Adaptation of the Quality-caring Model to Hospitalized School Aged Children and Their Parents

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Abstract

Background: the development of nursing theory improves nursing practice and consequently the health of those who receive nursing care. The aim of this article is to describe the adaptation of the quality-caring model to hospitalized school aged children and their parent.

Methods: a mixed methods study in 4 phases was outlined. Study integrated a literature review (phase 1); application of surveys to hospitalized children and their parents (phase 2); delphi panel with nurses as experts (phase 3); and the the adaptation of quality-caring model (phase 4). Participants included hospitalized children (n=252), their parents (n=251) and nurses (round 1 n=47; round 2 n=42). National Data Protection Commission provided authorization for the study as well as the ethics committee from 6 health institutions where the study was applied.

Results: Findings highlight the identifications of key aspects valued by children, parents, and nurses, such as: information, family involvement, play, distraction, and communication.

Conclusions: The adapted model includes fundamental aspects of children hospitalization and is focused on satisfaction with care as an outcome of nursing care. Its integration in daily clinical practice if fundamental to improve quality of care and accomplish parents and children satisfaction with nursing care.

Background

Family centered care has been considered as the best practice in pediatric hospitalized care [1]. This approach to child's health care lays on the belief that the emotional and developmental needs of children are best achieved when families are integrated and involved in care [2, 3]. Although it as has been used as a philosophy of care worldwide [4] there is still a lack of research that proves its greater effectiveness in comparison to other perspectives [5]. Further theoretical conceptions are applied to hospitalized children and have been reported in literature such as theory of basic human needs[6–8], theory of human care [9] or comfort theory [10]. The quality-caring model [11] is also identified as particularly suitable since it is based on Watson [12], King [13] and Donabedian [14] work. This model highlights the importance of nursing profession and has successively been implemented in pediatric hospital setting [15].

The model construction is settled in considerations regarding nursing interventions and while exploring outcomes variables of patient satisfaction [16]. The purpose of this model is to guide professional practice and to provide a foundation for nursing research. The model was initially developed in 2003 [17] and later updated in 2020 with four main concepts that include humans in relationship; relationship-centered professional encounters; feeling "cared for", and self-advancing systems [16]. The revised version accentuates the link between caring relationships and quality of care where patient satisfaction is integrated. A major proposition of this model is that relationships are important to care and positively contributes to outcomes in clients, families, care providers and ultimately the health system.

Theories are embraced by nurses to guide practice and to create practice that is meaningful to them. Also, the development and study of nursing theory improves nursing practice and consequently the health and quality of life of those who receive nursing care [18]. The main aim of this article is to adapt the revised quality-caring model [16] to hospitalized school aged children and their parents based on research findings.

Methods

This is a mixed method study that occurred in 4 phases. The focus was on nursing care provided to hospitalized school aged children and their parents. The study was applied in hospitals and all perspectives were considered namely from children, parents, and nurses. National Data Protection Commission provided authorization for the study (1644/2015) as well as ethics committees in each of the institutions where the study was undertaken. A brief description of each phase is presented for contextualization purpose. In this manuscript we are addressing results from phase 4.

Phase 1 – Literature review

Initially, extensive literature review was performed that included the clarification of patient satisfaction with nursing care concept [19]; an integrative literature review [20] to identify children satisfaction with nursing care during hospitalization [21]; and a scoping review [22] to identify nursing theoretical conceptions used in hospitalized child care [5] that led us to the selection of the quality-caring model [17] in its revised version [16].

Phase 2 – Evaluating satisfaction with care: children and parent perspectives

In phase 2, the aim was to identify children and parent satisfaction with nursing care. An observational, cross-sectional, and exploratory-descriptive study was performed with a non-probabilistic and accidental sample of 252 children aged 7–11 years and 251 parents from 6 health institutions.

Regarding children, data were collected through the Child Care Quality at Hospital (CCQH) [23] survey. The instrument has 49 items allocated within three domains: nurses' characteristics, nurses' activities, and the nursing environment. The last two items are open-ended sentences where children are asked to complete the following phrases: "in my opinion the best thing about the hospital is ..." and "In my opinion the worst thing about the hospital is ...". Original instrument development occurred in three phases: phase I version developed based on the literature review and submitted to expert panel; phase II instrument application to 41 children and appraised by 19 nurses; phase III instrument's psychometric characteristics were assessed (factor analysis and internal consistency through Cronbach's alpha: nurses' characteristics (0.557), nurses' activities (0.809), and nursing environment (0.761) [23]. For this study the instrument was translated and validated to Portuguese [24].

Parents perspective was evaluated with the application of Citizen Satisfaction with Nursing Care (CSNC) survey after validation to this particular population [25]. This survey assesses citizens' satisfaction with nursing care experiences and includes sociodemographic data, the Nursing Care Experiences scale with 28 items (seven-item Likert scale), the Opinions on Nursing Care scale, with 19 items (five-item Likert scale) and two open questions: "What aspects of nursing care could be improved?" and "Do you have any other comments?".

Both data were submitted to statistical analysis through SPSS statistical tool (version 24.0).

Phase 3 – Nurse's perspectives

In phase 3, the purpose was to identify strategies described by nurses that aimed at increasing children and parents' satisfaction with nursing care. Data were collected through delphi panel and a total of 90 nurses working in the institutions where phase 2 was applied, with at least 3 years of experience, were contacted. Data analysis included content analysis [26] in round 1 and statistical analysis in round 2 taking into account criteria for determining the degree of consensus previously established.

Phase 4 – Proposal for nursing care

In the final phase results from previous phases were incorporated in a proposal for nursing practice. This proposal included a synthesis of nursing interventions and nursing activities that promote satisfaction as well as a proposal to adapt the revised quality-caring model [16] to this particular setting and population. This process will be further explained in the next sections.

Results

As previously mentioned, the main results from each phase will be presented for contextualization purpose.

Phase 1 – Literature review

The conceptual analysis of patient satisfaction with nursing care concept comprised Walker and Avant' method [27] as well as an integrative literature review that included a sample of 19 studies. This allowed the identification of concept antecedents and consequences concerning patients and nurses. The definition of empirical references to the essential concept attributes allowed an operational definition of patient satisfaction with nursing care in the hospital. It was defined as a personal opinion that confronts perceived needs, expectations of care and experiences of care received in professional, personal and environmental domains [19].

The integrative literature review that aimed at synthesizing current knowledge about school-aged children's satisfaction with nursing care in hospital settings [21] was performed with the steps suggested by Whittemore and Knafl [20]. The sample of 23 studies showed that children perspective is yet poorly

understood. From articles analysis three themes were identified: expectations of nursing care, experiences with nursing care, and strategies to improve satisfaction during hospitalization.

Additionally, a scoping review complemented this phase. Tricco et al. [22] suggested steps were followed to identify nursing theoretical conceptions used in the particular setting of hospitalized children [5]. From the 21 articles selected it was possible to identify a range of theoretical conceptions. They were adapted from already existing conceptions, such as the synergy model [28], or specifically developed for this population and setting such as the child transitional communication model [29]. From the total of ten conceptions identified the quality-caring model [17] was chosen, in its revised version [16], due to its appropriateness to the setting, populations and concept of this study.

Phase 2 – Evaluating satisfaction with care: children and parent perspectives

Results from the application of the CCQH [23], in its Portuguese version [24], showed that children were generally satisfied.

Psychometric properties were measured to determine instrument's reliability and validity. Exploratory factor analysis of main components with Varimax rotation was used for construct validity as well as Cronbach's alpha coefficient for internal consistency (values between 0.66 and 0.82). Psychometric characteristics assured Portuguese version reliability and validity[24].

The sample (n = 252) included mainly boys (52.8%, n = 133) with average age 8.9 years (SD = 1.4), most children had surgical or medical unscheduled admissions (84,6%; n = 209) and 15,4% (n = 38) had scheduled hospital admission. Global nursing care (1–5) was rated with a score of 4.51 (SD = 0.645). Sociodemographic factors didn't had effect on overall satisfaction in our sample. Most valued aspects included nurses being "nice" (nurses' characteristics), "listens" (nurses' activities) and the nursing environment). Open ended questions were submitted to content analysis [26]. Children recognized 'people' (f = 113), 'physical environment'(f = 81), 'activities'(f = 49), 'outcomes'(f = 32) and 'food'(f = 10) from 209 answers as best experiences. 'Feelings'(f = 59), 'activities'(f = 54), 'food'(f = 48), 'environment'(f = 15) and 'outcomes'(f = 12) were identified as worst experiences from 203 answers [30].

Regarding parents the application of the CSNC survey also revealed satisfaction with nursing care. Psychometric properties of reliability (Cronbach's alpha coefficient) and content validity (exploratory factor analysis with principal components and orthogonal Varimax rotation) were assessed. Adequate psychometric characteristics were found (Cronbach's alpha of 0.92) ensuring the reliability and validity of the instrument [25].

The sample (n = 251) includes mainly women (83.7%, n = 210) with average age 37.65 years (SD = 6.3). In the scale "nursing care experiences", parents felt "at ease with nurses" (76.7%, n = 193), "saw nurses as friends" (53%, n = 133) and thought that "nurses promoted a pleasant atmosphere" (77.6%, n = 195), so most parents would return to the unit if the child needed it (76.9%, n = 193). In the scale "nursing care

opinion", parents considered that "a nurse was always around when needed" (73.3%, n = 184), frequently questioning if the child was well (74.9%, n = 188) and reassuring family and friends (66.2%, n = 174) [31]. When asked "which aspects of nursing care could be improved?" most parents did not respond to this question (53.4%, n = 134). Among the total respondents (n = 117), five categories were identified: "satisfaction" (f = 71), "personal domain" (f = 22), "environmental domain" (f = 18) "professional domain" (f = 1) and "nursing assignment" (f = 6) [32].

Phase 3 – Nurse's perspectives

In this phase nurse's perspective was sought. Delphi technique [33] was applied in two rounds and allowed the identification of nursing interventions to promote an increase in children and parents satisfaction [34]. The invitation to participate in the study was sent to a total of 90 nurses in each round.

Round 1

47 nurses (response rate 52%) participated in round 1. Open-ended questions were placed that addressed strategies to promote satisfaction in children and parents and difficulties / constraints to implement these strategies. Participant's age, ranged between 25 and 60 years (average age of 38.5 years; SD = 7.7) and 3 to 38 years of professional experience in child health. From content analysis [26] to answers from round 1 a total of 25 nursing interventions were identified. Nursing Intervention Classification taxonomy [35] was integrated in this analysis. In round 2 results from round 1 were presented to comprehend which strategies were considered significant by nurses.

Round 2

42 nurses (response rate 47%) participated in round 2 and all interventions reached consensus. Participant's age raged between 26 to 61 years (average age 40.1; SD = 8.5) and a professional experience between 6 and 38 years with an average of 16 years (SD = 8.2). Regarding interventions directed to children 13 interventions were considered in the following areas: information transmission; family involvement; play strategies; children's distraction; maintenance of children's routine; care environment control; humor; articulation with community resources and children's admission [34]. Regarding parents, 12 interventions reach consensus in round 2 in different areas namely: family involvement; information transmission; family support; communication; children's admission and family union strategies [34].

Difficulties / constrains to implement these interventions included for both children, and parents: lack of resources (time, human and materials); institutional and organizational aspects; communicational approach and previous hospitalization experiences.

Phase 4 – Proposal for nursing care

The final phase of this study incorporated results from previous phases into a proposal for nursing practice considering satisfaction of hospitalized school aged children and their parents. This proposal integrates a synthesis of interventions, a set of orientations to nursing practice and the adaptation of the

revised quality-caring model [16] as a result from all study phases. The set of orientations were proposed as general topics that include: systematic evaluation of school aged children and their parent's satisfaction with nursing care with valid surveys at each 3 months; inclusion of family members that are relevant to children in satisfaction evaluation; inclusion of a space for additional comments in satisfaction surveys; results of these evaluations should be disclosed for all health care teams; implementation of individualized care sensitive to each children and family; entertainment should be incorporated in nursing care in an effective way; improvement of communication with children and parents; use of satisfaction survey results to improve nursing care; institutional policies that aim at the improvement of hospital experience and implementation of nursing interventions and activities that promote children and parent satisfaction.

Finally the adaptation of the revised quality-caring model [16] that included results from all phases is further explained in the discussion section.

Discussion

Nursing theory development is a nursing research priority [36]. Particularly, theory guided practice is considered by Saleh [37] the future of nursing as a way to provide effective, efficient, and holistic care. To do so nurses must rely on theoretical principles to apply the plan care [37]. In this article we present an adaptation of a nursing model based on research results.

The first main component of the revised quality-caring model [16] is humans in relationship that refers to the notion that humans are multidimensional beings. This component considers human characteristics and its influence on nursing interventions. In this study personal characteristics of nurses were considered since they were identified as important both in literature review [21] and in study phase 2 [31]. Children value personal characteristics such as being friendly and approachable [38] or being treated with respect [39]. Parents mentioned these characteristics as something desirable and that can be enhanced to improve satisfaction [32]. Interestingly nurses didn't identify any intervention that was focused on this area of improvement.

Previous experiences of hospitalization were mentioned by parents, children and nurses as an important factor that can affect satisfaction with care. Also, in literature previous experiences appear as relevant [40] as well as socio demographic factors [41]. Demographic factors appeared as particularly relevant given the different development characteristics of children regarding age and gender. Age is identified as an important factor [42] however in our study there was no link between children's age and satisfaction.

In this population and setting, pediatric internment units, also resources such as toys, environment of care and resource adequacy must be considered given the characteristics of school aged children. The importance of play and toys in pediatric care is well documented in literature [43, 44] and was expected to appear as an important factor in all phases of this study. Similarly, the environment of care in physical, emotional, and social dimensions were also found in literature and in results from phase 2 and 3 of this study. Adequacy of resources were primary mentioned by parents [32] and nurses [34]. Parents highlight

the importance of having enough nurses and time when implementing care plans and nurses highlighted how time could be a constrain to implement interventions that improve satisfaction.

Second component of revised quality caring model [16] is named relationship-centered professional encounters. In this component the admission care appeared as a relevant moment. In our study both parent's and nurses mentioned the importance of having a satisfying experience when first entering the hospital unit. Also, respect appears repeatedly as the factor that most influences satisfaction [45] and was identified by parents in our study. Other aspects added were communication and information, family involvement, play / distraction / humor, union and family support and pain management. All these aspects were identified by children, parents, and nurses as central to a satisfying hospitalization and central in relationship with nurses. Time management is a particular area that appears in literature and was highlighted by all participants. Nurses identified time management as a constrain however, no strategies concerning this theme were suggested.

Play and humor were also identified by all participants as aspects that are central to children's hospitalizations and influence satisfaction with care. Good sense of humor is considered a desirable nurse characteristic by hospitalized children [42] since it can positively reduce tension and facilitate approachability, comfort and dialogue [46]. The importance of play to children's well-being is unquestionable but also to family and health team [47].

The third component feel "cared for" is identified as a positive emotion and an important antecedent to quality health outcome [16] were satisfaction is included. Pain management, satisfaction with care and knowledge / information were identified as relevant factors. Pain is also a central theme in children's hospitalizations that was mentioned by all participants. It is identified as one of the worst experiences for children [30] and good pain management is an expectation for both children [48] and parents [49].

Last component of the revised quality caring model is self-advancing systems and is identified as something that appears gradually as a reflection of "dynamic positive progress that enhances the systems' well-being" [16]. Implications in health care system include intention to re-use services and resources adequacy. The link between satisfaction with care and these two factors has already been established in literature [50]. When patients' own perspective is sought and taken into consideration, nursing care is more centered on patient real needs and therefore more satisfying [51]. Articulation with community resources was also mentioned by both parents and nurses.

The awareness of these components will allow to identify factors that predict patient satisfaction. Their integration in daily clinical practice is fundamental to improve quality of care and accomplish parents and children satisfaction with nursing care.

Conclusions

The adapted model integrates fundamental aspects of children hospitalization and is focused on satisfaction with care as an outcome of nursing care. It maintains the belief care subjects, in this case

children and parents, are multi contextual beings that are linked to a larger and diversified world. This adaptation allowed the identification of aspects of nursing care that are relevant to this population and setting. By doing so the adapted model integrates evidence from research that does in fact benefit children and parents.

Abbreviations

CCQH – Children Care Quality at Hospital; CSNC - Citizen Satisfaction with Nursing Care.

Declarations

Ethics approval and consent to participate:

National Data Protection Commission provided authorization for the study (1644/2015) as well as ethics committees in each of the institutions where the study was undertaken. Research was conducted according to relevant guidelines and regulations of Declaration of Helsinki. Written informed consent was obtained from parents and nurses as well as assent to participate from children.

Consent for publication:

not applicable.

Availability of data and materials:

data sharing is not applicable to this article as no datasets were generated or analysed during the current study. Results presented are already published in several other articles [5, 19, 21, 24, 30–32, 34].

Competing interests:

The authors declare that they have no competing interests.

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Authors' contributions:

Conceptualization, FL and ZC; methodology, FL and ZC; software, FL and ZC; validation, FL and ZC; formal analysis, FL,VA and ZC; investigation, FL,VA and ZC; resources, FL,VA and ZC; data curation, FL,VA and ZC; writing—original draft preparation, FL; writing—review and editing, VA and ZC; visualization, FL,VA and ZC; supervision, FL,VA and ZC; project administration, FL and ZC; funding acquisition, FL, and VA. All authors have read and agreed to the published version of the manuscript.

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