 (.46)	39	.001
Continuity	2.61 (.74)	3.34 (.59)	38	<.001
Planning and cooperation	2.93 (.50)	3.61 (.40)	37	<.001

Wilcoxon signed rank test. The statistical significant level was assumed at the p<.025. Response scale 4-point Likert-type scale, ranging from 1 (do not agree at all) to 4 (fully agree), was used for the PR and SI scales: 1 (of little or no importance) to 4 (of the very highest importance).

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Conclusions

These findings highlight palliative QoC problems in units with mixed care focus, i.e. acute, supportive and end of life care. Strategies to ensure PC when needed has to be developed and implemented in acute care settings to avoid futile interventions. Implementation of the 6S person centered care model could be a solution to develop the quality and improve continuity, information, and participation, three important factors in person centered palliative care. No conflict of interest.

