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Patient Evaluation of Nursing Care: A Danish Cross-Sectional Study

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ABSTRACT

Background: To perform patient-centered care and improve the quality of nursing care, patient's perspectives on the nursing care provided is essential. Systematic use of patient reported data has shown to be a potential method to gain knowledge about patient's experiences of the care delivered. The aim of this study was to investigate patient's assessment and experiences of nursing care during their hospital stay and thereby identify areas in need of improvement.

Methods: The study was a cross-sectional patient survey in May-June 2021 at a Danish University Hospital using a Danish translation of the 10-item Consultation and Relational Empathy (CARE) Measure. The CARE scores ranges from 1-5. The patients also had the option of adding free text comments. Quantitative data was analysed using descriptive statistics, qualitative data using content analysis.

Results: A total of 2,151 patients representing 23 departments responded. Hereof, 56% were women, and the mean age was 58.5 years of age. For the 10 items of the CARE measurement, participants assessed the care provided as very good (30%-35%) or excellent (52%-63%). In total, the median score for each item was 5 (Interquartile range 4-5). At department level (n=23), median scores were 4-5 (Interquartile range 4-5). At unit level, larger differences in patient's assessments of nursing care were found with medians ranging from 3-5 (Interquartile range 2-5). Content analysis of free-text comments identified two main themes: "Professional care" and "Room for improvement".

Conclusion: The majority of patients assessed the nursing care they had received as very good or excellent within all 10 areas included in the CARE Measure instrument, and it was in free-text comments described as being due to both the nurses' professional and personal competences. Using patients' assessments of nursing care helps to understand and maintain areas of high quality and to identify areas in need of improvement.

Keywords: Empathy; Nursing care; Patient reported outcome measures; Survey; The CARE Measure

Abbreviations: PROMs: Patient Reported Outcomes Measures; PREMs: Patient-Reported Experiences Measures; CARE: Consultation and Relational Empathy; IQR: Interquartile Range; SDM: Shared Decision-Making; STROBE: Strengthening the Reporting of Observational studies in Epidemiology

INTRODUCTION

Providing care within a holistic approach and in accordance with the wishes and values of the individual patients is a cornerstone in nursing [1]. Likewise, continuous focus on improving the quality and coordination of care provided are important aspects of nursing care. However, healthcare professional's understanding of patient's values and health beliefs may not always be in accordance with the patient's actual values and beliefs [2,3]. Therefore, to focus quality works on areas within nursing care in need of improvement,

it is important to ask patients to help identify these areas. To achieve this, Patient Reported Outcomes Measures (PROMs) [4,5] and Patient-Reported Experiences Measures (PREMs) [6,7] are increasingly being used to enhance patient-centered care [8].

The fundamental characteristics of providing patient-centered care are patient involvement in care and individualized care [9]. To emphasize the individual approach with focus on the entirety of patient's needs, wishes, beliefs and preferences also beyond the clinical and medical issues, the term "person-centered" is now

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often used instead of “patient-centered” [10]. This is in accordance with studies that show that patients expect technical competences and knowledge from healthcare professionals, but they also highly prioritize healthcare professionals having a caring attitude, which includes empathy, communication skills and non-judgmental patient-centered care [11,12]. Healthcare professional’s empathy has been associated with positive outcomes for both patients and healthcare professionals [13]. For patients, empathy is among other things associated with greater satisfaction with care [14,15], and improved outcomes [16]. For healthcare professionals, empathy has been identified as a protective factor of burnout [17]. Likewise, physician-patient communication has been associated with patient satisfaction [18]. Therefore, when using patient reported measures to improve the care provided, it is important to include assessments of empathy, communication skills and patient-centered care. The challenge is however, according to a systematic review of Koy V et al. that many essential instruments developed to measure nursing care quality have serious methodological flaws, and consensus about how to measure nursing quality care is lacking [19]. Moreover, measuring the outcomes of nursing care is often related to nurse staffing ratio, level of education and job satisfaction and patient mortality, nosocomial infections, falls and pressure ulcer [20]. Accordingly, current research literature focusses on ‘missed nursing care’ due to lack of resources in the health care system (e.g. low nurse staffing level, time scarcity) [21]. However, a caring empathic attitude of the nurses is of pivotal importance when providing high quality care [22,23], but research on how hospitalized patients perceive the attitude of nurses is, according to our knowledge, sparse.

One of the instruments developed to capture caring attitudes is the Consultation and Relational Empathy (CARE) measure, which is based on a broad definition of empathy in context of a therapeutic relationship within consultations. The aim of this instrument is to produce a holistic, patient-centered measure that is meaningful to patients, irrespective of their social class. The CARE measure consists of 10 items and is developed for patient’s assessment of specific consultations with doctors [24], and has also been tested for assessment of nursing care [25].

The aim of the study was to investigate patient’s assessment and experiences of nursing care with focus on empathy during their hospital stay and thereby identify areas in need of improvement.

MATERIALS AND METHODS

Design

The study employed a cross-sectional survey.

Data collection-questionnaire

To assess the nursing care, a Danish translation of the CARE measure questionnaire was applied [25]. The CARE measure was translated into Danish prior to this study and used in an unpublished study that asked oncology patients to assess the nursing care they received. In the current study, the instrument was used in two versions to evaluate nursing care. The first version was for patients who were assessing a single event, such as an outpatient clinic consultation, a surgery or a stay in the recovery unit. In this version, the overall question for the 10 items was asked in the past tense (“How good were the nurses at...”), as in the original CARE measure instrument. The second version was for patients admitted to a hospital ward, and as nursing care for this group was ongoing,

the question was in the present tense (“How good are the nurses at...”).

In addition to the 10 items, the participants were asked about their age and gender, and at the end of the questionnaire, they were given the opportunity to write free-text comments.

Participants

Participants included patients either admitted to or who had an outpatient appointment at a Danish university hospital. The survey was conducted in May and June 2021. Each unit (ward, outpatient clinic, etc.) received 50 questionnaires, and within the time period, each unit had 14 pre-planned days to participate. The units stopped including patients either when all 50 questionnaires were handed out or after the 14 days. Patients could only participate once, even if they were in contact with different units during the survey period. To minimise the risk of patients being asked more than once, wards and day surgery units conducted their surveys in the first two weeks; then, surgery/anesthesia units (assessed combined) and emergency departments conducted surveys over the next two weeks; and finally, recovery units and outpatient clinics had two weeks to conduct their surveys.

The survey was conducted during the COVID-19 pandemic, but at the time of the survey, only a few COVID-19 patients were admitted to the hospital. At the end of the study period, a national nursing strike began, and for some participating units, this meant that they only had one week to include patients in the study.

In each department, nurse specialists, quality improvement coordinators or the like were responsible for managing the survey and had the freedom to decide which inclusion method worked best in their units: either having one, a few or all unit nurses involved in recruiting patients in the survey.

Inclusion criteria were the ability to read and understand Danish and being of the age 18 years or above. The children’s department was excluded from the age criterion. Here, either the children themselves (if possible) or their parents could fill in the questionnaire. Exclusion criteria were a lack of mental capacity and dying patients.

The patients received a paper version of the questionnaire (an A4 page, printed professionally on thick paper with different blue colors) and an envelope to secure the anonymity of responses. When filled in, the sealed envelope was collected, and at the end of the survey period, all results were entered into a SurveyXact database.

After the completion of the study, all units received written reports: one with the overall results, one with the department results and various reports with the results for each individual unit to secure direct feedback to nurses from their “own” patients.

Data analysis

No sample size calculation was conducted, as 50 questionnaires per unit were pre-decided as the maximum. Quantitative responses were analyzed with descriptive statistics using the statistical software BE Stata 17.0. Results are presented as number and percentages for categorical data and as median and Interquartile Range (IQR) for ordinal and non-normal distributed continuous data. Additionally, the responses were scored in accordance with the CARE measure scoring system [21]. Each item received a score on a five point Likert Scale: “Poor”=1, “Fair”=2, “Good”=3, “Very good”=4 and “Excellent”=5. All 10 items were then added, giving

a maximum possible score of 50 and a minimum score of 10. Up to two "Not applicable" responses or missing values were allowable and were replaced with the average score for the remaining items. Questionnaires with more than two missing values or "Not applicable" responses were removed from the CARE measure score analysis [26]. Comparison between genders was analyzed using the Mann-Whitney U-test, and comparison between age groups (18-39/40-65/66-99 years of age) was analysed using the Kruskal-Wallis test. A p-value<0.05 was considered statistical significant. To examine the validity (how well the data measures what it is supposed to measure) of the CARE quantitative data, internal consistency between questions was analysed using Cronbach's Alpha. Qualitative data in the form of free-text comments were also entered in the SurveyXact database and analysed using manifest content analysis [27]. To get familiar with the data, the comments were read a number of times. Two of the authors (HIJ and MS) independently identified units of meaning and coded the comments, and then they together compared and discussed the codes, grouped the codes into categories and identified themes. The additional two authors subsequently approved the analyses and themes.

RESULTS

A total of 86 units received 50 questionnaires each. Due to organizational issues, three units withdrew from the study, leaving 83 participating units with the potential for 4,150 responses. The number of distributed questionnaires within the units ranged from 2 to 50, depending on eligible patients (i.e. very few at intensive care

units) and project management. Not all units had registered their numbers of distributed questionnaires, which precluded the overall response rate, but for the units where distributed questionnaires were registered, there was a median response rate of 93%, with a range of 68%-100%.

A total of 2,151 patients responded. The mean age was 58.5 years, and 56% were women. For the children's department, the mean age was 6.7 years, and 54% were girls. For filling in the questionnaire, 15% of the children filled it in themselves, 6% did so in collaboration with their parents, and the remaining were filled in by the parents.

As shown in Table 1, the majority of patients found the nursing care to be very good or excellent within all 10 areas included in the questionnaire. (1,7,10 showed in Table 1) was the item with the most "Does not apply" responses (Table 1). An overview of all responses can be found in Supplementary Material Table S1. No statistical significant differences in responses were found between genders and between age-groups. The question with the lowest p-values was 5. "Fully understanding your concerns" with men being less positive than women (p=0.06) and patients between 66-99 years of age being less positive than patients 18-39 years of age (p=0.11) (Supplementary Material Table S2a and S2b).

The median score for each item was 5 (IQR 4-5). At the department level (n=23), median scores were 4-5 (IQR 4-5). However, when looking at the results at the unit level (n=83), larger differences in patient's assessments of nursing care were found, with medians ranging from 3 to 5, 25 percentiles ranging from 2 to 5 and 75 ranging percentiles from 4 to 5 (Table 2).

Table 1: Overall responses on the CARE Measure instrument.

Questionnaires	Very good		Excellent	
	n	%	n	%
1. Making you feel at ease (Being friendly and warm towards you, treating you with respect; not cold or abrupt)	683	(32)	1,319	(63)
2. Letting you tell your "story" (Giving you time to fully describe your illness in your own words: not interrupting or diverting you)	740	(35)	1,151	(55)
3. Really listening (Paying close attention to what you were saying: not looking at the notes or computer, as you were talking)	688	(33)	1,279	(61)
4. Being interested in you as a whole person (Asking/knowing relevant details about your life, your situation: not treating you as "just a number")	660	(31)	1,242	(59)
5. Fully understanding your concerns (Communicating that he/she had actually understood your concerns: not overlooking or dismissing anything)	693	(33)	1,108	(53)
6. Showing care and compassion (Seeming genuinely concerned, connected with you on a human level: not being indifferent or "detached")	651	(31)	1,255	(60)
7. Being positive (Having a positive approach and a positive attitude: being honest but not negative about your problems)	659	(31)	1,294	(62)
8. Explaining things clearly (Fully answering your questions, explaining clearly, giving you adequate information: not being vague)	654	(31)	1,255	(60)
9. Helping you to take control (Exploring with you what you can do to improve your health yourself: encouraging rather than "lecturing" you)	661	(32)	1,148	(55)
10. Making a plan of action with you (Discussing the options, involving you in decisions as much as you want to be involved: not ignoring your views)	620	(30)	1,092	(52)

Table 2: CARE Measure results at unit level (n=83).

Questionnaires	Lowest Median	Highest Median	Lowest 25% Percentile	Highest 25% Percentile	Lowest 75% Percentile	Highest 75% Percentile
1. Making you feel at ease	4	5	3	5	4	5
2. Letting you tell your "story"	3	5	3	5	4	5
3. Really listening	3	5	3	5	4	5
4. Being interested in you as a whole person	3.5	5	2	5	4	5
5. Fully understanding your concerns	3	5	3	5	4	5
6. Showing care and compassion	3	5	3	5	4	5
7. Being positive	3.5	5	3	5	4	5
8. Explaining things clearly	4	5	3	5	4	5
9. Helping you to take control	3	5	3	5	4	5
10. Making a plan of action with you	3.5	5	3	5	4	5

Note: All items scored from Poor=1 to Excellent=5.

CARE measure score

A total of 75 participants (representing a number of different units) had more than two missing or "Not applicable" items and were excluded from the CARE measure score analysis. For participants with two or fewer missing pieces of data or not applicable responses, responses were replaced with the average score for the remaining items according to scoring guidelines. The overall median score was 47, with a range of 11 to 50 (IQR 40-50). At the individual unit level, the median scores ranged from 35 to 50.

Internal consistency

Good reliability was found with Cronbach's Alpha values ranging from 0.77 to 0.88 (Supplementary Material Table S3).

Free-text comments

In total, 529 participants had added free-text comments. Content analysis of the comments identified two main themes: "Professional care" and "Room for improvement".

Professional care: Most of the comments were short and positive. By using words as professional, positive, kindly, helpful, caring, listening, human, engaged, respectful, understanding, empathic, competent, and patient, the personal as well as professional qualifications of the nurses were emphasized and appreciated by the patients. The assessment of the provided care being excellent was in particular described as the nurse's ability to provide individualized care, seeing the individual patient: One wrote "Have in all ways been respected, heard and seen" and another "I often come to the department, and I really have a feeling of being remembered and thereby being a patient and not just a number".

Many of the comments included both an assessment of the professional standard of the nursing care and of the nurse's human qualities. One wrote "I felt so safe and comfortable. They were very professional, but also very human". One patient described how some nurses, who tried to solve a technical equipment, were really friendly, helpful and caring, but were not able to solve the problem, whereas the night nurse quickly fixed it. And the patient commented that being kind is not enough; it needs to be combined

with a high professional standard of care. In fact, it appeared that the combination of professional standard of care and the human qualities made patients feel very safe and calm.

Room for improvement: A small amount of the participants who provided free-text comments (app. 10%) wrote less positive comments which touched on a number of different issues, not all being connected with nursing (e.g. waiting time, low quality of food). Some of the main nursing issues where the patients expressed a need of improvement were lack of continuity and involvement in decisions about care difficulties getting in contact with a nurse because of busyness, and being "talked over the head". Busy and stressed nurses was described as very uncomfortable because it was associated with risk of errors and left patients on their own: "I had to do everything on my own". Another wrote: "There is a lack of help to get all the way around the patient in relation to diet, sleep, exercise, dietary supplements, alternative treatments etc.", i.e. a need to 'hold the patient more in the hand'. Some of the patients also described that they had experienced different levels of the quality of nursing care depending on the individual nurses. One wrote: "I have a good nurse today. But normally, I am just the '13:20' patient, and I don't find that the nurses are engaged". Other important issues were lack of information and lack of involvement: "Have not been asked about my wishes or my point of view".

DISCUSSION

The majority of patients rated their nursing care as very good or exceptional across all 10 categories of the CARE Measure instrument. The free-text comments helped elucidate that many of the participants found the nursing care provided to be excellent, mainly because of the nurse's personal qualifications. The results at the unit level showed larger differences in patient's assessments of nursing care, and the free-text comments also provided knowledge of areas where there was room for improvement.

The two items with the highest excellent scores were "Making you feel at ease" and "Being positive". The majority of patients experienced that the nurses were able to find the balance of being friendly, caring, honest but also positive [17,28]. US writer Maya Angelou has said: "I've learned that people will forget what you said,

people will forget what you did, but people will never forget how you made them feel” [29]. Making patients feel at ease and being positive is, according to Galvin and Todre’s existential theory of well-being, a core direction in caring as it provides a sense of vitality [30], which is essential for patient’s recovery [31]. The high excellent scores related to these items also confirm that high quality nursing care from the patient’s perspective is related to competencies like positive and helping attitude, effective communication skills, and emotional and relational engagement [32]. In other words, high quality nursing includes both professional and personal skills [32,33].

The results from the current study are in line with normative CARE measure scores of nursing care [34]. Getting positive feedback on the care provided can motivate and boost the nurse’s confidence and help them understand and develop their skills [35]. Furthermore, getting qualitative comments help nurses understand the essential elements of high quality care. In this way, they can continue focusing on these qualifications and improve upon them [35]. However, the results also included a small group of patients assessing the nursing care as poor, fair or just good. This may be because individual nurses did not provide an excellent level of care or due to a lack of person-centered care. Factors that facilitate individualized patient care have been found to include cultural factors, nurse’s personal qualities, a shared understanding of nursing care goals and of what constitutes good practice, the level of staffing and skills, as well as effective leadership and management of facilitating and supporting person-centered care [36].

A review by Baines et al. found that feedback from patients has the best effect if it is specific, collected through credible methods and contains narrative information [37], all of which were fulfilled in the current study. Likewise, Baines et al. found that results should be provided in a way that promotes reflective discussions and behavior change [37]. By providing each unit with a report of the results, both quantitative and qualitative, from its “own” patients and with the possibility of benchmarking the results at the hospital level, the units could work locally on improvements in the identified areas.

The item “Making a plan of action with you” had the highest number of “Not applicable” responses, but also the lowest “Excellent” scores. Likewise, this was one of the issues described in the negative free-text comments. Shared Decision-Making (SDM) can be defined as “a systematic approach aimed at improving patient involvement in preference-sensitive health care decisions” [38], and the goal is to make decisions with patients instead of healthcare professionals making decisions on behalf of the patient [39]. However, even though SDM during the last decades has been gaining momentum in healthcare [40], implementing SDM in practice is challenging [39,41]. It takes leadership, organizational support, training, skills, communication, and local ownership [41-43]. The results from the present study suggest that most of the participating patients experienced that options were discussed with them, that their views were acknowledged, and that they were as involved in the decisions as they wanted to be. However, the results also show that this was not the case for all patients and this is an area that needs improvement.

The item “Fully understanding your concerns” had the second-lowest number of “Excellent” responses. To fully understand patient’s concerns and not overlook or dismiss anything, careful attention and a sense of the situation is a prerequisite but also a challenge for nurses [44]. Although “Fully understanding your

concerns” had the second-lowest number of “Excellent” responses, the results show that most of the participants experienced that their concerns were understood by the nurses. However, the results indicate that, for some patients, this was not the case and that improvement in this area may include balancing instrumental routine work and paying sensitive attention to the individual patient’s needs. Studies have shown that clinicians must aim to be sensitive to the power imbalance inherent in the clinician–patient relationship, as patients are often reluctant to assert their concerns in the presence of clinicians [45]. Recognizing this imbalance and helping patients express their concerns may be part of future improvements in nursing care. A lack of fully understanding patient’s concerns might be related to the less-positive comments in the free-text section, for example, “lack of help getting all the way around the patient in relation to diet, sleep, exercise, dietary supplements and alternative treatments”. This is not a surprising result. Feo et al. argue that fundamental care such as nutrition, hydration and mobilizations in nursing is frequently missed [46], and several studies have shown that getting guidance in how to use dietary supplements and alternative medicine is not an integrated part of daily hospital care [47].

The psychometric analyses showed good internal consistency, indicating that the CARE measure instrument unidimensional examines the concept of empathy.

The strengths of this study include the fact that almost all relevant hospital units were part of the study, an internationally validated questionnaire was used, and free-text comments were included to complement and add nuance to the quantitative responses.

The study also had a number of limitations. The units were asked to include all eligible patients consecutively to prevent selection bias of patients, but whether this was complied with was not registered. As responses were anonymous, it is not possible to ensure that patients responded only once. The study was conducted within the same institution and country, which may decrease the generalizability of the results. The CARE measure was developed for adults, and no adjustment was made for children’s use in this study. The Danish version of the CARE measure used in this study was from a previous study. However, the translation and instrument have not been validated in Danish. Likewise, the instrument was slightly altered (one version using the present tense instead of the original past tense) to accommodate its use for patients admitted to the hospitals.

CONCLUSION

Most patients rated their nursing care as very good or exceptional across all 10 categories of the CARE Measure instrument, and it was described as being due to both the nurse’s professional and personal competences. However, the results at the unit level show larger differences in patient’s assessments of nursing care, and using patient’s assessments of nursing care identified areas that needed improvement. The main areas in need of improvement were involvement in decisions and fully understanding the patients’ concerns. Both areas indicate that in order to provide high quality care, patients need to be involved and their individual concerns need to be identified, understood and adhered to.

ETHICAL APPROVAL

According to Danish legislation, the study did not need permission from The Regional Committees on Health Research Ethics, and

as all responses were anonymous, registration with the Danish Data Protection Agency was not necessary. Hospital management gave permission to conduct the study. The procedures used in this study adhere to the tenets for the Declaration of Helsinki. All patients were orally informed about the study, that it was voluntary to participate, and that all responses were anonymous. By filling in the questionnaire, the patients consented to participate. The study did not involve any risks to the patients. The study conforms to the Strengthening the Reporting of Observational studies in Epidemiology (STROBE) Statement-Checklist for reporting cross-sectional studies.

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