

University of Pardubice

Faculty of Health Studies



Proceedings of the 4th International Conference

**Quality and Its Perspectives, with the subtitle:
Assisting Professions through Time**

April 19, 2017

Pardubice, Czech Republic, EU

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Editorial:

In 2017, it is the fourth time that we have met at an international scientific conference organized by the University of Pardubice, Faculty of Health Studies. Each year, the conference examines issues related to the helping professions, from new angles. These professions include general nurses, midwives, and also other professions that focus on helping people. The theme of this year's conference covers topics related to changes in the helping professions with the passage of time. Without a doubt, the theme encompasses a number of aspects that can provide those of us who work in the helping professions with inspiration and can help us find the right direction and can help us tackle the challenges of today and tomorrow.

The story of a midwife from the 19th century – her work and experience as well as the fact that so many times, she was present at the birth of a new life – provides a view to the past and, at the same time, an inspiration for our current work. Therefore, the editorial of *The proceedings of 4th International Conference On Quality and Its Perspectives* provides a glimpse into her work and the past as well as into other issues arising in this context.

Without a doubt, it is important to realize that although it is not possible to stop progress in all areas of life around us, several other aspects of life and our work have not changed. The creation of a new life, together with the associated happiness but also uncertainty and worries, is an example of an event touched by progress, and at the same time, an event accompanied by emotions that have existed for centuries and that, we expect, will be felt by future generations as well. And so *The Assisting Professions through Time* – which is the subtitle of this conference – have a special duty: to use progress and modern conveniences to the benefit of those people who need their help, while respecting the fundamental principles of humanity, which is an important quality regardless of one's location in the world or the circumstances.

The proceedings contain those contributions presented at the conference that are related to the above themes: to the assisting professions through the ages, progress, and also to emotions of people around us, with the aim to offer them support and help, and by doing so, to contribute not only to the quality of care and provided services, but also to the betterment of their quality of life.

Petra Mandysová, editor

Pardubice, May 2017

Introduction:

Anna Vondráčková, the midwife from Choltice, and her diary (1879–1898): A contribution on the history of the oldest female profession

Milena Lenderová

Pregnancy, childbirth, puerperium, an introduction, as well as the obstetrician and the midwife as figures, have attracted the attention of historians primarily in connection with the cultural turn in historiography. In addition, since the 1990s, the subject has been brought to the area of interest of Czech historians. The organizational development of obstetrics and the institutional foundation of “midwifery courses” have been studied within the history of medicine and the history of medical faculties. It is undisputed that the midwife represents a certain social type and the changing demands on her knowledge provide proof of the professionalization of the society in the 19th century. Therefore, it is extremely legitimate to ask: “What was the midwife like during her work in the small East Bohemian town of Choltice in the last quarter of the 19th century?”

Mrs. Vondráčková’s diary, which she kept between 1879 and 1898, i.e. from the beginning but not until the end of her career, prevented her from being lost to history. It is known that she was born on May 4, 1842 and was the daughter of Jan Jans, a weaver and sexton in Turkovice. She attended a parish school there. At the age of 31, she married Prokop Vondráček, a Master Butcher, and gradually gave birth to three sons.

The Vondráčeks came to Choltice sometimes before the mid-1870s. At that time, Vondráčková graduated from a midwifery course in Prague. Subsequently, she attended births in and near Choltice for over forty years.

She started keeping her diary on February 9, 1879, right after the first birth that she attended; the diary covered the period from 1879 to 1898. Between 1879 and 1898, she performed a total of 605 interventions, of which 600 were deliveries or the provision of abortion care, another five interventions were not related to the midwifery profession or, because of the word formulation, their nature is unclear. Although the data in Vondráčková’s diary are sometimes inaccurate, they are extremely valuable. She recorded the date, the name of the woman in labour, her place of residence, and in most cases also whether the woman was giving birth for the first time or whether she had already given birth before. She noted the order of each birth in a given year, the exact time of the child’s birth, the child’s gender and position as well as any deviations from what was regarded as normal: instrument-assisted deliveries attended by physicians, births of twins, difficult births, and deaths of a child or a mother. She also recorded abortions (a total of seventeen) and births of twins (five times); none of the twins survived infancy. Twenty-three children probably died immediately after birth or were born dead. In addition, the diary reports – at least partially – on her earnings. The social composition of Anna Vondráčková’s clientele was varied. She attended births of children of unwed mothers, seasonal labourers, farm workers, housekeepers and peasants as well as of craftsmen, teachers, and officials. On two occasions, she even attended the births of little barons.

At the beginning of the new century, Mrs. Vondráčková was 59 years old. She did not relent in her work at all – fewer children were being born; therefore, she was called by families less often. Yet in 1908, she attended 25 births, and three years later, 23 births. She practiced midwifery, even though rarely, even after the Republic had been established – she attended

the births of the last two Czechoslovak citizens, both in the district of Choltice, in 1921; she was 79 years old. She died on November 17, 1933 in No. 14, probably in an alms-house due to old age; nonetheless, reportedly, her death was not expected. She was buried in Choltice.

The diary that she left behind enables us to learn about a time-bound section of everyday life from below and to understand how an ordinary midwife perceived her difficult profession, at an epoch when giving birth ceased to be a spontaneous transient ritual and was gradually becoming a matter of public authority and medicine.

Symptoms of Estrogen Deficiency and Quality of Life

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Abstract

Introduction: The quality of life of every individual is influenced by many different factors. For women in menopause, estrogen deficiency is undoubtedly one of these factors. Estrogen deficit leads to a series of symptoms, which may affect their quality of life to some extent. In the clinical practice, it is important to have a tool to assess the quality of life that is practical and is able not only to assess the quality of life.

Aim: The aim of the research was to determine whether and to what extent the symptoms of estrogen deficiency occur in women during menopause and how they affect their quality of life.

Method: The survey ran from July to October 2016 in a medical facility in Zlín. The research involved 284 women aged 45–60 years who suffered from the symptoms of estrogen deficiency. The incidence and severity of symptoms were assessed using the printed form of the Czech version of the Menopause Rating Scale questionnaire.

Results: The respondents reported mostly mild or no problems. Only a few of the respondents rated the intensity of some problems as intolerable. Total score points to the fact that most women have high quality of life.

Conclusion: Given that women currently spend up to one third of their life in the postmenopausal period, it is very important to deal with these symptoms and address them. If women suffer from estrogen deficiency symptoms, it is necessary to evaluate their intensity and impact for which the Menopause Rating Scale is a suitable tool.

Keywords: estrogen deficiency, menopause, Menopause Rating Scale, quality of life

Introduction

The climacteric is an inevitable period in every woman's life. It is a period of cessation of the reproductive functions and hormonal instability. This transitional period from woman's fertile age to the beginning of old age may be accompanied by a number of symptoms, invoked by a lack of female hormones – estrogens (Roztočil, 2011, p. 91).

Estrogens are fundamental for the morphology and function of woman's organism throughout her life. Therefore, in the climacteric period, when their production is rapidly decreasing and estrogen deficiency symptoms start to appear, women need to be given adequate care. The aggregate of acute symptoms caused by estrogen deficiency is called acute climacteric syndrome. Its most frequent symptoms include: hot flushes, mood swings, anxious conditions, depressions, irritation, tiredness and fatigue, feeling of loneliness, loss of libido, headache and sleeping disorders. The lack of estrogen may start to take the effect of other symptoms over time. Women may experience symptoms of urogenital atrophy: the vagina starts to lose elasticity and its epithelium thins away; paracolpium and pelvic floor muscles become weaker. Urogenital atrophy considerably worsens women's sexual life, which may also significantly reduce their quality of life. These unwanted symptoms are numerous and occur in a varying extent in every woman. Atrophy caused by estrogen deficiency may also take effect outside the woman's urogenital tract, e.g. on eye, nose and other mucosas. These

symptoms are collectively referred to as organic estrogen deficiency syndrome (Kolařík, Halaška & Feyereisl, 2011, s. 287–298). The most serious group of symptoms is the metabolic estrogen deficiency syndrome. It is a combined glucose and lipid metabolism disorder in genetically determined persons with visceral adiposity and adipose tissue dysfunction. Metabolic syndrome is manifested by osteoporosis, hypertension, inflammatory protrombotic condition and glucose intolerance. The occurrence of metabolic syndrome is supported by estrogen deficiency, android body habitus with weight gain and lack of physical activity. Later metabolic syndrome is better known as pre-coronary syndrome because it correlates with an increased risk of cardiovascular accidents including most frequently heart attack, stroke or sudden death (Donát, 2011, p. 726).

Estrogen deficiency symptoms may negatively impact woman's physical and mental health and reduce her quality of life. It is important to recognize that for most women, the quality of life is rather more important than its length. Fortunately, estrogen deficiency is a condition that may be positively influenced, to a certain extent, by timely and adequate care (Fait, 2013, p. 17).

Women suffering from estrogen deficiency symptoms are mostly encountered by general practitioners and local gynaecologists, sought after by women especially due to subjective complaints and clinical climacteric symptoms. Communication between the healthcare professional and the patient is of major importance and often represents a highly effective treatment method available to the physician or obstetrician/general nurse (especially for sensitive and vulnerable clients). The quality and intensity of the relationship between the client and healthcare personnel may significantly affect the treatment result. It has been repeatedly proven that a good communicative relationship to the medical staff is an indispensable part of quality healthcare. To a great extent, a client appraises the quality of healthcare based on how the healthcare personnel communicate with her, what information they share with her (in what manner, amount and quality), how much room she obtains for expressing her wishes, how she is accepted by the personnel and whether they support her dignity and confidence (Payne, 2005, p. 181). Apart from a consequent and high-standard communication and careful education, superior quality of care and increase of women's adherence are also supported by tools that can be used for evaluating the extent of impact on the women's lives but also the intensity of present acute or subacute estrogen deficiency symptoms. One of such tools is the specific Menopause Rating Scale (MRS) questionnaire, applied for evaluating the quality of women's lives in the period affected by menopause.

Objective

The objective of the research study was to use the printed form of the Czech version of Menopause Rating Scale tool to determine what estrogen deficiency symptoms were present in the sample of respondents (n = 284) and what their intensities are. Another objective was to determine to what extent the present estrogen deficiency symptoms affect the quality of respondents' lives. An additional objective was to ascertain how estrogen deficiency symptoms evolve over the time in a group of respondents (n = 20) by a repeated completing of the MRS questionnaire.

Methodology

The research study took place from July to October 2016 at a healthcare facility in Zlín. The respondents were 284 women, aged 45 to 60, with at least one acute or subacute estrogen

deficiency symptom. It was not taken into account whether or not the respondents were already undergoing any treatment related to estrogen deficiency symptoms. The data collection took place while the respondents were waiting for a visit at the obstetric-gynaecology ward. The respondents were educated by an obstetrician and after providing informed consent they filled in the printed form of the standardized Menopause Rating Scale questionnaire in the Czech version (Tab. 1).

A sample of respondents (n = 20) with the same characteristics and conditions as those described above for the basic group of respondents was used for repeated administration of the MRS questionnaire.

Tab. 1 The Czech version of MRS

Menopause Rating Scale (MRS)										
<i>Standard Czech version 1.0</i>										
Jméno a příjmení:					Věk:					
Vzdělání: základní - střední bez maturity - úplné střední - vyšší odborné - vysokoškolské										
Léčba: bez léčby - před léčbou - 1 měsíc - 3 měsíce - 12 měsíců					Dnešní datum:					
<p><i>Které z následujících příznaků (obtíží) se Vás za poslední měsíc týkají? Zakroužkujte, prosím, u každého typu obtíží míru intenzity, která odpovídá Vaší reálné situaci za poslední měsíc. Zhodnoňte, prosím, VŠECHNY níže napsané obtíže (nelze jakoukoli položku přeskočit nebo vynechat)! Jestliže Vás některý z příznaků v tuto chvíli netrápí, zakroužkujte u něj 0 (žádné obtíže). Pokud se rozhodnete během vyplňování dotazníku některou ze svých odpovědí změnit, původní odpověď přeškrtněte a zakroužkujte odpověď novou.</i></p>										
Intenzita obtíží										
	0	ŽÁDNÉ	1	MÍRNÉ	2	STŘEDNÍ	3	VÝRAZNÉ	4	NESNESITELNÉ
1		Návaly horka, pocení (občasné pocení)	0	1	2	3	4			
2		Srdeční obtíže (bušení srdce, nepravidelný rytmus, zrychlený tep, pocit tísně)	0	1	2	3	4			
3		Poruchy spánku (potíže s usínáním, předčasné probouzení, potíže s trváním spánku)	0	1	2	3	4			
4		Depresivní nálady (pocity smutku, plačtivost, nedostatek energie, proměnlivost nálad)	0	1	2	3	4			
5		Předrážděnost (nervozita, vnitřní tíseň, pocity agresivity)	0	1	2	3	4			
6		Úzkost (vnitřní roztěkanost, pocity paniky)	0	1	2	3	4			
7		Vyčerpání (pokles výkonnosti, výpadky paměti, pokles koncentrace, zapomínání)	0	1	2	3	4			
8		Sexuální obtíže (změny sexuální chuti, aktivity a uspokojení)	0	1	2	3	4			
9		Močové obtíže (obtíže při močení, močová inkontinence, časté močení)	0	1	2	3	4			
10		Suchost pochvy (pocity suchosti a pálení v pochvě, obtíže při pohlavním styku)	0	1	2	3	4			
11		Bolesti svalů a kloubů (bolesti kloubů, revmatické potíže)	0	1	2	3	4			
<i>Děkují Vám za spolupráci a projděte si, prosím, ještě jednou úplnost a správnost všech svých odpovědí.</i>										

The Menopause Rating Scale questionnaire is one of the most frequently applied specific tools for evaluating women's health-related quality of life (HRQL) in the period affected by menopause in the global clinical practice (Zöllner, Acquadro, & Schaefer, 2005, s. 324). The questionnaire was elaborated in the mid-1990's in Germany, where it was standardized and its psychometric characteristics were defined (Heinemann, 2006).

The questionnaire includes 11 items (estrogen deficiency symptoms, subdivided into three domains – psychological, somato-vegetative and urogenital (Tab. 2). For each symptom, women indicate the experienced intensity in the given period, using a five-degree scale (0–4). The questionnaire evaluation approach is simple. The more points a woman obtains, the more serious are her complaints. Each of the three domains is evaluated by summing up the points in every single area. The sum total from all three domains then makes up the total score for total evaluation of difficulties. Generally, the more intensive the woman's complaints are, the higher the impact on her quality of life (Berlin Center for Epidemiology and Health Research, 2008; Moravcová and Mareš, 2011, p. 440).

The MRS is recommended by its authors as a suitable method for evaluating the level of quality of life, to evaluate the intensity of symptoms and, last but not least, to evaluate the evolution over time for assessing the effects of potential treatment. Monitoring the development of symptom spectre and intensity in a specific woman in clinical practice is undoubtedly very desired and useful. In our research study, the MRS was, among other things, used for monitoring the evolution over the time in a sample of twenty respondents.

Tab. 2 **Domains and symptoms of MRS**

Domain	Symptoms, item number
Somato-vegetative (score 0 – 16 points)	1) Hot flushes, sweating 2) Hearth discomfort 3) Sleep problems 11) Muscular and joint discomfort
Psychological (score 0 – 16 points)	4) Depressive mood 5) Irritability 6) Anxiety 7) Exhaustion
Urogenital (score 0 – 12 points)	8) Sexual problems 9) Bladder problems 10) Vaginal dryness
Total score (0 – 44 points)	

Results

The results of the research survey in the various areas are presented below. Table 3 shows the basic statistical indicators of the symptoms under consideration, or more precisely the intensity of problems for the various symptoms in 284 respondents, who completed the printed form of the MRS questionnaire.

In the **somato-vegetative domain** of the MRS, respondents rated the intensity of the following problems: hot flushes, heart discomfort, sleep problems and muscular and joint discomfort.

A vast majority of the totally 284 respondents reported minor (39.44%) or no (32.39%) intensity of hot flushes. Only two respondents (0.70%) reported this symptom as unbearable. The intensity of heart discomfort was present in the respondents almost to the same extent as hot flushes. 108 respondents (38.03%) experienced minor heart discomfort and 86 respondents (30.28%) did not experience any problems. 74 women (26.06%) reported medium intensity of these complaints. Sleep problems occurred in medium intensity in 72 women (25.35%) and no sleep problems were reported by 76 respondents (26.76%). Out of the 284 respondents under consideration, 85 women (29.93%) reported minor muscular and joint discomfort, 98 women (34.51%) did not suffer from any muscular and joint pain and 4 women (1.41%) rated these difficulties as unbearable.

We can thus imply that in somato-vegetative area, most symptoms occurred in no or minor intensity. The most frequently occurring symptom out of the somato-vegetative domain were sleep problems, reported by 208 women (73.24%) in varying intensities.

In **psychological** domain, the respondents assessed the occurrence and intensity of the following symptoms: depressive mood, irritability, anxiety and exhaustion. Out of the total number of 284 respondents, most women experienced depressive mood in minor (37.32%) or medium (30.28%) intensity. Only 44 women (15.49%) had no depressive mood at all. As

for irritability, 128 women (45.07 %) did not report any intensity at all and 102 women (35.92 %) experienced minor intensity. 54 women (19.01 %) encountered medium or major intensity of irritability but no woman was bothered so as to rate it as unbearable. Anxious conditions in minor or medium intensity were reported by 175 respondents (61.62%), 101 respondents (35.56%) did not encounter anxious conditions at all and 2 women (0.70 %) rated them as unbearable. The last symptom out of the psychosomatic domain is exhaustion. 232 women (81.69%) experienced exhaustion and only 52 women (18.31 %) were not affected by this symptom.

The **urogenital domain** includes the following three symptoms: sexual problems, bladder problems and vaginal dryness. Sexual problems were not encountered at all by 147 respondents (51.76%). 26 women (9.15%) faced major sexual problems and 2 respondents suffered from unbearable problems (0.70%). 129 respondents (45.42%) had no bladder problems. Minor or medium intensity of problems was reported by 130 respondents (45.77%) and 20 respondents (7.04%) experienced major complaints. The last symptom out of the urogenital domain is vaginal dryness. 113 respondents (39.79%) experienced no vaginal dryness, minor intensity of dryness was reported by 85 respondents (29.93%) and even unbearable vaginal dryness was reported by 9 women (3.17%).

Tab. 3 **MRS symptoms**

MRS symptoms	N	Average	M	Min.	Max.	Variance
1. Hot flushes, sweating (SV)	284	1,10	1,00	0,00	4,00	1,04
2. Heart discomfort (SV)	284	1,08	1,00	0,00	4,00	0,83
3. Sleep problems (SV)	284	1,28	1,00	0,00	4,00	1,10
4. Depressive mood (P)	284	1,52	1,00	0,00	4,00	1,02
5. Irritability (P)	284	0,81	1,00	0,00	3,00	0,83
6. Anxiety (P)	284	0,95	1,00	0,00	4,00	0,74
7. Physical and mental exhaustion (P)	284	1,56	1,00	0,00	4,00	1,19
8. Sexual problems (UG)	284	0,89	0,00	0,00	4,00	1,14
9. Bladder problems (UG)	284	0,89	1,00	0,00	4,00	1,03
10. Dryness of vagina (UG)	284	1,02	1,00	0,00	4,00	1,13
11. Joint and muscular discomfort (SV)	284	1,22	1,00	0,00	4,00	1,30

For all symptoms, the respondents reported a very low average intensity, ranging between no or only minor intensity of complaints. The most intensively sensed complaints by the respondents were those of **Fatigue**, where the total sum and the average symptom intensity achieved the highest values. As for the intensity of a specific symptom, the respondents mostly agreed on **Anxiety** (representing the lowest variance of values) (tab. 3).

Furthermore, we identified the total score achieved by the respondents. Based on the results, we determined to what extent the estrogen deficiency symptoms affect the quality of their lives. To assess the level of quality of life in specific women, the authors of the MRS tool use certain intervals, whereas the total score ranging from 0 to 15 points stands for high quality of life, 16 to 30 points mean slightly reduced quality of life and the interval of 31 to 44 points means a significantly reduced quality of life (Berlin Center for Epidemiology and Health Research, 2008). Out of the total 284 women, 208 (73.24%) experienced a high quality of life. 62 women (21.83 %) faced a reduced quality of life and 14 women (4.93 %) a low one (Tab. 4).

Tab. 4 MRS total score

	Total score	n _i	f _i (%)
0 - 15	high quality of life	208	73.24%
16 - 30	slightly reduced quality of life	62	21.83%
31 - 44	low quality of life	14	4.93%
	Total	284	100.00

Another outcome of our research survey was the finding that the occurrence and intensity of estrogen deficiency symptoms in respondents fluctuates. We found that out based on the repeated completion of the MRS questionnaire by a selected group of twenty women, who completed the questionnaire three times in three-month time intervals (Fig. 1). We are aware of the limits of findings regarding the monitoring of changes in time in the spectrum of symptoms and the related quality of life. We consider our use of the MRS questionnaire to represent only an initial attempt to use this tool in clinical practice to monitor changes in quality of life over time. We anticipate its further use with clearly specifying the course of treatment and respondents.

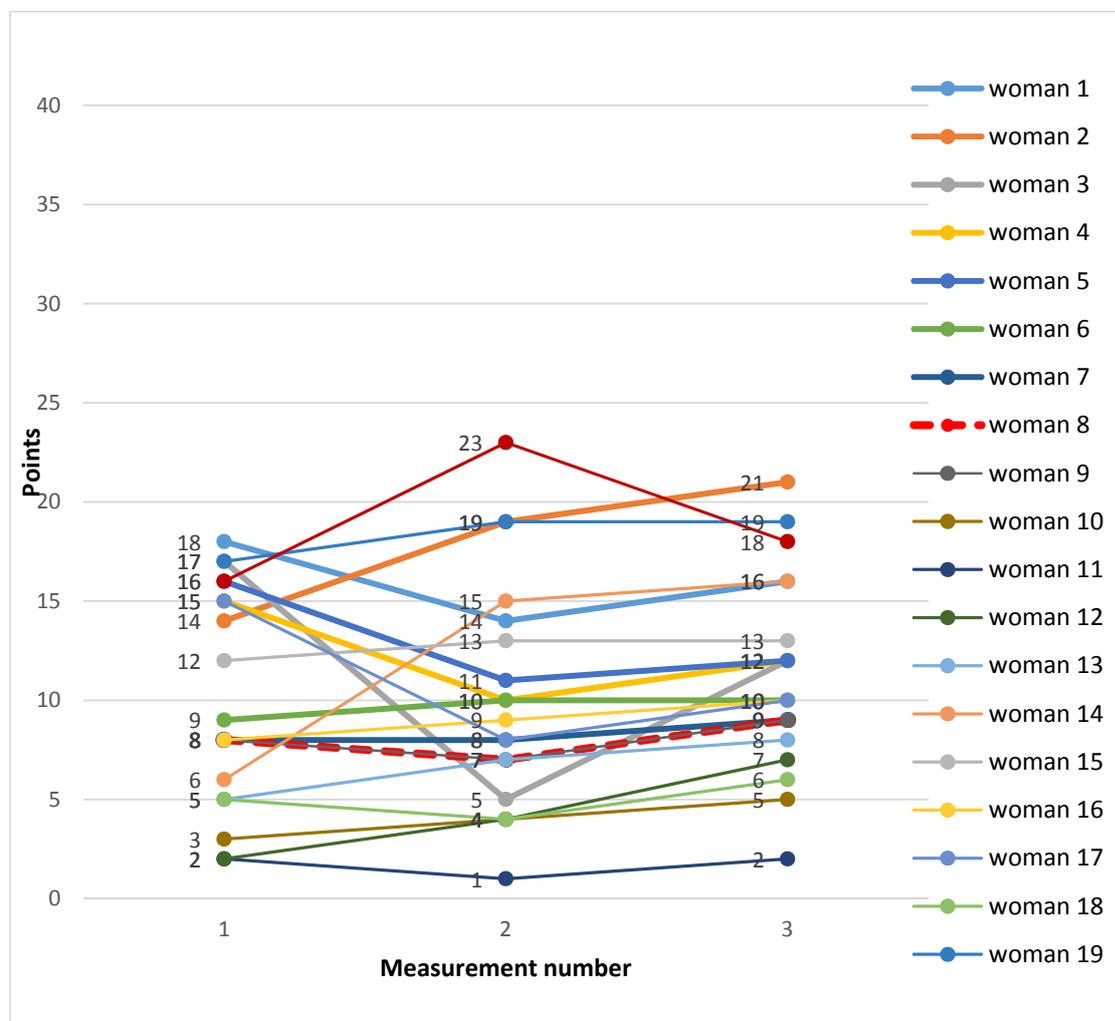


Fig. 1 Repeated measurements in 20 women

By repeated measurement of the intensity of symptoms in these 20 respondents, we found out that 10 of them (50.00%) encountered a deepening of the intensity of symptoms over time (woman No. 2, 6, 7, 10, 12–16 and 19). 9 respondents (45.00%) experienced an improvement

in the second measurement; but during the third measurement, the symptoms were again intensified. One respondent (5.00%) experienced the exactly opposite evolution as the second measurement revealed a higher intensity than the third measurement. No one of the total number of twenty respondents experienced an unambiguous improvement (Fig. 1).

Discussion

The objective of the research study was to determine the incidence and intensity of symptoms present in the women under consideration as a result of estrogen deficiency. These data were obtained using a printed form of the standardized Czech version of the MRS questionnaire, serving to assess the quality of women's lives in the period affected by menopause. The respondents were women from 45 to 60 years of age with present estrogen deficiency symptoms. The key questions of the research were what symptoms the respondents encountered, in what intensity and to what extent these symptoms affect the quality of their lives. Further, we explored how MRS could be used for evaluating changes over time.

The respondents in our research in all three domains most frequently reported no, minor or medium difficulties, which is comparable with the outcomes of the research by Urbánková, Moravcová a Dopitová (2016) and the research by Moravcová and Holá (2017). However, the most intensively sensed symptom according to our research was Fatigue, unlike in the research by Moravcová and Holá (2017), where women sensed Heart Discomfort most intensively. The most frequently occurring symptom in our research was Depressive Mood faced by 240 women (84.51%). This result differs from the research conducted by Urbánková, Moravcová, Dopitová et al. (2016), where respondents reported Muscular and Joint Discomfort as the most frequent symptom. On the other hand, the least frequent symptom was Sexual Problems, not experienced by 147 women (51.76%). In the research by Urbánková, Moravcová, Dopitová (2016), the least frequent symptom was Irritability, not reported by 51.80% of the respondents. Only a small number of the respondents assessed some symptoms as unbearable complaints.

The most frequently occurring levels of the total score ranged from 0 to 15 points. 208 (73.24%) of the respondents achieved these values. Contrariwise, a total score ranging from 31 to 44 points appeared in only 14 women (4.93%, Tab. 4). These results are comparable to all available research studies carried out worldwide using the MRS (e.g. Krajewska-Ferishah, Krajewska-Kulak, & Terlikowski, 2010; Moravcová, Mareš, & Ježek, 2014; Schneider, Heinemann, Rosemeier, Potthoff, & Behre, 2008).

Conclusion

The research study was focused on evaluating quality of life using a printed form of the standardized questionnaire for evaluating the quality of postmenopausal women's lives called the Menopause Rating Scale.

Like in similar research studies, utilizing the Menopause Rating Scale for evaluating the quality of life, we arrived at the conclusion that the quality of women's lives in the menopausal period may be affected by the presence of estrogen deficiency symptoms. However, we arrived at the conclusion that in most cases women encounter symptoms in minor or medium intensity or do not experience any symptoms at all. But as a matter of fact, the range of estrogen deficiency symptoms may significantly affect the quality of women's lives and, in a number of cases, even threaten their health.

Therefore, it is very important to pay the necessary attention to women in the menopausal period. Special emphasis should be placed on prevention, making women ready for the various phases in life and for the possible difficulties related to these phases, so that they can prevent them and can be prepared for them.

We also believe that it is important to address targeted education in the clinical practice and to detect problems in a timely manner that may affect women's lives or even their health. Tools for evaluating the changes in the quality of life, like the Menopause Rating Scale that we applied in our research, are valuable methods serving this purpose.

Ethical aspects and conflict of interest

From the perspective of possible conflict of interests, no circumstances potentially threatening the fundamental research principles and publishing the results were identified.

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Volunteering in the Context of Family Support

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Abstract

Introduction: The present paper is focused on identifying the motives of volunteers working in a family support program. Volunteers' motivation was identified by means of interviews while the objects under observation were volunteers in an unnamed non-profit organization in the Pardubice Region, offering services to families with children.

Objective: The main objective is to identify volunteers' motives for their volunteering work in the family support program.

Methodology: A qualitative research strategy was used for the research. A semi-structured interview method was utilized for data collection.

Results: The research has revealed that volunteers' motives primarily involved gaining experience and obtaining practical skills they could later use in their future careers. The second most important factor turned out to be knowledge-related as the volunteers were motivated by obtaining new information and learning new things. The third position was occupied by the area of life values. The respondents mentioned especially their altruistic and humanistic motives and the related selfless help to others. Apart from the above-stated, the research was also focused on identifying the motives that made the volunteers choose family support as their area of work. According to their responses, a significant motive turned out to be the target group of families with children. Another motive was also the prestige of the corresponding organization and the related positive references obtained by the volunteers from their friends.

Conclusion: Gaining new experience, practical skills related to preparation for a future career and altruism and the related selfless help to others, as well as an open and friendly relationship to the client turned out to be important motives. The research showed that it is an important factor for the respondents what target group they are supposed to work with.

Keywords: family support, motivation, motives, volunteering

Introduction

The subject matter of the present paper is volunteering in regards to family support. The reason for choosing this subject was an effort to bring forward the volunteering phenomenon that is still beyond the interest of the society. With respect to the numerous definitions, we chose a description covering all the substantial characteristics of volunteer work: "A volunteer is a person carrying out a certain activity in good faith, out of inner conviction and without the need to obtain any financial compensation for it" (Slowík, 2011). The European Volunteer Centre (CEV) understands volunteering as follows: "Volunteering is a means of social inclusion and integration. It fosters social coherence, creates bonds of trust and solidarity and thus supports the development of social capital. It is a powerful source of conciliation and reconstruction in segregated societies" (European Volunteer Centre, 2017). The two above-stated definitions are primary for the approach to the topic of volunteering in the present text.

The present paper is focused on volunteering in regards to family support. Family support can be perceived as protection and support of a threatened family, aiming to preserve the family as a whole (Bechyňová & Konvičková, 2008). In practice, family support takes place in the community and is mostly materialized by non-profit organizations within registered social services facilities. Family support is a method of work with the family, taking place in the context of social services. The Social Services Act works with the term “social mobilisation service for families with children”. Social mobilisation services include assistance in the assertion of rights, educative, formative and mobilising activities, mediation of contact with social environment or social and therapeutic activity (Ministry of Labour and Social Affairs, 2017). The supportive legislation also includes the Children’s Social and Legal Protection Act. It does not explicitly work with the term “family support” but obligates the personnel of municipalities with extended competence to support families and, in the event that a child is put into an institutional fostering facility, to arrange the family situation so as to enable such child’s return to their family (Ministry of Labour and Social Affairs, 2017).

This research is focused on studying the motives of volunteering activity. These motives are the fundamental basis for the volunteers’ decision to invest their time and energy into work for others. Motives can be understood as persisting behavioural factors. They are factors enabling the human to commence certain activity (Homola 1977; Švancara, 1984). The motivation-related reflections raise the question about motivation as a superior concept of motives. Motives are based on motivation and significantly influence the impact of motivation (Švancara, 1984). The various authors differ in their definitions of motivation; in our text we adopt Graumann’s definition: “That thing inside and around us that leads and drives us and makes us behave in a certain way and not in another way” (Graumann in Nakonečný, 1997, p. 102). We have adopted this definition of motivation mainly since it comprises the aspects of internal motives, external motives and behaviours, mentioned for instance by Plhánková (2004).

As a fundamental statistical description of the situation, we attach a table (Tab. 1) on the evolution of the number of volunteers in the Czech Republic through non-profit organizations. According to the Study for Governmental Policy Concept, it is impossible to provide a precise number of the persons involved in volunteering in non-profit organizations. Allegedly, the reason is the fact that one person may volunteer in more than one non-profit organization; therefore the data specified in the table are reported as re-calculated (Prouzová, 2015).

Tab. 1 Evolution of the number of volunteers in the Czech Republic in non-profit organizations and the number of their hours worked (Prouzová, 2015)

Year	Re-calculated number of volunteers in total	Number of hours worked by volunteers in total
2005	36,138	62,988,539
2006	28,045	48,884,067
2007	47,776	83,225,489
2008	27,255	47,205,654
2009	27,144	47,177,188
2010	25,039	44,320,933
2011	25,983	45,185,506
2012	25,964	44,866,218

Objective

The main objective of the present paper is to identify volunteers' motives for their volunteering work in the area of family support. We address mainly those motives that influenced the volunteers' choice to act as volunteer and their reasons to specifically choose the family support program.

Methodology

A qualitative research strategy was used. The objective is to comprehend volunteers' specific motives; therefore a qualitative research strategy appeared to be the most appropriate one. A semi-structured interview technique was selected for the research. All respondents participating in the research are volunteers in the same organization. This non-governmental non-profit organization has been operating since 2003 and for more than 8 years it has offered volunteers the possibility to work in the family support volunteering program. The organization has been selected mainly because it is a typical organization in terms of involving volunteers in the family support program – a volunteer carries out a complementary activity under the supervision of a support worker. To maintain anonymity, the exact name of the organization is not mentioned. Respondents were selected for the survey by purposive sampling. To achieve maximum possible comparability, the following requirement was applied: Respondents have been involved in their volunteering activity on a long-term basis, for at least 1 year. Nine respondents took part in the survey, including both students and working persons and people of retirement age (Tab. 2).

Tab. 2 Characteristics of the respondents

Respondent code	Gender	Age	Status	Length of volunteering practice
R1	female	23	student	3 years
R2	female	26	student	2 years
R3	female	27	student	6 years
R4	female	42	working	2 years
R5	female	35	working	1 year
R6	female	53	working	2 years
R7	female	68	retired	1 year
R8	female	41	working	3 years
R9	male	25	student	1 year

With respect to the specified main research objective, the respondents were asked: (a) what motives influenced their decision to become volunteers and to carry on their volunteering in the long-term, (b) what motives led them to volunteering work in the area of family support specifically, and (c) what motives for volunteering work they considered unsuitable/undesirable. The obtained data were analysed by applying an open-coding approach. Since the testimonies were numerous, the method of VFI - Volunteer Functions Inventory (Fetzer Institute, 2017) was applied to structure the motives affecting the decision to become a volunteer and to carry on volunteering in the long-term in a more comprehensible manner. The VFI classifies the volunteering functions into various categories. Only the above-mentioned categories will be used in the research as those areas that the volunteers' responses

will be subsequently attributed to. These categories will serve as a structure for a clearer orientation and better structuring of the responses. The VFI includes six areas – protective area, values area, career area, social area, area of knowledge and, finally, personal development area.

Results

The presentation of research results is ordered from the most frequently mentioned to the less frequent motives. All respondents gave multiple motives as the basis for their activity.

According to their testimonies, the career area was the most frequently represented one. This was mostly the case for student volunteers – see, for instance, Respondent R1's statement "*...it was also an expectation of new experience for me, allowing me to gain new practice for my future and allowing me to decide whether I would want to work in this area in the future.*" They mentioned motives regarding gaining practical skills and experience they could use later, in their future careers. Respondent R9 reported: "*...I knew that I wanted to work in this field in the future, so it was a chance for me to get closer to my dream job.*"

According to the research results, the second most frequently mentioned area was the knowledge area. The research implied that volunteers were motivated by obtaining new knowledge, information, and by learning new things. One of the respondents (R2) stated, for instance, that the practical exercise of volunteering helped her "*better understand the school theory*".

Another area was the values area; in this context, persons act as volunteers based on their fundamental values and preferences they deliberately wish to follow, such as humanism or altruism. Volunteers mentioned motives related to a vision of an open and friendly relationship with the client, or selfless help. The topic of an open relationship with the client was stressed, for instance, by Respondent R3 who stated that "*relationships in volunteering are always less formal and allow one to get to know the clients from a completely different perspective*". In terms of its importance, this motivation area ranks third for the respondents. Zášková and Mojžíšová (2011) point out that altruism and empathy are typical for volunteering. In this area, the research also identified motives concerning religious faith and a meaningful way of spending one's free time.

The fourth rank belongs to the area of social relationships. Using Maslow's Hierarchy of Needs, we can state that the typical indicators for the social area are the need to belong somewhere, the need for recognition by others or the need to succeed. According to Simonov, the term "need" is often linked to the terms "motivation" and "motives" (Simonov in Nakonečný, 1997). According to volunteers' responses, they can be subdivided into internal and external area. The internal area was linked to responses involving the need to belong somewhere and the need for recognition. The external area was linked to responses involving motivation related to influence from one's surroundings, i.e. an impact of friends and acquaintances. According to the VFI, the social area is characterized by strengthening social ties. Motives related to a desire for social integration are illustrated for instance by Respondent R7's statement: "*...I just live on my own now, my children have grown up, I have no husband ... so volunteering means becoming active again and sharing someone's company...*".

The research also uncovered motives related to personal development. The responses contained motives of positive self-esteem and raising one's own self-respect: "*...I was , to*

a large extent, influenced by the fact that I wanted to help because it gives me satisfaction...” (R2). The respondents placed the area of personal development to the second-to-last position.

The last area that appeared in volunteers’ responses was the protective area. One of the respondents mentioned a sense of guilt as the primary motive: “...*we were facing some problems in my family, which affected me, and I wanted to help another family although I wasn’t able to help my own very much...*” (R1). In regards to the protective area, the VFI mentions that people use volunteering activity for reducing negative emotions.

The research also focused on identifying motives that made the volunteers choose family support as their area of work. Volunteers’ decision-making was affected by the vision of working with a specific target group. Based on the results, the target group of families with children is one of the most attractive ones. Based on the information gained from the respondents, we can further imply that working in the family support program was strongly influenced by the choice of the specific organization. The results show that positive recommendations and references of the organization from friends played a significant role. Respondent R3 stated: “*It was my friend who told me about the organization as she had already worked there for some time.*” Volunteers mentioned higher confidence and safety in concerning the information on the organizations they wanted to work for. The respondents appear to value positive feedback from acquaintances, their next of kin or authorities.

Also, volunteers’ opinions about inappropriate/undesirable motives for volunteering were surveyed. Respondents defined them mainly as “a desire to self-sacrifice for another person”, “excessive curiosity”, “a desire to gain power” or “trying to have power over the clients”. In the context of inappropriate/undesirable volunteering motives, the respondents also mentioned the problem of insufficient self-identification with the principles of volunteering work.

Discussion

Findings concerning the area of social ties were related to egoistic motivation. Egoistic motivation is a topic studied for instance by Frič and Pospíšilová (2010); according to them, egoistic motives are a natural part of volunteering. These include such motives that serve to satisfy individual needs. Egoistic motives were also present in the personal development area. The research results obviously indicate elements of reflexive approach in volunteering, as well. The reflexive dimension, analysed for instance by Tošner and Sozanská (2006), is characterized especially by the fact that volunteers value the content of their work and who they work with while the egoistic motives of volunteering prevail. Next, volunteers’ motivation is the subject matter of a research study by Mlčák and Šamajová (2013) from the Psychology Department of the University of Ostrava. This study addresses, among other topics, the intensity and duration of volunteering activity; the aspect of motivation is also present. Mlčák and Šamajová (2013) use the VFI study for identifying motivation. Mlčák and Šamajová (2013) directly start from the VFI whereas our paper only uses one part of it for a clearer arrangement of the obtained responses. The research was conducted within one organization, as well. If we put their study into the context of our paper, the results will differ for instance in the positions of the various areas. In our survey, career motivation was the strongest represented motivation, contrariwise to Mlčák’s and Šamajová’s study (2013), where the career area is indicated as the least represented one. The reason for such a difference may depend on the volunteers’ age as the average age in the study conducted at the Ostrava University was around 50 years and the respondents were working women. In our paper, the interviewed volunteers were mainly students. The most strongly represented area in

Mlčák's and Šamajová's study was the value area. Motives related to life values rank third in our paper. However, based on the results, concordance was reached for instance in the fact that volunteers value the opinions of their next of kin, either acting as volunteers themselves or sharing positive attitudes to volunteering.

The research sample is small, which complicates its validity. It is therefore necessary to work with the fact that the obtained results correspond to a specific group of respondents.

In the international context, the subject matter of our survey could be viewed from yet another perspective – e.g., through a study conducted by the European Commission that addressed volunteering work in various EU member countries. It mentions “individual choice” and accentuates the topic of individual's “free choice” in the context of motives for volunteering (Frič & Vávra, 2012).

Conclusion

Volunteers' motivation is a key topic in relation to volunteer work. Studying motivation may serve to recruit new persons who are considering engagement in volunteer work and may result in improving the quality of volunteer work as a whole. Most frequently, volunteers tend to have motives related to their career and practical knowledge. Their responses often involved the effect of egoistic motives for volunteer work. In addition, a strong motivation turned out to be the target group and references to a specific organization provided by friends, who had already had volunteering experience.

Ethical aspects and conflict of interest

Since one of the authors works as a volunteer, the effect of her own motives could be perceived as a potential risk to the study. This risk can be eliminated and prevented especially by studying expert literature and by respecting the fundamental principles of qualitative research.

Certain issues could have been raised by the actual volunteers and could have been related to their ability to communicate openly. Respondents' open attitude can be supported by creating an atmosphere of maximum security and confidentiality during the interviews. According to Hendl (2016), maintaining confidentiality and anonymity is a substantial prerequisite for qualitative research.

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Pain – a Quality Indicator

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Abstract

Introduction: The quality and safety of healthcare is currently in the spotlight of experts and non-professionals. The need to implement them into healthcare is related to the supply of healthcare services, the general public pressure on standardizing processes and effectiveness, competition, prestige and last but not least, an effort to avoid patient complaints.

Objective: To conduct a pilot study focused on pain observation as a quality indicator; to observe pain management in postoperative patients; to conduct a content analysis of medical records of these patients and to create a checklist for a subsequent in-depth empirical study.

Method: A content analysis of medical records focused on compliance and non-compliance with existing policies in the following domains: 1) Records of patients' pain; 2) Records of medication orders and administration in three phases: I) Patient admission; II) Return to unit; III) First to fourth postoperative day, charting of physicians and nurses.

Results: Non-compliance with directives was determined in all observed domains. The most frequent non-compliance was in neglecting pain assessment intervals by nurses. The most dangerous discrepancy was observed between medication orders and their administration.

Conclusion: Content analysis of medical records of postoperative patients was conducted and the checklist for subsequent documentation audits was edited. The conclusion of this pilot study will be consulted with the patient care managers and an in-depth empirical study will be conducted based on the results of the present pilot study.

Keywords: analysis of medical records, pain management, quality, safety

Introduction

The phenomena of quality and safety of healthcare are currently in the spotlight of both professionals and lay public. They often trigger discussions, exalted disputations and resentful attitudes. The need to introduce them into healthcare is related to the broader supply of healthcare services, society's pressure on standardizing processes, effectiveness, competitive pressure, prestige and, last but not least, the effort to prevent patients' complaints. Healthcare is generally a rather risky area both for its actual content and because it is only rarely provided by an individual person. High-quality and safe healthcare cannot be supported only by an individual person's knowledge, skills and behaviours, however indispensable they are, but like a high-grade building it must have a solid foundation, a firm bond, good wiring and even a better roof.

The introduction of quality management systems into healthcare is based on the recommendations of the Council of Europe dating back to 1997. The legislative supports related to assessment of quality and safety of healthcare services in the Czech Republic (CR) are summarized in Table 1.

Tab. 1 **Legislative supports**

Definition of assessment of quality and safety of healthcare services.	<ol style="list-style-type: none"> 1. Act No. 372/2011 Coll., Act on Healthcare Services and Conditions of Their Provision (Czech Republic). 2. Decree No. 102/2012 Coll., on Assessing the Quality and Safety of Inpatient Care (Czech Republic).
The minimum requirements for the implementation of quality management systems.	<ol style="list-style-type: none"> 3. Journal of Ministry of Healthcare no. 12/2015, chapter 12: “Methodological instruction of Ministry of Healthcare for the supervision of authorized persons towards the assessment of quality and safety of health care.” 4. Journal of Ministry of Healthcare No. 16/2015, chapter 1: “The minimum requirements for the implementation of internal quality assessment system and safety of provided health service.”

Expert literature works with various definitions of “quality and safety of provided healthcare services”. Quality may be observed from the point of view of the care recipient, manager or even the relevant facility’s managing authority. According to WHO (1966), the quality of healthcare is: *“the aggregate of results achieved in prevention, diagnosing and treatment, determined by the needs of the population based on medical science and practice”* (Gladkij, 2003, p. 292; Madar, 2004, p. 33). Another definition of the quality of provided healthcare by WHO comes from 1982 and is referred to e.g. by Gladkij (2003, p. 292) as a: *“degree of perfection of the provided healthcare in regards to the contemporary level of knowledge and technical development”*. According to WHO documents from 2006, a quality healthcare is defined as effective, efficient, attainable, patient-focused, fair and safe care.

The Czech Ministry of Healthcare (2009) understands quality of healthcare services provided as *“an aggregate of those healthcare properties”* that can be subject to practical investigation and evaluation, *“have a delimited relationship to a clinical category”* and at the same time are *“related to a standard of care”*. The concept of the Czech Ministry of Healthcare was used as one of the starting points of our work – the objectives of our research start from the needs of the clinical practice at a specific healthcare facility and are related to specific standards of care.

Objective

Our objective was to execute a pilot study focused on pain monitoring as a quality indicator, to monitor pain management in postoperative patients, to execute a content analysis of medical records for such patients and to create a checklist for a subsequent in-depth empirical study.

Methodology

The survey took place in a hospital with nearly 400 beds with approximately 17,000 patients hospitalized and 5,000 surgical interventions executed in 2015 (to maintain anonymity, we are not mentioning specific figures and source of information). The survey took place in October and November 2016 and was preceded by a meeting with Nursing Care Deputy and her Quality Officer. This meeting indicated specific areas of difficulty, pain management-related needs in the given facility, and objectives and conditions for implementing the research study were determined.

Content analysis of postoperative patients’ medical records, focusing on pain as a quality indicator, was selected as the pilot survey method. The findings were recorded in a checklist

made ready for the purpose of this study. Its various items were based on the following Directives in force in the hospital:

- 1 *Ordering, storage, prescription and administering of medication;*
- 2 *Care for patient with pain;*
- 3 *Ordering, recording and rules – use of habit forming substances.*

Conformities and non-conformities were specifically monitored in two areas:

- Recording patients' pain in medical records (Directive No. 2);
- Recording of medication orders and administration (Directive No. 1 and 3).

In both areas, doctors' and nurses' records were monitored in 3 periods: 1: at patient's admittance, 2: situation after return to unit after operation until 06:00 am the following day; and 3: on the first to fourth postoperative day. One case record was evaluated only at two points - patient's admission and day of return from operating theatre because the patient was released the following morning.

Two surgery-type wards and one internal medicine-type ward, where minor surgical interventions are carried out, were included in the study (to maintain anonymity, we call them A, B, C). Table 2 shows wards, where medical records analysis took place and the number of documentation under consideration (13 case records). Documentation was selected according to the following criteria: 1: type of ward (where operations take place or where postoperative patients are hospitalized), 2: patient's records after surgical intervention, 3: closed documentation. Type of operative intervention was not decisive.

Tab. 2 **Research sample**

Ward	Piece count of records
A	7
B	4
C	2

n = 13; A, B – surgery-type ward, C – internal medicine-type ward

For the purpose of the present study, pain management as quality indicator is determined by the following areas: conformities and non-conformities in medical records with the existing standards and Directives, risks of unwanted occurrences, non-pharmacological pain attenuation, patient satisfaction with pain attenuation, personnel's satisfaction with the set-up of care for patients with pain. Assessment of application of medication from pharmacotherapeutic perspective **is not** included in the scope.

Terminological comments: the terms *patient*, *physician* and *nurse* are used regardless of their gender for both males and females. For simplification, the term *nurse* stands for general nurses, health care assistants and midwives.

Results

The obtained information was subdivided into the following groups: **1:** admission of patients into hospitalization, **2:** situation upon return to the unit from the operating theatre or postoperative room until 06:00 am on the following day **3:** situation on the following 1 to 4 days (in cases of longer hospitalizations, the situation was the same and no new information was obtained or patient did not report pain), **4.** further findings.

1 Admission of patients for hospitalization

Evaluation of patient's pain records at admission for hospitalization was based on Directive No. 2:

“Admission pain evaluation – physician: ...usually includes a description of the character of pain, localization, duration of pain, factors affecting the course of pain influence of pain on patient's activity and mood. **Admission pain evaluation – non-medical healthcare personnel:** ...includes evaluation of intensity according to VAS (visual analogous pain scale – the author's note), localization, duration of pain (acute vs. chronic pain), character of pain, factors affecting the course of pain, influence of pain on patient's activity and mood”.

1a. Physicians, documentation of pain: on ward A, pain was recorded in general terms (present vs. absent), not describing pain according to the Directive. On ward B, only records concerning abdominal pain were found even if the patient had been admitted due to complaints concerning another body part. On ward C, patients had no pain when admitted.

1b. Nurses, documentation of pain: the patients' pain was determined within personal history on admission; obtained information was not recorded entirely in compliance with Directive No. 2. In one case, pain evaluation was completely missing (ward A). In one case, the nurse recorded the patient's pain but did not state the nursing problem (ward A).

2 Situation upon return to the unit

The period from return from operating room or from postoperative room to the ward until 06:00 am of the following day, i.e. postoperative day zero, was monitored.

2a. Physicians, documentation of orders and administration of medication: orders on wards B and C by doctors were compliant with Directive No. 1. Records with a possible risk of medication errors were found on ward A. Detailed results are presented in Table 3.

Tab. 3 **Identified non-conformities with the Directive involving orders of medication by doctors**

Orders of medication	Reasons of non-conformity	Citations from Directives
Order of medication „p. p.“ (as necessary)	no need specified	<i>Directive 1: “If doctor expects e.g. patient's fever above 38.5°C or pain etc., he may order medication and specify need, i.e. for instance “in case of pain”, “in case of fever”...”.</i>
“in case of VAS < 5” or “VAS < 3”	wrong symbols	
“1 ampoule of Morphine”	no grammage specified	<i>Directive 1: “When ordering medication, the doctor shall always specify: unshortened, legible medication title incl. information on concentration of active substance, grammage, dosage, time and method of administration... Directive 3: Doctor's order shall always include: date, time of application, name of habit former, strength, quantity, method of application...”.</i>
“1 amp max. 4 hours”	no interval specified	<i>Directive 1: “If doctor expects ... he may order medication and specify need,... and further specify the maximum dosage and minimum interval...”.</i>

2b. Nurses, documentation of pain: this problem area is regulated by Directive No. 2: “Non-medical healthcare personnel shall start monitoring patient's pain always after each intervention involving expected pain ... or upon doctor's order. ... always immediately after patient's admission into further postoperative care from the post-

anaesthetic care unit to a standard ward or intensive care unit". In nine cases, the nursing problem was specified in the care plan (ward A, B.) In four cases, nurses did not specify the nursing problem, but actually implemented the approach (ward B and C). In the period under consideration, nurses asked about pain and recorded it in "*Pain Evaluation Record*" form or in nursing documentation on Ward B, but did not proceed pursuant to Directive No. 2. Time intervals for pain evaluation were not adhered to. According to records in documentation, nurses monitored pain less frequently than they were supposed to. The number of conformities and non-conformities with Directive No. 2 are specified in Table 4.

2c. Nurses, record of ordering and administration of medication: records of drug administration were completed according to Directive No. 1 or 3.

3 Situation on the following days of hospitalization

3a. Physicians, pain documentation: the physicians assessed patients' pain pursuant to Directive No. 1.

3b. Physicians, documentation of orders and administration of medication: drugs were ordered pursuant to Directive No. 2 in most of the cases (8). In two cases, drugs were not ordered at all as patient reported no pain (Ward C). In two cases, the same non-conformities (Table 3) as on the day of return from postoperative room recurred - again on the same ward (Ward A).

3c Nurses, pain documentation: Nurses evaluated patients' pain and determined the nursing problem in compliance with Directive No. 2 only in four cases. In other cases, records were incomplete or missing completely. Again, the time interval for pain evaluation was not adhered to. The number of conformities and non-conformities in this period of time is specified in Table 4.

Tab. 4 Conformities/Non-conformities with Directive No. 2, situation upon return to the unit and on following days of hospitalization

Text in Directive No. 2	situation upon return to the unit		situation on the following days of hospitalization	
	conformity	non-conformity	conformity	non-conformity
<i>“Non-medical healthcare personnel shall evaluate the presence of pain in every hospitalized patient at least once in 12 hours incl. entering into medical records. For patients reporting no pain, non-medical healthcare personnel shall enter: No pain reported, etc.”.</i>	12	1	2	10
<p>“Acute pain monitoring takes place:</p> <ul style="list-style-type: none"> ▪ at VAS 1 – 2 or NIPS 0 – 2 in time interval at least once in 12 hours;(NIPS =Neonatal/Infant Pain Scale – author’s remark) ▪ at VAS 3 – 4 in time interval after 8 hours or in shorter interval, according to doctor’s order and current condition; ▪ at VAS 5 – 6 or NIPS 3 – 4 in time interval after 2 hours or according to doctor’s order; ▪ at VAS 7 – 10 or NIPS >4 in time interval of 1 hour or in shorter time, according to current condition“. 	1	12	2	10
<p><i>„Non-medical healthcare personnel shall apply analgesics according to doctor’s order. After application of analgesics, non-medical healthcare personnel shall re-assess pain at least in the following time intervals:</i></p> <ul style="list-style-type: none"> - 30 minutes after parenteral administration of analgesics; - 1 hour after oral administration of analgesics; 	13	0	12	0
A number of checked medical records at the given time	a total of 13		a total of 12	

3d Nurses, documentation of orders and administration of medication: in eight cases, nurses recorded fulfilment of orders pursuant to Directive No. 1 or 3. Non-compliances were found in four case records at Ward A and are presented in Table 5.

Tab. 5 Non-compliance with Directive No. 1, situation on following days of hospitalization

Doctor's order	Non-compliance with Directive	Citation of Directive No. 1
"Indometacin supp 500 mg at VAS > 3, every 12 hrs"	Nurse added a handwritten note below the record: 0 – 0 – 1 and crossed the 1 off. This case was a so-called conditional ordering, but the time of administration and the person who administered the drug are unclear.	"...in cases of specific need, competent non-medical healthcare personnel shall administer the drug and record the time and drug administration by crossing it off directly in the prescription".
"Aulin tbl p. p. max. twice a day."	On two days in a row, the nurse crossed this ordering off. The crossing-off does not clearly indicate if the drug was administered (time, reason).	"In cases of no specific need, competent non-medical healthcare personnel shall not administer the drug and shall not cross it off ".
"Ibalgin 400 mg tbl in case of pain, max. every 12 hrs"	The nurse crossed off administration. The crossing-off does not clearly indicate if the drug was administered (time, reason).	"In cases of no specific need, competent non-medical healthcare personnel shall not administer the drug and shall not cross it off ".
"Indometacin supp 100 mg 1 – 1 – 1"	Ordering was not conditional, nurses were supposed to administer the drug but proceeded as in cases of conditional medication. Nurses changed Indometacin grammage by handwriting to a weaker dose (50 mg). These errors recurred in two patient cases.	"Drugs and medical preparations are always ordered by the physician ... changes in the order are carried out by the physician... competent non-medical personnel shall cross it off and confirm by signature the completion of the physician's order ..."

4 Other findings

While analysing the documentation in patients' records, we learned that application of non-pharmacological methods of pain attenuation was recorded neither by the physicians nor by the nurses. Only in one case, the following documentation was made by a physician on the day of intervention: "*Limb elevation and cooling*".

The documentation on Ward B revealed a duplicity in pain assessment – recording of pain assessment including the use of VAS was on one side of the sheet and verbal assessment was on the other side.

Discussion

From its very beginning, the present survey was conceived as a pilot study focusing on one specific healthcare facility. It had to be clarified what would be analysed in the medical records in the future and what would be the conditions of pursuing more extensive surveys.

Acute pain is a consequence of every surgical intervention. Its attenuation is a part of perioperative care provided by physicians and nurses. At present, there are sufficient means available for attenuating postoperative pain. The question is their sufficient and mainly safe utilization. Pain management but also the quality of the provided care must be conceived in a complex manner, as reported for instance by Škrála and Škrlová (2003). That means not only from the perspective of an executed operation, but also from the perspective of the environment in which it takes place, the operating team or patients receiving the care. These perspectives may differ, but in a high-quality organization they must come together.

Our survey was conducted from the perspective of quality managers. Conformities and nonconformities with the Directives were monitored. However, quality also depends on factors such as employees' values, behaviours and attitudes (Škrála & Škrlová, 2003).

The perspective of the personnel and the patient's satisfaction with pain attenuation will be subject to further expected studies.

Our study revealed non-conformities with Directives No. 1 and No. 3. These cases involved matters of safe care. Studies published as early as at the beginning of this century revealed cases of harm caused to patients in the course of care provision. One of the causes referred to is *"misinterpretation of medical orders or instructions"*. This is one of the reasons why medical facilities introduce systems of quality and safe care that are subjects to accreditation programs. Similar mistakes are also mentioned by Podstatová (2014). In this context, we arrive at the same question as Škrla and Škrlová (2003, p. 66): *"What factors support the creation of a safe environment and how do errors and mistakes occur, what role does the human factor play, to what extent is the management system accountable for them and what is the nurse's role in the entire process?"*

The documentation analysis revealed that the form in use does not allow nurses to record all the required information to be in compliance with Directive No. 2. It provides no room for items: *"factors influencing the course or pain, impact of pain on the patient's activity and mood"*. The importance of quality documentation also became obvious when comparing the results on Wards A, B and C. The documentation on Ward B was fully compliant with the Directive, unlike the documentation on Wards A and C. The reason might be the form and structure of nursing documentation that is very clear (one single record sheet) on Ward B but is unclear on Wards A and C because nurses must enter pain assessment, the nursing problem and their problem-solving into two or three different sheets. Incomplete documentation may also indicate incomplete care or non-conformity with organizational Directives, as reported by Podstatová (2014). Duplicity of pain assessment was revealed in the documentation on Ward B. Duplicity in documentation means extra work and less time for nurses. According to Samuels (2012), non-uniform documentation is a threat for successful pain management.

The most frequent non-conformity with the Directive was failure to keep the pain assessment intervals on postoperative day 0 and on the following days. The question is if it is feasible to precisely keep these intervals in real life. For instance, in cases of VAS = 5–6, the nurse is supposed to assess the patient's pain every two hours, in cases of VAS = 7-10, every hour. If analgesics are administered, another pain assessment should follow half an hour or one hour after administration (see Table 4). Since the nurse takes care of several patients and has other duties as part of her work, meeting the intervals exactly is not realistic. The nurses assessed patients' pain in longer intervals or whenever the patient informed the nurse about pain. In this context, the wording in the Directive or conditions for providing interventions required by the Directive should be subject to a review.

A separate topic was a question concerning how the hospital personnel records the application of non-pharmacological pain attenuation. Directive No. 2 merely permits but does not order non-pharmacological pain attenuation and specifies no method of recording. *"...altering patient's position, local application of heat or cold, breath exercises, rehabilitation positioning aids may be used for attenuating the patient's pain..."*. An analysis of the documentation gives no answer as to whether the personnel apply such pain attenuation methods. The results imply that these methods are not ordered by the physicians. Even if the nurses decided by themselves and within their scope of practice to apply such methods, the application was not documented anywhere. An unanswered question concerns the necessity and possibly the method of recording such interventions.

Conclusion

This pilot survey focused on pain monitoring as a quality indicator and on pain management in postoperative patients. The content analysis of medical records showed conformities and non-conformities with Directives pertaining to pain management and to quality and safety of the provided care. The most frequent non-conformities were encountered in terms of respecting the time intervals of pain assessment by nurses; the most risky non-conformities were identified in the area of drug orders and records of their administration. Problem areas were identified both in Directive No. 2 and in nursing documentation forms.

The results of pilot study will be consulted with the Nursing Care Deputy in the hospital where the survey took place. In collaboration with her, the final version of the assessment form will be developed and the methodology of an in-depth empirical study will be defined. Most facts that could not be precised by studying the documentation will be clarified by expected subsequent interviews with physicians, nurses and the hospital management team.

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The Process of Education in Health and Social Work

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Abstract

Introduction: Every one of us may face an adverse social situation due to his ill health. If the health condition requires it, a person is admitted to a medical facility, where a multi-disciplinary team takes care of him or her. Health social workers are part of such a team; they analyse and evaluate the patient's social situation. Based on a developed social case history profile, the health social worker educates the given patient on the options and/or tools available to improve his current adverse social situation.

Objective: To describe the process of patient education provided by health social workers in selected healthcare facilities.

Method: The sample of respondents consisted of health social workers working in healthcare facilities on the territory of Prague and the Central Bohemia Region. The research study was conducted using our own questionnaire and descriptive statistics were used to process the study results.

Results: Health social workers educate clients mainly by means of an interview over a time range of 10 to 15 minutes, which takes place repeatedly during their hospitalization. Education tools include leaflets containing information on social services and application forms for social benefits; they are distributed by the educators to the clients. Education takes place in the social department and in the department where the client is hospitalized. The client's family his or her next of kin are educated in the social department in the client's absence. In most cases, health social workers do not evaluate the achieved results together with the client.

Conclusion: Health social workers provide patient education regularly. In the sample under consideration, the record of education was a part of the nursing documentation. The educational process faces certain barriers. To prevent them, we see a suitable solution in demanding continuous feedback from educators in the course of the educational process and the involvement of the patient's family in shared education. We also think that an appropriate method of reducing educational barriers due to sensory impairment consists in a deeper cooperation within the multidisciplinary nursing team. Based on our study we consider it valuable to recommend continuous improvement in the quality of care for the client in healthcare facilities, with emphasis placed upon careful preparation of the educational process.

Keywords: educational process, educator, health social worker

Introduction

The roots of the term *education* originate from the Latin words *educō*, *educare* meaning *to lead forward* or *to train*. In a healthcare facility, education is part of the care for the patient (Nemcová & Hlinková, 2010). Juřeniková (2010) considers the education procedure to be

a process that constantly influences an individual's behaviour and conduct with the objective to incite positive changes in their knowledge, attitudes, habits and skills. The key components affecting the education process are: the educated person, educator, education constructs and education environment. The educated person is deemed any subject of learning, in a healthcare facility usually a healthy or ill client or his/her family, but also a healthcare professional enhancing his/her knowledge and skills. Every educated person is an independent individual with differentiated physical, affective and cognitive properties, ethnic identity, religion and original social environment. The educator's role in health and social work is adopted by the health social worker. Owing to the knowledge of education methods, forms and ability to practically apply them, the health social worker also acts as the patient's consultant and supporter in the context of education provided to a hospitalized patient. The professional scope of practice of the health social worker is defined by Act No. 96/2004 Coll. on Non-Medical Healthcare Professions (Czech). Decree No. 55/2011 Coll. on Healthcare Employees' Activities (Czech) further regulates the activities and competences of health social workers such as social prevention and an active identification of clients that find themselves in an adverse social situation due to their illness. By collaborating with public administration bodies, they develop a report assessing the client's life situation based on the obtained information. Subsequently, they diagnose the client's needs and draw up a psycho-social intervention plan in the client's life situation. In it, they specify the range and type of the necessary social action. These actions may be executed by the worker in cooperation with the client's nursing team. The health social worker participates in the integration and preparation of the patient's discharge and in this context provides social and legal consultancy concerning his/her illness or the consequences of such illness. He or she executes activities towards the provision of further care or services. As educational aids, they utilize informative leaflets and brochures on the services or care provided. They act as coordinators of the entire education process and at the same time as evaluators.

According to Kuzníková (2011), the task of the health social worker is to reduce or eliminate adverse impacts of the client's illness that reduce his/her quality of life. As part of health social rehabilitation in a healthcare facility, their task is to assist the client while creating a desirable level of quality of their life and at the same time, to act preventively against his/her readmission to the healthcare facility. The factors positively affecting the process of education include the educated person's compliance, taking the form of his/her effort to collaborate, high-quality educational materials and suitable educational environment. Contrariwise, factors slowing the education process down can be mainly seen in the patient's bad mental condition taking the form of anxiety, mistrust, lack of interest or poor physical condition. Also, cultural barriers, language barriers and adherence to different values may occur.

The interview method is used to understand the needs, express the wishes, formulate life planning towards meeting the client's expectations from the assistance provided. Therefore, the capability to engage in active listening is a vital skill for all the workers. It involves the art of focusing on what the client is telling them. And to recognize what they put major emphasis on in their communication (Matoušek et al., 2008).

Furthermore, the education process is affected by education constructs, understood to represent all laws, regulations, plans, education standards and materials, certificates, awards etc. (Magurová & Majerníková, 2009). Education barriers on the educator's part consist mainly in insufficient preparation of the education plan, which represents the base of education. Goals, methods and means of education are not clearly set. Education standards have been developed for the purpose of a professionally provided education. They determine

the standard and quality and, as Juřeníková (2010) states, an education standard should define the topic and objective of education, for whom the standard is binding, as well as the criteria for meeting the standard and the period of standard validity.

Objective

The objective was to describe the process of education while providing health social care within the competence of health social workers in healthcare facilities. The research questions determined in what manner, by what means and methods education is implemented by health social workers.

Methodology

A quantitative method, in the form of a questionnaire survey containing 24 questions formulated by the author, was selected to meet the research objective. The various questions in the questionnaire relate to the research questions, comprising 16 closed and 8 semi-closed questions. The research survey took place from March 2016 to June 2016. Questionnaires were administered in the selected facilities personally by the researcher in a printed form. The research sample was purposive. The purpose of the selection was to achieve considerable homogeneity of the research sample, representing certain common properties (Bártlová & Hnilicová, 2000). The respondents were health social workers in health social facilities in Prague and on the territory of the Central Bohemian Region. 31 health social workers from 5 healthcare facilities took part in the survey. The respondents were mainly in the 31–40 age category and also above the age of 50, with secondary and higher professional education, up to a university education degree. The return rate was 100 percent; one questionnaire was disqualified due to failure to respect the instructions specified in the introduction. The data obtained was processed and evaluated by means of descriptive statistic methods with graphic indication of absolute and relative frequencies.

Results

Findings concerning the number of educational sessions provided to hospitalized clients were observed; 13 respondents / health social workers (43%) educate a client more than three times over the period of his/her hospitalization. Seven respondents (23%) educate a client three times during the hospitalization period. 5 respondents (17%) educate a client twice during hospitalization and the same number (17%) educate a client once during hospitalization (Fig. 1).

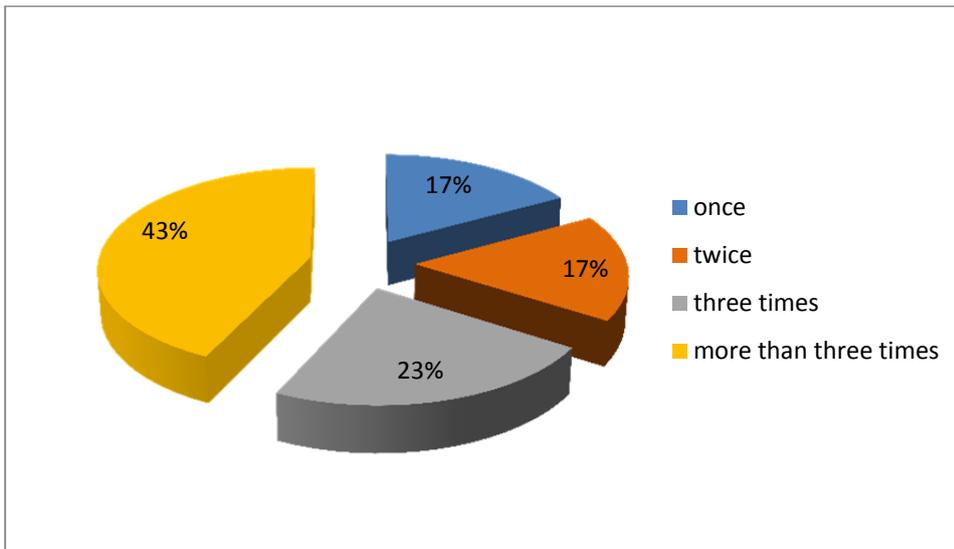


Fig. 1 Graph of variables under consideration – frequency of education of one client in the course of his/her hospitalization

The majority of respondents i.e. 19 (63%) reported that they educated clients by practicing a skill and 11 respondents (37%) did not use skill practice (Fig. 2).

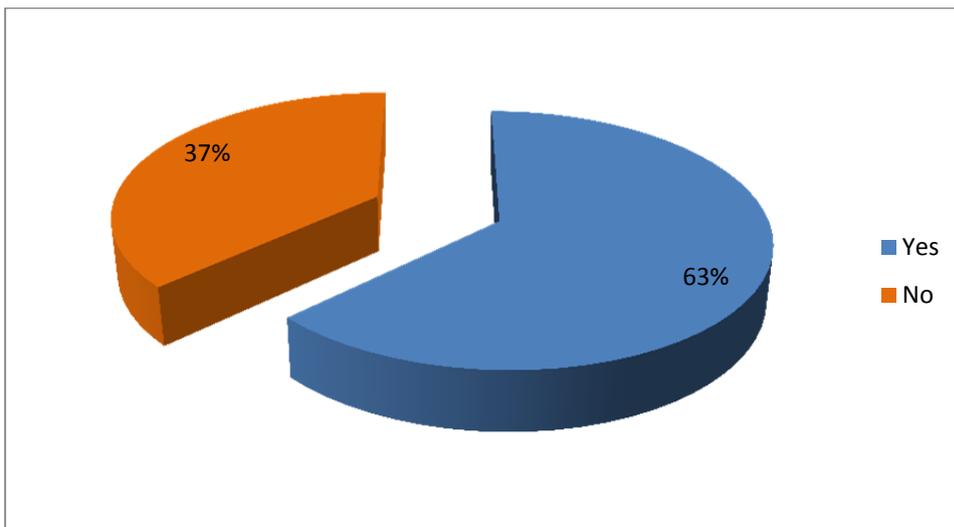


Fig. 2 Graph of variables under consideration – education by practicing a skill

Twelve respondents (40%) do not evaluate the implemented process of education. Final evaluation is carried out by 10 respondents (33%). Another 8 educators (27%) carry out continuous evaluation of education. None of the respondents carry out both continuous and final evaluation (Fig. 3).

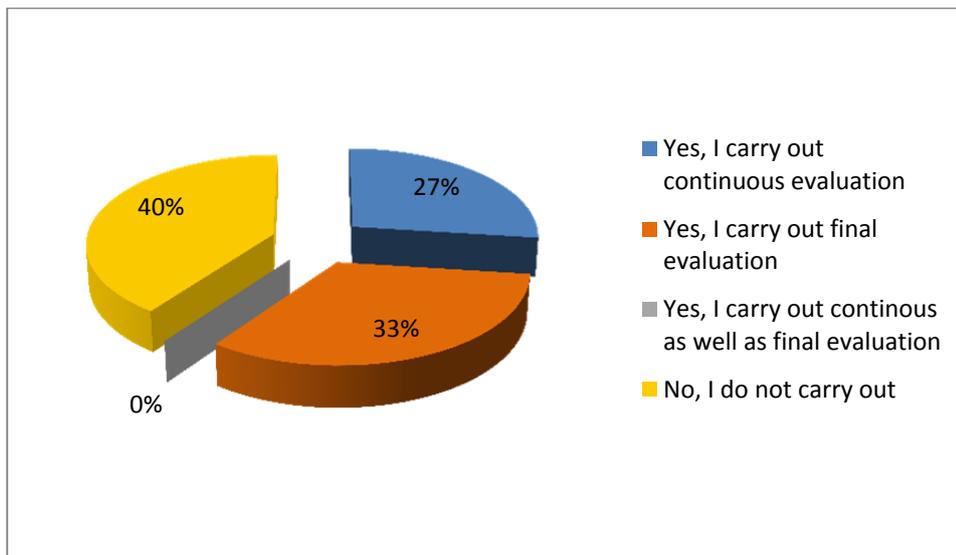


Fig. 3 Graph of variables under consideration – evaluation of education

Discussion

Due to a lack of similar surveys in the past, it was challenging to compare the research results in the discussion part with other research works concerning the same or a close topic. Research surveys focusing on patient's education by a health social worker in a healthcare facility mainly focus on education of patients with a specific illness. Therefore, comparison with expert literature and partially also with similar works focused on education in nursing practice was used in this discussion.

In order to describe the education process provided by health social workers in selected healthcare facilities, health social workers in hospitals in Prague and in the Central Bohemian Region were approached. The research sample consisted of health social workers, mainly in the age categories of 31–40 years and above 50 years, with education degrees ranging from secondary (13%) and higher professional education (34%) to university bachelor (33%) and master degrees (20%). Education is provided by health social workers to hospitalized patients repeatedly, usually more than three times, during 10 to 15 minutes per session. Seven health social workers (23%) educate their clients longer than 25 minutes. The educated clients are mainly patients with chronic illnesses and persons with dementia. Twenty-eight health social workers (93%) gain social case history and 2 health social workers (7%) do not. Clients are educated in the area of social services. Six respondents mentioned specifically community care services (18%). Frequent social care facilities that use education are retirement homes, as reported by 5 respondents (17 %); 4 respondents stated day care centres (13 %). As for the question concerning the setting up of education plans, most health social workers responded that they did set up an education plan – 10 respondents (33%) with occasional frequency and 10 respondents (33%) nearly always. According to Juřeniková (2010), an education plan should be set up in writing, ideally in cooperation with the patient and filed in the records. The vast majority of respondents (90%) mentioned the education plan as being part of the nursing documentation. Education in a healthcare setting in the Czech Republic was addressed by a survey that took place in 2015 (Černíková, 2015). In this survey, the author studied patients' education concerning self-care. The findings of the work show that education documentation is used. In this research, the respondents / general nurses specified that an education record also serves as a way how to inspect what the client has already been educated about and what further information needs to be provided. Based on this

characteristic of education materials, it can be concluded that such records may be parallel to the education plan, fulfilling the same purpose. Furthermore, the above-mentioned study focused on the length of the patient's education session. The findings mention that the length of education session is individual but the usual time range is 15 to 20 minutes, which is comparable with the results of our study. The research results of Zámečková's master's thesis (2011), addressing nursing documentation in practice, present different findings as only 35 respondents / general nurses (5%) out of 204 respondents mentioned the education plan as being a part of documentation.

As for the concrete benefit of education time planning, 11 respondents in our research (37%) see the main benefit of education time scheduling in that it supports implementation of the plan, and another 10 health social workers (33%) mentioned that owing to the education plan they could better describe the content of the necessary education. All health social workers execute client education in the form of interviews and by means of social benefit application forms. At the same time, all 30 health social workers provide clients with education materials.

As for the question concerning the education environment, 27 health social workers (87%) find their environment satisfactory and 4 health social workers (13%) do not. A half of the health social workers implement education both on the ward where the client is hospitalized and on the social ward. Eight health social workers (27%) mentioned that education was provided only on the ward of the client's hospitalization and 7 health social workers (23%) only educated clients on the social ward. None of the respondents mentioned another place where the client's education took place. Nine health social workers (30%) mentioned that they educated clients' families and close persons on the social ward in the clients' absence. Seven health social workers (23 %) mentioned that they educated clients' families and their next of kin on the social ward in the clients' presence. Shared education provided to clients and their families on the ward of the client's hospitalization was reported by 8 respondents (27%). Six educators (18%) indicated possible education of the client's family and their next of kin on the ward of the client's hospitalization but in the client's absence. The previously mentioned research by Černíková (2015) also studied the involvement of the family in the hospitalized client's education. The findings indicate that general nurses try to involve the family in education; in cases of non-self-supporting clients, nurses recommend home care agencies. Another method of involving the family in education consists in practicing the client's skills. Such education takes place on the ward of the client's hospitalization and in his/her presence. Based on these findings it can be anticipated that involving the family in shared education may prevent education barriers and other complications, which may occur as a result of the client's health condition. Similar assertions can also be found in Bártlová's research (2005), who considers maintaining the patient's active contact to his/her family members important not only for the natural continuation of personal relationships but also to increase the patient's motivation for self-care. Muma and Lyons (2012) perceive family involvement in the educational process as a form of support in moments when the patient has difficulty performing complex tasks. For 15 respondents in our survey (50%), education is obstructed by the client's health condition; specifically 5 health social workers (17%) perceive barriers due to the client's sensory impairment. Foreign language represents a barrier in education for 4 health social workers (13%). Three health social workers (10%) mentioned poor level of the client's information about his/her health condition as a barrier in education. Only 3 health social workers (10%) identified no education barriers. At the same time, none of the health social workers indicated different cultural habits as a possible barrier to education. Only 3 health social workers (10%) reported that their clients sign a declaration on the provided

education at the end of such education; other respondents do not let their clients sign any such declaration.

Conclusion

Health social workers meet the hospitals' international accreditation standards of care for patients at a medical facility by providing regular education. Education usually takes place on the social ward and on the ward of the client's hospitalization. The client's family and close persons are typically educated by health social worker at the social ward in the client's absence. Prior to the actual education, health social workers determine the client's social case history and when educators develop an education plan, they mostly do so in collaboration with the client. To make the education process more effective, we find valuable the setting of education goals and increasing continuous control of the level of the acquired knowledge or the patient's practical skills. All respondents use education materials and aids and at the same time, provide them to the client. These include mainly brochures and education leaflets concerning follow-up care after the patient's discharge from the healthcare facility. Health social workers make records of the content of education in the patient's documentation. Based on our findings we determined that a low percentage of educated persons/patients signed a document confirming that education had been provided. An important component of the treatment of every patient is team work involving both medical and non-medical professionals but also the patient himself/herself and his/her family. Based on our findings, as we found barriers in care for the patient due to his/her sensory impairment, we also think there is room for recommending a more intensive collaboration, involving both the interdisciplinary team and the actual family in a shared education with the patient. We believe that the positive effect of an adequate education process is beneficial both for the patient himself/herself and for the caring healthcare personnel. Based on our study, we find it valuable to recommend a further improvement of the quality of care for the patient in healthcare facilities with an emphasis placed on careful preparation of the education process, which focuses on actual and potential problems of health care and can be used to set plans for assessing the patient's needs. We should support the involvement of the patient's close family circle in shared education in order to improve the quality of follow-up care for the patient after his or her hospitalization in the healthcare facility.

In our opinion, the limitations of our study consist in the fact that the length of the educator's practical experience, frequency of education depending on the duration of the patient's/client's hospitalization and his/her actual social situation were not considered. We consider these topics relevant for further research studies on the education process in the practice of health social workers in healthcare facilities.

Ethical aspects and conflict of interest

Ethical principles were adhered to and no conflict of interest was encountered in the course of the research survey. While processing the survey results, the respondents' anonymity was maintained.

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Validity and Reliability of Nursing Intervention Breastfeeding Assistance 1054

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Abstract

Introduction: Nursing Interventions Classification (NIC) has the potential to become an indicator of the efficiency and quality of nursing care. In order to achieve computerization of nursing data and their use in the real nursing practice, it is necessary to determine the validity and reliability of the individual components.

Objective: The objective of this study was to evaluate the degree of Interventions Content Validity (ICV) and the reliability for nursing intervention *Breastfeeding Assistance 1054* implemented in mothers and newborns during lactation on a postpartum ward.

Method: For data collection, a measuring instrument consisting of 32 nursing intervention items, listed in the Nursing Interventions Classification system. A modified Fehring's Diagnostic Content Validity Model – in the context of validating nursing interventions usually referred to as Fehring Interventions Content Validation (ICV) – was utilized as the validation instrument. The sample consisted of expert nurses (n = 122) that gained 4 points by the modified Fehring criteria. Internal consistency of the instrument was verified by Cronbach's alpha coefficient. The measure of dependence among the defining nursing activities was tested using Spearman's correlation analysis. Cluster analysis was used for identifying statistical correlations in a group of expert nurses with respect to the length of practice and education.

Results: The ICV score value of nursing interventions *Breastfeeding Assistance 1054* as a whole was 0.83. A total of 22 activities achieved a weighted average of > 0.80 and 10 activities were within the range from 0.79 to 0.50. No activity achieved a weighted average of <0.50. No correlation between the selection of activities, experts' education and length of practice was confirmed (p > 0.05).

Conclusion: The ICV model was used for presenting a group of valid nursing activities for the performance of NIC intervention *Breastfeeding Assistance 1054* in mothers and newborns during lactation at a postpartum ward.

Keywords: breastfeeding, Nursing Interventions Classification, reliability, validity

Introduction

Like in other scientific disciplines, also in nursing, phenomena are not measured directly but using indicators representing the relevant phenomenon in question. Validity concerns the adequacy of the research methods determining and measuring what we actually wish to determine and measure. Reliability is an indicator of research accuracy and credibility. Given good reliability, by repeating a research study we should arrive at the same results provided that the condition of the subject of the research study has not changed (Hendl, 2006). The use of a standardized nursing language has a principal importance for nurses in clinical nursing practice as well as for nurses in primary care. It is a major attribute of professional nursing in the 21st century and opens up a new path for scientific evolution in nursing. The Nursing

Interventions Classification (hereinafter referred to as the NIC) comprises a complex classification of nursing interventions, composed based on precisely observed and uniform principles and rules. The taxonomy includes activities carried out by nurses while providing daily nursing care, resulting from nursing diagnoses. Part of the taxonomy are dependent and independent activities carried out by nurses independently for the client or in cooperation with him or her while providing direct or indirect nursing care. An intervention is understood to be any nursing procedure based on clinical assessment and on expert skills and knowledge applied by the nurse in order to improve the client's treatment results. The actual classification system is highly beneficial for clinical practice, presents a uniform nursing terminology with application in numerous healthcare disciplines, focusing not only on prevention and treatment of illnesses but also on supporting the health condition of individuals, families or communities (Bulechek, Butcher, & McCloskey-Dochterman, 2008). Nursing intervention *Breastfeeding Assistance 1054* is defined as preparation of the mother and her child for breastfeeding and includes 32 specific nursing activities.

Objective

The main objective of the present study was to evaluate the Interventions Content Validity (ICV) and reliability of nursing intervention *Breastfeeding Assistance 1054*, applied to mothers and newborns in the postpartum ward. Partial objectives were: To find out what nursing activities experts consider important, less important and abnormal for fulfilling nursing interventions. To verify the level of internal consistency (reliability) of NIC interventions, measured using the Cronbach's alpha coefficient. To analyse the importance of statistically significant correlations between the various nursing activities and to statistically objectivize the correlations in experts' data while selecting nursing activities in regards to the length of practice and to education.

Methodology

The research study took the form of a cross-sectional study applying Fehring's retrospective model Diagnostic Content Validation – DCV model (Fehring 1986, p. 187) and its modification to suit the needs of validating the Nursing Interventions Classification (NIC) - Interventions Content Validity (ICV). The research question that the study endeavours to answer was formulated as follows: “What is the validity and reliability of nursing intervention Breastfeeding Assistance in mothers and newborns while breastfeeding on the postpartum ward?”. A measuring tool containing 32 items of nursing activities within the nursing intervention specified in the NIC classification system was used for data collection. The approach used to analyse the importance of the various nursing intervention activities respected Fehring's methodology (1987) for calculating a weighted average of ICV. Evaluation on the Likert scale was carried out as follows: 5 on the scale = 1; 4 = 0.75; 3 = 0.5; 2 = 0.25 and 1 = 0. Afterwards, arithmetic means were used for obtaining ICV weighted averages for nursing activities. A weighted average value ≥ 0.80 = a *major, critical* indicator; a weighted average 0.79–0.50 = *minor*; and a weighted average < 0.50 = insignificant, to be disqualified from the sample of diagnostic characteristics. The sample consisted of 122 experts (a pilot study of 20 respondents) that had gained at least 4 points under the modified Fehring's criteria (Zeleníková, Žiaková, Čáp, Jarošová & Vrublová 2010). Internal consistency of the tool was verified by the Cronbach's alpha coefficient. The measure of dependence between the defining nursing activities was tested by means of Spearman's correlation analysis. Cluster analysis was used to determine statistical relations within the

group of experts with regards to the length of their practice and their education. A data matrix was developed in Microsoft Excel for processing the data using statistical methods. Experts' demographic data were subject to content analysis, based on which categories were defined and subsequently evaluated in Microsoft Excel. Another statistical data processing took place using the STATISTICA software, version 12, at a significance level of $\alpha = 0.05$; 0.01.

Results

Tab. 1 Nursing activities of validated intervention Breastfeeding Assistance

Nursing Activities	Average	\pm SD	Weighted average
Enable mother's timely contact with child and provide opportunity to breastfeed within 2 hours after birth	4.58	0.71	0.90
Instruct mother about correct position	4.54	0.64	0.89
Monitor newborn's ability to correctly grasp the nipple	4.50	0.67	0.88
When necessary, inform mother about possible suction in order to maintain lactation	4.53	0.74	0.88
Encourage mother to ask nurses for assistance during first attempts when necessary, in order to achieve feeding 8 to 10 times per 24 hours	4.48	0.66	0.87
Instruct mother about correct care for nipples including how to avoid nipple pain	4.49	0.70	0.87
Instruct mother on how to check for breast engorgement and on timely emptying by breastfeeding/suction	4.48	0.81	0.87
Monitor newborn's position relative to the breast, listen to swallowing sound and suction/swallowing manner	4.45	0.64	0.86
Instruct mother on watching the newborn while sucking	4.43	0.75	0.86
Instruct mother on the correct method of terminating infant's sucking	4.43	0.69	0.86
Watch integrity of skin on nipples	4.43	0.71	0.86
Monitor increased breast filling in regards to breastfeeding or suction	4.44	0.74	0.86
Monitor newborn's ability to suck	4.40	0.66	0.85
Instruct how the newborn is supposed to burp	4.40	0.82	0.85
Talk to mother about her desired intensity and period of breastfeeding	4.36	0.89	0.84
Encourage mother for sufficient water intake to satisfy thirst	4.36	0.84	0.84
Instruct mother on balanced nutrition in the breastfeeding period	4.34	0.88	0.84
Support mother's comfort and privacy during first breastfeeding attempts	4.31	0.83	0.83
Discuss possible use of breast pump if the newborn cannot be breastfed at the beginning	4.33	0.80	0.83
Instruct mother on the typical characteristics of newborn's urination and defecation	4.33	0.91	0.83
Assist parents to identify stimuli of an awoken newborn as opportunity to breastfeed	4.28	0.80	0.82
Recommend frequent relaxation	4.23	0.84	0.81
Encourage mother to offer both breasts during every breastfeeding	4.19	1.11	0.80
Encourage mother to breastfeed as long as the newborn is interested	4.20	1.02	0.80
Encourage the use of comfortable, cotton, supportive bra for breastfeeding mothers	4.19	1.05	0.80
Convince mother to avoid smoking cigarettes when breastfeeding	4.20	0.96	0.80
Monitor the defecation reflex	4.16	1.10	0.79
Identify mother's supportive system to maintain lactation	4.17	0.92	0.79
Support non-nutritive suction from the breast	4.12	1.08	0.78
Inform mother about lactation consultants as necessary	4.10	1.08	0.77
Provide written materials with sufficient information to be taken home	4.10	0.92	0.77
Convince mother to avoid the use of synthetic materials	3.96	1.18	0.74

SD – standard deviation

Based on an analysis of nursing activities using the ICV model we have documented a group of valid nursing activities for fulfilling NIC interventions *Breastfeeding Assistance 1054* in mothers and newborns during breastfeeding on the postpartum ward (Tab. 1). Weighted average values > 0.80 (major activities for fulfilling the intervention) were obtained for 22 activities and weighted average of $0.79-0.50$ (activities less important for fulfilling the intervention) were obtained for 10 activities. No activity was classified in the weighted average category of < 0.50 (activities abnormal for fulfilling the given intervention). The ICV score value of the nursing intervention *Assistance in Breastfeeding 1054* as a whole was 0.83. The value of Cronbach's alpha in *Assistance in Breastfeeding 1054* was 0.968 and we can state that the tool has high consistency and reliability. We have further tested the correlations between the various nursing activities. The statistical hypotheses were verified by means of Spearman's correlation analysis (r_s), at a statistical significance level of $\alpha = 0.05$ a 0.01. The following hypotheses were tested by means of the correlation analysis:

H₀₁ There is no significant correlation between the ICV values of weighted NIC scores for *Breastfeeding Assistance 1054*.

H_{A1} There is a significant correlation between the ICV values of weighted NIC scores for *Breastfeeding Assistance 1054*.

Strong positive correlation was found between the following nursing activities: Instructing mother to watch newborn while sucking and supporting comfort during first breastfeeding attempts ($r_s = 0.712$), instructing mother to watch the newborn while sucking and supporting non-nutritive breast sucking ($r_s = 0.703$), monitoring integrity of skin on nipples and instruction on correct care for nipples including how to avoid nipple pain ($r_s = 0.710$), supporting no-nutritive breast sucking and encouraging mother to offer both breasts during every breastfeeding ($r_s = 0.703$). However, most activities oscillate in the medium strong correlation area. Contrariwise, low correlation was identified in two cases, namely between: providing written materials with sufficient information and providing timely contact between mother and child and opportunity to breastfeed within 2 hours following birth ($r_s = 0.189$), providing written materials with sufficient information and instructing mother on correct position ($r_s = 0.118$). The formulated zero hypothesis was rejected at the level of statistical significance of 0.05 and 0.01 and, contrariwise, a measure of correlation i.e. existence of mutual relation between the various activities was found. Further, we examined correlations within the group of experts in regards to the length of their practice and education. The cluster analysis method was applied to the various statistical units in order to reveal clusters of respondents showing mutual similarities. The clusters were generated based on the length of practice or education and on the evaluation score up to 0.75 versus evaluation of 1.00. At first, we confirmed the hypothesis that pertinence to one or another cluster depends on the length of the respondent's practical experience. The results are summarized in the following tables. We differentiated practical experience up to 10 years (line 1 in each table) and longer practice (always line 2) and the evaluation (score) up to 0.75 vs. evaluation of 1.00. The division into clusters corresponds to the division into two columns as specified in Tab. 2.

The results of the cluster analysis were tested in the following way:

H₀₂ There is no significant correlation between the selection of the various NIC nursing interventions by the experts (pertinence to the cluster) and the length of their practice.

H_{A2} There is a significant correlation between the selection of the various NIC nursing interventions by the experts (pertinence to the cluster) and the length of their practice.

The dependence of the division into clusters on the length of practice was examined using the Chi-squared test.

Tab. 2 Pertinence to two clusters and length of practice

Practice	cluster 1		cluster 2		Total	
	n	%	n	%	n	%
up to 10 years	13	32	27	68	40	100
11 or more	32	39	50	61	82	100
Total	45	37	77	63	122	100

p – value 0.483

The results were statistically insignificant ($p > \alpha$) at level of $\alpha = 0.05$. The null hypothesis cannot be rejected (H_02). The dependence on the length of practice could not confirmed.

Subsequently, we confirmed the hypothesis that pertinence to one or another cluster depends on the respondent's education. The results are summarized in the following tables. We differentiated between the following levels of experts' education: higher professional school or at least bachelor university degree (university - always line 1 in all tables) vs. secondary healthcare school (secondary school - always line 2). Both of such diversified categories of education included an equal number of respondents (61). The division into clusters corresponds to the division into two columns as specified in Tab. 3.

The results of cluster analysis were tested in the following way:

H_03 There is no significant correlation between the selection of the various NIC nursing interventions by the experts (pertinence to the cluster) and education.

H_A3 There is a significant correlation between the selection of the various NIC nursing interventions by the experts (pertinence to the cluster) and education.

Tab. 3 Pertinence to two clusters and education

Education	cluster 1		cluster 2		Total	
	n	%	n	%	n	%
Higher school+BS+master	22	36	39	64	61	100
secondary healthcare school	23	38	38	62	61	100
Total	45	37	77	63	122	100

p-value 0.851

The results are statistically insignificant ($p > \alpha$) at a level of $\alpha = 0.05$. The null hypothesis cannot be rejected (H_03). The dependence on education could not be confirmed.

Discussion

As for Czech literary sources for comparison with our findings we can mention the outcomes of Michalová's (2013) master's thesis, focused on the management of care for the physiological newborn using classification systems. Apart from validation of nursing diagnoses, she also focused on verifying 9 nursing interventions. She also included Breastfeeding Assistance in the sample. The author found significant those characteristics that

reached relative frequency in the research survey higher than 60 percent. The results imply an obvious concordance in the selection of lower importance of activities - support non-nutritive suction from breast, inform mother about lactation consultants as necessary and provide written material with sufficient information to be taken home. At the same time, the above-stated activities are included in the approach recommended by “*Full-Term Newborns Breastfeeding*”, issued by the Czech Neonatology Society (Mydlilová, 2013). Also based on our clinical experience we dare assert that education on the possibilities of further lactation consultancy after release from hospital is not given sufficient attention. The NIC classification system as a standard for nursing physiological newborns was the topic of Machatová’s master’s thesis (2009). In the first stage of her study, she selected suitable NIC nursing interventions, in the second stage she analysed fifty random medical records of breastfed physiological newborns and in the third stage she used a quasi-experimental method to verify ten sets of the NIC classification system on 20 random newborns, including the Breastfeeding Assistance intervention. Nurses entered the various nursing activities of the given interventions into a ready-made documentation form. The results clearly imply that when using NIC sets, the highest number of nursing activities was focused on education of the mother and her involvement in the care for the child. The author confirmed a statistically significant difference between the recorded nursing activities in the analysed documentation and the selected samples of the NIC classification system. The prepared simple documentation with selected NIC sets additionally included the recorded interventions. The most frequent activity was: monitor the newborn’s ability to correctly grasp the nipple and areola; in our study this activity reached the weighted average of 0.88. The following most frequent activity was: monitor the newborn’s position at the breast and listen to swallowing/suction sound; in our study this activity again reached a high weighted average of 0.86. A similar study was executed by Pretáková (2011), focusing on the management of nursing NIC interventions in the care for premature infants. In the first stage of her study, she selected suitable NIC nursing interventions, in the second stage she analysed one hundred random medical records of nursed premature newborns for 19 days and in the third stage she used a quasi-experimental method to confirm 28 samples of the NIC classification system on six random premature newborns, pursuant to our study again including Breastfeeding Assistance intervention. The most frequently recorded activity was focused on supporting lactation in the first days of hospitalization. It was also applied on newborns whose mothers were not hospitalized together with the child and pumped breast milk in their home environment. The newest study focused on the problem of lactation consultancy was conducted by a group of authors Pokorná, Kameníková & Dvořáková (2016). The authors focused on the current situation in lactation consultancy and possibilities for improving lactation consultancy effectiveness. They executed a questionnaire survey on three target populations of perinatology centre managers, designated as Baby Friendly Hospitals (BFH), 241 mothers after delivery and 120 regular healthcare workers caring for mothers in BFH. As for the importance of information on breastfeeding from the mothers’ and healthcare personnel’s point of view, they provide some conflicting findings. When assessing the importance of the duration of breastfeeding on a 5-point Likert scale, healthcare professionals evaluated the duration of breastfeeding as the least important and frequency of breastfeeding, on the contrary, as very important. Paradoxically, they stated care for painful nipples and painfully overfilled breasts as the most important ones, which did not correspond to the declared interventions they provide to mothers but it did correspond with what mothers find important. Just like for the mothers, the importance of information on “pause in the movement in the child’s chin” when it swallowed was considered the least important, while

it is one of the indicators of effective breastfeeding and this information had not been evaluated by the twenty healthcare professionals at all. The authors believe that both participating parties did not even know this term. Another negative finding was the affirmation of 39 mothers that they had not been instructed on how to assess breastfeeding effectiveness.

Conclusion

The above-mentioned results of our survey make obvious that the selected intervention is valid for our socio-cultural environment. Both for nurses and midwives providing lactation consultancy, the validated nursing intervention is comprehensible regardless of the length of their experience and education. Other similar studies that have been identified support the effectiveness of nursing documentation if the Nursing Interventions Classification system is used. In the Czech environment, nursing professionals tend to maintain an opinion that using uniform nursing terminology and classification systems will only make administrative load rise. Implementing a uniform nursing language into usual practice focused on lactation consultancy will continue to provide evidence of its benefits to healthcare providers themselves but above all, to mothers after delivery during their hospitalization.

Ethical aspects and conflict of interest

From the perspective of possible conflict of interests, we did not find any circumstances that would threaten the fundamental publication principles. The research was preceded by an approval of data collection by the Ethic Committee of the Faculty of Health Studies, Jan Evangelista Purkyně University, Ústí nad Labem, including respondents' consent to participation in the study.

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Importance of Oral and Dental Health in the Elderly

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Abstract

Introduction: Oral health has a significant impact on the overall health condition. Both the lay public and experts often underestimate this problem area. Apart from the health of the oral cavity itself and overall health, care for one's oral health improves overall quality of life. The condition of oral health in the elderly population is not at the desired level. To a great extent, oral health can be influenced by correct care. More attention should be paid to educating the population and the subjective area of self-care should not be underestimated.

Objective: The objective of the study was to point out the importance of oral health in the context of overall health and to present the condition of seniors' oral health as well as their interest in care for the oral cavity (including dentures).

Method: A research probe was used, with a combination of quantitative and qualitative techniques in the process of data collection and analysis. We used our own questionnaire and semi-structured interviewing. The total number of respondents was 36 in the quantitative part and 7 in the qualitative part. Respondents in both parts of the study were elderly persons – members of a selected senior club older than 65 years. Respondents' cognitive status was determined by means of the clock drawing test. The questionnaire data were processed using statistical software STATISTICA©.

Results: The oral health condition in the selected sample of seniors is lower than desirable. Seniors in the research sample have no complex knowledge in the area of dental and oral care although they are interested in it. They are not aware of the impact of oral health on the overall health condition.

Conclusion: The research probe implies that public awareness of this subject matter should be continuously and systematically increased. Multidisciplinary importance of oral health must be emphasized. An educational lesson was provided in the senior club and educational posters and leaflets were created in reaction to the results of the research probe.

Keywords: education, elderly people, knowledge, oral health, overall health

Introduction

Oral health is a highly important factor affecting the overall health of an organism. Correct dental and oral care is an integral element of hygienic care. People often tend to give it less care than necessary and lack relevant information on how to correctly keep their oral cavity healthy and to what extent oral health impacts the overall health condition. Providing health in the oral area is a significant method of disease prevention in both soft and hard tissues. Multiplication of pathogenic microorganisms in the mouth and endotoxines produced by such microorganisms that may penetrate the human circulatory system may lead to the development of more serious illnesses in the entire organism. Furthermore, the substantial impact

of the condition of the oral cavity on the quality of life in terms of food ingestion, phonation, aesthetics and overall comfort must not be omitted (Mazánek et al., 2014).

Regular, effective and systematic reduction of plaque, which naturally grows in the mouth and may be a source of pathogens, plays a key role in maintaining oral health. According to Kovařová, Javorka a Dřízhal (2002), up to 98 percent of the population suffer from some form of gingivitis or parodontitis. Inflamed tissue around the tooth is a significant source of infection for the entire organism (Kovařová et al., 2002). An analysis of oral health in selected age groups of the population of the Czech Republic executed in 2003 revealed that the condition of oral health in the population was far from the desirable level in the context of overall health across all age categories. For instance, only 6.5 percent of the group of 18-year-old persons had intact permanent teeth and 57.7% needed treatment of at least one tooth (Broukal et al., 2004).

Preconditions for effective maintenance of oral health include: knowledge of correct tooth brushing technique, selection of suitable aids and, naturally, interest in care in this area. The vast majority of illnesses of hard and soft tissues in the oral cavity can be prevented by correct care (Mazánek et al., 2014).

The level of the required knowledge and the method of transmitting information differs across the various age stages of human life (Juřeniková, 2010). The motivation for research in this area is a question of whether the population shows sufficient interest in this problem area, to what extent the public is informed and of whether there are sufficient and appropriate sources of relevant information in the given area of care.

Every person should, in their own interest, be concerned about this problem area. Every healthcare professional should be able to make the patient aware of errors concerning their oral care, instruct them how to correct such errors and call their attention to the importance of this care in the context of overall health. Every healthcare professional should take the importance of oral health into consideration and refer the patient to a dental hygienist, in time. Successful treatment of the patient's overall disease cannot be expected if his or her body is exposed to numerous pathogens in the circulatory system, originating from the oral cavity. It is desirable to constantly increase the population's awareness of the importance of oral health and of how to maintain it. Numerous research studies confirm the overreaching impact of oral health on diseases such as diabetes mellitus (Duřková & Broukal, 2003) and mainly on the development of cardiovascular diseases, as revealed for instance by studies conducted by Haraszthy et al. (2000) or Kozarov et al. (2005). The likelihood of myocardial infarction is 1.5 to 2 times higher in patients with periodontitis than in the healthy population, the occurrence of stroke is even 2.8 times higher (Dřízhal, Prouzová & Úlehlová, 2012).

Objective

The main aim of the present paper is to draw attention to the importance of oral health and the need to constantly increase the population's awareness of this problem area. Sufficient attention must be paid to the care of one's oral health, at any age. The present paper is specifically focused on the importance of dental and oral care in the elderly population. Its basis was a research study called "Oral Health in the Elderly", determining the respondents', elderly persons' interest in the care of their oral cavity and dental prostheses and determining oral health in the elderly in a selected sample of respondents.

Methodology

The research probe was based on a quantitative and qualitative approach. The study sample consisted of respondents who were members of the Senior Club in the Pardubice Region and who had agreed to participate. The criteria for selecting the respondents included: age above 65 years and being successful in the cognitive test, regardless of their gender or level of education. Ethical acceptability of the study was approved by the faculty's ethical committee and prior to completing the forms, the respondents signed an informed consent. The data were collected using a questionnaire and interviews with seniors.

Data collection in the quantitative part of the study was done using own questionnaire. The questionnaire was developed based on research questions. Its final form was consulted with a dental hygiene specialist. The questionnaires were distributed to the respondents during one of the sessions of their Senior Club. The completion of the questionnaires containing 19 questions was completely anonymous and voluntary. The participants deposited the completed questionnaires into an identified and locked container. The questionnaire had been subjected to verification in a pilot study. A total of 36 completed questionnaires were used for participation in the research study. A so-called clock-drawing test, simple and reliable, was used for testing the respondents' cognitive function (Pokorná et al., 2013). In this test, the respondent is asked to draw the shape of a clock face and indicate a certain time on it – in this case 9:10 o'clock. This test preceded the first question in the questionnaire and its successful completion was a requirement for including the respondent in the study.

Another data collecting tool was a semi-structured interview with seven members of the Senior Club, who were willing to take part in it. All interviews were audio-recorded. The research probe took place from September to November 2016.

The questionnaire data were processed using statistical software STATISTICA©. Every question in the questionnaire was evaluated separately using descriptive statistics. Interviews were processed by transcription.

Results

The quantitative part of the research probe determined several influential factors affecting oral cavity health such as the condition of hard and soft dental tissues, respecting the principles of correct dental care, attendance to preventive check-ups, etc. The respondents' oral health proved to be at an inferior level and did not correspond with the population's parameters (see Tab. 1). The respondents' knowledge indicated that the importance of oral hygiene is being underestimated (see discussion below).

Tab. 1 Number of own teeth (own survey)

Number of own teeth	Absolute frequency	Relative frequency in (%)
At least 20	6	16.67
9–19	14	38.89
8 and less	16	44.44
Total	36	100.00

In semi-structured interviews the respondents replied to the following three questions.

- What does “health in the oral cavity” mean to you?
- How does oral cavity health affect you when you eat food?
- What affects your care for your own oral cavity?

Responses, in a shortened form based on selected keywords, were recorded in a probe table (Tab. 2), demonstrating the attitudes of the sample of the elderly respondents towards their oral cavity care. Out of all the respondents, only one person had own teeth with no prosthetics, the remaining six persons used dentures. The present overview supplements the conclusions of the quantitative research part as discussed below.

Tab. 2 Selected responses from interviews (own survey)

Respondent	Gender	Dentures / Own teeth	Question		
			1	2	3
1	Female	Dentures	Complete teeth; ability to speak; eat; most crucial	Penetrates under my dentures; too tight; frequent brushing; nuts; poppy; cumin; hard food	Remember it; aesthetics
2	Female	Dentures	Very important; necessity; nice smile	Nothing bothers; flush after meals	Aesthetics; smell prevention; embarrassment when carrying out hygiene in the public
3	Male	Dentures	Means a lot	Movement of the dentures; releasing; fine-grained food; hard food; cutting	Forgetting
4	Female	Dentures	Means everything, it would hurt; poor look; smell	Discomfort; release; bruises; no meal is difficult	Takes longer; forgetting
5	Female	Dentures	Very important; it would hurt	Sometimes swollen gums; to cut; nuts	Frequent hygiene; embarrassment; forgetting
6	Female	Dentures	Very important; would look terrible; basis for food	Crushing; hard food	Embarrassment in the public
7	Male	Own teeth	Important; ability to eat	No problems	Avoiding delicacies

All seven respondents gave similar answers to the question what “health in oral cavity” meant to them. The ability to eat or speak is highly important to them; aesthetics, pain and fear from smell were also mentioned. None of the respondents mentioned that they considered oral health important for their overall health, as well. We may thus imply that the respondents were not aware of this important fact. This finding is alarming because, as mentioned above, numerous studies confirm a direct correlation of oral health and overall health.

The answers to the second question concerning the impact of oral health on food ingestion were more diverse. The one respondent with own teeth did not face any difficulties in this regard, which was expected, and this fact confirms that having one’s own teeth eliminates complaints related to food ingestion. Two respondents with dentures had no problem with any kind of food, the remaining four respondents reported issues mainly with hard food. They had to cut or crush such food. Two respondents further reported that fine-grained food (poppy, cumin) was causing difficulties because it got stuck under the prosthesis. Also, two respondents complained about the fact that their dentures moved and got loose while eating. Moreover, two respondents mentioned the necessity to perform frequent hygiene, especially after eating. The respondents’ statements indicate limited quality of life in terms of food ingestion.

The third question concerned the impact on the care for one’s own oral cavity. The most frequently mentioned issue was forgetting about regular care. It was mentioned, for instance, that respondents did not remove their dentures from their mouth for the night. Three respondents mentioned embarrassment due to care for their dentures in the public or at home. Two respondents mentioned aesthetic aspects; one senior was concerned about bad breath. There were two complaints stating that care for one’s own dentures was time-consuming, and the respondent with his own teeth avoids eating delicacies because he has concerns.

Discussion

A total of 17% of the respondents reported that they had at least 20 own teeth. A 2003 oral health analysis states that the Czech population includes 25% of persons above 65 years of age with at least 20 own teeth without indication for extraction (Broukal et al., 2004). That implies that our study population included respondents with a below-average proportion of persons having at least 20 own teeth. Contrariwise, as many as 44% of our study participants selected an answer that indicated that they had 8 own teeth, at most (Tab. 1). This figure is relatively high and it can be assumed that a significant decline in the number of own teeth is not only due to degenerative changes caused by the respondents’ age but their life-long quality of care for their own teeth and the oral cavity must be mentioned as it is a key factor for oral health (Dostálová & Seydlová, 2008). A high percentage of respondents with a low number of own teeth supports the assumption that these people need a certain form of dental prosthesis. This is confirmed by the fact that even 80% of the respondents in our research sample reported that they actually did use some form of dental prosthesis. Broukal et al. (2004) states that in 2003, 23.1% of the population above 65 years used a partial removable prosthesis for the upper jaw and 32.9% for the lower jaw. 37% had a total dental prosthesis for the upper jaw and 22.1% for the lower jaw (Broukal et al., 2004).

The research study further addressed the condition of soft tissues in the oral cavity. Periodontal inflammation (periodontitis) manifests itself by gum bleeding and swelling, progressively deepening periodontal pockets and alveolar bone resorption. More than 60% of the respondents reported no issues with exposed tooth necks. Almost 70% of the respondents reported no reddish or swollen gums. However, it is disputable if the respondents are able to

critically assess the condition of their own periodontium. Around one third of the respondents mentioned complaints about painful gums and bad breath. This might imply periodontal impairment. Dřížhal, Prouzová and Úlehlová (2012) state that periodontitis is a very frequent disease of the oral cavity. In Central Europe, 40-50 percent of teeth with impaired periodontium are indicated for extraction. The most frequent cause of the development of this disease is incorrect care for the oral cavity. The international Community Periodontal Index (CPI) provides the most objective assessment of the periodontal condition (note: CPI = 0 indicates healthy periodontium, CPI = 3 periodontal pockets up to 3.5–5.5 mm and CPI = 4 periodontal pockets deeper than 5.5 mm). The national analysis of the dental condition implies that in the population above 65 years of age, 32.6% have CPI = 3 and 10.4% have CPI = 4 (Broukal et al., 2004). Such relatively high occurrence of periodontal impairment of soft oral tissues might indicate insufficient care for the oral cavity, which is closely related to this problem area, as mentioned above. Our study is limited by the absence of an objective assessment of the periodontium's actual condition using the CPI.

The following results were obtained in terms of the level of the elderly persons' care for their teeth and the oral cavity: most frequently, the respondents reported that they cared for their oral health twice a day for around 3 to 4 minutes. Since in oral care it is vital what aids are used, the respondents were enquired also about this area of care. Table 3 shows that all respondents used classical mechanical tooth brush. Only 14 percent used interdental brush, which occupies an irreplaceable position in dental care, even if the oral cavity includes only one single interdental space or a fixed dental prosthesis. Toothpaste, mouthwash or cleaning tablets for dentures were mentioned as the most frequent dental care accessories.

Tab. 3 Table of response frequencies - care aids (own survey)

Aid	Frequency of responses	Relative frequency of responses (%)
Toothpaste	33	91.67
Toothbrush	36	100.00
Interdental brush	5	13.89
Single-tuft toothbrush	2	5.56
Dental floss	6	16.67
Mouthwash	16	44.44
Fluoridating agent	2	5.56
Cleaning tablets for dentures	17	47.22
Others	2	5.56

The results of the quantitative part of the research study further imply that over 40% of the respondents do not have preventive dental check-ups twice a year. A patient is entitled to a preventive check-up by his/her stomatologist twice a year. Dental prevention is crucial for maintaining healthy and functioning teeth as long as possible. Timely detection of potential issues in the oral cavity considerably improves the prognosis of any disease in this area. A research conducted by Orbit shows that 66% of patients visit their dentist for preventive checks twice a year (Orbit klub, 2012). The Stomatologist's competences include an examination and care of the oral area as well as educating patients about correct care for their teeth and oral cavity, or the dentist should recommend the patient to see a dental hygienist.

A total of 44% of the respondents subjectively did not feel well informed about the problem area of care for their oral cavity, teeth and/or dental prosthesis. On the other hand, the

respondents are interested in new information on the topic of oral care and find their oral health important. This is mainly the case in terms of food ingestion, phonation and aesthetics.

The respondents most frequently gain information on care and oral health from their stomatologist. The media, other persons and educational materials were mentioned as other sources of information. This leads to questions about the relevancy of the resources the respondents use because non-certified resources give reasons for doubts about the quality of information. Due to the overreaching impact of oral health on one's overall health, preventive checks at the general practitioner's office and by other specialists should be considered as significant sources of information, as well. Further research might be stimulated by efforts to find out if healthcare professionals are, in general, concerned about the condition of their patients' oral cavity and teeth and if they are able to provide them with information on this issue.

The results of the qualitative part of the research study correspond with the results of the quantitative part of the survey.

The entire research probe was limited mainly by the fact that the sample of respondents was not representative and also by its generic focus, not involving an evaluation of the data obtained by means of an objective examination of the oral cavity. However, the present probe provides a brief insight into the area of oral care in seniors and gives inspiration for further research.

Conclusion

The research probe showed that elderly persons in the selected sample are lacking correct information on how to care for their oral cavity and teeth. They are not aware of the overreaching impact of oral health on their overall health. Subjectively, they do not feel sufficiently informed about this problem area although they are keen on receiving such information. Also, the condition of their oral health showed certain shortcomings. Data from future research surveys with the same subject should additionally include objective indicators of the condition of the teeth and the oral cavity. Another finding was that a relatively high percentage of the respondents do not regularly visit their stomatologist for preventive checks.

Since oral health influences the overall health condition, it would be desirable to constantly and systematically increase public awareness of the care for own teeth and the oral cavity. It is also important that they obtain information from relevant sources. The fundamental source of information is the stomatologist and dental hygienist. Other primary care physicians should also be able to inform their patients about this problem area and should not omit it in the context of their overall health. Experts should be urged to pay more attention to education on oral health. Other research surveys should be focused on this problem area. Increasing the population's awareness in the area of dental care is beneficial for preventing oral cavity diseases with overreaching positive impact on overall health, reducing related complications, which ultimately reduces care costs. Last but not least, it is worth mentioning that oral health plays a significant role in one's quality of life.

In reaction to the identified shortcomings, a practical outcome of the probe was the creation of an educational material in the form of posters and flyers containing all the important information on dental and oral care. Also, an educational session was held at the Senior Club and other sessions are planned. Approaching other similar community facilities should be considered in order to make public education as effective as possible.

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Influence of Drug Addiction on Pregnancy

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Abstract

Introduction: The present work deals with the problem area of drug addiction and its impact on pregnancy and the course of childbirth.

Objective: To describe the sociodemographic data of female drug addicts; to assess their impact on the provision of prenatal care and to compare this data with available foreign studies.

Method: A retrospective analytical study was conducted; the obtained data were encrypted and anonymized. Selection criteria: woman used drugs either before or during pregnancy; woman delivered in a healthcare facility in the Ústí nad Labem Region.

Results: The sociodemographic situation of female drug users has a significant impact on pregnancy and the form of delivery. Important factors for the development of drug addiction appear to be women's unemployment, lower education and socioeconomic instability. Addiction to habit-forming substances is directly related to cigarette smoking. The consequence of these factors is insufficient care in pregnancy due to a lack of interest by the pregnant drug-addicted woman.

Conclusion: Given the current development of our society, we must assume that the number of drug-addicted pregnant women will continue to increase in regions with higher unemployment, causing a lower socioeconomic status of the population. Addicted pregnant women in vulnerable communities should be detected and both existing and potential risks that such women are exposed to need to be addressed in the nursing care.

Keywords: drug abuse, health care, pregnancy, socioeconomic status

Introduction

The problem of addictive drugs in the case history and their use by pregnant women is a very serious social phenomenon. Drugs influence women's mental and physical health condition in the reproductive period and cause complications to the unborn child. From the nursing point of view a pregnant drug user represents a number of actual and potential problems. A group of pregnant drug users shows socio-demographic differences as compared to pregnant women from the normal population (Vavřínková & Binder, 2008). Foreign studies describe drug addicted pregnant women as younger, single women from lower socio-economic classes, with lower education (Bailey, McCook, Hodge & McGrady, 2012).

Objective

To support the dissemination of knowledge on the situation of drug addicted pregnant women in the Czech Republic; to describe the socio-demographic data on pregnant drug users and to find out from respondents if their drug addiction has an impact on their attendance in prenatal guidance clinics. To collect and evaluate the obtained data for preparing the basis for further

work towards identifying and evaluating the risks in nursing care of drug-addicted pregnant women.

Methodology

The retrospective study involved 54 drug-addicted pregnant women from the Ústí nad Labem Region from 2013 to 2015. The data were generated retrospectively from the individual case records and childbirth records. Statistical evaluation was executed with regards to the mutual correlations of the defined indicators: type of drug addiction (woman used drugs prior to conception or in the course of pregnancy; the method of drug use – by injection, inhalation), socio-economic factors, anamnestic data, the course of pregnancy and the newborn's health condition, and the course of the postpartum period. The study took place in collaboration with the Gynaecologic and Obstetric Clinic of the Faculty of Health Studies, J. E. Purkyně University in Ústí nad Labem, under the auspices of Head Physician doc. MUDr. Tomáš Binder CSc. The method of purposeful sampling was used for selecting the sample of study. The selection criteria were the following: women took drugs prior to conception or in the course of pregnancy, women delivered at a healthcare facility in Ústí nad Labem Region. The goodness of fit test with a significance level of $p = 0.05$ was used for comparing the data. Our paper refers to selected results of the study that regard mainly the demographic data and their correlations to the prenatal period of a female drug addict.

Results

The respondents' average age in this retrospective study was 29 years. The average age of heroin users was 33.4 years, and the average age of methamphetamine users was 29.5 years.

Family status: 47 women were single, 2 women were married, 3 women were divorced and 2 were widows. Out of the total of 54 women, 19 lived on their own, 28 women shared their household with a partner and 7 women lived with their parents.

Level of education: 40 women completed elementary education, 9 secondary education without a school-leaving exam, 2 women had no complete elementary education, 2 graduated from a special school, 1 women completed secondary education with a school leaving exam and none had a university degree.

Occupation: A significant characteristic of this group of women was unemployment. 37 women were registered at the Labour Office, 13 were on a maternity leave, 2 women worked and 1 reported a student status. One woman did not report any occupational status. Heroin users are unemployed in almost 100% of the cases, methamphetamine addicts are unemployed in 85%.

Drug application method: The most frequent application method is intravenous in 37 women (76.7%), and 15 women (23.3%) use inhalation or oral application. Two respondents provided no data. 100% of heroin addicts use intravenous application, methamphetamine addicts use intravenous application in 73% and inhalation in 27%. 70.3% of the women used methamphetamine, 13% took heroin, 5.6% a combination of the two and the remaining 11.1% another combination of drugs (combination with toluene 1x, marijuana 2x, LSD 1x, subuxone 1x). 78% of drug-addicted women smoke. A study in Denmark (Nørgaard & Nielsson, 2015) reports smoking in pregnancy in 72.5% of these women, which is comparable to

the occurrence of smoking in our sample. The high occurrence of smoking confirms the tendency of these respondents to addictions.

Confirmation of pregnancy (see Tab. 1): in 37% pregnancy was confirmed in the 1st trimester, in 24% in the 2nd trimester and in 13% as late as in the 3rd trimester. 20% of the women did not visit prenatal guidance clinic, including 6% of the respondents who only arrived for the actual delivery. More than a half of the women had no prenatal screening done; 6% of the women had had a positive screening and 33% a negative screening. 52% of addicted women had obstetric complications (pre-eclampsia, abruptio placentae, premature delivery), the delivery of the remaining 48% was free of complication (the occurrence of complications in the normal Czech population is nearly 15% [ÚZIS 2013]).

Infectious diseases: 48% of the women reported to have hepatitis C, 5% hepatitis C and B. There were two cases of a combination of syphilis with hepatitis.

Tab. 1 **Timing of confirmation of pregnancy**

Confirmation of pregnancy	n_i	f_i
1st trimester	20	37
2nd trimester	13	24
3rd trimester	7	13
Did not visit prenatal guidance clinic	11	20
Arrived only for delivery	3	6
Σ	54	100

Discussion

The average age of our sample of respondents was 29 years; compared to a foreign study, the average age of drug addicts is 2 years higher in the Czech Republic (27.4 years in the USA; Lind, Petersen, & Lederer, 2015). Both studies demonstrated a comparably low level of education: 73% in the US study vs. 74% in Czech respondents.

Comparing the family status and employment of our sample with an Italian study by Domenici, Cuttano et al. (2009), 87% of our respondents were single (vs. 58% single women in Italy). The difference in the higher percentual proportion of single women is probably due to the higher tolerance of our society towards unmarried couples. Unemployment in the Czech sample was 70%; the Italian study specifies 16% (but 45% out of that study reported to be on maternity leave, which reduces the occurrence of unemployment). The most frequent drug application method is intravenous in 37 women (76.7%), and 15 women (23.3%) use inhalation or oral application. Drug users using intravenous application represent the most hazardous groups due to a high risk of transmission of infections, especially hepatitis C, B and HIV; foreign studies report a higher occurrence of hepatitis C (Vavřínková & Binder 2008).

Pregnancy in drug users is typically confirmed only after the 12th week, which is why abortion is impossible. The sample includes 63% of women with pregnancy confirmation after the 12th week. 20% of the women did not attend any prenatal guidance clinic and 6% came to the hospital only at the onset of delivery. The usual number of visits during pregnancy is 10 for the normal population; for drug addicted pregnant women, there are only 4 visits at the prenatal guidance clinic on average. 11 respondents had not visited the prenatal

guidance clinic even once, 9 of them were completely methamphetamine addicted and 2 were fully heroin addicted. Only 7 women out of the total of 54 respondents had undergone all the visits that are considered standard in the normal population, i.e. 10 visits. We have found a significant correlation between the variable “low socio-economic status” and the variable “number of prenatal guidance visits” ($p = 3.86421^{-8}$).

Our study has proven a low number of women on substitution therapy: 22% (subutex, methadone; see Tab. 2). Foreign studies report 65.4% of women seeking substitution therapy (Nørgaard, 2015). The reason for this difference has not been explored so far; it may be due to a longer historical experience in care for drug addicts.

Tab. 2 **Number of women using substitution therapy**

Substitution	n_i	f_i
Substitution therapy	12	22
Non-treated women	42	78
Σ	54	100

Conclusion

Compared to the normal society, drug addicted pregnant women are more frequently single, with elementary education and unemployed. Their pregnancy is usually without any follow-up, their prenatal care is typically insufficient; the patients frequently seek out a healthcare facility only at the beginning of their delivery. The low socio-economic status of an addicted woman has a negative impact on the number of visits at the prenatal guidance clinic. The results are comparable to those of foreign studies and only differ in parameters related to the mentality and way of life in the individual countries.

The care for a drug addicted patient starts with her entry into the healthcare system. It is not advisable to force them to abstinence but rather to recommend them to seek professional care, supporting them while reducing the doses of the addictive substance they use. Drug-addicted women usually need to have the following issues addressed: food, housing in pregnancy and after giving birth, subsequent care for the newborn etc. Especially intravenous drug use involves an increased occurrence of infectious diseases, especially hepatitis C, B and sexually transmitted diseases (Vavřínková & Binder 2008).

Addicted women are less able to tolerate pain, tend to be agitated and anxious and have higher demands for obstetric analgesia. If it is possible, it is advisable to conduct natural delivery; indications for a Caesarian section from the foetus' perspective do not differ from indications in patients without any drug addiction.

Drug addicted woman always have a high-risk pregnancy, both for the mother and for the newborn; they are threatened not only by the direct drug effect but also by numerous health and socio-economic factors.

In practice, emphasis should be placed on informing and educating drug addicted women especially in the area of pregnancy care. It has been shown that drug addiction causes reduced attendance in the prenatal guidance clinic, which leads to a reduced quality of prenatal care provided to such women.

It can be assumed that the number of drug-addicted pregnant women will rise, and therefore actual and potential risks represented by such women from the perspective of nursing care must be addressed.

Ethical aspects and conflict of interest

The present paper does not interfere with ethical principles and does not pose any conflict of interest.

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Position of Supervision in Healthcare and in Practical Training of Students of Healthcare Programs

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Abstract

Introduction: This paper deals with the use of supervision in healthcare and in the studies and clinical placement of future healthcare professionals.

Objective: To present the results of foreign studies evaluating the benefit of supervision in healthcare and to introduce supervision models used in the supervision of students' clinical placement.

Method: This paper is based on bibliographic searches and the author's personal experience.

Results: Supervision in healthcare is more widely used abroad than in the Czech Republic, while its definition is very diverse. The results of foreign studies reveal the benefit of supervision consisting both in the support of the supervised staff and students and in their professional development. The paper also briefly describes three models of supervision during clinical placement.

Conclusion: Supervision in healthcare has a potential that has not yet been appreciated in the Czech Republic. The article opens to a discussion the results of foreign studies and the author's experience with supervision in the area of health and social work.

Keywords: clinical placement, healthcare, supervision

Introduction

Supervision is a tool intended to support employees in the performance of their profession. Its strength consists in the process of dialogue as it allows the personnel to understand themselves and their behaviour or perception in the context of their professional role. It is an opportunity for development, seeking explanations and understanding of one's own failures and uncertainties where one would only hardly search for them by oneself (Michková, 2008). Along with other mechanisms, it participates in securing and improving the quality of work and services provided and it defends the patient's interests (Hanáková, 2006).

As a method of work deliberately focused on supporting and developing the quality of work, supervision becomes increasingly more applied in the Czech environment (Michková, 2009, 2016). Among the helping professions, it has been a widely applied tool in psychotherapy for a long time. In the latest ten years it has gained a stable position in social work and now slowly enters also into schooling and education area. In healthcare, however, it is being applied rather marginally in the Czech Republic. Therefore, the present paper is focused specifically on the application of supervision in healthcare and in the preparation of future healthcare professionals. The following text presents the results of foreign studies evaluating the benefits of supervision in healthcare and introduces the various models of supervision in students' clinical placement (not exclusively) in healthcare.

Objective

The objective of the present paper is to present the results of foreign studies evaluating the benefits of supervision in healthcare and to introduce the various models of supervision applied in students' clinical placement.

Methodology

With respect to the practical approach of this paper we used information from continuous searches for foreign studies relating to supervision in healthcare and students' clinical placement, and from a desk research and our own experience in supervision.

Results

Even in the Anglo-Saxon environment, where supervision has been in use longer and has deeper roots than in the Czech Republic, its form for the purposes of application in healthcare went through a long process of evolution. On the one hand, professional and personal growth had to be differentiated first, i.e. boundaries between supervision and therapy had to be defined (Yegdich, 1999); on the other hand, the content of the term supervision was close to mentoring as it was conceived as a form of long-term guidance of younger personnel by their senior and more experienced colleague (Milne, 2007). An interconnection between the elements of supervision and mentoring can also be observed for instance in British obstetrics (Gillman, 2015).

The differences in the concept and definition of supervision were studied for instance by Milne (2007), who elaborated a systematic overview of studies focussing on supervision in helping professions and provided his own "universal" definition of supervision based on logical synthesis: Supervision is a relationship-based form of education and professional training, which regulates, supports, develops and evaluates the work performance of the supervised person. Its basic methods are corrective feedback, drill and joint formulation of goals.

Along with the progressive interconnection of health and social care, for instance in the UK, also the perception of supervision as a term is changing. In its methodological manual, the Care Quality Commission (independent institution regulating the provision of health and social care in England) defines supervision as a process supporting, affirming and developing professional knowledge, skills and values of individuals and teams (Care Quality Commission, 2013). The same document also specifies the objectives of supervision in health and social care: reflecting one's own practice, in-depth analysis of the various cases, supporting change in professional activity and monitoring employee's needs for development. The process characteristics of such supervision are identical with the concept generally adopted in the Czech Republic.

In the Czech environment, supervision has a prevailingly supportive character and is provided by external supervisor. Considering healthcare, we should note that this concept, prevailing in the Czech Republic, is not the only one. Kadushin and Harkness (2014) report that for instance in the USA, 85% of supervisors work in the area of social work on internal supervisor positions, where the character of supervision is more administrative.

In 2001, a group of authors in the UK executed a study focused on evaluating the effectiveness of supervision and informal support in nurses (Teasdale, Brocklehurst, & Thom, 2001). The study compared nurses working under supervision with those not using

supervision. The study implied that supervised nurses use both supervision and an informal supportive network for sharing their work-related topics. No significant connection was found between supervision and the prevention of burnout syndrome. Supervised nurses, however, tend to assess the management of organization (as supportive regular employees) more positively and to assess themselves higher in terms of coping with the demands of their profession. At the same time, they find that they have better access to support than nurses not using supervision. The study also shows that these positive impacts of supervision are more distinctive in younger nurses with less experience. Therefore, in case of limited resources available in the organization, authors recommend to provide supervision preferably to junior nurses.

Another study focuses on the benefits of supervision from the perspective of supervised nurses. Nurses perceive supervision meetings as room for them to stop and to share emotions and experience, which helps them cope with their professional role. Supervision is considered a supportive instrument while developing interpersonal skills and sensibility in nursing practice (Lindhahl & Norberg, 2002).

A qualitative study by S. Dilworth et al. addressed the description of the mechanism used in supervision to foster changes in healthcare professionals' practice. The authors were wondering if and how supervision affects change in the attitudes and behaviours of employees providing psychological and social support to adult patients with carcinoma. A considerable change was identified in the area of speech/language used by the employees in interventions and communication with patients (Dilworth, Higgins, Parker, Kelly, & Turner, 2014).

The topic of supervision in healthcare is closely related to supervision in students' clinical placement as part of their studies for healthcare qualifications. Holmlund, Lindgren and Athlin, (2010) from a Swedish university addressed this area in a detailed manner as he observed during a long-term project, amongst other subjects, also the importance of supervision and topics introduced into supervision by students of a bachelor nursery study program. In field practice in the fourth and sixth semester students take part in group supervision meetings. The supervision group is closed, consisting of 5 to 8 members, with a constant supervisor (out of teachers with supervision education), and there are a total of nine meetings during the clinical placement. Supervision meetings always last 1.5 hrs and have the same structure.

Holmlund et al. (2010) subdivided students' statements into 3 categories: "satisfaction by the fact that we are together", "new understanding and insight", "indecision and discomfort". The first two categories were closely related – supervision was perceived as a platform for a common reflection that supports learning. A small portion of the students expressed negative feelings concerning the participation in the supervised group, felt uncomfortable or unpleasant and did not wish to take part in the group work. The study addressed neither the evolution of these characteristics over time nor their correlation to other factors.

Holmlund et al. (2010) categorized the topics transferred into supervision (see Tab. 1) and monitored the frequency of occurrence of the various categories in time. The first three subcategories specified in the table only occurred during the first part of the clinical placement (three initial supervision meetings) and, contrariwise, the three final categories in the table only occurred during the second half of the students' field practice. The original focus on oneself, one's own concerns and safety gradually shifted to focus on executing the professional role.

Tab. 1 Categorization of supervision topics of nursery students' (Holmlund, Lindgren, & Athlin, 2010)

Category	Sub-category	Concretization
Myself in student role	I feel unprotected and vulnerable	Feeling of dependent and helpless; expecting support and help from employees
	“Observer” topic	I feel like I am only an observer, unable to influence the situation; frustration
	Feelings of failure	Confrontation with own mistake, inciting insecurity and fear
	Setting boundaries	Vicinity vs. distance, personal vs. professional, dealing with patients of the same age, ...
Encountering a challenging job	Demanding patients	Contact with an incurably ill patient, patient with psycho-social issues, communication specifics, ...
	Unexpected situations	Encountering unexpected/dramatic situations, strongly affecting the student (e.g. rapid change of the patient's health condition)
	Existential concerns	Caused for instance by encountering death (presence during dying); causes anxiety and brings up questions about sense
	Ethical ambiguities	Considering what is right; seeking one's own arguments and values
	Cultural clashes	Meeting patients from different socio-cultural environment, where proven approaches fail and values are in conflict
I am becoming a nurse	Assuming responsibility	I (already) feel responsibility, but cannot act (yet) x I act although I am not yet formally competent to do so
	Looking ahead	Focusing on one's own professional role in the future (expectations, readiness to adopt it vs. concerns about insufficient readiness)

The opportunity to use supervision for sharing experience and doubts experienced in the course of professional training raises stress resistance and readiness to cope with unexpected and difficult situations (Arvidsson, Skarsater, Ojervall, & Fridlund, 2008).

Working in all healthcare professions requires competence to work in a multidisciplinary team. Theoretical instruction gives students indispensable knowledge for such interdisciplinary cooperation and supervision enables their interconnection with the first experience in team work during clinical placement. Thus, it supports the creation of professional identity including solidarity with the team and respect of other members and their roles (Klein, 2015). The preparation for work in a multidisciplinary team develops, among other things, the students' ability to formulate their thoughts and to take part in team discussions, which ultimately leads to better cooperation, understanding of roles and mutual respect in the team but also to better work with documentation (Pollard, Miers, & Rickaby, 2012).

Discussion

Supervision is an integral part of professional training in health and social work not only at the Faculty of Health Studies, University of Pardubice, but also elsewhere in the Czech Republic. However, in other healthcare professions, it is an exception. Health and social work, as a specialization of social work, gratefully adopts social-work education standards (Association of Educators in Social Work, 2014) that clearly regulate the position of supervision in the education of future social workers.

The principle of supervision applied in health and social work and/or social work could, with certain modifications, be also applied in supervision in other healthcare professions. The present paper provides three models of supervision for further discussion: process-oriented

supervision, case supervision modified for students' clinical placement and supervision based on task-oriented approach.

Process-oriented supervision. This supervision is focused on past-oriented reflection on activities executed during clinical placement and is significantly supportive. It supports students' ability to reflect on and to assess their work activities, which is an important factor that increases stress resistance (Arvidsson et al., 2008). It addresses supervision-related subjects as students bring them up during their clinical placement and, although participation in supervision is compulsory, bringing up one's own topics is voluntary.

Case supervision, modified for students' clinical placement. Under this model, supervision addresses various "cases", i.e. student's interaction with the client in his/her specific situation and reflection on such situations. During the practical training, every student presents at least once his/her "case"; students may pre-schedule their specific dates/schedules. In this regard, the supervision is rather more directive and puts students under higher pressure.

Supervision based on a task-oriented approach. The task-oriented approach is one of the approaches of social work, whose principle is the creation of a systematic framework for mastering various practical problems in the client's life in the form of brief, time-limited and clearly structured cooperation. This approach is based on defining a series of activities necessary for achieving a concrete and practical objective; their fulfilment will result in a resolution or at least a partial progress towards resolving the client's issue. A task is a crucial point of this approach. The author of this approach, W. Reid, subsequently used it to create an expert framework for social work students' clinical placement; the student's and supervisor's objective is to develop student's practical skills and to achieve the set goals (Caspi & Reid, 1998). The approach is characterized by clearly formulating goals and by focusing on their achievement, and makes high demands on the student's activity.

All the three models specified above are utilized in practice and modified according to the needs and capacities of various educators. They put varying demands on time, the supervisor, cooperation with various workplaces and on the structuring of clinical placement and instruction as a whole.

Conclusion

Supervision during clinical placement of students studying to become a health care professional is, in my opinion, still an undervalued tool in the Czech Republic. It certainly puts great demands on educators from the personal and the organizational viewpoint. On the other hand, it provides fair benefits in the form of more effective learning and graduates' better preparedness for starting their practical careers. Well-proven models can be provided by educators in the area of social work. Also, supervision of healthcare professionals is a significant tool of their support and education in relation to daily practice, and thus deserves more attention.

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Health and Social Issues Related to Confidential Births

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Abstract

Introduction: The article describes the current Czech legal regulation of the area of confidential births with respect to actions that must be taken by healthcare providers, covering all phases including adoption, foster care or institutional care of the child, with an emphasis placed on the social and legal protection of children. Furthermore, the paper describes the controversy concerning real maternal anonymity.

Objective: The aim of the article is to describe the current Czech health and social legislative theory and practice in the field of confidential births and subsequent care.

Method: With regards to the theoretical nature of the article, the methods of analysis and compilation of expert texts were used.

Results: The current Czech legal regulation allows women to give a so-called confidential birth. Healthcare institutions have specific procedures in place, respecting the relevant legal regulations concerning the subject matter. Nevertheless, the mother continuously faces a disclosure of her identity in the course of guardianship-related proceedings regarding placing the child for adoption, into foster care or institutional care. Under the existing legal regulation, comprehensive legal approaches to confidential births and aftercare are set to protect the anonymity of the mother, but not entirely.

Conclusion: The current system of law enables women to give confidential births in official healthcare facilities. However, real anonymity is not guaranteed due to the disclosure of the mother's identity while reporting the provided health care to the health insurance company and in the course of legal guardianship proceedings concerning the child.

Keywords: confidential birth, mother's identity, social and legal protection of children

Introduction

The legal institution of confidential birth only became part of the Czech system of laws in 2004, namely by adopting Act No. 422/2004 Coll., amending Act No. 20/1966 Coll., Public Healthcare Act, as amended (Czech). This problem area is further regulated in detail by Act No. 301/2000 Coll., on Offices of Vital Records, Names and Surnames and on the Amendment to Some Other Related Acts (Czech), as amended, and Act No. 48/1997 Coll., on Public Health Insurance (Czech), as amended (Act No. 422/2004 Coll.).

As explained by the preamble of the above-stated act, the purpose of accepting a new legal regulation was especially the protection of children's health and life and the creation of conditions for reducing the number of abortions (Act No. 422/2004 Coll.).

Although the legislator's intention was certainly positive, the regulation of confidential births is rather confusing, lacks a solid concept and shows a number of imperfections and ambiguities. It is also still questionable whether the said legal regulation actually fulfilled the original intention of reducing the number of abortions as many women in the Czech

Republic do not even know about the possibility of confidential birth or have only incomplete information.

Objective

The aim of the present paper is to describe the current health and social legislative theory and practice in the area of confidential births and subsequent care for children in the Czech Republic.

Methodology

With respect to the theoretical nature of the present paper, we chose the method of analysis and compilation of expert texts, also called desk research. The principle of this method is searching, collecting, processing and evaluating already existing data. In the present paper, this involved work mainly with legislative documents (Soukup, 2009).

Results

The current regulation of confidential births is based on the provisions of Sections 37 and 56, Act No. 372/2011 Coll., on Healthcare Services and Conditions of Their Provision (Healthcare Services Act) (Czech). The Healthcare Services Act substituted the Act No. 20/1966 Coll., on Public Healthcare (Czech), which originally included the term of confidential birth under Section 67b Para 20 (Act No. 372/2011 Coll.).

The wording of the Healthcare Services Act implies that a confidential birth takes place in the mother's interest and based upon her written request to hide her identity during childbirth. The woman makes such a request to the provider of the corresponding healthcare service and is at the same time required to expressly declare that she has no intention to take care of the child (Act No. 372/2011 Coll.).

The legal system provides the option to give confidential birth to women with permanent residence on the territory of the Czech Republic. Logically, the woman must be fully legally competent not only to complete the application for hiding her identity during the delivery but also in general in order to provide informed consent, which always required from all patients. Another substantial requirement is that the woman must be single (not married). In cases of divorced women, there must be no presumption of their former husband's paternity, meaning that a legally required period of 300 days must have elapsed since the termination of the marriage (divorce). To prove this fact, a divorce judgement including the date of legal effect must be presented. Without meeting the above-mentioned conditions, the woman cannot be allowed to give a confidential birth (Act No. 89/2012 Coll., Civil Code, Czech; Act No. 372/2011 Coll.).

Apart from the legal preconditions for a confidential birth, Section 56 of the Healthcare Services Act also regulates the principles of maintaining medical records in cases of confidential births. As implied by Paragraph 1 of the above-stated provision, the name and surname of the woman provided to the healthcare facility concerning the pregnancy and confidential birth, as well as her written application for hiding her identity during delivery, her date of birth and date of delivery, are all kept separate from the medical records (Act No. 372/2011 Coll.).

Every medical facility should have a recommended procedure in place, based on the guideline of the Ministry of Healthcare of the Czech Republic for medical facilities when providing healthcare related to confidential births (Guideline of January 1, 2005, Ministry of Health).

The expectant mother is admitted to the delivery room under a fictitious surname “Undisclosed” and name corresponding to the serial number of the confidential birth in the given medical facility in the relevant calendar year and under a generated birth number.

As well as his/her mother, the newborn is most frequently admitted under surname “Undisclosed” and is systematically linked to the mother. It is desirable that the mother chooses a name for the child. If she does not, the court will do so. After hospitalization, the child will bear his/her mother’s surname; however, the mother’s surname is not specified in the records during hospitalization.

Actual data are entered into medical records only after the end of the woman’s hospitalization. They must be inserted into a corresponding cover, sealed and provided with a security code that will be handed over to the client.

Such sealed medical records can be opened only upon the court’s decision unless the woman who has delivered in confidentiality (Act No. 372/2011 Coll.) applies for opening of the medical records.

However, the law does not specify who may place an application for opening at the court or under what conditions the court may approve of unsealing the envelope. Due to a lack of relevant judicial practice in the given area, it may be assumed that one of the reasons might be the relevant child’s interest to learn the identity of his/her biological mother e.g. due to a health condition (Act No. 372/2011 Coll.).

It can be generally stated that the institute of confidential birth puts higher demands on the medical and healthcare personnel, exceeding the general confidentiality requirements as a fundamental principle of medical law.

The question of confidential births is also addressed by Act No. 301/2000 Coll., on Offices of Vital Records, Names and Surnames and on the Amendment to Some Other Related Acts, as amended (Act No. 301/2000 Coll.).

It addresses this problem area in regards to obligatory data entered into the Birth Log Book. As implied by Section 17 of the Act on Offices of Vital Records, a born child is recorded in the Birth Log Book based on a written communication by the healthcare services provider, in whose facility the delivery was completed. Such communication also specifies that the specific birth is confidential (under Act No. 301/2000 Coll.).

However, unlike in cases of regular births, in cases of confidential births, only child-related data is entered into the Birth Log Book – i.e. the child’s name(s) and surname, the day, month and year of birth, birth number, place of birth and gender. Respecting the essence of confidential births, no information on the child’s mother is provided. This practically means that the child’s birth certificate and all subsequent documents include no personal information on the biological mother. Moreover, the data on the father is missing and the father is reported as unknown (Act No. 89/2012 Coll., Act No. 422/2004 Coll.).

For the sake of completeness, it should be noted that the set of records maintained on the child's birth, whose mother applied for hiding her identity during delivery, may be consulted

only by the child's mother and only once the child has achieved the age of 12 years (Act No. 301/2000 Coll.).

Based on the relevant standards, the mother is separated from the child at the healthcare facility and hospitalized at the gynaecology ward for an indispensable period of time, unless she wishes to care for the child. If the operation and building layout of the ward allow so, she is offered a single-bed room. It is also desirable to facilitate her contact with a psychologist, social worker and a lawyer after delivery.

Subsequently, the obstetrician in charge will contact a health and social worker who then reports the confidential birth case to the authority for social-law protection of children and to the vital records office. The vital records office will inform the court about a birth of a child with no mother specified in the birth certificate and the court will initiate the proceeding for unsealing the envelope containing birth documentation and the mother's identification data (Act No. 89/2012 Coll., Act No. 301/2000 Coll., Act No. 372/2011 Coll.).

The financing of confidential births by the health insurance system is dealt with by Act No. 48/1997 Coll., on Public Health Insurance and the Change and Amendment of Some Related Acts. Health care related to pregnancy and to a birth of a child, whose mother applied for hiding her identity concerning the delivery, is covered by a health insurance company that is requested to do so by the relevant healthcare services provider based on the identification data of the insured person (Act No. 48/1997 Coll.).

With regards to numerous interpretational ambiguities related to the introduction of confidential births as a legal institution, the Ministry of Healthcare of the Czech Republic issued a Guideline regulating the procedures for healthcare facilities when providing health care related to confidential births (Guideline of January 1, 2005).

This document sets forth that confidential data are merely the mother's name, surname, date of birth, and the date of childbirth and that the data protection does not apply to the insured person's registration number and number (or name) of the relevant health insurance company. Health care provided in regards to a confidential birth is then covered by the mother's health insurance, who specifies in writing her insurance registration number and the number (or name) of the relevant health insurance company. If the mother is not willing or able to give this information, the healthcare facility will treat her as a private patient with no payment from the health insurance system. The same billing rules will apply to health care provided to the newborn child - i.e. through his/her mother's registration number – the insured person (Guideline of January 1, 2005).

On the date of discharge from the hospital, the IT department will replace the generated birth number by the actual birth number so that the provided health care can be billed to the health insurance company. In other cases, the healthcare facility will enforce the payment from the client directly. This practice raises numerous doubts if confidential births actually give the mother in her life situation the required anonymity when all care is covered by the health insurance of the woman delivering in hiding.

At the same moment, the electronic form of medical records is converted into a paper form and the electronic form is deleted from the system. The woman's medical records are further maintained under a symbol, for instance based on the date of delivery (20. 6. 2013 – 2006/2013). This numerical code is communicated to the woman in the event that she decides for disclosure in the future.

According to the interpretation of social-law protection of children, a child born in a confidential birth is considered a child at risk and thus is subject to interventions by employees of the authority for social-law protection of children. The basic intervention in cases of a child abandoned by the mother and left at the maternity clinic consists in filing an application for temporary injunction to a guardianship court, on the basis of which the child may be put into custody of a future adopter, fosterer for a temporary period, future fosterer or another caring person or placed into a children's centre, which is an alternative actually chosen only in extreme cases (Act No. 359/1999 Coll., on Social and Legal Protection of Children, Czech).

After a six-week period, starting on the date of the childbirth, the mother may give her consent to adoption. For all this time, the mother is the child's legal guardian, the child bears even her surname, the envelope with the mother's childbirth records has already been opened and the mother's identity is no longer confidential. After the sixth week since the date of birth, the caring person (adopter, fosterer) may file an application for foster care or adoption to the court. If the child is not in the custody of a caring person, the relevant authority for social-law protection of children will file an application for institutional care. A three-month period starts as of this moment, during which the mother may decide if she does or does not wish to become the child's parent. If she shows no interest in the child, all her parental rights and obligations towards the child are suspended. The mother is a participant to all the above-stated proceedings, her identity is no longer confidential and she must be present at the proceedings along with the adopters or fosterers (Act No. 89/2012 Coll., Act No. 359/1999 Coll.).

Discussion

The aim of the present paper was to describe the current health and social legislative theory and practice in the area of confidential births and subsequent care for the child in the Czech Republic. Following this objective, we have presented the problem area within the interpretation of the currently applicable legislation and arrived at the conclusion that women in the Czech Republic do have the chance to deliver in anonymity but the actual level of anonymity regarding the childbirth is very low, especially with regards to the reporting of medical procedures related to the childbirth to the health insurance company and also with regards to securing the future of their children. In 2012, only 11 pregnant mothers in the Czech Republic applied to have their identity hidden in regards to delivery (Zpráva o rodiče 2012, 2013).

For instance, Dvořáková (2015) arrives at the same conclusion in her master's thesis, trying to clarify the substance of the Czech legislative regulation of confidential births, as well as Řezábek (2005).

From the perspective of possible further research, we consider it principally important to observe the level of obstetricians' and gynaecologists' awareness of how a confidential birth is to be pursued but also how any subsequent care of the child is regulated. A sufficient level of awareness in these professions may correlate, to a certain extent, with the level of awareness of the mothers, which is surely insufficient and, without sufficient information, mothers are in our opinion not able to objectively judge the consequences of a confidential birth for their lives.

Conclusion

The current legal situation gives the women in the Czech Republic the option to deliver at healthcare facilities in a confidential birth mode. Although this option exists, it should be acknowledged that its practical application is very uneasy under the current legal conditions. A woman may deliver anonymously at healthcare facilities, but her identity is disclosed even at this point while billing the provided health care to the health insurance company. Her identity and subsequent “encounters with the child” occur especially while securing the future of her child born in a confidential birth. The woman participates in all guardianship-related court proceedings concerning her child, which means she can be repeatedly exposed to contact with the child and his/her future parents or fosterers, which must be psychologically highly demanding and exhausting for her. In compliance with the routines of guardianship courts, she is repeatedly interrogated on her consent to adoption (unless she signs the consent herself), foster care or institutional care. With respect to all these facts we conclude that the institution of confidential birth is too complicated, does not secure the mother’s actual anonymity anyway, and hence we assume that the woman who does not wish to be the child’s mother will more probably prefer putting the child into a baby box, avoiding numerous complications related to a confidential birth.

Ethical aspects and conflict of interest

From the perspective of possible conflict of interests, we did not identify any circumstances that would threaten the fundamental publication principles.

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Dementia as a Current Problem Due to Demographic Trends – Knowledge of Caregivers

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Abstract

Introduction: Dementia is not a disease but a collection of symptoms resulting from damage to the brain. These symptoms can be caused by a number of conditions. It is generally assumed caregiver's better knowledge of the symptomatology and symptoms result in a better quality of care.

Objective: To assess the knowledge about the causes and symptoms of dementia in a selected sample of family members of seniors with dementia and in non-medical healthcare personnel caring for seniors with dementia at geriatric-psychiatric wards.

Method: A questionnaire-based survey applied to a selected group of family members and to non-medical workers (questionnaire by the Institut Universitaire de Gériatrie in Montréal).

Results: Younger age lay persons ($p = 0.0012$) and relatives in a straight line of the elderly showed better knowledge of dementia ($p = 0.0002$). The relatives' satisfaction with care did not correlate with their knowledge of the causes and symptoms of dementia ($p = 0.5899$). The relatives' gender did not show a statistically significant correlation with knowledge ($p = 0.937$). However, women showed better knowledge from the objective point of view. In the sample of non-medical professionals, education correlated with the level of proven knowledge of the causes and symptoms of dementia while respondents with university education demonstrated better knowledge ($p = 0.0016$) as well as respondents with completed specialized education on dementia ($p = 0.0003$). Family members of seniors with dementia did not give correct answers to questions on the pathophysiology and symptoms related to the progression of dementia. Non-medical healthcare personnel did not have sufficient knowledge of the general aspects of dementia and some behavioural and psychological symptoms of dementia.

Conclusion: The analysis of the family members' and non-medical healthcare personnel's knowledge about dementia proved statistically significant differences. The knowledge demonstrated by the family members of patients with dementia differs depending on the age and relation to the patient. The level of knowledge demonstrated by non-medical healthcare personnel caring for patients with dementia differs by gender, their achieved level of education and specialized education.

Keywords: care, dementia, family, non-medical personnel, psychiatry

Introduction

Dementia is the most frequent mental disorder in old age. It develops gradually. The first emerging symptoms only indicate deteriorated mental functions, often generally connected with the senior age. However, it represents a serious condition for the patient, his family and, due to the demographic changes and population ageing, for the whole society. Dementia is a silent epidemic of the 21st century. This is due to the fact that every third person must expect some form of dementia after the age of 80 in their life (Haškovcová, 2012, p. 32). Statistical data give evidence

that the population of the European Union, the Czech Republic included, is ageing. The 2015 Annual Report on Dementia Status, published by the Czech Alzheimer Society, states that around 152.7 thousand persons suffer from dementia and two thirds of the patients are women. This means that the number of patients has grown by 50 thousand in the recent ten years. According to expert estimates, due to the social development and continuous prolongation of life expectancy, dementia might skyrocket up to 383 thousand persons by the half of this century (Mátl & Mátlová, 2016, p. 49). Dementia is being monitored not only in the Czech Republic but also in other developed countries where seniors are becoming an increasingly significant social group. For instance, an epidemiological survey on the Western-European population, assessing the occurrence of dementia in the course of 20-30 years, involving five various studies in Sweden, the Netherlands, England and Spain, informed that only Spain marked a decrease in dementia occurrence, concretely in men (Yu-Tzu et al., 2015, p. 116). More precise data on dementia prevalence in hospitalized persons are missing (Timmons et al., 2015) but it is certain that the quality of life of persons with dementia and their close persons is affected (Castro-Monteiro, et al., 2016). While assessing the impacts of dementia on seniors' life, the severity of the disease and the level of impairment of cognitive and other executive functions must be considered. The actual disease is not decisive for the quality of life; the most serious impact of the disease in higher age is the reduced self-sufficiency. Unfortunately, this often makes impossible the senior's and his relatives' efforts to stay in their natural social environment until the end of their life. The Czech Republic currently represents one of the oldest European populations by age, with a low proportion of infant population. Not only for the reasons stated above, it is indispensable to increase the public interest and awareness in seniors, to change the negative attitudes to age in the society and to endeavour to understand the current needs of seniors and their family members. This also involves the need for knowledge about dementia, especially in order to enable timely diagnosis, subsequent therapy and decision on provision of the corresponding care for people with dementia that are going to emerge due to the ageing population (Castro-Monteiro et al., 2016). The knowledge concerning dementia should become a priority for both professional and lay caregivers, i.e. family respecting the senior's wish to spend the "autumn of their life" in their natural environment. A support provided by family taking care of the senior should be a priority for the society.

Objective

The objective of the present study is to assess the knowledge of the causes and symptoms of dementia in seniors in a selected group of family members of seniors with dementia, and in non-medical healthcare employees caring for seniors with dementia.

Methodology

The tool for evaluating caretakers' knowledge was designed based on a questionnaire of the Institut Universitaire de Geriatrie in Montreal under the title "Dementia Knowledge Assessment Tool" (Robinson et al., 2014), applied in the translation of its full wording and supplemented by items focused on demographic data evaluation. The questionnaire included a total of 21 knowledge-related questions with possible answers: "I agree, disagree, don't know". The knowledge-related items were evaluated using a score according to the number of correct answers (all knowledge-related items were identical for both groups of respondents and the total score thus achieved values from 0 to 21 points, while average score values were subsequently tested in regards to demographic data). The subjective assessment of knowledge was based upon a self-assessment using a usual classification scale (1 = excellent to 5 =

insufficient knowledge). Answers were evaluated as correct or incorrect, “I don’t know” was considered a wrong answer. As described above, the knowledge-related explorative items were supplemented with items focused on identifying demographic data on the respondents. The data analysis was executed in IBM SPSS ver. 22 on significance level $\alpha = 0.05$ (tests: Shapiro-Wilk Test, Levene’s and F-Test, Sheffé’s multiple comparisons method, Kruskal-Wallis Test and Brown-Forsythe Test). Between December 2015 and March 2016, a total of 75 questionnaire forms were distributed to healthcare employees, respecting the general personnel coverage of care at the relevant healthcare facility and 100 forms were provided to relatives of patients with dementia. To eliminate the possibility of respondents’ searching for replies, the questionnaires for professional caretakers were distributed in the course of work meetings and immediately retrieved. The relatives completed their questionnaires during visiting hours.

Results

In total 93 questionnaires from relatives of seniors with dementia were analysed (93% return rate) and 75 (100% return rate) from non-medical healthcare personnel, working at Geriatric-Psychiatry Ward of the facility under observation. 28.0% of the relatives were males and 72.0% females. The average relatives’ age was 48 years. Most of the respondents (44.1%) stated son/daughter relation and 26.9% grandson/granddaughter, only 7.5% indicated husband/wife relation and 15.1% of the respondents indicated another relation (daughter-in-law, cousin, niece, aunt, great-granddaughter or son-in-law). A total of 57% of the seniors’ relatives were older than 45 years, with secondary level of education (44.1%) and sharing one household with the hospitalized senior (51.6%). Nevertheless, 57% of the relatives reported that after the hospitalization, the senior would be placed in a retirement home. Out of the 75 non-medical healthcare employees 21.3% were males and 78.7% females. By job position, 49.3% were general nurses, 10.7% were attendants, 32.0% medical orderlies and 8.0% specified “other” as their job position (ergo-therapists, physiotherapists). The average age of professional caretakers was 42 years. Most (45.3 %) respondents completed secondary-level education, with a school-leaving exam. Only 30.7% of the respondents had obtained specialized education in psychiatry. Their average length of practical experience in healthcare was 16 years and the average experience on a geriatric-psychiatry ward was 10 years. Most of the enrolled non-medical healthcare personnel (61.3%) did not share their household with an elderly person.

In the subjective evaluation of knowledge about dementia, the seniors’ relatives rated their knowledge mostly as good (53.8%); average grade = 3.0. In knowledge-related items, the relatives made mistakes mostly in questions related to dementia symptomatology and progression. They were, for instance, not aware of the fact that sudden confusion does not have to be a symptom of dementia (76.4%) or that swallowing disorders develop in late stages of dementia (58.1%). Also, they wrongly stated that it is important to always guide (correct) a person with dementia, when he/she is confused (71.0%). On the other hand, they proved good knowledge of behavioural symptoms and their compensation, as they correctly stated (84.9%) that a person with dementia must be supported in decision-making (e.g. on what clothes to wear) and also knew that people suffering from dementia may show atypical behaviours such as aggressive behaviour in usually moderate persons (87.1%). Most relatives (84.9%) also stated that if a person has a late stage of dementia, family members may help others (healthcare personnel) understand the needs of the given person (patient). The statistical testing of summary evaluation (score) of the knowledge verified that the knowledge of relatives differs depending on their age ($p = 0.002$). Younger relatives proved to have better knowledge, which is also confirmed by the fact that relatives in son/daughter and grandson/granddaughter relation proved

better knowledge ($p = 0.0002$). No difference between the knowledge of men and women was confirmed ($p = 0.0782$) and there was no difference in knowledge attributable to education ($p = 0.1759$). The relatives' degree of declared satisfaction with the care (services offered to the senior) did not correlate in a statistically significant manner with the level of relatives' knowledge about dementia ($p = 0.5899$).

The subjective self-evaluation of knowledge by non-medical healthcare personnel equalled to the average grade of 2.5 while most respondents assessed their knowledge as good (41.3%) and very good (37.3%). The most frequent incorrect answer provided by “non-physicians” was due to a lack of awareness that at a later stage of dementia, the degree of pain cannot be identified (incorrect answer 61.3% and 14.7% “Don't know”). An alarming finding was the fact that most professional caretakers (68%) believed that if a person with dementia is desperate, they cannot be helped by talking to them about their feelings. A positive fact is that the healthcare personnel are aware that a change of environment has an impact on persons with dementia (e.g. opening and closing window blinds), as 74.7% stated. Same as lay caretakers, also a high percentage (80%) of healthcare personnel stated that if a person has a late stage of dementia, family members may help others (healthcare personnel) understand the needs of the given person (patient). We have found that the level of knowledge about dementia is independent on the age of non-medical healthcare employees ($p = 0.8415$) but a difference between men and women was found ($p = 0.0417$). Women had better knowledge. The worst knowledge was found in healthcare personnel with primary education ($p = 0.0016$) and, contrariwise (vice versa), respondents with specialized education in psychiatry showed better knowledge ($p = 0.000$); nevertheless, the length of experience on a geriatric-psychiatry ward did not correlate with the level of knowledge ($p = 0.919$) of the healthcare personnel. As shown in Fig. 1 and Fig. 2, differences were found between objective (using knowledge scores obtained from the number of correct answers, see Methodology) and subjective assessment, both by relatives ($p = 0.000062$) and non-medical healthcare employees ($p = 0.004150$). Figure 3 shows the difference in objectively assessed knowledge (the sum of the knowledge scores) by the healthcare personnel and lay caregivers – seniors' relatives ($p = 0.00608$).

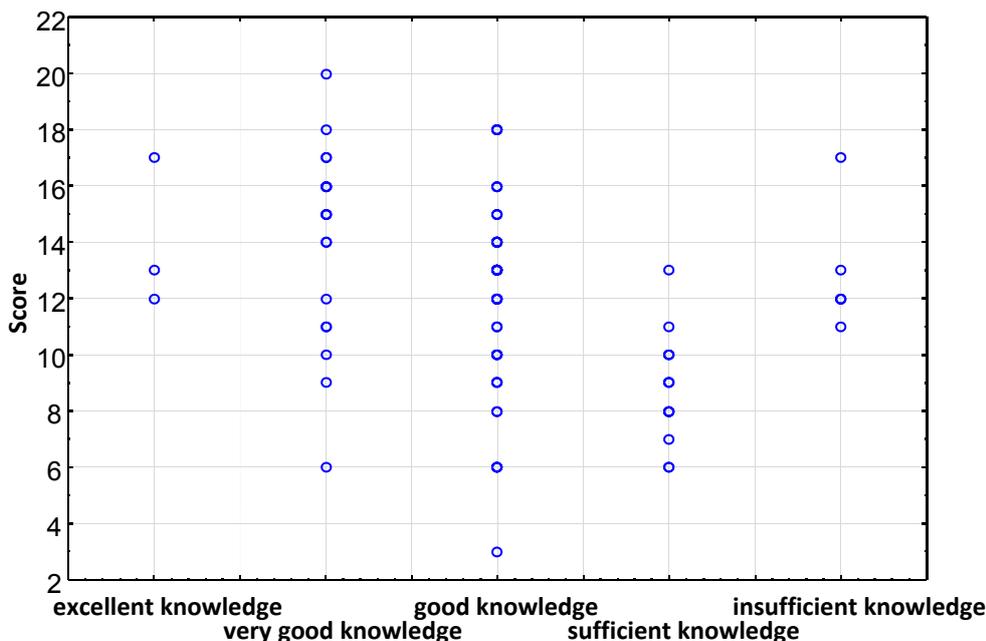


Fig. 1 Two-dimensional point diagram of total scores and subjectively assessed knowledge on dementia by seniors' family members

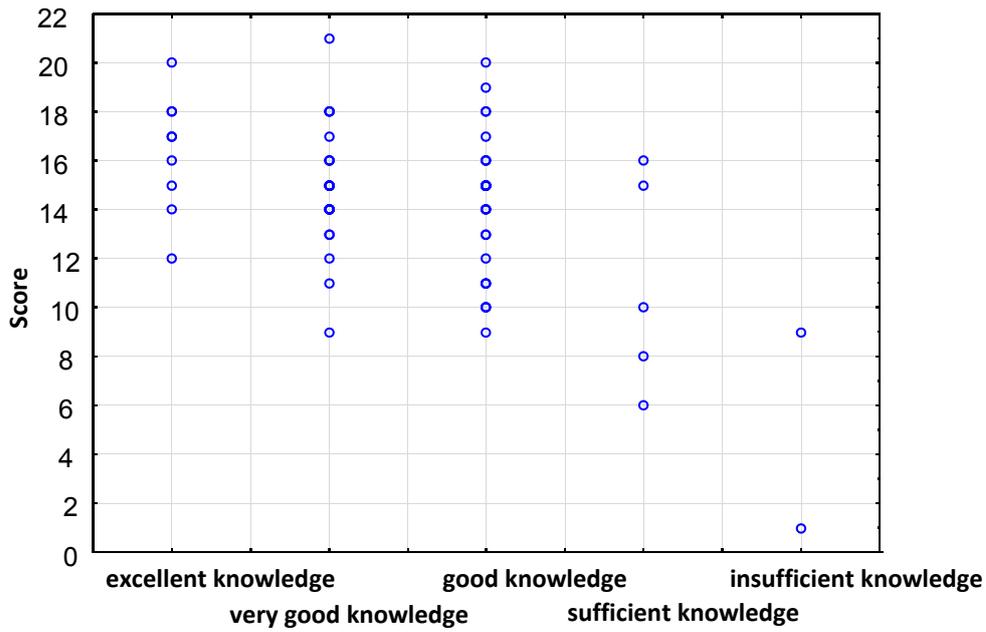


Fig. 2 Two-dimensional point diagram of total scores and subjectively assessed knowledge on dementia by non-medical healthcare personnel

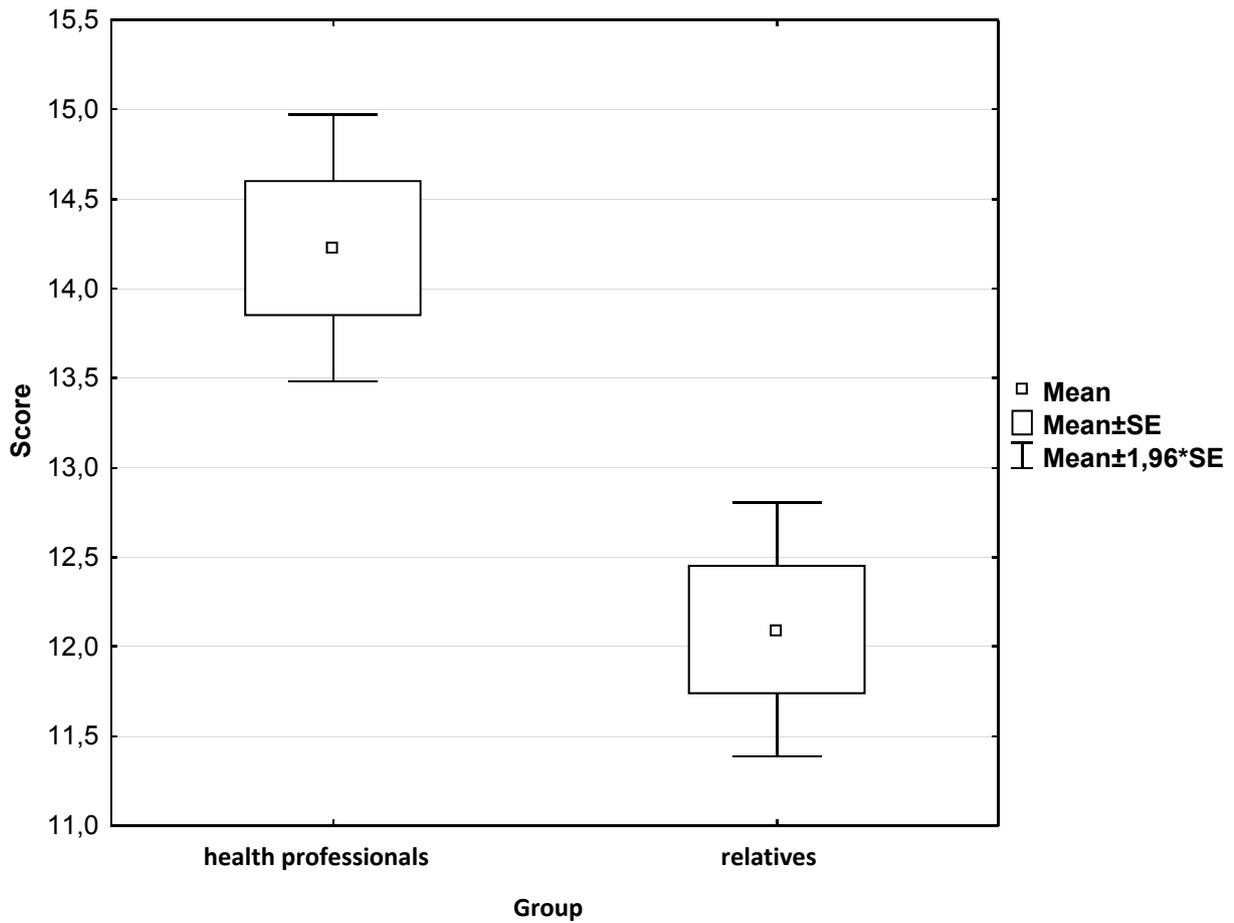


Fig. 3 Comparison of objectively assessed knowledge on dementia by healthcare personnel and relatives

Discussion

The executed study deliberately compared the knowledge of dementia symptoms in a group of professional carers – non-medical healthcare personnel and in relatives of hospitalized patients with dementia. The discussion only covers those areas that have not been mentioned in the results or that can significantly affect the quality of care. The main objective of this study was to find out if and how the knowledge of both groups of respondents under consideration differed in the specific healthcare facility providing geriatric-psychiatric care, but mainly to identify the areas that must be addressed in order to improve the quality of collaboration and care for seniors with dementia. It is assumed that the level of knowledge significantly affects the quality of care. An interesting finding was that 67.7% of family members and 60.0% of non-medical healthcare personnel correctly agreed with the statement that “knowledge of the probable cause of dementia may help predict its progression”. In a study conducted by the Institut Universitaire de Gériatrie in Montréal, more than 85% of the family members and healthcare personnel replied correctly to the same statements (Robinson et al., 2014, p. 160). While here the knowledge of both groups did not differ, in case of incontinence, the situation was different. 54.8% of the family members of patients with dementia and 86.7% of non-medical healthcare personnel correctly disagreed with the statement that “incontinence always occurs in early stages of dementia”. A great span in the knowledge in the two groups is obvious here. The professional caretakers have better knowledge in regards to patients’ incontinence. The same was revealed by the Montreal study, where 40.6% of the family members and 49.5% of professional caretakers gave the correct answer (Robinson et al., 2014, p. 162). This is probably due to the fact that professionals encounter seniors in advanced stages of dementia more frequently and have more experience with them. Based on epidemiological studies, 10 to 20% of the population above 65 years of age are affected by urine incontinence. Women are affected by incontinence more frequently (1.5 to 2 times more frequently than men). The prevalence rises up to 80-90 years when one half of women and more than a third of men suffer from incontinence. Thus, based on expert estimates there are 170 to 200 thousand seniors affected by urine incontinence in the Czech Republic (Topinková, 2010, p. 18). 50.5 % of the family members of patients with dementia and 58.7 % of non-medical healthcare personnel correctly agreed with the statement that “dementia probably limits the length of life”. The results of the Montreal research suggest that around 50% of the family members and 40% of professional caretakers do not know that dementia is a life-limiting disease (Robinson et al., 2014, p. 162). 84.9% of the family members of patients with dementia and 80.0% of non-medical healthcare personnel caring for patients with dementia correctly agreed with the statement that “if a person suffers from a late stage of dementia, family members may help others understand the needs of such person”. We may assume that this finding is a good starting point for future cooperation. And, 80.6% of the family members and 84.0% of non-medical healthcare personnel correctly agreed with the statement “people with dementia may develop problems with visual perception”. Accordingly, in the study conducted by Institut Universitaire de Gériatrie in Montréal, more than 85% of the family members and healthcare personnel replied correctly to the same statements (Robinson et al., 2014, p. 160). In our survey, most participating relatives (67.7 %) were those whose senior hospitalized with dementia diagnosis fell within the age range of 75–89 years. Alarming was the finding that although 34.4% of the relatives reported that prior to hospitalization their senior lived autonomously and 51.6% shared the same household with them prior to hospitalization, the relatives planned to place more than a half (57%) of the patients in a retirement home after the hospitalization. The fact that family members tend to rely on placing the senior in social service facilities after

hospitalization was also confirmed by a study from the Kroměříž Psychiatric Hospital, monitoring the return of female senior patients to their home environment between 2003 and 2013. It was found that in 2003 70% and in 2013, only 63% of hospitalized female seniors returned to their home environment after hospitalization (Lužný, 2014a, p. 38). Although the life expectancy continues to grow and the prevalence of organic mental disorders will continue to grow in this regard, the number of healthcare personnel is decreasing, so there are relatively fewer means for satisfying the continuously growing demand for geriatric-psychiatric services (Lužný, 2014b, p. 140–141). A reform of psychiatric care should take these data into account while securing a high-quality and available psychiatric care for the ageing population (Lužný, 2014b, p. 140–141). A fundamental element of a purposeful cooperation between lay and professional caretakers is the knowledge of the possibilities and rightful demands on care, but the lay public has not always the chance to gain it. In a survey conducted at the Long-Term Care Hospital in Klokočov, focussing on identifying the needs of caretakers out of the family members of seniors with dementia, 96% of relatives stated that it was important for them to have basic information on what to do for the senior with dementia at home and 82% of the respondents replied that it was important to know about people who would help in case of need (Stolička, 2013, p. 161). To our question if they knew who to contact in case of a senior patient's mental problem, our respondents out of relatives mostly replied positively (65.6%) and 89.2% of the relatives replied that they were happy with the services and care provided. This may imply that the quality of geriatric-psychiatric care in the facility of concern is considered good.

Conclusion

Dementia is the most frequent disorder in old age, the increasing incidence of which has a major impact on healthcare practice, nursing practice and private life. One of the fundamental prerequisites of an adequate care is the necessary knowledge, understanding and skills in the care for a person with dementia, both in their natural social environment and at healthcare and social care facilities. We found out that the knowledge of both lay and professional caretakers in the sample of concern showed significant differences. Family members of patients with dementia gave wrong answers to questions concerning the pathophysiology of the disease and symptoms related to the progression of dementia. Non-medical healthcare personnel working in the specific facility of concern (psychiatric hospital) had insufficient knowledge of the general aspects of dementia and of some behavioural and psychological symptoms of dementia. The results of the survey provide an impulse for improving the quality of care for seniors with dementia in a specific healthcare facility providing geriatric-psychiatric care.

Ethical aspects and conflict of interest

Authors declare that they are not aware of any conflict of interest in regards to the study carried out. The study was approved by the Ethical Committee of the relevant healthcare services provider (psychiatric hospital), where the healthcare employees and the relatives of patients with dementia were inquired.

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Suffering Related to Care

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Abstract

Introduction: The meaning and objective of caring is to alleviate suffering. In spite of this fact patients sometimes perceive the provided care as a source of suffering. Care that causes suffering has many forms, ranging from all forms of omission or neglecting the patient and ending with (ab)using the caretaker's power, ultimately resulting in threatening patient's life and health and violation of his/her human dignity.

Objective: The aim of this study is to outline the concept of suffering related to nursing care.

Method: A bibliographic survey focused on the phenomenon of suffering related to care.

Results: Suffering related to care (uncaring) arises due to healthcare actions that neglect the holistic and patient-centred approach to care. Inspired by D. J. Riemen, S. Halldorsdottir constructed a theory of caring and uncaring encounters in nursing and health care.

Conclusion: Suffering related to care exists but is not inevitable. Reflection on this phenomenon can contribute to changes in the healthcare personnel's behaviour and attitudes.

Keywords: caring, nursing care, suffering, uncaring

Introduction

Both care and suffering represent important concepts in the nursing theory while especially the concept of care occupies a very significant position in the discourse of nursing and nursing ethics even though its processing and the overall approach to it involve significant difficulties (Drahošová & Jarošová, 2016; Stasková, 2015; Šimek, 2016; Watson, 1999).

Many authors characterize care as a response to suffering (Gastmans, 1999; Smith, 2013), so that suffering tends to be understood as a motive for care (Berglund, Westin, Svanström, & Sundler, 2012; Nordman, Santavirta, & Eriksson, 2008) in its broadest meaning – to care for, take interest in and look after others and see their needs, like another person, sympathize with someone, be empathic and be concerned about another person's health (MacLeod, 2000). In her description of the three different forms of suffering differentiated by their source – illness-related suffering, life-related suffering (existential suffering) and care-related suffering (uncaring), K. Erikson points out that in practice we encounter suffering caused by the care itself although its real meaning is to alleviate suffering (Alligood, 2014). This is mainly the case whenever the caring person fails to fulfil the patient's needs, not only in the biological but mainly in the psycho-social area (Ptáček & Bartůněk, 2014).

Care inflicting suffering may take many forms, starting from all types of omission or neglecting the patient and ending with (ab)using the power by the caring person, not only threatening the patient's life and health but also trampling on his/her human dignity, representing an urgent ethical and professional issue.

Objective

The objective of the present study was to find out how the phenomenon of care-related suffering is reflected in the professional literature.

Methodology

The keywords GOOD (and) BAD NURSING (or) CARING (and) UNCARING NURSING (or) SUFFERING RELATED TO CARE were used to find articles dealing with the related problem area in the CINAHL plus database. The search was limited to articles in the English language with an available full text version. No time limitation was applied. The search yielded 52 articles, of which only 9 were relevant.

Additional articles and studies (including one doctoral thesis) were found using references in these articles, focused on the given problem area (4) and the related concepts and theories (16).

Results

In the 1980's, D. J. Riemen started to dedicate herself to suffering related to care, publishing her phenomenological study focused on patients' testimonies concerning their interaction with nurses in 1986. In the description of caring interaction she identified three groups of topics – **existential presence of the nurse**, who was available to the patient, **patient's uniqueness**, identified by genuine listening, and **results** of individualized care, described as pleasant feelings of comfort and safety. The description of non-caring interaction also involved three groups of topics – nurse's **presence only on physical level** for the absolutely indispensable period of time (or not at all) despite the patient's requests, **misunderstanding patient's uniqueness** (the nurse did not listen and appeared too busy to pay attention to the patient) and **consequences** such as feelings of frustration, fear, depression, anger, concerns and anxiety (Bailey, 2010; Halldorsdottir, 1996).

S. Halldorsdottir resumed D. J. Riemen's work, further developing this theory in her doctoral thesis called *Caring and Uncaring Encounters in Nursing and Health Care*. This doctoral thesis was based upon several studies, predominately focusing on patients' testimonies on their experience of care – both good and bad.

To provide a deeper insight into both kinds of interaction, S. Halldorsdottir uses the metaphor of the bridge and wall. Caring interaction is called bridge building. Such professional care includes three necessary components: **competence, care and relationship**, where competence involves professional knowledge and skills, care involves openness and responsiveness towards others, true interest in the patient, moral responsibility, true (existential) presence, dedication and courage to be engaged in an appropriate manner. Relationship is characterized by mutual respect and may be understood as a certain highly specific kind of friendship, combining closeness and distance at the same time. Contrariwise, non-caring interaction is described as wall building and involves **incompetence, indifference, distrust and mutual avoidance**. Indifference takes the form of lack of interest, unfeeling attitude, coldness and inhumanity (Halldorsdottir, 1996; Halldorsdottir & Hamrin, 1997; Wiman & Wikblad, 2004).

Also Björkdahl, Palmstierna, and Hansebo (2010) tend to use metaphors to better explain the results of their research, focused on the nurses' attitudes to patients in the environment of psychiatric intensive care. Nurses' testimonies revealed two different attitudes – one called by

the authors “ballerina attitude” and the other called “bulldozer attitude”. The ballerina attitude involved nurse’s sensible and helpful behaviour, aiming to create trust and to provide care. The same nurses, however, sometimes applied force and pressure to secure safety and order at the ward. This attitude was called by the authors “bulldozer attitude”. In this case, the patient becomes an object that can be dominated by the nurse-bulldozer anytime. The authors refer to S. Halldorsdottir’s theory as it was easy for them to identify the ballerina attitude as caring attitude, but it was less easy to identify the bulldozer attitude as uncaring interaction because the nurses were convinced that they acted in the patient’s best interest (applying force was understood as a valuable lesson for the patient) and their attitude (however paternalistic) often contained certain caring potential.

But this attitude also builds a wall between the nurse and the patient and, to say the least, leads to patients dehumanization – nurses are not concerned with the patient as a unique being but turn their attention to rules for securing good order at the ward. The environment of intensive psychiatric care is highly specific but a similar nurses’ attitude can be found anywhere.

The authors identified studies that were focused on the experience of patients after stroke (Widar, Ek, & Ahlström, 2007), patients with oncological diseases (Arman, Rehnsfeldt, Lindholm, Hamrin, & Eriksson, 2004; Halldorsdottir & Hamrin, 1997), patients on surgical wards (Mako, Svanäng, & Bjerså, 2016), patients with chronic or life-threatening diseases (Berglund et al., 2012) and women in labour (Eliasson, Kainz, von Post, & Högskolan, 2008). The study by E. Wiman and K. Wikblad (2004) was organized in a completely different manner, as it focused on nurses’ behaviour towards patients during their treatment in the emergency department. Situations were recorded and then analysed.

All these studies describe uncaring interactions reported by patients (or in the latter study by researchers) and point out the negative consequences of such interaction. Suffering related to care involved an omission of the holistic attitude and occurred when the patient was not in the centre of the caretakers’ interest, when the patient’s autonomy was trampled on and his perception of the illness was disregarded but also when patient and his description of difficulties were paid insufficient attention to, resulting in neglect in care. The above-mentioned consequences include not “only” feelings that negatively affect the health condition and course of treatment but also an impact on the patients’ future contact with healthcare personnel and, last but not least, neglect in care resulting in patient’s death were reported (Berglund et al., 2012; Halldorsdottir & Hamrin, 1997).

Discussion

Suffering related to uncaring is receiving attention especially in North European countries, following the works by D. J. Riemen, S. Halldorsdottir and K. Eriksson. While trying to bring this concept closer to our environment, we faced multiple issues. The first one was to find adequate expressions for important words so as to cover all levels of the meaning. As an example we can state the multiple levels of meaning of the word CARE that cannot be covered all by one single Czech expression to make obvious that it is not only care in a limited sense but also stands for interest and sympathy. This was reflected also in difficulties while searching for various articles and studies concerning the problem area. The original plan was to search for articles and studies written in English in ProQuest and EBSCO databases and to use the Google search engine using keywords CAR*, UNCAR*, GOOD,

BAD, NURS*, SUFFER* but the search in the ProQuest database alone yielded more than 170,000 results with no possibility to effectively filter them.

No less important is the issue of overreaching impact and mutual complementarity of the various concepts tightly related to the subjective problem area, such as *compassion* (see a review article by Bradshaw, 2011), *presence* (see a review article by S. Bozdogan Yeşilot and F. Öz, 2016), *caring relationship* (e.g. Gastmans, 1999, 2002), the understanding of which is vital for the reflection of the demands made by D. J. Riemen and S. Halldorsdottir on (nursing) care.

All these concepts point to the fact that the basis of care (not only in nursing) is a caring relationship, meaning reciprocity (Gastmans, 2002) and true presence, a “Me and You” relationship, not a “Me and It” relationship (It develops when efforts enabling to enter the relationship are weakened) to use the words of M. Buber (2005). In his understanding of relationships, E. Lévinas goes a lot further than M. Buber as he places the other person above freedom. According to Lévinas, a free person is betrothed to and responsible for another person, meaning that a helpless person must not be abandoned (Arman, 2007). M. Buber’s reciprocity is not mentioned by Lévinas, so that his idea of relationship is a lot closer to that of our concept of professional relationship.

This is exactly how we can understand a nurse’s presence more than only on physical level – the “Me and You” level, not the “Me and It” level. The absence of such presence can then be understood as uncaring attitude (Rehnsfeldt & Eriksson, 2004; Stasková, 2015). Referring to M. Heidegger, Šimek (2016) classifies care as a meaningful component of our existence while pointing out two principally differing methods of caring for another person, perceivable in Heidegger’s *Being and Time* – in the one we control another person and make them dependent, in the other one we develop their own abilities to care. Exactly these two different methods of care are reflected in the research by A. Björkdahl et al. (2010).

Most researches focused on suffering due to care deal with specific behaviours that can be classified as uncaring interaction. Quirk, Mazor, Haley, Philbin, Fischer, Sullivan, and Hatem (2008) however point out that in abstract meaning, there exists a group of behaviours representing (un)caring but the assessment whether or not an interaction is caring or uncaring consists “in the observer’s eye” and rather depends on the caretaker’s hidden abilities than on the specific behaviour. A certain behaviour may appear both caring and uncaring.

Researches concerning suffering related to care typically take the form of qualitative studies, which makes it important to pay attention to the effort by Nordmann et al. (2008) to create a standardized tool. Last but not least, attention must be paid also to the reasons for neglecting patients. It may be due to tiredness, exhaustion, overwork or insufficient motivation (Ptáček & Bartůněk, 2014) Distant attitude is also caused by phenomena mentioned in the literature as *moral distress* and *compassion fatigue* (Sabo, 2006).

Reflecting on the fact that something like this may and does occur and considering the causes of the phenomenon, we can also find a way to improvement.

Conclusion

Suffering related to care represents an acute ethical issue because human dignity is being trampled on and patients’ lives and health are being threatened. It occurs when the patient, as a unique human being, no longer represents the meaning and aim of care. However, such

suffering is not indispensable. Reflection on this phenomenon may lead us to a change in attitude.

Ethical aspects and conflict of interest

Authors declare that they are not aware of any conflict of interest concerning the present study.

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The Czech Version of the Purnell's Model for Cultural Competence

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Abstract

Introduction: The motive of this work was to create standardized Czech version of the Purnell Model for Cultural Competence which could help non-medical healthcare personnel in providing care to clients from different cultural backgrounds.

Objective: The aim was to create a standardized Czech version of the Purnell Model for Cultural Competence and to provide a description of the back translation methodology.

Method: After obtaining consent from the author of the Model for Cultural Competence, Larry Purnell, a translation to the Czech language from the original version in English was carried out by experts from the fields of nursing and midwifery, healthcare English and by linguist. Back translation was carried out by a native speaker from the United States who has lived in the Czech Republic for fifteen years. The native speaker did not know the original version. Subsequently, his version was compared with the original version. Significantly different terms were discussed and subsequently incorporated into the final Czech version.

Results: Altogether, 89 terms were translated. Absolute agreement occurred in 37 (41.6%) cases. In eight cases (9%), the translated terms were significantly different, but agreeing on the resulting expression was seamless. In three cases (3.37%), the different Czech variants also differed significantly and the translation did not correspond to the context. Using the Czech and English interpreting vocabulary linguists, the resulting expressions were reworked. There were synonyms in 38 (42.7%) expressions, singular and plural differences in three translated terms (3.4%). All the differences that appeared in translations were probably due to the different active vocabulary of the individual translators, and in such cases the linguist was chosen as the variant that most corresponds to the original meaning and which is most acceptable for the stylistic and meaningful aspects of the Czech language.

Conclusion: The Model for Cultural Competence is a tool for collecting data from the members of varying cultures from all regions of the world and is widely used by healthcare providers as well as for instance by teachers, research workers and sociologists. The Model for Cultural Competence has been translated into Czech language and brought closer to the wider professional public. It will be subject to further verification under a more extensive study.

Keywords: back translation, focus group, multicultural/transcultural care, nursing model

Introduction

As of January, 2000, Act No. 326/1999 Coll., on Residence of Foreign Nationals on the Czech Territory (CR) (Czech), entered into force, making the entrance to and residence in the Czech Republic more restrictive for most foreigners. Certain provisions of this act were moderated by an amendment effective only as of July 1, 2001, resulting in a slight new increase of resident foreign nationals.

With the Czech Republic joining the European Union (EU) in 2004, the categories of residence were extended. Apart from permanent residence and visa for periods longer than 90 days, there is also long-term residence and temporary residence for EU citizens and their family members.

On June 30, 2016, there was a total of 480,191 foreigners registered on the territory of the Czech Republic and this figure continues to grow every day (Czech Statistical Office, 2016). This situation also results in the fact that Czech healthcare facilities are more and more frequently visited by clients from various cultural environments. Nurses, obstetricians and other non-medical healthcare personnel should be able to provide culturally differentiated, culturally competent and culturally sensible care. Culturally competent care means having certain elementary knowledge concerning the health-related traditions of several cultural groups. Providing culturally differentiated care requires care providers to have deeper knowledge of such minority groups that represent fellow citizens in the given country and/or region with substantially different cultural and historical background (Tóthová, 2010). There are nursing models dealing with the problem of multicultural/transcultural nursing and facilitating the planning and implementation of care for patients from various cultural environments. These include for instance models by Larry Purnell, Madeleine Leininger, Papadopoulos, Tilki and Taylor, Josepha Campinha-Bacote, Joyce Newman Giger and Ruth Davidhizar, Rachel Spector (Sagar, 2012).

Purnell's Model for Cultural Competence

The Purnell Model is classified as a holographic and complex theory because it comprises a model and an organizational framework that can be utilized by all healthcare providers in various branches. The Model for Cultural Competence provides a detailed, systematic and apposite framework for learning about and understanding a culture. The empirical framework of this model provides a basis for healthcare providers, teachers, researchers, managers and administrators in all healthcare branches. The objective of the model is to provide holistic, culturally qualified and therapeutic interventions, support of one's health and wellbeing, prevention of injuries and illnesses, and maintenance and restoration of one's health (Purnell, 2013). The Model for Cultural Competence consists of four circular lines and 12 circle sectors representing the various domains. The outer circular line represents global society, the second outer one community, the third one family and the inner circular line the individual. The inner circle is divided into twelve sectors or domains. These domains create the organizational framework of the model. Every single domain includes concepts that need to be considered while assessing patients (Kutnohorská, 2013). The dark centre of the circle represents an unknown phenomenon. At the bottom of the model, the saw-toothed line represents the non-linear concept of cultural consciousness (Purnell, 2013).

The model intends: to provide a framework for all healthcare providers for learning terms and cultural characteristics; to define the circumstances affecting human cultural world view in the context of historical perspectives; to provide a model connecting the most crucial relations of a culture; to identify a characteristic of a culture, to support concordance and to enable the provision of conscious, sensible and competent healthcare; to provide a framework reflecting human characteristics such as motivation, intention and opinion; to provide a structure for analysing cultural data, the perspective of an individual, family or group within their unique ethno-cultural environment.

Presumptions supporting the model

As Purnell (2013) puts it, these ideas are the main premise of the model: all professions providing healthcare need similar information on cultural variety; all professions providing healthcare share the metaparadigm of the concept of global society, family, person and health; one culture is not better than another culture, they are only different; differences exist inside and between cultures; cultures change slowly in the course of time; variants of cultural characteristics determine in how much one differs from the prevailing culture; if patients take part in their care and have the choice of goal in terms of health, plans and interventions, then their adherence and health results will be better; culture has a strong impact on the interpretation and responsibilities regarding healthcare provided to the individual; care providers need culturally generic and culture-specific information to provide a culturally sensible and culturally competent care; contact with every patient is a cultural encounter (Purnell, 2013).

Objective

The objective of the present paper was to create a Czech version of the Purnell Model for Cultural Competence and a description of the backward translation methodology.

Methodology

The aim of the translation was to translate Larry D. Purnell's cultural competency model from English to Czech. There are several publications dealing with translations. In our case, the Model was translated based on the methodology given in the article by Chen & Boore (2009) *Translation and back-translation in qualitative nursing research: methodological review*. Furthermore, our translation was influenced by articles by other authors, who dealt in particular with translations of questionnaires and scales, namely Švec et al. (2009), Blanař et al., (2014). Last, but not least, our translation was influenced by the recommended methodology for translating questionnaires and other research tools: problems and solutions (Behling and Law, 2000).

The first step to create a Czech version of the Model for Cultural Competence was obtaining a consent to translation from the author, Larry Purnell. The original version was then translated from English into Czech language by three independent experts specialized in nursing, obstetrics and healthcare English and one translation (the fourth version) was provided by a linguist and translologist. All these four versions were compared and differences were discussed within a focus group consisting of the actual translators. The final version, which suits best the Czech language and the target group of users, was created out of the various versions. This version was then translated back into English by a native speaker from the United States of America, permanently residing in the Czech Republic. The native speaker did not know the original version. His version was subsequently compared with the original version. Expressions differing in their meanings were discussed and then implemented in the final Czech version (Blanař et al., 2014).

While creating the Czech version we endeavoured to make the translation comprehensible for the end users, i.e. personnel in healthcare services (obstetricians, general nurses), academic workers and university students in the selected fields and semantically correct, and to make sure that the final terminology is as identical as possible to the original version.

Results

As obvious, 89 expressions were translated in total. A full match was reached in 37 (41,6%) cases. In eight cases (9%), the translated terms were significantly different, but agreeing on the resulting expression was seamless. In three cases (3.37%), the different Czech variants also differed significantly and the translation did not correspond to the context. Using the Czech and English interpreting vocabulary linguists, the resulting expressions were reworked.

In three cases, the various Czech versions showed semantic differences and the translation did not match the context. The linguist subsequently used Czech and English monolingual dictionaries to reformulate the corresponding terms. Three terms in our translation raised the most intensive discussion. The first term is called “Spatial distancing” in the original and is part of the Communication domain. The various translations were “udržování prostorové vzdálenosti”, “odstup v prostoru”, “prostorový odstup”. Finally, we decided for “Komunikační vzdálenost” (*translator’s note [TN]*: “Communication distance”) as we think it reflects the given context the best. The second discussed term was “Temporality”, again in Communication domain. The various translations were “církevní statky”, “temporalita”, “duchovní statky”. In the focus group, we tried to find the most suitable term because everyone may imagine something else and not everybody perceives the terms the same way. A monolingual dictionary provides the following definition: “a traditionally linear course in the past, present and future. In social sciences it stands for human perception of time and social organization of time”. In his original work, Purnell (2013) describes in the relevant chapter that every culture has a different perception and understanding of time. Some cultures are rather past-oriented, some more present-oriented and some rather future-oriented. Therefore we did not use either of the proposed translations and adopted the final expression “Průběh minulosti, přítomnosti, budoucnosti” (*TN*: Course of the past, present and future). The third and last expression discussed was “Deficiencies” in the Nutrition domain. The various expressions were: “nedostatky” and “nedostatky / dietní chyby”. This translation appears relatively clear and the final term could be “nedostatky”. However, compared with the comments in Purnell’s original work (2013), “deficiencies” are understood more as “differences”. Therefore, the final translation is “Rozdíly” (*TN*: “differences”). There were synonyms in 38 (42.7%) expressions, singular and plural differences in three translated terms (3.4%). All the differences that appeared in translations were probably due to the different active vocabulary of the individual translators, and in such cases the linguist chose that option that most corresponds to the original meaning and that is the most acceptable one from the stylistic and meaningful viewpoint of the Czech language. The aim of the Czech version was to avoid the use of professional expressions, but in some cases their use was necessary. The native speaker received the final Czech version, according to which he made a translation into the English language. He did not know the original text. The individual non-conforming terms are given in Table 1. It shows the final Czech expressions on which the discussion group agreed. The final version of the translation is shown in Figure 1.

Discussion

To provide a culturally competent care, it is indispensable to obtain as much good-quality information on the given culture as possible. With the increasing number of international and multicultural research projects, there is a growing need to adapt research tools to the population and the language in which they will be used (Beaton et al., 2000). Retroreflection is a method that serves to preserve the meaning between the original version and the language translation. Brislin's classical retranslation model is widely used for translation of research

tools, and Brislin (1970) recommends repeated translations by several independent bilingual translators. One interpreter translates the research tool from the original language into the target language and the second interpreter translates this version from the target language back to the original language. Both versions are then compared and differences are detected. If a significant difference is discovered, the translation will be done by another independent interpreter. This process is repeated until there is a consensus among the members of the translation team. Jones et al. (2001) presents a combination of translation techniques that are used in a group approach when applying backward translation methods in bilingual texts. First, two bilingual experts will prepare two translated versions of the original original language into the target language. Subsequently, these two versions are translated back into the original language by two other specialists. These four translators will then come together and, through group discussion, identify the differences between the original and the translated version and try to find a consensus and create the final version. These versions are again translated by two other bilingual persons, and differences are compared and discussed. If significant deviations are found, translations are carried out until the group comes to a consensus. There are many factors that can affect the quality of translation in nursing research. These include, for example, translators and their language skills, reverse translation, culture and the language itself. Beaton et al. (2000) recommend that a text from the original language be translated into a target by at least two interpreters for comparisons. In our case, the translators were four and were made up of various nursing, linguistics and English specialists. It is important for the translating translator to speak fluently both in the language in which the original text is and in the language in which it is translated (Chen & Boore, 2009). It is essential that the individual translators are also experts in the field of linguistics. During the translation itself, different versions are produced that may vary or differ. It is necessary to be careful whether there are differences at the synonym level, or whether the meaning of words is changing. Imperfect translations may cause non-acceptance in the target user group and may alter the intention of the translated tool (Švec et al., 2009). A relatively large number of synonymous disagreements in our rewriting are attributed to differences in the active vocabulary of individual translators, education, and professional background.

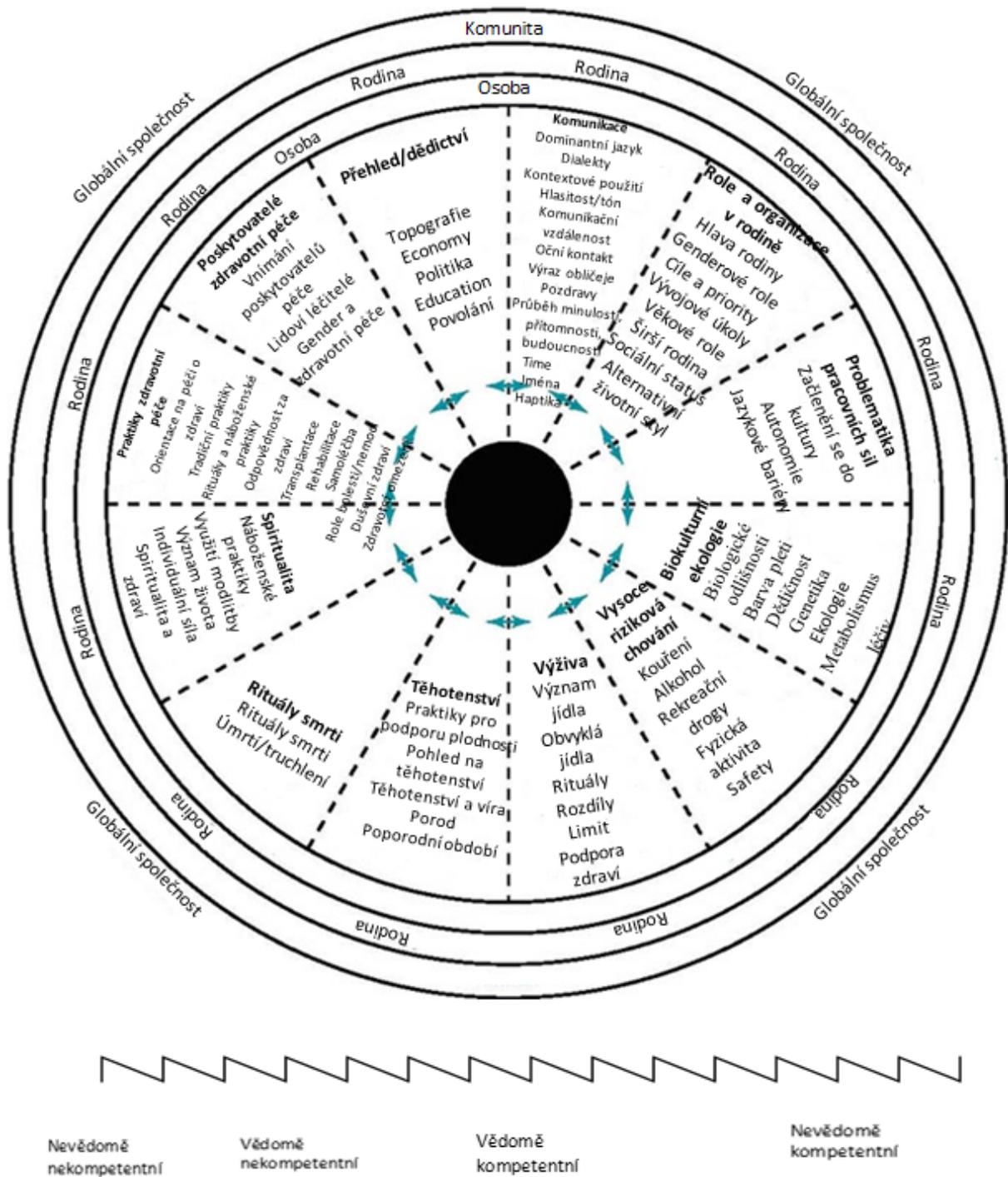


Fig. 1 The Czech version of the Model for Culture Competence. Translated by the authors, from Purnell (2013).

Table 1 Translated expressions

Translators	T1	T2	T3	T4
Differences in meaning	Ekonomika	Ekonomika	Ekonomika	Ekonomie
	Biologické variace	Biologické odlišnosti	Biologické změny	Biologické odlišnosti
	Metabolismus léků	Metabolismus léčiv	Metabolismus léčiv	Metabolismus léků
	Kouření	Tabák	Tabák	Tabák
	Truchlení	Úmrtí/truchlení	Úmrtí	Úmrtí blízké osoby
	Magicko-náboženské víry	Rituály a náboženské praktiky	posvátné náboženské víry	Magicko-náboženská a náboženská přesvědčení
	Lidoví léčitelé	Lidoví léčitelé	Lidoví lékaři	Lidoví léčitelé
	Pohlaví a zdravotní péče	Zdravotní péče u různých pohlaví	Zdravotní péče u různých pohlaví	Gender a zdravotní péče
Different; in a discussion	Prostorový odstup	Odstup v prostoru	Odstup v prostoru	Udržování prostorové vzdálenosti
	Temporality	Duchovní statky	Církevní statky	Temporalita
	Nedostatky	Nedostatky/dietní chyby	Nedostatky	Nedostatky
Singulars and plurals	Purnellův model kulturních kompetencí	Purnellův model kulturní kompetence	Purnellův model kulturních kompetencí	Purnellův model kulturní kompetence
	Dotyky	Dotyk	Dotyk	Dotyk
	Rekreační drogy	Rekreační drogy	Rekreační droga	Rekreační drogy
Synonyms	Povolání	Povolání	Povolání	Zaměstnání
	Dominantní jazyk	Převládající jazyk	Převládající jazyk	Dominující jazyk
	Nářečí	Nářečí	Nářečí	Dialekty
	Výraz tváře	Výraz tváře	Výraz obličeje	Výrazy obličeje
	Pozdravy	Pozdravy	Zdravení	Pozdravy
	Jména	Názvy/jména	Názvy	Jména
	Genderové role	Role pohlaví	Role pohlaví	Genderové role
	Vývojové úkoly	Rozvojové cíle	Vývojové úkoly	Rozvojové úkoly
	Sociální status	Sociální postavení	Sociální status	Sociální postavení
	Barva pleti	Barva pleti	Barva kůže	Barva kůže
	Výživa	Výživa	Výživa	Strava
	Význam jídla	Význam potravin	Význam potravin	Význam jídla
	Běžné potraviny	Obvyklá jídla	Obvyklá jídla	Běžné potraviny
	Duchovno	Duchovno	Duchovno	Spiritualita
	Smysl života	Význam života	Význam života	Smysl života
	Individuální síla	Osobní síla	Osobní síla	Individuální síla
	Duchovno a zdraví	Duchovno a zdraví	Duchovno a zdraví	Spiritualita a zdraví
	Role bolesti/nemoci	Úloha bolesti a nemoci	Úloha bolesti a nemoci	Role bolesti/nemoci
	Mentální zdraví	Mentální zdraví	Duševní zdraví	Duševní zdraví
	Vnímání poskytovatelů péče	Postřeh (vnímání) zdravotníků	Postřeh (vnímání) zdravotníků	Vnímání poskytovatelů péče
	Pohlížení na těhotenství	Názory na těhotenství	Pohled na těhotenství	Pohled na těhotenství
	Bydliště	Bydliště	Bydliště	Pobyt
	Rodinné role a organizace	Role a organizace v rodině	Role v rodině a organizace	Rodinné role a organizace
	Hlava domácnosti	Hlava rodiny	Hlava rodiny	Hlava domácnosti
	Věkové role	Role věku	Role věku	Role starých lidí
	Rozšířená rodina	Širší rodina	Širší rodina	Širší rodina
	Problematika pracovní síly	Problémy pracovní síly	Problémy pracovní síly	Problematika pracovních sil
	Akultura	Začlenění se do kultury	Začlenění se do kultury	Akultura
	Autonomie	Samostatnost/samospráva	Autonomie	Autonomie
	Praktiky plodnosti	Praktiky plodnosti	Praktiky plodnosti	Praktiky pro podporu plodnosti
	Těhotenství a víra	Víra/přesvědčení v těhotenství	Víra v těhotenství	Přesvědčení ve vztahu k těhotenství
	Poporodní období	Poporodní péče	Období po porodu	Poporodní péče
	Modlení	Využití modlitby	Využití modlitby	Užití modlitby
	Praktiky zdravotní péče	Praktiky zdravotní péče	Praktiky zdravotní péče	Zdravotnická praxe
	Zaměření na zdravotní péči	Zaměření na zdravotní péči	Zaměření na zdravotní péči	Orientace na péči o zdraví
	Zodpovědnost za zdraví	Zodpovědnost za zdraví	Zodpovědnost za zdraví	Odpovědnost za zdraví
	Samoléčba	Samoléčba	Sebeléčba	Samoléčení
	Omezení	Zdravotní omezení	Zdravotní bariéry	Omezení

Conclusion

Our aim was to translate the Cultural Competence Model into the Czech language by means of a retrospective translation and to bring it closer to the wider professional public. The model of cultural competences has a wide range of uses. It is applicable in education, research, pedagogical sciences, doctors and non-medical healthcare professionals, physiotherapists, psychotherapists and other professions.

Ethical aspects and conflict of interest

No risk of ethical conflict has been identified. The present work is part of a project approved by the Ethical Committee of the Faculty of Health Studies, University of Pardubice.

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Factors influencing satisfaction of non-medical healthcare personnel

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Abstract

Introduction: At present, monitoring of employee satisfaction is one of the standards of quality management in accredited hospitals. Assessment of satisfaction and finding incentives for greater engagement of employees should be a standard tool of personnel management. In healthcare organizations it is necessary to monitor employee satisfaction not only to ensure greater engagement, but also to prevent burnout syndrome, which also strongly affects the quality of provided health care.

Aim: The aim of this paper is to present part of the results of a satisfaction survey, focusing on the significance of factors influencing satisfaction of non-medical healthcare personnel in an acute care hospital.

Method: The data were collected in a satisfaction survey in an acute care hospital. The survey used anonymous online questionnaires, which were constructed on the basis of standardized questionnaires of the Gallup agency, surveys implemented in the project TNS AISA (Engagement of employees in the Czech Republic) and specific requirements of the hospital quality manager.

Results: 1 178 non-medical healthcare employees included in the research sample mention as the most important factors influencing their perception of the social climate the following: good cooperation in the department, friendly interpersonal relationships and good relations with the immediate supervisor.

Conclusion: The survey results lead to recommendations aimed particularly at improvement of internal communication and personnel management, which contribute to the creation of the desired social climate and organization culture. To stabilize the employees and improve their relationship with the organization it is necessary to build greater confidence in the top-level management through more transparent communication, focusing on the common goals and vision of the organization.

Keywords: engagement, non-medical healthcare personnel, organizational culture, professional satisfaction, social climate

Introduction

Recently, the interest in the issue of job satisfaction of healthcare professionals has been increasing, especially in the context of the continuing shortage of physicians and nurses. Medical facilities are facing the problem of how to recruit and retain qualified and motivated staff (Bártlová, 2006). Employee satisfaction affects the functioning of healthcare organizations and their results. The path leads from satisfied employees to satisfied patients, who are the main subject of interest of medical facilities. Monitoring employee satisfaction is the basis for successful human resources management; it is an important source of information and feedback to the management.

Job satisfaction is related to the content of one's work. It is a positive emotional state that results from the job evaluation or work experience (Locke, 1976 in Arnold, 2007). Employee satisfaction is reflected in their own engagement. However, engagement does not mean satisfaction (Gallup, 2008). A satisfied employee may not have the motivation to serve the organization for the best performance. According to Armstrong (2007), it is possible to talk about engagement when people are devoted to their work and if they are interested in what they do. Engaged behavior shows faith in the organization, spreading its good name, focus on their own work, working effort to make things better, close cooperation with colleagues in order to improve work performance, etc. (Gallup, 2008).

As reported by Holá (2011), engagement is a matter of quality management and effective internal communication. Employees should know what is happening in the organization, what the goal is, where the organization is going and what role the employees play in it. Satisfaction and employee engagement affect the quality of their work, reduce the probability of errors and influence attitudes to the medical profession. Dissatisfied and disengaged employees may have a tendency to a higher rate of absenteeism, lower productivity, poor morale, higher fluctuation etc., which ultimately have an impact on poorer results of the whole healthcare organization.

Organizational culture and social climate in the organization also have a significant influence on employee satisfaction and engagement. Organizational culture is presented by a complex of ethical norms, values and their fulfillment, a set of beliefs, attitudes, expectations and behavior patterns that form the behavior of employees (Denison, 1990). Organizational culture expresses the character, the spirit of the organization, the informal rules of the game that affect thinking and behavior of employees and the overall atmosphere in the institution (Bedrnová, Jarošová, & Nový, 2012).

Besides job satisfaction and engagement, organizational culture has an effect on mutual relations between managers and staff, on productivity, willingness to work and devotion of employees. A healthy organizational culture facilitates the process of managing an organization, helps to manage changes, and clarifies the development and orientation in the organization. It creates conditions for clear communication, enables quick decision-making, increases motivation (Armstrong, 1999; Bedrnová et al., 2012). The epiphenomenon of a healthy organizational culture in a medical facility is the loyalty of employees, their low fluctuation and joyful approach to work (Škrla & Škrlová, 2003). Management and communication play an important role in the creation, strengthening and maintaining of organizational culture (Holá & Pikart, 2014).

The provision of health care and improving its quality are influenced by a specific social climate of the workplace. The terms of social climate and organizational culture are sometimes used in the same sense, but their contents are different. While the term climate concerns mainly the atmosphere and it determines the relationship between employees and organizations, the term organizational culture describes the character of the institution, refers to the values and standards that members of the organization share and that influence their behavior (Arnold, 2007). A healthy social climate, according to Cejthamr and Dědina (2010), is characterized by good interpersonal relations, mutual trust and open discussion about issues, appropriate managerial behavior and appropriate managing style, opportunities for personal and career development, identification with the organization, loyalty of employees etc. Managerial communication and creating the desired communication environment play an important role in creating a social climate that is as a positive stimulant (D'Aprix, 2006).

It is then the management's duty to constantly cultivate and protect the social climate so as not to endanger the quality of the provided healthcare. According to Bedrnová (2012), an adverse social climate can make it difficult to meet the goals of the organization, lead to poor staff engagement, negatively affect workplace relationships and lead to conflicts; it may also intensify job dissatisfaction and subsequently increase employee fluctuation.

It is clear from the above-mentioned that a healthy social climate and organizational culture are important factors in the development and perspectives of medical facilities and it is necessary to accept satisfaction in the workplace as one of the preconditions for creating a positive attitude to work, and providing high-quality health care.

Aim

The aim of this paper is to uncover factors that influence satisfaction of a specific professional group of employees - non-medical healthcare personnel - in a selected regional acute care hospital.

Method

Data was obtained in a satisfaction survey, conducted in December 2015 and January 2016, in a selected acute care hospital. Anonymous online questionnaires were used in the survey. The questionnaires were designed on the basis of standardized questionnaires of the Gallup agency and surveys implemented in the project TNS AISA (Engagement of employees in the Czech Republic) and a discussion with the hospital quality team.

The questionnaire contained the following selected domains of stimulants involved in the creation of job satisfaction: *1. level of the formal setting of work, 2. education, professional and career development, 3. quality of the management, 4. level of engagement and the potential for innovation and cooperation, 5. level of self-realization, satisfaction with personal and professional development, 6. level of belonging to the organization.* The last part of the questionnaire contained the seventh domain: *verification of importance of selected factors for satisfaction and improvement of organizational culture.*

The entire population of the hospital employees was involved in the survey. The sample was created by those who completed the whole questionnaire properly. The sample included all employee groups according to the selected criteria: *professional occupation, membership to a department, job title and length of employment.* Employees anonymously completed the online version of the questionnaire. Anonymity was assured by one-time approach under an anonymously assigned password. Employees assessed their own satisfaction by the degree of agreement with the individual items, on a scale from 1 (definitely agree) to 5 (definitely disagree). In the last part of the questionnaire, they evaluated the importance of selected factors relevant to their work performance and influencing their satisfaction. The evaluation scale from 1 (very important) to 5 (unimportant) was used again. Ratings 1 and 2 are considered as the positive zone for evaluation of the satisfaction level. There was an option to express comments or other suggestions at the end of the questionnaire.

Results

In the survey, the entire population (physicians, non-medical healthcare personnel and other employees) of the selected acute care hospital, i.e. a total of 4 595 employees, were

approached. The proportions of individual professional groups in reality and in the sample are shown in Table 1. The sample consisted of 34% of all the employees working in the selected hospital. The proportion of respondents in the sample approximately corresponds to the distribution in the basic employee population. The largest group consists of non-medical healthcare personnel followed by other employees and physicians. This order also corresponds to the representation of individual professional groups in the hospital. The group of non-medical healthcare personnel includes nurses, midwives, radiologic assistants, paramedics, health and social workers, medical laboratory employees, nutritional therapists, pharmaceutical assistants, physiotherapists, clinical speech therapists and clinical psychologists, medical assistants, orderlies, and patient attendants. The largest group consists of nurses. The survey involved 1 178 non-medical healthcare personnel, i.e. 39% of the entire population of non-medical healthcare personnel in the selected hospital.

Tab. 1 A comparison of proportions of professional groups in reality and in the sample

Professional group	The number in the sample	Percentage	The number in reality	Percentage
Physicians	174	11.13%	756	16.45%
Non-medical healthcare personnel	1 178	75.32%	3 017	65.66%
Other employees	212	13.55%	822	17.89%
Total	1 564	100.00%	4 595	100.00%

Table 2 shows an evaluation of individual domains (1–7) of satisfaction assessment in the group of non-medical healthcare personnel. Positive evaluation (i.e. 1 and 2) by non-medical healthcare personnel is presented only in the domains 1 - *level of the formal setting of work* and 7 - *factors influencing satisfaction and improvement of organizational culture* (average rating 1.75 and 1.52, respectively). All other domains reached average values greater than 2 in the evaluation. The weakest rating is in the domain 6 - *level of belonging to the organization*. It uncovers instability of the staff, which could disrupt the functioning of the whole organization in the future because an employee as the most important source of information in the organization spreads its reputation towards patients and potential employees and significantly affects public relations of the organization and its image.

Tab. 2 Average values of individual evaluated domains in the professional group of non-medical healthcare personnel

Professional group	Domain number						
	D1	D2	D3	D4	D5	D6	D7
Non-medical healthcare personnel	1.75	2.21	2.38	2.47	2.22	2.68	1.52

Table 3 shows selected factors that have the greatest impact on the social climate in the workplace, organizational culture and that create a subjective feeling of employee satisfaction, which is reflected in their own engagement. The factors are listed by the frequency of the obtained evaluation 1 (very important) and 2 (important). They are arranged by rating 1 (very important), from the highest to the lowest values. The third column is a summary of the

frequency of evaluation 1 and 2. The difference to 100% is represented by those respondents for whom the given factor is insignificant (i.e. ratings 3, 4, 5).

Tab. 3 Evaluation of the importance of selected satisfaction factors by non-medical healthcare personnel

Selected factors	Very important (1)	Important (2)	Total (Important)
1. Good cooperation in my department	84.47%	10.27%	94.74%
2. Friendly interpersonal relationships in my department	79.88%	12.99%	92.87%
3. Correct relations with an immediate superior	74.87%	16.21%	91.08%
4. Respecting ethical standards and rules of conduct in the hospital	74.36%	18.25%	92.61%
5. Sufficient staff in my department	71.90%	13.41%	85.31%
6. Showing respect for my work	69.19%	18.42%	87.61%
7. My adequate financial remuneration	69.10%	10.44%	79.54%
8. Sufficient equipment in the department	68.34%	19.10%	87.44%
9. My job security in the hospital	62.39%	22.92%	85.31%
10. Stability of employees in my department	61.71%	24.79%	86.50%
11. Good cooperation between departments in the hospital	59.17%	27.76%	86.93%

Non-medical healthcare personnel perceive as the most important (first three ranks in the assessment of the importance) the following factors: *good cooperation in the department*, *friendly interpersonal relationships* and *correct relations with the immediate superior* that directly relate to the social climate and organizational culture. *Good cooperation in the department* and *friendly interpersonal relationships* indicate the importance of the social climate (especially interpersonal relationships) that must be constantly cultivated and protected particularly by a good managerial leadership.

The factor *respecting ethical standards and rules of conduct in the hospital* is in the fourth position in the evaluation of significance. This factor is strongly influenced by the organizational culture, by setting, respecting and enforcement of the code of ethics and other written and unwritten rules. Not following the rules and their difficult enforcement are the main demotivators that strongly disrupt the social climate and employee engagement. It is therefore appropriate here to focus the attention on the implementation and compliance with the new code of ethics.

The factor *sufficient staff in the department*, which appears in the fifth position, is significant due to the current unfavorable situation related to a lack of medical personnel in Czech health care organizations.

Non-medical healthcare personnel evaluate *showing respect for work* as being more significant (6th ranking) than *adequate financial remuneration* (7th ranking). The factors which follow are *sufficient equipment in the department* (8th ranking), *job security in the hospital* (9th ranking, it also corresponds to the present situation), and *stability of employees in the department* (10th ranking). The factor *good cooperation between departments in the hospital* ranked last in the ranking of significance. This factor is unimportant for about 13% of the non-medical healthcare personnel.

Discussion

The relatively low participation in the satisfaction survey (34%) may be due to a lack of interest and weak confidence in the top-level management, inadequate identification of employees with the vision and objectives of the hospital (which proves the worst average rating of the domain no. 6 - *level of belonging to the organization*: 2.68) and inadequate communication (the assessment of communication was part of the domain no. 4 - *level of engagement and the potential for innovation and cooperation*, which was considered by the non-medical healthcare personnel as the second worst: 2.47). It is evident from the above-mentioned facts that recommendations are aimed in particular at improving management of the personnel (creating and maintaining an organizational culture and background for professional and independent work, ensuring compliance with the code of ethics, implementing a system of regular reviews of employees and management, etc.), internal communication, better and more frequent explanation of the organization's vision or greater openness and a willingness of the management to receive employee comments.

These recommendations, for example, are supported by a model (Fig. 1) that shows the way towards employee engagement through the quality of the communication environment and social climate (D'Aprix, 2006). According to D'Aprix (2006), if there is performance feedback, if employees are aware of their responsibility and if their individual needs are respected, then the identification with the organization, enhanced by the possibility to say their own opinion, is what leads to higher levels of employee engagement. The model represents building of the communication environment, which is important for creating social climate and for functioning of an organization. The survey results clearly indicate that the needs of workers are mostly in the area of good cooperation and fair relations with superiors. D'Aprix's model shows in which way these needs could be met.

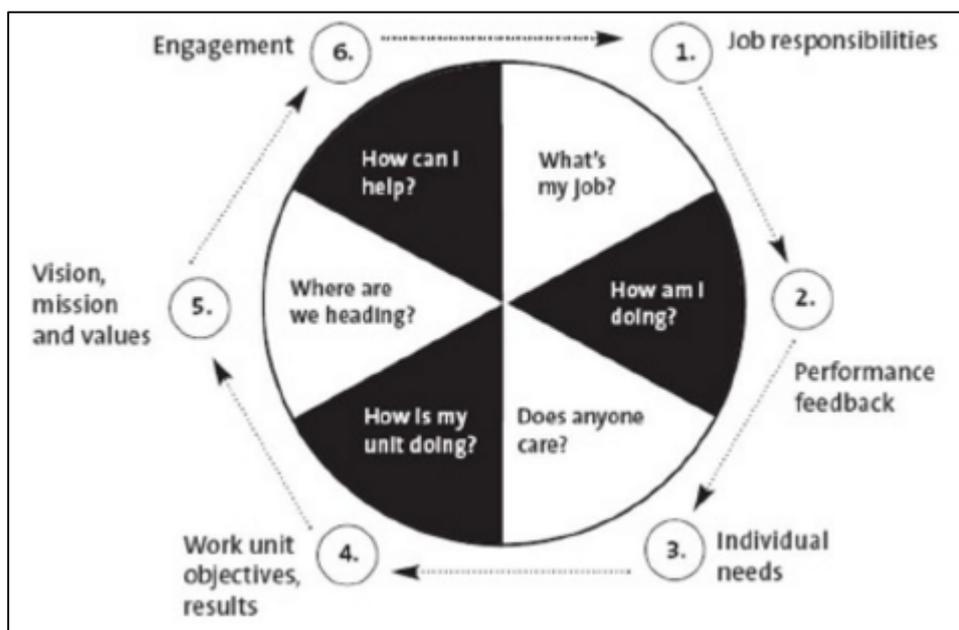


Fig. 1 **The quality of the communication environment for increasing employee engagement**
Source: D'Aprix, R. (2006).

The survey results can significantly help the management to improve specific stimulants for their employee satisfaction and to improve the quality of health care and gradually improve the image of the hospital. Engaged employees who are satisfied with their jobs and leadership,

identify with the goals of the organization and support their implementation, and spread the good name of the institution (Novotný & Pecáková, 2014). Non-engagement and dissatisfaction of employees can negatively affect whether they stay in the organization and they can also endanger the quality of the provided health care, especially if the staff don't recommend their own medical facility to the public, not even as an employer. Employees are the most important source of information about their organization (Holá, 2011) and therefore it is necessary to pay considerable attention to their satisfaction and engagement. It is important to create an appropriate communication environment that enables to discover non-functioning stimulants and change them to positive functioning stimulants.

According to research results of Ivanová and Kurfürst (2006), healthcare organizations do not look after human resources too well. Non-medical healthcare personnel (in this research, namely nurses) are satisfied with their jobs (they especially appreciate the content of their work and the job security), but not with the organization. In their opinion, medical facilities care especially about the quality of patient care, balanced economic budget, quality documentation and they prefer managerial values over care for human resources (Ivanová & Kurfürst, 2006).

The survey results can be compared with the results of Bártlová's research (2006) related to job satisfaction of nurses in the Czech Republic. The author states that half of the nurses in the Czech Republic are satisfied with their jobs. Factors that contribute the most to job satisfaction are good relations in the department, work diversity and good work organization. Financial remuneration contributes to job satisfaction only to a small extent (Bártlová, 2006).

Conclusion

Thanks to the survey the hospital management has received enough incentive for improvement in the area of personnel management. The results are significant especially as a kind of self-reflection for the management and should help to eliminate the weak points and to reorganize management of the personnel. The results also show that underestimating the social climate and the organizational culture in the workplace and insufficient respect for the employees lead to their job dissatisfaction and low engagement.

The assessment of factors influencing employee satisfaction shows that factors generating social climate, organizational culture and their implementation in the functioning of a specific workplace are very important for non-medical healthcare personnel. Non-medical healthcare personnel evaluate as the most significant the following factors: good cooperation in the department, friendly interpersonal relationships and good relations with their immediate superiors. These are the major challenges for the management.

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