CHRISTIAN SERVICE UNIVERSITY COLLEGE

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QUALITY OF NURSING CARE: PATIENTS PERSPECTIVE (SURGICAL PATIENTS)

BY

GIFTY AIDOO

ABIGAIL AMANKWAH

EVELYN FREMPONG

JALULAH JIMAKO DANIEL

AKUA ABREFI OWUSU

A PROJECT WORK PRESENTED TO THE DEPARTMENT OF NURSING IN PATIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF A DEGREE IN NURSING

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DECLARATION

STUDENT'S DECLARATION

We have read the university regulations relating to plagiarism and certify that this report is all our own work and do not contain any unacknowledged work from any other source. We also declare that we have been under supervision for this report herein submitted.

Name	**Index Number**	**Signature**	**Date**
Aidoo Gifty	10000236	**...**……..	……
Amankwah Abigail	10000169	……	……
Evelyn Frempong	10000537	……	……
Owusu Abrafi Akua	10000388	……	……
Jalulah Daniel Jimakol	10000278	……	……

SUPERVISOR'S DECLARATION

I hereby declare that the preparation and presentation of this dissertation was supervised in accordance with the guidelines on supervision laid down by Christian Service University College.

Cynthia P Akuoko.	……	…….
Supervisor`s name	Signature	Date
Ernestina Armah	……	…….
Head of Department	Signature	Date

ABSTRACT

This study is aimed at assessing the quality of nursing care from the patients` view point at Komfo Anokye Teaching Hospital which was the study setting. Descriptive study design was employed where the characteristics of nurses view by patients with regards to the quality of the care they render. The study sampled 100 patients out of a population of about 500 patients in a week using purposive sampling technique. Structured questionnaire was used to gather data. Following the data collection descriptive analysis was done on the data received. The studies found that majority of the patients were satisfied with the quality of nursing care of the hospital in question. Demographic factors that affected the perception of quality of care were age (p-value of 0.000), gender (p-value of 0.000), and educational background with p-value of 0.000 and religion also with a p-value of 0.000. It was found that majority (57%) of the respondents stated that the level of quality was good, 9% said it was very good whereas (2%) of the respondents said it was excellent. It was observed conversely that 32% of the respondents rated the quality of care as poor. The results show that majority of the respondents (78%) indicated the provision of needs of nurses as a means of improving the quality of nursing care. The study concludes that the quality of care as indicated by patient was rated good since more of the respondents had quality health care more of the time as compared to receiving poor quality care. Giving of incentives was mentioned by 7% of the respondent as a means of improving the quality of care.

DEDICATION

This study is dedicated to all patients visiting the surgery department of Komfo Anokye Teaching Hospital.

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CHAPTER ONE

1.0 INTRODUCTION

Nursing care has been identified as an integral part in health care since their role as health care professionals is critical to the wellbeing and survival of patients. Nurses spent most time with the patients than the other health care team members as such patients' perspective about the care nurses render is imperative.

Quality as defined by the oxford advanced learners dictionary as the standard of something when it is compared to other things like it; how good or bad something is.

A patient is a person who is receiving medical treatment especially in a hospital.

According to Clarke and Aiken (2006) the dissemination of numerous innovative patient safety and quality programs in recent years has not significantly improved the quality of health care. In their statement, Clarke and Aiken (2006) pointed out that 'There is consensus that the goal proposed by the International Organization for Migration (IOM) to halve the rate of medical errors within 5 years has not yet been achieved'.

According to Sholom Glouberman founder of Patients' Association Of Canada (PAC) 'Many health care professionals whose own personal experiences as patients have made them realized that the patient perspective is often not taken into account when decisions are made at clinical, organizational and governmental levels'.

As healthcare professionals, nurses are accountable for the quality and systematic improvement of nursing practice (American Nurses Association 2004).

It has come to light that 2.6 million nurses in the USA delivering patient care, their daily evaluation of that care is done without a shared understanding of what quality nursing care really means (American Nurses Association 2004). If in a nation such as USA where quality of care is well factored into the curricula of nursing training presents this number of nurses working without having fair knowledge in customer care then there is a big problem when it comes to nurses in developing countries including Ghana. Research related to the meaning, definition and perception of quality nursing care has been limited. This motivated the group into choosing this research.

1.1 BACKGROUND

Judging from comments from the general public, Ghana is also struck with this issue of some nurses not rendering quality customer care.

There is a problem of nurses being less concerned about how patients feel about the service they render. Nurses have therefore become less result oriented and relegating the emotions of the patient and the need to render quality customer care to the background. This problem could be as a result of the nurse-patient ratio that put pressure on them limiting the time available for patient oriented activities such as attending to the emotional and spiritual needs of patients. The study will be conducted at Komfo Anokye Teaching Hospital (KATH) in Kumasi the regional capital of Ashanti Region of Ghana.

1.2 PROBLEM STATEMENT

Nurses over the years have retained their prominence through high standard of academic excellence and intensive practical examinations but to others, upholding these has not kept pace with the nature of the demands that are increasingly placed on nurses. There is the challenge of

the general public's perception of a dwindling standard of care by nurses and the general lowering of standards in Ghana. (Asamani et al., 2012).

But the question is, is the falling standard of nursing care in Ghana a perception or a reality? With nationwide education on human rights through the media there is an increasing knowledge of the populace on customer care especially in the urban areas; as such the importance of the quality of customer care by nurses cannot be overemphasized under any consideration. Even though patients' perception about the quality of care nurses render is subjective, there is a need to make a precise evaluation of the quality of nursing care and determine the practices of nurses that affect quality of care rendered by nurses such that the knowledge and practices relating to patient care can be upgrade or recommended.

1.3 RESEARCH OBJECTIVES

The study specifically seeks to;

- Determine patients' description of quality health care
- Identify some practices of nurses that affect nursing care from the patient`s point of view.
- Determine the factors that work against quality of nursing care from the patient`s view

1.4 RESEARCH QUESTION

- What are patients' description of quality health care
- What are the practices of nurses that affects nursing care from the patient`s point of view.
- Which factors work against quality of nursing care from the patient`s view

1.5 JUSTIFICATION

In order to make effectual changes where necessary there is a need to make proper and accurate evaluation of issues, this study therefore is one of a kind that is poised towards making a concise

evaluation of the quality of patients' care rendered by nurses. This will then set the platform to make recommendations that when implemented would affect the quality of customer care among nurses. In the area of academia specifically research, the findings of this study will serve as background information for other related studies.

CHAPTER TWO

2.0 LITERATURE REVIEW

Literature from various countries supported the need to explore the lived meaning of quality nursing care. Coulon (1996) identified themes of professionalism, holistic care, practice, and humanism in Australian nurses' quest for excellence. The importance of these elements was supported by Gunther and Alligood's (2002) conclusion that 'high quality nursing equates with competence in the cognitive, affective, and psychomotor domains among USA nurses. Likewise, Glen (1998) argued that high quality nursing care in British nurses is influenced predominantly by values and that 'the key to improvement in practice may be the improvement of emotional and motivational tendencies. The findings of Attree (2001), Hogston (1995) and Idvall and Rooke (1998) supported evaluation criteria indicative of both external system influences on quality nursing care and internal characteristics evident through interpersonal processes and elements of performance among British and Swedish nurses. Aiken and Patrician (2000) reported that the presence of professional environments in the USA correlated with high quality nursing care. Williams (1998) proposed that Australian nurses' perceptions of quality care included themes of patient need fulfilment and therapeutic effectiveness mediated through selective focusing. Interpersonal relationship with patients and effective leadership were each identified as strong quality indicators by Redfern and Norman (1999a). Quality nursing care in Thailand by Kunaviktikul et al. (2001) was related to the degree to which the patient's physical, psychosocial and extra care needs were met. However, although these globally diverse researchers attempted to define quality nursing care, it is not known if or how the identified themes or elements relate to the lived meaning of quality nursing care from the perspective of practising nurses.

The subjective, stakeholder-specific nature of quality (Jennings & Staggers 1999; Lang & Mitchell 2004) is evident throughout the nursing literature. Nurses evaluating quality may focus on assessment, planning, or the effectiveness and skill with which treatments and medications are delivered. Patients, in contrast, are likely to care more about the communication, listening, kindness and responsiveness of their nurses. Meanwhile, nursing managers often favour a focus on the organizational elements of efficiency and cost-effectiveness. These differences reflect the knowledge, views and values of differing participants in the healthcare experience.

Research related to the meaning, definition and perception of quality nursing care has been limited. The lack of published studies addressing the unique perspective of nurses was specifically noted by Lynn, McMillen, & Sidani (2007), who observed that without knowing nurses' perspectives, the evaluation of quality patient care is incomplete and ineffective. In fact, the definition and meaning of quality in all healthcare disciplines remains elusive, subjective, and stakeholder-specific, resulting in measurement and improvement challenges (Burhans 2007).

Unscientifically, through over 30 years of experience in implementing quality improvement programmes and initiatives in acute care hospitals, practising nurses have often pointed out

to researchers that nursing managers were out of touch with the demands of bedside nursing and the real needs of patients by Linda Aikens Health Affairs, 2001 . Our premise was that nursing care improvement strategies focused on measures valued by nurses and identified by them as the core meaning of quality nursing care might result in more rapid, effective changes and improvements in nursing quality care. Related improvements in patient outcomes might be influenced by these changes. Nurse-valued measures can only be developed if the lived meaning

of quality nursing care is clearly identified. In the initial study reported here, we focused on practising nurses working in acute care hospitals in the USA because significant improvement efforts are currently focused in this arena.

Because the lived meaning of quality nursing care for practising nurses has not been specifically identified in the nursing literature, a new approach was proposed. An exploratory, qualitative study, using van Manen's (1990) approach to hermeneutic phenomenology, was conducted to explore and uncover the lived meaning of quality nursing care. Pope, van Royen, & Baker, (2005) supported the use of qualitative methods as appropriate in determining what really matters to caregivers in the arena of healthcare quality. They stated that, 'the emphasis in qualitative research on understanding meanings and experiences makes it particularly useful for quality assessment and for unpacking some of the complex issues inherent to quality improvement.

2.1 QUALITY OF NURSING CARE

In a study titled, 'Inpatient's Perspective on Nursing Care' by Laar (2013) was aimed at assessing the perspective of patients with regards to quality of nursing care they received at the health facility used for the study. In view of achieving this aim, a cross sectional study was conducted to find out patient`s perspective of nursing performance and the factors influencing their satisfaction. The study was conducted on 250 nurses in two hospitals. Data collection was done in the qualitative style where Quality from Patient`s Perspective Questionnaires were employed.

The results of the study by Laar (2013) showed that the satisfaction of patients was weak and this was recorded by majority of the patients being 48%. It was also identified that the socio-demographic characteristics of patients affected the perspective on the quality of nursing care they received at the hospitals. There was a significant relation between impatient satisfaction and gender with a p-value of 0.001, age also had a p-value of 0.000, level of education gave a p-value of 0.001, and marital status recorded 0.03 as p-value. Others socio-demographic factors that gave significant relationship with the level of satisfaction were the occupation of patients which gave a p-value of 0.005. Place of residence, previous hospitalization, shift of nursing, undergoing surgery and the particular hospital also gave significant relationship with the quality of care since the p-values that predicted their significance.

Laar (2013) therefore recommended that one valuable way of improving the quality of nursing care is routine quarries of patients concerning the care experiences and their suggestions to improve the care received.

2.2 HEALTH FACILITY CONTRIBUTION TO QUALITY OF CARE

Williams (1998) carried out a grounded theory study of the nurses' perceptions in relation to the delivery of quality nursing care. Ten registered nurses purposively selected from four surgical specialty wards of an acute-care public hospital located in Perth, West Australia were interviewed. Additionally, transcripts of 12 additional interviews were made available for comparison and clarification of categories towards the end of the analysis. Data were analysed with the use of constant comparative method of analysis, whereby collection, coding and analysis occurred simultaneously (Glaser & Strauss 1967). The presence or absence of needs holds a central role in determining the quality of nursing care. Nurses described and assessed the

concept in terms of the degree to which the patients' needs were met. Quality nursing care was described as 'meeting all the needs of the patients or clients you are looking after' whilst low quality nursing care was related to the omission of nursing care required to meet patients' needs' (Williams 1998, p. 811). According to the nurses, patients' needs were identified as physical or psychosocial. The physical needs were related to a lack of personal independence in the physical daily functional activities of the person. Psychosocial needs required the nurses to assume a supportive role for the patient. This care involved specific ways of communicating, providing information, caring and advocating for the patient whilst the patient's family and aspects of their social life were also included in this care .The nurses placed great emphasis on meeting patients' psychosocial needs and described the care of these needs in greater detail than care for physical needs (Williams 1998).

However, the excessive workload limited the nurses available time for patient care, forcing them to priorities care providing more emphasis on the physical needs rather than on psychosocial or extra care needs of the patients.

Hogston (1995) explored practicing nurses' perceptions of quality nursing care and from these to establish a definition. The opportunistically selected sample was consisted of eighteen nurses from a large hospital in the south of England. Data were collected with unstructured interviews and analysed with a modified grounded theory method. Even though the nature of quality in nursing is intricate, nurses have readily identified the infrastructure. The data analysis revealed three categories described as 'structure', 'process' and 'outcome'. This supports previous work on evaluating quality care but postulates that structure, process and outcome could also be used as a framework for defining quality. The category of 'structure' emerged from substantive codes

such as skill mix, time, workload (human resources). For nurses the human resources and quality seem to be complimentary.

'Quality of care is depended on having enough staff of the right skill mix, which in turn allows time to be spent with patients' (Hogston 1995, p. 119). The category of 'process' revealed the complexity of nurses' perceptions of quality. Nurses cited teamwork, multidisciplinary process, and 'being competent' as the most important elements of this category. These findings demonstrate a conviction towards patient-centre, holistic care which is provided by competent nurses. The third category to describe nurses' perceptions of quality is 'outcome'.

Here nurses defined quality in terms of patient satisfaction, meeting patient needs and giving information.

McKenna et al. (2006) performed a study which aimed at developing a tool to measure the perceptions of professional hospital staff in the UK regarding the quality of care provided to patients. Cronenwett & Slattery (1999) already developed an instrument in the US and this study aimed at exploring whether the validity of the tool could be transferred to the UK. Five hospitals were randomly selected in Northern Ireland and 4 hospitals in Oxford, England. The participants consisted of nurses, medical consultant, speech therapist, physiotherapists and social workers. The results indicate that for professionals in clinical areas both in the UK and in the US, issues related to competency, communication, confidentiality and dignity of patients, cleanliness, and hygiene, expertise and judgement, safety, discharge procedures, information and education, staff morale and continuity of care are important when it comes to determine their perceptions of the quality of care. In the UK, issues such as waiting lists, resources, leadership, and infections rates were also important for the staff whilst for the staff in the US, general attitude and accessibility of staff and collaboration appeared to be important.

2.3 PATIENTS PERSPECTIVES

Oermann (1999) asserts that despite the extensive research on defining and measuring health care quality, less attention has been given to consumers' perspectives. Furthermore, she asserts that consumers and providers often hold different perspectives when it comes to define "quality nursing care" (Larrabee 1995, Lynn & Moore 1997, Lynn & McMillen 1999). Convenience samples of 239 consumers were interviewed on their perspectives of quality health care and quality nursing care and data analyzed through content analysis. Consumers were recruited from the waiting rooms of clinics and in neighbourhoods of a large metropolitan area in the Midwest. Consumers defined quality nursing care as having nurses who were concerned about them and demonstrated caring behaviours, were competent and skilled, communicated effectively with them and taught them about their care. Consumers defined the quality of health care in terms of access to care, having competent and skilled providers, receiving proper treatment, having freedom to choose their physicians and hospitals, having providers who communicate effectively with them, who teach them about their conditions and treatments and who demonstrate caring behaviours and concern for them as individuals (Oermann 1999).

Oermann et al. (2000) acknowledged the fact that the perceptions of quality nursing care also differ among patients. In-patients have different views of quality care than do consumers in ambulatory facilities. Whilst hospitalized patients describe quality care as hospital staff respecting patients' values and needs, coordination of care, communication and education, physical comfort, emotional support, family involvement and continuity in the transition to home (Edgman-Levitan & Cleary 1996, Ketefian et al.,1997),ambulatory patients are also concerned with issues such as access to care, waiting times, assistance from office staff, and follow-up care and information (Chung et al., 1999, Healy et al., 1995).

Thorsteinsson (2002) performed a phenomenological study in order to investigate how individuals with chronic illnesses perceive the quality of nursing care. Eleven Icelandic participants aged 38-80 years with various chronic illnesses were interviewed and data analysed through the coding and categorisation method. The analysis revealed that there is not a simple definition of the phenomenon "quality of nursing care". The findings emphasise that the quality of nursing care cannot be separated from the nurses who provide the care. When asked to describe their experiences, participants mostly described nurses who had given that care, indicating that participants did not separate the two components. The character of the nurses seemed to play a major role in providing high quality nursing care, as attitude and manner infiltrated all discussion of quality. This is consistent with findings from various studies (Williams, 1998; O'Connell et al., 1999; Redfern and Norman, 1999) along with clinical competence (Irurita, 1999; Radwin, 2000). The findings also indicate connections between quality and caring. The importance of caring has been highlighted in the nursing literature (Watson, 1988; Benner and Wrubel, 1989). Ludwig Beymer et al. (1993) state that professional caring in nursing and quality of nursing care are undoubtedly linked, as one essential component of quality seems to be caring.

A grounded theory study by Radwin (2000) aimed at analysing theoretically oncology patients' perceptions of the attributes and outcomes of quality nursing care. The purposive sample comprised 22 oncology patients being treated at an urban medical Centre; they were interviewed using semi-structured schedule. Eight attributes of quality nursing care emerged from the data: excellent care was characterized by professional knowledge, continuity, attentiveness, coordination, partnership, individualization, rapport, and caring. In addition, two outcomes of quality care included increased fortitude and a sense of well-being with its constituents of trust,

optimism and authenticity. Lymer and Richt (2006) chose a phenomenographic approach to describe patients' conceptions of quality care and barrier care. Fourteen adult orthopaedic patients were interviewed.

The analysis of the patients' conceptions of quality care resulted in the following categories: nice manners; mutual achievement; being involved; being cured; being cared for; and having safe care. These findings confirmed to a large extent the findings from other studies of quality care (Radwin and Alster, 2002; Attree, 2001; Williams, 1998; Wilde et al., 1993). Wilde et al.. (1993) performed a grounded theory study to develop a theoretical understanding of quality of care from a patient perspective. Thirty-five interviews were conducted with a sample of 20 adult hospitalised patients in a clinic for infectious diseases. Data were analysed according to constant comparative method. The data analysis suggests that patients' perceptions are formed by their encounter with an existing care structure and by their system of norms, expectations and experiences. For patients quality of care 'can be regarded as a number of interrelated dimensions which taken together form a whole'. These dimensions include the 'medical-technical', the 'physical-technical conditions', the 'identity-oriented approach' and the 'socio-cultural atmosphere'. Wilde et al. (1993) assert that 'The content of this whole can be understood in the light of two conditions (core variables) which are labelled as the 'resource structure of the care organization' and the 'patient's preferences'. The resource structure is of two kinds: person-related and physical- and administrative amenities.

2.4 OTHER STUDIES ON QUALITY OF CARE

Gordon (2005) described the historical, stereotypical (iconic) view of the nurse as that of a physician's handmaiden, dependent on the physician for direction. She explained that the nursing profession has been negligent in sharing with the public the importance of nurses' critical

thinking, problem-solving, and research skills. Nurses have failed to help the public understand that nurses' actions involve more than nurturing; they also include assessing, surveying for risks, identifying client goals, planning independent actions, and prioritizing care. Gordon (2006) has stated that in order to gain and maintain the respect of the public and other healthcare professionals, nurses must emphasize and communicate the knowledge and skills required for professional nursing. It is also imperative that those responsible for reimbursement of nursing care understand that nurses "save lives, prevent complications, prevent suffering, and save money" (para. 5). O'Mara (1999) has argued that in order to assure reimbursement and access to needed resources nurses need to articulate the cognitive abilities nurses need in order to provide competent care. Benner, Sutphen, Leonard, and Day (2010), too, have written that nurses must learn to emphasize the tangible benefits of nurses, beyond that of caring. In the remainder of this literature review we will look at motivations for choosing nursing as a career and review the literature identifying the need for both competence and caring skills in nursing.

2.5 MOTIVATION

According to Locke and Latham (2002), personal goals are vital for direction and maintenance of behaviours that help to achieve future rewards. Effective goal setting can be a source of motivation as an individual pursues a career. The social cognitive career theory (SCCT) has postulated that self-efficacy beliefs and outcome expectations are key motivators for career selection. Individuals who are confident of goals, who believe in their ability to reach their goals, and who believe that goal attainment will lead to a successful career are able to complete the tasks required to achieve their goals (Lent, Brown, & Hackett, 1994).

In a systematic review of literature related to career choices of gifted and talented students, Miller and Cummings (2009) identified one career motivator as the perception of a *fit* between a career and one's personal self-concept. Miller and Cummings found career choices to be based on the belief that an individual possesses the necessary traits to be successful. They also found that career choices were influenced by family members, specifically mothers. These gifted students preferred careers that were prestigious and required higher levels of education. Hoke (2006) observed that to recruit talented students, the nursing profession must educate the public regarding the high level of critical thinking required for nurses and the potential for nurses to impact global problems.

Emmons (1999) approached career choices from a *strivings* perspective in which goals are assessed based on what the individual is striving to achieve. The list of possible goals is then assessed for the impact of specific motives on the person's choice of goals. Other motivating factors for career choices may be based on spiritual beliefs, feelings of being 'called' into a specific area, and materialistic desires (Dik, Sargent, & Steger, 2009).

2.6 COMPETENCE

The U.S. Institute of Medicine (IOM) (2003) mandated increased attention to factors that promote quality and safety of patient care. Since this mandate was issued, outcomes of patient care have become increasingly important. In response, Cronenwett et al. (2007) have proposed that "statements of the knowledge, skills, and attitudes (KSAs) for each competency … should be developed during prelicensure nursing education" (p. 122). Competencies identified by the IOM and addressed by the Quality and Safety Education for Nurses (QSEN) now include

patient-centred care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics (Cronenwett et al., 2007; IOM, 2003).

2.7 CARING

The American Association of Colleges of Nursing (1998, 2008) and the National League for Nursing (2007) have identified caring as a foundational value for nursing. Shultz (2009) has described attempts in nursing education to guide progression from a personal identification as a caring person to a professional 'identity of caring.' Benner (2000), Benner, Tanner, and Chelsa (2009), and Benner and Wrubel (1989) have proposed that caring is a requisite for the development of critical thinking. Stowe (2006) investigated educational strategies in nursing education that were designed to promote understanding of caring as an abstract concept and concluded that nursing education's efforts to "impact a more consciously caring individual for our society is invaluable" (pp. 127-128).

The above insights support Purnell's (2009) conclusion that caring includes themes of struggle, discovery, hope, humility, and spirituality (p. 115). Falk-Rafael (1996) proposed that caring in nursing has evolved from an ordered (or required) caring (associated with characteristics such as nurturing), to an assimilated caring (as nursing developed into an autonomous profession), and then further evolved to an empowered caring (as individual nurses realized nursing interactions support caring connections) within an interprofessional healthcare delivery system that has an ever-changing power base. Falk-Rafael suggested that empowered caring is informed by both knowledge and experience.

2.8 QUALITY ASSURANCE

According to Offei et al. (2002), Quality of care has being a concern to many patients and the public. Although Quality means different things to different people, the common definition is the

degree to which a product or service meets the expectations of an individual or group. Continuous improvement of quality of service is necessary because expectations change and therefore what meets today's expectations may not meet tomorrow's expectations. The quality of health care services depends on several dimensions which include accessibility, equity, amenities, technical competence, efficiency, effectiveness, safety, continuity of services and good interpersonal relations in health care. Quality can be measured from the perspectives of various stakeholders in health care that is, the community, the client, the provider and the manager. Again we have to monitor measure and improve the structures, processes and outcomes.

Quality assurance in health care is a planned, systematic approach for continuously monitoring, measuring and improving quality of health services with available resources, to meet the expectations of both providers and users. Quality assurance focuses on how to improve the way we do things on a continuous basis. It can be done whether in well-equipped teaching hospital or a small rural health centre.

Quality assurance focuses on five principles which are;

- Meeting the needs and expectations of the patient and community.
- Focuses on systems and processes.
- Uses data analyses service delivery processes.
- Encourages team approach to problem solving and quality improvement.
- Communication is vital to the success of quality assurance.

There are several factors that make it difficult to apply the principles of quality assurance and these barriers must be prevented. These barriers are;

- Non-commitment to top management to quality.

- Wrong attitude to staff.
- Lack of team work.
- Concept of quality poorly understood.
- Fear of change.
- Suspicion about comparisons
- Patient views are not given adequate attention

Low staff motivation: Proper quality assurance is beneficial to the users, the community, the health care staff, the health care manager and the health institution.

Many authors have debated the question of whether ethical principles should be universal across settings and cultural groups, or be relative to the setting or culture (Brink 1989; Ijsselmuiden & Faden 1992; Lützén 1997). In the opinion of the authors of this paper, nursing practice in international settings must meet international ethical standards in promoting health, preventing illness, restoring health and alleviating suffering (International Council of Nurses 2006). At the same time, such practice must acknowledge the ethical standards related to the institutional setting and cultural environment in which the practice takes place (Mill & Ogilvie, 2002). Cultural values refer to enduring ideals or belief systems to which a person or a society is committed (Ludwick & Silva, 2000). For example, on the one hand, values of nursing practice in North America are embedded in the values of the North American culture with its emphasis on self-reliance and individualism (Davis, 1999). On the other hand, many African cultures are based on the extended family system (i.e. loyalties of a person to a group exceed the rights of the individual) rather than individualistic. In such collectivistic cultures, health decisions usually are not made by an individual but by the family. It is therefore important to become knowledgeable about local cultural traditions and to be able to discuss contentious ethical issues. Moreover,

reflecting on how universal ethical standards and cultural values complement or conflict with each other in the culture in which one practices, receives education or conducts research is a requirement for ethical thoughtfulness.

Nurses and Midwives constitute the largest number of health care professionals within the health care fraternity in all settings. To a large extent, nursing and midwifery contribution in the health care continuum influence the direction of the management of disease burden across communities in the preventive, curative and rehabilitation dimensions. Nurses in Ghana work under very difficult circumstances (Talley, 2006). They are always being called upon to treat increasing numbers of sick people and seriously injured patients (Asigri, 2009). Treatment must often be rendered without optimal equipment and resources (Health Sector Support Office (HSSO) of Ghana, 2001). Globally, with the gradual rise in people's living standards, knowledge about patient rights and a highly educated population, nurses are constantly reminded to do their work by international ethical standards. In Ghana, some of the predominant cultural practices and beliefs in the country contribute to ethical dilemmas for nurses. In recent times, as disease management has become more complex, with the emergence of new disease conditions, health seekers are becoming aware of their rights to respect and quality care from carers at the same time. It is therefore required of nurses to live up to client expectations through the adoption of acceptable practices and innovations that will impact positively on health care outcomes. Among these are respect for human rights and individuality of the client and the reshaping of our professional ethics that will strengthen our code of conduct.

In this light, the Ghana Registered Nurses Association dedicated their 2011 nurses' week celebration to addressing shortfalls in their care contribution with particular reference to attitude towards care and the human subjects who constitute their clients and stake holders. For this

reason, the theme, 'Nurses/Midwives: Self-assessment on Attitude' was chosen to address the question of client satisfaction deficit in our care. This was to examine the quality of nursing and midwifery contribution to health care as demanded by the Nightingale philosophy of patient-centred care. Many things have gone amiss with our caring attitude. Over the years, the standards of care have kept falling and this has translated to a multiplicity of shortfalls in nursing and midwifery outcomes that has huge repercussions on the quality of health care generally. I share the opinion that nurses and midwives are to blame more for the gloomy picture of gross disease burden arising from chronic ailing conditions, addiction of unhealthy lifestyles among the populations, the seemingly unassailable toll of malaria on members of our communities and the prevalence of maternal and infant morbidity and mortality. The conviction of the fact that we are more to blame among all other health care professionals for poor quality of health care arises from the fact that to whom that more is given, more will be expected. How can we continue to pride ourselves in the truth that nurses and midwives constitute the largest percentage of health care professionals and not take more of the blame when the general care across the health care continuum is seen to have been compromised?

In the summer of 2009, the Department of Nursing of the Valley View University in Accra, Ghana hosted an international nursing conference led by a team of health experts from the USA and Canada. The theme, 'Nursing in the 21st Century: New Approaches for Improved Outcomes', was geared towards equipping nurses and health care educators with modern knowledge and skills in health care delivery. During several pre-workshop sessions on nursing ethics, the authors, two health educators (one Ghanaian who teaches pre-medical and pre-nursing students in Canada, and one American who teaches nursing students in Ghana) surveyed Ghanaian nurses to find out how they reflect on their practice and respond to ethical issues,

especially with respect to the ICN Codes for Nurses and five ethical principles of non-malfeasance, beneficence, autonomy, social justice and confidentiality. During this conference, the nurses examined many real situations that happen to them during the delivering of their services to their clients in respect to their ICN codes and how they conform to those codes or contrarily to them. At the end of the conference, it was concluded that nurses need to collaborate with patients, families, and other health team members to plan and provide nursing care that would help achieve optimal level of health and wellness.

CHAPTER THREE

3.0 METHODOLOGY

3.1 STUDY SETTING

The study was conducted at Komfo Anokye Teaching Hospital (KATH) in Kumasi the regional capital of Ashanti Region of Ghana.

It was established in 1955. KATH is the second largest hospital in Ghana under the auspices of Ministry of Health and has a bed capacity of 1000.It is accessible to about 80% of the population of Ghana: Northern, Western, Central Brong Ahafo and neighbouring countries such as La Cote d'Ivoire, Burkina Faso, and Togo due to its strategic location in the middle belt of Ghana.

Specifically, this study is set to be conducted at the surgical department of the hospital.

3.2 STUDY DESIGN

Qualitative descriptive study design was used which covered the description of characteristics of nurses in terms of the quality of service they render from the patent's point of view. Discrete quantification of the patient's description of quality of health care will be measured based on a scale format such that an accurate documentation of quality of nursing care in the health facility under being used as the study setting can be made.

3.3 STUDY POPULATION

The population for the study was patients visiting the surgical department of the Komfo Anokye Teaching Hospital.

3.4 SAMPLING SIZE

A sample size of 100 patients was drawn from the study population. Purposive sampling technique was employed.

3.4.1 Calculation for Sample Size

The sample size estimation was done using the formula below;

$$n_i = \frac{X^2 NP(1-P)}{D^2(N-1) + X^2(1-P)}$$

Where;
n_i - required sample size

X2 = the table value of chi-square for 1 degree of freedom at the desired confidence level

(3.841).

N= the population size.

P= the population proportion (assumed to be .50 since this would provide the maximum

Sample size).

d= the degree of accuracy expressed as a proportion (.05).

Therefore, if N is approximately 500 for a week.

$$n_i = \frac{3.841\ x\ 500\ (0.5)(1-0.5)}{0.05^2(500-1) + 3.841(1-0.5)}$$

n_i = 151.7

This value was corrected to 100 since it researchers had a shorter time for data collection.

3.5 INSTRUMENT, TECHNIQUE FOR DATA COLLECTION AND ANALYSIS

Structured questionnaire was used as a data collection tool based on a survey done. This form of data collection tool was used due to its ease in application and because all the information needed was not obtainable through only observing the subjects.

The collected data was then subjected to descriptive analysis where the results were interpreted in simple percentages and frequencies and presented in tables and graphs and other statistics.

3.6 LIMITATIONS

For such a study, a large sample size is required such that the results can be well generalized to the population on the ground. A limitation that the study faced was that of time and financial constraints that affected the sample size used in the study. From the researcher`s schedules, the study was conducted amidst the normal semester activities and other personal commitments. The study was funded by the researchers and as a result a large sample size could not be used, therefore a moderate sample size was used to aid quick data collection and analysis of the results obtained from the data collection process.

3.7 ETHICAL CONSIDERATION

This involves obtaining a permit to conduct the study and covers an agreement of maintaining the privacy and anonymity of the respondents or members in the sample for data collection. An introductory letter was obtained from the school and given to the research authority of the Komfo Anokye Teaching Hospital for authorization to be granted for the study. Individuals who took part in the study was first given a brief introduction on the study and its essence. They were encouraged to participate without any compulsion reassuring them that their responses would be treated with confidentiality.

3.8 VALIDITY AND RELIABILITY

This is a measure of how best the research instrument measures the parameters being considered and how reproducible the result obtained from using this research instrument could be. To make this measurement a pretesting process was conducted at the Suntreso District Hospital .This pretesting helped the researchers in making the needed amendments in the research instrument before the actual data collection process was carried out.

CHAPTER FOUR

4.0 RESULTS AND DATA ANLYSIS

This chapter displays and examines the results of the study. The results have been shown on tables and graphs where frequency and percentage measures have been employed to represent responses given. In all data was collected from hundred (100) respondents. The data collection has been segmented into two main parts which are the demographic information and the section with responses pertaining to quality of care.

4.1 DEMOGRAPHIC INFORMATION

Table 4.1 Demographic information

		Frequency	Percent
Gender	Male	40	40
	Female	60	60
	Total	100	100
Age range	21-30	37	37
	31-40	29	29
	41-50	24	24
	51-60	10	10
	Total	100	100
Educational background	No formal education	18	18
	Junior secondary school	10	10
	Senior secondary school	26	26
	Tertiary education	46	46
	Total	100	100
Religious affiliation	Christian	53	53
	Moslem	26	26
	Traditionalist	14	14
	No response	7	7
	Total	100	100
Marital status	Single	28	28
	Married	40	40
	Divorced	5	5
	Separated	6	6
	Widow	8	8
	No response	13	3
	Total	100	100

Source: Field Survey Data, 2014

The study according to the demographic information indicates that majority (60%) of the respondents were females whereas 40% were males. This trend could be linked to the fact that females are more concerned about their health than males. Ages of respondents showed that majority (37%) of the respondents were aged 21-30years, respondents with aged 31-40 years were 29% of the distribution while the least was 10% for age range 51-60 years.

Tertiary education was the most prominent educational background that was identified in this study and respondents with this educational background were 46%, 26% had secondary school educational background while the least was 10% with junior high school background. On the contrary, 18% of the respondents did not have any formal education.

With regards to religious affiliation, Christians were the majority with a representation of 53%, Muslims had 26% of the distribution whereas traditionalist among the respondents were14%. It was also indicated that 7% of the respondents did not indicate their religious affiliation.

According to the results, the majority of the respondents (40%) were married, 28% of them had not married and were single while the least (5%) of the distribution had divorced.

Table 4.2 Cross tabulation of demographics against rating of quality of care

		Rating of level of quality received in health facility		Total	
		Good quality Care	Poor quality care		Asymp. Sig. (2-sided)
Age range	21-30	29	8	37	0.000
	31-40	29	0	29	
	41-50	9	15	24	
	51-60	1	9	10	
Total				100	
Educational background	No formal education	5	13	18	0.000
	Junior secondary school	10	0	10	
	Senior secondary school	15	11	26	
	Tertiary education	38	8	46	
Total				100	
Religious affiliation	Christian	46	7	53	0.000
	Moslem	15	11	26	
	Traditionalist	0	14	14	
Total				100	
Gender	Male	15	25	40	0.000
	Female	53	7	60	
Total				100	

Table 4.2 above is the results from cross tabulation between the demographic characteristics of patients and the rating of level of nursing quality at the health facility. It is indicated that the ages of patients cross compared with the rating of quality of nursing care shows that majority of patients mentioned that the quality of care was good and among them 29% were recorded for age ranges 21-30 and 31-40 years. It was also indicated that 8% of the patients aged 21-30 years mentioned that they received poor quality nursing care. It also worth noting that majority 15% and 9% of the patients who were aged 41-50 and 51-60years respectively indicated that the

nursing care they received was poor as against 9% and 1% of the patients aged 41-50 and 51-60 respectively also stated that the care received was good.

Second on table 4.2 was the educational background compared against the level of quality of nursing care. The results show a decline from no formal education to tertiary education with regards to the percentage of patients who indicated that the quality of nursing care was good. Out of the 18% patients who were having no formal education, 13% stated that the nursing care was poor whereas 5% mentioned the opposite. All 10% of the patients with junior secondary educational background indicated that the care given was good. Secondary level patients were 26% and out of this number 15% stated that the nursing care was good as against 11% who mentioned otherwise. Finally out of the 46% of the patients who had tertiary education, 38% stated that the nursing care was of good quality whereas 8% said it was of poor quality. There was a significant relationship between the educational background of patients and the rating of quality of nursing care.

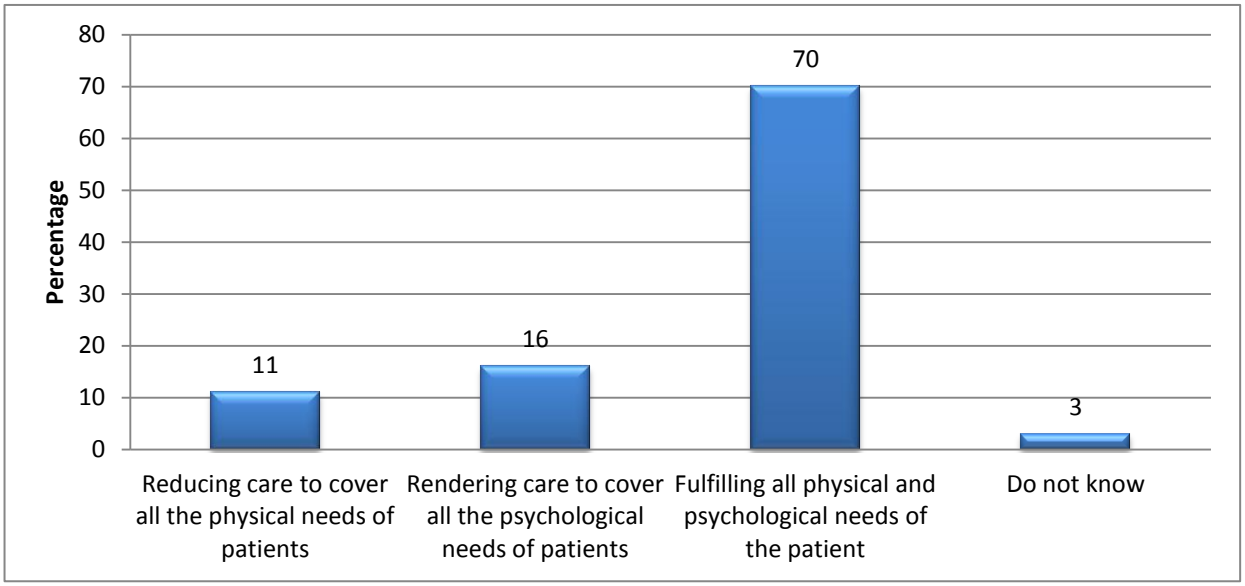
With regards to religious affiliation of patients who took part in this study, Christians were the majority (53%) and had 46% mentioning that the quality of nursing care was good, 7% also indicate that the care was poor. Fifteen percent (15%) of the Muslims who took part in the study said that the quality of nursing care was good whereas 11% said it was not good, finally out of the 14 traditionalists representing 14% all of them mentioned that the quality of nursing care was poor. Once again there was a significant relationship between religious affiliation of patients and the rating of quality of care.

Finally, gender was compared to the rating of quality of nursing care. It was found that males mostly rated the quality of nursing care as poor since out of 40 males (40%), 25% mentioned that the quality of nursing care was poor and 15% said it was good. Females on the other hand were

in agreement that the quality of nursing care was good by majority of them since 53% out of 60% said it was good and 7% mentioned otherwise. This shows a clear and a significant difference in the gender distribution and the rating of quality of nursing care rendered at the study setting. It was also identified that the socio-demographic characteristics of patients affected the perspective on the quality of nursing care they received at the hospitals. There was a significant relation between inpatient satisfaction and gender.

4.2 MEANING AND PRACTICES AFECTING QUALITY OF CARE

Figure 4.1 Meaning of quality of care

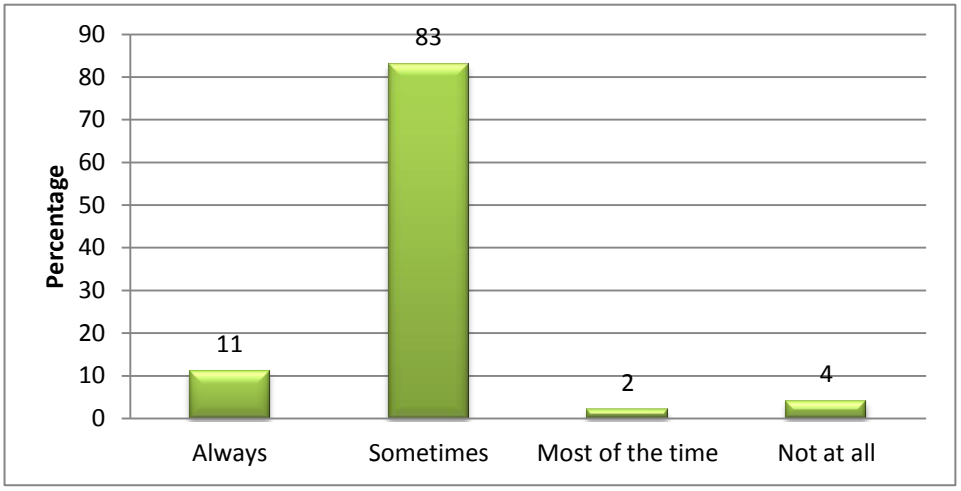


Source: Field Survey Data, 2014

Figure 4.1 shows the meaning of quality of care according to the respondents of this study. It was shown that majority (70%) of the respondents said quality of care was fulfilling all physical and psychological needs of the patient, 16% also added that it was rendering care to cover all the psychological needs of patients. The study found that 11% of the respondents indicated that quality of care was reducing care to cover all the physical needs of patients. Three percent of the

respondents indicated they did not know what this quality of care was. The findings indicates that majority of the patients were aware of what quality of care was.

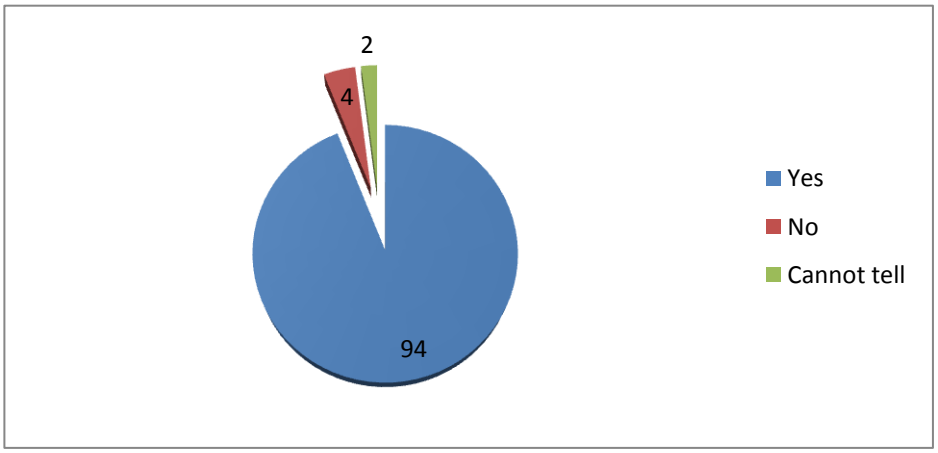
Figure 4.2 Frequency of reception of quality care at hospital



Source: Field Survey Data, 2014

Figure 4.2 displays the distribution of frequency of receiving quality of care. It was shown that majority of the respondents (83%) had quality care sometimes, 11% indicated that they always had quality of care rendered to them, 2% indicate this was possible most of the time where as on the contrary 4% said that quality care was never rendered to them.

Figure 4.3 Detection of quality of care at hospital



Source: Field Survey Data, 2014

Figure 3.4 shows the responses to whether quality care was detected at the hospital among respondents. It was shown that almost all the respondents (94%) indicated that they could detect quality care where as 4% mentioned the opposite and 2% also indicated they could not tell if they could detect quality care or not.

Table 4.3 Responses to attitude of health personnel

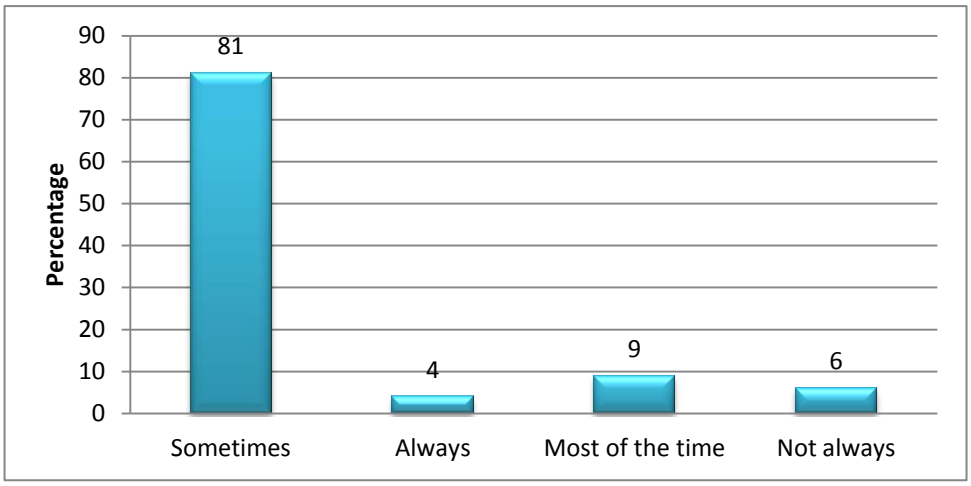
	Yes	No
Showing disrespect	69	31
Being intolerant	73	27
Not being approachable	13	87
Referring to patients wrongly	47	53
Lateness	16	84
Negligence of duty	46	54
Absenteeism	16	84
Carelessness	54	46

Source: Field Survey Data, 2014

Table 4.2 displays responses on the various attitudes shown by nurses by the respondents. It was shown that majority of the respondents (69%) disrespected the respondents, 73% were intolerant to patients, 13% were reported as not being approachable. It was also indicated that 47% of the respondents referred to patient wrongly, 46% of them also were negligence of their duty. Eighty-four percent (84%) of the respondents reported absenteeism among health personnel whereas 54% of the respondents stated that health personnel were careless. the prominent finding here was intolerance among health personnel followed by disrespecting patients.

4.3 QUALITY OF NURSING CARE

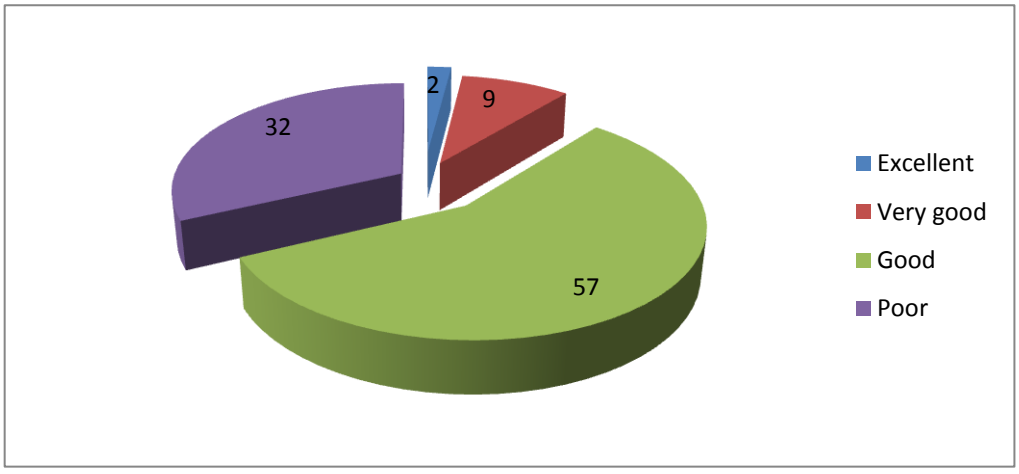
Figure 4.4 Victim of poor quality practices among nurses



Source: Field Survey Data, 2014

Figure 4.4 shows the responses on the frequency for which respondents had been victims of poor quality practices among nurses. The results indicated that majority (81%) of the respondents were victims of poor health care sometimes. Nine percent (9%) of the respondents stated that they were victims to poor quality care most of the time, 6% experienced this unfortunate situation not always whereas 4% on the other hand experience poor quality care always.

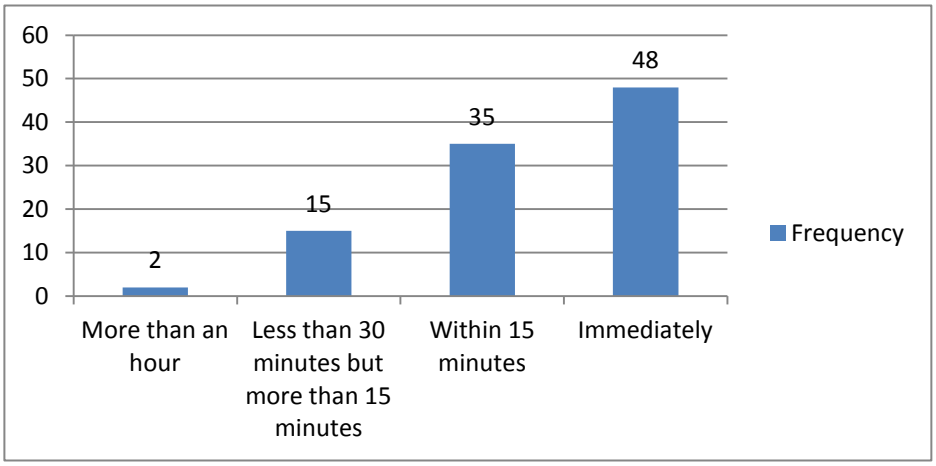
Figure 4.5 Rating of level of quality received in health facility



Source: Field Survey Data, 2014

Figure 4.5 shows the rating of quality of care received in health facility among respondents. It was revealed that majority (57%) stated that the level of quality was good, 9% said it was very good whereas (2%) of the respondents said level of quality was excellent. It was observed conversely that 32% of the respondents rated the quality of care as poor.

Figure 4.6 Waiting time



Source: Field Survey Data, 2014

Waiting time for respondents is shown in figure 4.6 above and indicates that majority (48%) of the respondents was immediately attended to. Thirty-five percent of the respondents were waited for 15minute before they were given attention, 15% also said they were attended to in less than 30minutes but after 15minutes. It was however surprising that 2% of the respondents reported they waited for more than an hour before given attention.

4.4 CHALLENGES AND POSSIBLE SOLUTION TO QUALITY OF NURSING CARE

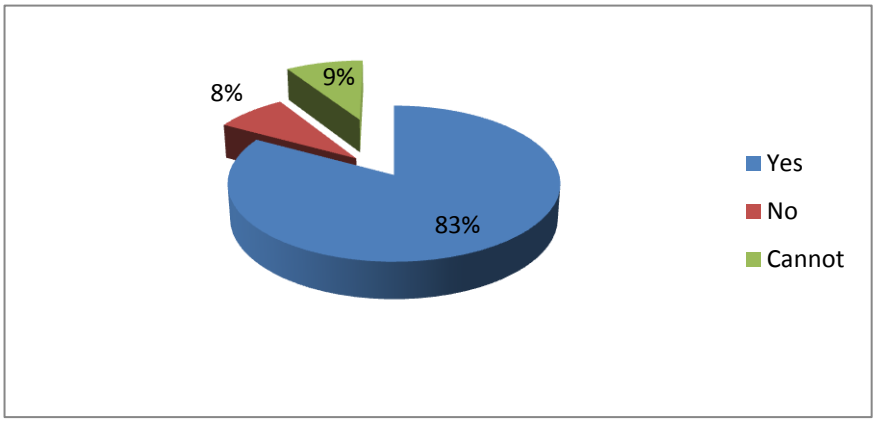
Table 4.4 Challenges of nurses in discharging duties and whether it affects quality of care.

		Frequency	Percent
Nurses facing challenges in discharging duties	Yes	100	100
Challenges affect the quality of care rendered	Yes	100	100

Source: Field Survey Data, 2014

Table 4.3 shows that all the respondents indicated that nurses faced challenges and those challenges affected the quality of care.

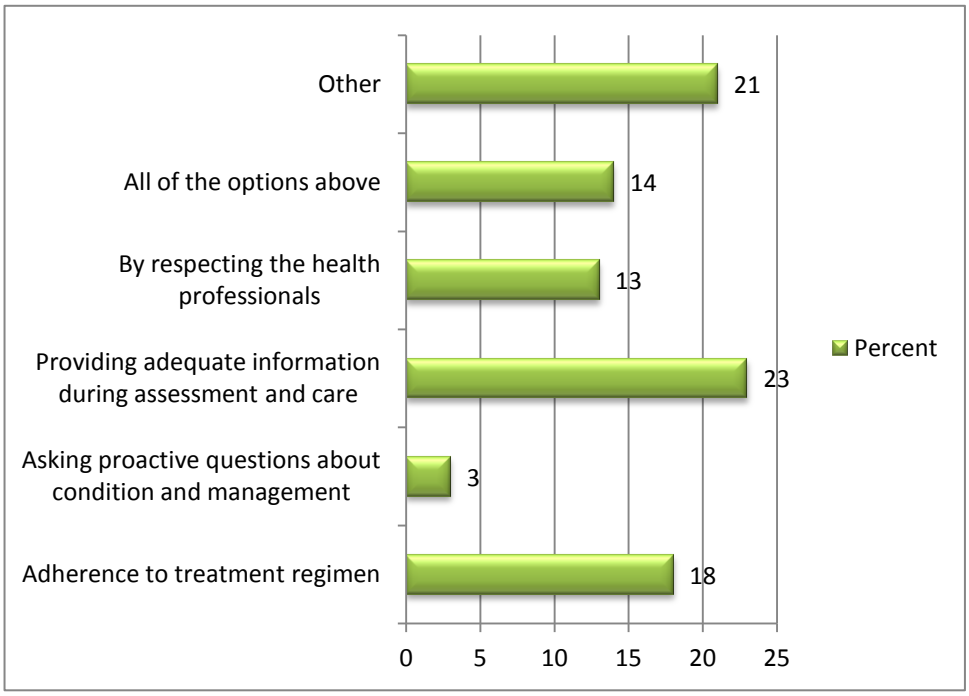
Figure 4.7 Patient contributions to quality of care



Source: Field Survey Data, 2014

The distribution on the need for patient to contribute quality of care is shown in figure 4.7. it was indicated that majority of the respondents indicated that patient had a role to play in attaining quality care. Eight percent (8%) of the respondents stated that the patient had no role to play in quality care provision where as 9% could not tell.

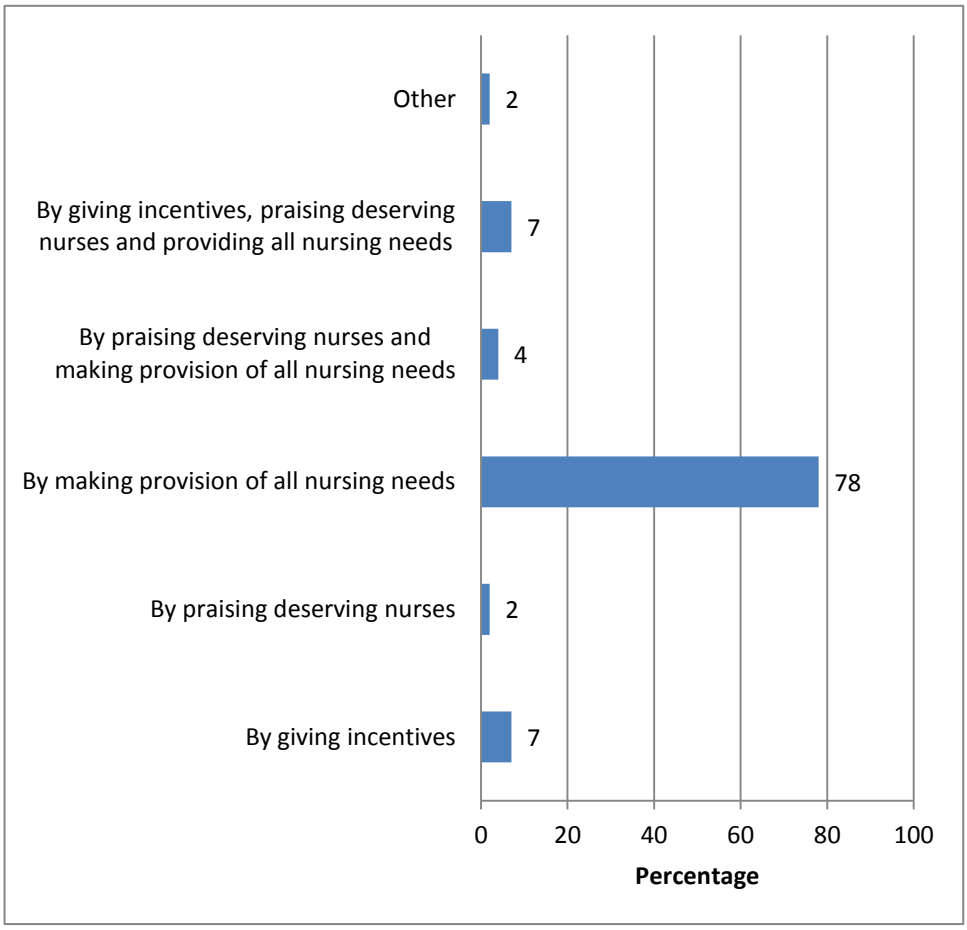
Figure 4.8 Contribution of patients to quality of care



Source: Field Survey Data, 2014

Figure 4.8 displays the contribution of patient to quality of care. The results indicates that majority (23%) of the respondents said provision of adequate information during assessment and care, 18% of them added that adherence to treatment regimen was a way patients could contribute to quality of care. Thirteen percent of the respondents indicated that patients needed to respect health personnel and 3% added that patients should ask proactive questions about condition and its management. Other means by which patient could contribute was 21%

Figure 4.9 Improvement of quality of care among nurses



Source: Field Survey Data, 2014

Figure 4.9 shows the means by improving the quality of care among nurses. The results show that majority of the respondents (78%) indicated the provision of needs of nurses as a means of improving the quality of nursing care. Giving of incentives was mentioned by 7% of the respondent as a means of improving the quality of care. Among the respondents 4% said that the quality of care could be upgraded by praising deserving nurse and providing all nursing needs. Seven percent of the respondents stated that the quality of care could be improved by praising deserving nurses, providing all their needs and giving them incentives.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.0 INTRODUCTION

Nursing care is perceived as the mainstay of health care because of the contribution the nurse makes to health care delivery, this study therefore examines the quality of nursing care from the patient`s view point. This chapter presents the findings of the study in a rationalized form and compared with findings of other studies. The discussion is aimed at answering the research questions posed in this study.

5.1 DISCUSSION

Demographic characteristics of respondents

Demographic information of respondents indicates that females (60%) were dominant among the patients who were sampled in this study, majority of them (37%) were aged 21-30years. Tertiary educational background patients were in majority represented with a percentage of 46% where as 18% had no educational background. Christians were also dominant (53%) in the distribution and majority (40%) of the patients were married.

In another question to determine the detection of quality of nursing care among patients, it was shown that 94% were able to detect quality nursing care. This could be linked to the fact that most of the respondents (46%) had tertiary education so they were well informed on what quality health care means. The educational background of patients clearly gave a positive relationship to the rating of quality of care. There is a strong point that patients with tertiary education considered that quality of nursing care as good since probably they knew the what quality of nursing care entailed. It could be predicted that as these areas of care were fulfilled to them they were given quality care. On the other had majority of the patients who had no formal education

13% perceived that quality of nursing care was poor. This could also be attributed to the fact that the roles of the nurse were not well known among these patients and they expected more than what the nurse had to contribute to the care. Lynn, et al. (2007) made an indication that to really define the quality of care; patients need to know the meaning of quality and the role of the nurse. In this study, it is noted that majority of the patients who had tertiary education might have been well informed on the role of the nurse and what quality care really entailed. They therefore appreciated the care rendered to them. In the study by Laar (2013) it was shown that a p-value of 0.001 occurred when the test for significance was run. This finding by Laar (2013) confirms the findings in this study regarding educational background and the quality of nursing care.

It was also found that majority of the patients who had ages 21-30 and 31-40 years (both groups recorded 29%) each admitted that the quality of nursing care was good. Patients who were older indicated that the quality of care was not good enough. This could be an indication that patients with chronic diseases such as disease that were linked to old age were not well handled in terms of nursing care. According to the patients aged 41years and above 15% out of 24% mentioned that the quality of care was poor. According to Laar (2013), a significant relationship occurs between age's ranges of patients and the quality of nursing care. This study therefore agrees with that his study.

Religious affiliation of patients upon being compared with the rating of quality of care indicated that Christians mostly accepted the nursing care rendered to them as compared to traditionalists who all (14%) indicated that the quality of nursing care was poor. Among the Christians, 46% out of 53% stated that quality of nursing care was good. The religious beliefs of patients might have affected their rating of quality of care as stated above.

Finally, gender distribution of patients pointed out that females perceived the quality of nursing to be good more than males. Fifty-three per cent out of 60% rated the quality of nursing care to be good as against 25% out of 40% of the males who indicated that they were not in agreement that the quality of nursing care was good. The difference in the results was significantly proven as not as a result of chance but rather it was due to the gender differences.

A study by Laar (2013) showed significance between gender and the quality of nursing care in, there is therefore a positive relationship between this study and that of Laar (2013).

Patients` description of quality of nursing care

Result of the study showed that majority (70%) of the patients mentioned that quality of care was attained by fulfilling all physical and psychological needs of the patient. However, some (16%) of the patients also mentioned that quality of nursing care was, rendering care to fulfil all the psychological needs of the patients. This finding is a good predictor that majority of the patients were knowledgeable of the meaning of quality of care in accordance with Jennings & Staggers (1999) and Lang & Mitchell (2004) as they stated quality of health care is noted to surround the provision of both physical and psychological or emotional needs of patient. There is therefore an affirmation of the findings of this study by delivery of Jennings & Staggers (1999) and Lang & Mitchell (2004) who specifically indicated that quality nursing care embroils assessment, planning, or the effectiveness and skill with which treatments and medications are delivered, communication, listening, kindness and responsiveness of their nurses. Since patients were more interested in communication, listening kindness and other qualities. In accordance with the findings of Laar (2013), it is noted that the quality of nursing care was not good since 48% indicated the nursing care was weak. However, the reverse was found in this study since majority

of the patients (70%) perceived the care rendered as quality. There is a contradiction in the findings of this study compared to that of Laar (2013).

Practices of nursing care that affect customer care

With regards to the practices of nurses, the patients mainly indicated that nurses were disrespectful (69%) and intolerance (73%) to the patients they worked on. It was also found that nurses referred to patients wrongly as indicated by 47% of the patients, whereas 46% of them were negligent of their duties. Absenteeism was one poor attitude of nurses that was mentioned by 84% of the patient who took part in the study. Finally carelessness of nurses in discharging their duties was reported among 54% of the patients. These responses given could be linked to the nurse not willing to give out all their possible best in the roles they play. It could also be related to lack of proper remuneration or acknowledging the work of nurses and giving incentives to boost their morale. According to Gordon (2005), negligence to duty is one poor nursing quality observed in nursing staff as is indicated in this study hence an affirmation in the findings.

Quality of nursing care among nurses

This study cannot be complete without a careful evaluation of quality of care rendered by nurses. In view of this, patients were asked to indicate their frequency at which they receive quality care. It was found that 11% of the patients received quality nursing care all the time whereas 83% of the patients received quality care sometimes. Four percent of the patients also indicated that they never received quality nursing care at the hospital. The distribution shows that quality of nursing care was not good enough but some respondents did received quality care sometimes. Larrabee (1995) and Lynn et al (1999) made mention of quality of nursing care as indicated in their

findings to be of high quality for nurses who integrated competence and skill, apt communication and teaching about disease condition.

The level of quality of care was further confirmed by a question on the frequency at which patients were victims of poor quality nursing practices. It was found that 81% of the patients were victims to poor nursing care sometimes whereas 9% were victims most of the time. To consolidate on the quality of nursing care transpiring at the hospital under study, patients were asked to rate the quality of nursing care received. The study revealed that more than half (57%) acknowledge the level of nursing care quality as good whereas 32% stated that it was poor. The high percentage of patients who indicated that the quality of nursing care was poor is a clear indicator that the quality of care was generally poor. Another area of hospital attendance and quality health care was the time patients spent waiting to be attended to by health personnel. In this study patients were asked on the time they spent before given attention and findings obtained reveals that patient did not wait for long since majority (48%) of them were attended to immediately they reported. The finding obtained on the quality of care suggests that majority of the patients came across nurses who were skilled and caring and were ready to educate them on their disease condition as indicated by Larrabee (1995) and Lynn et al (1999).

Factors affecting the quality of nursing care

The third research questions, 'which factors that work against quality of nursing care from the patient`s view' was answered first by a question on the existence of challenges nurses face in rendering quality nursing care. All the hundred patients admitted that the nursing staff faced challenges in performing their duties and also indicated that these challenges affected the quality of service they rendered to patients. This finding is captured in table 4.3

In an attempt to find possible solutions to problems that militate against quality of nursing care, patients were asked whether they could play a part in improving the quality of care, their contribution to the quality of care and general means by which the nursing quality of care can be improved. The study found out that majority (83%) of the patients agreed that patients had a role to play in improving the quality of nursing care at the hospital. However, it was noted that 8% of the patients mentioned that the patient had no part to play in improving the quality of nursing care. According to Radwin and Alster, (2002), Attree, (2001) patient involvement in the care rendered by nurses was mentioned as an integral part in delivering quality nursing care. This could be in the areas of giving vital information on the lifestyle of the patient or information on the disease. Specifically, patients outlined the means by which patients could aid improve the quality of nursing care. It was found in this study mainly that majority (23%) of the patients highlighted the provision of adequate information during assessment and care, adherence to treatment regimen and respect for health personnel were mentioned by 18% and 13% of the respondents respectively. Williams (1998) stresses on the importance of availability of needed resources and equipment for quality nursing care. In this study, the quality of nursing care was noted as hindered by a lack of nursing needs which is also stressed by the Health Sector Support Office (HSSO) of Ghana, 2001).

All these practices of patient are able to provide nurses with the needed information for between diagnosis and effective planning of care. The study also found that improving the quality of care could be achieved by incentives as mentioned by majority (78%) of the patients who took part in the study. Other possible solutions were acknowledging deserving nurses and making provision for all needed equipment and materials for effective nursing work. In the study by Locke and

Latham (2002) it is indicated that one means of improving nursing care was through motivation as was mentioned in this study hence an agreement in findings is established.

5.2 CONCLUSIONS

The study concludes based on the findings that;

Majority of the patients mentioned that quality of care was attained by fulfilling all physical and psychological needs of the patient which indicated that patient were aware of what quality of nursing care was. Attitude of nurses that affected the quality of nursing care were mostly, absenteeism, intolerance, disrespect, referring to patients wrongly and carelessness.

The quality of care as indicated by patient was rated good since more of the respondents had quality health care more of the time as compared to receiving poor quality care.

Patients reported short waiting time when they visited the hospital for health care which is a predictor of quality of health care.

Nurses were reported facing challenges in the discharge of their duties in the health facility and these challenges were noted to affect the quality of care they delivered.

Patients had their role to play in aiding nurses render quality care by cooperating with nurses in terms of giving information during physical assessment and treatment, showing respect and adhering to treatment regimen.

The health facility can aid nurses to render quality care by providing all the needed materials for nurses in their work.

Quality of care was achievable by giving nurses the needed incentives, motivation and encouragement to do their work better.

5.3 RECOMMENDATIONS

The study recommends that nurses should eliminate all forms of disrespect, intolerance, absenteeism, carelessness, negligence, lukewarm attitude and favouritism from their work.

Nurses are to use title of patient to identify them rather than referring to them by their bed numbers or their disease conditions.

The health facilities should combine efforts to provide all the needs of nurses to enhance the discharge of their duties.

Patients should also show a sense of respect for nurses and be willing to provide any needed support that is necessary for their effective treatment.

The nursing curriculum should be designed to educate nurses more on quality of nursing care and nursing ethics such that this education can translate into quality nursing care.

It is finally recommended that further studies should be conducted to find out whether patients have adequate knowledge on the services nurses render to be able to compare to the standard.

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APPENDIX

QUESTIONNAIRES

We are final year nursing students of Christian Service University College conducting a study on the **'Quality of Nursing Care At Komfo Anokye Teaching Hospital, Patient Perspective.** This questionnaire has been structured to elicit needed responses to enable the researcher complete the study which will be for academic purposes only. You are therefore encouraged to give your frank responses. You are also assured of utmost anonymity and privacy in the course of the data collection process.

Please tick in the spaces provided as ( ) or write in the dotted lines where appropriate.

Background Information

1. Gender

a) Male b) Female

2. Age Range

a) 21-30 ( ) b) 31 – 40 ( ) c) 41 – 50 ( ) d) 51-60 ( )

3. Education background

a. No formal education ( )
b. Basic education ( )
c. Secondary education ( )
d. Higher education ( )
e. Other ( )

4. What religion do you belong to?

a) Christian ( ) b) Moslem ( )
c) Traditionalist ( ) d) Other ( )

5. What is your marital status?

a) Single ( )
b) Married ( )
c) Separated ( )
d) Widow ( )
e) Living with partner ( )

6. Occupational Background

a) Housewife ( )
b) Teacher ( )
c) Farmer ( )
d) Trader ( )
e) Other ( )

7. What is the meaning of quality care?

a) Rendering care to cover all the physical needs of patient ( )
b) Rendering care to cover all the psychological needs of patients ( )
c) Fulfilling all physical and psychological needs of the patient ( )
d) Do not know. ( )
e) Other please specify…….

8. Do you receive quality care when you attend the hospital?

a) Yes ( )
b) No ( )
c) Cannot tell ( )

9. Are you able to detect when poor quality of care given?

a) Yes ( )
b) No ( )
c) Cannot tell. ( )

10. How do determine whether care given is quality?

……..

……..

……..

11. What are some of the practices of nurses that affect the quality of nursing care?

a) Showing disrespect ( )
b) Being intolerant ( )
c) Not being approachable ( )
d) Referring to patients wrongly eg. Using bed names or condition names to refer to patients
e) Other, please specify……..

12. Have you been a victim of these practices mentioned immediately above?

a) Yes ( )
b) No ( )

13. How would you rate the level of quality that exists the health facility you receive care?

a) Excellent ( )
b) Very good ( )
c) Good ( )
d) Poor ( )
e) Very poor ( )

14. How would you rate the length of time you spend on an average before being attended to by a health personnel?

a) More than an hour ( )
b) More than 30 minutes but not up to an hour ( )
c) Less than 30 minutes but more than 15 minutes ( )
d) Within 15 minutes ( )
e) Immediately ( )

15. Do you think nurses face challenges in discharging their duties?

a) Yes ( )

b) No ( )

16. Do these challenges affect the quality of your care rendered?

a) Yes ( )

b) No ( )

17. Please mention some of the problems you think nurses faces?

…….

……...

……....

18. Can patients also contribute to the quality of care rendered by health professionals?

a) Yes ( )

b) No ( )

c) Cannot tell ( )

19. How can patients contribute to quality of care?

a) By cooperating as much as possible ( )

b) By observing regulations at the health facility ( )

c) By respecting the health professionals ( )

d) Other, please specify……..

20. How can the quality of care rendered be improved among nurses?

a) By giving incentives to nurses ( )

b) By appraising deserving nurses ( )

c) By making provision of all nursing needs in giving care ( )

d) Other, please specify…….