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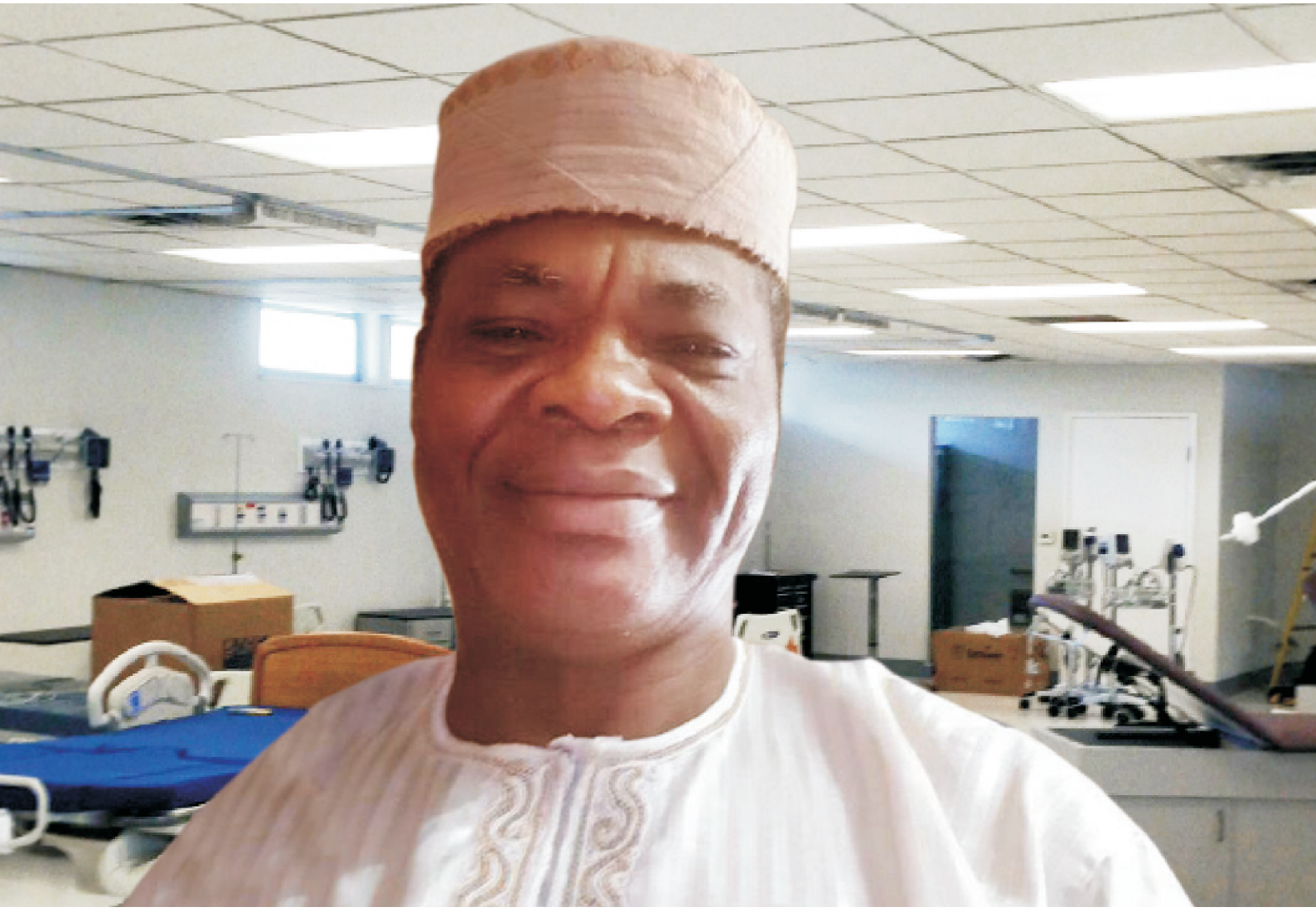

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TABLE OF CONTENTS

NURSES PERCEPTION OF CANCER PATIENT QUALITY OF LIFE

BOLAJI-OSAGIE, SARAH O., OKO-OSE JOSEPHINE & ISIBOR EWERE ANITA

ABSTRACT

Cancer is a terminal disease that needs prompt care palliative. The assessment of the quality of life of cancer patient will help proffer better health and prolongation of life. This study seeks to assess cancer patients' quality of life as perceived by staff nurses in the University of Benin Teaching Hospital and the Central Hospital, in Benin city, Edo state, Nigeria. The study adopted the descriptive cross sectional research design and a simple random sampling technique was used to select 300 staff nurses in the various institutions. A 40-item well-structured questionnaire was used as instruments of data collection. The descriptive and inferential statistics were used to analysed the data generated. The result from the study showed that the respondents had low level of knowledge, positive perception of quality of life and the factors outlined that hindered the utilization of quality of life measurement tools were reported positive. Furthermore, there was a significant relationship between the level of education of the nurses and their level of knowledge as P<0.05. The study also revealed significant relationship between knowledge and perception as well as perception between institutions. Therefore, it is recommended that there should be active education of nurses and training on the use of the cancer quality of life and its measurement tools. Quality of life and its measurement tools should be added to nursing curriculum to be taught in schools of nursing and departments of nursing. Furthermore, Quality of life assessment tools should be made available in health institutions.

Keyword: Perception; quality of life; Nurses; cancer patients.

INTRODUCTION

Health is wealth as some would say, the way people perceive their health depends on how pertinent the quality they define their lives and the types of health services they accept. Quality of life (QoL) is an important aspect of the cancer patient care (Lavdanti & Tsitsis, 2015). Individuals, families and community well being can be ascertained by a negative or positive facet of the quality of their lives. QoL is a concept used to emphasize that different aspects of individuals' lives such as physical, psychological, social and emotional are important in determining the experience of living and its quality which needs to be taken into consideration by health care professionals when caring for those whose life is under threat (Bahrami, 2016). The World Health Organization (2017) purport the quality of life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. However, assessing quality of life as a subjective and abstract construction is often seen as a complex task. Quality of life is the general well-being of individuals and societies, outlining negative and positive features of life (Sosnowski, *et al*., 2017; Karimi& Brazier, 2016).

This is a multidimensional concept that deals with the relationship between environment and physio-psychological aspects of the individual, level of independence, social relationships and personal beliefs (Minayo, Hartz & Buss, 2017). In addition, QoL information can be used for screening and prioritizing potential problems, facilitating communication with patients and identification of their preferences (Kamisli, Yuce, Karakilic, Kilickapb & Hayran, 2017). Patients can communicate their problems and priorities by filling out a QoL questionnaire or through an interview. Issues like sex life, personal relationships and financial issues, for example, are amongst those important matters patients usually do not express explicitly unless they are questioned. QoL assessment can prompt the process of revealing hidden problems more appropriately and lead to more holistic care (Bahrami, 2016). Therefore, many instruments can be used to measure the quality of life of cancer patients.

They are divided into three categories: generic instruments, cancer specific and domain specific instruments. Also, there are further instruments

which can be applied when assessing children and adolescents, patients or families or cancer survivors (Adamakidou & Kalokerinou, 2012; Avis et al., 2020). Some of the most popular cancer specific instruments are the EORTC Core Quality of Life Questionnaire (EORTC QLQ C-30), the Functional Assessment Cancer General (FACT-G), World Health Organisation Quality of Life Assessment (WHOQOL–BREF) the Functional Living Index Cancer (FLIC) and the Cancer Rehabilitation Evaluation System (CARES) (Adamakidou & Kalokerinou, 2012).

According to World Health Organization (WHO 2017), cancer is the second leading global cause of death with 14.9 million new cancer cases in 2013 and 8.8 million deaths in 2015. Although the early detection and new treatments decline cancer and offer better prognoses as cancer is a chronic illness. Care in the context of palliative assistance differs from curative care because it reaffirms life and faces death as a reality to be experienced with relatives. In such a situation, care has the premise of improving the quality of life of patients and their families before an advanced illness by the prevention and relief of suffering, the appreciation of culture, spirituality, beliefs and values that permeate the "terminality" (Song & Happ,2017). When a person has been diagnosed with a terminal illness, the assessment of quality of life becomes significant, since the search for it in all its nuances, and even to the detriment of the prolongation of life, becomes very important (Meneguin, Matos & Ferreira, 2018).

All patients deserve to be cared for in a human nature especially when approaching death as caring refers to being humane and remains the core of the nursing profession. Caring behaviors demonstrated by nurses have been linked to high patient satisfaction with nursing care and the intent to return to a facility for care. In the hospital environment, nurses interact more closely with cancer patients, hence, nurses can help cancer patients attain rehabilitation or help them achieve a peaceful death as observed by Virginia Henderson. Other health care providers may rely on nurses to inform them of the uneasiness and apprehensions of the patients. Persistent deficiencies and variables exist in end-of-life nursing care practice and education to support its care.

The increase work load in the health institutions has probably made nurses retarded in the utilization of nursing care process talk less of the Quality-of-life measurement models tools while caring for the patients with cancer. In some instance, the QoL models are rarely found in the health institution. These have also led to the less attention being paid to cancer patients by health care professionals as envisaged in some health institutions. Also, less assessment of the quality of life of a cancer patient can hamper their health thereby leading to untimely death amidst symptoms. The thoughts and feelings of nurses about patients affect the quality of their care (Kamisli, *et al*., 2017).

People living with life limiting chronic conditions like cancer often have multifaceted health care needs related to the complex symptoms and the impact of the advancing illness on their quality of life (Greenhalgh,2009). Quality of life assessment instruments are increasingly promoted as a means of enabling nurses to efficiently assess the aspects of health and healthcare that is relevant to the QoL of patients and family caregivers. Despite evidence supporting the benefits of QoL assessments, the integration of these instruments into caring for cancer patients has been elusive, this may be due to lack of consultation with nurses about the design of the QoL assessment instruments, inadequate information on how to integrate them into practice and nurses unwillingness to measure outcomes they feel ill-prepared to address.

Findings from Rothen, Sticker & Heyland (2010) reported that for patients high-priority communication, areas that required improvement are related to feelings of peace, assessment and treatment of emotional problems, physician availability; and satisfaction that the physician took a personal interest in them, communicated clearly and consistently, and listened. Several studies identified the lack of knowledge about care of cancer patients as a factor influencing perceived quality of life in caring for cancer patients (Efstathiou & Clifford, 2011). Moreso, sometimes many nurses are contingent on experience to inform practice regardless of the existence of recognise care planning frameworks that may help nurses in proffering patient care.

Cancer and its treatment cause many complications with a detrimental effect on quality of life and a significant influence on health-related quality of life (HRQOL) in general (Lavadanti, 2018). It can create difficulties in fulfilling family and social roles such as the ability to work or participate in common social activities (Lavdanti &Tsitsis, 2015). The diagnosis of cancer brings major

changes in the way of living, with emotional and physical changes caused by the discomfort, pain, disfigurement, dependency and loss of self-esteem. Furthermore, it is known that over 50% of cancer patients present five common symptoms that may interfere with the perception of quality of life: fatigue, weakness, pain, weight loss and anorexia. Toxicities and adverse effects, affects the quality of life in cancer patients (Holmenlund, Sjøgren & Nordly 2017). It is towards these the researcher seeks to assess nurses' perception about cancer patients' QoL and its measurement.

Objectives of the study

The aim of this stuy is to examine cancer patients' quality of Life (QoL) and its measurement as perceived by Staff Nurses in selected institutions in Benin City, Edo State, Nigeria, with the following objectives:

1) Assess nurses' knowledge of quality of life and its measurement in cancer patient care.
2) Elicit nurses' perception of cancer patient quality of life and its measurement.
3) Determine the perceived factors influencing nurses' utilization of quality of life measurement.

Hypotheses

Ho1 There is no significant relationship between the level of education of respondents and their knowledge of cancer patients' quality of life and its measurement tools.

Ho2: There is no significant relationship between knowledge of cancer patients' quality of life/measurement with perception of nurses

Ho3: There is no significant difference in the perception of cancer patients' quality of Life (QoL) and its measurement based on health facilities.

METHODOLOGY

The cross-sectional descriptive research design was adopted for this study. The settings used were the University of Benin Teaching Hospital (UBTH) and Central Hospital, Benin City, Edo State, Nigeria, i.e. the federal and state teaching hospitals respectively in Benin City, Edo State. Edo State is an inland state in the Southern part of Nigeria. The target population comprised of all staff nurses employed in the University of Benin Teaching Hospital Benin City and Central hospital Benin City. The sample size was determined using Taro Yamane Formula and out of a population of 1158 an estimated sample size of 300 was drawn including an attrition rate of ten percent. A simple random sampling technique was used to select registered staff nurses with six months and above working experience, available and willing to participate in the study. However, the nurses below six months working experiences were excluded.

Instruments for data collection: A 40-item self-structured questionnaire was the instrument used for the study and was divided into four (4) sections. Section A contained information on the sociodemographic profile of staff nurses; Section B measured variables on the knowledge of quality of life (QoL); Section C enclosed variables on perception towards quality of life (QoL); Section D entailed variables on factors affecting quality of life assessment. Face and content validity of the instrument was determined. Additionally, reliability was ensured with a pilot study conducted and using Cronbach's Alpha coefficients which yielded 0.71, 0.75, and 0.77 respectively for each objective.

Method of data collection: Questionnaires were distributed to the respondents who voluntarily participated in the study. The questionnaires were duly filled within the hours of 8-4pm and were collected immediately. However, some were left with the unit head for those who were on night shift to fill and was retrieved within seven days. The study was carried out in six months (June – October, 2019). Ethical committees of both institutions were sought and research approval granted. Anonymity and confidentiality was ensured to gain candid response.

Method of data analysis: Data was coded into the International Business Machine Statistical Package for Social Sciences (IBM SPSS) version 24.0 and analyzed using descriptive statistics (frequencies, percentage, means in tables, pie chart, scatter plot) as well as inferential statistics (chi-square, linear regression) to test the null hypotheses. The level of significance was set at $p<0.05$. The knowledge questionnaire, where yes = 1 and no = 0 and were grouped into (poor knowledge (0-49.9%), moderate (50-59.9%), High =70% and above); perception was measured using likert scale, where strongly agree=4, agree=3, disagree=2 and strongly

disagree=1; mean scored as (Negative = 0-2.49, Positive = 2.50 -4.00); factors was scored with mean score of <2.5 as Negative and 2.5 and above as positive.

RESULTS

Socio-demographic Characteristics of Respondents

As presented in Table 1, majority of the respondents 99(33.0%) were within the age group 20 – 29years, 80(26.7%) were 30-39years , 89(29.7%) were 40-49years while 32(10.7%) were 50years and above. Majority of the respondents in this study 217(72.3%) were females, while the remaining 83(27.7%) were males. 84(28%) were single, 187(62.3%) were married, 11(3.7%) were divorced, and 18(6%) were widowed. Level of education showed that 33(11%) had diploma, 61(20.3%) had post-basic diploma, majority 151(50.3%) had BNSc, 49(16.3%) had MSc, 6(2%) had Ph.D. Also, 210(71%) were Christians, 56(18.7%) were Muslims, 17(5.7%) were traditionalist, the remaining 17(5.7%) practiced other religions. Respondents years of experience showed that 65(21.7%) had an experience < 1 year, 51(17%) had an experience of 1-2 years, 37(12.3%) had an experience of 3-4 years, majority 147(49%) had an experience > 4 years. Additionally, 69(23%) earned <80,000, 93(31%) earned between 80,000 to 129,999, 45(15%) earned between 130,000 to 179,999, 33(11%) earned above 230,000. The distribution of respondents by rank revealed that majority 101(33.7%) were Nursing officers II, 70(23.3%) were Nursing officer I, 60(20%) were Principal nursing officers, 34(11.3%) were Senior nursing officers, 25(8.3%) were Assitant Chief nursing officers while 10(3.3%) were Chief Nursing officers.

Table 1; **Socio-demographic Characteristics of Respondents**

Variables	Attributes	Frequency	Percentage
Age (Years)	20 – 29	99	33.0
	30 – 39	80	26.7
	40 – 49	89	29.7
	50 and above	32	10.7
Gender	Male	83	27.7
	Female	217	72.3
Marital Status	Single	84	28.0
	Married	187	62.3
	Divorced	11	3.7
	Widowed	18	6.0
Level of Education	Diploma	33	11.0
	Post-Basic Diploma	61	20.3
	BNSc	151	50.3
	M.Sc	49	16.3
	Ph.D	6	2.0
Religion	Christianity	210	70.0
	Muslim	56	18.7
	Traditional	17	5.7
	Other	17	5.7
Years of experience	<1year	65	21.7
	1-2years	51	17.0
	3-4years	37	12.3
	>4years	147	49.0
Monthly income	< #80,000	69	23.0
	#80,000-#129,999	93	31.0
	#130,000-#179,999	60	20.0
	#180,000-#229,999	45	15.0
	>#230,000	33	11.0
Rank	Chief Nursing Officers	10	3.3
	Assitant Chief Nursing Officers	25	8.3
	Principal Nursing Officers	60	20.0
	Senior Nursing Officers	34	11.3
	Nursing Officers I	70	23.3
	Nursing Officers II	101	33.7

Figure 1 revealed the distribution of the respondents in various wards and institutions.

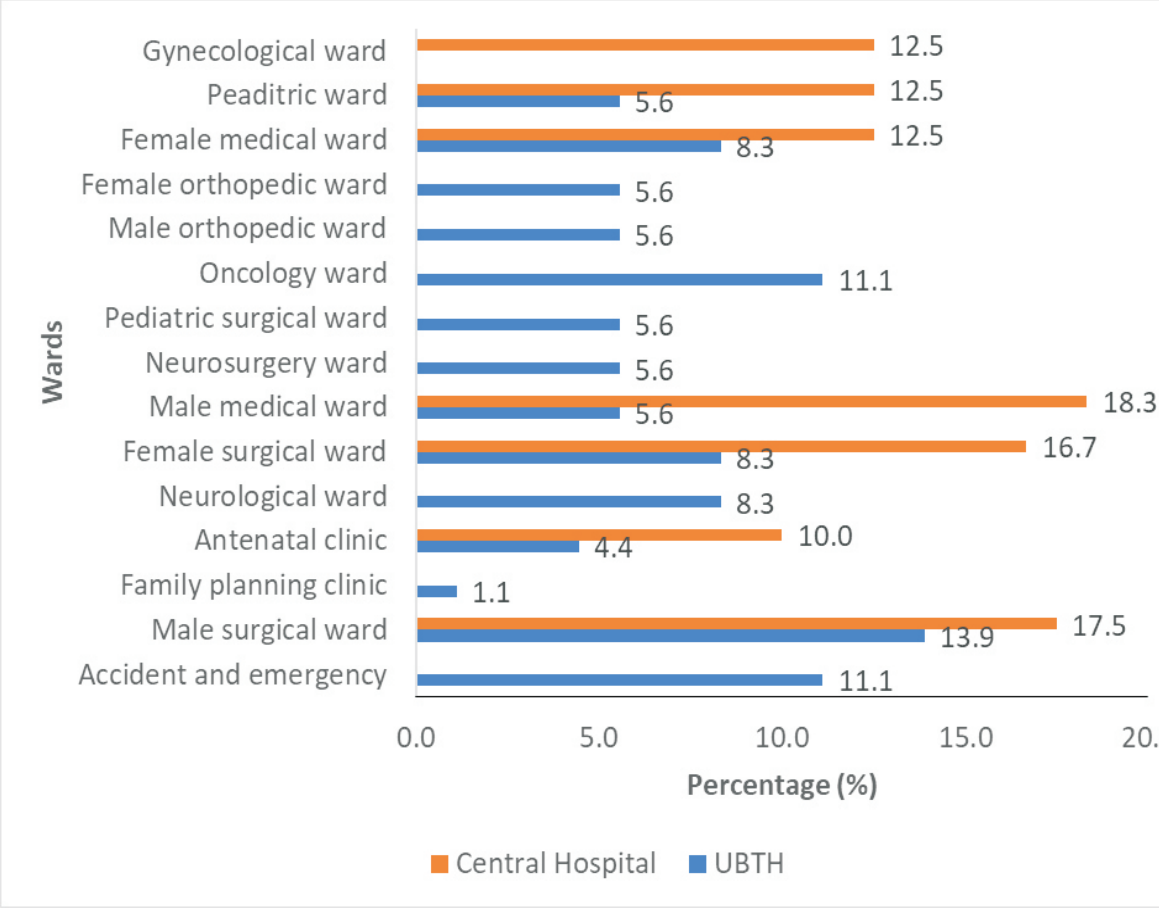

Figure 1: Distribution of subjects in wards in the selected facilities

Nurses' knowledge of cancer patients' Quality of Life (QoL) and its measurement

Table 2 revealed that 129(43.4%) affirmed that the goals of quality-of-life assessment was to improve quality of care, 93(31.3%) reported it is to help patients better understand their treatment options, 116(39.1%) reported it was to improve a cancer patient's ability to participate in daily activities, 42(14.1%) reported it was to assess patient's satisfaction with nursing care, 87(29.3%) reported it was to reduce mortality of cancer patients. It was reported by 25(9.6%) that quality of life assessment tools is centre for disease control health related quality of life-14, 24(9.2%) reported it was European organization for research and treatment of cancer quality of life questionnaire, majority 222(85.4%) reported it was World Health Organization quality of life instrument, 16(6.2%) reported it was functional assessment in chronic illness therapy. It was reported by 86(28.8%) that quality of life measures the individuals' feelings towards their body image, 56(18.7%) reported it was towards cognitive functioning, majority 239(79.9%) reported it was towards health behaviours, 52(17.4%) reported it was health distress, 21(7%) reported it was mental health, 58(19.4%) reported it was pain felt, 55(18.4%) reported it was social functioning, 36(12%) reported it was sexual functioning. 110(36.7%) reported that quality of life can be described as the general wellbeing of individuals and societies, outlining positive and negative features of life.

Also, 98 (32.7%) reported it can be described as observes life satisfaction including physical health, family, safety and security to freedom, 138(46%) reported it can be described as the degree to which an individual is healthy, comfortable and able to participate in or enjoy life events, majority 122(40.7%) reported it can be described as the standard of health, comfort and happiness experienced by a person,

65(21.7%) reported it can be described as the individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals. It was reported by 27(10.4%) that the tool they utilized in the care of cancer patients was Centre for Disease Control Health Related Quality of Life-14, 17(6.6%) reported they utilized European Organization for Research and Treatment of Cancer Quality of Life questionnaire, majority 204(78.8%) reported they utilized World Health Organization Quality of Life instrument, 18(6.9%) reported they utilized functional assessment of cancer therapy/functional assessment in chronic illness therapy.

It was reported by 15(5%) that the frequency of uptake of quality-of-life assessment tools was always, 19(6.3%) reported it was often, majority 161(53.7%) reported it was rarely, 105(35%) reported they never did. It was reported by 115(38.3%) reported that quality of life assessment tools has been used in their institution for < 1year, majority 127(42.3%) reported it was between 1-2 years, 40(13.3%) reported it was between 3-4 years, 18(6.0%) reported it was > 4 years. It was reported by 27(10.4%) that the tool they utilized in the care of cancer patients was Centre for Disease Control Health Related Quality of Life-14, 17(6.6%) reported they utilized European Organization for Research and Treatment of Cancer Quality of Life questionnaire, majority 204(78.8%) reported they utilized World Health Organization Quality of Life instrument, 18(6.9%) reported they utilized functional assessment of cancer therapy/functional assessment in chronic illness therapy. Similarly, 15(5%) that the frequency of uptake of quality of life assessment tools was always, 19(6.3%) reported it was often, majority 161(53.7%) reported it was rarely, 105(35%) reported they never did. It was reported by 115(38.3%) reported that quality of life assessment tools has been used in their institution for < 1year, majority 127(42.3%) reported it was between 1-2 years, 40(13.3%) reported it was between 3-4 years, 18(6.0%) reported it was > 4 years. This study therefore concludes that Nurses' knowledge of cancer patients' quality of Life (QoL) and its measurement is low (27.5%)

Table 2; Nurses' knowledge of cancer patients' quality of Life (QoL) and its measurement

Variables	Attributes	Frequency	Percentage
The goals of quality-of-life assessment includes	improve quality of care	129	43.4
	to help patients better understand their treatment options	93	31.3
	to improve a cancer patients' ability to participate in daily activities	116	39.1
	to assess patients' satisfaction with nursing care	42	14.1
	to reduce mortality of cancer patients	87	29.3
Quality of life assessment tools are	Centre for Disease C ontrol Health Related Quality of Life-14	25	9.6
	European Organization for Research and Treatment of Cancer Quality of Life questionnaire	24	9.2
	World Health Organization Quality Of Life instrument	222	85.4
	Cancer Rehabilitation Evaluation System	39	13
	Functional Assessment of cancer Therapy/ Functional Assessment in Chronic Illness Therapy	16	6.2
Quality of life measures the individuals' feelings towards their	body image	86	28.8
	cognitive functioning	56	18.7
	health behaviours	239	79.9
	health distress	52	17.4
	mental health	21	7.0
	pain felt	58	19.4
	social functioning	55	18.4
	sexual functioning	36	12.0
Quality of life can be described as	the general well -being of individuals and societies, outlining positive and negative features of life	110	36.7
	observes life satisfaction including physical health, family, safety and security to freedom	98	32.7
	degree to which an individual is healthy, comfortable and able to participate in or enjoy life events	138	46.0
	the standard of health, comfort and happiness experienced by a person	122	40.7
	the individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals	65	21.7
Which of these too ls do you utilize in the care of cancer patients?	Centre for Disease Control Health Related Quality of Life-14	27	10.4
	European Organization for Research and Treatment of Cancer Quality of Life questionnaire	17	6.6

Table 3 revealed the perception of the nurses revealed that in cancer care, nurses assess patients' QoL and its measurement. Furthermore, all the items revealed the positive response of the respondents except for the item on assessment of Quality of life had no effect on response to treatment (2.47) which showed a negative perception with a mean score < 2.5. This study had a mean score of 2.8 this indicated respondents' positive perception of cancer patient's quality of life.

Table 3 Nurses' perception of cancer patients' quality of life

	SD	D	A	SA	X	St.D
In cancer care, nurses assess patients' QoL across several aspects including the physical, the emotional, and the spiritual dimensions.	2 (0.7)	38 (12.7)	222 (74.0)	38 (12.7)	2.99	0.53
In cancer care, nurses picking up on cue of patients' alone is an important way for QoL assessment particularly for those patients who have communication de? cits.	3 (1.0)	57 (19.0)	184 (61.3)	56 (18.7)	2.98	0.65
The heavy w orkload/ exhaustion make s it difficult for nurses to carry out a thorough Qol assessment.	0 (0.0)	88 (29.3)	149 (49.7)	63 (21.0)	2.92	0.71
The nurse's opinion on immediate patient care is not welcome or valued by the patient during quality of life assessment.	6 (2.0)	95 (31.7)	168 (56.0)	31 (10.3)	2.75	0.66
Quality of life assessment and care has no effect on prognosis of disease.	10 (3.3)	119 (39.7)	133 (44.3)	38 (12.7)	2.66	0.74
Quality of life assessment can be used to access patients ability to carry out activities of daily living.	2 (0.7)	21 (7.0)	230 (76.7)	47 (15.7)	3.07	0.50
Quality of life assessment can be used to measure patients pain level.	1 (0.3)	51 (17.0)	206 (68.7)	42 (14.0)	2.96	0.57
Quality of life assessment can be used to measure patient satisfaction with life.	4 (1.3)	61 (20.3)	205 (68.3)	30 (10.0)	2.87	0.58
Assessment of Quality of life has no effect on response to treatment.	16 (5.3)	148 (49.3)	114 (38.0)	22 (7.3)	2.47	0.71
Nurses' assessment of quality of life reduces incidence of request for euthanasi a/ cessation of treatment.	28 (9.3)	125 (41.7)	103 (34.3)	44 (14.7)	2.54	0.85
Quality of life assessment cannot be used to assess patients' mood swings and negative feelings	12 (4.0)	141 (47.0)	122 (40.7)	25 (8.3)	2.53	0.71
Quality of life assessment can serve as a guide to health education.	9 (3.0)	47 (15.7)	213 (71.0)	31 (10.3)	2.89	0.61
Quality of life assessment has no effect on patient's adherence to treatment regimen.	9 (3.0)	119 (39.7)	135 (45.0)	37 (12.3)	2.67	0.73
Quality of life assessment can help the nurse in identifying the immediate needs of her clients	1 (0.3)	38 (12.7)	199 (66.3)	62 (20.7)	3.07	0.59
Assessment of quality of life can be used to measure patients' satisfaction with health care services	3 (1.0)	40 (13.3)	199 (66.3)	58 (19.3)	3.04	0.61
	2.6%	26.5	67.2	13.9	2.8	

Perceived factors influencing uptake of quality-of-life measurement in cancer patients' care

Table 4 showed the perceived factors influencing the uptake of Qol measurement tool in cancer patient care. Patients meddling in the care had a mean and standard deviation of 2.96

Table 4: Perceived factors influencing nurses uptake of quality of life measurement in cancer patients' care

	SD	D	A	SA	X	St.D	Remark
Patients meddling in the care	2 (0.7)	55 (18.3)	195 (65.0)	48 (16.0)	2.96	0.61	Positive
The patients satisfaction with nursing care	4 (1.3)	41 (13.7)	207 (69.0)	48 (16.0)	3.00	0.59	Positive
Usually there is no time for conversations with patients about their wishes concerning the end of life decisions	7 (2.3)	102 (34.0)	131 (43.7)	60 (20.0)	2.81	0.77	Positive
The patient's relatives inadequate understanding of the situation interfere with the nurses' duties	1 (0.3)	69 (23.0)	172 (57.3)	58 (19.3)	2.96	0.66	Positive
The nurses self -efficacy on cancer care and how to treat the patient's grieving family	5 (1.7)	88 (29.3)	157 (52.3)	50 (16.7)	2.84	0.71	Positive
The patient's family members disagree on what kind of care is the most adequate	3 (1.0)	74 (24.7)	170 (56.7)	53 (17.7)	2.91	0.68	Positive
Lack of resources for QoL assessment.	2 (0.7)	22 (7.3)	158 (52.7)	118 (39.3)	3.31	0.63	Positive
Lack of improvisation materials for quality of life assessment tools.	0 (0.0)	40 (13.3)	161 (53.7)	99 (33.0)	3.20	0.65	Positive
Inadequate training on us e of quality of life assessment tools.	2 (0.7)	36 (12.0)	133 (44.3)	129 (43.0)	3.30	0.70	Positive

Hypothesis one

There is no significant association between the level of education of respondents and their knowledge of cancer patients' quality of Life (QoL) and its measurement.

Table 5 showed the association between the level of education of respondents and their knowledge. This revealed that there is a significant association ($p<0.05$) between the level of education of respondents and their knowledge of cancer patients' quality of Life (QoL) and its measurement. We therefore reject the null hypothesis.

Table 5: level of education and knowledge of quality of life and its measurement

	Low (0-49.9)	Fair (50-69.9)	Good (70 - 100)	$?^2$	P
Diploma	28(84.8)	5(15.2)	0(0.0)	15.582	0.049
Post-Basic Diploma	60(98.4)	1(1.6)	0(0.0)		
BNSc	136(90.1)	15(9.9)	0(0.0)		
M.Sc	41(83.7)	7(14.3)	1(2.0))		
Ph.D	4(66.7)	2(33.3)	0(0.0)		

Hypothesis Two:

There is no significant relationship between knowledge of cancer patients' quality of life/measurement with perception of nurses.

Figure 4 showed the relationship between perception and knowledge of quality of life of cancer patients. It revealed that there is a significant positive correlation ($r = 0.227$; $p <0.001$) between perception and knowledge of quality of life of cancer patients. We therefore reject the null hypothesis which states that there is no significant relationship between perception and knowledge of quality of life of cancer patients.

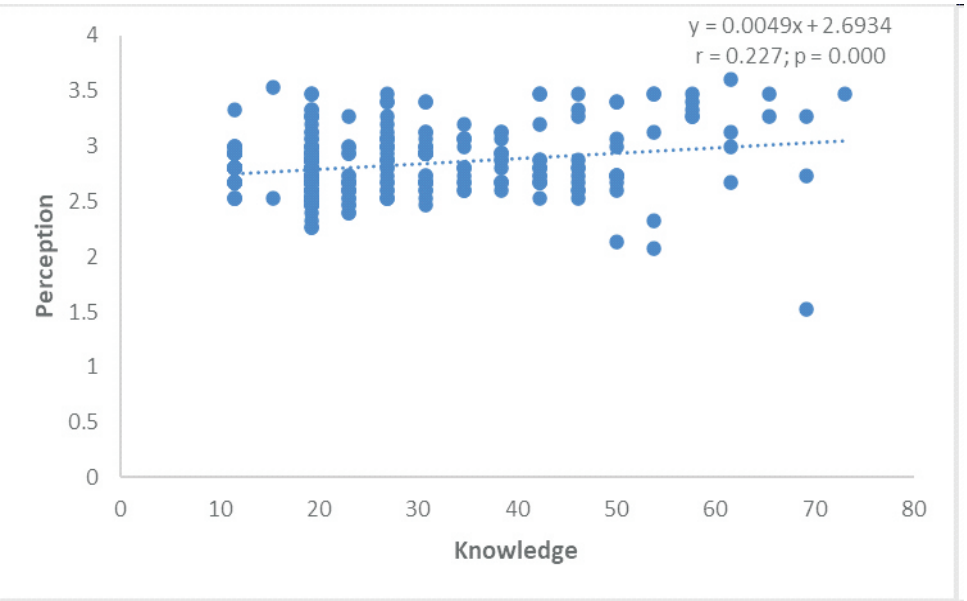

Figure 4: Relationship between perception and knowledge of quality of life of cancer patients

Hypothesis Three:

There is no significant difference in the perception of cancer patients' quality of Life (QoL) and its measurement based on health facilities.

Table 6 showed the mean comparison of perception of cancer patients' quality of life (QoL) and its measurement based on health facilities. Nurses in UBTH reported higher mean perception about cancer patient's quality of life and its measurement than those nurses from Central hospital. We therefore rejected the null hypothesis which stateed that there is no significant difference in the perception of cancer patients' quality of Life (QoL) and its measurement based on health facilities

Table 6: Mean comparison of perception of cancer patients' qualit y of life (QoL) and its measurement based on health facilities.

	Mean	SD	t-value	sig.
UBTH	2.94	0.28	8.940	0.000
Central	2.66	0.23		

DISCUSSION OF FINDINGS

The socio demographic variables of the respondents examined, characterized more of the female gender this is because the professions traditionally is being predominated by females. A greater percentage of the nurses have BNSc, this lookedlike the nursing profession is stemming into a higher professional degree standard. This is in accordance to Bahrami (2016) study which revealed 90% of oncology nurses had a Bachelor of science in nursing. Christian religion was significantly higher than the Muslims religion in this study possibly because of the location (Benin) which is predominantly occupied by Christians. Most of the nurses have experience of over 5 years which implies that most of the nurses must have managed a patient with cancer. Nursing officers II were the majority with distribution to rank and the nursing staff respondents were from the male medical ward.

In this study, the level of knowledge of quality of life and its assessment among nurses can be described as low. This study is in accordance with Silva et al., (2015) who reported the lack of knowledge in palliative care in a high complexity oncology care centre. This study also supports Efsthiou & Clifford (2011) who identified the lack of knowledge about care of cancer patients as a factor influencing perceived quality of life in caring for cancer patients. This study is in line with Sunanda et al (2018) who revealed a low level of knowledge among his respondents due to the fact that the uptakes of the measurement tools are poor and health care professionals view the quality of life of cancer patient mainly from a therapeutic outcome.

In respect to the perception of cancer patients' quality of life among the staff nurses, this study indicated that the respondents had positive perception of cancer patients' quality of life. This is relatable to the study carried out by Bahrami, (2016) who revealed that nurses generally have a moderate perception of cancer patients' QoL.

This study report that the major perceived factors influencing nurses' uptake of quality-of-life measurement in cancer patient's care as reported by the respondents is lack of resources for quality-of-life assessment, lack of improvisation materials for quality-of-life assessment tools, patients' satisfaction with nursing care, lack of time for conversations with patients about their wishes concerning the end-of-life decisions. This is in accordance to the study by Kamsili, *et al*., (2017) who reported positive factors that hinders the higher standards of oncology nursing. All the items on the factors that influence the nurses' uptake of quality-of-life measurement in cancer patient's care were positive meaning they are all the determinants that impede compliance to the cancer quality of life measurement.

The test of association showed that there is a significant relationship ($p<0.05$) between the level of education and their knowledge, education is a key to academic success. However, respondents with PhD reported highest proportion with good level of knowledge owning to the fact that the doctorate holders have had a longer continued professional development strategies than other degree holders which propels a higher tenacity for knowledge. The relationship between nurses'

perception and knowledge of cancer patients' quality of life and its measurement revealed that there was a significant positive correlation ($r = 0.227$; $p < 0.001$) indicating that the knowledge of the nurses determines how well the cancer patient's quality of life is perceived.

Furthermore, there was no significant difference in the perception of cancer patients' quality of Life (QoL) and its measurement based on health facilities. The nurses in UBTH reported higher mean perception about cancer patient's quality of life and its measurement than those nurses from Central hospital, this maybe as a result of the federal institutions having better chances to more cases, more staff and being the final point for all referrals.

Implication to Nursing

Evidence from this study has elicited the perception of nurses on quality of life and its measurement and will help to proffer insight in increasing the awareness, knowledge and utilization of the quality of life assessment tool among nurses in health institutions. It will also be relevant to nurses in reducing the incidence of morbidity and mortality rate among cancer patients thereby promoting health and behavioural changes.

CONCLUSION AND RECOMMENDATIONS

The result from the study showed that the respondents had low level of knowledge, positive perception of quality of life and the factors outlined that hindered the utilization of quality of life measurement tools were reported positive. Therefore, there is need for active education of nurses and training on the use of the cancer quality of life and its measurement tools. Quality of life and its measurement tools should be added to nursing curriculum to be taught in schools of nursing and departments of nursing. Furthermore, Quality of life assessment tools should be made available in health institutions. Suggestively, there's need for further research to assess the application of the various quality of life assessment tools among nurses in health care institutions. Also, the assessment of the level of uptake quality of life assessment tools among nurses can be studied.

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