

Aleksandra Korzeniewska-Eksterowicz^{1,2}, Łukasz Przysło², Tomasz Grzelewski¹,
Małgorzata Stolarska², Wojciech Młynarski², Iwona Stelmach², Jan Krakowiak³,
Włodzimierz Stelmach³

¹Department of Pediatrics and Allergy, N. Copernicus Hospital, Medical University of Lodz, Poland

²Unit of Pediatric Palliative Care, Department of Pediatrics, Oncology, Hematology and Diabetology,
Medical University of Lodz, Poland

³Department of Social and Preventive Medicine, Medical University of Lodz, Poland

Job satisfaction among health professionals of Home Hospice for Children of Lodz Region

Abstract

Background: Job satisfaction in palliative care professionals seems to be one of the most important factor for effectiveness and quality of care. The aim of this study was to evaluate job satisfaction in our team.

Material and methods: The anonymous questionnaire designed specifically for the study was divided into six domains: evaluation of self-abilities, evaluation of job responsibility, relationships within the team, relationships with patients and their families, work organisation and social conditions and general work evaluation. All variables have been standardized to a range of 0 to 100 points.

Results: Mean level of job satisfaction was evaluated as good. Mean results in all six domains were above 50 points. Highest level of satisfaction (above 75 points) was shown in the domain regarding relationship with patients and their families. Lowest level of satisfaction was shown in domains showing relationship within the team and general work evaluation.

Conclusion: Highest job satisfaction could contribute to improve the quality of home palliative care

Key words: palliative care, children, quality improvement


Adv. Pall. Med. 2010; 9, 3: 67–72

Address for correspondence: Iwona Stelmach, Tomasz Grzelewski
Department of Pediatrics and Allergy, N. Copernicus Hospital, Medical University of Lodz, Poland
ul. Pabianicka 62, 93–513 Lodz, Poland

tel: (+48 42) 689 59 72, fax: (+48 42) 689 59 73

e-mail: t.grzelewski@kopernik.lodz.pl; alergol@kopernik.lodz.pl

Advances in Palliative Medicine 2010, 9, 67–72

 Copyright © 2010 Via Medica, ISSN 1898–3863

Introduction

Since the first children's hospice in Poland — Warsaw Hospice for Children — was founded in 1994, home palliative care for children has been forcefully developed in our country [1–3]. Poland have a professional paediatric hospice home care programme [4, 5]; at 2008 thirteen children's hospices provided home care in Poland, and Home Hospice for Children of Lodz Region is one of the youngest children's hospice [6]. Home Hospice for Children of Lodz Region was founded by Gajusz Foundation at the end of 2004 and now takes care of 25–30 children monthly. Home care is provided by a multidisciplinary team consisted of six paediatricians (two doctors working full-time in the hospice), five nurses (all working full-time in the hospice), two social workers, physiotherapist and psychologist. Hospice cooperates with Catholic chaplain, consultants: neurologist, laryngologist, anaesthesiologist, surgeon and group of 40 volunteers. Few years of hospice activity allows to evaluate the quality of care by parents and health professionals and this study is the part of that complex evaluation. Job satisfaction among health professionals in palliative care seems to be one of the most important factor for effectiveness and quality of care [7–9]. The aim of this study was to evaluate job satisfaction in our team.

Material and methods

It was a questionnaire study directed to all 15 members of Home Hospice for Children of Lodz Region team. Job satisfaction was assessed using an anonymous questionnaire designed specifically for the study. The questionnaire consisted of 40 questions which were divided into six domains: evaluation of self-abilities (six questions), evaluation of job responsibility (five questions), relationships within the team (five questions), relationships with patients and their families (six questions), work organisation and social conditions (twelve questions) and general work evaluation (seven questions).

To make the scoring of domains with different numbers of items and/or answering categories comparable, all variables have been standardized to a range of 0 to 100 points, according to formula [10]:

$$TR = \frac{RR - Min}{Max - Min} \times 100$$

where:

TR — transformed result;

RR — raw result;

Min — minimal result possible to achieve in the scale;
Max — maximal result possible to achieve in the scale.

In the 100 points scale 0 represented the worst possible level of job satisfaction, 100 represented the best possible, ranges from 0 to 25 points were classified as poor and ranges from 26 to 50 points as weak level; results between 51 and 75 points were described as good, and above 75 points as a very good.

This study was approved by the Medical Ethics Committee of the Medical University of Lodz (RNN/419/06/KB)

Statistical analysis

All descriptive analyses were performed using STATISTICA for Windows release 6.0 software. Data was presented as with mean with 95% confidence interval. To determined deference between parameters Student's t-test were used. P-values < 0.05 were considered to be significant.

Results

Twelve of 15 team members responded to the questionnaire. Mean level of general job satisfaction (all questions) was evaluated as good. Mean results in all six domains were above 50 points. However evaluation of self-abilities revealed did not reach statistical significance. Highest level of satisfaction was shown in relationship with patients and their families domain, and in that domain results were classified as significantly above 75 points. Lowest level of satisfaction was shown in relationship within the team and general work evaluation domains. All results are given in Figure 1. The best and worst evaluated items in each domain are shown in Table 1.

Discussion

Palliative care has been defined as the active holistic care of patients whose disease is not responsive to curative treatment and their families [11, 12]. In ideal palliative care model the needs of patients and their families and also needs of all people involved in care should be taken into consideration, and considering a wide range of needs supports improvement of palliative care quality [13–16]. Job satisfaction among health professionals in palliative care seems to be one of the most important factors for effectiveness and quality of care [13–17]. Although job satisfaction has been examined among health professionals taking palliative care of adults, there are only casual reports about that issue in pediatric

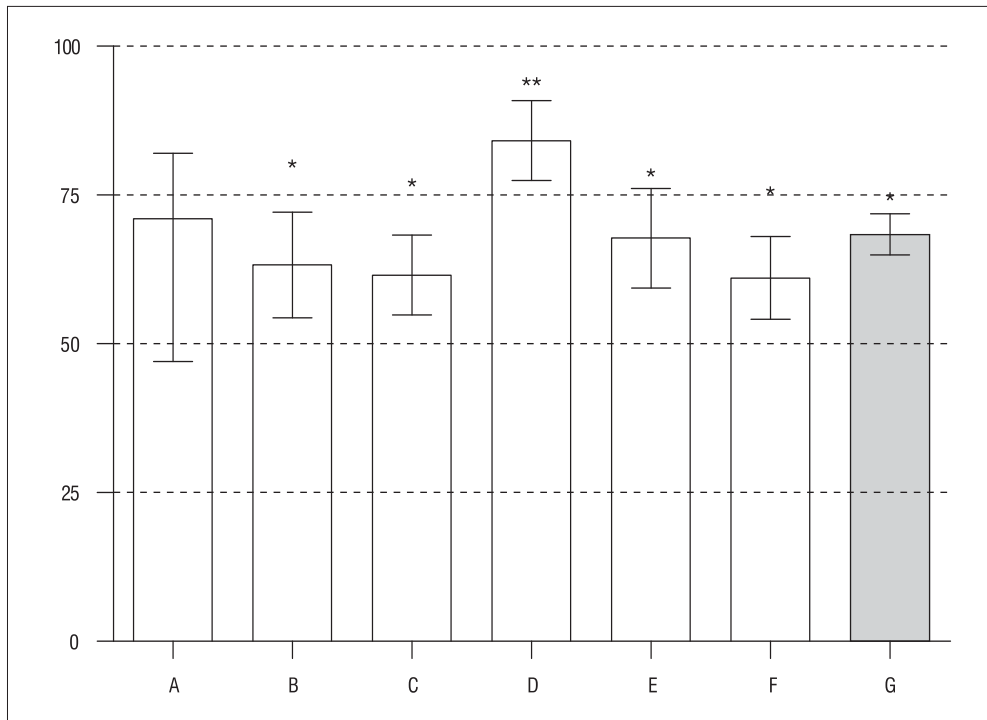


Figure 1. Levels of job satisfaction. Data are presented with mean with 95% confidence interval. *significantly above 50 points scale; **significantly above 75 points scale; A — self-abilities domain; B — job responsibility domain; C — relationship within the team domain; D — relationship with patients and their families domain; E — work organisation domain; F — general work evaluation domain; G — general job satisfaction (all questions)

Table 1. The best and worst evaluated items in each domain

Domain	The best evaluation		The worst evaluation	
	Item	Points (mean)	Item	Points (mean)
Self-abilities	Vocational preparation	75	Psychological preparation	50
Job responsibility	Division of tasks	83	Participation In decision making process	60
Relationships within the team	Relationships within health professionals	78	Information flow between hospice team and management team	54
Relationships with patients and their families	Influence of conflict with patients family on relationships within the team	81	Influence of conflict with patient' family on quality of work	52
Work organisation	Possibility of qualifications' improvement	81	Length of visits	33
General work evaluation	Quality of hospice care	85	Work burden	33

palliative care field [17–23]. Even though in Poland we recently observed the development of home palliative care for children there exist no report about that issue from our country.

The results of this study showed that general job satisfaction was good and our finding is consistent

with that of the other authors. Additionally team members identified high quality of care as the most important source of general job satisfaction. Multiple studies have shown that palliative care health professionals have significantly higher level of job satisfaction compared with health professionals working in

other specialities [17, 23–25]. In this study relationships with patients and their families were identified as the most important source of staff satisfaction. Level of satisfaction in this domain was the highest and as only one was classified as very good. Relationships and communication between health professionals and patients and their families are the central aspects of palliative care and a measurement of communication skills is an integral part of complex evaluation of palliative care quality [26–28]. Our finding shown that relationships and communication between patients and team members are main source of job satisfaction, but that issue could be a major source of both stress and satisfaction among health professionals and also among patients. Ramirez et al. described personal relationships of clinical nurse specialists in palliative care with patients and their relatives and simultaneously showed a closed relationship with patient as the major source of job stress in the cases of death and dying [17]. Also patients death is reported as a more stressful when the patient is young. Poor relationships and conflicts with the child's family were identified as most important factors hindering care. These results are consistent with that of Barnes and Woolley et al. who identified poor relationships with the child's family as most important causes of staff stress and dissatisfaction in the children's hospice [18, 19]. Simultaneously in respondents opinion poor relationships and conflicts with the child's family have no influence on relationships within the hospice team. Our observations can be partially explained by high professional qualifications of all team members and our own recruitment procedures. Candidates for the work in our hospice must have appropriate education, provide character references from the previous employer and they have to spend one-month probationary period in our Hospice. If our future health professionals achieve positive opinion they must undergo professional one-month training course before employment in our hospice. Additionally we can speculate that the period of two-three years of working is too short for job dissatisfaction caused by stress or burnout syndrome, but from the other side we try to prevent it through an early recognition of job stress and the developing of strategies of self-control. In the presented study lowest level of satisfaction was shown in relationship within the team and those results are consistent with that of other authors, including studies conducted among health professionals in children's hospices [17–22]. Relationships within hospice staff were the best evaluated item in relationship within the team do-

main and communications skills between staff and management team were the worst evaluated item. Those findings could be the result of lack of understanding of roles or poorly defined roles within the team and showed the need of systematical appropriate training and education. The improvement of interprofessional communication requires a careful analysis of the interactions among hospice team members and identification of possible barriers to information flow. Gaps in the information flow can potentially lead to a lack of coordination for the scheduled services, as members may have different levels of access to information sources or may not all be present during the decision making process [29, 30]. Based on the deficiencies identified in this study, we decided to implement in our hospice Quality Management System consistent with ISO 9002:2000 standards. ISO standards helped us to improve information flow and to define roles within the team. In our study work organisation and social conditions were generally evaluated as good, hospice staff valued the possibility of qualifications' improvement, but it allows us to identify areas and factors which should be improved in the future such as duration of a visit at patient's home, number of ambulance cars, poor collaboration with general practitioners, need for another work room in the hospice office. Level of satisfaction in self-abilities and job responsibility domains were evaluated as good, but health professionals emphasized the need of continual improvement of qualifications. Team members identified vocational preparation and division of tasks as the best items among those domains. Those results have confirmed effectiveness of our recruitment procedures and pressure on permanent education. Psychological preparation was the worst evaluated item in self-abilities domain. Our observations could be partially explained by palliative care education deficiency. Over the past two decades, most medical schools in Poland have incorporated palliative and end-of life programs into their medical curricula. Despite much strength in the medical education system, palliative care education especially in psychological issues remains deficient. In Poland medical curricula include only palliative care of adults and omit the whole subject of pediatric palliative care. Previous studies have showed that Palliative Medicine is well area to provide teaching about other areas of medical practice to students such as: the patient–doctor relationship, and caring and empathy [31, 32]. That teaching corresponds with a new perspective in medicine which emphasis quality of life and changes a way the patients are treated.

The emphasis on the human aspect of the treatment process changed the biomedical determination to save life (which sometimes proved harmful to a dying person) into a meeting with a patient as an individual; valuing their value system, emotions and experience. Working with dying children can be particularly stressful for doctors; evoking their sense of helplessness and disturbing their rational perception of reality. That shift in thinking provided doctors with new challenges. Instead of the traditional, paternalistic attitude which emphasised only the somatic symptoms the doctors are expected to build a relationship with their patients. Passing on difficult information, palliative care, assisting dying patients and their families is very difficult and requires appropriate training both medical and psychological.

The conclusions of current research and observation underline the importance of preparation of the medical staff for looking after a dying patient and their family. On one hand such a preparation would minimise the risk of re-traumatising the patient and their family. On the other hand it decreases the risk of emotional overloading among doctors, their tendency to keep emotional distance which disturbs their perception of the situation and the risk of a burnout among the medical staff [33].

An important limitation of our study is the small number of participants, which not allow to investigate the relationships between job satisfaction items and socio demographic characteristic of respondents such as sex, age or period of service. From the other point of view almost all members of our team returned the questionnaire, and that is why results are very important and significant for our institution. Moreover our results are the part of a complex study designed to assess the quality of home palliative care for children provided by our Hospice in Lodz area.

Conclusions

Results of this study helped us to take appropriate actions for increasing job satisfaction level among our professional team. Highest job satisfaction could contribute to improve the quality of home palliative care for children in our region.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

References

1. Dangel T. The status of pediatric palliative care in Europe. *J. Pain Symptom. Manage.* 2002; 24: 160–165.
2. Dangel T. Poland: the status of pediatric palliative care. *J. Pain Symptom. Manage.* 2002; 24: 222–224.
3. Hare A. Palliative care for children in Poland. *Eur. J. Palliat. Care* 1999; 6: 137–139.
4. Wright M., Clark D. The development of paediatric palliative care in Warsaw, Poland. *Eur. J. Palliat. Care* 2003; 10: 120–123.
5. Dangel T., Fowler-Kerry S., Karwacki M., Bereda J. An evaluation of a home palliative care programme for children. *Ambulatory Child Health* 2000; 6: 101–114.
6. Dangel T. Pediatric home palliative care in Poland 2008. *Warsaw Hospice for Children, Annual Report X, 2009.*
7. Clark L., Leedy S., McDonald L. et al. Spirituality and job satisfaction among hospice interdisciplinary team members. *J. Palliat. Med.* 2007; 10: 1321–1328.
8. Maunder E.Z. Emotion work in the palliative nursing care of children and young people. *Int. J. Palliat. Nurs.* 2006; 12: 27–33.
9. Morgan D. Caring for dying children: assessing the needs of the pediatric palliative care nurse. *Pediatr. Nurs.* 2009; 35: 86–90.
10. De Haes J., Olschewski M., Fayers P. Measuring the quality of life of cancer patients with the Rotterdam Symptom Checklist (RSCL). *Northern Centre for Health Care Research, University of Groningen* 1996.
11. Bosanquet N., Salisbury Ch. *Providing a Palliative Care Service.* Oxford University Press, Oxford 1999.
12. Woodruff R. *Palliative Medicine.* Oxford University Press, Oxford 1999.
13. James N., Field D. The routinization of hospice: charisma and bureaucratization. *Soc. Sci. Med.* 1992; 34: 1363–1375.
14. Clark D., Malson H., Smal L.N., Daniel T., Mallett K. Needs assessment and palliative care: the views of providers. *J. Public Health Med.* 1997; 19: 437–442.
15. *A guide to the development of children's palliative care services.* Report of a joint working party of the Association for Children with Life-threatening or Terminal Conditions and their Families and the Royal College of Paediatrics and Child Health. London: Royal College of Paediatrics and Child Health, 1997
16. Middleton W., Raphael B., Burnett P., Martinek N. A longitudinal study comparing bereavement phenomena in recently bereaved spouses, adult children and parents. *Aust. N.Z.J. Psych.* 1998; 32: 235–241.
17. Ramirez A., Addington-Hall J., Richards M. ABC of palliative care. *The carers. BMJ* 1998; 316: 208–211.
18. Barnes K. Staff stress in the children's hospice: causes, effects and coping strategies. *Int. J. Palliat. Nurs.* 2001; 7: 248–254.
19. Woolley H., Stein A., Forrest G.C., Baum J.D. Staff stress and job satisfaction at a children's hospice. *Arch. Dis. Child* 1989; 64: 114–118.
20. Swinney R., Yin L., Lee A., Rubin D., Anderson C. The role of support staff in pediatric palliative care: their perceptions, training, and available resources. *J. Palliat. Care* 2007; 23: 44–50.
21. Graham J., Ramirez A.J., Cull A., Finlay I., Hoy A., Richards M.A. Job stress and satisfaction among palliative physicians. *Palliat. Med.* 1996; 10: 185–194.
22. Fillion L., Dupuis R., Tremblay I., De Grâce G.R., Breitbart W. Enhancing meaning in palliative care practice: a meaning-centered intervention to promote job satisfaction. *Palliat Support Care* 2006; 4: 333–344.

23. Dougherty E., Panzarella T., Le L.W., Rodin G., Zimmermann C. Staff stress, work satisfaction, and death attitudes on an oncology palliative care unit, and on a medical and radiation oncology inpatient unit. *J. Palliat. Care* 2007; 23: 32–39.
24. Karlsen S. A national survey of health professionals and volunteers working in voluntary hospice services in the UK. I. Attitudes to current issues affecting hospices and palliative care. *Palliat. Med.* 2005; 19: 40–48.
25. Komesaroff P. Ideals and compromises in palliative care. *J. Palliat. Med.* 2006; 9: 1339–1347.
26. Hson I.J., Mc Carthy M. A comparison of two measures of quality of life: their sensitivity and validity for patients with advanced cancer. *Palliat. Med.* 2000; 8: 282–290.
27. Carson M.G., Fitch M.I., Vachon M.L. Measuring patient outcomes in palliative care: a reliability and validity study of the Support Team Assessment Schedule. *Palliat. Med.* 2000; 14: 25–36.
28. de Walden-Galuszko K., Majkowicz M. Measurement of quality of palliative care in theory and practice. Medical University of Gdansk 2000.
29. Hirokawa R.Y., DeGooyer D., Valde K. Using narratives to study task group effectiveness. *Small Group Research* 2000; 31: 573–592.
30. Demiris G., Washington K., Oliver DP., Wittenberg-Lyles E. A study of information flow in hospice interdisciplinary team meetings. *J. Interprof. Care* 2008; 22: 621–629.
31. Lloyd-Williams M., Dogra N. Caring for dying patients — what are the attitudes of medical students? *Support Care Cancer* 2003; 11: 696–699.
32. Mack J., Hilden J., Watterson J. i wsp. Parent and physician perspectives on quality of care at the end of life in children with cancer. *J. Clin. Oncol.* 2005; 35: 9155–9161.
33. Nancy A., Larson J., Scofield S., Sourkers B., Cohen H. Hospital staff and family perspectives regarding quality of pediatric palliative care. *Pediatrics* 2004; 114: 1248–1252.