

Patients' satisfaction received from nursing staff
in the Home Care Programme run by the Ministry of Health in Cyprus

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Disclaimer:

The views expressed in this document are mine and are not necessarily the views of my supervisory team, or examiners or the Middlesex University.

'To all nurses of Home Care who silently and tirelessly struggle to heal the wounds of elder people. And to all the elder age people who cannot speak loudly their gratitude but... they silently give their blessings'

Maria Leonidou, August 2014.

ACKNOWLEDGMENTS

*Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveler, long I stood
And looked down one as far as I could*

...

*Two roads diverged in a wood, and I—
I took the one less traveled by,
And that has made all the difference.¹*

When I embarked onto *'the road less travelled'* I did *'looked down ...as far as I could'* but irrespective of how *'long I stood'* I never imagined how life demanding would be and how indeed *'that has made all the difference'*

Yet *'one traveller'* I was, this journey would had been impossible to complete without the great assistance and support of a lot of wonderful people, these being colleagues, patients, nurses, managers who on the way most have become great new friends!

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Finally but most importantly my gratitude to my husband for providing an open *'hug'* when mostly needed and continuous support when

*'Yet knowing how way leads on to way
I doubted if I should ever come back.'*

...throughout this *'epical'* journey which I shall be

*'telling this with a sigh
Somewhere ages and ages hence:'*

Here is to days of happiness and joy ...and catching up with my family and three boys!

¹Poem: *'The Road Not Taken'* by Robert Frost

ABSTRACT

The main purpose of this study was to investigate the home care patients' satisfaction received from the nursing staff in the public home care program in Cyprus.

Patients' satisfaction has become an important part in evaluating the quality of health care services. Patients are the ones who can identify better than anyone else the aspects of nursing care which need improvement. Home care services are quite new and still developing in Cyprus while the need for these services is increasing rapidly.

This study, utilized the QPP survey questionnaire, in depth semi-structured interviews and observations. The questionnaire was delivered to the home care patients who received long term care during the period of February 2011 to May 2011. A purposive sample was used for the interviews of the patients, the nursing staff and the management staff of the home care program and for the observations of the home care visits.

The results of this study showed that the home care patients of the public home care program in Cyprus are very satisfied from the services they receive from the home care nursing staff. The quality of care, QPP index was found of the highest score in all items of the questionnaire. This study revealed high standards in the elements relating to the humane approach, the medical competence, the information and advising provided to the patients. At the same time, this study identified a deficiency in the abilities of the nursing staff to provide psychological support in difficult cases and the patients' inadequate control of their medical care according to their desires rather than by the procedures of their home care nurse. It also identified the need of the home care patients for help in the activities of daily living (ADLs).

Additionally, this study surfaced the aspects of the nursing care which the home care patients consider more important and highlighted the characteristics of an ideal home care nurse through the patients' eyes; placing the humane approach as the most important aspect, followed by the psychological support provided and then by the nursing knowledge. A deviation was identified between the nursing and management views, with the later placing the nursing knowledge as first, followed by leadership skills and then by the humane approach. This study, also identified those problematic areas of the program which negatively influence the nursing services; these were the absence of a team of health professionals in the program, the limited operating hours, the non-implementation of the

concept of prescribing nurses, the non-eligibility of the nurses to refer the patients to other health professionals, inadequate technology, insufficient financial support of the program, and the cumbersome procedures of the public sector.

Home care patients' satisfaction from the nursing staff is very high; yet there are some areas which need improvement. Recommendations emanated from the project include the enhancement of the nursing undergraduate and post graduate education in home care nursing, with courses and workshops on the psychology of home care patients, on gerontology, on leadership and communication skills. Recommendations also include individual and organizational development interventions for providing more support to the home care nurses, higher quality of care to the home care patients within a client-centred environment and feedback strategies.

TABLE OF CONTENTS

CHAPTER 1 : INTRODUCTION	11
PROJECT RATIONALE AND CONTEXT	11
RESEARCH AIMS AND OBJECTIVES.....	15
OUTCOMES AND INTENDED IMPACT	16
ASSUMPTIONS AND LIMITATIONS.....	17
DEFINITION OF TERMS.....	17
THE PROJECT'S STRUCTURE	22
CHAPTER 2 : LITERATURE REVIEW	24
INTRODUCTION	24
HOME CARE TODAY	24
THE NEED FOR HOME CARE	28
HOME CARE PROGRAMME IN CYPRUS	33
PATIENTS SATISFACTION	34
HOME CARE NURSES	41
MODELS OF ASSESSING PATIENTS' SATISFACTION.....	44
CHAPTER 3 : RESEARCH METHODOLOGY AND PROJECT ACTIVITY	50
INTRODUCTION	50
PHILOSOPHICAL APPROACHES	50
RESEARCH DESIGN.....	56
RESEARCH QUESTIONS	57
DATA COLLECTION METHODS	57
DATA ANALYSIS.....	75
RELIABILITY AND VALIDITY	78
ETHICAL CONSIDERATIONS	81
CHAPTER 4 : RESEARCH FINDINGS	84
INTRODUCTION	84
FINDINGS OF THE SURVEY QUESTIONNAIRE.....	84
FINDINGS OF THE IN DEPTH INTERVIEWS OF THE PATIENTS.....	107
THE FINDINGS' COMPATIBILITY OR DIVERSITY TO THE LITERATURE REVIEW	194
CHAPTER 5 : DISCUSSION OF FINDINGS AND CONCLUSIONS.....	196
INTRODUCTION	196
DISCUSSION ON THE QUANTITATIVE RESEARCH FINDINGS.....	197
DISCUSSION ON QUALITATIVE RESEARCH FINDINGS.....	206

CHAPTER 6 : RECOMMENDATIONS	227
INTRODUCTION	227
RECOMMENDATIONS EMANATED FROM THE PROJECT’S FINDINGS	227
OUTCOMES AND INTENDED IMPACT	241
CHAPTER 7 : REFLECTIONS	242
REFERENCES	249
APPENDICES	266
APPENDIX A: QPP QUESTIONNAIRE – IN ENGLISH	266
APPENDIX B: QPP QUESTIONNAIRE USED FOR THE SURVEY (TRANSLATED IN GREEK).....	270
APPENDIX C: QPP QUESTIONNAIRE BACK TRANSLATION (GREEK TO ENGLISH).....	275
APPENDIX D: CONSENT FORM USED FOR THE SURVEY (IN ENGLISH).....	280
APPENDIX E: CONSENT FORM USED FOR THE SURVEY (IN GREEK).....	281
APPENDIX F: INSTRUCTIONS FOR ANSWERING THE SURVEY QUESTIONNAIRE (IN ENGLISH).....	282
APPENDIX G: INSTRUCTIONS FOR ANSWERING THE SURVEY QUESTIONNAIRE (IN GREEK).....	283
APPENDIX H: PERMISSION FROM THE ORIGINATORS TO USE THE QPP QUESTIONNAIRE	284
APPENDIX I: PERMISSION FROM THE NATIONAL BIOETHICS COMMITTEE OF CYPRUS	285
APPENDIX J: PERMISSION FROM THE MINISTRY OF HEALTH OF CYPRUS	286
APPENDIX K: IN DEPTH INTERVIEWS’ QUESTIONS FOR THE PATIENTS	287
APPENDIX L: THE PHOTOS USED FOR THE PATIENTS’ IN DEPTH INTERVIEWS	289
APPENDIX M: IN DEPTH INTERVIEWS’ QUESTIONS FOR THE NURSING STAFF	292
APPENDIX N: IN DEPTH INTERVIEWS’ QUESTIONS FOR THE MANAGEMENT	295
APPENDIX O: RESEARCHER’S SKETCHES OF THE OBSERVATIONS	298
APPENDIX P: THE NARRATIVE NOTES OF THE OBSERVATIONS OF HOME CARE VISITS	309
APPENDIX Q: OBSERVATION OF A NURSE’S WORKING DAY AT HOME CARE	333
APPENDIX R: SAMPLES OF FIELD NOTES TAKEN AFTER THE PATIENTS’ IN DEPTH INTERVIEWS.....	335
APPENDIX S: STATISTICS OF CYPRUS STATISTICAL SERVICE (CYSTAT) AND MINISTRY OF HEALTH OF CYPRUS	338
APPENDIX T: REPORT ON HEALTH SYSTEM OF CYPRUS, EUROPEAN COMMISSION 2010.	342
APPENDIX U: EXECUTIVE SUMMARY FOR THE MINISTRY OF HEALTH	343
APPENDIX V: EXECUTIVE SUMMARY FOR THE COUNCIL OF THE EUROPEAN UNIVERSITY OF CYPRUS	358
APPENDIX W: ACCEPTANCE OF THE PROJECT’S OUTCOMES BY THE MINISTRY OF HEALTH	369
APPENDIX X: ACCEPTANCE OF THE PROJECT’S OUTCOMES BY THE COUNCIL OF EUROPEAN UNIVERSITY OF CYPRUS.....	370
APPENDIX Y: THE STATEMENTS INCLUDED IN EACH DIMENSION OF THE QPP QUESTIONNAIRE.....	371
APPENDIX Z (A): SUGGESTIONS FOR SAFEGUARDING FINANCIAL AND OTHER RESOURCES	372
APPENDIX Z (B): SUGGESTIONS FOR AUTOMATION OF HOME CARE PROCEDURES	374

LIST OF FIGURES

Figure 2-1: Model of Quality of Care from the Patient’s Perspective.	46
Figure 3-1: Research Design.....	56
Figure 3-2: Triangulation of Research Methods.....	73
Figure 3-3: Triangulation of Data Collection Methods.....	74
Figure 3-4: Triangulation of Sources of Information.....	75
Figure 5-1: The patients’ perception of an ideal home care nurse (RQ 6).....	210
Figure 5-2: The nurses’ perception of an ideal home care nurse (RQ 6).....	212
Figure 5-3: The management’s perception of an ideal home care nurse (RQ 6)	213
Figure 5-4: The nursing staff’s difficulties which negatively influence the satisfaction of their patients (RQ 9).....	217
Figure 5-5: The management staff’s difficulties which negatively influence the satisfaction of their patients.....	220
Figure 5-6: The problematic areas in the services provided by the nursing staff of the program that need improvement (RQ5)	224

LIST OF GRAPHS

Graph 4-1: Demographic Characteristics of Respondents	85
Graph 4-2 Q8 - AGE against – Received useful information as to how therapeutic treatment should occur.....	90
Graph 4-3 Q9: AGE against – I received useful information e.g. blood sugar graphs related to the results of tests taken by the visiting nurse.....	90
Graph 4-4 Q10: AGE against – I received useful information on self-care; “the best way to take care of myself”	91
Graph 4-5 Q11a: AGE against - I received Useful Information as to who was the visiting nurse responsible for my program care	91
Graph 4-6 Q13a: AGE - against – The help I received was very effective and provided relief from pain.....	92
Graph 4-7 Q25: AGE against – I was easily able to convince the visiting nurse to visit me at home.	92
Graph 4-8 Q16a: AGE against – I received useful advice from the visiting nurse as to how to prevent accidents in my home.....	93
Graph 4-9 Q20a: AGE against - I had the opportunity to participate in decisions relating my medical care	94

Graph 4-10 Q11b: GENDER against - I received Useful Information as to who was the visiting nurse responsible for my program care.....	95
Graph 4-11 Q12a: GENDER against – I received the best possible medical care/assistance from the visiting nurse (as far as I can tell).	95
Graph 4-12 Q14a: GENDER - against – I received help from the visiting nurse within an acceptable waiting time.....	96
Graph 4-13 Q15: Gender against – I received useful assistance from the visiting nurse obtaining equipment which I needed.	96
Graph 4-14 Q16b: GENDER against – I received useful advice from the visiting nurse as to how to prevent accidents in my home.....	97
Graph 4-15 Q24a: GENDER against – I was able to contact the visiting nurse on the phone easily	98
Graph 4-16 Q20a: GENDER against - I had the opportunity to participate in decisions relating my medical care	98
Graph 4-17 Q21b: GENDER against – My medical care was controlled more by my own desires rather by the district nurse’s procedure.....	99
Graph 4-18 Q12b: Co-HABITING - against – I received the best possible medical care/assistance from the visiting nurse (as far as I can tell).....	100
Graph 4-19 Q13b: CO-HABITING - against – The help I received was very effective and provided relief from pain.....	100
Graph 4-20 Q14b: Co-HABITING - against – I received help from the visiting nurse within an acceptable waiting time.....	101
Graph 4-21 Q16c: Co-HABITING against – I received useful advice from the visiting nurse as to how to prevent accidents in my home.....	101
Graph 4-22 Q24b: CO HABITING against – I was able to contact the visiting nurse on the phone easily	102

CHAPTER 1 : INTRODUCTION

Project Rationale and Context

In recent times, the role of the patient has changed considerably; patients are now seeking to take on a more active role in their own health care; since patients are no longer passive recipients, there is a need and a developed interest, to learn more about the satisfaction of patients (Merkouris et al., 1999).

In order to improve the quality of care, the satisfaction of the consumer, in this case the patient must be carefully examined; the patients' satisfaction will ultimately determine the quality of care provided and will specifically offer nurses the necessary feedback to improve patient care (Johansson et al., 2002).

As Laferriere (1993: 75) explains,

'With the overwhelming citizen concern for change in health care delivery, it is anticipated that more and more services will be provided in client homes rather than in institutions.' (Laferriere, 1993: 75)

Prior to World War II, the practice of house calls was the most common mode of health care delivery in Europe and the United States; the well-known image of the doctor with black bag in hand, was the primary care giver to those in need, due to the lack of medical technologies and transportation facilities and the relatively low number of available hospitals (DeCherrie, 2012).

However, during the 20th century, the rapid growth of medical and transportation technology and the changes in economics of medical care which demanded the increase of productivity and the maximization of patients seen; such shifts resulted in the movement of health care from the home into institutions (DeCherrie, 2012).

However, as Aguzzi et al, for the World Health Organization (2008) argue, that over the last decades, the social, demographic, cultural and epidemiological trends in European and other developed countries, has created the need for changes in this traditional institutional way of delivering health care.

According to Aguzzi et al, for the World Health Organisation (2008), European, statistics have shown that the proportion of older people within the general population has risen steadily and is predicted to continue to rise in the coming decades. The expansion of the aged population highlights the need for long-term care for the frail aged (Low et al., 2011).

Additionally, the increase of life expectancy due to technological and medical practice advances, has driven to the rise in the number of the elderly population. The probabilities for a person to need long term care at some stage of one's life reaches the alarming levels of 60% of all citizens and for people of over 65 years of age this probability increases to 75%.

Moreover the epidemiological changes of increased chronic diseases such as cardiovascular, diabetes and cancer and the social changes such as the numbers of women workforce, the break-up of the traditional large family group and urbanization will also lead to gaps in the care of older or disabled family members (Aguzzi et al. for the World Health Organization, 2008).

In Cyprus people who were 65 years or older constituted the 12% of the Cypriot population in 2003 and an increase of 50% is expected by 2030 (Council of Europe, 2005). Additionally, life expectancy has increased; from an average of 72 years in 1980 to an average of 77 years in 2006 (World Health Organization 2006). It is anticipated that most of these elderly people will face chronic health problems; cardiovascular diseases ranking first, neuropsychiatric conditions ranking second, followed by the sense organs diseases, the unintentional injuries, the malignant neoplasms, the respiratory diseases, the musculoskeletal diseases, the digestive and the infectious diseases ranking last (World Health Organization, 2005). According to the World Health Organisation (World Health Organization 2006), Cypriots spend an average of 10 years of their lives with illnesses and this indicates that there will be an increased need for long term care. At the same time, the national health care expenditure in the Cyprus public sector has increased from 80 million in 1990 to 609 million in 2012, with an average increase of 9,67% per year (Ministry of Health of Cyprus, 2012), (Appendix R, Table 3). These statistics reinforce the need to seek new alternative solutions and changes in the health care system of Cyprus.

Home health care can be viewed as one such solution. This service is provided to the patients in their homes, to restore their functional capacity and allowing them to manage their care independently, while remaining safely in the community (Panasci, 2009). Health

care at home can now be viewed as a feasible solution, due to the large availability of technology solutions, reducing the hospital length of stay, preventing re-hospitalization and emergency room visits, and providing continuity of care, thus improving the outcomes and increasing the patient's satisfaction (Panasci, 2009) and reduces health care costs.

As Kisa, (2007: 98), indicates,

'Home health care is a labour intensive industry that relies on nursing personnel as a major resource in the production of services.'

Consequentially, nursing care is the dominant determinant of patients' satisfaction for home care services. Patients are demanding the right to participate actively in informed decision making and seek satisfaction from the nursing care provided; in the competitive arena of home care, agencies will need research-based methods to assess the quality of the care provided. Client satisfaction should be an aspect of that evaluation process this nursing care will be client centred and outcome oriented (Laferriere, 1993)

There is a lack of research in the area of Home Care services and according to Genet et al., (2011), there are very few research projects dealing with home care programmes in the central and eastern European countries, such as Cyprus, Greece, Bulgaria, Croatia, Malta, Romania and Hungary. While there are many research projects based on health care within hospital settings, seldom studies have been conducted on Home Health Care in Cyprus. Globally, there appears to be a growing interest in the research of Home Health Care as an alternative to hospital treatment, in order to offset the ever rising health care costs. As such, Cyprus, a country dramatically affected by the global financial crisis, must now also seek other possible avenues to provide patients with quality care for recuperative treatment and chronic disease management.

The present study took place within the framework of the Public Home Care Programme of the Ministry of Health of Cyprus. This program provided by the Ministry of Health started in 2004 with only two nurses who were situated at the Kyperounta Hospital. In 2011 the program employed nineteen nurses, 18 female and 1 male, while it operated in the provinces of Nicosia, Limassol and Paphos with the major coverage being in the capital Nicosia. During 2011, the Home Care Program delivered its services to 562 patients for long term care and 2872 patients for short term care (Ministry of Health of Cyprus, 2012). Since the programme's beginnings, the only health care professionals involved are specially trained nurses. Patients eligible for entering the programme are beneficiaries of

public health care cards, that is, those patients who are entitled to free public healthcare services, they must be aged 18 and above and reside in the area covered by the programme. Additionally, patients enrolled in the programme must have no other support and require health care treatment, must have limited or no mobility, are in need of post-operative care and finally patients who require medical advice and guidance to self-treat their condition. Moreover, for patients dependent on ventilators, this programme provides specialist home care nurses and a pneumologist. A liaising office at Nicosia General Hospital helps to create awareness to members of the community and health care professionals about the available home health care services.

The purpose of this study is to assess the patients' level of satisfaction of the nursing care offered within the Cyprus home care programme, in order to deliver feedback and make recommendations. The parties involved in this programme will use these outcomes to support changes within the current system and lead to the rise in the quality of home care and patient satisfaction, consequently resulting in improved quality of life for patients.

The researcher is a medical doctor and a lecturer at the School of Health Sciences at the European University of Cyprus and possesses significant experience in the Health Care sector. As a medical doctor, the researcher has deep knowledge of the Home Health Care programme, and its nursing procedures. Having worked within the public health sector, the researcher has gained invaluable insight into the culture and processes utilized in the Cyprus Health Care system. This experience has allowed her to develop an appreciation of the norms and sensitivities involved in the professional environment between nursing personnel and medical doctors and between nursing personnel and patients. Additionally it has enabled her to have a greater understanding of the patients' physical and psychological state in chronic diseases as well as other diseases which need home health care. Furthermore, the researcher's experience in research projects in academia as a faculty member of the university, are an added value to this research. Based on her experience the researcher believes that the assessment of patient's satisfaction is a very important indicator for the quality of care provided. She also believes that the measuring of patients' satisfaction will identify the problematic areas in home health care and provide conclusions and suggestions for improvement, and this will lead to a better quality of life for the patients. The researcher considers her own work experience both as a medical doctor and a lecturer and her medical knowledge, as an indispensable part of this research, an added value for this project in its own right and a unique stand to venture this project.

It is a promising sector to be expanded in the near future as this is the answer to the high costs of health care among with many other benefits.

Research Aims and Objectives

The Quality of Care from the Patients' Perspective questionnaire (QPP), the in depth interviews and the observations will identify where the positive and negative elements in patients' satisfaction lie, therefore providing the organization with a clear view of the strengths and the weaknesses. Such assessments form the basis for corrective actions to be adopted.

The research is quantitative and qualitative in nature and seeks the following:

1. To identify the patients' level of satisfaction from the nurses operating under the Government Home Care program in Cyprus, as perceived by the patients.
2. To identify any significant differences in patients' level of satisfaction based on their personal characteristic; age, gender, educational level, co-habit or live alone and their psychological and physical state.
3. To identify the importance of each parameter of satisfaction for the patients.
4. To identify any significant differences in the importance of each element of satisfaction for the patients based on their personal characteristic; age, gender, educational level, co-habit or live alone and their psychological and physical state.
5. To identify any problematic areas in the services provided by the program's nursing staff.
6. To identify the patients' perception of an ideal home care nurse and the nurses' and the management perception of an ideal home care nurse.
7. To understand the interactions between the nurse and the patient during a homecare visit.
8. To identify the natural environment where the home care visits take place.
9. To identify any possible difficulties that the Nursing staff and the Management face in order to increase the level of satisfaction of their patients.

These objectives try to answer the research questions and provide the basis for achieving the following research outcomes:

- Derive a set of recommendations for the improvement of patient satisfaction within the Home Care program.
- Derive a set of recommendations and insights for the European University of Cyprus that will be used for the formulation and structure of a postgraduate course in Home Care.

Upon completion of the project, the researcher will prepare an executive report, which will underline the major findings and highlight the recommendations for further action. This report will be disseminated to key people and decision makers at the Ministry of Health and at the European University of Cyprus. In her endeavour to raise social awareness and stimulate action by decision makers, she will make every effort to publicize and present this project's insights and outcomes to the relevant parties.

Outcomes and Intended Impact

The present research intends to identify key aspects of patients' satisfaction within the context of 'Nursing Home Care' in Cyprus. Valuable insight will be provided, so as to make necessary changes to improve patient satisfaction and subsequently increase the quality of health care. In addition to the main project report, the following papers have been prepared:

1. An executive summary report to be presented to the Ministry of Health, highlighting the project's major findings and proposing modifications to the nursing care provided within the Home Care setting, achieving higher patient satisfaction and resulting in improving home health care quality.
2. A summary report to be presented to the Board of Directors at the European University of Cyprus, who will in turn utilize the findings in order to create a holistic curriculum which will encompass the most significant elements of the Home Care Nursing as identified through the project, for the creation of a post graduate programme in Home Nursing Care.
3. Finally, the researcher will submit for publication the main findings of the study, the main conclusions and recommendations, in order to raise awareness and inform the nursing world about the issues of home care which have emerged from this project and encourage action by health care decision makers. Such a publication will share the outcomes with the wider health care professional community.

Assumptions and Limitations

The study population is limited to patients who have been enrolled in the government homecare program in Cyprus for at least two months prior to the survey. As such, the results of this project cannot be generalized to patients who have received home care services for less than two months, and are considered short-term care patients. This selection was made on the assumption that long term patients had a more informed perception of their own satisfaction. Another limitation was that the patients who were on a respiratory machine and patients with mental disabilities were excluded from the study due to their inability to communicate. Thus the outcomes were not representative of all patients within the homecare program. The research was conducted within the public sector and therefore cannot be generalized to the private sector of home care services.

The definition of the population was based on the assumption that the patients surveyed, interviewed or observed, were representative of the defined population. It was also assumed that the patients themselves were able to express their views and thoughts freely. Finally, the results of the research were limited to the validity and reliability of the questionnaire used. The nursing staff who participated in this research was limited to those with at least one year of experience in the program. This decision was centred on the assumption that those with more experience had a greater understanding of areas that were deemed to be problematic and could identify the obstacles faced.

Definition of Terms

In this section the definitions of the most important terms used in this study are explained to facilitate the better understanding of words and concepts that the reader may not be that familiar with; thus accommodating a clearer picture of the theme under investigation.

Activities of Daily Living: Are the activities inside and outside the house which help to the daily living of an individual; the use of objects such as the use of the telephone, the purchasing of different items, the use of transportation, the preparation of a meal, the house cleaning, the use of electric machines, the use of money and the ones related to the personal care of the individual such as personal hygiene, dressing, eating, bathing and the use of the toilet (Roe et al., 2001).

Ageing / aging: The lifelong process of growing older at cellular, organ or whole body level throughout the life span (World Health Organization, Centre for Health Development, 2004).

Care: The application of knowledge to the benefit of a community or individual (World Health Organization, Centre for Health Development, 2004).

Caregiver: A person who provides support and assistance, formal or informal, with various activities to persons with disabilities or long-term conditions, or persons who are elderly. This person may provide emotional or financial support, as well as hands-on help with different tasks. Caregiving may also be done from long distance (World Health Organization, Centre for Health Development, 2004).

Case management: case management: A continuous process of planning, arranging and coordinating multiple health care services across time, place and discipline for persons with high-risk conditions or complex needs in order to ensure appropriate care and optimum quality, as well as to contain costs (World Health Organization, Centre for Health Development, 2004).

Client: Client is a person or group that uses the professional advice or services of a lawyer, accountant, architect, etc. / a person who is receiving the benefits, services, etc., of a social welfare agency, a government bureau, etc./ a customer (Webster's College Dictionary, 1991).

Community Health Care: Includes health services and integrates social care. It promotes self-care, independence and family support networks (World Health Organization, Centre for Health Development, 2004).

Customer: a person who purchases goods or services from another, buyer, patron (Webster's College Dictionary, 1991).

Disabled people: people who have disability: Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner, or within the range, considered to be normal for a human being. The term disability reflects the consequences of impairment in terms of functional performance and activity by the individual. Disabilities

thus represent disturbances at the level of the person (World Health Organization for Health Development, 2004).

Health Care Services: Services performed by health care professionals or by others under their direction, for the purpose of promoting, maintaining or restoring health (World Health Organization, Centre for Health Development, 2004).

Home Care Nurses: are the nurses who deliver home nursing care.

Home Care Patients: are the patients who receive home care services.

Home Care Visits: Professional visits in the home.

Home Care: ‘Care provided by professional carers within clients’ own homes’ (Genet et al., 2012: 9).

Home Care: Home care can be defined as an array of health and social support services provided to clients in their own residence. Such co-ordinated services may prevent, delay or be a substitute for temporary or long term institutional care. (Knight and Tjassing, 1994: 16 in Mello et al, 2012:1).

Home care: is care is care provided to patients in their homes to restore their functional capacity, to allow them to manage their care independently, and to enable them to remain safely in the community (Panasci, 2009: 190).

Home health care: Care provided in an individual’s own home (World Health Organization Centre for Health Development, 2004).

Home Nursing Care: Nursing care provided in an individual’s own home. It includes assessment of the clinical status of the patient, glucose monitoring, injections or infusions, catheter insertion and removal, rehabilitation therapies, wound or any ostomy care, , pain control, disease prevention, instructions and advice on self-care, on physical exercise and medication, on disease diagnosis, treatment and expected outcomes, on environmental and social conditions, help in activities of daily living and identification of the appropriate health care professional to refer to according to the circumstances (Panasci, 2009).

Homebound: Homebound elderly people are considered ailing or injured individuals who the leaving of home requires considerable and taxing effort or absences from the home is infrequent of short duration or to receive medical treatment (Qui et al., 2010).

Long-term care (LTC) / long-term aged care A range of health care, personal care and social services provided to individuals who, due to frailty or level of physical or intellectual disability, are no longer able to live independently. Services may be for varying periods of time and may be provided in a person's home, in the community or in residential facilities (e.g. nursing homes or assisted living facilities). These people have relatively stable medical conditions and are unlikely to greatly improve their level of functioning through medical intervention (World Health Organization, Centre for Health Development, 2004).

Multidisciplinary team: Consists of members of different disciplines, involved in the same task (assessing people, setting goals and making care recommendations) and working alongside each other, but functioning independently. Each member undertakes his or her own tasks without explicit regard to the interaction. These teams are traditionally led by the highest ranking team member. (World Health Organization, Centre for Health Development, 2004).

Natural environment: is the environment in which usually specific actions take place e.g. the natural environment where a home care visit occurs is the house of the patient including all the physical and human elements that it encompasses.

Nursing: Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations (American Nurses Association (ANA), 2014).

Nursing: The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and achieve the best possible quality of life, whatever their disease or disability until death. (Dame et al. for the Royal College of Nursing (RCN), 2003: 3).

Old people (old old): Persons aged 75 to 84 years in a categorization of “young old” (60-74) and “oldest old” as 85 years and over. (World Health Organization, Centre for Health Development, 2004).

Patient Centred Care: patient-centred care: An approach to care that consciously adopts a patient’s perspective. This perspective can be characterized around dimensions such as respect for patients’ values, preferences and expressed needs; coordination and integration of care; information, communication and education; physical comfort, emotional support and alleviation of fear and anxiety; involvement of family and friends; or transition and continuity (World Health Organization, Centre for Health Development, 2004).

Patient: A person in contact with the health system seeking attention for a health Condition (World Health Organization, Centre for Health Development, 2004).

Patient: Patient is a person who is under medical care or treatment (Webster’s College Dictionary, 1991).

Patients’ Satisfaction: the satisfaction of the patient by the services provided to them.

Perceptions: Refers to customers’ beliefs concerning the service received (Parasuraman et al, 1988).

Place of belonging: The construction of a social place in terms of interpersonal relationships occurring between nurses and patients and between nurses and relatives (Oresland et al., 2008).

Quality of life: The product of the interplay between social, health, economic and environmental conditions which affect human and social development. It is a broad-ranging concept, incorporating a person’s physical health, psychological state, level of independence, social relationships, personal beliefs and relationship to salient features in the environment. As people age, their quality of life is largely determined by their ability to access needed resources and maintain autonomy and independence (World Health Organization, Centre for Health Development, 2004).

Satisfaction (in a consumer context): is a desirable end-state of consumption or patronization; it is a reinforcing pleasurable experience (Richard, 2010).

Satisfaction: Satisfaction is the state of feeling of being satisfied, contentment, pleasure/ a cause or means of fulfilment or contentment/ the act of satisfying, fulfilment, gratification (Webster's College Dictionary, 1991).

Self-care: Health activities, including promotion, maintenance, treatment, care and health related decision-making, carried out by individuals and families (World Health Organization, Centre for Health Development, 2004).

Sense of belonging; 'the meaning and significance people accord to a specific place' (Oresland et al., 2008).

The Project's Structure

Chapter one provides the rationale, the aims and the objectives and the intended outcomes of the project. It also provides the assumptions and limitations of the study, the definitions of important terms and the structure of the project.

Chapter two provides a review of the literature in the relevant areas of the study; patients' satisfaction, home nursing care and methods for assessing the home-care patients' satisfaction.

Chapter three describes and justifies the research methodology; the research approaches, the research methods, the data collection techniques and the data analysis methods of the project. It also discusses the validity and reliability and the ethical considerations of the project. Additionally, it describes the project activity throughout the research.

Chapter four provides the project's findings derived from the data analysis of the survey questionnaire, the in depth interviews and the observations.

Chapter five presents a discussion of the findings with a link-back to the literature review and conclusions derived from the research findings.

Chapter six presents recommendations made by the researcher.

Chapter seven provides the reflections of the researcher on the project.

Finally, the appendices include:

- a. The survey questionnaire in English, a translation in Greek by the authors, a back translation in English (Appendices A, B, C), the consent form (Appendices D, E), and the instructions for answering the survey questionnaire (Appendices F, G).
- b. The permission from the authors of the survey questionnaire to use the questionnaire in this study (Appendix H).
- c. The approvals for the conduction of the research, from the National Bioethics Committee of Cyprus (Appendix I) and the Ministry of Health of Cyprus (Appendix J).
- d. The in depth interviews' questions to the patients (Appendix K), the nursing staff (Appendix M) and management (Appendix N) and the photos used for the patients' in depth interviews (Appendix L).
- e. The researcher's sketches of the observations (Appendix O).
- f. The narrative notes of the observations (Appendix P, Q) and the samples of the field notes taken after the patients' in depth interviews (Appendix R).
- g. The statistics of the Cyprus Statistical Service (CyStat) and the Ministry of Health of Cyprus (Appendix S) and the report on health system of Cyprus from the European Commission (2010) (Appendix T).
- h. The executive summary for the Ministry of Health (Appendix U) and the executive summary for the European University of Cyprus (Appendix V).
- i. The acceptance of the project's outcomes by the Ministry of Health (Appendix W) and by the Council of the European University of Cyprus (Appendices X).
- j. The statements included in each dimension of the QPP questionnaire (Appendix Y).
- k. The suggestions for the safeguarding of the financial and other resources (Appendix Z (A)) and the automation of the Home care procedures (Appendix Z (B)).

CHAPTER 2 : LITERATURE REVIEW

Introduction

The literature review leads the progress and implementations of the study, providing the researcher with up to date knowledge on the topic as researched by others and allowing for a comparison between the researcher's study findings and any previous research conducted in this field. As Burns and Grove, (2009: 38) state,

'A review of relevant literature is conducted to generate an understanding of what is known about a particular situation or phenomenon and the knowledge gaps that exist.' (Burns and Grove, 2009: 38)

Furthermore,

'...a literature review helps to lay the foundation and provide context for a new study' (Polit and Beck, 2008: 106)

In this study, the literature review was used as a tool to gather information regarding the theme of the project and the approaches, methods, research collection techniques and data analysis methods that would guide the process of the study.

This chapter investigates the theoretical knowledge upon which the project is based. It is worth saying that there is a scarcity of literature on home care in general but most specifically on home care patients' satisfaction. Genet et al., (2011) in their study on a systematic literature review on home care among European countries, stated that only very little information on home care was found through the literature review for the countries situated in Central and Eastern Europe and no information was found on home care in Bulgaria, Croatia, Cyprus, Estonia, Greece, Hungary, Iceland, Latvia, Lithuania, Luxembourg, Malta, Romania and Slovakia. However, the researcher, in her review of the relevant literature, aimed to provide adequate understanding of 'patient satisfaction, home-care services, and home nursing care and assessment methods for patient satisfaction.

Home Care Today

What is Home Care?

While the definition of home-care may vary, the core elements of its substance remain the same, as is evident in the following definitions:

'Home care can be defined as an array of health and social support services provided to clients in their own residence. Such co-ordinated services may prevent, delay or be a substitute for temporary or long term institutional care.'(Knight and Tjassing, 1994: 16 in Mello et al., 2012:1).

Thome et al. (2003) define home care as the care provided to patients by professionals at their homes, covering a wide range of activities, from preventive assessments and actions to end of life care, and aims to contribute to the patients functional health status, improve their quality of life, maintain independence and minimize hospital care.

Panasci (2009), gives emphasis on home care's facilitative capacity to enable patients to stay at home, to giving them the freedom to manage their own care independently and maintain their active presence in the community. More specifically he maintains that the activities and services provided by home care today range from basic nursing activities such as vital sign measurements and changing dressings to more skilled activities such as physical therapy, occupational therapy and to providing durable medical equipment and specialists for direct treatment for specific conditions such as congestive heart failure, diabetes and asthma.

The majority of home-care patients are elderly with chronic diseases and functional impairments; most frequently not only one but a complex of diseases, who need support to keep up with activities of daily living such as: bathing, movement and eating. Some of these patients require palliative or terminal care. Most of the home care patients are homebound. Homebound elderly people are individuals who have complex medical, psychiatric and cognitive issues along with social frailty, which confine them at home and they usually suffer more than other elderly patients from higher rates of metabolic, cardiovascular, cerebrovascular and musculoskeletal diseases, cognitive impairment, dementia and depression (Donelson et al., 2001).

Tornkvist et al. (2000) found in their research, that home care patients in comparison to patients of health care centres, were of an older age, with their physical and psychological state being worse off and were more likely to be living alone.

The duration a patient may require home care services ranges from a few months to a life-time. These services vary in their delivery in order to accommodate individual needs and health requirements.

'Today's home healthcare clinicians deliver high quality, personalized care for a wide variety of disease states and conditions that is supported by superior technology and leading edge care pathways and protocols. This evolution has positioned home healthcare as the ideal future model for recuperative care and chronic disease management.' (Alliance Insurance, 2008: 4).

Advanced technology makes home care a more feasible solution for a larger number of patients. The availability of technology based solutions from adaptive medical devices to telehealth monitoring, that can now be provided in the home makes it feasible for patients who at one time had no choice but to enter a hospital to be adequately cared for in the community and helps people to age in place (Panasci, 2009).

Inaki et al. (2011: 1), also state,

'Telemonitoring technology offers one of the most promising alternatives for the provision of health care services at the patient's home.'

Home health care services differ from one country to another. Medicare, the largest single payer of home health care services in the United States provides: skilled nursing care, physiotherapy and occupational therapy, speech therapy, social services, assistance from a home health care giver, complete assessment and case management and 24 hour on call nursing (Alliance Insurance, 2008). In Greece, the home care services include nursing care and social services. However, medical services by doctors, physiotherapy and psychology services and help on activities of daily living, such as preparing patient's meals, might or might not be included depending on different policies of the individual municipalities (Aletras, 2010). In Sweden, there are three types of home care; nursing care provided by skilled nurses, social care provided by staff with no medical knowledge and 'hospital at home' service which is provided by a multidisciplinary team of health professionals (Modin et al., 2010) and it provides acute medical care at home instead of acute inpatient hospital care (Leff and Burton, 1996 in Leff et al 2006:1355). In Cyprus, only nursing care is provided through the home care program whereas social services are provided to some of the home care patients but by a separate program of the welfare services and not as a

part of the home care program (Ministry of Health, 2010). In Europe, as Genet et al. (2011: 207), stated, there is heterogeneity, concerning the regulations of the home care programmes, the financing system, the availability and the delivery of the services of the home care programmes among European countries. Also there were identified differences in different areas within the countries; lower level authorities set their own criteria for enrolment in the program, provide different types of services and have their own financing sources, resulting in differences in quality of services and accessibility for the citizens. The most prevalent are the public providers; nevertheless there are many different types of public providers; National Health Service agencies as in England, municipalities as in the Scandinavian countries or semi state organizations as in Bulgaria.

Contrast with other European countries, the governments in several Mediterranean countries limited the enrolment in the home care program to the poorer citizens, some European governments gave more responsibilities concerning development policies, financing and organization to local authorities, while in many countries poor coordination and integration of services provided at home, were identified (Genet et al., 2011). In some European countries, the services are provided free of charge by the government or the municipalities whereas in other countries, the services are provided depending to a contribution of the citizens to a health care insurance fund system.

A usual criticism of home care services is that multiple services are provided to the patients by different providers, and very often this lacks coordination (Low, 2011). Therefore in some programs, case management was introduced to coordinate the multiple services focusing on the individual consumer needs; case management was found to improve clinical outcomes and decrease the admissions to the hospitals and the nursing homes and at the same time decrease the use of the services (Low, 2011).

As the Visiting Nurses Association of America (VNAA), state in their website, elderly people with chronic diseases, in previous decades, were sent to '*sanatoriums*' to be cared for, while more recently, these patients have been sent to nursing homes or skilled nursing facilities; although home health care has long been an alternative solution, it was once considered an option only for the wealthy or those with trained family caregivers (Visiting Nurses Associations of America, 2014).

Home care prevents or postpones institutionalization, keeps families together, promotes healing, and in contrast to the institutions it allows maximum freedom for the individual. It

is personalized to the specific needs of each individual (Longo, for the World Health Organization, 2008).

The last decades have shown a shift in the manner in which patients in a recuperative state and chronic disease patients are taken care of.

The need for Home Care

Aging population

The world population of the older people is increasing due to the increase of the life expectancy because of technological and medical practice advances, the ageing of baby-boom generation (1945-1965) which reaches 65+ in 2010 and beyond, much lower fertility rates (Lafortune, 2005).. This picture is common to all the developed countries and certainly true for all European countries, with a huge increase of the percentage of the oldest-old citizens in Japan, France and Switzerland (Robine et al., 2005). In many European countries the proportion of the group of old and very old people is increasing steadily and it is predicted to rise more in the next decades, while the proportion of children, young people, young adults and adults, is predicted to decrease due to the fertility decline (Aguzzi et al., for the World Health Organization, 2008). The percentage of Cypriot people that are 65 or older is 12% of the population and it is expected to increase by an astonishing 50% by 2030. Indeed, the rising of life expectancy at older ages is a sign of progress, however the aging of the population concerns the modern policy makers as the cost and funding of public and private pensions, healthcare and long term care is increasing (Lafortune, 2005). Furthermore, there is feminization of ageing; life expectancy of women is higher than men at the very old population, (Mehta, 2002),. At the same time, women tend to suffer more from chronic diseases than men, whereas men tend to suffer more from acute and fatal diseases like cardiovascular diseases from women (Muller, 1992).

It is expected that most of these will phase chronic health problems. At 1980 the life expectancy of the Cypriot was 72 where at 2006 has increased to an average of 77 (World Health Organization, 2006). Cypriots spend an average of 10 years of their lives with illnesses according to the statistics of the World Health Organisation. Recent studies and research indicates that people will increasingly need long term care. The probabilities for a

person to need LTC at some stage of one's life reaches the alarming levels of 60% of all citizens and for people of over 65 years of age this probability increases to 75%.

The national health care expenditure in Cyprus increased from 0,73 billion in 2003 to 1,31 billion in 2011, with an average increase of 7,58 % per year (Ministry of Health of Cyprus, 2011), (Appendix R, Table 4). In the public sector for the same period the health care expenditure increased from 80 million in 1990 to 609 million in 2012, with an average increase of 9,67% per year (Ministry of Health of Cyprus, 2012), (Appendix R, Table 3). The reasons for the increase of the national health expenditure in Cyprus are mainly the increase of population, the improvement of welfare and raise of standard of living and the increased cost of advanced technology used in health care.

In more detail, the population in Cyprus increased from 722,900 in 2003 to 862,000 in 2011 (Statistical Services of Cyprus, 2011), (Appendix R, Table 2). The Cypriot population of age 65 and older has increased from being 66,167 which comprised 11% of the total population in 1992 to 111,767 which comprised 13% of the total population in 2011 (Statistical Services of Cyprus, 2011), (Appendix R, Table 2). The increasing aging of the Cypriot population is also shown on the same statistics which indicate the ages up to 14 were 152,055 in 1992 which was the 25% of the population compared to 2011 where the ages up to 14 decreased to 134,948 which was only 16% of the population (Statistical Services of Cyprus, 2011), (Appendix R, Table 2). The main reasons for the increase of population are the increase of life expectancy, and the increased inflow of people from European Union and developing countries.

The increase in welfare in Cyprus is indicated in the measurement of Gross Domestic Product (GDP) which enjoyed a steady increase of more than 3.3% per year from 1995 to 2011. For 2012 and 2013 the welfare has indicated a decrease in the aftermath of the world financial meltdown and recent financial crisis of Cyprus, (Statistical Services of Cyprus, 2014), (Appendix R, Table 1).

The cost of new technology is primarily because of the advances in modern and specialized diagnostic equipment and equipment used for advanced treatments, the increased cost for utilizing new drugs, new and specialized treatments.

The following changes are expected in Cyprus from 2008 to 2060: increase of the population by 500,000 people, increase of life expectancy by 7 years for both genders,

increase of the elderly people (over 65) by 13,8 pps, increase of the oldest old (over 80) by 5,8 pps and increase of health expenditure by 0,9 pps of GDP (European Commission, 2010). Extensive details of the above are found in Appendix T.

These statistics reinforce the need to seek new alternative solutions and changes in the health care system of Cyprus.

'Providing the care that lets people live at home if they want is less expensive than providing nursing home care. It frees resources that can help other people. And obviously, many people are happier living at home' (Leavitt, 2005, Home Health Services' (HHS) Secretary Speech to the World Health Congress)

As (OECD), (2005: 2) states that:

'...supporting an old person in their own home generally costs less than keeping them in a nursing home or other residential care.'

The increasing need of home care services is additionally fuelled by the growing demand of the patients to be treated at their home. But what is 'home'?

'Home is a place of emotional and physical associations, memories and comfort' (Longo, for the World Health Organization, 2008: vii).

Many people prefer home care instead of other options; for some people leaving home and enrolling a nursing home or a retirement community can be disruptive and depressing (Longo for the World Health Organization, 2008).

Most older people in need of care prefer to be cared in their own homes, however, informal caregivers who are often older people too, should be supported by the home care services in order to continue to provide care without becoming ill themselves. The home care services should be available to all of the citizens and not only the ones who either know about them or for just the ones who can afford to pay for them (World Health Organization, 2002).

Dogan and Deger (2004) concluded that elderly people want to stay in their familiar environment and be in continuous communication with familiar health care professionals, they want their autonomy and dignity to be protected, ethical principles to be respected; they feel lonely and out of place in institutions, they do not want to be hospitalized and

they have unexpressed fears of not being respected and of not being well informed about interventions related to their treatment.

According to European Commission (2006) evidence suggests that there is a tendency for disabled and older people not wanting institutional care and at the same time their caregivers, either being informal or relatives prefer to care for their patients in the friendly environment of their homes or that one of the local community. Furthermore, the frequent hospitalizations in times of predicament of the patients' health, often lead to fast functional worsening and elderly patients lose their ability to live independently, which in turn increases the possibility for their admission to long term care institutions permanently (Sinha, 2011). Moreover, as Brumley (2007) support, patients at the end of life stage are more satisfied by receiving care at home rather than being hospitalized.

The rapid increase of the non-communicable otherwise called chronic diseases which are diseases with a long duration and slow progression such as cardiovascular, diabetes, cancer, chronic respiratory diseases and mental illnesses (Boutayeb, 2006), is an additional reason for the growing need of home care. As Luthi et al. (2012), argue home care is a very good alternative for patients with cancer, as the treatments at their own environment, '...home care is a valuable alternative for oncology patients, even for the administration of intensive chemotherapies'(Luthi et al., 2012: 581). Luthi et al (2012) supported that not only chemotherapies were feasible and safe in the context of home care, but at the same time there was a psychosocial benefit with a very high satisfaction level for the patients and their relatives and there was a cost benefit compared to hospital treatments.

People with chronic diseases may stay at home due to mobility difficulties, which in turn will further increase the rate of care- dependent older people and at the same time aging population profile will reduce the dependency ratio of caregivers to dependents and will affect the tax base which primarily fuels the funding of public health services (Eurostat, 2008). The pool of formal and informal caregivers is also reduced due to the steady increase of females entering the labour market and emphasis is given on women career opportunities and women paid work (Vlasblom and Schippers, 2004).

There is an increasing tendency of the people, both men and women, who are single and they do not have a partner who could possibly take care of them and at the same time these people are lonely who often require social support (Mehta, 2008).

The age range of informal caregivers is between 45 -60 years, the Lisbon's strategy for growth and employment of the European Union which discourages early retirement in order to increase labour market participation, further reduces the pool of informal caregivers (European Commission, 2004).

The relatively recent expansion of European Union to include new countries has driven a considerable number of younger people to migrate, in pursue of employment, which increases the distances between family members, thus considerably, contributing to the lack of caregivers for the older people in need (Eurostat, 2008).

The increased mobility and urbanization leads to the breakup of the traditional large family groups which for many generations were intact, facilitating the taking care of the older or disabled members and replaced it with smaller families, living in limited spaces in the cities, further increases the requirement for a different approach to health and social sector policy and services (Aguzzi et al. for the World Health Organization, 2008). In the United States of America and Japan, the elderly people who expect to depend on their children has decreased from 65% in 1965 to 10% in 2000 and the elderly people who consider that the caring of parents from their children is a custom or a natural duty, has decreased from 80% in 1965 to 50% in 2000 (Ogawa et al, 2004, in Robine et al., 2005: 2). In China, the traditional moral and religious system of Confucianism, which says that an individual's life is an extension of the parents' life thus the children should take care of their parents, still keeps some standards of care but it is declining the last decades due to the influence of the western culture in the younger generations, the limiting of the family to the nuclear family; not including grandparents, the fact that women are more educated and work and the fact that financially it is not affordable; the one child – one family policy makes the financial burden worse as one child should need to afford the care of two parents (Chao-Yin, 2010).

The availability of new medical technology increase the life expectancy and the availability of non-medical technologies support residential settings to the needs of disabled people enhancing the feasibility of home care (Aguzzi et al. for the World Health Organization, 2008).

Home care reduces the length of patients' stay in hospitals and thus reducing their exposure to in hospital infections,, prevent avoidable hospitalizations and emergency response visits, offers continuity of care and ensures a safe stay at home with a focused attention to the individual patient's health needs, provides comfort and increased

satisfaction and gives added incentive to the patient to get better and thus improving the outcomes of the treatment (Panasci, 2009). Holmqvist et al (2000) concluded in their research, that early discharge from the hospital after acute strokes followed by rehabilitation at home reduced in total hospitalization, reduced the visits in outpatient rehabilitation, reduced the resource utilization of health related services and increased patients' satisfaction.

The World Health Organization in Health21 placed healthy ageing policy as one of the main targets for the 21st century in Europe. More specifically it stated that

'Most older citizens want to stay in their homes as long as possible. However, there is a lack of appropriate home care services in a number of countries in the Region ...' (World Health Organization, 1999: 34)

Home care service is considered as a primary means to achieve the above target.

Conclusively, in a world where the majority of people will become the elderly; with multiple chronic diseases and a progressive social exclusion and with increased financial difficulties, there is an enormously rising need for home care services.

Home Care Programme in Cyprus

The program is provided by the Ministry of Health. It first started to operate in 2004 with only two nurses who were placed at Kyperounta Hospital, which is a small hospital serving the mountainous areas of Cyprus.

Eligible for entering the programme are those patients who are entitled to free public healthcare and must be aged 18 and above and reside within the geographic area covered by the programme. Additionally, they must have no other support and have the need for health care treatment; they are patients of limited or no mobility, patients that need of post-operative care and patients who require medical advice and guidance to self-treat their condition (Ministry of Health of Cyprus, 2009a and Ministry of Health of Cyprus 2009b).

At 2011, which was seven years after it was launched it employed 19 nurses; of which 18 were female and 1 male. At yearend 2011, there were 562 patients enrolled for long term home nursing care of whom 207 were men and 355 were women and 2872 patients enrolled for short term care. Eighteen patients needed ventilations machines of which 14

were long term patients and 4 short term, for which the programme provides specialist home care nurses for the purpose and a pneumologist. (Ministry of Health of Cyprus, 2012)

It operates only at certain geographic areas of three provinces with the largest coverage in Nicosia with 353 enrolled patients, Limassol with 192 patients and Paphos with 27 patients (Ministry of Health of Cyprus, 2012 Department of Home nursing care services).

The patients who enrolled the program for long term care services were between 18 and 100 years old, with the majority between elderly people between the ages of 65 and 85.

The main reasons for the patients referral for the home care program in 2011 were for: care of pressure ulcers, care of wounds (e.g. diabetic foot), care of colostomy/ileostomy, care and change of urethric and suprapubic catheter, care and change of rhino gastric tube, care and change of gastrostomy, tracheostomy, administering medication, checking of vital functions, glucose control and insulin therapy, training the diabetic patients for self-care, care of patients requiring oxygen therapy at home, aspiration of bronchial secretions, administering subcutaneous and intramuscular injections, vaccinations, blood and other sampling for laboratory tests and counseling to prevent immobility or other disease implications (Ministry of Health of Cyprus, 2012, Department of Home nursing care services)

Patients Satisfaction

'Quality of care is a multidimensional concept, which has been given different meaning in the literature' (Wilde et al, 1995: 140).

As Davies and Ware (1988:34) argue

'Quality of care' refers to the worth or excellence of various attributes of medical care'.

Zeithaml (1988) argue that irrespectively to the type of services, the quality of services is determined by the reliability, the responsiveness, the competence, the credibility, the access, the courtesy, the understanding, the communication, the physical tangibles and the security.

When it comes to home care Lalonde (1988:20) states that:

'Quality assurance is the promise or guarantee home health agencies make to themselves, clients and their families, and their accreditation bodies that certain standards of excellence are being met in the care delivered'

However, Sixma, et al (2000) argue, that the aspects related to the outcomes of the home nursing care services, like the improvement of the patients' health status, are remarkably difficult to determine the quality of care for the elderly or disabled patients or for the patients with chronic diseases. The outcomes per se, of the home nursing care services could not define the quality of care, and hence 'an important aspect of this quality assurance is client satisfaction' (Laferriere, 1993: 67).

Deming (1993) defines quality as the satisfaction of the clients' needs.

Davies and Ware (1988) argue that patient satisfactions is a valid and warrant indicator of the quality of health care.

As Grant and Ramcharan (2006) in Gerrish and Lacey (2006) state, one of the most significant challenges has been the growing emphasis placed on user and carer involvement in the research; those on the receiving end of such services are the most suitable to inform service development.

In the developed world, the phenomenon of 'client centred' approaches demands that 'Patients must now be viewed as clients and consumers' (Laferriere, 1993: 67).

The purpose of client-centred care is the provision of care that fulfils the needs and the demands of each individual client (Restall et al., 2003 in Witte et al., 2006).

As Witte et al (2006) explains, there is a rising approval among the health care professionals that a client centred approach has encouraging results in the patients' treatment.

Despite the increased interest in client centred approaches in health care, professionals in the health care sector have problems implementing these practices, predominantly in the cases of patients with chronic diseases (Restall et al., 2003 in Witte et al., 2006). In the home care setting, a large proportion of patients face chronic diseases.

'Consumers are demanding the right to actively participate in informed decision making regarding the health and nursing care they will receive. This nursing care

will be client centred and outcome oriented. One of these outcomes that consumers should expect and will demand is satisfaction with nursing care. In the competitive arena of home care, agencies will need research-based methods to assess the quality of the care provided. Client satisfaction should be an aspect of that evaluation process.' (Laferriere, 1993: 75)

'If the aim is genuinely to increase user participation in care, and to try to work to some extent to a user-led agenda, it is important to use methodologies that give voice to users, and allow them some scope to lead agendas for change, rather than being restricted to providing data for provider-led agendas' (Edwards and Staniszewska, 2000: 423 in Hopkins and Niemiec 2006: 46).

In home care, patient satisfaction is based on the quality of services offered by the various health care professionals even though

'The highest measure of quality was attributed to the client's perception of nursing care' (Schmele, 1985: 120).

Wagner, (1988), states that health care providers should view home care patients' satisfaction as a reality; a subjective perception which reflects the quality of nursing care and understand that

'...quality of care as measured by patient satisfaction is most closely tied to patient satisfaction with the quality of nursing care because most health care is nursing care' (Mahon, 1996: 1243)

During the literature review, the researcher detected, as did Laferriere, (1993), a scarcity of published research regarding client satisfaction in the home care setting; there is however a wide study of client satisfaction in other settings such as: hospitals, physician offices, clinics, and other areas of the medical field.

Patient satisfaction within the home care setting continues to remain a difficult concept to define, as literature describing its definition is minimal. Law et al., (1995), define patient satisfaction as

'...an approach to providing services that embraces a philosophy of respect for and partnership with people receiving services'

While respect and partnership are key elements in the quest for patient satisfaction it is not always evident in the home care setting.

'One of the most alarming aspects of the poor care given at home is that it not only affects the most vulnerable group of people but it is often invisible, as it happens behind closed doors.' (Sagnella, 2011: 22).

As such, it is and will be of utmost importance that patients within the home care setting must have a voice;

'...consumer clients can and will participate in the evaluation of the nursing care they receive' (Laferriere, 1993: 75).

Patients' dissatisfaction is an indicative of the problematic areas in the nursing services. However it should be noted that on those settings that there is an established continuous monitoring of the nursing services through a patients' feedback system we should also take in account that

'... increased complaints, as well as being indicative of reduced satisfaction, are not straight forward or direct measures of changes in nursing quality. For example, the social context in which patients are nursed may be changed, thus enabling and even encouraging them to make complaints, or at least comment on things they would like to be different. An increase in the number of complaints, then, may be indicative of a less oppressive regime rather than of worsening care' (Senga and Lois, 1991: 53).

Patient satisfaction is determined by different factors such as age, gender, marital status, social class and educational level of the patients (Sitzia and Wood, 1997).

'Understanding how patients' baseline characteristics affect patient satisfaction is critical to interpreting patient satisfaction data and to making correct inferences about the effectiveness of specific interventions and the performance of individual providers.' (Jaipaul and Rosenthal, 2003: 23).

Campbell et al (2001), researched comprised of a large survey research for variations in assessments of primary care in different primary care settings in London. They concluded that the older patients are more satisfied than the younger ones that the people from ethnic minorities are less satisfied than the major ethnicities but there were no significant differences between genders. Further, Johansson et al (2002) have also found in their

research that older patients are more satisfied than younger patients, but have indicated that there is a difference between genders where males are more satisfied than females. Bikker and Thompson (2006), argue that age is a predicting factor for the patients' satisfaction in community care; indicating that patients of older ages are more likely to score high levels of satisfaction than the younger ones. On the same end, Manal et al (2013), argue that patients with a lower educational level are more satisfied with nursing care than patients with a higher educational level whereas the effect of gender in the level of satisfaction of the patients seems to be varying in different populations.

Tornkvist et al (2000) found in their survey research using the QPP questionnaire, that the patients who rated their physical and psychological state being poor, reported less satisfaction from the home nursing care, than patients who rated their physical and psychological as being good. They also found that there were no significant differences between the level of satisfaction of the home care patients who lived alone and the patients who cohabited.

Aletras et al (2010), concluded that patients' satisfaction in home care is influenced by the monthly income of the patients; patients with comparatively less income were more satisfied by the home care services because they needed the services more compared to the ones with more financial resources.

They have also identified that duration of enrolment to the program influenced also the level of satisfaction of the home care patients; the longest the duration, the higher the satisfaction because the patients trusted their nurses more (Aletras et al., 2010).

In the same study it was also identified that the majority of the participants were generally satisfied with the home care program, with higher levels of satisfaction related to professional skills of the nurses and the nurses' attitude and the suitability of the services and with lower levels of satisfaction related to the social and economic issues of the services provided, (Aletras et al., 2010). Tornkvist et al, (2000) concluded that the dissatisfied patients were most frequently dissatisfied by the possibility of reaching the home care nurse on the telephone, how possible it was to have the same home care nurse in all home care visits, the pain relief, the safety of the patients' environment, the nurses' interest in their spiritual needs and the possibility that the nursing care was based on the patients' wishes and desires rather than by the nurse's procedure.

Groenewegen et al. (2005), suggest that although there are differences between countries in the importance patients give to the different factors evaluating the health care quality, the ranking and the hierarchy concerning the importance of some aspects of home care might be common; for example values concerning respect are almost always ranked of highest importance whereas waiting time is always ranked as least importance for the patients.

'In general, there is a positive relation between what people find important and their experiences, both on an individual level and related to the average experience in a country.' (Groenewegen et al., 2005: 7).

Johansson et al.(2002), argue that the nurses more than other health professionals can influence the factors of patients' satisfaction related to communication , information, the participation of the patient and the interpersonal relations, as these factors are the basis of their discipline.

'Establishing clear communication and providing information about nursing care are a prerequisite for patient satisfaction. Patients state that information plays an important part in their satisfaction. Patients also emphasize that if nurses are to be understood, the information they give should be clear and comprehensible' (Ozsoy et al, 2007: 253).

On the same lines, Walshe et al.(2011) state that it is very important that the nurses simplify their way of communication so as to become more easily understood by their patients. However it should be mentioned that low educational levels of the patients and inadequate number of nursing staff resulting in heavy nursing staff workloads may affect negatively the quantity and the quality of the information given to the patients, leading to a decrease in patients' satisfaction (Ozsoy et al, 2007).

Bikker and Thompson (2006) argue that interpersonal care and the information given to the patients, are very important parameters for the patients' satisfaction. Fitzpatrick (1984) described a model of satisfaction that suggests that patients' satisfaction is related to the affective behavior and the communication skills of the health professionals.

Crow et al. (2002), in their research; a systematic literature review on the measurement of satisfaction with healthcare in different settings, concluded that there is a consistent evidence that the relationship between the patient and the health care professionals and the information given to the patients by the professionals, are the most important factors

affecting the patients' satisfaction. They also state, that older patients and patients in a better physical or psychological state, record higher levels of satisfaction whereas gender, socioeconomic status and ethnicity record equivocal results.

Crow (2002), also argue that patients' satisfaction is influenced by the patients' satisfaction with previous experiences with healthcare. They also state that although, patients' expectations are potentially important in measuring satisfaction, there are however investigated only in a limited number of studies and record vague results. On the same subject, Baron-Epel, et al., (2001) specify that patients' expectations are important in determining patient satisfaction and that these expectations and their fulfilment are a subjective evaluation by the patients.

The participation of the patients in the decision making process of their care is another important factor for the satisfaction of the patients, as patients nowadays are more educated and demand to participate in the decision making of their health care.

Richards and Lambert (1987) and Wilde et al. (1995), found in their researches that patients were not completely satisfied with their possibilities to participate in the decision making of their care. The picture seems to be the same over the past few decades and the message is clear; patients are increasingly demanding participation in the decision making of their care.

'If patients are to have a real say in their care, nurses must change their attitudes and learn to share decision making in a real and meaningful way' (Richards and Lambert, 1987: 561).

Nordgren and Fridlund (2001), concluded that patients described the feeling that they were not involved in decisions regarding their care, that nobody asked them about, and that nobody listened to their expectations and wishes before the decisions about their treatment were taken. This feeling along with a lack of knowledge and information about nursing interventions promoted a sense of powerlessness against the health professionals and restricted their possibilities of self-determination in the context of their health care.

To this end, Nordgren and Fridlund (2001) have also indicated that there were patients who did not wish to be fully involved in the decisions concerning their care, mainly because they had confidence in the care and treatment they received by the professionals and hence accepted their opinion and judgement.

A further factor that seems to influence patients' satisfaction is how much time the nurses spend to accomplish their tasks. Janicijevic et al. (2013), concluded in their study, albeit referring hospital patients, that the satisfaction of patients increases with the increase of time available for the nurses to accomplish their tasks.

Porter and Ganong (2005), found in their research that the duration of the relationship between the nurse and the home care patient was an important parameter influencing satisfaction; the longer the duration the more familiar patients became with their nurse as a person and the more used they became with their nurse's approach to work, thus patients' expectations were formulated by what their nurse routinely did.

When thinking satisfaction of customers or for this matter satisfaction of patients received by the front line providers of an organization which in the case of home care are the nurses, one could very reasonably wonder whether a dissatisfied employee can indeed provide a service or an experience of excellence, which will live the customer/patient satisfied.

Rosati et al. (2009: 50) argue that

'... there is a direct relationship between increases in employee satisfaction and patient satisfaction in home healthcare' and that *'organizational commitment to patient care and customer service is fundamental to patient satisfaction'*.

In the same study it was argued that it is equally important for the organization to deliver high quality care and customer service and to communicate it effectively by best practices by the employees and the managers. Further factors that were significant in relating to patients' satisfaction was the employee growth and development, work-life balance, fair compensation and regard for employees; all influenced patient satisfaction (Rosati et al., 2009).

According to many studies, Rosati et al (2009), patient satisfaction with their nurses is increased if nurses' satisfaction is increased. Consequently there is value to investigating and *'understanding where there might be opportunities to enhance employee satisfaction in areas that concurrently drive patient satisfaction'* (Rosati et al, 2009: 50).

Home Care Nurses

Home care nurses are nurses who deliver nursing care at the patient's own home. They are also called district nurses, a term credited to Florence Nightingale (1820-1910) for the

nurses who cared for the sick at home (Rice, 2006: 3). Home care nurses provide nursing care that may cover the following: management of glucose monitoring, injections or infusions, catheter insertion and removal, rehabilitation therapies, wound or any ostomy care, evaluation of clinical status, neurological and physical functioning, pain control, give instructions on activities of daily living, on disease prevention, environmental and social conditions, self-care, physical exercise and medication, discuss with the patient about the disease diagnosis, process, treatment and expected outcomes, identify the appropriate health care professional to refer to according to the circumstances and fulfil such referrals, and generally support the patient to master those skills that will maintain self-sufficiency at home (Panasci, 2009). Home care nurses also provide information and training to the family and the caregivers of the patients, in order to handle the health issues of the patient more effectively (Aletras et al., 2010) states that the frequent contact of the patient with his or her nurse, increases the feeling of safety, wellness and improves the psychological state of the patient, thus this contact is more important for the patient than the everyday contact with his or her caregiver. Richardson (2002), states that the nurse's humane approach improves the psychological state of the patients.

The provision of psychological support to the home care patients by their nurses is very important according to Barrett et al. (2007), who characteristically state that albeit the 'bad news' for the health state of a patient are usually announced by the physician in a health care setting, the process of acceptance by the patient of the disease and the understanding of the disease's following stages and progression, are achieved through the continuous communication of the patient with his or her community nurse. Charalambous and Protopapa (2012), go further to support that nurses should additionally offer spiritual care to their patients as a part of a holistic care considering that the patient has a biological, psychological, social and spiritual dimension.

Vasiliou et al (2013), state that community nurses, a part of which are the home care nurses, should comprehend cultural competence; be able to take into consideration the cultural background, the beliefs, the values and the traditions of each patient, respect different language, incorporate the culture of each patient to the nursing, be open to different ways of incorporating the patients' treatment and possess social skills such as patience, respect and avoid rejection, in order to provide holistic and individualized nursing care. Characteristically they state that this

‘Cultural competence should not only be employed when caring for immigrants or ethnic minority groups, but also in encounters with all patients’ (Vasiliou et al, 2013: 50).

In most home care programs, along with the home care nurse, there is a team of other health professionals who provide their professional services to the patients of homecare. The existence of a team of health professionals in such programs is essential in all cases; chronic diseases’ treatments, care of end of life stage, palliative care or other. However, according to Kennedy (2005), the patient’s more frequent contact with the nurse than the other health professionals, leads to a leading and coordinating role of the nurse to the whole setting. On the same lines are the arguments of McHugh et al (2009), who maintain that in the United Kingdom policy perspective, community nurses are placed at the forefront of health care and they are given a leading role in the coordination and the delivery of more responsive services for patients with long term care conditions; they are

‘...in a key position to promote health through their access to individuals, families and communities’, (McHugh et al., 2009: 2563).

Home care nurses like other home care providers, should

‘seek to provide high quality , safe care in way that honour patient autonomy and accommodate the individual characteristics of each patient’s home and family’ (Nadarevic-Stefanec et al., 2011: 216)

Markham and Carney (2006), in their attempt to explore factors that influence the delivery of quality nursing care in the community, identified that the home care nurses acknowledged the need to be educated and that they advocated that information on the delivery of evidence-based service would have a positive impact on the quality of the delivery of service. Additionally the home care nurses accredited that enhanced knowledge was associated with feelings of competence and confidence. Four main categories emerged that according to the nurses, needed attention:

‘... namely, role change, components of quality nursing care, barriers to quality nursing care and the factors that facilitate the delivery of quality nursing care in the community’

As Rice (2006: 14) states

'...ongoing educational programs that advance knowledge and clinical expertise...' are essential to the home care nurses in order to provide quality nursing care.

On the same lines, Kisa (2007) concludes in her study, that only nurses who are highly educated are able to understand and support a home health care system and play a domain role in the formation of a patient-centred, patient-sensitive and cost effective home care program.

On a different note home care nurses should perform from a dual position towards the patient; the position of the guest and the position of the professional. Oresland et al, (2008), argue that it seems impossible to perform from both positions at the same time as such nurses should be able to realize the demands of each situation and act according to the ethical framework related to each of the two positions.

Additionally it was identified by Markham and Carney (2006) that the home care nurses admitted that there was a need for better communication with the line managers and the multidisciplinary team and this would be instrumental to supporting them in their role to higher quality levels.

Conclusively, as Rice (2006: 14) state

'Home care nursing is an art and a science and dedicated to providing quality patient care in the home and community setting'.

Models of assessing Patients' Satisfaction

'Users of health and social care services should be involved in the development and testing of quality of care measuring instruments from the outset' (Sixma et al, 2000: 178)

These instruments should cover all the aspects of health care which influence the patients' satisfaction. Sixma et al (1998:91), state that

'...patient's judgements are related to different aspects of the health care system, and therefore measuring instruments should reflect the multidimensionality of the care giving process.'

Instruments for measuring patients' satisfaction may differ in context and structure depending on the health care setting they refer to; adjusting to the specific characteristics

of each setting. The last decades, there are instruments formulated or adjusted specifically for measuring patients' satisfaction at the setting of home care.

'Now it is essential that home care formulate comprehensive, practical, and systematic approaches to evaluate client satisfaction. One approach is the development of reliable and valid client satisfaction survey instruments.' (Laferriere, 1993: 67)

During the last decades, literature surrounding this area reveals a number of survey questionnaires which assess home care patient satisfaction.

QPP Questionnaire

Through the literature research the researcher acknowledged a predominant instrument that was developed to measure patients' satisfaction from the health care they receive, the Quality of care from the Patients' Perspective (QPP) questionnaire, developed by Wilde et al., (1993, 1994).

QPP evaluates Quality of Care under

'the light of two conditions, the recourse structure of the care organization and the patient's preferences. The recourse structure of the care organisation consists of the person related as well as physical and administrative environmental qualities. The patients' preferences have both rational and a human aspect' (Wilde et al, 1995: 141).

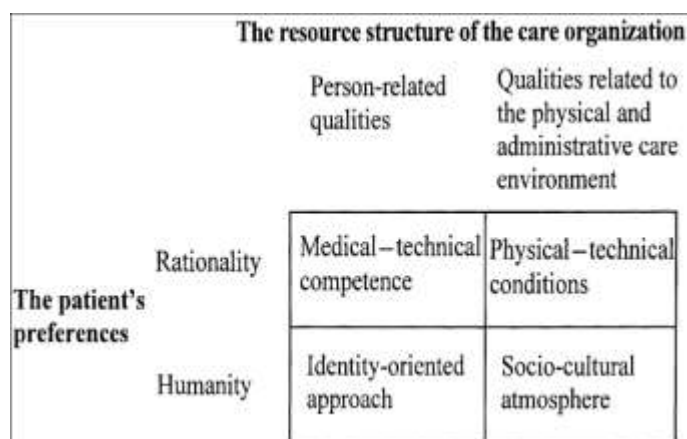
This is shown in figure 2.1 below. Within this framework patients' perceptions in health care are considered in four dimensions:

1. Medical- technical competence of the nurses (e.g. pain alleviation)
2. Physical technical conditions of the organisation (e.g. advice and directions from the nurse to obtain a safe environment at home).
3. Identity orientation in the attitudes and actions of nurses (e.g. nurses' interest in the patients' spiritual needs, the patients possibility of participating in the

decision making process with regards to the medical care, the received information) and the

4. Socio-cultural atmosphere of the care organization (e.g. care based on their desires and needs and recreation during the day) (Wilde et al, 1995)

Figure 2-1: Model of Quality of Care from the Patient's Perspective.



(Wilde et al, 1995)

The statements included in each dimension of the QPP questionnaire are shown in Appendix Y.

All QPP questionnaire statements are assessed by the respondents in two ways (a) the 'perceived reality'; the perception of the patients for the care they received, with a four point response scale (Likert scale): 'Fully agree', 'Mostly agree', 'Partly agree' and 'Do not agree at all' rating from 4 to 1 respectively and the 'subjective importance', the importance of each aspect of care, with a four point response scale (Likert scale): 'Of the very highest importance', 'Of high importance', 'Of some importance' and 'Of little or no importance' rating from 4 to 1 respectively.

A formula was created to compute the quality of care (QPP index) on each item of the questionnaire:

QPP Index=Subjective Importance Score x (2 x Perceived Reality Score – Subjective Importance Score). (Wilde et al, 2002).

The QPP index can range from 16 as the highest score for quality of care and -8 as the lowest score for quality of care.

QPP short version has major advantages which make it appropriate to the profile of the home care patients of the Cyprus program. Of major importance is that the items of the questionnaire are derived from the patients' perspective and they are formulated in words used by patients and the items still have a theoretical foundation which makes the interpretation results more meaningful (Wilde and Larsson, 2002). QPP also avoids global and generalist formulations such as 'What do you think about your care?' and the fact that it is short it makes the questionnaire more attractive for many patients to respond to (Wilde and Larsson, 2002) especially in the case that the majority of the respondents are elderly people, as in a home care program. Overall, QPP is short, valid and a reliable instrument.

The researcher has studied numerous other questionnaires which attempt to measure patient's satisfaction or similar dimensions from the nursing staff. However, the QPP questionnaire was considered the most suitable for this research project. Here below there is the summarised description with regards to four worth mentioning questionnaires.

The QUOTE-elderly Questionnaire

Sixma et al. (2000) produced a self-administered questionnaire on quality of health care from the perspective of elderly people (QUOTE-elderly), at Netherlands Institute of Primary Health Care (NIVEL).

They developed the instrument by measuring quality of care from the perspective of non-institutionalized elderly people (QUOTE-elderly) by using a combination of qualitative and quantitative methods. The QUOTE-elderly questionnaire's quality aspects refer to the process quality, the structure quality and the category specific quality

The aim of QUOTE-elderly questionnaire is to develop an instrument that would:

1. Produce data related to the expectations and experiences of non-institutionalized elderly people
2. Contain items that had been formulated in collaboration with elderly people
3. Measure quality from the perspective of the users of health care services and
4. Produce data on generic quality aspects and quality aspects specifically related to the needs of elderly people.

Client-Centred Care Questionnaire (CCCQ)

Witte et al (2006), reported the development and testing of the Client-Centred Care Questionnaire (CCCQ), which evaluates the client-centeredness of the home nursing care from the patients' perspective. It consists of 15 items which were derived from the home care patients' interviews, it is short and comprehensive and it evaluates the degree of client-centeredness of the nursing services as perceived by the patients' experiences. Although this instrument does not assess the patients' satisfaction, it assesses the client centeredness of the home care nursing services which is an important aspect and indeed it could be utilised as an instrument that home care providers can use it to evaluate their services.

Consumer Quality Index Long-term Care (CQ-index) Instrument

Triemstra et al., (2010), describe in their study, the development, the testing and the optimization of the Consumer Quality Index Long-term Care (CQ-index) Instrument, that measures the patients experiences from long term care services. There are three formats of this questionnaire, for different patients; one of them is made for home care patients and it investigates quality of homecare services from the home care patients' perspective, it is self-reported and more comprehensive than others. However, this questionnaire focuses on the patients' experiences rather than the patients' satisfaction or their opinions' ratings and it does not focusses to assessing only the nursing services but the services of the whole home care setting.

Satisfaction Scale for Community Nursing (SSCN)

Cheng and Lai (2010), provide a report of the development and testing of the Satisfaction Scale for Community Nursing (SSCN) instrument for measuring patients' satisfaction with the community nursing. The authors of the questionnaire believe that if patient judgment is used as a quality indicator to evaluate the quality of the service, it is important to use a psychometrically sound instrument. SSCN is a short self-administered questionnaire which

consists of 17 items and a 5 point option answering system, developed after a thorough analysis of the views of both patients and providers of the services, with a sample from the Hong Kong Chinese community. The three common domains identified from both, the patients and the providers, were the technical competence, the coordination of care and the interpersonal relationships. Even though this questionnaire is not made specifically for home care patients' satisfaction, it could possibly be used for home care being part of community care, however adjusting alterations would be necessary changes for better fit.

Nonetheless, qualitative research is another potential method in investigating patients' satisfaction in home care.

As Porter (2008: 36) states,

'By refining and testing tools that are negatively skewed, researchers have found themselves in the non-scientific position of expecting home –care clients to be satisfied. There is more to learn about older persons' perceptions of home care than simply reaffirm that they are satisfied. A new emphasis on qualitative approaches is needed to draw out older persons' perspectives about their care and to bring those perspectives to providers.'

CHAPTER 3 : RESEARCH METHODOLOGY AND PROJECT ACTIVITY

Introduction

This chapter focuses on the methodology behind the exploratory research, the collection and analysis of data utilized during the research and the project activity.

It is important here to mention what constitutes a paradigm:

'A paradigm is a comprehensive belief system, world view, or framework that guides research and practice in a field.' (Willis, 2007: 8).

The researcher's own view of the world will inevitably influence the methodologies selected for the collection and analysis of the data. Two significant paradigms are positivistic, which is rooted in quantitative, objective and scientific approaches and phenomenological, which is qualitative, subjective and humanistic in nature (Hussey and Hussey, 1997). The positivistic, the phenomenological and the ethnographic approach are utilized in this research project.

Philosophical Approaches

Positivism

'A fundamental assumption of positivism is that the use of the scientific method is the primary or only way of discovering truths about the world and it assumes that we can discover universals about human behaviour if we do a good job of scientifically and objectively studying them in well –controlled contexts' (Willis, 2007: 32-33).

Positivism argues that there is an objective, existing reality, a truth, which can be fully known by observation and verification by the means of the experimental method. It states that the scientific method –with the cause and effect explanation –can be used in both the natural and the social sciences. Positivism denotes that science pursues technically useful knowledge. It assumes that objectivity and neutrality can be achieved in the research process as, according to positivism believes science is a neutral activity in which the pursuit of scientific truth is arrived free of social and ethical values.

Positivists believe that the scientific method used for natural science is superior to all other methods and hence appropriate for the social sciences. The statement that ‘there is physics and there is stamp-collecting’ by the physicist Rutherford is a classic representation of scientism.

Positivists argue that the objects and the events exist independently of people’s perceptions, thus there can be only one version of truth and that knowledge is politically and socially neutral and it is gained by a rigid plan for gathering information while using statistical precision, seeking for the uniform, and precise rules, which they claim, organize the social behaviour (Rubin and Rubin, 2005).

As a scientist herself, the researcher could not avoid to include a scientific method in the investigation of this study utilizing the rigid plan of a survey questionnaire and the statistical analysis precision, to gain an objective inside and a technically useful information of the theme under investigation, to assess the existing reality of the home care patients’ satisfaction so as to construct a valid foundation and a solid backbone on which data emanated by other more humanistic approaches, could be added afterwards. At the same time the data from the positivistic approach were used to provide a compass for the following humanistic approaches.

Phenomenology

Edmund Husserl (1962) argues that the researcher should study the meanings of objects, not from an objective approach as used in natural sciences, that is reflective of the ‘*life world*’, but from an approach within the experiences of the ‘*life world*’.

There is a subjective truth and the aim of the researcher is to discover the meaning and the being of humanity. Knowledge begins with consciousness and the world of objects is normally conceived in what Edmund Husserl (1962) called the ‘natural standpoint’. Objects materially exist and exhibit properties that we see as emanating from them.

Schwandt (2001 in Groat and Wang 2002: 186) explains that the quality of phenomenology is demonstrated in its ‘goal of understanding the complex world of lived experience from the point of view of those who live it’. This approach celebrates the permanence and importance of the individual’s subjective experience of the real world (Groat and Wang, 2002).

As Van Maren (1996) states

'...phenomenology aims to explore the different ways in which people experience and understand their world and their relations with others and their environment'.

It focuses on individual's interpretation of their experiences and the ways in which they express them. 'Only those who experience phenomena are capable of communicating them to the outside world' (Kader Parahoo, 2006).

The anthropologist Clifford Geertz (1973 in 2001 in Groat and Wang 2002: 186) argues that the phenomenologist researcher provides a 'thick description' of the context under study. A 'thick description' is

'...one that describes not only the wink, but also what that wink can mean within the semantic systems of the culture in which it happens (the wink can mean something romantic, some kind of signal for action, or simply a muscle tic)' (Groat and Wang, 2002: 186)

The phenomenological paradigm argues that

'It is impossible to treat people as being separate from their social contexts and they cannot be understood without examining the perceptions they have of their own activities' (Hussey and Hussey, 1997: 53)

Phenomenologists assume that there is an essential invariant structure, an essence, that makes a subjective phenomenon what it is, and without which it would not be, what it is; it is believed that critical truths about reality are grounded in people's lived experiences which give meaning to each person's perception of a particular phenomenon (Polit and Beck, 2008).

As Parahoo (2006: 205) argues,

'The researcher is interested in how respondents give meaning to their experience and in particular, in how they perceive their world.'

People have physical ties to their environment and through their bodies' interaction with the world, they have consciousness of their existence by seeing, hearing, feeling, thinking, believing, remembering, evaluating, and acting (Polit and Beck, 2008).

The phenomenological approach views the person as integral with the environment, thus they want to capture the ‘lived experience’ of the participants; the different ways each one of them experiences the same phenomenon. In the case of health professions, it seeks the differences between how each patient experience their circumstances and individual needs (Burns and Grove, 2009).

As Parahoo, (2006: 207) argues,

‘The primary tool of data collection in a phenomenological study is the interview, during which the researcher seeks to gain insight into how respondents make sense of their experiences. The emphasis is on facilitating respondents to talk freely about the topic; questions are asked in an attempt to seek clarification, illustration or further exploration.’

The phenomenological approach was used at the in-depth interviews of this study in order to gather data on the experiences as these were lived by the interviewees, providing knowledge on the theme under investigation, from the interviewees’ ‘natural standpoint’ (Edmund Husserl, 1962). This methodology was adopted by the researcher to enhance the understanding of the home care patients’ world from ‘the point of view of those who live it’ (Schwandt 2001 in Groat and Wang 2002: 186) as *‘the ones who lived it’ are considered the most capable of communicating these phenomena to the outside world* (Parahoo, 2006).

As Parahoo, (2006: 205) argues

‘Phenomenology, as a research method, is especially suited to the study of people’s experience of illness and the care they receive’.

This approach also aimed to reveal the different ways that home care patients experience and understand the nursing home care services, their relation with their nurses and their relation with the home care program environment. This is very important if a client-centred approach is desirable because

‘The client-centered approach requires nurses to take the perception of each client into account.’ (Parahoo, 2006: 205).

Ethnography

Finally the approach of ethnography was implemented during the researcher's observations, with the purpose of capturing the interactions during the home care visits.

Ethnography is

'The study of people in naturally occurring settings or 'fields' by methods of data collection which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting, if not also the activities in order to collect data in a systematic manner but without meaning being imposed on them externally' (Brewer, 2000: 6)

Ethnography aims to recognise human behaviour within the cultural and social context in which it takes place in order 'to understand another way of life from the native point of view.' (Spradley, 1980: 3).

In ethnography, the researcher stays for an extended period of time with the individuals being studied and participates in their lives, shares experiences and at the same time collects data mainly through observations; by watching and listening and by asking questions through interviews.

As Willis (2007) argues ethnography puts the researcher in the natural, 'real- world' environment that he or she wants to study and which requires the researcher to get involved in the collection and the interpretation of the data.

Care should be taken by the researcher, not to immerse in the specific culture under observation, to ensure an objective view of the situation.

Ethnography includes the qualitative methods used to gather information about a culture; this could be the culture of a country, or the culture of a race, or the micro-culture of a corporation (Willis, 2007).

'Institutional ethnography seeks to understand the social determinants of people's everyday lived experiences, especially the institutional work processes that form the ground of people's lived experiences' (Polit and Beck, 2008: 226).

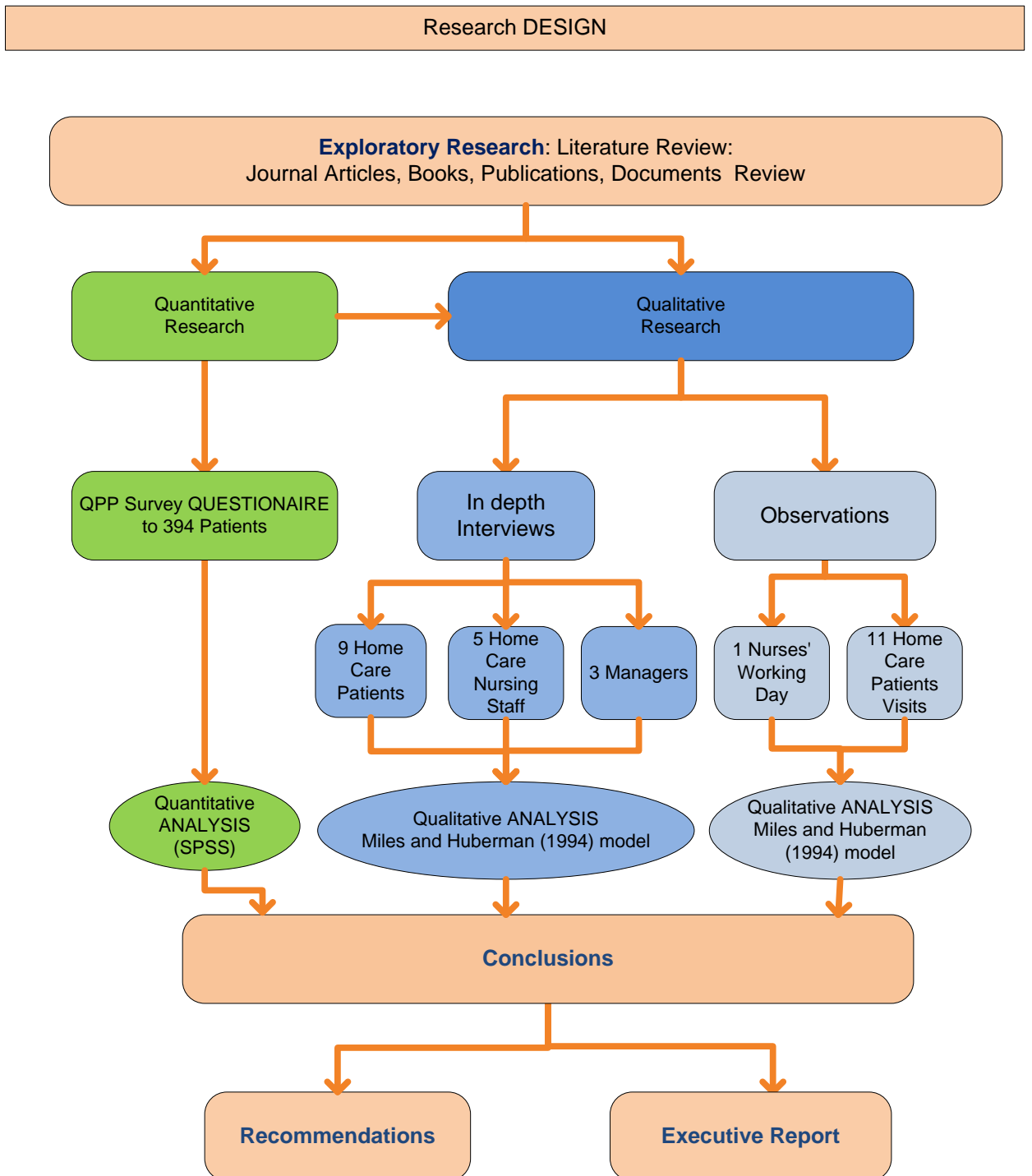
Ethnography was adopted by the researcher in this study, in order to investigate the interactions between the home care patients and their nurses in the naturally occurring settings of home care visits; so as to capture the human behaviour within the ‘real-world environment’; the cultural and social context in which it takes place in order to enhance the understanding of the patients’ lived experiences from their point of view.

‘Ethnography is concerned with understanding human behaviour in the cultural and social context in which it takes place’ (Parahoo, 2006: 204).

Research Design

This was a descriptive study using the QPP instrument, in depth interviews and observations, for measuring the patients’ satisfaction.

Figure 3-1: Research Design



Research Questions

This study aimed to answer the following research questions:

1. What is the patient's level of satisfaction from the nursing staff of the Government Home Care program in Cyprus?
2. Are there any differences in patients' level of satisfaction based on age, gender, living status, educational level and the patients' psychological and physical state?
3. What is the importance of each parameter of satisfaction for the patients?
4. Are there any differences in the importance of each parameter of satisfaction for the patients based on age, gender, educational level, living status and the patients' psychological and physical state?
5. Are there any problematic areas in the services provided by the nursing staff of the programme that needs improvement?
6. What is the patients' perception of an ideal home care nurse and what is the nurses' and the management perception of an ideal nurse?
7. What are the interactions between the nurse and the patient during a homecare visit?
8. Which is the natural environment of the home care visits?
9. What are the nursing staff's and the management's difficulties in order to increase the satisfaction of their patients?

Data Collection Methods

Quantitative Research Methodology

'Quantitative research is based on numerical data, or quantities, and is concerned with the detection of general laws (nomothetic) and the examination of aggregated views' (Watson et al., 2008: 16).

As Bell, (2005: 7) argues,

'Quantitative researchers collect facts and study the relationship of one set of facts to another. They use techniques that are likely to produce quantified and, if possible, generalizable conclusions'.

Survey Questionnaire

A survey is designed to obtain information from populations regarding the prevalence, distribution and interrelationship of variables within those populations (Polit and Hungler,

1995). The survey enables the fast collection of data from a large number of people at a relatively low cost. As Gerrish and Lacey (2006: 265) argue, surveys are considered

'...valuable source of data about respondents' attitudes, beliefs, experience and behaviour.'

Survey questionnaires are structured and provide a straightforward way of obtaining information. Information is collected about the same variables or characteristics from two or more cases. The cases are directly comparable (Vaus, 2002) and could cover subject matters such as

'...demographic characteristics, the social environment, the activities, or the opinions and attitudes of some group of people' (Moser and Kalton, 1971:1 in Bell 2005: 13).

The researcher decided to use a proven and validated instrument, the short version of the QPP questionnaire, which was specifically designed for home care research. The QPP has the advantages of being short and easily understood by the patients (Larsson W.B. & Larsson G., 2002) considering that the majority of the home care patients are elderly people. The questionnaire enabled a descriptive analysis of the collected data.

The QPP questionnaire (Appendix A), was developed by Wilde et al (1993, 1994) and Larson and Larson (1998) and it has been tested for validity and reliability by the authors. The QPP questionnaire was designed as a diagnostic instrument to assess the level of patients' satisfaction from the patients' perspective. It is a patient-centred questionnaire that measures the patients' perceptions of the quality of care in four dimensions: the medical-technical competence, the identity-oriented approach, the socio-cultural atmosphere and the physical-technical conditions (Wilde et al, 1995). The QPP was used after the consultation and written consent of the originators (Appendix H).

A Greek translation and a back translation had been requested by the researcher, from the originators, in order to preserve the reliability and validity of the survey instrument. The originators provided a translation in Greek (Appendix B) and a back translation in English (Appendix C). There was no problem identified at the back translation of the questionnaire.

The survey questionnaire translated in Greek was pilot tested with five elderly home care patients of different ages, gender and educational levels, in order to ensure that the population being investigated would be able to comprehend the style, the approach and the

wording of the questions being asked and that the correct meanings of the questions were clearly understood. A few minor changes of the wording were suggested by the researcher after the pilot testing, to make the statements more comprehensive and to minimize the possibility of misconception. These minor changes were approved by the originators of the questionnaire.

Population and Sample

The study population consisted of patients of the public home care program in Cyprus who were receiving home care services at the time of the survey and had been enrolled in the program for at least two months prior to the survey, the interviews and the observations.

Patients of the following groups were excluded from the sample population and did not take part in the survey, the interviews or the observations:

1. Patients who were enrolled in the program for less than two months prior to the research taking place.
2. Patients who enrolled for the short term care program (Short term care is a care of maximum two months).
3. Patients who left the program before the research prior to the research taking place
4. Patients with mental disabilities
5. Patients who were on a respiratory machine

The intention of the research framework was to include in the survey, interviews and observations, the patients with sufficient experience and exposure to the home care program. Additionally, the intention was to include in the survey, interviews and observations, patients with sound judgment and patients who were able to communicate.

In this study it was also assumed, that the patients surveyed, interviewed or observed were representative of the defined population. An additional assumption of this study was that these patients were able to express their perceptions freely.

The study population for the nursing staff and the management staff, who participated in the in-depth interviews, consisted of staff, which has been in the government home care program for at least one year prior to the interviews taking place. The one year experience limitation was imposed with the intention of including in the research, nursing and

management staff that had sufficient experience and exposure to the program. The nursing staff responsible for the care of patients on a respiratory machine was also excluded.

The total number of the patients who received long term care in the home care program excluded the ones on respiratory machines in 2011, were 562. The total number of patients who fulfilled the above criteria to take part in the survey was 394.

The survey took place during the period of February 2011 to May 2011. Three hundred and eighty four self-report questionnaires were distributed to the patients of the public home care program who fulfilled the criteria to participate in this study. The survey questionnaire was administered to the patients and collected back, by the home care nurses of the program. The home care nurses were thoroughly informed for the purpose, the context and the process of this research project.

The direct delivery of the questionnaire by the researcher was not feasible because the restricting regulations of the Ministry of Health with regards to protection of the patients' personal data.

The patients were thoroughly informed, orally and in writing, by the nurses for the purpose, the context and the structure of the questionnaire. Then the patients were given the questionnaire with the consent form which they had to sign should they were willing to participate.

The questionnaires were collected in following nurse visits, in a closed and sealed envelope with the time frame of one month. Reminders were sent to the nurses accordingly.

The QPP questionnaire consisted of 18 statements measuring the level of satisfaction of the patients from the nursing staff and at the same time measuring the importance of each element. It also consisted of 2 open ended questions which enabled the patients to state any parts of the care that they were particularly satisfied with and state any suggestions for improvements in their own words. The questionnaire also included 6 questions referring to the following personal characteristics of the patient: age, gender, nationality, whether they co-habit or live alone, educational level and occupation. Furthermore the questionnaire included 3 questions referring to the patient's current physical and psychological state and the context of medical care that they receive through the visits. Additionally there was one

question about the patients' intention to follow the nurse's instructions regarding their treatment.

The QPP questionnaire included statements such as:

'I received the best possible medical care/help from the district nurse (as far as I can tell)'

The patients had to fill in two sets of answers: Set (A) was a set of responses assessing the 'perceived reality'; the perception of the patients for the care they received, with a four point response scale (Likert scale): 'Fully agree', 'Mostly agree', 'Partly agree' and 'Do not agree at all' rating from 4 to 1 respectively. Set (B) was a set of responses assessing the 'subjective importance'; the importance of each aspect of care, with a four point response scale (Likert scale): 'Of the very highest importance', 'Of high importance', 'Of some importance' and 'Of little or no importance', rating from 4 to 1 respectively.. There was also the option of answering 'Not applicable' in case a statement was not applicable to the specific patient's care. For example consider the following statement:

'I received useful help from the district nurse with obtaining the appliances that I needed, e.g. wheeled walking frame, wheel chair, pads and clutching tongs.'

This statement is not applicable for a group of patients who do not need any appliances for their treatment.

The 18 statements of the QPP questionnaire assess the level of satisfaction and the importance of each factor of satisfaction for the patients. The QPP authors' divide the factors of patients' satisfaction (Figure 2.1) in the four following groups:

1. Humanity- Person related qualities of the care givers

This group includes statements such as:

'The visiting nurse showed empathy 'she looked after me'

2. Humanity- Physical and administrative environmental qualities and socio-cultural atmosphere of the care organization.

This group includes statements such as:

'My care was determined by my own desires rather than by the nurse's procedures'

3. Rationality- Person related qualities and medical technical competence of the caregivers:

This group includes statements such as:

'The help I received was very effective and provided relief from pain'

4. Rationality-Physical and administrative environmental qualities and physical technical conditions of the care organization (Technical/Practical Support)

This group includes statements such as:

'I had access to equipment and devices which were necessary for my medical care (as far as I know)'

Qualitative Research Methodology

As Bell, (2005:7) argues,

'Researchers adopting a qualitative perspective are more concerned to understand individuals' perceptions of the world. They seek insights rather than statistical perceptions of the world'.

Qualitative researchers try to find

'...answers to questions that stress how social experience is created and given meaning.' (Denzin and Lincoln, 1994: 4).

As Denzin and Lincoln (2008: 14) state

'Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry.'

During the qualitative data collection process, qualitative researchers should gain and maintain high levels of trust with participants trying to 'be like' the people being studied; by being sensitive in issues like dressing, way of talking and customs and by not taking sides on any controversial issue or appear close to the power (the leaders/management) but at the same time not getting too emotionally involved and too close to the participants a pitfall called 'going native' as this may lead to less objectivity and overwhelming with participants suffering; at the same time listen carefully and be supportive , be aware of

themselves; the part they play in their own study and reflect on their own behaviour and how this behaviour affects the data and finally do the collection of the data in a pace that minimizes the emotional impact that emerges as qualitative data collection causes emotional strains and can be exhausting requiring high levels of concentration and energy (Polit and Beck, 2008).

In Depth Interviews

'If what you need to find out cannot be answered simply or briefly, if you anticipate that you may need to ask people to explain their answers or give examples or describe their experiences, then you rely on in –depth interviews' (Rubin and Rubin, 2005: 2-3).

In this project, the purpose of the patients' in depth interviews was to gather in-depth data on the patients' experiences from the nursing care of the program, as the patients experienced it. The thematic areas investigated were: the satisfaction of the patients from their nursing care, the importance of the elements of this satisfaction from the patients' point of view, the problematic areas in the care and why and how they occur, the patients' perceptions of the ideal home nursing care and suggestions for improvement.

The purpose of the in-depth interviews with the nursing staff and the management was to gather in- depth information of the home care program as they experienced it. The topics of investigation were the nurses' experiences of the home care program, their perceptions of what an ideal home care nurse should be, the problematic areas of the program, their suggestions for improvement and the challenges they face in implementing these improvements.

The researcher incorporated a triangulation of three different sources of information by conducting in- depth interviews with three different types of respondents; the home care patients, the home care nurses and the home care management, in order to capture a more holistic view and a wider understanding of the theme under investigation.

As Rubin and Rubin (2005: 4) argue,

'Though ordinary life roots you in one position, when you are interviewing, you see life in the round, from all angles, including multiple sides of a dispute and different versions of the same incident. Observing life from separate yet overlapping angles makes the researcher more hesitant to leap to conclusions and encourages more nuanced analysis. Qualitative interviewers explore new areas and discover and unravel intriguing puzzles.' (Rubin and Rubin, 2005: 4).

The formulation of the in depth interviews was based on the findings of the literature review and the findings of the survey questionnaire. The themes identified in the literature and the issues and the trends identified from the survey questionnaire, were then explored in the in-depth interviews to (a) the patients (b) the nursing staff and (c) the management. The researcher prepared a series of semi structured main questions, with following or probing questions for each group of interviewees (Appendices K, M, N). This process was used to gain a more deep and detailed understanding of the themes being investigated. The researcher remained flexible in adding any new questions that may have emerged during the interviewing process. The interviews were semi-structured in order to allow open but focused expression of the patients' thoughts. The interviews were audiotaped and then transcribed precisely. Other than the tape recording, the researcher also noted in the field notes the non-verbal responses of the interviewees, in other words, the manner in which the interviewees responded to the questions, such as: facial expressions, posture and eye contact. These non-verbal responses were also taken into account during the analysis of the interviews. Additionally, the researcher noted in the field notes a rough description of each interviewee (Appendix R).

The advantage of the semi-structured interview in relation to the structured interview is that it allows a researcher to be flexible, to expand and explore areas and issues that the researcher had not previously considered and which arose during the interview and were deemed to be important for the patients.

On the other hand, the advantage of a semi-structured interview over an unstructured interview is that it provides the researcher with the opportunity to have a list of questions on which the interview will be based, so as to avoid slipping into irrelevant subjects. This was particularly valuable in this study, due to the obvious time constraints of a visit in a patient's home. Furthermore, the fact that the researcher of this study was interviewing

elderly people, who can be easily lured off topic or cannot concentrate for a long period of time, was the reason behind the selection of the semi-structured interviews.

'Qualitative interviews are conversations in which a researcher gently guides a conversational partner in an extended discussion. The researcher elicits depth and detail about the research topic by following up on answers given by the interviewee during the discussion. Unlike survey research, in which exactly the same questions are asked to each individual, in qualitative interviews each conversation is unique, as researchers match their questions to what each interviewee knows and is willing to share.' (Rubin and Rubin, 2005: 4).

The in depth Interviews Framework

At the patients' interviews, a purposive sample was used in an effort to include: both genders, varying ages, different districts, patients with differing illnesses and the length of time enrolled in the program. All participants fulfilled the criteria to take part in this study (page 58, population and sample). Of the nine home care patients, 5 were female and 4 were male. The sample was ensured to consist of interviewees of all the provinces which have a home care program and interviewees from different districts of each province to cover. As the researcher delved further into the interviews, new themes began to emerge. As such the initial sample size increased from 6 to 9 interviewees mentioned above.

The patients were interviewed in order to gain insights regarding their satisfaction of the home nursing care they received, the identification of the most important elements of satisfaction from the patient's perspective, the problematic areas they identified in the care and suggestions for improvements and their expectations of an ideal home care nurse from their personal point of view. The researcher prepared, a series of 32 main questions with some set follow-up or probing questions to assist in the clarification and elaboration of the subjects raised (Appendix K). Some of the follow-up or probing questions were added as the interviews took place; when new themes emerged through the patients' discussions, and were considered useful to the researcher. The questions were simple and open-ended in order to allow the patients to describe their experiences and their opinions freely, such as:

- *How do you feel about your nurse?* and
- *How would you describe your ideal nurse?*

Some questions were followed by probing or following up questions such as:

- *Does the nurse take into account your wishes regarding your care? If not, does this bother you? Why in your opinion, do you believe that this happens?* and
- *If something comes up, is it easy to contact your nurse? If not, does this bother you? Why in your opinion do you believe that this happens?*

As Singh and Kaur, (2012: 19) state

'From the preceding discussion, the key point that emerges is the importance of bringing out the unexpressed desires of the patients while determining their satisfaction with the services of healthcare facility'

In addition to the 32 interview questions, the researcher used four pictures showing a nurse and a patient in a home-care visit, to gain further insight into the patients' justifications for the selection of an ideal nurse, allowing the patients to reveal their unexpressed perceptions. The pictures were chosen by the researcher carefully so that the nurses' physical and body language characteristics differed in each picture, thus covering a wider range of nurses' characteristics such as: age, gender, body language and professional formality. These differences offered the patients the opportunity to identify the characteristics they considered the most important to them. The pictures selected were not standardized or used in any other clinical research, rather the aim of using them was solely to provoke the patients' rational behind their choice; concern was not for the actual picture chosen. The rational of the choice would reveal what is important to each patient from a personal point of view, regarding the home care nurse.

After patients were asked to select the picture they viewed as 'the ideal nurse', patients were then asked to state their 2nd, 3rd and 4th choices and justify their reasoning. The patients were also asked to ignore the characteristics of the patients in the pictures and focus their attention on the nurses presented in the pictures.

Three pictures with female nurses and one picture with a male nurse were selected based on the fact that nursing is a profession mostly occupied by women. A man was included in the pictures in order to examine if gender plays a role in the preferences of patients. Furthermore the nurses were of different ages: one nurse was of an older age; one of middle age, the third female nurse and the male nurse were young. The target was to examine whether age plays a role in the preferences of patients.

Moreover, there were differences in the body language of the nurses in the pictures; two of the nurses looked more serious while the two others were smiling. Additionally, there were differences in the outside appearance of the nurses; one nurse was wearing a uniform while the others did not, two of the nurses were holding a stethoscope and the other two did not. The nurses' appearance resembled the complexion of the Cypriot people and no other races, as the public Cyprus home care program employs only Cypriot nurses and as such race was not an area requiring investigation.

The researcher chose to display only four pictures, as most patients of Home Care were of an elderly age with reduced memory and concentration. An assumption was made that four pictures was a reasonable number to cover a good amount of different characteristics and at the same time not too many to confuse the patient or get them tired, ultimately affecting the results.

At the nursing staff interviews, a purposive sample was taken in an effort to include: nurses from different districts and gender. All participants fulfilled the criteria to take part in this study (page 58, population and sample). Of the 5 nurses, one was male and four were female. The sample consisted of nurses from different provinces and of different districts within each province, to cover the program's geographical scope. It also included the only male nurse within the program. The purpose of these interviews was to identify the problematic areas relating to the home-care program, to determine the nurses' perceptions of an ideal home care nurse, to understand the difficulties nurses face in achieving higher levels of patient satisfaction and their suggestions for improvements. The interviews took place in the nurse's office and their duration was approximately one and a half hours. The nurses were informed about the purpose and content of the study and they were guaranteed that neither they nor their place of work could be identified. The interviews were audio taped and then transcribed verbatim. Prior to the commencement of the recording, time was set aside for a short friendly chat to allow both parties to get to know each other and for the respondents to feel more comfortable.

Two management interviews took place. The first interview was with one of the Senior Public Servants who primarily designed and set up the Home Care Program and who was responsible for its operations within its first years of operation. The other interview was with one of the senior nurses responsible for the home care nursing personnel. The aim of these interviews was to identify problematic areas of the program, the views of

management regarding the patient satisfaction from the nursing staff and the difficulties management faces within the program. Additionally these interviews allowed management to make suggestions for improvements.

'The role of the interviewer then is governed by conventions rather than by standards, rules or laws; it is a role that is relatively lightly held even by professionals, and may be abandoned in favour of certain alternative roles if the occasion arises' (Bulmer, 1984: 218).

The researcher tried to set up an environment where the interviewee could talk openly and where their confidentiality could be ensured. The researcher used a number of strategies to ensure the interviewees fully comprehended the questions being asked. For example if the interviewee appeared puzzled, the researcher would repeat, or reword the question. The researcher made certain that she did not in any way lead the interviewee to a specific answer and remained neutral during the entire process. Additionally the researcher was flexible and adaptive to the possible change of the sequence or the context of the questions, when it was considered useful.

When answering questions, the interviewees were at times asked to provide examples of the specific situation they described. This was to confirm that their answer was based on lived experiences.

As Rubin and Rubin (2005), argue that unlike a survey questionnaire, an in depth interview is created new each time it occurs and therefore it can be unpredictable; the interviewee may take charge of the interview, change the topic, lead the tempo, indicate to the interviewer that the wrong questions are being asked, or act in an inappropriate manner.

A qualitative researcher should understand that the interview direction is shaped by both the interviewer and the interviewee and have the skills to adapt quickly to all unforeseen situations while at the same time, establish a connection with the interviewee, capture the meaning of what people say or don't say, ask the right questions and customize each interview to accommodate each interviewee, taking into consideration what the person knows, interests and personal and social characteristics (Rubin and Rubin, 2005).

The researcher should always have in mind that

'An interview is a window on a time and a social world that is experienced one person at a time, one incident at a time.' (Rubin and Rubin, 2005: 2-3).

New questions emerged during the process of the first interviews; questions on new topics were added to the following interviews.

Observations

'...sometimes observing the subject may give a more accurate picture of the behaviour in question than asking the subject' (LoBiondo-Wood and Haber, 2006: 322).

The purpose of the observations as Willis (2007) says, is to allow the researcher to gather detailed data in a real-world setting and provide a holistic picture of the human behaviour, which is better understood as a lived experience in a social context.

In this study, the researcher spent time in the real environment of the home care patient and observed the interactions that took place during a home care visit. She also observed the physical and human environment at the visits.

There are different ways of collecting data during an observation. The researcher had planned for the information to be gathered with the following aspects to be considered relevant: the participants –who they are, their role and their characteristics, their activities, the interactions, the communication and the emotions between them. In the observations of the interactions between the relevant parties, the researcher took special notice of the wording or pauses or the absence of wording, the pitch, the tone, the body posture, gestures, faces or the absence of faces, eye contact or the avoidance of eye contact, movements or the absence of movements and other non-verbal communication types.

'During any human interaction, unlike verbal, non-verbal communication is always present and although it is not something others intentionally want to reveal, it has a great value in determining how people feel about each other' (Adler, 2006: 5-6).

The nonverbal communication is the externalization of the sentimental state of a person at a particular moment and every gesture, movement, face, posture, distance, gaze or touching are a key to discover what this person feels and reveals his or her interpersonal emotional state (Pease and Pease, 2004)

During the home-care visit, the researcher also observed the interconnections associated with the actions of the participants: an action or face or gesture with a reactive behaviour e.g. a face after a wound rapping or after an insulting comment. Additionally, the researcher logged down some positive or negative phrases that the patients or the nurses used which revealed their psychological or their physical state, their feelings or understanding of a situation. Furthermore, the researcher observed whether the verbal and non -verbal messages of the participants were agreeable or contradictory. Repetitions of words or phrases, movements or behaviours were also marked. Moreover the researcher observed the absence of any activities, interactions, communication or feelings. The researcher recorded all the data gathered from the observations, in field notes.

Finally, the researcher observed the physical setting where the human behaviours and interactions took place and recorded this information in field notes and in a sketch of the physical setting (Appendix O). The sketch comprised of the room where the visit occurred including the items and the people within it: the size and the scheme of the room, the windows, doors, the furniture, any pictures/photographs, other remarkable items, as well as the persons' presence in the room- giving attention to their position, their posture, the distances between them and the dominant expression on their faces.

The observation was pilot tested in three home care visits, in order to ensure that the observation techniques would be successful, include any other details which were previously not considered and solve any problems which may have appeared during the visits.

At an observation

'The researcher keeps field notes that summarize what has happened during the observation periods. These are generally rich, or thick, descriptions of what is going on. There is quite a difference between thick and thin data from observations. A positivist researcher might observe in a community center for seniors and use an observation system that requires him or her to look around the room every 30 seconds and count the number of seniors who are engaged in socialization. The result of many hours of observation might then be summarized as a percentage. By contrast, an ethnographer observing at the same center might generate 10, 20 or more pages of notes each day.' (Willis, 2007: 236).

In this study, the researcher took notes during the observations having a set of fixed codes to refer to, in an ethnographic paradigm rather than a positivist paradigm. Nevertheless, any data which did not fit in one of the codes, but was considered important, was also included in the notes. Just after each observation, the researcher used the notes to write a more structured narrative.

The researcher did not video record, tape record or take any photographs during the observation, as she assumed that it would affect the behaviour of the patient, the nurse and the other participants.

In order to maintain objectivity, the researcher must observe the human activities that take place, as well as the physical setting in which these activities occur, without interfering with the people and the activities or with a balanced participation (Denzin and Lincoln, 2005).

Throughout the observation the researcher's participation was balanced and she tried to be as neutral as possible.

The researcher conducted an observation of a working day of a home care nurse.

The observation of a home care nurse's day was not in the initial plan of the research. The need for this observation emerged as the research progressed. It seemed useful to observe more carefully the physical and technical environment of the work, as well as the human environment of the home care nurse. Moreover, the culture of the organization would be observed more closely through this observation. Additionally, the ability of the nurse to adapt in different physical and human environments, as well as her physical and emotional changes throughout a working day would be more specifically observed.

The researcher observed the physical and the technical conditions of the work environment, the interaction of the nurse with colleagues, the interaction of the nurse with patients, the ability of the nurse to adapt to different physical and human (socioeconomic and educational) environments and the physical and emotional changes of the nurse throughout a working day.

The Observations Framework

Eleven observations were conducted, each to a different patient. All participants fulfilled the criteria to take part in this study (page 58, population and sample). Five different nurses, three from Nicosia, one from Limassol and one from Paphos, delivered these visits. The sample of the participants was purposive in an effort to cover: gender, districts and the care of patients from different nurses. At the observations, six male and five female home care patients took part. Six observations were conducted in various districts of Nicosia, as this is the area with the greatest number of patients covered by the program. The Nicosia districts: Engomi, Ayios Dometios, and Central Nicosia, were chosen to ensure coverage of different socioeconomic status. Three observations were conducted in Paphos and two in Limassol.

The nurses' and the patients' consent was taken before the observations. No patient or nurse, who was asked to participate, declined to take part in the researcher's observations.

A questionnaire was not delivered to the nursing staff as it was considered unnecessary because the in-depth interviews would cover the data that needed to be collected.

Focus groups were not conducted as the nursing staff declined to participate in any other time other than their working hours and the management did not allow them to participate during working hours.

Triangulation

Triangulation of research philosophical approaches

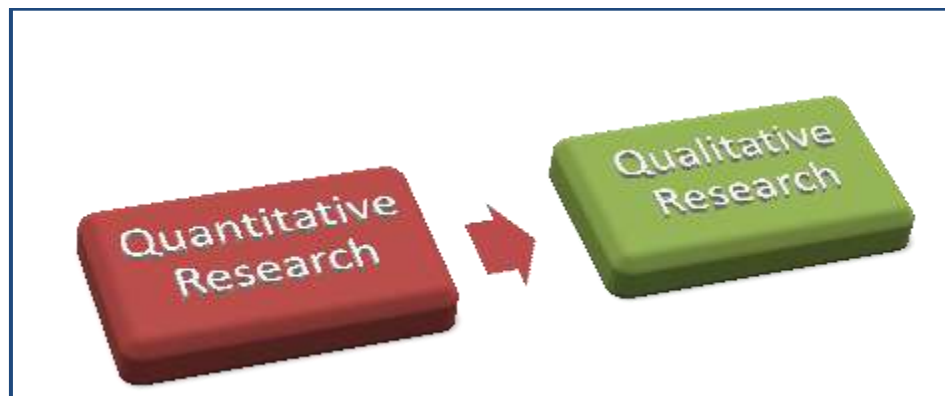
Triangulation of research philosophical approaches was used to enhance the reliability and validity of the research project. In this research, the positivistic approach was adopted through the survey questionnaire in order to assess the existing reality of the home care patients' satisfaction. The phenomenological approach was adopted in the in-depth interviews which aimed to gather data on the experiences as lived by the interviewees. Finally the ethnographic approach was implemented during the researcher's observations, with the purpose of capturing the interactions between patients and nurses in the natural environment of the home care visits.

Triangulation of Research Methods

As Polit and Beck (2008: 309) argue,

'The dichotomy between quantitative and qualitative data represents a key methodological distinction in the social, behavioural, and health sciences. Some argue that the paradigms that underpin qualitative and quantitative research are fundamentally incompatible. Others, however, believe that many areas of inquiry can be enriched and the evidence base enhanced through the judicious triangulation of qualitative and quantitative data'

Figure 3-2: Triangulation of Research Methods



In this study, primarily quantitative data was gathered and used to provide guidance for the formulation of the qualitative research collecting methods. Thereafter, the qualitative data provided insights on the quantitative research findings; in depth explications of the meaning of the quantitative data descriptions and the relationships between them leading to a better interpretation of the results. In this project, there is an integration between the two approaches, neither approach is dominant; both are equal, but the approaches are sequenced, with the qualitative data collection occurring after the quantitative data collection, so that the qualitative research would enrich and give more in-depth knowledge and understanding of the quantitative research findings.

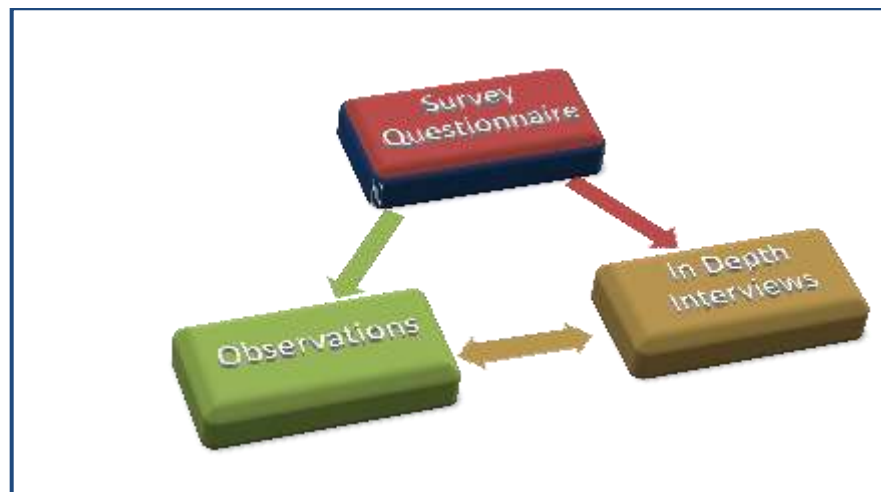
Quantitative data collection **----->** **Qualitative data collection**

Triangulation of Data Collection Methods

Moreover, in this study there was a triangulation of data collection methods: Survey questionnaire, in depth interviews and observations.

Firstly, the survey questionnaire enabled a collection of data from a large number of patients. Its purpose was to provide information regarding the prevalence, the distribution and the interrelationship of the variables investigated in this study. Then followed the in-depth semi structured interviews, which were formulated based on the survey questionnaire findings and aimed to gather in depth data on the patients', the nurses' and the management's experiences from the home care programme. In this study there was an additional triangulation of three different sources of information (Figure 3.3) by contacting in- depth interviews with three different types of respondents; the home care patients, the home care nurses and the home care management.

Figure 3-3: Triangulation of Data Collection Methods

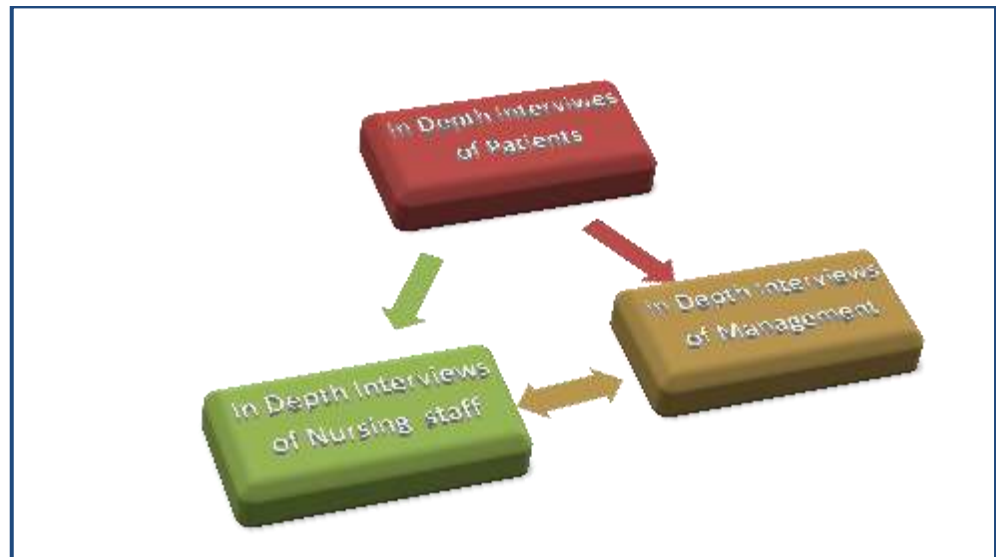


Triangulation of Sources of Information

Another data collection method, the observations, were conducted during the same period of the in-depth interviews, thus each incident fuelled and amended the next one; for example, an issue that may have surfaced in an interview was taken into consideration at the next observation and visa-versa. The observations aimed to gain detailed data on the interactions and the physical environment of home care visits; a holistic view of the human behaviour in its own real world setting.

The triangulation of the research methods and the triangulation of the data collection techniques enhanced the reliability and validity of this study.

Figure 3-4: Triangulation of Sources of Information



Data Analysis

Quantitative Analysis

Quantitative analysis can only be carried out with numbers, but numbers in some cases have no intrinsic worth: they have to be given meaning by those using them. (Parahoo, 2006: 376).

The survey analysis aims to describe or to compare the cases in some characteristics; this will enable the researcher to determine the characteristics of a set of cases or the causes of phenomena. The researcher seeks for an understanding of what may cause a phenomenon through the comparison of various characteristics. Correlation analysis can lead to causal inferences e.g. 'the age of the patients affects the level of satisfaction'. In its correlational capacity, the survey questionnaire enables the researcher to explore links between variables, establish links and develop hypotheses.

Survey Questionnaire

Out of the 394 questionnaires that were given, 112 were answered and out of these, 5 were deemed unsuitable. The total number of questionnaires used for analysis was 107 (N =107).

The survey data collected was coded and the statistical analysis was performed by using the SPSS (Statistical Package for Social Science Computer program). The data analysis included both descriptive and correlation analysis.

The quantitative analysis procedure had the following four stages:

- Coding of data; meaning organising into categories and numbering each category of data
- Data entry into specialised software (spreadsheet or statistical package (SPSS))
- Analysing data as a whole: Descriptive analysis: describing the main characteristics of the data.
- Analysing data through cross-tabulation: Correlation analysis: examining the similarities and differences between variables.

Finding the quality of care index (QPP index) by using the formula: subjective importance score x (2 x perceived reality score – subjective importance score) (Wilde et al, 2002). The QPP index can range from 16 as the highest score for quality of care and -8 as the lowest score for quality of care.

The frequency distribution enabled a descriptive analysis of the survey. The Pearson chi-squared tests allowed cross-tabulations and inferential statistical analysis of the demographic data.

Qualitative Analysis

'Quantitative results can often be summarized in a few tables. Qualitative researchers, by contrast, must balance the need to be concise with the need to maintain the richness and evidentiary value of their data' (Polit and Beck, 2008: 507).

Qualitative data analysis is an ongoing process, with earlier analysis feeding later data collection like a reciprocal cycle. At the analysis of the research findings, the researcher tries to find patterns, interpret them, and understand their meaning and the reason why these patterns occur (Bernard and Ryan, 2010).

Through the data analysis process the researcher tried, as Burns & Grove, (2009), says, to exercise sound judgment and critical thought in categorizing and coding the narrative materials of qualitative data. The goal was to develop a content analysis; identify important

themes, recognize patterns among the themes and scopes of an issue, and integrate pieces into a meaningful whole and confirm inferences and conclusions.

The qualitative data collected via the in-depth interviews and the observations, was analysed using the following generic 3-stage qualitative data analysis process, based on Miles and Huberman (1994) model:

- Data reduction: Involves coding and processing of data. It requires a detailed reading and re-reading of transcripts and then coding the data to identify key issues.
- Data display: Involves the recognition and representation of codes which allows the scrutiny of texts and the display of data in groups, graphs or matrices to facilitate comparison.
- Conclusion drawing: this involves further interrogation of data and identification of links between the identified themes and categories resulting in possible theories and explanation of relationships.

Data Analysis of In Depth Interviews

'Analysis entails classifying, comparing, weighing, and combining material from the interviews to extract the meaning and implications, to reveal patterns, or to stitch together descriptions of events into a coherent narrative.' (Rubin and Rubin, 2005: 201).

The interviews that were conducted were all transcribed verbatim. This transcribing enabled the identification of categories that had appeared. Content analysis methods were utilized for the text analysis of the interview transcripts.

Initially, the themes that arose through the transcripts were highlighted- these included: patients' satisfaction, description of an ideal nurse, problematic areas, communication and suggestions for improvement. The importance of each theme was determined by focusing on the extent and 'colour' which surfaced from the interviews. As Bernard et al (1984: 512) argue,

'If informants agree with one another in information that they independently provide, then there must be a basis for this.'

In order to make comparisons easier, after the coding phase, data was arranged in groups. Patterns within the themes and links between the categories were identified, and an effort was made to provide an explanation for these.

Data Analysis of Observations

'Confronted with a mountain of impressions, documents, and field-notes, the qualitative researcher faces the difficult and challenging task of making sense of what has been learned.' (Denzin, 2009: 85)

In this study, at the analysis of the observations, the narrative data of the observations was analysed by the same data analysis process as in the in-depth interviews. The sketches drawn by the researcher through the observations were also analysed and added to the narrative data analysis.

As Delanty, (2005: 40) argues,

'...the scientist must interpret in order to reach the deeper levels of reality'

The researcher, based on her life experiences and world views, interpreted the situations in her own unique way.

The themes that arose through the observations' narrative, were highlighted- these included: the communication between the nurse and the patient, the psychological support given, the respect and the care. After coding, data was arranged in groups. Patterns and links were identified, and an attempt was made to provide an explanation for these.

Reliability and Validity

Triangulation of research approaches, methods or data collection techniques, is a planned combination of two or more approaches, methods or techniques respectively, in the study of the same subject under investigation.

'The rationale for this strategy is that the flaws of one method are often the strengths of another, and by combining methods, observers can achieve the best of each, while overcoming their unique deficiencies.' (Denzin, 1970: 308 in Willis, 2007).

Furthermore, as Bell (1999) argues, triangulation is needed to cross-check the findings of a research project.

This study combines three research approaches: positivism, phenomenology and ethnography. It also combines two research methods, the quantitative and the qualitative. Furthermore, it encompasses three data collection methods: survey questionnaires, in depth semi-structured interviews and observations. The different research methods and data collection techniques complemented each other and triangulation aimed to overcome the narrowness of a single method and increase the validity of the research findings. As Hubermann and Miles, (1994), state, triangulated data, data which is derived from different sources and diverse methods, ensures the validity of the findings of the research. Moreover, in this study there was triangulation of three different sources of information by contacting in- depth interviews with three different types of respondents; the home care patients, the home care nurses and the home care management.

QPP is validity and reliability tested instrument (Wilde et al, 1994). As Wilde et al (1994) explain, the wording of the QPP questionnaire was derived from patients' interviews and the QPP questionnaire was tested by its originators for its content validity, for clarity and comprehensibility of its items and principal factor analysis was performed for each dimension of the theoretical model. The empirical validity of the questionnaire was also tested. Additionally, the questionnaire's internal consistency was high and it was assessed by Cronbach Alphas coefficients (0,84) (Wilde et al, 1994).

QPP short version has major advantages; the items of the questionnaire are derived from the patients' perspective and they are formulated in words used by patients and the items still have a theoretical foundation which makes the interpretation results more meaningful (Wilde and Larsson, 2002). QPP short version also avoids global and generalist formulations such as 'What do you think about your care?' and the fact that it is short it makes the questionnaire more attractive for many patients to respond to (Wilde and Larsson, 2002) especially in the case that the respondents are elderly people, as they are in the present study.

The QPP questionnaire was translated from English to Greek by the originators of the questionnaire and then back-translated to English by the same originators, to maintain its validity. There was no problem identified in the back translation of the questionnaire. The Greek translated questionnaire was pilot tested to five patients of different ages, gender and educational level, to ascertain the comprehensibility of the instrument. After the pilot testing, a few minor changes of the wording were suggested by the researcher to make the

statements more comprehensive and to minimize the possibility of misconception and they were approved by the originators of the questionnaire.

In terms of the chosen sample for the survey questionnaire, the researcher attempted to cover the whole population of the program, in an effort to add validity and accuracy to the findings of the research. The questionnaires were sent to all the nurses of the home care program to be given to all of their patients who fulfilled the criteria to participate in the research. The home care nurses were thoroughly informed for the purpose, the context and the process of this research project. Reminders, in the form of telephone calls, were made by the researcher as and when necessary to remind the nurses, for the delivery and the collection of all the questionnaires. The patients were thoroughly informed by the nurses for the purpose, the context and the structure of the questionnaire. Furthermore, written instructions for the completion of the questionnaire were given to the participants in order to ensure that they would understand and remember how to answer correctly the questionnaire. Within a month, the questionnaires were delivered back in sealed envelopes, together with the consent forms.

The chosen samples of the in-depth interviews of the patients, the nurses and the management staff, were purposive samples. An effort was made to include both genders, different ages, patients from different districts, different health problems, different length of time within the program and also care provided by the different nurses, in order to draw inferences about the population as a whole and add validity to the research findings.

The researcher tried to enhance the reliability of the in depth interviews and the observations by clarity and transparency in the qualitative research processes and by comprehensive literature review on the theme under investigation as well as advice and training from experienced colleagues on the qualitative research methods.

At the same time, the researcher made a conscious effort to deliver the interviews and the observations with objectivity. She tried to avoid the selective use of data that were aligned to her preconceptions on the subject under investigation of this project. This was attempted by discussing the content of the data, and the conclusions derived from it, with her advisor and consultant and requesting feedback in order to preserve the objectivity in the selection and interpretation of the selected data and to clear out any ambiguous areas so that the validity of the research would be enhanced. To the same end, the ‘social desirability response effect’, where the participants adapt their responses, either consciously or

unconsciously, to what they think the researcher's expectations are, was an area of awareness of the researcher.

Cross-confirmation between the results of the different research methods was conducted during the analysis. In the event that contradictory results emerged, the researcher re-examined the research plan and the data collection techniques, in order to detect any flaws or bias. This process strengthened the validity of the results.

'During the process, the researcher explores personal feelings and experiences that may influence the study and integrates this understanding into the study.' (Burns and Grove, 2009: 545).

Throughout this study the researcher made an effort to identify and record her reflections, (Chapter 7: Reflections), and discussed them with colleagues who had extensive experience in qualitative research. This critical thinking has been integrated into the study, in order to add validity to the results.

The research plan was assessed and approved by the National Bioethics Committee of Cyprus and the Ministry of Health (Appendix I, J), before it was implemented. This ensured the avoidance of any unintentional, implicit threats with consequences to the prospecting participants, in the event that they declined to participate, or answer questions negatively. Furthermore, it ensured full disclosure of the research, eliminating the possibility of any deception towards the participants. This assessment, in addition to the protection of human rights of the participants, enhanced the validity of the research, as the methodology and the procedures of the research were double checked by other professionals; this overcame the possibility of the researcher, not being objective.

Ethical Considerations

'When humans are used as study participants-as they usually are in nursing research-care must be exercised in ensuring that the rights of those humans are protected' (Polit and Beck, 2008: 167).

Ethical issues require a deep and careful consideration in a research, especially when the population under investigation is a sensitive segment, such as elderly home care patients. The researcher should require an appreciation, understanding and respect of the ethical

issues and yet the ability to formulate a plan that will navigate within the boundaries of the ethical codes.

'There are ethical implications at every stage of the research process, including the choice of topic to research, the selection of the design and the publication of the findings. Even the decision to research or not to research has ethical implications. By continuing to base practice solely on customs and traditions, consumers are denied the best possible care.' (Parahoo, 1991 in Parahoo 1997: 101). *'Therefore, one can ask whether it is unethical not to examine one's practice.'* (Parahoo, 1997).

Therefore, is it unethical not to examine the patients' level of satisfaction from the service of home nursing care? By not doing so, do we deprive the home care patients from the best possible care? In this study, the researcher considers it an ethical duty to examine the practice of home nursing care as perceived by its consumers, the vulnerable population of home care patients.

Throughout this research, all the rules of ethics that should determine any research were strictly kept. The researcher conformed to the ethical code and the guidelines of the National Bioethics Committee of Cyprus (CNBC, 2005) which has adopted, with minor changes the 'Operational Guidelines for ethics committees that review biomedical research' of the World Health Organisation's as the basis for ethics committees reviewing biomedical research involving human subjects in Cyprus (European Commission, Salvi, M. (ed.), (2009). A sample of the National Bioethics Committee in Cyprus guidelines for the research is demonstrated in Appendix I.

Additionally the researcher was guided by the six ethical principles of International Council of Nurses (ICN), (1996). This research project, maintained the ethical code 'above all, do no harm' (Hippocratic Oath, 5th Century B.C.) , it maintained beneficence that means to benefit the society in general, preserved all the participants' rights of non-maleficence meaning protection from any discomfort or harm including psychological, and maintained the privacy, the anonymity and the confidentiality.

Throughout all the stages of this project the researcher made a conscious effort to safeguard the dignity, rights, safety and well-being of all participants (Cyprus National Bioethics Committee (CNBC), 2005). Everybody involved was treated equally and fairly, with respect and honesty.

Full disclosure; the purpose, the context, the procedures, the right to refuse participation, the researcher's responsibilities, the possible risks and the possible benefits were explicitly explained to all the participants of the research, to ensure that they were fully aware of what they were consenting to, before their informed consent was obtained.

The right for human dignity was also maintained. The principle of self-determination; meaning the right to decide voluntarily to participate or not at the research, (Polit and Beck, 2008), was maintained, and any possible refusal to participate would not affect prejudicially negatively or positively to the participants' treatment or care. The patients maintained the rights, to change their mind and withdraw from the research at any time while the research was being carried out-even if they had already given their informed consent- refuse answering questions and doing questions themselves. All the participants were treated equally, irrespective their physical or psychological state and extra care was given to disabled people such as bed burdened, blind or patients of terminal stage.

The names and any other elements which could reveal the true identity of the participants were hidden in order not to cause any negative consequences, to patients' nursing care or to the nursing staff's or management staff's job. All the personal data of the participants, including health information, was protected and the research data was used only for the purpose of the research. In the case of the male nurse who was only one in the program and the management staff who was easily photographed, confidentiality was promised by the researcher, meaning that the data given from them would not be revealed publicly or be accessible to any other people without the participants' prior consent.

Human rights of the participants were also protected, by the review and the assessment of the research plan of this study, by the National Bioethics Committee of Cyprus and the Ministry of Health, before this was implemented. A permission for the conduction of this study was obtained from both; the National Bioethics Committee of Cyprus (Appendix I) and from the Ministry of Health of Cyprus (Appendix J). This impartial assessment of the research plan ensured that all the human rights mentioned in the previous paragraphs would be preserved, as it was possible that the researcher's assessment might not have been objective.

CHAPTER 4 : RESEARCH FINDINGS

Introduction

The purpose of this chapter is to present an account of the findings of this research, hence enabling further discussion and elucidation of their significance in the following chapter. The first section presents the findings of the survey questionnaire. The second section presents the findings of the in depth interviews to the patients, the nurses and the management of home care. The third section presents the findings of the observations of home care visits. For each of the above sections the research findings are presented by addressing and linking them to the research questions.

Findings of the Survey Questionnaire

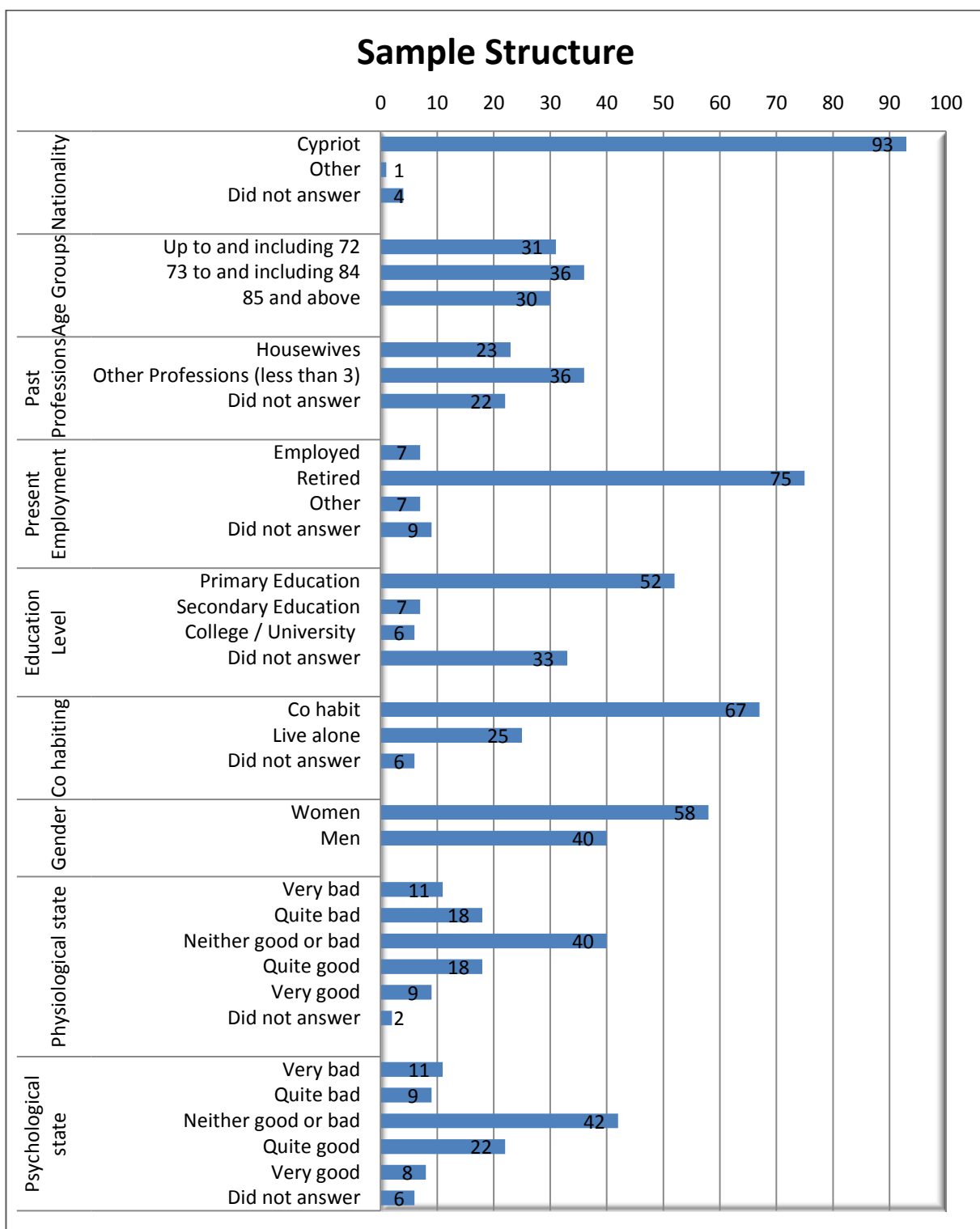
The total number of patients who fulfilled the above criteria to take part in the survey was 394. Out of the 394 questionnaires that were given, 112 were answered and out of these, 5 were deemed unsuitable. The total number of questionnaires used for SPSS analysis was 107 (N =107). The response rate of the survey questionnaire was 27.1%.

The major findings of the survey are presented, first by examining the demographic characteristics of the respondents, and then by analysing the data with respect to the research questions. Descriptive statistics are used to analyse the raw data, and analysis of variance (ANOVA) and t-test are used to determine statistical significance between groups of the demographic characteristics of the patients. Finally the validity and reliability of the survey are presented.

The profile of the respondents of the survey questionnaire

Graph 4.1 summarizes the profile and the demographic characteristics of the respondents as these were derived from the survey questionnaire questions one to six, twenty six and twenty seven.

Graph 4-1: Demographic Characteristics of Respondents



As indicated in graph 4.1 above most of the respondents were Cypriots (93), and only 1 was of other nationality. The respondents’ age range, was equally distributed to practically cover all the three age groups of up to 72, between 73 and 84 and 85 and above. The

distinct majority; 23 of the respondents were house wives, where 36 had other professions and the remaining 22 did not answer this question. Another distinct characteristic of the respondents is that the vast majority, 75 were retired, and only 7 were still employed. The remaining either did not answer the question or they chose the ‘other’ option. Most of the respondents’ education level (52) was that of primary education, 7 had secondary education level and only 6 had college or university educational level, whereas the remaining did not answer. About two thirds (67), were co habiting with the remaining 25 living alone. Sixty per cent of the respondents, (58) were women and about 40% (40) were men. Finally the respondents’ physical and psychological state resembles that of a standard distribution with the majority, about 40 respondents in both statements, indicating neither good nor bad. About 30 respondents indicated a very bad or quite bad physical state and about 30 respondents indicated that their physical state was quite good or very good. Fewer respondents (20) indicated that their psychological state was bad or quite bad and 30 answered that their psychological state was quite good or very good. Very few respondents did not answer the questions about their physical and psychological state.

RESEARCH QUESTION 1

What is the patient’s level of satisfaction from the nursing staff of the Government Home Care program in Cyprus?

At the statements in **the medical-technical competence dimension**, the majority of the respondents (around 90 to 95% of the respondents for each item) reported high levels of satisfaction; answering either ‘fully agree’ or ‘mostly agree’ in all statements:

I received the best possible medical care/help from the district nurse (as far as they can tell).

I received effective help with pain relief.

I received help from the district nurse within an acceptable waiting time.

I received useful information on self-care; “the best way to take care of myself”.

Concerning the statements in **the identity-oriented dimension** the vast majority of the respondents (around 90 to 95% of the respondents for each item) reported high levels of satisfaction; answering that they “fully agree” or “mostly agree” in statements:

The nurse seemed to understand how I experienced their situation.

The nurse treated me with respect.

The nurse showed commitment; ‘cared about me’.

I received useful information on how treatments would take place.

I received useful information on the results of samples, e.g. blood sugar curve that the district nurse took.

I received useful information on which district nurse was responsible for planning my care.

I had good opportunities to participate in decisions that applied to my medical care.

At the statements in **the Physical and Technical dimension**, the majority of the respondents (around 90 to 95% of the respondents for each item) reported high levels of satisfaction; answering either ‘fully agree’ or ‘mostly agree’ in all statements:

I had access to the apparatus and equipment that were necessary for their medical care (as far as they can tell).

I received useful help from the district nurse with obtaining the appliances that I needed e.g. wheeled walking frame, wheelchair, pads and clutching tongs.

I received useful help from the district nurse with measures to prevent accidents in my home.

At the statements in **the Socio-culture dimension**, the majority of the respondents (around 90 to 95% of the respondents for each item) reported high levels of satisfaction; answering either ‘fully agree’ or ‘mostly agree’ in three of the four statements:

I was easy for them to get to the telephone the district nurse.

I was easy to get the district nurse to come out on a home visit.

My relatives and friends were treated well.

In response to the statement:

My medical care was controlled by my own desires rather than by the district nurse's procedures

Almost half of the respondents (40, 9%) reported low levels of satisfaction; answering that they partly agree or do not agree at all that their medical care was controlled by their desires rather than by the district nurse procedure. The researcher considered this percentage significant. At the same time the respondents answered that this statement is “of the very highest importance” or “Of high importance” to the majority of them (93, 9%). It is worth noting that on the above statement women reported lower levels of satisfaction than men; with a percentage of 51.2% ‘fully agree’ or ‘mostly agree’ for women and a percentage of 72% ‘fully agree’ or ‘mostly agree’ for men.

Conclusively, the vast majority of the respondents reported high levels of satisfaction from their nurses, in all the statements of the questionnaire except from the statement:

My medical care was controlled by my own desires rather than by the district nurse's procedures,

in which about half of the respondents reported low levels of satisfaction.

Open Question: I was especially satisfied with the following.

With reference to the open question:

I was especially satisfied with the following.

About 50% of the respondents stated that they were especially satisfied with the humane approach; the politeness, the interest and the caring of the nurse.

About 25% of the respondents stated that they were especially satisfied with the useful advices that they received from the nurse.

About 25% of the patients stated that they were especially satisfied with the medical care they received from their nurse e.g. Taking blood samples for analysis, wound dressing, injections, vaccination, changing of catheter and treatment of diabetes's complications.

Around 10% of the patients were especially satisfied with the psychological support they received from the home care nurse.

Fewer patients stated that they were especially satisfied with the professionalism demonstrated by their nurse, the easy telephone access to telephone contact with the nurse when they needed support, the frequency of home visits and that they did not have to travel to the health center for their treatment.

The number of respondents for the above statement was small to extract safe conclusions for any variances related to the demographic characteristics of the patients. However, it might be worth mentioning that patients who were especially satisfied by the humane approach; politeness and interest of the nurse were of the lower educational level.

RESEARCH QUESTION 3

Are there differences in patients' level of satisfaction based on age, gender, living alone or co habit, educational level and the patients' psychological and physical state?

Satisfaction by Age

Patients of higher age reported higher levels of satisfaction (>3%) than younger patients in 30% of the statements.

These statements are the following:

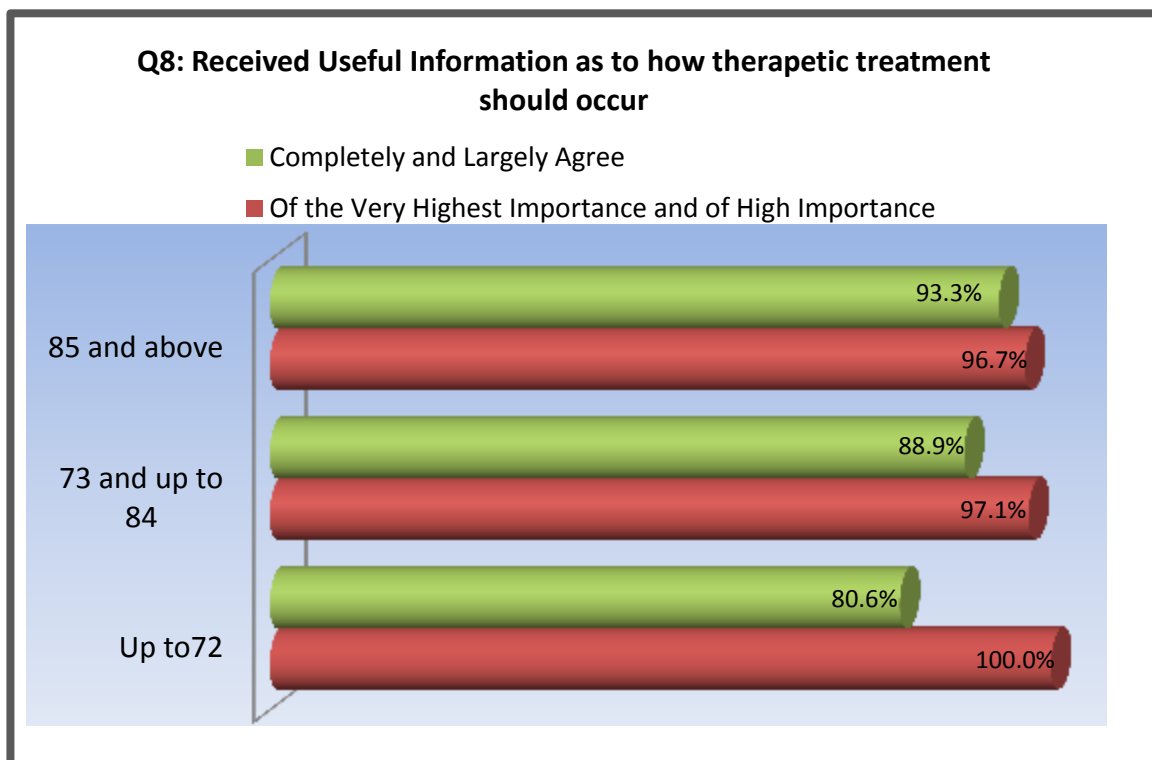
The help I received was very effective and provided relief from pain.

I was easily able to convince the visiting nurse to visit me at home.

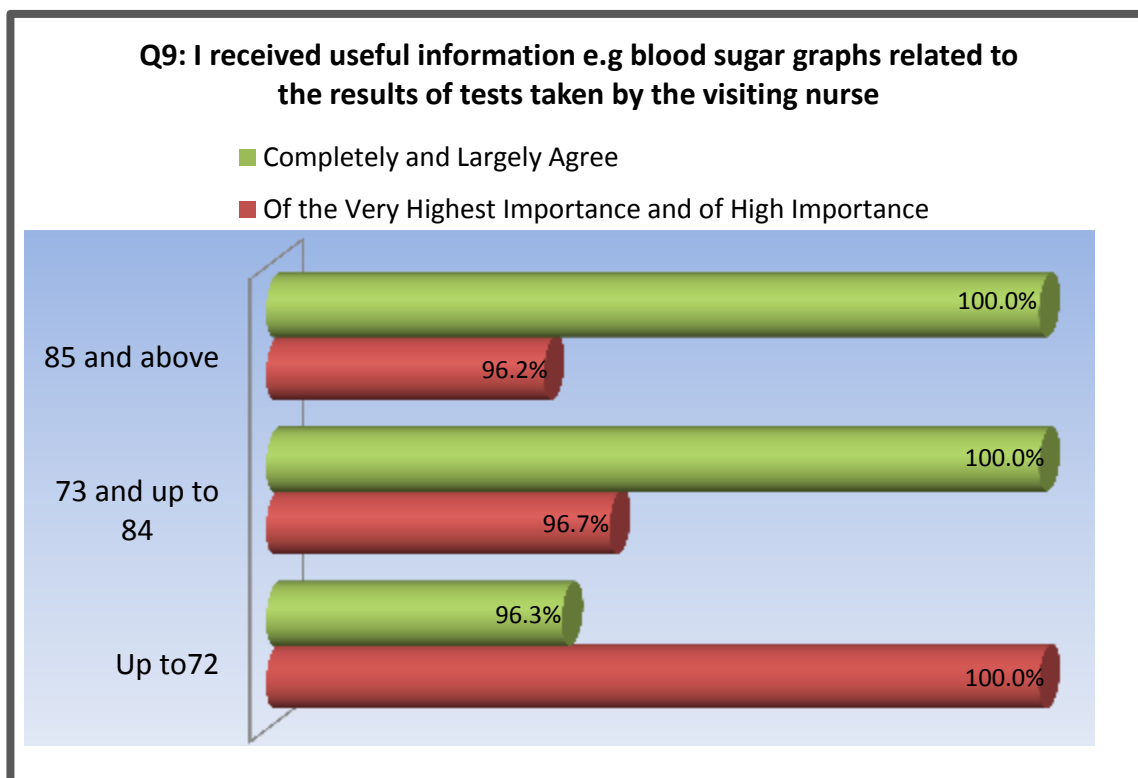
And all the statements related to receiving useful information

Some of the above findings are demonstrated in the here below graphs:

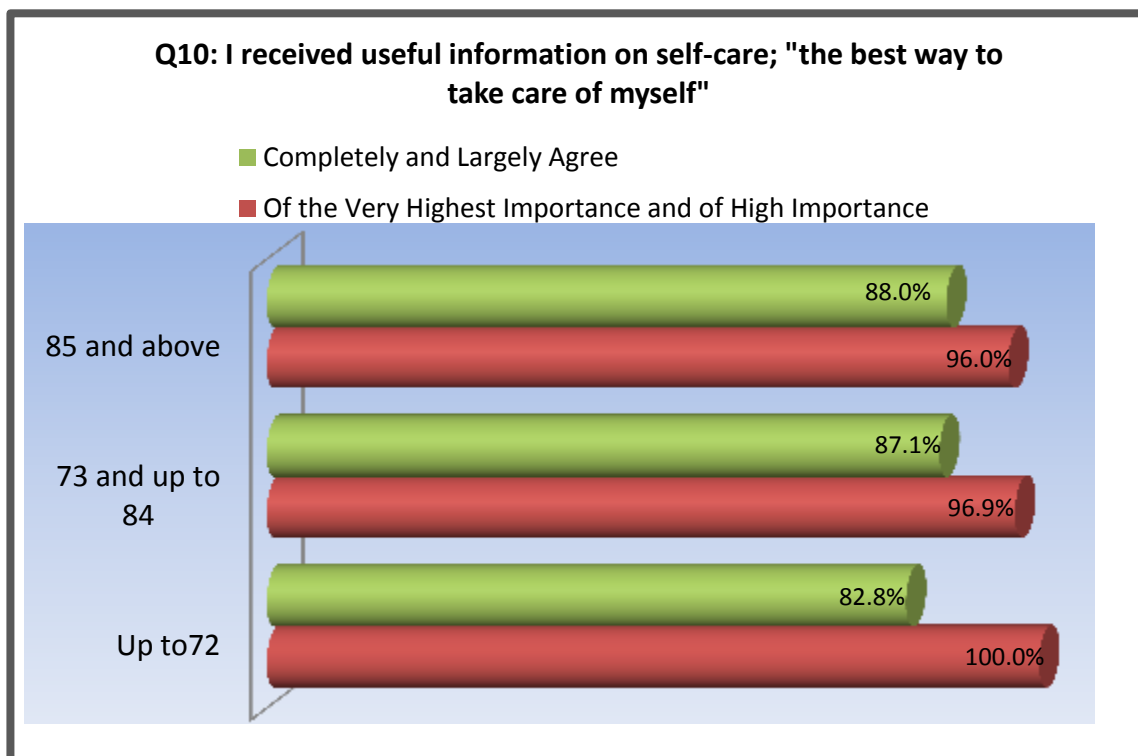
Graph 4-2 Q8 - AGE against – Received useful information as to how therapeutic treatment should occur



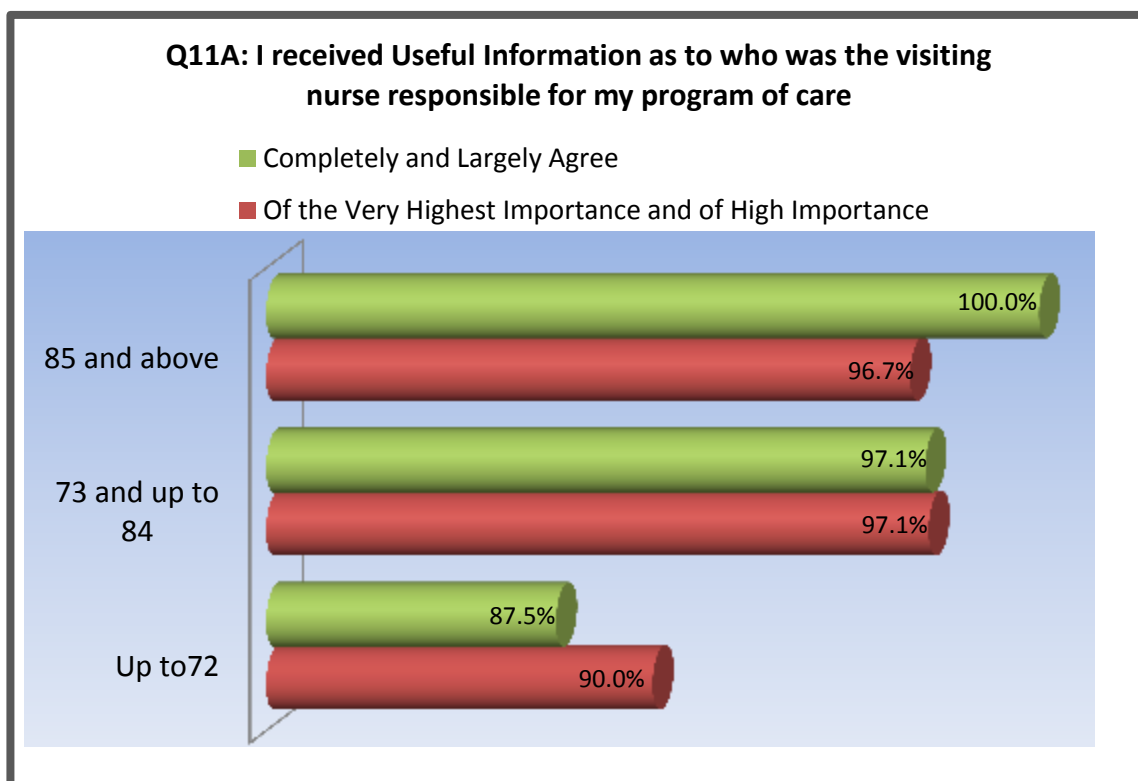
Graph 4-3 Q9: AGE against – I received useful information e.g. blood sugar graphs related to the results of tests taken by the visiting nurse



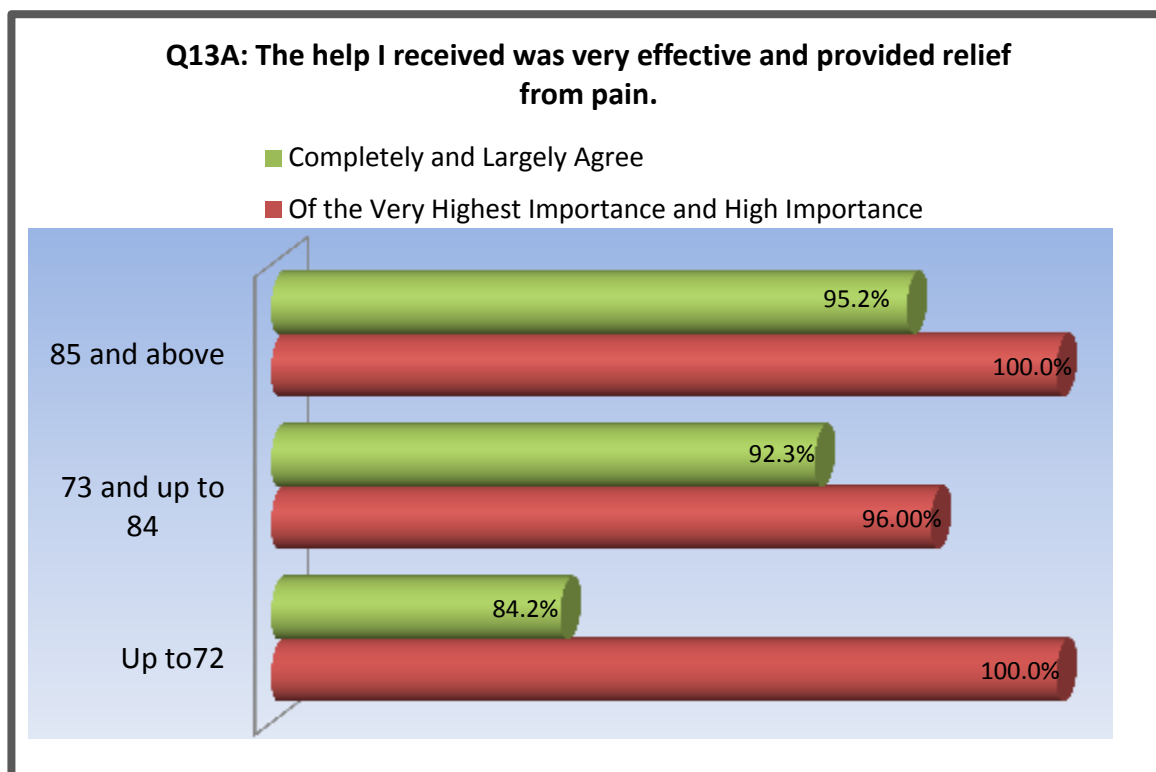
Graph 4-4 Q10: AGE against – I received useful information on self-care; “the best way to take care of myself”



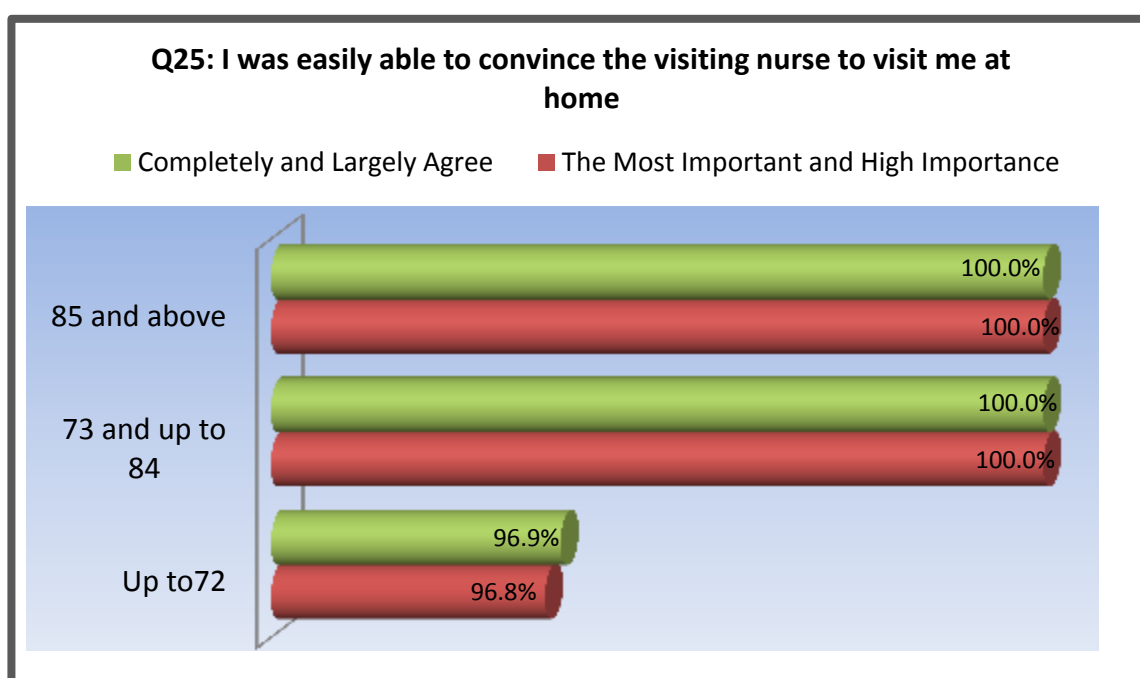
Graph 4-5 Q11a: AGE against - I received Useful Information as to who was the visiting nurse responsible for my program care



Graph 4-6 Q13a: AGE - against – The help I received was very effective and provided relief from pain.



Graph 4-7 Q25: AGE against – I was easily able to convince the visiting nurse to visit me at home.



Patients of younger age reported higher levels of satisfaction (>3%) than older patients

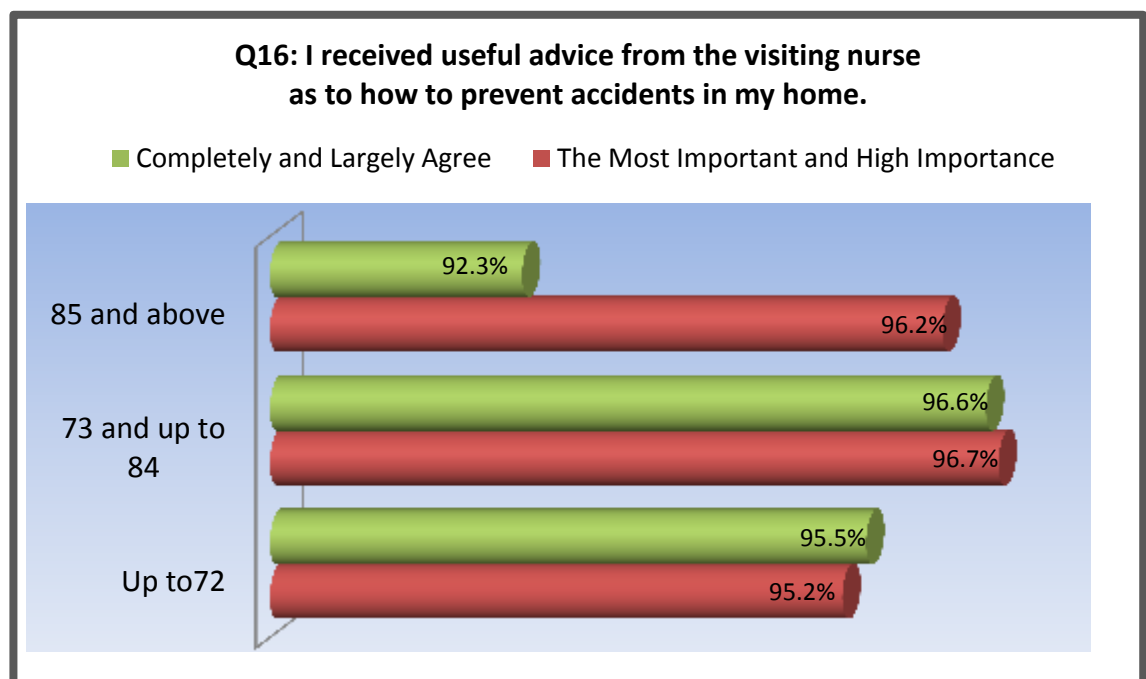
only in the two following statements:

I received useful advice from the visiting nurse as to how to prevent accidents in my home.

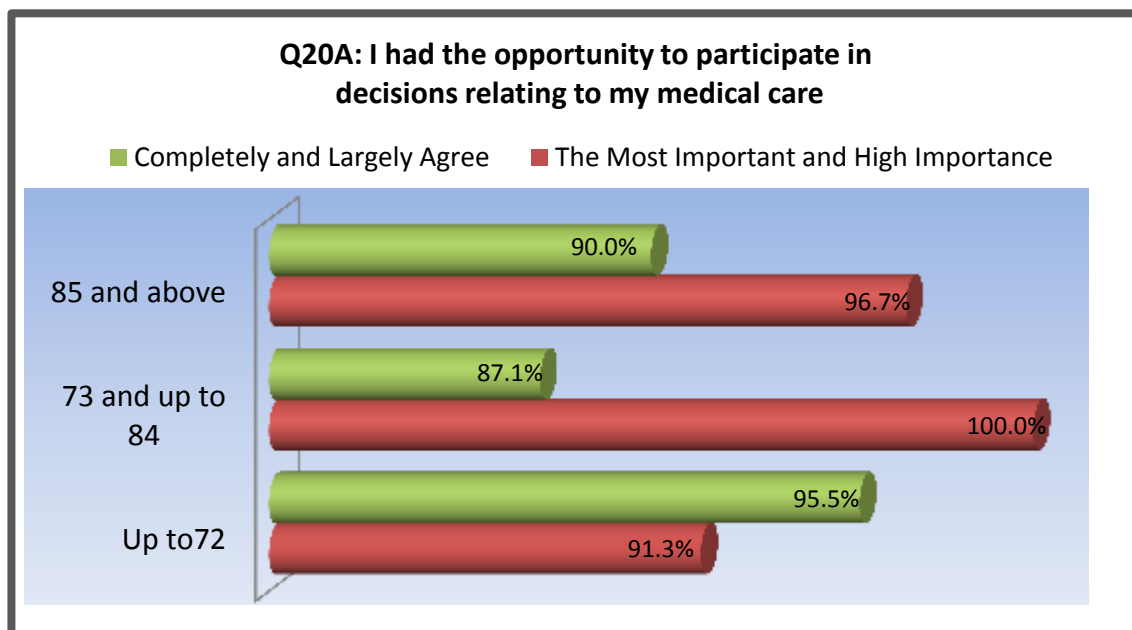
I had the opportunity to participate in decisions relating my medical care

Which are demonstrated in the following graphs:

Graph 4-8 Q16a: AGE against – I received useful advice from the visiting nurse as to how to prevent accidents in my home.



Graph 4-9 Q20a: AGE against - I had the opportunity to participate in decisions relating my medical care



There is a statistically significant difference on the statement 'I received useful information as to how therapeutic treatment should occur' between age groups, $df=97$, $p=0,03$.

There is a statistically significant difference on the statement 'I received useful information on the results of samples e.g. Blood sugar curve that the district nurse took' between age groups $df=82$, $p=0,01$.

Satisfaction by Gender

Women reported higher levels of satisfaction (>3%) than men in 30% of the statements.

These statements are the following:

I received useful information e.g. blood sugar graphs related to the results of tests taken by the visiting nurse.

I received Useful Information as to who was the visiting nurse responsible for my program care

I received the best possible medical care/assistance from the visiting nurse (as far as I can tell)

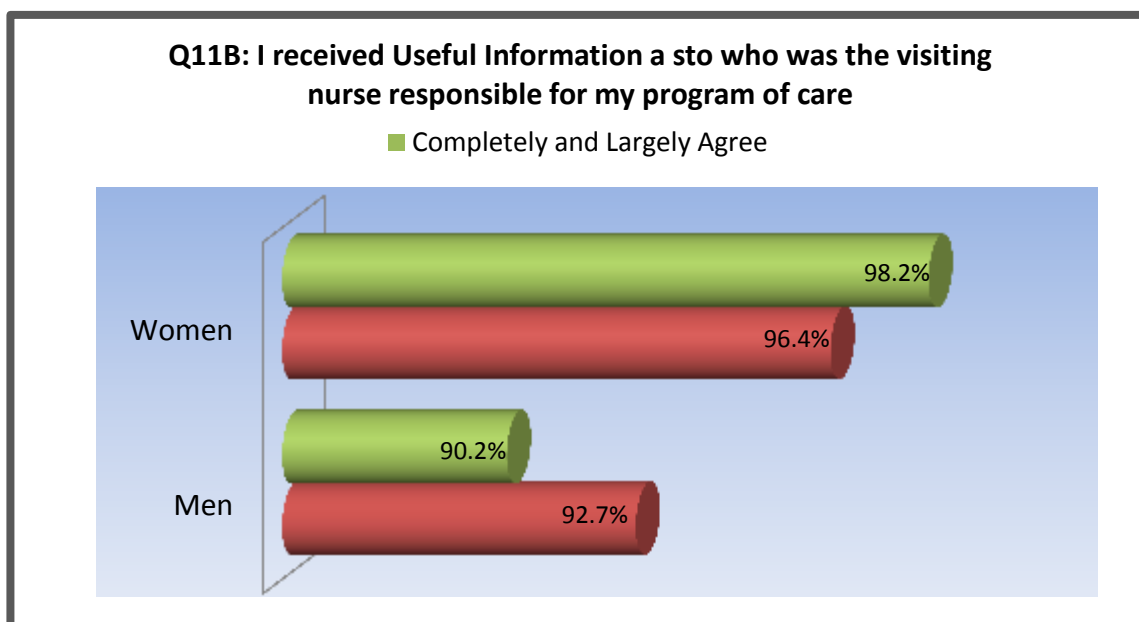
I received help from the visiting nurse within an acceptable waiting time.

I received useful assistance from the visiting nurse obtaining equipment which I needed.

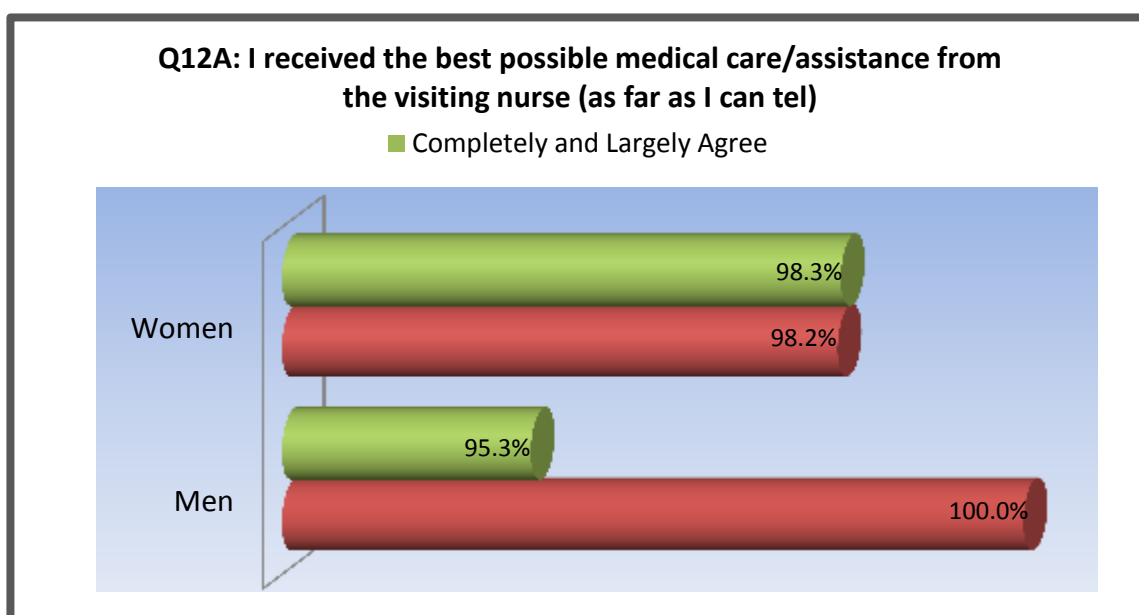
I received useful advice from the visiting nurse as to how to prevent accidents in my home.

Examples of the above results are graphically demonstrated below:

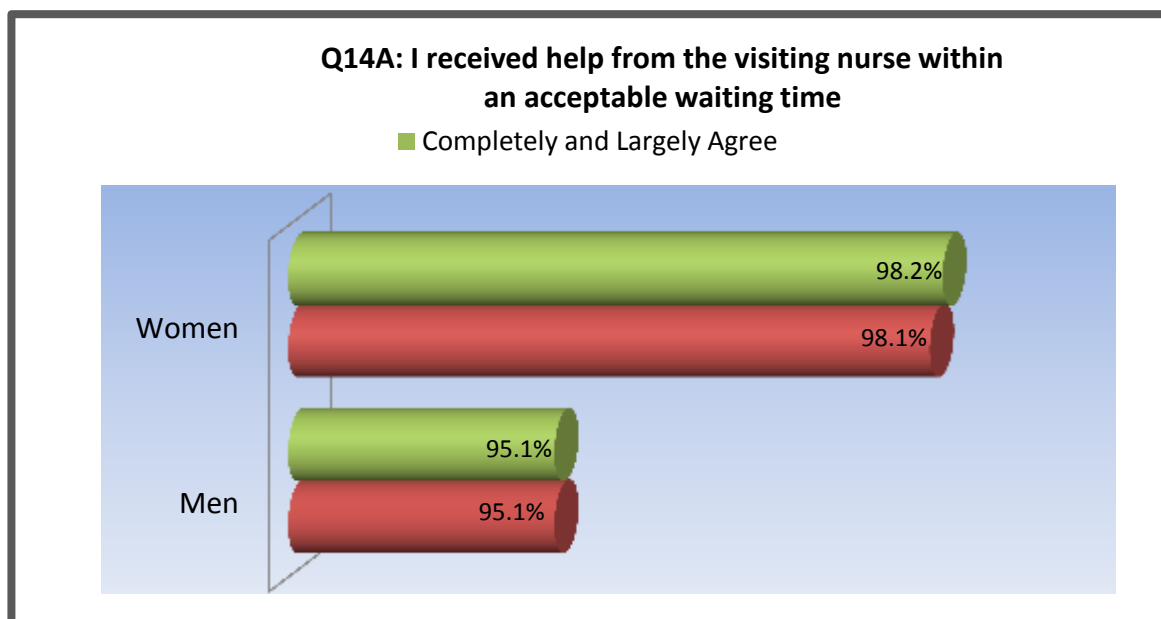
Graph 4-10 Q11b: GENDER against - I received Useful Information as to who was the visiting nurse responsible for my program care



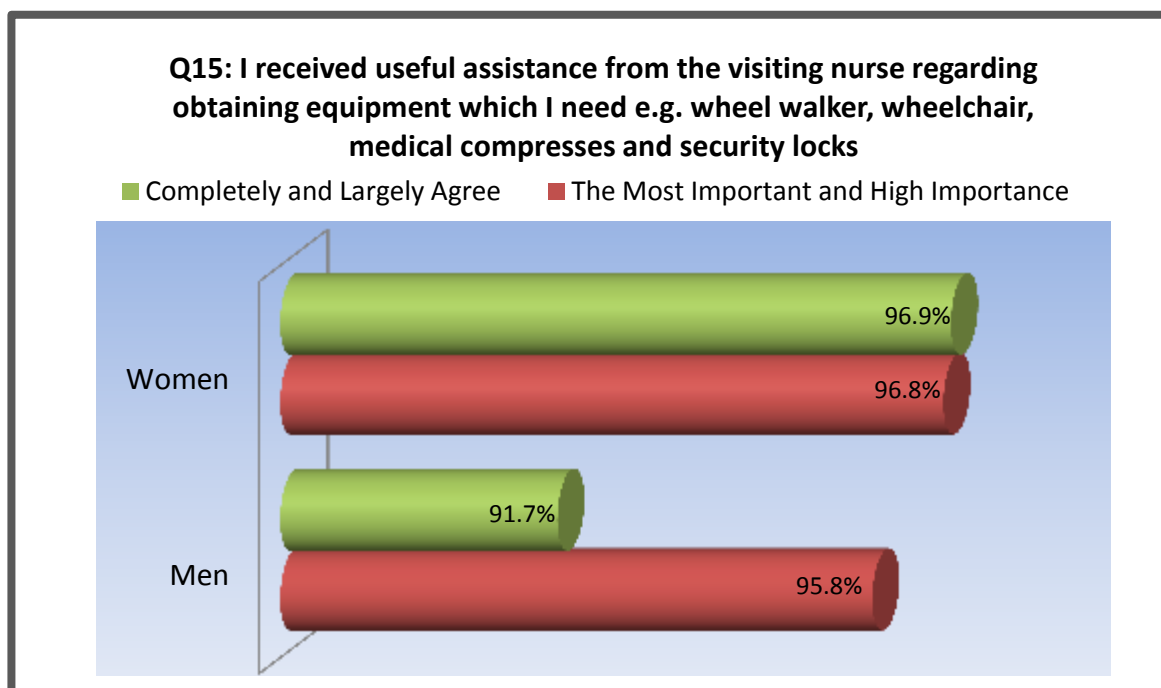
Graph 4-11 Q12a: GENDER against – I received the best possible medical care/assistance from the visiting nurse (as far as I can tell).



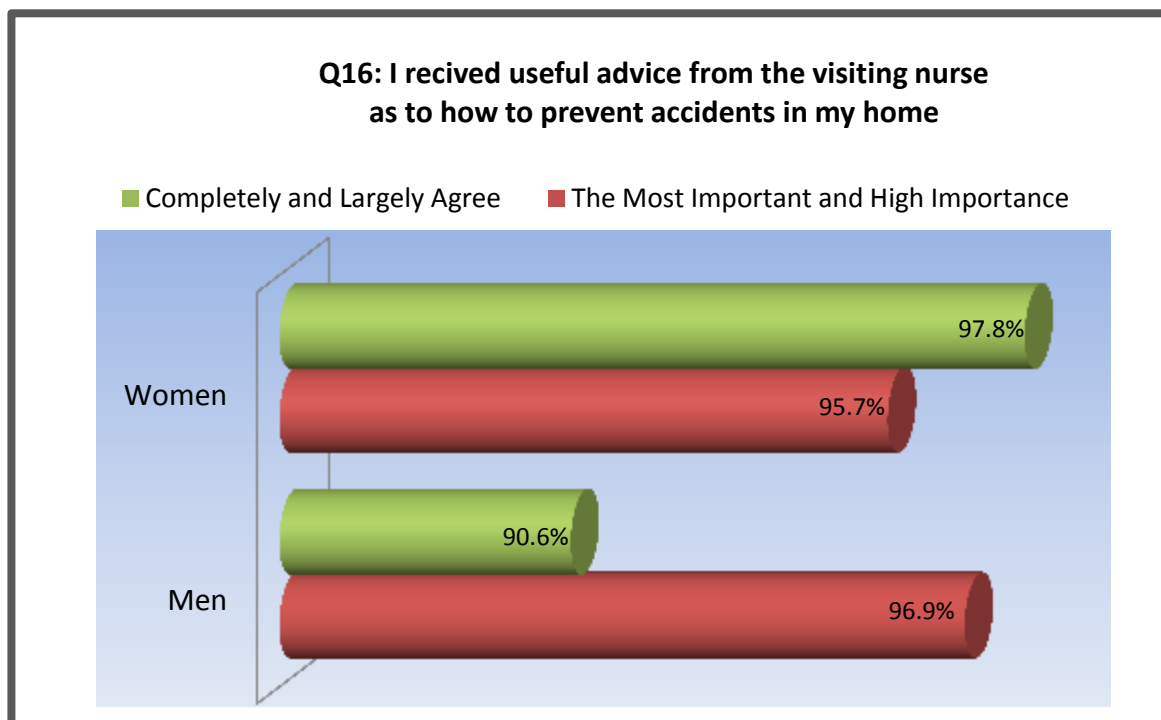
Graph 4-12 Q14a: GENDER - against – I received help from the visiting nurse within an acceptable waiting time.



Graph 4-13 Q15: Gender against – I received useful assistance from the visiting nurse obtaining equipment which I needed.



Graph 4-14 Q16b: GENDER against – I received useful advice from the visiting nurse as to how to prevent accidents in my home.



Men reported higher levels of satisfaction (>3%) than women only in around 15% of the statements:

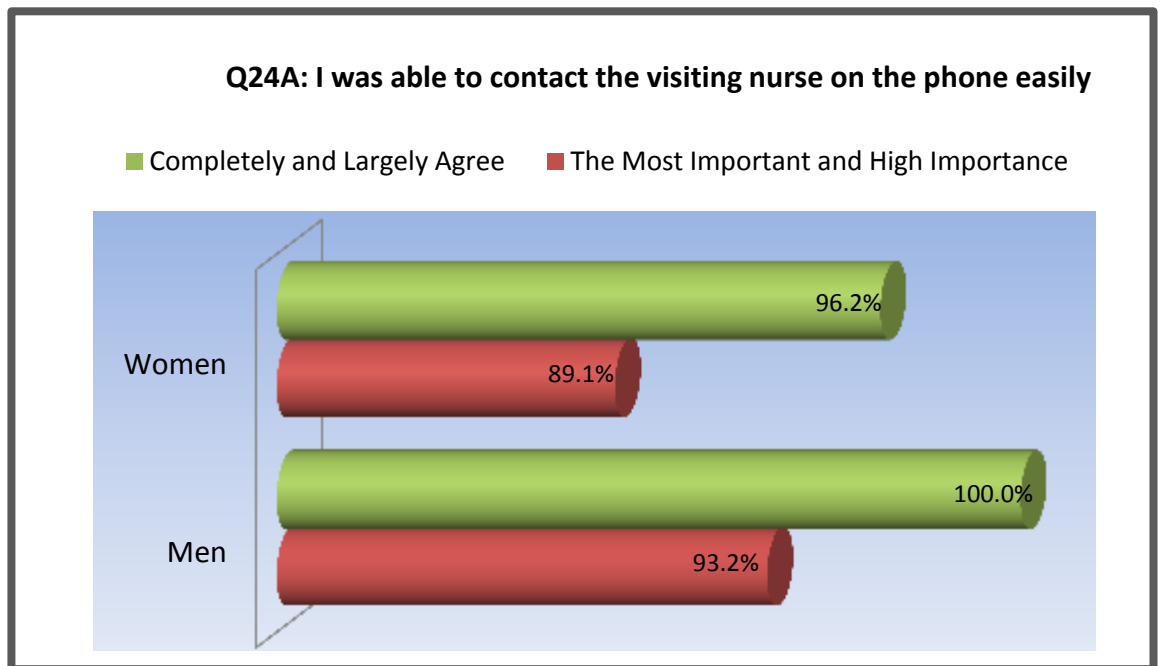
I was able to contact the visiting nurse on the phone easily

I had the opportunity to participate in decisions relating my medical care

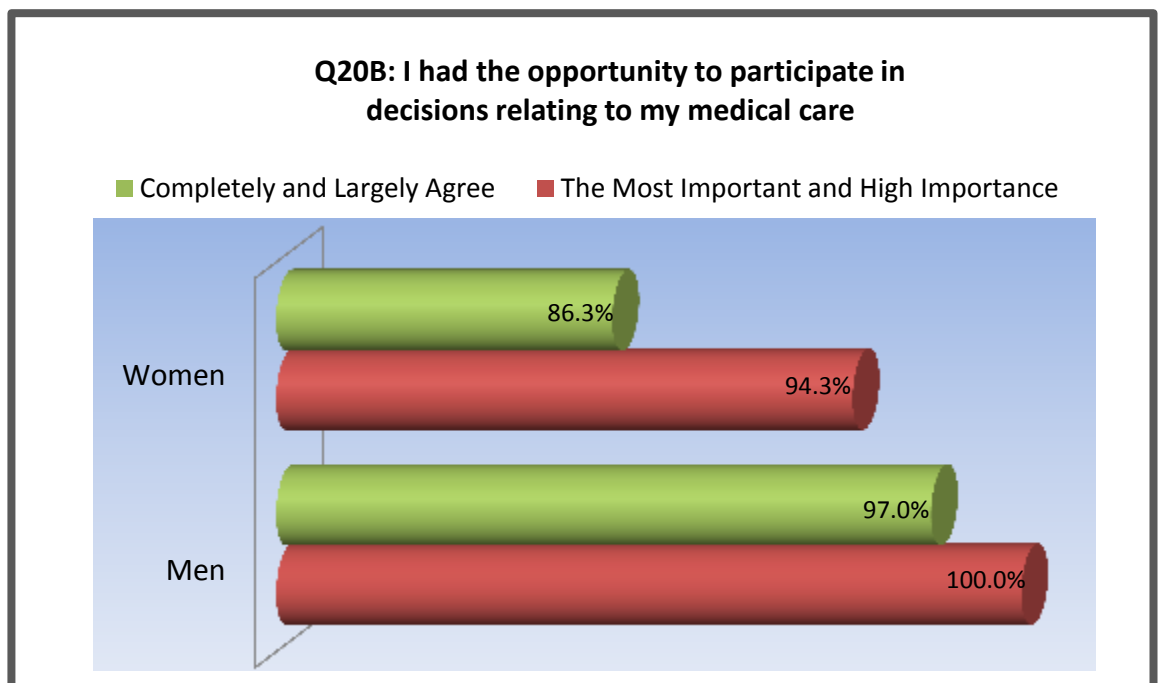
My medical care was controlled more by my own desires rather by the district nurse's procedure

The above are demonstrated in the graphs below:

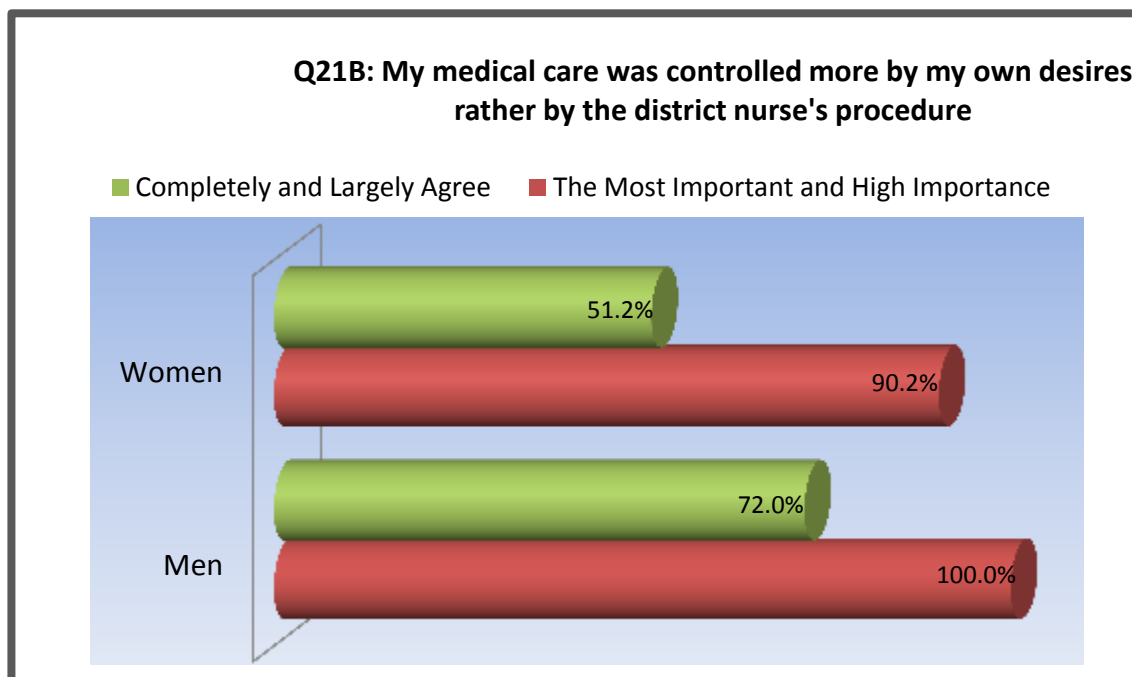
Graph 4-15 Q24a: GENDER against – I was able to contact the visiting nurse on the phone easily



Graph 4-16 Q20a: GENDER against - I had the opportunity to participate in decisions relating my medical care



Graph 4-17 Q21b: GENDER against – My medical care was controlled more by my own desires rather by the district nurse’s procedure



On the statement ‘I received useful information as to how therapeutic treatment should occur.’ Men were less satisfied (Mean=1,25, SD=0,44) than women (Mean=1,07, SD=0,41). This difference is statistically significant $t(96)=2,08$, $p=0,04$

On the statement ‘I had good opportunities to participate in decisions that applied to my medical care’ women were less satisfied (Mean=1,57, SD=0,78) than men (Mean=1,24, SD=0,50). This difference is statistically significant $t(82)=-2,13$, $p=0,04$

Satisfaction by Living Alone or Co-Habit

The patients who lived alone reported higher levels of satisfaction (>3%) than patients who co habited in about 40% the statements. These statements are the following:

Received useful information as to how therapeutic treatment should occur.

I received useful information on self-care; “the best way to take care of myself”.

I received Useful Information as to who was the visiting nurse responsible for my program care.

I received the best possible medical care/assistance from the visiting nurse (as far as I can tell).

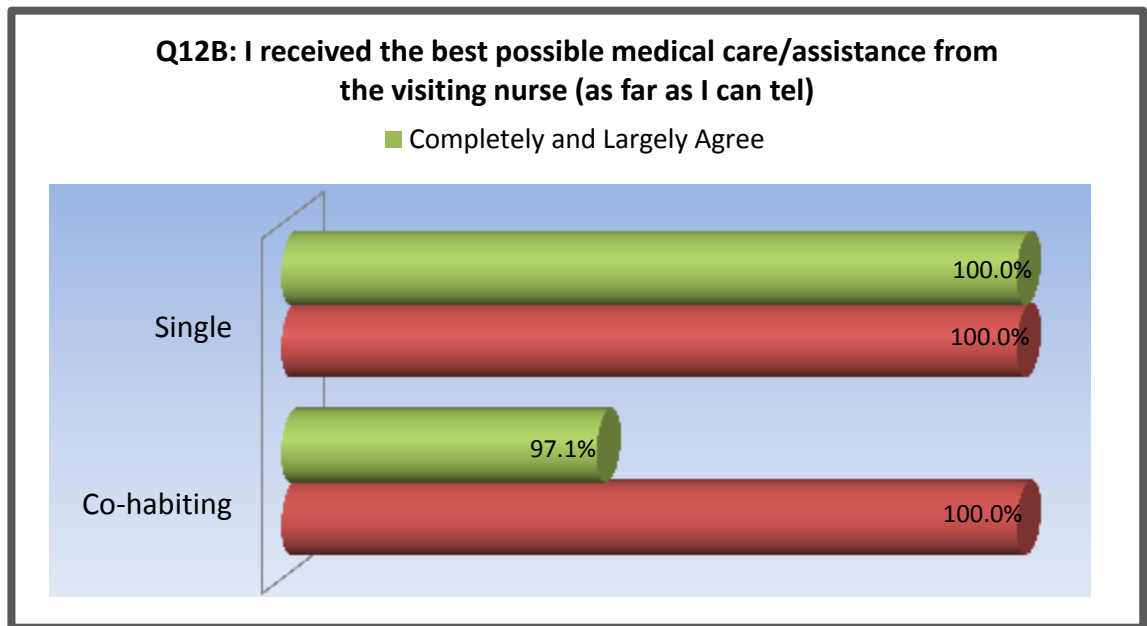
The help I received was very effective and provided relief from pain.

I received help from the visiting nurse within an acceptable waiting time.

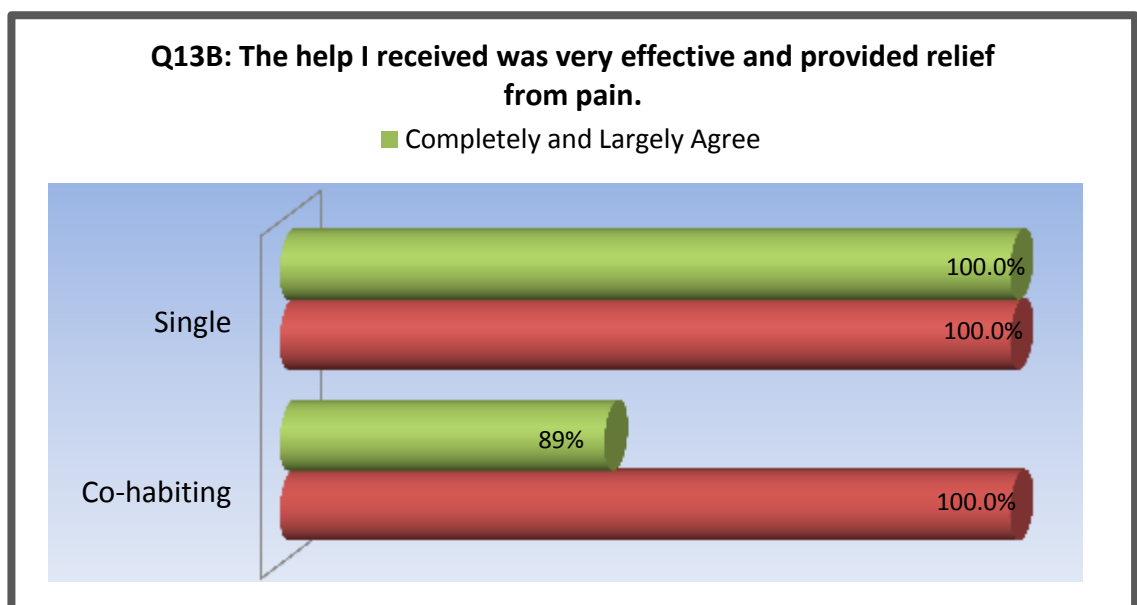
I received useful advice from the visiting nurse as to how to prevent accidents in my home.

Examples of the above results are shown in the following graphs:

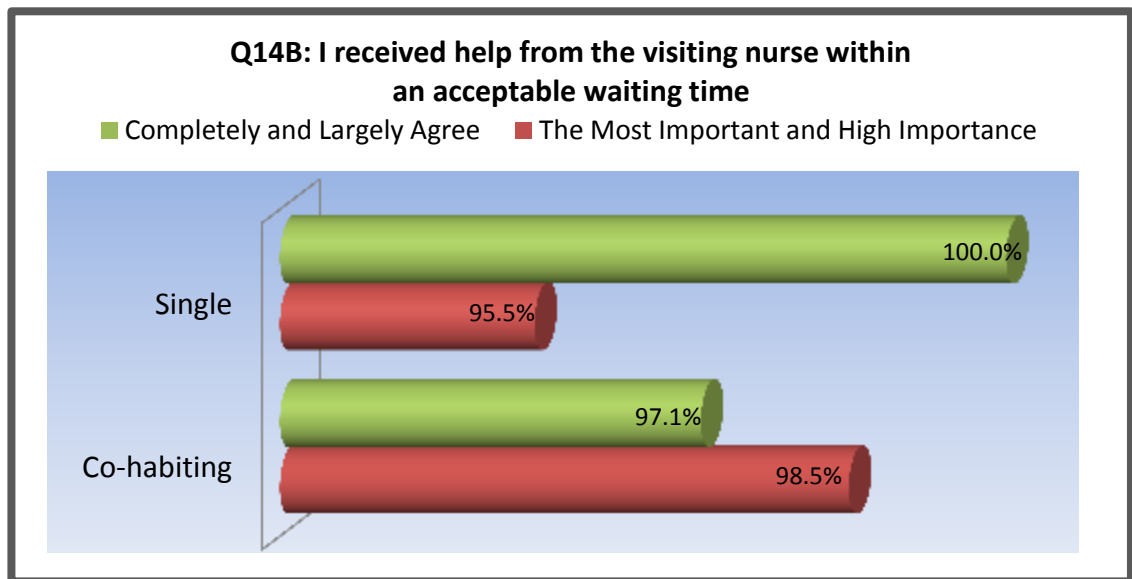
Graph 4-18 Q12b: Co-HABITING - against – I received the best possible medical care/assistance from the visiting nurse (as far as I can tel)



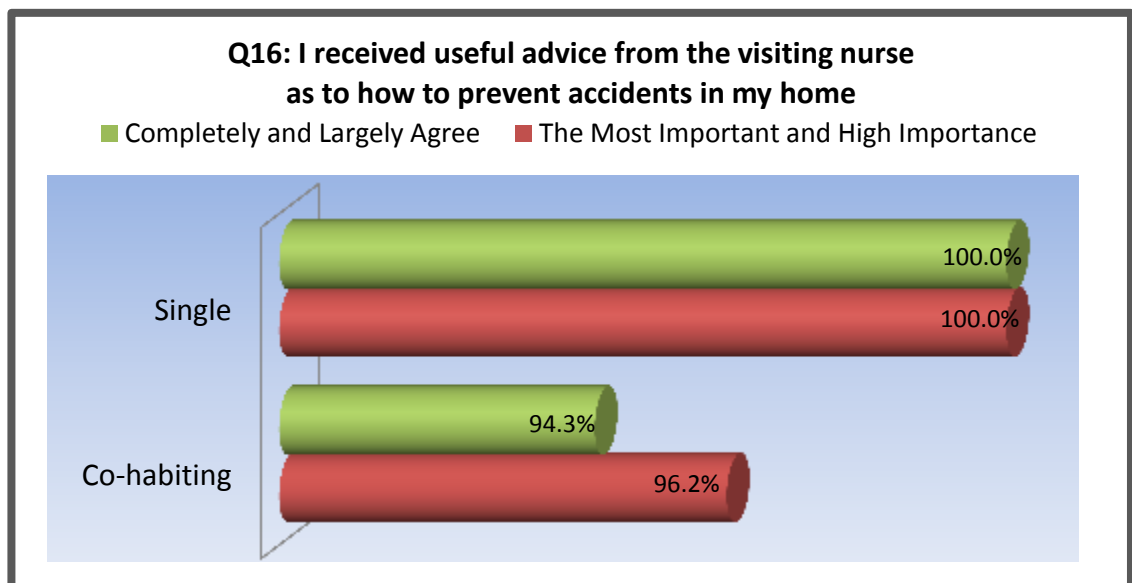
Graph 4-19 Q13b: CO-HABITING - against – The help I received was very effective and provided relief from pane.



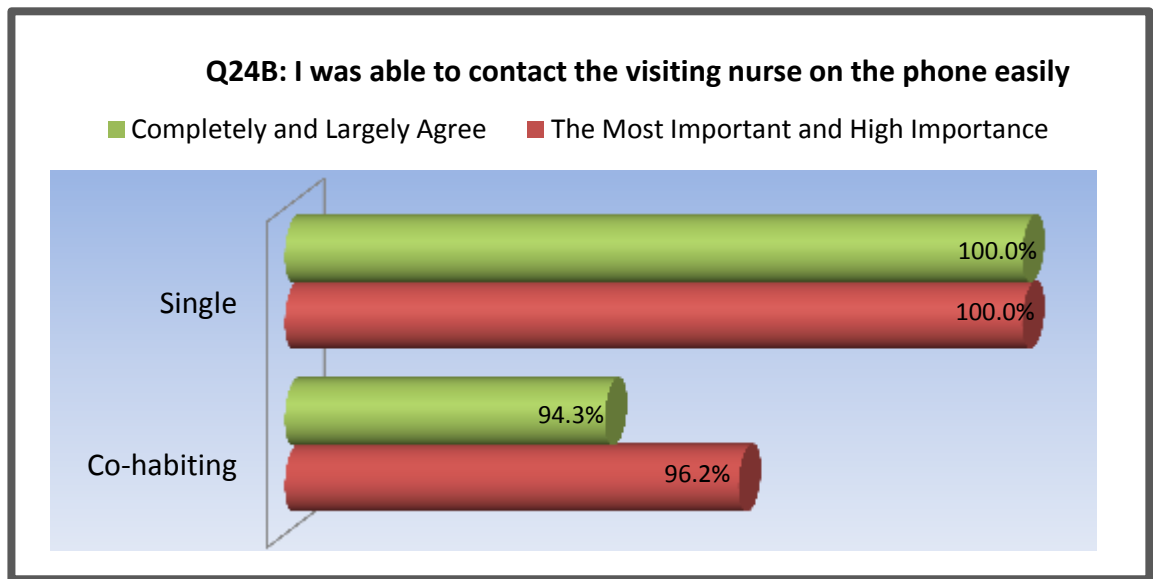
Graph 4-20 Q14b: Co-HABITING - against – I received help from the visiting nurse within an acceptable waiting time.



Graph 4-21 Q16c: Co-HABITING against – I received useful advice from the visiting nurse as to how to prevent accidents in my home.



Graph 4-22 Q24b: CO HABITING against – I was able to contact the visiting nurse on the phone easily



On the statement ‘I received useful information on how treatment would take place’ The respondents who co –habit are less satisfied (Mean=1,15, SD=0,36) than the respondents who co-habit (Mean=1,00, SD=0,00). This difference is statistically significant $t(90)=2,07$, $p=0,041$.

On the statement ‘I had good opportunities to participate in decisions that applied to my medical care’ respondents who live alone were less satisfied (Mean=1,70, SD=0,70) than respondents who co-habit (Mean=1,30, SD=0,63). This difference is statistically significant $t(78)=-2,48$, $p=0,015$.

Satisfaction by Educational Level

Patients of different educational levels; elementary school, secondary school and college/university, did not report higher or lower levels of satisfaction (>3%) in any statements.

However, it is worth mentioning some differences in the level of satisfaction, less than 3%, in some of the statements. Patients of higher education reported lower levels of satisfaction with the information they received and with the help that they received from the nurse for measures to prevent accidents at their homes whereas patients of lower education reported lower levels of satisfaction with the help they received by the nurse with obtaining the appliances they needed, with the access they had to the apparatus and the equipment they

needed, with how easily they got the nurse to come out on a home visit and with how their medical care controlled by their own desires rather than by the nurses procedure.

Satisfaction by the physical state of the patient

Patients of different physical states; very bad, quite bad, neither good nor bad, quite good, very good, did not report higher or lower levels of satisfaction (>3%).

Satisfaction by the psychological state of the patient

Patients who rated their psychological state as neither good nor bad, quite good or very good, reported higher levels of satisfaction (>3%) than patients who rated their psychological state as quite bad or very bad, in two statements. These statements were the following:

I received useful information on which district nurse was responsible for planning my care.

I received the best possible medical care/help from the district nurse (as far as they can tell).

I received effective help with pain relief.

My medical care was controlled by my own my desires rather than by the district nurse's nurse procedure

My relatives were treated well

I had access to the apparatus and equipment that were necessary for their medical care (as far as they can tell)

RESEARCH QUESTION 2

What is the importance of each parameter of satisfaction for the patients?

The majority of the respondents reported high levels of importance to all the statements of the questionnaire; answering either 'of the very highest importance' or 'of high importance'. This shows that the respondents consider of high importance all the items included in the questionnaire.

RESEARCH QUESTION 4

Are there any differences in the importance of each element of satisfaction for the patients based on their personal characteristics; age, gender, educational level, co-habit or live alone and their psychological and physical state?

Importance by Age

There was an increase, with a difference more than 3%, of the importance of the elements of satisfaction with the increase of age in the following statements:

I received useful information on which district nurse was responsible for planning my care.

I had good opportunities to participate in decisions that applied to my medical care

It was easy to get the district nurse to come out on a home visit

Whereas contrary to the older ages, the younger age respondents considered the statements more important, with a difference of more than 3%, in the following two statements:

I received useful information on self-care; “the best way to take care of myself”.

I received useful help from the district nurse with obtaining the appliances that I needed e.g. wheeled walking frame, wheelchair, pads and clutching tongs.

The statement:

I received help from the district nurse within an acceptable waiting time’

was considered more important by the younger age group, followed by the oldest age group, followed by the middle age group, with difference more than 3%.

There is a statistically significant difference on the statement ‘I had good opportunities to participate in decisions that applied to my medical care’, between age groups, $df = 84$, $p = 0,021$.

Importance by Gender

Women considered more important than men, with a difference more than 3 %, the following statements:

I received useful information e.g. blood sugar graphs related to the results of tests taken by the visiting nurse.

I received useful information on which district nurse was responsible for planning my care.

I received help from the district nurse within an acceptable waiting time.

It was easy for them to get to the telephone the district nurse.

Men considered more important than women, with a difference more than 3 %, the following statements:

My medical care was controlled by my own desires rather than by the district nurse's procedure.

I had good opportunities to participate in decisions that applied to my medical care

On the statement 'I had good opportunities to participate in decisions that applied to my medical care' Men consider this factor more important (Mean=1,24, SD=0,50) than women (Mean=1,57, SD=0,78). This difference is statistically significant $t(83)=-2,041$, $p=0,044$.

Importance by Live Alone or Co-Habit

There was no difference more than 3 %, in the importance of the statements between respondents who live alone and those that co-habit. However there is a trend indicating that the respondents who live alone considered more important the following statements:

I received useful information on self-care; "the best way to take care of myself".

I received useful information on which district nurse was responsible for planning my care.

I received help from the district nurse within an acceptable waiting time.

I received useful help from the district nurse with measures to prevent accidents in my home.

My medical care was controlled by my own desires rather than by the district nurse's procedure.

On the statement 'I had good opportunities to participate in decisions that applied to my medical care' respondents who live alone are less satisfied (Mean=1,27, SD=0,46) than the respondents who co-habit (Mean=1,19, SD=0,47). This difference is statistically significant $t(78)=-2,481$, $p=0,015$.

Importance by Educational Level

There is not a difference more than 3% in the importance of any statement, between the three levels of education: elementary school, secondary school, university.

There is a statistically significant difference on the statement 'I received useful information on which district nurse was responsible for planning my care', between educational level groups, $df=94$, $p=0,032$.

RESEARCH QUESTION 5

Are there any problematic areas in the services provided by the nursing staff of the programme that need improvement?

At the **open question**: '*Suggestions for improvement*':

- About half of the respondents, suggested the increase of the frequency of home care visits.
- Approximately 10% of the respondents suggested an increase of the number of the nurses at the home care program.
- Fewer patients suggested that the program be expanded, to include other health care professionals; doctors, physiotherapists, psychologists and the home delivery of the medication.
- Finally, approximately 10% of the respondents suggested that this program continues to operate. This is not a suggestion for improvement but it is more likely a wish or a worrying concern.

Intention to follow the instructions

To the statement:

Will you follow the instructions and advice that you have now received from the district nurse?

The majority of the respondents answered either 'yes, completely' or 'yes, partly' and most of them considered this 'of the very highest importance' or 'of high importance'.

Correlations between Part A: This is what I experienced and Part B: This is how important it was to me, for all the statements.

As the researcher investigated the level of satisfaction and the importance of each factor for the patients, the correlation between the two issues investigated was considered good to be investigated too. The findings showed that there was a positive relationship between ‘this is what I experienced’ and ‘this is how important it was to me’, in all the statements, except the following two statements where there was no positive relationship between the experience and the importance:

I received effective help with pain relief.

I received help from the district nurse within an acceptable waiting time.

Nevertheless, the above negative relationship in these two statements was not statistically significant.

Findings of the in Depth Interviews of the Patients

This second section of this chapter includes the in depth interviews to the patients, the nurses and the management of home care. The major findings of the in depth interviews of the patients are presented, first by presenting interviewees profile and then by analysing the data with respect to the research questions. In this section the remarks made by the interviewees are highlighting the following issues under investigation in this research; the level of satisfaction of the patients from their nurses, the importance of the elements of satisfaction from the patients, the patients perception of the ideal nurse, the problematic areas of the home care program and suggestions for improvement.

The patients - interviewees’ profile

The variables investigated in order to formulate the profile of the patients were age, gender, marital status, co-habiting or not, past profession, the type of health problems of the patient, the length of time that the patient has been in the program and how often the nurse visited the patient.

Age

The patients’ ages vary between 52 and 86. In general, there were no great differences in the replies of the patients that could be correlated with age. The only noticeable variance

was related to their preferences while choosing the picture which best represented the ideal nurse in their perspective. There was a tendency for the younger ages, patients between 60-70 years old, to prefer older nurses because they associated older age with advanced nursing experience and knowledge. The older patients, above the age of 70, showed a preference to younger nurses because they are perceived as being more cheerful, lively, pleasant and smiling.

Profession

The patient interviewees had the following professions: one was the owner of a small business, one was the founder, owner and director of a private high school, four were housewives, one was a shepherd, one was a truck driver and one was employed in the private sector

State of health- the type of health problems the patients face

The patients interviewed faced various types and of different severity health problems. Some examples were: high blood pressure, diabetes, stroke, respiratory problems, heart diseases, hip fractures, impaired vision, prostate diseases, paraplegics, etc.

Marital status – co habiting or not

Five patients were married and living with their spouses. Two male patients were single. One of them lived with his widowed sister. The other one lived with his house keeper and his sister lived next door. The remaining two patients were two women, one divorced and one widowed and both lived with the housekeeper.

Out of the above patients that were interviewed some had children. In most cases their children did not stay close to the patient's home. As such their children could not help when there was an emergency situation. On one case the patient's children rarely visited him because they were not in good terms with their stepmother.

The length of time that the patient has been in the program

Most of the patients were in the program for about 3 to 4 years. One patient was in the program for 6 years, two patients for 2 years and one patient for 3and a half months.

How often the nurse visited the patient

The frequency of the visits to patients ranged from 3 times per week, two times per week, once a week, once every two weeks and once a month.

Gender

From the patients 5 were female and 4 were male.

The findings of the in depth interviews are presented in this section, grouped according to the research question they support and provide evidence for.

RESEARCH QUESTION 1:

What is the patient's level of satisfaction from the nursing staff of the Government Home Care program in Cyprus?

Patients Satisfaction from the Home Care nurse

All the patients who were interviewed expressed their utmost satisfaction from their nurses. When they were asked what they thought about their visiting nurse they all said without any hesitation that their nurse was either brilliant or outstanding. However, what exactly did they mean by '*brilliant*' and '*outstanding*'?

For the great majority of the patients the above characteristics for their nurse were mainly based on the nurses' outstanding soft skills upholding a humane approach. They thought that their nurse was a good person, treated them well and genuinely cared about them.

The main elements underlying the humane approach according to the patients' perception were identified during the in depth interviews and these are listed here below in order of frequency:

- Well-behaved
- Caring
- Offered psychological support
- Offered good information, guidance and advice
- The nurse conveyed a sense of protection and security

- Further to the above the following was mentioned by two interviewees:
- The reliability (Int.2) and the medical competence (Int.4).

In more detail the above are explained below.

Well-behaved

A foremost factor of satisfaction as perceived by the patients was described as that of being 'well behaved'. This characteristic seemed to integrate politeness, kindness, patience but as important was the smile and the fact that the nurses were very accommodating and lenient to the patient's individual needs and desires. Characteristically Int.6 quoted in the Cypriot dialect:

“With all her good moods and good manners, (...) our nurse is one of those rare women. (...) Ehm, her ways...she talks to you in the best possible way (...)’ (...) ‘I like everything on her; her manners, her smile, and her politeness. (...) she is not difficult, I mean, she won’t say ‘hmm’ and sidestep (...)”.

Caring

Another factor of satisfaction which was important to the patients was that of the caring, the interest and the dedication that nurses showed to their patients. The patients primarily perceived the caring, through the empathy showed to the patients for their medical condition and pain, the fact that the nurse responded to their calls beyond the allocated visiting hours, and the speedy accommodation to their desires without any objection. In addition to the above the patients valued the most the nurses' interest on calling them beyond the working hours and on weekends to check on their health and their well-being, and to confirm that they took their medication promptly and correctly and check whether the medication had the desired results. Some patients also greatly appreciated the fact that their nurses gave them their private mobile numbers with the freedom to call them whenever they needed them, even during night hours. Others appreciated the fact that their nurse paid them additional visits which were beyond the program's schedule and outside their working hours should there was urgency. There were a few cases that the nurse visited the patients without any special reason but merely to check and make sure that all was well.

In one case (Int.7), the patient also mentioned that at times the nurse brought to them cakes, fruits and other goods. This was perceived by the patient as caring. In another case (Int9) the patient thought that the fact that the nurse brought to her some medication and bandages was an act of caring.

A typical description of caring was given by patient (Int. 9):

“He does not treat me as I am a drudgery, to merely come to my place, change my wound and then leave, eh, he talks with us, with me at least, eh, I consider him being a friend before all other things.”

Psychological support

The humane approach was also perceived by the patients when the nurses offered psychological support. As described by the patients, the nurses gave them hope that their health would improve and encouraged them to keep trying and that they would soon be better.

Some patients also mentioned that when they were depressed and nearly gave up all hope, their nurse tried to change their negative thoughts by finding something positive and hopeful to say, using good humour and telling funny jokes and in all creating a cheerful atmosphere which was helpful to overcome their depression. This element of psychological support is shown in the following interviewees’ quotes:

Int.5 “(...) gives you courage, (...) gives you hope that one day you will get out of this bed, that you won’t spend the rest of your life on this mattress, (...).”

Int.9 “My nurse is a cheerful person... a person that, even if you have, like me, I have depression because I am not well, when I am like this my nurse tries to make me forget this...eh, my nurse tries to make me forget my problem that I have and take me somewhere else, to make jokes (...).”

Offered good information, guidance and advice

Good information, guidance and advice were an important factor of satisfaction and what was perceived as ‘humane’ approach. This was mentioned by many interviewees in various forms of actions; the nurses updated the patients on the progress of their health, provided advice regarding self -care, the quantity, the duration and side effects of the patients’

medication, information regarding the supply of the needed medication, advice on which doctor was the most appropriate to visit. As explained by the patients, the above information and guidance was of great importance to them as some of them were of an elderly age and some of them of a low educational level which made it difficult to read and comprehend drug or equipment instructions.

Some of the patients had, as they stated, weak memory and they needed constant reminding and written instructions by the nurse, in order to take their medication promptly and accurately.

The nurses conveyed a sense of protection and security

On one case the patient felt satisfied mainly because the nurse conveyed a sense of protection and security which was important for him.

The reliability (Int.2) and the medical competence (Int.4)

One patient (Int.2) was very satisfied because his nurse was very reliable on her timings during the visits. Another patient (Int. 4) was satisfied because her nurse was efficient, knowledgeable and highly competent providing the needed nursing care.

RESEARCH QUESTION 6:

What is the patients' perception of an ideal home care nurse? and

RESEARCH QUESTION 3:

What is the importance of each parameter of satisfaction for the patients?

The Patients' perception of an ideal Home Care Nurse

When patients were asked to describe the ideal nurse, the description they gave was not far from the description they gave when they were asked to describe their own nurse. However, one new element emerged in describing the ideal nurse which was not stated when describing their own nurse. This new factor was stated as: 'high standards of nursing knowledge'.

The main elements underlying the ‘ideal nurse’ according to the patients’ perception were identified during the in depth interviews and are listed here below based in order of frequency:

- Having a good character,
- Offer psychological support,
- High standards of nursing knowledge,
- Caring,
- To convey a sense of security comfort and relief,
- To listen to their opinion and respect their wishes,
- To be on time.

Having a good character

Almost all patients stressed as the first and foremost feature of an ideal nurse the good character. Patients described this ‘*good character*’ as a nurse who is compassionate, kind, one who talks to the patient in a ‘*good way*’, who is polite, and one who ‘*never gets angry*’ and who is ‘*not whimsical*’.

Additionally as the patients explained an ideal nurse should always smile, be sweet and be well behaved. The ideal nurse should not pretend but be genuinely kind and caring. One of the main characteristics of the ‘ideal nurse’ was described as the ‘*nice way*’ that the nurse approaches and communicates with the patients. As some patients explained the state of their health affects the way they feel, making them more sensitive to ‘*the way*’ in which one talks to them. Nurses who ‘*get angry*’ with them and ‘*shout at them*’ make them feel very bad and effectively unable to freely express their thoughts and feelings. The patients explained that due to their dependence on the nurses, they would not react as otherwise they would on a nurse’s misbehaviour. To the contrary, when the nurse is soft-spoken, smiling and polite and makes jokes, then they feel comfortable to talk freely to the nurse; they are not frightened or embarrassed, they feel safe to share their inner thoughts and feelings, and seek information and advice on issues concerning their health. To this effect, the patients are well aware that feeling free to communicate provides opportunities for the nurse to identify issues and hence intervene on time and effectively to improve their physical and psychological state.

The following quote is characteristic of what the patients meant by ‘good character’ and indicate the benefits to the patient:

Int.1 “(...) and when a person is happy, you feel more comfortable talking to them let’s say(...) and if you need something from them, you don’t feel bad asking// you are not embarrassed you know, when a person is sweet, you go ahead and ask them what you want and hmm... you feel relief. (...) if a girl is sweet it gives you strength, this is the way she talks to you/ but if she is difficult, she speaks to you in a moody manner right? But if her manner is let’s say kind and this kindness is genuine, you feel more safe.”

Int.9 “First of all the nurse must be human (...) speak with the patient, (...), make the patient feel comfortable...this is the most important thing in my opinion...because when a nurse goes and straight forward says to the patient, ‘Come on, turn to check your wound’, and then finishes and leaves immediately, it is somewhat cold... after all it is someone who sees your body, you should feel comfortable with this person. At the first meetings with my nurse I was embarrassed, but when we made some jokes (...) I got over this problem. (...) So, yes, as we have said the nurse should above all be human and try to communicate with the patient, and not face the patient as a piece of meat, do the visit and leave. This patient is a human being, it has got a name (...), so be social, as the word says, be social, not communal (laughter).”

When the researcher asked a patient (Int. 4) to give an example of what he meant by an ideal nurse ‘having a good character’, he offered an example of how a nurse having a good character should not behave:

Int.4 “I was holding my walking aid like this and the boss (meaning the nurse) starts shouting at me, - ‘Why are you holding this?’, (...) Next time you come, don’t bring this with you.’ I was not letting it touch the ground, to be honest, you know...- ‘Why are you carrying it with you since you do not use it?’ -Well, I have it in case I lose my balance so that I can use it to hold on it. - ‘Well, next time you come don’t bring it with you”.

Offer psychological support

Offering psychological support was another major characteristic of the ‘ideal nurse’. Dissimilar to the above example the following one given by patient Int. 4 surfaces the importance of the nurses offering psychological support to the patients and how beneficial this encouragement can be to their medical improvement:

Int.4 “There was this guy (meaning the nurse) from Paphos, a tall man...I used a wheelchair then, and I used to go there to the bed and sit in order to stand up, when I left the hospital I couldn’t walk. – ‘Stand up and you will walk.’ (...) ‘Come on, stand up and we walk together, don’t be afraid (...) Walk and I am holding you.’ He was holding me by the shirt, - ‘Come on my man, walk, don’t be afraid.’ And we actually walked up and down. - ‘You see mate, we did it. Let’s go once more. Walk, don’t be afraid, walk alone now.’ So, after all we did walk.”

High standards of nursing knowledge

Another characteristic of the ‘ideal nurse’ that was not identified by the researcher when the patients were asked to describe the characteristics of their own nurse, was the patients’ prerequisite that the nurse should have high standards of knowledge, theoretical and practical, and to be confident in order to act impromptu at any given moment to ‘do what she had to do properly’.

Caring

Some patients identified that the interest and caring that the nurse shows to them is another important factor that the ‘ideal nurse’ should have. The patients indicated that if a nurse was indifferent and not genuinely caring for them this would have detrimental effects to the advancement of their health. They also said that this is especially important for the elderly patients who face mobility difficulties.

When asked by the researcher to give examples supporting what they meant by ‘caring’ some patients chose to give examples of what not caring meant to them out of their own experiences. Irrespective of these examples took place when the patients were in the hospital they still show what they meant by saying ‘lack of interest’ and ‘lack of understanding’, hence lack of caring, to the patients and to the patients’ relatives:

Int.2 “(...) although I was not operated, I was placed in the surgical unit. (...) Well, there was a man, not very old but old enough, who had been operated, and his

daughter was with him taking care of him. Ehm, she did not cope on her own and the nurses did not help her. This made the worst impression to me, they did not help her, ...she was calling them... -come and I cannot do it on my own...-come and I cannot lift him up for example... (...) They did not go. The next day the old man died out of heart attack (...). The next day his sons came and, oh Mother Mary, (...) how did the doctors got away with it, it is a miracle. (Laughter).”

Int.2 “My mother was for many months in the hospital because she fell and broke her pelvis (...) and I went every day to visit her (...), next to her there was an old lady who had no visitors, her children were living abroad (...). They brought her meal, they did not help her to eat it, they brought it ...and took it away untouched as they brought it (...), because she could not eat it. Eh! A matron passed by and I complained about this. She told me – the complaints must be done in writing.”

To convey a sense of security

One patient stated that the ‘ideal nurse’ should convey a sense of security to the patient.

To listen to their opinion and respect their wishes

One patient stated that the ideal nurse should be “*obedient*”, meaning that the nurse should listen to the patients’ opinions and respect their wishes.

To be on time

One patient pointed out the ‘ideal nurse’ should be on time on her visits.

Further to the descriptions of the ideal nurse by the patients as these were described above, the findings to the challenge where the patients had to choose a picture out of four that depicted the best nurse for their care in their perception and thereafter asked to justify their selection threw more light to answering the following research questions.

RESEARCH QUESTION 6:

What is the patients' perception of an ideal home care nurse? And

RESEARCH QUESTION 3:

What is the importance of each parameter of satisfaction for the patients?

IDEAL NURSE – Choosing pictures of Home Care nurses and justifying their choice

Four pictures (Appendix L) showing snapshots of home care nurses with their patients while on a home care visit were shown to the interviewed patients. Then they were asked, by the researcher, to choose which nurse they would prefer as their own nurse; then they were asked to justify their choice. The same was repeated by the researcher for the remaining three pictures and then for the remaining two. Int.2 could not participate in this question due to impaired vision.

The following findings were found out of the patients' justification comments:

Patients' criteria for making their first choice

The following two criteria were the primary reason for the patients' first choice: Humane approach and Age.

The nurse's humane approach seems to be the most important factor for about two thirds of the patients. The way they understood the 'humane approach' was because the nurse was smiling, she looked 'sweet', gentle and encouraging.

This humane approach of the nurse was identified by most patients in the nurse in picture No 3 (Appendix L), in one case in picture No1, and one in nurse of picture No2. However, which picture the patients' chose as their first, second and third choice was not important. Of importance was the patients' justification as to why they made the choice, albeit subjective in nature.

Age

Age as a factor of preference, was not identified during the interviews, when the patients were asked to describe their own nurse or when they were asked to describe the *'ideal nurse'*. However when the researcher showed to them the four pictures to choose from, age emerged as a primary factor of preference that influenced the patients' first choice. One third of the patients made their first choice of picture, based on the age of the nurse. However age had a contradicting influence across the patients. Two interviewees chose the one they thought was the oldest nurse as their first choice and they substantiate their choice as being more experienced and consequently she had more knowledge than the younger ones. As Int. 4 stated:

"I would choose the oldest one, who understands, whose eyes have seen a lot. (...) her eyes have seen a lot, she has seen many cases".

To the contrary another interviewee chose the youngest nurse because she thought that a younger nurse would have more energy, be more joyful and buoyant.

It should be noted, that the patient's perception as to which nurse was the older or the younger is not important. However, and for the purpose of additional information and good record, Int.4 and Int. 8 had chosen the nurse in picture No 2, as the oldest nurse. Int.7 chose picture 1 as the youngest nurse.

It is noteworthy that no interviewee selected the male nurse as a first choice. As explained by some female interviewees they prefer female nurses because they feel more comfortable with them. To the same line, all the male interviewees selected as their first choice, a female nurse possibly due to a cultural impression that women are better caretakers than men. Exceptions to this were the cases when there was a need to change the urinary catheter of male interviewees. In these cases the male patients felt uncomfortable if the nurse was a female.

Also remarkable is the fact that interviewees that their nurse was a male had not chosen the picture showing the male nurse irrespective to the fact that they were satisfied with their male nurse.

Overall, as their first choice most patients chose picture No. 3, followed by pictures No. 1 and then No. 2. Picture No 4 was not chosen by any patient.

Patients' criteria for making their second choice

The criteria for the patients' second choice were: Humane approach, Age, Gender.

Humane approach persists as the most important criterion for the interviewees preferred choice. This is explained as being a nurse who is well behaved, one that smiles, who is encouraging, kind, caring and one who genuinely 'enjoys' homecare nursing.

As Int.5 characteristically explained:

"Well, the girl in this picture, (meaning the nurse in Int.'s 5 second choice) , again... the way that she approaches the patient, eeh! She helps her in a way. You see, she places it (meaning the blood pressure monitor) to measure her blood pressure and she is smiling, with a small smile she approaches the old lady (...) her looks make the patient to take courage. (...) it is like she is saying do not be afraid (...)".

Likewise Int.4 said:

"Because he (meaning the nurse) has his hand over the shoulder of the grandfather (meaning the patient). – So, what does this mean to you? Kindness, it is not that she is doing it to grab the check (meaning the salary) and go, understand?"

Age

The choice of some patients is based on age, each one, though, looking at it from a different angle. One interviewee chose the eldest nurse because he thought that the nurse had more experience where as another interviewee thought that the youngest nurse was more joyful.

Gender

Two interviewees, one male and one female, chose the picture showing the male nurse. However their choice was not based on the gender. On one case, Int 4., as described in the previous quotation above, the choice was based on the nurse's humane approach indicated by his posture. On the other case a female patient, Int.7, based her selection on the nurse's young age.

Int. 6 thought that the gender of the male nurse prevented her from choosing this picture as her second choice. As she stated:

“Eeh, I usually choose the girls (meaning the female nurses) that you can tell them your complaints (...). Eeh, a man understands a man.”

Overall, as their second choice most patients chose picture No. 4, followed by pictures No.2, No.1 and No. 3.

Patients’ criteria for making their third choice

Subsequently, patients were asked to make a third choice. The patients’ criteria for their third choice were: Gender, Humane approach, Physical strength and Professionalism

Gender

As options narrow down, the matter of gender becomes more intense.

Two female patients firmly rejected the male nurse based on gender. As they explained they would not be comfortable talking to a man concerning their medical state and their psychological and personal issues and they would feel embarrassed to ‘show their body’ to a man as and when necessary for the required nursing care.

Int. 5 chose the picture with the male nurse without hesitation, because of his humane approach in his way, but then she immediately rejects her choice to making it clear that she would not like him for her own nursing care. However, she explained that the male nurse would be perfect for a male patient as clearly illustrated in the following quotation:

Int.5 “Eeh!...No, I would not like a man (meaning a male nurse) because, you know you can trust a woman more, a woman to a woman, I would prefer a woman to a woman (...) and you can talk more freely, (...) her problems, her mistakes (meaning her own(Int.5) problems and mistakes)(...) to a man are restrained, you cannot say everything. But a woman to a woman, has more comfort (...) you can easier loosen up to show your painful part to the girl, because you are a woman but and there is the matter a man to man, you see(showing the picture with the male nurse visiting a male patient) these two are better together....”

Humane approach

For two female interviewees the gender was not an issue. Int.1, chose the male nurse for his humane approach which she traces in his smile. The humane approach of this male nurse made her feel that she could open up and have the courage to communicate her thoughts and feelings freely.

Int.1 “Because he is smiling (...) He is smiling, he is not a gloomy face (...) and a man and smiling, you have more courage to talk to him and ‘more freely’ (...) and to ask a thing from him you will not feel that embarrassed,...when someone is sweet you ask him, you ask him and for a thing that you want, shall we say, so hmm! You feel relieved. – ‘Would you not mind the fact that he is a man?’ ‘ No, it doesn’t matter. Man, woman now they do everything...(laughter)’”.

Physical strength

A female and a male interviewee chose the man because of his physical strength. As they explained it would be easier for him to lift them up when needed.

Professionalism

Professionalism was identified by Int.4:

“This one here is more formal in her job; she has her stethoscope with her. (...)A stethoscope and medical bag, too. (...)She pays attention to her job.”

This was the only picture that the nurse was in a nursing uniform and she had a medical bag.

This criterion appears only in the third choice of the interviewees which implies that the professional appearance of a nurse is not important for the patients of Home Care.

Overall, as their third choice most patients chose picture No. 4, followed by pictures No.2, No.1.

Patients' criteria for making their fourth choice

The researcher did not elaborate on the underlying reasons for the interviewees' fourth choice as these were surfaced when substantiating the other three choices.

RESEARCH QUESTION 5:

Are there any problematic areas in the services provided by the nursing staff of the programme, that need improvement?

Before elaborating on the areas of improvement the patients were asked to identify the benefits of the program which are described below.

What are the benefits of the home care program according to the patients?

When the patients were asked what they thought about the program of Home Care, they all replied that the program's major advantage was the fact that their treatment was taken at home and as such they did not have to travel to the hospitals for their medical needs. This factor, as the interviewees explained, was especially important for them mainly because their health condition was a chronic one and its nature provided additional burdens for them to move or travel. The following quotation, through Int. 5 experience, supports the added value the program offers to the patients for not needing to go to the hospital.

Int.5: "(...) I cannot walk. I must use the wheelchair to move about, to go down the stairs to get in to the car, I must have two persons to lift me up and carry me down the stairs. This is impossible to happen; to have two persons to carry me to the hospital or anywhere else to take my injection. (...) the day before yesterday that I went to the hospital (...) my son had to come from Dali (a suburban village of Nicosia) and he brought with him (meaning other persons) to lift me with the chair, to take me down the stairs and to help me get into the car, something that was difficult for one woman (meaning the employed care taker). We had also our housemaid with us."

Additionally, they indicated that another benefit of the programme was that they did not have to depend on other people, usually relatives, for their transport to the hospital. Not only it made the patients' feel uncomfortable but at the same time they pointed out that it was time and money consuming for their relatives. This is characteristically described in what In. 5 and Int. 4 said below:

Int5. *"(...) for my son to come to take me to the hospital is a great burden...it is a big loss of time and big loss of money...// while for one girl to come for ten minutes, a quarter of an hour, to give me the injection is not a big deal(...)"*.

Int.4: *"Eh! But our own (meaning his own relatives) cannot look after us for a long time; they looked after us for so long... (...)."*

The patients who could possibly use public transport mentioned that cost was a major concern as most of the patients lived out of government pension. Int.7 gives an example of the cost benefit by describing the cost of a recent visit to the hospital:

Int.7 *"The day before yesterday I went to the doctor, we called a taxi to take us to Polis (a town in the district of Paphos). We gave him (the taxi driver) 10 euros...then he brought us back, we gave him another 10 euros, 20 euros in total. Eh! The doctor left from Polis..., they told us to go to Paphos (a major city), we found another taxi driver, he took us to Paphos and took 40 euros to take us only, to take us to the Paphos' hospital (...), not to take us back home (...)."*

Int.8, mentioned that enrolment to the home care program provided a sense of safety. As he explained, he had no one close to him with any nursing knowledge that could possibly help him when needed. The fact that a nurse was visiting him at home, promoted a feeling of comfort and content that he was looked after by a professional, he could trust his health care with.

What the patients would like to change concerning the Home care program and Suggestions for improvement

When patients were asked what they would like to change in the program there were the following suggestions: to extend the program's geographical area coverage, to recruit more nurses, to provide support on a 24/7 basis, to give authority to the nurses to bring to the patients at home the required medicine, to extend the offerings of the program so that it

covers activities of daily living such as preparing meals and bathing and to provide the required equipment free of charge.

Only one patient stated that he did not have any suggestions to make as he thought that all his needs were attended by the existing program.

To extend the program's geographical area coverage

The program currently covers only a small part of the geographical area of Cyprus. The patients enrolled conveyed the program's benefits to relatives and friends who, however, live in areas which are not geographically covered by the program.

To recruit more nurses

Most patients also indicated that the program should recruit more nurses in order to be able to cover a larger number of patients with similar needs, but also to enable their requirement for more frequent visits by their nurse and for longer duration of the visits. The visits as they explained were at times rushed due to the heavy daily schedule of their nurse.

To provide support on a 24/7 basis

Currently the program operates only on weekdays from 7:30 a.m. to 14:30 p.m. Most of the interviewed patients strongly suggested to extend the program's operating hours to a 24/7 hour basis. Three major justifications were surfaced: the requirement for their normal treatment beyond the current hours of coverage, the need to cover emergency cases and the need to provide information, advice and psychological support.

What the patients meant by normal treatment beyond the current hours of coverage, was the need for repetitive injections, blood tests or the cleaning of wounds. For these, some patients resorted to willing relatives that had basic knowledge of nursing care or employed private nurses. In the worst case, they would try to treat themselves, something which at many instances made their situation worse. The great need for a 24/7 support is described in the *interviewees' quotations below*:

Int.9: *"(...) when I was released from hospital, my wound needed to be changed every day, every day, but P. (her nurse) could not come during the weekend, we had to wait until Monday, I changed my wound alone... (...) because it was discharging fluids, and I waited until Monday when P. would come, and I was careful, I did not*

sit many hours, to put weight on it...(…) well, I am here all day, I lay down, I get up, something can happen to me that I need help. What do I do? I must have something....to call to help me.”

Int.5: “Eh! Our visit should be on all days of the week...the injection, but Mrs A. (her nurse) cannot, she is a public servant, she cannot work on a Saturday and a Sunday. She gave me, though, the directive to call one other nurse (meaning a private nurse) on Saturday and Sunday to give me my injection. This injection, on Saturday and Sunday is undertaken by my daughter in law who is a doctor and she works at Larnaca Public Hospital... and we have to call her over (meaning from the city of Larnaca to the city of Nicosia) to cover the missing days of the nurse.”

Most patients were aware of the seriousness of their health state; some were in a ‘very bad’ health state and some were at the terminal stage and this awareness increased their anxiety. Additionally some patients expressed great concern of not having any means or anyone to whom they could resort and nowhere to go in case of an emergency beyond the operating hours of the program. The following quotations are characteristic of their concern.

Int.4 “(…) if it was on a 24 hour basis the nursing care, any patient would also feel psychologically comfortable, because ...until mid-day, until 2:00 – 2:30...thereafter... ‘wait until next day!’. Eh!! People that die from heart attacks and other things, is at 5:30 in the morning... (..) in case of a danger (meaning emergency) , my sister is next door and she calls the doctor (...) but my sister... she is terrified, she will die before me from ahha – ouhha (expressions of stress).”

Int.1 “ Eh!, for the program, we cannot demand for them to come every day to take care of us (meaning activities of daily living) (laughter). (...) the same thing it would be for me (...) my blood tests, my injections, she does that, what more would the girl (the nurse) come to do? It is a burden for her to go about there and here (...). So I do not request, to say, to come more times. –‘But, would you liked for her to come more often?’ ‘Eh! It would be better.’ -‘Why would you like that?’ ‘Because you feel ‘lighter’ (meaning psychologically relieved) that you have a doctor (meaning the nurse) near you, you do not say ‘I am here and I do not have anyone to look after me’. This way, she comes, she sees you, you take some relief, shall we say!’”

Some nurses in order to fill this gap gave their private phone number to their patients allowing them to call at any time of the day in case of an emergency. Worth noting is the fact that such gesture was against the programs guidelines.

To authorise the nurses to take the patients' required medication at their home

Another interviewee wished that the nurses were permitted to bring the patients' medicines and other required consumables, to his home so that he would not have to go to the hospital himself to merely get his medication, as per the existing rules and procedures. This also had to be at specific working hours and specific weekdays that the public hospital services were available. In the quotation below, the interviewee explained why this facility was important for her.

Int.5 "(...) yesterday I was anxious on who would bring my medication, the working hours of my daughter do not match, she is a public servant, her working hours are the same hours as the their hours (meaning the public pharmacy) (...) this was for me a big anxiety because I did not have anybody. Because I was hoping to send my sister's maid to get my medicine from the medical centre of Engomi (which is close to her house) but only the General Hospital of Nicosia, the old one and the new one have the medicines."

To provide required equipment at no cost

One interviewee put across, that the medical equipment necessary for the treatments of the patients should be provided to them at no cost.

All the above suggestions were unprompted and were made by the interviewees when they were asked 'what they wanted to change in the home care program'. Further below the researcher asked more specific questions on certain issues that had emerged by the findings of the survey questionnaire.

The need to incorporate other health professionals in the program

Subsequently, patients were asked whether they would like to see other kinds of health care professionals in the program of Home Care.

The need for a physiotherapist

Almost all interviewees strongly advocated that the program should include physiotherapy at the premises of their homes. This need is vividly expressed at the following interview quotation:

Int.4 *“Last year my arm was better, I washed a cup now and then, with the oxygen (therapeutic carry-on oxygen bottle), I walked all the way to the sink. Now ‘our’ hand, ‘our leg’ is tighten (...). (...) If, it can happen, for a physiotherapist to come home for some time, at least the arm.../to improve at least the arm it would be great. (...) it is because of the oxygen (the oxygen bottle), that ‘we’ do not walk and you cannot walk a distance and... you sit, sit, sit, sit... (...)”*

Most of them, due to the nature of their illness, need such treatment which presently is provided by the major Public Hospitals of the cities after an in advance appointment. However they claimed that they have extreme difficulties when it comes to transport because of the nature of their illness which could be, for example, deficiencies in mobility, impaired vision or the requirement of oxygen support. Most of the patients stated that it is difficult for their relatives to transport them, that it is difficult for them to use the ‘public busses’ and that the city hospitals are at a considerable distance from their homes. The necessity of physiotherapy in the program and the difficulties are described vividly in the following interview quotations.

Int.3 *“Since I had the stroke, this hand cannot hold anything, now and this one (showing the other hand) is playing tricks to me too. (...) if there was a physiotherapist to come once or twice a month, to help the patient, yes! (...) because for me it is difficult to go to the hospital frequently. (...) when I left the hospital, they told me to go for physiotherapy, I could not go. (...) I cannot go to the hospital, I cannot go outside (meaning to a private physiotherapist), financially I am a pensioner.”*

One interviewee indicated the added benefit if the physiotherapist could come to his home, which was the opportunity to show to the patients’ relatives and the care taker how some exercises are done so as in turn they could assist the patient to repeat the necessary physiotherapy exercises every day.

Int.4 *“(...)... maybe I will tell my sister when the man (meaning a home care physiotherapist) comes, for my sister to be present to see the injury that I have, the therapy done, and maybe my sister could also ‘massage’ me a bit. (...)”*

What practically happens, according to the interviewees’ description is that most of the patients adhere to the initial schedule for the physiotherapy treatment which is done at the

General Hospitals. Thereafter they fall back and stop for the reasons explained above. As they describe this has detrimental effects on their health; they forget how to do the necessary exercises at home and they are not monitored on their health improvement at all. Should a physiotherapist visit them at home their monitoring and health improvement would substantially become better. Only a few patients could afford to employ a private physiotherapist to come at their home. As one patient characteristically pointed out:

Int.5 “(...) I will need a physiotherapist who will guide me how I will work my leg, little by little..., because it is not suddenly that I will make the steps, it is slowly-slowly that it will be done (...) I will call a private physiotherapist, I have to. (...) I would like to go to the hospital but I do not have anybody to transport me. My husband is very old, he cannot drive, my children are living far, and one child I have near me works (...). (...) if there was a public program that could send a physiotherapist at home it would be a blissful thing.”

Int.2 “Eh! It would be easy for us to, let’s say, to come at home (meaning the physiotherapist) (...) It would be good for us, it is different when we cannot (meaning physically difficult) and take one (meaning ask for someone) to take us and again with a push, we cannot, it is better to come at home.”

The need for doctors in the program

When asked, the interviewee’s gave diversified opinions as to whether it would be beneficial for the program to incorporate medical doctors; some thought it was important, some thought that it was not necessary and some thought that it would be beneficial only if these medical doctors were specialists.

As it was then explained, the underlying reason given, by those interviewees that thought that it was not necessary to incorporate doctors, was the fact that they did not trust that the government officials will employ the right specialists.

Int.2 “Well, I will tell you my opinion...if I knew that I would have the physician appropriate for my health problems, of course and I would like the program to be able to provide me with one, but because I know that something like this is impossible, I don’t ask for such things, (...) Do you believe that I would be able to ask for an endocrinologist or cardiologist to come here? Well, (...) the Public Health Department doesn’t have an endocrinologist, how would they send one here?”

One patient indicated that he consults a private doctor and that the communication between his consultant and the home care nurse was good without any issues, resulting to the best possible treatment for him, hence he did not see any added value for the home care program to employ doctors.

Need for psychologists

Only one patient, (Int.9), stated the need for a psychologist as described in the following quotation:

Int.9 “(...) one psychologist is important to be in the program...sometimes I am feeling down (depressed) and I will sit down to drink (alcohol) and I want to cut it out... in any case that is a long story, a big chapter... the alcohol. -Does any nurse from the Mental Health Department visit you?’ ‘No!’ -Have you asked for one?’ No, I did not ask...but...I do not know...I do not know who to contact. -Have you at least asked P.(the nurse)? I think I did not ask him”

Communication with the nurse via the phone

When the patients were asked the above question their answers varied. Some patients were very satisfied with the communication with their nurse via the phone because they had the mobile number of the nurse and they were using it to call at any time without any concern as described below:

Int.6 “(...) and at noon, and after noon and during night many times and she answers in the best manner (...). (...) ouou! We call her every so often, every so often I disturb her, especially ‘her grandfather’ (the patient’s husband) always.”

Some others had the mobile number of their nurse and they were satisfied by the communication via phone but they were more considering when it came to using it:

Int.8 “Yes, I do have his mobile number but I as a man I think of it, I prefer some hours that I think I will not disturb him.”

But most of the patients did not have the nurses’ mobile and were only able to call her on the nurse’s office phone number:

Int.1 “She gave me her phone number at the office and I call her. (...) because she works I must call her at 13:30 to find her in, if I call her earlier I will not find her because she has her work, she is out (meaning out visiting patients).”

Int.4 “(...) There is another girl (meaning another nurse), they will leave a message for her and she will call me back when she goes back at her office (...)’ ‘(...) when she will go in (meaning return to her office) she will call back and say: ‘Yes, C. what do you want?’”

The nurses report at work at 07:30 in the morning, check in, take the required apparatus and they promptly go out to collect blood samples for the patients that need the blood tests. This has to be completed until 08:30 when the blood samples will be sent to the laboratory. Between 8:30 and 9:30 they stay at the office to prepare for the day, before they go out for the scheduled patients' visits. They are back to the office at 13:30 until 14:30 where they deal with administration and report writing. It is during this time when they will check for any messages from their patients and call them back and it is during this time when a patient could reach them on the office line. To this end, there is an answering machine to collect messages that are recorder beyond normal working hours and during weekends and public holidays.

These inherent restrictions for the patients to contact their nurse created some stress and concern to these patients as described below:

Int.4 “If something unexpected happens beyond the working hours of the nurses, can you contact them?’ ‘She does not answer the phone; she does not have a phone’ (...) ‘Eh! If something happens during the night, it is dangerous, because last year ‘we’ had it at 1 ¹/₂ the oxygen (...) this year ‘we’ put it, ‘we’ go 2.5, 3, it is increasing...the situation (...).”

Some patients enjoyed more support from their environment thus they did not feel the need to have access to their nurse on a 24/7 basis:

‘If you need the nurse during the afternoon or during the night, can you reach her on the phone?’ Int.3 “I did not need her, if I need something I go to the emergency response department.”

Int.2 “(...) I did not think about this because in a case like this I have other people to help me. (...) so I never thought of it, that I will need her during night time to help me”

One interviewee clearly suggested that it would be good if there was a 24/7 help line that could support the patients around the clock and a shift roster for the nurses so that the program operated 24/7.

At the same time, it was sensed by the researcher an attempt by some interviewees to ‘protect and excuse’ anything that could be taken or thought of against their nurses:

Int.9 “Well, in the weekend, on Saturday or Sunday, well, no, I don’t think so...they also need a day to rest...unless they will work on shifts...that would be ok.”

Information Given

Most of the interviewees expressed high levels of satisfaction with regards to the information they received from their nurses. This information invariably revolves about issues concerning their medical health, the nursing care, information on existing and new medication and on providing guidance and references for further or remedial treatment. The quotations below are characteristic:

Int.6 “Oouou! Many, many, any different things you can think off she will explain it in the best possible way’ ‘(...) Eeh! I might tell her, they gave me a medicine that I do not understand it, she tells me ‘ I will pass over while on my way’ and on her way to somewhere else she passes by, for a moment to guide us. (...) and for the medicines and when the medicines change, to explain to us to tell us everything. (...) The day before yesterday she came, she takes my sugar levels, it was 265 something like this, that high. She told me, now, immediately go to Polis and ask for that specific doctor who specializes for this sort of things and she cares more.”

Int.7 “(...) the fly infected his leg (her husband’s leg) and because she is the one who saw the old man, and she saw his leg, the fly there and she tells us ‘now at once to call a taxi to take you to Polis’ (...) it was infected, and we took a taxi from there, they said they cannot at Polis, and she was explaining to us how to get to the surgeon.”

The nurses invariably informed the patients about themselves before performing the treatment to them:

Int.4 “(...) She sat close to me and she told me I am this and this lady, I am coming from the hospital to treat you for such and such purpose, (...).”

The nurses undertake to liaise, the patient’s concerns to the specialised doctor, and furnish back to the patient the necessary doctor’s advice on the recommended treatment:

Int.9 “Yes, of course, of course, of course, of course. That is I may ask him, eeh! for example with my blood that he takes (blood sample) eeh! I tell him to put some injections since it is so high, he tells me to discuss this with a doctor first and then I will call you and I will call you back, and he calls me back and he tells me ‘it is not necessary to take the injection, I will tell you when...’ that is we discuss things, he is not that kind of a man...”

The nurses keep their patients informed when there is a change of schedule. They seem to be aware that the patients get anxious when the nurses are late or for whatever reason do not show up as scheduled:

Int.5 “ (...) one or two times she calls us to let us know that she will be late, or that she will not be able to come on the scheduled time. (...) I know that tomorrow she will come, but in case that she will be late or she has a different schedule, like as yesterday, she had scheduled to be late because she wanted to remove other patients’ catheters. As such I knew that she would be late.”

The nurses will pass over their knowledge with regards to the details of where and how the patients can acquire the required medication. This information seems to be highly valued by the patients as it saves them time and effort as I.nt 5 describes:

Int.5 “(...) Mrs A. (the nurse) she guided me and told me that these medication is not available at the Medical Centre, only at the new General Hospital of Nicosia are available. As such she ‘opened my eyes’ (meaning she has enlighten her with this information)”

Int.5, also mentioned that her nurse provides her with advice regarding her nutrition, on how to treat her wound and on how to bathe safely.

There are cases, as in that of Int.6 described below that discussions evolve on some personal issues. People of lower socio economic status find it important to create a personal relationship with their nurses. The nurses are aware of this and provide some limited information regarding their personal life. This creates a relationship of trust and cooperation:

Int.6 “Eeh! Certainly, she told me, I asked her, let’s say concerning her family, my family is at that place, I live at that place, I have so many children, because I ask her are you married, are you...and she explained to me, (...).”

Considering the opinion and the wishes of the patient

Within the survey questionnaire the patients were asked to rate whether *‘The medical care I received was guided mostly according to my wishes rather than the procedure the nurse wished to follow’*. The responds varied across the scale henceforth the researcher decided to explore the issue more during the interviews.

According to the patients’ interviews, the nurses take into account the opinions of the patients when providing nursing care. Int.5 and Int.1 replies were slightly differentiated by stating that even though they were aware that they could freely express their opinion about their care, they did not feel that it was necessary as they had confidence in their nurses that they would do the best possible for them. Patient Int.3 realised that he could freely express his opinion but it would only be accepted by his nurse if it was feasible to do so.

Equipment

Patients were asked whether they could have easy access to any devices or equipment necessary for their medical care.

Two patients, (Int.6) and (Int.1), did not need any kind of equipment. One patient, (Int.2), needed some kind of equipment but he did not ask for it, explaining the reason in the following quotation:

Int.2 “(...) I may need something but I usually purchase what I need on my own, I did not ask for... for the government to provide me with this equipment.’ ‘Why did you not ask for it? Did you think that they would not provide the equipment to you?’ ‘No, it is rather due to the way I think of it’ ‘Ah!, You want to purchase it

yourself? Do you believe that the one you will purchase will be of better quality?’
‘No, no, no this is not the reason. It is the psychology, I was brought up with since I
was young.’ ‘Would that be not to ask for anything?’ ‘And not to ask, and not to
ask, but also those things that I can, I do them on my own.’”

The remaining 6 patients needed some equipment which they had to purchase themselves because the program did not provide for it. This equipment included therapeutic oxygen bottles (Int.3), (Int.4), a wheelchair and a bath seat (Int.5), a walking supporter (Int. 7), an airbed and a wheelchair (Int. 8) and only a wheelchair (Int. 9).

The program does not provide the patients with any kind of equipment that is needed for their health care. Therefore the patients who are in need for any supporting equipment or consumables must purchase these bearing all expenses.

There are cases, as explained that they only need a particular equipment for an interim short time. However there is not a system in place where by they can borrow the needed equipment and then return it back. As explained by many interviewees, the private companies who sell such equipment will not purchase it back, will not provide any sort of refund and will not provide any exchange facilities.

The same stands for the oxygen bottles along with the oxygen regulator. In this case they also have the choice to rent the specific equipment. Apart from the cost of the purchase of the oxygen bottles, they have to pay for the transport of the bottles to their home, every time they need to be refilled.

The case of the provision for therapeutic oxygen bottles is unique in the sense that there is only one Supplier Company. This company will sell the oxygen bottle to the patient and then refill it at his place. Apart from the monopolistic issues in terms of price control some patients expressed concerns with regards to their health being dependant on only one company without any alternative should something happens to this company as vividly expressed in the following interview quotation:

Int.4 “(...) but it is another thing/ our worries...// eh we run out of oxygen eh!/ that
fear / for example ...if they bombed H.(the name of the company that provides the
oxygen bottles), it means that all the dying will die all of them.”

Some interviewees suggested that the program should provide the patients with an electrical therapeutic oxygen generator which as the patients supported, has the benefits of being small, portable and easy to move around and about and it is independent of any supplier or third party agent. They also said that apart from being safer, more secure and convenient its operation would be cost efficient to the patients.

For the rest of the equipment most of the patients suggested that the program provided the equipment at no cost. Additionally, Int. 5, suggested that a system should be put in place so that equipment required for a short time could be provided by the program and circulated amongst the enrolled patients as and when needed: for example a patient needing a walking assisting device or a wheelchair after a broken leg, only for the period it requires to heal.

Conflicts and Complains

Patients were asked whether there were times that they disagreed with their nurses on issues regarding their health care and following a question whether they had complained about it.

They all said that they never had any kind of differences or disagreement with their nurse and therefore there was never a need to complain. In some cases there was an obvious feeling of the patients *'being terrified'* to surface their complaints if they had any. In fact they would acknowledge that in the case they did have a complaint they would not make it. This is possibly because of the fear of a negative effect on their nursing care. As characteristically Int.7 specifies:

Int.7 *"I do not have any complain, I do not complain to no one, (...) even if I had, I will do nothing. I do not make any complains I do nothing."*

Only one interviewee admitted that she had a complain at the first visits of the nurse, but immediately reassuring that in the end the issue; a developed wound as a result of long hours of staying in bed, was not the nurse's fault.

Int.9 *"(...)Only at the beginning, with my wound, I took it all on him(the nurse, Mr. P.), my mistake...mine, I tell him 'you saw it and you told me nothing, I thought it was his fault, but it was not his fault and he did not tell me anything because he knows my character P., he thinks, if I tell her anything now she will...(...) No, no I never become...to get angry with P."*

Findings of the In Depth Interviews of the Nursing Staff

Nursing staff profile

The researcher has interviewed five home care nurses; four were female nurses and one was male. Three were working in the district of Nicosia, one in the district of Limassol and one in the district of Paphos. An effort was made to interview nurses from different geographical areas of the home care program. All the nurses who participated in the in depth interviews graduates of the Nursing Academy of Cyprus and had between 17 to 22 years of service as nurses in the public sector. They had also completed a post degree course on community nursing, which was a prerequisite for being transferred to work in home care. They have been working in the home care program for the last 3 to 7 years.

RESEARCH QUESTION 1:

What is the patient's level of satisfaction from the nursing staff of the Government Home Care program in Cyprus?

All the nurses who were interviewed believed that in general all the patients of Home Care were very satisfied from the nursing care they received. In their modesty when they were asked they identified that the main pillars for the patients' satisfaction were: the high quality of nursing care that they received and the good and helpful advice that the patients, their relatives and their caretakers received regarding the patients' treatment, self-care, safety at home and other matters such as access to government benefits and other supportive public services.

The benefits of the Home Care Programme

All the nurses who were interviewed, thought that the home care program was very beneficial for a number of reasons; it makes the patient's life easier because they do not have to be transported to the public hospitals or the public health centres for their treatment. This is most important as most of the patients who enrol on the program are either elderly or immobile or both as Int. 1 describes;

“They (meaning the relatives and the care takers of the patients) are very positive towards this service (meaning the home care program) and basically they are

relieved. (...) The discomfort they had, the burden they had, required to recruit other people to help them to transfer the patient, or they had to call for ambulance just for a blood collection, (...) they had to pay a private laboratory to come home.”

The public hospitals are decongested as patients can be de-hospitalized earlier and their post operation treatment can be continued at home through the home care program; Int. 1 continues;

“(...) by staying in the hospital just to get / some wound to closing up or by staying in the hospital simply to be taught / to get the patient to know how to get his medication, the insulin treatment etc. the costs is much higher compared to the patient staying at home and for the nurse to visit him once or twice (...) (meaning per week).”

The nurses shared the opinion that the home care program offers a continuum to monitoring the progress of the patients' health, a prompt reaction and treatment to any deterioration and at the same time the patients, their caretakers and their relatives are advised and trained for the care as required for the patients' treatment. This gives back a high degree of independence to the patients and their relatives and in turn it creates a feeling of security and safety which in turn boosts their psychological and emotional state. To this end Int. 1 said:

“Or we may, let us say (dialect idiom), teach F. ... the girl (meaning the care taker), maybe we will not teach directly the children (meaning the patient's children), or may not teach the husband or the wife we may teach the care taker and they treat and change the wounds on their own, or if he(the patient) is diabetic they will do / check the sugar levels and administer the insulin (...).”

“(...) they(the nurses) can tackle more difficult situations in the sense of (meaning for example) gastrostomy, tracheotomy which is one of the most difficult cases and they feel safe when they(the nurses) know that the caregiver also knows and they(the caretakers) know that someone (meaning the nurse) came and checked on him at least once a week (...).The(the caretakers) know that there is someone (meaning the nurse) that can listen to them and give some instructions, if nothing else to help them solve the problem if they cannot solve it themselves.”

The nurse said they also advise their patients on issues beyond their nursing care such as their better wellbeing, home safety and security.

Most of the nurses that were interviewed considered that home care will be increasingly popular and vital as an alternative for the healthcare of the elderly. The nurses supported this on the fact that the newer generation gradually, will not take responsibility for the care of their elderly as previous generations did. This is partly because they feasibly cannot and partly because they do not want to, as Int. 2 noted:

“(...) many times we might not find response and the children may be many and no none of them is in contact with the parents and they are left in abandonment or at some stage they will necessarily be placed in an elderly home because they do not have any other option.”

However, another interviewee indicated that still in Cyprus the family bonding is still strong.

Int.3 “(...) we are in Cyprus and fortunately the family still keeps well (...). Previously, when I had said in P. (name of a village) that they (elderly home care patients) were alone it was because of the distance, because the young people leave (meaning leave the villages) and the elderly are left alone, (...)”.

RESEARCH QUESTION 5:

Are there any problematic areas in the services provided by the nursing staff of the programme that needs improvement?

The interviewees have identified the ‘problematic areas’ of the program which are described in this section below.

The need for physiotherapists and other professionals

As most of the interviewees explained the absence of physiotherapy offering at home is a major factor that troubles the patients that need it.

Int.3 “(...) I now have a Mr. B. that I will arrange for him for physiotherapy at the physiotherapy department of the General (meaning the General Public Hospital), that he will be taken there by his wife. But they want, they prefer similarly to the nurse to do physiotherapy (meaning at home) by calling a private (meaning physiotherapist) until he walks (...).”

The home care nurses try to fill the absence of this service by providing basic advice and showing simple exercises to their patients in order to help them. Int. 3 continues with another example:

Int.3 “(...) ... I brought this example, a grandmother with hip faction who cannot walk at all. For her to go for physiotherapy up there (meaning the distant General Hospital) is a lengthy process (...). But they might simply need a few exercises, a bit of walking, a few exercises up and down, (if so) I will show them // (...)”

The interviewees believe that the service they provide on this sector is inadequate because they are not specialists on physiotherapy issues and they can only provide basic advice only in mild cases.

Some interviewees said that other specialists were also needed but not as urgently and to the same extent, these were the psychologists, social service servants, specialized doctors and nutritionists.

The need for more male nurses

Most of the nurses are women. The female interviewees explained that when it comes to perform some ‘sensitive’ nursing activities such as the change of a catheter to male patients, both the female nurses and the male patients, feel uncomfortable.

In the district of Nicosia the home care nurses mobilize a male nurse who is assigned to serve the public prison. They call him in when there was a need, but usually once every end of the month, for the required catheter changes of male patients. Int. 1 noted that:

*“(...) we did not reach that stage yet that we can change the catheters for our male patients and we cooperate with him (meaning the male nurse who works at the public prison)’ **‘Is the issue that you do not want to do it or the male patients do not want you to?’** ‘(...) none of the two sides, we are not comfortable (...), nor do the male patients want it. They feel uncomfortable. I had an incident, my patient refused an appointment with a female urologist he told me to make an appointment with a male urologist. It is not comfortable yet in our society. We cannot see things strictly professional, that is to shut off all other sides of your life, to act strictly professionally, to do your job and leave. (...).”*

In one village at Paphos district, a local male nurse serves his fellow villagers as needed. In the other villages of Paphos and the villages over the mountainous areas of Nicosia the male patients employ a male nurse for the required change.

In the district of Limassol there is a male nurse and as such there is no issue.

Insufficient telephone communication

All the interviewees shared the common opinion that the time that the patients can reach them on the phone is very limited and insufficient. The only time they are at ‘base’ at their office is one hour during the morning and one hour before they finish their work. As Int 3 describes:

“(...) and the telephone, there is a major issue when the patients want to communicate with us on the phone because they(meaning the government) do not provide a mobile phone and we wait specific hours that they (meaning the patients) can call us so that they can find us in (meaning in the office). That is because in the morning we collect blood samples from 7:30am when we start and we are away

until 8:30am where we will come back in to send the blood samples (meaning to the public laboratory). Ehh! From 8:30am until about 9:30am they can find us in the 'base' (meaning the office) and then again when we return back between 01:00pm until 2:30p.m.as such it is not possible, the fact that there is no mobile, to have a continuous communication (meaning with the patients)."

Two of the interviewed nurses gave their personal mobile number to their patients. One of these two, a female nurse allowed her patients to call her at any time of the day and at any day of the week. The other one, a male nurse had a second mobile number which he used specifically for this purpose and he would answer it during all his working hours but he would switch it off when he was off duty.

Most of the nurses did not give their personal mobile number to the patients.

Inability to take the patients medication at their home

Considering that by nature the patients that were enrolled in the home care program were either elderly or immobile or both, the fact that the nurses were not allowed to take their patients' medication at home was an issue that caused major inconvenience to the patients, as the Int. 3 gave two examples:

"(...) it might, the wife who takes care of the husband, let us say, that he suffered a stroke, she will tell you that it is very difficult for her to go all the way to the general hospital leaving behind the man who suffers.

I also have an elderly grandmother who always complains that she is alone (meaning that she has no one to purchase her medication from the hospital for her)... (...)."

Not providing coverage on 24/7

All the nurses share the same opinion that the program should be expanded on 24 hours a day and 7 days a week (24/7) basis. Int. 5 specifically explains:

"(...) look, the main purpose...one of the main purpose of the home care program is the discharge of the public hospitals, if it is done on a 24 hours basis, it will serve even better the discharge of the public hospitals. For example if I have a patient...with diabetes he can even leave the hospital unregulated if there was 24 hour coverage and on weekends."

Prescriptions for medication and consumables by the nurses

Another issue that creates many inconveniences to the patients is the need for doctor's prescriptions for medication that is either plain or an extension of existing one or consumables. The existing procedure was very cumbersome and inelastic which wanted the patients to make an appointment with the doctor at the general hospital and then collect the medication from the public pharmacy. Some interviewees admit that sometimes they help the patients by asking the doctors to write them a prescription without a visit and a physical examination of the patient. Int. 2 elaborates:

Int.2: "(...) because we have worked many years at the hospital some (meaning the doctors) may know us in person and they will do the paper(meaning write the prescription), let us say, for some cases because they know. (...) To write to the nurse a prescription, or to send the patient's relative to the doctor's office and to-oo/ let us say if I find/in the blood tests something up normal, that it is not normal the patient cannot move easily, to send the patient's relative to the office of the doctor to write a prescription for him to continue the treatment..."

On the same lines another example was given by an interviewee, that it was the case that a patient had dry skin and all the patient needed was an over the counter ointment; In this case the nurse could prescribe for it and this would minimize hassle, alleviate any inconvenience for the patient, save time for the patient, the consultant doctor and most importantly expedite treatment.

At times when the consultant doctor knew the nurse in person he or she would prescribe the necessary for the nurse's patient, based on the nurse's description and judgment.

Restricted geographical coverage of the program

The nurses have conveyed a feeling of unfair treatment to the fact that the home nursing care program is available only to a few areas of Cyprus;

Int. 3 "(...)It is unfair that my neighbor who lives in Engomi (a municipality and an area within the city of Nicosia) to be allowed (meaning to enroll in the home care program) and next door Lakatameia (another municipality and an area within the city of Nicosia) not, but take it vice versa, for Lakatameia to be covered and not Engomi

(the comment is based on the fact that Engomi is primarily of a higher influencing neighborhood).(…).”

Int. 3 continues with a more emotional example:

“(…) is it not a pity, not to be eligible/ is he of a second God, ‘your grandfather’ (dialect idiom: meaning for example – a grandfather), because his home happens to be in Kaimakli (an area of Nicosia city) not to be eligible for a catheter change and to pay for his nursing care where ‘my grandfather’ (meaning who lives in an eligible area) to be eligible for the nurse to go to his home to take care of him?”

RESEARCH QUESTION 9:

What are the nursing staff’s difficulties in order to increase the satisfaction of their patients?

The absence of a team of other health specialists to support the nurses’ task, and the home care program

All the interviewees agreed that a major difficulty they face in dealing with the issues of their patients is the absence of other health specialists in the program. Half of the interviewees considered important the formation of a team of specialists that would cooperate with the nurses in solving the patients’ problems expeditiously, efficiently to minimize effort and latency. To this end Int. 1 stated:

“(…)they (meaning the different patients’ problems) are all very different ones, ok in England things are very different but, you see it, there is a complete team that, for sure it should also be formed in Cyprus eehm! e.g. the doctor, the psychologist who is needed, sometimes there was a physiotherapist, it depends from the problem, and it was a complete team and you had backup to see and discuss the problem, to be able to put through, to resolve problems without complicated and overwhelming administration like we have now in Cyprus. Because I work alone, I communicate with the doctor who might not know me ehh! in person (…).”

The nurses considered of major importance the presence of a medical doctor followed by that of a physiotherapist and a psychologist. Of lesser importance they considered the need

of a social worker and that of a nutritionist. One mentioned that rarely there was the need for a dentist too. The need of other health professionals in the program in order to increase the satisfaction of the patients and suggestions on this matter, are shown in the following interview quotations:

Int.5 “(...) the support of a doctor, there could be regular visits (meaning to the patients) by a doctor. (...) A doctor, once every fifteen days, when we need him to come with us to see the patient at his house.”

Int.1 “(...) to bring some doctors with us (meaning in the program), to cooperate with them, to have more flexibility, to be able to subscribe medication with us, to be able to do our job easier, and with the consumables, and with everything and with our job, what I mean so they understand what our tasks is (...).”

Int 2 “The primary and biggest problem is that there is no team eeh! a team of doctors eeh! of other specialties because we are alone when we work, we do not have a team to support us, or a doctor, a physiotherapist or anybody else that when we need him, the moment we need him (meaning the specialist) to find him (meaning to be available). This is our biggest problem and as such we must, on our own to communicate with the General Hospital, with the specialists, which is very difficult when they do not know and they do not rememb.../they do not remember the patient so that the doctor to give to him instructions and the subscript...to be given”

In the quotation below emphasis is given to the need of a home care patient to be monitored by a medical doctor at his home due to his immobility. Int 5 explained:

“Ok, the... the problems that I face and those that obstruct my task is after the patient leaves the clinical space (meaning the hospital) (...), (...) we go to patients that are bedridden and it is very difficult to be followed up by a doctor of the General Hospital. That is, if I have to nurture a bedridden and the progress is not as I expect it and it is getting worse it is very difficult for me eeh! to...it is very difficult for me to find a solution. That is a patient who is bedridden...it is very complicated for him to get up and go to the hospital for the the doctor to see him there.”

The interviewees pointed out that they had repeatedly asked management to form a team of health specialists on home care but it has never been done. One of the reasons, according to

the interviewees' opinion was the fact that the home care is at its infancy, not yet widely known and not yet well accepted by other health specialists, as such their unwillingness to be transferred to serve home care. When asked, Int. 2 specifically said that:

“(...) because it is the beginning of this concept it is difficult for the doctors to accept a transfer to home care. It must also be expanded to other..., to all Cyprus, I believe, for them to accept a transfer. (...) they are not used to it (meaning home care) / this is what I believe (laughter).”

Another reason that management is latent to formulate a supporting team of health specialists is their perception of financial cost.

Communication difficulties with the medical doctors.

All the nurses shared the opinion that they had difficulties to communicate effectively with the medical doctors of the patients; doctors who work at the public sector, in the Public Hospitals.

The public medical doctors, as they explained have a very heavy schedule and treat many patients during the day, as such they do not remember the case of their home care patients.

At the same time unless the specific doctor has worked with the home care nurse during the time she was working at the General Hospital, they would not know each other. As such the medical doctors would not show trust to a nurse that they did not know her or his calibre, competence and expertise. Consequently, they refused to issue any subscriptions based on the nurse's observations and telephone narratives, without first examining the patient at their premises.

However, the appointment with the medical doctor would be after many days due to the long waiting lists. Not only was this detrimental to the patient's health, but also the clinical symptoms of the patient sometimes changed and they were different to those that the nurse described to the doctor, days before the visit. In such cases the doctor would be crossed with the nurse and would spoil even more the trust and the cooperation between them. All this, to the expense of the patient's treatment and care.

Int. 1 indicates her view on the above:

“(...) They(the doctors) might feel a little resented especially if we give some / not instructions, for God’s sake we will not give instructions, to provide / to describe a situation, just to suggest , this might not be welcome to all of them (meaning the doctors). (...) But it is because they do not know us, or because they are not very familiar with the / with the service (meaning home care) and there are a lot of doctors that do not utilize it yet, (...).”

The situation seemed to become more challenging when the patient was monitored by doctors of other specialties such as an ophthalmologist, a neurologist etc., in addition to the pathologist: Int. 5 explained how she found a way to deal with this issue:

“(...) lately I have made a list, and I have all the mobiles (meaning the mobile numbers) of all the doctors, all of them and I can call them at one stage and on their mobile eeh! And I can solve it (...).”

Here below Int. 5 reflects the difficulties he faces in describing the clinical case of the patient :

“(...) it is not easy to describe what you see eeh... with words, a bedridden case, let us say. If I have to deal with the sugar level parameters, it is easy to convey this over the phone, the levels of sugar - with measurements of a patient, but with bedridden cases it is a little (language idiom: meaning more than little) difficult.”

Another area of difficulty was that the nurses had to do with the inconsistent instructions for the same treatment, given by different medical doctors for the same incident. This was also reflected on the written instructions that the nurses received from the doctors which made the issue worse when on top of it, they were not clearly written.

“(...) there is not one routine, one doctor wants you to take care a bedridden with this wa...with one way, another doctor wants you to take carethere is not a protocol, let us say (dialect idiom), where it will describe exactly how to treat someone, a bedridden case.”

Lack of communication also exists when a patient would require to visit the Emergency Response for an urgent situation. There is not a way, a system for the nurse to inform the Emergency Response on the patient’s medical history and vice versa for the medical doctor that treated the patient at the Emergency Response, to inform the nurse and give exact instructions on the following treatment and required follow up. This is not the case when

patients resort to private consultants as these doctors make sure to contact the patient's nurse and inform her about the following treatment.

There is also a gap in communication when the patient will be discharged from the hospital to continue treatment under home care program. Some doctors are not well aware of how exactly the home care program works, its offerings and limitations. As such, sometimes the doctors issued instructions that were not feasible to be followed within the limitations of the home care program. A vivid example that one interviewee gave was the case of the medical doctor discharging a patient who needed an injection with the instructions that the home care nurse would administer the injection for him when he got home in the afternoon; obviously not aware that there was no coverage after 2:30 pm and not knowing that the homecare nurses do not visit all patients every day.

Finally, they pointed out that out of all the doctors of the General Hospital, only one pulmonologist works at home care program and only for the purpose of monitoring the patients who are on a respiratory machine.

Difficulties on the nurses transport to the patients' homes: use of own car.

A major difficulty shared amongst all the nurses that were interviewed are issues revolving about their transportation from the office to the patient's homes. Their concerns were basically two-folded. One was the cost and the other were various external factors such as traffic, lack of parking place, driving to remote mountainous villages and dealing with adverse weather, heat, cold, rain, slush and snow.

The nurses were unhappy with the present arrangement by which they used their own car and bared all associated costs including petrol, insurance and maintenance. As compensation they got a mileage allowance but as they explained it was not sufficient to cover the running costs. Most of them utilized an old cheap car with limited facilities such as lack of air conditioning which in turn made their travelling more frustrating and uncomfortable.

When they had to visit a new patient they would use traditional maps to find the house. They had requested for the provision of GPS but it was not approved yet.

To alleviate the issue of parking and that of walking long distances in the city of Nicosia they had requested from the municipality of Nicosia to be given the right to park anywhere

convenient free of cost, as to be as close as possible to the patients home. An additional argument was that they needed to carry consumables and equipment on them, while the distance from the peripheral parking places around the old medieval walls of the city where they could park by the hold of a special card, to the patient's home, were long.

Non acceptance of the program by medical doctors and other fellow nurses.

All the interviewed had identified an obvious resentment and rejection for the program of home care by their fellow nurses and the doctors who worked at the General Hospitals, who did not believe on the value of the program;

Int.2 "At the beginning we had many objections by many doctors, 'and now you will go at their homes we will spoil them' (meaning the patients)(...) and these sort of things, (...) and that it is not needed in Cyprus to do these things/ the reactions, the initial ones were of the like, now it is because they saw us and we cooperate with them at the medical centres and they saw how we work and what we do (...) their attitude has changed(...)."

The interviewed nurses pointed out that the doctors and the nurses see the program, and their job with suspicion, doubt and negativism;

Int.1 "(...) That is, it can be heard the fact that you (meaning the home care nurses) do not have a heavy job, that is one patient and you will go to change, let us say (dialect idiom) the wounds, or you will explain the medication, what more easiest task."

However, the home care nurses 'excused' their colleagues' negative attitude which they thought it was because of their ignorance of the program and its benefits;

Int.1 "(...) it is still a new program at the eyes of the people (meaning the other colleagues) and not all / they do not know well enough what exactly it is that we do. That is, you (dialect idiom meaning their colleagues) need to live with the new situation to get an understanding of the job (...) and hence, the attitude is still outlandish and suspicious, they doubt some things that are done etc. (meaning within the program) (...),(...) and most of the times how difficult the job is, the-ee/what the home care nurse goes through."

The case was different with the nurses of mental health with whom home care nurses had a close cooperation and mutual understanding and respect for the mere reason that they too were supporting patients while at their home.

Insufficient cooperation with the mayors and the municipalities

All the interviewed have characterized the cooperation and involvement of the mayors and the municipalities as insufficient, sporadic, unstructured and reactive and uncoordinated contrary to other countries where the municipalities have an active role and involvement in home care which is organized, substantive, proactive and structured, with specific schemes and supporting programs in place.

Some nurses indicated that if they utilize personal contacts to involve and mobilize some initiative on behalf of the municipalities, or the church to help a patient, their response is usually positive and helpful but yet on an ad hoc and on a ‘personal favors’ basis.

There were some cases that when the nurses resorted to the municipalities or the mayors directly, they received negative responses, something that they could not explain.

Finally, their cooperation with other NGOs such as the Center of Oncology of Bank of Cyprus, or the Heart Institute, is very limited, infrequent, inconsistent and uncoordinated and heavily based on personal initiatives of the home care nurses and on their personal contacts.

Taking blood samples in the morning

Most of the interviewees characterized the procedure of taking blood samples in the morning, a very inefficient procedure with unnecessary time consuming and ‘double runs’ to the same patient on the same day. As they explained the blood samples must be collected and be at the office by 8:30 am when the messenger will take them all to the government laboratory for analysis. As such between 7:30 am, when they report to work, until 8:30am when they need to be back to the office, they leave the office to go out to the patients’ homes to collect blood samples.

There are cases that the nurse would return back to the same patient for a scheduled visit;

Int.4 “Yes, the shortest area is 15 kilometers to go and 15 kilometers to return back. / ...if I have to collect blood samples I need to go at 7:30am to take the samples, to come back to bring it for the laboratory (meaning the messenger who

will leave for the laboratory by 8:30 am) *and then go back out at 10:00 am* (implying for a scheduled visit to the same patient or to another patient at the same area).”

What they suggested is to collect the blood samples during their scheduled visit and have the facility to dispatch the samples when they return to their office before the end of the working day. This would save one hour every day for every working nurse.

Relationship of the home care nurses with middle management

During the interviews all the nurses stated that they were in good terms with their supervising nurse and that they had an excellent relationship.

However, the researcher has reservations on the above, finding on the basis that the nurses might have been concerned for anonymity when responding. The fact that the number of home care nurses was small might have created concerns that they could be possibly identified with adverse consequences.

What the interviewees suggested was to have supervisors with previous experience on home care so that they would have a clear understanding of the nature and challenges of the work.

Shortage of nursing staff at home care

All the interviewees shared the same view that there was a need for more nurses to adequately cover the existing needs of the home care program. As they explained the long term planning caters for about 30 to 35 patients per nurse. Add to this number can be another 15 to 20 short term patients. There is no limit to the maximum number of patients that a nurse can serve. The patients are divided in specific geographic areas and each nurse or each number of nurses are assigned to a specific area. There are cases where there is only one nurse for a specific geographic area. When the patients in one geographic area are increased then there is no contingency plan for increasing the nurses serving that area. In such a case the adjacent geographic area of the next nurse is increased to take some of the ‘load’ off the other nurse.

In the cases where one nurse only is assigned for a geographic area there are additional issues since the program does not cater for contingencies such as for an urgency absence of the nurse, for facilitating annual leave or for requiring some sort of support by a colleague;

Int. 5 “Even when I go to a home for a blood sample of a patient and I do venipuncture and I cannot find blood, and it is difficult...I cannot do something, I cannot call a colleague (meaning in the case there is no other colleague working for the specific geographical area) ‘come, you give it a try’. I have to manage to do the venipuncture.”

As explained in such cases the nurses tried to break down their annual leave entitlement in small block days so that they minimize their continuous absence period.

Also they all pointed out the need of having the availability to spend more time for each visit;

Int.5 “(...) the number of nurses of home care must be increased so that I can have more... not to have such a heavy schedule in order to devote more ehh! More specifically to each patient and to the problem that he faces. (...) it is more convenient to be able to-oo at least spend 45 minutes for each patient, it is bett... it is easier. (...).”

The fact that the nurses are on their own in the area of their coverage, bares a greater responsibility which the interviewees were well aware of;

Int.4 “(...) Eeh! Simply when you are on your own you are more responsible for what you do, you cannot say ‘I did not do this, the previous shift did it’(meaning a mistake), or ‘the doctor told me’ or... you must always take your own responsibilities and you must be very careful.”

However, all nurses said that there was a positive side on the fact that they are on their own;

“On the other side you are independent, you do not have somebody on top of you to tell you ‘today you must...’ you do your own schedule, do your job, you are more independent.”

Finally, one nurse supported that if there were more nurses working in the program then they could take turns so that one nurse each day could take all the blood samples, so that time was saved, for the remaining nurses.

Lack of ICT support

Two of the nurses identified that there ICT support is insufficient and they specifically pointed out the need for a fax machine and a computer which is connected to the central system;

Int. 3 “(...) we do not have one and this is very important because at any given moment that I want to have the results of the blood tests / I need to go down stairs, ok my job will be done but you (dialect idiom) will disturb other colleagues to get the results. (...)”

Int. 3 continues;

“I have a woman for a hospitalization, I can at any given moment through the computer to see, she got out of the hospital, is she in, to find information (...), yes we do not have one, as such this (meaning the computer) is also needed.”

Equipment

The nurses confirmed that the equipment required for the patients treatment is not offered by the program and that the patients have to bear the cost of acquiring them.

They also indicated an issue of quality with regards to the pads for bedsores that were available at the General Hospital which were of lower quality than a specific make which was only available at private pharmacies. The nurses recommended and prescribed, the higher quality specific pads to their patients, which were however expensive to purchase and the costs were bared by the patients.

To take into account the patients' opinion

When asked, all the nurses replied that they indeed took into account the patients' opinions and views regarding their treatment and discuss all issues concerned. Most of the nurses stated that on those cases that the patients disagree or insist on a different approach to the one suggested the nurses invariably attempt to explain and persuade the patients with facts and arguments; if the patients still insists of the opposite, the nurses respect the patient's will. However, they explained that there were cases where the wish of the patient could not be sustained or accepted by the nurse. In such cases the nurse attempted to involve the patient's family to satisfy the patient's needs.

Only one interviewee, Int.5, stated that there were some cases though that he run out of options and suggested that the patient is withdrawn from the program; as in the following example:

Int.5 “Basically is that...if I agree with the patient’s suggestion I will take it into account and I...might adopt it. If I do not agree eeh! Then I can even stop, to stop the....to suggest interruption of the home care for that patient, and there have been such cases, let us say (dialect idiom)’ ‘Can you give an example?’ ‘For example, the administration of ‘klexan’. I had a patient, and I did... I administered ‘klexan’, for me it was three visits (meaning three times per week). One I would do it, the other to be done by the caretaker and the other one again by the care taker so that I can be sure 100% that it is all done correctly. The daughter was eeh! The daughter of the patient, who was the caretaker was a health professional and she was telling me that we need to take the air out of the ...out of the anticoagulant injection, the pre-prepared one and I was telling her that we must not and she insisted that we should take the air out eeh! I proved it to her, I took to her (meaning shown to her) the instructions leaflet of the injection and she insisted still and I told her ok! Since you insist, that you must take out the injection (meaning the air) I cannot keep coming, I will have to interrupt with you; she tells me ‘ok! Do not come back again.”

Information given

All interviewees maintained that they provided and furnished to the patients, all the information required with regards to the immediate concern of the patients’ treatment and medication or for any other peripheral or associated information to the patients’ well care, consultation, wellbeing, safety and security.

Suggestions for improvement

The suggestions that have emerged from the in depth interviews with the nurses of home care program concise of the following key issues: the need for a team comprising of other needed health professionals in the program, provision of a mobile phone to the nurses and to those patients that do not afford one, provision of a government car equipped with a navigation system, the facility to park conveniently and free at parking slots close to the patient’s home, increase of the number of nurses in the program and increase of the number of mail nurses, the facility to prescribe consumables to the patients and the facility

for the nurses to directly refer their patients to specialists of health care, the geographic expansion of the program for nationwide coverage and the expansion of the working hours to 24/7, the organized, targeted and planned involvement of the municipalities, the private health centres, the provision of equipment free of charge, NGOs and other philanthropically not for profit organizations in supporting home care, the provision of ICT such as internet access and fax and finally to better inform and increase the awareness on home care of the other professionals through seminars and conferences.

RESEARCH QUESTION 6:

What is the nursing staff's perception of an ideal home care nurse?

The interviewed nurses described a number of characteristics and skills that the home care nurse must have in order to be able to provide impromptu solutions for a numerous issues and challenges.

In the quotation below Int.1 characteristically describes the challenges of the home care nurse that the nurse who is serving at the hospital does not face;

Int. 1 “(...) it is not as easy as when at the hospital, it is impersonal at the hospital. That is, it is such and such patient but up to that. Here, when opening the door at the patient's home, you do not know what you will find behind it, there might be two thousand problems that could be aggravating the patient's medical condition.”

As all the interviewees explained in conjunction to the above, the home care nurse works alone without the back up and cover up of the hospital in terms of the other nurse colleagues, but also of all the other medical professions and specialties, mainly the medical doctors, advanced medical equipment and other facilities. The luxury of discussing an issue for a ‘second opinion’ or for that of ‘the meeting of different health professionals’ as tools to confirm the correctness of a decision or explore other possible options, is not available in home care.

Consequently, the homecare nurse in addition to advanced nursing knowledge and skills must demonstrate an advanced critical thinking and combinatorial capacity to exercising good leadership. As the interviewees explained, experience and having a ‘sharp-eye’ in home nursing is instrumental to draw upon when the new and unexpected springs up.

Verbal communication skills are considered also essential by the participants, for there is the frequent need to describe the clinical situation of the patient to the medical doctor over the telephone.

All the interviewees stated that the need for the home care nurse to show respect, love, caring and empathy for the patient, is of most importance;

Int.2 “(...) the patient is not just a wound, he is not just a medication. You cannot walk into the home his home for ten minutes, a quarter of an hour. To listen to him, you cannot just open the door and go and tell him time is up, I have finished, I will go.”

Some of the participants supported that the changing external environment of home care requires high discipline in self-management and organizational skills.

Finally, the participants stated that the nurse must be sensitive and caring for the people of elder age, as most patients of home care are elderly people.

RESEARCH QUESTION 1:

What is the patient's level of satisfaction from the nursing staff of the Government Home Care program in Cyprus?

The researcher tried to capture some more insights on the level of satisfaction of the patients, through exploring the details on the relationship between the nurses and their patients from the nurses' point of view.

Most of the nurses are motivated by the fact that they have the freedom and the responsibility required to manage their own schedule according their patients' needs and priorities. They characterized their job as highly interesting and unique because they interact with the patient's own environment which provides additional opportunities to influence and intervene for the patient's better medical treatment, welfare and psychological support; they have the opportunity to alter more aspects on their patient's life than the nurses that work at the hospital's wardens.

They all described a very close relationship with their patients. The fact that they interact and become part of their patients' own personal space and get to know well the relatives

and the closed ones of the patient, inevitably leads to a deeper and more personal and emotional relationship:

Int.2 “(...) when you are sensitive and when you are at the other’s home (meaning the patient’s home) and you try to cooperate with him for some things, you cannot stay emotionally distant. (...)”

When the nurses cannot help their patients as much as they wanted to, possibly on issues that are beyond their control or beyond their capabilities and reach they feel sorrow;

Int.2 “(...) many times, I feel sorrow, for some things, (...) you might leave (meaning the patient’s home) without being able to do all, but I cannot, it is not up to me (...)”.

Some interviewees said that they felt that they did not have the means and jurisdiction to intervene, something that could had been possible if there was the support or the availability of other health care professionals in the program;

Int.2 “(...) that is, how can you handle this on your own, when you (dialect idiom) do not have other means and facilities, and that is that makes me *makes me sad, greatly* (...)”

Int. 5 revealed that sometimes the patients and their relatives expect more, which are beyond his duties and jurisdictions such as the demand for the nurse to bring the patient’s medication at home or to visit the patient during weekends, or bathe a patient who is bedridden, and these demands saddened him.

However, most interviewees felt that most of the times, most patients, likewise most of the patients’ relatives appreciate, respect and trust them. This gave great satisfaction to the nurses and in turn was a strong motivation for doing an even better job to leave their patients even more satisfied.

Feedback from the patients

Finally, when the interviewed nurses were asked by the researcher whether they would find it useful to introduce an evaluation and feedback tool, such as a questionnaire, through which the patients could evaluate the nurses’ work, at regular intervals; they all thought that it would be very welcomed and very useful. Indicative is what Int. 3 said;

Int.3 “*Certainly, why not, anything that we provide in our lives we need to have an evaluation. Even when you make a cake and you offer it and you ask ‘is it good?’ (...)*”

I am all for! Because you go to his home (meaning the patient's), you serve, you work and maybe/ maybe it is not what the man expects, I do not know, maybe it is something else."

Findings of the In Depth Interviews of the Management

Management Interviewees' Profile

Two key management persons were interviewed.

Management Interviewee 1 (Int.1), graduated the Cyprus Nursing School and she had thirty seven years of experience serving as a nurse and in other positions in the public sector. For the past four years she was assistant Nursing Officer, and for the past two years she was the responsible supervisor of the nursing staff of the medical centres of Nicosia which included the Home Care program. Since June 2012 until recently she was also the responsible manager for the home care nurses who served the home care patients who were on a respiratory machine.

Management Interviewee 2 (Int.2), also graduated the Cyprus Nursing School and he had attended specialized training in pre and post operational nursing treatment at the University of Anglia (Ruskin University). He has retired in 2009. Before he retired he was the Head Nursing Officer at the General Hospital of Nicosia. During the last three years of his service he was assigned to organize the Public Community Nursing Care which included the set up and running of the Home Care program. Before his retirement, he was the general operating officer of the Home Care Program.

RESEARCH QUESTION 1:

What is the patient's level of satisfaction from the nursing staff of the Government Home Care program in Cyprus?

Patient's Satisfaction

The management of the Home Care program expressed the opinion that the patients of the program are very satisfied from the services that the program provides to them. They supported this based on feedback comments that get from the patients and the patients' relatives. More specifically they thought that the patients were particularly satisfied on the

knowledge that the nurses demonstrated on practical nursing care issues and on the humane attitude of the nurses to the patients:

Int. 1 “(...) your girl (meaning the nurse) is very polite. She does my wound, she takes care of it very smoothly, I do not feel any pain (meaning while the wound is being treated), and sometimes she sits and we talk, and we have a good talk, for this and that difficulty’. (...) They (meaning the patients) do not complain in general, they are all satisfied.”

Int.2 “I believe that yes, I believe that yes, most of them are satisfied. Ok there are the cases that the patient expects more things but with the passage of time I believe that the personnel becomes more experienced and the eee e satisfaction of the patients will be...greater’

Likewise, the above two officers considered the fact, that the home care patients frequently gave presents to their nurses, was an act of respect and one which proved that they were satisfied with their nurses:

Int.1 “(...) There is no way that a nurse will go to a home (meaning a patients’ home) and create a dispute, these things do not happen. And I am telling you it is in the nature of their job, and they come really close with the people (meaning the patients and their relatives), and I understand, let’s say, nurse A. comes in with a bag of fruits ‘where did you find them?’ ‘from the yard of Mrs. M. (a patient’s name)’. But for her (Mrs M.) to cut fruits...she(the nurse) comes another day ‘put that rose there and it is from Mrs. P’. What does it mean to give her(the nurse) the rose... the best rose of her yard (meaning the patient’s yard). It means that she(the patient) is satisfied with her(the nurse) , you can see from these sort of things.”

Int.1 mentioned that there are times that the patients might expect more, however when they realize that the nurses have a very busy schedule and increased amount of work they lower their expectations and they do not ask for more.

Benefits of the Home Care Programme

Both interviewees said that home care is a very useful foundation which should be extended to cover the whole geographic area of Cyprus. As they claimed, when they were interviewed, with the facility of Homecare, patients may be discharged earlier from

hospitals whereas their monitoring and post operational treatment can be continued at their own homes; this leads to the patients being more satisfied, there is decongestion of the public hospitals making more space available for those who need it most, and reduction of the health care costs.

In their view, with home care there is a marked improvement of the state of the patients' health, because of the better health care provided, the counseling and the education for self-care offered, the psychosocial support, and the early detection for any deterioration or complication due to the good monitoring within homecare. Additionally, the patients are in a better psychological state when staying at their own home environment for their treatment. In this way, they also alleged that home care reduces re-imports of patients back in the public hospitals because it facilitates early recognition and treatment of possible deterioration of their health. Finally, they claimed that home care serves as a means to decentralize the public hospitals.

Int. 1 *"(...) a good job is done, that is injections, treatment of wounds, (...), many times psychologically too because the grandmothers are well, well, but they are awaiting for their person (meaning their nurse) to come, 'she told me at 8:00 and it is 8:30 and she did not come yet', because they want to hear and two good words. And I know that a very good work is done."*

RESEARCH QUESTION 6:

What is the management's perspective of an ideal home care nurse?

It seems that the model of the ideal nurse as described by the management interviewees coincides with the model of the ideal nurse as described by the patients to a great degree. The high standards of nursing knowledge and an advanced critical thinking; exercise good judgment and take initiatives, were the two of the main characteristic that both interviewees primarily stated.

As Int. 2 characteristically pointed out that the home care nurse should be:

"(...) hard worker to start with, kind , a good communicator with him / with them / with the people/, have the ability to face (...) all cases, the new and the unexpected and be ready to judge, whether that the patient, the client, is not well and need to be seen

by a doctor , 'I did not like his wound today, it is infected and must be seen .. / should be seen by a medical doctor'. She must be able to judge (...) be knowledgeable, with skills and judgment ... (...) ... and skills... (...) I mean nursing skills, professional skills, nursing capabilities."

In addition to the above, they share the opinion that the ideal nurse should be a good character; demonstrate compassion, kindness, and good communication skills. Moreover, the ideal nurse should show genuine interest for the patient and genuine love for her or his work as characteristically described at the interview quotation below:

Int.2 "Other than the nursing skills (...) he (meaning the ideal nurse) must be sure of himself that he loves what he does and what he wants to do (...). (...) ... each patient opens up his home, / you get in the house and it is wide open, the house of the other (meaning the patient) who welcomes you (...) as such you must be gifted (...) must have a solid personality. Must be active, but not staring at the clock (...) because imagine to finish your work fast and efficient and just get up and go because the time is over."

Int. 2 also said that the ideal nurse should know how to organize and facilitate the patients; this skill is demonstrated in the interview quotation below:

Int.2 "If I go today (meaning to a patient)(...), but Mrs. Maria (language idiom: using the researcher's name but implying a patient) / this was not here yesterday (pointing to arm of the researcher's , showing a hypothetic dermatological anomaly). Then I speak up (meaning the ideal nurse), book an appointment with a dermatologist, I did not like it, must be seen by a dermatologist; if the relative, the caregiver can, to take him there, otherwise to call an ambulance, arrange for an ambulance for the patient."

RESEARCH QUESTION 9:

What are the nursing staff's and the management's difficulties in order to increase the satisfaction of their patients?

RESEARCH QUESTION 5:

What are the problematic areas in the services provided by the nursing staff of the program that needs improvement?

The need to expand the program nationwide.

As both interviewees said, it is imperative that the program is expanded and consequently recruit and employ more nursing staff because of the increasing needs underlying the social phenomenon of the modern Cypriot society where children take responsibility for the care of their parents to a lesser degree, the increasing growth of the ageing population and the general rising costs of health.

The social shift in the Cypriot society is characteristically shown in the following quotation:

Int1: “(...) *they* (meaning the daughter or the granddaughter of the patient) *did not employ a care taker for her* (meaning the patient) *and they claimed that they looked after her and Mr. A* (meaning the nurse) *had an issue* (meaning with this case) *‘she tells me I am stressed, what will happen with this woman?’*(meaning the patient) *She was all alone and they* (meaning the daughter and the granddaughter) *they claimed, they were going upstairs to see her, the granddaughter, the daughter, and whatever. How can this happen to... (...) it happens every now and then* (meaning phenomena as this example). *Either because they* (meaning the patients’ children) *do not want to spend money for a caretaker or because they want to care of the patient themselves.*”

Int. 1 added another example:

Int.1 “(...) *the children do not understand many things that Mrs. A.* (meaning the nurse) *tells them, for example something that needs to be done... say that ‘you*

should take her to the ER should something happens' 'no, why should we(the patients' children), the ambulance car should come to take her'. Things such as this they (meaning the children) do not go out their way to take care of their elderly (...)."

Reasons for not expanding the program

When asked, management claimed that the reasons, albeit the programs benefits, that the home care program coverage was not expanded geographically or it was expanded at an extremely low rate, were mainly financial, the scarcity of nursing personnel personal interests.

When they were asked, they elaborated that in general there is lack of enough nursing personnel to cover the existing needs of the public hospitals and the needs of other public health institutions. As they explained, should there is an opening for health care nurses, the nurses that are eligible to apply are the nurses that currently work in the public general hospitals. In turn their positions would need to be filled up by newly employed nurses something that the government did not want to do due to budget restrictions.

At the same time, the nurses that serve the general hospitals are mostly experienced ones therefore the management of the public hospitals would typically not consent for their transfer to other institutions.

In addition to the above, the management interviewees claimed that there is a general resistance to change by the nurses; that is to switch from hospital work to home care, because of the fear of the new and the unknown and of doing something different to what they were used to do for years.

At the same time the basic salary of the nurses that work in the public hospitals is enhanced by shift and overtime allowances something which is not the case at home care.

The above factors are depicted below as vividly explained by Int. 2:

Int. 2 *"(...) Perhaps, perhaps one important reason is that the-eh the nursing staff not wanting to work out of the hospitals. The institutionalization, I work in a place where I am used to work , I earn enough money , I have my overtimes, my shifts, my Sundays' allowance, my public holidays allowance and this might be one important reason, the financial part. (...)."*

As the Int.2 explained, one of the prerequisites for promotions for the nurses is the requirement for a post nursing degree or approved course. Home care post nursing degree course is one of the approved courses that count towards the nurses' requirements for promotions. Such courses are usually sponsored every so often by the government. As such when such an opportunity becomes available a lot of nurses apply merely for qualifying reasons rather than genuine interest or willingness to work at home care. As Int. 2 explains:

Int. 2: *"(...) we were faced with the oxymoron that some (meaning nurses) to enrol for the post degree course on community care, and when you called them we (meaning we as management) to tell them that we will expand community care (meaning home care) they refused to go, to be transferred to community care (...) Just did the course for the requirements of promotion, for example. They would say, my turn will come, let me do a course, love it, hate it, the course, I would need it for my promotion. The same happened when we needed nurses to be transferred to the obstetric department and yet once again when we trained midwives... and after two to three years they retired (meaning early retirement) and we ended up with the same shortage for obstetric staff."*

The home care program run by the ministry of Health compared to programs at other countries in Europe

According to the management interviewees the nurses of the home care program are equally qualified, trained and skilful compared to the nurses of other European countries. They also pointed out that there is an ongoing training program for the home care nurses through their participation in relevant seminars and conferences.

They said that the system in other countries was more supportive for the nurses and provided more tools for them towards accomplishing their tasks more efficiently and in a better way, for example would be the provision of a car and access to other health professionals. To this end Int. 2 pointed out that:

Int. 2: *"(...) they (meaning the nurses) are holders of a post-graduate in Community care which means that they have the knowledge, sometimes they just do not have the tools, the supplies the materials / they...had no means of transport they used their*

own car, there was an issue of insurance in case of an accident since you are using your own car what does it (meaning the insurance) covers the end of the day.”

Moreover, the management said that the system on other European countries covered all the population of the country, was more organized and collaborated with other institutions, municipalities, non for profit and philanthropic organizations so that efficiency and cost reductions were accomplished. Int.2 described vividly the situation at the following quotation:

Int.2: *“(...)definitely, it (meaning home care in other European countries) is more organized and is for all the people, covering the ... entire population of the country. We (meaning the Cyprus governmental body) to cover only certain municipalities. That infringes the rights of every citizen; why my area and not the other area as well. Definitely, they (meaning the other European countries) are more organized, there is a system in place and if we followed some sort of an organized system, for example (...) in the English system (...) there is active participation of the municipalities and through them it could (...) be developed a program where now there is none. Take for example the municipality of Latsia or the municipality of Aglatzia and Geri that are close (meaning close to Nicosia), why should we only have Strovolos, Lakatameia and old city of Nicosia for home care and not to cover the other municipalities?”*

On another instance Int. 1 also stated according to his opinion that in Cyprus collaborations with the municipalities are done in a superficial, non-organized and at a personal level. They are random and sporadic rather than being a holistic targeted, clear and substantial effort. There had been thoughts for more effective and organized cooperation between the various stakeholders and institutions but it was never implemented.

Expanding the program on a 24/7 coverage

When asked, the opinion administrative officers had contradicting opinions with regards to the program operating on 24 hours a day and 7 days a week (24/7). Int.2 was strongly positive to the idea, emphasizing the necessity of a 24/7 operation of the program.

Int. 2 *“But the patient who is in need, his needs do not stop on weekends and he says(meaning the patients), you know, I do not have any needs on the weekend, or I do not have needs in the afternoon, or in the evening I do not have needs. (...) it*

cannot happen; the needs... the needs of the patients exist 24 hours a day (...)’ ‘Did you suggest it?’ ‘No, we just had some discussions and thoughts but there were enough problems that we were trying to put in / in action some of them had priority...).”

In the interview Int. 2 said that there were some thoughts exchanged between the nurses and the administration of the home care program but pending more important unresolved issues the matter was not pursued further.

Unlike Int.2, Int.1 was strongly negative at the idea of a 24/7 operation of the program and she supported that the patients should not depend on the nurses and they should become autonomous and self-serviced:

Int. 1: *“Pay attention, to connect with your patient, to love him, to love you but not to be depended on you, that this he will then never leave you at ease (meaning that the patient will be disturbing the nurse all the time).”*

The delivery of medication to the patients at home by the nurses

Int. 2 said that the suggestion for the nurses to be able to deliver the required medication to the patients’ homes was discussed but it was not pursued further.

Referrals and prescriptions by the nurses

Int. 2 suggested that there are cases that the nurses are the most suitable to evaluate their patient and as such should be allowed to refer their patients to other health professionals and institutions such as a psychologist, a social worker or a specialized doctor.

Emphasis was given for the cases that the patients needed psychological or psychiatric support. The nurse in their advisory role would sometimes not be adhered by patients due to the nature of the illness, for example depression. However, if the nurse was allowed to refer the patient to the specialist then the patient would have the chance to be treated.

Finally, he stated that this would simplify existing procedures, enhance efficiency and reduce latency for the benefit of the patients.

On the same line as Int. 2 noted:

Int. 2: *“(...) There are some cases, let us say (expression used in Cypriot dialect), that the nurse can certainly issue a prescription (meaning for the nurse’s patient). Why*

should the doctor prescribe, to go to the doctor to prescribe the change of the catheter, to prescribe the change of the wounds or to prescribe the antiseptic or one thing or the other?"

Do nurses take into account the opinion and wishes of their patients?

The management interviewed shared the opinion that the nurses of the home care program look into the patients on a one to one basis, *'certainly, this they do it, they take into consideration the patient'*, (Int. 1) and try their best to accommodate their wills and wishes. A vivid example was given by Int.1;

Int.1 "A. (meaning the nurse's name) I will be away on Wednesday, will you come on Thursday for my injection?', 'I will arrange it Mrs. M. (meaning the patient's name) at 12:00 pm I will come for your injection'".

In the case where the patient's perception and wants contradicted the best practices regarding their treatment the nurses would patiently explain the reasons behind the alternative suggestion.

Information given to the patients

Management interviewees shared the opinion that the level of information provided to the patients and their relatives was very high and to the standard appropriate to their understanding. Int.2 described the importance of communicating;

"(...) I believe that the nursing staff is experienced and communicative, they have learned that nursing is the science of communication and we always had it as our primary concern that we must communicate (...)"

where Int.1 described the practical reasons behind the necessity of good communication;

"And it is a must and for the illness and the care, because if you do not inform well and if the caregiver does not understand well how can he then take care of the patient, because the community nurse is not with the patient every day, (...) she may see him (meaning the patient) in a once a week or two, let us say, but most of the work is done by the caregiver."

On a different note Int. 2 indicated that the level and the details of information given to the patients depended on their educational level;

“(…) they should normally be involved , now, how deep is their (meaning the patients) participation it depends on the level, if you're dealing with educated people the questions are certainly more numerous and they seek to learn more, okay , but if you're dealing with a someone whose educative level is, let us say, of primary education the questions are correspond respectively. Huh he says, what they (meaning the nurses) will do to me, they know better, it is for sure that it is the right thing for me. I think that it is a matter of educational level, as to what level of involvement the patient will have in the decision making.”

On a different case the interviewees mentioned that the nurses would invariably inform the patients of their real medical condition. In other words they believed that the patient had the right to know where he or she stood. However, there were cases, when the news was not good, when the relatives of the patients insisted not to tell the patient the developing situation. In such cases the nurses find themselves in a very difficult situation.

Finally additional information would be given for matters related, but not of immediate relevance, to their treatment. Examples of this would be information with regards to private and public home care houses, and discussion as to whether the decision to opt for this choice was suitable for the specific patient, or information regarding social insurance eligibility.

Consumables, Medication and Equipment

The management of home care was aware of the deficiency of the program for not providing the required equipment for patients' treatment. They were also aware on the difficulty the nurses faced with respect to getting consumables promptly.

It seems that on some instances the nurses had found ways to bypass the cumbersome administration, by ordering, for example, more consumables than they needed so that they would always maintain some extra, for the unexpected urgencies.

In the case of medication though it had not been possible to 'stock' medicines as the system was more centralized and strictly monitored by the central pharmacy. When the interviewees were asked to furnish some suggestions for improvement they expressed their disappointment;

Int. 1: 'How could it (meaning improve). Within the public sector nothing of all these can improve, Maria(the researcher's name). Let me tell you, a nurse works in a private clinic, you want so many things (meaning consumables), they (meaning the management of the private clinique) will buy them for you, the following day, we, we are 'eaten by the procedures'(language idiom) . But you /(...) go to that on and the other one, the so and so, the such and such, talk of such and such, such and such but I am not the supervisor , it is him and him and such and such. Ehh! You give up, and at one stage you stop. ... (...) in any case, 'ekaman ta shionin oulloi' (language idiom meaning that they all made a mess of everything)'

However, the interviewees did point out that at times they forwarded suggestions that could possibly resolve partly or totally the pending issues. They suggested that the municipalities should take responsibility for supply of the required equipment for the citizens in their area. They also suggested that the required consumables and medication to be made available at the medical centres in the area of the patients. This would depopulate the central pharmacy, decentralize distribution and most importantly serve the patients better as they would not need to travel long distances where the central pharmacy is to collect their medicine.

Management Suggestions for improvement of the program

Most of the suggestions that the management has pointed out were derived from the above interviews and are summarized here below.

Learn from the research and experience of other European countries and incorporate best practices

Some of the European countries have a vast experience running the home care program which in most cases it geographically covers the whole nation. The interviewees suggested that the other European countries' experience should be utilized in structuring and developing the program further but also expanding it across the nation. To this end, it would be necessary to recruit and train more home care nurses.

Increase awareness and involvement of other stakeholders such as the municipalities, the non-profit and charity organizations and the NGOs (Non-Government Organizations)

Health care involves many stakeholders apart from the government; the people of the country, that is the existing and potential users of the program, the municipalities and all the NGOs which are active in health care and wellbeing of the people.

Int. 2 points out that

“(...) there is the need to enlighten the public, not to expect it all...from the government...”

24/7 coverage

Although there were conflicting approaches as to whether the patients should have access to 24/7 coverage, the suggestion made by Int.2, was to establish a telephone line that would provide support and urgency guidance for the patients at all times and to expand the program to cover 24/7. This would need recruiting more nurses and a shifts schedule for the nurses.

Incorporate and modernize procedures that improve efficiency

Examples of these as described above were to allow the nurses to refer their patients to other professionals, to allow them to issue prescriptions regarding their nursing care and to implement a system that would allow the nurses to bring the required medicine to the patients' home, provide easy access to required equipment and facilitate the nurses transport means.

Procedures that increase the efficiency of the program minimize lead times and improve the quality and the satisfaction of the home care patients.

Incorporate a wider range of professionals and expertise to support of the offerings of the program

It is vital that the program provided the expertise of other professionals. Physiotherapy was considered of prime importance as Int. 2 stated:

Int.2 “(...) charity is intertwined with many of the situations they face in home service. It is inconceivable to me that there is no way for a physiotherapist to be able to monitor the patient. Most such patients have mobility problems that must be treated with physiotherapy.”

Int. 1, when asked what the existing procedure was and whether the patients could utilize the physiotherapists at the public general hospitals he identified long waiting queues due to shortfalls in the system and overcrowding:

Int.1 “(...) *they* (meaning the physiotherapists at the general hospital) *cannot do everything. The patients* (meaning all the patients, inpatients and outpatients that resort to the general hospital for physiotherapy) *are many (...). ‘Do you mean that they* (meaning the physiotherapist at the general hospital) *will not book an appointment for them* (meaning the home care patients)? (...) *They cannot they have too much work’/ ‘Eh, yes, and there is lack of staff, and lack of equipment that they* (meaning the physiotherapists at the general hospital) *need and ask for, anyway there are lots of things that are wrong* (meaning at the general hospital).”

Of similar importance was the requirement of a psychologist as Int.2 stated:

Int.2 “*other patients require (...)* (...) *psychological support, or their family sometimes needs more* (meaning psychological support) *than ... the patients (...)*”.

Finally, the interviewees suggested that the program had home care doctors that the nurses could have fast and efficient access for medical advice, prompt referrals and medical subscriptions.

Perception of Cost, mismanagement, lack of staff

The interviewees identified that the perception of cost; being measured on strict accounting terms rather than evaluating opportunity cost and added value in a more holistic approach, the culture of management in public health; reactive rather than proactive, the lack of initiative and responsibility, were the primary factors that underlie the chronic stagnation of solving issues.

Int. 2 “(...) *always, everyone hides behind (...)* *not to give impetus to radical and permanent changes(...)* *we are understaffed (...)* *I think that now they* (meaning the government) *are more matured ...(...), (...)* *at last they need to decide.*”

RESEARCH QUESTION 9:

What are the nursing staff's and management's difficulties in order to increase the satisfaction of their patients?

The perception of management on the difficulties that the nurses face.

It appeared through the interviews that the management interviewees, rather focused on logistical issues when it came to the difficulties the nurses face; they mainly pointed out the issue of transportation of the nurses to the patients' homes and the cost and difficulties related to it.

Cost of transportation

As the interviewees explained, in more detail the nurses use their own car to go back and forth from the office to the patients' homes. This has been a major factor of concern of the nurses and the management for some time however it remained unresolved. The historical facts were that long before the service would provide a company (government) car for their transport. This was abolished probably based on high running costs to the government and possibly careless use by the nurses. A non interest personal loan was then provided to the nurses for the purchase of their own car. However, running costs, such as fuel, insurance and maintenance was bared by the nurses. This was recently abolished as well. The present situation was that the nurses use their own transport and bare associated costs. As compensation they get a mileage allowance but as management claims it is not sufficient to cover the running costs.

Special difficulties with parking were pointed out for the nurses that have to visit patients who live downtown the old city centre of Nicosia. Traffic is heavy and parking is scarce. Recently, the management came in agreement with the municipality of Nicosia so that the nurses were entitled to use the main parking places around the old medieval walls of the city but not the parking slots adjacent to the town streets. This had alleviated the problem in part, but there were cases that the nurses needed to walk a considerable distance to the patients' home. Considering the weather elements; extreme heat during the summer period and low temperatures during the winter time, rainy days and the fact that they invariably need to carry consumables and equipment on them, walking to and from the patients'

home becomes a trivial, difficult and tiring task. The interviewees believed that these difficulties, exhaust the nurses and may adversely affect the quality of services they provide to the patients and in turn reduce the patients' satisfaction.

Inherent risks involved on visiting the patients' homes

Management was also aware that the nurses were at some risk by nature of their job which derived from the fact that they visit to the patient's home, which is an unknown environment, at least at the beginning. Management also claimed that the nurses developed a high sense of self protection, adjustment and endurance. The researcher got the impression that this was perceived by the management as an adequate line of defence for this issue. Int. 1 characteristically stated that:

Int.1 "Okay, the kids (meaning the home care nurses) do not complain (...) we, the nurses, Maria 'mou' (meaning my dearest: my Maria) have learned to adjust and compromise, always, always. (...)."

The relationships between the nurses, management and nurses, nurses and other professionals

Management shared that they have a good relationship with the nurses. They also said that the relationship amongst the nurses was similarly very good and likewise between the nurses and other professionals.

However Int. 2 took the opportunity to share the historic development of homecare program since it was launched, admitting that the management structure of the program was much less than optimum and hence incapable to solving developing issues.

As he explained, initially homecare was under the supervision of the Matron (meaning senior supervising nurse) of the general hospital.

Hence it was considered necessary to assign this responsibility to one specific supervising nurse, one for each of the district general hospitals. However this responsibility was in addition to the existing duties of the supervisor, which proved difficult to cope due to existing heavy load.

Therefore it was then decided to assign home care under the managing nurse responsible for community health care centres.

The researcher identified that still the managing nurse is over loaded hence she had not inspected any home care visit for over two years that she was responsible for home care in an attempt to acquire feedback and personal experience for the job.

When Int. 2 was asked if there were any problems emerging from the middle management he supported that management should be people that

Int.2 “(...) work at nursing home care (...) yes, certainly, would be the most beneficial to speak the same language and to emerge from the ranks of the people who know things by their name.”

Difficulties faced by the management of the nursing staff

The main difficulties as expressed by the management of home care interviewees were cumbersome procedures which were inefficient and lack of ICT (Information and Communion Technology) support. These factors had a negative influence on day to day communication with the nurses and hence solving issues fast and efficiently for the better of the patients.

It appeared that the governmental administration, decision making and procedures for approving, purchasing and installing IT or other technical support, to be very overbearing, inefficient, slow and ineffective which results for people to give up on requests.

Lack of ICT support

At this age and time the main means of communication between management and the nurses was the telephone. When Int. 1 was asked what could be done to improve communication, she stated:

Int.1 “ To start with I need a fax, and they (meaning the government) do not get me one and I need to go down to the center (meaning that there was a fax in the building but at a different floor level) and climb up and go down to send a fax (...), (...) a fax of 33 euro.’ ‘Do you have internet access for emailing?’ ‘I have internet but not all the community care centres have one, and not all of them are integrated in the system’, ‘Do the nurses of home care have internet? Can you send them an email?’ ‘(...) they do not even have a computer. Certainly it would have been easier if the

centres were close(meaning close to her office)', 'How could they be close?' 'Eh! How could it be, it cannot be.'

Inefficient and cumbersome procedures

As an example was the use of internal mail which it seemed important in the absence of other means of communication such as emailing. As explained, for a letter to be sent from the management office to a home care nurse, it needed to be dispatched from management office, to the general hospital through which it was the only way that it could reach the community centres and the nurses. It was stated that frequently letters got lost somewhere on the way. On these lines Int. 2 said:

"(...) for something important it cannot go to via the internal post because there is (...) a possibility for it to be lost; I go in person to take it."

Monitoring and control

The difficulty in monitoring and control of the nurses is identified by Int. 1 in the following quotation:

Int.1 "My big problem is that the centres are far, and they are isolated and my office is at this point and this place, so yes, you cannot have them all near you, to see them every day to check on them, or ... ehh for help or anything. Our communication is via phone or when I go for a visit (...)."

Int. 1, when asked she noted that she devoted one week of each month for visiting the community centres and that she made an effort to grouping the near ones.

Relationship between the middle management and higher management at the ministry of Health

Both interviewees said that the relations between the management of the nursing staff and the senior management of the health ministry were good; there seems to be a spirit of good communication, one of understanding each other and one of mutual respect, however the researcher felt that to some extent, there was an attempt to cover or underplay some problematic areas between management and the nurses.

Int.1 "Our relationship with the Ministry of Health is quite good / supportive and good enough. (...) we understand each other fully, ehh, Mr. A does not listen to me

lately but I do not know (laughter), when I get angry he listens. No, no, no, I have no issues, he gives us (meaning approving requests) because we have meetings every so often or whatever issues concern us / we talk specifically about the community (meaning community health), I am always, let us say, updated and ehh, I am invited to attend at meetings etc. that concern us and the minutes and everything they will send them all, I have no issues.”

On the same lines as described above, and according to management view, was the relationship between the nurses and the personnel of the liaison department of the ministry of health.

Cooperation with other stakeholders and institutions

The participants stated that there was some sort of cooperation with the municipalities, the church of Cyprus, and the municipalities’, the state’s nursing homes, the NGOs and the voluntary organizations.

This cooperation though was not on an organized, long term focused level and it was heavily dependent on personal relations. Management believed that there was room for a closer cooperation based on a common plan of action with targeted results and outcomes. However they also identified the lack of the necessary willingness and commitment for the required to change the present inactivity.

Assessment of the patients’ satisfaction from the Nursing staff

The nurses are evaluated internally only by their superior managers. There is no other evaluation or review body or any specific tool that is used for evaluating the nurses.

When put forward by the researcher the idea of having a tool that could be used to evaluate the nurses from the patients’ perspective and through the patients’ satisfaction levels at regular intervals, it was most welcomed and it was considered to be a very valuable feedback tool. As they pointed out *‘the patients are the best judges’*.

Dependence of the patients to their nurses

However they indicated that they believe that the results of such measurement would indicate high levels of satisfaction for two main reasons. As they explained, the first reason is that indeed the level of treatment and caring they receive is to a high standard and the

second reason is that the patients are dependent on the nurses and they would not risk spoiling their good relationship with them. To these lines Int. 1 tried to explain

Int.1 “(...) *he* (meaning the patient) *will accuse A.* (meaning his nurse), *A. will be crossed and she will see him* (meaning the patient) *with a different eye, I believe*’.
‘But the questionnaires are anonymous.’ *‘They answer the questionnaires ok, no issues; it is a good thing (...).’*”

Unofficial and unstructured feedback

There were no means for the nurses’ managers to get any feedback on whether patients were satisfied apart from friends of the patient that happen to know them personally or by random encounters with relatives or friends of the patient which is unstructured, unofficial, undocumented, random and sporadic;

Int.1 “(...) *At the church that I go, at the supermarket that I go, these are the places where I hear from the caretakers and the relatives. (...)/ (...) and I hear from the patients’ children.*”

Int. 1 had never been to a patient’s home and had never been with a nurse on a visit to a patient’s home. She said that she wanted one day to join the nurses to observe and meet some of the patients but she did not manage yet;

“(...) *I want and I plan to go with my girls* (meaning the nurses) *to some of the homes to see how it is done but I did not manage yet of being busy with work.*”

Patients’ Complaints

Patients were not informed on any procedure if they wanted to make a complaint. If the patients requested the telephone number of their nurses’ supervisor, the nurses gave it to them.

The interviewed management said that they never had a complaint from any patient about their nurses, however, they were aware that some patients became anxious when the nurse turned late for a scheduled visit. However as they elaborated, the patients were worried whether something happened to the nurse and not complaining about the delayed visit.

Another issue that they had recently identified that bothered some patients was the fact that they felt uncomfortable when asked if they would consent for a nursing student to accompany their nurse during a visit. Some patients refused. As the interviewees explained

the reasons could be the violation of their private space by someone that they did not know, the opposite gender of the student, the nationality and the skin colour of the student; they felt most uncomfortable if the students were from other nationalities.

The Future of the programme

Both interviewees shared the same strong opinion that home care should and would expand both vertically to offer more services and laterally to cover more geographic areas. The major reasons as explained before were the earlier de-hospitalization of patients, the decongestion of the public general hospitals, the lower costs involved in the patients' treatment, the higher satisfaction of the patients, the better emotional and psychological health of the patients and the decreased re-hospitalization.

Finally, the interviewees believed that home care would be incorporated within the National Health Insurance Scheme which was currently under development. Findings of the Observations

Findings of the Observations of Home Care Visits

The major findings of the observations of the home care visits are presented by analysing the data with respect to the research questions. In this section the observations' findings are highlighting the following issues under investigation in this research; the interactions between the nurse and the patient during the home care visits and the natural environment of the patients, the problematic areas of the home care program and the difficulties that the nursing staff faces.

RESERCH QUESTION 7:

What are the interactions between the nurse and the patient during a homecare visit?

Relationship between the Nurse and the Patient

In most cases the relationship was friendly. However in observations that took place in rural areas the relation was sometimes more than friendly; the nurse was appreciated and treated as being part of the patient's family. Also in the rural areas, there was a marked

degree of high intimacy between female patients and the nurse. This was manifested with hugs and kisses and verbalized with salutations such as “*my darling*” and “*honey*”.

In support of the above, a vivid example was the rural case of Mrs. K, the wife of a patient who was referring to her husband as being ‘*the grandfather*’ of the nurse. This seemed so natural to the researcher who had to inquire whether there was indeed an actual relationship between the nurse and the patient. Mrs. K., smiled only to clarify that although there was no natural relationship between the nurse and the family but however, the specific wording was used simply because that was how they felt for the nurse; as being their own granddaughter.

To the same end was the case of another observation of a nurse who behaved such as the 95 year old patient was her own grandfather. This was expressed by her wide smile, her joyful attitude, the close body distance, the caring look towards the patient.

In a few cases the relationship between the nurse and the patient was ordinarily friendly. Both, the patient and the nurse kept a business-like distance. In these cases the patients’ faces were expressionless, sad or indifferent to the presence of the nurse. The patients’ nonverbal movements and speech were very limited and confined. In some rare cases the patient would even refuse to follow the nurse’s instructions.

In most observations that took place in the urban areas, joviality beyond the professional context of the relationship was the norm contrary to what was observed in rural areas. Moreover people of a higher social and educational level maintained a professional like distance from their nurse. It was a typical relationship between a service provider and a service receiver.

Of all the observations there was only one case that the relationship was not friendly. On one side, the nurse eye contact with the patient was to the minimum, and on the other side the patient was defensive most of the time. This behaviour might be associated with the fact that the nurse was crossed and disappointed with the patient’s daughter who, being the responsible person, would in fact miss the patient’s appointments with the doctors and forget to administer the relevant medication to the patient. She was indifferent to her father’s nutrition schedule and guidance and at the same time she never answered any phone calls made by the nurse for the purpose of reminding appointments and furnishing new instructions regarding the medication. The dynamics evolved about the nurse

persistently inquiring the reasons for non-complying with doctors, and medication instructions which in turn provoked a reaction by the patient who would defend his daughter based on domestic and financial stressors. Manifestation of the patient's defensive attitude was a stiff posture of crossed arms over the chest and verbal conversation kept to the minimum.

In the cases where the relationship was typical and as in the latter case as above, the patients did not verbalize their possible objections or complains to the nurse as one would expect. This behaviour might imply a degree of dependence from the patient to the nurse. In these cases although the environment was highly subjugated by the nurse; it was never observed any hostile behaviour or any sign of threatening or gross indifference by the nurses.

Gifts to the Nurses

About half of the patients offered a gift to their visiting nurse. This would be for example, a flower pot of basil, a pen, a key ring, a basket of fruits grown out of their own garden. This gesture was an indication of appreciation for the care that they received. On the receiving end the nurses would politely refuse to accept any gift and pointed out that it was not necessary. However they would accept it in order not to offend them. It should be noted that according the culture of Cyprus, it would be considered as an offense if someone rejected a gift, especially from an elderly person

In addition to the above it was the norm that the patients would invite the nurses to a drink or a snack. In most cases the nurses refused to eat or drink anything. The underlying reason as explained to the observer was the fact that they wanted to avoid the need to visit the bathroom at any patients home either because of sanitary reasons or because they felt uncomfortable..

Empathy-Respect-Caring

It was the norm for the nurses to demonstrate empathy to the patients. However in some cases there seemed to be a conscious effort by the nurses to preserve an emotional distance from their patients. Although difficult to achieve, it was deemed necessary in order to protect them from becoming emotionally attached. As they explained to the researcher, in such a case, it would affect their own psychological state and personal life.

As a rule the nurses revealed great respect to the patients. An exception was only one occasion when a female nurse asked an elderly male patient to take off his trousers in the living room, in presence of his wife, a female caretaker and the researcher, in order to facilitate a required injection. Irrespective of the fact that the patient did not object nor he showed to be annoyed, the researcher thought that this could be considered as an action of disrespect to the patient.

The nurses demonstrated respect to the patient's wishes on all matters, these being relevant to their treatment or not. The nurses listened with great patients the patient's wishes, which could be domestic, dietary, or treatment related and then patiently explained and discussed with them the advantages and disadvantages of their thoughts and suggestions.

An indicative example of the above was the occasion of a patient who insisted on eating olives, against the doctor's strong recommendations. The nurse discussed the patient's wish and thereafter calmly attempted to convince the patient to at least initially reduce the amount of olives. At the same time offered alternative suggestions and finally managed to convince the patient to soon comply.

The nurses exhibited a high degree of dedication and caring to the patients as this was witnessed on all the observations. There were many examples to manifest this not limited the following ones; the nurses would persistently make sure that the patients would remember to take their medication as per the prescription. As a technique they would ask the patients to verbalise the instructions to making sure they explicitly understood what they had to do and when. Additionally the nurses would write down all relevant instruction and highlight the next appointments with their doctors. They would go the extra mile by calling the patients while not on duty to remind them of their appointments or to confirm that they adhere to their medication schedule. The nurses would keep an open eye in evaluating the patients' physical, relational and emotional environment and evaluated how this might affect their medical progress and domestic life. In cases where negligence or gross misbehaviour was observed by any relative or sometimes a doctor, they tried to strategically discuss the issue, offer suggestions and when and as needed intervene. On other cases they would help on logistical issues such as facilitating the purchasing of the required medication from the general hospital, by arranging an appointment with the doctor based on the patients' needs, capabilities and restrictions. The nurses were not obliged but invariably they would avail their personal mobile number to the patients so that

to facilitate their support continuously and well beyond their duty hours, which also included inappropriate hours. There were cases that the nurse would pay an additional visit to the patients' house in order to offer additional support.

Communication

Throughout the observations, all the nurses spoke clearly, loudly, utilised simple words, short, simple sentences and vocabulary which were narrowed in commonly used words. They avoided the more complex and scientific terms and definitions. They have developed these skills which seemed very important as most of the patients were people in their third age, often with reduced hearing ability. Their vision was often impaired which made the spoken words as a sole means of communication. In many cases the patient's illness per se affected their level and ability of communication and understanding. This would be for example the case of a stroke or that of arteriosclerosis.

It was observed that the same mode of verbal communication was maintained throughout the patients irrespective of whether the patient was of higher socio educational level.

Cyprus uses various dialects of the Greek language throughout the different geographical areas of the island. These dialects, especially on the areas of west Cyprus, Paphos district, and east, Ammochostos district can be heavy and strong. The older the patient the strongest the dialect he would use. In fact the younger generation would not understand a lot of words as these are no longer used.

All nurses, however have developed a good understanding of these dialects and their idioms and were able to fluently understand their patients. However the nurses would not adjust their conversation to the local dialect but would maintain the widely and commonly used language. This was possibly done in contribution to maintaining their professional image.

On those instances where the patient would not understand the meaning of a definition or a medication instruction or the use of medical equipment, the nurse would patiently explain the specific instruction and insist on getting feedback from the patient to ensure understanding and compliance.

The conversation between nurses and patients was mainly evolved about their medical state and how they were progressing. In more detail these would be issues relating to the

patients' medication, discussion of medical test results, issues related the patients' diet and safety at home. However discussions would also develop around domestic and financial issues and how these affected the patients' physical and emotional health. Advice and guidance would also be offered as how the patient could access financial help from government support programs and ways to increase opportunities to exercise and socialize more. There were instances where the patient guided the conversation that touched personal and family issues which might involve their relation with their children or care taker and how these affected them and made them feel. The nurses would offer a listening ear and empathise with the patient, but when there was an attempt from the patients to ask personal questions relating to the nurse's personal life the nurses would invariably find ways to defer and redirect the conversation safeguarding the privacy of their own lives. Finally there would be instances where the conversation would just be of social nature evolving around a Television soap opera or the weather.

Almost all nurses demonstrated moderate nonverbal communication skills, facial and body language, which supported and enhanced their ability to effectively convey their verbal messages across. Additionally they conveyed professionalism, confidence and knowledge. Nonverbal communication also facilitated the important and primary factor of effective communication, that of empathy.

Written communication was also utilised according to the needs of the patients; writing simple instructions with big bold highlighted letters or words to emphasise important dates, medicine dosages and instructions. This also facilitated the transmission of the correct information from the patient to his or hers supporting relative and minimised misunderstandings and errors.

There were two cases that the female patients hugged and kissed their nurse. In these two cases the nurses accepted their patients' gesture. However on all other observations the communication was confined in the boundaries of their professional work.

Finally the nurses used eye contact to a high degree to get and maintain the attention of the patient, convey empathy, show respect, attention and caring. However they would pitch eye contact down to convey dissatisfaction or discontent to the patient who did not respond to previous instructions or consultation, but even on these cases they would be careful not

to insult or put down the patient. Eye contact was also a means to adjust the professional distance and maintain the professional relationship between the nurse and the patient.

Consulting and informing

In all observations it was noted that the nurses gave any information they could when asked by the patients. This information was not only confined and related to their health situation, treatment and medication but it extended to the patients' self-care such as for example advice and instructions regarding wheelchair bath seats, the use of special socks to alleviate pain caused by varicose veins.

Nutrition and physiotherapy services are not provided by the program and as such the nurses travelled the extra mile to fill in the gap and offer basic advice on nutrition and physiotherapy exercises. This was restricted to basic advice without getting into details.

The nurses would also offer advice on other issues when asked, such as the availability and quality of nursing homes and discussed alternative solutions such as for example employing a care keeper. They would offer information concerning the services provided by social welfare programs and motivating advice on opportunities to socialize with people of their age by utilising the public facilities of Elderly Care.

The nurses would also offer advice to the patients' relatives mainly regarding the patients' healthcare but also advice regarding their own health issues, such as simple advice how to use eye drops, a foot cream, how to book a check-up for osteoarthritis for example or how to control their blood pressure and cholesterol levels.

They also provided information and advice for maintaining a healthy environment for the patient such as aerating the rooms and the house by frequently opening the windows and advice on home safety such as removing a rug minimising the risk of slipping over it.

The psychological state of the patients

Variances are noticed in the psychological state of the patients for a number of reasons the main one being the state of their medical condition and whether it is improving or not.

The case where the psychological condition of the patients was very good and buoyant was when their health was good and improving. These patients shared hope for a better future.

To the other end though there were the patients who were down and depressed because they saw their health deteriorating.

However there were other factors influencing their psychological health. It was observed that important role to the patients psychological health was their human and natural environment surrounding them; patients who have their children, grandchildren, partners or any other relatives close to them are in a much better psychological state than patients who live alone or whose children and relatives rarely or never visit them or others that do live close to relatives but yet they feel that they do not really care about them.

The natural environment of the patients also seemed to play an important role to their psychological state. It has been observed that most people who live in villages and rural areas are in a better psychological state than patients with a similar medical condition who live in cities. The close conduct and activities with nature and animals, the fresh unpolluted air the peaceful tranquillity of the village, the short distances, the empty roads without traffic and the close contact with other people in a small society where everybody knows everybody, appear to be very beneficial for the socialization and physical activity of the patients.

It was also observed that the patients who were unable to do the activities they used to do before the deterioration of the health without assistance by another person were usually feeling depressed and disheartened.

How the patients feel during the visit

Most of the patients were looking forward to welcoming the visiting nurse. They welcomed the nurse with great joy, enthusiasm and joy. However those patients that suffered depression were indifferent of the nurse's presence.

During the visit, the patient's feelings would vary depending on the findings of the nurse's examination. In the cases where the physical examination and findings was within the expected or better limits the patient would become joyful, optimistic, vibrant and talkative. On the opposite case however the patients would be stressed, worried and concerned about their health which in turn affected their mood. In this case they would become less expressive and quiet. This change of emotional state would usually remain throughout the nurses' visit.

Psychological support from the nurses to the patients

In about half of the observations the nurses offered a reasonable psychological support to the patient but on the other half of the cases, the effort to do so was limited to some verbal confirmations such as: *“Bravo! Your blood pressure is very good!”*, *“Bravo! Your sugar levels are fine!”*, *“Good news your wound is getting better! Soon you will be able to walk!”*

In the cases where the patients expressed their sorrow or disappointment for their condition of their health the nurses’ were less than supportive keeping an emotional distance with the verbal communication limited to short and cold sentences. Long pauses of silence gave the feeling of disappointment without a convincing solution being offered.

The following examples were observed where little or no psychological support was offered by the nurses.

In one case, where the psychological state of the patient was low, the nurse felt uncomfortable and she merely repeatedly inquired why in the following manner:

“Why Mrs K.?... Why Mrs. K? ...?” only to offer the following suggestion: *“Why Mrs K.? Why do you feel like this? You should get out of the house every now and then, go to the church!-Go to visit your doctor and tell him how you feel!”*

At another case when the female patient expressed her wish to die, the nurse just turned to the patient’s husband looking for support by inquiring:

“Oh, now Mr E. what is this talk by Mrs. E?”

In another observation, when the patient was discussing with her nurse various issues concerning her care taker the patient’s eyes filled with tears in despair as she was realising that she could not resolve the issues. In this case the nurse did not make any attempt to comfort her patient either practically by discussing alternative solutions nor emotionally.

Likewise, as above, was the case of a male patient who was in a very low psychological state and the nurse completely avoided discussion and she did not provide any support.

RESEARCH QUESTION 8:*Which is the natural environment of the home care visits?*

The patients' homes varied from traditional mud brick houses built before the sixties, to concrete built houses of the sixties and seventies. In one case the patient lived in a service house built within the same plot of a main house which was in a very bad state. On one case the patient lived in a newly built house and on another two cases in city apartments which one was serviced by an elevator and on the other access was only through a staircase. The maintenance of the patients' homes and gardens varied from being well-maintained to the other end of needing heavy maintenance.

In terms of neatness, cleanness and hygiene some homes were clean and tidy where others were not. In one case the home was untidy, messy and filthy. There were cases in the cities where the homes were not ventilated and aerated well. In these cases there were persisting odours in the house and the atmosphere was stuffy, smelly, hot and uncomfortable. When the patient was living in a traditional house the air ventilation was of better quality. These houses were by nature cooler, a natural quality of the mud bricks, and architecturally built with high ceilings and roomy areas. They also had windows which were tall and wide and as such inviting fresh air and sunlight. They were of single level, and ground floor with an easy access to all areas but also easy access to the garden surrounding them. This physical environment in conjunction with the minimal traffic found in the rural areas and the villages supported a pleasant peaceful and tranquil environment for the patients. Because of the less populated rural areas and minimal traffic patients could go or transported to places easier. Also the more let back and relaxed rhythm in the small communities and the villages supported more opportunities for the patients to socialize.

Lighting and brightness was good on only half of the observed houses and in some of the observations the patient's room was doomy and dark with restricted natural sun light. In the cases where the observations took place in the patients' bedrooms, these were generally very small, heavily furnished, with lots of stuffs and belongings piled up in the corners of the room and on any possible available space. This created an asphyxiating setting which made the already small rooms look even smaller suffocating and claustrophobic.

Human environment also varied throughout the observations. On most occasions there was at least one more person with the patient. This person was either a relative; the husband or

the wife of the patient, or the brother or sister, or the child or grandchild of the patient, or this person was the employed care taker. In one case the co habiting person was also a patient of the home care program. In most of the cases there was an employed care taker either alone or with the relatives of the patient. Employed care takers were mainly of Asian or East Asian origin, workers that came to Cyprus specifically to work as such. There were less cases where the care taker was from an ex eastern European country. Only in one case the patient was living completely alone.

RESEARCH QUESTION 5:

Are there any problematic areas in the services provided by the nursing staff of the programme that need improvement?

Nursing Competence

It has been observed that the nursing procedures were conducted correctly, precisely and with confidence. This was the case irrespective of other factors such as the environment, the patient, the time of the day or the tiredness of the nurse. The nurses were skilful in multitasking; while performing their procedural and line work they were able, at the same time, to talk to their patients and to the other people that were present such as the patients' relatives. During this process they were at the same time closely observing and monitoring every single detail on their patients, relatives and surrounding environment.

All the nurses, some in greater and others in lesser degree had the necessary confidence required to tackle any unexpected event concerning the patients treatment or the patients environment. They showed ability to solving new problems and issues on all areas that concerned their patients. They also demonstrated leadership skills by taking the responsibilities of resolving issues that many times were beyond their strict terms of reference or were beyond the home care's program offering. One example supporting the later was the cases when the nurses took the initiative to ask the doctor concerned to write the required prescription without the patient visiting the doctor per se. This alleviated the patients from the task of going to the hospital for this purpose. Another example was the cases that the nurses liaised between the patient and the social services

An opportunity for the patients to express their opinion

In general the patients were given the opportunity and freedom to express their opinion openly. The nurses were very accommodating in listening to the patients' opinion and when they would disagree they would try to persuade the patients of their opinion through supporting arguments and facts. In the cases that the patient would persist, the nurses respected the patients' final decision.

The relation between the nurse and the patients' relatives and care takers

Generally the attitude of the nurses towards the patients' relative was friendly, polite and supportive. The nurses accommodated any questions or inquiries that the patients' relatives. When the relatives offered good caring to the patients' the nurses took this opportunity to offer praise which motivated the relatives to continue offering their support and caring to the patients. However on the cases where the relatives' caring was not adequate the nurses would not offend the relatives in any way.

On the same line the relatives were invariably happy to welcoming the nurses and they felt well in the case when the nurse furnished good news with regards to the patients' health progress and when she offered good comments on the quality of the caring the relatives offered to the patient. Also the patients' relatives showed respect to the nurses and on all observation that relatives were present they agreed to the nurses' indications and directions.

The care takers of the patients were either relatives of the patients or employed people from Asian countries or from countries of the ex-eastern European block. There were cases where the care taker was a relative assisted by an employed person who was under the relative's and the patient's directions. There was also one case that the care taker was from the social welfare for half of the week days and a relative who was employed by the patient to attend for the other half days of the week.

The nurses were distant polite to the Asian origin care takers. The nurses addressed the care taker in order to give strict guidance and directions regarding the health care of the patient. These instructions were always in Greek and not English language, hence the Asian care takers would sometimes not understand fully or at all. An example in the case of a bedbound patient was: *"You should turn him on the sides from time to time."*

On the cases where the employed care taker was from an ex Eastern European country, they would speak Greek and be able to give feedback to the nurses regarding the patients' health, dietary habits, for example "*She eats a lot of olives!*", and domestic issues and information regarding the patients relatives such as "*the wife of the patient is abroad and there is no one to give him his medication*" or issues and difficulties they faced regarding the wellbeing of the patients such as: "*He doesn't listen to me when I tell him to place his feet higher when in bed..*". In general the European caretakers' habitual habits were culturally closer to the patients. Consequentially the nurses respected these caretakers more. Also the European care takers seemed more confident to take initiatives and discuss these with the nurse.

In two cases the nurses were crossed on the care takers. In one observation, the care taker who was employed by the welfare services did not show up without giving any notice to the patient who was found by the nurse past lunch time, left without any food and as such not being able to take her medication. The nurse called the care taker to strongly complain about her behaviour. The telephone conversation was very intense.

On this same observation the patient employed a relative with the amount of 500 euro per month in order to clean the house three times a week on the days that the social worker did not come. However the house was filthy and untidy. The nurse was very unhappy with the situation she found her patient in and brought up her previous suggestion to employ a care taker instead of the relative who, with the same salary, would come to the patient's house every day including weekends to assist with the activities of daily living such as to cleaning, cooking and bathing. The care taker would also make sure that the patient would take her medication properly and on time.

On another case, the nurse clearly expressed strong discontent to the patient against the patient's daughter who was her care taker because she forgot the doctor's appointments and did not answer any of the nurse's phone calls.

On another observation, the patient's wife complained that their children never visit them; the nurse asked more questions in an attempt to get a better view of the situation but skilfully avoided to express any personal opinion or show her own feelings

On a different case the patient complained to the nurse that the care taker was sometimes annoyed with her and misbehaved by shouting to the patient in a very bad manner.

RESEARCH QUESTION 9:

What are the nursing staff's and the management's difficulties in order to achieve maximum satisfaction for their patients?

Findings of the Observation of a Working Day of a Home Care Nurse

While in the office where the nurses' working day starts and ends the observer noted a number of difficulties that the nurses encounter. Their office space was small for the number of nurses that accommodated. There was lack of storage space and it was messy. Files were spread about everywhere one on top of the other. Ventilation and temperature control was inadequate; the air-conditioning unit was unserviceable and old. The office technology was insufficient; there was no fax machine, or access to email and internet. They only had an office telephone and a printer. Although the nurses were most of their working time out of office visiting patients' homes their service did not provide a mobile phone for them. As such some of them had to use their own to administer the needs of the home care program and the needs of the patients.

The service provided access to an interest free personal loan for the nurses to purchase a car in order to accommodate their transport needs from one patient's house to another and from and to their office premises. Effectively the nurses chose to purchase a pre-owned cheap car usually without any air-conditioning and of poor condition. As indicated to the observer by the nurses, this choice was made because they did not want to subject a new car to the adverse conditions of their work needs. Effectively the use of an old car contributed to their tiredness and fatigue as the day progressed.

The nurses were subjected to adverse physical conditions throughout the working day. Apart from using a substandard car for their transportation needs they chose not to eat or drink throughout their consecutive visits from one patient's home to another. This was, as explained in order to refrain to visit the toilet in a patient's home.

In addition to the nurses physical stress, as the day progressed the emotional stress also accumulatively increased. The suffering of their patients influenced their emotional state; sometimes they felt disappointed, sad and helpless to help within the framework and restrictions of the program.

Within the above emotionally evolving daily stress they had to adapt to changing and different physical and human environments. The home visits took about an hour and as such the nurses needed to make a new adaptation to a new environment every hour. The patients were of different educational backgrounds ranging from sub primary education to university degrees, different socioeconomically backgrounds, different sex, age, emotional and health state with different attitudes towards home care and government provisions. The nurses needed to adapt to different communication capabilities of the patients and to the different health status of their patients.

Emotional and physical fatigue did not seem to have an impact to the performance level of the nurses. They provided the same level of care as the day progressed. What was noted though was that their verbal communication use was progressively becoming less as fatigue and tiredness was amplified.

Likewise their behaviour towards the patients did not change but their ability to encourage and offer emotional support was reduced. In fact it seemed that the nurses needed emotional self-support and self-encouragement towards the end of the working day.

On the same end it was observed that the nurses lost faith on improvements that could be implemented to the home care in terms of administration and support. They accepted the norms of the cumbersome and inefficient governmental mechanism and they tried to work within these boundaries and limitations to their best ability. Their mind-set was that of *'nothing more can be done'* and that of *'it doesn't worth even asking for more facilities because of the bureaucratic public attitude, lack of funds and lack of support of the management.'* They were also afraid of being *'blacklisted'*.

In discord of other public sectors though where the attitude usually is *'do as less as possible and stay out of trouble'* the nurses of Home Care, did exactly the opposite; they would do the maximum they could within the restrictions of the program and in fact they would go the extra mile to do more for their patients. They considered that what they did was not just for *'getting their salary'* and they felt that they were making a real difference to their patients.

It was identified by the observer that the nurses of the Home Care program felt that the task of visiting the patients at their own home and personal space alone had some inherent safety risks that they were aware of and worried. Some of the root causes of these inherent

risks of their work would be visiting a patient with a mental illness, or visiting a patient that co habits with a relative who is alcohol or drug addicted, whose behaviours would not be rational. In some identified high risk cases the nurses would visit the patient in groups of two. In more severe cases the patient would be taken off the program.

Finally the visiting of the patient in their private homes encloses an inherent difficulty per se. This is also documented by the requirement for a written consent to the nurses by the patients for the contact of the Home Care visits.

The findings' compatibility or diversity to the literature review

Some of the findings of this study support the literature review; high levels of patients' satisfaction in most of the items of the questionnaire, older patients reported higher levels of satisfaction than younger ones in many items and patients in a good psychological state reported higher levels of satisfaction than patients in a bad psychological state. In literature review, gender influence varies in different populations; in this study women reported higher levels of satisfaction than men in many items of the questionnaire. This finding, in my opinion, could be explained by the cultural attitude of elderly Cypriot women being more patient and easier to satisfy by the care provided than elderly Cypriot men. Moreover, there is a compatibility with the literature review concerning the hierarchy of the importance of the factors that influence the patients satisfaction; for example items related to the humane approach of the nurses were identified the most important for the patients whereas the item related to the nurse being on time was of the lowest importance for the patients. On the same line, the medical competence and the information and advising provided and the nurses' communication skills were identified as very important factors of satisfaction for the patients. The item concerning the possibilities that the care of the patients is based on the patients' wishes and desires rather than on the nurse's procedure, was an area of dissatisfaction. Additionally, some dissatisfaction was identified on how easy the patients' could reach the nurse on the telephone, the frequency and duration of the home care visits and the economic issues related to the purchasing of equipment and appliances for their treatment.

However, some of the findings of this study differ from the literature review's findings; there was no significant difference of the level of satisfaction between the different educational levels and there was no significant difference of the level of satisfaction

between different physical states of the patients. The literature review supports that patients of lower educational level are more satisfied than patients of higher educational level and patients of good physical state are more satisfied than patients of a bad physical state. An explanation for the above difference relating to the educational level is that many patients did not report their educational level in the questionnaire, thus the number of respondents was very low to extract clear conclusions. On the same line, in this study patients who lived alone reported higher levels of satisfaction than patients who co-habit in many items whereas in literature review there was no significant difference in the level of satisfaction related to the living state of the patients.

Finally, two items influencing the satisfaction of the home care patients which the researcher did not find in the literature review, were identified. One item was the gender of the nurse; there was a preference for female nurses whereas the preference for male nurses was only by male patients for the nursing procedures relating to their genital area and male nurses were considered an advantage for both male and female patients where physical strength was demanded to move the patient. Another item influencing the patients' satisfaction was the age of the nurse; many patients justified their second or third choice of an *'ideal nurse'* by the criterion of the age of the nurse but in contradictive ways; some preferred the older ages because they assumed that these nurses had more experience than the younger ones and some preferred the younger ones because they assumed that the younger nurses adopted a humane approach at a higher degree than the older ones. The above items influencing the patients' satisfaction; the gender and the age of the nurse need to be investigated by further research.

CHAPTER 5 : DISCUSSION OF FINDINGS AND CONCLUSIONS

Introduction

The purpose of this chapter is to discuss the meaning of the main findings derived from the survey questionnaire, the in depth interviews and the observations of this study as these have been elaborated in the previous chapter. It also examines how the findings answer the research questions of this project. At the same time it extracts and presents the main conclusions of this study.

The present study investigates the level of satisfaction from the nursing staff of the public home care program in Cyprus, not as this is perceived and assessed by the management of the Ministry of Health, but as perceived by the home care patients, something which is a new way of approaching and assessing the health care services.

Additionally this study investigated the natural environment where the home care visits take place in order to look into the peculiarities and the specifics of the setting and the specific characteristics of the leading participants as this service is a novelty, in the health field, vastly different to the hospital health care services and environment.

As Thomas (1996: 36) argues bringing a research problem to a conclusion

'...requires the solution of all sorts of complex instrumental, conceptual, and mathematical puzzles. The man who succeeds proves himself an expert puzzle-solver and the challenge of the puzzle is an important part of what usually drives him on'.

The research questions of this study are here below repeated for the easy reference.

1. What is the patient's level of satisfaction from the nursing staff of the Government Home Care program in Cyprus?
2. Are there any differences in patients' level of satisfaction based on age, gender, living status, educational level and the patients' psychological and physical state?
3. What is the importance of each parameter of satisfaction for the patients?

4. Are there any differences in the importance of each parameter of satisfaction for the patients based on age, gender, educational level, living status and the patients' psychological and physical state?
5. Are there any problematic areas in the services provided by the nursing staff of the programme that needs improvement?
6. What is the patients' perception of an ideal home care nurse and what is the nurses' and the management perception of an ideal nurse?
7. What are the interactions between the nurse and the patient during a homecare visit?
8. Which is the natural environment of the home care visits?
9. What are the nursing staff's and the management's difficulties in order to increase the satisfaction of their patients?

Discussion on the Quantitative research findings

The response rate of the survey questionnaire was 27.1%. The possible reasons for the low response rate might be that some patients were at a deteriorating physical or psychological state which deterred them from putting the effort; some of them did not see any tangible reason for answering it or that there would be an added value for them; some were possibly concerned for anonymity; and some might not understand the questionnaire. The low response rate possibly influences the validity of the results, however the data of the questionnaire served an additional important purpose formulate the questions of the in depth interviews and the guidelines of the observations and to further investigate areas of interest.

The patients' level of satisfaction from the nursing staff of the Government Home Care program in Cyprus (RQ1) and the differences in patients' level of satisfaction based on age, gender, living status, educational level and the patients' psychological and physical state (RQ2)

The results of this study showed that the home care patients of the public Home care program in Cyprus are very satisfied from the care they receive from the home care nursing staff. More specifically, the vast majority of the respondents of the survey

questionnaire (around 90 to 95%) answered either *'fully agree'* or *'mostly agree'* to almost all the statements of the QPP questionnaire concerning the perceived reality of their care in the various items in all four dimensions; the medical-technical competence, the identity-oriented approach and the physical-technical dimension and the socio-cultural dimension. At the same time the vast majority of the respondents answered that the items in all statements were *'of the very highest importance'* or *'of high importance'* for them. The quality of care, QPP index was found of the highest score in all items related to the care the patients' receive. The findings of the survey questionnaire were also supported by the qualitative research findings. This reveals a high level of quality of nursing care provided to the home care patients; although the results might have been influenced by factors like the dependence of the patients on their nurse and the patients' fear that their care might be negatively influenced.

There was only one statement in the survey questionnaire with lower score in satisfaction; *'My medical care was controlled by my own desires rather than by the district nurse's procedures'*; an item of the sociocultural dimension. Almost half of the respondents (40, 9%), answered that they *'partly agreed'* or *'do not agree at all'* that their medical care was controlled by their desires rather than by the home care nurse's procedure.

At the open question 'I was especially satisfied', the respondents stated especially satisfied with the humane approach; the politeness, the interest and the caring of the nurse, followed by the useful advices and the medical care they received from their nurse. Fewer respondents stated especially satisfied with the psychological support they received and less patients with the professionalism demonstrated by their nurse, the easy telephone contact with the nurse, the frequency of home visits and finally with the fact that they did not have to travel to the health center for their treatment.

The above results are in line with the results of the qualitative research of this study. Even though, the number of respondents at the open question 'I was especially satisfied' was small to extract safe conclusions for any variances related to the demographic characteristics of the patients, it might be worth mentioning that patients who stated especially satisfied by the humane approach; politeness, interest were of the lower educational level.

Statements related to receiving information

The respondents of the survey questionnaire reported high levels of satisfaction for the useful information they received from their nurse concerning different themes related to their care and at the same time they scored high levels at the importance of these items. These findings reveal a high level of information given from the home care nurses to their patients and they are compatible to the findings of the in depth interviews and the observations.

More satisfied in the above elements were patients of older ages, patients who lived alone and women. Patients of primary educational level reported higher levels of satisfaction than patients of higher level of education but with a difference of less than 3 %.

I believe that younger patients and patients with higher levels of education are more demanding in the quantity and quality of the information they receive. These patients have more knowledge, have more access to information and they are more fluent in the use of technology e.g. internet. Also the patients who co habit have an opportunity to share and exchange information from their co-habitants, spouses, relatives, friends or caregivers, unlike the patients who live alone and are generally more isolated. Consequently, people who co-habit are possibly more demanding in the information they receive from their nurses whereas for the patients who live alone their nurses might be the only source of information they have. Finally, in my opinion, Cypriot women of elderly ages, by culture are not so demanding as Cypriot elderly men.

Statements related to the medical competence

The high levels of patients' satisfaction concerning the medical competence of the nurses show that the home care nurses have a high standard of theoretical and practical medical knowledge.

More satisfied in the above factors were patients of older ages, women and patients who lived alone. Patients of younger ages are possibly more demanding than the older ones and in my opinion, elderly Cypriot male patients, are culturally more demanding on the care they receive and they show less patience with regards to the process of the treatment, whereas elderly female patients are usually more enduring and less demanding.

Patients who live alone are more satisfied possibly because they more depended on the nurse's medical care as they do not have any other close alternative for their support. As

such they are more appreciative, thankful and satisfied from the medical care provided by their nurses.

There is no significant difference on the level of satisfaction among patients of different ages or educational levels. I would expect that patients of higher educational level to be more demanding yet less satisfied, however the research has shown no difference on this element.

Statements related to the humane approach

The respondents reported high levels of satisfaction against all the statements related to the humane approach of their nurse. This indicates that the home care nurses of the public home care program, have high levels of understanding, respect and caring for their patients.

It is noteworthy, that there is no significant difference between ages, gender, living alone or co-habiting and the level of education of the patients. I believe that elements relating to the humane approach are comprehensive, clearly understood and appreciated, by all patients irrespective of their age, gender, level of education and living state. The respondents were elderly people; possibly the experience of life enabled them to recognize whether their nurse encompassed a humane approach. On the other hand, the fact that there is no difference in the level of satisfaction among the diverse demographic characteristics, might reveal that the nursing staff does not discriminate between genders, ages, educational level and living state when it comes to empathy, respect and caring.

How nurses treated the patients' relatives and friends

The high levels of satisfaction in this item show that the nursing staff treats and behaves well against the patients' relatives and friends. This finding is also supported by the findings of the observations of the home care visits. There were no significant differences related to the patients' age, gender, and educational level and living state.

Participation of the patients in the decisions concerning their care

The respondents reported high levels of satisfaction for this element and this is also supported by the findings of the qualitative research of this study. More satisfied were patients of younger ages and men. Possibly the nursing gives fewer opportunities to the older patients to participate in the decisions concerning their care than to the younger ones

as they possibly think that the oldest old have limited knowledge and reduced cognitive abilities and as such they are unable to participate in a decision regarding their health care.

The medical care controlled by the patient's desires rather than by the nurse's procedure

This was the only statement of the questionnaire; an item of the sociocultural atmosphere dimension, where respondents reported low levels of satisfaction. I believe that the attitude that the medical care is controlled by the nurses' procedure rather than by the patient's desires, is an extension of a more generalized culture of the whole health care system in Cyprus. Most of the health care professionals do not accept and are unwilling to factor in the medical care of their patients, their patients'- clients' own wishes, and they are rather entirely focused on their own health procedures. Such approach by health professionals cultivates such a culture where the patients are passive recipients of the health care they receive.

Once the quantitative part of this research has identified low scores on the patient's satisfaction regarding their medical care be highly controlled by the nurse's procedure rather their own desires and wants, the researcher tried to investigate the issue further during the in depth interviews, which refuted the low scores derived from the survey questionnaire.

The difference between the results of quantitative and qualitative research on this issue were possibly because of the patients' concern for anonymity when responding during the in depth interviews to the question whether their medical care was controlled more by the nurse's procedure rather than their own desires, as the question was referring directly to their nurse and it was not a more general one such as 'suggestions for improvement' or 'how should an ideal nurse be?'

Another reason for the difference might be the possibility of the patients' misinterpreting the question of the survey questionnaire. More specifically the term 'medical care', which is used in the specific question, might have created a confusion to the patients who might have thought that it was referring to the medical care that they receive from their doctors; public doctors at the hospitals or the medical centres or the private doctors, who at certain instances treated them at home.

More satisfied were men and there is a trend that more educated patients were more satisfied. The female patients possibly have a greater desire than the male patients to control their medical care by their own desires. Possibly the nursing staff pays less consideration to the need of the less educated patients' to control their medical care by their own desires as they may think that the less educated patients have limited knowledge and as such they are unable to control their treatment by their own desires.

Access to the nurse by telephone communication

The respondents reported high levels of satisfaction for this factor. Men were more satisfied than women at this statement. The in depth interviews of both the patients' and the nurses' revealed some problems in the communication by telephone which are presented at the discussion of the qualitative research findings.

How easy it is to persuade the home care nurse to come for a visit

Respondents showed high levels of satisfaction for this factor and qualitative research supports this finding.

Waiting time

The respondents indicated high levels of satisfaction on this statement. In qualitative research this factor was one of the least important characteristics at the description of the 'ideal nurse'. Patients who lived alone and women reported higher levels of satisfaction.

Equipment

The respondents indicated high levels of satisfaction on the statements: '*I received help to obtain the appliances they needed...*' and '*I had access to the apparatus and equipment...*'. However, the in depth interviews of the patients revealed some problems in the access of the patients to the apparatus and the equipment which are presented at the discussion of the qualitative research findings.

Satisfaction by Age

Patients of higher age reported higher levels of satisfaction (>3%) than younger patients in 30% of the statements.

Patients of higher age are usually less demanding and easier to satisfy than the younger age ones. However, patients of younger age reported higher levels of satisfaction (>3%) than older patients only in the 'opportunity to participate in decisions relating my medical care'. This was possibly because nurses may consider younger people more updated with recent treatments, more knowledgeable and as such more capable to offering them more opportunities to participate in the decisions concerning their treatment.

Satisfaction by Gender

Men are less satisfied, than women, with a difference more than 3 %, in about 30% of the statements. Culturally elderly women in Cyprus are used to low expectations and they have cultivated patience during their live path whereas elderly men patients are culturally more demanding on the care they receive. Cypriot men of older ages, part of the male dominated society of the recent past generation, are used to be taken care off by their wives and other female members of the family, daughters or daughters in law. As such, they are more demanding in the services especially if these are offered by females.

Even though women are less demanding than men, when it comes to communication issues such as the facility to contact the nurse on the phone and in participating in decisions that relate to their medical care, women may be more demanding; women reported less satisfied than men in the relevant statements. Men may be more factual in their communication style where as women are often looking for reassurance about various emotional needs; such as being afraid, feeling alone, feeling insecure on making a mistake with regards to a treatment procedure, rather than the mere factual and informative

requirements on a possible issue that they are unsure of. Women are usually more dependent and in greater need of verbal communication than men, they need to chat more which seems to be one of the primary means to fulfilling their needs of reassurance and security. At the same time they want more participation in decisions related to their health possibly because of their general need to get involve in everything that happens around them, including their health care.

Satisfaction by Living Alone or Co-Habit

Patients who live alone are more satisfied than patients who co-habit, with a difference more than 3%, in one third of the statements. I believe that patients who live alone are more depended on the nurse's medical care and pain relief treatment as they do not have any other close alternative for their support. As such they are more appreciative, thankful and satisfied from the medical care and the pain relief received by their nurses.

Satisfaction by Educational Level

There are no significant differences in the level of satisfaction between the different levels of patients' education.

However, in some statements, there was a trend that patients of higher education were less satisfied with the information they received and by the help that they received regarding measures to prevent accidents at their homes. More educated people may have greater access and fluency in modern information databases such as the internet. As such, they may inform themselves on their own health issues and consequently they demand higher level of information and advice by their nurses and other medical professionals.

Patients of lower education were less satisfied by the help they received with obtaining the appliances they needed, by the access they had to the apparatus and the equipment they needed, by how easy they would get the nurse to come out on a home visit and by how their medical care was controlled by their own desires rather. These people may need more detailed and thorough help, instructions and directions for technical and procedural issues like how to obtain appliances or how to have access to the apparatus and equipment they need. They might not have been exposed to dealing with governmental bodies in their course of life and as such may find it difficult to cope. The less educated patients may not have the skills to debate against arguments and persuade the nurse on their desires relating

to their medical care or to for the nurse ‘come out to a home visit’. At the same time the nurses may generally be prejudiced against the less educated patients with respect to good judgement, knowledge and cognitive abilities with relation to evaluating their own health issues.

Satisfaction by the physical state of the patient

There was no relation found with regards to the physical state of the patients.

Satisfaction by the psychological state of the patient

The patients with a better psychological state reported more satisfied than the patients in a worse psychological state in approximately 25% of the statements.

Suggestions for improvement (open question)

The patients requested more visits and for each visit to be longer. This indicates that the patients may not be so satisfied with the frequency and the duration of the home care visits. Some of respondents related this wish to the requirement to employ more nurses. However the researcher is not fully supporting this standpoint which should be subjected to an organizational study as how better to utilize human resources.

The patients stated the need for the program to continue its operation. Why would they express such a worry? Possibly because they are unsecure of the fact whether indeed it will continue to operate pending the political decisions from time to time and from government to government.

The patients explicitly indicated the need for enriching the program with more health professionals like physiotherapists, psychologists and others.

All the above suggestions are well-matched with the findings of the qualitative research. However more problematic areas were revealed and the researcher was able to derive more details and insights on the above themes, during the qualitative part of this research.

The importance of each parameter of satisfaction for the patients (RQ3) and the differences in the importance of each parameter of satisfaction for the patients based on age, gender, educational level, living status and the patients’ psychological and physical state (RQ4).

The majority of the respondents reported that all the statements of the questionnaire were of the very highest or the highest importance for them. This shows that the respondents consider all the parameters included in the questionnaire as very important to them. So it was not possible through the quantitative research to identify the order of importance of the elements of satisfaction for the patients; something that was however endeavoured and achieved through the qualitative part of this research. The deviance of the results in this research question between the quantitative and the qualitative part, is possibly because the patients might have not understood how to utilise 'set B' of the answers on the questionnaire which refer to the importance of each element as the aspect of the importance was not usually included in previous questionnaires that they possibly were asked to answer.

Discussion on Qualitative Research Findings

The patient interviewees have overall expressed high levels of satisfaction from the nursing services. However, one should take into account the dependence of the patient to their nurse and how this dependence might have influenced the patients' in such a way that patients refrained from expressing all their complaints freely and openly; to add to this most home care patients are elderly people who grew up in a world much different of today, that might have not allowed them to express any complaints and sorrows. Additionally, the sociocultural environment of the programme as this has been observed by the researcher may not encourage enough the surfacing of any complaints that the patients might have. On the operational level it was identified that there is not a routine assessment of the patients' satisfaction in place so that trends are followed up by management. At the same time the patients are not formally informed of any means or any available channels that they could resource to making a complaint or expressing any form of discontent which in itself may discourage the patients from expressing any complaints. An additional influencing factor that one should consider might be the fact that the patients do not know exactly what to expect of the program, they do not have measure of comparison; the home care program was in its infancy not widespread and at the time of the research there was not any other public or private organization that could offer Home care nursing.

Nevertheless the qualitative research revealed more problematic areas in the home care nursing services and in much more detail and in greater clarity than the quantitative research.

Finally the researcher has identified a level of ‘protectionism’ by the patients to their nurse. This protectionist attitude the researcher has at frequent instances observed may reveal a strong emotional connection between the patients and the nurse which in some cases goes beyond the professional nurse- patient context and boundaries.

Age

The researcher identified a preference of the younger patients to older nurses which possibly reflects their maternal prototype enhanced by their increased need for safety and protection. The patients generally related experience with older aged nurses, hence their preference for older nurses, while the older old patients’ preference for younger nurses may reflect their attachment or possibly lack of, own grandchildren. Additionally, nurses of younger ages are possibly perceived by the oldest old patients, as more cheerful and lively; as hope and life itself.

Gender

The patients’ gender did not seem to affect their answers in most matters; however both genders of patients seem to prefer a female nurse for their nursing care except when it comes to procedures concerning their genital area.

Some of the women eliminated at once the male nurse from their choices when they were asked to choose the ideal nurse out of 4 pictures, supporting their decision by saying that ‘*a woman can speak to a woman*’ much easier and a woman can feel more comfortable with a woman nurse rather than with a man.

However, on one case a female patient, who was treated by a male nurse, explained that she did indeed feel uncomfortable at first, but soon after, the male nurse made her feel comfortable with him on all aspects of her treatment - even for changing her urinary catheter.

The male patients feel uncomfortable and do not want their urinary catheter be changed by their female nurse; most male patients demand a male nurse.

To a great extent this is also true for the female patients. Most patients feel embarrassed in front of the opposite sex when it comes to nursing procedures that involve their genital

organs. The researcher believes that this attitude is deeply rooted in cultural taboos of the Cypriot people.

Finally, male nurses are appreciated by the patients for their physical strength where there is a need to move the patient.

Alone or Co-habiting

The majority of the patients are co-habiting with their housekeepers who are usually from a foreign country. Only two of the patients did not have a living-in housekeeper, but instead they were co-habiting with a relative; a spouse or a brother or a sister. No one of the patients was living completely alone.

Educational level

Educational level was evident on the proper use of the spoken language, with good description skills of ideas and concepts. However the patients of lower educational level although basic in verbal use of language but with more utilisation of the local dialect had no issues in putting across their message clearly and precisely and without any reservations. It was also noticed that these patients created a closer and more intimate relationship with their nurse that those of higher educational level who maintained a more business like relationship; one of 'service provider' and 'service receiver' or 'customer'. Patients of a lower educational level emphasised more on the importance of the humane approach of their nurse. Patients of a higher educational level appreciated more factors such as nursing knowledge and nursing competence and professionalism.

Health State

The patients' physical state and psychological state did not influence their level of satisfaction from their nurses. It was observed that most of the interviewees had signs of depression, faced loneliness, isolation and social exclusion.

Irrespective of the nature or the state of their health problem, the common issue amongst most of the patients that were interviewed was the difficulty they faced when they had to be transported.

Gifts given to the nurses

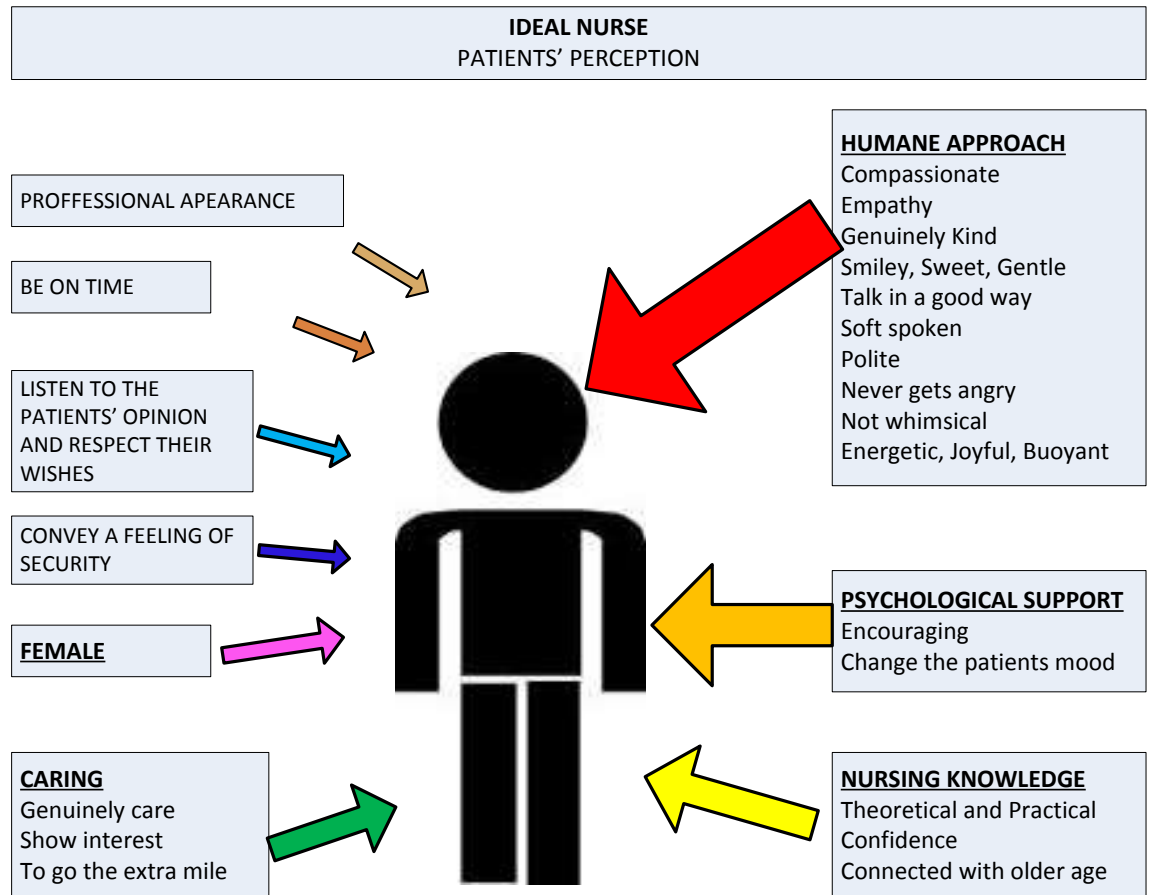
“Just as spoken languages differ from one culture to the next, so do unspoken, nonverbal behaviors.... Just as people from different cultures have their own rules for

engaging in nonverbal behaviors, they have their own rules for interpreting the nonverbal behaviors of others". (Matsumoto, 2000: 343-344).

The giving of gifts to the nurses by the patients and the receiving of these gifts from the nurses, might implicate ethical issues in other cultures, however when we consider the Cypriot culture the interpretation of such action is different; to give a small gift is an action of appreciation by the patients and denial of the gift by the nurses would be considered an insult to the person that offers it. This cultural distinctiveness is stronger amongst the previous generations which are the elderly people, and it is well within the ethical framework of the job, as long as the concerned gifts are small and innocent such as fresh fruit and flowers usually from the giver's own garden, small accessories such as key rings and pens. These were examples that were observed in this research's observations. It would; however become a concern if the gifts were more expensive.

Ideal Nurse

Figure 5-1: The patients' perception of an ideal home care nurse (RQ 6)



What is the perception of the ideal nurse through the eyes of the home care patients? Do the patients see the ideal nurse in the same way that the home care nurse or the management of the home care program do? Do they have the same stand point as it concerns an ideal home care nurse?

This study identified a different view between the patients' perceptions. It is obvious that the most important aspect by far through the home care patients' eyes is the humane approach of the nurse; build up with genuine compassion and kindness, enriched by a smiley, sweet and gentle nonverbal communication and communicated verbally with soft speaking and politeness. Moreover, joyful and buoyant attitude often connected by the patients with a younger age, completes most of the figure in the ideal nurse's picture. The psychological support; consisting mostly by encouragement is a big piece of the puzzle. High nursing knowledge sometimes connected by the patients with higher age, comes as a

third piece of the picture, followed by a gender preference; pink is the color of nursing in the patients' eyes. A male nurse would be appreciated for his humane approach, his physical strength and preferred only in procedures where the genital area of a male patient was involved.

On the contrary, through the nurses' and the management's eyes, the main material for the formation of the picture of an ideal nurse, is the high nursing knowledge mixed with high portions of critical thinking and a leader's attitude. Humane approach, the patients' domain material for the formation of the sculpture of an ideal nurse, comes in a smaller portion from the nurses and the management's stand point. The psychological support is not a piece of the puzzle and caring is not emphasized. Discipline in self-management and organizational skills is a smaller piece that almost completes the picture of an ideal nurse in the nurses and the management's eyes.

Communication skills, a main part of the perception of a humane approach by the patients, both nonverbal and verbal, is not in the forefront for nurses and management; restricted in the narrow limits of verbal communication, mostly for the purpose of transmitting diagnostic or treatment related messages, underestimating the broad aspect of communication in the patients perception; the transmission of feelings like caring, empathy and kindness.

Alder and Rodman (2006: 5-6) stated,

'...communication isn't a series of incidents pasted together like photographs in a scrapbook; instead, it is more like a motion picture in which the meaning comes from the unfolding of an interrelated series of images'.

Moreover, communication is not only verbal but also non-verbal; a part of communication which is strong enough to change the meaning of the words.

'.... The words coming out of someone's mouth may tell you one thing but the person's nonverbal behaviors may tell you something else. Someone may say "I love you" in words but communicate "not really" with nonverbal behaviors.' (Matsumoto, 2000: 340-341).

Concerning, the smallest parts of the picture, the ability to convey security and take into account the patients' opinion is an issue for the patients, whereas love and sensitivity for

people of older age is an issue for the nurses and love for the job is an issue for both the nurses and the management.

Elements of professionalism such as the appearance; white nursing clothes and a medical bag in the hand, are not important neither for the patients nor for the nurses or the management.

Conclusively, there is a gap in the perception of the ideal nurse between the patients and the group consisting of nurses and management; two groups which are almost compatible. Therefore, patients' satisfaction is built mainly on the humane approach of the nurses and the smaller pillar of psychological support and caring whereas nurses and management put their weight on the high nursing knowledge and the leadership skills of the nurse, in order to achieve high standards of satisfaction.

Figure 5-2: The nurses' perception of an ideal home care nurse (RQ 6)

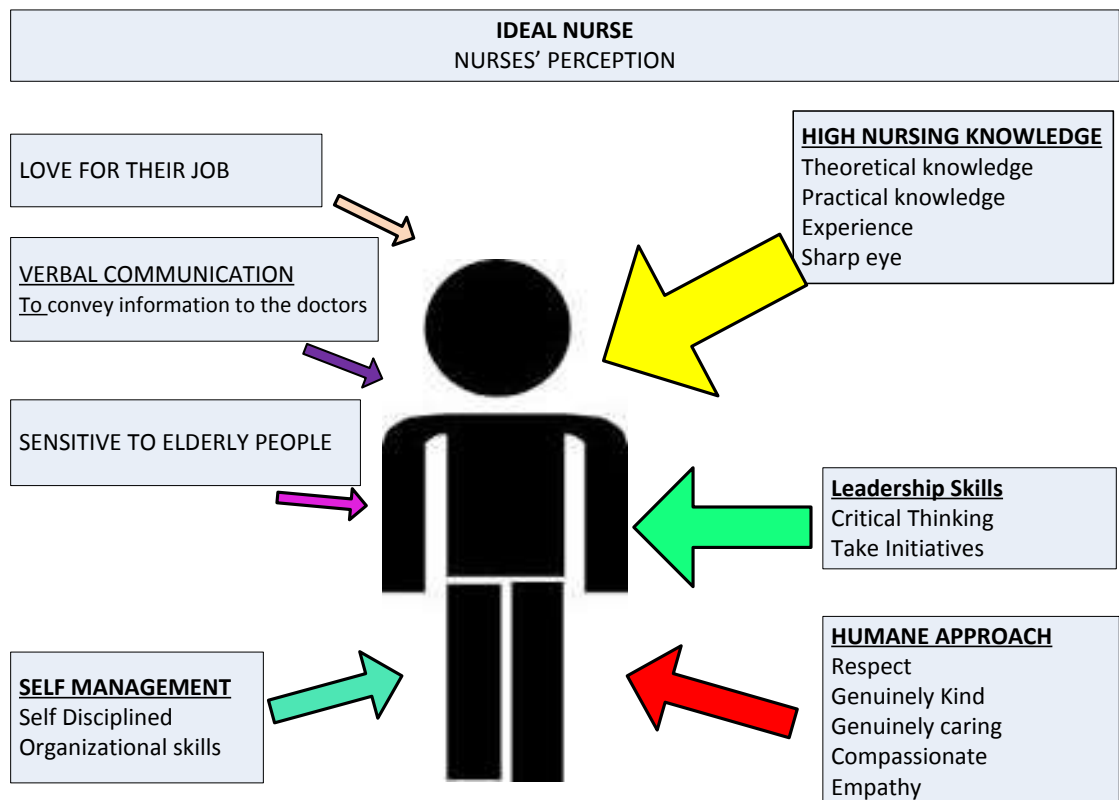
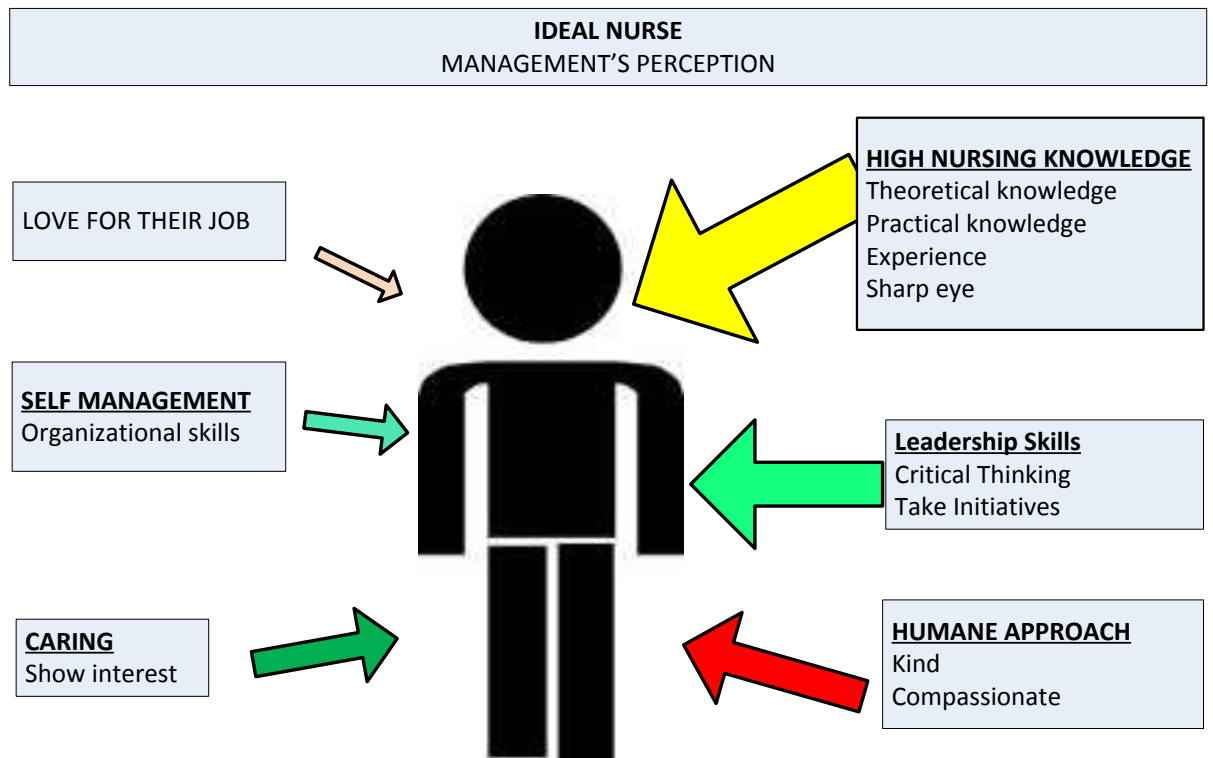


Figure 5-3: The management's perception of an ideal home care nurse (RQ 6)



The possible underlying reason that the nurses' and the home care management indicated, the high standards of nursing knowledge and leadership as the primary two attributes of an ideal nurse, is possibly a reflection of the context of their nursing academic education which follows up on their training and assessment in their professional environment. When on university or college, the nurses are trained and assessed on nursing skills and knowledge, while the subjects of communication and psychology are 'listed' as 'secondary' and underestimated and the context of such subjects is limited to basics and general. When the nurses move on to work in public hospitals they are primarily assessed on their nursing skills. Respect, caring, empathy and communication skills are viewed as 'secondary'.

The natural environment of the home care visits (RQ 8)

The natural environment of the patients varies in the size and the maintenance state of the building is maintained, in the cleanliness, tidiness, ventilation, brightness, room temperature and the natural surroundings and the human environment. The natural environment was either supportive or not supportive. Where the natural environment of the patient was supportive, it helped the nurse's job and added to the patient's well-being. Where the natural environment was not supportive, a deficiency was identified in the nursing care provided by the program concerning the activities of daily living (ADL). The ADL, a part of the nursing care program, in contrast with most of the other countries is absent in Cyprus. Most possibly, the patients of the Cyprus home care program are unaware that ADL is part of the duties of the home care nurses in the programs of other countries and this might, hence, be the reason that they do not ask for it and the reason, it did not come out as a suggestion.

Interactions between patient-nurse at the home care visits (RQ7)

What was the meaning of the findings of the observations concerning the interactions between the patients and the nurses?

Where the patients' psychological state was moderate to good, the psychological support offered by the nurses was adequate. To the contrary, where the patients' psychological state was bad to very bad, the psychological support offered by the nurses was insufficient and inadequate. It was obvious that the nurses did not know how to handle such situations. Their discomfort and bewilderment was very obvious; they conveyed mixed feelings of sadness and disappointment towards the patient; they would not understand why the patient was psychologically down and the nurses could not empathize with the patient.

Their bewilderment and discomfort was also evidenced in their verbal communication, by repeated stereotyped phrases like: '*Why Mrs. K.?*'...*Why Mrs. K.?*...*Why Mrs. K....?*' and by long pauses of silence. The nurses kept an emotional distance from the patients, evidenced, by limiting their talk to short and cold sentences without offering any convincing support, or elevating the patient's psychological state but instead transmitting a feeling of disappointment. At the same time they were not eligible to refer the patient to a psychologist.

It was interesting to identify a discord between the findings of the observations and the in depth interviews; some interviewed patients stated that they considered the psychological support they received from their home care nurses as an advantage of the nursing care they received, whereas in some of the observations, a deficiency was identified.

One explanation to this is that the interviewed patients, who raised it as an advantage, possibly fell in the category where their psychological state was good or very good or they were in that category where they had a supportive human environment. Another explanation might be that the patients were comparing the psychological support they received while in the hospitals compared to what they received at home care, whereas the researcher observed it as a standalone criterion and not as a comparison to what patients received at the general hospitals.

This study has indeed identified that the nurses were unable to understand and empathize with the patients, in bad psychological state, and at the same time a bigger deficiency was identified to coping with these situations and conveying psychological support to these patients. One though, should ask whether the nurses were trained to handle such situations and whether their past professional experience provided the necessary exposure. Possibly not; in the public hospitals where the nurses of home care worked before, the nurse-patient relationship is distant and more professional-like. Should a patient faces psychological downturns the psychiatrist or the psychologist is called in to handle and support the specific patient. At home care though the situation is different; the relationship between the nurse and the patient is a close one and giving psychological support becomes one of the major duties of the nurse ; the home care nurse in Cyprus has to handle it by herself without the backup of a psychologist.

At this point it should be indicated that both at the quantitative and the qualitative research revealed that only very few participants signposted the need for a psychologist in the programme. The researcher believes that the underlying reason for this is possibly a social taboo in the Cypriot society who relates the need for psychological support with the people that are 'mentally ill' and 'insane', especially if this support and treatment comes from a professional psychologist; hence the patients' reluctance to identify the need for one.

To sum up, the Cypriot home care nurse seems unready to cope to this duty whereas the need for psychological support is increased for the home care patients especially the ones who are lacking a supportive human environment.

Information and advice given to the patients of home care

Most of the patients reported a high level of satisfaction by the information and advice given to them and they thought that it was adequate. This was indicated in the questionnaire, the in depth interviews and it was confirmed during the patient's observations but with one distortion.

Where the educational level of the patients was low to medium, the way that the nurses communicated; context, syntax, wording, tone and pace, seemed appropriate and adjusted to the reception and understanding capabilities of these patients.

However where the educational level of the patients was high, the nurses did not adapt the level to which they should communicate. They kept the same attitude as if the patient was of the lower socio-educational level. Why did the nurses not adapt? The reason could not be identified for sure. The possibility of the nurse being unable to change her communication attitude, as appropriate when in front of a highly educated patient, seems distant to me. The explanation might be twofold. One reason has possibly its roots to the nurses past training, and the inherited communication style that they have been exposed to and practiced while their many years of working in the wardens of the public hospitals. They might be with the impression that what they have learned is still appropriate for home care irrespective of who the patient is. The other reason might have to do with the culture of the health professionals in Cyprus. I have experienced many instances as a medical doctor, where I have seen health professionals, seeing the patients from aloof, underestimating their understanding capabilities and promoting a '*we know best*' attitude and '*you (the patient) do not know and there is no need to know*'. This attitude seems to be aggravated with the age of the patient. The elderly people are treated as ignorant and of limited cognitive capabilities irrespective of educational level and expertise; '*being old*' equals to '*you do not understand*' seems to be the predominating culture.

Qualitative research revealed some problematic areas in the home care nursing services. But what are the difficulties of the nursing and management staff that are hurdles to the improvement of the services provided and consequently limit the patients' satisfaction?

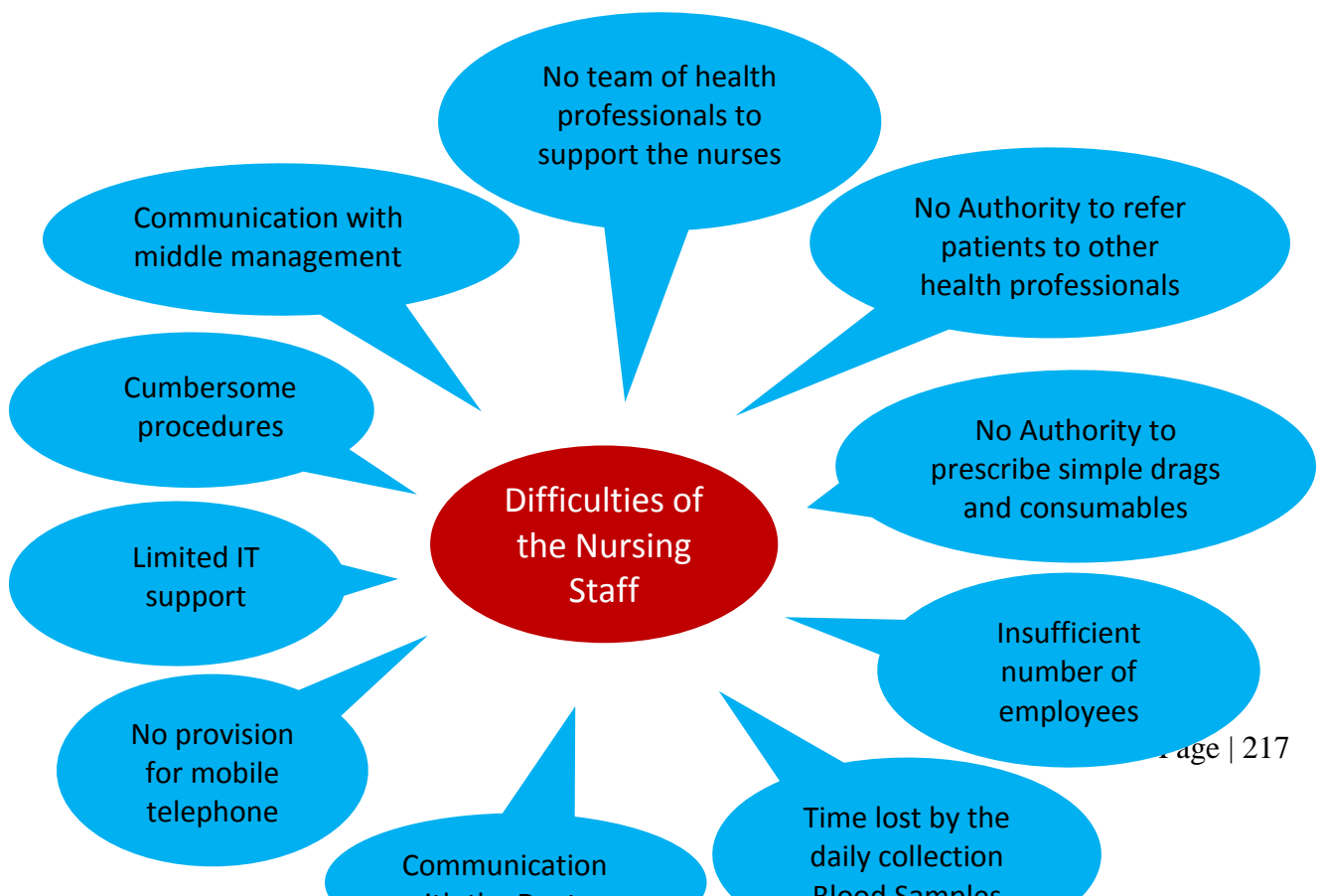
These difficulties are discussed in this section, trying to answer the related research question.

The nursing staff's and the management's difficulties, to increase the satisfaction of their patients (RQ9).

Nursing staff's difficulties

Further to the problematic areas of the program that the interviewees identified above they expanded on more issues when they were challenged to describe 'the difficulties' that they as nurses, face. Some of the issues are an expansion of the 'problematic areas' however more insides are surfaced when the interviewees thought of them as the 'difficulties' that they face. These are cited below and are summarized in figure 5.4. The new risen issues are aspects of two categories, one that involves productivity which are expressed as insufficient number of employees, and time lost by the daily collection of blood samples, and one that touches leadership and communication which is indicated as a difficulty to manage the communication problems with middle management and doctors.

Figure 5-4: The nursing staff's difficulties which negatively influence the satisfaction of their patients (RQ 9)



Process Innovation

The nurses think that the main reason that they are pressed for time during the day or that there is a stagnation of cumbersome procedures such as the blood sample collection, is that they are understaffed and that more nurses are required. The researcher acknowledges most of the difficulties that they face, however she has not been persuaded that the remedy of all is to employ more nurses for the existing load of work. There are other means to increase productivity either by employing technology, changing procedures and innovating on the many ways that the daily work is done. All of which is what the nurses should be exploring with the assistance and facilitation of their management. Overall there is virtually no process innovation in home care which limits progress and efficiency.

Managing Upwards

The nurses blame middle management and the doctors when it comes to communication; they feel that management is distant to their working needs and daily challenges. Indeed these two groups, management and doctors, might have room for improving their understanding of the nurses' job in home care; their difficulties, their daily struggles, as these have already been discussed in this project, however, from the nurses side, the researcher has identified an attitude of '*resignation*' and '*acceptance*' of the existing situation. It requires some skills to be able to '*manage upwards*' in an attempt to get what you want; yet, an area that will be tackled within the proposed training and experiential workshops.

From the doctors' point of view, Modin et al (2010), state in their research, that some doctors retain the initiative to the home care nurse and some doctors leave the initiative to the home care nurse; the same doctor may have a different attitude for different diseases. The doctors retained the initiative mainly when they felt that they could not rely on the home care nurse. The doctors' feelings that there were satisfactory grounds for relying on the home care nurse were influenced by the doctor's attitudes towards collaboration. To this end common workshops on '*understanding each other*' and teamwork could be beneficial for both, the home care nurses and public doctors.

It should finally be noted that this study has barely touched the area of satisfaction of the nurses and it is very limited to drawing any conclusions on improving the nurses' satisfaction to those areas that will positively influence patients' satisfaction. As such there

is scope and benefit if further to this project an individual further study be done to investigate what are those drivers that increase nurse satisfaction and which of those drivers influence patients' satisfaction.

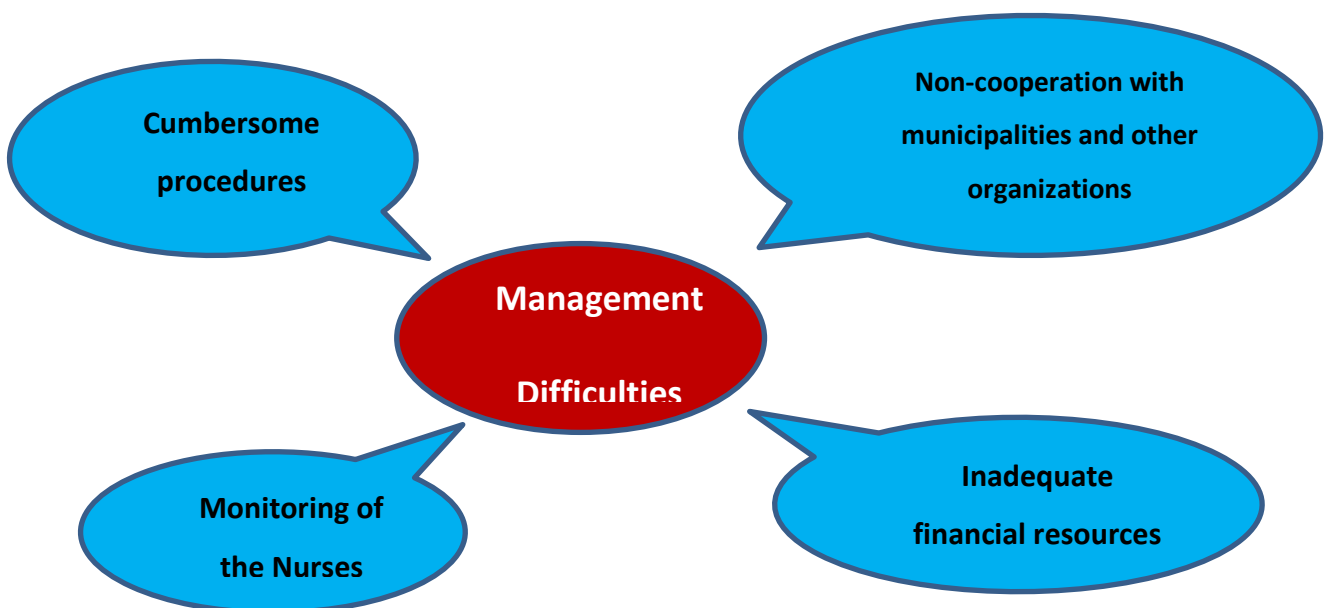
Referrals by the nurses

Management staff interviewees noted that nurses are the most suitable to evaluate their patient's state and therefore they should be allowed to refer their patients to other health professionals such as a psychologist, a specialized doctor or a social worker. The interviewees emphasized the cases where the patients needed psychological support. Patients sometimes would not be adhered due to their psychological state, for example depression, thus they would not follow the nurse's advice to visit a psychologist. However, if the nurse was allowed to refer the patient to the psychologist then the patient would have the chance to be treated.

Management Difficulties

The management difficulties are summarized in figure 5.5 and they are focused on either financial constrains or administrative issues.

Figure 5-5: The management staff's difficulties which negatively influence the satisfaction of their patients



Limited financial support – limiting initiatives and expansion

The main financial income of the program is through the government's fiscal budget which is enabled via the budget of the Ministry of Health. The allocated amount is for the community care to which home care is considered as part of it. As such the home care program is not properly and individually budgeted and consequently the funds always seem to be insufficient for any effective initiatives and for any further expansion to other geographical areas.

Cumbersome procedures hindering responsibility and motivation

Typically managed by the attitude of *'this is not my job...ask Mr. ...'* the job is invariably stuck or pushed from one person to another, which is a source of frustration and conflict. The weak internal procedures and vague terms of job descriptions and responsibilities is an internal hurdle to the nurses who need things to get done. Issues remain unsolved and people including management become demotivated and give up. Everybody seems to be blaming the system.

Commitment of the municipalities and nonprofit organizations

Municipalities are clear stakeholders when it comes to the well fare and health care of their citizens. At the same time they are partly funded by the central government. These two factors are substantial enough and provide sufficient leverage to persuade the municipalities to get involved in an official, structured and committed long term plan to support home care with all the means they have. Home care must become a major theme in their activities as an increasing number of their citizens will be in need

Control and Monitoring by middle management

In some instances the difficulty to monitor, control and to getting feedback from the nurses was emerged as an issue by middle management. The researcher thought that the reasons given to support the management's case although valid they had to do with the nature of the operations of home care. One example was that the nurses operated at a distance from main headquarters. This project had no intent to provide management advice neither on each individual issue nor to help management with their individual challenges and responsibilities such as the control and monitoring but it has indeed identified the lack of some management skills to this end. The researcher within the scope of the outcomes of

this project, will however present the issue where appropriate and with the explicit suggestion that appropriate training be given to middle management in order to enhance their skills. Management efficiency will at some stage provide added value to the end users which are the patients of home care.

Feedback – a means for improving patient satisfaction

European Commission (2010), at its joint report on health systems, indicates as one of the challenges for the Cypriot health care system, is

‘to continue to improve data collection and monitoring of inputs, processes, outputs and outcomes so that regular performance assessment can be conducted and used to continuously improve access, quality and sustainability of care’ (European Commission, 2010:115).

Two of the unique areas of this research are the triangulation of data collection and research methodologies and the utilization of the core concept of measuring satisfaction from the patients stand point. As a whole this researcher’s methodology will be forwarded, as a tool to keep measuring patients’ satisfaction in regular time frames, as for example every two years. Data could be compiled so that areas of weakness and trends concerning the level of satisfaction of the patients would be identified. Comparison of past data will measure progress and serve to identify whether the previous decisions and implementations were effective enough. Although the QPP questionnaire adjusted for home care is a very good and appropriate tool, in my opinion a more realistic and holistic picture would be captured only by qualitative research.

None of the patients refused to be interviewed or observed, whereas a considerable percentage of patients did not answer the survey questionnaire. One of the reasons could be that the patients who did not answer the survey questionnaire, fell in the group of patients who were either less satisfied or who were in a worse physical or psychological state. This group of patients would possibly be more willing to accept to be interviewed or be observed whereas they would be unwilling to answer an impersonal questionnaire. Similarly, Larsson and Larsson (2002: 681), argue that,

‘patients’ views on quality of care are important and it is desirable that these can be assessed using short, yet valid and reliable instruments’,

however they also suggest that ideally after the use of the short version of the QPP, there should be a follow up questionnaire, with an inclusion of some of the items of the long version of the questionnaire related with the areas where problematic issues were suspected from the findings of the short version, combined with interviews taken not only from the patients but from other care related participants as well, such as the staff of home care (Larsson and Larsson, 2002). Finally, the difficulties that were experienced by the researcher during the qualitative part of this research will be shared in terms of valuable tips and guidelines.

ICT and back office automation

Basic tools that are of essence in the modern business are missing from homecare something that hinders efficiency, productivity, monitoring and feedback. For example the lack of laptops, access to internet and email, the lack of printing and faxing, the non-provision of GPS and mobile phones are just a few issues that have been emerged as obstructions to the day to day operation of the services provided. The researcher will put forward a suggestion for a three step to incrementally improve the productivity and efficiency of the program as indicated in the table 6.1: Suggestions for automation of Home Care Procedures.

Figure 5-6: The problematic areas in the services provided by the nursing staff of the program that need improvement (RQ5)



The survey questionnaire utilizing closed questions showed high levels of patient satisfaction in all areas of the nursing services provided by the home care program; however one open question inquiring suggestions for improvement surfaced some problematic areas. This was further investigated during the in depth interviews to the

patient, the nurses, and the management as well as on the observations, where more areas that need improvement emerged.

The main deficiency is the absence of other health professionals in the program in order to team up with the home care nurses. The lack of a team of health professionals, mainly physiotherapists and psychologists, leads to the nursing staff to provide support in these areas, which is inadequate. As Panasci, (2009: 190), characteristically indicates

'Unfortunately, long-established images of home care consist of visiting nurses simply performing vital sign measurements and changing dressings while home companions do household chores. This, however, is an especially narrow view. Today home care can include skilled nursing, physical therapy, occupational therapy, home health aides, social workers and nutritionists. Patients are provided with needed durable medical equipment, diagnostic testing and laboratory services. Sometimes when required, clinical nurse specialists are called upon to provide supervision or direct treatment for specific conditions; for example, wound care, congestive heart failure, diabetes or asthma.'

The lack of doctors in the home care program and the problematic communication between the nurses and the doctors of the public hospitals, negatively affects the level of nursing care provided.

The second bigger problem is the lack of a 24/7 operation of the program. This negatively affects the level of satisfaction because home nursing care is needed at any time of the day, and all the days of the week; some treatments need to be done at specific time which might be beyond the existing working hours, for example an injection, taking of a blood sample or changing a wound. Consulting, information, guidance, advice, psychological support and support in case of emergencies is also frequently needed round the clock. The 24/7 operation of the program, is requested by the patients, it is supported by the nursing staff, however the management has a contradictive view.

Other areas of improvement that have been surfaced were the need to increase the duration and the frequency of the home care visits according to individual needs. The heavy daily schedule of the nurse which usually results to the nurse becoming very tired may also negatively influence the quality of nursing care provided. It seemed that one of the

underlying reasons for the above mentioned deficiencies is the under staffing of nursing personnel.

The fact that the nurses are not allowed to prescribe simple medication and consumables creates an issue for the patients who in this case have to pay a visit to a doctor at the public hospitals. This is a very long and slow process as it requires an advanced appointment, patient transportation assistance, long queuing and unnecessary time consuming for the patients and their caregivers.

The Department of Health and Social Security (DHSS), (1986, in While and Biggs, 2004: 560) indicated that there was potential for more efficient use of resources in the health care staff, if community nurses were allowed to prescribe from a limited list of items. Since then community nurses in many countries are permitted to prescribe a limited or an extended range of medication and other products, after a preparation training to become prescribing community nurses.

Fisher (2013), stated in his study, that the relationship of the prescribing community nurses with the doctors was positive; the doctors were happy with the nurses' prescribing, as it lessened their own workload and at the same time enabled the patients to receive a faster service, by speeding up the process of delivery of the items they required for their treatment. Nevertheless some doctors viewed this expansion of the nursing role as a threat and an intrusion in their profession.

The receiving of the medication from the public pharmacies at the hospitals is another problem for the patients. The working hours of the pharmacies are limited, the geographical position of the public hospitals is at the outskirts of the cities and the patients have increased difficulty to travel.

Finally, the fact that the patients have to bear the cost for the equipment needed for their treatment is an issue as most of them are low income pensioners.

CHAPTER 6 : RECOMMENDATIONS

Introduction

The purpose of this chapter is to provide recommendations emanated from this project's findings as these have been derived from the quantitative and qualitative part of this research and discussed in the previous chapter 5. The recommendations are related to individual and organizational development interventions for providing more support to the Home care nurses, higher quality of care to the Home care patients within a client-centred environment and feedback strategies. They also relate to the enrichment of the curriculum of existing under graduate and post graduate nursing degrees and the formulation of a new post graduate degree in Home Care Nursing, at the European University of Cyprus. Additionally, they provide recommendations for the formulation of other supplementary courses for advanced and continuous education of the home care nurses.

Also in this chapter the project outcomes, the intended impact and the intention to communicate the results of this study to the health care community are presented.

Recommendations emanated from the project's findings

Ideal nurse

'As nursing educators strive to prepare new graduates for the future, they are likely to include home health care as an important component of the clinical practicum experience. With careful planning of curricula and activities designed to provide students with not only technological skills but also the ability to think critically, act independently, and apply theoretical frameworks creatively, nursing educators can greatly facilitate effective care to clients in home care and other alternative settings'
(Kisa, 2007: 105)

The structure and the context of nursing education at the post graduate home care degree should give emphasis on psychology with the inclusion of courses on the psychology of patients with chronic diseases and on the psychology of the elderly, enforced and combined with experiential workshops. Emphasis should also be given on verbal and nonverbal communication skills with a focus on the elderly people. Development of leadership skills, self-management and organizational skills focused and adjusted on health

care (and not general business) should also be core subjects of the post graduate degree on home care.

World Health Organization, (2002: 51) suggests that educators should

‘Incorporate modules on active ageing in medical and health curricula at all levels. Provide specialist education in gerontology and geriatrics for medical, health and social service professionals. Inform all health and social service professionals about the process of ageing and ways to optimize active ageing among individuals, communities and population groups. (...) Train health promotion workers to identify older people who are at risk for loneliness and social isolation.’

The results of this study show that the humane approach is the main factor for satisfaction for the home care patients thus it is important that home care nurses deeply understand the ageing process and all the *matters* relating to the elderly people. This can only be achieved through education and more specifically through incorporating courses in gerontology as it is suggested above. An extra effort should be given to train the future home care nurses in identifying elderly patients who are at the risk of social exclusion, isolation and loneliness and at the same time enabling the nurses with tools and skills to provide practical and soluble solutions for these patients. Nursing knowledge on the process of ageing; where on one hand cognitive and functioning capacities decline sometimes due to lack of patient motivation, confidence, patient isolation and loneliness, and on the other hand wisdom, knowledge and experience have increased; would enable the home care nurses promote ‘active ageing’ which is

‘...the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age’. (World Health Organization, 2002: 12).

Training seminars including experiential workshops

The researcher suggests continuous training seminars to the existing Nursing staff of Home care on areas that the research project identified that there is room for further improvement. These training seminars and experiential workshops should focus on psychology and on communication skills with a concentration on elderly people and on patients with chronic diseases.

The needs of the home care patients and the communication challenges of home care are different and distinct compared to the needs of the patients of the public hospital. The relationship 'nurse-patient' is different and the psychological support required to these patients is more demanding and vital. Furthermore, it was identified in this study that there is room for improvement when it comes to the nurses allowing the medical care to be controlled more by the patients' desires rather than by the home care nurse's procedures. This new attitude can be cultivated through training seminars and experiential workshops.

The researcher also suggests that the Ministry of Health encourages the future home care nurses to attend a post graduate degree in Home Care Nursing. To the same lines, the researcher suggested to the European University of Cyprus the formulation of a post graduate degree in Home Care Nursing. This degree will attend all the identified areas by this research that needed improvement and the areas that were considered as the most important for the patients.

I am also suggesting the introduction of training on Medical

'Crew resource management(...)', which, '(...)has been used for many years in the aviation industry (EU OPS, 2008 and UK CAA, 2013) and has been generally shown to produce positive reactions, enhance learning, and promote desired behavioral changes ' (Eswar, 2007: 2,).

Selection criteria for the future home care nurses and the introduction of the financial bonding principle.

The selection of home care nurses is of primary importance for safeguarding the present and future quality of the program. The two pillars that the selection of the future home care nurses should be based on are their attitude relating to the humane approach to the patients of home care who are by majority elderly people with chronic issues and on the level of nursing knowledge and leadership skills. (Ref. Figure 5.1: Ideal Nurse: Patients' view and Ref. Figure 5.2: Ideal Nurse: Nurses' view and Figure 5.3: Ideal Nurse: Managements' view).

Once selected the home care nurses should be encouraged through sponsorships to go through a post graduate degree which specializes on home care. It is only fair and common practice on all cases of sponsorships that there is a financial bonding period thereafter. The

suggestion is to bond the new nurses to serve at home care for a minimum of five years. This will hopefully appeal only to the nurses who genuinely want to work and offer in home care and at the same time deal with existing practices where nurses sometimes enroll on any convenient post graduate degree for the mere purpose of getting a qualification towards a promotion, which could invariably be in other departments.

Nurses eligibility to prescribe basic medication and consumables

The existing procedures within the Home care program with regards to the prescription of simple medication and consumables required by the patients are presently inefficient and cumbersome because they require the approval and the prescription by medical doctors, whose main line of work, is at the public hospitals, thus creating discomfort and difficulties to the patients. Instead, if the nurses of home care were eligible to prescribe simple medication and consumables, the issue would be resolved for the benefit of all involved, something which is a common practice at some other European countries.

This research recommends that the challenge of *'role change'* for community nurses, which in other countries became widely integrated into nursing practice over the last decades, should also be taken up by the management of Home care of Cyprus; if the nurses could directly prescribe for the basics, there would be a great benefit to increasing efficiency, eliminate lead times, enhance the quality of patients' nursing care and increase patient satisfaction. The implementation of a major role change such as nurse prescribing requires adequate education and training and a comprehensive knowledge of pharmacology. It also requires the acceptance of the new role for the nurses, by the physicians with the need for a formulary that will meet the physician's needs (While and Biggs, 2004).

It is also important to carefully select the nurses who will attend the training to become prescribing nurses which in turn will enhance their role in nursing (Department of Health of England, 2002).

The researcher suggests that the selected prescribing nurses participate in a prescribing nursing course which will educate the home care nurses with sufficient knowledge as described above to take up the responsibility of a *'prescribing nurse'*.

Finally, a piloting program should follow up, involving role rehearsal in order to facilitate the acceptance and support of this new nursing role by the physicians, should the change be finally successful.

Nurses eligibility to refer their patients to other health professionals

Home care nurses are not eligible to refer their patients to other health professionals. The existing procedure for referring a home care patient to another health professional requires the written referral of a public medical doctor, thus creating difficulties and discomfort to the patients. On the same line, patients who need psychological support sometimes are not adhered due to the nature of their illness, for example depression, thus they do not follow the nurse's advice to visit a psychologist. However, if the nurse was allowed to refer a patient to the psychologist then the patient would have the chance to be treated, at least before a severe deterioration.

As Monks (2003: 377) states that when a patient has depression, it is a home care nurse's duty to

'...provide referral to appropriate groups, depending on client's condition'.

The implementation of nursing referral in home care, as Int2 states would 'simplify existing procedures, enhance efficiency and reduce latency for the benefit of the patients'.

The formation and inclusion of a team of other medical professionals in the program

The only medical professionals in the Home care program are the home care nurses who are called to support the patients on areas that otherwise a health professional of a different specialty would do. Irrespective of how hard the nurses attempt to fill in the gaps created by the lack of physiotherapists, psychologists, doctors, they cannot substitute these expertises. For this, and in order to achieve a holistic approach, it is suggested that a team of health professionals be formulated in order to support the nurses task and deal with the patients' issues promptly, more efficiently and more effectively, which will result to the harmonization of many aspects of the operations for a clear benefit to the patients.

Operations of the program on a 24/7

The patients of the Home care program are invariably elderly people with limited financial capabilities, either living alone with their spouse or their caregiver. Throughout this research, it was emerged that these patients not only need care on health related issues and on activities of daily living, but their needs also extend to emergency incidences, psychological support and advice and guidance and it is evident that these cannot be confined to a specific and limited time constrains; hence the suggestion to study the possibility to increase the coverage of the program to a 24/7 basis. This could be accomplished as a full scale coverage from the start or incrementally. For example a first step could be the introduction of a 24/7 telephone service for advising and guidance as required. However, the details of how to implement it, and the analysis based on opportunity cost, rather than the mere financial cost, would be the product of a different study which this research also suggests.

Easier access to required medication and consumables

Within this study there were instances where the emerged suggestion called for the nurses to deliver themselves the required medication and consumables to their patients. The researcher does not adopt such suggestion as it is far beyond the duties of the home care nurse. However, the issues surrounding the difficulties that the patients face in acquiring their medication and consumables must be resolved. One cannot expect an elderly patient with reduced mobility, who requires assistance and depends on others, to frequently visit the distant public hospitals and join a long queue to get his medication; not to mention that this has to be taken place within the working hours of the civil servants which are limited until early afternoon.

This study suggests that the required medication become available closer to the patient's homes. One suggestion could be to utilize private pharmacies as outlets of the required medication, through a general agreement between the government and the private sector (it should be noted that once NHSC operates the problem will be resolved and no special agreement will be needed). Another option which could be possibly implemented faster would be to utilize the local medical centers as outlets of medication and consumables for the patients of that specific area.

Cost of equipment required for specific treatments

Some types of treatments require specific equipment which it is not provided by the Home care program and as such the patients must bear the cost to purchase them. Understandably the provision of the required equipment by the program would bear an additional cost, however this has emerged as a factor of dissatisfaction by the patients.

One could argue that this is not directly related to the ‘services’ provided by the nursing staff, but it does however affects the overall services offered by the program, hence it was decided that it was worth bringing it to the attention of the management, offering some possible suggestions that could formulate the baseline for alleviating the cost to some of the patients. Some equipment, such as a walking assistance device, is in some cases of a temporary use and there is no need for it by the owner once the specific treatment is ended. These equipment, could then be used equally well by other patients.

The suggestion is therefore to form a system whereby used equipment in good condition could be made available to patients. Varieties of this idea could be explored, one of which would be the hiring facility of used equipment by the patients which would only be at a fraction of the purchasing cost. The management should endeavor to provide an improved solution to the present situation.

Common protocols for specific treatments

*‘We may think that the only part, or the main part, of communication is the words....
But the words we use are only one part of the entire communication process....’*
(Matsumoto, 2000: 340).

It has been identified that there were some communication issues between the nurses and the doctors, one area of which was the case of the medical doctors at the public hospitals giving instructions to the nurses to follow specific treatments. These, however differ from one doctor to another for the same medical case, which frequently confused the nurses and possibly affected the treatment of their patients.

The suggestion is borrowed from common practices found in most hospitals whereby common treatment protocols are established and these become policies that all the doctors agree upon and follow. These common procedures minimize the chance of

misunderstandings and increase the situational awareness of all the medical staff involved in the patients' treatment, including management.

The need to include the Activities of Daily Living (ADL) in the offerings of the program

The ADLs should be included in the duties of the homecare nurses. However this service should be offered on a case to case basis and when it is needed. This will most possibly require the time of the nursing visit to be lengthened and the employment of more home care nurses. At the same time and in the same context the program should provide official and structured training by the nurses to the caregivers and volunteers according to the individual needs of the patient and to cater for the ADLs of the specific patient on the days that there is not a scheduled visit.

The need to formalize the cooperation of all the stakeholders of home care in the society

It is a solid recommendation of this research that the management of home care to formalize agreements between home care and other organizations, such as the local municipalities, NGOs and charity organizations in order to become real stakeholders of the program and facilitate their capabilities and financial aid where needed, according to the individual needs of the patient. These other organizations are already stakeholders in the sense of their duty and purpose, in terms of their citizens' welfare and wellbeing, hence it is only logical and an obligation for them to get formally involved and allocate resources in the home care within their jurisdiction.

Strengthening of Middle Management capabilities

To manage line personnel, it is vital that the manager has first-hand knowledge and experience of the line job. At the same time middle management should be educated to have a good understanding of general management principles and best practices.

In order to enhance the future managements' expertise it is suggested that managers should have a post graduate degree, preferably a Masters' in Public Health (MPH) or a Masters in Public Sector Management (MPSM), with emphasis at the subjects of leadership, communication skills, decision making, managing and controlling and process innovation to be eligible for the position. Additionally, a five years' experience in Home Care Nursing is also suggested as an obligation for this position. A financial bonding and an obligation to serve the program for at least 5 years should be enforced in order to safeguard that internal

human resources are utilized appropriately and cost effectively, and at the same time build and safeguard internal management experience and expertise.

Process innovation

This study revealed a lack of process innovation and a lack of attempts to change existing procedures; the overall attitude is to blame the existing stagnation either ‘on the system’, the government or on insufficient staff. Continuous process innovation is both a skilled based competency and an attitude that have to be rigorously attended within a Master’s degree in Public Health or with targeted continuous training seminars.

ICT and back office automation

Office automation and the utilization of available Information and Communications Technology (ICT) is well lagging behind modern practices and certainly influencing the productivity of the program. It is suggested that the home care nurses are provided with

laptops with appropriate software, access to internet and email, faxing and printing, GPS and mobiles. This will boost the productivity on day to day operations, improve communications and record keeping and increase the patients’ satisfaction.

Additionally, the implementation of a CRM (Customer Relationship Management) system supported by relevant software will increase case awareness for the needs of each patient.

On the same line, the implementation of a Centralized Patients’ filing system would have a major impact to case management, office automation, productivity boosting, feedback and valuable data for needs analysis and future planning and expansion.

A table with all the above suggestions for the automation of the Home Care Procedures are shown in Appendix Z(B).

Safeguarding Financial and other Resources for future expansion of the Program

Although the viability and the future of the program were not part of the investigation of this research program, through the extensive literature review and the experience of this research, the researcher feels that should provide a three tier plan found in Appendix Z(A)

of this report, on possible ways that financially and strategically could help the program expand.

Case Management

A usual criticism of home care services is that multiple services are provided to the patients by different providers, and very often this lacks coordination (Low, 2011). Therefore in some programs, case management was introduced to coordinate the multiple services focusing on the individual consumer needs; case management was found to improve clinical outcomes and decrease the admissions to the hospitals and the nursing homes and at the same time decrease the use of the services (Low, 2011).

The researcher suggests the implementation of case management in the program for the coordination of the various services which will be provided by the different health care professionals who will consist the team of home care program.

As Aguzzi, G. et al for the World Health Organization (2008: II) states

‘...the technological innovation together with new and modern forms of service delivery organization can represent a viable solution to developing home care in Europe provided that health care systems can further enhance integration and coordination.’ The researcher suggests that case management be recruited by experienced nursing personnel because nurses are closer and have a more personal relationship with the patients.

Case management in home care, justifies the use of the home care services by bringing additional providers into the setting such as physiotherapists, social workers and psychologists which eventually translates into diversification of providers and resources, reduces the number of the home nursing care visits and the caregiver’s visits to the healthcare centres and achieves higher levels of patients’ satisfaction (Morales-Asencio et al, 2008). Low (2011: 3) concluded that *‘On average, the (...) quality for studies of case management was highest of all the models of home and community care’*. Case management was introduced to coordinate the multiple services focusing on the individual consumer needs and as Low (2011: 4) states *‘case management improves clinical outcomes, decreases nursing home care admission and hospital use.’*

Matching the right people for the right job

Within the in depth interviews of the patients, the researcher showed four pictures of home care nurses and asked the patients to choose the nurse of their preference and to justify their choice. The findings of this part of the research inspired the concept of ‘matching the right people for the right job’. Although patients indicated a general frame with common preferences and priorities for their nursing care, the researcher has at the same time identified differences in the individual needs, specificities and preferences. Thus, the emergence of this ambitious suggestion for elevating patient satisfaction to even higher levels at some point in the future; to ‘*match the right nurse for the right patient*’. The details of how to plan and implement the concept are beyond this project’s scope but it is however indicated that such venture necessitates careful planning and implementation which will involve a comprehensive initial interview with each new patient with the scope of not only understanding each patient’s medical and treatment needs but also comprehending the patient’s personal and demographic profile and individual preferences.

Marketing of the Home care program

This study has identified that the Home care program is not well known and at many times underestimated by other health professionals of the public sector. Home care, as many experts, health analytics, and part of this study indirectly support, is the solution to the increasing trend of the fiscal financial budget of public health, the solution to increased productivity, the efficient use of public health resources and a means to increase patients’ satisfaction. The suggestion is to promote the Home care program both internally and externally. The immediate benefits would be to change the attitudes of the professionals that directly or indirectly are involved or could be involved in the program, increase the credibility and respect in the minds of people, increase the sensitivity levels of the decision makers in the society, influence nonprofit organizations and attract good professionals who would be willing to work for or be associated with the program. The means of promoting the program should be a product of an internal management study which the researcher will also suggest.

National Health System of Cyprus (NHSC)

As Kisa and Ersoy, (2005), state, in Turkey, one main reason for not including home care in the public insurance schemes, is the traditional feeling of some doctors who believe that

patients should be treated at hospitals. Some of the nursing staff who participated at the in depth interviews of this study, pointed out that this ‘traditional’ attitude was also characteristic of some doctors of the public sector in Cyprus. This attitude has been an obstruction to the implementation and the expansion of the program.

Although not of the immediate research area of this research the researcher has identified a number of important benefits, as these are summarised here below, for the future of Home care program should it be included in the National Health System of Cyprus (NHSC) which was decided to be implemented in Cyprus (Governmental Journal, 2008) in the upcoming years and which is therefore the researcher’s strong recommendation.

The benefits for the Home care program if the program is included in the NHSC

- All citizens will gain equal access at the home care services and within the NHSC a complete health care service package can be offered.
- Within NHSC, each patient will be attended by a personal Medical Doctor who will have the responsibility to coordinating access to the available home care services and NHSC services according to the individual patient needs. Each patient will be registered within the centralized computerized on line system of NHSC which will further optimize treatment, feedback and seamless follow up resulting to better treatment outcomes, better quality of life for the patient and at the same time minimizing waste of resources. .
- A smooth and integrated cooperation between the national hospitals and home care will be feasible resulting to depopulation of the national hospitals; patients’ post operating treatment will be done at the patients’ home within home care. This liberates the load of the hospital nurses and at the same time minimizes treatment expenditure- data support that hospitalized treatment is more costly than home care treatment for the same case.
- A centralized coordination and management of supplies and services will enable utilization of economies of scale to minimize the cost of services, consumables and human resources.
- The financial future of Home care program will be safeguarded within the NHSC and will be unrestrained from political variations that affect its financial resourcing, planning and development according to the views of the governing political party. At the same time each patient will feel more secured if within the wider NHSC system.

- Competition between the health care providers is promoted as a founding principle of NHSC. As such the private sector will have the opportunities and be allowed to provide alternative home care services in addition to the government home care program, resulting to healthy competition between more than one provider and hence more choices for the patients. This will in turn improve the quality of the overall services provided.

A final word

Home care can possibly prove to be one of the most important tools to contain the continuous growth of healthcare costs. It reduces the hospital stay duration of the patients, it prevents the health deterioration of patients and it reduces rehospitalisation.

In the European countries, the Home care programs are evolving in an effort to support the vulnerable increasing group of elderly people who are progressively socially excluded, have financial difficulties and face multiple chronic diseases. The increasing focus on the provision of patient-centred services creates an emerging need of reconfiguration of the existing health care systems in order to improve response time.

'Home healthcare is the most logical and cost-effective alternative to other sub-acute services, such as nursing home stays or extended hospital visits for recuperative and chronic disease care. Patient satisfaction is high, clinical outcomes are positive and home healthcare is more cost-effective than nursing home care or additional days in hospital. Advances in technology and development of protocols for managing chronic diseases have made home healthcare the preferred approach to chronic care and disease management' (Alliance for Home Health Quality and Innovation, 2008)

As Johansson et al, (2002) indicate, in order to improve the quality of care, the satisfaction of the patient must be carefully examined; the patients' satisfaction will ultimately determine the quality of care provided and will specifically offer nurses the necessary feedback to improve patients' care.

The findings and the conclusions of this research project provide feedback on the quality of care of the existing nursing care provided by the home care nurses in Cyprus as this is viewed through the patients' eyes, alongside with feedback by the nursing staff and the

home care management. The findings reveal the high quality of home nursing care provided to the patients and the high standards of the home care nurses in humane approach, medical competence and advising and information. The suggestions of this study have a forward look and an aspiring hope to contribute in the support of the home care nurses work, the enrichment of the nurses skills by continuous education and the formulation and exploration of new ideas in order to become a base on which the home nursing care will evolve.

However, continuous feedback is required if sustainable change is to happen. More research is necessary to facilitate the follow up and assessment of the home nursing care in Cyprus at some time after the suggested changes are applied. This research identified the lack of a procedure for assessing the quality of care of the public Home care services. The instruments utilized in this research could therefore be used at regular intervals for a continuous assessment of the care provided by the home care nursing staff to the home care patients. At the same time and within the above scope more research is necessary to specifically determine whether the differences in the results, found in the quantitative part of this research which relate to the demographic characteristics of the patients, actually mirror the dissimilarity in the delivery of care by the nurses, whether they are due to greater expectations by the patients, or whether they are solely differences in the attitude on reporting amongst the various patient demographic groups.

The decision makers at the Ministry of Health but also the political parties and the politicians of Cyprus should seriously consider advancing and developing the existing program for the benefit of the people of Cyprus.

Finally, the researcher expresses her willingness to offer her knowledge and advice as requested.

Outcomes and Intended Impact

The present research, as mentioned in Chapter 1, in its practical aspect intended to provide valuable insights, so as to make necessary changes to improve patients' satisfaction and subsequently increase the quality of health care of the home care patients. For this purpose two reports have been prepared as follows:

1. An executive summary report for the Ministry of Health (Appendix U), highlighting the project's major findings and providing recommendations to the Ministry of Health related to individual and organizational development interventions for higher quality of care to the home care patients within a client-centred environment and feedback strategies. Additionally, it provides recommendations for the advancement and continuous education of the home care nurses.
2. A summary report for the Council of the European University (Appendix V) emanated from the findings of this study, related to the enrichment of the curriculum of existing undergraduate degree in Nursing and the creation of a post graduate programme in Home Nursing Care. Also, it suggests the formulation of other supplementary customized courses for advanced and continuous education of the existing home care nurses.

The above reports were submitted respectively and they have been accepted as an important contribution towards prospective change and future planning (Appendices W and X).

3. Finally, the researcher will submit for publication the main findings of the study, the main conclusions and recommendations to various journals, in order to raise awareness and inform the nursing world about the issues of home care which have emerged from this project and encourage action by health care decision makers. Such a publication will share the outcomes with the wider health care professional community. The researcher will also be presenting the finding of this research to national and regional conferences.

CHAPTER 7 : REFLECTIONS

This chapter embraces my reflections through the experience gained of being a worker researcher and how my personality, character and profession may have influenced the research findings.

Firstly, I now, have a better understanding of the importance, but at the same time the difficulties of the dual role of the worker researcher. I certainly, believe that this type of research is very beneficial to offering tangible added value, not only for the researcher but most importantly for the organisation of which the theme under investigation involves.

From the start, from the time that I was preparing myself to go on board on this '*journey of research*' I have set the baseline; which was to conduct all the processes and thereafter interpret the findings of this research, as objectively as I could, otherwise, I knew, the value would be diluted. However, I was aware that my personality, my profession, my character and values, may have influenced the way I perceived and recorded the facts. At times, these personal attributes have helped me to observe the facts more objectively and other times they may have hindered the cautious attempt and effort of being objective.

My profession, medicine, has helped me to understand straightaway whether the nursing procedures applied by the nurses were correct. It was easy for me to understand and evaluate while observing the nurses; through the movements and techniques they used in applying their practice on the patients, through observing the details that only an experienced medical professional could do, whether they were experienced and confident or inexperienced, confused and doubtful.

On the same lines I could also realise promptly the medical condition of the patient and the complications and issues that come along with that specific health condition. I had the knowledge to impartially evaluate the seriousness of the patient's condition and whether the information and advice the nurse gave was correct, useful and important.

Additionally, I am aware that I am very sensitive when it comes to matters of abandonment, neglect and loneliness, especially when it concerns the elderly people. This might have provoked a more judgmental defiance when it came to judging the behaviour

and attitude of relatives or care givers of the patients. I believed and trusted the patients in their testimonies when they complained that they were neglected and I could see their utmost need of psychological support and I could detect when the caregiver, relative or not, could sometimes take advantage of the patient's needs. These personal sensitivities were the driving potency to being more than just an '*spectator*' of the nursing procedures but to observe deeper, sense and capture all the aspects that concerned the psychological state of the patients, of their relatives and of their nurses. As such, my personal values and sensitivities might have directed my strong opinion on the great importance for psychological support to these patients and the need to include psychologists in the program.

The interests I have as an individual and the knowledge I have acquired through my profession life as a medical doctor and a lecturer in communication skills; the many different aspects and ways that communication can happen, not only in the verbal context but also in all that is conveyed through the non-verbal clues as these were evidenced by the participants, has been an added value in accomplishing this research project. I traced and noted down clues such as the tone, the intonation and the face expressions. I could identify how successful the nurses were in communicating their message clearly and precisely, and whether they were persuasive enough, through observing the reactions and the answers that the patients gave. I could also understand whether the patients felt comfortable to ask questions. On the same lines, my good knowledge of the Cypriot dialect and the Cypriot nonverbal cultural specifics and its geographical variations has also been instrumental for me to understand the elderly patients.

So as an observer who is also an academic, I had the advantage of my experience in the observations and the in depth interviews, especially as far as it concerns the training of the patients and their care takers by the nurses and the way that the nurses would brief in and advise their patients.

My medical profession helped me to set a tone of mutual understanding between the two professions; nurse and doctor, both serving the people in need.

Conveying my understanding of their profession and the challenges they face, rapidly enabled a pleasant, relaxed and comfortable environment between us before the observations, making the nurses feel comfortable and allowing them to behave naturally

throughout the patients' visits. Likewise was the environment that I had '*naturally*' created in case of the in depth interviews with the nurses, which, in turn, encouraged them to speak freely. However, the deep respect I share for the nurse's job and the '*on hands*' experience to appreciate the difficulties that their profession embraces might have affected me to be positively prejudiced towards the nurses by '*finding*' and '*providing*' '*easy excuses*' concerning some aspects of their behaviour.

Similarly, my professional capacity as a medical doctor, has been instrumental to creating a trustful environment at the in depth interviews with the patients, enhancing the thought that '*I was qualified*' to understand their situation and giving a meaning and a purpose in describing the problems, the difficulties and the insecurities they were going through.

My personal interest, medical profession and relevant experience, offered the ground for me to have a relatively good perception of the psychology of the nurses, the patients, the relatives and the caregivers. Nevertheless, I am aware that I do not have the in depth knowledge of a professional psychologist or sociologist and hence I found it difficult precisely analyse the data related with behaviour and emotional and psychological reactions.

The ability to '*putting yourself in other's shoes*', what is sometimes referred to as '*empathic intelligence*' is a fundamental skill of the researcher, however I realise that it was difficult to put myself in '*the shoes*' of the elderly people; the age difference and other disabilities such as difficulties in movement, vision and hearing are gaps between myself, and the patients. To the alleviation of this '*putting yourself in the other's shoes*' difficulty, is somewhat diluted through my deep involvement and experience in dealing and helping people with special needs as a member in the University's committee of "Special Needs" in which I share a seat for the past four years. This experience has offered me the knowledge and the skills to better recognise insidious underlying problems and increased my awareness on the impact that such deficiencies can create on the physical and psychological health of the individual. At the same time, dealing with people of '*special needs*', albeit concerning people of younger age, has helped me understand and appreciate '*the special abilities*' and sometimes unique potentials that these people have.

On one hand my sensitivity and love for nature impelled me to pay good attention to observe the natural environment of the patients; on the other hand this same sensitivity

might have influenced my conclusion that the patients who lived in the village enjoyed a better quality of life than the patients who lived in the city.

Further to the above, my thoughtfulness on hygiene and my sensitivity on space aesthetics; my high regard for bright well sun-lighted spaces, well ventilated and lightly furnished rooms, painted with pleasant colours and my affection for traditional houses with surrounding might have influenced the way I perceived and recorded the personal spaces and the natural environment of the patients. However, my attention to the above enabled me to observe details in the patient's environment.

My sociable and friendly character made the nurses feel more comfortable during the observations and the in depth interviews in order to for the nurses to express themselves freely without pretending or trying to withhold and hide any facts, information or feelings. Nevertheless, an initial feeling of distrust, due to the fact that I am a doctor and not a nurse, made the nurses seem slightly worried before meeting them for the in depth interviews or the observations. This feeling would, however, diluted within the first minutes of our meetings. The fact that the nurses were thoroughly informed about the aim and the procedures of the research and my friendly and pleasant personality, have helped to attenuate any doubts or fears that might have been present on behalf of the nurses at the beginning of the meetings.

Being a doctor and not a nurse might have sometimes negatively affected the nurses, who didn't see me as "*one of their own*", and therefore they sometimes hesitated to participate in the interviews or the observations; yet, no one denied and we were able to overcome this issue as soon as they would meet me in person. On the same note, the fact that I was not a nurse and I was not '*one of their own*' had the advantage that they were not worried of the possibility of me transferring what they would say to any of their colleagues and this made them feel more relaxed and enabled them to express themselves freely and without any fear. Additionally, the nurses respected to the fact that I was a doctor and this was an important element for their good collaboration for the purpose of this research.

The first-hand experience with my 85 year old grandmother, who lived with my family at the time when she broke her hip and needed medical and nursing care at home, helped me understand the problems and difficulties the patients and their relatives face daily, and empathise with the wishes of the patients to stay in their homes, their need for

independence, self-care and respect and certainly appreciated more the importance and necessity of the home care program. Back then, the home care program did not exist but regardless of the fact that she was lucky enough to have me, to give her the injections she needed and to take care of her, it was still not easy for her, or for me. My grandmother employed a foreigner care giver but she did not get well with her due to language and cultural communication barriers.

Despite the fact that from the beginning, I had ensured the patients of the anonymity and confidentiality of the interviews and that I had ensured them that their care would not be in any case negatively be affected, the thought that there was even a slight possibility for their nurse to find out, should they said something negative might at times have affected some of their answers in such a way that they would not mention an incident or a complain that they might have had.

My first-hand experience from the time that I was working as a doctor in the public hospitals enabled me to comprehend how cumbersome the governmental administrative and procedural mechanisms are. I knew how some processes get “*stuck*” and how difficult is for change to happen, if it happens at all. I knew of the internal power and territorial straggles and I was aware who could and who could not interfere and influence changes and improvements in the home care program and who would barricade advances. Did this influence me by being negatively prejudiced against the system? Maybe, to some extent; albeit I had put a great effort not to be!

On the other hand this ‘*systemic knowledge*’ has led me to structure and target my questions towards the correct directions in order to get the answers I needed when I interviewed management personnel.

In this study, I worked for the first time with the qualitative research and I experienced and appreciated the value and the power of this type of research within two research techniques; the in depth interviews and the observations. Though more difficult from the quantitative research, I found myself excited by the process and the analysis of the qualitative research methodology. I also found it ‘*to fit*’ to my personality and character. I felt like a detective exploring unknown and secret aspects of events and human attitudes and behaviours. I was impressed by the vast potentials that the qualitative research could offer to a researcher, when used properly, carefully and objectively. I also understood

clearly that it is neither feasible nor wise to go in qualitative research without a deep and detailed theoretical literature review before such an attempt. The qualitative research is very robust when studying social phenomena but it is like a multiuse knife which from one point has various different uses but it also requires more advanced skills to be used properly, such as critical thought and combinational and interconnecting skill.

The data was huge compared to the quantitative data but I found the analysis and interpretation much more exciting and fulfilling. The qualitative researcher is much more involved in the whole process of qualitative research than in the quantitative one. The qualitative research is more time consuming and more complicated but on the other hand more satisfying at the end.

I felt like I was able to take a glance behind the closed doors and the darker corners of a room and hear the lighter sounds, hidden behind the noise of a storm. I found myself, as a researcher, more personally involved in all the stages of the process.

I also felt and understood the continuous movement of the qualitative process being like a stream with many interconnected branches where the water flow is changing direction as it moves from one route to another; but finally it gives a large, clearer and powerful amount of water at the end when meeting with the endless ocean of knowledge. The importance of each branch of the stream was revealed and sometimes a branch, small in size and invisible, or ignored at the quantitative research process, was surprisingly powerful and important at the whole existence and flow of the stream.

I also appreciated the value of using different research methods and different research techniques and I understood how triangulation improves the validity of the findings of a project.

I believe that this challenging journey enabled me to become a better researcher; much more familiar with the various research methods, research collection techniques and the analysis processes. Additionally, after the whole experience, I feel more confident to select the right methods and techniques in a future research project. The fact that I had to interpret an enormous amount of data derived from three different research collection techniques, identify patterns and synthesize complex and sometimes contrasting views, extract conclusions combining the findings from two research methods; the quantitative

and the qualitative method, I believe that improved my analytic skills and my critical and interconnecting abilities enormously!

I was always sensitive in ethical considerations, however the experience of this journey, made ethical issues more meaningful and important to me.

I feel now more confident to participate in the creation of a post graduate degree in home care at my university. I feel that I have a better and clearer view of what is important for the satisfaction of the home care patients and the areas that need improvement. This will enable me to choose the right subjects in content and length to suggest in the syllabus of the postgraduate program, in order to create a powerful and dynamic course which will cover all the areas which are needed in an attempt to '*generate*' nurses that will fulfil the home care patients' perceptions of an '*ideal*' nurse.

I also understood better the major importance of getting feedback for a service from its '*clients*' and '*end users*' and not only from the service providers.

Finally, while on this journey I have yet once again learned the power and the importance of the non- verbal communication and how much data a researcher can derive from the interpretation of this type of messaging. One of the things I learned to capture was the language of silence. The silence of my participants! The silence of my patient participants; the loneliness, the isolation, and sometimes the abandonment, their silent look wishing me to stay longer, changed my worldview for ever.

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APPENDICES

Appendix A: QPP Questionnaire – In English

1. Age

.....(years)

2. Sex

- Man
- Woman

3. Civil status

- Cohabiting
- Single

4. Nationality

-
-
- Other

5. Education (indicate highest)

- Elementary school/Compulsory school (or equivalent)
- Vocational college/Upper secondary school (or equivalent)
- College of higher education/University

6. Occupation

- Working
- Studying
- Other

7. What was your reason for today's visit?

- To have a wound dressed
- To have stitches removed
- Blood pressure check
- Vaccination
- Other injection
- Help with medicine
- Incontinence appliances
- Technical appliances
- Advice
- Other

Fill in both **A** (☐) and **B** (○) for each question or mark Not applicable.

	A This is what I experienced				B This is how important it was to me				
	Fully agree	Mostly agree	Partly agree	Do not agree at all	Of the very highest importance	Of high importance	Of some importance	Of little or no importance	Not applicable

- | | | | | | | | | | |
|-----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 8. | I received useful information on how treatments would take place | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | I received useful information on the results of samples, e.g. blood sugar curve that the district nurse took | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | I received useful information on self-care; "the best way to take care of myself" | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | I received useful information on which district nurse that was responsible for planning my care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. | I received the best possible medical care/help from the district nurse (as far as I can tell) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. | I received effective help with pain relief | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. | I received help from the district nurse within an acceptable waiting time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. | I received useful help from the district nurse with obtaining the appliances that I needed, e.g. wheeled walking frame, wheelchair, pads and clutching tongs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. | I received useful help from the district nurse with measures to prevent accidents in my home | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. | The district nurse seemed to understand how I experienced my situation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. | The district nurse treated me with respect | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. | The district nurse showed commitment; "cared about me" | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

	A This is what I experienced				B This is how important it was to me				
	Fully agree	Mostly agree	Partly agree	Do not agree at all	Of the very highest importance	Of high importance	Of some importance	Of little or no importance	Not applicable
20. I had good opportunities to participate in decisions that applied to my medical care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
21. My medical care was controlled by my own desires rather than by the district nurse's procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
22. My relatives and friends were treated well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
23. I had access to the apparatus and equipment that were necessary for my medical care (as far as I can tell)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
24. I was easy to get to the telephone for the district nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
25. I was easy to get the district nurse to come out on a home visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
26. How would you describe your current physical health?									
<input type="checkbox"/> Very bad									
<input type="checkbox"/> Quite bad									
<input type="checkbox"/> Neither good nor bad									
<input type="checkbox"/> Quite good									
<input type="checkbox"/> Very good									
27. How would you describe your current psychological well-being?									
<input type="checkbox"/> Very bad									
<input type="checkbox"/> Quite bad									
<input type="checkbox"/> Neither good nor bad									
<input type="checkbox"/> Quite good									
<input type="checkbox"/> Very good									

28. Will you follow the advice and instructions that you have now received from the district nurse?

- Yes, completely
- Yes, partly
- No
- Don't know
- I have not received advice and instructions

29. I was particularly pleased with the following:

30. Suggestions from improvements:

Thank you for your co-operation!

Appendix B: QPP Questionnaire used for the Survey (Translated in Greek)**1. Ηλικία**

.....(ετών)

2. Φύλο

Άρρεν

Θήλυ

3. Οικογενειακή κατάσταση

Συγκατοικώ

Ζω μόνος/η

4. Υπηκοότητα

Κυπριακή

Άλλο

5. Εκπαίδευση (αναφέρετε την ανώτερη)

Σχολή πρωτοβάθμιας εκπαίδευσης/ Υποχρεωτική φοίτηση (ή αντίστοιχο)

Ινστιτούτο Επαγγελματικής Κατάρτισης/ Λύκειο (ή αντίστοιχο)

Σχολή ανώτατης εκπαίδευσης/ Πανεπιστήμιο

6. Ενασχόληση

Εργασία. Αναφέρετε το επάγγελμά σας:

Σπουδές

Αφυπηρέτηση. Αναφέρετε το επάγγελμά σας πριν την αφυπηρέτηση:

.....

Άλλο

7. Ποιος ήταν ο λόγος για τη σημερινή σας επίσκεψη;

Επίδεση τραύματος

Αφαίρεση ραμμάτων

Έλεγχος πίεσης αίματος

Εμβολιασμός

Άλλου είδους ένεση

Βοήθεια σχετικά με κάποιο φάρμακο

Συσκευές ακράτειας

Τεχνικές συσκευές

Παροχή συμβουλών

Άλλο

Συμπληρώστε τα A (□) και B (○) για κάθε ερώτηση ή σημειώστε Δεν ισχύει	A Αυτή ήταν η εμπειρία μου				B Η σπουδαιότητα για εμένα				Δεν ισχύει
	Συμφωνώ απολύτως	Συμφωνώ κατά το πλείστο	Συμφωνώ εν μέρει	Δε συμφωνώ καθόλου	Υψιστης σημασίας	Υψηλής σημασίας	Κάποιας σημασίας	Μικρής ή καμίας σημασίας	
8. Έλαβα χρήσιμες πληροφορίες για το πώς πρέπει να λαμβάνουν χώρα οι θεραπευτικές αγωγές	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
9. Έλαβα χρήσιμες πληροφορίες, σχετικά με τα αποτελέσματα δειγμάτων, π.χ. καμπύλη σακχάρου αίματος τα οποία πήρε η επισκέπτρια/ης νοσηλεύτρια/ης	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
10. Έλαβα χρήσιμες πληροφορίες σχετικά με την αυτοφροντίδα - "Ο καλύτερος τρόπος για να φροντίζω τον εαυτό μου"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
11. Έλαβα χρήσιμες πληροφορίες για το ποια/ποιος ήταν η/ο υπεύθυνη/ος επισκέπτρια/ης νοσηλεύτρια/ης για τον προγραμματισμό της φροντίδας μου	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
12. Έλαβα την καλύτερη δυνατή ιατρική φροντίδα/ βοήθεια από την/τον επισκέπτρια/η νοσηλεύτρια/η (εξ όσων μπορώ να κρίνω)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>

13. Έλαβα αποτελεσματική βοήθεια για την ανακούφιση από τους πόνους
14. Έλαβα βοήθεια από την επισκέπτρια/η νοσηλεύτρια/η εντός ενός αποδεκτού χρόνου αναμονής
15. Έλαβα χρήσιμη βοήθεια από την/τον επισκέπτρια/η νοσηλεύτρια/η για τη λήψη των συσκευών που χρειαζόμουν, π.χ. τροχήλατο περιπατητήρα, αναπηρική καρέκλα, επιθέματα και αρπάγες κλειδώματος
16. Έλαβα χρήσιμη βοήθεια από την επισκέπτρια/η νοσηλεύτρια/η αναφορικά με μέτρα για την αποφυγή ατυχημάτων στο σπίτι μου
17. Η/Ο επισκέπτρια/ης νοσηλεύτρια/ης έδειξε να κατανοεί τον τρόπο με τον οποίο αντιμετώπισα την κατάσταση μου
18. Η/Ο επισκέπτρια/ης νοσηλεύτρια/ης με αντιμετώπισε με σεβασμό
19. Η/Ο επισκέπτρια/ης νοσηλεύτρια/ης έδειξε αφοσίωση, "με φρόντισε"
20. Είχα καλές ευκαιρίες συμμετοχής σε αποφάσεις που αφορούσαν την ιατρική μου φροντίδα

21. Η ιατρική μου φροντίδα καθοδηγήθηκε περισσότερο από τις δικές μου επιθυμίες παρά από τη διαδικασία της επισκέπτριας/η νοσηλεύτριας/ης
22. Οι συγγενείς και οι φίλοι μου είχαν καλή αντιμετώπιση από την/τον επισκέπτρια/η νοσηλεύτρια/η
23. Είχα πρόσβαση στις συσκευές και στους εξοπλισμούς που ήταν απαραίτητοι για την ιατρική μου φροντίδα (εξ όσων μπορώ να κρίνω)
24. Μπόρεσα εύκολα να βρω στο τηλέφωνο την/τον επισκέπτρια/η νοσηλεύτρια/η
25. Μπόρεσα εύκολα να πείσω την/τον επισκέπτρια/η νοσηλεύτρια/η να με επισκεφτεί στο σπίτι

26. Πώς θα περιγράφατε την τρέχουσα φυσική σας υγεία;

- Πολύ κακή
- Αρκετά κακή
- Ούτε καλή ούτε κακή
- Αρκετά καλή
- Πολύ καλή

27. Πώς θα περιγράφατε την τρέχουσα ψυχολογική σας ευεξία;

- Πολύ κακή
- Αρκετά κακή
- Ούτε καλή ούτε κακή
- Αρκετά καλή
- Πολύ καλή

28. Θα ακολουθήσετε τις συμβουλές και οδηγίες που έχετε λάβει από την/τον επισκέπτρια/η νοσηλεύτρια/η;

- Ναι, πλήρως
- Ναι, εν μέρει
- Όχι
- Δεν γνωρίζω

30. Εισηγήσεις για βελτίωση

- Δεν έλαβα συμβουλές και οδηγίες

29. Ικανοποιήθηκα ιδιαίτερα με τα εξής:

Ευχαριστούμε για τη συνεργασία σας!

Appendix C: QPP Questionnaire Back Translation (Greek to English)

	A My experience				B Level of importance for me				Not applicable
	I agree completely	I largely agree	I agree to a point	I disagree entirely	The most important	High importance	Some importance	No or little importance	
Please select A (□) and B (○) for each question or select Not applicable									
1. I received useful information as to how therapeutic treatment should occur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
2. I received useful information e.g.blood sugar graphs related to the results of tests taken by the visiting nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
3. I received useful information regarding self-care - "The best way to look after myself"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
4. I received useful information as to who was the visiting nurse responsible for my program of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>

A
My
experience

B
Level of
importance for
me

I agree completely	I largely agree	I agree to a point	I disagree entirely	The most important	High importance	Some importance	No or little importance	Not applicable
--------------------	-----------------	--------------------	---------------------	--------------------	-----------------	-----------------	-------------------------	-----------------------

Please select **A** (□) and **B** (○) for each question or select Not applicable

- | | | | | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------|-----------------------|-----------------------|-----------------------|--------------------------|
| 5. I received the best possible medical care/assistance from the visiting nurse (as far as I can tell) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |
| 6. The help I received was very effective and provided relief from pain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |
| 7. I received help from the visiting nurse within an acceptable waiting time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |
| 8. I received useful assistance from the visiting nurse regarding obtaining equipment which I need e.g. wheel walker, wheelchair, medical compresses and security locks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |
| 9. I received useful advice from the visiting nurse as to how to prevent accidents in my home | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |

A
My
experience

B
Level of
importance for
me

I agree completely

I largely agree

I agree to a point

I disagree entirely

The most important

High importance

Some importance

No or little importance

Not applicable

Please select **A** (□) and **B** (○) for each question or select Not applicable

- | | | | | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------|-----------------------|-----------------------|-----------------------|--------------------------|
| 10. The visiting nurse showed understanding in how I cope with my situation. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |
| 11. The visiting nurse treated me with respect. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |
| 12. The visiting nurse showed empathy "she looked after me". | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |
| | | | | | | | | | |
| 13. I had the opportunity to participate in decisions relating to my medical care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |
| 14. My medical care was driven more by my own wishes than the procedures of the visiting nurse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |
| | | | | | | | | | |
| 15. My relatives and friends were treated well | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |

A
My
experience

B
Level of
importance for
me

I agree completely

I largely agree

I agree to a point

I disagree entirely

The most important

High importance

Some importance

No or little importance

Not applicable

Please select **A** (□) and **B** (○) for each question or select Not applicable

16. I had access to equipment and devices which were necessary for my medical care (as far as I can tell)

17. I was able to contact the visiting nurse on the phone easily

18. I was easily able to convince the visiting nurse to visit me at home

19. How would you describe your current state of physical health?

- Very bad
- Quite bad
- Neither good nor bad
- Quite good
- Very good

20. How would you describe your current state of psychological well being?

- Very bad
- Quite bad
- Neither good nor bad

- Quite good
- Very good

21. Will you follow the advice and instructions you received from the visiting nurse?

- Yes fully
- Yes in part
- No
- Not sure
- I did not receive advice or instructions

22. I was especially satisfied with the following:

23. Suggestions for improvement:

Thank you for your cooperation!

Appendix D: Consent form used for the Survey (In English)

Consent Form for participation in a research project
Short title of the program:
Patients' satisfaction received from nursing staff in the Home Care Programme run by the Ministry of Health in Cyprus

INFORMATION FOR PATIENTS and/or VOLUNTEERS

The researcher is Dr. Maria Papaconstantinou Leonidou, medical doctor (MD) and lecturer at the European University of Cyprus.

The purpose of this research is for the researcher to evaluate the Patients' satisfaction received from the nursing staff in the Home Care Programme run by the Ministry of Health in Cyprus.

The results of this research will contribute to improve the quality of the health care provided to the patients in the Home Care Program and to formulate a post graduate program on Home Care at the European University of Cyprus.

The research will be submitted to Middlesex University in partial fulfilment of the requirements for the degree of Doctor of Professional Studies.

The patients' participation is voluntary.

The personal data requested will only be used by the researcher, only for the purpose of this research, after which they will completely be destroyed.

The answer sheet of the questionnaire is anonymous.

You are free and entitled to reclaim your consent in participating in this research project at any moment you wish. Should you decide not to participate at any time there will not be any ramifications to the health care and treatment you presently receive or you might be receiving in the future.

<u>Surname:</u>		<u>Name:</u>	
<u>Signature:</u>		<u>Date:</u>	

Appendix E: Consent form used for the Survey (In Greek)

ΕΝΤΥΠΙΑ ΣΥΓΚΑΤΑΘΕΣΗΣ για συμμετοχή σε πρόγραμμα έρευνας
Σύντομος Τίτλος του Προγράμματος στο οποίο καλείστε να συμμετάσχετε
Ικανοποίηση των ασθενών του προγράμματος κατ' οίκον νοσηλείας του Υπουργείου Υγείας Κύπρου από το νοσηλευτικό προσωπικό.

ΠΛΗΡΟΦΟΡΙΕΣ ΓΙΑ ΑΣΘΕΝΕΙΣ ή/και ΕΘΕΛΟΝΤΕΣ

Η ερευνήτρια είναι η Δρ. Μαρία Παπακωνσταντίνου Λεωνίδου, ιατρός και λέκτορας στο Ευρωπαϊκό Πανεπιστήμιο Κύπρου.

Η έρευνα αυτή γίνεται για να ερευνήσει η ερευνήτρια την ικανοποίηση των ασθενών του προγράμματος της κατ' οίκον νοσηλείας του Υπουργείου Υγείας, από το νοσηλευτικό προσωπικό.

Τα αποτελέσματα της έρευνας θα βοηθήσουν στην βελτίωση της κατ' οίκον νοσηλείας και στην δημιουργία ενός μεταπτυχιακού προγράμματος στην κατ' οίκον νοσηλεία στο Ευρωπαϊκό Πανεπιστήμιο Κύπρου.

Επίσης η έρευνα θα γίνει στα πλαίσια απόκτησης διδακτορικού τίτλου από την ερευνήτρια από το πανεπιστήμιο Middlesex University.

Η συμμετοχή των ασθενών είναι εθελοντική.

Τα προσωπικά δεδομένα των ασθενών που θα δώσουν την συγκατάθεσή τους για να συμμετάσχουν στην έρευνα θα χρησιμοποιηθούν μόνο από την ερευνήτρια για σκοπούς μόνο της έρευνας. Με το πέρας της έρευνας θα καταστραφούν.

Στα ερωτηματολόγια θα τηρηθεί ανωνυμία.

Είστε ελεύθεροι να αποσύρετε οποιαδήποτε στιγμή εσείς επιθυμείτε την συγκατάθεση για την συμμετοχή σας στην έρευνα αυτή. Εάν αποσυρθείτε, δεν θα υπάρξουν επιπτώσεις στην νοσηλευτική φροντίδα και στην θεραπεία που παίρνετε ή που μπορεί να πάρετε μελλοντικά.

<u>Επίθετο:</u>		<u>Όνομα:</u>	
<u>Υπογραφή:</u>		<u>Ημερομηνία:</u>	

Appendix F: Instructions for Answering the Survey Questionnaire (In English)**Instructions for the completion of the survey questionnaire**

The questioner is anonymous. You will need 5-10 minutes to answer it.

1. In the first page mark with \surd the answer that best represents you.
2. In the second and third page you are asked proposal and you are asked to answer whether you: fully agree, mostly agree, partly agree or if you do not agree at all by marking \surd at the corresponding circle.
3. You are also asked to indicate the importance of each proposal by marking \surd at the corresponding square box according to whether the proposal is: of the very highest importance, of high importance, of some importance or of little importance.
4. If a proposal is not relevant to you simply add \surd at the last square box to the right which corresponds to the answer: Not applicable. For example, if a proposal is referring to the use of technical equipment required for your therapy but however you do not use any technical equipment, then the specific proposal does not apply to you. In this case you will mark \surd at the last box on the right which corresponds with the answer: Not applicable.
5. In the last page you will add \surd to the box corresponding to the answer which represents you.
6. The last two questions are open and you may freely write your opinion. In the penultimate question answer on what issues you are especially satisfied and in the last sentence indicate any possible ways that your care can be improved.

Thank you for your time and help.

With appreciation,

Dr Maria Leonidou

Appendix G: Instructions for Answering the Survey Questionnaire (In Greek)**Οδηγίες για την συμπλήρωση του ερωτηματολογίου**

Το ερωτηματολόγιο είναι ανώνυμο. Θα σας πάρει 5-10 λεπτά να το απαντήσετε.

1. Στην πρώτη σελίδα, βάλτε ✓ στην απάντηση που σας αντιπροσωπεύει.
2. Στις επόμενες δύο σελίδες υπάρχουν προτάσεις στις οποίες καλείστε να απαντήσετε κατά πόσο: συμφωνείτε απολύτως με την πρόταση ή συμφωνείτε κατά το πλείστο ή συμφωνείτε εν μέρει ή δεν συμφωνείτε καθόλου, βάζοντας ✓ στο αντίστοιχο με την απάντηση σας τετραγωνάκι.
3. Επίσης στις ίδιες προτάσεις, καλείστε να απαντήσετε κατά πόσο το συγκεκριμένο θέμα που αναφέρετε στην πρόταση είναι: υψίστης σημασίας για σας ή υψηλής σημασίας ή κάποιας σημασίας ή μικρής ή καμίας σημασίας, βάζοντας ✓ στον αντίστοιχο με την απάντηση σας κύκλο.
4. Αν κάποια πρόταση δεν έχει σχέση με την φροντίδα που παίρνετε θα βάλετε απλά ✓ στο τελευταίο τετραγωνάκι δεξιά που αντιστοιχεί με την απάντηση: Δεν ισχύει. Για παράδειγμα, αν η πρόταση αναφέρεται στον τεχνικό εξοπλισμό για την θεραπεία σας, και εσείς δεν χρησιμοποιείτε τεχνικό εξοπλισμό για την θεραπεία σας, τότε η συγκεκριμένη πρόταση δεν ισχύει για σας οπότε θα βάλετε ✓ στο τελευταίο τετραγωνάκι δεξιά που αντιστοιχεί με την απάντηση: Δεν ισχύει.
5. Στην τελευταία σελίδα θα βάλετε ✓ στο τετραγωνάκι της απάντησης που σας αντιπροσωπεύει.
6. Οι δύο τελευταίες ερωτήσεις είναι ανοικτές και εκεί μπορείτε να γράψετε ελεύθερα την άποψη σας. Στην προτελευταία ερώτηση απαντήστε από τι είστε ιδιαίτερα ικανοποιημένος/η και στην τελευταία ερώτηση εισηγηθείτε διάφορους τρόπους για την βελτίωση της φροντίδας σας.

Σας ευχαριστώ πολύ για τον χρόνο και την βοήθεια σας.

Με εκτίμηση,

Δρ. Μαρία Λεωνίδου

Appendix H: Permission from the Originators to use the QPP Questionnaire

2014-06-09

Permission to use the QPP

To whom it may concern,

Maria Leonidou, Lecturer, Medicine, Department, M.Leonidou@euc.ac.cy has been granted the permission to use the QPP questionnaire– short version for home care in her research studies.

Best regards,

Kalle Svensson
ImproveIT AB
Stationsgatan 58
30250 Halmstad
Sweden

+ 46 35 22 70 50
www.improveit.se
info@improveit.se

IMPROVEIT
IN TOUCH WITH YOUR ORGANISATION

Appendix I: Permission from the National Bioethics Committee of Cyprus



ΚΥΠΡΙΑΚΗ ΔΗΜΟΚΡΑΤΙΑ
ΕΘΝΙΚΗ ΕΠΙΤΡΟΠΗ ΒΙΟΗΘΙΚΗΣ ΚΥΠΡΟΥ

Αρ. Φακ.: ΕΕΒΚ/ΕΠ /2010 / 17
Αρ. Τηλ.: 22809038 / 22809039
Αρ. Φαξ: 22809025

Ημερ.: 09 Νοεμβρίου 2010

Δρα Μαρία Παπακωνσταντίνου-Λεωνίδου
Ετεοκλέους 15
2057 Στρόβολος
Λευκωσία

Αξιότιμη κυρία Λεωνίδου,

Ερευνητική πρόταση με τίτλο:
“Patients’ satisfaction received from the nursing staff of the home care programme run by the Ministry of Health of Cyprus”

Επιθυμώ να αναφερθώ στο πιο πάνω θέμα και να σας πληροφορήσω ότι η Επιτροπή Βιοηθικής Αξιολόγησης Βιοϊατρικής και Κλινικής Έρευνας ενεργώντας με βάση την εκχωρηθείσα σ’ αυτήν αρμοδιότητα από την Εθνική Επιτροπή Βιοηθικής Κύπρου (ΕΕΒΚ), να αξιολογεί βιοηθικά ερευνητικές προτάσεις που αφορούν την βιοϊατρική και κλινική έρευνα στον άνθρωπο, μελέτησε την πιο πάνω αναφερόμενη ερευνητική πρόταση που έχετε καταθέσει στις 27/10/2010, στην συνεδρίαση της ημερομηνίας 09/11/2010.

2. Από την μελέτη του περιεχομένου των εγγράφων που έχουν τεθεί ενώπιον της Επιτροπής (αίτηση αξιολόγησης ερευνητικής πρότασης, πρωτόκολλο και δείγμα ερωτηματολογίου) που αφορούν την πιο πάνω έρευνα, η Επιτροπή έχει την γνώμη ότι η εν λόγω έρευνα σας δεν εμπίπτει στη σφαίρα αρμοδιοτήτων της ΕΕΒΚ για βιοηθική αξιολόγηση. Πρόσθετα, σημειώνεται ότι η προκαταβολή που έχετε πληρώσει δεν επιστρέφεται (βλέπετε σχετική ανακοίνωση της ΕΕΒΚ ημερομηνίας 05/11/2008).

Με εκτίμηση,

Δρ. Ανδρέας Χατζηγεωργιάδης

Πρόεδρος

Επιτροπής Βιοηθικής Αξιολόγησης
Βιοϊατρικής και Κλινικής Έρευνας

Νίκου Κρανιδιώτη, 2411 Έγκωμη, Λευκωσία
Ηλεκτρονικό Ταχυδρομείο: cnbc@bioethics.gov.cy Ιστοσελίδα: www.bioethics.gov.cy

Appendix J: Permission from the Ministry of Health of Cyprus



ΚΥΠΡΙΑΚΗ ΔΗΜΟΚΡΑΤΙΑ
ΥΠΟΥΡΓΕΙΟ ΥΓΕΙΑΣ

Αρ. Φακ. : ΥΥ 5.4.05
10 Δεκεμβρίου 2010

Δρ. Μαρία Παπακωνσταντίνου-Λεωνίδου
Ετεοκλέους 15
2057 Στρόβολος
Λευκωσία

Θέμα: Αίτημα για την παραχώρηση άδειας διεξαγωγής έρευνας

Έχω οδηγίες να αναφερθώ στην επιστολή σας με ημερομηνία 1/11/2010 σχετικά με αίτημα σας για την παραχώρηση άδειας διεξαγωγής της έρευνας με τίτλο: « **Patients' satisfaction received from the nursing staff of the home care programme run by the Ministry of Health of Cyprus** » και να σας πληροφορήσω ότι η Επιτροπή Αξιολόγησης Ερευνητικών Προτάσεων της Διεύθυνσης Νοσηλευτικών Υπηρεσιών έχει εγκρίνει το αίτημα σας.

Επισημαίνεται ότι η ικανοποίηση του πιο πάνω αιτήματος σας προϋποθέτει ότι η έρευνα θα διεξαχθεί στον ελεύθερο χρόνο των νοσηλευτών του προγράμματος Κατ' Οίκον νοσηλείας με τρόπο που να μην και διαταράσσεται η ομαλή λειτουργία της υπηρεσίας τους. Εννοείται επίσης ότι η Προϊσταμένη της πιο πάνω υπηρεσίας θα τύχει της ενημέρωσης σας για την διεξαγωγή της σχετικής έρευνας.

Επιπλέον, προϋποθέτει την αυτόματη δέσμευση σας για κοινοποίηση των ερευνητικών αποτελεσμάτων στη Διεύθυνση Νοσηλευτικών Υπηρεσιών.

Η Διεύθυνση Νοσηλευτικών Υπηρεσιών σας εύχεται κάθε επιτυχία στην εκπόνηση της έρευνας σας.



(Χριστίνα Ιωαννίδου-Ευσταθίου)
για Γενικό Διευθυντή
Υπουργείου Υγείας

Κοιν. :

- Προϊσταμένη Νοσηλευτικό Λειτουργό Μακάρειου Νοσοκομείου Λευκωσίας.



Προδρόμου 1 Χίλωνος 17 Υπουργείο Υγείας, 1448 Λευκωσία
Τηλ. 22605740 Φαξ 22772246 Ιστοσελίδα: <http://www.moh.gov.cy>

Appendix K: In Depth Interviews' Questions for the Patients

PART 1: Introduction-Interview scope and Structure

1. Introduce myself: my name, my job/ title; explain my role, explain that this interview is a part of a research that will lead to my doctorate degree, that it has been approved by the National Bioethics Committee and the Ministry of Health of Cyprus, the theme of the research, the aim, the objectives and the intended outcomes and the research.
2. Briefly explain the process of the interview: the structure and the context and the duration : approximately 1 -1,5 hours.
3. Explain that the interview is anonymous. (The name of the interviewee will not be used in my thesis and at my dissertation. I will refer to the interviewees as: Interviewee 1, Interviewee 2 etc.) All personal and interview data will be confidential.
4. Request permission to tape record the interview. Explain the process of personal data protection that I will employ: write the context of the interview and then erase the tape recording.
5. Ask for the interviewee's informed consent to participate.

PART 2: Interviewee Profile

6. For how long have you been in the Home Care Programme?
7. Why are you in this programme? Probe: What are your health problems?
8. How would you describe your physical and psychological state?
9. How long is the current nurse taking care of you?
10. How old are you?
11. What is/was your job?
12. Do you live alone or are you cohabiting? If cohabiting: Who do you live with?

PART 3: Related to Patient and the Nurse

13. How do you find your nurse?
14. Is there anything you would like your nurse to do in a different way?
15. Is there anything that you do not like about your nurse?
16. What do you like about the Home Care program?
17. What would you like to change in the Home Care program so as to become better?
18. How do you imagine an ideal nurse for you?

The following questions are asked, in the case that the patient does not mention these issues in the answers of one of the previous questions.

19. What do you think about your nurse's knowledge related to her/his job?
20. What do you think about your nurse's ability at providing you psychological support?
21. What do you think about your nurse's ability at providing advice, information and guidance?
22. Does your nurse take into account your opinion regarding your care? Could you give an example? If the answer is no, does this bother you? Why in your opinion do you believe that this happens?
23. If something comes up, is it easy to contact your nurse? If not, could you give an example? If not, does this bother you? Why in your opinion do you believe that this happens?
24. Is any equipment necessary for your treatment provided to you? If not, does this bother you? Why in your opinion do you believe that this happens?
25. Are your nurse's visits enough for you? If not, does this bother you? Why in your opinion do you believe that this happens?
26. Does it bother you the fact that you are visited at home only by your nurse and not by other health care professionals (doctors, physiotherapists, psychologists, chemists for analysis)?
27. The following questions are asked to all patients.
28. If you have any complaints related to your nurse what do you do?
29. If you have a disagreement with your nurse what do you do? Could you give an example?
30. Do you believe that the patients of Home Care should assess their nurses? If yes, how often should that be?
31. I will show you 4 pictures of nurses at home care visits. Who would you choose for your nursing care? After choosing: Why? After the justification: From the remaining three pictures, who would you choose for your nursing care? After choosing: Why? The same procedure is repeated.
32. Is there anything else you would like to say?

Appendix L: The Photos used for the Patients' In Depth Interviews

Photo 1



Photo 2



Photo 3



Photo 4



Appendix M: In Depth Interviews' Questions for the Nursing Staff

PART 1: Introduction-Interview scope and Structure

1. Introduce myself: my name, my job/ title; explain my role, explain that this interview is a part of a research that will lead to my doctorate degree, that it has been approved by the National Bioethics Committee and the Ministry of Health of Cyprus, the theme of the research, the aim, the objectives and the intended outcomes and the research.
2. Briefly explain the process of the interview: the structure and the context and the duration: approximately 1 -1,5 hours.
3. Explain that the interview is anonymous. (The name of the interviewee will not be used in my thesis and at my dissertation. I will refer to the interviewees as: Interviewee 1, Interviewee 2 etc.) All personal and interview data will be confidential.
4. Request permission to tape record the interview. Explain the process of personal data protection that I will employ: write the context of the interview and then erase the tape recording.
5. Ask for the interviewee's informed consent to participate.

PART 2: Interviewee profile

6. What is your academic and professional background?
7. What is your role in the home care program?
8. How long do you work in the home care program?

PART 3: Related to the patients

9. How satisfied do you think that the patients of home care are, from the care provided by the home care nurses? Why?
10. Are there any issues that make the patients dissatisfied? If yes, what are these? Why?
11. How could these issues be improved?
12. Is there a formal procedure that facilitates feedback from the patients?
13. How can a patient complain? Is there a procedure for this? Are the patients aware of this procedure?
14. What complaints do the home care patients have? Could you give me an example?.

The following questions are asked, in the case that the interviewee does not mention these issues in the answers of one of the previous questions.

15. What do you think about the psychological support that the nurses provide to their patients?
16. What do you think about the advising, guidance and information that the nurses provide to their patients?
17. What do you think about the nurses taking into account the patients' opinions related to their care?
18. What do you think about the telephone communication between the home care nurses and their patients?
19. Is the equipment necessary for the patients' treatment provided to them? If not, why?
20. What do you think about the frequency and the duration of the home care visits?
21. What do you think about the participation of other health care professionals (doctors, physiotherapists, psychologists, chemists for analysis) in the program? Whose participation do you consider most important for the patients? Whose participation do you consider most important for you?

The following questions are asked to all participants:

22. Is there a formal procedure that facilitates feedback from the patients?
23. How can a patient complain? Is there a procedure for this? Are the patients aware of this procedure?
24. What complaints do the home care patients have? Could you give me an example?.
25. What happens if a patient is in disagreement with the nurse? Are you aware of such cases? Please give an example.

PART 4: Related to the nursing staff

26. How would an ideal home care nurse be for you?
27. What difficulties do you face as nursing staff? What are the solutions according to your opinion?
28. What do you think about a formal assessment of the home care nurses by their patients? How often do you think it should be done?

PART 5: Related to the management

- 29.** What do you think about the communication between the nurses of home care and the management?

PART 6: Close up

- 30.** Anything else you would like to add?
- 31.** Anything you would like to ask?

Appendix N: In Depth Interviews' Questions for the Management

PART 1: Introduction-Interview scope and Structure

1. Introduce myself: my name, my job/ title; explain my role, explain that this interview is a part of a research that will lead to my doctorate degree, that it has been approved by the National Bioethics Committee and the Ministry of Health of Cyprus, the theme of the research, the aim, the objectives and the intended outcomes and the research.
2. Briefly explain the process of the interview: the structure and the context and the duration: approximately 1 -1,5 hours.
3. Explain that the interview is anonymous. (The name of the interviewee will not be used in my thesis and at my dissertation. I will refer to the interviewees as: Interviewee 1, Interviewee 2 etc.) All personal and interview data will be confidential.
4. Request permission to tape record the interview. Explain the process of personal data protection that I will employ: write the context of the interview and then erase the tape recording.
5. Ask for the interviewee's informed consent to participate.

Part 2: Interviewee profile

6. What is your academic and professional background?
7. What is your role in the home care program?
8. How long do you work in the home care program?
9. How long do you hold your present position?

Part 3: Related to the patients

10. How satisfied do you think that the patients of home care are, from the care provided by the home care nurses? Why?
11. Are there any issues that make the patients dissatisfied? If yes, what are these? Why?
12. How could these issues be improved?
13. The following questions are asked, in the case that the interviewee does not mention these issues in the answers of one of the previous questions.

14. What do you think about the home care nurses' knowledge related to their job?
15. What do you think about the home care nurses' ability at providing you psychological support?
16. What do you think about the home care nurses' ability at providing advice, information and guidance?
17. What do you think about the nurses taking into account the patients' opinions related to their care?
18. What do you think about the telephone communication between the patients and the home care nurses?
19. Is the equipment necessary for the patients' treatment provided to them? If not, why?
20. What do you think about the frequency and the duration of the home care visits?
21. What do you think about the participation of other health care professionals (doctors, physiotherapists, psychologists, chemists for analysis) in the program? Whose participation do you consider most important in the program?

The following questions are asked to all participants:

22. Is there a formal procedure that facilitates feedback from the patients?
23. How can a patient complain? Is there a procedure for this? Are the patients aware of this procedure?
24. What complaints do the home care patients have? Could you give me an example?.
25. What happens if a patient is in disagreement with the nurse? Are you aware of such cases? Please give an example.

Part 4: Related to the management

26. What difficulties do you face as management? What are the solutions according to your opinion?

Related 5: Related to the nurses

27. What are the criteria of employment for the nurses in home care program?
28. How would an ideal home care nurse be for you?
29. Are there any issues that create difficulties to the nurses' tasks? How could these be solved?
30. Is there any ongoing training offered to the nurses of home care? On what areas is the training focused?
31. What do you think about the communication between the management and the nurses? How could it be improved?
32. Do you get any suggestions from the nurses for improvement of the program? Give examples. Are the nurses' suggestions taken into account? Give examples please. If not why?
33. How do you assess the nurses? What is the formal process, if any?
34. What do you think about the assessment of the nurses by their patients? How often do you think it should be done?

Part 6: Related to the program and the management


35. How do you find the Home care program of Cyprus compared to that of other countries?
36. What do you think is the future of home care? How about its future in the National Health System which is planned to operate in the future?
37. Is there a structured plan or a timeline for the expansion and improvement of home care? If not, could you give any suggestions for improvement?
38. What do you think about the cooperation with other organizations such as NGOs, the church, municipalities etc.? Could you give any suggestions?

Part 7: Close up

39. Anything else you would like to add?
40. Anything you would like to ask?

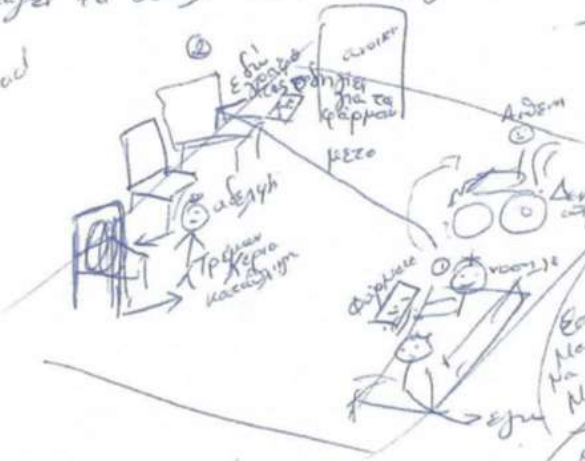
Appendix O: Researcher's Sketches of the Observations

OBSERVATION 1

ΑΣΘΕΝΗΣ (1)	ΘΕΜΑΤΑ ΠΟΥ ΣΥΖΗΤΟΥΜΕ (1)	ΝΟΣΗΛΕΥΤΡΙΑ
<p>ΕΧΕΣΗ ΜΕ ΝΟΣΗΛΕΥΤΡΙΑ</p> <hr/> <p>κυριαρχική, καταδικαστική, φόβου χθιστική, αδιαφορία σιγική, εχθρική)</p> <p>Φίγκος</p> <p>"Είχαμε X4 για εσένα" εχθρική</p> <p>ΤΡΕΣ ΝΙΣΘΕΙ? (αρχή, μέσο, τέλος)</p> <p>Χαράμενος που τον είδε</p> <p>Το ίδιο η αυγού</p>	<p>Πώς σε φέρονται.</p> <p>Τι έχουν τα μάτια της γυναίκας του. Είναι κακή</p> <p>Κοιτό μόνιμ Κομμωτήριο. Δουλεύει για να είναι κούρετ σωβεί (± ωσθ) Πώς λένε τον άντρα της; Τι κάνει το</p> <p>ΦΥΣΙΚΟ ΠΕΡΙΒΑΛΛΟΝ</p> <p>Πόσο 95 χρονών. Ταίρια</p> <p>Τι είναι η κατάσταση? Φαίνεται χαρούνη γυναίκα. Ζέστη-χρυσό συμβαίνει για παραπάνω. Πόσο και γενικά του. Ζέστη-χρυσό Αδυναμία.</p> <p>Μπορεί χύμα εσείς παραπάνω καλό</p> <p>Τρώει; ο άρρωστος</p>  <p>Χαράμενος αγροσύνη Αγιών Ζηζυφίας</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΦΡΟΝΤΙΔΑΣ</p> <p>Πόσο Χαράμενος σου Γρήγορα Ξέρει τι κάνει</p> <p>Προσέγγιση Βιολογίας Έχεται ΠΡΟΗΡΘΟΦΟΡΗΣΗ</p> <p>Δεν είναι. Δεν είναι.</p> <p>ΣΥΜΒΟΥΔΕΙ</p> <p>Πόσο eye contact</p> <p>ΕΠΙΠΕΔΟ ΓΝΩΣΙΑΣ</p> <p>Από</p> <p>ΠΕΛΕΧΟΛΟΓΙΚΗ ΣΤΗΡΙΞΗ</p>
<p>ΚΑΤΑΝΕΙ ΤΙ ΤΟΥ ΔΕΙ Η ΝΟΣΗΛΕΥΤΡΙΑ?</p> <p>Χαράμενος / Ναι / Δεν είναι / Δεν είναι / Δεν είναι</p>	<p>ΤΡΕΣ ΝΙΣΘΕΙ Η ΝΟΣΗΛΕΥΤΡΙΑ? (αρχή, μέσο, τέλος)</p>	<p>ΕΝΙΣΤΗΝΑΙΣΙΧΣΗ</p> <p>ΣΕΒΑΣΜΟΣ</p> <p>ΑΦΟΣΙΩΣΗ-ΝΟΙΑΣΤΑ</p> <p>ΤΟΝ ΑΦΗΝΕΙ ΝΑ ΠΕΙ ΤΗΝ ΓΝΩΜΗ ΤΟΥ</p> <p>ΜΕ ΣΥΓΓΕΝΕΙΣ</p>

OBSERVATION 2

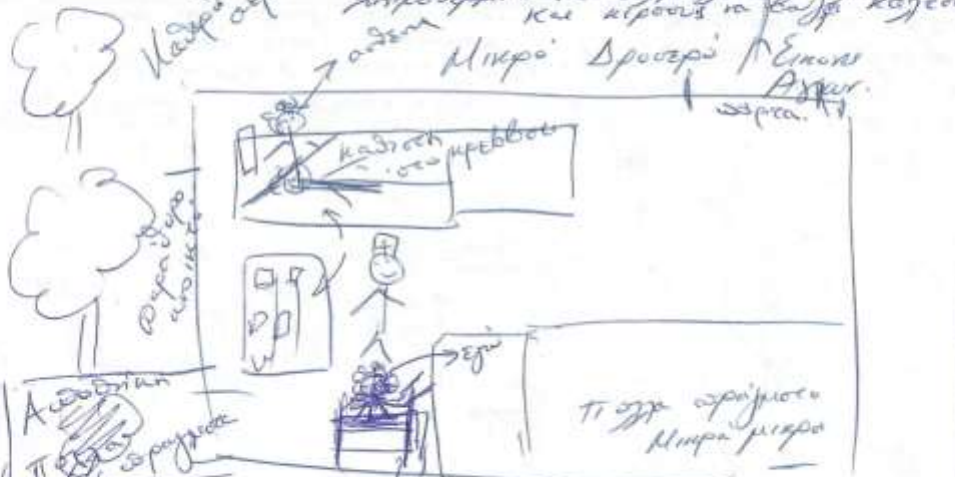
ΑΣΘΕΝΗΣ ②	ΘΕΜΑΤΑ ΠΟΥ ΣΥΖΗΤΟΥΝ	→ Αντικείμενα ή ερωτήσεις που θέλει ο ασθενής να συζητήσει	ΝΟΣΗΛΕΥΤΡΙΑ
<p>ΣΧΕΣΗ ΜΕ ΝΟΣΗΛΕΥΤΡΙΑ</p>	<p>Καλά; ↓ γαλ. αβελγίς Ταβέρου (Καλά μίση Καλό καρδιακά. Φρούτα)</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>
<p>κυριαρχική, καταδεδειγμένη, φέβω κβλαστική, αβλαβή σωματικά, εχθρική)</p>	<p>Προβληματισμοί αβελγίς - γαλ. καρικά. Δεν φαίνεται. Σαχάρο σως αβελγίς. Συμβουλές. Φρούτα -- Διατροφή ή αβελγίς. Γιατί αβελγίς αβελγίς. Χάρτι για το τι να φάει</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>
<p>Σε καρτοτόκι Φιλικά Σιωπηλός Μόνο αν του μιλήσει μαζί</p>	<p>ΦΥΣΙΚΟ ΠΕΡΙΒΑΛΛΟΝ</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>
<p>ΤΩΣ ΝΙΣΘΕΙ?</p>	<p>Παλιό αραβιστική χλωσ Ανώταση 1 μέτρο γιατί</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>
<p>άρχη, μέσο, τέλος)</p>	<p>Καθαρό όχι αβελγίς Φρούτα Ανοικτή αέρα</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>
<p>Σκεπτικός</p>	<p>Του έκοψε τα δέντρα σου? Στο ρυθμ</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>
<p>Προβληματισμοί για ανάλυση</p>	<p>Αρκετά eye-contact</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>
<p>Σιωπηλός Ανοικτός για τον αβελγίς του.</p>	<p>Τα πάντα κώρε (πότε αβελγίς)</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>
<p>Σολυαβί Αν δεν πωρτίσει</p>	<p>Μαζίνια - Καρτοτόκι.</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>
<p>ΚΑΤΑΝΟΕΙ ΤΙ ΤΟΥ ΠΕΙ Η ΝΟΣΗΛΕΥΤΡΙΑ?</p>	<p>Πωρατά και θα του φέρει η ίδια</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>
<p>Ναι.</p>	<p>Πρωταρχικός στόχος</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>
<p>Δεν έχουν κώρε είναι κώρε και δεν φέρει κώρε</p>	<p>ΠΩΣ ΝΙΣΘΕΙ Η ΝΟΣΗΛΕΥΤΡΙΑ? (άρχη, μέσο, τέλος)</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>
<p></p>	<p>Προβληματισμοί για κατάσταση/Ανοικτός/Ανοικτός/Ανοικτός/Ανοικτός</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΠΡΑΞΙΑΣ</p>



OBSERVATION 6

ΑΣΘΕΝΗΣ (6)	ΘΕΜΑΤΑ ΠΟΥ ΣΥΖΗΤΟΥΝ ΑΠ' ΟΧΤΗ ΝΕΥΡΩΣΗ ΚΟΡ. ΑΝΩΤ.	ΝΟΣΗΛΕΥΤΡΙΑ
<p>ΥΕΣΗ ΜΕ ΝΟΣΗΛΕΥΤΡΙΑ</p> <p>κυριαρχική, καταδικαστική, φόβου κβλαστική, αδιαφορία υγιική, ευθρανή)</p> <p>Ζίστη μέσα στο δωμάτιο</p> <p>Επιγ' κώμα</p> <p>ΠΩΣ ΝΙΒΘΕΙ? (αρχή, μέσο, τέλος)</p>	<p>Την Παρασκευή βράδυ επήγαρε. Μας χέει καλύτερη ζίστη. Φι. Ξανά. Αυτό Ξίγα από δω και να μ' ερωτά.</p> <p>Πίεση. "Δεν βούρεα το air bed?" "Είχαμε κορμί στην τήν ασφαλισμένη γυαλά;"</p> <p>Πώς είναι το χέρι σου "τη κόψη (α μασών)"</p> <p>ΦΥΣΙΚΟ ΠΕΡΙΒΑΛΛΟΝ</p> <p>Εξοχή ρωτά "Τοίμαξ! Ούστε το σταματήσω εσένα."</p> <p>Αμηνά και μετά stop. Ρωτά γελοιοποιεί.</p> <p>Πίεση κορμί "και βέρει και αγγό."</p> <p>Μπαράβο σου! Μπαράβο</p> <p>Τίπεν νερό; "Όταν αρραβούρε γάστειχ ωστ' να είνεν."</p> <p>"Τούτο το δωμάτιο...?" "Είμαι ο κορμί..."</p> <p>Δεν μπορεί να επημέρω. Δεν το βίε. "Να κάτσει ασπασού με χέρι"</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΦΡΟΝΤΙΔΑΣ Πύχνη</p> <p>Δραπέζι εστιασ</p> <p>Ευδεμής, Χειρουργική ΠΡΗΡΟΦΟΡΗΣΗ</p> <p>Ομιλητική</p> <p>Δύοσην απασσών αιώσετα)</p> <p>ΣΥΜΒΟΥΛΕΣ</p> <p>Χαίρετα με Αυστηρά</p>
<p>Ποιος μίσο το έρεζε</p> <p>ΟΤΙ ΔΑ ΓΙΝΟΥ ΤΟΥΣ ΧΡΟΝΑ;</p> <p>Κακού βεν βρε</p> <p>Σε γροντοζου και αγαδούσε σε και είσαι με τα παρτίδα σου</p>	<p>κρεβάτι φροντιστήρι</p> <p>Ποιή κορμί</p> <p>Περίε, σε τήν κορμί</p> <p>Ποιή κορμί</p> <p>Περίε, σε τήν κορμί</p> <p>για την</p> <p>υγιή</p> <p>αυρεκαδέτη</p> <p>Εχέσα μ μιν έχαν αιώσετα</p> <p>Να μιν γέυω</p>	<p>ΕΠΙΠΕΔΟ ΓΛΩΣΣΙΑΣ</p> <p>Συζητούμεν οργάνωμεν</p> <p>Κινεί τήν ζίστη</p> <p>Αρνη/Κινούσε εστ</p> <p>ΠΕΥΧΟΛΟΓΙΚΗ ΣΤΗΡΙΞΗ</p> <p>απορροχική εστ</p> <p>ζίστη</p> <p>Η κορμί έχει μίγαμ</p> <p>ΕΝΙΣΧΑΙΩΣΗ</p> <p>"Πού χτιώνσε,"</p> <p>Πρόσεχε σου τή</p> <p>ΣΕΒΑΣΜΟΣ</p> <p>ΑΒΟΣΙΩΣΗ-ΝΟΙΑΣΕΤΑ</p> <p>Ανισώσε το λοφέ.</p>
<p>ΚΑΤΑΝΔΕΙ ΤΙ ΤΟΥ ΙΕΣΙ Η ΝΟΣΗΛΕΥΤΡΙΑ?</p> <p>"Και επί αγαδά τους"</p> <p>"Οι και... ζαζα"</p> <p>με αγαδά</p> <p>Είσε σου αιώσετα</p> <p>να μιν τε αγαδά</p>	<p>Ποιός</p> <p>βίετα τήν κορμί: "50 κορμί"</p> <p>Η πρώτη έμεινε. "2 τρ. αγγών ερχόμενα 3"</p> <p>ΠΩΣ ΝΙΒΘΕΙ Η ΝΟΣΗΛΕΥΤΡΙΑ? (αρχή, μέσο, τέλος)</p> <p>Ουμν. είνεν ηί έχει. Κατί σεα χέρι</p>	<p>Δεν έχει υπά μίγαμ</p> <p>ΤΑΝ ΑΘΗΜΕΙ ΝΑ</p> <p>Είσε στήν. Με. Είσε</p> <p>ΠΕΙ ΤΗΝ ΓΝΩΣΜΗ</p> <p>το γκαρμί μου μίγαμ</p> <p>Χρυσό μου "μίγαμ"</p> <p>ΜΕ ΣΥΓΓΕΝΕΙΣ</p> <p>12 Αγγώνικου</p> <p>"Αίσε τήν νερό"</p>

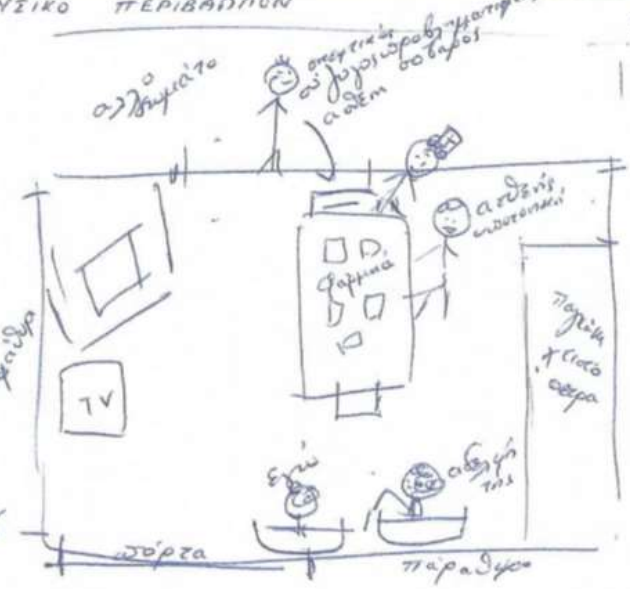
OBSERVATION 8

<p>Ευχαριστώ Φιλάρενοι</p>	<p>Καταγραφή 1980 - 81 03.11.81 Βαζελ Γερμανία. (8)</p> <p>για να μην κινείται. Κάθε ενόχληση κα'δε μέρα προβληματισμός</p> <p>Πηγαίνει και για την διατροφή στο εστιατόριο είδα τα γέφυρα σπινθηρίων να τα ισοβάτα του προσπαθώντας να βάλει γελ και κίρρους να βάλει καρέου.</p>	<p>Μικρό Αυτογράφο Πα'ει τα γέφυρα κόντρα του κίρρου του γέφυρα να βάλει καρέου και κίρρους να βάλει καρέου</p>
<p>"Θα αφαιρέσεις έντομα"</p>	<p>Καίει αέρα Μικρό Δροσερό Έκτομα Αυτογράφο</p> 	<p>Οχι, κάδαρι Μην ανακαμψα Νοσηλεία</p>
<p>Η αδέσμη χαίρεται παιδί που βλέπει την νοσηλεύτρια Ανακουφισμένη.</p> <p>Ηρεσος στηριξη</p>	<p>Αυτογράφο Παιδί Τις αράδες Μικρό μικρό</p> <p>Τις αράδες Μικρό μικρό</p> <p>υποδοχέας Παιδί παραδοσιακά ενόχλη.</p>	<p>Μεγάλο κάδαρι Body language Δείχνει με κινήσει την χρήση του κάδαρι στο κέντρο Ακριβώς, στις κινήσεις τα Παρατηρητικός</p>
<p>Κάδαρι γυμνή δυναμί.</p> <p>Αυτογράφο γυμνή.</p>	<p>Η νοσηλεύτρια δείχνει σίγουρα για το εαυτό της. Εμφανίζει συναισθηματικά. Δεν χαίρεται ότι την άρα δίνει ενδιαφέρον "Μεγάλο" "Τεχνητά" "Θα δα αρά κατά" Δείχνει φαινομενικά η κούραση της όμοια Δεν δείχνει να αδέσμη βέβαια. Δηλαδή προσπαθώντας αργά κίρρους και μια αδέσμη ασφαλείας για τα μην απειραστεί περισσότερο ή ίδια.</p> <p>Να κινείται Αν κινείται αέριο για να της δίνει. Εφίξει ώμοι</p>	<p>Δείχνει κάδαρι τα κέντρο. Δείχνει Εχει σκεψί το κέντρο Το εστιατόριο σκεψί είναι έντονα. Της δείχνει ώμοι να τα βάλει.</p>
<p>Κατανοεί τα δώρα η αδέσμη</p>	<p>Να δίνει ούρα κέρ για άρα της.</p> <p>Δα δίνει για οι γαστρίτις</p>	<p>Της δείχνει ώμοι να τα βάλει.</p>

OBSERVATION 9

<p>Η κόρη μου η χήρα μου. Εύχαρι</p>	<p>Πίση / Πύρ + Κρησίδα / Πόλη & Αγγελοπούλου 80ΧΡ. Πίση / Ζήχος / Ουροκαθετήρα 82ΧΡ.</p>	<p>Καί μου κόρη μου. Βασίλειος Στην (υπέκου) Μαμά μου</p>
<p>ΣΧΕΣΗ ΜΕ ΚΑΙ ΟΥΡΟ ΝΟΣΗΛΕΥΤΡΙΑ ΕΞΕΙΝΕΙ ΔΕΙΝΑ Με την εισαγωγή Επίδομα Παράκληση Ευχαρί Κοφεί 13 + 4 (αγγελοπούλου) (Ευχαρί Ουροκαθετήρα) ΠΩΣ ΝΙΩΘΕΙ?</p>	<p>ΒΕΒΗΛΑ ΤΟΥ ΣΥΣΤΗΤΟΥ Επίδομα Ε60 ελάττωσε Ρωτά για φάρμακα. Αρνή ουροκαθετήρα Να ατεί ατεβίωση Αν όχι ανήκω σ'αυ - Αρδε γιατροί Περίοδια Να δίνω αγγα' υπά Πίση 'Ησθε φάρμακα για υγιεινή Ζήχος? Πύρ' καί. Αφίσα με σε νοσηριο. Καί με Ζήχος. ΦΥΣΙΚΟ ΠΕΡΙΒΑΛΛΟΝ Εισόδος TV Κουζίνα Αοδενί Εργαζομένη Εργαζομένη 100% Έχει και άρωμα ούρου.</p>	<p>ΕΠΙΤΕΛΟΣ ΝΟΣ ΕΡΩΤΗΣΕΩΣ Χαροχέρη Δυσκολία καθαρίσ Γωτη Στάθης ΠΛΗΡΟΦΟΡΗΣΗ ΣΟΧΙ με Ζήχος. ΣΥΜΒΟΥΛΕΣ Τους καταλείπει μάτια. Αποστατική ΕΠΙΤΕΛΟΣ ΓΝΩΣΙΑΤ Δυσκολία. ΨΥΧΟΛΟΓΙΚΗ ΣΤΗΡΙΞΗ Πώς γιατροί σου το εργαζομένη τα φάρμακα ΕΝΣΥΝΑΙΣΘΗΣΗ Φαίνο αίνων Ανιχνεύομαι ΣΕΒΑΣΜΟΣ Εκρηκτική άδραση Όσο γωτη ΑΦΟΣΙΑ ΣΗ-ΝΟΗΤΙΣΜΟ ΟΧΙ ΚΑΤΑΨΥΧΗ. ΤΩΝ ΑΘΗΝΕΙ ΝΑ ΠΑΙ ΤΩΝ ΓΝΩΣΗ ΤΟΥ Τους γράφει Προσφέρει ώστε να υγιεινών τα φάρμα ΜΕ ΣΥΓΓΕΝΕΙΣ "Τι δεν καθαρίζεις;</p>
<p>Ο άρσος σφαιρικός για το αίσθημα. Πιπρωμένοι. Την περιμετρική νοσηριο Η αοδενί Χαίρετα ποτα που του μιλάει ΚΑΤΑΝΕΙ ΤΙ ΤΟΥ? ΑΡΕΙ Η ΝΟΣΗΛΕΥΤΡΙΑ</p>		<p>Εκρηκτική άδραση Όσο γωτη ΑΦΟΣΙΑ ΣΗ-ΝΟΗΤΙΣΜΟ ΟΧΙ ΚΑΤΑΨΥΧΗ.</p>
<p>Ο αοδενί Δεν ακαί ζώο καί. Κρέμα με σίτρο Πόσε σφαιρική; Ησθε, ο Γρανίκος ωπίρ? Νοσηλεύει ωύρ βασί σουτ</p>	<p>Εξοχή Γραφείο Πεντακάδαρο. Συμπόρευο. ΠΩΣ ΝΙΩΘΕΙ Η ΝΟΣΗΛΕΥΤΡΙΑ? Ρωτά για φάρμακα. Τους ρωτά τι αίνω - για να εφέξει αν τα ωύρων σουτα - Ρωτά την αοδενί</p>	<p>ΤΩΝ ΑΘΗΝΕΙ ΝΑ ΠΑΙ ΤΩΝ ΓΝΩΣΗ ΤΟΥ Τους γράφει Προσφέρει ώστε να υγιεινών τα φάρμα ΜΕ ΣΥΓΓΕΝΕΙΣ "Τι δεν καθαρίζεις;</p>

OBSERVATION 10

	<p>♂ = εκουράσιον Γλυφά ΟΙΚΙΑΣ 49. 10750</p> <p>75 χρ. Χρυσόμαλλο 2.2. Οσομωδών Περσίδα 500000 10</p>	
<p>ΣΧΕΣΗ ΜΕ ΝΟΣΗΛΕΥΤΡΙΑ</p>	<p>ΘΕΜΑΤΑ ΠΟΥ ΣΥΝΕΧΤΟΥΝ</p> <p>Φουσκωτήν Αλλά μέσα σου είναι κρύα είναι κρύα (βρογχίτιδα) Δεν ανησυχώ περισσότερο για η αβγύνη από Αγγελο Έγινε Ουμική γιατί δεν μπορεί να κάνει ταξίδια. Η κοιλία Πίεση δεν καταλαβαίνει. Τακτοποιη. Δίπλα μέσα της είναι. Τα σπλάχνα η κοιλότητα γιατί δεν μπορεί.</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΦΡΟΝΤΙΔΑΣ</p>
<p>♂ Ρωτά για φάρμακα Πίεση</p>	<p>ΦΥΣΙΚΟ ΠΕΡΙΒΑΛΛΟΝ</p>  <p>Βαρέ είναι. Σπύραρο Προσεκτική. Λιγούρη. Απορρυπαντική</p>	<p>ΠΛΗΡΟΦΟΡΗΣΗ</p> <p>Πρέπει να έρθει</p> <p>ΣΥΜΒΟΥΛΕΣ</p>
<p>ΠΡΟΣ ΝΙΣΘΕΙ?</p>		
<p>Η αδελφή α'ιο down. Η αβγύνη συνεχίζει να είναι σε ένα ιδίωμα. γιατί είναι όχι γιατί Τρόπος στα πρώτα της ♀ και βγαίνει ΚΑΤΑΝΕΙ ΤΙ ΤΟΥ ΔΕΙ Η ΝΟΣΗΛΕΥΤΡΙΑ.</p>	<p>Έχω φαγητό για να φάμε (αποκιδάκια με αυγά) ♀ κάνει εστίες απλά μεση στην κοιλότητα. Μετα α'ιο αβγύνη. Ίσως κερδία είναι εκατ. Τουρκουίτζει της αβγύνης. Ποτε παρέμβαση De call</p>	<p>Ρωτά την φροντίδα. Η γιαγιά κατά? ΕΠΙΠΕΔΟ ΓΝΩΣΤΑΣ Αν χρειαστεί η κοιλία κάτω ΨΥΧΟΛΟΓΙΚΗ ΣΤΗΡΙΞΗ στο νοσηκομείο να την εφοδία</p> <p>ΕΝΙΣΧΥΣΗ ΤΟΥ Δα εφδ, ώστε ο γιαγιά να της φάει και</p> <p>ΙΣΘΑΙΝΟΣ στο βιβλιοστάσιο του γιαγιά</p> <p>ΑΦΟΣΙΣΗ-ΝΟΙΑΙΣΜΟ</p>
<p>Εγώ βρω ρεί η κυρία ο νεράς μου δεν βγεί. Δεν θα μπορούσε να είναι χυμώ. Δεν ήταν σου έχουν ιαφάρμακα. ΠΕΣΑΝΤ. Ακριβά 1000 ευρώ το άτομο. Το ηχοκομείο</p>	<p>Εφ. Εφ. Μικρό ήταν βεβαιό και το εχέριαν Κωδάρη / Συγγενείς. Φωτεινή Κωδάρη προσφέρει αγάπη</p> <p>ΠΩΣ ΝΙΣΘΕΙ Η ΝΟΣΗΛΕΥΤΡΙΑ?</p>	<p>ΤΟΝ ΑΦΑΝΕΙ ΝΑ ΠΕΙ ΤΗ ΓΝΩΜΗ ΤΟΥ</p> <p>ΜΕ ΣΥΓΓΕΝΕΙΣ</p>

OBSERVATION 11

<p>ΠΙΣΤΗ ♀ Παντελον (Μερα για ανδρες τους)</p>	<p>(11) Ξυλοπλάτης ΟΥΧΡ. ♀ Σ, ειν Απορ. (απορ. 10) Καλαγγα ΟΥΧΡ. ♀ Σ, ειν Απορ. (απορ. 10) Δεκατα ομαδα εισηγη κατω του αυτου Μεινει -> εκουσια.</p>	<p>Δεν ειναι να φεραν ενα χρυσο μερο του χρυσο. Να ειναι φυσικα λεγομενα</p>
<p>ΣΧΕΣΗ ΜΕ ΝΟΣΗΛΕΥΤΡΙΑ κυριαρχικη, ? καταπιεστικη, φουβου? εκβιαστικη, οβριση? φιλικη, εχθρικη) Η κωρη δεν βουβα ειναι κοιδαβα φουβα Ο γιος δεν εφρανε Αφρανε των ΠΡΩΣ ΝΙΒΕΙ.</p>	<p>ΘΕΜΑΤΑ ΠΟΥ ΣΥΖΗΤΟΥΝ Να μας φημιζει. Χαρουμερασι Κωροι Ψυχολογια. Ποσοδα; Πιρρι φημιζει για ωσω? Αφρανε σμυγι. Κυρια Ζινα ο καρλ. ωστε μεσα? Καθε μερα ΦΥΣΙΚΟ ΠΕΡΙΒΑΛΛΟΝ ♀ Τονω της μεση μου & ΚΕΡΑΤΑ Αφρανεταει σμυγι του αυτου Πιρρι στα αυταρα. Χαρουμερασι και οι δυο Δεκατα μου Κωρη μου μεσα. Προσωδα αφρανα/ φημι. Πιρρι με τζι. να αυραναδα να μεν φημιζει αφρα. Ο Γαρμυ εν μεση να εφρανε ΚΑΔΕΡΥΡΑΙ. Να τον αφρανα εφρα τζι. Εξωτα αφρανεταει εφρα η για τον φημι του</p>	<p>ΕΠΙΠΕΔΟ ΝΟΣΗΛΕΥΤΙΚΗΣ ΦΡΟΝΤΙΔΑΣ Να σε δω σου αφραναταει. ΠΛΗΡΟΦΟΡΗΣΗ Δεχεται την κωρη του. 'Οχι Κωρηρασι ΣΥΜΒΟΥΛΕΣ ΠΙΣΤΗ.</p>
<p>(αρχη, μεσο, τελος) Οτι δεκα ας κανει Ο αφρανα των αφρανα φουβα κωρη δεν φημιζει.</p>	<p>Εφρα Ζαμενο.</p>	<p>ΕΠΙΠΕΔΟ ΠΡΩΣΙΑΣ Για φημιρασι φημιρασι ΨΥΧΟΛΟΓΙΚΗ ΣΤΗΡΙΞΗ ΠΡΩΣΕΧΕ ΤΟΥ! Εφρα τζι να εφρα ΕΝΙΣΤΗΝΑΙΣΘΗΣΗ εφρα αφρανα εν αφρανα ΣΕΒΑΣΜΟΣ Αφρανα φημι φημιρασι εν ΑΦΡΑΝΕΤΗ-ΝΟΙΣΜΟΣ αφρανα Χαρουμερασι ωσω -> ΤΟΝ ΑΦΡΑΝΕΙ ΝΑ ΠΕΙ ΤΗΝ ΓΝΩΜΗ ΤΟΥ Να αφρανα ωσω 1-2 ΜΕ ΣΥΓΓΕΝΕΙΣ Αφρανα εφρα φημιρασι αφρανα</p>
<p>ΚΑΤΑΝΟΕΙ ΤΙ ΤΟΥ ΠΕΙ Η ΝΟΣΗΛΕΥΤΡΙΑ Περκι μερα σε δω. Περκιρασι αφρανα Ο Κωρηρασι τι να κανει;</p>	<p>ΚΑΤΑΝΟΕΙ ΤΙ ΤΟΥ ΠΕΙ Η ΝΟΣΗΛΕΥΤΡΙΑ? (αρχη, μεσο, τελος) Κωρηρασι/ αφρανα αφρανα αφραναταει. Αφρανα. Κωρηρασι αφρανα Η αφρανα</p>	<p>ΕΠΙΠΕΔΟ ΠΡΩΣΙΑΣ Για φημιρασι φημιρασι ΨΥΧΟΛΟΓΙΚΗ ΣΤΗΡΙΞΗ ΠΡΩΣΕΧΕ ΤΟΥ! Εφρα τζι να εφρα ΕΝΙΣΤΗΝΑΙΣΘΗΣΗ εφρα αφρανα εν αφρανα ΣΕΒΑΣΜΟΣ Αφρανα φημι φημιρασι εν ΑΦΡΑΝΕΤΗ-ΝΟΙΣΜΟΣ αφρανα Χαρουμερασι ωσω -> ΤΟΝ ΑΦΡΑΝΕΙ ΝΑ ΠΕΙ ΤΗΝ ΓΝΩΜΗ ΤΟΥ Να αφρανα ωσω 1-2 ΜΕ ΣΥΓΓΕΝΕΙΣ Αφρανα εφρα φημιρασι αφρανα</p>

Appendix P: The Narrative Notes of the OBSERVATIONS of Home Care Visits

OBSERVATION 1

13/06/2012

Mr K. is 95 years old. We are in an old traditional house in a peaceful neighbourhood. We are in the living room, situated immediately after the main entrance of the house. The door is open. The garden is very tidy. The house is tidy and clean. The air is fresh. The atmosphere is pleasant. I see smiling faces. The nurse is smiling, too, and she looks happy. She looks glad to see them. The same stands for the patient, his wife and their caregiver (foreigner). The relationship between the patient and the nurse is very friendly. While the nurse is going through the necessary nursing procedures they talk about different subjects. The patient considers the nurse as a friend and asks about her son, her husband, and wants to know if they are all well. The nurse feels comfortable with the patient at all times and answers his questions with pleasure, having always a big smile on her face. She looks like she is enjoying his company. The nurse is sitting really close to the patient (almost touching him-about one foot away), and she is leaning her body towards him. Mr K. is as happy as a little child. The nurse speaks loudly and clear, but there is always softness in her voice. She stresses out the words she wants to emphasise. Sometimes she repeats parts of her sentences because the patient has minor hearing difficulties. The nurse asks the couple if they are both feeling well, while she has already noticed (before even entering the house) that his wife's eyes are sore. She wishes them to have a nice month. She talks about the weather. She asks them about their sons who are living abroad with their families and talk about them visiting over during the summer.

The nurse has a big smile on her face all the time and from time to time she laughs with Mr K.'s jokes. She tells Mr K. that he should have a party in the summer for his 95th birthday. At the same time she measures his blood pressure. "Well done", she says, "Your blood pressure is good!" She is fast. She seems like she knows what she is doing. She is preparing a vitamin injection.

She notices that the patient is wearing a jumper and she gives some advice with regards to the cleaning of the windows.

The nurse asks Mr K.'s wife about the program she is watching on the TV. She says that she is watching a medical program about feet problems. The nurse makes some comments while watching the program. The nurse cares a lot about her patient and shows that she is happy that the patient is getting better. She asks him to stand up and lower his trousers and underwear in order to give him the injection. The patient complies at once to the nurse's instruction without being annoyed at all that he has to do this in the middle of the living room, in front of everybody who is present there. While she is giving him the injection she notices that he has lost weight and she gives them some advice on his nutrition.

The couple is sitting close to each other. They look like a loving couple who care for each other. The nurse continuously keeps eye contact with her patient -she looks at him straight in the eyes. The patient is grateful. He thanks the nurse four times, with a big smile on his face.

The nurse refuses to have a drink or a snack. She says goodbye to them, with a big smile on her face and leaves.

OBSERVATION 2

13/06/12

We are in the middle of the living room of an old traditional house. The living room is situated right after the main entrance.

It is small and clean, but not tidy. It is slightly cold. The door remains open. Mr A. with his sister Mrs K. live in this house. They are both in their early 70s.

Mr A. is sitting in a wheelchair and a barber is shaving him. He gives a weak smile when he sees the nurse. His sister is standing in some distance from us. She is not smiling. She seems depressed. She is neither friendly nor hostile. Her posture is rather defensive.

The nurse realises right away that Mrs K. is depressed and she tries to find out what is wrong.

Then she wishes them to have a nice month and a good summer, and gets right away on work. She is placing their pills in a plastic compartmental box, labelled with the days of the week so they know which pill to take every day. While she is doing this she is sitting in one metre distance from Mr A who is still shaving.

When he finishes shaving, she moves next to him and measures his sugar levels. She finds the sugar level to be quite high. She asks him if he is careful with his daily diet and she gives some advice on their diet.

Then the nurse measures Mr A.'s blood pressure. She finds that it is really low, and she makes a joke so that Mr A. does not get stressed about it but he does not laugh. He seems troubled.

The nurse speaks in a steady, loud, clear voice in a decisive manner and she uses simple structure and vocabulary.

Mr A. remains silent for a long time. He looks serious, and you get the feeling that something is bothering him. However he remains receptive. If the nurse does not talk to him, he does not talk either. Mrs K. goes and stays in the kitchen for a long time, probably in order to avoid conversation. The nurse calls her back in the room. She keeps her distance, having a defensive posture, with her arms crossed over her chest. The nurse approaches her, but she does not come as close as with Mr A. Now she is more than one metre away. She asks Mrs K. once more how she is feeling. Mrs K. speaks in a flat voice, and her hands are shaking. She says that she is not feeling psychologically well. It takes great effort for her to find the courage for any housework, and she does not go out at all, not even at the church, anymore.

The nurse with kindness repeatedly asks: "How come, Mrs K.? Why?" and she advises her to go out and meet people. They talk about the only relative they have, their nephew, who almost never visits them, and when he does, this is just for a few minutes. The nurse seems annoyed, sad and worried about this. She sounds slightly strict when giving instructions but she is always polite with them.

Mrs K. hands over to the nurse the name of a nursing home for elderly people, which was recommended to them by a doctor. The nurse's eyes widen at the sight of the name, and she remains silent for a while. It is obvious that she does not like what she sees. She is trying to hide it, though. She begins with the advantages and disadvantages of moving

to a nursing home. She asks each one of them if it is their wish to go there. Mr A. does not answer. Mrs K. says that she wants to, but she does not have the money. Now the nurse advises Mrs K. to try and socialise, and asks her to pay a visit at her doctor so as to inform him she is not psychologically well. As far as it concerns the nursing home, the nurse advises them to study with greater care the matter. She also suggests they should first visit the place so as to see with their own eyes whether they like it or not, and ask about the cost. Then they can decide. She tells them the alternative option of hiring a caretaker so as to help them with the housework, but they both reject this right away. The next thing the nurse does, is to try and help them to find a way to go and check out the nursing home. She volunteers to call their nephew herself and ask him to drive them there. Mrs K. refuses to give her nephew's phone number as she does not want to involve him in this. The nurse respects her wish and does not insist.

“We have no one” says Mrs K. Silence...the nurse through her silence and the sadness in her eyes shows that she understands the situation and empathises with them. It is obvious that she is thinking hard to find a solution.

She tries to give them courage: “If I can do anything to help, I will” she says. She respects though their wish not to involve their nephew in this.

She also offers to bring their blood tests' results herself, even though it does not fall within her duties.

She says she will call in a few days and check on Mrs K.. Mrs K. says “Why call me? There's no reason to call me!” so the nurse says that she will call Mr A. instead. Mr. A. thinks for a while and then he explains that because he does not have a self-phone and by the time he reaches the phone, it stops ringing. Throughout the conversation, the nurse looks at them in the eyes and seems really worried about them.

Leaving from this house, the prevailing feelings are sadness and worry. The nurse looks troubled and thoughtful to the patients' problems.

OBSERVATION 3

13/06/2012

We are in a rented house, situated on the first floor of a building which is not new. The house is not well maintained, it is untidy but clean. Things are scattered around. Mr L, around 60 years old welcomes us standing up, wearing his top underwear, shorts and socks but no shoes. He was waiting for his nurse. He was standing on the balcony looking down in the street until he saw the nurse coming. He is friendly and polite.

He takes us to his bedroom. He is staying with his fourth daughter and her family. He has previously been for a short time to each one of his other daughters. His bedroom is small, full of furniture and the room is overloaded. It is clean but untidy. The balcony door is open.

The nurse is sitting at the desk now, in one foot distance from Mr L. and she is placing his pills in the plastic compartmental boxes. At the same time she is talking with him but she does not have eye contact with him. She is fast. She is talking and working at the same time. "How does she manage not to make a mistake?" I wonder to myself. She takes out some hospital appointment cards with Mr L.'s appointments written on them; she organizes them and then writes all his appointments on a piece of paper, in big, easy to read letters. She attaches the paper on the bookcase using home care stickers, in order to make sure that his daughter will see it.

She tells him that he had missed his appointment with the ophthalmologist and for this she called his daughter many times but she would not answer her phone calls. She stresses out that he should not miss his appointments because then the next possible date for the appointment is after a long time (6-8 months), and this kind of checks should not be delayed for so long. She pleaded him so as to make sure that he will go to the next one. She avoids looking at him in the eyes. I think that she does not want him to see how angry she is with his daughter who has forgotten to take him to his doctor's appointment, and above all that she does not answer her phone calls. She is trying really hard to hide her anger.

The nurse takes his blood pressure and checks his sugar levels. His sugar levels are high. The nurse looks worried. She notices that there is one extra pill left in the box and she asks him why he did not take his pills yesterday. Mr L. tells the nurse that his

daughter took him out with the family to the beach yesterday and they had forgotten to take his pills with them. As if that was not enough he ate watermelon, too. “Come on Mr L...!!!” she exclaims. She feels sad and angry at the same time. “Why didn’t your daughter remember to take your pills with you?” The patient finds excuses for his daughter; he says that she has got a lot on her mind right now, she has got her son’s move over, and that they are all stressed about their jobs and their financial situation. “I had called her! Why wouldn’t she answer to me? She should have called me back!”, the nurse keeps on complaining but in a polite way. The patient takes a defensive stand now, with his hands crossed over his chest and keeps on giving more excuses for his daughter. The nurse is not convinced by the excuses. The patient is gloomy now and looks troubled. He is sad and worried. “I want you to write down your daily sugar measurements for me Mr L., please!” the nurse keeps pleading him.

The nurse cautions him for his diet and in a strict voice she advises him on his nutrition. She repeats her advice a few times. The patient seems to understand all the instructions given by the nurse, but gives the impression that he will not follow the instructions at all times.

The nurse speaks slowly, in a clear, loud voice, emphasising some of her words. She asks him if any of his other daughters come to visit him. He says they do not come because they have their own problems. One of his daughters is unemployed as well as her husband and they have four children to feed. “As long as I worked, I gave them money. Now..?” he says. While the patient is talking the tone lowers but the he continued at a steady pace. Everything about him is flat now.

The patient makes a sudden move and he lets out a sound as if he is in pain. The nurse asks him if his hands hurt. She gives him some advice about his hands. He complains that his vision is sometimes blurred. The nurse tells him for once more that he should definitely go to his next appointment with the ophthalmologist. She explains to him what he should take with him to the appointment -his medical booklet and card.

The patient mentions his last visit to the neurologist who told him: “Your hands and legs are no longer moving properly. Why have you come now?” – “Oh, my God...” the nurse says, and she shows to him that she empathises with him.

She asks him what he will eat for lunch. He says that he does not know yet, but that the others come home at midday eat something and leave, so he is certainly going to eat something. She tells him that it would be a good idea to join a Care Centre for Elderly people. A bus will pick him up every day and take him there, and in this way he will socialise, but most importantly he will get out of the house a bit. He will not have to stay home alone for so many hours; he will be with the company of others and the nurses there will make sure that he keeps a right and balanced diet and that he takes his pills correctly. At the end of the day a bus will bring him back home and it will only cost 5 euros a month. The nurse is trying to convince him that it will be good for him. Mr L. is negative. He does not like the idea at all. He says that he does not like food other than his home. He does not like to be with other old and sick people. He prefers to stay alone in his peace and quiet. He does not even like watching TV.

The patient says that the area on his belly where he gets the injections is bruised. The nurse touches the bruised spot and it hurts. The nurse sighs.

On the walls around I notice that there are a lot of small frames with the icon of Jesus, as well as a lot of quotes from the Bible.

While leaving, sadness is the dominant feeling. The patient's blank expression has left a feeling of emptiness inside me. I can also sense the nurse's anger about his relatives and her disappointment for his condition and the fact that she has not been able to do anything to help him after all, not even to convince him to join a Care Centre for Elderly people. I can also sense her physical and mental fatigue.

OBSERVATION 4

13/06/2012

We are standing in front of something that looks like a shack at the back yard of the main house. What I see is horrible. Inside the shack there are three really small rooms. Old things are piled up everywhere around the rooms. It is dirty and there is an awful smell in the air. It is also hot. The air is not fresh. The rooms are stuffy and untidy. Mrs K., an old lady of about 80 years old is living here with her son. They both seem to be of lower intelligence than the average.

Mrs K. is friendly and she is happy to see the nurse. It seems like she was waiting for her. She has some difficulty in walking. During the whole visit she remains seated on a chair right in front of the TV. "What would you drink?" she asks both of us. She reminds me of my own grandmother. The nurse politely refuses to drink anything. Mrs K. asks the nurse if her child is well. "Everything is fine Katerina" she says and she smiles. The nurse talks using simple language slowly and loudly. She addresses the patient with her first name.

She asks her if she has eaten anything today, what and when. Mrs K. says that she has had something for breakfast but not for lunch yet. She is looking at her watch ever since she has woken up, waiting for the care taker from the social services who comes to clean the house and cook something for them. She comes three times a week for only an hour. For the other three days her best maid comes who is paid 500 euros per month. Normally the care taker from the social services comes at 8 o'clock in the morning but today is already 12 o'clock and she still has not come. The nurse seems disgusted, disappointed and angry about this situation. She asks for the care taker's phone number and she calls her. The care taker herself had written her phone number on a jar of almond sweet!!! The care taker tells the nurse that she is on a leave. The nurse demands to know why she did not inform Mrs K. that she would not come and she sounds really angry.

The nurse goes to the kitchen to get Mrs K.'s medicine and she finds spider webs all over them. She realises that Mrs K.'s best maid who comes to clean the house does not clean it well at all and asks Mrs K. to give her more details about her visits; what time she comes, what time she leaves and whether she does any cleaning after all. Mrs K. says that she comes around 8 and she looks at her clock all the time until it is time to leave, and that lately she leaves earlier than the time agreed after she has had lunch at their house.

The nurse is sitting in front of the table, one metre away from Mrs K., and she is preparing her medication. She seeks for no eye contact. "Oh, Katerina if you would only listen to me!" she tells her with sorrow and complain in her eyes. "If you had only listened to me and hired that lady I had found for you from Georgia...you would pay her the same amount of money and she would clean and cook for you...she would even come around in the weekends to give you your medication." She sighs... "Mother of

God...” The nurse says these words feeling really sorry that Mrs K. did not accept her offer of hiring the Georgian care taker that she had found for her, in replacement to her best maid. Mrs K.’s eyes are full of tears now. She seems like she has regretted for her choice. The nurse seems to empathise with her. It is obvious that her relative is just taking advantage of the situation...According to the hours that she spends there in order to clean this small house should have been clean and shiny.

The nurse takes her blood pressure and the sugar levels. Her sugar levels are high. “Ohhh!” the nurse lets out a cry when she sees the results. The nurse realises that Mrs K. must have forgotten to take her morning pills and a few seconds later she confirms her suspicions. She also asks her what she has had for breakfast. Mrs K. remains silent, serious, staring at the nurse. It seems that she is in agony.

Then Mrs K. asks the nurse if she can bring her some medicine she must take for her stomach, from the hospital’s pharmacy. The nurse even though this is not something that it is within her duties, she says that she will check with the doctor of the health center and if it is possible to prescribe her the medication she will gladly bring it to her.

Mrs K.’s son now comes from his bedroom. The nurse greets him and tells him to go right away to a nearby bakery that also offers food so as to bring something for him and his mother to eat. She also asks him if he had been to the doctor to get advise concerning the problem he has with his blood pressure. “How would I go...?” he answers without looking at the nurse. Unconsciously, I turn my head and look out in the garden through the open door and at that moment I realise that the only mean of transportation he has is an old bike...

OBSERVATION 5

25/06/2012

We are in a house of the 70s which looks like it has not been maintained or renovated at all for many years. The garden is not well taken care of and the wooden door is wrecked. The walls look like they have not been painted for years. Inside the house the furniture are old and in a bad condition. It is half dark, the windows are shut and the

atmosphere is hot and stuffy. The house is untidy, not dirty but not particularly clean either.

We proceed to the bedroom at the end of the corridor. Mr S., a 77 year old man is resting in an old double bed. All the furniture is old and the room is a bit untidy. It is quite clean but dark. All the windows are shut; there is a bad smell of urine. It is stifling. A foreign care taker who the nurse has not met before accompanies us to the room. She does not speak any Greek at all. The nurse asks in Greek the new care taker where the full time care taker of Mr S. is, and where is his wife. The care taker using a couple of words in Greek and some signs with her hands explains to the nurse that there is no one else home.

In Mr S. bedroom, in his bed, a little boy of a dark color, around 4 to 5 years old, is sleeping. The nurse explains to me that the little boy is the full time carer's son, and asks the boy who has just woken up where his mother is. The boy says that she is out for a job.

Mr S. is happy to see the nurse. He smiles and laughs all the time for no particular reason. He has had a stroke and ever since he is always in a mood of euphoria. He explains to us that he has not managed to get up today.

The nurse asks the new care taker to open the windows and let the light and fresh air come in. She asks her whose responsibility is now to give Mr S. his medication and for once again she wants to know where the full time care taker is. She addresses the same question to Mr S., without receiving any clear answers from neither of them. She repeats the question accompanied with signs this time in order to help the new care taker to understand what she means. "Just show me" the nurse tells to the care taker, and speaking to herself, says that she just want to check if she knows where they are. Now the care taker takes some bottles of medicine and shows them to the nurse, but the nurse is still not convinced that she has even a clue of what to do with them. She looks worried. "Is Lia coming or not?" she asks again. Finally the nurse rings Lia herself. She finds out that Lia is actually coming back and that she is the one who gives Mr S. his medicines. The nurse now relaxes.

She asks about the sore skin that she spotted in her last visit, and she checks it. "Thank God there is nothing there now...thank God!" "You shouldn't lie all the time on your

back Mr S. Turn on the side a bit. Try to move your legs a bit, too.” Mr S. says ‘yes’ to whatever the nurse tells him smiling and laughing all the time. He seems that he can understand whatever the nurse tells him and the importance of her advice, but whether he is going to follow her advice or not that is not certain.

Mr S. turns towards the boy now and he asks him to come close. He strokes the boy on the back and he seems like he gains strength from this little boy. The little boy takes his distance from Mr S., and at some point tells him “You stink!” Mr S. strokes him once again and the reaction of the boy feeling uncomfortable, make me feel strange-I do not like this contact. The nurse does not seem to worry about the child. Mr S. is coughing and has a lot of mucus. “You should give him some tissues for his mucus” the nurse tells the care taker in a strict manner. I am worried about the fact that the child is so close to him when he coughs. The nurse tells to Mr S. that he should keep taking his cough syrup and do the inhalers that the doctor prescribed. If his condition remains the same after a few days the nurse advises him to pay a visit to his doctor as he might need to take antibiotics. The nurse speaks loudly, using simple language, in a clear and steady tone, having a decisive and powerful manner that leaving no space for any further questions or conversation. Throughout her visit, she has a weak smile and she is always polite. Her body posture and her voice tone show confidence and gain control. She is characterised by a kind of strictness and she gives the impression that she does not accept any objections.

The nurse takes Mr S. blood pressure and sugar levels. “Your sugar levels are perfect!” She is fast. She speaks and at the same time she acts with great accuracy and seems confident while doing her job. Then she takes a blood sample from Mr S. for analysis. While she pricks him with the syringe Mr S. shouts, gets angry and swears, “D.....you! That hurt, my daughter!!!”, he shouts angrily at the nurse who very calmly asks him: “Oh, did that hurt?”

“He should get up more!” the nurse says using signs at the same time so as for the care taker to understand what she wants her to do. “He should walk more. He shouldn’t stay all day in bed.” Then she turns towards Mr S. and she asks him, “When will you get up?” – “Tomorrow” he says and he laughs. “No, now!!” the nurse says. “If you listen to what the ladies tell you, you will be just fine.”

The nurse washes her hands in the sink, says “Goodbye” to Mr S. and his care taker and we leave.

Mr S. is in the program for two years now, after he had a stroke. He suffers from diabetes and high blood pressure. Mr S. used to be a doctor. After the stroke he can still understand everything but he is smiling and laughing permanently for no specific reason. He uses a wheelchair which is in his room to move around. He lives with his wife and their care taker’s family. Lia, their care taker, has settled in with her four year old boy, her husband and now she is pregnant with her second child. According to the nurse, Lia takes really good care of Mr S., and he is always smiling and feeling happy when he is with Lia.

OBSERVATION 6

25/06/2012

We are standing outside a newly built block of flats. There is still work in progress located in the surrounding area. We are trying to find a way to get in the building but that is impossible. The doorbell is broken. The nurse rings Mrs A.’s daughter in order to explain to us how to get in. She tells her that we should walk over two wooden beams and enter the building through the basement. She also explains that the work being done is for the preparations of Mrs A.’s granddaughter’s wedding which will take place in a few days. Only relatives of Mrs A live in this block of flats, Mrs A.’s children and grandchildren. The nurse looks at the beams we were asked to walk over and she hesitates. She decides that she will come back another day, and heads towards her car. Then she thinks it over, she changes her mind and we go back. We walk over the beams. Some balance is needed in order not to fall over. We find ourselves in the basement of the building which is terribly messy and untidy, full of old stuff which ended in there because of the renovations that are taking place in the building. We find where the lift is and we manage to go up to the flat.

Mrs A.’s daughter, along with her Philippine care taker, is there to welcome us both with a big smile on their face.

The nurse immediately asks Mrs A.'s daughter how is her arm. I can see that it is bandaged. The woman explains to me that she was diagnosed with breast cancer so she had a mastectomy, and now she has problems with her arm.

She takes us to Mrs A.'s bedroom. The house is clean, tidy and well maintained. Inside the bedroom it is really hot, there is a lack of fresh air but it is very bright. In the bedroom there are two single beds one next to the other, and all around the room there is a lot of furniture (a bookcase, some chairs etc.). The room is small but clean. The second bed is for the care taker who sleeps in the same bedroom with Mrs A as Mrs A. is afraid to be alone.

Mrs A., a smiling old lady, of 96 years old, is lying in bed. She is overweight and she can't walk. She suffers from heart failure and kidney disease, and she is almost completely blind. She seems to be happy when she listens to her nurse's voice. She has a complete understanding of her surroundings and she is in a good psychological state. She has difficulty in breathing -you can understand this only by listening her.

The nurse greets her and asks her how she is feeling. She moves around fast and there is confidence in her moves. She is organised and tidy. Her moves show that she knows what she is doing and that she has a dynamic personality.

The nurse measures her blood pressure and says that it is very good. "Good for you!" she says and she touches the airbed. "Doesn't the airbed work?" "It works the daughter answers. "Did you have any sore wounds last time?" the nurse asks Mrs A. and she is trying to remember herself. Mrs A. can't remember. "Does she drink water?" the nurse asks. "Yes I do!" Mrs A. replies. "Good! Now after we change the tube of the catheter you should drink a lot of water." The nurse is now preparing the equipment she needs in order to change the catheter and at the same time she gives instructions to Mrs A. for what to do. She wishes that everything goes well and that not a lot of urine will leak. With fast movements that show great confidence she changes it. "Take a deep breath" tells to Mrs Antogni and she quickly places the catheter. "There is no leak! Good for you! You are clean. Don't worry about anything my dear. Well done my dear. Excellent Mrs A." The nurse encourages Mrs A. by telling her all these. Mrs A. doesn't exhibit any pain or discomfort. "Now give her water" the nurse says to the care taker.

“I sweat a lot...” Mrs A. comments. “You have no fever” the nurse tells her, “it must be from the weather, it is getting hotter.”

She gives her some water. Mrs A. drinks it and the nurse checks the catheter. She gives instructions to the care taker as to when to change the sack of the catheter. She also tells to her daughter that they should change the sack again on the wedding day so that it doesn't smell. She also explains to them how they should place the catheter under the covers on the wedding day so it will be hidden. The nurse asks Mrs A. who is getting married. “My granddaughter from my second daughter” she explains. “My first daughter has not got married yet...I have 50 grandchildren, 2 great grandchildren and now there are three more on the way” she says. The nurse smiles at her and wishes her the best for them. “At the wedding I will sing. I have even made up a song for them” Mrs A. says and she recites her song. It is indeed very nice.

In the room now enters another one of the granddaughters, and asks Mrs Antigoni about her own osteoarthritis. “The doctor has prescribed me this medication for one month” she says and she shows the box to the nurse. Now that she has stopped taking them her joints hurt again. The nurse asks for more details on that. Then the nurse says that she has heard the best for the specific doctor and that since she still feels the pain when she stops taking the pills, it is possible that she might need to keep on taking them for a longer time. She tells her that it would be a good idea to visit her doctor again as soon as possible and take his advice. Her granddaughter leaves satisfied by the advice. Her daughter goes in and out of the room all the time while her care taker remains in the room the whole time.

“Ah, now I remember! You had a sore wound on your lips last time and I gave you a balm to put on, and from what I can see you are just fine now. Whatever comes up we fix it!” says the nurse proudly. “Good for us!” she completes.

The nurse notices some bruises on Mrs A.'s belly. “Where did this come from?” she asks her. Mrs A. doesn't know. She turns towards the care taker and tells her: “You should be more careful when you change her clothes”, looking angry. “You somehow hurt her on the belly.” The care taker seems to understand everything but doesn't answer. She is not smiling anymore, and by her body posture you can understand that she is more self-conscious now.

“She must do exercises for her arms and legs. And she should turn a bit on the side, too, when she is in bed.” Mrs A. interrupts her and she says to her: “You are very good! Tell her that she must turn me on the side” referring to the care taker. So the nurse gives instructions to the care taker. She also asks Mrs A. if she takes the syrup for her cough, and Mrs A. says that she does.

“Who would imagine that I would live for so many years?!” says Mrs A. “No one can know these things...”, says the nurse. “They all love you and take care of you, and you are with your children and that’s important” adds the nurse. “I love them, too.” says Mrs A. and adds “Oh, and my doctor loves me!” “It is impossible for someone who knows you, not to love you!” says the nurse and smiles.

The nurse is polite, and smiles at everyone but with her body posture and tone of her voice keeps some distance.

The nurse washes her hands in the sink, says goodbye to Mrs A. and heads towards the exit. In the living room, where Mrs A.’s daughter is sitting makes a quick pose in order to congratulate Mrs A.’s daughter for the way she takes care of her mother. She stresses out that it is this care and love that keep her alive. “Your love and care keep her alive” she says to her. The daughter, Mrs M. a woman of about 60 years old, says that they do take good care of her and that her husband is a very nice person and has never complained that her mother lives with them for so many years. She also stresses out that they don’t do this for the money since they have nothing to gain. She explains to us that Mrs A. had about 80 000 euros in the bank which have all gone on her care takers and doctors. She adds that they have not told her anything about this, because she would die from her sorrow if she knew, since she feels really proud about that money that she will leave for her children to share when she dies.

I am impressed and touched by the sensitivity, love and respect that Mrs A.’s children and grandchildren show to her. In the world we live today, it is something really rare and unique. ‘The best environment that someone can have in such an old age’, I think to myself as we are leaving, walking over the beams once again.

OBSERVATION 7

25/06/2012

We are in a rich neighbourhood, outside a new house. The garden is neat and very beautiful. A care taker, probably from Bulgaria, welcomes us. She is a well build woman who speaks Greek. She is smiling and she is polite. She accompanies us to the living room, where Mrs M. an old lady of 85 years old is sitting. She uses an walking frame to help her lean on it and walk. The room is quite big, clean and tidy. Every single thing is in the right place. The room is brightly lighted and the door that leads to the porch is open, so there is a good ventilation of the space.

Mrs M. is sitting on a big, tall chair, at the head of the living room table, like a queen. She is holding the walking frame that helps her walk in front of her in order to keep her balance. She is smiling; she is really polite and very happy to see her nurse. She is in a very good psychological state. The patient looks very clean and tidy and that she seems to take very good care of herself.

“How are you?” the nurse asks her. “The same as always” answers Mrs M. The nurse right away notices that Mrs M.’s left foot is swollen and she immediately asks her why is it in such condition. Mrs M. doesn’t have an answer. “You should always place it higher while sitting” the nurse tells her. “Have you given her, her medication?” asks the care taker. The care taker gives a positive answer but the nurse nevertheless checks the bottles just to make sure. “You won’t eat any salt with your food and you will place your feet high while you are resting!” the nurse tells to Mrs M. Right away her care taker says that Mrs M. eats a lot of olives. “You will not eat any olives at all!” the nurse tells her. Mrs M. doesn’t look like she agrees with the nurse’s opinion. The nurse realises that, and she tells her that it is ok to eat only a few and tries to show to Mrs M. that she respects her wish and that she understands her desire for olives. Then she tries kindly to persuade her not to eat olives at all and explains to her that olives have a lot of salt which is not good for her health. It appears that the nurse has managed to convince Mrs M.

“Even when you are resting in bed you should place a pillow under your feet.” The nurse is trying really hard to persuade her to do that, when Mrs M.’s care taker tells the nurse that she doesn’t even want to do that. Mrs M. has a really guilty look on her face but she still smiles.

The nurse asks to find out what the doctor told them on Mrs M.'s recent appointment, and Mrs M. explains everything to the nurse. The nurse is moving fast and with confidence in every single thing she does, she measures Mrs Maria's blood pressure and also checks her medicine. She uses simple language, she speaks loud and clear, her voice tone shows certainty and confidence. She is polite. The patient understands every single thing that the nurse says.

Then the nurse gives Mrs M. her injection. "That hurt a lot!" Mrs M. complains. There is no reply by the nurse.

"Do you have any news?" Mrs M. asks. "You tell me" the nurse replies. "I only go to the church, what news could I possibly have?!" Mrs M. answers. "Well, then you should walk more" the nurse advises her. "How is my friend?" Mrs M. asks her. They have some common acquaintances because they come from near-by villages and Mrs M. wants to learn their news. "She is good. They are getting ready for the wedding." the nurse answers. But stops there and avoids to give more details.

Then the nurse reminds them that her new examinations are coming up soon, and she checks her appointments with the care taker, and informs them about the day and the time she is coming next week to pay her a visit. While the nurse is getting ready to leave, the care taker comes in with a flower pot with a very beautiful fresh basil planted in it and gives it to the nurse. "This is for you" she says. The nurse says that they shouldn't have done that, she smiles and accepts the gift.

The nurse bids them farewell and we leave the house.

OBSERVATION 8

25/06/2012

We are in an old traditional house in a traditional neighbourhood. At the entrance Mrs G.'s husband is waiting to welcome us. He is very polite. He suffers from a mild form of arteriosclerosis. The nurse notices immediately the dry skin which is pilling off, on his full of varicose veins legs. She straight away recommends to him to wear the special socks he has got for his legs and use a special lotion to calm down his dry skin. The

house is not well maintained, it is untidy and not really clean. The bedroom is cramped and too many things are piled-up.

Mrs G. is sitting in her bed. She is polite and there is a big smile on her face. She is happy to see the nurse. She says that she was waiting for her anxiously and now that she sees her, she feels relieved. She is 85 years old. She is unable to move.

The nurse speaks loud and clear, and keeps sentence structure and vocabulary simple. The patient seems to have a complete understanding of everything.

The nurse moving fast prepares and gives her an injection. The patient doesn't seem to experience any pain. The nurse looks really confident. She arouses trust. She is not smiling all the time. She continuously encourages the patient by saying "Bravo", "Perfect", "Everything is going to be ok", and similar encouragements. She has a precision in her movements and she is really observant. "You will walk soon", she says to the patient. "You look better today". The patient explains to the nurse that the previous days she was really stressed because her medicine had finished and she didn't know how she would get a new packet. She then talked with the nurse on the phone who explained to her how and from where to get her medication and the problem was solved, making Mrs M. more relaxed. Now she is calm.

The nurse checks the special seat they had installed for the bathroom. She says that everything is ok, and she shows Mrs G. how to place it safely in the bathroom. She explains to her everything in detail and at the same time she acts out every single step that Mrs G. needs to do. She explains to her how to sit safely on the wheel chair and how to put it correctly in the bathroom.

Then the nurse tells to Mrs G. that if her care taker is there when she visits them again the next day, she will explain to her as well how to use it correctly. She also asks to buy the ointment she recommended for her feet, and also advises her to wear the special socks she's already got which will also help with the problem of her feet.

The nurse's fatigue progressively starts to show but she doesn't give up. She does care a lot about her patient but it seems that she is trying to keep a safety distance so that whatever she sees and experiences will not further affect her.

Mrs G.'s husband offers to go out in their garden and pick up some apricots for the nurse, but the nurse thanks him and tells him that she doesn't eat the particular fruit.

The nurse says goodbye to them and heads towards the exit. She says to Mr C. that his wife is getting better. They also talk a little about their daily diet, and after she says once more goodbye, we leave.

OBSERVATION 9

28/06/2012

We are in a village in the countryside. The house, which is situated out in the countryside, is cool, clean and sparkling. The garden is full of big, tall trees and the sound of thousands of cicadas is heard coming from the trees. Mrs C. welcomes us in the garden with her hands wide open. She is smiling and she hugs and kisses us. She doesn't know me but she gives me a warm welcome in the same way she did with the nurse. She treats us as if we are her own close people. "Darling, sweetheart" she says to the nurse. "When I called you yesterday my husband said to me: "if she has 20 patients like you, calling her all the time she wouldn't be able to do any work. Don't bother her all the time". Her husband is sitting a bit further away. He greets us warmly and friendly like his wife did.

Mr N. has had two surgeries on the hip joint. He has high blood pressure and he suffers from diabetes. He has a catheter and he walks with the help of walking aid. He is 82 years old. Mrs C. is 80 years old. She also suffers from high blood pressure and diabetes but she has no walking problems. They are both in the program. A Vietnamese girl who helps them with the housework lives with them.

The nurse asks them how they are. Mr N. right away starts complaining about the social services that cut of the aid of 60 euros that Mr N. received from them until recently. He feels disappointed. The nurse explains to him that it is a matter that she can do nothing about, but she gives him advice on who he can contact in order to help him.

Then the nurse asks about their pills and checks them. She notices that there is some medication in there and she wants to know who prescribed that medication. Mr N. explains to her. The nurse wants to know what medication they are taking now, when,

how much and how often so that she makes sure they are taking everything in the correct way and she writes some extra notes on the bottles to help them. Mrs C. looks confused about something. The nurse asks her to tell her what she hasn't understood and she explains it for her for once more. Then right away the nurse asks Mr N. if he has changed his catheter. He says that a nurse from the village came and changed it but he feels a little burning now. So the nurse tells him to make sure he takes all his antibiotics and if that feeling doesn't go away she advises him to visit his doctor. She also recommends to drink a lot of liquids. At the same time she checks his blood pressure and sugar levels. "Very good" she tells him. She asks him if he has taken his pills for his blood pressure and sugar and if the doctor has come to the village for his regular visits. Mr N. gives a positive answer to both questions. Then the nurse asks him what he has had for breakfast and he says that beside a coffee with sugar he hasn't eaten anything else because he was waiting for her. She tells him that he shouldn't put sugar in his coffee. Her voice when she speaks is loud, clear and steady and she smiles all the time. She looks at them in the eyes when she talks. She seems decisive and dynamic.

Mrs C. wants to treat us something and we accept. They say cheers when they bring us the orange juice and wishes us all the best. Mr N. says that some foreigners have stolen 13 chickens and 4 rabbits from them the other days.

These people are really hospitable and open hearted. Mrs C. is a very active person full of life. Mr N. says that he uses his walking frame and he slowly goes to the traditional café of the village every day. I can see that he has great difficulty in walking and that he walks really slow. I wonder how much power and will, someone in his condition needs in order to walk up all those steep roads of the village until he goes to the café.

The nurse tells them that she will visit them again soon. She says goodbye to Mrs C. who hugs and kisses us again, and gives us her blessings. We say goodbye and we leave.

OBSERVATION 10

28/06/2012

We are in a house situated in the centre of the village. It is built from natural stones, in the traditional way many houses are built in the villages, attached to other houses. We enter a room that was previously a veranda. It is clean and tidy. It is brightly lit up and the air is cool and fresh. Mrs C. is 75 years old. She is sitting in this room. She suffers from osteoporosis and she has a lot of problems with her back. She walks with a great difficulty. She gets B12 injections. Her sister who has come to visit from Australia is also there to welcome us. She speaks English. After a while Mrs C.'s husband comes, too. Mr G., who is 78 years old and suffers from a fracture of the left hip. He has difficulty in walking.

They are all very polite with the nurse.

Mrs C. has sadness in her eyes, she looks solemn and depressed. Mr G. is also rather solemn and looks like something is troubling him.

Mrs C. has her feet up on a chair. "Ever since you advised me to place my feet high they are much better" she says. "She never gets out of this house to walk a bit" her sister complains. "I beg them to go out for a walk with me but no one comes" she completes and she goes on: "She gets angry because she can't do any housework and she fights with her care taker because she doesn't understand what she tells her."

The nurse measures Mr G.'s pressure and asks about his medication. She checks them. They are all placed on the table. The nurse has a seat there and checks them one by one. She is sitting next to Mrs C. one foot away. Mrs C. is obvious that she is in a bad psychological state. Her face is apathetic and depressive.

The nurse lifts Mrs C. up and gives her the injection. She is fast but careful and sure about what she does. She is confident and decisive. They invite the nurse to have lunch with them. She denies politely.

Mrs C. is showing of her English knowledge. She explains to the nurse that she had studied at a private English school in Kyrenia. "Now the Turkish live there" says her sister and they all agree.

Mr G. gives to the nurse a box with a pen in it that Mrs C.'s sister has brought from Australia. The nurse doesn't want to accept the present but Mr G. insists and at the end he convinces the nurse to accept in order to please him.

Mrs C.'s sister suggests that they should both patients go to a nursing home. For the first time you can see some real spark and interest in Mrs C.'s eyes. "I want to but my husband doesn't" she says. Mr G. doesn't say anything but he looks really sad and troubled. "They won't be able to manage by themselves in a year from now" her sister continues. "They have no idea where they put their staff. They waste their money on the care taker and they also spend money so that you come here and offer them the care they need. In the nursing home they will take good care of them" she adds.

The nurse listens to her carefully without interrupting and when she finishes she explains the positives and the negatives of nursing homes and tells her that in Cyprus these places are very different from what she has in mind in Australia. She also explains that these kind of nursing homes cost a lot. Then she stresses out that patients don't give money directly to her for the visits.

Then the nurse informs them about their next appointment and tells them that she will also call them to check how they are doing. She says goodbye and we leave.

OBSERVATION 11

28/06/2012

We are in an old traditional stone house in the village. It is sketchy and small but very clean and tidy. Next to the chairs and a small table that the couple is sitting there are also two single beds. It looks like they spend some hours of the day resting in that room.

Mr E., 90 years old, and his wife 70 years old, are sitting in the back yard. Mr E. has a fracture of the left hip and he has injections to prevent the formation of blood clots. He had walked after the accident but then he fell again and broke his leg. A sore wound was created at which he didn't pay any attention and dirt and flies would sit on it infecting in and creating the formation of warms inside it. The nurse had noticed that at her previous visit and sent him straight to the hospital to treat that wound. He also suffers from overgrown prostates. His wife Mrs E. has had her aortic valve replaced and she has to conduct regular tests to check the density of her blood. She also suffers from high pressure.

Mrs E. is waiting to welcome us with her arms wide open. She hugs and kisses us. They are both smiling and they seem very kind people.

The nurse asks them how they are feeling. “We are struggling” Mrs E. says. The nurse turns to Mr E. and asks him: “Was she in pain? Did she take her pills for the pain?”. Mr E. says that she took the pills but the pain didn’t stop. The nurse treats his wound while they are talking. Mrs E. asks the nurse if she knows when the cardiologist will come at the health centre. The nurse tells her that he is always there but before they go it would be better to call just confirm that he will be there when they go. She also asks about the male nurse who changed his catheter the last time so that they can call for him to come and change it again. The nurse offers to call him herself and arrange for him to come. Mrs E. explains to her that this male nurse changes the catheter of everyone in the village who needs a change, even though that is not within his duties, and he never gets money from them. He just does it because he feels good with himself. Other people have to pay for someone to change their catheter.

The nurse checks Mr E.’s pressure. She finds it really low so she asks him if he drinks enough liquids. She wants to know exactly how much he drinks every day. He says that he drinks more than two bottles a day. The nurse explains to him that if he doesn’t drink enough water besides his pressure that will be really low, his catheter will also be infected. She asks him if he has walked at all today and he says he has. “Let me see you walking” she says to him. He stands up and walks slowly. ‘There are people who accept their faith and they do not get depressed’ I think to myself.

Mrs E. explains that her back and head hurt today.

The nurse advises Mr E. on his nutrition. “Bravo Mrs E.” the nurse tells her, “You do take good care of him”. “Whatever the company you have, it is still a company for you. Even if he is ill, he is still my company” Mrs E. says.

The nurse wants to know how Mr E. showers. “Out here with the bucket” Mrs E. says. The nurse gives directions to him as how to shower without letting any water touch his wounds.

She tells them that she believes it would be a good idea if they could hire a care taker to help them at home. “We get 700 euros a month” Mrs E. says, “if I give this money to a care taker then where would we find money in order to live? And what would a care taker do better than me?”

The yard is tidy and the atmosphere is fresh and cool. Everything is well taken care off and it is clean and peaceful.

Mrs E. is complaining about the indifference that Mr E.’s children show to him. Mr E. has 3 children from his first wedding. They don’t have any children together. “They never come to see him” she says. “And when they come they don’t bring him a cake or something. Next time they come I will give them some money and tell them to go and get something for him. His daughter used to come at nights and help a little bit when she came back from the herds. Now nothing.” The nurse is listening but she doesn’t say anything. Mrs E. goes on: “I want to die.” “What would Mr E. do then if you die?” the nurse says immediately. “Whatever he wants” says Mrs E., “If I die they will send him to a nursing home. That’s for sure.”

The nurse advises Mr E. to walk more, and when he rests to place his feet high. The nurse also notices a small rug that is right in front of his chair, and she asks Mrs E. to remove that because Mr E. might trip over it and fall. She stresses out that if he falls and breaks his leg again he won’t be able to recover. Mrs E. agrees with the nurse but she says that he wants it there. At the end they manage to convince him to let them remove it. The nurse tells them when their next appointment is for cleaning his wound and take blood for his tests.

She says goodbye and we leave.

When we arrive at her car the nurse shows me the equipment she has at the back of her car (bandages, testing tubes for blood tests, catheters, oxygen mask, medicines, pressure gauge). She explains to me that she carries all that with her in case there is an emergency in one of the villages she goes to. She wants to be ready to offer help.

Appendix Q: Observation of a Nurse's Working Day at Home Care

13/06/12

It is Thursday. In the morning the nurse of home care visits two houses from where she takes blood from the patients for tests. Then she has to rush back in order to have it at the centre before the messenger who is responsible to take them to the chemistry laboratory leaves. At 9 o'clock I meet her at her office. The office is small and packed. There is only one window. The furniture is old. There are files and papers everywhere. It is obvious that they don't have enough storage space. Three nurses work together in one small office. The phones don't stop ringing. Two nurses speak on the phone at the same time as they do not have any other choice. I wonder how they can concentrate and how they don't get headaches having to work in that way. They are all full of energy. They answer the phones politely and are willing to offer any kind of information and help they can. It is hot. There is an old air-condition in this room which the nurses chose not to use for obvious reasons. The curtains in that room are also really old. In the same small room there is also a sink with antiseptic liquid and right next to it a small fridge for water.

I admire them. I am surprised they know what they are doing lost in all those papers. From time to time they talk to each other and they discuss things that happened during their visits and that still trouble them. They talk about the news of their patients, and what the patients tell them during the phone calls. They try to help each other solve problems of their patients that bother them.

Around 9:30 I leave the office with one of those nurses. She is about 40 years old. We leave from there to go to the home care visits she has to do for the day. We drive in her car to 4 different houses where she attends to 5 patients. I notice a progressive fatigue taking her over as the day progresses. This fatigue is not only a physical one but also mental and emotional. All nursing procedures are executed as fast, correct and precise from the first to the last visit. She is observant, her thoughts are clear and there is clarity in her speech all day long.

Physically I notice signs on her body that show she is becoming progressively fatigue. I can notice this in the way she walks and the way she moves. Even I feel tired and I don't do anything but sit in a corner and observe. The fact that she has to move from one place to another by car and the traffic, the alert state that she has to be at all times so

that she doesn't get lost in the roads, even the hot weather, the difficulty in finding a parking place, and carrying all the necessary equipment, are certainly the factors that contribute to the nurse's fatigue.

What comes up more intensively in my observations though is the mental and psychological tiredness that I notice on the nurse. The nurse feels the pain of the patients, sometimes she feels sad, gets angry, disappointed and worried. Her brain must be alert permanently so as to find solutions in different problems. From every house we left I felt that the nurse carried a piece of what she faced in there. If the things that she witnessed were nice and pleasant she was happy. If not she was thoughtful and sad. I could understand that she was still thinking of what she had just seen or heard, and that her mind was trying to work out solutions. As we moved from house to house all the negative experiences would gather and the nurse carried them with her, making her shoulders feeling heavier and her body more and more tired. This burden she had to carry with her even altered her face characteristics on which you could see the agony she felt.

I could feel that she was upset at moments because she couldn't do anything more for her patients. She was upset that she couldn't interfere in order to do something more to help the patients improve their lives.

At this point eye contact is also progressively reduced.

The nurse has a very difficult mission in every single house she visits. She has to adjust first of all according to the patient's and any relatives' or care takers that live with each patient. She has to adjust according to their age, gender, educational level, social level and health problems.

The nurse has also to adjust to the natural environment whether that is comfortable or not, clean or dirty, tidy or untidy, fresh air or stuffy, cold or hot, on a small uncomfortable chair or a comfortable one, well lit or dark, having the basic materials or not.

These circumstances demand that the nurse should be alert at all times, full of energy and have a high level of communicative and emotional intelligence skills. All this naturally leads to fatigue. I noticed that the nurse refused to eat or drink anything at the homes she visited. From 9 o'clock to 1 o'clock when she returned to the office she

didn't have anything to eat or drink besides some water that she carried with her in her car. When I asked her why, she explained to me that if she did she would need to go to the toilet at some point, thing which she didn't want to do at one of the patient's houses because she felt uncomfortable. In her car she also carried a bottle of antiseptic liquid which she used to clean her hands after the visits. She avoided washing them at the patients' houses.

When we returned to the office the same chaotic situation existed. It was hot. The window was open and fresh air came in but at the same time the noise of the cars too. The nurses now made phone calls to set the appointments of the next day and fill in forms...we drunk some water, and went to the toilet. The nurses in the office talked about their day and things that happened during the visits they had that day which was more intense, and they tried to help each other find solutions. It was then that I had realised that they didn't have an internet connection and therefore they neither had electronic mail. The only mean of communication was the phone.

At 2:30 their working day finished and they left.

The nurse's words were characteristic: "In home nursing care you can make interventions when you want to make a difference. You feel happy that your patients show you their love. You feel satisfied. When you work in a hospital is not the same. The things there, are more impersonal. However, home nursing care can be very troubling. You go home and all these thoughts never stop hunting your mind and sometimes you just don't feel well!!"

Appendix R: Samples of field notes taken after the patients' in depth interviews

After each patient's interview the researcher took some time to reflect on her impressions which she wrote down and are found here below in this section.

Interview 1: Ms. H.

A really sweet grandmother 88 years old. She broke her leg 4 years ago and she cannot move without holding a walking aid. She is always smiling. She is in a good mental state. She is willing to talk to me. In her eyes there is sadness-loneliness. She wants company.

Courteous. She lives with her housekeeper in an old traditional house with a yard, where she lived her whole life. The furniture is old. Poor. The home has only the necessary staff. The house is clean and tidy but unmaintained both the house and the yard (needs to be painted, etc.).

Interview 2: Mr. A.

He is 82 years old. Nice, polite and educated. He told me that he was a professor of Economics, but later on I found out from his sister that he was the owner of a private school in Cyprus that operated until recently. He is a serious gentleman. He has complete clarity. His physical condition is poor due to diabetes. His vision is seriously limited. In order to move around in the house he needs the help of his housekeeper and his sister. He is not married. He has no children. His house is old but big, not a traditional house, it is of the 60s or 70s. He lives from a really young age with his sister who lost her husband. The house is clean and tidy. It is tidy and well enough maintained.

He is in a quite good mental state even though you can sense the disappointment he feels because he cannot do anything he wants by himself and he has to depend on his sister and his housekeeper. He looks eager to speak. He has got great clarity in thought and language. He is a humble man.

Interview 3: Mr. L.

He is 66 years old. He lives in an old, traditional house in the old city of Nicosia. The house is tidy, clean and well maintained. He lives with his wife. He needs oxygen in order to breathe normally. His wife is always with him. If she goes away for a while the patient remains alone.

He is in the last stage of heart failure, and he has also nephropathy, prostate, hernia (after a surgery caused by the fact that they couldn't give him whole anesthesia, they just took a part of the herniated outwards, and now his belly is really swollen).

He sits all the time with his oxygen bottle. He is tall. He is polite, kind and willing. He gets easily tired. He keeps his voice down when he speaks because he gets tired. His wife is smiling and willing.

Interview 4: Mr. C.

He is 60 years old. He suffers from pulmonary due to smoking as well as his profession. He worked in pottery and he also had an Excavator-he inhaled a lot of dust. He lives on oxygen. His mood is very good. He is smiling, polite and willing to talk. He gets tired when he speaks. In general he is very active, as much as his physical condition allows him to. Just before my visit, he had gone by himself to the migration office to renew his housekeeper's license in Athalassa Avenue (a fifteen minutes' drive by the car) and he carried his oxygen bottle at the back seat of his car. He lives in a very small, humble house at the back of the main house. It is clean and tidy. He has a small cat for company. He is sad because he cannot go anywhere without the oxygen bottle. He needs company. He invited me to stay for lunch. When I was leaving he made an attempt to ask me again but then he repented. His sister lives nearby. Loneliness. He needs company. When I asked him if he would like to have the chance to meet with other patients of Home Care, he responded negatively, saying: "Why should we meet? So that we can tell each other how much worse is our health and when we are going to die?"

Appendix S: Statistics of Cyprus Statistical Service (CYSTAT) and Ministry of Health of Cyprus

Table 1: Gross Domestic Product Values for Cyprus 1995-2013 – Cyprus Statistical Services 2014

Gross Domestic Product Values for Cyprus 1995-2013									
2013	2012	2011	2010	2009	2008	2007	2006	2005	2004
16,503.7	17,720.2	17,878.0	17,406.0	16,853.5	17,157.1	15,829.7	14,432.5	13,402.0	12,522.3
-6.9%	-0.9%	2.7%	3.3%	-1.8%	8.4%	9.7%	7.7%	7.0%	7.7%
	2003	2002	2001	2000	1999	1998	1997	1996	1995
	11,630.6	10,892.3	10,547.7	9,756.0	9,007.6	8,367.2	7,733.5	7,385.4	7,087.7
	6.8%	3.3%	8.1%	8.3%	7.7%	8.2%	4.7%	4.2%	

Table 2: Population of Cyprus per AGE – Cyprus Statistical Services 2011

	AGE																		Not Declared	
	Total	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+		
2011	840,407	45,015	42,635	47,298	55,818	66,073	74,114	69,834	61,862	59,728	57,240	56,128	47,762	45,034	36,328	29,433	21,058	24,948	99	
		134,948			593,593									111,767						
	100%	16%			71%									13%						0%
2001	703,529	43,958	53,386	53,973	55,619	53,475	49,830	49,134	52,524	53,263	46,431	43,383	35,202	31,325	25,924	21,362	16,278	18,462		
		151,317			470,186									82,026						
	100%	22%			67%									12%						
1992	602,025	152,055			383,803									66,167						
	100%	25%			64%									11%						

Table 3: Population of Cyprus per Nationality – Cyprus Statistical Services 2011.

Total Population of Cyprus	
2011	862,000
Greek Cypriots	681,000
EU	113,300
Third Country nationals	67,700

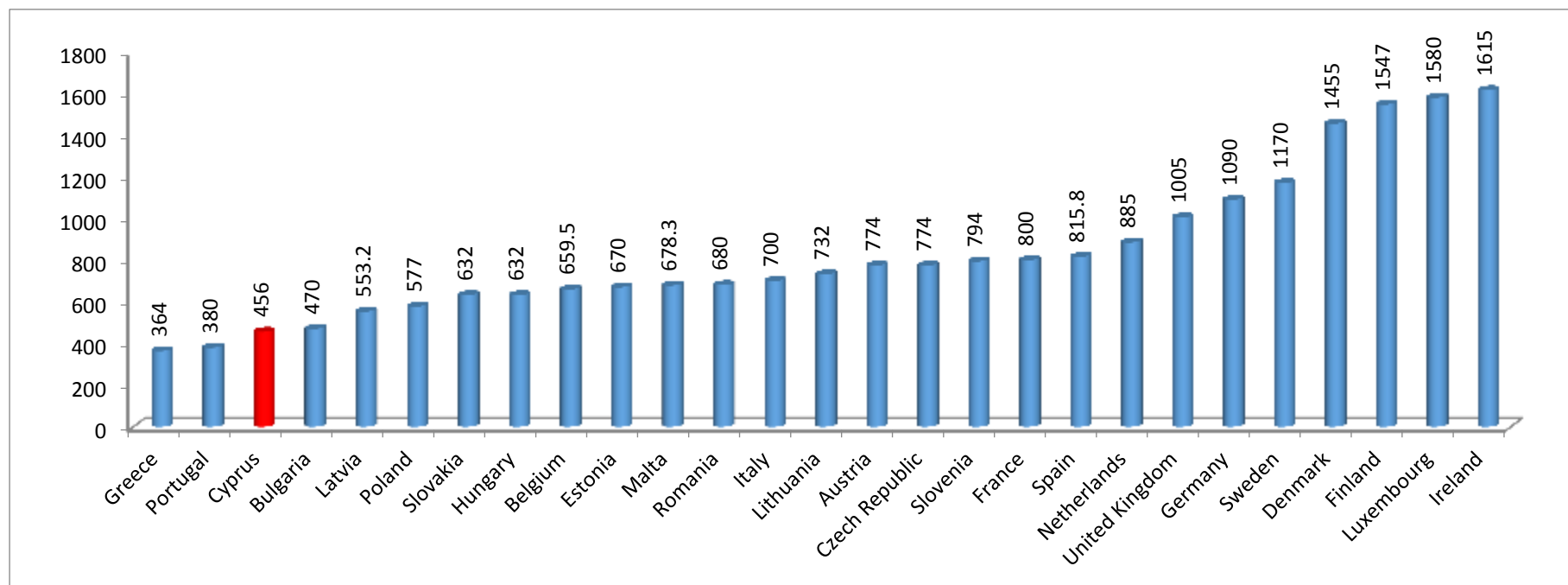
Table 3: Budget of Ministry of Health 1990-2012 – Ministry of Health 2012.

Ministry of Health Budget																						
2012	2011	2010	2009	2008	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1992	1991	1990
€ 609	€ 643	€ 642	€ 615	€ 526	€ 460	€ 424	€ 390	€ 374	€ 297	€ 261	€ 230	€ 215	€ 205	€ 189	€ 174	€ 157	€ 138	€ 119	€ 117	€ 105	€ 93	€ 80
-5.4%	0.2%	4.3%	16.9%	14.5%	8.5%	8.6%	4.5%	25.8%	13.9%	13.5%	7.0%	4.7%	8.2%	9.1%	10.9%	13.7%	15.6%	1.6%	11.5%	13.0%	16.3%	

Table 4: Cyprus Expenditure in Health 2003-2011 – Ministry of Health 2011.

General Indicators	2011	2010	2009	2008	2007	2006	2005	2004	2003
Total Expenditure in Health (billions)	€ 1.31	€ 1.26	€ 1.19	€ 1.06	€ 0.98	€ 0.91	€ 0.86	€ 0.77	€ 0.73
Change	3.8%	5.8%	11.8%	9.0%	7.9%	5.9%	11.4%	5.3%	
Public Sector (millions)	€ 608	€ 575	€ 551	€ 517	€ 458	€ 451	€ 391	€ 367	€ 368
Change	5.8%	4.2%	6.7%	12.8%	1.6%	15.4%	6.6%	-0.4%	
Private Sector (millions)	€ 700	€ 685	€ 639	€ 548	€ 519	€ 454	€ 464	€ 401	€ 361
Change	2.1%	7.2%	16.6%	5.7%	14.2%	-2.2%	15.8%	11.1%	

Table 5: Practicing nurses per 100 000 inhabitants in 2008



Sources:

Cyprus Statistical Service, 2008, Health and Hospital Statistics AND

Joint Report on Health Systems, COUNTRY FICHES prepared by the European Commission (DG ECFIN) and the Economic Policy Committee (AWG)

Note: the numbers for the countries of Portugal, Bulgaria, Slovakia, Romania, Italy, Lithuania, France, Netherlands, Sweden, Denmark, Finland, Luxembourg are a calculated from past years. Data for 2008 were not available on the above references

Appendix T: Report on Health System of Cyprus, European Commission 2010.

Statistical Annex - Cyprus⁹

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	EU - 2007	EU - 2008
Expenditure on health													
Total expenditure on health as % of GDP	5.5	5.5	5.7	5.7	6.1	6.6	6.4	6.3	6.3	6.0	6.8	6.3	6.6
Total expenditure on health per capita PPS	810	871	904	1025	1115	1245	1242	1295	1339	1405	1403	2295	2281
Public expenditure on health as % of GDP	2.5	2.4	2.4	2.4	2.7	3.1	2.8	2.7	2.7	2.6	2.5	7.2	7.4
Public expenditure on health per capita PPS	329	373	405	431	463	552	545	542	559	599	593	1756	1826
Sources: OECD, WHO and EUROSTAT													
Projected public expenditure on healthcare* as % of GDP													
	2010	2020	2030	2040	2050	2060							
	2.6	2.9	3.0	3.1	3.2	3.3							
Sources: 2009 EC-EPIC Ageing Report													
Expenditure drivers (income, technology, life style)													
GDP per capita PPS	14700	15600	16600	16000	18300	18400	19800	20400	21400	23300	24000	24673	25075
MRI units per 100 000 inhabitants	..	..	0.3	0.3	0.3	0.3	0.4	0.7	0.8	0.9	1.0	1.0	0.7
Angiography units per 100 000 inhabitants	..	..	0.4	0.4	0.4	0.4	0.4	0.8	0.8	0.8	0.8	0.7	0.6
CTIS per 100 000 inhabitants	..	..	1.6	1.6	1.5	1.5	1.7	2.0	1.9	3.5	3.5	1.9	1.1
PET scanners per 100 000 inhabitants	..	..	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Total pharmaceutical expenditure as % of GDP	..	..	..	..	..	1.4	1.3	1.3	1.3	1.2	1.3	1.5	1.5
Public pharmaceutical expenditure as % of GDP	..	..	..	..	..	0.3	0.3	0.3	0.3	0.3	0.3	1.0	1.0
Proportion of the population that is obese	..	..	..	..	..	12.3	..	..	..	..	..	16.3	15.2
Proportion of the population that is a regular smoker	..	..	..	..	..	23.9	..	..	..	..	..	22.7	24.1
Alcohol consumption litres per capita	9.0	9.3	8.3	8.8	9.0	10.0	9.9	9.3	..	..	..	11.0	10.8
Sources: EUROSTAT, OECD and WHO													
Health status													
Life expectancy at birth females	79.5	79.9	80.1	81.4	81.0	81.3	81.9	80.9	82.2	82.2	83.1	82.3	82.3
Healthy life years at birth females	..	..	..	..	..	69.4	..	57.9	65.2	62.7	68.1	62.3	61.6
Life expectancy at birth males	74.7	70.0	75.4	76.6	76.4	76.9	76.6	76.8	78.4	77.8	78.5	76.3	75.0
Healthy life years at birth males	..	..	..	..	..	68.4	..	59.5	64.3	63.0	64.5	61.5	..
Infant mortality	7.0	..	5.6	4.9	4.7	4.1	3.5	4.6	3.1	3.7	6.3	4.6	4.3
Sources: EUROSTAT, OECD and WHO													
Coverage and financing mechanisms													
Proportion of the population covered by public or primary private health insurance	..	..	..	..	..	..	..	..	..	..	..	99.5	99.5
Public expenditure on health as % total expenditure on health	41.9	42.7	41.7	42.4	45.0	45.1	43.8	41.8	42.4	42.6	42.1	77.3	77.3
Out-of-pocket expenditure on health as % of total expenditure on health	57.1	54.8	55.0	55.2	52.8	43.4	46.5	47.0	46.6	47.8	50.2	14.4	14.4
Sources: EUROSTAT, OECD and WHO													
Collection and Pooling of funds													
Total expenditure on health administration and health insurance as % GDP	..	..	..	..	..	0.2	0.2	0.2	0.2	0.2	0.2	0.4	0.4
Total expenditure on health administration and health insurance as % current health expenditure	..	..	..	..	..	3.6	3.7	3.5	3.5	3.7	4.2	4.6	4.4
Public expenditure on health administration and health insurance as % GDP	..	..	..	..	..	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3
Public expenditure on health administration and health insurance as % current health expenditure	..	..	..	..	..	3.7	3.6	3.4	3.4	3.6	4.1	3.3	3.1
Sources: EUROSTAT and OECD													
Providers													
Proportion of physicians with 45 years and more	..	..	..	..	..	..	..	..	..	..	..	60.8	63.6
Practising physicians per 100 000 inhabitants	252.0	255.2	258.0	260.7	260.8	267.3	262.3	267.8	260.4	271.5	..	324.1	321.5
Practising nurses per 100 000 inhabitants	..	..	..	..	..	..	..	..	..	..	..	830.0	879.2
General practitioners per 100 000 inhabitants	..	..	37.4	..	..	..	..	..	..	..	..	94.3	94.1
Acute hospital beds per 100 000 inhabitants	400.3	304.8	404.0	401.7	400.5	398.7	389.7	346.1	348.8	348.0	351.1	388.0	383.2
Sources: EUROSTAT and WHO													
Outputs													
Doctors consultations per capita	2.0	1.8	2.0	1.8	1.8	1.9	2.0	2.0	2.0	2.0	..	6.8	7.1
Hospital inpatient discharges per 100 000 inhabitants	..	..	8795	7031	6856	6821	6778	6617	6536	7500	..	16231	18081
Day cases discharges per 100 000 inhabitants	..	..	504	507	546	502	571	632	701	..	..	6120	5031
Hospital average length of stay	..	..	6.4	6.5	6.4	6.0	6.3	6.0	5.9	6.2	..	8.0	7.9
Day cases as % of all surgical procedures	..	..	6.9	6.8	7.4	7.7	7.8	8.7	9.7	..	..	28.1	20.8
Total pharmaceutical expenditure per capita PPS	..	..	..	..	..	253.4	256.3	267.3	273.6	286.1	303.9	406.6	416.1
Public pharmaceutical expenditure per capita PPS	..	..	..	..	..	62.2	51.6	60.3	60.0	66.0	72.2	280.0	284.2
Total pharmaceutical expenditure as % of total current health expenditure	..	..	..	..	..	32.4	32.2	32.0	31.2	31.1	31.7	17.1	16.9
Public pharmaceutical expenditure as % of total current health expenditure	..	..	..	..	..	5.5	4.5	5.0	4.8	4.8	5.2	11.5	11.2
Sources: EUROSTAT, OECD and WHO													
Health promotion and disease prevention													
Total expenditure on prevention and public health services as %GDP	..	..	..	..	..	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.3
Public expenditure on prevention and public health services as % of GDP	..	..	..	..	..	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
Total expenditure on prevention and public health services as % total current expenditure on health	..	..	..	..	..	0.6	0.6	0.6	0.6	0.7	0.7	2.7	2.7
Public expenditure on prevention and public health services as % of total current expenditure on health	..	..	..	..	..	0.5	0.4	0.5	0.5	0.5	0.6	2.3	2.1
Proportion of infants vaccinated against polio	98.0	97.0	97.0	97.0	98.0	97.5	97.5	97.5	96.5	96.5	97.0	95.0	95.8
Proportion of women 20-69 screened for cervical cancer	..	..	..	..	..	..	..	..	..	..	..	59.2	49.3
Proportion of women 50-69 screened for breast cancer	..	..	..	..	..	..	..	..	..	..	..	66.9	62.7
Sources: EUROSTAT, OECD and WHO													

* Projected public expenditure on health care excludes expenditure on long-term nursing care and expenditure on services not allocated by function.

⁹ The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units and units of staff where relevant. The EU average for each year is based on all the available information in each year. For some indicators this could create some discrepancies when very few data are available, especially for 2008.

Appendix U: Executive Summary for the Ministry of Health

EXCECUTIVE SUMMARY

Mr. Andreas Xenofontos

Director of Nursing Services, Ministry of Health of Cyprus

13 August, 2014

A report investigating ‘Patients’ satisfaction received from nursing staff in the Home care programme run by the Ministry of Health in Cyprus’ and suggestions for its improvement.

This document is an executive summary report on the research project on ‘Patients’ satisfaction received from nursing staff in the Home care program run by the Ministry of Health in Cyprus’.

This executive report aims to provide recommendations to the Ministry of Health emanated from the findings of this study, related to individual and organizational development interventions for providing more support to the Home care nurses, higher quality of care to the Home care patients within a client-centred environment and feedback strategies. Additionally, it provides recommendations for the advancement and continuous education of the Home care nurses.

Mrs Maria Leonidou., M.D.

Lecturer at the European University of Cyprus.

This project aimed to investigate 'Patients' satisfaction received from nursing staff in the Home care program run by the Ministry of Health in Cyprus' and it was undertaken by Mrs. Maria Leonidou. The project will be submitted to Middlesex University, National Centre for Work Based Learning Partnerships, Middlesex University in partial fulfilment of the requirements for the degree of Doctor of Professional Studies in August 2014.

The researcher is a Medical Doctor by profession and she has practiced medicine with experience in the public hospitals in Cyprus. The researcher has been a lecturer in medical related subjects for the past twelve years. She is currently a lecturer at the School of Sciences of the European University of Cyprus, a position that holds for the past 8 years.

The main purpose of this study was to investigate the home care patients' satisfaction from the nursing care they received, at the public Home care program in Cyprus.

Patients' satisfaction has become an important part in evaluating the quality of health care services. Patients are the ones, who can identify better than anyone else the aspects of nursing care which need improvement.

Thome et al (2003), define Home care as the care provided to patients by professionals at their homes, covering a wide range of activities, from preventive assessments and actions to end of life care, and aims to contribute to the patients functional health status, improve their quality of life, maintain independence and minimize hospital care. Home care prevents or postpones institutionalization, keeps families together, promotes healing, and in contrast to the institutions it allows maximum freedom for the individual (Longo, for the World Health Organization, 2008). In a world where the majority of people will become the elderly; with multiple chronic diseases and a progressive social exclusion and with increased financial difficulties, there is an enormously rising need for home care services. Home care services are quite new and still developing in Cyprus while the need for these services is increasing rapidly.

As Davies and Ware (1988) support patients' satisfaction is a valid and warrant indicator of the quality of health care.

In home care, patient satisfaction is based on the quality of services offered by the various health care professionals even though

'The highest measure of quality was attributed to the client's perception of nursing care' (Schmele, 1985: 120).

Wagner, (1988), states that health care providers should view home care patients' satisfaction as a reality; a subjective perception which reflects the quality of nursing care and understand that

'...quality of care as measured by patient satisfaction is most closely tied to patient satisfaction with the quality of nursing care because most health care is nursing care'

This study, utilized the well proven and validated instrument entitled the Quality of Care from the Patients' Perspective (QPP) survey questionnaire (Wilde et al., 1994), in depth semi-structured interviews and observations. The questionnaire was delivered to the Home care patients who received long term care during the period of the survey. A purposive sample was used for the interviewees of the patients, the nursing staff and the management staff of the Home care program and for the observations of the Home care visits.

It involved self-reported survey questionnaires that were distributed between February 2011 to May 2011 to Home care patients receiving long term care and had been enrolled in the program for more than two months prior to the survey, were over 18 years old and they were patients with sound judgement and able to communicate; 112 questionnaires were answered and they were analysed by Statistical Package for the Social Sciences (SPSS). The survey questionnaire was followed by in depth interviews to 9 home care patients, 5 home care nursing staff and 3 home care managers and by observing 11 home care patients' visits and a nurse's working day.

The results of this study showed that the home care patients of the public Home care program in Cyprus are very satisfied from the care they receive from the home care nursing staff. More specifically, the vast majority of the respondents of the survey questionnaire (around 90 to 95%) answered either *'fully agree'* or *'mostly agree'* to all the statements of the QPP questionnaire concerning the perceived reality of their care in the various items in all four dimensions. At the same time the vast majority of the respondents answered that the items in all statements were *'of the very highest importance'* or *'of high importance'* for them. The quality of care, QPP index was found of the highest score in all

items related to the care the patients' receive. The findings of the survey questionnaire were also supported by the qualitative research findings.

There was only one statement in the survey questionnaire with lower score in satisfaction; '*My medical care was controlled by my own desires rather than by the district nurse's procedures*'. Almost half of the respondents (40, 9%), answered that they '*partly agreed*' or '*do not agree at all*' that their medical care was controlled by their desires rather than by the district nurse procedure.

The respondents stated especially satisfied with the elements relating to humane approach; the politeness, the interest and the caring of the nurse, the medical competence and the information and advising provided to the patients. These findings were also strongly supported by the in depth interviews' and the observations' findings.

Additionally, this study surfaced the aspects of the nursing care which the home care patients consider more important and highlighted the characteristics of an ideal home care nurse through the patients' eyes; placing the humane approach as the most important aspect, followed by the psychological support provided and the nursing knowledge. Interesting enough, a deviation was identified in the nursing and management views, which placed the nursing knowledge first, followed by the leadership skills and the humane approach only third.

This study also identified those problematic areas of the program which negatively influence the nursing services; as the participants stated these were the absence of a team of health professionals in the program, the limited operating hours, the non-implementation of the concept of prescribing nurses, inadequate technology, insufficient financial support of the program, and the cumbersome procedures of the public sector.

At the same time, through the interviews and the observations, this study identified a deficiency in the abilities of the nursing staff to provide psychological support in difficult cases, even though they were very willing to do so. This accentuated the lack of a team of professionals in home care. Additionally, the need of the home care patients for help in the activities of daily living (ADLs) was revealed through the interviews and the observations.

Home care patients' satisfaction from the nursing staff is very high; yet there are some areas which need improvement. Recommendations emanated from the project include

individual and organizational development interventions for providing more support to the home care nurses, higher quality of care to the home care patients within a client-centred environment and feedback strategies. Recommendations also include the enhancement of the nursing undergraduate education in nursing and the creation of a post graduate degree in home care nursing, with the inclusion of courses and workshops on the psychology of home care patients, on gerontology, communication and leadership skills.

More specifically are the following recommendations to the Ministry of Health of Cyprus.

Training seminars including experiential workshops

The researcher suggests continuous training seminars to the existing Nursing staff of Home care on areas that the research project identified that there is room for further improvement. These training seminars and experiential workshops should focus on psychology and on communication skills with a concentration on elderly people and on patients with chronic diseases.

The needs of the home care patients and the communication challenges of home care are different and distinct compared to the needs of the patients of the public hospital. The relationship '*nurse-patient*' is different and the psychological support required to these patients is more demanding and vital. Furthermore, it was identified in this study that there is room for improvement when it comes to the nurses allowing the medical care to be controlled more by the patients' desires rather than by the home care nurse's procedures. This new attitude can be cultivated through training seminars and experiential workshops.

The researcher also suggests that the Ministry of Health encourages the future home care nurses to attend a post graduate degree in Home Care Nursing. To the same lines, the researcher suggested to the European University of Cyprus the formulation of a post graduate degree in Home Care Nursing. This degree will attend all the identified areas by this research that needed improvement and the areas that were considered as the most important for the patients.

Selection criteria for the future home care nurses and the introduction of the financial bonding principle.

The selection of home care nurses is of primary importance for safeguarding the present and future quality of the program. The two pillars that the selection of the future home care

nurses should be based on are their attitude relating to the humane approach to the patients of home care who are by majority elderly people with chronic issues and on the level of nursing knowledge and leadership skills.

Once selected the home care nurses should be encouraged through sponsorships to go through a post graduate degree which specializes on home care. It is only fair and common practice on all cases of sponsorships that there is a financial bonding period thereafter. The suggestion is to bond the new nurses to serve at home care for a minimum of five years. This will hopefully appeal only to the nurses who genuinely want to work and offer in home care and at the same time deal with existing practices where nurses sometimes enroll on any convenient post graduate degree for the mere purpose of getting a qualification towards a promotion, which could invariably be in other departments.

Nurses eligibility to prescribe basic medication and consumables

The existing procedures within the Home care program with regards to the prescription of simple medication and consumables required by the patients are presently unnecessarily inefficient and cumbersome because they require the approval and the prescription by medical doctors, whose main line of work, is at the public hospitals, thus creating discomfort and difficulties to the patients. Instead, if the nurses of home care were eligible to prescribe simple medication and consumables, the issue would be resolved for the benefit of all involved, something which is a common practice at some other European countries.

This research recommends that the challenge of *'role change'* for community nurses, which in other countries became widely integrated into nursing practice over the last decades, should also be taken up by the management of Home care of Cyprus; if the nurses could directly prescribe for the basics, there would be a great benefit to increasing efficiency, eliminate lead times, enhance the quality of patients' nursing care and increase patient satisfaction. The implementation of a major role change such as nurse prescribing requires adequate education and training and a comprehensive knowledge of pharmacology. It also requires the acceptance of the new role for the nurses, by the physicians with the need for a formulary that will meet the physician's needs (While and Biggs, 2004).

It is also important to carefully select the nurses who will attend the training to become prescribing nurses which in turn will enhance their role in nursing (Department of Health of England, 2002).

The researcher suggests that the selected prescribing nurses participate in a prescribing nursing course which will educate the home care nurses with sufficient knowledge as described above to take up the responsibility of a *'prescribing nurse'*.

Finally, a piloting program should follow up, involving role rehearsal in order to facilitate the acceptance and support of this new nursing role by the physicians, should the change be finally successful.

The formation and inclusion of a team of other medical professionals in the program

The only medical professionals in the Home care program are the home care nurses who are called to support the patients on areas that otherwise a health professional of a different specialty would do. Irrespective of how hard the nurses attempt to fill in the gaps created by the lack of physiotherapists, psychologists, doctors, they cannot substitute these expertises. For this, and in order to achieve a holistic approach, it is suggested that a team of health professionals be formulated in order to support the nurses task and deal with the patients' issues promptly, more efficiently and more effectively, which will result to the harmonization of many aspects of the operations for a clear benefit to the patients.

A usual criticism of home care services is that multiple services are provided to the patients by different providers, and very often this lacks coordination (Low, 2011).

Therefore in some programs, case management was introduced to coordinate the multiple services focusing on the individual consumer needs; case management was found to improve clinical outcomes and decrease the admissions to the hospitals and the nursing homes and at the same time decrease the use of the services (Low, 2011).

As Aguzzi, G. et al. for the World Health Organization (2008: II) states

'...the technological innovation together with new and modern forms of service delivery organization can represent a viable solution to developing home care in Europe provided that health care systems can further enhance integration and coordination.' The researcher suggests that case management be recruited by

experienced nursing personnel because nurses are closer and have a more personal relationship with the patients.

Operations of the program on a 24/7

The patients of the Home care program are invariably elderly people with limited financial capabilities, either living alone with their spouse or their caregiver. Throughout this research, it was emerged that these patients not only need care on health related issues and on activities of daily living, but their needs also extend to emergency incidences, psychological support and advice and guidance and it is evident that these cannot be confined to a specific and limited time constrains; hence the suggestion to study the possibility to increase the coverage of the program to a 24/7 basis. This could be accomplished as a full scale coverage from the start or incrementally. For example a first step could be the introduction of a 24/7 telephone service for advising and guidance as required. However, the details of how to implement it, and the analysis based on opportunity cost, rather than the mere financial cost, would be the product of a different study which this research also suggests.

Easier access to required medication and consumables

Within this study there were instances where the emerged suggestion called for the nurses to deliver themselves the required medication and consumables to their patients. The researcher does not adopt such suggestion as it is far beyond the duties of the home care nurse. However, the issues surrounding the difficulties that the patients face in acquiring their medication and consumables must be resolved. One cannot expect an elderly patient with reduced mobility, who requires assistance and depends on others, to frequently visit the distant public hospitals and join a long queue to get his medication; not to mention that this has to be taken place within the working hours of the civil servants which are limited until early afternoon.

This study suggests that the required medication become available closer to the patient's homes. One suggestion could be to utilize private pharmacies as outlets of the required medication, through a general agreement between the government and the private sector (it should be noted that once NHSC operates the problem will be resolved and no special agreement will be needed). Another option which could be possibly implemented faster

would be to utilize the local medical centers as outlets of medication and consumables for the patients of that specific area.

Cost of equipment required for specific treatments

Some types of treatments require specific equipment which it is not provided by the Home care program and as such the patients must bear the cost to purchase them. Understandably the provision of the required equipment by the program would bear an additional cost, however this has emerged as a factor of dissatisfaction by the patients.

One could argue that this is not directly related to the ‘*services*’ provided by the nursing staff, but it does however affects the overall services offered by the program, hence it was decided that it was worth bringing it to the attention of the management, offering some possible suggestions that could formulate the baseline for alleviating the cost to some of the patients. Some equipment, such as a walking assistance device, is in some cases of a temporary use and there is no need for it by the owner once the specific treatment is ended. These equipment, could then be used equally well by other patients.

The suggestion is therefore to form a system whereby used equipment in good condition could be made available to patients. Varieties of this idea could be explored, one of which would be the hiring facility of used equipment by the patients which would only be at a fraction of the purchasing cost. The management should endeavor to provide an improved solution to the present situation.

Common protocols for specific treatments

It has been identified that there were some communication issues between the nurses and the doctors, one area of which was the case of the medical doctors at the public hospitals giving instructions to the nurses to follow specific treatments. These, however differ from one doctor to another for the same medical case, which frequently confused the nurses and possibly affected the treatment of their patients.

The suggestion is borrowed from common practices found in most hospitals whereby common treatment protocols are established and these become policies that all the doctors agree upon and follow. These common procedures minimize the chance of misunderstandings and increase the situational awareness of all the medical staff involved in the patients’ treatment, including management.

The need to formalize the cooperation of all the stakeholders of home care in the society

The researcher also suggests that the management should set the target to formalize agreements between home care and other organizations, such as the local municipalities, Non-Government Organizations (NGOs) and charity organizations in order to become real and active stakeholders of the program and to facilitate their capabilities and financial aid where needed, according to the individual needs of the patient. These other organizations are already stakeholders in the sense of their duty and purpose, in terms of their citizens' welfare and wellbeing, hence it is not only logical but an obligation by the nature of their purpose, for them to get formally involved and allocate resources in the home care within their geographical jurisdiction.

The need to include the Activities of Daily Living (ADL) in the offerings of the program

The researcher also suggests that the ADLs should be included in the duties of the homecare nurses. However this service should be offered on a case to case basis and only when it is needed. This will most possibly require the time of the nursing visit to be lengthened and as a result the employment of more home care nurses. At the same time and in the same context the program should provide official and structured training by the nurses to the caregivers and volunteers according to the individual needs of the patient in order to best cater for the ADL of the specific patient on those days that there is no scheduled visit. If the implementation of the ADL's in the nurses duties is not possible, then cooperation with the municipalities could cover this need by volunteer caregivers trained for the ADL's.

Strengthening of Middle Management capabilities

To manage line personnel, it is vital that the manager has first-hand knowledge and experience of the line job. At the same time middle management should be educated to have a good understanding of general management principles and best practices.

In order to enhance the future managements' expertise it is suggested that managers should have a post graduate degree, preferably a Masters' in Public Health (MPH) or a Masters in Public Sector Management (MPSM), with emphasis at the subjects of leadership, communication skills, decision making, managing and controlling and process innovation to be eligible for the position. Additionally, a five years' experience in Home Care Nursing is also suggested as an obligation for this position. A financial bonding and an obligation to serve the program for at least 5 years should be enforced in order to safeguard that internal human resources are utilized appropriately and cost effectively, and at the same time build and safeguard internal management experience and expertise.

ICT and back office automation

Office automation and the utilization of available Information and Communications Technology (ICT) is well lagging behind modern practices and certainly influencing the productivity of the program. It is suggested that the home care nurses are provided with laptops with appropriate software, access to internet and email, faxing and printing, GPS and mobiles. This will boost the productivity on day to day operations, improve communications and record keeping and increase the patients' satisfaction.

Additionally, the implementation of a CRM (Customer Relationship Management) system supported by relevant software will increase case awareness for the needs of each patient.

On the same line, the implementation of a Centralized Patients' filing system would have a major impact to case management, office automation, productivity boosting, feedback and valuable data for needs analysis and future planning and expansion.

National Health System of Cyprus (NHSC) (GESY)

Although not of the immediate research area of this study, the researcher identified a number of important benefits, for the future of Home care program should it be included in the National Health System of Cyprus (NHSC), which is therefore the researcher's strong recommendation.

The benefits for the Home care program if the program is included in the NHSC are summarized here below:

- All citizens will gain equal access (if specific conditions are met) at the home care services and within the NHSC a complete health care service package can be offered.
- Within NHSC, each patient will be registered to a personal Doctor who will have the responsibility to coordinating access to the available home care services and NHSC services according to the individual patient needs.
- Each patient will be registered within the centralized computerized on line system of NHSC which will further optimize treatment, feedback and seamless follow up resulting to better treatment outcomes, better quality of life for the patient and at the same time minimizing waste of resources.
- A smooth and integrated cooperation between the hospitals and home care will be feasible resulting to the depopulation of the hospitals; patients' post operating treatment will be done at the patients' home within home care. This will liberate the load of the hospital nurses and at the same time will minimize treatment expenditure since hospitalized treatment is proved to be more costly than home care treatment for the same case.
- A centralized coordination and management of supplies and services will enable utilization of economies of scale to minimize the cost of services, consumables and human resources.
- The financial future of Home care program will be safeguarded within the NHSC and will be unrestrained from political variations that can affect its financial resourcing, planning and development. At the same time each patient will feel more secured if treated within the wider NHSC system.
- Competition between the health care providers will be promoted as a founding principle of NHSC. As such the private sector will have the opportunities and be allowed to provide alternative home care services in addition to the government. Home

care program, resulting to healthy competition between more than one provider and hence more choices for the patients. This will in turn improve the quality of the overall services provided.

A final word

Home care can possibly prove to be one of the most important tools to contain the continuous growth of healthcare costs. It reduces the hospital stay duration of the patients, it prevents the health deterioration of patients and it reduces rehospitalisation.

In the European countries, the Home care programs are evolving in an effort to support the vulnerable increasing group of elderly people who are progressively socially excluded, have financial difficulties and face multiple chronic diseases. The increasing focus on the provision of patient-centred services creates an emerging need of reconfiguration of the existing health care systems in order to improve response time.

'Home healthcare is the most logical and cost-effective alternative to other sub-acute services, such as nursing home stays or extended hospital visits for recuperative and chronic disease care. Patient satisfaction is high, clinical outcomes are positive and home healthcare is more cost-effective than nursing home care or additional days in hospital. Advances in technology and development of protocols for managing chronic diseases have made home healthcare the preferred approach to chronic care and disease management' (Alliance for Home Health Quality and Innovation, 2008)

As Johansson et al., (2002) indicate, in order to improve the quality of care, the satisfaction of the patient must be carefully examined; the patients' satisfaction will ultimately determine the quality of care provided and will specifically offer nurses the necessary feedback to improve patients' care.

The findings and the conclusions of this research project provide feedback on the quality of care of the existing nursing care provided by the home care nurses in Cyprus as this is viewed through the patients' eyes, alongside with feedback by the nursing staff and the home care management. The findings reveal the high quality of home nursing care provided to the patients and the high standards of the home care nurses in humane approach, medical competence and advising and information. The suggestions of this study

have a forward look and an aspiring hope to contribute in the support of the home care nurses work, the enrichment of the nurses skills by continuous education and the formulation and exploration of new ideas in order to become a base on which the home nursing care will evolve.

However, continuous feedback is required if sustainable change is to happen. More research is necessary to facilitate the follow up and assessment of the home nursing care in Cyprus at some time after the suggested changes are applied. This research identified the lack of a procedure for assessing the quality of care of the public Home care services. The instruments utilized in this research could therefore be used at regular intervals for a continuous assessment of the care provided by the home care nursing staff to the home care patients.

The decision makers at the Ministry of Health but also the political parties and the politicians of Cyprus should seriously consider advancing and developing the existing program for the benefit of the people of Cyprus.

Finally, the researcher expresses her willingness to offer her knowledge and advice as requested.

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Appendix V: Executive Summary for the Council of the European University of Cyprus

EXCECUTIVE SUMMARY

Dr. Andreas Eleftheriades,

The President of the Council, European University of Cyprus

August 2014

This document is an executive summary report on the research project on ‘Patients’ satisfaction received from nursing staff in the Home Care Programme run by the Ministry of Health in Cyprus’.

This executive report aims to provide recommendations to the Council of the European University emanated from the findings of this study, related to the enrichment of the curriculum of existing under graduate and post graduate degrees and the formulation of a new post graduate degree in Home Care Nursing. Additionally, it provides recommendations for the formulation of other supplementary courses for advanced and continuous education of the home care nurses.

Dr. Maria Leonidou., M.D.

Lecturer at the European University of Cyprus.

This project aimed to investigate 'Patients' satisfaction received from nursing staff in the Home Care Programme run by the Ministry of Health in Cyprus' and it was undertaken by Mrs. Maria Leonidou. The project will be submitted to Middlesex University, National Centre for Work Based Learning Partnerships, Middlesex University in partial fulfilment of the requirements for the degree of Doctor of Professional Studies on August 2014.

The researcher is a Medical Doctor by profession and she has practiced medicine with experience in the public hospitals in Cyprus. The researcher has been a lecturer in medical related subjects for the past twelve years. She is currently a lecturer at the School of Sciences of the European University of Cyprus, a position that holds for the past 8 years.

The main purpose of this study was to investigate the home care patients' satisfaction from the nursing care they received, at the public home care program in Cyprus.

Patients' satisfaction has become an important part in evaluating the quality of health care services. Patients are the ones who can identify better than anyone else the aspects of nursing care which need improvement.

Thome et al (2003), define home care as the care provided to patients by professionals at their homes, covering a wide range of activities, from preventive assessments and actions to end of life care, and aims to contribute to the patients functional health status, improve their quality of life, maintain independence and minimize hospital care. Home care prevents or postpones institutionalization, keeps families together, promotes healing, and in contrast to the institutions it allows maximum freedom for the individual (Longo, for the World Health Organization, 2008). In a world where the majority of people will become the elderly; with multiple chronic diseases and a progressive social exclusion and with increased financial difficulties, there is an enormously rising need for home care services. Home care services are quite new and still developing in Cyprus while the need for these services is increasing rapidly.

As Davies and Ware (1988) support patients' satisfaction is a valid and warrant indicator of the quality of health care. In home care, patient satisfaction is based on the quality of services offered by the various health care professionals even though

'The highest measure of quality was attributed to the client's perception of nursing care' (Schmele, 1985: 120).

Wagner, (1988), states that health care providers should view home care patients' satisfaction as a reality; a subjective perception which reflects the quality of nursing care and understand that

'...quality of care as measured by patient satisfaction is most closely tied to patient satisfaction with the quality of nursing care because most health care is nursing care'.

This study, utilized the well proven and validated instrument entitled the Quality of Care from the Patients' Perspective (QPP) survey questionnaire (Wilde et al., 1994), in depth semi-structured interviews and observations. The questionnaire was delivered to the home care patients who received long term care during the period of the survey. A purposive sample was used for the interviewees of the patients, the nursing staff and the management staff of the home care program and for the observations of the home care visits.

It involved self-reported survey questionnaires that were distributed between February 2011 to May 2011 to home care patients receiving long term care and had been enrolled in the program for more than two months prior to the survey, were over 18 years old and they were patients with sound judgement and able to communicate; 112 questionnaires were returned answered and they were analysed by SPSS. The survey questionnaire was followed by in depth interviews to 9 home care patients, 5 home care nursing staff and 3 home care managers and by observing 11 home care patients' visits and a nurse's working day.

The results of this study showed that the home care patients of the public home care program in Cyprus are very satisfied from the services they receive from the home care nursing staff. More specifically, the vast majority of the respondents of the survey questionnaire (around 90 to 95%) answered either *'fully agree'* or *'mostly agree'* to all the statements of the QPP questionnaire concerning the perceived reality of their care in the various items in all four dimensions. At the same time the vast majority of the

respondents answered that the items in all statements were *'of the very highest importance'* or *'of high importance'* for them. The quality of care, QPP index was found of the highest score in all items related to the care the patients' receive. The findings of the survey questionnaire were also supported by the qualitative research findings.

There was only one statement in the survey questionnaire with lower score in satisfaction; *'My medical care was controlled by my own desires rather than by the district nurse's procedures'*. Almost half of the respondents (40, 9%), answered that they *'partly agreed'* or *'do not agree at all'* that their medical care was controlled by their desires rather than by the district nurse procedure.

The respondents stated especially satisfied with the elements relating to humane approach; the politeness, the interest and the caring of the nurse, the medical competence and the information and advising provided to the patients. These findings were also strongly supported by the in depth interviews' and the observations' findings.

Additionally, this study surfaced the aspects of the nursing care which the home care patients consider more important and highlighted the characteristics of an ideal home care nurse through the patients' eyes; placing the humane approach as the most important aspect, followed by the psychological support provided and the nursing knowledge. Interesting enough, a deviation was identified in the nursing and management views, which placed the nursing knowledge first, followed by the leadership skills and the humane approach only third.

This study also identified those problematic areas of the program which negatively influence the nursing services; as the participants stated these were the absence of a team of health professionals in the program, the limited operating hours, the non-implementation of the concept of prescribing nurses, inadequate technology, insufficient financial support of the program, and the cumbersome procedures of the public sector.

At the same time, through the interviews and the observations, this study identified a deficiency in the abilities of the nursing staff to provide psychological support in difficult cases, even though they were very willing to do so. This accentuated the lack of a team of professionals in home care. Additionally, the need of the home care patients

for help in the activities of daily living (ADLs) was revealed through the interviews and the observations.

Home care patients' satisfaction from the nursing staff is very high; yet there are some areas which need improvement. Recommendations emanated from the project include the enhancement of the nursing undergraduate education in nursing and the creation of a post graduate degree in home care nursing, with the inclusion of courses and workshops on the psychology of home care patients, on gerontology and on leadership and communication skills. Recommendations also include individual and organizational development interventions for providing more support to the home care nurses, higher quality of care to the home care patients within a client-centred environment and feedback strategies.

More specifically are the following recommendations to the Council of the European University of Cyprus.

Recommendation for adjusting the existing curriculum of the bachelor's degree in Nursing and the recommendation relating to the formulation of a post graduate degree in Home Care Nursing.

'As nursing educators strive to prepare new graduates for the future, they are likely to include home health care as an important component of the clinical practicum experience. With careful planning of curricula and activities designed to provide students with not only technological skills but also the ability to think critically, act independently, and apply theoretical frameworks creatively, nursing educators can greatly facilitate effective care to clients in home care and other alternative settings' (Kisa, 2007: 105).

The structure and the context of nursing education at the post graduate home care degree should give emphasis on psychology with the inclusion of courses on the psychology of patients with chronic diseases and on the psychology of the elderly, enforced and combined with experiential workshops. Emphasis should also be given on verbal and nonverbal communication skills with a focus on the elderly people. Development of leadership skills, self-management and organizational skills focused and adjusted on health care (and not general business) should also be core subjects of the post graduate degree in home care.

World Health Organization, (2002: 51), suggests that educators should

‘Incorporate modules on active ageing in medical and health curricula at all levels. Provide specialist education in gerontology and geriatrics for medical, health and social service professionals. Inform all health and social service professionals about the process of ageing and ways to optimize active ageing among individuals, communities and population groups. (...) Train health promotion workers to identify older people who are at risk for loneliness and social isolation.’

The results of this study show that the humane approach is the main factor for satisfaction for the home care patients thus it is important that home care nurses deeply understand the ageing process and all the *matters* relating to the elderly people. This can only be achieved through education and more specifically through incorporating and emphasizing courses in gerontology as it is suggested above. An extra effort should be given to train the future home care nurses in identifying elderly patients who are at the risk of social exclusion, isolation and loneliness and at the same time enabling the nurses with tools and skills to provide practical and soluble solutions for these patients. Nursing knowledge on the process of ageing; where on one hand cognitive and functioning capacities decline sometimes due to lack of patient motivation, confidence, patient isolation and loneliness, and on the other hand wisdom, knowledge and experience have increased; would enable the home care nurses promote ‘active ageing’ which is

‘...the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age’. (World Health Organization, 2002: 12).

Recommendation for formulating and providing training seminars and experiential workshops to existing Nursing staff of Home Care.

The researcher suggests continuous training seminars to the existing Nursing staff of Home care on areas that the research project identified that there is room for further improvement. These training seminars and experiential workshops should focus on psychology and on communication skills with a concentration on elderly people and on patients with chronic diseases.

The researcher also suggests that the Ministry of Health encourages the future home care nurses to attend a post graduate degree in Home Care Nursing. To the same lines, the researcher suggested to the European University of Cyprus the formulation of a post graduate degree in Home Care Nursing. This degree will attend all the identified areas by this research that needed improvement and the areas that were considered as the most important for the patients.

The needs of the home care patients and the communication challenges of home care are different and distinct compared to the needs of the patients of the public hospital. The relationship 'nurse-patient' is different and the psychological support required to these patients is more demanding and vital. Furthermore, it was identified in this study that there is room for improvement when it comes to the nurses allowing the medical care to be controlled more by the patients' desires rather than by the home care nurse's procedures. This new attitude can be also achieved by continuous participation in training seminars and experiential workshops.

I am also suggesting the introduction of training on Medical Crew resource management. Crew resource management '*(...)has been used for many years in the aviation industry (EU OPS, 2008 & UK CAA,2013) and has been generally shown to produce positive reactions, enhance learning, and promote desired behavioral changes*' (Eswar, 2007: 2,). Recently, such training has been adopted in the health industry.

The researcher's suggestion to the Council of European University of Cyprus is to establish a co-operating relationship with the Ministry of Health and be the body that will deliver the above seminars to the existing Home Care Nurses. This should be structured as individual unities that could possibly count towards the completion of the Master's degree at Home Care, at a later stage. At the same time a sponsorship program could be established between the Ministry of Health and the EUC that will be exclusively offered to existing Home care nursing staff.

Recommendation for creating a course for prescribing nurses in coordination with the Ministry of Health.

The existing procedures within the home care program with regards to the prescription of simple medication and consumables required by the patients, are presently unnecessarily inefficient and cumbersome because they require the approval and the prescription by medical doctors, whose main line of work, is at the public hospitals, thus creating discomfort and difficulties to the patients. Instead, if the nurses of home care were eligible to prescribe simple medication and consumables, the issue would be resolved for the benefit of all involved, something which is common practice at some other European countries.

This research recommends that the challenge of ‘role change’ for community nurses, which in other countries became widely integrated into nursing practice over the last decades, should also be taken up by the management of Home care of Cyprus; if the nurses could directly prescribe for the basics, there would be a great benefit to increasing efficiency, eliminate lead times, enhance the quality of patients’ nursing care and increase patient satisfaction. The implementation of a major role change such as nurse prescribing; extended and supplementary prescribing by community nurses, requires adequate education and training and a comprehensive knowledge of pharmacology. It also requires the acceptance of the new role for the nurses, by the physicians and that there is also the need for a formulary that will meet the physician’s needs (While and Biggs, 2004).

It is on this era where the EUC could get actively involved in a number of ways. At the time that the Ministry of Health decides to implement this new nursing role, EUC should cooperate with the Ministry of Health and formulate a prescribing nursing course which will educate the home care nurses with sufficient knowledge as described above to take up the responsibility of a ‘prescribing nurse’. Furthermore, the post graduate degree in home care nursing should include pharmacology as one of its subjects.

Recommendation for enriching the post graduate degree in Public Health

To manage line personnel, it is vital that the manager has first-hand knowledge and experience of the line job. At the same time middle management should be educated to have a good understanding of general management principles and best practices.

In order to enhance the future managements’ expertise and improve the problematic areas that have been identified by this research project, which range between core

competencies but also soft skills, EUC could well become the education forum through its existing offering of Master in Public Health (MPH) but however tailoring it to the needs of the working home care nurse in terms of convenience and practical variables and by giving emphasis at the subjects of leadership, communication skills, decision making, managing and controlling. Moreover, this study revealed a lack of process innovation and a lack of attempts to change existing procedures; the overall attitude is to blame the existing stagnation either 'on the system', the government or on insufficient staff. Continuous process innovation is both a skill based competency and an attitude that have to be rigorously attended within the Master's degree in Public Health. This is usually developed through case studies, group projects and experiential learning, which the researcher in her experience as an educator is of great support.

At the same time and in association to the Ministry of Health the MPH of EUC could become the preferred Master's degree that the Ministry in association to the Cyprus Academy of Public Administration which in turn associates with the European Academy of Public Administration, could offer scholarships for the above MPH.

A final word

In the European countries, the home care programs are evolving in an effort to support the vulnerable increasing group of elderly people who are progressively socially excluded, have financial difficulties and face multiple chronic diseases. The increasing focus on the provision of patient –centred services create an emerging need of reconfiguration of the existing health care systems in order to improve response time.

'Home healthcare is the most logical and cost- effective alternative to other sub-acute services, such as nursing home stays or extended hospital visits for recuperative and chronic disease care. Patient satisfaction is high, clinical outcomes are positive and home healthcare is more cost-effective than nursing home care or additional days in hospital. Advances in technology and development of protocols for managing chronic diseases have made home healthcare the preferred approach to chronic care and disease management' (Alliance for Home Health Quality and Innovation, 2008).

EUC in its capacity as a high quality educational organization should stand up against this challenge and act swiftly on the following pillars as explicitly explained above:

- Enrich and enhance the existing bachelor's degree in Nursing
- Create and launch a Master's degree in Home care nursing, which is forward looking and tangible to the existing need of Home care.
- Enhance the existing Master's degree in Public Health.
- Customise and provide a structure series of training seminars attending the identified problematic areas of the existing Home care nurses and management.
- Cooperate with the Ministry of Health on all the above areas with the scope of becoming an approved provider for educating new and existing nurses through possible sponsorships offered either directly by the Ministry of Health or through the Academy of Public Administration in association to possible sponsorship programs of the European Academy of Public Administration.

Finally, the researcher offers her availability and willingness to participate and offer her knowledge and advice on all the above activities as needed.

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Appendix W: Acceptance of the Project's outcomes by the Ministry of Health



REPUBLIC OF CYPRUS

TO WHOM IT MAY CONCERN

Dr. Maria Leonidou has submitted to the Nursing Services of the Ministry of Health of Cyprus an executive report which was produced as part of her doctorate research project on 'Patients' satisfaction received from nursing staff in the Home Care Programme run by the Ministry of Health in Cyprus'.

This report has been accepted by the Nursing Services of the Ministry of Health and is considered as a substantial contributing documentation to the master planning of the Ministry and may be utilised in the drawing of an action plan to improve and expand the Home Care Program.

The report, per se will therefore be distributed and disseminated to all appropriate channels within the Ministry of Health and or to other ministries or relevant bodies when and where appropriate.

A handwritten signature in black ink, appearing to read 'Α. Χενόφοντος'.

Andreas Xenofontos

Director of Nursing Services
Ministry of Health of Cyprus

Nicosia, August 19, 2014.

Προδρόμου 1 Χίλωνος 17 Υπουργείο Υγείας, 1448 Λευκωσία
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Appendix X: Acceptance of the Project's outcomes by the Council of European University of Cyprus



**European
University Cyprus**

LAUREATE INTERNATIONAL UNIVERSITIES

6 Diogenes Str. Engomi
P.O.Box 22006, 1516 Nicosia, Cyprus
Tel: +357 22713000, Fax: +357 22713172
www.euc.ac.cy

Nicosia, August 20, 2014.

TO WHOM IT MAY CONCERN

This is to certify that Mrs. Maria Leonidou has submitted to the President of the Council, European University Cyprus, an executive summary report as part of her doctorate research project on '*Patients' satisfaction received from nursing staff in the Home Care Programme run by the Ministry of Health in Cyprus*'.

This report has been accepted by European University Cyprus and will be considered as a valuable document in two directions; on the one hand it will serve to improve, enrich and upgrade the existing curriculum of the undergraduate degree in Nursing and on the other hand it will be valuable to the development and possible introduction of a Master's Degree on Home Care Nursing.

This report will therefore be made available and disseminated to the faculty and management of the University as appropriate.



Dr. Andreas Eleftheriades
President of the Council

Appendix Y: The statements included in each dimension of the QPP questionnaire

Identity orientated approach

- I received useful information as to how treatments would take place.
- I received useful information related on the results of samples, e.g. Blood sugar curve that the district nurse took.
- I received useful information on which district nurse was responsible for planning my care.
- The district nurse seemed to understand how I experienced my situation.
- The district nurse treated me with respect.
- The district nurse showed commitment; ‘cared about me’.
- I had good opportunities to participate in decisions that applied to my medical care.

Socio-Cultural Atmosphere

- My care was controlled by my own desires rather than by the district nurse’s procedure.
- My relatives and friends were treated well.
- I was easy to get to the telephone for the district nurse.
- I was easy to get the district nurse to come out on a home visit.

Medical- Technical Competence

- I received the best possible medical care/help from the visiting nurse (as far as I can tell)
- I received effective help with pain relief.
- I received useful information on self-care; ‘the best way to take care of myself’
- I received help from the district nurse within an acceptable waiting time.

Physical Technical Conditions

- I received useful help from the district nurse with obtaining the appliances that I needed. E.g. wheeled walking frame, wheelchair, pads and clutching tongs.
- I received useful help from the visiting nurse with measures to prevent accidents in my home.
- I had access to the apparatus and equipment that were necessary for my medical care (as far as I can tell).

Appendix Z (A): Suggestions for Safeguarding Financial and other Resources

1. Individual Budgeting	
Short term	<p>The Home care program is currently budgeted under the general umbrella of community care. If a separate budget is allocated, the needs would be more clearly identified and consequently increase their success on being funded.</p> <p>Process: No main obstacles are anticipated.</p> <p>Responsibility: Management would be responsible to putting forward this change</p>
2. Strategically involve and commit the municipalities as responsible stakeholders and contributors to home care	
<p>Immediate</p> <p>Short term</p> <p>Long term</p>	<p>A structured and long term vision and plan is required to include all stakeholders in order to join and make available different resources and capabilities.</p> <p>Currently the involvement of municipalities is based on individuals, personal contacts and rather unofficial and temporary in nature.</p> <p>Process: It can be immediately initiated by management at the lower level. For the longer term it has to be at higher Ministry level in order to agree and commit all stakeholders to a common vision, a common platform and with measurable milestones for the expansion and funding and support of the program.</p> <p>Responsibility: All management levels. However the formation of the strategically long term vision and plan lies with higher management, will involve the Minister of Health.</p>

3. Included the Home care program in the National Health Insurance System (NHIS)

**Medium
Term**

The NHIS is currently still at the planning stage. It is possibly one of the largest projects to be launched nationwide in Cyprus over the next few years that hopes to radically change health care quality for the better.

If Home Care is included in NHIS will have ample advantages including secured financial resources and good expansion prospects. The advantages are expanded further below.

Process: This decision lies at higher political level and it will be part of government policy. The key stakeholder is the Minister of Health who will put the case forward. Management of Home Care should make every effort to convince all parties concerned.

Appendix Z (B): Suggestions for automation of Home Care Procedures

	PROVISIONS	BENEFITS	COSTS	OTHER CONSIDERATIONS
STEP 1 For Immediate Implementation	Provide the basics: Laptops with appropriate software, access to internet and email, faxing and printing. Provision of GPS and mobile	Immediately boost the productivity of the nurses on day to day operations. Increase the patients' satisfaction. Improve communications and record keeping. Basic office automation to increasing productivity.	Minimal to insignificant. The suggested technology for this step has become very cheap and is considered a commodity today.	No need to endeavor any study for this step as it is more of a common sense and common practice. Internal approval of these tools should be relatively easy and short
STEP 2 For the medium term.	CRM system and software (Customer Relationship Management) system, supported by relevant software.	Increase case awareness for the needs of each patient. Increase productivity, follow up, opportunities for growth, feedback	The costs are usually medium to high. Implementation requires a separate and dedicated study	CRM has been used in marketing and human resources of many industries during the past twenty years. Some organizations consider the information they collect from their customers (patients) as key to their business success and growth.
STEP 3 For the medium to longer term.	Centralized Patients' filing system	Such a system will have a major impact to office automation and boosting productivity, feedback and valuable data for needs analysis and expansion.	The costs are high for a stand-alone system dedicated exclusively for this purpose. However the cost can be minimal to zero if Home Care is offered through NHSC (NHSC will operate centralized patient filing system anyway). Requires decision making at highest level, possibly including the political level. It needs to be a product of the National Health Strategy.	Centralized patient system will be vital for the operation of the National Health Plan (NHP) which has been under construction for the past years. However it is not yet certain whether Home Care will be included in the NHP. This study will suggest the above.